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Redefining Child under the State Children's Health Insurance Program: Capable of Repetition, Yet Evading Results

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REDEFINING CHILD UNDER THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM: CAPABLE OF REPETITION, YET EVADING RESULTS

ELISABETH H. SPEROW*

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INTRODUCTION

Providing prenatal health care for working poor and immigrant women is a worthy goal, which the Bush Administration should strive to meet, but the Administration's recent regulation redefining "child" under its State Children's Health Insurance Program ("SCHIP")¹ to

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1. See State Children's Health Insurance Program, Eligibility for Prenatal Care and Other Health Services for Unborn Children, 67 Fed. Reg. 61,956 (Oct. 2, 2002) [hereinafter *Program*] (codified at 42 C.F.R. pt. 457) (expanding the definition of children covered under SCHIP to allow unborn children to be considered "targeted low-income child[ren]").

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include the unborn undermines the tenets of *Roe v. Wade*² without providing any tangible benefits to uninsured women and their unborn children. This Article examines the legal, political, and medical implications of the recent change announced by President George W. Bush and the Department of Health and Human Services (“HHS”) to expand its definition of child under SCHIP to begin at conception and continue until age nineteen.³ In addition, HHS announced that this coverage applies to all unborn children, regardless of the pregnant woman’s immigration status.⁴ This change may allow a court to find fertilized eggs, fetuses, and embryos entitled to the status of born children and thus the entire constitutional rights which accompany personhood without resulting in significant increases in prenatal care for pregnant women.⁵

Part I provides a brief background of the SCHIP program and its successes and failures throughout its first five years.⁶ Part II addresses the potential effects of the new definition of child on legal precedents and how it relates to the concept of child as defined by courts and legislatures in other areas of the law.⁷ Part III explains how the new definition is doomed to fail at providing prenatal care for uninsured women and their unborn children because of SCHIP’S lack of additional funding and also the conflict it creates between the woman and the unborn child.⁸ Part IV discusses the highly charged political climate in which the change was announced, while part V, proposes some alternative routes the Administration could have taken to actually provide prenatal care to uninsured poor and immigrant women without entering the quagmire of when life begins.⁹ Finally,

2. 410 U.S. 113, 162 (1973) (finding that unborn persons “represent only the potentiality of life”).

3. See generally Press Release, United States Department of Health and Human Services, HHS to Allow States to Provide SCHIP Coverage for Prenatal Care: Would Allow Use of Existing Resources to Expand Prenatal Care Immediately (Jan. 31, 2002) (justifying the decision to include the age of nineteen years as necessary to provide prenatal healthcare to women).

4. See *Program*, *supra* note 1, at 61,966 (stating that the exclusion of children from coverage based on immigrant status would be contrary to SCHIP’s purpose of providing care to children).

5. See Dawn Miller, *SCHIP Change Won’t Help State Expand Prenatal Coverage*, CHARLESTON GAZETTE, Sept. 28, 2002, at 2A (commenting on SCHIP’s lack of funding as the major impediment to expanding prenatal care). But see *Program*, *supra* note 1, at 61,963 (arguing that regulation will allow more women to obtain prenatal care).

6. See *infra* Part I.

7. See *infra* Part II.

8. See *infra* Part III.

9. See *infra* Part IV.

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the Article concludes that the decision to expand the definition of child to include the unborn is a bold step into the abortion rights controversy aimed at emboldening abortion rights opponents and attracting Hispanic voters in an election year, and also to serve as a step toward overturning *Roe v. Wade* without providing any substantial benefits to pregnant low income and immigrant women.¹⁰

I. THE SCHIP PROGRAM

In 1997, Congress created SCHIP as part of its Balanced Budget Act¹¹ in a bipartisan attempt to provide health insurance coverage for the approximately eleven million children whose families were unable to qualify for Medicare because their family's income was above the Federal Poverty Level yet were unable to afford private health insurance.¹² SCHIP was enacted in response to a disturbing increase in the number of uninsured children in families earning between 100% and 150% of the federal poverty level.¹³ The level of uninsured children was deemed a serious national concern, particularly for certain minority children.¹⁴ Early health care coverage for children is an important public policy goal for "it impacts their ability to learn, their ability to thrive, and their ability to become productive members of society."¹⁵ Thus, government officials proudly touted SCHIP as "a landmark opportunity to improve children's health."¹⁶

10. See *infra* Part V.

11. 42 U.S.C. §§ 1397aa-1397hh (subch. XXI) (1997) (proposing and defining the State Children's Health Insurance Program).

12. See *id.* at § 1397aa (declaring that the goal of this section is to allow states to provide for health assistance coverage for "uninsured, low-income children"); see also Lisa J. Andeen, Note, *Improving Health Care for Uninsured Children in the Wake of the State Children's Health Insurance Program (SCHIP)*, 27 J. LEGIS. 299, 303-04 (2001) (noting that more than one-half of uninsured children come from families whose incomes were above the federal poverty level); *New Data: Nearly 5 Million Children in America are Needlessly Uninsured: HHS Sec. Thompson Helps Kick Off Enrollment Drive*, U.S. NEWswire, Aug. 1, 2002, available at 2002 WL 22070112 [hereinafter *New Data*] (quoting Senators Orrin Hatch and Edward Kennedy regarding the importance of SCHIP).

13. See MARGO ROSENBACH ET AL., IMPLEMENTATION OF THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM: MOMENTUM IS INCREASING AFTER A MODEST START, FIRST ANNUAL REPORT 8-9 (2001) (calculating that 27.8% of children between 100% and 150% of the poverty level were uninsured between 1993 and 1997 before SCHIP was implemented).

14. See *New Data*, *supra* note 12 (reporting that African-American and Latino children are significantly affected by the lack of insurance).

15. *Extension of Remarks at the Introduction of the MediKids Health Insurance Act of 2000*, 106th Cong. (2000) (statement of Congressman Pete Stark), available at <http://www.house.gov/stark/documents/106th/medikidssumm.html>.

16. *Administrator Health Care Financing Administration on the Children's Health Insurance Program Before the Senate Finance Comm.*, 106th Cong. (1999) [hereinafter *Senate Finance*] (testimony of Nancy-Ann Deparle), available at

Under SCHIP, the federal government gives a portion or full coverage to states to provide healthcare coverage to uninsured children who are: 1) not eligible for Medicare, 2) under age nineteen, and 3) in families where household income is at or below 200% of the Federal Poverty Level or a percentage not higher than fifty points above the state Medicaid eligibility requirements.¹⁷ Family coverage, including prenatal care, was also available to parents meeting the income requirements if the states sought and were granted a waiver from the Secretary of Health and Human Services.¹⁸ The statute outlines that the states may provide SCHIP coverage through an expanded Medicaid program, a state created health insurance program, or “a combination of both.”¹⁹ Currently, every state and territory has a SCHIP plan with twenty-one states operating Medicaid expansion programs, sixteen states conducting separate SCHIP programs, and nineteen states operating combination plans.²⁰

Experts credit SCHIP with turning the trend of increasing rates of uninsured children around and providing much needed health insurance to previously uninsured children.²¹ Since its enactment, SCHIP has provided insurance coverage for millions of children.²² It began slowly with states covering 982,000 children in 1998, but quickly evolved to covering nearly 4.6 million children under SCHIP at some point during 2001.²³ While its rapid expansion created

<http://www.cms.hhs.gov/media/press/testimony.asp?Counter=565>.

17. See 42 U.S.C. § 1397jj, (subch. XXI) (1997) (defining the requirements for eligibility for “targeted low-income children” under SCHIP); see also THE 2002 HHS POVERTY GUIDELINES: ONE VERSION OF THE [U.S.] FEDERAL POVERTY MEASURE (establishing the 2002 Federal Poverty Level for a family of four as \$36,300), available at <http://www.aspe.hhs.gov/poverty/02poverty.htm> (last updated Sept. 11, 2003).

18. See 42 U.S.C. § 1315(a)(1) (subch. XI) (1997) (outlining the circumstances in which waivers may be granted).

19. *Id.* at § 1397aa(a)(1)-(2).

20. JENNIFER M. RYAN, SCHIP TURNS FIVE: TAKING STOCK, MOVING AHEAD 2 (2002), available at http://www.njpf.org/pdfs_ib_IB781_SCHIP5_8-15-02.pdf; see also CTRS. FOR MEDICARE AND MEDICAID SERVS., STATE CHILD HEALTH INSURANCE PROGRAM PLAN ACTIVITY MAP, at <http://www.cms.hhs.gov/schip/chip-map.asp> (last visited Aug. 13, 2002).

21. See Robert J. Mills, *Health Insurance Coverage: 2001: Consumer Income* (Sept. 2002) (noting that the actual number of uninsured children below the age of eighteen did not change between 2000 and 2001), available at <http://www.census.gov/prod/2002pubs/p60-220.pdf>.

22. See RYAN, *supra* note 20, at 3 (illustrating the strong growth trend in the number of children enrolled in SCHIP).

23. See *Senate Finance*, *supra* note 16 (describing the upward trend in SCHIP’s enrollment); see also CTRS. FOR MEDICARE AND MEDICAID SERVS., THE STATE CHILDREN’S HEALTH INSURANCE PROGRAM ANNUAL ENROLLMENT REPORT: FISCAL YEAR 2001: OCTOBER 1, 2000-SEPTEMBER 30, 2001 (highlighting a 38% increase in the number of children enrolled in SCHIP during fiscal year 2001), available at <http://www.cms.hhs.gov/schip/schip01.pdf>.

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health care coverage for many, a 2002 study showed that approximately five million children who were eligible for SCHIP coverage were still not enrolled.²⁴

Despite its success in providing health care coverage to the children of the working poor and the need to continue to expand the program to the millions of eligible children still not enrolled, SCHIP funding and thus coverage is scheduled to decline in the future.²⁵ When Congress enacted SCHIP, it provided \$4.3 billion for the years 1998-2001, but as part of the budget balancing act, Congress decreased funding for the following years to \$3.15 billion.²⁶ This decrease in funding comes at a time when many states are also facing the worst budget shortfalls since World War II and having to limit their own funding of low income health programs such as Medicaid.²⁷ Currently, the states contribute about 30% of the SCHIP funding and the federal government contributes the remaining 70%.²⁸ The SCHIP dip and state budget woes are causing many states to cut back on their SCHIP programs and creating crisis situations in other areas.²⁹

The Center on Budget and Policy Priorities notes that due to the 26% reduction in federal SCHIP monies and increasing SCHIP enrollments, twenty states will be unable to maintain their current enrollments.³⁰ The Office of Management and Budget has estimated that as many as 900,000 children will no longer be covered due to the

24. See *New Data*, *supra* note 12 (noting that the enrollment of children in SCHIP and Medicaid for health insurance coverage would decrease by one-half the number of uninsured children in the U.S.).

25. See RYAN, *supra* note 20, at 4 (documenting the 26% decrease in federal funding available to states between 2002 and 2004).

26. See *id.* (raising the possibility that the SCHIP dip could result in approximately one million children losing their SCHIP coverage).

27. Robert Pear, *States Are Facing Big Fiscal Crisis*, *Governor's Report*, N.Y. TIMES, Nov. 26, 2002, at A1 (reporting that unclaimed federal funds allocated to the states were reverted back to the Treasury Department, resulting in a \$1.2 billion loss to states for health insurance coverage for children covered by SCHIP).

28. See Press Release, United States Department of Health and Human Services, States May Provide SCHIP Coverage For Prenatal Care, New Rule to Expand Health Care Coverage for Babies, Mothers (Sept. 27, 2002) [hereinafter *Press Release*] (referring to SCHIP's \$40 billion budget), available at <http://www.hhs.gov/news/press/2002pres/20020927a.html>.

29. See *infra* section IV(A).

30. See EDWIN PARK ET AL., CTR. ON BUDGET AND POLICY PRIORITIES, OMB ESTIMATES THAT 900,000 CHILDREN WILL LOSE HEALTH INSURANCE FUNDING DUE TO REDUCTIONS IN FEDERAL SCHIP FUNDING: CONGRESS COULD EXTEND THE AVAILABILITY OF EXPIRING SCHIP FUNDS AND UNDO THE REDUCTION IN SCHIP FUNDING LEVELS TO AVERT A LARGE ENROLLMENT DECLINE 4-7 (2002) (drawing attention to the likelihood of future state SCHIP spending exceeding state and federal funding), available at <http://www.cbpp.org/7-15-02health.pdf>.

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decreased funding.³¹ For example, Oklahoma, faced by severe budget shortfalls, has greatly reduced the number of SCHIP eligible children in the state by changing the eligibility requirements from as much as 185% above the federal poverty level to 115%.³²

Another \$1.6 billion³³ to \$2.8 billion in unspent federal funds reverted back to the United States Treasury at the end of 2003.³⁴ This reversion occurred because SCHIP requires a state to use its allotment of federal funding within three years and, if any money remains unused, the funds are reallocated to states that already used their allotments.³⁵ Any money left over after one more year returns to the Treasury.³⁶ Texas, for example, relinquished more than \$285 million to other states because it could not afford to contribute its part of the funding.³⁷ In an attempt to alleviate the funding shortfall, Congress has introduced several bills over the last few years to provide prenatal and postpartum services to women and children, including immigrant children and optional care, however, none of the measures has passed.³⁸ Thus, the Bush administration's decision to expand SCHIP coverage to unborn children increases the number of eligible

31. See *id.* at 11 (arguing that returning expired funds to the states and providing full federal funding will enable many states to avoid this drop in SCHIP enrollment).

32. See IRIS J. LAW, CTR. ON BUDGET AND POLICY PRIORITIES, STATE FISCAL CONDITIONS CONTINUE TO DETERIORATE, FEDERAL ASSISTANCE BADLY NEEDED 2 (2002) (stating that, because of the reduction in SCHIP eligible children, "these changes nearly eliminate Oklahoma's SCHIP program"), available at <http://www.cbpp.org/9-20-02sfp.pdf>.

33. See Amy Goldstein, *Children's Health Plan at Center of Dispute, Rules May Forces States to Drop Enrollees*, WASH. POST, Oct. 24, 2002, at A33 (addressing the fact that this is part of a general funding problem with SCHIP, as states began their SCHIP programs with a significant abundance of funding and are now facing budget deficits because of the rapid increase in the number of enrollees in their programs).

34. See ROSENBAUGH ET AL., *supra* note 13, at 5 (finding that these much needed funds were unused due to several factors, generally revolving around issues states had in implementing their programs).

35. See *id.* (noting another problem with SCHIP's funding structure, which has created SCHIP's budget shortfall).

36. See *id.* (explaining the reason for the billion dollar return of funds to the Treasury Department).

37. See Karen Masterson, *Texas Loses Millions in Health Care Funds: Other States to Receive Unused Money*, [corrected Oct. 17, 2002], HOUSTON CHRON., Oct. 16, 2002, at A1 (finding that because Texas did not use all of its funds, its portion of SCHIP funding between 2002 and 2004 diminished by \$200 million).

38. See Start Healthy, Stay Healthy Act of 2003, S. 1033, 108th Cong. (2003) (providing states with the opportunity to increase coverage of "certain women" and children); see also Immigrant Children's Health Improvement Act of 2001, S. 582, 107th Cong. (2001) (stating as its primary purpose the coverage of "certain legal immigrants," including pregnant women and children); Mothers and Newborns Health Insurance Act of 2001, H.R. 2610, 107th Cong. (2001) (advocating "coverage of pregnancy related assistance for targeted low-income pregnant women," and "automatic enrollment of children" whose mothers receive such assistance).

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recipients under SCHIP at a time when there is not enough state or federal funding to cover the currently eligible recipients.³⁹

II. REDEFINING CHILD

A. *The New Regulation*

On September 27, 2002, less than six weeks prior to the pivotal November 6, 2002 election where Republicans retained control of the House and regained control of the Senate, HHS Secretary Tommy G. Thompson first announced the new SCHIP definition of child to include “an individual under the age of 19 including the period from conception to birth.”⁴⁰ Conception is typically deemed the moment when a male reproductive cell, the sperm, unites with the female reproductive cell, the egg.⁴¹ Once the fertilized cell divides, it is called an embryo until the eighth week when it is called a fetus.⁴² Thus, this new definition characterizes fertilized eggs, embryos, and fetuses as children.⁴³ The new rule was published in the Federal Register on October 2, 2002 and came into effect on November 1, 2002.⁴⁴

While announcing the change, Thompson stated that “Prenatal care is one of the most important investments that we can make to ensure the long-term good health of our children and their mothers.”⁴⁵ Some hailed the change as intended to assist pregnant low-income women⁴⁶ while others saw it as a thinly veiled attempt to begin building a legal case to overturn *Roe v. Wade*.⁴⁷

39. See Miller, *supra* note 5, at 2A (noting that if the state must enroll more children, it will require additional funding).

40. See *Press Release*, *supra* note 28, at <http://hhs.gov.news.press.2002pres/20020927a.html>.

41. J.E. SCHMIDT, ATTORNEY'S DICTIONARY OF MEDICINE AND WORD FINDER Z-17, Vol. 6, (2000).

42. See *id.* at E-67 and F-62.

43. See *Press Release*, *supra* note 28, at (incorporating conception in the definition of childhood).

44. See *Program*, *supra* note 1, at 61,956 (explaining the reason for expanding the definition of child).

45. See *Press Release*, *supra* note 28.

46. See Vicki Kemper, *The Nation White House Issues Regulation That Defines Fetuses as Children*, L.A. TIMES, Sept. 28, 2002, at A23 (mentioning the National Right to Life Committees' support for the new rule).

47. See Joan Ryan, *Pre-emptive Strike on Roe vs. Wade*, THE S.F. CHRON., Oct. 1, 2002, at A17; see also Pear, *supra* note 27, at A13 (mentioning *Roe* and the disapproval of Planned Parenthood regarding the regulation).

The controversy is fueled because rather than simply extending the SCHIP program to provide prenatal care to eligible women, this regulation actually takes on the very definition of child, and as such the much debated question of when life begins and what rights the unborn possesses.⁴⁸ Furthermore, by providing care for the fetus as a separate entity from the pregnant woman, the new definition gives individual status and rights to the unborn child, which brings the unborn child closer to the status of a person. If the unborn are persons, then they should be entitled to the full panoply of legal rights guaranteed by the Constitution. This goal of slowly gaining personhood for the unborn as an attack on abortion rights, as outlined by *Roe*, was acknowledged by Samuel B. Casey, Executive Director of the anti-abortion group of the Christian Legal Society, when he stated: "In as many areas as we can, we want to put on the books that the embryo is a person. That sets the stage for a jurist to acknowledge that human beings at any stage of development deserve protection, even protection that would trump a woman's interest in terminating a pregnancy."⁴⁹ This tactic is clearly consistent with Supreme Court statements regarding what it will take for the Court to go beyond the doctrine of *stare decisis* and overrule *Roe*.⁵⁰

B. Judicial Treatment of the Unborn

For centuries, judges and legislators struggled to define what rights the unborn possess. This struggle has led to variations in the legal status of the unborn from "jurisdiction to jurisdiction, from context to context."⁵¹ Courts and legislatures have considered such weighty issues as whether the mother and unborn child are one or two entities, and whether standing to sue should be based on whether the injury occurred before or after viability or only when followed by a live birth.

Originally, under the common law, unborn children "were not given any rights until birth."⁵² In 1884, Justice Oliver Wendell

48. See Erin P. George, Comment, *The Stem Cell Debate: The Legal, Political and Ethical Issues Surrounding Federal Funding of Scientific Research on Human Embryos*, 12 ALB. L.J. SCI. & TECH. 747, 748 (2002) (noting that "people have been grappling with the legal, ethical and moral issues surrounding human embryos since early English common law").

49. Aaron Zitner, *Abortion Foes Attack Rose on New Research*, L.A. TIMES, Jan. 19, 2003, at A1.

50. See *infra* section III(B) and accompanying notes.

51. BONNIE STEINBECK, *LIFE BEFORE BIRTH: THE MORAL AND LEGAL STATUS OF EMBRYOS AND FETUSES* 4 (1992).

52. See George, *supra* note 48 at 759.

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Holmes relied on the lack of common law precedent, the remoteness of the injury to a fetus, and the fact that the unborn child was still a part of its mother to hold that there was no duty of care owed to an unborn child for wrongful death.⁵³ Laws were later changed to allow unborn children to have some rights, based on injuries or bequests made while they were *in utero* and were subsequently born alive. However, they still did not possess the right to an action in civil court.⁵⁴

Today, courts in over thirty-six states and the District of Columbia allow wrongful death actions for stillborn children where the injuries occur after viability.⁵⁵ Ten state courts allow recovery in wrongful death actions where there was a live birth.⁵⁶

Two of these states denied a cause of action under the wrongful death statutes to the representative of the unborn child, but gave the parents a right to recover for the child's wrongful death.⁵⁷

In fact, all states, which have considered the issue, and the federal government, allow recovery in tort for prenatal injuries if the injured is subsequently "born alive."⁵⁸ In property law, courts have also been willing to recognize bequests made to unborn children if the children are subsequently born alive.⁵⁹

In criminal law, courts have looked at whether the victim was born alive in determining whether the victim sustained actionable injuries.⁶⁰ More than twenty states recognize some form of criminal

53. Dietrich v. Inhabitants of Northampton, 138 Mass. 14, 15-17 (1884).

54. See George, *supra* note 48, at 760.

55. See, e.g., CAL. CIV. CODE § 29 (West 1982); Endo Laboratories, Inc. v. Hartford Ins. Group, 747 F.2d 1264 (9th Cir. 1984) (applying California law); Walker by Pizano v. Mart, 790 P.2d 735, 739 (Ariz. Ct. App. 1990) (dictum in wrongful life action); Keleman v. Superior Court, 186 Cal. Rptr. 566, 568 (Ct. App. 1982) (prenatal injury); Paul Benjamin Linton, *Planned Parenthood v. Casey: The flight From Reason In the Supreme Court*, 13 ST. LOUIS U. PUB. L. REV. 15, 49 (1993) (citing *Wolfe v. Isbell*, 280 So. 2d 758, 761 (Ala. 1973) (express statement in context of wrongful death action)).

56. See Stokes v. Liberty Mut. Ins. Co., 213 So. 2d 695 (Fla. 1968); Stern v. Miller, 348 So. 2d 303 (Fla. 1977); Hernandez v. Garwood, 390 So. 2d 357 (Fla. 1980); Simon v. United States, 438 F. Supp. 759, 761 (S.D. Fla. 1977) (applying Florida law); Linton, *supra* note 55 at 49 (citing *Justus v. Atchison*, 565 P.2d 122 (Cal. 1977)).

57. See Weild v. Moes, 311 N.W.2d 259 (Iowa 1981) (by court rule); Giardina v. Bennett, 545 A.2d 139 (N.J. 1988) (common law).

58. See Michael Holzapfel, Comment, *The Right to Live: The Right to Choose, and the Unborn Victims of Violence Act*, 18 J. CONTEMP. HEALTH L. & POL'Y 431, 447 (2002); see also United States v. Spencer, 839 F.2d 1341, 1343 (9th Cir. 1988).

59. See, e.g., *In re Will of Holthausen*, 26 N.Y.S.2d 140, 143 (1941); see also Cowles v. Cowles, 13 A. 414, 417 (Conn. 1887).

60. See Holzapfel, *supra* note 58, at 433-34.

liability for injuries sustained in the womb.⁶¹ For example, if a child, born alive, dies from injuries sustained while in the womb, some states allow homicide actions.⁶² However, absent an expression of legislative intent to do otherwise, thirty-three state courts have held that an unborn child is not a “person,” “human being,” or an “other” under their states’ murder, vehicular homicide, and manslaughter statutes.⁶³ Courts have been willing to recognize legal rights for injuries and bequests made to the unborn, but such rights are typically contingent upon the unborn child successfully entering this world. No courts claimed to base these rights on the status of the unborn as a person in their own right prior to birth.

In addition to the born-alive rule, courts also rely on the issue of viability in determining standing to sue in civil suits on behalf of the unborn.⁶⁴ Courts have defined viability as the time when there is “a reasonable likelihood of the fetus’ sustained survival outside the womb, with or without artificial support.”⁶⁵ Fetuses typically reach viability between the twenty-fourth and twenty-eighth week of gestation.⁶⁶ The *Bonbrest v. Katz* opinion in 1946, was the first time a federal court held that a fetus was a separate entity from the pregnant woman, and should have standing to sue in its own right.⁶⁷ *Bonbrest* held that at viability the fetus has all the characteristics of a human being and thus should be entitled to the full panoply of civil rights.⁶⁸ Thus, the evolving law provides fetuses with property rights, wrongful death claims, the protection of criminal laws, and the right to sue in civil courts if they were born alive or reached the point of viability.⁶⁹ In 1973, however, the Supreme Court decided what was to be the benchmark for all laws and cases to come involving the unborn in the abortion case of *Roe vs. Wade*.⁷⁰

61. See *id.*

62. See Sandra L. Smith, Note, *Fetal Homicide: Woman or Fetus as Victim? A Survey of Current State Approaches and Recommendations for Further State Applications*, 41 WM. & MARY L. REV. 1845, 1851 (2000).

63. See Linton, *supra* note 55, at 58 (citing *Vo v. Sup. Ct.*, 836 P.2d 408, 416 (Ariz. Ct. App. 1992), and the cases cited therein). Recently, one of the cases cited in *Vo* in support of the born-alive rule, *State v. Harbert*, 758 P.2d 826 (Okla. Crim. App. 1988) was overruled by the Oklahoma Court of Criminal Appeals in *Hughes v. State*, 868 P.2d 730 (Okla. Crim. App. 1994), thus reducing the number of jurisdictions that follow the born-alive rule to thirty-two. *Id.*

64. See George, *supra* note 48, at 761.

65. *Colautti v. Franklin*, 439 U.S. 379, 388 (1979).

66. *Roe v. Wade*, 410 U.S. 113, 160 (1973).

67. 65 F. Supp. 138, 140 (D.D.C. 1946).

68. *Id.* at 141.

69. See George, *supra* note 48, at 761.

70. 410 U.S. 113 (1973).

In *Roe*, the Supreme Court noted the disagreement among theologians, philosophers, and doctors regarding the point at which life begins,⁷¹ and held that, although the state has an interest in protecting the potential life a fetus represents in the third trimester of pregnancy, a fetus is not a person entitled to constitutional protections.⁷² In fact, the Court noted that if a fetus is a person then the appellant's case "collapses."⁷³ The *Roe* decision developed the trimester approach by holding that in the first two trimesters, the woman's right to privacy outweighs the state's interest in the potential life the unborn child represents.⁷⁴ In the third trimester, however, states can regulate or prohibit abortion except in cases where the woman's life is in danger, because the Court found that the state's interest in the potential life is very strong, but not stronger than the existing life of the mother.⁷⁵ Thus, the interest of the life in being, the pregnant woman, is always paramount to the potential life of the unborn child.

Nearly two decades later, in *Planned Parenthood v. Casey*, a more conservative Court weakened the *Roe* ruling by substituting an "undue burden test" for the trimester approach established in *Roe*, but still did not claim that a fetus is a child or a person entitled to constitutional protection.⁷⁶ On the contrary, the majority opinion underlined the view that the unborn are not legally deemed persons until after birth, when it noted that *Roe* clearly speaks to the state's interest in "potential" life.⁷⁷ The Court specifically relied on the doctrine of *stare decisis*, the need to follow and respect precedent, in not overruling *Roe* despite the anticipation that the Court would use the opportunity presented in *Casey* to overturn *Roe*.⁷⁸ However, the Court in *Casey* noted that certain circumstances, including "whether facts have so changed, or come to be seen so differently, as to have robbed the old rule of significant application or justification" would warrant the overruling of prior cases.⁷⁹ At that time, the Court did

71. See *id.* at 156 (holding that the judiciary is also not in a position to decide when life begins).

72. See *id.* at 158-59.

73. See *id.* at 156-57.

74. See *id.* at 162-65 (allowing the state, during the second trimester, to regulate abortion procedures that promote maternal health).

75. See *id.* at 162-65 (finding that a woman's right to privacy is not absolute).

76. 505 U.S. 833, 873-74 (1992) (concluding that the trimester framework was not part of *Roe*'s essential holding).

77. *Id.* at 871.

78. See *id.* at 853 (citing also to a woman's "individual liberty" to uphold the central holding of *Roe*).

79. *Id.* at 854-55.

not find such a determinative change in facts to exist.⁸⁰ Thus, in order to justify overruling *Roe*, abortion opponents would need to show a change in facts meriting overturning the Court's previous decision.

In 1975, the Supreme Court in *Burns v. Alcala*,⁸¹ reinforced the precedent that the unborn are not children when it used a plain meaning approach and held that the term "dependent child" as used in the Social Security Act⁸² does not include unborn children.⁸³ Thus, while courts have afforded the unborn various levels of rights and protections in the areas of criminal law, property law, constitutional law, and tort law, these rights have been based on the potential life the unborn represents or subsequently achieves, and not by elevating the unborn to the same status as living children.⁸⁴ At most, the Supreme Court recognizes that states have an interest in the potential life of a fetus, but no such protected interest has been provided for a fertilized egg or an embryo. If the Bush Administration simply wanted to extend SCHIP benefits to the unborn without making a political statement, it could have extended coverage to fetuses and embryos rather than redefining "child."

C. Legislative Treatment of the Unborn

State and federal legislators have also grappled with what rights to afford the unborn. Their struggles are not reflected by the lack of a comprehensive treatment of the unborn, but rather the varying recognition of rights on a state-by-state, area-by-area, basis.⁸⁵ Under traditional tort law, neither the fetus nor its family could maintain a cause of action for injuries suffered *in utero*.⁸⁶ Today, however, a majority of states have statutes that include children injured *in utero* as "persons" for purposes of their wrongful death statutes.⁸⁷ In

80. See *id.* at 860 (determining that despite some factual changes since *Roe*, such as an earlier point of viability due to medical advances, the changes have no bearing on the validity of the central holding of *Roe*).

81. 420 U.S. 575, 578 (1975).

82. 42 U.S.C. § 602 (West 2003).

83. 420 U.S. at 578.

84. See Linton, *supra* note 55, at 64 (noting that courts have used *Roe* to reject civil rights claims of the unborn under 42 U.S.C. §1983).

85. See generally Kayhan Parsi, *Metaphorical Imagination: The Moral and Legal Status of Fetuses and Embryos*, 4 DEPAUL J. HEALTH CARE L. 703 (1999) (discussing the process of various state and federal legislators in granting rights to unborn children).

86. See, e.g., *Justus v. Atchison*, 565 P.2d 122, 131 (Cal. 1977) (denying tort recovery of stillborn fetus for wrongful death).

87. Mamta K. Shah, *Inconsistencies in the Legal Status of an Unborn Child*:

addition, fourteen states recognize unborn children as victims under their homicide laws throughout the gestation period,⁸⁸ and one-third of the states have statutes, which make it a homicide to kill an unborn child regardless of the stage of pregnancy.⁸⁹ Other states, such as Arkansas, have redefined “person” under their homicide laws to include a fetus beyond twelve weeks of conception,⁹⁰ and some states, such as Louisiana, have gone so far as to recognize life as beginning at conception.⁹¹ States have also attempted to use tort law to restrict abortion rights by prohibiting claims for wrongful birth actions.⁹² Thus, treatment of the unborn by the state legislatures ranges from recognizing conception as the beginning of life to providing limited rights to the unborn.

The United States Congress has addressed the treatment of the unborn. Congress has prohibited federal funding for research involving non-viable fetuses or fetuses whose viability is not yet ascertained, unless the research will enhance the health or well-being of the fetus.⁹³ Recently, the House of Representatives debated the “Unborn Victims of Violence Act of 2004”, House Bill 1997, which it passed on February 26, 2004.⁹⁴ The Senate, which had failed to vote on the Bill twice before when introduced in previous years, also passed the Bill on March 25, 2004.⁹⁵ The law, dubbed “Laci and Conner’s Law,”⁹⁶ creates a separate federal crime for any injury or death caused to an unborn child by a third party while committing a

Recognition of a Fetus as Potential Life, 29 HOFSTRA L. REV. 931, 939 (2001).

88. These states include: Arizona (ARIZ. REV. STAT. ANN. §13-11-03 (West 1989)), Idaho (IDAHO CODE §18-4001(2002)), and Illinois (ILL. ANN. STAT. CH. 38 ¶9-1.2, ¶9-2.1, ¶9-3.2 (Smith-Hurd 2003)).

89. See Linton, *supra* note 55, at 60.

90. See, e.g., ARK. CODE ANN. § 5-1-102(13)(B)(i)(a)(b) (2003).

91. See LA. CIV. CODE ANN. art. 26 (West 1999).

92. See generally A.J. Stone, III, Article, *Tort Law as an End Run Around Abortion Rights After Planned Parenthood v. Casey*, 8 AM. U. J. GENDER, SOC. POL’Y & L. 471 (2000) (discussing two states’ legislation prohibiting wrongful birth claims).

93. 42 U.S.C. § 289g (2003).

94. H.R. 1997, 108th Cong., 2d Sess. (2004). The House passed this bill twice previously, in 1999 and 2001. See H.R. 503, 107th Cong., 1st Sess. (2001). However, the Senate never acted on the 1999 and 2001 bills. Sheryl Gay Stolberg, *Washington Talk: From CNN to Congress, Legislation by Anecdote*, N.Y. TIMES, May 8, 2003, at A26.

95. *Senate Passes Unborn Victims Bill*, FOX NEWS CHANNEL, March 26, 2004, (reporting that the Senate passed the identical bill that the House passed), available at <http://www.foxnews.com/story/0,2933,115189,00.html>.

96. See H.R. 1997 (noting the short title of the Bill); see also *Senate Passes Unborn Victims Bill*, *supra* note 95 (explaining the Bill was named after Laci Peterson, a California woman who was murdered and her unborn son, who was to be named Conner).

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federal offense against the pregnant woman.⁹⁷ This bill, like other “feticide” laws, was intended to punish those who cause great harm or death to unborn children.⁹⁸ Importantly, this law grants the unborn child the same status as living children by making it a separate offense for harm to the child in utero.⁹⁹

Until the recent passage of the Unborn Victims of Violence Act of 2004, legal and legislative precedent is clear that any protections or rights the unborn have are predicated on their status as potential life and not as existing children.¹⁰⁰ HHS’s decision to include the unborn as children is a bold step into the much debated question of when life begins, and may very well be one of a series of calculated steps geared to changing the way our government, our country, and our courts consider and treat the unborn. The Court in *Roe* specifically referenced the lack of agreement among theologians, philosophers and doctors regarding when life begins in devising their trimester approach. In fact, the Court specifically noted that if the fetus is a person, the case would have been decided differently.¹⁰¹

Thus, HHS’s changing the definition of child, in the medical insurance arena no less, to include the unborn could be just the type of evidence the *Casey* Court indicated it would need to find; “a change in facts;” warranting the decision that life begins at conception and therefore justifying the overturning of *Roe*.

III. WHY THE NEW DEFINITION FAILS TO ACHIEVE THE STATED GOALS

In addition to entering the controversial debate regarding when life begins, the expansion of SCHIP coverage without providing additional funding is doomed to fail for economic and practical

97. See Unborn Victims of Violence Act of 2004, Pub. L. No. 108-212, § 1841(a)(1), 118 Stat. 568 (2004) (signed into law by President Bush on April 1, 2004).

98. See 150 CONG. REC. S3125 (daily ed. Mar. 25, 2004) (statement of Sen. DeWine) (stating that the Bill is about “simple justice” by “recognize[ing] when someone attacks and harms a mother and her unborn child that attack does in fact result in two separate victims: the mother and her child.”).

99. See Unborn Victims of Violence Act of 2004 § 1841(a)(1) .

100. Critics of the Unborn Victims of Violence Act note that this law could have serious implications on women’s rights. Senator Feinstein of California, who authored an amendment that was defeated keeping an attack on a pregnant woman a single-victim offense, stated, “If this result is incorporated, it will be the first step in removing a woman’s right to choice.” *Senate Passes Unborn Victims Bill*, *supra* note 95. But see Unborn Victims of Violence Act of 2004 § 1841(c)(1)-(2) (expressly stating that the provisions of the law do not apply to abortion by consent or to any medical treatment to the pregnant woman or her unborn child).

101. See *Roe v. Wade*, 410 U.S. 113, 156-57 (1973) (noting that considering the fetus as a person would defeat *Roe*’s claim, as the fetus’ life would then be protected by the Fourteenth Amendment).

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reasons. The bleak economic situation, which is facing the federal SCHIP funding and the state budgets, in combination with SCHIP's awkward configuration pitting the interests of the women against their unborn children, creates a bind for states seeking to expand prenatal care.

*A. Lack of Funding Will Prevent Meaningful Expansion of SCHIP
Benefits to Include Unborn Children*

As discussed in Section II, the expansion of the definition of "child" to cover the unborn comes at a time when, due to economic woes, almost every state is in "fiscal crisis."¹⁰² In fact, the National Governor's Association stated that "state budgets are in their worst shape since WWII."¹⁰³ Under this crisis situation, many states must restrict their current SCHIP coverage.¹⁰⁴ Thus, even if the intent of the change was to increase the number of people eligible for coverage under SCHIP, due to state budget shortfalls and federal reductions in matching funds, it is unlikely that many states will actually be able to expand their coverage to include prenatal care. Sharon Carte, director of West Virginia's SCHIP program, noted that the new regulation will not help cover any pregnant women in West Virginia because the state's spending is already stretched as far as it can go trying to cover the previously eligible children.¹⁰⁵

Representatives of the SCHIP programs in New Hampshire, Vermont, Connecticut, and Massachusetts, share Carte's belief that due to tight constraints on the state budgets this change will not increase coverage.¹⁰⁶ Lori Real, the Medicaid director in New Hampshire's Department of Health and Human Services, pointed out that states would need to come up with about 35% of their own funds to expand their SCHIP coverage to include unborn children, something they cannot do under current budget constraints.¹⁰⁷ Some states, such as Texas, are already facing a funding gap in SCHIP

102. Robert Tanner, *Republican Governors Lament Lag in Security: Needs are Pressing, but Funds Limited*, SAN DIEGO UNION-TRIB., Nov. 24, 2002, at A11.

103. Eun-Kyung Kim, *States Face Bleakest Budgets in Decades; Many Legislatures are Turning to Tax Increases to Replenish Depleted Coeffers*, ORLANDO SENTINEL, Nov. 26, 2002, at A4.

104. Oklahoma, facing severe budget shortfalls, has greatly reduced the number of SCHIP eligible children in the state by changing the eligibility requirements from 185% above the federal poverty level to 115%. See LAW, *supra* note 32, at 2.

105. See Miller, *supra* note 5, at P2A (noting that the state will have to use unused funds from previous years to meet its coverage needs for 20,000 enrolled children).

106. Jim Geraghty, *State Health Care Providers Doubt Big Changes From Bush Prenatal Care Proposal*, States News Service, October 2, 2002.

107. See *id.*

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coverage in the tens of millions of dollars just trying to cover the previously eligible children.¹⁰⁸ Citing budget deficits, ex-California Governor Gray Davis vetoed a \$50 million item in the 2003 California state budget to extend California's SCHIP coverage to 300,000 low-income parents.¹⁰⁹

Other states noted that this change in the definition of "child" is unlikely to increase coverage in their states because they already had programs in place to provide prenatal care.¹¹⁰ Thus, by not creating any new funding for SCHIP, this change creates the potential for new members to a program that is already at the breaking point.

*B. HHS's Change in its Regulation Creates a Conflict of Interest
Between the Woman and her Unborn Child*

Even if funding were available in some states to increase the SCHIP program to cover unborn children, the new regulation sets up a conflict of interest between the pregnant woman and her unborn child, which may prevent women from seeking coverage under the program and also may inhibit a physician's ability to provide proper care. HHS was clear in its proclamation that the coverage extends to the unborn child only, not to the pregnant woman, unless she is under age nineteen and thus also considered a child.¹¹¹ The irrationality of this selective coverage is emphasized by the fact that HHS expressly stated that the pregnant woman is not entitled to coverage for any care after the birth of the child.¹¹² Therefore, as soon as the child enters the world, the woman is on her own. Thus, the patient to whom the doctor owes his or her duty of care is clearly the unborn child and not the pregnant woman. This situation begs the question: how are doctors to treat the unborn child without also treating the pregnant woman? This may not be a problem in areas where the pregnant woman acquiesces to the doctor's recommended prenatal treatment; but how are doctors to behave when the interests of the pregnant woman and the interests of the unborn child conflict,

108. Gary Susswein, *Texas Budget Facing Strain of Foster Care; Additional \$62 Million Needed as Bad News Buffets State's Finances*, AUSTIN-AM.-STATESMAN, Jan. 30, 2002, at B1 (reporting that Texas' need for additional funding will increase its payments nearly 9%).

109. Pear, *supra* note 27, at A1.

110. See Geraghty, *supra* note 106.

111. See 67 Fed. Reg. 61,956 (2002) (codified at 42 C.F.R. pt. 457) (stating that "while a pregnant woman under age 19 could be eligible as a targeted low-income child and benefit, a pregnant woman over age 19 would not").

112. See *id.* at 61,969 (stating that coverage is only available "during the period from conception to birth").

or the woman wishes to pursue an alternate plan of treatment or forego treatment altogether?

The law is unclear on this point. Although it is well established that a competent adult has the right to refuse medical treatment, when that competent adult is a pregnant woman, the law becomes less clear.¹¹³ In *Cruzan v. Director, Missouri Dept. of Health*, the Supreme Court relied on the Due Process Clause of the Fourteenth Amendment to hold that an individual has a right to preserve his or her own bodily integrity by avoiding an unwanted medical procedure.¹¹⁴ This right has cultivated the doctrine of informed consent, which means that doctors must inform their patients of all risks associated with contemplated procedures and then give the patient the option of having or not having the procedure.¹¹⁵ Justice Cardozo articulated the strength of this right: "Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent committed an assault for which he is liable in damages."¹¹⁶

The Supreme Court has also held that a woman does not relinquish her right to personal autonomy when she becomes pregnant.¹¹⁷ In *Thornburgh v. American College of Obstetricians and Gynecologists*,¹¹⁸ the Supreme Court held that a Pennsylvania statute which forced a trade-off between the pregnant woman's health and the survival of the fetus was unconstitutional.¹¹⁹ Similarly, in a recent decision, *Ferguson v. City of Charleston*, a case involving a law aimed at preventing substance abuse among pregnant women, the Supreme Court ruled that the interests of women not to be subject to unreasonable searches and seizures outweighed the interests of the state in protecting unborn children from the pregnant woman's

113. See generally *Cruzan v. Director, Missouri Dept. of Health*, 497 U.S. 261, 262 (1990) (holding that "an incompetent person" is "unable to make an informed and voluntary choice to exercise" the right to refuse such treatment); see also Bradley J. Glass, *A Comparative Analysis of the Right of a Pregnant Woman to Refuse Medical Treatment for Herself and Her Viable Fetus: The United States and The United Kingdom*, 11 IND. INT'L & COMP. L. REV. 507, 509 (2001) (commenting that British courts "operate on the legal principle that each individual's body is inviolate unless the individual consents [to a medical procedure]").

114. *Cruzan*, 497 U.S. at 281.

115. Alan Meisel et al., *Toward a Model of the Legal Doctrine of Informed Consent*, 134 AM. J. PSYCH. 285, 286-87 (1977).

116. *Schloendorff v. Soc'y of N.Y. Hosp.*, 105 N.E. 92, 93 (N.Y. App. Div. 1914).

117. See Glass, *supra* note 113, at 512.

118. 476 U.S. 747 (1986).

119. *Id.* at 768-69.

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substance abuse.¹²⁰ In *Ferguson*, the Court addressed a conflict of interest between the pregnant woman and her unborn child and held that the pregnant woman's constitutional right under the Fourth Amendment to be free of unreasonable searches and seizures is more important than the need to protect unborn children from the pregnant woman's drug addiction.¹²¹ These rulings seem to indicate that the woman's interest shall trump the state's interest when medical decisions are at issue.

In addition, there are no state laws providing courts with jurisdiction to hear cases where a pregnant woman refuses to undergo medical treatments, even when her refusal may jeopardize the well-being of the fetus.¹²² All states currently have laws preventing child abuse and neglect, however, and the applicability of these laws to actions taken by a pregnant woman would hinge on whether the fetus is classified as a child.¹²³ Some states, such as New Jersey, have expressly incorporated a fetus as covered by their child abuse laws.¹²⁴ Thus, the question remains whether foregoing recommended prenatal medical treatment could be actionable child abuse or neglect.

Despite the lack of jurisdiction to hear such cases, doctors have successfully obtained court intervention in order to subject a pregnant woman to a medical procedure which she has objected to but the doctor believed to be in the best interests of the unborn child.¹²⁵ In fact, the Kolder study done in 1987, found that in twenty-one cases where court orders were sought to override the wishes of the pregnant woman on behalf of the fetus, the orders were granted in 86% (seventeen) of the cases.¹²⁶

There are two main schools of thought concerning court ordered medical intervention over the objections of the pregnant woman. The first school, the majority approach, claims to give absolute

120. 532 U.S. 67 (2001).

121. *Id.* at 82-86.

122. Pamela Harris, Note, *Compelled Medical Treatment of Pregnant Women: The Balancing of Maternal and Fetal Rights*, 49 CLEV. ST. L. REV. 133, 150 (2001) (arguing that the law should honor a pregnant woman's refusal of medical treatment because it is a more ethical and legally appropriate alternative).

123. *See id.*

124. *See* N.J. STAT. ANN. §30:4-11 (West 1981).

125. *See* Veronika E.B. Kolder et al., *Court-Ordered Obstetrical Interventions*, 316 NEW ENGLAND J. MED. 1192, 1192 (1987) (finding that typically this has been done regarding cesarean sections); *see generally* Raleigh Fitkin-Paul Morgan Hosp. v. Anderson, 201 A.2d 537 (N.J. 1964) (ordering a blood transfusion despite the pregnant woman's religious objections).

126. *See* Kolder et al., *supra* note 125, at 1192.

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deference to a woman's choice regarding health care.¹²⁷ The other school, the minority view, balances the rights of the pregnant woman against those of the fetus and when treatment is deemed beneficial to both or not too intrusive for the pregnant woman, is ordered by the Court.¹²⁸

The American Medical Association has noted that in no other circumstance is a patient forced to undergo medical treatments for the benefit of another¹²⁹ and recommends that courts honor the pregnant woman's choice unless there are exceptional circumstances.¹³⁰ It is unclear, however, exactly what would be an exceptional circumstance. Even courts subscribing to the majority view, however, have ordered medical intervention over a woman's wishes where the court found the procedure not to be too invasive. Such court-ordered "non-invasive" procedures have included cesarean sections or blood transfusions over the pregnant woman's objections when the doctor believed the procedure to be in the best interests of the unborn child.¹³¹ If abdominal surgery is considered "non-invasive," it is difficult to imagine what some courts would exclude. In addition, the court has ordered a pregnant woman to be held in custody in a prison hospital facility until after the birth of the child to ensure delivery of the child in a manner the court considered appropriate¹³² and also ordered a woman dying of cancer to prematurely deliver a baby over her objections.¹³³ The Supreme

127. See Glass, *supra* note 113, at 522 (comparing the rights of pregnant women to maintaining her own bodily integrity with the interests of the state).

128. See *id.* at 526-27.

129. See H.M. Cole, *Legal Intervention during Pregnancy: Court-Ordered Medical Treatment and Legal Penalties for Potentially Harmful Behavior by Pregnant Women*, 264 J. AM. MED. ASS'N 2663, 2664 (1990).

130. See Glass, *supra* note 113, at 521-22.

131. See, e.g., *Jefferson v. Griffin Spalding County Hosp. Auth.*, 274 S.E.2d 457 (Ga. 1981) (ordering Caesarian section over objections of mother who opposed operation and blood transfusions on religious grounds); *In re Jamaica Hosp.*, 491 N.Y.S.2d 898 (N.Y. Sup. Ct. 1985) (holding that the woman's interest in exercising her religious beliefs was not enough to override the interests of the state in protecting the fetus); *Crouse v. Irving Memorial Hosp., Inc.*, 485 N.Y.S.2d 443 (N.Y. Sup. Ct. 1985) (allowing the hospital to administer a blood transfusion to the mother and child against the mother's objections); Cole, *supra* note 129; Kolder et al., *supra* note 125, at 1192 (finding that typically this has been done regarding cesarean sections); *Raleigh Fitkin-Paul Morgan Hosp. v. Anderson*, 201 A.2d 537 (1964) (holding that a pregnant woman must have a blood transfusion despite her religious objections).

132. Brian MacQuarrie & Richard Higgins, *Attleboro Sect Member Gives Birth State Custody Seen; Court Hearing Is Set*, BOSTON GLOBE, Oct. 17, 2000, at B1; see also Marilyn L. Miller, *Fetal Neglect and State Intervention: Preventing Another Attleboro Cult Baby Death*, 8 CARDOZO WOMEN'S L.J. 71 (2001) (discussing the case of Rebecca Corneau who was held in custody because she refused a prenatal medical examination on religious grounds).

133. See generally *In re A.C.*, 573 A.2d 1235 (D.C. 1990) (discussing the death of

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Court has, however, struck down laws that required a woman to accept an increased medical risk to save a viable fetus¹³⁴ and to undergo a mini-cesarean section because it offered the best opportunity for the fetus to be born alive.¹³⁵ It is important to note that all of these cases occurred in a context where the mother was the primary patient and it is therefore reasonable to assume that the doctor and the court may have a more compelling reason to intervene over the objections of the woman than where the unborn child is the primary patient. Thus, the current regulation places women and doctors in the awkward position of not knowing how to proceed in a situation where the doctor may be treating and interacting with the woman but be primarily concerned about and interested in the unborn child. Given the lack of clear guidance from the courts, a woman's fear that the doctor may order or subject her to medical procedures she does not wish to have, but the doctor deems to be in the best interests of the unborn patient, may be enough to prevent her from seeking the prenatal care the revision claims to provide.¹³⁶

IV. THE POLITICAL UNDERPINNINGS

President Bush made clear that the November 2002 midterm election was a mandate on his presidency and his ability to get things done so he heavily invested his time and energy in seeing that the Republicans held on to their majority in the House and regained the Senate.¹³⁷ Thus the timing and place of the announcement of the change in HHS's definition place it right in the middle of a highly charged political scene. A Gallup Poll conducted during the month before the November 2002 election, found that the abortion issue was moderately to extremely important for 70% of voters in deciding how they would vote in the November 2002 election.¹³⁸ In addition, the Bush Administration chose to announce the change during a speech

both mother and baby within two days of the delivery procedure).

134. *Thornburgh v. Am. College of Obstetricians & Gynecologists*, 476 U.S. 747, 747 (1986).

135. *Colautti v. Franklin*, 439 U.S. 379 (1979).

136. *In re A.C.*, 573 A.2d 1235, 1248 (D.C. 1990) (en banc), (noting that fear of being subject to a medical procedure to which she objects may prevent a woman from seeking the medical care she needs).

137. *Bush, Cheney Raise Cash For Candidates*, THE TALLAHASSEE DEMOCRAT, Oct. 15, 2002, at A3 (detailing a fundraiser in Maryland designed to gain support for Republican Congressional candidates).

138. Roper Center at University of Connecticut Public Opinion online, "How important will each of the following issues be to your vote for Congress this November (2002)– will it be – extremely important, very important, moderately important, or not that important? How about abortion?" Gallup Organization, Sept. 20-22, 2002.

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given by the Secretary of Health and Human Services, Tommy Thompson, before the Conservative Political Action Committee as one of several examples of the Administration's commitment to the unborn.¹³⁹ Thus, the expanded definition was a clear reminder to anti-abortion activists that a Republican victory was important in the fight to overturn *Roe*. The new provision also expands coverage to the unborn children of immigrants, regardless of the citizenship status of their parents, which is seen as a political outreach to the Hispanic vote at a time when the Republicans were attempting to woo them for the November election.¹⁴⁰

While providing health care for the uninsured working poor had not been a previous priority for the Bush Administration,¹⁴¹ maintaining the support of the religious right and other abortion opponents has been a clear goal.¹⁴² In keeping with his goal of opposing abortion rights, Bush has appointed conservative pro-life advocate John Ashcroft as Attorney General. On his first day in office and coincidentally the 28th anniversary of *Roe*, President Bush issued an executive order halting United States funding to international family planning groups that support abortion rights.¹⁴³ Redefining children to include the unborn in the health context is another step towards changing facts warranting an overruling of *Roe*. The Bush Administration has also stated that it is deeming the unborn fetus to be a "child." This statement has been lauded by anti-abortion activists and condemned by pro-choice groups.¹⁴⁴ Thus, the timing of the regulation combined with its effect of increasing the number of eligible recipients in a program that is already over capacity supports the view that it is a politically motivated change without the intention or likelihood of providing real medical benefits.

139. See Tommy G. Thompson, Remarks at the Conservative Political Action Committee Conference (Jan. 31, 2002) (describing changes in the Department of Health and Human Services under the Bush Administration), available at <http://www.hhs.gov/news/speech/2002/020131.html>.

140. See Times Wire Reports, *Latino Voters Not of Single Mind, Poll Finds*, Oct. 4, 2002, at A22 (noting that Latino voters are likely to be unpredictable when it comes to core beliefs associated with either conservatives or liberals).

141. See Amy Goldstein, *States' Budget Woes Fuel Medicaid Cuts; Poor Lose Coverage and Services*, WASH. POST, Oct. 11, 2002, at A1 (noting that many former welfare recipients are also losing Medicaid benefits).

142. Alexandra Starr, *Enough With The Rhetoric, The Right Wants Results*, BUS. WK, Feb. 10, 2003, at 43 (noting that balancing both conservative and moderate social goals is a priority of the Bush Administration).

143. See *Swift Action by Bush*, ABCNEWS.COM, Jan. 23, 2001, available at <http://abcnews.go.com/sections/politics/DailyNews/bush-abortionrights>.

144. See Ralph Ranalli, *Bush Plan On Fetus Sparks Debate*, BOSTON GLOBE, Sept. 30, 2002, at B3 (describing the adverse reaction to Bush's prenatal care plan among liberal voters in Massachusetts).

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IV. THERE ARE BETTER WAYS TO PROVIDE PRENATAL COVERAGE

Providing prenatal health insurance coverage to all pregnant women is an important health benefit that the Bush Administration should seek to provide. Studies link the absence of prenatal health insurance, and thus the lack of health care, to higher infant mortality rates.¹⁴⁵ Currently, the United States ranks 28th in the world with an infant mortality rate of 6.8 deaths per 1000 live births.¹⁴⁶ There is obviously room for improvement. Thus, HHS should seek legitimate ways to provide prenatal health insurance coverage to those not covered by Medicaid or private health insurance. The current action falls short by its lack of funding and its structural problems. This coverage could have been provided by speeding up the current waiver program, giving more funding to the SCHIP program, preventing the SCHIP dip, preventing the reversion to the federal treasury of the unused SCHIP funds, or creating a new program geared specifically toward providing prenatal care for uninsured pregnant women.

In keeping with the regulation's provisions for providing prenatal care, nine states had already obtained waivers from the Secretary of HHS under Section 1115 of SCHIP, to cover parents or pregnant women fitting the income criteria, as well as their children.¹⁴⁷ Arizona, California (not implemented by the state but approved by HHS), Minnesota, New Mexico, Ohio (not implemented by the State but approved by HHS), and Wisconsin all obtained waivers from HHS to cover parents of SCHIP recipients.¹⁴⁸ Such family coverage, of course, is included in prenatal care. While Colorado, New Jersey, and Rhode Island specifically obtained permission to cover pregnant women who are not eligible for Medicaid using SCHIP funds.¹⁴⁹ At the writing of this article, Arkansas and Maryland also had requests pending with HHS to provide such coverage.¹⁵⁰

HHS notes that the new definition of child will enable states to cover unborn children in a few weeks or months, as opposed to the

145. See Jim Weill, *The Convention on the Rights of the Child and the Well-Being of America's Children*, 5 GEO. J. ON FIGHTING POVERTY L. & POL'Y 257, 259 (1998) (discussing American attitudes towards the needs of children).

146. *Faststats Infant Deaths/Mortality*, National Center for Health Statistics, available at <http://www.cdc.gov/nchs/fastats/infmort.html> (last visited Dec. 4, 2003).

147. Andeen, *supra* note 12, at 324-25; State Children's Health Insurance Program (SCHIP), Centers for Medicare and Medicaid Services CMSO, FCHPG, Division of State Children's Health Insurance (DSCHI) [hereinafter *State Children's*], at <http://www.cms.hhs.gov/schip/stateplans/waivers/1115waivers.pdf> (last visited Apr. 6, 2004).

148. See *State Children's*, *supra* note 147, at 1-4.

149. See *Press Release*, *supra* note 28.

150. See *State Children's*, *supra* note 147, at 5-6.

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previous waiver procedure, which HHS claims could take three to six months.¹⁵¹ However, the figures provided by HHS show that some states had their waivers approved as quickly as eight days (California), while the longest wait was five months (Minnesota).¹⁵² Eight days is a not very long period of waiting time, and shows that HHS can process these waivers quickly. If HHS were truly concerned about the speed of approving the waivers, it seems that the easier solution would be simply to implement an internal program which would allow HHS to more quickly grant the waiver requests to states to cover pregnant women, or to make the waiver process easier. Once the waiver is obtained, the woman as well as the unborn child would be covered which would eliminate the conflict of interest problems discussed above in section II(A).

Furthermore, under the new definition of child, states must rewrite their current programs to define the additional type of coverage, if any, that will be available for this new subset of children. Thus, the new regulation does not automatically provide prenatal care. Rewriting state insurance coverage policies is hardly a quick and simple process. Some states have already said that due to funding shortfalls they already are unable to continue funding for the currently covered children,¹⁵³ so it is questionable whether states will be able to cover any unborn children, and if they do, it may very well come at the expense of older children.

In the alternative, HHS could have proposed a new program aimed specifically at providing prenatal care to pregnant women and their unborn children, who need it and are unable to afford it. Such a program would need to provide its own funding, and thus would not be competing with the already thinly stretched SCHIP funds. It would also cover both the woman and the child, thereby avoiding a conflict of interest problem. In addition, if the Bush Administration believes the best option is to provide coverage under the scope of SCHIP, it should aggressively support the bills introduced in Congress to prevent the "SCHIP Dip," and the return of unused funds to the United States Treasury. Each of these suggested methods would

151. See Kemper, *supra* note 46, at A23, (quoting HHS spokesman Bill Pierce stating that the new regulation extends citizenship to all children born in the U.S. regardless of the immigration status of the mother).

152. CTRS. FOR MEDICARE AND MEDICAID SRVS., STATE CHILDREN'S HEALTH INSURANCE PROGRAM ANNUAL ENROLLMENT REPORT: FISCAL YEAR 2001: OCTOBER 1, 2000-SEPTEMBER 30, 2001 (2002), at <http://www.cms-hhs.gov/schip/enrollment/schip01.pdf> (last visited July 30, 2002).

153. See *infra* part III(A).

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provide the needed prenatal care, without entering the legal quagmire of when life begins.

CONCLUSION

Prenatal care is an important public health benefit, which the United States should strive to provide for all pregnant women. The Bush Administration's rewriting of SCHIP's definition of child to include fertilized eggs, embryos, and fetuses, regardless of the pregnant woman's immigration status, is a bold foray into the legal quagmire of abortion rights and the question of when life begins. The new definition further fails to provide any real steps toward improving prenatal coverage for those who need it. The regulation's failure to provide additional funding, and the built-in conflict of interest between the pregnant woman and the unborn child make it little more than political and legal ammunition for abortion opponents to overturn *Roe*, rather than a legitimate policy aimed at providing prenatal care for women and their unborn children.