



findings brief

Pregnant and Poor: Did Medicaid and Welfare Policy Changes Improve Care for these Women as Intended?

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Infant mortality rates in the United States remain higher than in most industrialized countries, particularly for minorities and women who do not receive adequate prenatal care.¹ Since many low-income pregnant women receive cash assistance (welfare) or are eligible for Medicaid, changes in these public programs affect them directly. Two projects funded by The Robert Wood Johnson Foundation's Changes in Health Care Financing and Organization (HCFO) program examined how Medicaid expansions, Medicaid managed care, and welfare reform affected the insurance status, utilization of prenatal care, and birth outcomes for low-income pregnant women.

Genevieve Kenney, Ph.D., principal research associate and health economist at the Urban Institute, Lisa Dubay, Sc.M., principal research associate at the Urban Institute, and their colleagues studied the impact of the move to Medicaid managed care on prenatal care nationally and in two states. They found that the effects of Medicaid managed care on prenatal care were mixed, depending on state-specific environments and differences in implementation. Although managed care was asso-

ciated with reductions in smoking during pregnancy, rates of smoking among Medicaid-covered women remained high. The research also confirmed earlier work showing that Medicaid eligibility and coverage expansions for pregnant women promoted earlier prenatal care. However, neither managed care nor coverage expansions had any measurable positive effect on birth outcomes.

E. Kathleen Adams, Ph.D., associate professor at the Rollins School of Public Health at Emory University, and colleagues found that even prior to the enactment of The Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996,² or welfare reform, pregnant women experienced more transition in insurance status than anticipated. Ultimately, more low-income women were uninsured before pregnancy following welfare reform compared to the period prior to PRWORA enactment. Adams' study provided evidence that welfare reform led to less take-up and delayed take-up of Medicaid benefits. Adams and colleagues also simulated a variety of potential policy reforms. They found that an expansion of private insurance for low-income women prior to preg-



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nancy was the intervention that was most likely to have an effect on early prenatal care and, potentially, birth outcomes.

Background

Medicaid eligibility was expanded to cover more poor and near-poor pregnant women in the late 1980s. At the same time, Medicaid programs streamlined their enrollment processes, covered additional services, and increased fees paid to obstetricians. Since the early 1990s, states also have enrolled a growing number of Medicaid enrollees in managed care plans. Nationwide, the percentage of Medicaid enrollees in some form of managed care plans grew from 9.5 percent in 1991 to 57.4 percent in 2002.^{3,4} Many hypothesized that providing an ongoing source of continuous care for pregnant women enrolled in Medicaid through managed care would result in better prenatal care and improved maternal and child health outcomes.

While Medicaid enrollees and programs were responding to the eligibility expansions and the market shift toward managed care, welfare reform was enacted. This legislation, designed to reform the welfare system, replaced Aid for Families with Dependent Children (AFDC) with Temporary Assistance for Needy Families (TANF), required most individuals to work in order to receive cash assistance, limited the period of time over which one could receive cash assistance, and separated eligibility for cash assistance from eligibility for Medicaid. Concerns were raised about the impact of the legislation on low-income pregnant women and their children, since women would now have to enroll separately for welfare and Medicaid.

Impact of Medicaid Expansions and Managed Care on Prenatal Care and Birth Outcomes

Prior studies had found inconsistent evidence about the impact of the Medicaid eligibility expansions. Using data from the national natality files for 1980, 1986, and 1993, Kenney, Dubay, and colleagues re-examined the national impacts of the Medicaid expansions on eligibility, prenatal care timing, and low birth weight.

They created separate treatment and comparison groups for white and black women, based on education and marital status. They then compared changes for women of low socioeconomic status for the periods 1980 to 1986 and from 1986 to 1993. For the latter group, they also compared the changes for women of low socioeconomic status to those for women of high socioeconomic status. They found that Medicaid expansions led to an increase in early initiation of prenatal care for both white and black women. However, there was no evidence of significant improvement in birth outcomes as a result of the expansions. In addition, large differentials in prenatal care timing and low birth weight persisted according to race, educational attainment, and marital status of the mother.

Kenney, Dubay, et al., also examined:

- ◆ The national impacts of Medicaid managed care on prenatal care timing and low birth weight infants;
- ◆ The impacts of managed care enrollment for Medicaid enrollees on prenatal care timing, smoking during pregnancy, and low birth weight in Ohio and Missouri; and
- ◆ Implementation issues faced by Ohio and Missouri when adopting managed care enrollment for pregnant women in Medicaid.

The analyses of those enrolled in Medicaid managed care programs showed mixed evidence of the effects of mandatory enrollment on prenatal care timing and use. There were reductions in smoking during pregnancy in both Missouri and Ohio, and lower rates of Caesarean sections overall (although it varied by county). There was no evidence that mandatory enrollment in managed care programs resulted in reductions in the prevalence of low birth weight infants. In terms of implementation, Medicaid managed care programs added an administrative layer and led to more of a focus on case management and related services. Participation in managed care plans in voluntary counties was low, and exemptions for pregnant women were common in counties where managed care enrollment was mandated.

“Medicaid managed care alone is unlikely to lead to dramatic improvements in prenatal care use or birth weight, nor is it likely to reduce smoking substantially,” says Kenney.

According to Dubai, future policy interventions may need to address more of the underlying risk factors for these women and take into account that linking eligibility to pregnancy may limit the impact of interventions on outcomes.

Impact of Welfare Reform on Insurance Coverage and Use of Prenatal Care

In their study of the impact of welfare reform on low-income pregnant women, Kathleen Adams and her colleagues addressed the following questions:

- ◆ Did the characteristics of low-income pregnant women change pre- and post-welfare reform?
- ◆ Did welfare reform affect the pre-pregnancy insurance coverage of low-income pregnant women?
- ◆ Does insurance coverage affect early and adequate prenatal care and did welfare reform have an additional effect?
- ◆ Did welfare reform improve the timing of the initiation of prenatal care as outlined in the Healthy People 2010 goals?

Using the Pregnancy Risk Assessment Monitoring System (PRAMS) data for 1996 through 1999 for Alaska, Florida, Maine, New York, Oklahoma, South Carolina, Washington, and West Virginia, the researchers conducted a pre-/post- analysis on pooled state data with higher-income women as a control group. In the insurance analysis, they controlled for Medicaid eligibility categories, age, race, marital status, education, income, aid recipient, income from work, state policies, county economic measures, and a pre-/post- welfare reform indicator. The prenatal care analysis corrected for bias from women simultaneously enrolling in insurance and entering prenatal care.

The researchers found that following welfare reform, welfare-eligible women (compared to non-eligible women) had an increased likelihood

of being uninsured pre-pregnancy; no change in their likelihood of being privately insured versus uninsured; and a decreased likelihood of being Medicaid insured versus uninsured. Moreover, they had a higher probability of delaying enrollment into Medicaid until the prenatal period compared to expansion-eligible women.

Having private insurance pre-pregnancy significantly increased the odds that a woman would initiate prenatal care during the first trimester, but having Medicaid coverage pre-pregnancy did not. Pre-pregnancy Medicaid coverage did, however, result in an increased likelihood of early and adequate prenatal care.

“Women eligible for Medicaid when welfare reform was enacted in 1996 were no more likely to be privately insured after welfare reform and yet were less likely to be enrolled in Medicaid pre-pregnancy,” Adams says. “Medicaid is structured such that low-income women will have insurance coverage at delivery, and the PRAMS data indicate that many low-income women make transitions during pregnancy, with the largest transition group moving from uninsured pre-pregnancy to Medicaid at delivery.”

Discussion

Debbie Chang, director of strategic development and policy for the National Academy for State Health Policy, commented on these studies during a HCFO-sponsored Cyber Seminar to disseminate research results for policymakers. “States recognize the complexity of the problem and are trying to address the needs of these women, but the current budget environment makes this difficult,” she said. “Future research should focus on evaluating which policies are effective in achieving the desired birth outcomes.”

Rachel Benson Gold, director of policy analysis and Washington office operations for the Alan Guttmacher Institute, agreed. “It is important for policymakers to consider incentives for inter-pregnancy and pre-pregnancy care, particularly family planning, and to streamline enrollment procedures,” she said.

Both studies support the contention that the timing of Medicaid enrollment is critical, and policy interventions promoting earlier insurance coverage for pregnant women could have a beneficial effect on initiation of prenatal care and birth outcomes. The potential of the Medicaid expansions and other Medicaid interventions to affect outcomes is limited by the current criteria under which many women do not become eligible for Medicaid until after they are pregnant and are covered by the program only until they give birth. These limitations may be compounded by the fact that health status at the time of pregnancy and one's desire to be pregnant are factors that have been associated with the timing of prenatal care,^{5,6} although the findings regarding adverse outcomes are not consistent.⁷

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Endnotes

- 1 www.mchlibrary.info/KnowledgePaths/kp_infmort.html
- 2 www.acf.dhhs.gov/programs/cse/new/prwora.htm
- 3 www.cms.hhs.gov/medicaid/managedcare/pctoftot.pdf
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- 5 Centers for Disease Control and Prevention. "Unintended Childbearing: Pregnancy Risk Assessment Monitoring System-Oklahoma, 1988–1991," *Mortality and Morbidity Weekly Report*, 1992, Vol. 41.
- 6 Kost, K. et al. "Predicting Maternal Behaviors During Pregnancy: Does Intention Status Matter?" *Family Planning Perspectives*, March/April 1998, Vol. 30, No. 2.
- 7 Colley-Gilbert, B. et al. *Family Planning Practices and Pregnancy Intention*, 1997. Division of Reproductive Health, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention, 2000.

