Infant Mortality and Medicaid Reform

Shelly Gehshan, M.P.P.
Sr. Program Director
NASHP

Accomplishments

- Infant mortality rate has dropped steadily
- Medicaid enhancements in the late 1980s, embraced by states
- Smoking rates have dropped (from 20% in 1987 to 12% in 2002)
- Neural tube defects down
- Breastfeeding is up

Medicaid coverage for pregnant women, (as of 2002)

- Only 10 states cover at minimum levels
- 27 states cover between 134-199% FPL
- 9 states cover at 200% FPL
- 4 states cover above 200% FPL
- Medicaid pays for 37% of all births

Medicaid enhancements aided infant mortality prevention

- 1985—State option for enriched services not available to others: health education, nutrition counseling, case management
- 1986—State option to use presumptive eligibility and drop asset test
- 1990—Required continuous eligibility thru 60 days post partum, 1 year for newborns

Medicaid Family Planning Helps

- Provides 61% of all family planning $$
- 21 states have Section 1115 Medicaid family planning waivers
- 1998: 2 million women rec'd family planning service through Medicaid

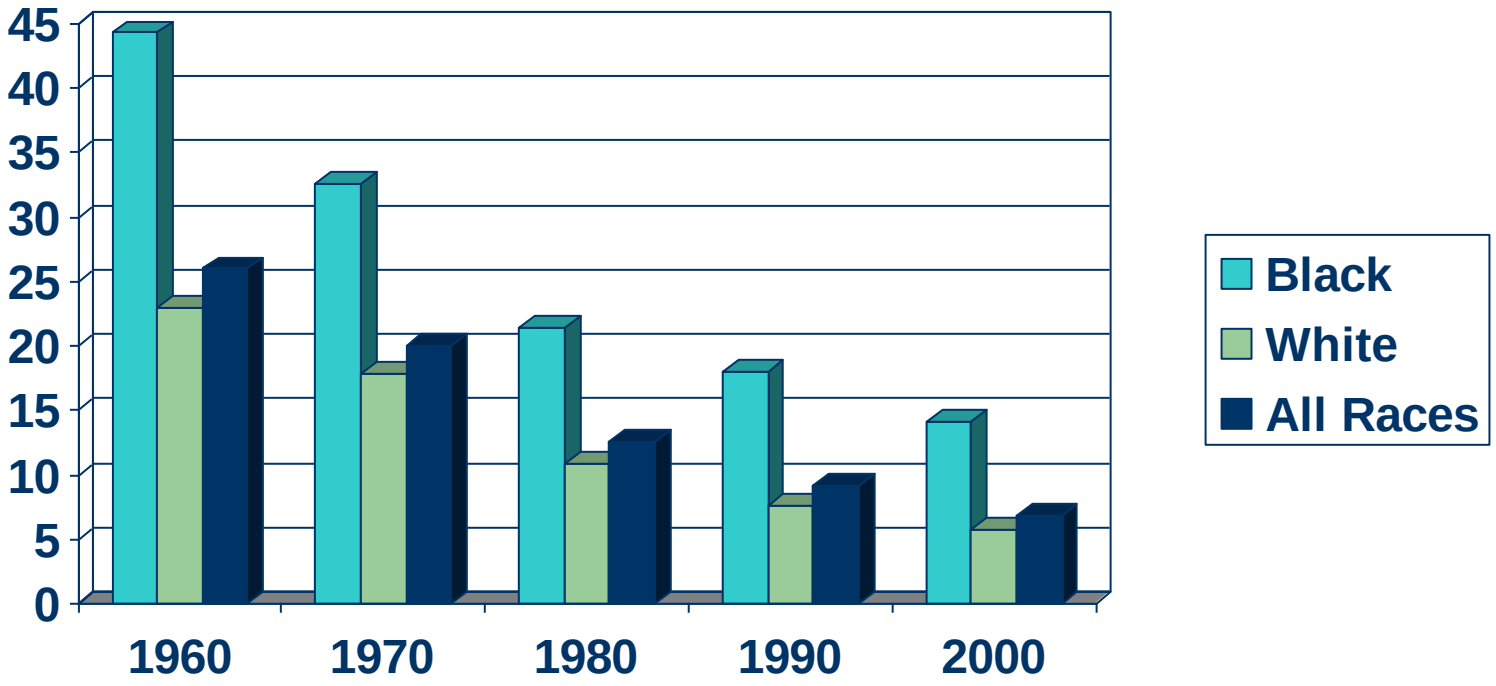
Challenges

- 20% pregnant women lack insurance
- Erosion in employer insurance base
- Rates among African-American women
  - 13.6 IM rate compared to 6.9 overall
  - 13 % LBW rate compared to 7.7% overall
  - 74% rec'd PNC in 1rst trimester, 83% overall

Challenges

- Pregnant women enrolled in Medicaid twice as likely to smoke as others
- % of women not practicing family planning small but rising
- Percent with no prenatal care rising
- Only 7 states have Medicaid dental for adults

Infant Mortality, 1960-2000--
Higher Rates Among Blacks Persist



Challenges in the South

- Alabama 9.5
- Arkansas 8.2
- Delaware 9.2
- Louisiana 9.4
- Mississippi 10.4
- North Carolina 8.7
- South Carolina 9.3
- DC 13.0
- Puerto Rico 9.7
- Virgin Islands 9.0
- Guam 8.2
- **US** **6.9**

LBW and Poor Oral Health

- Severe periodontal disease is associated with a 7-fold increase in risk of LBW, controlling for other risk factors.
- More research is needed on links.
- Low income pregnant women have poor access to dental care.

NASHP Making Medicaid Work Recommendations

- Cover all people below poverty level, regardless of category
- Continue to require states to cover pregnant women and children below poverty, expansions allowed
- Simplify eligibility based on income alone
- http://www.nashp.org/Files/Overview_of_Recommendations.pdf

MMW recommendations, Cont'd

- Comprehensive benefits for mandatory groups; less comprehensive benefits for optional groups (minimum standard)
- No block grants, counter cyclical FFP
- Enhanced match like SCHIP for expansion groups
- Coordinate with employer insurance without a waiver

How Would This System Affect IM?

- Poor women of childbearing age would have coverage before, during and after pregnancy
- No loss of eligibility 60 days post-partum
- Pregnant women > 100% FPL might lose coverage in states that chose minimum level

Eligibility

- Option to waive asset test
- Potential for simpler forms, more application sites, less state expense to process eligibility
- Simpler process could expand options for enrollment (electronic, mail-in, providers)
- Less churning on and off

Financing

- No block grant means no cap, no waiting lists
- Eligibility by income means continued individual entitlement
- Counter cyclical FFP means states less likely to contract eligibility, benefits, provider payments, during recession

Continuous eligibility could mean…

- Fewer delays, earlier entry for prenatal care
- Family planning services
- More consistent care with opportunities for education, prevention, intervention
- One insurance source, medical home for families

Benefits (- / +)

- For women below poverty, comprehensive package
- Optional higher income pregnant women could have fewer benefits than needed
- Ancillary, enabling services may not be there
- Potential for state-designed package tailored for pregnant, post-partum women

Benefits used in Medicaid (2000)

- 39 states, DC, dropped the asset test
- 27 states and DC use presumptive eligibility
- 41 states and DC provide care coordination and transportation
- 34 states provide nutrition counseling
- 37 states provide psychosocial counseling

NGA Medicaid Reform

- Governors seek more, enforceable, cost-sharing (5% to 7.5% of family income),
- Flexibility to tailor benefit packages to populations,
- Simplified waiver process,
- Right to manage optional populations without court intervention

How would this system affect IM?

- Cost sharing may cost more money than it brings in
- Targeted benefit packages could be a plus or minus (SCHIP not a good model for perinatal care)
- Joint federal-state control over Medicaid basic feature that is not “waivable”

Cost Sharing

- Cost sharing impedes enrollment and receipt of services among low income people.
- Copayments reduce utilization of preventive services, raise costs among people with chronic diseases.
- Premiums and copayments for low income pregnant women could raise costs.

Waiver authority

- Ensures a balance between flexibility and legal obligations
- Provides federal oversight to safeguard the rights of beneficiaries, providers, jurisdictions
- Has allowed substantial state creativity

Conclusion

- High costs in Medicaid come largely from disabled, institutionalized population
- Many reforms target high cost areas
- Medicaid is vehicle for health care reform
- The devil is in the details…