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impairments.[3]

The toll that infant death and disability take can also be measured financially. Between 1978 and 1990, because of the lack of comprehensive, preventive maternity programs, the nation will experience more than 300,000 low birthweight births that might have been averted through comprehensive services.[4] The first year costs alone associated with caring for these infants will exceed $2 billion,[5] and over $500 million of this amount will be spent by the Medicaid program.[6]

B. Millions of poor women do not receive the care they need

Low income women are significantly less likely to receive early and continuous prenatal care. Poor women are less likely to begin prenatal care early in pregnancy.[7] They are also twice as likely to receive either no prenatal care at all or none until the final trimester of pregnancy.[8]

Many factors contribute to low income women's failure to receive comprehensive maternity care. But a fundamental cause is their inability to purchase needed services. In 1984, one-third of all low-income women of childbearing age were completely uninsured.[9] Another third were covered by Medicaid,[10] but of these, studies suggest that only about half are covered for a full year, because of the program's low eligibility standards.[11] The remainder rely chiefly on private health insurance, which all too frequently provides inadequate pregnancy benefits for low-income maternity patients.[12] Comprehensive maternity care (including medical and hospital care associated with labor and

delivery) costs to thousands of dollars. As a result, uninsured, or partially insured, pregnant women living at or near the federal poverty level are without the means to purchase care on an out-of-pocket basis.

II. Medicaid And Pregnant Women

Medicaid is a vital source of health care for pregnant women. Medicaid-eligible pregnant women are entitled to coverage for a comprehensive array of prenatal, delivery and postpartum care. By dramatically increasing poor women's access to maternity care, Medicaid has contributed to the nearly 60 percent reduction in infant mortality that occurred between 1965 and 1984. Moreover, comprehensive Medicaid coverage during pregnancy is cost-effective, because it improves infant health outcomes and thus reduces the need for intensive infant care. Federally funded studies show that comprehensive Medicaid coverage during pregnancy can save nearly $2.00 for every $1.00 spent.[14]

A. Pre-SOBRA Medicaid

Observers have known for years that Medicaid was not reaching sufficient numbers of low income pregnant women. Medicaid's historic eligibility barriers fall into three major categories. These are: restrictive financial eligibility standards, restrictive categorical eligibility standards, and an extremely complex and time consuming application and eligibility determination process that deters even eligible women from gaining entry into the program.

1. restrictive financial eligibility standards

Prior to SOBRA, state Medicaid financial eligibility standards for pregnant women were, by law, tied to states' AFDC income and resource eligibility levels. This was true even in states that had "medically needy" programs (which permit women who have incomes and resources that exceed AFDC standards to become eligible by "spending down" to Medicaid eligibility levels by incurring high medical costs), since state "medically needy" income eligibility levels (the level to which women must "spend down") can be no greater than 133% of its AFDC payment level. In many states the medically needy income eligibility levels are no greater than 100% of the AFDC payment level, particularly are for larger families. Table I.

By 1986, 30 states maintained AFDC payment levels that were less than 50 percent of the federal poverty level.[15] Table II. Indeed, so low are AFDC payment levels that in only one states (California) did the 1986 medically needy eligibility level for a family of three exceed the federal poverty level.[16] Table I.

2. Restrictive Categorical Eligibility Standards

Another major barrier to adequate Medicaid coverage of pregnant women has been the automatic exclusion of two parent working families. Until passage of the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA),[17] 20 states maintained categorical Medicaid eligibility criteria that excluded women who were extremely poor but who lived in two-parent working families. COBRA, which was enacted in April, 1986, removed all

categorical barriers to Medicaid eligibility for pregnant women.[17a] As of July 1, 1986, all states were required to provide Medicaid to all pregnant women, including married and employed women with family income and resources at or below AFDC eligibility levels.

3. Complicated eligibility determination procedures

In addition to restrictive eligibility standards, however, there are other reasons why Medicaid has failed to reach thousands of women who need coverage--even women who meet their state programs' limited eligibility standards. These reasons have to do with Medicaid's isolation from the rest of the public prenatal care delivery system, the difficulty many women encounter in applying for aid, and the long waiting times they must endure until their eligibility is determined.

- Isolation: Many low income pregnant women first seek assistance by going to a health department clinic or a health center site or some other health care location where they can obtain free or reduced-cost prenatal services. Yet in virtually all states, the Medicaid application site is located somewhere other than the clinic -- normally at the local welfare office.

  Studies show that Medicaid's penetration into the eligible population is low when eligibility is not tied to the receipt of cash assistance.[18] This depressed penetration phenomenon is intensified by Medicaid's isolation from the public health system. Individuals who are sick or who need medical care often do not think about going to the welfare office, which they associate with cash aid and food stamps. As Medicaid's availability for the non-AFDC population becomes better known, this tendency may begin to change. But because Medicaid enrollment has not been physically located within the "service stream" that low income pregnant women turn to, this has greatly delayed their entry into the program.

By 1986, a few states had begun to place Medicaid applications at provider sites in order to facilitate enrollment.[19] However, once applications are completed and filed, women must wait at least 45 days, until the eligibility determination process completed,[20] before their coverage begins.

- Complicated applications: A Medicaid application is often enormously complicated, many pages long and requiring extensive verification. Many of these verification requirements relate to measuring an applicant's assets (e.g., the value of a home, car, and personal possessions, and the existence, if any, of savings accounts, checking accounts, and so forth). exceed welfare eligibility levels. Moreover, there are frequently no applications for Spanish-speaking and other non-English-speaking persons, thereby making the process even more difficult.

Throughout this complicated and time-consuming process, women -- even women who clearly are poor enough to qualify for Medicaid -- continue to go uncovered. Moreover, many who have struggled to enroll are denied coverage, not because their income and assets exceed eligibility levels, but because they are unable to verify that they meet the program's myriad eligibility requirements.

As a result, some indigent and uninsured women may make one prenatal visit but never return, because they are billed for services and unable to pay. Others fear commencing care at all, because they know they cannot pay. Still others may seek physicians who will extend care "on credit" until their Medicaid applications are processed, only to find that physicians demand either evidence of insurance or payment in advance. Finally, women who do find at least some care at free or reduced-cost health clinics (such as health centers) may go without the highly specialized services they require because they are uninsured and

thus cannot be referred for specialty care.

In theory, women should have fewer access problems once they have applied for benefits, because Medicaid eligibility is retroactive to the date on which a written application is filed[20a] and actually can begin up to 3 months prior to that date if the woman would have been eligible for benefits at the time services were rendered.[21] But provision of services in advance of eligibility verification requires a leap of faith on a provider's part that the patient has applied for benefits at the time of her first visit and will in fact be found eligible for coverage. Few providers other than those serving the poor will take this risk.

B. Congressional Response to the Need: The Elements of SOBRA

Recognizing the dual problems of limited eligibility standards and highly complex enrollment procedures, Congress included two important provisions in SOBRA. The first permits states to dramatically liberalize Medicaid's financial eligibility standards for pregnant women and children under age five. The second allows agencies to establish a program of "presumptive eligibility" for pregnant women.

1. SOBRA's financial eligibility reforms

SOBRA liberalizes Medicaid financial eligibility criteria in 3 distinct ways. First, it permits states to use a more generous income eligibility standard, that exceeds AFDC and medically needy eligibility levels. Second, SOBRA permits states to

eliminate use of an asset test entirely in the case of pregnant women and children under age five. Third, SOBRA allows states to eliminate the threat of "on-again-off-again" Medicaid eligibility among pregnant women that results from the application of restrictive income and asset standards.

a) liberalized income standards

SOBRA permits states to estabilsh an income eligibility standard for Medicaid for pregnant women and children under age five, which is higher than AFDC or medically needy eligibility levels, but less than the federal poverty level.[21a] Since one-third of all uninsured pregnant women have family incomes below the federal poverty level, if all states were increase Medicaid eligibility to this level, the number of uninsured pregnant women would drop by one third nationwide.[21b]

b) elimination of an assets test

SOBRA allows states to eliminate use of an asset test entirely for pregnant women and children under age five[21c] (if states do elect to use an asset test for pregnant women, they may use a standard no more restrictive than that used under the SSI program, which is more liberal than the AFDC asset test).[21d]

The importance of persuading states to eliminate use of an asset test for these populations cannot be overstated. Almost no indigent pregnant women or children have assets that exceed SSI eligibility levels.[22] The asset test adds immeasurably to the complexity and time-consuming nature of the application process, and increases the likelihood that applicants will be denied

coverage for failure to comply with documentation requirements. Moreover, states are subject to severe penalties if their Medicaid eligibility approvals turn out to be erroneous.[23] A complicated asset test adds many more criteria to the eligibility determination process, further exposes the state to serious federal error rate sanctions (which involve the reduction of federal funds).

Even if a state does not have the resources to lift its income eligibility standards to the federal poverty level, it can use its SOBRA flexibility to waive the imposition of an asset test for pregnant women and children under age 5, thereby greatly simplifying both its eligibility standards and the application procedure, thereby reducing the potential for error rate sanctions.

c) Continuous eligibility

It is possible that women who are found eligible for coverage will lose their benefits midway through pregnancy because of a slight change in their countable income levels resulting from the complex AFDC budgetting system (a woman can find herself with increased "countable" income even if her actual income level does not change at all). To avoid this, SOBRA gives states the option of treating any Medicaid-eligible pregnant woman as continuously eligible for coverage until 60 days following the termination of her pregnancy, without having to reverify of her eligibility.[24] This benefit is similar to the 6 month minimum eligibility option for HMO enrollees.

As with the option to waive an asset test, the continuous eligibility option can be exercised either alone or in combination with the other SOBRA financial liberalization options.

One final note: In determining any pregnant woman's eligibility for Medicaid when her application is based on her pregnancy status, federal law mandates that she be treated as at least a family of two (herself and her unborn child).[25] Medicaid eligibility standards for women applying on the basis of pregnancy should thus identify a family of two as the smallest family unit size.

2. Presumptive Eligibility

The second major SOBRA option allows states to establish presumptive eligibility (PE) programs for pregnant women. States may adopt a PE program regardless of whether they also liberalize their eligibility standards as described above. But for reasons that will be discussed below, PE will work best in states that have: (1) eliminated all but an income eligibility test for pregnant women as discussed above; and (2) developed a short Medicaid application form.

Under a PE program, a state Medicaid agency may contract with one or more Medicaid clinical providers furnishing maternity care to low income women to perform on-the-spot Medicaid enrollments for a 45-day period for all outpatient maternity services in the case of any woman who is pregnant and who

qualifies for Medicaid on the basis of income alone. This presumptive eligibility period effectively ensures that pregnant women will have Medicaid coverage for the 45-day period during which their formal Medicaid applications are being processed by the state agency.

a) **Why presumptive eligibility is important**

Presumptive eligibility is important for seven reasons:

- First, the program permits commencement of Medicaid coverage on the day that pregnant women first seek maternity care. At their initial visit, pregnant women can be enrolled in Medicaid and thus insured for all necessary outpatient care.

- Second, the program permits states to better consolidate Medicaid with other pregnancy programs. As noted above, federal law has always permitted Medicaid agencies to make Medicaid applications available through their health providers, who in turn can assist their patients apply for coverage. Some health department and other clinical providers now do this. But the presumptive eligibility program improves on this option by actually permitting certain providers to make a Medicaid eligibility determination so that their patients are temporarily insured while their formal applications are pending.

- Third, permitting Medicaid to be placed with other health services constitutes a tremendous Medicaid outreach program. By placing the benefits where the patients are, a presumptive eligibility program better ensures that the large number of Medicaid-eligible, but unenrolled, women will enter the program.

- Fourth, the program stimulates and encourages pregnant women to receive early and continuous prenatal care by reducing financial considerations that may affect their decision to remain in a prenatal care program once they have initially sought services.

- Fifth, the program is low-cost. Establishing a presumptive eligibility determination process itself should be reimbursable as a Medicaid administrative expense; morever, since Medicaid coverage is already retroactive to the date of application, the state will incur extra costs only for women who ultimately are found ineligible for coverage, and then only for outpatient care.

- Sixth, PE, by increasing the likelihood that a woman will seek out and remain in a pregnancy program, promotes access to cost-effective care. Studies have shown that nearly $2.00 can be saved by Medicaid for every dollar spent to provide early comprehensive and continuous prenatal care to pregnant women, by reducing the number of low birthweight infants who need extraordinary levels of care during the first year of life.

- Finally, a state suffers no penalty in the event that a presumptively eligible woman is ultimately not found eligible for permanent coverage. States keep the federal funds paid to providers on behalf of presumptively eligible women and will thus receive federal matching funds for expenditures for prenatal care furnished to indigent women that otherwise might have been made entirely out of state and local offers. If a woman is ultimately not found eligible for Medicaid after her period of presumptive eligibility, the presumptive determination is not considered erroneous under federal Medicaid error rate rules,[25a] and the state is not liable for recoupment of federal funds claimed for services furnished to presumptively eligible women. Presumptive eligibility is just that -- a period of time during which a pregnant woman is treated as if she had applied and been found eligible for Medicaid.

b) **Elements of the Presumptive Eligibility Program**

1) Who is eligible for presumptive eligibility?

Any woman whose pregnancy has been verified and who is determined by a qualified PE provider, on the basis of "preliminary information" to have family income that does not exceed the state's Medicaid eligibility level. The presumptive eligibility program uses no resource test.[26] Any pregnant woman whose income is low enough is presumptively eligible. As with permanent Medicaid eligibility, no categorical test may be applied. All pregnant women, regardless of family composition work status, are potential candidates for both regular and presumptive Medicaid benefits.

2. What benefits are covered during the presumptive eligibility period?

A presumptively eligible woman is entitled to coverage for all ambulatory prenatal care services provided under a state's Medicaid plan.[27] No inpatient care may be reimbursed on the basis of presumptive eligibility. However if a woman is hospitalized after she has filed her formal Medicaid application (or up to 3 months prior to the date on which she files the application if she was eligible at the time services were rendered) her hospital bills will be covered retroactively once she is found eligible for permanent coverage.

3. When does presumptive eligibility begin?

Presumptive eligibility begins on the date on which a "qualified" PE provider determines, on the basis of "preliminary information,"[28] that the woman's family income does not exceed the state's Medicaid income eligibility level.

4. When does presumptive eligibility end?

Presumptive eligibility lasts for 45 days after the date on which a woman's presumptive eligibility is determined.[29] If the state completes work on the woman's formal Medicaid application in less than this 45-day period, then the presumptive eligibility period ends as of the date that eligibility is finally determined.[30] As of that date, either the woman's regular Medicaid eligibility begins, or else she is no longer covered by Medicaid.

HOWEVER: A woman's presumptive eligibility period will end 14 days after the date on which she is found eligible by the presumptive eligibility provider if she fails to file a formal Medicaid application with the Medicaid agency within 14 days.[31] Thus, it is vital that women file a formal Medicaid application as soon as their PE period begins.

5. Who can be a presumptive eligibility provider?

Only certain types of Medicaid maternity providers can act as presumptive eligibility providers. Moreover, states are given wide discretion to select among the qualified PE providers they wish to use (in other words, not all providers that meet federal qualifications need be given PE contracts, even though all qualified providers must be allowed to furnish medical assistance).[32]

The term "qualified provider", in the context of presumptive eligibility, means any provider that:

1) is participating as a Medicaid provider under the state's plan; and

2) furnishes "services of the type described in Section 1905 (a)(2) or 1905(a)(9) of the Act -- that is, a provider that is either hospital outpatient or freestanding clinic. Only maternity providers that are also clinics -- either hospital-based or free-standing, -- are eligible to act as presumptive eligibility providers; and

3) receives funding under the Community or Migrant Health centers programs, OR the Title V Maternal and Child Health Block Grant, OR is a participant in a state's perinatal health services program OR is a WIC or Commodity Supplemental Food Program grantee.[33]

As a practical matter, only states that reimburse clinical providers at a clinic rate should use PE. A PE clinic thus

provide or purchase under contract with office-based physicians, pharmacies, and so forth, services needed during the PE period and bill Medicaid for all care rendered. Doctors who are not clinic-based cannot be PE providers. But PE providers can refer their patients to office-based physicians, reimburse them under contract as clinical staff, and bill Medicaid directly for all covered services.

b) What reponsibilities do states have under the PE program?

States must:

- o develop income eligibility criteria for PE providers to use
- o develop a PE application form
- o select PE providers
- o determine the type of "preliminary information" a provider may use to determine a woman's eligibility (but this information may not include a resource test).
- o supply providers with regular Medicaid application forms and training so that they can assist women apply for benefits.

- o ensure that the formal Medicaid application can be filed within the required 14-day period.

- o Ensure that women's formal Medicaid applications are processed quickly and that PE providers are trained to assist their patients identify and gather all verification that is needed.

7) What are the obligations of presumptive eligibility providers?

Providers must:

- o make sure that workers are properly trained to not only make the presumptive determination but also to provide assistance on completing and filing the formal Medicaid application.
- o Use all forms designated by the state agency and file the names of PE women within 5 days.
- o ensure that applications for regular Medicaid benefits are filed within 14 days.

8. How would a good presumptive eligibility program operate?

To be simple and effective, PE should be instituted in states that have:

a) developed simple income eligibility criteria.
b) used the SOBRA option to waive the asset test, so that PE standards and formal Medicaid standards are as closely aligned as possible.
c) developed a "short form" for Medicaid applications for pregnant women that can double as both the PE and the regular application form. This allows consolidation of the PE and formal application form into one step to be completed at the provider's location and filed with the state.

a) developing a simple income eligibility chart

(1) In states that elect to use a Medicaid eligibility level equalling 100 percent of the federal poverty level, the income eligibility chart furnished to PE providers can be the federal poverty guidelines for a family of two or larger. See table III, reproduced from the 1987 Federal Register.

(2) In states whose SOBRA income eligibility is lower than the federal poverty level, special income criteria for families of two or larger will have to be developed. To develop schedule, states could take their AFDC eligibility levels (either the payment standard or, in five states including SC, MS, UT, ME, and CO, the standard of need) and instruct provider to add $235.00 in the case of working applicants to take into account an allowance for work-related and child care costs. States could also simply use 185% of the AFDC standard of need for families of 2 or larger (this is the initial AFDC eligibility threshold).

States with medically needy programs could use the medically needy income level for families of two or greater (increased by

$235.00 per unit for working families work-related and child care expenses). For example, if the AFDC income eligibility level for a family of three is $500, the PE income level applied to a working pregnant woman with one child already born would be $735 ($500 + 235.00 for child care and work-related expenses).

The best test of all would probably be a two-tiered one consisting of either the state's SOBRA level (whatever it is) or 185 percent of the AFDC standard of need for families of two or greater. This would pick up women whose incomes exceed SOBRA levels but are low enough to permit them to be considered for categorically needy coverage.

b) Waiving the asset test

Once a state waives application of an asset standard, PE is more easily meshed with formal Medicaid eligibility. Both programs would require only that a woman's pregnancy be verified and that she be income-eligible.

c) developing a "short form" for PE and formal Medicaid applications

With financial eligibility criteria pared down to a minimum, a PE application form that doubles as the regular application form can be developed. The essential elements of the form are as follows:

- Date
- Name of woman
- Name of PE provider and the provider's Medicaid ID Number
- Social Security Number of the woman (or affirmation that the woman has or will apply for a number).
- Verification that the woman has been found to be pregnant
- A statement of the woman's estimated monthly income and an

affirmation that her income is to be equal to or less than the state's income eligibility level for a family of that size. Earned and unearned income (such as disability or child support payments) should be separated listed. Step-parent income and incomes of a minor applicant's siblings should not be included.

- o Verification of the woman's legal status (affirmation of citizenship or lawful alienage status) including temporary status under the 1986 immigration amendments.
- o Affirmation that the woman is a resident of the state
- o Any information pertaining to private insurance the woman has.

These are the basic items that will be needed (along with documentation, which the woman can supply at a later date) to prove that she is eligible for formal Medicaid coverage. The items are not so lengthy that they cannot readily be added to the PE form.

9. What is "preliminary information" that is used to determine PE income eligibility?

The type of information that can be used by providers to preliminarily determine Medicaid eligibility is not defined by law and can be identified by states. Since the purpose of this program is to permit providers to make the determination quickly, states should keep their definition simple. Ideally, the information should be the same type of information that providers use to make eligibility determinations for their other programs. Thus, if eligibility for Title V, WIC, or community health center subsidized services is based on a patient's oral affirmation that her income is below the eligibility level for the program, then the state Medicaid agency should use oral affirmation for its program.

The bottom line is to **KEEP IT SIMPLE.** States can choose the type of information they will require. Congress was so concerned about the need to get benefits to pregnant women that it has allowed states to reduce or entirely eliminate normal documentation procedures during the PE period. Moreover, because only federally or state-funded clinics praticed in doing eligibility determinations can be PE providers, this in and of itself acts as a safeguard.

C) States that do not wish to use PE

Some states may decide that for various reasons they do not want to adopt PE. Even if a state choose not to use PE, it should be persuaded to:

- Waive the asset test
- develop an income screening charts for providers to use to identify eligible women
- develop a "short form" application
- distribute the short form to providers
- arrange for an expedited determination of Medicaid eligibility in the case of pregnant women.

However, once formal Medicaid eligibility is simplified it should be relatively simple to add PE and modify the Medicaid claims payment system to pay PE providers for services furnished to women during the 45-day period following the date of presumptive eligibility. States wishing to use this option should reimburse PE providers on the basis of a cost-based clinic rate for services furnished during the 45-day period. The PE provider can furnish the service directly or subcontract for services not furnished in the office, pay the subcontractor, and then bill Medicaid on an all-inclusive basis.

FOOTNOTES

1. Egbuonu, Lisa & Starfield, Barbara, "Child Health and Social Status," 69 Pediatrics 550 (May, 1982).

2. Ibid.

3. U.S. Dept. of Health and Human Services, Healthy People (HHS, 1979).

4. Hughes, Dana, Johnson, Kay, Rosenbaum, Sara, Simons, Janet, Butler, Elizabeth, The Health of America's Children (CDF, Washington. D.C., 1987).

5. Ibid

6. National Center for Health Services Research, National Hospital Discharge Survey (1984 data).

7. Kleinman, Joel, Use of Ambulatory Care by the Poor: Another Look at Equity" Medical Care (1981).

8. Ibid.

9. Gold, Rachel and Kenny, Asta, "Paying for Maternity Care", Family Planning Perspectives (May/June, 1985).

10. Ibid.

11. Statistics derived from National Medical Expenditure Survey data presented in Wilensky, Gail and Berk, Mark, "Health Care of the Poor and the Role of Medicaid."

12. Rosenbaum, Sara "Reducing Infant Mortality: The Unfulfilled Promise of Federal Health Programs for the Poor", Clearinghouse Review (1983).

13. CRS, Infant Mortality (Washington, D.C., 1985).

14. California Health Department, Final Evaluation of the Obstetrical Access Project (1985).

15. Hughes, op. cit.

16. Unpublished data, National Governor's Association.

17. Pub. L. 99-272.

17a. Section 9501 of Pub. L. 99-272.

18. Rymer, Marilyn Comprehensive Review of Medicaid Eligibility (Urban Systems Services, Inc., 1977).

19. Sec., e.g., Jones, Judith, presentation at APHA, October 1985, regarding Medicaid eligibility among New York city women.

20. 42 CFR Section 435.911 requires that Medicaid agencies complete the determination process on application filed by non-disabled persons within 45 days of the date they are filed.

20a. 42 CFR Section 435.907.

21. 42 USC Section 1396a(a)(34).

21a Section 9401 of Pub. L. 99-507.

21b Computation by Sara Rosenbuam, based on 1984 census data.

21c Section 9401 of Pub. L. 99-507.

21d Ibid.

22. State officials indicate show that only about 4 percent of AFDC applicants are rejected on the ground that they have excess assets. Virtually none of these applicants would be rejected if the SSI test were used, since the basis for the rejection often has to do with possession of a slightly too valuable car or extra household goods. All of these non-liquid assets (as well as liquid resources) are treated more liberally under the SSI program.

23. 42 CFR Section 431.800.

24. Section 9501 of Pub. L. 99-507.

25. See HCFA Transmittal dated August, 1986.

25a Section 9407 of Pub. L. 99-5-7.

25b Ibid

26. Ibid

27. Ibid

28. Ibid

29. Ibid

30. Ibid

31. Ibid

32. Ibid.

33. Ibid.

Appendix A

Table 1.
Annualized Medicaid Eligibility Thresholds –
AFDC, Medically Needy, SSI – as Percent of Poverty
Current as of December 1986

State	AFDC Family of 3	Percent of Poverty ($9,120)[2]	Medically Needy Family of 3	Percent of Poverty ($9,120)[2]	SSI Independent Individual[3]	Percent of Poverty ($5,360)[3]
Alabama	$1,416	15.5%	[3] –	– %	$4,752	88.7%
Alaska	8,880	77.9	–	–	7,260	108.4
Arizona[4]	–	–	–	–	–	–
Arkansas	2,304	25.3	3,100	34.0	4,032	75.2
California	7,404	81.2	9,900	108.6	6,396	119.3
Colorado	5,052	55.4	–	–	4,728	88.2
Connecticut	6,060	66.4	7,300	80.0	5,780	107.8
Delaware	3,720	40.8	–	–	4,032	75.2
District of Columbia	4,200	46.1	5,800	63.8	4,212	78.6
Florida	3,024	33.2	4,092	44.8	4,032	75.2
Georgia	3,072	33.7	4,104	45.0	4,032	75.2
Hawaii	5,616	53.5	5,700	54.3	4,091	66.3
Idaho	3,648	40.0	–	–	4,656	86.9
Illinois	4,092	44.9	5,496	60.3	–[5]	–
Indiana	3,072	33.7	–	–	4,032	75.2
Iowa	4,572	50.1	6,096	66.8	4,032	75.2
Kansas	4,524	49.6	5,520	60.5	4,032	75.2
Kentucky	2,364	25.9	3,204	35.1	4,032	75.2
Louisiana	2,280	25.0	3,096	33.9	4,032	75.2
Maine	6,432	70.5	6,300	69.0	4,152	77.5
Maryland	4,140	45.4	4,908	53.8	4,032	75.2
Massachusetts	5,712	62.6	7,896	86.5	5,578	104.1
Michigan	5,388	59.0	6,252	68.5	4,366	81.4
Minnesota	6,384	70.0	6,384	70.0	4,452	83.1
Mississippi	4,416	48.4	–	–	4,032	75.2
Missouri	3,348	36.7	–	–	4,032	75.2
Montana	3,984	43.7	4,848	53.2	4,032	75.2
Nebraska	4,200	46.1	5,400	59.2	4,692	87.5
Nevada	3,420	37.5	–	–	4,469	83.4
New Hampshire	4,668	51.2	5,604	61.4	4,200	78.4
New Jersey	4,848	53.2	6,492	71.2	4,407	82.2
New Mexico	3,096	33.9	–	–	4,032	75.2
New York	5,964	65.4	7,300	80.0	4,895	91.3
North Carolina	2,952	32.4	3,996	43.8	4,032	75.2
North Dakota	4,452	48.8	5,220	57.2	4,032	75.2
Ohio	3,624	39.7	–	–	4,032	75.2
Oklahoma	3,720	40.8	5,004	54.8	4,752	88.7
Oregon	4,764	52.2	6,348	69.6	4,052	75.6
Pennsylvania	4,380	48.0	5,100	55.9	4,421	82.5
Rhode Island	5,292	58.0	7,600	83.3	4,698	87.6
South Carolina	4,560	50.0	3,192	35.0	4,032	75.2
South Dakota	4,392	48.2	–	–	4,212	78.6
Tennessee	1,860	20.4	2,496	27.3	4,032	75.2
Texas	2,208	24.2	3,204	35.1	4,032	75.2
Utah	8,316	91.2	6,012	65.9	4,152	77.5
Vermont	6,372	69.9	7,296	80.0	4,700	87.7
Virginia	3,492	38.3	4,300	47.1	4,032	75.2
Washington	5,904	64.7	6,624	72.6	4,368	81.5
West Virginia	2,988	32.8	3,480	38.1	4,032	75.2
Wisconsin	6,528	71.6	7,692	84.3	5,252	98.0
Wyoming	4,320	47.4	–	–	4,272	79.7
Average State	**$4,428**	**48.2%**	**$5,470**	**59.5%[6]**	**$4,422**	**81.8%**

Source: Ian Hill, State Medicaid Information Center, National Governors' Association, December 1986.

TABLE II

In 1986, levels for AFDC payment and Medicaid coverage for families with no other income were extremely low. The unweighted national average among states was only 47.4 percent of the federal poverty level. In no state did payment levels reach the federal poverty level. Thirty-two states maintained payment levels less than 50 percent of the federal poverty level for a family of three.

The standard of need is the threshold for determining AFDC and Medicaid eligibility for most families with children. In theory it reflects the amount a family would need to subsist, but in most states it is much lower. In 1986 the standard of need in Alabama was $384 a month for a family of three (50.5 percent of the federal poverty level).

In 1986, payment levels to AFDC recipients were so low that in more than half of the states actual payments did not meet their own official definition of the amount a family would need to subsist. The payment level in Alabama was only 31 percent of its standard of need, which was only 50.5 percent of the federal poverty level (see Table 2.21b). In dollars, this meant a payment of $118 per month for a family of three.

TABLE 2.21A

AFDC Maximum Payment Levels* and Medicaid Coverage for Families with No Other Income as a Percent of the Federal Poverty Level, 1986

Rank	*State Name*	*Percent*
1	Alaska	77.9
2	California	77.2
3	Vermont	76.7
4	Connecticut	74.9
5	Wisconsin	72.9
6	Minnesota	69.5
7	Rhode Island	66.2
8	New York	65.4
9	Washington	64.7
10	Michigan	63.9
11	Massachusetts	56.6
12	Hawaii	53.5
13	New Jersey	53.2
14	Oregon	52.2
15	Kansas	51.5
16	Maine	51.2
17	New Hampshire	51.2
18	Pennsylvania	50.3
19	Iowa	50.1
20	Utah	49.5
21	North Dakota	48.8
22	Wyoming	47.4
23	Montana	46.6
24	Virginia	46.6
25	Nebraska	46.1
26	Colorado	45.5
27	Illinois	44.9
28	Maryland	43.3
29	South Dakota	43.3
30	District of Columbia	43.0
31	Oklahoma	40.5
32	Idaho	40.0
33	Ohio	39.7
34	Delaware	39.2
35	Arizona	36.6
36	Nevada	37.5
37	Missouri	36.1
38	New Mexico	33.9
39	Indiana	33.7
40	Florida	33.2
41	West Virginia	32.8
42	North Carolina	32.4
43	Georgia	29.3
44	South Carolina	26.2
45	Kentucky	25.9
46	Arkansas	25.3
47	Louisiana	25.0
48	Texas	24.2
49	Tennessee	20.1
50	Mississippi	15.5
51	Alabama	15.5

*All AFDC recipients are entitled to Medicaid coverage

Source: National Center for Health Statistics. Calculations by Children's Defense Fund

TABLE III

Federal Poverty Guideline

Family Size	Continental U.S.	Alaska	Hawaii
2	7,400	9,240	8,500
3	9,300	11,620	10,690
4	11,200	14,000	12,880
5	13,100	16,380	15,070
6	15,000	18,760	17,260
7	16,900	21,140	19,450
8	18,800	23,520	21,650
Each Add'l	+1,900	+2,380	+2,190

The HHS notice defines "family" as "all persons related by birth, marriage or adoption who reside together" (unrelated individuals, even in the same house, would be considered separate families); and it defines "income" as "total annual cash receipts before taxes from all sources" (including salaries, public assistance/unemployment/retirement payments, Social Security, child support, etc., but excluding gifts, assets from sale of property, or non-cash benefits such as Medicaid, food stamps, public housing, etc.)

* Family size of 1 is inapplicable to pregnant women.

Source: Fed. Reg. 2/20/87

ALASKA STATE LEGISLATURE
HOUSE OF REPRESENTATIVES
RESEARCH AGENCY

P.O. Box Y, State Capitol
Juneau, Alaska 99811-3100
Mail Stop 3100
(907) 465-3991

October 7, 1987

MEMORANDUM

TO: Representative Niilo Koponen

ATTN: Lisa McLaren

FROM: Brad Pierce
Legislative Analyst

RE: Omnibus Budget Reconciliation Act (OBRA) Option for Pregnant Women
Research Request 88.052

You requested this agency to analyze some assumptions used by the Alaska Department of Health and Social Services (DHSS) in computing the cost of adopting the Omnibus Budget Reconciliation Act of 1986 (OBRA) option for pregnant women, infants and children. This option would allow pregnant women, infants and children with family incomes above the current State Medicaid threshold income level ($8,988 for a family of three) but below the federal poverty level ($11,620) to receive Medicaid payments for prenatal, delivery and post partum medical services.[1] The federal government would share the cost of the program at a 50 percent matching rate.

We have included the DHSS cost estimates for this option as well as background material explaining the program in detail in Attachment A. According to Nancy Bennett, Acting Program Officer with the DHSS-Division of Medical Assistance, the total cost of offering the OBRA option would be approximately $5.2 million, exclusive of increased administrative costs to the department for the anticipated increase in their Medicaid caseload. The methodology used in this estimate is straightforward--simply multiplying the average cost per delivery for pregnant Medicaid women in Anchorage ($4,163) plus the Medicaid cost for children up to age one ($1,198) times the estimated number of eligibles (974). There are several reasons to be cautious in using this estimate, however.

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[1]Aid to Families with Dependent Children (AFDC) resource eligibility criteria for pregnant women may be eliminated under the OBRA option in favor of simple income threshold criteria. States which do not choose to eliminate resource eligibility criteria cannot adopt more restrictive standards and must use the SSI standard.

First, the number of potential eligibles was taken from a National Governor's Association report, using 1980 census data to derive their estimates for each state, which makes it quite dated. According to Greg Williams, State Demographer, there are no more recent income distribution figures by state from which to make more accurate estimates. The current DHSS vital statistics database cannot provide information on the number of statewide Medicaid pregnancies and is therefore useless in this regard. A new Medical Management Information system will become operative in 1988, which will make this information available in the future.

Another uncertainty is the number of potential eligibles that are already receiving financial assistance from other sources, most notably the Indian Health Service (IHS). According to Jackie Greenman, Chief of Maternal and Child Health Care, the IHS has handled 2,500 - 2,700 deliveries annually during the past few years (out of approximately 13,000 deliveries statewide). For those IHS clients who would qualify for Medicaid under the OBRA option, transportation expenses and prematernal home services (for high-risk pregnancies) are likely to be the main costs picked up by the program. These individuals would then have costs that are substantially lower than average Medicaid pregnancy costs. On the other hand, just a few complicated pregnancies could dramatically increase the cost of the program. For example, the State's Catastrophic Illness Program (no longer in existence) experienced an average pregnancy cost of $31,928 and single cases that cost over $200,000.[2]

All of the factors listed above add uncertainty to the estimation of the cost of the adoption of the OBRA option. The health care providers we have spoken with in preparing this memorandum focus on fulfilling perceived health care needs, not on costs. The DHSS-Medical Payment System cannot provide the information necessary to make accurate forecasts. Information from other states with different population characteristics and health care cost structures is not readily applicable. In short, we have examined the cost estimates used by DHSS for the OBRA option and have found no information that would allow a more accurate forecast. In our judgment, the $5.2 million total cost figure by DHSS may overstate actual costs somewhat because some of the potential eligibles may be receiving primary care from other sources. However, the great amount of uncertainty inherent in these projections indicates that using the upper range of probable cost is prudent budget planning.

I regret that we have not been able to answer your question more conclusively. Please call if we can be of further assistance or if you have any questions.

Attachment

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[2]For an analysis of the Alaska Catastrophic Illness Program, see House Research Agency memorandum 87.002.

ATTACHMENT A
Memorandum to Karen Perdue from Nancy Bennett,
Optional Coverage of Categorically Needy Groups Article,
National Governors' Association Article and
"Expanded Medicaid Coverage for Pregnant Women
and Children" Issue Paper

MEMORANDUM State of Alaska

TO: Karen Perdue, Deputy Commissioner
Department of Health & Social Services

DATE: September 11, 1987

FILE NO: M-1

TELEPHONE NO: 465-3355

THRU:

SUBJECT: OBRA option for pregnant women and children

FROM: Nancy Bennett, Acting Program Officer
Division of Medical Assistance

You have asked for cost estimates for adopting the new OBRA Medicaid option covering pregnant women and children with incomes up to 100% of the federal poverty level. This estimate comes with several caveats, of which you are well aware, but they include: 1) inadequate data concerning the number of potential eligibles; 2) lack of data to base transportation, neonatal intensive care unit and extraordinary medical procedure cost factors; and 3) lack of data relating to IRS transportation cost shift. Given these factors, I have estimated the cost of adopting the option (including only current Medicaid covered services; excluding enhanced services and new positions which may be requested by DPA) at $5,221,614.

This estimate is based on the existing average cost for Medicaid pregnant women and children (including inpatient hospital care, physician services and laboratory and x-ray services). The average cost per pregnant woman is $4,163 or $4,054,762 for all pregnant women in the OBRA group. The average cost per child is $1,198 or $1,166,852 for all newborns in the OBRA group. The number of persons used in making this estimate is 974; the estimate made by the National Governor's Association by extrapolating the data from their telephone survey and the 1980 census figures. These costs would be shared at the federal matching rate - 50%.

Given that the average cost in Anchorage for a normal delivery, including prenatal care is $3,510; and the range for a cesearean section is $5,180 to $7,180 (and a 25% C-section rate in the state); the $4,163 figure may be low. In addition, we believe that prenatal and delivery costs in other parts of the state are much higher (we will have a break down of these costs by region from Public Health in a few weeks). With all these "yellow lights", it's the best estimate we can make right now.

3571 OPTIONAL COVERAGE FOR POOR PREGNANT WOMEN, INFANTS, AND CHILDREN

Section 9401 of the Omnibus Budget Reconciliation Act of 1986 (OBRA 86) authorizes a new optional categorically needy eligibility group of poor pregnant women (through 60 days following pregnancy), infants and children. In determining financial eligibility for this group you may set an income standard which does not exceed 100 percent of the Federal poverty level. You need not employ a resource standard. The Federal poverty levels are published in the Federal Register annually within 30 days after the Consumer Price Index data are released. The methods and standards employed in determining income and resource eligibility may not be more restrictive than those applied under the cash assistance programs, as described in detail below.

3571.1 Coverage of Poor Pregnant Women, Infants, and Children.—Section 9401 amends §1902(a)(10)(A)(ii) of the Act and adds §1902(l), creating a new optional categorically needy group. This new group consists of pregnant women, infants, and children who do not qualify as mandatory categorically needy (are not cash assistance recipients or qualified pregnant women or qualified children under age 5) and whose family income does not exceed a level you have established. This level must not exceed 100 percent of the Federal poverty level. Application of a resource standard is optional. You may elect this group only if:

- o Payment levels in effect under your established AFDC plan (part A of title IV) are not less than the payment levels in effect under the AFDC plan on April 17, 1986, and
- o You cover both pregnant women (through 60 days following pregnancy) and infants under 1 year of age.

You may not cover only pregnant women or only infants and children. If you opt to cover one group, you must also cover the other. Furthermore, those which elect to cover groups of children over age 1 must cover all children below the age specified (up to age 5). Coverage of children over age 1 may be phased-in in accordance with the effective dates set out in §3571.5.

3571.2 Financial Requirements of the New Group.--

A. Income Standards.—Family income level must not exceed your set income level for the appropriate family size. The family income level shall be no higher than 100% of the official nonfarm income poverty level applicable for a family size equal to the size of the family, including the woman, infant, or child. The pregnant woman will be budgeted as if her child were born and living with her at the time she applied for assistance.

The official nonfarm income poverty level is determined by the Department of Health and Human Services and published in the Federal Register annually in or around the month of February. The published levels apply to both nonfarm and farm income standards.

B. Income Methodologies.—Family income must be determined in accordance with the methodology applied under the State AFDC or the State IV-E adoption assistance or foster care plan, as appropriate. Family income is income remaining after appropriate disregards are applied.

Costs incurred for medical care or for any other type of remedial care shall not be taken into account. That is, no spenddown is applied to the new group. Individuals who do not meet the eligibility criteria for this new optional categorically needy group must meet current medically needy eligibility criteria to establish eligibility.

C. Resource Standards and Methodologies.—The application of a resource standard for the pregnant woman, infant, or child is at your option.

If you set a resource standard for pregnant women and women during the 60-day extended period, that standard and the methodology applied may be no more restrictive than that applied in the Supplemental Security Income Program.

If you set a resource standard for infants and children, that standard and the methodology applied may be no more restrictive than that applied in the State AFDC plan.

NOTE: If you establish resource standards for both the woman and an infant or child, you may need to perform two separate resource computations, since the woman's resources are determined in accordance with SSI methods and the infant or child's resources are determined in accordance with AFDC methods. As a result, you may count the same resources in each computation.

3571.3 Benefits.--

A. Pregnant Women.—Benefits to pregnant women eligible under this new category are limited to services related to pregnancy, including prenatal, delivery and post partum services, and other conditions which may complicate pregnancy. While we are not listing specific services or conditions to be included, States are expected to reasonably interpret these statutory provisions. Services included must be services which are coverable under §1905 of the Act.

B. Children.—Children eligible under this new category are entitled to all services included in the State plan.

3571.4 Continuation of Assistance.—

A. Pregnant Women.—Once a pregnant woman is determined eligible for services under the optional categorically needy group and continues to meet all established eligibility criteria you must provide services throughout the pregnancy and the 60-day period beginning the last day of the pregnancy. The woman may remain eligible, at your option, during the pregnancy and through the end of the 60-day period beginning on the last day of her pregnancy without regard to any change in family income.

B. Children.—If an infant's or child's eligibility ends because the maximum age with respect to which you provide coverage has been reached, but the child continues to meet all other eligibility criteria, and is receiving inpatient services provided under the State plan on the date that eligibility should end, the child's eligibility continues until the end of his or her inpatient stay.

3571.5 Effective Dates of §9401 of OBRA 86.—

- o Pregnant Women and Infants Under Age 1: April 1, 1987
- o Children between Ages 1 and 2: October 1, 1987
- o Children between Ages 2 and 3: October 1, 1988
- o Children between Ages 3 and 4: October 1, 1989, and
- o Children between Ages 4 and 5: October 1, 1990.

These effective dates are without regard to whether or not final regulations have been promulgated by the applicable date. If you elect to cover this group, do so by indicating your election on the revised State plan preprint, and submit the amendment to the appropriate HCFA Regional Office for review.

o U.S. GOVERNMENT PRINTING OFFICE 1987—181-270 60270

National Governors' Association

John H. Sununu
Governor of New Hampshire
Chairman

Raymond C. Scheppach
Executive Director

September 8, 1987

TO ALL MEDICAID DIRECTORS:

MEDICAID ELIGIBILITY THRESHOLDS FOR FAMILIES AND PREGNANT WOMEN
INFORMATION UPDATE

The Health Policy Studies unit at the National Governors' Association continues to receive frequent inquiries regarding state income eligibility thresholds under Medicaid and updated information on states which are adopting OBRA-86 authority to provide Medicaid for pregnant women and young children with family income up to the federal poverty level. The attached table represents our most current data. Three types of income levels are presented for each state (where applicable) - AFDC eligibility thresholds, Medically Needy Protected Income Levels, and OBRA-86 special income levels for pregnant women and young children. In all cases, income limits for a family of three (the average unit size under AFDC) are displayed.

At this time, 24 states will, by January 1, 1988, provide Medicaid coverage to pregnant women and young children under special income ceilings allowed by OBRA-86. Two other states, California and Minnesota, provide such expanded coverage under medically needy authority. This level of activity is noteworthy, given that optional authority under OBRA-86 was granted less than one year ago and states have had only one legislative session under which to develop, approve and implement program expansions. Several other states, including Pennsylvania, Ohio, Virginia, Georgia and Hawaii, will either receive final approval this year, or pursue pregnant women expansions in their next sessions. Additionally, up to eleven states either have or plan to adopt presumptive eligibility programs for pregnant women (Arkansas, Florida, Maine, Maryland, New Jersey, New York, North Carolina, Pennsylvania, Tennessee, Utah, and Wisconsin).

Under the AFDC programs, nearly one-half of the states increased their income eligibility thresholds on July 1, 1987. This level of activity is much higher than in past years, when states have been slow to adjust income limits under AFDC. Today, the AFDC eligibility threshold for a family of three, in the average state, is $4,616 per year - or 49.3% of the federal poverty level. This amount represents an improvement over the average state rate of 48.9% in January 1987 and 47.9% in January 1986, and thus marks a reversal in the decade-long trend of declining AFDC thresholds which in 1975 averaged 71.4% of poverty for a family of three.

Twenty states also increased their medically needy income thresholds in July of this year. The annual limit for a family of three in the average state is now $5,748 (61.3% of the federal poverty level), an improvement over the level in January 1987, which was set at 59.8% of poverty.

For further information, call Ian Hill at 202-624-7820.

ANNUALIZED MEDICAID ELIGIBILITY THRESHOLDS[1] -
AFDC, MEDICALLY NEEDY - AS OF JULY 1987
OBRA-86 PREGNANT WOMEN - EFFECTIVE BY JANUARY 1988

	AFDC Family of 3	Percent of Poverty ($9,300)[2]	Medically Needy Family of 3	Percent of Poverty ($9,300)[2]	OBRA-86 Pregnant Women Family of 3	Percent of Poverty (9,300)[2]
Alabama	$1,416	15.2%	$---	---%	$ ---	---%
Alaska	8,988	77.3	---	---	---	---
Arizona	3,516	37.8	---	---	9,300	100
Arkansas	2,424	26.1	3,300	35.5	6,975	75
California	7,596	81.7	10,200	109.7	10,200	109.7[3]
Colorado	5,052	54.3	---	---	---	---
Connecticut	6,168	66.3	7,500	80.6	9,300	100
Delaware	3,720	40.0	---	---	9,300	100
District of Columbia	4,368	47.0	5,820	62.6	9,300	100
Florida	3,168	34.1	4,308	46.3	9,300	100
Georgia	3,156	33.9	4,200	45.2	---	---
Hawaii	5,892	55.1	5,892	55.1	---	---
Idaho	3,648	39.2	---	---	---	---
Illinois	4,104	44.1	5,496	59.1	---	---
Indiana	3,456	37.2	---	---	---	---
Iowa	4,572	49.2	6,096	65.5	---	---
Kansas	4,596	49.4	5,580	60.0	---	---
Kentucky	2,364	25.4	3,204	34.5	9,300	100
Louisiana	2,280	24.5	3,096	33.3	---	---
Maine	6,696	72.0	6,492	69.8	---	---
Maryland	4,308	46.3	5,004	53.8	9,300	100
Massachusetts	6,600	71.0	8,796	94.6	9,300	100
Michigan	6,480	69.7	6,444	69.3	9,300	100
Minnesota	6,384	68.6	8,508	91.5	8,508	91.5[4]
Mississippi	1,416	47.5	---	---	9,300	100
Missouri	3,384	36.4	---	---	9,300	100
Montana	4,308	46.3	4,848	52.1	---	---
Nebraska	4,200	45.2	5,400	58.1	---	---
Nevada	3,420	36.8	---	---	---	---
New Hampshire	5,832	62.7	6,468	69.5	---	---
New Jersey	5,088	54.7	6,792	73.0	9,300	100
New Mexico	3,168	34.1	---	---	9,300	100
New York	5,964	64.1	7,400	79.6	---	---
North Carolina	3,108	33.4	4,200	45.2	9,300	100
North Dakota	4,452	47.9	5,220	56.1	---	---
Ohio	3,708	39.9	---	---	---	---
Oklahoma	3,720	40.0	5,004	53.8	9,300	100
Oregon	4,944	53.2	6,588	70.8	7,905	85
Pennsylvania	4,380	47.1	5,100	54.8	---	---
Rhode Island	6,036	64.9	7,896	84.9	9,300	100
South Carolina	4,656	50.1	---	---	9,300	100
South Dakota	4,392	47.2	---	---	---	---
Tennessee	4,236	45.5	2,604	28.0	9,300	100
Texas	2,208	23.7	3,204	34.5	---	---
Utah	8,316	89.4	6,012	64.6	9,300	100
Vermont	7,236	77.8	7,404	79.6	9,300	100
Virginia	3,492	37.5	4,300	46.2	---	---
Washington	5,904	63.5	6,804	73.2	8,370	90
West Virginia	2,988	32.1	3,480	37.4	9,300	100
Wisconsin	6,600	71.0	8,268	88.9	---	---
Wyoming	4,320	46.5	---	---	---	---
Average State	$4,616	49.3%	$5,748	61.3%[5]	$9,125[6]	98.1%

SOURCE: State Medicaid Information Center, National Governors' Association
July 1987

NOTES

1. Based on annualized monthly maximum countable income for a family of three (AFDC, Medically Needy, OBRA-86 Pregnant Women). Under AFDC, the term "threshold" refers to that income limit which truly drives program eligibility, and can be either a state's AFDC Need or Payment Standard, depending on how each state determines eligibility.

2. Poverty levels for Alaska and Hawaii differ from other states: Alaska - family of 3 = $11,620; Hawaii - family of 3 = $10,690.

3. California already covers pregnant women (and all other groups) with family income below the federal poverty level by virtue of its medically needy threshold.

4. In response to OBRA-86, Minnesota elected to raise its medically needy threshold to the highest possible level (133 1/3% of AFDC payment standards) and, as a result, now covers all pregnant women with family incomes up to 91.5% of the federal poverty level.

5. The percentage represents the average medically needy threshold as a percent of poverty only for those states which have medically needy programs. If states without medically needy programs were included in the calculation (AFDC levels would represent eligibility thresholds), the percentage would drop significantly.

6. The percentage represents the average OBRA-86 pregnant women income threshold only for those states which have elected to expand such coverage, and includes California and Minnesota.

ISSUE PAPER

TOPIC: Expanded Medicaid coverage for pregnant women and children

September 4, 1987

CURRENT MEDICAID COVERAGE FOR PREGNANT WOMEN AND NEWBORNS

The Consolidated Omnibus Reconciliation Act, P.L. No. 99-272 (COBRA), effective July 1, 1986, mandated coverage for all financially eligible pregnant women under the Medicaid program, regardless of marital status. In determining eligibility, the needs of the unborn child are included, providing a higher income standard under which the mother can qualify (i.e. if the mother is single, she could qualify under the financial need standard of two people which is $665). The woman must also provide medical verification of pregnancy.

COBRA also provides that any woman receiving Medicaid on the date of termination of her pregnancy (through delivery of the child, miscarriage or a Medicaid-funded abortion) automatically receives 60 days of postpartum Medicaid, without being required to meet any financial or categorical program requirements during the 60 day window. The only way a new mother could lose Medicaid coverage is if she refuses to document the child's birth, as this is the only way to determine the 60 day time period, or if she moves from the state. During this period, as with all Medicaid coverage, a recipient is entitled to the full array of Medicaid services offered by the state.

In addition, COBRA requires that the newborn child of a mother receiving Medicaid on the date of delivery be guaranteed Medicaid coverage as long as the mother is continuously eligible and the child remains in the mother's home, up to one year from the date of birth. In order to receive newborn coverage, the mother must verify the birthdate of the child and submit monthly reports to her Public Assistance office documenting that the child remains in her household. If the mother loses Medicaid coverage, has a break in coverage, or permanently leaves the state, the newborn also loses Medicaid coverage. All Eligibility Technicians (ETs) in the state have been instructed to re-evaluate a child's circumstances when newborn coverage is lost to determine if the child is eligible for "under 21" Medicaid coverage.

In Alaska, Medicaid operates on a "one-day one-month principle", meaning that if a person qualifies for Medicaid for one day of any given month, that person is eligible for the entire month. What this means in terms of the 60 day postpartum coverage is that, depending on the date of birth, the mother could qualify for up to three months of actual coverage, but will be guaranteed at least 60 days of coverage.

Retroactive Medicaid coverage is also available to any individual for a three month period prior to application or re-application, providing the applicant was eligible in each of the three prior months. For pregnant women, retroactive coverage is available as long as the woman meets the eligibility standards and was pregnant during each of the three prior months. Postpartum Medicaid coverage, however, cannot be granted retroactively, as the mother must be "receiving" Medicaid on the date of pregnancy termination to be eligible for postpartum coverage. For purposes of postpartum coverage, a person is considered to be "receiving" Medicaid if she has actually filed an application prior to termination of the pregnancy, whether or not the application has been acted upon by the state agency.

Pregnant women in Alaska can also receive an AFDC cash grant during the third tri-mester of pregnancy if there are no other children in the household. Eligibility for AFDC is determined by including the unborn child in the need standard, although the payment standard is based on the actual number in the household. (i.e. a single pregnant woman would need to qualify under the 2 person standard of $665 per month, but the payment would be based on the single pregnant woman standard of $421 per month).

OBRA 86

The Omnibus Budget Reconciliation Act of 1986 granted states flexibility in covering pregnant women and children whose family income is up to 100% of the federal poverty level under the Medicaid Program. In selecting this option, states may not lower their AFDC standards below those in effect on April 17, 1986 in order to finance the new option. Beginning in FY 88, states may increase the age level of covered children by one year each year until children up to the age of five are covered. States who select this option must cover both groups, and cannot elect to cover only pregnant women, or only infants and children. 26 states have taken advantage of this option.

OBRA INCOME STANDARDS

States may now opt to cover pregnant women (through 60 days following pregnancy) and newborn children (defined as birth through age one) with incomes above the state's AFDC eligibility threshold but below a state established threshold which can be set as high as the federal poverty level. Alaska's AFDC income standards are currently at 77.8% of the federal poverty level for Alaska (this equals 97% of the poverty level for the lower 48 states).

In Alaska, the income standards and payment standards are the same:

AFDC

Adult included		Adult not included	
		1	$264
2	$665	2	$528
3	$749	3	$612

4	$833	4	$696
5	$917	5	$780
6	$1001	6	$864
7	$1085	7	$948
each add	$84	each add	$84

single adult pregnant woman	$421
increment for incapacitated spouse	$156

OBRA RESOURCE STANDARDS

OBRA allows states to eliminate any resource eligibility criteria for pregnant women. States who do not opt to eliminate the resource criteria must use the SSI resource standard rather than the AFDC resource standard. For children, states may not use a resource criteria more restrictive than the AFDC criteria.

The resource limits are:

AFDC	APA/SSI
- a home of any value	- a home of any value
- a car worth $1,500	- a car worth $4,500
- other real or personal property worth up to $1,000	- personal effects worth up to $2,000
	- liquid resources worth $1,800 for individuals and $2,700 for couples
	- a burial plot
	- up to $1,500 for burial expenses
	- life insurance with face value up to $1,500

Newly covered pregnant women may also be considered as eligible throughout their pregnancy, regardless of any changes or fluctuations in family income. In addition, children receiving inpatient hospital care must be covered through the hospitalization, even if it goes beyond the child's first birthday.

OBRA SERVICES

Coverage for pregnant women is limited to pregnancy-related services (prenatal, delivery and postpartum) and services required for other conditions which complicate pregnancy; however, it is allowable for states to provide the full range of Medicaid services under this option.

States may also opt to provide enhanced services to pregnant women, without offering similar services to other eligible groups of recipients. The enhanced services may encompass the provision of case management, dietary counseling, social worker evaluations, prenatal education, etc., as

defined by the state. Infants and children under this option are eligible for the full scope of Medicaid services offered under the state plan.

Alaska provides the following Medicaid services:

- inpatient hospital care
- outpatient hospital care
- laboratory and x-ray services
- skilled nursing facility and home health services for individuals 21 and older
- physicians services
- rural health clinic services
- early and periodic screening, diagnosis and treatment for individuals under 21 (EPSDT)
- family planning
- medical transportation
- nurse midwife services
- community mental health clinic and state operated mental health clinic services
- intermediate care facility services
- intermediate care facility for the mentally retarded services
- skilled nursing facility services for individuals under 21
- optometrists services and eyeglasses
- mental institution services for persons under 21
- institution for mental diseases services for persons aged 65 and older
- treatment of speech, hearing and language disorders
- outpatient surgical care center services
- physical therapy
- occupational therapy
- prosthetic devices
- medical supplies
- adult dental services (limited to relief of pain and acute infection)
- chiropractic services
- personal care attendant services

Prescription drugs are provided to Medicaid recipients through the General Relief Medical Assistance Program.

PRESUMPTIVE ELIGIBILITY DETERMINATIONS

Another option provided by OBRA is one called presumptive eligibility. Under this option, ambulatory prenatal care may be made available to pregnant women when a qualified medical provider makes a presumptive eligibility determination based on the preliminary information that the family's income does not exceed Medicaid limits. Medical providers who can make presumptive eligibility decisions must meet certain federal criteria, be qualified by the state Medicaid agency, and be enrolled as a Medicaid provider with the state. These medical providers do not receive any additional compensation for making eligibility determinations.

Once a woman has been determined presumptively eligible, she must apply for Medicaid within 14 calendar days. The state has 45 days from the date of the presumptive eligibility determination to make a final determination of eligibility. Erroneous presumptive eligibility determinations made by medical providers are exempt from error rate calculations for the 14 day period and will receive matching funds from the federal government. The presumptive eligibility option is most useful when combined with the OBRA option covering pregnant women up to 100% of the federal poverty level with no resource test, since eligibility determinations involving income (and not resources) are simpler, and less prone to error.

The OBRA 86 changes were recommended to Congress by the National Governor's Association as a way of providing essential medical care to pregnant women and young children, improving the health status of the working poor and refocusing Medicaid back to its original purpose - providing medical care to poor children and their caretaker relatives. These options would provide extensive additional coverage of pregnant women and children, overlapping most of the same populations mandated to be covered by the medically needy program, without forcing the state to incur additional administrative costs. In addition, the OBRA changes would have a significantly smaller impact on error rates than a medically needy program. The major problem in implementing the OBRA pregnant woman option would involve developing a special claims processing system to accommodate the restriction of services to those related to pregnancy; and also making programming changes to the eligibility system if Alaska decided to allow for differing resource standards.

SUMMARY OF OBRA OPTIONS

NOTE: All of these changes require legislative action amending Title 47.07.020 and 47.07.030, as well as additional funds to cover selected optional groups and services.

1. Medicaid coverage of pregnant women, infants and children up to the age of one year. The pregnant women would be eligible for 60 days of postpartum coverage. The children would be eligible until the last day of the month of their first birthday, unless the child is hospitalized at that time, in which case the Medicaid coverage would continue until the child is released from the hospital.

2. Medicaid coverage for children can be expanded each year by a one year increment until children up to the age of five are covered.

3. Coverage of these two groups can be selected by the state at any income level above the AFDC standard but below 100% of the federal poverty level.

Alaska's federal poverty level

Family size	annual income
1	$6,860

2	$9,240
3	$11,620
4	$14,000
5	$16,380
6	$18,760
7	$21,140
8	$23,520
each additional	$2,380

4. States may select a higher resource limit for these two groups; for pregnant women, the resource standard may be no more restrictive than the SSI standard, for children the limit may be no more restrictive than the AFDC standard. States may opt for no resource limit.

5. States may elect to limit coverage for pregnant women to prenatal, delivery and postpartum care, or provide the full range of Medicaid services. Children must be provided all Medicaid services.

6. States may choose to provide enhanced services for pregnant women.

7. States may choose to allow certain providers to make presumptive eligibility determinations.

PROBLEMS WITH IMPLEMENTATION

1. Estimating the cost of adopting the OBRA option. Unfortunately, Alaska has very little data upon which to base cost projections for the pregnant women and children option. There are approximately 13,000 births in the state each year; how many of these births are funded through Medicaid is unknown. The National Governor's Association made preliminary cost estimates for the OBRA option based on surveys within states and 1984 - 1986 population surveys. Their report estimated that 10,011 women in Alaska of childbearing years (age 15 to 44) live below the poverty level and do not have Medicaid coverage. The same study estimated that 974 births will occur to women without Medicaid coverage.

2. Resource options. Once again, estimating the number of women and children who would fall into particular groups based on the OBRA resource options (no resource limit, the SSI resource limit, or the AFDC resource limit for children) is not possible at this time. If women and children have differing resource options, there is a probability that pregnant women and their newborns would receive Medicaid through the 60 day postpartum period, and the children would then lose Medicaid coverage for the rest of their first year. The resource options would require some system changes in the Division of Public Assistance computer system, since the AFDC resource standard is currently on line as the resource limit. Additionally, adoption of the OBRA option would allow pregnant women and children who currently have incomes within the AFDC level, but are ineligible for Medicaid because they are over the resource limit, to attain Medicaid eligibility. Since the $1,000 resource limit is so low, many families

who may own land, or a vehicle valued over the $1,500 limit, are ineligible for Medicaid.

3. Medicaid services. Although states are allowed to limit the services available to pregnant women to pregnancy-related services and services for conditions which complicate pregnancy, in fact the current Alaska Medical Payment System is not capable of distinguishing these types of claims. It would be costly to implement a work order to accomplish this, and impractical since the current contractor will be replaced with a completely new Medical Management Information System in 1988. Additionally, the Division of Medical Assistance does not have the available staff resources to make medical judgements relating to claims for services for conditions which complicate pregnancy. In order to accomplish this, claims would have to be suspended, manually reviewed, and medical judgements made based on a review of each case file to determine if the claim was valid for payment. The Division does not have a physician on staff, and would need additional medical personnel to accomplish such a task. Denials of claims would result in increased hearings and may create unrest among enrolled medical providers, as providers would be less willing to provide services if they are aware that they may not be paid. Providing the full range of Medicaid services to pregnant women would be a more workable option.

4. Presumptive eligibility. If selected, this option should be chosen in conjunction with the "no resource limit" option, as eligibility determinations based solely on income are much simpler. This option would require that the division choose providers based on the federal criteria, complete outreach and training with the qualified providers, and develop and distribute simplified Medicaid applications. This option would place some stress on the Division of Public Assistance district offices, since the applications filed by pregnant women must be acted upon within 30 days. It would also require that the Division of Medical Assistance hire staff or expand its contract to provide outreach and training.

5. Personnel. A major increase in the eligible Medicaid population will have a direct impact on the Division of Public Assistance. Offices are already operating beyond capacity, and a significant increase in the number of applications would require additional staff to absorb the caseload, if the offices are to continue to process applications timely. The Division of Public Assistance estimates that they would need 9 new Eligibility Technicians to handle the increased workload: 4 for intake, and 5 for maintenance.

ALASKA'S IMPROVED PREGNANCY OUTCOME PROJECT

The Improved Pregnancy Outcome (IPO) project was initiated in Alaska at the Fairbanks Health Center in 1980. Funded by a Federal grant (Health & Human Services MCJ-023119-02-0), it was administered by the Alaska Department of Health & Social Services. The goal of the project was healthier babies through increasing accessibility of prenatal care to high-risk women, especially teenagers. Assessment of risk was based on medical, social, and economic criteria.

Staffed by a full-time Public Health Nurse and a half-time Community Health Aide, IPO services included: 1) financial assistance for prenatal doctor visits; 2) prenatal education classes; 3) teen pregnancy support groups; 4) individual counseling; 5) referral to other agencies (including the WIC nutrition program); and 6) coordination of care and services.

An evaluation of the program was conducted in 1983. After an extensive literature review of both the measures of and factors affecting pregnancy outcomes especially among teenagers (available upon request), three indicators were chosen as outcome measures: infant's birth weight, gestational age, and 5-minute Apgar score. Prematurity, low Apgar score, and especially low birth weight have all been consistently linked to higher rates of infant mortality.

Factors influencing pregnancy outcomes were divided into two categories: socio-demographic (mother's age, race, education, and marital status; father's race and education; family size; annual income;

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and amount of IPO financial assistance), and medical-obstetric (mother's risk score, gravidity, and parity; timing and frequency of prenatal care; complications of pregnancy, labor, and delivery; and specific risk factors such as use of tobacco, alcohol, and drugs).

Data on these explanatory variables were gathered for the 309 women enrolled in the IPO program during 1981, 1982, to mid-1983. A random control group of 275, stratified by age, race, and marital status, was selected of women who delivered in Fairbanks during the 20 months immediately preceding the initiation of the IPO program. The second phase of the study, not included here, assessed the level of satisfaction with the IPO program by clients, providers, and staff.

The average monthly enrollment in IPO was 72 in 1981, 71 in 1982, dropping to 45 in 1983, the result of funding reductions. Over half of the women were in their 20's at delivery; over a third were teenagers (15 percent 17 years of age or younger); a tenth were in their 30's. Over 80 percent were white. Natives and blacks each constituted about 8 percent, with 2 percent Asian. At delivery, 54 percent were married. Two out of 3 mothers and almost 9 of 10 fathers had completed at least high school, while 9 percent and 12 percent respectively had completed at least 4 years of college. Over half (55 percent) of the IPO women were assessed as medical high risk, 38 percent as social high risk.

The percentage of IPO financial assistance for doctor visits was determined by a sliding scale based on client's income. Of 254 annual incomes reported, 82 percent were less than $10,000; half were under $5070. Two out of 3 enrollees (201 in all) were assisted with IPO funds at some level, IPO paying 100 percent for 154. The amount per client ranged from $13 to $954, half receiving $152 or less. Other

sources of financial aid included Medicaid (11 percent), Alaska Area Native Health Service (9 percent), military (4 percent), and private means (8 percent).

Of IPO women, 71 percent initiated prenatal care in the first trimester; 24 percent in the second, and 5 percent in the third. The number of prenatal doctor visits ranged from 0 to 28; half had 10 or more. It was the first pregnancy for 45 percent of the IPO clients; the first child for 68 percent. In all, 268 of the 309 clients (87 percent) delivered babies while enrolled. Of the 41 who did not deliver, 31 had either moved out of town or were lost to follow-up. Ten women, 4 of them teens, had spontaneous abortions, half before 14 weeks gestation. Of all deliveries, 21 percent were by Cesarean section; 96 percent of all deliveries occurred in a hospital.

As the data in Table 1 reveal, nearly 90 percent of the IPO mothers delivered babies of normal birth weight. The median birth weight of infants born to IPO women was 3387 grams. The tiniest baby that survived

Table 1

BIRTH WEIGHT FOR IPO BABIES
(in grams)

	N	%
Very Low BW (≤1499 grams)	7	2.6
Low BW (1500-2499)	12	4.5
Normal BW (2500-4499)	238	88.8
High BW (≥4500)	11	4.1
TOTAL	268	100.0

weighed 870 grams; the heaviest baby weighed 4918 grams.

Table 2 shows that over 87 percent of the IPO babies were term, ten percent were pre-term, with nearly 3 percent post-term. The range of gestational age was 28 to 43 weeks, the median being 40. All 7 of

the VLBW babies were premature, as were 6 of the 12 LBW babies.

Table 2

GESTATIONAL AGE FOR IPO BABIES
(in weeks)

	N	%
Pre-term (< 38)	27	10.1
Term (38-42)	234	87.3
Post-term (> 42)	7	2.6
TOTAL	268	100.0

The data in Table 3 show that nearly 94 percent of IPO infants had high Apgars; fully half had scores of 9 or 10.

Table 3

APGAR SCORES FOR IPO BABIES

	N	%
Low(< 7)	16	6.2
High (7-10)	244	93.8
TOTAL	260	100.0

Nearly 3 out of 4 VLBW babies had low Apgars, as did over one fourth of the HBW babies. However, all 12 LBW babies had Apgars of 7 or above. High Apgars characterized 80 percent of the premature babies, nearly 86 percent of the post-term babies as well as over 95 percent of term babies.

Table 4 compares the measures of the 3 outcome variables for the IPO and Control groups. The mean birth weight for IPO babies was 3351.1 grams, compared to 3327.5 grams for the Controls, a difference which was not statistically significant as determined by the difference of means t test. Neither did the groups differ significantly on gestational age or Apgar score.

Table 4

MEANS FOR IPO GROUP AND CONTROL GROUP

	IPO	Control	
Birth Weight	3351.1	3327.5	$p > .05$
Gestational Age	39.5	39.8	$p > .05$
Apgar Score	8.6	8.7	$p > .05$

The data in Table 5 show, however, that the birth weight of babies born to IPO women age 18 years of age or less (3473.0 grams) was significantly higher than that for the babies of Control group women of the same age (3209.3 grams).

Table 5

BIRTH WEIGHT OF BABIES OF IPO AND CONTROL GROUPS
born to women age 18 years or less

	IPO	Control	
Mean Birth Weight	3473.0	3209.3	
Standard Deviation	469.9	584.9	
N	65	122	$p < .05$

Thus, for the teens, who were the real focus of the program, IPO services did in fact result in healthier babies, as measured by birth weight.

The IPO data were examined in greater detail in order to determine which explanatory variables were highly associated with pregnancy outcomes. Pearson product-moment correlation coefficients between each variable and each of the 3 outcome measures were calculated, and then tested for statistical significance. Table 6 presents the result of that analysis for only those variables which were found to be

significantly correlated with one or more of the 3 outcome measures.

Table 6

PEARSON PRODUCT-MOMENT CORRELATION COEFFICIENTS

	Outcome Measures		
Explanatory Variables	Birth Weight	Gestational Age	Apgar Score
Socio-demographic:			
Mother's Age	-.05	-.17**	-.14*
Mother's Race	-.16*	-.14*	.00
Father's Education	.06	-.02	.15*
Medical-Obstetric:			
Gravidity	.01	.00	-.14*
Parity	.13*	.07	-.04
Risk Score	.01	-.06	-.17*
Number of Prenatal Visits	.23**	.22**	.06
Number of Health Ctr Visits	.07	.14*	.02
Number of Home Visits	-.20**	-.20**	-.19**
Number of Phone Contacts	-.16*	-.11	-.18**
Complications of Pregnancy	-.04	.09	.17**
Illness or Condition affecting Pregnancy	-.12	-.05	.18**
Type of Delivery	-.07	-.14*	-.05

* $p < .05$
** $p < .01$

Of the socio-demographic variables studied, 3 were significant: mother's age, mother's race, and father's education. Research studies have consistently reported that adolescents are more likely than older women to deliver premature babies. In this study, however, younger mothers were less likely to have premature infants. IPO teens under 15 years of age delivered babies with a mean gestational age of 40.3 weeks, while women 25-29 years old, generally considered to be the prime age for childbearing, delivered babies with a mean gestation of 38.9 weeks. Teens made up nearly 40 percent of the entire IPO group, yet delivered

only 19 percent of the premature babies. The results for Apgar scores are similar. In general, babies of younger mothers had higher Apgars. These findings contrast with research data that have consistently reported higher infant mortality rates for newborns of mothers under 20 years of age. It appears that the IPO program was successful in promoting healthier babies among teenagers.

The mean birth weight of infants born to black women (2670 grams) was significantly lower than that for whites (3386 grams), Natives (3728), and Asians (3156). Blacks accounted for about 8 percent of the entire IPO group, yet delivered nearly 43 percent of the Very Low Birth Weight babies. Similarly, infants of black women had shorter gestations on the average than others. These findings of less successful pregnancy outcomes for black women are consistent with the research literature.

The level of father's educational attainment was positively correlated with the baby's Apgar score. Fifty-five of 56 babies born to fathers who had had some college had high Apgar scores, while nearly 9 of 10 low Apgar babies were born to men who had a high school education or less.

While differences in birth weight between IPO women actually financially assisted with IPO funds as compared to IPO women whose prenatal expenses were paid by other sources were not statistically significant, the mean birth weight for IPO-assisted babies was 3367.5, which was within 60 grams of the mean birth weight of babies born to mothers using insurance and private means for prenatal expenses, a group generally characterized by lower risk pregnancies. The IPO babies' average birth weight was 350 grams higher than that for Medicaid patients. Perhaps the education and counseling components of

the IPO program resulted in higher birth weights than a program such as Medicaid that gives financial assistance only.

The medical-obstetric variables which were significantly related to one or more of the outcome measures included mother's gravidity, parity, and risk score; number of prenatal doctor and Health Center visits, home visits, and telephone contacts; whether or not there had been pregnancy complications; and type of delivery.

Gravidity refers to the total number of pregnancies which a woman has had. The results of this study showed that the Apgar score of the baby decreased as the number of pregnancies increased. The mean Apgar for babies of first pregnancies was 8.6, but dropped to 5.3 for sixth through tenth pregnancies. Parity is the total number of live births a woman has had. Baby's birth weight increased as parity increased. Higher birth weight babies were more likely to be born to women with a greater number of previous live births. The mean birth weight of women giving birth to a first child was 3327.4 grams, compared to a mean of 3532.8 grams for mothers having a third, fourth, fifth, or sixth child, a difference of over 200 grams. It is unclear why Apgar scores were negatively correlated with number of pregnancies, while birth weight was positively correlated with number of live births. A suggestion is the increasing evidence that multiple abortions negatively impact subsequent births.

The risk assessment, an evaluation of the woman's risk regarding favorable birth outcome, was completed at enrollment or first prenatal visit, and was based on her prenatal history and current health status. An assessment of social high risk indicated potential problems during the pregnancy or after the baby's birth such as unmarried mother,

maternal age under 16, use of alcohol or drugs, or psychiatric problems. A woman was assessed as financial high risk if her annual income would be insufficient to pay for adequate prenatal care. IPO was of the most help to that group of women caught in the gap between eligibility for welfare and economic solvency. Over 93 percent of the IPO women were assessed as high risk on one or more of these three dimensions.

The data revealed that lower risk scores were related to higher Apgar scores. The women whose risk assessment scores of 6 to 9, indicating the highest risk, constituted less than 20 percent of the total enrollment, yet accounted for over 36 percent of the low Apgar infants. Every one of the low Apgar babies was born to a high-risk mother. As for specific risk factors, non-smokers delivered babies that were on the average 232 grams heavier than those of smokers, although this difference was not statistically significant. Birth outcomes did not differ significantly between users and non-users of either alcohol or street drugs.

Better birth outcomes were associated with a higher number both of prenatal doctor visits and prenatal Health Center visits, the latter occurring as the client picked up a voucher prior to each doctor's appointment, attended prenatal education classes or teen pregnancy support group meetings, or received nutritional counseling. Better birth outcomes were also associated with fewer home visits by the Public Health Nurse and with fewer telephone contacts with the Health Center. Women with problem pregnancies or premature, low birth weight babies prompted more intensive staff follow-up.

Mothers with pregnancy complications of any kind delivered babies

with significantly lower mean Apgar scores (8.0) than mothers having no complications (8.7). The mean number of weeks gestation for babies of mothers having vaginal deliveries was significantly greater than that for Cesarean section deliveries (39.8 versus 39.0 weeks).

Multiple stepwise regression analysis showed that variables which in combination explained the greatest amount of the variance in each of the 3 outcome measures were essentially the same ones discussed above.

In summary, the babies of IPO teens had significantly higher birth weights than did the babies of the Control teens. Healthier babies did in fact result from IPO intervention for the targeted group, the high-risk teenager.

Florida's Handicap Prevention Act of 1986

At the national meeting of Project Zero to Three in December, 1986, a number of participants requested copies of Florida's new legislation, which is designed to foster a continuum of integrated services to identify, diagnose, and treat high risk conditions in pregnant women and in young children between the ages of birth and five years. The legislative language is reproduced below. For further information contact Robert Furlough, Ph.D., Assistant Director, Children's Medical Services Program, Department of Health, 1323 Winewood Boulevard, Building 5, Room 130, Tallahassee, FL 32301.

Section 41.

(1) Short title--This section and the following seven sections of this act may be cited as the "Handicap Prevention Act of 1986."

(2) This section shall take effect July 1, 1986.

Section 42.

(1) **Legislative intent**--The Legislature finds and declares that 50 percent of handicapping conditions in young children can be prevented and such conditions which are not prevented can be minimized by focusing prevention efforts on high risk pregnant women and high risk and handicapped young children, in the formative years from 0 to 5, and their families. The Legislature further finds that by preventing handicaps in young children, infant mortality and child abuse can be reduced and Florida can reap substantial savings in both human potential and state funds. The Legislature finds that a continuum of integrated services is needed to identify, diagnose, and treat high risk conditions in pregnant women and in young children between the ages of 0 to 5 years. The Legislature further finds that intra-agency and interagency coordination can enhance the framework of a continuum that is already in existence and that coordination of public and private sector prevention services can reduce infant mortality and handicapping conditions in young children and minimize the effects of handicapping conditions. It is the intent of the Legislature, therefore, that a continuum of efficient and cost-effective prevention services be identified, that a plan for interagency and intra-agency coordination be developed for the purpose of implementing such a continuum and that the continuum of services be implemented as resources are made available for such implementation.

(2) This section shall take effect July 1, 1986.

Section 43.

(1) **Definitions**—As used in this act, the term:

(a) **"Handicapped child"** means a preschool child who is developmentally disabled, mentally handicapped, speech impaired, language impaired, deaf or hard of hearing, blind or partially sighted, physically handicapped, health impaired, emotionally handicapped, or who has a specific learning disability or any other child who has been classified under rules of the State Board of Education as eligible for preschool special education services.

(b) **"High risk child"** means a preschool child with one or more of the following characteristics:

(1) A victim or a sibling of a victim in an indicated report of child abuse or neglect.
(2) A graduate of a perinatal intensive care unit.
(3) A mother under 18 years of age, unless the mother received necessary comprehensive maternity care and the mother and child currently receive necessary support services.
(4) A developmental delay of one standard deviation below the mean in cognition, language, or physical development, whose family is below poverty level.
(5) A child surviving a catastrophic infectious or traumatic illness known to be associated with developmental delay.
(6) A child of a parent or guardian who is developmentally disabled, severely emotionally disturbed, drug or alcohol dependent, or incarcerated and who requires aid in meeting his child's developmental needs.
(7) A child who has no parent or guardian.

(c) **"Neonate"** means a child from birth to 28 days of life.

(d) **"Prenatal"** means the time period from pregnancy to delivery.

(e) **"Preschool child"** means a child from 0 to 5 years of age.

(f) **"Preventive health care"** means periodic physical examinations, immunizations, and assessments for hearing, vision, nutritional deficiencies. and developmental of language, physical growth, small and large muscle skills, and emotional behavior, as well as age-appropriate laboratory tests.

(g) "Teen parent" means a person under the age of 18 years who is pregnant, who is the father of the unborn child, or who is the parent of a child.

(2) This section shall take effect July 1, 1986.

Section 44.

(1) Continuum of services--The Department of Education and the Department of Health and Rehabilitative Services shall utilize the continuum of prevention services to high risk and handicapped children outlined in this section as a basis for the intra-agency and interagency program coordination, monitoring, and analysis as required in the Handicap Prevention Act of 1986. The continuum shall be considered to be a guide and may be expanded or reduced as determined by intra-agency or interagency findings and agreement, whichever is applicable. Implementation of the continuum shall be based upon interagency prioritization when programs impact both agencies or upon single agency prioritization when programs impact only one agency and shall be based upon availability of resources. The continuum shall include, but not be limited to:

(a) FAMILY LIFE EDUCATION AND SUPPORT SERVICES PRIOR TO PREGNANCY--

1. Education of the public on the causes of handicapping conditions, normal and abnormal child development, and parenting skills important to the healthy development of young children.
2. Family planning services to low income women on a voluntary basis.

(b) MATERNITY AND NEWBORN SERVICES--

1. Comprehensive prenatal care, accessible to all pregnant women and provided for low income and high risk pregnant women.
2. Nutrition services for low income pregnant and lactating women and low income preschool children.
3. Delivery and postpartum care services for indigent pregnant women.
4. Perinatal intensive care.
5. Developmental training, parent training, and appropriate follow-through services for neonatal intensive care unit infants.
6. Metabolic screening for all newborns.
7. Registry of high risk newborns and newborns with birth defects which utilizes privacy safeguards for children and parents who are subjects of the registry.

8. A well-mother information program at the birth site to provide an informational brochure on immunizations, normal child development, and community services for all parents of newborns and to schedule Medicaid eligible infants for a health check-up.

(c) HEALTH SERVICES FOR PRESCHOOL CHILDREN--

1. Preventive health care accessible for all preschool children.
2. Preventive health care provided for indigent preschool children.
3. Well-baby insurance for preschool children included in the family policy coverage.
4. Medical care for seriously impaired and spina bifida preschool children.
5. Cost-effective quality health care alternatives for medically involved infants and young children in or near their home.

(d) EDUCATION AND RELATED SERVICES FOR HANDICAPPED AND HIGH RISK PRESCHOOL CHILDREN--

1. Special education and related services for handicapped children.
2. Education and related services for high risk children.
3. Local registry of preschool children with handicapping and high risk conditions which utilizes privacy safeguards for children and parents who are subjects to the registry.
4. Information sharing system between the Department of Health and Rehabilitative Services and the Department of Education on children eligible for services. Information may be shared when parental or guardian permission has been given for release.

(e) SUPPORT SERVICES FOR HIGH RISK AND HANDICAPPED CHILDREN AND THEIR FAMILIES--

1. Child care, parent education, counseling, prenatal care, and transportation for teen parents.
2. Respite care, homemaker care, crisis management, and other services that allow families of high risk and handicapped children to maintain and provide quality care to their children at home.
3. Utilization of the elderly, either as volunteers or paid employees, to work with handicapped or high risk children.

(2) This section shall take effect July 1, 1986.

Section 45.

(1) **Agency responsibilities; joint report--**

(a) The Department of Health and Rehabilitative Services and the Department of Education shall prepare a joint report to be presented to the President of the Senate, the Speaker of the House of Representatives, and the Governor by March 1, 1987, which shall include, but not be limited to, the following:

1. Identification of the department which has the responsibility for each program area described in the continuum;
2. Identification of the unit within each department which has responsibility for each program area described in the continuum and the unit which has responsibility for coordination, monitoring, and implementation as described in paragraph (c);
3. Identification of existing continuum programs on an intra-agency and interagency basis;
4. Identification of methodology for reduction of duplication and coordination of services on both an intra-agency and interagency basis;
5. Identification of coordination and integration of prevention services with state agencies other than the Department of Education or the Department of Health and Rehabilitative Services;
6. Description of the progress of the reduction of duplication and coordination as described in subparagraphs 4 and 5;
7. Prioritization of implementation of continuum components;
8. Identification of barriers impacting implementation of components of the continuum of services;
9. Proposed changes to the continuum of services;
10. Recommendations, if any, for legislative, administrative, or budgetary changes. Recommendations on budgetary changes shall include recommendations regarding the development by the Department of Health and Rehabilitative Services and the Department of Education of a unified program budget for all prevention services to high risk and handicapped children.

(b) At least biennially, the Department of Health and Rehabilitative Services and the Department of Education shall readdress the joint report submitted pursuant to this section and make necessary revisions. The revised report shall be submitted to the Governor, the Speaker of the House of Representatives, and the President of the Senate no later than January 1, 1989, and by January 1 of alternate years thereafter.

(c) The Department of Health and Rehabilitative Services and the Department of Education shall identify a unit within each respective agency with intra-agency responsibilities for the development of the report, for ongoing monitoring and implementation of the continuum, and for interagency coordination in the analysis of the implementation of the continuum.

(d) The Florida Developmental Disabilities Planning Council shall serve as the interagency coordinator for the activities of the Department of Health and Rehabilitative Services, the Department of Education, and other state agencies and shall monitor the development of the joint reports required by this section. The council shall advise the substantive committees of the Senate and the House of Representatives and the Office of the Governor on the progress of activities required by the Handicap Prevention Act. For the purpose of carrying out their responsibilities, the council shall have access to statistical information, budget documents and workpapers developed by the Department of Health and Rehabilitative Services and the Department of Education in preparing the joint report. By March 1, 1989, the council shall recommend to the President of the Senate, the Speaker of the House of Representatives, and the Governor a permanent placement for the interagency coordination function.

(2) This section shall take effect July 1, 1986.

Section 46.

(1) Uniform standards--

(a) The Department of Health and Rehabilitative Services, in consultation with the Department of Education, shall establish a minimum set of procedures for each preschool child who receives preventive health care with state funds. Preventive health care services shall meet the minimum standards established by federal law for the Early Periodic Screening, Diagnosis and Treatment program and shall provide guidance on screening instruments which are appropriate for identifying health risks and handicapping conditions in preschool children.

(b) If funds are appropriate, the interagency coordinator shall contract for a study to determine the feasibility of a uniform system for diagnosis and eligibility for services to handicapped or high-risk children by district schools and the Department of Health and Rehabilitative Services. If determined

feasible, the study shall also include recommendations of a uniform system for diagnosis and eligibility for services to handicapped or high-risk children. The study shall be completed by March 1, 1987. The uniform system, if recommended, shall be reviewed by both the Department of Education and the Department of Health and Rehabilitative Services to determine whether or not the system should be used by the diagnostic and learning resource system to assist school districts in diagnosing, evaluating, and determining multiple eligibility resources for handicapped or high-risk children pursuant to ss.229.832-229.834, Florida Statutes, and by the Department of Health and Rehabilitative Services in determine multiple eligibility resources for its clients.

(c) Duplicative diagnostic and planning practices shall be eliminated to the extent possible. Diagnostic and other information necessary to provide quality services to high-risk or handicapped children shall be shared between the program offices of the Department of Health and Rehabilitative Services, pursuant to the provisions of s.228.093, Florida Statutes.

(2) This section shall take effect July 1, 1986.

Section 47.

(1) Prenatal care--The Department of Health and Rehabilitative Services shall:

(a) Provide a statewide prenatal care program for low-income pregnant women which includes early, regular prenatal care by practitioners trained in prenatal care and delivery. access

(b) Provide a risk factor analysis to identify women at risk for a preterm birth, or other high-risk conditions, and provide education on maintaining health birth conditions.

(c) Monitor the availability and accessibility of prenatal care services and the development of special outreach programs for medically underserved and rural areas.

(d) Establish by rule the eligibility criteria for prenatal care for indigent pregnant women when state funds are used for prenatal care.

~ 550,000 base pop
70,000 9% - 12%

(e) Develop guidelines for expediting the provision of prenatal care for eligible women and monitor the implementation of the guidelines to determine the need for further action.

(f) Expand, to the extent possible, training of state and local health providers in programs and practices pertaining to improved pregnancy outcomes.

(2) This section shall take effect July 1, 1986.

Section 48.

(1) The Department of Health and Rehabilitative Services and the State Board of Education shall adopt rules necessary for the implementation of the Handicap Prevention Act of 1986.

(2) This section shall take effect July 1, 1986.

DRAFT

AN ACT Relating to prenatal care; adding a new chapter to Title 74 RCW; and making an appropriation.

BE IT ENACTED BY THE LEGISLATURE OF THE State of Washington

NEW SECTION. Sec. 1. The legislature finds that early and continuous comprehensive prenatal care is a major factor in assuring healthy, full-term infants. Research findings show that inadequate prenatal care is associated with stillbirths and low birthweight in infants and is the leading cause of neonatal and infant mortality, as well as continuing health and developmental problems during childhood and adulthood. Early comprehensive prenatal care will result in reduced human suffering, improved life quality, and reduced social service and education costs. Public funds invested in comprehensive prenatal care will result in corresponding, but greater reductions in hospital costs for delivery and perinatal care.

The legislature therefore establishes a comprehensive prenatal care program to increase participation in early care for low-income women who do not fully qualify for medical assistance or have adequate private insurance or other resources. The legislature further finds it in the public interest to provide public education on the benefits of early and continuous prenatal care and healthy lifestyles during pregnancy.

NEW SECTION. Sec. 2. Unless the context clearly requires otherwise, the definitions in this section apply throughout this chapter.

(1) "Comprehensive prenatal care" means the continuum of services required to promote optimal mother and infant health. Services shall include prenatal, delivery, and postpartum care and preventative education and counseling, as appropriate.

services, and individual outcomes is provided as required by local contractors in a manner which preserves client confidentiality.

(6) Adopt rules under chapter 34.04 RCW to carry out the purposes of this chapter.

NEW SECTION. Sec. 4. The department shall report, by January 15 of each odd-numbered year, to the appropriate committees of the senate and house of representatives on the comprehensive prenatal care program. The report shall include eligibility levels, numbers of persons served, an estimate of persons potentially eligible for program services, information on public education programs, and an analysis of the effectiveness of the program.

NEW SECTION. Sec. 5. The sum of ..... dollars or so much thereof as may be necessary is appropriated to the department of social and health services from the general fund for the 1987-89 biennium to carry out the purposes of this act.

NEW SECTION. Sec. 6. Sections 1 through 4 of this act shall constitute a new chapter in Title 74 RCW.

CORRECTION

THIS DOCUMENT
HAS BEEN REPHOTOGRAPHED
TO ASSURE LEGIBILITY

DRAFT

AN ACT Relating to prenatal care; adding a new chapter to Title 71 RCW; and making an appropriation.

BE IT ENACTED BY THE LEGISLATURE OF THE State of Washington:

NEW SECTION. Sec. 1. The legislature finds that early and continuous comprehensive prenatal care is a major factor in assuring healthy, full-term infants. Research findings show that inadequate prenatal care is associated with stillbirths and low birthweight in infants and is the leading cause of neonatal and infant mortality, as well as continuing health and developmental problems during childhood and adulthood. Early comprehensive prenatal care will result in reduced human suffering, improved life quality, and reduced social service and education costs. Public funds invested in comprehensive prenatal care will result in corresponding, but greater reductions in hospital costs for delivery and perinatal care.

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NEW SECTION. Sec. 2. Unless the context clearly requires otherwise, the definitions in this section apply throughout this chapter.

(1) "Comprehensive prenatal care" means the continuum of services required to promote optimal mother and infant health. Services shall include prenatal, delivery, and postpartum care and preventative education and counseling, as appropriate.

(2) "Department" means the department of social and health services.

(3) "Local health agency" means a health department, primary care clinic, private nonprofit agency, or other public or private agency that either has an appropriately qualified physician on staff or subcontracts with one or more physicians and is willing to coordinate comprehensive prenatal care within a designated geographic area.

(4) "Low income" means the eligibility levels established by the department for services provided under this chapter and does not include persons who fully qualify for medical assistance or have adequate private insurance or other resources.

(5) "Perinatal" means the period from the establishment of pregnancy to one month following delivery.

NEW SECTION. Sec. 3. The department shall establish a comprehensive prenatal care program for low-income women. In implementing the program, the department shall:

(1) Establish income or other eligibility standards, minimum standards for services to be provided, indicators and methods for measuring effectiveness, reimbursement methods, reporting, and other policies or guidelines as the department deems appropriate.

(2) Contract with local health agencies to provide comprehensive prenatal care services meeting the minimum standards required by the department.

(3) Provide technical assistance to local health agencies and encourage locally designed, cost-effective systems that coordinate with existing programs and promote community and provider participation in the delivery of prenatal care services under this chapter.

(4) Provide or arrange for public education programs emphasizing the benefits of early and continuous prenatal care and healthy lifestyles, with particular attention directed to high-risk populations such as teenagers and certain minority groups.

(5) Develop and implement a perinatal data system to monitor the rates of low birthweight and perinatal and infant mortality and evaluate effects of the services provided. The department shall ensure that information regarding client characteristics, use of

services, and individual outcomes is provided as required by local contractors in a manner which preserves client confidentiality.

(6) Adopt rules under chapter 34.04 RCW to carry out the purposes of this chapter.

NEW SECTION. Sec. 4. The department shall report, by January 15 of each odd-numbered year, to the appropriate committees of the senate and house of representatives on the comprehensive prenatal care program. The report shall include eligibility levels, numbers of persons served, an estimate of persons potentially eligible for program services, information on public education programs, and an analysis of the effectiveness of the program.

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NEW SECTION. Sec. 6. Sections 1 through 4 of this act shall constitute a new chapter in Title 74 RCW.

September 23, 1987

Mr. Lawton Chiles
Chairman
National Commission to
Prevent Infant Mortality
Switzer Building, Room 2006
330 C Street, SW
Washington, DC 20201

Dear Mr. Chiles:

Thank you for letting me know about the establishment of the National Commission to Prevent Infant Mortality. This is a vital issue of concern to all of us, but especially to parents of infant children.

I am taking the liberty of sharing your letter with Myra Munson, Commissioner of Department of Health and Social Services.

Good luck in your worthwhile endeavors and, please, keep me informed as to your progress.

Sincerely,

S/S Steve Cowper

Steve Cowper
Governor

SC/GP/CR/jh/mae 0601/02
CAREN2/chiles

National Commission to Prevent Infant Mortality
Switzer Building • Room 2006
330 C Street, S.W. • Washington, D.C. 20201
202-472-1364

September 3, 1987

The Honorable Steve Cowper
Governor
Pouch A
Juneau, AK 99811

Dear Governor:

I am pleased to announce the establishment of the National Commission to Prevent Infant Mortality. Created by Congress (P.L. 99-660), the Commission, made up of Members of Congress, federal and state government officials, along with maternal and child health experts, has been charged with putting together a national plan for reducing and preventing infant mortality in the United States.

For many reasons an unacceptably high number of infants, nearly 11 out of 1000 born each year, die before their first birthdays. Although this rate is a marked improvement over years gone by, our progress in lowering our infant mortality rate has come to a virtual standstill in recent years. Indeed, the United States, which ranked sixth internationally in the early 1950's, now ranks fourteenth among industrialized countries.

Both the causes of infant mortality and potential solutions have been well documented in numerous studies and reports. The main cause of infant death is low birth weight and the most significant way to prevent low birth weight is for the mother to receive adequate, early prenatal care. It is such a simple sounding solution yet, as you know, it has remained an elusive goal in this country.

The answers are out there. They involve both health and social strategies, as well as filling in the gaps in programs and services for pregnant women and infants and finding ways to better coordinate and organize these programs and services. The National Commission to Prevent Infant Mortality has been established to galvanize a national strategy for preventing infant mortality. The Commission will be holding public hearings and meetings across the country to bring the problems and solutions to the attention of public policymakers and private sector leaders. We will be presenting our plan to the President and Congress within one year.

All of us have a stake in this and an important role to play. I ask for your support of our efforts during this year, and even more importantly, your leadership on this important public health issue. We will keep you informed of our progress as the year proceeds.

Sincerely yours,

Lawton Chiles

Lawton Chiles
Chairman

enclosures

National Commission to Prevent Infant Mortality
Switzer Building • Room 2000
330 C Street, S.W. • Washington, D.C. 20201
202-472-1864

COMMISSION MEMBERS

The Honorable Lawton Chiles
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United States Senate
Washington, D.C. 20510
202/224-5274

The Honorable J. Roy Rowland
Vice Chairman
U. S. House of Representatives
Washington, D.C. 20515
202/225-6531

The Honorable Otis R. Bowen
Secretary, Department of
Health and Human Services
Hubert H. Humphrey Building
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The Honorable Charles A. Bowsher
Comptroller General of the
United States
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The Honorable David F. Durenberger
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803/799-2000

Lynda Johnson Robb
Hunton and Williams
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9th Floor
Washington, D.C. 20006
202/955-1692

(over)

NATIONAL COMMISSION TO PREVENT INFANT MORTALITY

BIOGRAPHICAL SKETCHES OF MEMBERS

The Honorable Lawton Chiles, Chairman
United States Senator

Senator Chiles (D-Florida) was first elected to the U. S. Senate in 1971. One of the Senate's key advocates for maternal and child health, he sponsored the legislation to establish the National Commission to Prevent Infant Mortality. Senator Chiles' committee assignments include the Senate Appropriations Committee and its Subcommittee on Labor, Health and Human Services which he chairs, and the Senate Budget Committee, which he also chairs. He is also a member of the Senate Children's Caucus.

Charles Bowsher
Comptroller General of the United States

Mr. Bowsher was appointed by President Reagan in October, 1981, to serve as Comptroller General, a 15 year appointment by law. Prior to that, he was with Arthur Andersen and Co. for 25 years, except for a 4 year appointment, 1967-1971, as Assistant Secretary of the Navy for Financial Management, under Presidents Johnson and Nixon.

The Honorable Otis R. Bowen, M.D.
Secretary, Department of Health and Human Services

Dr. Bowen was sworn in as Secretary of Health and Human Services on December 12, 1985. He is a former two-term governor of Indiana (1973-1981) and member of the state House of Representatives in Indiana (1957,1958, and 1961-1972). Dr. Bowen came to HHS from the Indiana University School of Medicine in Indianapolis where he was serving as Lester D. Bibler professor of family medicine and director of undergraduate family practice education. He has served on a number of federal advisory bodies, including the Advisory Council on Social Security, 1982-1984, of which he was the chairman.

The Honorable David F. Durenberger
United States Senator

Senator Durenberger (R-Minnesota) was first elected to the U.S. Senate in 1978 to fill the seat of Hubert H. Humphrey. He is a key leader in the Senate on maternal and child health issues, and has sponsored legislation to improve access to prenatal and postnatal care for low income women and health care for their

General and Assistant Secretary for Health and served in those capacities concurrently from July, 1977 through January, 1981. Dr. Richmond is a pediatrician.

The Honorable Richard Riley

Governor Riley serves as the chairman of the advisory committee to the Southern Regional Project on Infant Mortality and also chairs the Advisory Board to the new Robert Wood Johnson Healthy Futures Initiative, a project to reduce infant mortality in the southern states. Governor Riley is a former two-term Governor of the State of South Carolina.

Lynda Johnson Robb

Mrs. Robb, a former First Lady of the State of Virginia, is a strong national spokesperson on infant mortality and children's health issues. She has served on the Southern Regional Task Force on Infant Mortality and is a member of the Advisory Committee on Infant Mortality for the State of Virginia.

The Honorable J. Roy Rowland
Member of Congress

Representative Rowland (D-Georgia, 8th District), a physician, was first elected to the U.S. House of Representatives in 1983. His committee assignments include the Select Committee on Children, Youth, and Families and its Crisis Intervention and Prevention Strategies Task Forces. He also is a member of the Congressional Biomedical Ethics Board and the Congressional Rural Caucus.

The Honorable Thomas J. Tauke
Member of Congress

Representative Tauke (R-Iowa, 2nd District) was first elected to the U.S. House of Representatives in 1979. His committee assignments include the Energy and Commerce Committee and its Subcommittee on Health and the Environment, and the Education and Labor Committee and its Subcommittee on Human Resources of which he is the Ranking Minority Member. Mr. Tauke also is a member of the Congressional Biomedical Ethics Board.

The Honorable James Thompson
Governor of Illinois

Governor Thompson is serving his fourth term as Governor of Illinois. Prior to this, he was a U.S. Attorney for the Northern District of Illinois. Governor Thompson was the chairman of the

National Commission to Prevent Infant Mortality
Switzer Building • Room 2006
330 C Street, S.W. • Washington, D.C. 20201
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CONCEPT PAPER

NATIONAL COMMISSION TO PREVENT INFANT MORTALITY

INTRODUCTION

The National Commission to Prevent Infant Mortality was created by Congress (PL 99-660) and established on July 1, 1987. The Commission consists of 15 members, including Members of Congress, the Secretary of Health and Human Services, the Comptroller General of the United States, representatives from state governments, and members of the maternal and child health care community. Through a series of public meetings and hearings, the Commission will develop recommendations which it will publish and present to the President and Congress within one year of its establishment.

MISSION STATEMENT

The National Commission to Prevent Infant Mortality is charged with recommending a cohesive and effective national policy to reduce and prevent infant mortality in the United States. This will involve outlining (1) appropriate strategies for high risk populations, (2) the appropriate roles of local and state governments, the Federal government, and the private sector in establishing a comprehensive approach to preventing infant mortality, and (3) specific changes needed within Federal laws and Federal programs, including changes needed to improve the national vital statistics registration system.

DUTIES OF THE COMMISSION

The Commission will develop its recommendations by:

1. Identifying and examining Federal, state, local, and private resources that impact infant mortality -- including, but not limited to:

   - the effectiveness and adequacy of programs such as the Supplemental Feeding Program for Women, Infants, and Children (WIC), the Maternal and Child Health Block Grant, Community Health Centers, prepregnancy services

National Commission to Prevent Infant Mortality
Switzer Building • Room 2006
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202-472-1364

PRESS RELEASE

For Immediate Release
August 5, 1987

For Further Information:
Rae Grad (202)472-1364

NATIONAL COMMISSION FORMED TO TAKE ACTION TO PREVENT INFANT DEATHS

Washington, D.C. -- Congress has just appointed a one year National Commission to Prevent Infant Mortality, representing the first time Congress has given such high-level attention to the complex social and health problems that each year cause nearly 11 out of every 1000 babies in the United States to die before their first birthdays, a rate that places the United States 14th internationally behind other countries such as Japan, Canada, and France.

The 15-member Commission includes Senator Lawton Chiles (D-Fl.), chairman, Representative J.Roy Rowland (D-Ga.), vice chairman, Senator Dave Durenberger (R-Mn.), Representative Thomas Tauke (R-Ia.), Dr. Otis Bowen, Secretary of Health and Human Services, the Governor of Illinois, James Thompson, former Governor of South Carolina, Richard Riley, and Mrs. Lynda Johnson Robb. The Commission will hold public hearings and meetings around the country throughout the year and will recommend to Congress a national plan for solving the problems of infant mortality, defined as the number of infants born alive but who die before their first birthday, per 1000 live births.

The factor most associated with infant death is low birth weight, that is, babies born weighing less than 5 pounds, 8 ounces. Low birth weight is largely preventable when pregnant women receive adequate prenatal care, started early in pregnancy. Unfortunately, many pregnant women do not receive necessary prenatal care, particularly those with low incomes, minorities, and teenagers. Not only is it costly in terms of lost human potential when babies are born unhealthy, it is also expensive in terms of health care dollars. Low birth weight babies are more likely to need costly special care, and are also more likely to suffer from lifetime physical or mental disabilities which are expensive to treat.

"We are either unwilling or unable in this country to put together a plan so that all infants have a fair start on life. We're here today to do all we can to alert this nation and its leaders to what can and should be done," stated Senator Chiles.

"All of us have to solve this problem, not just lawmakers. The private sector and the business community - we have to get to them and move them too," commented Commission member, Lynda Johnson Robb.

National Commission to Prevent Infant Mortality
Switzer Building • Room 2006
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INFANT MORTALITY FACT SHEET

The infant mortality rate is the number of babies who are born alive but die before their first birthday per one thousand live births. The 1984 U.S. infant mortality rate is 10.8 per one thousand live births, ranking our country approximately 14th worst among industrialized nations.

The factor most closely associated with infant mortality is low birth weight, that is, babies born weighing less than five pounds, eight ounces. The percentage of babies born too soon or too small in the U.S. has remained virtually unchanged since the 1940s.

- In 1984, the most recent year for which final data is available, 39,580 babies died in this country before reaching their first birthday.

- The U.S. infant mortality rate is higher than many other industrialized nations, including Japan, Canada, Ireland, Switzerland and France.

- The infant mortality rate in the black population in the U.S. is nearly twice that of the white population. In 1984, the rate for blacks was 18.4 deaths per thousand live births compared to 9.4 among whites.

- In 1984, 6.7% of babies born in the U.S. weighed less than five pounds, eight ounces. Another 1.2% weighed less than three pounds, four ounces.

- Over the past seven years, there has been a disturbing increase in the percentage of babies born to women receiving late or no prenatal care. The number of babies born without receiving adequate prenatal care has grown by nearly ten percent since 1979.

- Many babies born low birth weight survive the first critical month of life because of costly high technology, but remain at risk during the remainder of their first year of life. Many of these children are left unprotected by any form of health care coverage. In fact, nearly one in five children under six years old have no health care coverage.

SOURCE: National Center for Health Statistics and Health U.S., 1986, U.S. Department of Health and Human Services

Ann Rev Public Health 1985 6:21–40

CC Kay Dana Janet I wish we'd had this before!

POSTNEONATAL MORTALITY

Barbara Starfield

Department of Health Policy and Management, The Johns Hopkins University, Baltimore, Maryland 21205

THE PROBLEM: FREQUENCY AND TRENDS

> In the field of infant mortality I believe we are facing a slower rate of decline in the death rate over the next decade than we have experienced in the past. This follows because a low point has already been reached for the age division beyond one month and because of the stationary condition of the high rate in the first four weeks of life. . . . It is the concentration of effort upon the causes of infant mortality beyond one month of age which brought about this reduction (11).

The success of public health interventions in the first two decades of the twentieth century was reflected in marked declines in postneonatal mortality, as indicated in the above quotation, which was published in 1927. As a result, neonatal mortality became relatively more important as a health concern and attention shifted to its control. Figure 1 shows the success of the ensuing activities: the neonatal mortality rate fell from over 30 per thousand in 1935 to well under 10 per thousand in 1980 in the United States.

Progress in the decline of postneonatal mortality continued to occur even as neonatal survival improved, however. In 1935, more than half (54%) of all infant deaths occurred in the postneonatal period; that is, after the first four weeks of life. Gradually thereafter, neonatal deaths assumed an increasingly larger share of the problem of infant deaths: 50% in the 1920s, 58% in the 1930s, 65% in the 1940s, and 75% in the mid-1960s despite the marked fall in neonatal mortality. From 1970 onward, however, the percentage of infant deaths occurring in the postneonatal period has been increasing yearly as follows: 24.7% in 1970, 25.5%, 25.9%, 27.1%, 26.3%, 28.0%, 28.3%.

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Telephone (202) 628-8787

Dana Hughes, M.S., M.P.H.
Senior Health Specialist

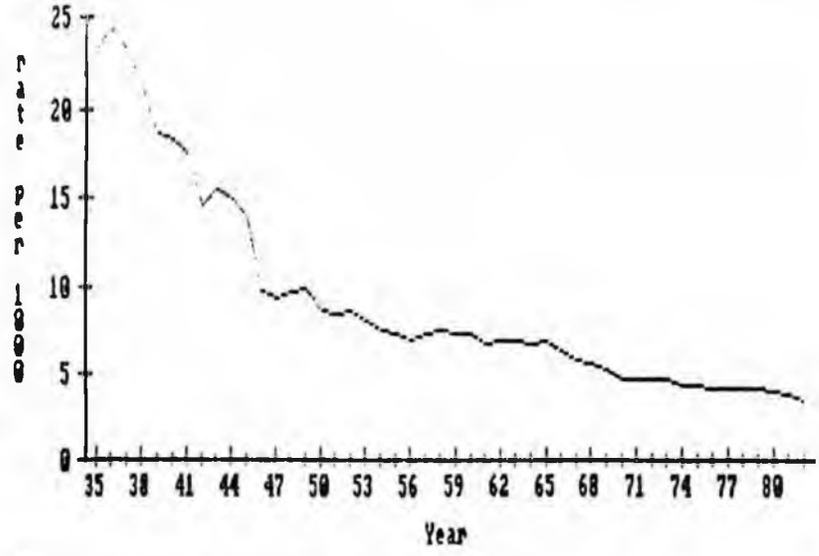

Figure 2 Postneonatal mortality. United States. 1935–1982.

deferred in time. Figure 3 shows the rate for the two components of infant mortality. The decline in the mid and late 1940s was primarily concentrated in the postneonatal component. The marked and continued fall in the neonatal component in the most recent 15 years has not been accompanied by a parallel decline in the postneonatal component. Although it might be postulated that rapid declines in neonatal mortality might be accompanied by some increase in postneonatal mortality because of the possibility of postponement of deaths due to the saving of highly vulnerable infants by neonatal interventions, there is evidence that this is not the explanation for the lagging postneonatal rates (24, 28, 34). Although some institutions may be experiencing postponement of deaths of very low-birth-weight infants as a result of developments in neonatal management (14), there is no evidence that the general lag in postneonatal mortality is a result of an increase in survival of infants born with very low birth weight. For example, a study of all births and infant deaths in Upstate New York from 1968 to 1979 showed that the proportion of deaths that were postneonatal increased in all birth-weight groups. The relatively small proportion of deaths that were among very low-birth-weight infants was too small to account for the overall relative increase in importance of postneonatal mortality (45). Moreover, there was no shift in time of death to earlier in the postneonatal period, except among the 500–1000 gram infants [who accounted for less than 5% of all postneonatal deaths (calculated from 45)].

Of particular concern is the *increase* in postneonatal mortality rates among infants of teenage mothers. A study of mortality and morbidity of infants born

CORRECTION

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Ann Rev Public Health 1985 6:21–40

CC Ian Gordon
Janet
I wish we'd
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before!

POSTNEONATAL MORTALITY

Barbara Starfield

Department of Health Policy and Management, The Johns Hopkins University, Baltimore, Maryland 21205

THE PROBLEM: FREQUENCY AND TRENDS

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Progress in the decline of postneonatal mortality continued to occur even as neonatal survival improved, however. In 1935, more than half (54%) of all infant deaths occurred in the postneonatal period; that is, after the first four weeks of life. Gradually thereafter, neonatal deaths assumed an increasingly larger share of the problem of infant deaths: 50% in the 1920s, 58% in the 1930s, 65% in the 1940s, and 75% in the mid-1960s despite the marked fall in neonatal mortality. From 1970 onward, however, the percentage of infant deaths occurring in the postneonatal period has been increasing yearly as follows: 24.7% in 1970, 25.5%, 25.9%, 27.1%, 26.3%, 28.0%, 28.3%,

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Dana Hughes, M.S., M.P.H.

Senior Health Specialist

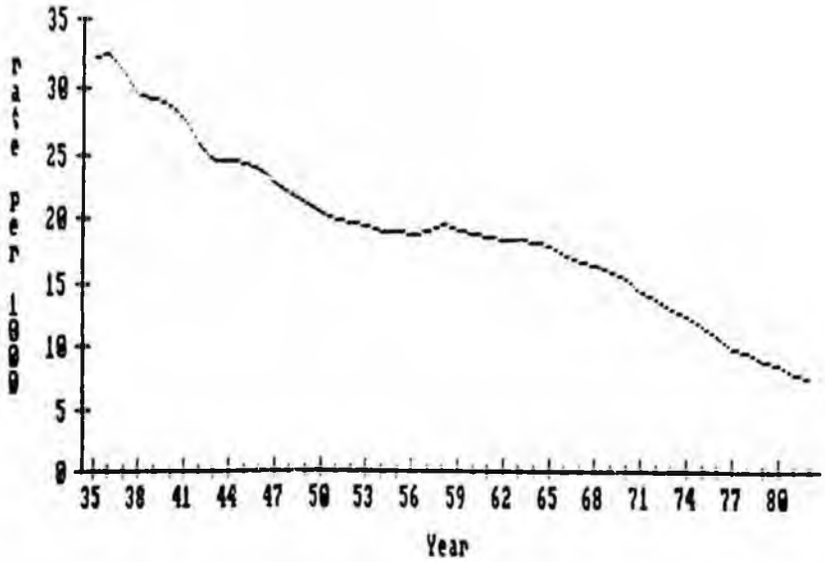

Figure 1 Neonatal mortality, United States, 1935–1982.

29.8%, 31.2%, 32.3%, 32.5%, and in 1981 (the latest year for which final data are available) 33.0%.

This reversal of a long-standing trend in the relatively greater decline of postneonatal mortality is the stimulus for this review. The widespread perception that postneonatal mortality is a disappearing problem is probably the reason that so little has been written on the subject in recent years. A computerized search of the English language medical literature resulted in only six citations with the words "postneonatal mortality" between 1979 and 1983. Even as recently as 1977, Antonovsky & Bernstein's (1) comprehensive review of the relationship between social class and infant mortality suggested that postneonatal mortality is a "minor" component of infant mortality. Recent trends suggest that, at least relatively, postneonatal deaths should begin to command renewed attention.

Figure 2 shows the long-term trends of postneonatal mortality. Huge declines occurred in the late 1930s, then again during and just following the Second World War. From 1955 to 1965 little change occurred, but renewed decline characterized the late 1960s. During the 1970s the rate of decline slowed, with some periods of stability during that time. Declines in postneonatal mortality have not always occurred concurrently with declines in neonatal mortality, thus suggesting that the factors responsible for one have not been the same factors responsible for the other. Moreover, periods of maximum decline in neonatal mortality have not been followed by a period of slowed decline in postneonatal mortality, as might be expected to occur if early deaths were

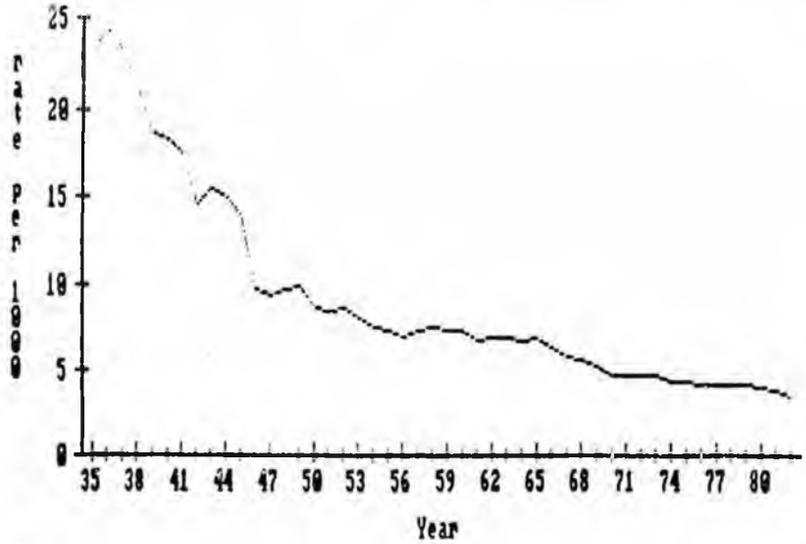

Figure 2 Postneonatal mortality, United States, 1935–1982.

deferred in time. Figure 3 shows the rate for the two components of infant mortality. The decline in the mid and late 1940s was primarily concentrated in the postneonatal component. The marked and continued fall in the neonatal component in the most recent 15 years has not been accompanied by a parallel decline in the postneonatal component. Although it might be postulated that rapid declines in neonatal mortality might be accompanied by some increase in postneonatal mortality because of the possibility of postponement of deaths due to the saving of highly vulnerable infants by neonatal interventions, there is evidence that this is not the explanation for the lagging postneonatal rates (24, 28, 34). Although some institutions may be experiencing postponement of deaths of very low-birth-weight infants as a result of developments in neonatal management (14), there is no evidence that the general lag in postneonatal mortality is a result of an increase in survival of infants born with very low birth weight. For example, a study of all births and infant deaths in Upstate New York from 1968 to 1979 showed that the proportion of deaths that were postneonatal increased in all birth-weight groups. The relatively small proportion of deaths that were among very low-birth-weight infants was too small to account for the overall relative increase in importance of postneonatal mortality (45). Moreover, there was no shift in time of death to earlier in the postneonatal period, except among the 500–1000 gram infants [who accounted for less than 5% of all postneonatal deaths (calculated from 45)].

Of particular concern is the *increase* in postneonatal mortality rates among infants of teenage mothers. A study of mortality and morbidity of infants born

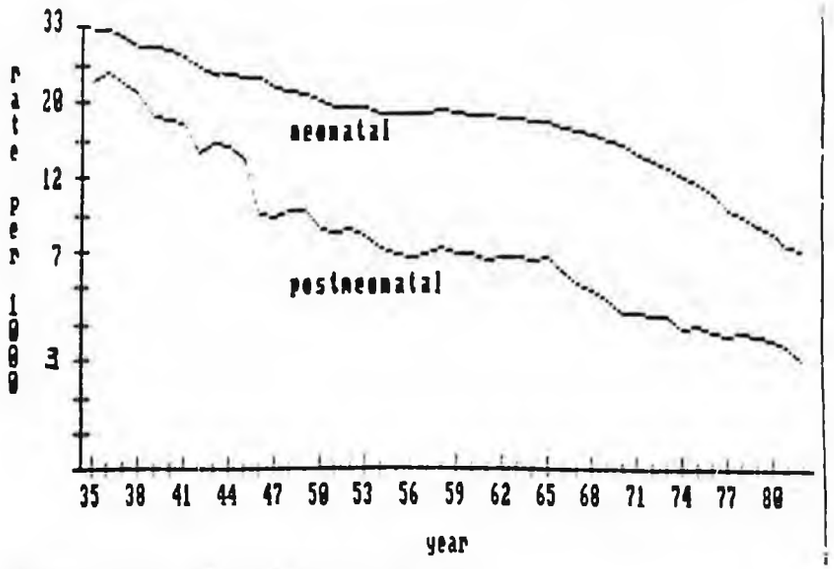

Figure 3 Infant mortality, United States, 1935–1982.

in eight areas across the United States, including approximately 6% of the births in the country, found that the postneonatal death rate of infants born to mothers under the age of 17 and to multiparous mothers of ages 18 and 19 increased during the decade of the 1970s, especially among nonwhites, and even when birth weight was controlled (25).

AN INTERNATIONAL PERSPECTIVE

The existence of differences in the definition of live births complicates comparison of trends in neonatal mortality across international boundaries, but there is little problem in the case of postneonatal mortality. Infant mortality rates below 70 per thousand were found in most industrialized countries as late as the 1920s (a rate of 70 was reached in 1926 in the United States), except in Norway, Sweden, Australia, and New Zealand, all of which reported rates under 70 earlier than 1915 (37). In France and Japan, rates below 70 were not reached until after World War II. These differences in infant mortality rates and differences in the rates of decline over time are largely a reflection of differences in the postneonatal component. In fact, the gap in postneonatal mortality rates between countries with high rates and those with low rates is much greater now than it was decades ago. Shapiro examined trends in infant mortality rates in a large number of nations with rates no greater than 30 per thousand. Figure 4 shows trends for several of these countries, selected to provide examples of the

situation in which the rates were very low, low, and moderate in the early 1970s. Countries with very low rates included Japan and the Netherlands, with rates below 4.5 per thousand in the early 1970s; those with low rates included the United States and the United Kingdom, with rates between 5 and 7 per thousand in 1971; and countries with moderate rates included Italy, with a rate of 9.2 in 1970. Japan's postneonatal mortality rate in 1950 was approximately equal to that of the "moderate" mortality countries in 1950 (32.0); its rate had halved by the end of the decade of the 1950s and reached a low of 4.2 by the early 1970s. The Netherlands had a rate of 8.8 in 1950 (approximately equivalent to a rate of 8.7 in the United States at the same time); the rate halved by 1960 and declined to 3.1 by the early 1970s. The United Kingdom's rate of 11.3 in 1950 had not quite halved even by 1971, a situation similar to that in the United States, which still experienced a rate as high as 4.9 in 1971. Italy's rate of 34.1 in 1950 had halved by 1963 and then fallen by 46% between 1963 and 1970. The periods since 1950 in which the maximum rates of decline were experienced by these countries were as follows: 50% drop between 1960 and 1965 in Japan, 50% drop between 1955 and 1960 in Netherlands, 30% drop between 1965 and 1970 in the United States, 33% drop between 1950 and 1955 in the United Kingdom, and a 30% drop between 1960 and 1965 in Italy. In both Japan and Italy, the rate of decline in several other five-year periods approximated the maximum rate, so that overall improvements in survival in the postneonatal period were relatively continuous over the 20-year time span. Uneveness in the rate of decline was most notable in the United States, which

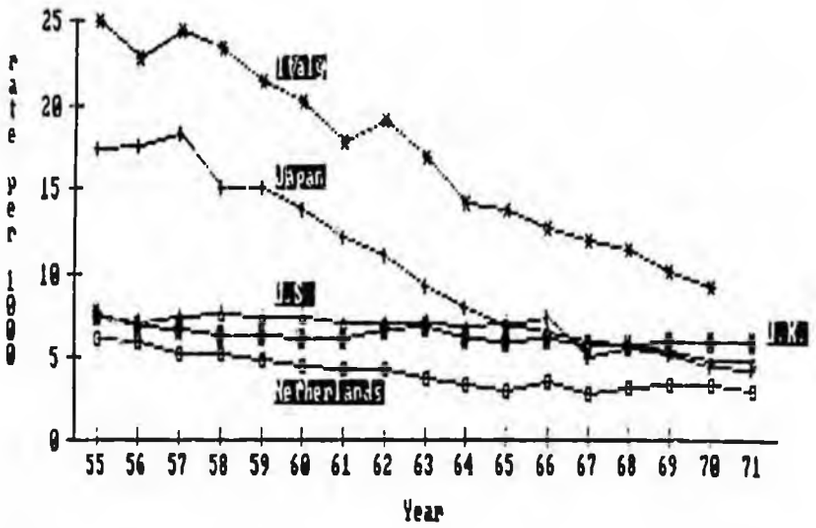

Figure 4 Postneonatal mortality, 1955–1971.

showed no improvement during the 1950s and little improvement in the early 1960s. These marked differences in both the rate and timing of improvements in postneonatal survival strongly suggest an impact of factors other than the availability of specific medical technologies; in several cases, the periods of maximum improvement coincided with national changes in the organization or financing of health services, such as enactment of the entitlement legislation in the United States in the mid 1960s.

Although it is apparent that the overall differences in neonatal infant mortality rates in the United States and Scandinavia are a result of differences in birth-weight distributions rather than differences in birth-weight-specific mortality, this is not the case for postneonatal mortality, at least among the nonwhite population in the United States. For example, the differences between Norwegian postneonatal mortality rates and nonwhite postneonatal mortality rates in the United States are a result of higher birth-weight-specific mortality in the United States (10). For the country as a whole, however, the overall postneonatal mortality rate improved relative to that of Scandinavia between 1965 and 1978. For example, the ratio of postneonatal mortality rates in the United States to that of Sweden was 2.6 in 1960, 2.6 in 1965, 2.7 in 1970 (Sweden changed its system of reporting deaths at this time and the very low postneonatal mortality rate reported for 1970, i.e. 1.9, may not be accurate), 2.0 in 1975, 1.9 in 1977, and 1.8 in 1978 [calculated from data in (44, 37)].

Countries that differ in their postneonatal mortality rates also differ in the relative importance of certain causes of postneonatal deaths. In rural Bangladesh, postneonatal mortality comprised 44% of all infant mortality, with a rate of 71 per thousand compared with a neonatal mortality rate of 89 per thousand in 1976–1977 (19). More than four of five deaths (86%) were due to tetanus, pneumonia, malnutrition, diarrhea, "fever," and measles; if these were eliminated, postneonatal mortality would have comprised only 10% of all infant mortality, or a rate of 9.6 per thousand.

Rates of postneonatal death associated with congenital anomalies are similar internationally, at least for Denmark, England and Wales, Finland, Norway, Sweden (33), Japan, Switzerland, Australia, and the United States (37). The disparities in death rates from accidents have not changed substantially over time among the industrialized countries (at least for Netherlands, Sweden, Canada, United States, and the United Kingdom), except for Scotland, where deaths due to accidents rose progressively from 1958 to the early 1970s, greatly increasing the disparity between that and other counties. For example, the death rate due to accidents in the postneonatal period in the United States in the early 1970s was four times higher then those in Sweden at the same time; in 1964–1965, rates of death due to accidents were three times higher than in Sweden, and in 1958–1960 they were 3.5 times higher. Mortality associated with diseases of the respiratory system, infective and parasitic diseases, and

symptoms and ill-defined conditions, however, vary widely across the countries and over time (33, 37). For example, in the late 1960s and early 1970s postneonatal death rates from respiratory causes or influenza ranged from about 20–40 per 100,000 live births in Netherlands, Norway, Denmark, and Sweden, to 60–120 per 100,000 in Switzerland and Japan, and to 130–250 per 100,000 in the United States, Canada, Australia, New Zealand, and the United Kingdom. Postneonatal deaths due to infections and parasitic diseases ranged from 20–30 in Netherlands, Norway, Sweden, Switzerland, and Denmark to 35–70 in Canada, the United States, United Kingdom, Australia, Japan, and New Zealand. Disparities in the death rate attributed to pneumonia or influenza increased between the late 1950s (1958–1960) and mid-1960s (1964–1966) and between the mid 1960s and early 1970s among these countries, from the order of 4–5-fold in the late 1950s to 10–15-fold in the early 1970s [calculated from (37)]. That is, disparities in the postneonatal death rate associated with these causes of infection actually have widened in the most recent 30 years among the industrialized nations.

CAUSES AND CORRELATES

Environmental factors have long been associated with deaths during the first year of life (33). William Farr, and before him Fredrick Engels, documented the concentration of deaths in working class districts. Engels attributed the excess mortality to conditions of work and poor living conditions (43). Historically, high infant mortality rates resulted from relatively high postneonatal mortality rates rather than from relatively high neonatal mortality rates.

Changes in the cause of death between 1920 and the present provide ample evidence of the importance of nonbiological factors in the genesis of postneonatal mortality. Table 1 indicates that, in the period 1918–1925, infections (including respiratory tract infections) were by far the most common cause of death in the United States, comprising over two-thirds of all deaths in the postneonatal period. By 1940, these conditions comprised less than half of the deaths (46%). In the early 1950s, the proportion of deaths accounted for by infections fell to 38%, a proportion that did not change, and perhaps even increased slightly by the end of the decade to 43%. It is important to recall that this latter period (the 1950s) was the same period during which overall postneonatal mortality rates were not declining in the country as a whole. Coincident with resumption of the decline in postneonatal mortality after 1965, the proportion of deaths associated with infections also fell: to 29% in 1973 and to 17% in 1978.

Although infants of low birth weight are at higher risk of dying in the postneonatal period as well as in the neonatal period, the vast majority of infants who die in the postneonatal period are of normal birthweight: 80% of