

The 'New Medicaid': An Incremental Path To National Health Care Reform

by Christine C. Ferguson and Tricia Leddy

From the 1960s (when the Medicaid program began) through the mid-1980s, Medicaid provided health coverage for the poor, serving as a "payor of last resort" of health care claims for families receiving cash assistance. Yet for much of this time, Medicaid programs never made use of their potential clout as large health care payors to assure access and quality of care for the population that they served.

This should not be surprising, given the rules of the game. While each state administers its own Medicaid program and each program is supported by a combination of state and federal funds, Medicaid operated under rules established by the federal government. And historically, states had little autonomy in how they ran their Medicaid programs.

For much of Medicaid's history, eligibility was linked to Aid to Families with Dependent Children (AFDC), or welfare. Individuals who were neither elderly nor disabled could obtain Medicaid-covered care only if they met state-set eligibility requirements for welfare, which generally meant that they had to be members of a family with dependent children and an extremely low income. (The average was only about 46% of the federal poverty level.)

But beginning in the mid-1980s, the rules began to change dramatically—at least for pregnant women and infants. Mindful both of the low income-eligibility levels and of the emerging consensus that prenatal care could reduce the incidence of low birth weight, Congress undertook a series of incremental steps designed to broaden Medicaid eligibility for pregnant women. By the end of the decade, states were required to provide Medicaid coverage for pregnant women

with incomes up to 133% of the federal poverty level, and could, at their discretion, extend coverage to pregnant women up to 185% of poverty.

The result of these changes was that more women than ever could have their prenatal care, labor, delivery and postnatal care (including the provision of family planning services and supplies) covered by Medicaid. However, once the postpartum period ended (60 days after delivery), the woman's eligibility ended as well.

Overall, the success of the Medicaid expansions was impressive. Within only a few years, every state had at least met the federal mandate (and many had gone beyond the minimum levels required by law).¹ Moreover, as an article published elsewhere in this issue documents,² the expansion of Medicaid eligibility in Florida in 1989 not only increased by almost half the number of deliveries funded by Medicaid, but also expanded women's access to prenatal care. In just a short period of time, Medicaid-funded prenatal visits increased by about 260,000, and evidence suggests that many of these visits were made by women who would otherwise have been uninsured. Other research indicates that following the Medicaid expansion in Florida, birth outcomes improved among women who previously lacked private insurance coverage.³

In the early 1990s, however, those seeking to rationalize the health care delivery and finance system and expand access to care shifted their attention for a time from the states to Congress, which, at the behest of the Clinton administration, was struggling to adopt some type of national health care reform. The subsequent failure of these efforts at the national level once again shifted the action back to the states, which began to design and implement their own reform initiatives. This trend accelerated when states realized that federal money could be used to subsidize

such initiatives if Medicaid was used as the foundation for these efforts.

Making substantial changes in how a state's Medicaid program operates is not simple, however. The only way to effect such a change within the confines of the joint federal-state Medicaid program is for states to apply for and receive a federal waiver that effectively constitutes federal "permission" to alter basic Medicaid rules. Unfortunately, the waiver process is often cumbersome and time-consuming, and can sometimes delay for years the implementation of, for example, a change in coverage criteria.

Despite the complexity, several states used the waiver process to greatly expand their Medicaid programs. In particular, in 1994 Rhode Island obtained a waiver to begin its plan to incrementally extend coverage to uninsured families by insuring previously uninsured pregnant women and children. Significantly, the Rhode Island program, known as RIte Care, also included coverage for family planning services for 26 months postpartum for women who would otherwise have become uninsured two months after delivery.

At the same time, South Carolina obtained a waiver to institute a similar expansion for family planning services for women who were covered under its prenatal care expansion, but as a freestanding program rather than in the context of an overall revamping of the state's Medicaid effort. By early 1999, similar waivers are in place in a total of nine states, including a program in Delaware that extends eligibility for Medicaid-covered family planning services to women who lose Medicaid for any reason, not just after pregnancy. In addition, four other waivers expand eligibility for Medicaid-funded family planning services by offering coverage to all women in the state based solely on their income, regardless of whether

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they have had any previous association with the Medicaid program.⁴

In Rhode Island, both the expanded eligibility for prenatal care and the expanded eligibility for family planning were done in the context of our overall RIte Care program. More recently, we added yet another expansion group to the program, having made children up to age 18 eligible for the newly created State Children's Health Insurance Program (CHIP), which was adopted by Congress in 1997.

A combination of federal policy changes and state initiatives to implement health care reform have led states to draw on significant new federal funds to provide uninsured children, and in some cases entire families, with comprehensive health insurance coverage.

Rhode Island, for example, has expanded Medicaid coverage significantly. Children up to age 18 are now covered in families with incomes of up to 250% of the federal poverty level (\$41,750 for a family of four), as are families with minor children with family incomes under 185% of poverty (\$30,895 for a family of four). Pregnant or postpartum women with incomes below 350% of poverty (\$58,450 for a family of four) receive coverage for prenatal, maternity and family planning services through 26 months postpartum. Rhode Island also provides family health insurance, through enrollment in RIte Care, to home-based child care providers who participate in Rhode Island's subsidized child care program, a cornerstone of the state's welfare reform initiative.

As a result of these expansions, the number of RIte Care enrollees who do not otherwise receive cash assistance from the state has grown to about one-third; these generally are working families who lack access to employer-based health insurance. RIte Care has become Rhode Island's "New Medicaid," enrolling families receiving cash assistance, uninsured working families and state child care providers, while utilizing a mix of Medicaid, CHIP and state funds, combined with "sliding scale" cost-sharing by members.

However, health insurance coverage alone is not the ultimate goal of such efforts. Improved health status and outcomes, improved access to care and im-

proved quality of care are the desired results. Using these expansions to improve access to family planning services, as earlier expansions were able to do for prenatal care, is an important component of this endeavor.

Ensuring that pregnancy ends positively and healthfully for both the woman and her child is a vital outcome of these efforts. Providing access to prenatal care and delivery services is an important way to achieve this goal: Rhode Island has shown significant improvements in the adequacy of prenatal care after the implementation of RIte Care.⁵ However, the prevention of unintended pregnancies is also important.

There is a well-established association between adverse birth outcomes and a short interval between pregnancies. Infants born following a short interval since the previous pregnancy are at higher risk of low birth weight, preterm birth and small size for gestational age.⁶ Each of these problems is associated with a higher rate of neonatal intensive care unit admissions and higher overall health care costs.

Furthermore, more than half of pregnancies among American women are unintended, and some researchers have argued that intention status is closely linked with higher rates of short-interval births.⁷ Beyond the greater health care costs incurred in these instances are the potentially high social costs for families: Families in which births are closely spaced or in which unintended births are common will experience greater levels of stress, particularly when their financial resources are limited.

Family planning coverage for women who have already had a Medicaid-financed delivery is intended to give women the means to decide whether and when to have more children. The state investment to provide this service through an expansion of Medicaid is minimal, because the federal government pays 90% of Medicaid family planning services expenditures. And the potential for state savings through the prevention of unintended births is high.

Yet despite the clear advantages of moving to expand eligibility for family planning, states still must go through the cumbersome and difficult process of obtaining federal waivers before they may do so.

Legislation introduced in Congress in 1999 by Rhode Island's Senator John Chafee would allow state Medicaid programs to expand coverage for family planning services to uninsured women without the current cumbersome waiver process. Given the clear indications of extensive benefits for delivery and prenatal care of eligibility expansions in Florida, such legislation would also produce strong benefits for women who wish to avoid unwanted pregnancy, and for their families.

Regardless of the decision on any one piece of legislation, though, the overall trend is clear: "New Federalism," a term coined to describe a loosening of federal rules to allow states to call their own shots in designing health care reform and other initiatives, provides us both with flexibility and with the financial ability to cover the uninsured. States continue, albeit some more quickly than others, to move forward through incremental expansions of health insurance coverage, largely building on Medicaid and CHIP, and newly evolving partnerships with employers. But the options available already give states a great deal of latitude to modify their Medicaid plans, and more flexibility may come soon. We have long sought this kind of authority, and we now have the opportunity to act. There is no longer any excuse for delays.

References

1. Gold RB, State efforts to expand Medicaid-funded family planning show promise, *The Guttmacher Report on Public Policy*, 1999, 2(2):8-11.
2. Marquis MS and Long SH, Medicaid eligibility expansion in Florida: effects on maternity care financing and the delivery system, *Family Planning Perspectives*, 1999, 31(3):112-116 & 121.
3. Long SH and Marquis MS, The effects of Florida's Medicaid eligibility expansion for pregnant women, *American Journal Public Health*, 1998, 88(3):371-376.
4. Gold RB, 1999, op. cit. (see reference 1).
5. Griffin JF et al., The effect of a Medicaid managed care program on the adequacy of prenatal care utilization in Rhode Island, *American Journal of Public Health*, 1999, 89(4):497-501.
6. Zhu BP et al., Effect of the interval between pregnancies on perinatal outcomes, *New England Journal of Medicine*, 1999, 340(8):589-594.
7. Klebanoff MA, The interval between pregnancies and the outcome of subsequent births, *New England Journal of Medicine*, 1999, 340(8):643-644.