



## Births to Mothers in HUSKY A: Birth Outcomes, 2002

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Low birthweight and preterm birth are major predictors of infant morbidity and mortality.<sup>1</sup> Compared to normal weight babies, the risk of dying before 1 year of age is five times higher for moderately low birthweight babies (1500-2499 grams) and more than 100 times higher for very low birthweight babies (<1500 grams). Low birthweight infants who survive the neonatal period are more likely to experience long-term physical and developmental disabilities.

This report is part of the third annual summary of data on births to mothers in HUSKY A (Medicaid managed care), previously issued by the Children's Health Council, and now issued by Connecticut Voices for Children in 2005.<sup>2</sup>

### METHODS

Records of births in 2002 were linked with HUSKY A enrollment data files in order to identify births to mothers who were enrolled in HUSKY A at the time they gave birth.<sup>3</sup> Rates for low birthweight (LBWT, < 2500 grams), very low birthweight (VLBWT, < 1500 grams), and preterm births (< 37 weeks gestation) to mothers enrolled in HUSKY A were compared with birth outcomes for all other babies born in Connecticut in 2002. Results are summarized and compared to birth outcomes in HUSKY A for 2000 and 2001.

### RESULTS

In 2002, there were 41,191 births to Connecticut residents, including 9,775 births (24%) to mothers enrolled in HUSKY A when their babies were born.<sup>4</sup>

Compared with other mothers, mothers who gave birth while enrolled in HUSKY A were younger (average age 25, compared with 31 for other mothers) and far more likely to be teens (21% v. 3% of other mothers). They were more likely to be Black non-Hispanic (25% v. 7%) and Hispanic (32% v. 12%).

**Low birthweight:** Babies born to mothers enrolled in HUSKY A were significantly more likely than babies born to other mothers to be LBWT (Table 1). Among singleton births (which are at lower risk than multiple births for

VLBWT) babies born to mothers in HUSKY A were 60% more likely to be VLBWT.

**Table 1. 2002 Births: birth outcomes**

	Births to mothers in HUSKY A	Births to other mothers
<b>Low birthweight</b>	<b>9.7%</b>	<b>7.1%</b>
<b>Very low birthweight</b>	<b>1.9%</b>	<b>1.4%</b>
<b>Very low birthweight (singletons)</b>	<b>1.6%</b>	<b>1.0%</b>
<b>Preterm births</b>	<b>10.9%</b>	<b>9.3%</b>

Compared with births to other mothers, the LBWT rate in HUSKY A was 20 percent higher for White non-Hispanic births (7.8% v. 6.5%) and 40 percent higher for Hispanic births (9.6% v. 6.8%). This difference was not evident when comparing LBWT rates for Black non-Hispanic births in HUSKY A (12.9%) with other Black non-Hispanic births (12.4%).

In 2002, 17 percent of mothers in HUSKY A smoked, compared with 4 percent of other mothers. The LBWT rate for babies born to HUSKY A mothers who smoked (13.6%) was about 50 percent higher than the rate for HUSKY A mothers who did not smoke (8.9%). Nearly one in five babies born to Hispanic and Black non-Hispanic HUSKY A mothers who smoked weighed less than 2500 grams at birth.

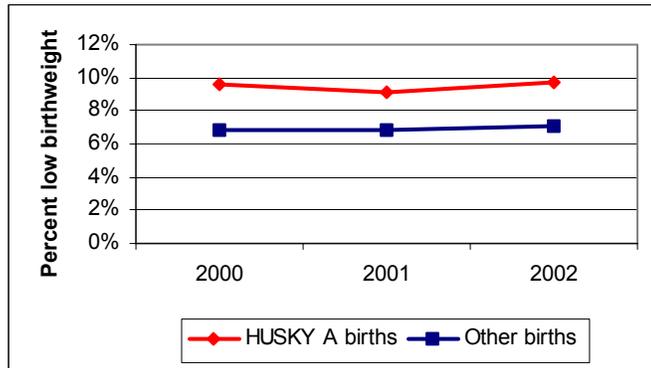
**Preterm birth:** Compared with other babies born in 2002, babies born to mothers enrolled in HUSKY A at the time of birth were more likely to be born preterm (Table 1). Babies born to Hispanic mothers in HUSKY A were 30 percent more likely than babies born to other Hispanic mothers to be preterm.

Pregnancies with twins or other multiple births are at greater risk for preterm birth. In Connecticut, the percentage of births that were multiple births was significantly lower for mothers in HUSKY A than it was for other mothers (2.8% v. 4.6%). However, even after excluding these multiple births, the preterm birth rate is about 30 percent higher for singleton babies born to

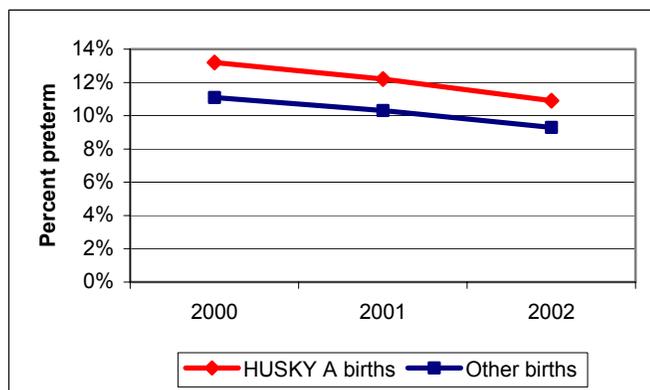
mothers in HUSKY A, compared with singleton births to other mothers (9.4% v. 7.2%).

**Trends:** Since 2000, the LBWT rate has remained fairly steady (Figure 1) while the preterm birth rate has declined somewhat for babies born to HUSKY A and other mothers (Figure 2).

**Figure 1. Low birthweight Rate: Trends**



**Figure 2. Preterm Births: Trends**



## DISCUSSION

Despite expanded Medicaid coverage for pregnant women and advances in clinical care, birth outcomes in the US have not improved in recent years. In 2002, the LBWT rate rose to 7.8 percent, the highest level recorded in the US in more than 30 years.<sup>5</sup> The preterm birth rate (11.9%) was the highest in two decades. An increase in multiple births accounts for some but not all of the increase in poor birth outcomes.

National data show that the risk of LBWT is highest for babies born to the youngest and oldest mothers and babies born to mothers who smoked during pregnancy. Nationwide, the LBWT rate for Black infants continues to be about twice the rate for White infants, similar to the disparity observed in Connecticut in 2002 (12.7% LBWT

for Black non-Hispanic infants v. 6.7% LBWT for White non-Hispanic infants).

Public policy efforts to prevent low birthweight are mainly focused on improving access to timely, high quality prenatal care for all women and risk-appropriate care for women at risk for adverse birth outcomes. Access to prenatal care is better for women with health care coverage. In Connecticut, pregnant women in families with income below 185% of the federal level are eligible for Medicaid and to enroll in HUSKY A (Medicaid managed care) during pregnancy and for 60 days postpartum.<sup>6</sup> HUSKY A health plans are responsible for identifying pregnant women as early as possible; conducting risk assessment; providing needed assistance with appointment scheduling, transportation, and other support services; making referrals to the WIC program; providing care coordination and specialized services for high risk women; and offering prenatal health education aimed at promoting healthy birth outcomes.

## RECOMMENDATIONS

- Strengthen collaborative efforts between HUSKY health plans and community providers to improve early identification, early enrollment, and early care for HUSKY-eligible pregnant women.
- Ensure Medicaid coverage for smoking cessation services for teens and pregnant women.

<sup>1</sup> Mathews TJ et al. Infant mortality statistics from the 2001 period linked birth/infant death data set. National Vital Statistics Reports, 2003; 52(10): 1-28.

<sup>2</sup> CT Voices for Children is a non-profit organization that conducts research and policy analysis on children's issues. This report on births was prepared under a contract between the CT Dept. of Social Services and the Hartford Foundation for Public Giving (HFPG), with a grant to CT Voices from HFPG. Performance monitoring in HUSKY A builds on work begun by the Children's Health Council. CT Voices for Children contracts with MAXIMUS, Inc. for data management and data analysis. This report, also available at [www.ctkidslink.org](http://www.ctkidslink.org), was prepared by Mary Alice Lee, Ph.D., Senior Policy Fellow.

<sup>3</sup> Data sources: CT Department of Public Health (2002 birth records, released to CT Voices with the approval of DPH Human Investigations Committee) and CT Department of Social Services (HUSKY A enrollment data). For a detailed description of the data elements, data linkage and evaluation, see technical notes in: Children's Health Council. Births to mothers in HUSKY A: 2000. Hartford, CT: CHC, February 2003.

<sup>4</sup> Birth certificates in CT do not identify source of payment for prenatal care or birth, so births to women whose care was covered by fee-for-service Medicaid (n=2,153) and births to mothers in HUSKY B (number not available) are included with births to other mothers.

<sup>5</sup> Martin JA et al. Births: Final data for 2002. National Vital Statistics Reports, 2003; 52(10): 1-116.

<sup>6</sup> Pregnant women are eligible if family income is less than \$23,736 for family of 2, \$29,767 for family of 3, and \$35,798 for family of 4. For eligibility determination, a pregnant woman is counted as two persons.