CONNECTICUT VOICES FOR CHILDREN

# Births to Mothers in HUSKY A: Birth Outcomes, 2004

**February 2007**

Low birthweight infants, especially those with very low birthweight, are at increased risk of morbidity and death in the early days, weeks, and months of life.[1] Babies born preterm are also at increased risk for poor health outcomes. Preterm infants are far more likely to die in the first year of life than full-term babies and are more likely to suffer neurological and developmental problems.

## METHODS

This report is part of the fifth annual summary of data on births by outcome to mothers in Medicaid.[2]

Records of births in 2004 were linked with HUSKY A enrollment data files and with Medicaid eligibility data in order to identify births to mothers who were enrolled in HUSKY A (Medicaid managed care) or fee-for-service (FFS) Medicaid at the time they gave birth.[3] Rates for low birthweight (LBWT) (< 2,500 grams), very low birthweight (VLBWT) (< 1,500 grams), and preterm births (< 37 weeks gestation) to mothers enrolled in HUSKY A were determined and compared for mothers in HUSKY A, FFS Medicaid, and other mothers.

## RESULTS

In 2004, there were 42,004 births to Connecticut residents, including 10,373 births (25%) to mothers enrolled in HUSKY A and 2,535 births (6%) to mothers whose births were covered by FFS Medicaid.[4]

Mothers who were enrolled in HUSKY A when they gave birth were far more likely to be teens 19 and under (20% of births), compared with mothers with FFS coverage (11% of births) and all other mothers (2% of births). Black non-Hispanic and Hispanic mothers were more likely to give birth while in HUSKY A than White non-Hispanic mothers (53% and 46%, respectively, v. 15%).

**Low birthweight:** Babies born to mothers enrolled in HUSKY A and mothers with FFS Medicaid coverage were equally likely to be low birthweight but more likely to be low birthweight than babies born to other mothers (Table 1). Among singleton births, which are at lower risk than multiple births for VLBWT, babies born to mothers in HUSKY A were more likely to be VLBWT than babies born to other mothers. Compared with births to other mothers, the LBWT rate in HUSKY A was 11 percent higher for White non-Hispanic births (7.2% v. 6.5%), 25 percent higher for Black non-Hispanic births (13.4% vs. 10.7%), and 28 percent higher for Hispanic births (9.7% v. 7.6%).

**Table 1. 2004 Births: Birth Outcomes**

| | Births to HUSKY A mothers | Births to FFS mothers | Births to other mothers |
|---|---|---|---|
| Low birthweight | 9.7% | 10.1% | 7.0% |
| Very low birthweight | 2.2% | 2.5% | 1.3% |
| Very low birthweight (singletons) | 1.8% | 1.9% | 0.9% |
| Preterm births | 10.7% | 12.2% | 8.8% |
| Preterm births (singletons) | 9.4% | 11.2% | 6.7% |

In 2004, babies born to Connecticut mothers who smoked were twice as likely to be low birthweight (15%) compared to those born to non-smokers (7%). Nearly one in five babies born to Black non-Hispanic HUSKY A mothers who smoked weighed less than 2,500 grams at birth.

**Preterm birth:** Babies born to mothers enrolled in HUSKY A and babies born to mothers with FFS

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Medicaid coverage at the time of birth were significantly more likely to be born preterm than babies born to other mothers. Among all births in Connecticut in 2004, babies from multiple births were more than seven times more likely than singleton babies to be born prematurely (56% v. 8%, respectively). After excluding multiple births, the preterm birth rate was significantly higher for singleton babies born to mothers in HUSKY A and mother with FFS Medicaid coverage, compared with those born to other mothers.

Overall, 14 percent of babies born to Connecticut mothers who smoked were premature in 2004, compared to 9 percent of births to non-smokers.

**Trends:** Since 2000, the LBWT rate has remained fairly steady (Figure 1) while the preterm birth rate declined somewhat through 2003 and rebounded in 2004 for babies born to HUSKY A and all other mothers (Figure 2).

**Figure 1. Low Birthweight: Trends**

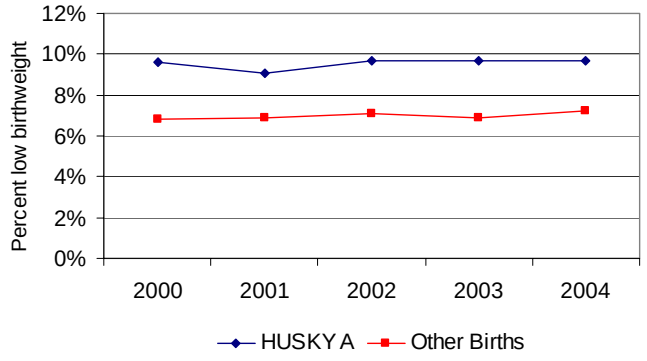
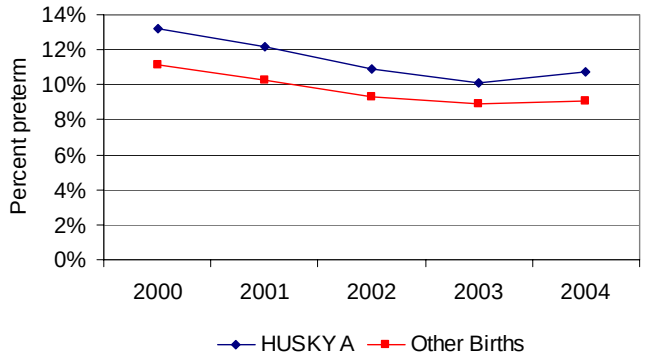



**Figure 2. Preterm Births: Trends**




## DISCUSSION

This report finds that babies born to mothers in Connecticut's Medicaid program are at risk for poor birth outcomes. Compared to all other babies in Connecticut, rates for low birthweight, very low birthweight, and preterm birth were higher for babies born to mothers covered by HUSKY A and FFS Medicaid compared to all other babies born in Connecticut.

While Connecticut's low birthweight rate remained unchanged over 2004, nationally the low birthweight (<2,500 grams) rate increased to 8.1 percent from 7.6 percent in 2003.[5] This increase marks the continuance of a more than three-decade rise in low birthweight in the United States, up from 7.0 percent in 1990, a trend in both singleton as well as multiple births. The low birthweight rate rose among babies born to non-Hispanic white and Hispanic mothers, but not among other babies of other races or ethnicities. The preterm birth (<37 weeks gestation) rate was 12.5 percent in 2004, an increase over the previous year (11.5%) and up 18 percent since 1990. In fact, the number of preterm births in 2004—more than half a million—was the highest recorded in over two decades.

While the antecedents of poor birth outcomes are found both before and during pregnancy,[6] public policy efforts to prevent these outcomes are mainly focused on the prenatal period—more specifically, improving access to timely, high quality prenatal care for all women and risk-appropriate care for women at high 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 percent of the federal level are eligible for Medicaid and enrollment in HUSKY A (Medicaid managed care) during pregnancy and for 60 days postpartum.[7] 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 A 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.

[1] Mathews TJ, MacDorman MF. 2006. Infant mortality statistics from the 2003 period linked birth/infant death data set. *National Vital Statistics Reports* 54(16): 1-29.

[2] Connecticut 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 Connecticut Department of Social Services and the Hartford Foundation for Public Giving, with a grant to Connecticut Voices from the Hartford Foundation. Performance monitoring in HUSKY A builds on work begun by the Children's Health Council. Connecticut Voices for Children contracts with MAXIMUS, Inc. for data management and data analysis. This report was prepared by Karen M. Sautter, M.P.H, under the direction of Mary Alice Lee, Ph.D., Senior Policy Fellow. This report is available at www.ctkidslink.org.

[3] Data sources: CT Department of Public Health (2004 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. (Available at www.ctkidslink.org.)

[4] Births to women whose care was covered by HUSKY B (number unavailable) are included with births to other mothers.

[5] Martin JA, Hamilton BE, Sutton PD, et al. 2006. Births: Final data for 2004. *National Vital Statistics Reports* 55(1): 1-101.

[6] Lu MC, Halfon N. 2003. Racial and ethnic disparities in birth outcomes: a life-course perspective. *Matern Child Health J* 7(1): 13-30; and Kotelchuck M. 2003. Building on a life-course perspective in maternal and child health. *Matern Child Health J* 7(1): 5-11.

[7] 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.