CONNECTICUT VOICES FOR CHILDREN

Births to Mothers in HUSKY A: Smoking During Pregnancy, 2004

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Smoking is the leading cause of preventable mortality and disease in the US today.[1] Among women, it is the major cause of cancer of the oropharynx and bladder and increased the risk for cervical cancer, liver cancer, and colorectal cancer. Women who smoke during pregnancy are at risk for pregnancy complications, preterm birth, low birthweight infants, stillbirth, and infant death. Exposure to environmental tobacco smoke (second hand smoking) during childhood and adolescence is associated with increased risk for chronic bronchitis and wheezing and for the development of asthma.[2]

METHODS

This brief on smoking during pregnancy is part of the fifth annual summary of data on births to mothers in Medicaid.[3]

Records of births in 2004 were linked with HUSKY A enrollment 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.[4] Maternal smoking rates for HUSKY A, FFS, and other mothers, based on birth data recorded by clinicians, were determined and compared overall and by racial/ethnic group. Low birthweight (<2,500 grams) and preterm birth (<37 weeks gestation) rates for smokers 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.[5] 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%).

Smoking in pregnancy: Among births in 2004, 16 percent of HUSKY A mothers smoked during pregnancy, compared with 8 percent covered by FFS Medicaid and 3% of other mothers (Table 1). Babies born to Connecticut mothers who smoked were twice as likely to be low birthweight (15%) compared to those born to non-smokers (7%). Overall, 14 percent of babies born to Connecticut mothers who smoked were premature in 2004, compared to 9 percent of births to non-smokers. Among mothers in HUSKY A, these rates were slightly higher (15% and 10%, respectively).

Table 1. Smoking during pregnancy by low birthweight and preterm births, 2004

Births to:	HUSKY A Mothers	FFS Mothers	Other mothers
Smokers	15.9%	8.2%	2.8%
Low birthweight births:			
Smokers	14.8%	22.6%	12.3%
Non-smokers	8.7%	8.9%	6.8%
Preterm births:			
Smokers	14.8%	25.3%	9.7%
Non-smokers	9.9%	11.2%	8.8%

Among babies in HUSKY A, the low birthweight rate was highest for babies born to Black non-Hispanic mothers who smoked (20%) (Figure 1). The preterm rate was highest for HUSKY A babies born to Black non-Hispanic mothers who smoked (18%) and Hispanic mothers who smoked (18%) (Figure 2).

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Figure 1. Smoking in pregnancy by low birthweight

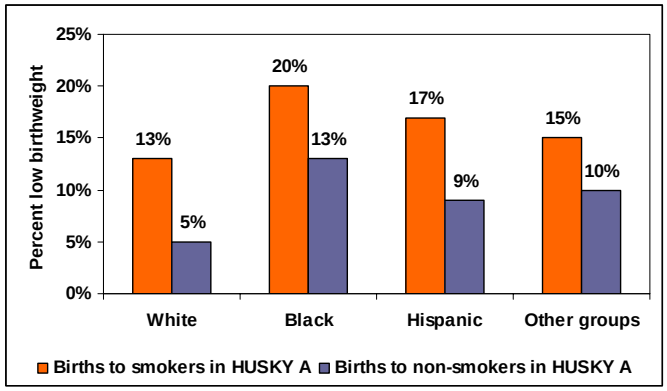
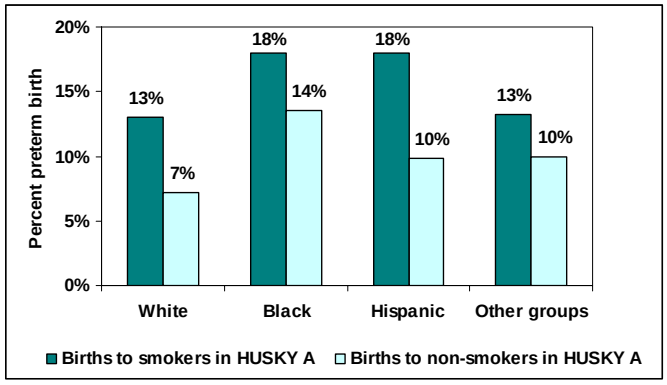


Figure 2. Smoking in pregnancy by preterm birth



Trends: In 2004, the proportion of women in HUSKY A who smoked during pregnancy (16%) was down somewhat from previous years (19% in 2000, 18% in 2001, 17% in 2002 and 19% in 2003).

DISCUSSION

Nationwide, smoking during pregnancy has declined from nearly 20 percent in 1989 to just over 10 percent of mothers who gave birth in 2004.[6] Maternal smoking is highest among American Indian/Asian Pacific Islander mothers and those with a high school education or less.

Medicaid coverage for smoking cessation: In 2000, the US Public Health Service issued guidelines for treating tobacco use and dependence.[7] In 2001, in a letter to State Medicaid Directors, the Center for Medicare and Medicaid Services (CMS) reminded States that under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) component of Medicaid they are "required to cover smoking cessation drug therapy when it is determined medically necessary for eligible individuals under age 21."[8] Further, the CMS Director stated that State Medicaid programs are "required to provide pregnancy-related services that are necessary for the health of the pregnant woman and the fetus," citing clear evidence that smoking during pregnancy can cause adverse births outcomes. This CMS directive informed State Medicaid Directors that "State Medicaid agencies must ensure that such services are available to pregnant women and children as appropriate under EPSDT…[and that the] State should also make sure that Medicaid managed care contract specifically reflect coverage for these services."

In 2005, Medicaid programs in 38 states and the District of Columbia covered at least some smoking cessation services for all Medicaid recipients.[9] *Tobacco dependence treatment, however, is not a covered benefit in Connecticut's HUSKY A or fee-for-service Medicaid programs.* HUSKY A managed care contracts do not specify that when medically necessary, tobacco dependence treatment is a covered service for children and pregnant women. CHNCT, Health Net, and Preferred One cover counseling, nicotine replacement, and medication to reduce withdrawal symptoms. BlueCare refers members to the toll-free CT QuitLine for motivational assistance and counseling.

RECOMMENDATIONS

- Connecticut's Medicaid program should cover effective treatments for tobacco dependence, including both medication (nicotine replacement therapy, antidepressants) and counseling (individual and group) for pregnant women and children; and
- HUSKY A contracts with managed care plans should specify that managed care plans are responsible for providing these services when medically necessary
  for pregnant women and children and for informing members about the availability of treatment.

[1] National Center for Health Statistics. Health, United States, 2004 Chartbook on trends in the health of Americans. Hyattsville, MD: Department of Health and Human Services, 2004.
[2] McQuaid EL, Walders N, Borrelli B. Environmental tobacco smoke exposure in pediatric asthma: overview and recommendations for practice. Clinical Pediatrics, 2003; 42: 775-787.

[3] 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 which was created by the Connecticut General Assembly in 1995 and charged with evaluating the impact of Medicaid managed care on children's health services. Connecticut Voices for Children contracts with MAXIMUS, Inc. for data management and data analysis. This report was prepared by Karen Sautter, M.P.H., under the direction of Mary Alice Lee, Ph.D., Senior Policy Fellow. A detailed report on 2003 and 2004 births is available at www.ctkidslink.org.

[4] Data sources: Connecticut Department of Public Health (2004 birth records, released to Connecticut Voices with the approval of DPH Human Investigations Committee) and Connecticut 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.)

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

[6] Martin JA, Hamilton BE, Sutton PD, et al. Births: Final data for 2004. National vital statistics reports; vol 55 no 1. Hyattsville, MD: National Center for Health Statistics. 2006.

[7] US Public Health Service. Treating tobacco use and dependence: a public health service clinical practice guideline. Washington, DC: Agency for Health Care Quality and Research, 2000.

[8] Centers for Medicare and Medicaid Services. Dear State Medicaid Director (letter). Baltimore, MD: CMS, January 5, 2001.

[9] Centers for Disease Control and Prevention. State Medicaid coverage for tobacco-dependence treatments—United States, 2005. Morbidity and Mortality Weekly Report, 2006: 55(44): 1194-7.