



# ESTIMATING MEDICAID-ELIGIBLE PREGNANT WOMEN & CHILDREN LIVING BELOW 185% OF POVERTY

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by Paul W. Newacheck

Health Policy Department  
Human Resources Policy Studies Division  
Center for Policy Research

National Governors' Association

Cover design by Stewart Winner

Cover illustration courtesy of the East Bay Perinatal Council, Oakland, California

ISBN 1-55877-010-0

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444 North Capitol Street  
Washington, D.C. 20001-1572

Preparation of this document was supported by a Cooperative Agreement with the Bureau of Health Care Delivery and Assistance and the Bureau of Maternal and Child Health and Resources Development, Health Resources and Services Administration, Public Health Service (CSU-110001-01-0), the U.S. Department of Health and Human Services. Ms. Joan Holloway and Ms. Ann Koontz are the Project Officers.

Additional support was provided by the National Commission to Prevent Infant Mortality. Ms. Rae Gradis is the Executive Director.

All opinions expressed herein are those of the author and do not represent those of the Department of Health and Human Services, the Robert Wood Johnson Foundation or the National Governors' Association.

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Printed in the United States of America.

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## Acknowledgements

This report is the second in a series of documents to be completed under a project entitled "Facilitating Improvement of State Programs for Pregnant Women and Children." With a primary goal of highlighting innovative, collaborative state efforts to implement improved perinatal programs, this project is supported by the Bureau of Health Care Delivery and Assistance (BHCDA) and the Bureau of Maternal and Child Health and Resources Development (BMCHRD), Health Resources and Services Administration (HRSA), U.S. Department of Health and Human Services. For their assistance in framing project issues and activities, the author extends sincere thanks to project officers Joan Holloway (BHCDA) and Ann Koontz (BMCHRD).

For this specific report, additional funding support was generously provided by the National Commission to Prevent Infant Mortality. Many thanks to the Commission's Executive Director, Rae Grad, for her interest in and support of the report.

The author is also grateful to Ian Hill, director of the NGA project, for assisting with the analytical context surrounding the passage and implementation of OBRA-87 and for providing initial information on state responses. Also at NGA, thanks to Barbara Tymann for preparing this report for publication and to Gerry Feinstein for her editorial assistance.





## Preface

### An Overview of OBRA-87

As a result of the Omnibus Budget Reconciliation Act of 1986 (OBRA-86), states received the unprecedented flexibility they had requested to expand their Medicaid programs' ability to cover poor mothers and children. Specifically, for these populations, the law allowed states to sever the traditional link between AFDC and Medicaid eligibility by extending Medicaid coverage to pregnant women and children with family incomes as high as the federal poverty level. States have responded enthusiastically to the new law. As of April 1988, 33 states had adopted OBRA-86 coverage.<sup>1</sup>

#### THE PROVISIONS

Building incrementally upon the previous year's law, the Omnibus Budget Reconciliation Act of 1987 (OBRA-87) gives states even more flexibility to cover low-income pregnant women and young children. Signed by the President in December 1987, OBRA-87 (P.L. 100-203):

- Allows states, effective July 1, 1988, to further expand income eligibility thresholds for pregnant women and infants under age one as high as 185 percent of the federal poverty level. Mirroring OBRA-86, states may choose to set new thresholds at any point between existing levels and the upper limit of 185 percent of poverty. Also, states retain the authority to waive assets restrictions for these groups and allow for continuous eligibility to last through 60 days postpartum, regardless of fluctuations in income. Finally, benefits for eligible pregnant women continue to be limited to pregnancy-related services – which have, thus far, been defined quite broadly by states – while infants are eligible for the states' complete package of Medicaid services.
- Provides a further option to states of imposing an income-related premium on pregnant women and infants with family incomes between 150 percent and 185 percent of the federal poverty level. The monthly premium may not exceed 10 percent of the amount by which a family's countable income (defined as total income minus actual child care expenses) exceeds 150 percent of the poverty level. States may not require prepayment of the premium; may waive the

premium in cases of undue hardship; and may permit state or local funds available through other programs (such as Title V-MCH) to be used to pay the premium on behalf of the woman.

- Permits states to accelerate coverage of children under age five living in families with income up to 100 percent of poverty. Instead of following the OBRA-86 schedule of phased-in coverage, OBRA-87 allows states to immediately cover all children under age five (born after September 30, 1983) as of July 1, 1988. Under the OBRA-86 timeframe, year-by-year coverage would not result in coverage of four-year-olds until October 1990. (As under the OBRA-86 structure, states may opt to immediately cover children under upper age limits of two, three, four, or five years.)
- Allows states to continue a phase-in of coverage for these children up to age eight. Mirroring the OBRA-86 schedule, beginning October 1, 1988, states may cover all children born after September 30, 1983, below 100 percent of poverty up to age eight. Thus, states may begin coverage of children under age six in October 1988, under age seven in October 1989, and under age eight in October 1990.
- Requires states to cover all children, regardless of family structure considerations, born after September 30, 1983, up to age seven who live in families with income and resources below a state's AFDC program levels. Building upon the Deficit Reduction Act of 1984 (DEFRA), which required phased-in coverage of all such children up to age five, this law continues the phase-in so that children under age six must be covered beginning in October 1988 and children under age seven must begin in October 1989.

Other OBRA-87 Medicaid provisions:

- Helped strengthen the automatic eligibility rules for newborns originally passed under DEFRA so that, beginning July 1, 1988, providers may begin billing Medicaid for services rendered to a newborn using the mother's Medicaid I.D. number until the baby receives a Medicaid card of its own;
- Clarified that family planning received during the postpartum period constitutes a covered pregnancy-related service for OBRA-87, OBRA-86, and other eligible pregnant women;
- Clarified that postpartum eligibility will now last through the end of the month in which the 60-day period ends;
- Clarified that states may not require pregnant women to apply for AFDC before applying for OBRA-86 or OBRA-87 status (rectifying a problem in a few specific states that were acting on an oral interpretation of the statute by an HCFA regional office); and
- Allows states to consider services covered by another state-funded indigent care program as incurred expenses under the state's Medi-

cally Needy program, thereby counting against an individual's spend-down liability.

## ANALYSIS

At this time, it is unclear how states will respond to the various provisions contained in OBRA-87. It seems certain that many fewer states will expand coverage to 185 percent of poverty than took advantage of OBRA-86. As can be deduced from the data presented in this document, many issues confound what seems, at first, to be a simple extension of poverty-level maternal and infant coverage. Several factors make the implications of adopting OBRA-87 very different from those of expanding Medicaid to 100 percent of the poverty level. Namely,

- As a family's income moves up the scale to higher and higher percentages of the poverty level, the likelihood increases that these working poor possess other forms of insurance. As displayed in Table 6 of this report, regional data show that well over half of the women of child-bearing age living below 185 percent of poverty are likely to have some form of insurance coverage. States considering adoption of OBRA-87 expansions should study carefully the insurance status of potential newly eligible groups and weigh the possible negative outcome of whether OBRA-87 coverage creates incentives for small businesses to discontinue their provisions of health benefits to lower wage employees and/or their dependents.
- Additionally, as states consider expanding Medicaid coverage of pregnant women and infants to nearly twice the poverty level, it may be important to also study the distribution of personal income statewide and the level at which median family income falls. In particularly "poor" states, which also operate relatively stringent AFDC programs, equity questions must be addressed regarding the distribution of limited state resources. For example, is it good public policy to subsidize coverage of pregnant women with incomes at 185 percent of poverty and, at the same time, deny Medicaid coverage to other women, children, and spouses who might need both health care and financial assistance because AFDC eligibility thresholds stand at 25 percent of poverty? As shown in Table 7 of this report, in several states, nearly half of all women of child-bearing age live in families with incomes below 185 percent of poverty.

Thus far, the first states to adopt OBRA-87 are those that already cover, with state dollars, the maternity care needs of women with income above 100 percent of poverty. In states such as Rhode Island ("RIte Start") and Minnesota ("Children's Health Plan"), OBRA-87 offers obvious economic benefits given the infusion of federal matching funds. In addition, preliminary survey data indicate that the states of Massachusetts, Michigan, Mississippi, Vermont, and

West Virginia will actively pursue further extensions of Medicaid coverage for pregnant women and infants.

In contrast to the provision relating to extending maternity coverage to 185 percent of poverty, those provisions that allow for immediate coverage of children under age five and continued phased-in coverage of children up to age eight are straightforward, simpler to administer than current law, and raise none of the equity issues discussed above. In this case, preliminary anecdotal data indicate that a large number of those states that adopted OBRA-86 and opted to phase-in coverage of older children also will take advantage of OBRA-87 and immediately extend Medicaid to all children under age five.

Regarding the imposition of cost sharing premiums on pregnant women with incomes between 150 percent and 185 percent of poverty, initial state response has been negative. First, according to Medicaid officials, the administrative complexity of calculating, tracking and collecting monthly premiums would be significant. Also, Medicaid offices have predicted that the revenues collected from such a premium would probably not offset the administrative cost required to keep the structure in place. The formula below illustrates the relatively low current maximum premium that could be imposed by any state adopting this provision.

\$1,494	Monthly Income at 185% of Poverty – Family of Three
– 1,211	Monthly Income at 150% of Poverty – Family of Three
283	Total Amount Subject to Cost Sharing
x 10%	Maximum Premium Percentage
\$28.30	Maximum Monthly Premium

The OBRA-87 provision mandating coverage of all children under age seven in families with income below AFDC thresholds will only affect those 16 states that do not already cover all "Ribicoff" children under age 18, 19, 20, or 21.

The following report is designed to assist states in making a decision on whether or not to adopt expanded coverage of pregnant women and infants with incomes below 185 percent of poverty. With these population estimates, states can further refine projections of potentially eligible women and infants, project expected participation rates, and apply cost data to develop budget estimates. Given the extensive expansion by states under OBRA-86 authority and the different issues raised by the prospects of OBRA-87, it will be interesting to see how states respond to this additional flexibility.

Ian T. Hill  
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## Introduction

This publication is designed to assist states in estimating the number of beneficiaries and the costs of extending optional Medicaid coverage to pregnant women and infants up to age one as permitted under the 1987 Omnibus Budget Reconciliation Act. Under this law, states are authorized to extend Medicaid optional categorically needy coverage to pregnant women and infants up to one year of age whose family income is above existing Medicaid eligibility thresholds, but below a state-established threshold that may be set as high as 185 percent of the federal poverty level.

In order to estimate the state costs of the implementing coverage for this optional group of eligibles, estimates of the size of the potentially eligible population are needed. This report uses combined data from the March 1984, 1985, and 1986 Current Population Survey (CPS) to provide estimates of the eligible population of pregnant women and infants under one year of age for each state. It is assumed that not all states will have the resources necessary to extend coverage to all pregnant women and infants with incomes below 185 percent of the poverty level. Consequently, separate estimates of the potentially eligible population with incomes below 100 percent, 125 percent, 175 percent, and 185 percent of the poverty level are presented.

The CPS is a national household interview survey of approximately 160,000 persons that is conducted each month by the Bureau of the Census. Three years of the survey data were pooled to increase the precision of estimates. The March CPS includes a series of questions related to income and Medicaid participation, and is used to produce official U.S. poverty estimates. Although less than ideal in many respects, the CPS represents the most up-to-date survey data available for producing state-level estimates of pregnant women and infants below various poverty thresholds without Medicaid coverage. The estimates reported here can be used in conjunction with state data on costs of care and program participation rates to produce cost estimates for newly eligible persons. It should be noted that the estimates presented are based on extending coverage to pregnant women and infants with incomes between 100 percent and 185 percent of the federal poverty level; states interested in less ambitious extensions of coverage should find the information in this report helpful, but will have to derive independent estimates of the eligible population.

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This information is organized into three sections. The first section presents estimates of the eligible population calculated directly from CPS data on poverty status and reported Medicaid coverage. The second section describes how

these population estimates can be used in developing state level cost estimates for pregnant women and infants. The final section discusses limitations of the CPS data. Appendices describe briefly the structure and sampling design of the Current Population Survey, the poverty concept, and alternative approaches to estimating the eligible population using data sources other than the CPS. This is based largely on a similar report prepared last year entitled "Estimating the Number and Costs of Newly Medicaid-Eligible Pregnant Women and Infants: A Technical Report on Implementing the 1986 Omnibus Budget Reconciliation Act." Readers may refer back to that report for more detailed information on estimation methods. Copies are available from the National Governors' Association or the Southern Governors' Association.

# 1

## Estimating the Size of the Eligible Population

The new optional category includes pregnant women and infants whose family incomes are below 185 percent of the poverty level but above existing state Medicaid eligibility thresholds. The CPS provides state-level information on women of child-bearing age whose incomes are below various poverty thresholds as well as interview information on the presence or absence of Medicaid coverage. This information, combined with state fertility rates, can be used to develop annual estimates of births to women with incomes below different poverty thresholds but without existing Medicaid coverage. In turn, this information can be used to provide estimates of eligible women and infants in each state.

Estimates of births to women with incomes below each of five poverty thresholds – but without Medicaid – are shown for each state in the last column of Tables 1 through 5. These estimates were derived using several steps. First, the CPS data were used to provide an average annual estimate of the number of women of child-bearing age (15 to 44 years) with family incomes below the relevant poverty thresholds (see column 2 of Tables 1 through 5). Next, the sub-population of women with reported Medicaid coverage (including Medically Needy coverage) was subtracted to yield an estimate of impoverished women of child-bearing age without existing Medicaid coverage. State fertility rates<sup>2</sup> (live births per 1,000 women ages 15 to 44 of all income levels) were then applied to produce an estimate of births to women with incomes below each poverty threshold but without existing Medicaid coverage (see column 5 of Tables 1 through 5).

If it is assumed that each birth is the result of an eligible pregnancy, the estimated number of births also serves as an estimate of the number of eligible pregnant women (excluding those whose pregnancies end in miscarriages, stillbirths, or abortions). Similarly, each birth should result in approximately one eligible infant.<sup>3</sup>

The estimates provided in Tables 1 through 5 can be improved by using state-level fertility rates specifically for low-income women, if available from other sources. Previous studies have demonstrated that fertility rates are higher for low-income women. For example, unpublished Census data indicate that fertility rates for women with family incomes below \$10,000 in 1983 were 31 percent higher than fertility rates for all women aged 18 to 44 years. These results suggest that some adjustment of the state fertility rates used in Tables 1

**Table 1**  
**Average Annual Population Estimates for Women Aged 15 to 44**  
**Below the Poverty Level: United States, 1984-86**

<i>State</i>	<i>Sample Size</i>	<i>Estimated Number of Women</i>	<i>Estimated Number of Women without Reported Medicaid Coverage</i>	<i>Unadjusted Fertility Rate*</i>	<i>Estimated Number of Births to Women without Reported Medicaid Coverage</i>
<b>NORTHEAST</b>					
Maine	176	38,233	17,933	62.6	1,123
New Hampshire	79	17,030	11,751	59.1	694
Vermont	153	18,131	10,086	61.2	617
Massachusetts	392	142,635	60,244	55.2	3,325
Rhode Island	142	31,001	13,010	55.8	726
Connecticut	118	63,546	29,027	56.4	1,637
New York	1,471	730,881	279,182	59.3	16,555
New Jersey	429	199,964	78,829	57.4	4,525
Pennsylvania	631	411,683	169,137	58.0	9,810
<b>MIDWEST</b>					
Ohio	635	371,719	173,065	62.9	10,886
Indiana	279	191,435	121,184	61.8	7,489
Illinois	749	451,874	196,636	66.0	12,978
Michigan	736	391,938	139,607	62.5	8,725
Wisconsin	215	159,374	62,825	65.9	4,140
Minnesota	202	111,664	55,834	67.6	3,774
Iowa	284	124,207	76,535	64.8	4,959
Missouri	288	185,995	121,059	65.4	7,917
North Dakota	211	23,613	18,279	76.8	1,404
South Dakota	260	25,088	20,444	81.3	1,662
Nebraska	195	50,279	36,328	72.0	2,616
Kansas	180	79,897	62,122	72.9	4,529
<b>SOUTH</b>					
Delaware	130	17,161	9,802	61.8	606
Maryland	149	88,978	49,652	59.8	2,969
Dist. of Columbia	223	32,510	14,279	57.5	821
Virginia	194	136,238	93,643	59.1	5,534
West Virginia	273	93,432	56,841	55.5	3,155
North Carolina	445	203,903	154,258	57.9	8,932
South Carolina	206	133,645	83,317	62.9	5,241
Georgia	272	241,253	147,671	63.7	9,407
Florida	641	379,082	278,193	65.4	18,194
Kentucky	276	173,911	120,691	61.3	7,398
Tennessee	255	197,271	116,654	57.6	6,719
Alabama	275	187,512	123,140	63.3	7,795
Mississippi	375	147,154	101,325	73.1	7,407
Arkansas	303	126,992	84,466	66.4	5,609
Louisiana	289	203,162	152,307	75.4	11,484
Oklahoma	242	119,217	94,092	71.8	6,756
Texas	1,135	595,994	456,786	76.9	35,127
<b>WEST</b>					
Montana	253	33,094	25,002	74.4	1,860
Idaho	296	42,751	33,554	79.1	2,654
Wyoming	143	15,246	11,823	79.3	938
Colorado	200	89,672	68,347	66.6	4,552
New Mexico	391	71,257	54,597	80.7	4,406
Arizona	228	112,245	87,917	77.4	6,805
Utah	209	52,209	41,016	101.9	4,180
Nevada	124	25,696	20,214	64.9	1,312
Washington	170	128,408	77,169	65.7	5,070
Oregon	208	102,077	68,396	62.0	4,241
California	1,745	928,240	510,040	71.3	36,366
Alaska	196	13,959	10,011	97.3	974
Hawaii	146	28,783	15,964	76.7	1,224

\*1984 state fertility rate (births per 1000 women 15-44 years old of all income levels).

SOURCE: Microdata from the March 1984, 1985, and 1986 Current Population Surveys.

**Table 2**  
**Average Annual Population Estimates for Women Aged 15 to 44**  
**Below 125% of Poverty Level: United States, 1984-86**

<i>State</i>	<i>Sample Size</i>	<i>Estimated Number of Women</i>	<i>Estimated Number of Women without Reported Medicaid Coverage</i>	<i>Unadjusted Fertility Rate*</i>	<i>Estimated Number of Births to Women without Reported Medicaid Coverage</i>
<b>NORTHEAST</b>					
Maine	246	53,578	32,044	62.6	2,006
New Hampshire	112	24,870	18,604	59.1	1,099
Vermont	200	24,283	14,496	61.2	887
Massachusetts	504	187,149	95,074	55.2	5,248
Rhode Island	177	38,455	18,548	55.8	1,035
Connecticut	144	78,328	41,754	56.4	2,355
New York	1,809	907,697	408,108	59.3	24,201
New Jersey	532	247,551	118,414	57.4	6,797
Pennsylvania	797	510,066	245,555	58.0	14,242
<b>MIDWEST</b>					
Ohio	783	457,690	245,789	62.9	15,460
Indiana	362	247,540	171,976	61.8	10,628
Illinois	920	546,479	278,573	66.0	18,386
Michigan	877	466,807	190,224	62.5	11,889
Wisconsin	274	202,168	83,548	65.9	5,506
Minnesota	280	151,407	87,293	67.6	5,901
Iowa	354	153,283	99,816	64.8	6,468
Missouri	363	234,144	164,525	65.4	10,760
North Dakota	278	30,537	24,219	76.8	1,860
South Dakota	350	34,186	29,024	81.3	2,360
Nebraska	267	68,757	53,963	72.0	3,885
Kansas	242	105,146	86,157	72.9	6,281
<b>SOUTH</b>					
Delaware	190	25,183	17,118	61.8	1,058
Maryland	193	114,164	71,704	59.8	4,288
Dist. of Columbia	272	39,609	20,129	57.5	1,157
Virginia	276	195,233	147,941	59.1	8,743
West Virginia	361	123,968	84,337	55.5	4,681
North Carolina	592	272,778	218,193	57.9	12,633
South Carolina	292	184,743	129,502	62.9	8,146
Georgia	358	312,029	213,149	63.7	13,578
Florida	875	520,166	409,943	65.4	26,810
Kentucky	370	233,644	175,597	61.3	10,764
Tennessee	348	267,973	179,729	57.6	10,352
Alabama	357	238,296	171,986	63.3	10,887
Mississippi	479	186,676	135,939	73.1	9,937
Arkansas	398	164,838	121,134	66.4	8,043
Louisiana	360	255,716	200,639	75.4	15,128
Oklahoma	315	156,592	129,036	71.8	9,265
Texas	1,504	793,216	641,590	76.9	49,338
<b>WEST</b>					
Montana	357	46,982	37,581	74.4	2,796
Idaho	384	55,061	44,101	79.1	3,488
Wyoming	198	20,850	16,929	79.3	1,342
Colorado	266	117,411	94,878	66.6	6,319
New Mexico	496	89,505	71,537	80.7	5,773
Arizona	279	135,915	108,986	77.4	8,436
Utah	296	73,037	59,303	101.9	6,043
Nevada	170	35,092	28,631	64.9	1,858
Washington	236	172,168	116,686	65.7	7,666
Oregon	260	126,058	87,844	62.0	5,446
California	2,274	1,194,204	712,003	71.3	50,766
Alaska	273	19,644	14,232	97.3	1,385
Hawaii	199	39,027	25,333	76.7	1,943

\*1984 state fertility rate (births per 1000 women 15-44 years old of all income levels).

SOURCE: Microdata from the March 1984, 1985, and 1986 Current Population Surveys.

**Table 3**  
**Average Annual Population Estimates for Women Aged 15 to 44**  
**Below 150% of Poverty Level: United States, 1984-86**

<i>State</i>	<i>Sample Size</i>	<i>Estimated Number of Women</i>	<i>Estimated Number of Women without Reported Medicaid Coverage</i>	<i>Unadjusted Fertility Rate*</i>	<i>Estimated Number of Births to Women without Reported Medicaid Coverage</i>
<b>NORTHEAST</b>					
Maine	318	69,155	45,934	62.6	2,875
New Hampshire	149	33,941	27,381	59.1	1,618
Vermont	279	33,958	23,066	61.2	1,412
Massachusetts	628	235,099	136,457	55.2	7,532
Rhode Island	220	47,546	26,747	55.8	1,492
Connecticut	184	102,219	62,350	56.4	3,517
New York	2,150	1,088,163	562,413	59.3	33,351
New Jersey	657	304,686	167,641	57.4	9,623
Pennsylvania	981	625,237	339,867	58.0	19,712
<b>MIDWEST</b>					
Ohio	975	567,781	345,793	62.9	21,750
Indiana	444	304,607	228,352	61.8	14,112
Illinois	1,112	661,501	379,931	66.0	25,075
Michigan	1,044	555,132	261,976	62.5	16,374
Wisconsin	351	256,130	131,849	65.9	8,689
Minnesota	341	189,061	120,447	67.6	8,142
Iowa	422	180,199	124,995	64.8	8,100
Missouri	467	301,169	229,559	65.4	15,013
North Dakota	353	38,885	32,196	76.8	2,473
South Dakota	444	43,927	38,051	81.3	3,094
Nebraska	330	85,885	69,742	72.0	5,021
Kansas	291	126,367	105,823	72.9	7,714
<b>SOUTH</b>					
Delaware	245	33,163	24,058	61.8	1,487
Maryland	243	142,650	96,962	59.8	5,798
Dist. of Columbia	326	47,898	26,072	57.5	1,499
Virginia	362	263,021	213,588	59.1	12,623
West Virginia	443	152,101	110,492	55.5	6,132
North Carolina	762	352,857	293,600	57.9	16,999
South Carolina	363	227,029	171,229	62.9	10,770
Georgia	443	388,256	284,903	63.7	18,148
Florida	1,110	657,725	539,598	65.4	35,290
Kentucky	440	276,534	216,804	61.3	13,290
Tennessee	436	340,974	245,972	57.6	14,168
Alabama	463	310,840	238,400	63.3	15,091
Mississippi	584	229,267	176,323	73.1	12,889
Arkansas	493	202,018	155,729	66.4	10,340
Louisiana	434	310,011	253,454	75.4	19,110
Oklahoma	392	193,855	164,109	71.8	11,783
Texas	1,887	1,003,234	838,250	76.9	64,461
<b>WEST</b>					
Montana	436	58,273	48,085	74.4	3,578
Idaho	488	71,017	59,582	79.1	4,713
Wyoming	250	26,112	21,599	79.3	1,713
Colorado	344	152,529	127,325	66.6	8,480
New Mexico	622	111,893	92,231	80.7	7,443
Arizona	359	171,721	144,792	77.4	11,207
Utah	405	99,213	84,479	101.9	8,608
Nevada	231	47,403	40,224	64.9	2,611
Washington	310	221,394	159,768	65.7	10,497
Oregon	315	152,092	112,321	62.0	6,964
California	2,829	1,476,496	946,447	71.3	67,482
Alaska	337	24,443	18,498	97.3	1,800
Hawaii	264	52,380	37,391	76.7	2,868

\*1984 state fertility rate (births per 1000 women 15-44 years old of all income levels).  
SOURCE: Microdata from the March 1984, 1985, and 1986 Current Population Surveys.

**Table 4**  
**Average Annual Population Estimates for Women Aged 15 to 44**  
**Below 175% of Poverty Level: United States, 1984-86**

<i>State</i>	<i>Sample Size</i>	<i>Estimated Number of Women</i>	<i>Estimated Number of Women without Reported Medicaid Coverage</i>	<i>Unadjusted Fertility Rate*</i>	<i>Estimated Number of Births to Women without Reported Medicaid Coverage</i>
<b>NORTHEAST</b>					
Maine	399	87,101	62,335	62.6	3,902
New Hampshire	189	44,256	37,429	59.1	2,212
Vermont	335	41,101	29,958	61.2	1,833
Massachusetts	752	284,394	180,599	55.2	9,969
Rhode Island	271	58,628	36,650	55.8	2,045
Connecticut	225	125,428	84,260	56.4	4,752
New York	2,494	1,273,488	729,286	59.3	43,247
New Jersey	790	368,229	226,678	57.4	13,011
Pennsylvania	1,174	746,983	455,847	58.0	26,439
<b>MIDWEST</b>					
Ohio	1,166	676,988	448,653	62.9	28,220
Indiana	535	366,843	289,934	61.8	17,918
Illinois	1,313	778,104	493,462	66.0	32,568
Michigan	1,200	637,494	333,654	62.5	20,853
Wisconsin	428	312,557	182,534	65.9	12,029
Minnesota	414	231,537	161,571	67.6	10,922
Iowa	498	215,092	155,345	64.8	10,066
Missouri	536	344,946	270,734	65.4	17,706
North Dakota	433	47,732	40,747	76.8	3,129
South Dakota	530	52,251	46,253	81.3	3,760
Nebraska	422	111,057	94,755	72.0	6,822
Kansas	351	152,260	129,886	72.9	9,469
<b>SOUTH</b>					
Delaware	311	41,449	32,055	61.8	1,981
Maryland	315	185,589	138,986	59.8	8,311
Dist. of Columbia	378	55,756	33,057	57.5	1,901
Virginia	430	312,645	260,029	59.1	15,368
West Virginia	529	182,004	137,764	55.5	7,646
North Carolina	949	436,000	375,094	57.9	21,718
South Carolina	451	277,812	219,785	62.9	13,824
Georgia	527	455,314	346,683	63.7	22,084
Florida	1,332	792,265	666,886	65.4	43,614
Kentucky	523	328,033	263,158	61.3	16,132
Tennessee	520	408,112	310,413	57.6	17,880
Alabama	532	360,286	286,597	63.3	18,142
Mississippi	680	265,870	212,563	73.1	15,538
Arkansas	592	242,066	192,660	66.4	12,793
Louisiana	512	366,062	305,421	75.4	23,029
Oklahoma	476	236,604	204,956	71.8	14,716
Texas	2,265	1,211,408	1,042,442	76.9	80,164
<b>WEST</b>					
Montana	547	72,963	62,706	74.4	4,665
Idaho	569	83,061	70,908	79.1	5,609
Wyoming	300	31,265	26,751	79.3	2,121
Colorado	402	177,664	150,043	66.6	9,993
New Mexico	739	133,544	113,187	80.7	9,134
Arizona	430	208,397	181,468	77.4	14,046
Utah	500	121,953	106,722	101.9	10,875
Nevada	302	61,906	53,963	64.9	3,502
Washington	360	254,499	190,781	65.7	12,534
Oregon	385	186,804	145,170	62.0	9,001
California	3,370	1,754,922	1,185,141	71.3	84,501
Alaska	426	30,401	23,838	97.3	2,319
Hawaii	327	64,367	49,066	76.7	3,763

\*1984 state fertility rate (births per 1000 women 15-44 years old of all income levels).

SOURCE: Microdata from the March 1984, 1985, and 1986 Current Population Surveys.

**Table 5**  
**Average Annual Population Estimates for Women Aged 15 to 44**  
**Below 185% of Poverty Level: United States, 1984-86**

<i>State</i>	<i>Sample Size</i>	<i>Estimated Number of Women</i>	<i>Estimated Number of Women without Reported Medicaid Coverage</i>	<i>Unadjusted Fertility Rate*</i>	<i>Estimated Number of Births to Women without Reported Medicaid Coverage</i>
<b>NORTHEAST</b>					
Maine	442	96,359	71,090	62.6	4,450
New Hampshire	206	48,501	41,673	59.1	2,463
Vermont	360	44,132	32,989	61.2	2,019
Massachusetts	803	303,549	199,354	55.2	11,004
Rhode Island	279	60,324	38,034	55.8	2,122
Connecticut	242	134,453	93,090	56.4	5,250
New York	2,630	1,344,821	796,060	59.3	47,206
New Jersey	850	397,248	254,607	57.4	14,614
Pennsylvania	1,266	801,491	509,095	58.0	29,528
<b>MIDWEST</b>					
Ohio	1,260	731,171	502,316	62.9	31,596
Indiana	579	397,109	320,200	61.8	19,788
Illinois	1,400	826,277	538,858	66.0	35,565
Michigan	1,272	675,791	365,593	62.5	22,850
Wisconsin	463	338,596	207,175	65.9	13,653
Minnesota	437	244,147	173,509	67.6	11,729
Iowa	532	229,834	170,086	64.8	11,022
Missouri	578	370,594	294,941	65.4	19,289
North Dakota	465	51,149	44,038	76.8	3,382
South Dakota	572	56,485	50,281	81.3	4,088
Nebraska	449	118,613	102,056	72.0	7,348
Kansas	377	162,755	139,659	72.9	10,181
<b>SOUTH</b>					
Delaware	331	43,911	34,390	61.8	2,125
Maryland	339	200,067	152,810	59.8	9,138
Dist. of Columbia	398	58,604	35,766	57.5	2,057
Virginia	458	332,328	279,713	59.1	16,531
West Virginia	555	191,203	146,629	55.5	8,138
North Carolina	1,030	470,505	408,869	57.9	23,674
South Carolina	470	290,794	232,767	62.9	14,641
Georgia	564	488,322	378,900	63.7	24,136
Florida	1,417	843,423	714,731	65.4	46,743
Kentucky	555	348,228	283,354	61.3	17,370
Tennessee	555	433,635	335,301	57.6	19,313
Alabama	556	376,432	302,744	63.3	19,164
Mississippi	713	279,372	225,161	73.1	16,459
Arkansas	615	251,408	201,596	66.4	13,386
Louisiana	552	394,218	333,577	75.4	25,152
Oklahoma	524	260,827	228,654	71.8	16,417
Texas	2,422	1,302,510	1,132,531	76.9	87,092
<b>WEST</b>					
Montana	585	77,975	67,188	74.4	4,999
Idaho	615	90,037	77,884	79.1	6,161
Wyoming	326	34,088	29,575	79.3	2,345
Colorado	441	194,340	165,777	66.6	11,041
New Mexico	790	142,766	122,170	80.7	9,859
Arizona	463	227,907	200,671	77.4	15,532
Utah	540	132,304	117,072	101.9	11,930
Nevada	324	66,291	58,347	64.9	3,787
Washington	380	270,826	206,598	65.7	13,573
Oregon	403	196,239	153,985	62.0	9,547
California	3,564	1,859,528	1,278,674	71.3	91,169
Alaska	455	32,708	25,924	97.3	2,522
Hawaii	349	68,168	52,866	76.7	4,055

\*1984 state fertility rate (births per 1000 women 15-44 years old of all income levels).  
SOURCE: Microdata from the March 1984, 1985, and 1986 Current Population Surveys.



through 5 is necessary to ensure that estimates of the eligible population are accurate. The adjustment factor used should be based on state-specific data, if available.

To obtain accurate estimates of the newly eligible population, persons who are eligible under current Medicaid rules should be excluded. Unfortunately, it is impossible to directly estimate the size of this "already eligible" population using CPS data. The information provided in Tables 1 through 5 on the estimated population is based on reported Medicaid coverage rather than eligibility for Medicaid. For several reasons, the CPS estimate of the size of the existing covered population is likely to be an underestimate of the size of the population eligible under current Medicaid regulations. First, many persons are eligible for Medicaid but have not applied for coverage. This may be because Medicaid is viewed as a welfare program, and thus applying for benefits is resisted, or simply because individuals are unaware that they are eligible for coverage. In states with Medically Needy programs, the proportion of the eligible population that applies for and receives Medicaid benefits can be quite small. Those with limited medical expenses whose family incomes are above AFDC payment standards, but below Medically Needy protected income limits, are often unaware that they are eligible or may choose not to apply due to the burden of the application process. Second, many low-income women who were childless at the time of the survey would be eligible under existing public assistance or Medically Needy programs if they become pregnant. In addition, some persons with coverage may not recall that they have Medicaid coverage at the time of the survey. This is especially likely to occur if Medicaid-financed services were not used in the months or weeks immediately preceding the interview. These types of biases are less important at higher poverty thresholds.

Another major source of bias in the estimates presented in Table 1 is temporal in nature. Major changes in Medicaid eligibility policies have been implemented in the last few years at both the federal and state levels. Because they are so recent, their effects on pregnant women and infants are not fully accounted for in the CPS data. The three most significant federal legislative changes are the Deficit Reduction Act of 1984 (DEFRA), the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), and the Omnibus Budget Reconciliation Act of 1986 (OBRA-86). DEFRA and COBRA mandated broader coverage of pregnant women and infants.<sup>4</sup> OBRA-86 provided states with the option of raising income eligibility thresholds to 100 percent of the poverty level for pregnant women and young children. Because of time lags in implementation and the fact that three years of data are combined in producing these estimates, it is likely that substantial numbers of persons classified as not having Medicaid coverage would be eligible for Medicaid under DEFRA, COBRA, and OBRA-86 rules. These conceptual and temporal problems result in underestimates of the population with existing Medicaid eligibility and overestimates of the population that would be newly eligible.

There are then two major sources of inaccuracy in the estimates shown in Tables 1 through 5. The first stems from using fertility rates for women of all in-

comes. This error may cause the size of the newly eligible population to be understated. The second error, undercounting of persons eligible under existing Medicaid eligibility criteria, may cause the size of the newly eligible population to be overstated. The fertility rate inaccuracy can be addressed directly if state data are available on fertility rates for low-income women. Corrections for undercounting of persons eligible under existing Medicaid policies require use of alternate estimation methods, as described below.

## **ADJUSTING FOR MEDICAID ELIGIBILITY EXPANSIONS UNDER OBRA-86**

States that have not implemented expanded eligibility for pregnant women and infants as permitted under OBRA-86 can use Tables 1 through 5 directly. However, adjustments are required for states that expanded their programs, since the effects of OBRA-86 changes are not reflected in the CPS data. Those states that have expanded eligibility to 100 percent of the poverty level should adjust the estimates in Tables 2 through 5 by subtracting births to women with incomes below poverty without reported Medicaid coverage (the last column in Table 1). For example, since Mississippi has expanded births to women with incomes below poverty, the estimated 7,487 births to women with incomes below poverty but without reported Medicaid coverage (shown in Table 1) are now covered by Medicaid. Hence, if Medicaid coverage was expanded to 125 percent of the poverty level in Mississippi, the net number of births covered would be 2,530 (9,937 minus 7,407) rather than 9,937 as shown in Table 2.

## **ESTIMATES USING CPS AND STATE MEDICAID DATA**

To avoid much of the undercounting inherent in the CPS Medicaid data, actual state Medicaid data can be used. Under this approach, states would subtract the number of Medicaid-funded deliveries from the number of births to women with incomes below each poverty threshold.<sup>5</sup> The result provides an alternate estimate of births to women with incomes below poverty but without Medicaid coverage, and can be used to provide estimates of newly eligible pregnant women and infants, as described above.

Estimates of the size of the newly eligible population derived in this fashion are likely to be more accurate than estimates based on CPS data alone (i.e., those in Tables 1 through 5). However, even when Medicaid-funded delivery data are used, the resulting estimates are likely to overstate the size of the newly eligible population. This is because the estimate of the newly eligible population will include women who choose to rely on private health insurance or other means to cover the costs of pregnancy-related services and infant care, even though their incomes are below existing Medicaid eligibility thresholds. The degree of error will depend on Medicaid participation rates for pregnant women and infants with incomes below existing eligibility thresholds.

# 2

## Estimating State-Level Costs

### PREGNANT WOMEN

States can utilize the population estimates provided in Tables 1 through 5, or those generated using other approaches, combined with state-level estimates on participation rates and costs to produce state cost estimates using the following formula:

$$\begin{array}{l} \boxed{\text{Estimated Number of Pregnant Women Below the Selected Poverty Threshold without Medicaid Coverage}} \times \boxed{\text{Estimated Program Participation Rate}} \times \boxed{\text{Estimated Cost Per Pregnancy}} \\ \times \boxed{\text{State Percentage Share of Medicaid Expenditures}} + \boxed{\text{State Share of Estimated Administrative Expenses}} = \text{PROGRAM COST} \end{array}$$

To estimate programmatic costs, states will have to provide their own estimates of the program participation rates, cost per user, state share of Medicaid service expenses, and state administrative costs. Program participation will vary by state depending on how aggressively the programs are promoted. In most cases, states that conduct only limited outreach efforts, or do not attempt to streamline eligibility processes for pregnant women can expect limited participation. States conducting intensive outreach efforts, such as mailings, press releases, and advertising; and/or states that implement presumptive eligibility, outstation eligibility workers at providers sites, shorten application forms, or otherwise expedite determinations can expect to achieve higher participation rates. Even higher levels of participation should result when outreach and service delivery efforts are linked.

Because participation under Medicaid is partly based on whether other health insurance coverage is available, this report also provides regional estimates of other types of health insurance coverage reported for women below poverty without Medicaid coverage (see Table 6). These data indicate whether alternate insurance is available, but offer little information about the breadth or depth of benefits offered. It is reasonable to assume that group health insurance and coverage provided through the military or the Civilian Health and Medical Program for the Uniformed Services (CHAMPUS) is likely to be more

**Table 6**  
**Health Insurance Coverage of Women Aged 15 to 44 Without Medicaid**  
**Coverage at Different Poverty Thresholds: United States, 1984-86**

<i>Region and Income Level</i>	<i>Covered by Group Health Insurance</i>	<i>Covered by Medicare</i>	<i>Covered by CHAMPUS/Military</i>	<i>Covered by Other Types of Health Insurance</i>	<i>Covered by Any Type of Health Insurance</i>
<i>PERCENT OF WOMEN</i>					
<b>BELOW 100% OF POVERTY</b>					
Northeast	24.0	0.7	1.3	14.7	38.8
Midwest	24.1	1.3	2.1	22.1	46.5
South	23.9	0.9	3.0	10.7	37.0
West	21.0	0.7	4.7	12.9	37.2
<b>100% TO 124% OF POVERTY</b>					
Northeast	51.3	0.7	4.2	12.3	64.6
Midwest	41.6	0.6	2.7	15.8	57.8
South	43.4	0.4	6.4	11.2	57.1
West	38.0	0.8	6.8	11.7	54.7
<b>125% TO 149% OF POVERTY</b>					
Northeast	57.4	0.4	2.2	12.4	69.1
Midwest	57.3	0.3	2.5	15.4	71.9
South	51.5	0.7	7.5	11.3	66.2
West	46.8	0.4	8.2	11.4	63.1
<b>150% TO 174% OF POVERTY</b>					
Northeast	61.4	0.1	4.0	14.7	76.5
Midwest	64.7	0.8	2.6	15.0	78.8
South	60.4	0.5	7.3	10.4	73.7
West	54.8	0.3	5.9	14.1	69.8
<b>175% TO 184% OF POVERTY</b>					
Northeast	69.2	*	1.9	12.0	79.7
Midwest	68.5	0.4	2.4	17.2	84.1
South	64.0	0.4	6.5	13.4	77.8
West	54.1	0.4	7.0	15.5	70.5

\*Less than .1 percent.

SOURCE: Microdata from the March 1984, 1985, and 1986 Current Population Surveys.

comprehensive than other types of health insurance. States can use this information to refine their estimates of program participation.

In selecting participation rates, states should be aware that previous experience suggests that participation levels begin low and do not reach a plateau for several years.<sup>6</sup> Hence, a lower participation rate should be used in projecting first-year costs of the program.

Cost data should be available from state Medicaid management information systems or through an analysis of paid claims data. Since not all enrollees will receive the full complement of maternity services, care must be taken in calculating cost per recipient. However, it is important to recognize that all participating pregnant women are likely to use the most expensive component of care – the delivery. The average cost per pregnancy also should be adjusted to reflect the large proportion of newly eligible women with other types of health insurance coverage. Since Medicaid is a secondary payor, Medicaid costs should be reduced substantially for women with alternate coverage.

### INFANTS

Estimating the state level costs for infants is similar to estimating the costs for pregnant women. The following formula can be used:

$$\begin{array}{ccccc}
 \boxed{\begin{array}{l} \text{Estimated Number of Infants} \\ \text{Below the Selected Poverty} \\ \text{Threshold Without Medicaid} \\ \text{Coverage} \end{array}} & \times & \boxed{\begin{array}{l} \text{Estimated} \\ \text{Program} \\ \text{Participation} \\ \text{Rate} \end{array}} & \times & \boxed{\begin{array}{l} \text{Estimated} \\ \text{Cost} \\ \text{Per} \\ \text{Infant} \end{array}} \\
 & & & & \\
 \times & & \boxed{\begin{array}{l} \text{State Percentage} \\ \text{Share of} \\ \text{Medicaid} \\ \text{Expenditures} \end{array}} & + & \boxed{\begin{array}{l} \text{State Share of Estimated} \\ \text{Administrative} \\ \text{Expenses} \end{array}} & = & \text{PROGRAM COST}
 \end{array}$$

The estimated number of eligible infants can be taken from Tables 1 through 5 or can be derived from independent estimates.

Cost-per-recipient information should be available from Medicaid-paid claims data. Participation rates for infants will likely be lower than those for pregnant women since infant care costs are relatively low, and since families are less likely to seek Medicaid coverage of a child unless that child is ill. As with estimates of participation rates for pregnant women, states should utilize their own experience with previous program extensions whenever possible. Since it is important to keep in mind that those individuals most likely to participate are persons with substantial care needs and expenses, if a state assumes a very low participation rate, it should also assume that the average cost per user will be higher than would be the case if a higher level of participation was achieved.

The formulas described above for producing state cost estimates for pregnant women and infants do not include offsets or potential state savings that may result from expanding Medicaid coverage. Although difficult to quantify,

**Table 7**  
**Average Annual Percent of Women Aged 15 to 44**  
**Below Various Poverty Thresholds: United States, 1984-86**

<i>State</i>	<i>Estimated Number of Women of All Income Levels</i>	<i>Percent of Women with Incomes Below 100% of Poverty</i>	<i>Percent of Women with Incomes Below 125% of Poverty</i>	<i>Percent of Women with Incomes Below 150% of Poverty</i>	<i>Percent of Women with Incomes Below 175% of Poverty</i>	<i>Percent of Women with Incomes Below 185% of Poverty</i>
<b>NORTHEAST</b>						
Maine	276,080	13.9	19.4	25.1	31.6	34.9
New Hampshire	240,643	7.1	10.3	14.1	18.4	20.2
Vermont	128,191	14.1	18.9	26.5	32.1	34.4
Massachusetts	1,422,324	10.0	13.2	16.5	20.0	21.3
Rhode Island	233,283	13.3	16.5	20.4	25.1	25.9
Connecticut	761,549	8.3	10.3	13.4	16.5	17.7
New York	4,262,110	17.2	21.3	25.5	29.9	31.6
New Jersey	1,824,891	11.0	13.6	16.7	20.2	21.8
Pennsylvania	2,711,257	15.2	18.8	23.1	27.6	29.6
<b>MIDWEST</b>						
Ohio	2,543,102	14.6	18.0	22.3	26.6	28.8
Indiana	1,293,835	14.8	19.1	23.5	28.4	30.7
Illinois	2,757,875	16.4	19.8	24.0	28.2	30.0
Michigan	2,207,616	17.8	21.2	25.2	28.9	30.6
Wisconsin	1,124,660	14.2	18.0	22.8	27.8	30.1
Minnesota	975,798	11.4	15.5	19.4	23.7	25.0
Iowa	650,192	19.1	23.6	27.7	33.1	35.4
Missouri	1,161,992	16.0	20.2	25.9	29.7	31.9
North Dakota	156,077	15.1	19.6	24.9	30.6	32.8
South Dakota	155,594	16.1	22.0	28.2	33.6	36.3
Nebraska	369,903	13.6	18.6	23.2	30.0	32.1
Kansas	576,812	13.9	18.2	21.9	26.4	28.2
<b>SOUTH</b>						
Delaware	150,559	11.4	16.7	22.0	27.5	29.2
Maryland	1,056,363	8.4	10.8	13.5	17.6	18.9
Dist. of Columbia	156,044	20.8	25.4	30.7	35.7	37.6
Virginia	1,350,278	10.1	14.5	19.5	23.2	24.6
West Virginia	413,697	22.6	30.0	36.8	44.0	46.2
North Carolina	1,455,784	14.0	18.7	24.2	30.0	32.3
South Carolina	773,336	17.3	23.9	29.4	35.9	37.6
Georgia	1,418,756	17.0	22.0	27.4	32.1	34.4
Florida	2,454,893	15.4	21.2	26.8	32.3	34.4
Kentucky	883,985	19.7	26.4	31.3	37.1	39.4
Tennessee	1,114,316	17.7	24.1	30.6	36.6	38.9
Alabama	891,263	21.0	26.7	34.9	40.4	42.2
Mississippi	580,772	25.3	32.1	39.5	45.8	48.1
Arkansas	528,501	24.0	31.2	38.2	45.8	47.6
Louisiana	1,064,882	19.1	24.0	29.1	34.4	37.0
Oklahoma	770,731	15.5	20.3	25.2	30.7	33.8
Texas	3,934,887	15.2	20.2	25.5	30.8	33.1
<b>WEST</b>						
Montana	204,613	16.2	23.0	28.5	35.7	38.1
Idaho	226,727	18.9	24.3	31.3	36.6	39.7
Wyoming	120,688	12.6	17.3	21.6	25.9	28.2
Colorado	786,531	11.4	15.0	19.4	22.6	24.7
New Mexico	332,079	21.5	27.0	33.7	40.2	43.0
Arizona	706,831	15.9	19.2	24.3	29.5	32.2
Utah	363,470	14.4	20.1	27.3	33.6	36.4
Nevada	230,839	11.1	15.2	20.5	26.8	28.7
Washington	1,031,547	12.5	16.7	21.5	24.7	26.3
Oregon	642,190	15.9	19.6	23.7	29.1	30.6
California	6,319,046	14.7	18.9	23.4	27.8	29.4
Alaska	137,394	10.2	14.3	17.8	22.1	23.8
Hawaii	233,293	12.3	16.7	22.5	27.6	29.2

SOURCE: Microdata from the March 1984, 1985, and 1986 Current Population Surveys.

savings may be incurred by reducing spending for 100 percent state- and local-funded government health care programs for indigent pregnant women and infants (e.g., general assistance, county clinic and hospital expenses, etc.). Even harder to quantify are long-term savings that can result from providing timely and comprehensive prenatal care. A growing body of evidence suggests that early and comprehensive prenatal care can result in significant cost reductions from complications during pregnancy and reduced morbidity among infants.<sup>7</sup>

### **ESTIMATING THE PROPORTION OF WOMEN OF CHILD-BEARING AGE ELIGIBLE UNDER OBRA-87**

Personal income is unevenly distributed across states. In 1985, personal per capita income ranged from \$9,187 in Mississippi to \$18,187 in Alaska.<sup>8</sup> As a result of this widespread variation in state income levels, adoption of a given poverty threshold for eligibility determination will result in a different proportion of women of child-bearing age gaining coverage in each state. For informational purposes, CPS data were used to provide estimates of the percent of women aged 15 to 44 years in each state with incomes below each of five different poverty thresholds. These data, shown in Table 7, provide states with an indication of the proportion of women who would be covered for pregnancy care if Medicaid eligibility thresholds were expanded. (For example, an estimated 31.6 percent of all New York women of child-bearing age would be covered if New York were to adopt an eligibility threshold of 185 percent of the poverty level.) At the 185 percent threshold, the proportion of women of child-bearing age who would gain coverage under an OBRA-87 expansion range from a high of 48.1 percent in Mississippi to a low of 17.7 percent in Connecticut.





# 3

## Cautions Regarding Use of the CPS Estimates

While the CPS represents the most current national survey data available for estimating the newly eligible population, it does have some limitations. A significant problem for some states is the limited number of sample observations used in computing population estimates (see column 1 of Tables 1 through 5). Smaller states should consider alternate approaches to estimating the eligible population, including one of the approaches described in Appendix 3. Data provided in this report are also likely to be less reliable for states experiencing recent and substantial changes in income levels. In such states, adjustments can be made to the estimates provided in this report, or alternative approaches, such as special state-level surveys, should be considered.

A more difficult problem concerns the absence of available information on resources or assets. Since no data are available on assets, some individuals and families included in the estimated newly eligible population may, in fact, be ineligible based on resources. While a majority of states electing OBRA-86 have chosen not to impose resource restrictions, in states that do retain limits, this report's estimates of the newly eligible population will be on the high side. However, the absence of asset data should not pose a problem in states that choose not to apply resource standards for this population.

The lack of useful data on assets and resources applies to all census data sets. Two methods are available to examine how asset levels will affect eligibility. First, states can analyze their own data on reasons for rejected Medicaid applications, if available. Second, special household surveys such as those described in Appendix 3, can be used to collect information on level of assets according to income level.

A final consideration concerns filing status for Medicaid. Medicaid rules concerning filing status (and deeming of income between relatives) are quite complex. In calculating the population below the various poverty thresholds used in this report, family units were defined in the manner used by the Bureau of the Census in computing the official poverty estimates for the United States. This census approach counts members of extended families residing in the same household (members related by blood, marriage, or adoption) as a single family unit. Hence, members of primary families and subfamilies residing in the same home are considered as a single family unit in calculating family size and poverty status.

These conceptual differences in family composition and income accounting between Medicaid and CPS will result in some degree of error in estimat-

ing the size of the eligible population. However, the magnitude of error is unknown. Consequently, states should view the estimates of the newly eligible population derived from this report as approximate. They should be useful for planning purposes, especially in conjunction with other information available at the state level, but should *not* be considered as a basis for precise budget estimates.

Many of the limitations of the CPS (both conceptual and those related to sample size) can be addressed by states with a capacity for additional analysis. States desiring more precise estimates and with a capacity to conduct their own studies should consider alternative approaches to estimating the eligible population described in Appendix 3.

## **APPENDICES**



## APPENDIX 1: A DESCRIPTION OF THE CURRENT POPULATION SURVEY<sup>9</sup>

This report presents findings from the Annual Demographic File of the Census Bureau's Current Population Survey (CPS) for March, 1984, 1985, and 1986. The information was collected from a sample of persons representing the civilian noninstitutional population and members of the Armed Forces living off post or with their families on post in the United States. Because the collection of income data in the survey is restricted to persons 15 years old or over, individuals under 15 are excluded from this report.

### Sample Size, Noninterviews, and Nonresponse

The March Current Population Survey includes a sample of approximately 60,000 households annually. The combined sample for 1984, 1985, and 1986 included some 177,000 households and 480,000 persons. Population weights are attached to each individual sample person to produce population estimates. In this report, the original population weights for 1984, 1985, and 1986 were divided by three to produce a single average annual estimate for the poverty population and its characteristics. Pooling CPS data sets results in a small degree of duplication of sample households. The CPS sampling design is based on panels of sample households that rotate in and out of the sample frame. The result is that some sample households are included in two contiguous March samples. However, the degree of duplication is quite small and should have little effect on the results presented. Because interviews were not obtainable at certain households and because some households could not provide or refused to provide answers to selected questionnaire items, statistical adjustments were required. In the CPS, no interview was obtained for approximately 5 percent of the households in the sample. Interviews were not obtained at these households for reasons such as "no one home," "temporarily absent," or refusals. In order to account for these households, the weights assigned to households in which interviews were obtained were increased slightly. This "noninterview" adjustment procedure adjusts the weights of sample households by race of head and within a specified set of geographical restrictions.

Another response problem is caused by incomplete answers to the survey questions. This nonresponse problem, which is sometimes referred to as "item nonresponse," is a serious problem in most household surveys and is especially troublesome for income. In the CPS, dozens of questions are used to arrive at a figure for income from all sources. In many cases, even though an interview is obtained, complete information for all of the income questions is not available, unknown, or refused. For example, in 1984 income data were incomplete for about 30 percent of the persons 15 years old or over. About 36 percent of the families had one or more members with incomplete income information. To utilize the maximum amount of information, missing income items are statistically imputed or allocated by values obtained from active respondents with similar economic and demographic characteristics.

Although nonresponse rates for families by poverty status are not available, it is known that families in the lower-income intervals tend to have lower nonresponse rates for income information than those in the middle- and upper-income intervals. This is due, in part, to the fact that lower-income families have less complicated financial arrangements than those in other income groups.

### **Reliability of the Estimates**

Since the CPS estimates are based on a sample, they are likely to differ from the figures that would have been obtained if a complete census had been taken using the same questionnaires, instructions, and enumerators. There are two types of errors possible in an estimate based on a sample survey: sampling and nonsampling. Sampling errors are the result of the variability inherent in any sample; smaller sample sizes naturally result in greater variability or error when estimating characteristics of the population as a whole. Nonsampling errors can result from enumerator and respondent bias, language barriers, and other factors. The accuracy of a survey result depends on both types of errors, but the full extent to the nonsampling error is unknown. Consequently, care should be exercised in the interpretation of the results, especially those based on a relatively small number of sample observations.

## APPENDIX 2: THE POVERTY CONCEPT<sup>10</sup>

The poverty definition used in this report is based on an index developed at the Social Security Administration (SSA) in 1964, and revised by Federal Interagency Committees in 1969 and 1981. A directive from the Office of Management and Budget, originally issued in 1969, established the Census Bureau's statistics on poverty as the standard data series to be used by all federal agencies.<sup>11</sup>

The poverty concept is a statistical measure based on the Department of Agriculture's 1961 economy food plan. The food plan reflects the different consumption requirements of families in relation to their size and composition, and the age of the family householder. A ratio of food expenditures to income of one-third, based on the Department of Agriculture's 1955 Survey of Food Consumption, was used to derive the original poverty thresholds from the economy food plan. The poverty cutoffs have been updated annually based on changes in the Consumer Price Index.

In estimating the population below the federal poverty level or at other thresholds based on the poverty level (e.g., 185 percent of poverty) family income is compared to the established poverty thresholds. Data on family income collected in the CPS are limited to money income received before payments for personal income taxes and deductions for Social Security, union dues, Medicare premiums, etc. Money income is the sum of the amounts received from earnings; Social Security and public assistance payments; dividends, interest, and rent; unemployment and worker's compensation; government and private employee pensions; and other periodic income. (Certain money receipts such as capital gains are not included.)





## **APPENDIX 3: ALTERNATIVE METHODS OF ESTIMATING THE NEWLY ELIGIBLE POPULATION**

As indicated, the Current Population Survey provides rough estimates of the population eligible under the 1987 OBRA legislation. Individual states with a capacity for additional analysis may want to consider alternative approaches toward a more precise estimation of the eligible population.<sup>12</sup> These alternatives include state-level telephone or household interview surveys and analysis of microdata from the 1980 census of the population.

### **State-Level Surveys**

The optimal approach to estimating the size of the eligible population is to conduct a special household survey. Such a special purpose survey would permit a state to collect detailed information on family composition, income, resources (assets), expenses and deductions from income, and existing types of health insurance coverage. A state-level survey can produce highly reliable estimates if the sample size is large enough. For example, Colorado conducted a state survey in the past to produce estimates of the uninsured population.<sup>13</sup> This survey can serve as a model for other states interested in implementing special surveys.

The cost of conducting a state-level survey can be substantial. Savings can be achieved by utilizing telephone interviews rather than in-person household interviews. National and regional survey research agencies are available to conduct special purpose surveys on a contractual basis.

Traditionally, household interview and telephone surveys are conducted using random selection methods, such as random digit dialing for telephone surveys. However, randomly selecting households to identify persons potentially eligible under OBRA-87 is likely to be inefficient since relatively few randomly selected respondents fit the eligibility categories. In some states, it may be possible to improve greatly the efficiency of collection by selecting a sample of birth certificate records during the previous year and using them as a basis for identifying a sample. This sample can then be used as the basis for collecting retrospective data on pregnant women and infants.

### **Census Data**

In the absence of specialized survey data, states may want to develop additional estimates of the potentially eligible population using decennial census data from 1980. Data from the 1980 census is collected in a similar fashion to that of the Current Population Survey. However, the sample sizes are much larger, resulting in smaller sampling errors. This makes 1980 census data especially useful for smaller states where the CPS estimates are based on relatively few cases. However, the advantage of a larger sample size must be weighed against the dated nature of the 1980 census. Because the data are now eight years old, ad-

justments must be made to income levels to reflect current prices and changes in personal income.

## ENDNOTES

1. For more details, see Ian Hill, "Reaching Women Who Need Prenatal Care: Strategies for Improving State Perinatal Programs" (Washington, D.C.: National Governors' Association, 1988).
2. National Center for Health Statistics, "Advance Report of Final Natality Statistics, 1984," *Monthly Vital Statistics Report*, vol. 35, no. 4 supp. DHHS Pub. No. (PHS) 86-1120 (Hyattsville, Md.: Public Health Service, July 18, 1986).
3. For purposes of estimating costs, the number of infants who remain eligible the entire first year following birth is likely to be less than the number that is eligible at birth due to changes in income and other factors that can lead to loss of eligibility. For example, a study in California showed that 22 percent of public assistance families and 29 percent of Medically Needy families lost eligibility for Medicaid within one year of their case opening. See Connie Cellum, Paul Newacheck, and Jonathan Showstack, "Patterns of Medicaid Eligibility: A Sample of 408 Medi-Cal Eligibles in San Francisco, California," *Health Care Financing Review*, vol. 2, spring 1981.
4. DEFRA and COBRA required states to provide Medicaid coverage, including prenatal care, delivery, and postpartum care, to pregnant women with incomes below existing AFDC eligibility thresholds regardless of family structure. Similarly, all financially eligible children under age five are required to be covered by states by federal fiscal year 1989.
5. Births to women below the poverty level can be derived from data presented in Tables 1 through 5. For states with Medically Needy programs, Medicaid-funded births will include women who have spent down to achieve eligibility. The spend-down population with incomes below 185 percent of the poverty level should be eligible without a spend-down.
6. Harriette B. Fox and Ruth Yoshpe, "Memorandum on 1986 Legislative Amendments Affecting Access to Care by Children and Pregnant Women" (Washington, D.C.: Fox, Inc., December, 10, 1986); and Harriette B. Fox, "Memorandum on the Medically Needy Option for Expanding Medicaid Eligibility," prepared for the Division of Maternal and Child Health, U.S. Department of Health and Human Services (Washington, D.C.: Fox, Inc., December 6, 1985).
7. See Institute of Medicine, *Preventing Low Birthweight* (Washington, D.C.: National Academy Press, 1985).
8. U.S. Bureau of the Census, *Statistical Abstract of the United States: 1987*, 107th edition (Washington, D.C.: U.S. Government Printing Office, 1986).
9. Material in this appendix is based on *Characteristics of the Population Below the Poverty Level, 1984*, Current Population Reports, series P-60, no. 152, by the U.S. Bureau of the Census (Washington, D.C.: U.S. Government Printing Office, 1986).
10. This description of the poverty concept is based on *Characteristics of the Population Below the Poverty Level, 1984*.
11. Office of the Federal Statistical Policy and Standards, U.S. Department of Commerce, *Statistical Policy Handbook*, May 1978, Directive 14.
12. Fox and Yoshpe, "Memorandum on the 1986 Legislative Amendments Affecting Access to Care by Children and Pregnant Women"; and Fox, "Memorandum on the Medically Needy Option for Expanding Medicaid Eligibility."
13. Colorado Task Force on the Medically Indigent, "Colorado's Sick and Uninsured: We Can Do Better," January 1984.



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## RELATED HEALTH POLICY PUBLICATIONS AVAILABLE FROM THE NATIONAL GOVERNORS' ASSOCIATION

*Estimating Medicaid Eligible Pregnant Women and Children Living Below 185 Percent of Poverty: Strategies for Improving State Perinatal Programs* is one of a series of publications on state perinatal program issues published by the Health Policy Studies unit within NGA's Center for Policy Research. Other recent publications addressing state perinatal program issues include:

*Reaching Women Who Need Prenatal Care: Strategies for Improving State Perinatal Programs* by Ian T. Hill. June 1988. \$15.00.

Since early 1987, a majority of states have implemented expanded Medicaid programs for pregnant women and young children living in poverty. In order to improve these populations' access to early and appropriate prenatal care, this book describes how numerous states are also reshaping and enhancing their systems for eligibility and outreach. Extensive discussion of presumptive eligibility is included.

*Increasing Provider Participation: Strategies for Improving State Perinatal Programs* by Deborah Lewis-Idema. July 1988. \$15.00.

Assuring adequate provider participation has been a perennial concern for Medicaid, Maternal and Child Health, and other programs for low-income pregnant women and children. Given the recent enactment of OBRA-86 and states' enthusiastic response to the flexibility that allows broader coverage of these populations, the growing sense of a "crisis" in obstetrical care comes at a particularly inopportune time. This document describes the scope of the problem and provides new insights into strategies states are employing to expand provider participation in public perinatal programs.

*Estimating the Number and Costs of Newly Medicaid Eligible Pregnant Women and Infants: A Technical Report on Implementing the 1986 Omnibus Budget Reconciliation Act* by Paul W. Newacheck and Margaret A. McManus. March 1987. \$15.00.

This report is designed to assist states in estimating the potentially eligible populations of pregnant women and children under expanded, poverty-level Medicaid programs. Individual state estimates are provided.

*Implementing a Workable Presumptive Eligibility Program: The Experience In Arkansas* by Ian T. Hill. June 1987. \$5.00.

The country's first presumptive eligibility program (to allow pregnant women to receive short-term Medicaid coverage while formal eligibility is being determined) is highlighted in this case study. Early problems, issues, and strategies surrounding implementation are described in detail.

*Broadening Medicaid Coverage of Pregnant Women and Children: State Policy Responses* by Ian T. Hill. February 1987. \$9.00.

This volume describes, in detail, the provisions of the Omnibus Budget Reconciliation Act of 1986, which allowed states to expand Medicaid coverage of pregnant women and children up to the poverty level. Early projections are made regarding expected state responses. Additionally, baseline data regarding states' existing coverage of maternal and child populations prior to OBRA-86 are provided.

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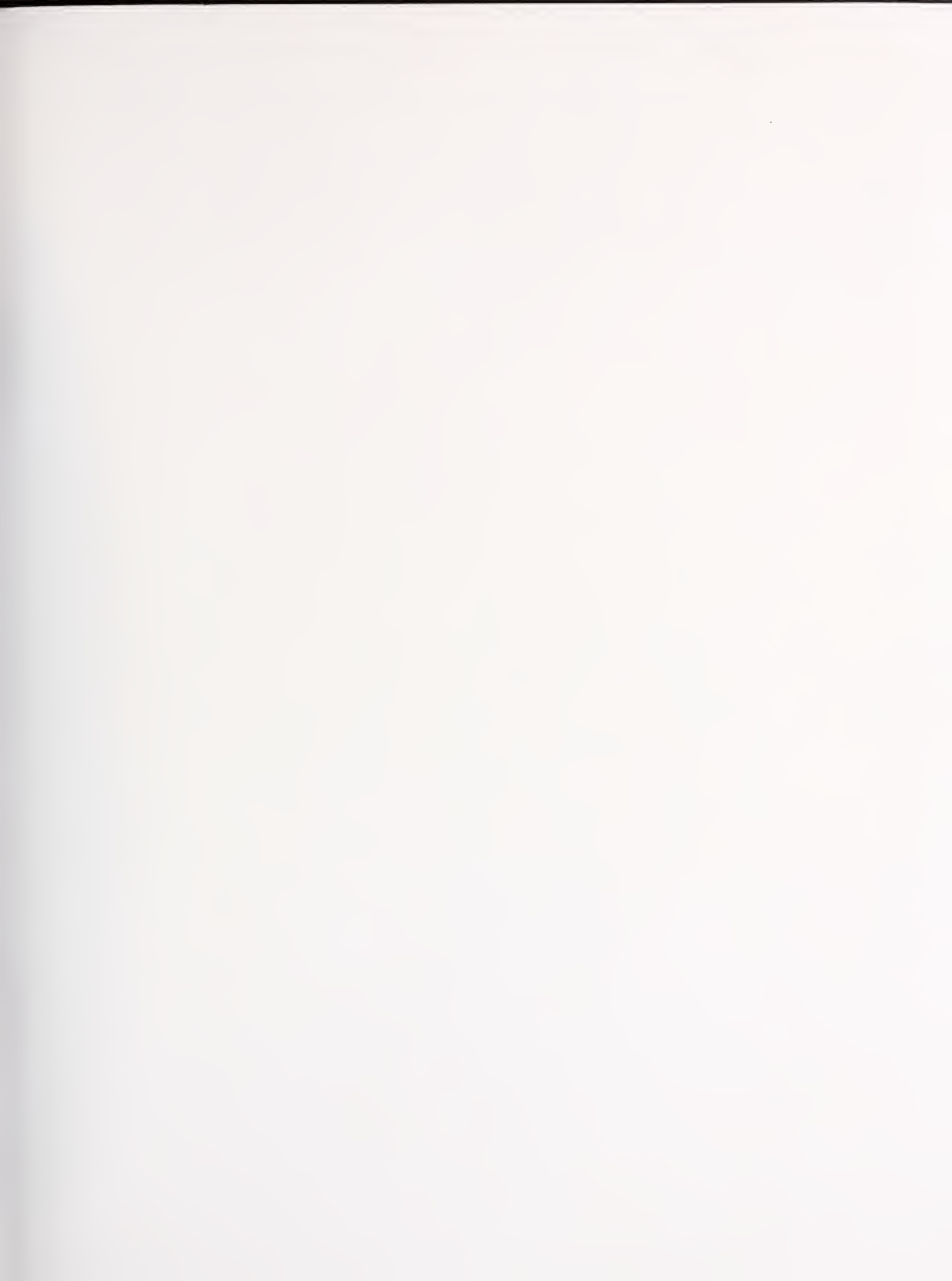
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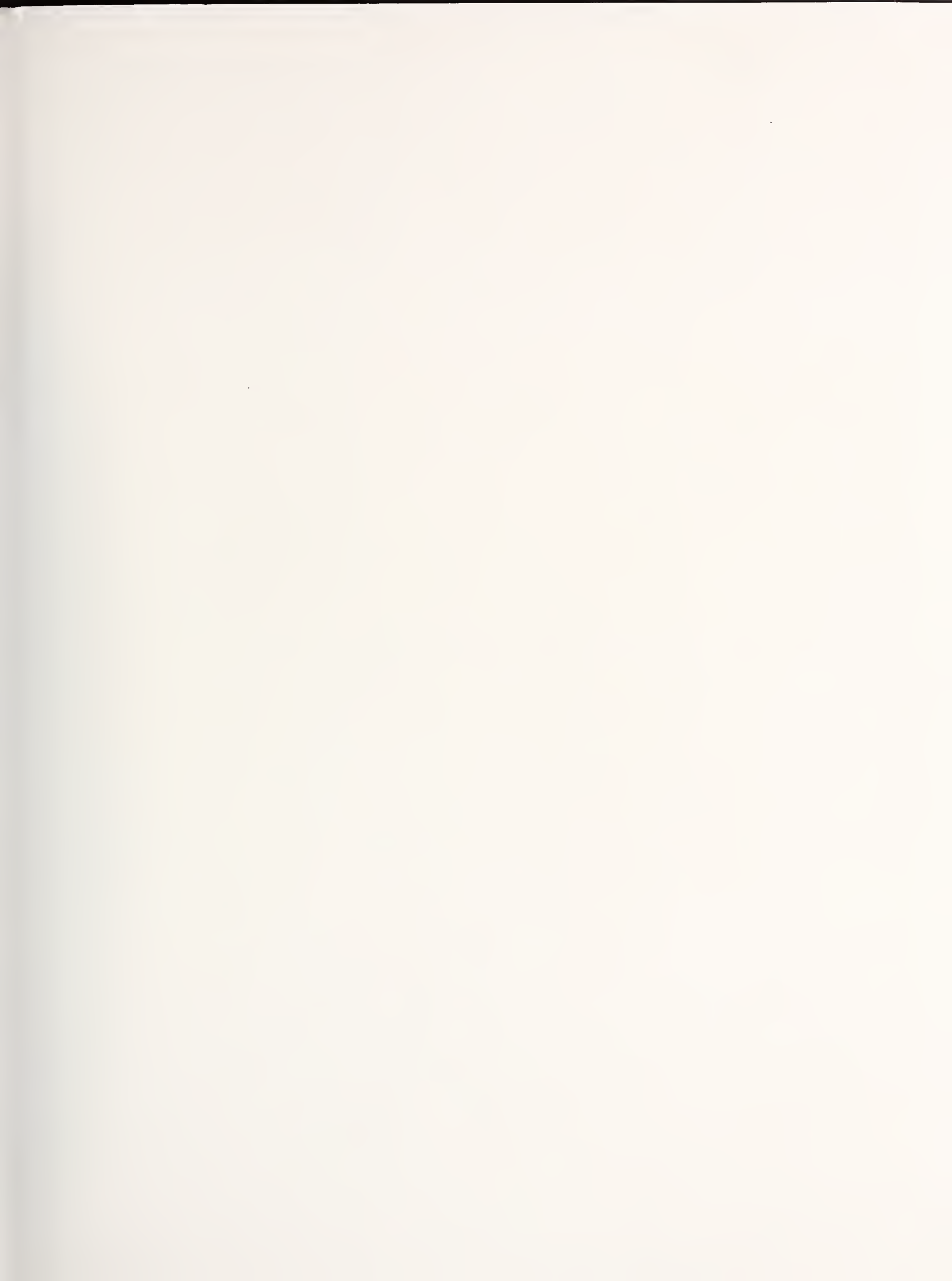
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