Wisconsin’s Future Newborn Citizens: Potential Medicaid Cost Savings in Covering Immigrants’ Prenatal Care

April 2004
Volume 5 Number 2

Wisconsin’s Medicaid, Healthy Start, and BadgerCare programs do not cover prenatal care for resident immigrant women who would by all income and asset guidelines be eligible, except for their immigrant status. “Qualified immigrants” (legal permanent residents and others) include those persons who have entered the United States legally after August 22, 1996. Federal law bars them, as well as other immigrants from receiving Medicaid and other “public benefits” for five years after acquiring legal permanent residency. Coverage of post-1996 and undocumented immigrants is limited to emergency coverage only, including childbirth, but not prenatal care.

Regardless, however, of the immigration status of their parents, children born in the United States are legal U.S. citizens upon birth. These citizen babies, born to both documented and undocumented immigrants in Wisconsin, are upon birth often eligible for state Medicaid and Healthy Start programs. The State thereby maintains at least a financial stake in assuring that these babies are born healthy. The current policy, which denies coverage of prenatal care for this population, may be counter to these interests.

Changing Demographics
In the last decade, the Hispanic population in Wisconsin has more than doubled, growing from 93,194 (1.9% of Wisconsin’s population) in 1990, to 209,074 (3.8% of the population) in 2002. Hispanics/Latinos are Wisconsin’s second largest and fastest growing population. These figures do not take into account the number of immigrants who did not participate in the Census, often due to a fear and misunderstanding of government agencies. At the same time, the number of Asians in Wisconsin has grown dramatically, increasing more than 70%, from 52,284 in 1990 to 87,995 in 2000. Most Asians in Wisconsin are estimated to be foreign born, and Wisconsin is third in the nation as home to Hmong refugees from Southeast Asia.

Disparate Prenatal Care
As the numbers of Hispanics in Wisconsin continue to increase rapidly, so too do the number of births to Hispanic mothers. Among women of childbearing age (15-44), Wisconsin’s Hispanic/Latina women in the year 2000 had the highest fertility rate, at 100 births per 1000 women, compared to 60 per 1000 for Wisconsin’s overall population of women. Asians had the next highest rate, at 88 per 1000. This rise in births to Hispanic mothers raises concerns about Wisconsin’s already longstanding racial disparities in prenatal care.

In 2002, 69% of Wisconsin’s Hispanic women received prenatal care in the first trimester, compared to 88% of the non-Hispanic white population in Wisconsin and 76% of Hispanics nationally. As well, 53% of Laotian/Hmong women received first trimester prenatal care in Wisconsin. Among both Hispanic and Laotian/Hmong mothers in Wisconsin, 6% received only third trimester or no prenatal care, while only 3.2% of white mothers were thus limited in their care in 2002.

Fully one-quarter of Laotian/Hmong births are to women under age 20 and one-fifth of Hispanic births are to women under age 20; this compares to about 7% of white births and 10% of Wisconsin’s total births.

Wisconsin’s Hispanic infant mortality rate in 2002 was 6.6 per 1000, compared to 5.5 for whites and 6.9 for Wisconsin’s total population. In 2002, the Hispanic rate of low birthweight was 5.8%, about the same as the white rate of 5.9%, and less than the statewide rate of 6.6%. Yet about 22% of Hispanic infant deaths from 2000-2002 died from disorders related to short gestation and low birthweight, compared to about 16% of white infant deaths. Further, the risk status of Hispanic women and their babies may be understated by standard vital statistics. Hispanic women often suffer from diabetes, which puts them and their babies at risk for adverse outcomes. The risks are often not reflected in the standard vital statistics data, which focus on the rate of low birthweight, while diabetes pregnancies often produce babies that are larger than the norm. Nonetheless,

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the risks associated with lack of prenatal care are well established. 11

Cost Shifting: Hidden Tax on Counties and Health Care Providers
The lack of state Medicaid coverage for this population shifts the costs to local providers and to county tax payers. In Milwaukee County, immigration status appears to be a major reason for enrolling in the General Assistance Medical Program (GAMP), which is supported through a combination of state and federal Medicaid dollar transfers and Milwaukee County tax levy. A Wisconsin DHFS 2001 briefing note12 notes that many of the 1,000 children that participated in the program in calendar year 2000 did not have social security numbers listed, and notes also the substantial proportion of women enrolled in the program. Interviews with local service providers reveal that they often refer immigrant women to GAMP for funding prenatal care.

Costs Associated with Adverse Birth Outcomes
The cost-benefit of prenatal care is undisputed; it is well established throughout the literature that prenatal care is highly effective in reducing the risks of pregnancy complications and adverse birth outcomes. 13 Charges associated with postnatal diagnoses are among the highest of all hospital diagnoses.14

A peer-reviewed California study that analyzed the impact of eliminating prenatal coverage for undocumented immigrants in its Medicaid (Medi-Cal) program15 found the following:

* Women with no prenatal care were four times as likely to give birth to a baby of low birthweight and more than seven times as likely to give birth prematurely.
* For every $1 saved by eliminating prenatal care, $3.33 would potentially be spent on the cost of postnatal care and $4.63 in incremental long-term costs.

Investing in Wisconsin’s New Citizens
Wisconsin Medicaid currently allows any person, regardless of immigration status, to receive Alien Emergency Medical Assistance (AEMA) in medical emergencies, including labor and delivery. Pregnant immigrants may apply for AEMA and receive coverage thirty days prior to their due date, and up to 60 days postpartum care. Wisconsin could consider modifying its AEMA plan to include prenatal care coverage upon first notice of pregnancy, thus investing in preventive, prenatal care services for its future newborn citizen babies.16

With the current budget shortfalls and growth in Medicaid spending, policy makers are justifiably skeptical about the costs and potential savings. What are current expenditures for post-delivery care of babies born to immigrant women whose deliveries were covered by AEMA? A gross look at the figures suggests potential for cost savings as well as for improved health.

In Wisconsin’s state fiscal year 2002, 1,606 deliveries occurred to women on AEMA. Of these, 1,183 surviving children born to AEMA Women in SFY 2002 became Medicaid cases, and the average payment per child through the first 91 days of life was $1,871.64. This compares to $1,343.55 for all Wisconsin Medicaid children born in that time period.

These limited data reflect 39% higher costs in the first three months of life for those children born on AEMA. Truly conclusive interpretation of these cost differences would require study of the medical records, the birth certificates and prenatal records of these cases to determine the type and amount of prenatal care actually received. Nonetheless, an extensive literature supports both the efficacy of prenatal care and the correlation between insurance coverage and utilization of services.17

Thus, policy could follow from a logical extrapolation of limited data, suggesting that these babies were born with health care needs greater than might otherwise have been if, like other Medicaid eligible populations, their mothers had received coverage for appropriate and complete prenatal services.

Extending Medicaid coverage under AEMA to first identification of pregnancy for immigrant women could potentially reduce adverse birth outcomes among these new citizens, save the State immediate and future Medicaid costs and, ultimately, reduce the human pain and suffering associated with potentially avoidable adverse birth outcomes among its newborn citizens.

This brief was authored by Donna Friedsam, based on earlier writing by Jim Dale and Linda Hall for Covering Kids and Families – Wisconsin.

References:
7. Wisconsin Interactive Statistics on health (WISH). http://wishes.dhs.state.wi.us