ISSUE BRIEF
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PROMOTING ACCESS TO PRENATAL CARE: Lessons from the California Experience

Improving access to prenatal care has been a public policy priority in the United States for the past 15 years. Prenatal care, provided early in a woman's pregnancy and consistently thereafter, plays an important role in keeping women and infants healthy. For low-income women who may lack ongoing preventive health care before pregnancy, timely prenatal care and regular visits may be particularly important to promote healthy pregnancies and detect and treat health risks early on.

During the late 1980s, national legislation started to expand Medicaid maternity coverage and establish related reforms throughout the U.S. California, like many other states, began implementing major expansions in eligibility for Medi-Cal (California's Medicaid program) along with related reforms to improve access to prenatal care for uninsured low-income women in the state. This issue brief summarizes the findings of a report, *Promoting Access to Prenatal Care: Lessons from the California Experience*, that examines the impact of the Medicaid prenatal care expansions and reforms in California since 1989. The report's findings are based on statewide birth certificate data and the California Maternal and Infant Health Assessment survey.

Background

The U.S. Department of Health and Human Services *Healthy People 2010* objectives for the nation include the goal that, by the year 2010, 90% of all pregnant women begin prenatal care during the first three months of pregnancy.[1] Early prenatal care is likely to matter most for women who are at elevated risk of poor birth outcomes, such as women who smoke, are low-income, have poor nutritional status, are HIV-positive, or have other serious health problems prior to pregnancy.[2,3]

In the 1980s, strict eligibility requirements and a lengthy or difficult application process were recognized barriers to Medicaid enrollment for maternity care.[2,4,5] In an attempt to improve enrollment and remove such barriers, the Medicaid program underwent major changes at the federal level affecting both eligibility criteria and enrollment procedures during the late 1980s and early 1990s. Many states like California took advantage of these policy changes to not only expand eligibility but also to improve the enrollment process for pregnant women.

Improving Access to Prenatal Care

Significant progress has been made in improving access to prenatal care in California since 1989-1990, when major expansions in Medi-Cal maternity coverage and accompanying systems reforms were first implemented (Figure 1). The expansions mirror the efforts of many other states across the country.

Figure 1. Medi-Cal Eligibility Expansions and Systems Reforms

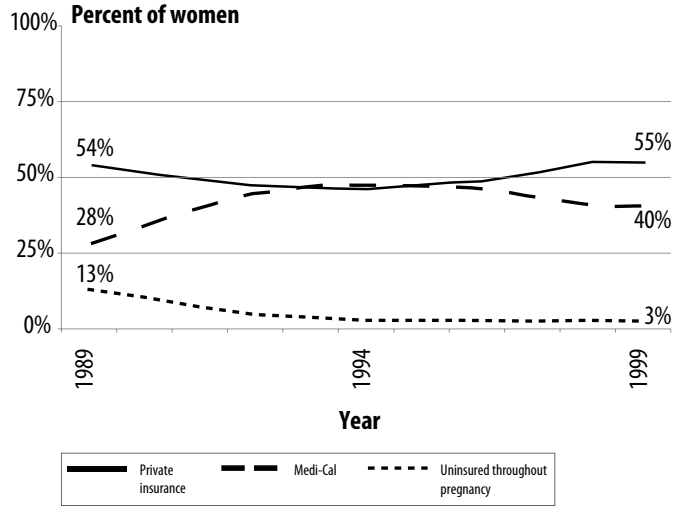
1988	• Coverage extended to undocumented foreign-born women
1989	• Income eligibility raised from 110% to 185% of poverty
	• Eligibility workers 'outstationed' at prenatal clinics
	• Reimbursement to providers increased
1990	• Income eligibility increased to 200% of poverty
1992	• Assets test eliminated for women with incomes 185-200% of poverty
1993	• Presumptive eligibility implemented
	• Shortened application form
1994	• Assets test eliminated for women under 200% of poverty

- A trend toward marked improvements in coverage and in the receipt of early prenatal care and adequate numbers of visits began in 1991 (Figure 2). During the 1990s, the proportion of women who were uninsured throughout their pregnancy dropped from approximately 13% to 3% overall. During that same time period, the share of women initiating prenatal care in the first trimester rose from 73% to 84%, and the share of pregnant women with adequate numbers of prenatal visits rose from 70% to 83%. In contrast, there were no improvements in receipt

of early prenatal care evident during the 1980s before these changes had been implemented.

- Use of prenatal care improved for all population groups during the 1990s, but improvements were considerably larger for certain key groups such as women with limited schooling, African American and Latina women, immigrant women, and teens (Figure 3). For example, between 1989 and 1999, the number of teens under 20 who initiated early prenatal care went from just 54% to 71%. Similarly, among Latinas the rates grew from 61% to 80%, and among women without a high school degree from 56% to 75%. These groups, who historically have been least likely to receive prenatal care at recommended levels, are disproportionately low-income and were the target populations of the Medicaid expansions. The result of these improvements was a significant reduction in the disparities between women at high risk for receiving inadequate prenatal care and other women.

Figure 2. Prenatal Care Coverage: Women Giving Birth in California, 1989-1999



Source: California birth certificates.
Note: Prenatal insurance coverage in birth certificates is the "principal prenatal payer" without regard for when coverage began.
Excludes women with no prenatal care, for whom no insurance information is available in birth certificate data.

The findings suggest that the Medi-Cal eligibility expansions, in combination with the related systems reforms, were likely to have had a substantial impact on access to prenatal care. The pattern and timing of the improvements in coverage and prenatal care use - and in particular the disproportionate improvements in care among vulnerable groups - cannot be explained solely by changes in the economy or by demographic or other secular trends. Poverty and unemployment actually *increased* in California during the early 1990s, and the proportion of births to immigrants, particularly Latinas, increased as well. Although it is not possible to separate the effects of expanded Medi-Cal eligibility from those of systems reforms affecting the Medi-Cal enrollment process, this analysis suggests that both were likely to have been important in improving access to prenatal care.

Still room for improvement

Despite this progress, about one in six women (16%) who gave birth in 1999 still lacked early prenatal care. Efforts should continue to focus on low-income women (with family incomes at or below 200% of the federal poverty level), who comprise half of all women giving birth in California.

Figure 3. Prenatal Care Use by Women's Characteristics: Women Giving Birth in California, 1980-1999

	Percent with early care [1]		
MATERNAL CHARACTERISTICS	1980	1989	1999
All Women	77	73	84
Age			
<20	60	54	71
20-34	80	75	85
>34	77	82	88
Race/Ethnicity			
African-American	75	67	81
Asian and Pacific Islander	79	78	86
White	83	83	89
Latina	65	61	80
Native American	66	63	73
Other	64	79	79
Birth Place			
US-born	80	78	85
Foreign-born	68	65	82
Education			
Less than high school		56	75
High school graduate	n/a	74	82
Some college		84	88
College graduate or more		91	94

Source: California birth certificate data.
*Only includes women who obtained some prenatal care.
Note: Information on level of educational attainment was not added to the California birth certificate until 1989.
[1] Beginning in the first 3 months of pregnancy.

- Although gaps between income groups have narrowed, low-income women remain less likely to receive early prenatal care than higher income women. One-quarter (25%) of women with family incomes at or below 200% of poverty did not get early prenatal care, compared with only 6% of higher-income women.

- In California, low-income women comprised 53% of all women giving birth in 1999. Almost one-third lived below poverty – $16,700 for a family of four in 1999 – and another 21% were "near-poor," with incomes between 101% and 200% of the poverty level. Of women delivering in California in 1999, one-quarter had less than

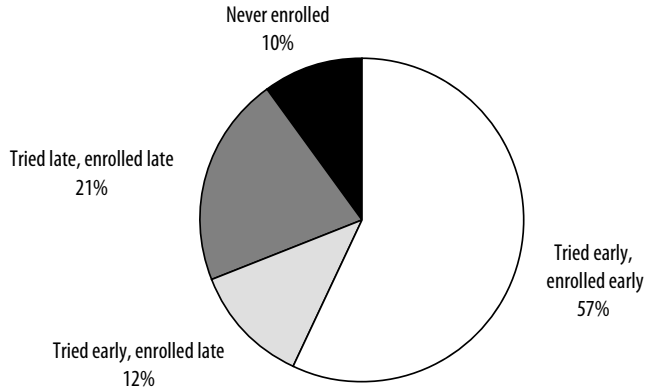
a high-school education and 41% were born outside the U.S. Almost one-half (45%) were Latina, while white women comprised one-third of the total.

Access to early insurance coverage could improve receipt of prenatal care

Ensuring that pregnant women have insurance coverage during the first trimester of pregnancy could improve receipt of early prenatal care; coverage later in pregnancy does not assure early care.

- The effectiveness of coverage in removing financial barriers to early prenatal care depends on when during the pregnancy coverage actually begins. While only a small fraction of California women (3% in 1999) lacked insurance coverage throughout pregnancy, in 1999, approximately 16% of all women with live births (and one-quarter of women with Medi-Cal during pregnancy) did not get prenatal coverage until the second or third trimesters of pregnancy. These women, who were uninsured throughout the first trimester, were markedly less likely to receive early prenatal care.

Figure 4. First Attempt to Obtain Medi-Cal and Enrollment in Medi-Cal During Pregnancy: Low-Income Women in California, 1999



Source: California Maternal and Infant Health Assessment (MIHA), 1999.
Note: N=611 women who had family incomes ≤200% of poverty, were uninsured prior to pregnancy, were aware of their pregnancies in the first trimester, and for whom information on sociodemographic characteristics was available.
"Early" is during the first trimester of pregnancy; "late" is after the first trimester.

- Most low-income women are motivated to obtain early prenatal coverage and, presumably, early care. Over two-thirds of low-income women who were uninsured before pregnancy (69% in 1999) tried to obtain Medi-Cal coverage during the first trimester of pregnancy and enroll sometime during pregnancy (Figure 4). However, 12% of women who met the income eligibility criteria in 1999 tried to enroll early but did not actually enroll in Medi-Cal until after the first trimester, and over one-third of these women did not receive early care.

— Lack of awareness of pregnancy was an important reason for delays in trying to obtain Medi-Cal for prenatal care among uninsured women who met Medi-Cal income eligibility criteria. Factors related to poverty also appeared to affect the timing of women's attempts to apply for Medi-Cal.

— Among women who tried to obtain Medi-Cal in the first trimester, those who reported a perception that Medi-Cal workers were unhelpful were nearly four times more likely to enroll in Medi-Cal after the first trimester, even after accounting for differences in other characteristics.

Family planning and other 'non-insurance' factors also play a key role

In addition to ensuring first-trimester insurance coverage, efforts to increase use of family planning services and to address other 'non-insurance' factors are also important for promoting early prenatal care.

- Lack of awareness of pregnancy during the first trimester is a major barrier to early prenatal coverage and care. A woman cannot seek early coverage or prenatal care if she does not know that she is pregnant. In 1999, among low-income women who had public or private coverage, 23% of those who did not have first-trimester prenatal care lacked early awareness of pregnancy.

- Women with unintended pregnancies and pregnant teens were two to three times more likely to have had delayed awareness of pregnancy, suggesting that increases in effective use of family planning services (which could decrease unintended and teen pregnancies) and education might lead to increases in early awareness. African American women had a similarly increased risk of delayed awareness of pregnancy, suggesting a need for additional efforts to address this issue in this community.

- In addition to lack of early awareness of pregnancy, low-income women who had the following characteristics were one and one-half to two times more likely to lack early prenatal care:

— Unintended pregnancy – again suggesting the importance of family planning in relation to prenatal care;
— A belief that their receipt of prenatal care was not "very important" to those close to them – suggesting the need for community-wide outreach and education regarding the importance of prenatal care; and
— Low educational attainment – suggesting the need for efforts beyond the health sector itself.

Policy implications

The California experience reflects the importance of a strong dual emphasis on reducing systems barriers while fully utilizing federal options to expand eligibility criteria. Along with public information campaigns and outreach, this two-pronged approach is likely to have been key in achieving the favorable results observed in this study.

Access to health coverage early in the pregnancy is crucial for timely prenatal care. The results of the study suggest that the following issues should be considered to further improve access to coverage during the first trimester:

- Additional training and encouragement for Medi-Cal workers to project a more helpful image and further facilitate women's efforts to apply for coverage. Perceiving Medi-Cal workers as unhelpful was a barrier to timely enrollment among women who tried to apply in the first trimester.

- Further work to assess if presumptive eligibility is working as well as it could, followed by efforts to identify and address key obstacles are important. A substantial number of women who tried to obtain Medi-Cal in the first trimester did not enroll or start care until the second trimester or later – despite being eligible for coverage.

The findings also indicate that policies to improve access to early prenatal care must also focus on women *before* they become pregnant. The results repeatedly underscore the role of effective family planning services as a major factor increasing the likelihood that prenatal care begins in a timely fashion. Thus, policies to promote family planning are crucial not only because they reduce the rate of unintended pregnancy but also for improved receipt of prenatal care. In addition, this study's findings suggest that policies to improve access to prenatal care must address broader issues such as low educational attainment and poverty that are beyond the immediate reach of the health sector but have profound influences on health and health care.

California succeeded during the early 1990s in improving access to coverage among pregnant women and improving the timeliness and adequacy of prenatal care during a period of rising poverty and unemployment. This indicates that even in the face of formidable challenges, it is possible – with sufficient political will, support from federal policies, and attention to the multi-faceted nature of barriers to care – to make further progress toward the goal of timely prenatal care for all pregnant women. With many states facing fiscal crises, state policymakers are increasingly looking to cuts and restrictions on Medicaid coverage to address budgetary concerns. Given California's example of the gains possible in improving prenatal health for women and infants, it will be important to consider the effects of Medicaid program changes on the health of women and infants as policymakers work to preserve the progress that has already been accomplished in prenatal care and as they continue to work toward the goal of reducing the disparities that persist.

Based on the report *Promoting Access to Prenatal Care: Lessons from the California Experience*, by Paula Braveman, Kristen Marchi, et al., University of California at San Francisco (Pub #3332). Additional copies of this issue brief (Pub #3333) and the full report are available on our website at www.kff.org.

[1] United States Department of Health and Human Services. Healthy People 2010. 2nd ed. With Understanding and Improving Health and Objectives for Improving Health. 2 vols. Washington, DC: U.S. Government Printing Office, November 2000.

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[3] Murray JL, Bernfield M. The differential effect of prenatal care on the incidence of low birth weight among blacks and whites in a prepaid health care plan. N Engl J Med 1988;319:1385-1391.

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[5] Piper JM, Ray WA, Griffin MR. Effects of Medicaid eligibility expansion on prenatal care and pregnancy outcome in Tennessee. JAMA 1990;264(17): 2219-2223.