

# **Making Babies Healthier by Providing a Managed Care Option for California's Poor**

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## **Extended Abstract**

Offering high quality, low cost health care was a goal of managed health care. With the advent of health care reform, and the need to develop lower cost and effective health insurance plans, it is imperative to examine whether managed care plans meet these goals.

Past studies have taken advantage of the rolling out of managed care among the Medicaid population during the 1990s within states in the US to determine the effectiveness of managed care on birth outcomes. The analyses of the impact on birth outcomes to date are mixed. Recent research has moved beyond cross-sectional analysis and used longitudinal data and both double difference and mother fixed effects models to compare counties that were mandated to switch to managed care to those that continue to provide health care on a fee-for-service (FFS) basis. However, these studies fail to test if their control group is a valid counterfactual. This is important because the counties that were mandated to switch to managed-care are different from those who remained in a FFS system. We therefore cannot be sure if their results are due to the initiation of managed care for the Medicaid population or other county factors, which may have caused the groups to have differing trends in the growth rate of the outcome variables.

In this paper, we investigate the impact of California mandating that Medicaid beneficiaries be given a managed care option on their access to prenatal care and birth outcomes. We take advantage of the fact that California mandated that Medicaid recipients in 22 out of 58 counties be provided with a managed care option. In addition, counties began implementing the mandate at different times between 1994 and 2000. This variation in time and geography provides us with a potential instrument for estimating the impact of managed care on the health outcomes. We compare Medicaid covered birth outcomes in managed care and FFS counties. However, analysis of the pre-intervention trends in birth outcomes shows that FFS counties are not a good counterfactual. Therefore, we turn to a triple difference approach and use the uninsured in the managed care and FFS counties to control for differences in secular trends between the intervention and non-intervention counties. Once we have controlled for the secular trends between the counties, the pre-intervention trends in the birth outcomes are similar between the managed care and FFS counties. Our models also include zip-code fixed effects and county level trends to control for possible unobservables.

Only those Medicaid beneficiaries who were on welfare were mandated to switch from FFS to managed care. Births covered by Medicaid to undocumented mothers or to women who were ineligible for welfare but had incomes below 200% of the poverty line were not mandated to switch to a managed care system, rather it was optional. When examining the same research question, other studies have restricted their sample to those for whom the mandate is more likely to effect. In particular, they restrict the sample to those who are native born to ensure there are no undocumented women in the sample, and to those who have high school education or less and

are unmarried to since they are more likely receive welfare. However, 37% of the births to mothers on welfare in California in 1998 were to married women. We show how each of these restrictions affects the results and point at that restricting the sample to those who are unmarried changes the results. We argue that while the results may be internally consistent that they may not have much external validity and indeed the results may be quite different for the mandated group as a whole.

Another important confounding factor that has not been controlled for in past studies is the initiation of welfare reform in the mid 1990s. Studies of the effect of welfare reform on birth outcomes show that the reforms resulted to worsening access and health outcomes, perhaps due to the reduction in number of people on welfare and hence Medicaid. Due to the similar timing in the expansion of managed care and the initiation of welfare reform, results from past studies are likely to be biased if they do not control for welfare reform. In this paper, we include county level welfare expenditure data to account for this possible bias.

Our results show that, depending on the type of managed care program, managed care led to important increases in initiating prenatal care in the first trimester and reduced the number of low-birth weight and premature births. That managed care had important positive health benefits is in contrast to recent papers and is important for public policy given that there do not appear to be many cost savings from the managed care in California.