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Original research article

Health insurance coverage among women of reproductive age before and after implementation of the affordable care act

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Abstract

Objectives: The Affordable Care Act's expansions to Medicaid and private coverage are of particular importance for women of childbearing age, who have numerous preventive care and reproductive health care needs.
Study design: We conducted two national surveys, one in 2012 and one in 2015, collecting information about health insurance coverage and access to care from 8000 women aged 18–39. We examine type of insurance and continuity of coverage between time periods, including poverty status and whether or not women live in a state that expanded Medicaid coverage.
Results: The proportion of women who were uninsured declined by almost 40% (from 19% to 12%), though several groups, including US-born and foreign-born Latinas, experienced no significant declines. Among low-income women in states that expanded Medicaid, the proportion uninsured declined from 38% to 15%, largely due to an increase in Medicaid coverage (from 40% to 62%). Declines in uninsurance in nonexpansion states were only marginally significant.
Conclusions: Despite substantial improvements in health insurance coverage, significant gaps remain, particularly in states that have not expanded Medicaid and for Latinas.
Implications: This analysis examines changes in insurance coverage that occurred after the Affordable Care Act was implemented. While coverage has improved for many populations, sizeable gaps in coverage remain for Latinas and women in states that did not expand Medicaid.

Keywords: Health insurance; Affordable Care Act; Medicaid; Poverty

1. Introduction

The Affordable Care Act (ACA) included two major expansions to coverage that started in 2014: an expansion in Medicaid eligibility up to 138% of the federal poverty level and subsidized private coverage through new health insurance marketplaces [1]. As of May 2015, 22 states had opted not to implement a Medicaid expansion under the ACA [2]. In these states, individuals at or above 100% of the federal poverty level may be eligible for subsidized marketplace coverage, but many below poverty fall into a coverage gap.

In addition to that gap, many lawfully present immigrants are ineligible for Medicaid for the first 5 years of legal residency [3] and undocumented immigrants are generally barred from public coverage and prohibited from purchasing any coverage, with or without subsidies, through the federal and state marketplaces.

The ACA's coverage expansions are of particular importance for reproductive age women, who have numerous preventive and reproductive health care needs — including contraceptive services, maternity care, abortion care and cervical cancer screening — that are important to their health and well-being and to the health and well-being of their families. In 2013, prior to the ACA's major expansions, 18% of women aged 15–44 were uninsured, with particularly high levels among those who were poor (32%) and foreign born (37%) [4].

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Multiple studies and reports have found evidence that Medicaid and private insurance coverage have increased substantially under the ACA and that uninsurance has decreased substantially — particularly in states that have initiated the ACA's Medicaid expansion [5,6,7].

In this analysis, we attempt to gauge the impact of the ACA specifically for reproductive age women. We examine changes in insurance status and differences in these changes according to whether the woman's state has expanded Medicaid. We also explore which sociodemographic groups were still uninsured.

2. Materials and methods

2.1. Survey design

Data for the analyses come from two national surveys, both developed by the Guttmacher Institute and administered by the online recruitment company GfK. The first study gathered data from a national sample of women aged 18–39 in 2012. The second survey collected information from a national sample of women aged 18–39 in 2015.

GfK administered both surveys using their KnowledgePanel, and each panel was composed of approximately 50,000–55,000 individuals intended to be representative of the US population. GfK obtains informed consent from all individuals, and we obtained expedited approval from the Institutional Review Board of the Guttmacher Institute for both surveys. Surveys were available in English and Spanish.

The purpose of both surveys was to understand pregnancy attitudes and contraceptive use among women within the context of access to health care, including the potential impact of health care reform [8,9]. Both surveys were restricted to women aged 18–39 who had ever had vaginal sex with a man, were not pregnant at the time of the survey, had not had a tubal ligation and whose main male sexual partner had not had a vasectomy. Both surveys utilized the full GfK sample of women aged 18–39. Over a 3-week period in November and December 2012, 11,365 women aged 18–39 were invited to participate in the initial study. Of those, 6658 answered the four screening items, yielding a response rate of 59%; of the 4647 eligible respondents, 4634 completed the full survey. For the second study, 9539 women aged 18–39 were invited to participate over a 3-week period in May and June of 2015; 5029 answered the four screening items yielding a response rate of 53%; all of the 3428 respondents eligible for the survey filled it out. For both samples, GfK provided weights to account for survey nonresponse [10], and weighted data were used for all analyses.

2.2. Analysis

Our analysis focuses on type of health insurance coverage and lack of coverage. For both surveys, women were asked which type of health insurance they currently had: private, Medicaid, some other type of health insurance or no insurance. For the 2015 survey, women were also given the option of indicating that they had obtained coverage from their state-specific health insurance marketplace and whether this coverage was provided through their state-specific Medicaid program. The 62 women who did not provide information about type of health insurance were excluded from all analyses.

Women who currently had insurance were asked if they had had coverage all of the last 6 months. Women who were currently uninsured or had been uninsured any of the last 6 months were asked for how many of these months they had been uninsured.

Demographic characteristics used in the analyses include age group, race and ethnicity, union status, number of children, employment status and educational degree. We also used income, divided into two groups: at or below 138% of poverty or above that cutoff, chosen to let us most directly look at the impact of the ACA's Medicaid expansion. We also examined several measures according to whether or not the woman resided in a Medicaid expansion state. States that had not expanded Medicaid at the time of the 2015 survey included Alabama, Alaska, Florida, Georgia, Idaho, Kansas, Louisiana, Maine, Mississippi, Missouri, Montana, Nebraska, North Carolina, Oklahoma, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, Wisconsin and Wyoming. All demographic information was provided by GfK, with the exception of union status.

We first compared the demographic profiles of the two samples. We next examined differences in type of insurance coverage and gaps in coverage during the two time periods, and then assessed whether changes in type of insurance coverage differed according to income and whether or not the woman lived in a Medicaid expansion state.

We relied on simple (bivariable) logistic regression to determine whether changes in dichotomous and categorical outcomes (e.g., percentage uninsured) were statistically significant, using time period as the independent variable. We used multivariable logistic regression to examine whether living in a Medicaid expansion state moderated change between the two time periods in the probability of being insured, adjusting for respondents' demographic characteristics. All analyses were conducted using Stata 14.0.

3. Results

The 2012 sample was larger by 1206 women, presumably due to a larger sampling frame and the slightly lower response rate of the more recent study, and the two samples, after weighting, differed slightly on a few characteristics (Table 1). A higher proportion of women had no children and was employed full-time in 2015, and a lower proportion was employed part time; this latter difference could be due to fluctuations in the labor market. In addition, the proportion of women without a high school degree was higher in the 2015 sample.