Focus on Insurance Coverage

Among Maryland Women Giving Birth 2016-2020

Introduction

Medicaid is a joint federal and state program which serves as the primary source of health care coverage for many low-income families, pregnant women and children. In Maryland, Medicaid was the source of payment for one third of all births from 2016-2020. The majority of women qualify for Medicaid only after they became pregnant.

In the U.S., Medicaid was the main source of payment for 42% of live births in 2018[1]. Being uninsured is associated with receiving fewer prenatal care services, and worse pregnancy and delivery outcomes.[2] Studies have found significant differences between women without insurance and women with private insurance, and smaller differences between women with private insurance and those with public insurance (i.e. Medicaid). Policy changes in the past decade have resulted in pregnant women having increased access to insurance, through Medicaid Expansion and private insurance via the Health Insurance Marketplace created by the Affordable Care Act.

Pregnancy Risk Assessment Monitoring System (PRAMS)

The Maryland PRAMS survey in 2016-2020 has a weighted sample of 5,217 women. In 2016-2020, the survey included the following three questions about health insurance coverage (each question asks respondents to "check all that apply"):

1) During the month before you got pregnant with your new baby, what kind of health insurance did you have?

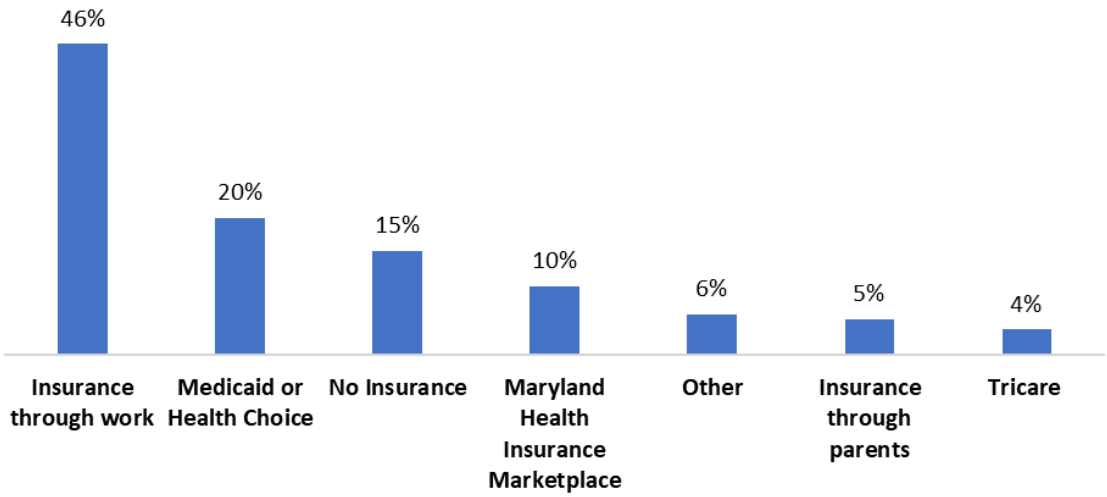
-Private insurance through job (or job of husband/partner)
-Private insurance through parents
-Private insurance through the Maryland Health Insurance Marketplace
-Medicaid or Health Choice
-TRICARE/other military health care
-Other
-Did not have health insurance

2) During your most recent pregnancy, what kind of health insurance did you have for your prenatal care? (Same options as 1)

3) What kind of health insurance do you have now? (Same options as 1)

Prevalence of Insurance Coverage

Figure 1. Health Insurance Status Just Before Pregnancy, 2016-2020*



*Respondents were instructed to identify all sources of payment, therefore percentages do not sum to 100.

Figure 2. Source(s) of Payment for Prenatal Care, 2016-2020*

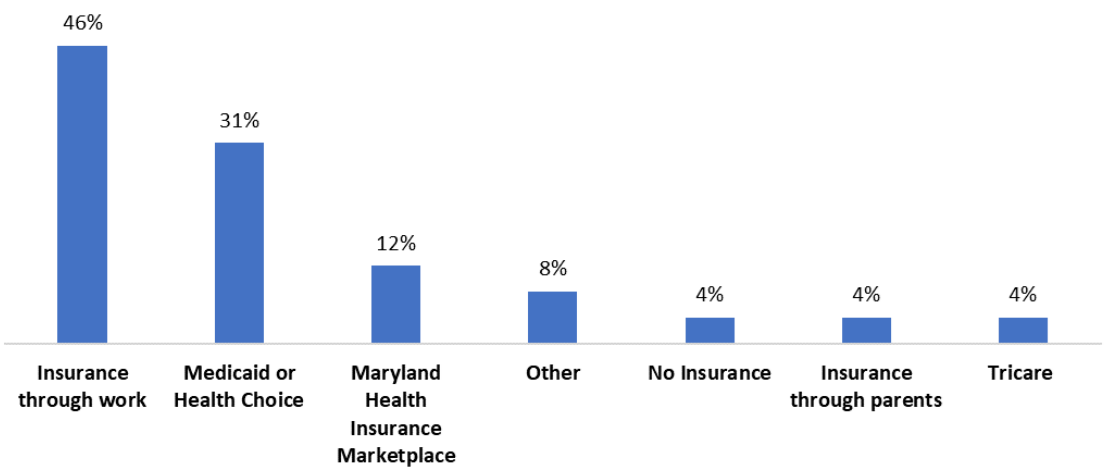


Figure 3. Medicaid Coverage for Prenatal Care by Percentage of Total Births, Maryland 2016-2020

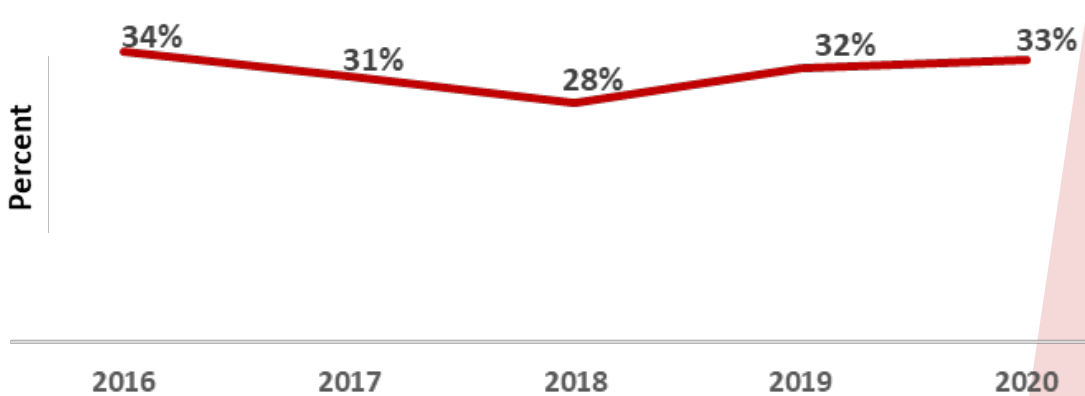
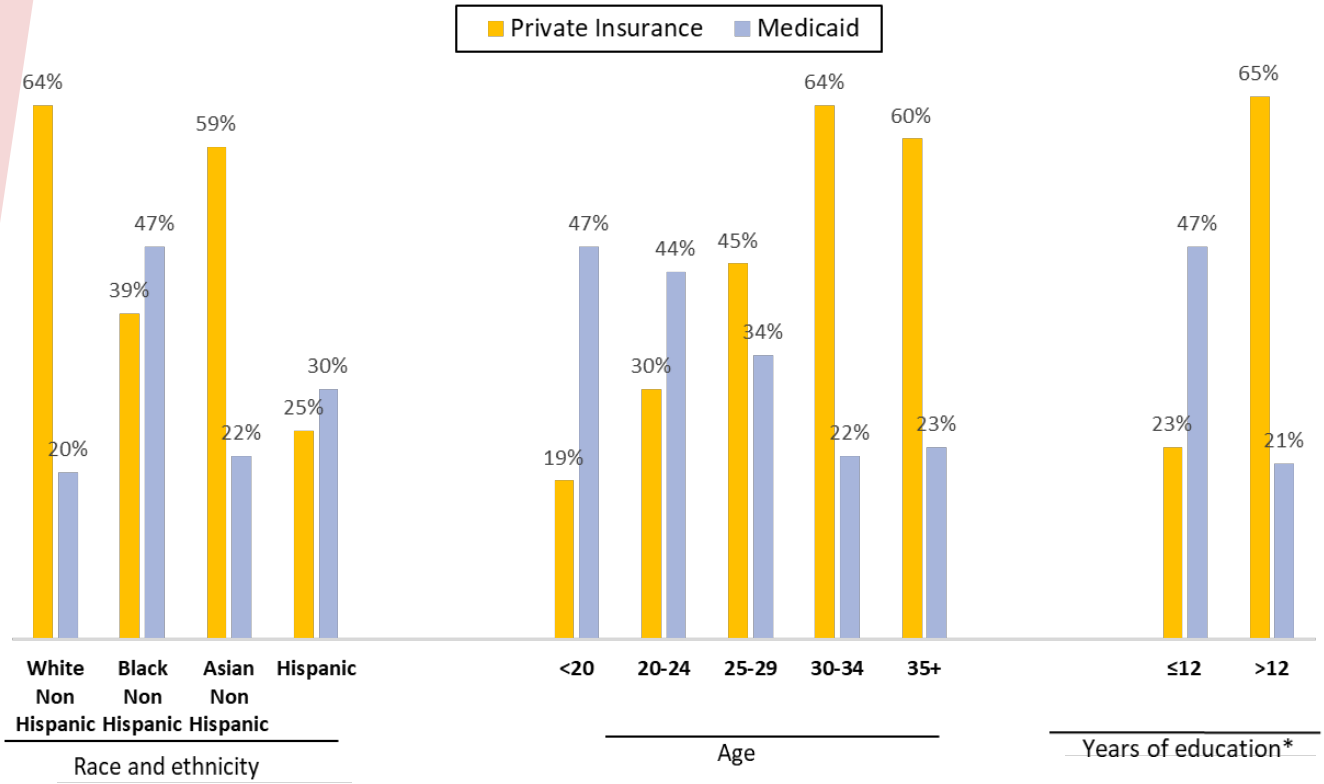


Figure 1 displays health insurance status before pregnancy reported by Maryland mothers who delivered between 2016-2020. Nearly half, 46%, reported having health insurance through work, one-fifth had Medicaid, and 15% had no insurance. Figure 2 displays health insurance status during pregnancy (source of payment for prenatal care): 46% again reported health insurance through work, however the prevalence of those with Medicaid increased compared with prevalence before pregnancy, from 20% to 31%. Additionally, prevalence of no insurance was lower, at 8%,. Figure 3 displays the prevalence of Medicaid coverage for births in Maryland between 2016-2020. Overall, the proportion of births covered by Medicaid remained steady at around one-third of all births, with a transient decrease to 28% in 2018.

Demographics

Figure 4 displays the percentage of Maryland mothers who identified either private insurance or Medicaid as a source of payment for prenatal care. Non-Hispanic White mothers had the highest prevalence of private insurance coverage (64%) followed by Non-Hispanic Asian mothers (59%); Hispanic mothers had the lowest (25%). Medicaid coverage was highest for Non-Hispanic Black mothers (47%) and lowest for Non-Hispanic White mothers (20%). Among age groups, Medicaid coverage was highest among the youngest age group of <20 years (47%), with decreasing prevalence among older age groups. Private insurance coverage demonstrated the opposite pattern. Less education (non-high school graduates) was associated with lower prevalence of private insurance and higher prevalence of Medicaid coverage (23% and 47% respectively) compared to the higher education group.

Figure 4. Percentage of Mothers Who Identified Private Insurance* or Medicaid as a Source of Payment for Prenatal Care



*Insurance through work, parents, or the marketplace

**Includes only mothers ages 20 and above

Prevalence of Select Maternal Factors by Insurance Status

Table 1. Factors Associated with Private and Medicaid Health Coverage for Prenatal Care, Maryland 2016-2020

Factor*	Private† (%)	Medicaid (%)
Folic acid, daily, one month pre-pregnancy	47	23
Unintended pregnancy	30	57
Any health care visit, pre-pregnancy	83	69
First trimester prenatal care	95	85
Late (third trimester) or no care	1	2
Tobacco use, last 3 months pregnancy	3	10
Partner abuse, before/during pregnancy	1	5
Dental cleaning during pregnancy	58	49
Symptoms of postpartum depression	5	10
Breastfed, ever	94	82
Breastfed, 8+ weeks	64	52
Infant sleep position, back	84	74
Postpartum contraception	77	77
Infant low birth weight (<2500g)	7	9
Preterm delivery (<37 weeks)	8	10

*All factors except postpartum contraception and preterm delivery were statistically significant at $p<0.05$ level for Chi-square test
†Private insurance through work, parents, or the marketplace

Compared with women with private insurance, women with Medicaid coverage for their prenatal care differed on several maternal health and infant factors (Table 1). Women with private insurance were significantly more likely to have reported taking daily folic acid one month prior to pregnancy, had a health care visit prior to pregnancy, and had a dental cleaning during pregnancy. Those with private insurance were additionally more likely to have initiated early prenatal care, breastfed their babies, and lay infants on their backs to sleep most often.

In contrast, women with Medicaid reported significantly higher prevalence of unintended pregnancy, late or no prenatal care. tobacco use during pregnancy, partner abuse, symptoms of postpartum depression, and low birth weight. Postpartum contraception use and preterm delivery were not significantly different between those with private insurance and those with Medicaid.

Conclusions

In PRAMS data from 2016-2020, nearly one-third of Maryland mothers reported Medicaid as a source of payment for their prenatal care. This percentage has remained relatively constant. Medicaid coverage was most prevalent among women who were Black, younger than 20 years, and non-high school graduates. The prevalence of those without insurance coverage during pregnancy was lower than the prevalence of those without coverage during the pre-pregnancy period, largely explained by women obtaining Medicaid during pregnancy,

Behaviors and stressors associated with adverse pregnancy outcomes such as insufficient pre-conception folic acid consumption, cigarette smoking, unintended pregnancy, late initiation or no prenatal care were significantly more prevalent among mothers who used Medicaid to pay for prenatal care. While Medicaid coverage importantly increases access to prenatal and postpartum care, critical gaps between mothers with Medicaid and those with private insurance still exist. Further, along with access to supports and services that address the social determinants of health, pre-pregnancy health insurance coverage needs improvement, as this coverage is a key component of ensuring women's' preventive and chronic health needs are met and risk factors are optimized.

Large numbers of women at high risk of poor pregnancy outcomes have their maternity care funded by Medicaid. Medicaid has been an invaluable partner within the state maternal and child health infrastructure to fund, design and implement cost effective programs and community services. Maryland has expanded Medicaid coverage for eligible pregnant women through 12 months postpartum, which is an important step to ensuring that maternal health is optimized throughout the reproductive life course. It will be important to continue to address the needs of the growing Medicaid population to improve the health of mothers and infants.

PRAMS Methodology

Data included in this report were collected through the Pregnancy Risk Assessment Monitoring System (PRAMS), a surveillance system established by the Centers for Disease Control and Prevention (CDC) to obtain information about maternal behaviors and experiences that may be associated with adverse pregnancy outcomes.

Each month, a sample of approximately 200 Maryland women who have recently delivered live born infants are surveyed by mail or by telephone, and responses are weighted to make the results representative of all Maryland births. This report is based on the responses of 5,217 Maryland mothers who delivered live infants between 2016 to 2020.

Limitations

The data in this report are based on the mother's perceptions and recall of their circumstances before, during and after pregnancy. PRAMS data is retrospective, and therefore subject to recall bias. The percentage of Medicaid births reported by mothers in the survey is similar to the percentage reflected on the birth certificate. The length of time women are enrolled prior to delivery was not determined. Further, Medicaid users included women who do not qualify for Medicaid except for labor and delivery (e.g. undocumented immigrants). This report presents only basic associations between risk factors and pregnancy intention. Interrelationships among variables are not described, and could explain some of the findings of this report.

References

1. Centers for Medicare and Medicaid Services (CMS). Medicaid and CHIP Beneficiary Profile: Maternal and Infant Health. December 2020. Available from: https://www.medicaid.gov/medicaid/quality-of-care/downloads/mih-beneficiary-profile.pdf
2. Institute of Medicine (US) Committee on the Consequences of Uninsurance. Health Insurance is a Family Matter. Washington (DC): National Academies Press (US); 2002. 6, Health-Related Outcomes for Children, Pregnant Women, and Newborns. Available from: https://www.ncbi.nlm.nih.gov/books/NBK221019/

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