

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.

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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 Knowledge-Panel, 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.

Table 1
Demographic profile of respondents in the 2012 and 2015 study samples

	2012	2015 ^a	p value
Unweighted <i>N</i>	4593	3407	
Age			
18–24	30.9	28.0	0.072
25–29	26.8	26.4	0.750
30–34	23.0	25.1	0.134
35–39	19.2	20.6	0.285
Marital status			
Married	47.7	45.3	0.146
Not married	52.4	54.7	0.146
Number of births			
0	48.4	51.6	0.048
1	21.6	20.6	0.440
2+	30.0	27.8	0.127
Race and ethnicity			
White, Non-Hispanic	58.7	56.9	0.263
Black, Non-Hispanic	13.6	13.8	0.890
Other, Non-Hispanic	8.5	9.4	0.409
Hispanic	19.2	20.0	0.069
Born in US	10.3	12.1	0.286
Not born in US	8.9	8.0	0.525
Employment status			
Not employed	37.7	34.9	0.075
Part time (1–34 h)	22.8	19.1	0.006
Full time (35+ h)	39.5	46.0	0.000
Highest degree			
Less than high school	5.8	9.6	0.000
High school	23.4	19.4	0.007
Some college	36.2	34.8	0.353
Bachelor's degree or higher	34.5	36.2	0.235
Income status			
≤ 138% of poverty	22.4	22.1	0.765
139+ %	77.6	78.0	0.765
Lived in Medicaid expansion state			
Yes	58.8	60.4	0.324
No	41.2	39.6	0.324

^a Simple logistic regression using year as the independent variable was used to assess differences between the two samples.

The proportion of women who were currently uninsured declined from 18.9% in 2012 to 11.5% in 2015 (Table 2), due to increased coverage in both private insurance and Medicaid. A larger proportion of women had been insured all of the last 6 months in 2015 than in 2012 (83.4% vs. 77.1%), and any reported gaps were more likely to be short ones.

While women in 2015 were more likely to have insurance, we did not find any changes in their access to care as measured on our survey. In both time periods, similar proportions of women had a regular health care provider (79%) or had made a visit in the last 6 months for a general health exam (47%–48%) or because they were sick (44%–45%) (not shown). Women in the most recent survey were asked how satisfied they were with their health care coverage and did not differ significantly in whether they were satisfied (rating of five or six on a 6-point scale) according to whether they had Medicaid (65.3%) or private coverage (69.5%, $p = .178$).

There were important differences in type of coverage according to poverty status and whether or not the woman

Table 2
Percentage distribution of type of health insurance, continuity of coverage and gaps in coverage, 2012 and 2015

	2012	2015 ^a	p value
Unweighted <i>N</i>	4593	3407	
Type of health insurance			
Uninsured	18.9	11.5	0.000
Private	66.1	69.5	0.033
Obtained through the exchange	na	5.3	
Medicaid	14.2	18.2	0.001
Other	0.8	0.8	0.939
Insured all of last 6 months	77.1	83.4	0.000
Among those without insurance in any of last 6 months			
Unweighted <i>N</i>	1036	506	
How long without insurance (months)			
1	7.7	15.9	0.002
2	5.5	5.7	0.888
3	7.8	9.4	0.423
4	6.7	6.6	0.954
5	2.6	7.2	0.011
6	69.7	55.1	0.000

na = not applicable.

^a Simple logistic regression using year as the independent variable was used to assess differences between the two samples.

resided in a state that had adopted the Medicaid expansion (Table 3). Women at or below 138% of poverty showed substantial declines in the proportion uninsured, 40.0% to 24.6%, due to increased Medicaid coverage. Substantially fewer women with incomes greater than 138% were uninsured in 2015 than in 2012. This group also experienced slight increases in both types of coverage, but neither was statistically significant.

Even prior to the implementation of the ACA, women in states that did not adopt the Medicaid expansion were more likely to be uninsured, 22.3% compared to 16.5% ($p = .002$, significance not shown). In Medicaid expansion states, there was a significant decline in the proportion of women who were uninsured due to an increase in Medicaid coverage. The decline in the proportion of women who were uninsured in nonexpansion states was only marginally significant ($p = .052$), though there was a significant increase in private coverage.

Among women at or below 138% of poverty residing in expansion states, the proportion uninsured decreased from 37.6% to 15.1%, as Medicaid coverage increased from 39.9% to 61.8%. In nonexpansion states, the proportion of women at or below 138% of poverty with private insurance increased from 26.1% to 36.3%. (Many of those between 100% and 138% of poverty were eligible for subsidized marketplace coverage in states that had not expanded Medicaid.)

The proportion of women who were uninsured declined significantly for all but a few groups when looking at additional demographic characteristics (Table 4). The exceptions were nonsignificant changes in the proportion uninsured for women aged 35–39, women without a high school degree and Latinas. Still, substantial disparities in

Table 3

Type of insurance coverage by poverty status, by whether the respondent lived in a Medicaid expansion state and by both, 2012 and 2015

	≤ 138% poverty		p	139 + % poverty		p	Expansion state		p
	2012	2015 ^a		2012	2015 ^a		2012	2015 ^a	
Unweighted N	1337	908		3256	2499		2846	2109	
Uninsured	40.0	24.6	0.000	12.8	7.8	0.000	16.5	7.3	0.000
Private	23.4	28.1	0.088	78.5	81.2	0.103	66.3	68.2	0.350
Exchange	na	5.6		na	4.5		na	4.5	
Medicaid	34.8	46.3	0.000	8.2	10.2	0.088	16.3	23.5	0.000
Other	1.8	1.1	0.334	0.5	0.7	0.480	0.9	1.0	0.773

uninsurance remained in 2015, particularly for non-White women, those employed less than full time and those with lower levels of education.

We used logistic regression to simultaneously examine associations between all characteristics and uninsured status. Relative to young adults, women in all other age groups were more likely to be uninsured once other factors were taken into account. Compared to White women, Latina women born in the US had twice the odds of being uninsured, and the odds for foreign-born Latinas were more than four times as high.

Women who lived in a nonexpansion state had twice the odds of being uninsured. After taking individual characteristics into account, the odds of being uninsured were reduced by half for women in 2015 compared to 2012.

Finally, in order to better understand factors associated with lack of insurance coverage among Latinas, we ran logistic regression models limited to this subgroup (not shown). The odds of being uninsured were about twice as high for immigrant women (odds ratio [OR], 1.88) compared to those born in the United States. Compared to Latinas in nonexpansion states in 2012, those in expansion states had .59 the odds of being uninsured during the same time period, and this difference became even more pronounced by 2015 (OR, .23, $p < .001$). However, in 2015, Latinas in nonexpansion states were no more or less likely to be uninsured than they were in 2012.

4. Discussion

This study provides further evidence that the ACA is increasing health care coverage and for women of reproductive age specifically. The proportion of women who were uninsured declined by nearly 40% between fall 2012 and spring 2015, driven by increases in both Medicaid and private coverage. These findings echo those of other studies looking at the broader US population [5,6,7].

Moreover, more women reported 6 months of continuous coverage, and among those reporting a gap, the gap was more likely in 2015 to last only 1 month. Reducing this “churn” promotes continuity of care and helps women afford

care — including often time-sensitive reproductive health care — when they need it.

This study also makes it clear that states’ decisions about whether to expand Medicaid matter greatly for health insurance coverage among women of reproductive age. Among women at or below 138% of poverty in states that implemented the ACA’s Medicaid expansion, the proportion uninsured dropped by 60%, while the proportion with Medicaid coverage increased by 55%. By contrast, we found no significant increase in coverage among low-income women in states that had not expanded Medicaid, although some of them obtained subsidized private coverage on the new marketplaces. Our regression analyses points to the same conclusion: The ACA has had a particularly strong effect in states that have expanded Medicaid. On a related note, women were roughly just as likely to be satisfied with Medicaid as with private coverage, contrary to frequent criticisms of Medicaid’s quality by ACA opponents.

In our study, women aged 18–24 were substantially less likely to be uninsured than older women, after controlling for other demographic factors. This finding echoes earlier studies, which estimated that an ACA provision allowing individuals to remain on a parent’s health plan until age 26 helped insure more than 2 million young adults [11].

Although nearly every demographic group has seen improvements in coverage since the ACA was implemented, real disparities persist. The trends for Latinas are particularly notable: They did not experience a significant increase in insurance coverage between 2012 and 2015. We also found that US-born Latinas had twice the odds of being uninsured as White women, and foreign-born Latinas had more than four times the odds. Taken together, our findings strongly suggest that federal restrictions on immigrant women’s eligibility for Medicaid and marketplace coverage are interfering with many Latinas’ ability to obtain coverage. Those restrictions may have indirect effects even for women who are eligible for coverage. For example, some US citizens and lawfully present residents may be wary of signing up for coverage because they fear that it will put undocumented family members at risk of deportation, despite assurances from the federal government to the contrary [12].

Table 3 (continued)

Type of insurance coverage by poverty status, by whether the respondent lived in a Medicaid expansion state and by both, 2012 and 2015

Nonexpansion state			≤ 138% poverty					
		p	Expansion state		p	Nonexpansion state		p
2012	2015 ^a		2012	2015 ^a		2012	2015 ^a	
1788	1319		803	563		534	345	
22.3	18.0	0.052	37.6	15.1	0.000	43.1	38.5	0.382
65.9	71.4	0.027	21.2	22.6	0.659	26.1	36.3	0.040
na	6.6		na	1.7		na	8.5	
11.2	10.1	0.520	39.9	61.8	0.000	28.4	23.3	0.261
0.6	0.5	0.672	1.3	0.5	0.207	2.4	1.9	0.731

^a Simple logistic regression using year as the independent variable was used to assess differences between the two samples.

We are aware of several potential shortcomings. Both samples were limited to women aged 18–39 and attempted to capture women most likely to be at risk of unintended

pregnancy. Moreover, while GfK maintains that its panel is nationally representative, only 53%–59% of eligible women aged 18–39 answered the four screening items that

Table 4

Percent of women uninsured, by selected characteristics and multivariable logistic regression model for uninsured status

	% Currently uninsured			Odds ratios	95% Confidence interval	p values
	2012	2015 ^a	p			
Unweighted N	4593	3407		7984		
Total	18.9	11.5	0.000			
Age						
18–24	20.3	11.0	0.000	1.00		
25–29	19.7	10.7	0.000	1.58	1.17–2.12	0.003
30–34	17.7	11.6	0.015	1.54	1.09–2.18	0.014
35–39	16.8	13.2	0.153	1.47	1.04–2.09	0.031
Marital status						
Married	16.0	9.8	0.000	0.71	0.55–0.92	0.009
Not married	21.6	13.0	0.000	1.00		
Number of births						
0	17.4	9.9	0.000	1.00		
1	17.3	9.6	0.002	0.66	0.50–0.89	0.006
2+	22.1	16.0	0.010	0.63	0.47–0.86	0.003
Race and ethnicity						
White, Non-Hispanic	12.8	6.3	0.000	1.00		
Black, Non-Hispanic	22.6	12.1	0.013	1.30	0.91–1.87	0.147
Other, Non-Hispanic	16.1	4.4	0.007	1.25	0.80–1.95	0.327
Hispanic	37.0	29.2	0.052	na		
Born in US	26.2	19.4	0.090	2.20	1.67–2.90	0.000
Not born in US	47.3	44.2	0.593	4.57	3.37–6.20	0.000
Employment						
Not employed	24.8	18.8	0.013	1.00		
1–34 h	21.4	12.8	0.003	1.00	0.76–1.30	0.987
35 or more hours	11.8	5.5	0.000	0.57	0.43–0.76	0.000
Highest degree						
Less than high school	44.1	33.3	0.098	1.00		
High school	30.1	18.7	0.001	0.81	0.57–1.17	0.258
Some college	19.2	10.0	0.000	0.49	0.34–0.71	0.000
Bachelor's or higher	6.8	3.4	0.004	0.22	0.14–0.33	0.000
Income status						
< 139% of poverty	40.0	24.6	0.000	2.12	1.67–2.69	0.000
139 + %	12.8	7.8	0.000	1.00		
Lived in Medicaid expansion state						
Yes	16.5	7.3	0.000	1.00		
No	22.3	18.0	0.052	2.01	1.64–2.47	0.000
Time period						
2012	na	na		1.00		
2015	na	na		0.50	0.40–0.61	0.000
Intercept	na	na		0.25	0.16–0.39	0.000

^a Simple logistic regression using year as the independent variable was used to assess differences between the two samples.

determined if they were eligible to participate in the study. Thus our samples cannot be considered to be nationally representative. Still, our findings are based on two national samples totaling 8000 women combined, and patterns are likely real and applicable to the national population of women of reproductive age. In addition, prior studies have documented that self-reported health insurance status is prone to measurement error [13], and this may be even more pronounced as individuals adjust to the ACA. However, patterns in private and Medicaid coverage follow those we would generally expect, suggesting many people answered the items correctly. In addition, we expect our measurement of uninsured is largely accurate as most individuals generally know whether they have coverage or not.

Overall, our findings provide evidence that the ACA has greatly expanded Medicaid and private coverage for reproductive age women and has reduced disparities in coverage, particularly for low-income women. This means that many more US women now have comprehensive coverage to help them afford a wide range of care.

Despite this progress, significant gaps remain, particularly in states that have not expanded Medicaid and for Latina women. These gaps would be reduced if all states took up the ACA's Medicaid expansion, Congress removed eligibility restrictions for immigrants and policymakers at the state and national levels took other steps to address barriers to eligibility and enrollment for Latinas, immigrants and other disadvantaged groups.

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