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The Dependent Coverage Provision Is Good for Mothers, Good for Children, and Good for Taxpayers

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Association of the Affordable Care Act Dependent Coverage Provision with Prenatal Care Use and Birth Outcomes

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IMPORTANCE The effect of the Affordable Care Act (ACA) dependent coverage provision on pregnancy-related health care and health outcomes is unknown.

OBJECTIVE To determine whether the dependent coverage provision was associated with changes in payment for birth, prenatal care, and birth outcomes.

DESIGN, SETTING, AND PARTICIPANTS Retrospective cohort study, using a differences-in-differences analysis of individual-level birth certificate data comparing live births among US women aged 24 to 25 years (exposure group) and women aged 27 to 28 years (control group) before (2009) and after (2011-2013) enactment of the dependent coverage provision. Results were stratified by marital status.

MAIN EXPOSURES The dependent coverage provision of the ACA, which allowed young adults to stay on their parent's health insurance until age 26 years.

MAIN OUTCOMES AND MEASURES Primary outcomes were payment source for birth, early prenatal care (first visit in first trimester), and adequate prenatal care (a first trimester visit and 80% of expected visits). Secondary outcomes were cesarean delivery, premature birth, low birth weight, and infant neonatal intensive care unit (NICU) admission.

RESULTS The study population included 1 379 005 births among women aged 24 to 25 years (exposure group; 299 024 in 2009; 1 079 981 in 2011-2013), and 1 551 192 births among women aged 27 to 28 years (control group; 325 564 in 2009; 1 225 628 in 2011-2013). From 2011-2013, compared with 2009, private

insurance payment for births increased in the exposure group (36.9% to 35.9% [difference, -1.0%]) compared with the control group (52.4% to 51.1% [difference, -1.3%]), adjusted difference-in-differences, 1.9 percentage points (95% CI, 1.6 to 2.1). Medicaid payment decreased in the exposure group (51.6% to 53.6% [difference, 2.0%]) compared with the control group (37.4% to 39.4% [difference, 1.9%]), adjusted difference-in-differences, -1.4 percentage points (95% CI, -1.7 to -1.2). Self-payment for births decreased in the exposure group (5.2% to 4.3% [difference, -0.9%]) compared with the control group (4.9% to 4.3% [difference, -0.5%]), adjusted difference-in-differences, -0.3 percentage points (95% CI, -0.4 to -0.1). Early prenatal care increased from 70% to 71.6% (difference, 1.6%) in the exposure group and from 75.7% to 76.8% (difference, 0.6%) in the control group (adjusted difference-in-differences, 0.6 percentage points [95% CI, 0.3 to 0.8]). Adequate prenatal care increased from 73.5% to 74.8% (difference, 1.3%) in the exposure group and from 77.5% to 78.8% (difference, 1.3%) in the control group (adjusted difference-in-differences, 0.4 percentage points [95% CI, 0.2 to 0.6]). Preterm birth decreased from 9.4% to 9.1% in the exposure group (difference, -0.3%) and from 9.1% to 8.9% in the control group (difference, -0.2%) (adjusted difference-in-differences, -0.2 percentage points (95% CI, -0.3 to -0.03)). Overall, there were no significant changes in low birth weight, NICU admission, or cesarean delivery. In stratified analyses, changes in payment for birth, prenatal care, and preterm birth were concentrated among unmarried women.

CONCLUSIONS AND RELEVANCE In this study of nearly 3 million births among women aged 24 to 25 years vs those aged 27 to 28 years, the Affordable Care Act dependent coverage provision was associated with increased private insurance payment for birth, increased use of prenatal care, and modest reduction in preterm births, but was not associated with changes in cesarean delivery rates, low birth weight, or NICU admission.

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The Affordable Care Act sought to increase the number of people in the United States with health insurance through a number of mechanisms. Most of the adults who obtained new coverage under the Affordable Care Act either did so through the health insurance exchanges or through the expansion of Medicaid in many states. Young adults had a third option: coverage on their parents' family plans until age 26 years.

The dependent coverage provision component of the Affordable Care Act requires private health insurance policies that cover dependents to offer coverage for policyholders' children through age 25 years. Since the dependent coverage provision's enactment in 2010, there appears to have been a significant reduction of uninsurance in this population with an increase in private coverage. The dependent coverage provision has also been linked to lower out-of-pocket health

care costs, increased health care access, greater use of behavioral health treatment, and higher self-reported health for young adults.¹

Nearly one-third of US births are to women between ages 19 to 26 years who are covered under the dependent coverage provision. Previous work has shown a significant increase in private insurance coverage and a significant decrease in Medicaid coverage of childbirth among women aged 19 to 26 years associated with the dependent coverage provision.² This in and of itself was an interesting result. Often, expansions in insurance coverage through reform have come in the form of “crowd-out.” In other words, public insurance coverage expands while private insurance contracts. But in this case, deliveries to those most affected by the dependent coverage provision showed the opposite.



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Moving beyond coverage, evidence of the dependent coverage provision's effect on more downstream outcomes on childbirth has remained unknown. However, in the February 13, 2018, issue of *JAMA*, Daw and Sommers³ reported on results of a retrospective cohort study of data from the Centers for Disease Control and Prevention natality files. They, too, found significant associations between the dependent coverage provision and increases in private insurance payment and a reduction in Medicaid payment for childbirth. They were also able to show that the dependent coverage provision was associated with increased rates of prenatal care and lower rates of preterm birth. Their study adds to the literature by showing for the first time, to our knowledge, the significant association of the dependent coverage provision with health outcomes for pregnant women and their children.

It is reasonable to believe that changes in insurance among reproductive-aged and pregnant women could lead to improved outcomes. Prior to the dependent coverage provision, low-income women were only eligible for health care coverage under Medicaid during pregnancy and immediately after childbirth. During this time, Medicaid was the largest financier of maternity services in the nation, paying for approximately 45% of all US births. However, uninsured pregnant women who became eligible for Medicaid as a result of their pregnancy often faced delays accessing prenatal care⁴ and had much more difficulty accessing care in the preconception period, if they could at all. Under the dependent coverage provi-

sion, women under age 26 years are eligible for insurance coverage regardless of their income or pregnancy status.

As with many young adults, pregnant women are at increased risk for poor health behaviors and conditions known to contribute to negative pregnancy outcomes. In 2016, almost 57% of women aged 18 to 25 years consumed alcohol, and 22.4% used tobacco, which are known risk factors for preterm birth, low birth weight, and fetal alcohol syndrome. Moreover, health conditions known to contribute to negative pregnancy outcomes (eg, diabetes, hypertension, asthma, obesity) affect more than a quarter of women of reproductive age.⁵ Although research supports the effectiveness of preventive services administered both prior to and during pregnancy in several areas in improving maternal and neonatal outcomes, the receipt of these services, particularly among low-income women, is low. In turn, births to low-income women are at increased risk of complications and adverse birth outcomes.⁶

Maternal mortality in the United States is high compared with other developed countries, as well as morbidities that have lasting effects on mothers and their children.⁷ We know from decades of work that adverse birth outcomes, including preterm birth, have serious health consequences across the life course. Prematurity is the most frequent cause of infant mortality, and infants born preterm have higher rates of health complications and lifelong disabilities. Many causes of morbidity and mortality in this population (eg, prenatal smoking, sexually transmitted infections, substance use, obesity, other chronic diseases) are addressable. This study³ demonstrates the effectiveness of health care expansion in ensuring that pregnant women receive adequate health care, a critical step in improving these outcomes.

These results do not come to us from a randomized clinical trial, of course, and causality is far from certain. However, given the relative rarity of the outcome and the ethical difficulties of randomizing people to insurance, studies like these may be the best evidence we get as to the benefits of the dependent coverage provision on outcomes for the next generation. It is also not clear how much the dependent coverage provision cost beneficiaries receiving care and those outside the risk pool who might be subsidizing it. Regardless, the dependent coverage provision appears to be the rare policy that seems to have improved outcomes without increasing the burden on taxpayers or broadening a public program.

ARTICLE INFORMATION

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