PREGNANCY RISK ASSESSMENT MONITORING SYSTEM

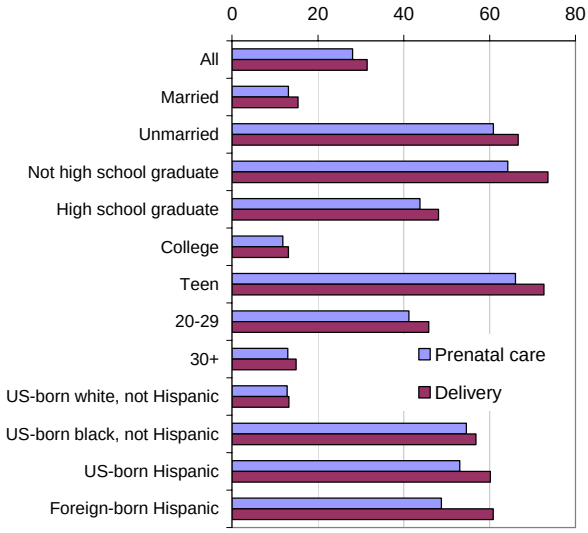
A survey for healthier babies in New Jersey

NJ-PRAMS is funded by the Centers for Disease Control and Prevention to help plan better health programs for New Jersey mothers and infants—such as improving access to high quality prenatal care, reducing smoking, and encouraging breastfeeding. ▫ One out of every 38 new mothers are sampled each month, when newborns are 2-6 months old, about their feelings and experiences before, during and after their pregnancy. ▫ From 2002 to 2005, 7,661 mothers were interviewed with a 72% response rate. Data for 2004-05 are preliminary. For more information about survey operations, see Summary of Survey Methodology for New Jersey PRAMS.

Health Insurance and Healthy Pregnancy

The challenges and opportunities surrounding America's health insurance system are highlighted by childbirth. Health insurance is a critical factor in receiving early and adequate *prenatal care*, the bundle of services that support a healthy pregnancy and newborn. Women who do not have privately funded health insurance may be enrolled in New Jersey FamilyCare, which combines the traditional Medicaid program for poor families and New Jersey's expanded program for near-poverty families partially funded by the Children's Health Insurance Program. The funding source affects cost sharing (premiums and copayments) only; the benefits and managed care contracts are the same. Previously uninsured women typically enter the FamilyCare program at the first medical encounter of their pregnancy. A wide variety of medical providers and facilities participate in FamilyCare, and many of those also treat uninsured women on sliding fee scales that are subsidized by state funds. New Jersey PRAMS, launched in 2002, improves our surveillance of health insurance and pregnancy-related health services.

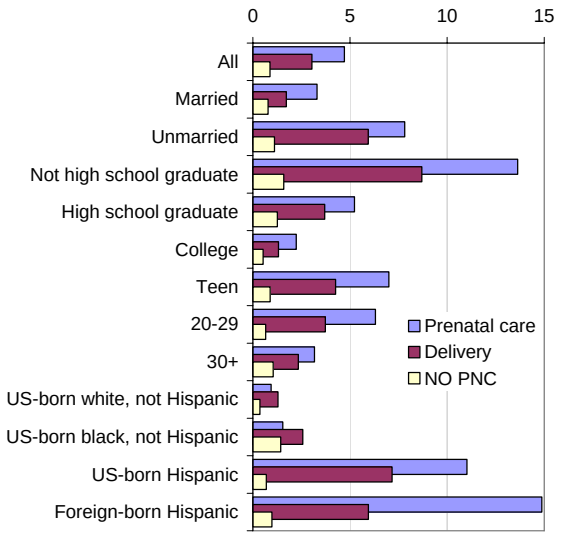
Figure 1. FamilyCare Coverage During Pregnancy and At Delivery (percent of live births)



Who Has Health Insurance Coverage for Pregnancy?

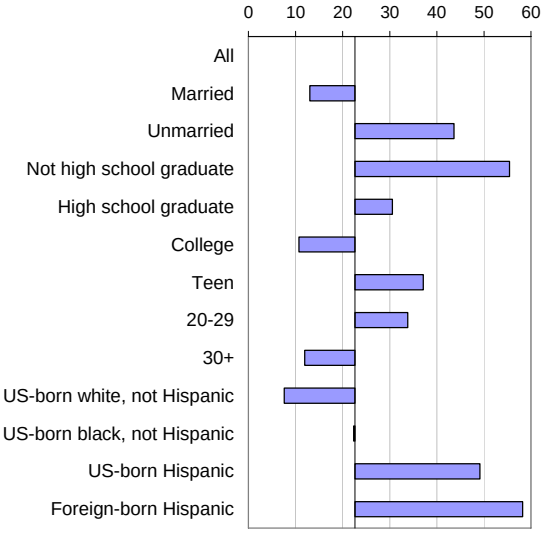
Based on self-reports, about two thirds (65%) of women who had a live birth from 2002 through 2005 were covered by private insurance for prenatal care services they received. Prenatal care for 28% of new mothers was reportedly paid for by FamilyCare. This left 5%, an estimated 5,000 births each year in New Jersey, with no insurance coverage for prenatal care. (Another 1% received no prenatal care; see below.) By the time of delivery, 32% of women were covered by FamilyCare, and 3% were still uninsured (about 3,200 annual births). Figure 1 indicates the rate at which different sociodemographic groups participate in FamilyCare. Figure 2 indicates the risk of being uninsured for the same groups.

Figure 2. No Insurance During Pregnancy and At Delivery (percent of live births)



The insurance gap starts before pregnancy: 22% of all new mothers, including 57% of FamilyCare enrollees, had no insurance prior to becoming pregnant. This amounts to an additional 16,600 women giving birth each year whose pre-pregnancy health may be compromised, and whose prenatal care may be delayed by lack of continuous insurance coverage. Important risk factors for no insurance coverage prior to pregnancy (relative to the 22% average incidence) are indicated in Figure 3.

Figure 3. No Insurance Prior to Pregnancy (percent)



Because of their higher risk and large share of all births, Hispanics accounted for two thirds of all mothers uninsured for prenatal care (evenly divided between native and foreign born); just under half were unmarried and/or had less than a high school education. Over half those uninsured before pregnancy were unmarried and/or Hispanic. One in nine were teens, and two in five were first-time mothers.

Timely Start of Prenatal Care

Among women with no insurance prior to pregnancy, 69% enrolled in FamilyCare for prenatal care and 13% obtained private insurance, while 17% remained uninsured. As shown in Figure 4, insurance status strongly influenced whether women started prenatal care in their first trimester, as recommended. Overall, 78% of women started prenatal care on time, but this ranged from 90% for women covered by private insurance to 60% for FamilyCare participants. In a separate PRAMS question, women who did not have continuous private coverage were up to a third less likely to say that they started prenatal care "as early as they wanted to." These women most frequently mentioned obtaining insurance coverage and arranging first appointments as the barriers to timely start of care.

Figure 4. Prenatal Care in First Trimester by Insurance During Pregnancy

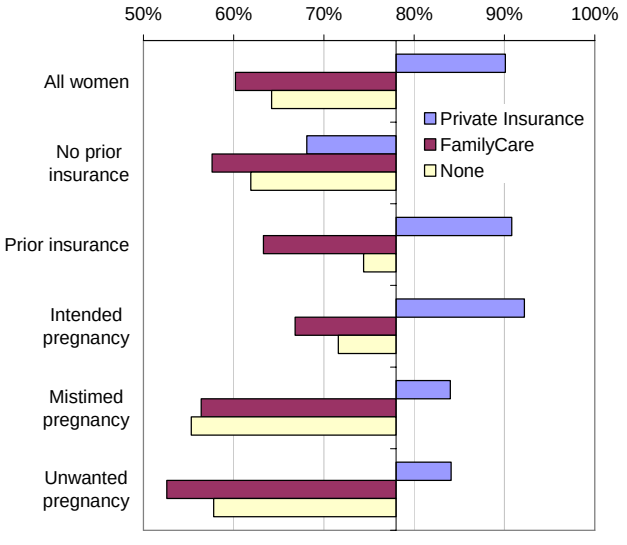


Figure 4 also illustrates the effect of unintended pregnancy on prenatal care. Women who said their pregnancy was mistimed (they wanted to be pregnant later) or unwanted were more likely to start prenatal care late. Women with unintended pregnancies were about 50% more likely to be uninsured both prior to and during pregnancy, and accounted for half of all mothers uninsured prior to pregnancy (data not shown). (Another NJ-PRAMS Data Brief addresses

unintended pregnancy in more detail.)

About 1% of women overall, about 1,000 each year, did not receive any prenatal care. We do not know their insurance status for their pregnancy, but 64% of these women had some type of health insurance prior to becoming pregnant. At the time of delivery, 47% of women with no prenatal care were covered by private insurance and 39% by FamilyCare; 14% had no health insurance.

Disparities in Perinatal Health and Delivery of Care

Insurance coverage during pregnancy was associated with some differences in maternal morbidity, as seen in Figure 5. FamilyCare enrollees reported higher rates of preterm labor, high blood pressure and several other complications (all self-reported) than the privately insured. FamilyCare women also reported higher rates of hospital visits resulting from these complications, including outpatient visits and admissions for seven days or less.

Insurance coverage during pregnancy had ambiguous effects on birthweight and preterm delivery. Among outcomes presented in Figure 6, the only statistically significant difference by insurance was for low birthweight among full-term infants. More detailed multivariate analysis (not shown) indicates that after adjusting for maternal age, marital status, race, Hispanic origin and number of previous live births, FamilyCare recipients were less likely than mothers with private insurance to deliver premature or low birthweight infants.

PRAMS asks women whether they recalled receiving health education on a number of specific topics during prenatal care. As shown in Figure 7, FamilyCare enrollees were 15-30 percentage points more likely than those with private insurance to report they were counseled on the impact of tobacco, alcohol and illegal drugs on pregnancy, the benefits of breastfeeding, and potential physical abuse (all differences shown are statistically significant). Women with private insurance were about 10% more likely to be counseled about screening for birth defects and safe medications during pregnancy.

Figure 5. Morbidity During Pregnancy
(* = significant different by insurance status)

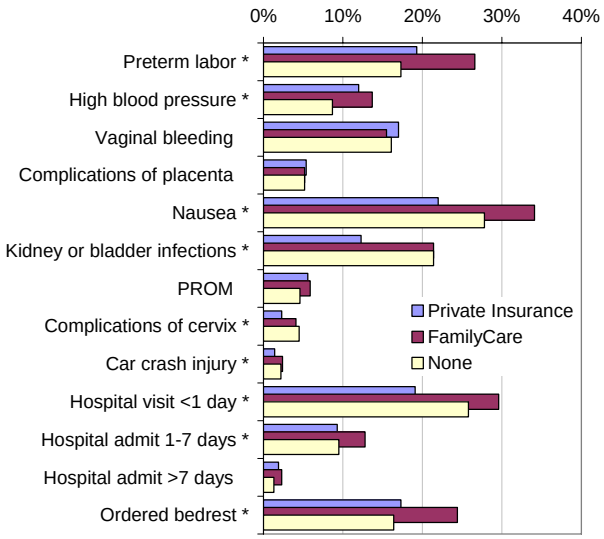


Figure 6. Infant Birth Outcomes

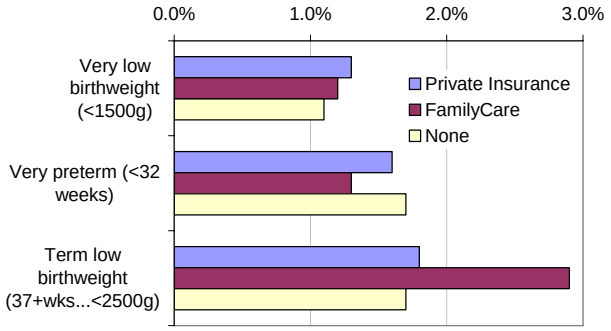
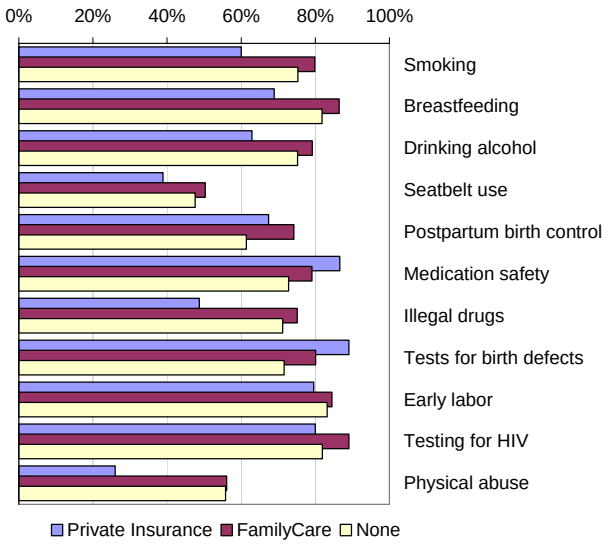


Figure 7. Content of Prenatal Care by Insurance Status



Agenda for Action

One in four New Jersey mothers depend on the publicly financed FamilyCare program for health insurance during pregnancy, and another 5% have no insurance coverage. One in five mothers has no insurance prior to pregnancy.

In general, lack of health insurance and intermittent insurance is associated with delayed or underutilized preventive services, more severe illness at the time of treatment, and poorer overall health outcomes. An unfortunate but typical chain of events—unintended pregnancy, delayed confirmation and new insurance enrollment— can significantly delay enrollment in prenatal care. Measures that streamline FamilyCare enrollment and the initiation of prenatal services are extremely valuable, and should be continued and intensified.

Lack of health insurance coverage prior to and between pregnancies also contributes to persistent poor health and untreated illness, including genitourinary infections, chronic disease, mental illness, and STIs. Two of the most common risk factors for adverse pregnancy outcomes, tobacco use and obesity, originate well before pregnancy and are most effectively treated then. Insurance coverage and regular medical care increases access to wellness resources and preconceptual counseling. The importance of universal health coverage for women in likely childbearing circumstances cannot be overemphasized.

New Jersey's FamilyCare and safety net service providers appear to be levelling insurance-related disparities in low birthweight and preterm birth. Nevertheless, we should continue to monitor for any potential insurance-related differences in perinatal health outcomes.

Health education is an important component of prenatal care. Universal rather than selective screening and counseling regarding tobacco, alcohol, domestic violence, HIV, proper seatbelt use, etc., is rapidly gaining credibility as "best practice" prenatal care. In this regard providers who serve both FamilyCare participants and the uninsured appear to achieve high standards. State contracting practices and priorities that support broad-based health education should be maintained; the diverse array of private insurance arrangements should adopt similar standards.

Resources

NJ FamilyCare home page: www.njfamilycare.org/

NJ Centers for Primary Health Care home page and facility locator: www.state.nj.us/health/fhs/cphc/

NJ Family Health Line, for health information and referrals: 800-328-3838

NJ Division of Medical Assistance and Health Services home page: nj.gov/humanservices/dmahs/about_dmahs.html

U.S. Health Resources and Services Administration, Maternal and Child Health Bureau, home page: mchb.hrsa.gov/

Kaiser Family Foundation, national insurance advocacy: www.kff.org/womenshealth/repro.cfm

Contact NJ-PRAMS

nj.gov/health/fhs/professional/prams.shtml

Lakota K. Kruse, MD MPH
Project Director.
Tel: 609-292-5656
Lakota.Kruse@doh.state.nj.us

Document compiled October 2006 by Charles E. Denk, PhD (NJ-PRAMS staff).