

How Does Health Insurance Buffer the Consequences of Intimate Partner Violence in Ohio?

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Intimate partner violence (IPV) is a significant public health issue. Among non-elderly adults in Ohio, it is more common than cancer or motor vehicle accidents. A growing research literature has documented the health-related consequences of such abuse, including depression, post traumatic stress disorder, and numerous physical and somatic symptoms.

Medicaid and other health insurers assume many of the health care costs associated with IPV. Unfortunately, most research on the topic has studied samples with only a single insurance provider. By studying a general population sample with different types of insurance, this study sought to understand how health insurance might buffer the association of IPV with health outcomes and care utilization. Using data from the 2008 and 2010 Ohio Family Health Survey (OFHS), our project had three specific aims:

1. to estimate the prevalence of IPV for people with different types of health insurance as well as for other select subgroups;
2. to describe the association of IPV with adverse consequences, including serious psychological distress, fair or poor self-rated health status, financial distress, unmet health needs and emergency room use; and
3. to determine if health insurance can buffer the association of IPV with health care utilization.

Methods

To address these aims we analyzed data from the Ohio Family Health Survey (OFHS) – a telephone survey of a random sample of Ohio adults including 8,276 respondents in 2010 and 50,944 in 2008. By using appropriate statistical methods, our findings are representative of all Ohio adults. Because IPV disproportionately affects women under 65, we focused most of our analyses on this group.

To measure IPV, we provided respondents with a definition of “intimate partner” and then asked “‘Has an intimate partner ever used physical violence against you? This includes hitting, slapping, pushing, kicking, or hurting you in any way.’” Those responding “yes” were classified as having lifetime experience of physical IPV and were then asked, “When was the last time an intimate partner used physical violence against you?” Those who reported that the violence occurred during the past 12 months were classified as having past-year physical IPV. Note that

the definition omits people who experience sexual and emotional abuse by an intimate partner but not physical abuse.

To measure health insurance, we used a hierarchical scheme devised by OFHS staff based on the answers provided by survey respondents. The mutually exclusive categories included uninsured, Medicaid, employer-sponsored insurance and other (e.g., directly purchased plans). Because women who have employer-sponsored insurance through a spouse may be less able to leave an abusive relationship compared to women who have insurance through their own employment, we distinguished these groups in our analyses.

Results

Our analyses yielded five key findings, each of which is summarized below. Please refer to the complete report² for more details.

Physical IPV is very common. Last year in Ohio, about 2.5% of women ages 18-64 were physically assaulted by an intimate partner. This means that conservatively, over 68,705 Ohio women were physically abused by an intimate partner last year, and the actual count may have been as many as 120,226 women. In comparison, about 51,007 Ohio women are injured in motor vehicle crashes and 30,550 are newly diagnosed with cancer each year.¹

Most Ohio women who experienced physical IPV were uninsured or on Medicaid. Among women who experienced physical IPV last year, roughly one third (36%) were uninsured and another third (32%) were on Medicaid, and one fifth (21%) had employer-sponsored insurance. Nonetheless, physical IPV affected women in every community and social class.

Physical IPV had significant adverse consequences. Physical IPV was associated with markedly higher rates of adverse consequences and health care utilization. For example, 19% of women who experienced IPV in the past year tested positive for serious psychological distress, compared to 7% who had never experienced abuse. These effects persisted over time – even women whose last reported episode of physical IPV occurred more than 5 years ago still had elevated levels of adverse consequences. Some of this association was likely due to

the influence of demographic factors like poverty, since lower socioeconomic status tends to be associated with both IPV and serious psychological distress. Yet even after controlling for such effects, women experiencing physical IPV were 30% more likely to have financial distress and 40% more likely to have serious psychological distress.

Health insurance reduced the impact of physical IPV on emergency room use. Even after accounting for the influence of poverty, marital status, age and other demographic factors, uninsured women who experienced physical IPV were 90% more likely to visit an emergency room compared to uninsured women who did not experience physical IPV. In contrast, abused women with employer-sponsored insurance were not more likely to visit an emergency room. Findings for women on Medicaid were less certain, as findings were inconsistent between the 2008 and 2010 OFHS data sets.

Physical IPV has the strongest association with unmet health needs among women who have employer-sponsored insurance through their own employer. After controlling for demographic factors, physical IPV was only marginally associated with having unmet health needs. This may be because other influences like poverty have such a pervasive effect, that the additional contribution of physical IPV is modest. Among women with employer-sponsored insurance through their own employer, however, physical IPV had a very strong association. Among such women, those who had experienced such abuse in the past year were more than twice as likely to have unmet health needs compared to women who had not experienced abuse.

Policy Implications

Relative to other well-established threats to health, physical IPV is remarkably common and is associated with significant adverse consequences. Far from being an overblown, socially-constructed problem, IPV represents a genuine threat to Ohio's families – as real as cancer. Because previous reports³ suggest that funding for relevant programs are inadequate for the scope of the problem, **Ohio should re-examine its investment in preventing and reducing IPV.**

Our findings suggest that certain state agencies and programs bear a disproportionate share of the costs and consequences associated with IPV. In particular, **Medicaid is uniquely well-positioned to help Ohio address IPV** since it covers nearly one third of all Ohio women who experience physical abuse each year. Moreover, Medicaid's ability to create standardized structures for health care providers across the state would facilitate the development of screening and intervention processes that can be evaluated rigorously.

Medicaid should also be concerned with IPV because of it ultimately shoulders much of the costs of treating the uninsured. Because the greatest potential cost savings from preventing IPV exist among the uninsured, Medicaid along

with hospitals and other providers and institutions that ultimately pay for the uninsured have much to gain from successful prevention of IPV. As such, they should play a leading role in supporting these efforts.

The possible savings from effective prevention of IPV may also be relevant when calculating the costs of current efforts to expand health insurance coverage to more Ohioans. If, as our results suggest, health insurance reduces the effects of physical IPV on emergency room use, then expanding coverage may yield additional cost savings that have not previously been considered. **Additional research linking claims data and other sources of IPV history (e.g., survey self-reports) would be worthwhile** for documenting the magnitude of such savings. This information could help determine what investments in IPV prevention could be cost-effective.

Although this study did not examine specific approaches to IPV screening in health-care settings, our findings offer some tentative support for this approach. The fact that abused women with employer-sponsored insurance are not more likely to visit an emergency room suggests that greater access to services can help interrupt violence before it becomes severe. As such, **screening for IPV in a wide range of health-care settings (e.g., urgent care centers, physicians' offices) may be useful for offering victims multiple opportunities to seek help.** We hope providers that offer such screening will continue to do so.

In many health-care settings, however, universal screening is impractical. **Further research linking claims data with other sources of IPV history may help providers identify particular constellations of risk factors (e.g., age, insurance type, presenting condition) that can guide selective screening that is both efficient and effective.**

Finally, private insurers may be particularly interested in our findings related to women with employer-sponsored insurance through their own employer. Unlike other women, physical IPV was strongly associated with unmet health needs in this group. **Employee health plans should consider IPV screening and intervention for women who report difficulty accessing services to meet their own health needs.**

As our findings indicate, research can help guide the development of thoughtful policies for IPV. We hope that future policy in this area will similarly lead to the development of opportunities for thoughtful research.

References

1. Health Policy Institute of Ohio. *Family Violence in Ohio*. Columbus, OH: Health Policy Institute of Ohio; 2010. See also, *Ohio Family Violence County Profiles: Sources and Methods* (pp. 22-23). www.hpio.net/familyviolence
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3. Health Policy Institute of Ohio. *White Paper on Preventing Family Violence in Ohio*. Columbus, OH: Health Policy Institute of Ohio; 2008. Available: www.hpio.net/familyviolence