Trends in Healthcare Access and Needs of Ohio Women of Reproductive Age

Yoshie H. Kim, MS[1]; Elizabeth H. Conrey, PhD, RD[2]
[1]*Ohio Colleges of Medicine Government Resource Center;*
[2]*Ohio Department of Health*

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INTRODUCTION

There is a growing awareness of the need to improve health outcomes for women of reproductive age (WRA) 19-44 years. While global maternal mortality rates have decreased significantly over the past two decades, the United States has seen an increase in maternal deaths over the same period[1]—falling behind the rest of the developed world in preventing pregnancy-related deaths.

Maternal health directly impacts infant mortality rates. Ohio has a high rate of infant mortality, compared to the nation.[2] In addition, studies indicate that midlife chronic disease is linked to a woman's experiences starting with gestation.[3] Hence, improving WRA's health and access to care can contribute to improving the health outcomes of Ohio's future population. Furthermore, early detection and prevention during a woman's reproductive years are important for addressing health issues in later years.

In 2014, Medicaid expansion through the Patient Protection and Affordable Care Act (ACA) allowed lower-income Ohio adults without dependent children to become eligible for Medicaid – this included WRA who did not have dependents. The WRA study analyses are stratified by racial/ethnic group in addition to health insurance type, as the most notable disparity in both maternal and infant mortality rates is defined by race.[a]

METHODS

OMAS is a telephone survey that samples both landline and cell phones in Ohio. The survey examines access to the health system, health status, and other characteristics of Ohio's Medicaid, Medicaid eligible, and non-Medicaid populations. In 2017, researchers completed 39,711 interviews with adults and 9,202 proxy interviews of children. The sample size for females ages 19-44, women of reproductive age, was 6,408. The 2017 OMAS is the seventh iteration of the survey.

For details, please see the OMAS methods at http://grc.osu.edu/OMAS.

KEY FINDINGS IN 2017

- The proportion of women of reproductive age (WRA) with health insurance increased from 2012.
- The proportion of WRA who reported having unmet health, dental, and vision decreased from 2012.
- Hispanic WRA had worse access and health status and more unmet needs compared to White or African-American WRA.
- Despite positive trends from 2012 regarding insurance status and access to care, the proportion of WRA utilizing healthcare went down.

Table 1. Proportion of Ohio WRA who have Health Insurance, by Age Group and Race/Ethnicity, 2012-2017			
	2012 (95% CI)	2015 (95% CI)	2017 (95% CI)
WRA - Overall, Age 19-44	83.0% (81.3 - 84.6)	92.3% (91.6 - 93.1)	90.7% (89.8 - 91.7)
White	84.6% (82.7 - 86.4)	93.8% (93.0 - 94.6)	92.2% (91.2 - 93.3)
Black	78.9% (74.1 - 83.8)	89.5% (87.1 - 91.9)	89.8% (87.3 - 92.4)
Hispanic	57.4% (47.6 - 67.1)	76.0% (70.3 - 81.7)	68.4% (61.8 - 75.0)

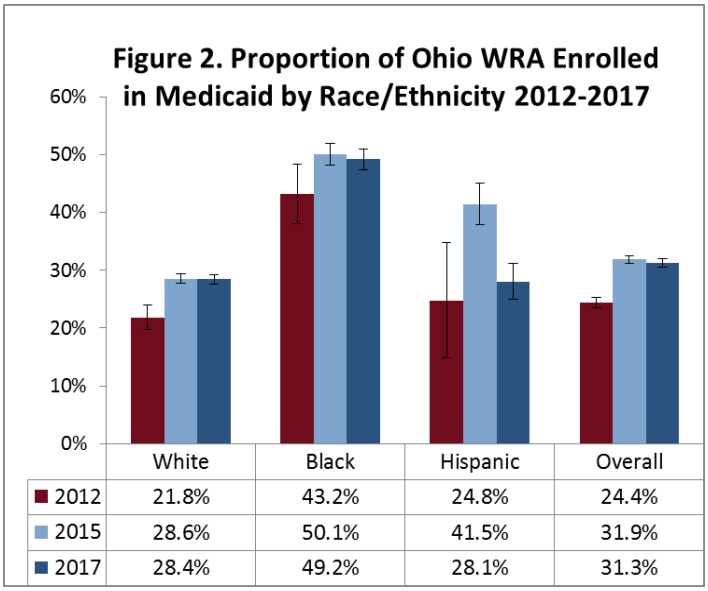
Source: 2012-2017 OMAS Series

RESULTS

Health Insurance Status and Medicaid Enrollment

Overall, the proportion of WRA with health insurance increased from 83.0% in 2012 to 90.7% in 2017. Table 1 shows trends in health insurance status, stratified by race/ethnicity. In 2017, Hispanic WRA were much less likely than White or African-American WRA to have health insurance. Whites had the highest proportion insured (92.7%), followed by African-Americans (85.6%) and Hispanics (67.6%).

Figure 2 shows trends in Medicaid enrollment, stratified by racial/ethnic group. Across all racial/ethnic groups, the proportion of WRA enrolled in Medicaid increased from 24.4% in 2012 to 31.9% in 2015, and then held steady in 2017 (31.3%). This trend held for both Whites (21.8%, 28.6%, and 28.4% respectively in 2012, 2015, and 2017) as well as for African-Americans (43.2%, 50.1%, and 49.2%). Among Hispanics, however, the proportion enrolled in Medicaid increased from 24.8% in 2012 to 41.5% in 2015, but then decreased to 28.1% in 2017.



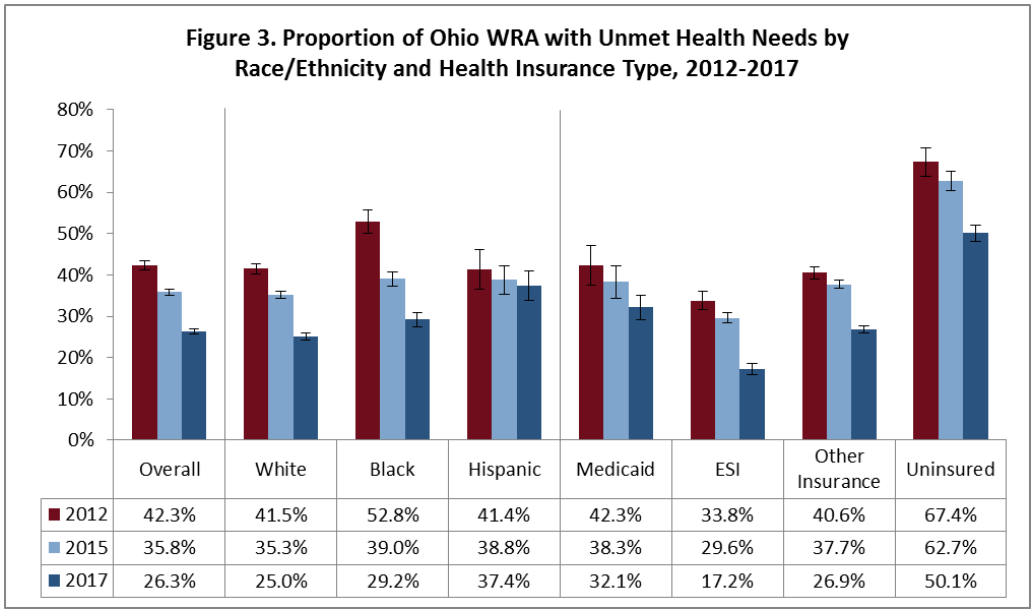
	White	Black	Hispanic	Overall
2012	21.8%	43.2%	24.8%	24.4%
2015	28.6%	50.1%	41.5%	31.9%
2017	28.4%	49.2%	28.1%	31.3%

Source: 2012-2017 OMAS Series

Unmet Health Needs

In 2017, 26.3% of WRA reported that they had a time in the past 12 months when they had dental, vision, mental or other healthcare needs but were unable to get it at the time. Figure 3 shows that in 2017, Hispanics had a higher proportion of unmet health needs (37.4%) compared to Whites (25.0%) and African-Americans (29.2%).

Uninsured WRA were also more likely to have difficulty obtaining needed healthcare, with half (50.1%) reporting that they had an unmet health need in 2017. This was nearly three times the percent of unmet health needs among WRA with employer-sponsored insurance (ESI). White WRA and WRA with ESI coverage were least likely to report having an unmet health need, 25.0% and 17.2% respectively.



	Overall	White	Black	Hispanic	Medicaid	ESI	Other Insurance	Uninsured
2012	42.3%	41.5%	52.8%	41.4%	42.3%	33.8%	40.6%	67.4%
2015	35.8%	35.3%	39.0%	38.8%	38.3%	29.6%	37.7%	62.7%
2017	26.3%	25.0%	29.2%	37.4%	32.1%	17.2%	26.9%	50.1%

Source: 2012-2017 OMAS Series

Across all racial/ethnic groups, the proportion of WRA who reported having unmet health needs decreased, from 42.3% in 2012 to 26.3% in 2017. The biggest change was seen among African-Americans (Figure 3) – a 23.6% point decrease in having unmet health needs, from 52.8% to 29.2%. This trend was least pronounced among Hispanic WRA, for which the

Table 2. Proportion of Ohio WRA with Difficulty Getting Needed Dental Care, 2012-2017			
	2012 (95% CI)	**2015** (95% CI)	**2017** (95% CI)
Overall	**20.0%** (18.2 - 21.7)	**17.2%** (16.1 - 18.3)	**15.0%** (13.9 - 16.1)
By Race			
White	18.6% (16.7 - 20.5)	16.5% (15.2 - 17.8)	13.6% (12.4 - 14.9)
Black	29.8% (24.6 - 35.0)	20.3% (17.3 - 23.2)	19.0% (16.0 - 22.0)
Hispanic	26.9% (18.0 - 35.9)	23.8% (17.7 - 29.8)	24.2% (18.0 - 30.5)
By Insurance Type			
Medicaid	20.5% (17.0 - 23.9)	21.8% (19.7 - 24.0)	18.6% (16.5 - 20.7)
Employer Sponsored	11.0% (9.1 - 12.9)	10.0% (8.7 - 11.3)	7.6% (6.4 - 8.7)
Other Insurance	22.0% (16.4 - 27.7)	17.5% (14.0 - 21.1)	17.0% (13.7 - 20.3)
Uninsured	42.7% (37.3 - 48.1)	43.9% (38.6 - 49.1)	36.1% (30.9 - 41.4)

Source: 2012-2017 OMAS Series

Table 3. Proportion of Ohio WRA with Difficulty Getting Needed Vision Care, 2012-2017			
	2012 (95% CI)	**2015** (95% CI)	**2017** (95% CI)
Overall	**15.1%** (13.6 - 16.7)	**13.0%** (12.0 - 14.0)	**10.4%** (9.4 - 11.3)
By Race			
White	15.1% (13.3 - 16.8)	12.4% (11.3 - 13.5)	9.1% (8.1 - 10.2)
Black	18.1% (13.7 - 22.5)	14.2% (11.7 - 16.8)	13.3% (10.7 - 16.0)
Hispanic	15.2% (8.0 - 22.4)	18.2% (12.5 - 23.9)	17.8% (12.2 - 23.3)
By Insurance Type			
Medicaid	15.5% (12.4 - 18.7)	15.6% (13.7 - 17.5)	12.8% (11.0 - 14.6)
Employer Sponsored	10.4% (8.5 - 12.2)	9.1% (7.8 - 10.3)	5.4% (4.3 - 6.4)
Other Insurance	12.9% (8.3 - 17.5)	12.0% (9.0 - 15.0)	12.7% (9.7 - 15.6)
Uninsured	29.2% (24.2 - 34.2)	28.6% (23.8 - 33.4)	23.7% (19.1 - 28.3)

Source: 2012-2017 OMAS Series

proportion reporting having unmet health needs remained relatively steady (41.4%, 38.8%, and 37.4% in 2012, 2015, and 2017 respectively). Stratifying by health insurance type, the greatest change was seen among the uninsured, with a 17.3% point decrease from 67.4% in 2012 to 50.1% in 2017.

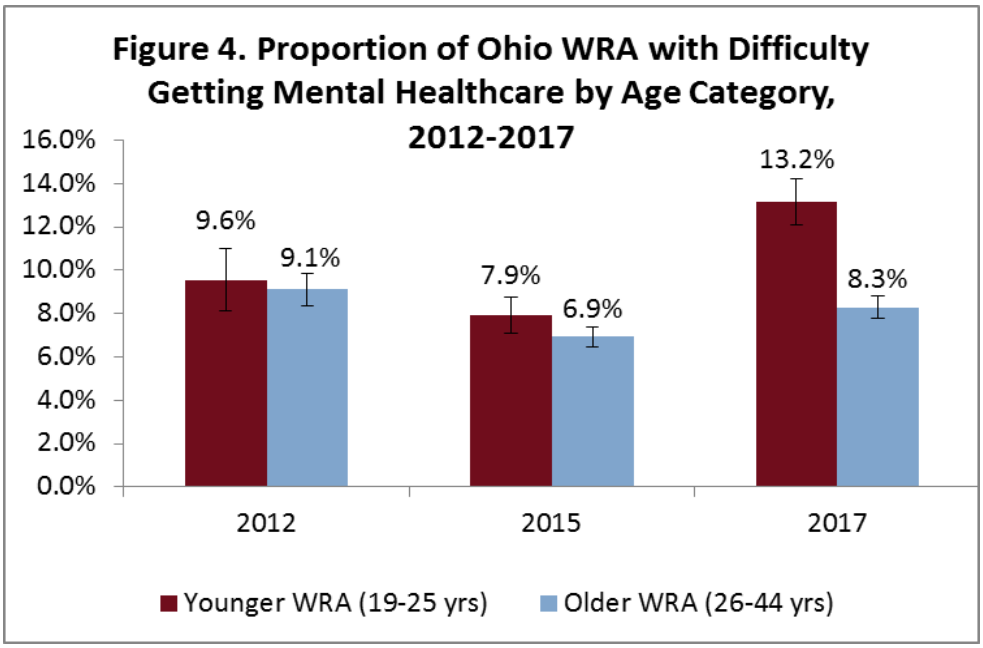
The findings were similar for the proportion of WRA reporting having unmet dental and vision care needs in the past 12 months (Table 2 and 3, respectively). Stratifying by race/ethnicity, Hispanic WRA had the highest proportion reporting having unmet dental needs in 2017 (24.2%), followed by African-Americans (19.0%), and Whites (13.6%). In addition, WRA with ESI were much less likely than WRA with Medicaid and other health insurance to report having unmet dental needs (7.6% vs 18.6% and 17.0% respectively), whereas uninsured WRA were more than four times likely as WRA with ESI to report having unmet dental needs. Overall, the proportion of WRA who reported that they had difficulty getting needed dental care in the past year decreased from 20.0% in 2012 to 15.0% in 2017.

The findings were similar for WRA reporting unmet vision care needs. The downward trend held true for all groupings for vision care, except for Hispanic WRA, whose proportions reporting having difficulties obtaining needed vision care went up slightly, from 15.2% in 2012 to 17.8% in 2017, and WRA with other health insurance, for which proportions remained fairly constant.

Table 4. Ohio WRA with Difficulty Getting Needed Mental Healthcare, 2012-2017			
	2012 (95% CI)	**2015** (95% CI)	**2017** (95% CI)
Overall	**9.2%** (7.9 - 10.5)	**7.2%** (6.4 - 8.0)	**9.7%** (8.7 - 10.6)
By Race			
White	10.0% (8.5 - 11.5)	7.1% (6.2 - 8.0)	9.7% (8.6 - 10.8)
Black	7.2% (4.2 - 10.1)	6.8% (4.9 - 8.7)	9.2% (7.2 - 11.3)
Hispanic	7.9% (3.5 - 12.3)	12.8% (7.6 - 18.0)	11.2% (6.7 - 15.7)
By Insurance Type			
Medicaid	10.2% (7.6 - 12.9)	8.6% (7.2 - 10.1)	11.9% (10.1 - 13.7)
Employer Sponsored	5.8% (4.3 - 7.3)	3.9% (3.1 - 4.8)	6.2% (5.1 - 7.3)
Other Insurance	7.8% (4.1 - 11.6)	9.6% (6.8 - 12.5)	10.2% (7.5 - 12.8)
Uninsured	18.3% (14.0 - 22.6)	19.1% (14.7 - 23.6)	18.5% (14.1 - 22.9)

Source: 2012-2017 OMAS Series

However, although the proportions of WRA with unmet health needs, in general, decreased over the past five years, we see a different trend regarding access to mental healthcare. Table 4 indicates steady or slightly increasing difficulty in getting needed mental healthcare for all groupings, stratified by race/ethnicity and health insurance type, from 2012 to 2017. For instance, the percent of African-American WRA who reported problems getting needed mental healthcare increased from 7.2% in 2012 to 9.2% in 2017. There were also age-related discrepancies in access to mental healthcare, particularly in 2017. In 2017, younger WRA, ages 19-25, were significantly more likely to report difficulty in getting needed mental healthcare than older WRA, ages 26-44 (Figure 4).



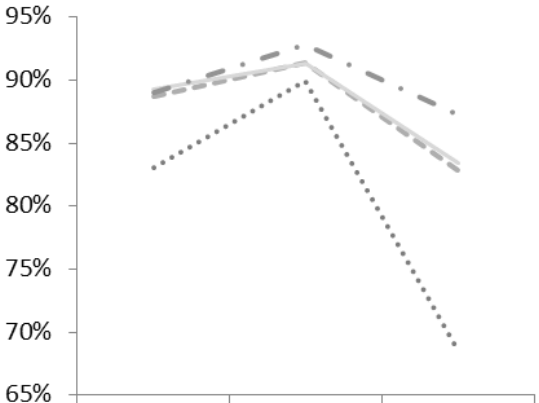
Source: 2012-2017 OMAS Series

Table 5. Ohio WRA with Usual Source of Care by Health Insurance Type, 2012-2017			
	2012 (95% CI)	**2015** (95% CI)	**2017** (95% CI)
Overall	**90.1%** (88.7 - 91.4)	**91.0%** (90.3 - 91.8)	**89.6%** (88.7 - 90.5)
Medicaid	90.7% (88.2 - 93.2)	91.7% (90.3 - 93.0)	90.6% (89.2 - 92.0)
Employer Sponsored	93.9% (92.4 - 95.5)	92.7% (91.7 - 93.8)	92.8% (91.7 - 94.0)
Other Insurance	89.9% (85.7 - 94.1)	89.4% (86.8 - 91.9)	86.5% (83.8 - 89.2)
Uninsured	78.5% (74.0 - 83.0)	80.1% (76.0 - 84.2)	75.2% (70.7 - 79.6)

Trends in Access and Utilization of Care

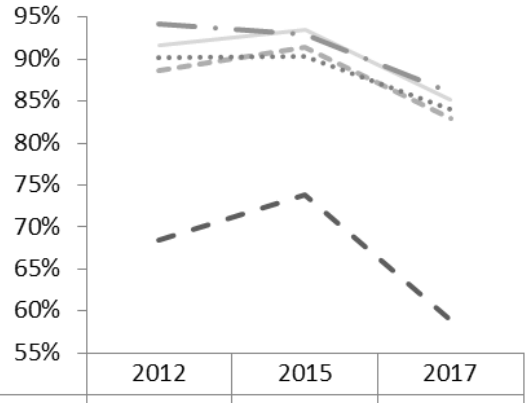
Table 5 shows the proportion of WRA reporting having a usual source of care, or a place they usually go to when sick or for advice about their health. Uninsured WRA were least likely to report having a usual source of care, with only 75.2% reporting that they had a usual source of care in 2017. In comparison, more than 90% of WRA enrolled in Medicaid and WRA with ESI reported having a usual source of care (90.6% and 92.8% respectively). The proportion of WRA with a usual source of care stayed the same or decreased slightly for all groupings stratified by health insurance type, from 2012 to 2017.

Figure 5. Proportion who saw Healthcare Provider in the Past 12 Months by Race/Ethnicity



	2012	2015	2017
Overall	88.7%	91.4%	82.9%
White	89.3%	91.3%	83.4%
Black	89.1%	92.9%	87.3%
Hispanic	83.0%	89.9%	68.6%

Figure 6. Proportion who saw Healthcare Provider in the Past 12 Months by Insurance Type



	2012	2015	2017
Overall	88.7%	91.4%	82.9%
Medicaid	91.6%	93.5%	85.1%
Job-based	94.2%	93.0%	86.0%
Other	90.3%	90.3%	84.0%
Uninsured	68.4%	73.8%	58.8%

Source: 2012-2017 OMAS Series

In comparison, 82.9% of WRA reported having seen a healthcare provider in the past 12 months in 2017 (Figure 5 and 6). African-American WRA had the greatest proportion reporting that they saw a healthcare provider, at 87.3%. On the other hand, Hispanics were least likely to have seen a provider in the past 12 months (68.6%). Stratifying by health insurance type (Figure 6), uninsured WRA were least likely to have seen a provider in the past 12 months (58.8%).

From 2012 to 2017, there was a 9.6% point decrease in the proportion of WRA who saw a healthcare provider in the past 12 months. Stratifying by race and ethnicity, the greatest decrease was seen among Hispanics, with a 14.4% point decrease from 2012 (83.0%) to 2017 (68.6%). WRA with ESI coverage saw the second to greatest decrease, with an 8.2% point decrease over the same time.

Health Status and Behaviors

Table 6 (on page 6) shows the proportion of WRA who smoked, had diabetes, hypertension, mental health impairment (MHI)[b], and were obese. In 2017, 5.4% of WRA reported having diabetes and 13.4% reported having hypertension. A greater proportion of African-American WRA were obese or had hypertension (47.1% and 19.0%, respectively), compared to White and Hispanic WRA. White WRA, in general, had lower prevalence of chronic diseases and negative health status compared to African-American and Hispanic WRA, except for smoking and MHI status. In 2017, more than a quarter (28.4%) of White WRA smoked and 8.3% had MHI.

The prevalence of smoking, diabetes, and hypertension declined overall from 2012 to 2017. For diabetes, the prevalence declined for Whites and Hispanics in particular; however, among African-Americans, the percent remained stable between 2012 (7.5%) and 2017 (7.6%). In contrast, obesity rates increased for all racial/ethnic groups, from 30.5% overall in 2012 to 34.2% in 2017. Overall, the prevalence of MHI increased slightly, from 7.4% in 2012 to 8.0% in 2017.

Table 6. Health Status and Behavior of Ohio WRA by Race/Ethnicity, 2012-2017			
	2012 (95% CI)	2015 (95% CI)	2017 (95% CI)
Currently Smoking			
Overall	29.4% (27.4 - 31.4)	25.1% (23.8 - 26.4)	26.9% (25.5 - 28.3)
White	31.2% (28.9 - 33.5)	26.7% (25.2 - 28.2)	28.4% (26.8 - 30.1)
Black	27.4% (22.4 - 32.3)	21.4% (18.4 - 24.5)	23.4% (20.2 - 26.6)
Hispanic	20.9% (13.4 - 28.5)	21.6% (15.5 - 27.8)	18.9% (13.7 - 24.2)
Obese			
Overall	30.5% (28.5 - 32.5)	33.2% (31.8 - 34.6)	34.2% (32.6 - 35.7)
White	29.9% (27.6 - 32.1)	32.3% (30.7 - 33.9)	32.2% (30.4 - 34.0)
Black	39.6% (34.2 - 45.0)	41.5% (37.9 - 45.1)	47.1% (43.2 - 50.9)
Hispanic	31.2% (21.5 - 40.9)	38.4% (31.3 - 45.5)	39.3% (31.9 - 46.7)
Diabetes			
Overall	6.8% (5.7 - 7.8)	7.1% (6.4 - 7.9)	5.4% (4.7 - 6.0)
White	6.6% (5.4 - 7.8)	7.0% (6.2 - 7.9)	4.8% (4.0 - 5.6)
Black	7.5% (4.8 - 10.2)	7.9% (6.0 - 9.8)	7.6% (5.7 - 9.4)
Hispanic	13.4% (6.6 - 20.2)	8.2% (5.4 - 11.0)	7.7% (3.6 - 11.7)
Hypertension			
Overall	15.8% (14.3 - 17.4)	14.0% (13.0 - 15.0)	13.4% (12.3 - 14.5)
White	15.6% (13.8 - 17.4)	13.1% (11.9 - 14.2)	12.5% (11.2 - 13.7)
Black	20.0% (15.8 - 24.1)	22.0% (19.0 - 25.0)	19.0% (16.2 - 21.9)
Hispanic	17.0% (9.2 - 24.8)	11.6% (7.0 - 16.1)	14.4% (9.5 - 19.3)
Mental Health Impairment*			
Overall	7.4% (6.3 - 8.6)	6.8% (6.1 - 7.6)	8.0% (7.1 - 8.8)
White	7.5% (6.2 - 8.8)	6.7% (5.9 - 7.6)	8.3% (7.2 - 9.3)
Black	8.2% (5.1 - 11.2)	7.5% (5.6 - 9.4)	6.6% (4.8 - 8.4)
Hispanic	8.3% (3.0 - 13.7)	8.3% (4.3 - 12.3)	8.7% (4.6 - 12.7)

*14+ days in the past month for which the individual was unable to perform usual activities due to a mental health or emotional problem

Source: 2017 Ohio Medicaid Assessment Survey

Medicaid Eligible Women of Reproductive Age

In 2017, there were 865,880 Medicaid eligible WRA (defined as those having a household income of ≤138% of the Federal Poverty Level). Among these Medicaid eligible WRA, 54.6% were enrolled in Medicaid, 21.1% had ESI coverage, 11.7% had other health insurance, and 12.6% were uninsured in 2017.

Table 7. Unmet Health Needs and Avoiding of Care by Medicaid Eligible WRA by Health Insurance Type 2017			
	Unmet Health Needs in Past 12 Months	Unmet Mental Health Needs in Past 12 Months	Avoided care in past 12 months
Overall	**33.9%**	**12.6%**	**37.2%**
Medicaid	33.1%	12.6%	35.6%
ESI	24.2%	7.7%	36.8%
Other	35.6%	13.5%	35.9%
Uninsured	52.4%	20.2%	45.9%

Source: 2017 Ohio Medicaid Assessment Survey

Table 7 indicates that uninsured Medicaid eligible WRA were more likely to have delayed or avoided care and have unmet health needs compared to their peers. In 2017, over half (52.4%) of uninsured Medicaid eligible WRA reported having unmet health needs compared to a third of Medicaid-enrolled WRA with unmet health needs. In addition, uninsured Medicaid eligible WRA were more likely to have avoided care in the past 12 months (45.9%) compared to Medicaid eligible WRA with Medicaid (35.6%), ESI (36.8%), and other health insurance (35.9%). In general, among lower-income Medicaid eligible WRA, those with ESI were the least likely to have unmet health needs and avoid care. Medicaid eligible WRA with other health insurance and Medicaid enrolled WRA had similar proportions with unmet needs and avoiding care.

CONCLUSIONS

Overall, there were positive trends in healthcare access and needs for Ohio WRA. A greater proportion of WRA had health insurance coverage in 2017 than in 2012. Furthermore, in general, the proportion of WRA who reported having unmet health, dental, and vision needs decreased. Although racial and ethnic disparities still exist, the gap between access to care between Whites and African-Americans narrowed. However, Hispanics had worse access and health status and greater unmet needs compared to Whites and African-Americans.

Despite seeing some positive trends regarding health insurance status and access to healthcare, the proportion of WRA utilizing care went down. WRA were less likely to have seen a provider in the past 12 months in 2017 than in 2012. Utilization of care may be bolstered by educating WRA on the importance of regular checkups for maintaining and improving their health.

POLICY CONSIDERATIONS

- The proportion of insured WRA increased from 2012 to 2015, while disparities between White WRA and African-American or Hispanic WRA decreased. Those improvements were largely maintained in 2017, with the notable exception of Hispanic WRA. As expected, Hispanic WRA were also less likely than other groups to have seen their healthcare provider in the past year. Policy makers may consider further examining these disparities.

- Unmet needs decreased steadily among WRA, and disparities declined between African-American and White WRA. However, the proportion of WRA with unmet needs, especially among Hispanic WRA and WRA with Medicaid, remain high. Areas of specific concerning include dental care and the rising unmet needs for mental health services. Policy makers may consider examining and addressing potential barriers to needed care through policy or program changes.

- A decline in smoking rates among WRA stalled between 2015 and 2017. In addition, while reported rates of diabetes and hypertension have fallen, obesity rates continue to rise for all WRA. Policy makers may consider boosting population efforts to reduce smoking and obesity among WRA.

References

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2. "National Center for Health Statistics." Centers for Disease Control and Prevention, Centers for Disease Control and Prevention, 11 Jan. 2018, www.cdc.gov/nchs/pressroom/sosmap/infant_mortality_rates/infant_mortality.htm.

3. Jacob, C. M., Baird J., Barker, M., Cooper, C., & Hanson, M. (2017). *The Importance of a Life Course Approach to Health: Chronic Disease Risk from Preconception through Adolescence and Adulthood* [White paper]. World Health Organization: https://www.who.int/life-course/publications/life-course-approach-to-health.pdf

Footnotes

a. WRA who are in the "other" race category have been left out of this brief due to the challenge of making generalized conclusions about this population. For many of the variables, WRA in the "other" race category had worse outcomes than White and African-American WRA.

b. Mental health impairment (MHI) is defined by having 14 or more days in the past month for which an individual was unable to perform usual activities due to a mental health or emotional problem.

FOR MORE INFORMATION

To view more information about OMAS and the findings in this policy brief, please visit the OMAS website at the Ohio Colleges of Medicine Government Resource Center: http://www.grc.osu.edu/OMAS.