# **Annotated Bibliography set 1**

# **Quantitative Research Study**

Solomon, J. (2021). Closing the coverage gap would improve Black maternal health. Center

on Budget and Policy Priorities, 26.

**Summary**

Solomon (2021) performed independent policy research and asserted that the primary way to decrease maternal mortality, medical morbidity, and healthcare racism towards women of color is to expand the Medicaid coverage gap in all states of America. Solomon's research hypothesis states that expanding Medicaid will allow women of reproductive age (19-49), low-poverty income women, and above-poverty income women to have Medicaid healthcare access during the preconception, prenatal, and post-delivery maternal stage. This research revealed that although many states under the Affordable Care Act have expanded Medicaid to adults whose income is below the 138 % poverty line, unfortunately, 12 southern states did not expand Medicaid. These states have higher rates of uninsured women of reproductive age and higher Black maternal mortality percentage.

Medicaid coverage is available when women become pregnant. However, Medicaid coverage is not available during preconception. Solomon's research elaborated that women being uninsured before pregnancy is related to risk factors that contribute to poor pregnancy outcomes, especially in black women. Nationally, in 2019, the infant mortality rate decreased(5.6% per live birth)  but increased double for infants of  Black women (11% per live birth). Furthermore, Solomon's research observed that maternal morbidity would significantly decrease if all states adopted the American Rescue Plan of expanding Medicaid coverage 12 months after the end of pregnancy. Without the extension, Medicaid only covers six months after the end of pregnancy.  Though legislation Medicaid has addressed prenatal and post-pregnancy maternal mortality and morbidity by allowing states the option to extend Medicaid coverage financially, many states have not taken up the option. Medicaid coverage only covers reproductive women during pregnancy and women with children, 40% percent of the poverty line (8,000 annual income single parent with two children). Medicaid does not cover reproductive women during preconception or women without children, regardless of income.

**Analysis**

Solomon (2021), Using reliable maternal statistics data from 2017-2021, states the similarities and differences in mortality and morbidity rates among Medicaid coverage states. The finding of research reveals sufficient data that providing Medicaid health coverage before a woman is pregnant and 365 days after will decrease mortality and morbidity for the mother. Based on policy research studied by a Senior fellow, the article is descriptive and well-researched, allowing for the observations of the different statistical data among specifically black maternal women. The researcher stated in a 2006-2017 Oregon study that the expansion of Medicaid decreased the maternal mortality rate because of increased Medicaid enrollment and timely and sufficient prenatal care. Solomon gives a brief statistical graph on the percentage of uninsured reproductive women Medicaid coverage gap from southern states that did not extend Medicaid. The statistical graph shows the overwhelmingly high percentage of Black women. However, Solomon needs to present detailed statistical data for other minority races, such as infant mortality and the statistical effects on Medicaid coverage care in southern states that did not expand Medicaid.

**Application**

# This source is highly relevant for discussing how healthcare access and the type of healthcare affect Black maternal women in America. The source will help elaborate on the impact of uninsured adult women of color leading to an increase in maternal mortality, maternal morbidity, and substance abuse disorders. Utilization of this article will allow me to show the association between insurance coverage and women's overall maternal health, especially Black women. Women who have access to healthcare prior to pregnancy will decrease the neglect of self-care, increase the utilization of healthcare, and address risk factors such as substance abuse disorder, hypertension, diabetes, smoking, and mental disorders.

**Quantitative Research Study**

Johnson, D. L., Carlo, W. A., Rahman, A. F., Tindal, R., Trulove, S. G., Watt, M. J., & Travers, C. P. (2023). Health Insurance and Differences in Infant Mortality Rates in the US. *JAMA Network and Open*, *6*(10), e2337690-e2337690.

**Summary**

Johnson et al. (2023) conducted a study to analyze infant mortality rates and maternal healthcare medical treatment associated with the maternal patient's type of insurance (private, Medicaid, or uninsured). Preconception, prenatal, and postnatal medical treatment can reduce health risk factors such as low birth rates, preterm births, breech vaginal births, infant mortality, and post-neonatal mortality. The result of the survey reveals that material women who have private insurance are associated with 50 % lower infant mortality rates than Medicaid maternal insurance counterparts.

**Analysis**

Johnson et al. (2023) used statistical analysis from a 2017-2020 epidemiologic research database from the Centers for Disease Control and Prevention (CDC) online data records. The study investigated approximately 13 million hospital-born infants aged 20 to 42 weeks and their maternal mother insurance type. The study did not consist of stillborn, congenital anomalies infants, or non-hospital-born infants. Using R statistical software, the National Center for Health produced the CDC WONDER data. The study used negative binominal regression to estimate the relative risk with a Confidence Interval (CI) of 95% to compare the analysis of maternal health outcomes between private insurance and Medicaid. The study's relative risks included race, infant sex, multiple births, gestational diabetes, gestational hypertension, eclampsia, educational level, and tobacco use.  The study compared the timeline of infant mortality from birth to 60 days after birth by insurance type. Unfortunately, the study does not provide evidence of why there is a higher risk of infant mortality rate amongst Medicaid-insured maternal women or consider other potential maternal factors such as self-pay patients, education, substance abuse, mental health, and physical health.

**Application**

This source is relevant to the effects of the kind of Maternal health care treatment determined by insurance (income) class. The study also provides significant information on infant mortality rates after birth.  Applying the cohort study statistical confidence interval may provide foundation evidence on the positive impact of insurance on maternal health. In contrast, the study can reveal equity bias treatment on maternal women's insurance type.   Observation of this source will build on one of the foundation questions: Why and what are the underlying equality treatment of care for Medicaid-insured or uninsured maternal women versus private insurance.