Workplace Accommodations for Pregnant Employees: Associations With Women's Access to Health Insurance Coverage After Childbirth

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Objective: This study evaluates the associations between workplace accommodations for pregnancy, including paid and unpaid maternity leave, and changes in women's health insurance coverage postpartum. **Methods:** Se-Secondary analysis using *Listening to Mothers III*, a national survey of women ages 18 to 45 years who gave birth in U.S. hospitals during 2011 to 2012 ($N = 700$). **Results:** Compared with women without access to paid maternity leave, women with access to paid leave were 0.4 times as likely to lose private health insurance coverage, 0.3 times as likely to lose public health coverage, and 0.3 times as likely to become uninsured after giving birth. **Conclusion:** Workplace accommodations for pregnant employees are associated with health insurance coverage via work continuity postpartum. Expanding protections for employees during pregnancy and after childbirth may help reduce employee turnover, loss of health insurance coverage, and discontinuity of care.

Learning Objectives

- Identify possible contributing factors and consequences of loss of health insurance coverage after childbirth.
- Summarize the new findings on the association between workplace accommodations, including maternity leave, on women's risk of losing health insurance after giving birth.
- Discuss the implications for policies related to workplace accommodations for pregnant women.

Labor force participation among women with young children (ages three or under) has nearly doubled from 34% in 1976 to 61% in 2014.[1,2] Maternal employment may contribute positively to maternal and child health by improving the physical and mental health of women.[3,4] Employment is associated with lower likelihood of depression, especially for women with supportive workplace environments.[3,5] Paid maternal employment also prevents wage loss, which in turn may reduce stress and increase the amount of financial resources women have to invest into their own and their children's health.[6,7]

Another important benefit of continued employment may be protection against the loss of health insurance following childbirth. As of 2015, 34% of working-age women in the U.S. were insured directly through their employers (ie, not through their spouses or partners).[8] Transitioning to a different employer or out of the labor market entirely could substantially affect women's access to health insurance and health care services after childbirth. In particular, women whose maternity care is provided through public programs such as Medicaid—which finances approximately 48% of pregnancies nationally, but covers pregnant women for only 60 days postpartum[9]—may face difficulties retaining health insurance coverage. As a consequence, women may experience either insurance ''churning''—transitions between different types of coverage, resulting in insurance gaps and discontinuity of care—or loss of coverage altogether.[10,11] This is especially the case in states that did not expand Medicaid eligibility during the implementation of the Affordable Care Act, which leaves women with incomes between the Medicaid eligibility threshold and 100% of the Federal Poverty Level (FPL)—at which point they become eligible for subsidized individual coverage through state-based Health Insurance Marketplaces—without affordable options for either public or private health insurance. Data from 2016 show that nearly one-fourth (24%) of adults in this ''coverage gap'' are parents of dependent children, and slightly more than half (52%) are women.[12] Maintaining health insurance coverage throughout pregnancy, childbirth, and the postpartum period plays an integral role in allowing women and infants to continue accessing needed health care services at a critical stage in the life course.[13,14]

One potential contributing factor to women's insurance continuity after childbirth is employer support in the form of accommodation during pregnancy. Some evidence suggests women's anticipation of workplace support to be associated with employee retention and return to work postpartum, which then protects their access to employer-based health insurance.[15,16] However, no known studies to date have directly and empirically examined the associations between employer accommodations during pregnancy, such as fewer physically demanding tasks or the anticipation of maternity leave availability, and changes in women's health insurance status after giving birth. Most research on family-friendly work environments focus mainly on policies during the postpartum period, such as flexible work hours and child care arrangements.[15,17] While paid maternity leave has been associated with return to work, most existing studies use older or non-U.S. data, which limits their generalizability to the conditions currently faced by U.S. women of childbearing age.[18,19]

Federal laws addressing accommodation of pregnant women in the workplace include (1) the Pregnancy Discrimination Act (PDA) of 1978, which includes pregnancy and childbirth, as conditions employers are banned from discriminating against during hiring, and (2) the Americans with Disabilities Act (ADA) of 1990, under which employers must provide reasonable accommodation for both occupationally and nonoccupationally related disabilities, including pregnancy- or childbirth-related conditions.[20,21] The 2008 Americans with Disabilities Amendments Act (ADAAA) greatly

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expanded the number of medical conditions that qualify as disabilities. As a result, many pregnancy-related medical conditions, even when temporary, are considered disabilities under the ADAAA and require employers to provide reasonable accommodation for women who are pregnant or returning to work from maternity leave.[22] Maternity leave is governed federally by the Family and Medical Leave Act (FMLA) of 1993, which requires employers with more than 50 employees to provide up to 12 weeks of unpaid, job-protected family leave each year to employees who have worked more than 1250 hours during the past 12 months.[23,24] However, strict eligibility criteria means that as many as 40% of employed women in the United States have no maternity leave available, and up to two-thirds also lack access to paid maternity leave.[25]

Protecting the health of pregnant women and families was established as a federal policy priority by several provisions of the Affordable Care Act (ACA) of 2010, which require the inclusion of maternity care as an ''essential benefit'' of health insurance, mandate workplace accommodations for breastfeeding, and no longer allow premium rating based on gender. As of 2015, 15 U.S. states and five cities have adopted laws requiring employers to provide reasonable accommodation to pregnant employees, and the Pregnant Workers Fairness Act, proposed to the U.S. Congress in 2013, would extend similar protections to women in all 50 states.[26,27] In addition, the U.S. Supreme Court decided in March 2015 to remand *Young v. United Parcel Service* (UPS) to the U.S. Court of Appeals, 4th Circuit, overturning previous district and appeals court rulings that UPS had not violated the PDA by refusing to accommodate a pregnant employee's request for tasks involving less heavy lifting during her pregnancy.[28]

Identifying workplace policies and practices that may influence women's access to health insurance after childbirth can help reduce insurance churning and gaps in coverage, producing potential long-term improvements in the health of women and children. This study uses data from a recent national survey of U.S. childbearing women to examine the association between workplace accommodations for pregnant employees—including the availability of paid and unpaid maternity leave—and changes in women's health insurance coverage postpartum, with consideration for the role of employment continuity. The results of this research are expected to produce useful information on the benefits of workplace accommodations to employers and policymakers interested in supporting women in the workplace.

METHODS

Data and Study Population

This study uses data from *Listening to Mothers III*, a national panel survey of English-speaking women ages 18 to 45 who gave birth to a singleton infant in a U.S. hospital between July 2011 and June 2012. Commissioned by Childbirth Connection and funded by the Kellogg Foundation, LTM3 consists of a core survey administered October to December 2012 ($N = 2400$) and a follow-up postpartum survey in January to April 2013, between 7 and 21 months after respondents had given birth ($N = 1072$). Respondents were drawn from four online panels maintained by Harris Interactive, Inc., a national market research firm, using probability-based sampling methods to create a nationally representative sample. Propensity score weighting was applied to all responses to offset any potential bias stemming from Internet use, as well as demographic variables, including age, race/ethnicity, level of education, household income, and geographic region. The sample population for this study was drawn from the postpartum survey, which contains all questions regarding women's workplace experiences before and after childbirth, and includes all 700 women who indicated they were working full- or part-time for an external employer during pregnancy.

Measurement

The main outcomes of interest included the loss of (1) private, (2) public, and (3) all health insurance (ie, becoming uninsured) between the time of childbirth and the postpartum survey. Respondents were asked to characterize the primary payer for their maternity costs (private insurance, public insurance, or out-of-pocket) and their health insurance status at the time of survey. Those who had private insurance at the time of childbirth and were publicly insured or uninsured at time of survey were considered to have lost private insurance coverage; those who switched from public to no insurance were considered to have lost public coverage; and those who had been privately or publicly insured at childbirth, but were uninsured at the time of survey, were considered to have lost all coverage.

Three main predictors were examined: unmet workplace accommodations during pregnancy, availability of unpaid maternity leave, and availability of paid maternity leave. Workplace accommodation is based on a series of questions asking whether respondents needed, requested, and were granted any of the following pregnancy-related accommodations: (1) ''a change in duties, such as less lifting or more sitting;'' (2) ''more frequent breaks, such as extra bathroom breaks;'' (3) a change in schedule or more time off, for example, to see prenatal care providers;'' or (4) ''some other type of workplace adjustment due to a pregnancy-related condition.'' Respondents described their experiences with each type of accommodation separately; owing to limited numbers of women reporting need for each individual accommodation, we created a single dichotomous variable indicating whether any needed accommodations were not addressed by their employers. To capture maternity leave availability, we created two dichotomous variables indicating whether or not each respondent reported having unpaid and paid maternity leave benefits available.

Covariates included the following socio-demographic and birth-related characteristics: age, race/ethnicity, education, household income, Census region, marital status, return to work with the same employer, mode of delivery, parity, maternal health pre-pregnancy, and whether the infant had stayed in a nenonatal intensive care unit (NICU) after birth. These covariates were selected on the basis of existing literature,[23,29] and each model was tested for goodness of fit.

Analysis

Sample characteristics were described using one-way tabulation. Two-way tabulation with design-based F-tests were used to identify significant differences in access to workplace benefits by each covariate. We then used a series of logistic regression models to determine the relationships between each type of workplace benefit (pregnancy-related accommodations, unpaid maternity leave, and paid maternity leave) and the three health insurance outcomes. Each insurance outcome was regressed on each of the three workplace accommodation variables without (Model 1) and with (Model 2) the covariate indicating return to the same employer, in order to assess the degree to which employment status may have mediated or moderated the relationship between workplace accommodations and health insurance coverage. All other covariates described above were included in all regression models. All analyses were weighted to be representative of the target population and conducted using Stata 11.2 (StataCorp LP, College Station, TX).

RESULTS

Out of 700 study participants, 31.6% needed at least one pregnancy-related accommodation that was not addressed by their employers, 70.3% had unpaid maternity leave available, and 63.9% had paid maternity leave available (Table 1). Nearly 10% of women became uninsured between the time of childbirth and survey, with 6% reporting that they lost private coverage and another 6% reporting that they lost public insurance coverage.

TABLE 1. Sample Characteristics ($N = 700$)

	N	% (weighted)
Accommodations and insurance		
Workplace accommodations		
Unmet accommodation while pregnant	227	30.6
Unpaid maternity leave available	507	70.3
Paid maternity leave available	444	63.9
Insurance outcomes		
Lost private insurance	45	6.2
Lost public insurance	37	6.0
Lost all insurance	67	9.8
Socio-demographic characteristics		
Age, yrs		
18–24	125	23.3
25–29	182	28.3
30–34	231	28.4
35 or older	162	19.9
Race/ethnicity		
White, non-Hispanic	469	63.2
Black/African-American, non-Hispanic	72	12.7
Hispanic/Latina	114	18.3
Other/Missing	45	5.8
Education		
High school or less	69	25.2
Some college/Associate's degree	231	29.6
Bachelor's degree	245	26.6
Graduate education/degree	155	18.7
Income		
≤$15,000 to $44,700	158	26.0
$44,701–$75,300	233	32.7
$75,301 and above	309	41.3
Census region		
Northeast	120	19.3
Midwest	172	22.8
South	244	38.5
West	164	19.5
Married at time of childbirth	524	71.2
Employment status		
Returned to paid work	549	78.7
Returned to same employer	488	69.7
Birth-related characteristics		
Mode of delivery		
Vaginal	497	69.1
Cesarean	203	30.9
First-time mother	371	46.1
Complex pregnancy*	236	35.5
NICU stay	115	19.8

*Complex pregnancy refers to any of the following conditions being present before pregnancy: depression, Type 1 or 2 diabetes, high blood pressure, or obesity (BMI ≥30 kg/m^2).

Respondents' experiences with workplace benefits differed significantly by socio-demographic and family characteristics (Table 2). Fewer women in the middle age ranges (25 to 29 and 30 to 34) had all their accommodation needs met ($P = 0.039$) than women in the youngest (18 to 24) and oldest (35+) age categories, as did women who were married at the time of childbirth ($P = 0.047$). Maternity leave availability varied largely by education and income, with highly educated women tending to have paid maternity leave available ($P = 0.045$) compared with those with a high school education or less, and high-income women tending to have both paid ($P < 0.001$) and unpaid ($P = 0.001$) leave available compared with women in the lowest income tertile. Women who indicated having paid or unpaid leave available tended to return to paid employment ($P < 0.001$), while those with unmet pregnancy-related accommodations tended not to do so ($P = 0.007$). Return to the same employer also differed across workplace benefits, with the lowest percentage of return found among women with unmet accommodations during pregnancy ($P = 0.020$), higher returns for those with unpaid maternity leave available ($P = 0.004$), and highest return rates among women with paid maternity leave available ($P < 0.001$).

Out of the three types of workplace accommodations we examined, only paid maternity leave availability significantly predicted insurance outcomes (Table 3). Women with paid maternity leave available were 0.43 times as likely to lose private health insurance coverage [95% confidence interval (95% CI), 0.2 to 0.9], 0.28 times as likely to lose public insurance coverage (95% CI, 0.1–0.9), and 0.25 times as likely to lose all health insurance coverage (95% CI, 0.1–0.5) compared with women who did not have paid leave available. Some of these associations, however, came via women's decision to return to the same employer after giving birth. When an indicator for returning to the same employer was added into the regression models, paid maternity leave availability was no longer significantly associated with loss of private health insurance, indicating that the relationship between paid leave availability and loss of private health insurance was mediated by employee retention. In contrast, the relationship between paid leave availability and loss of public coverage (such as Medicaid) or becoming uninsured is not mediated in this way. Specifically, the relationships between paid maternity leave availability and the loss of public insurance (AOR, 0.32; 95% CI, 0.1 to 0.9) and all health insurance (ie, becoming uninsured; AOR, 0.32; 95% CI, 0.2 to 0.7) remained significant even when the models accounted for returning to the same employer.

DISCUSSION

More than 2.5 million of the 4 million working U.S. women who give birth each year are employed during their pregnancies.[2,30] Our analysis shows that nearly one-third of these women are not receiving needed pregnancy-related accommodations from their employers, and over one-third have no paid maternity leave available. We also found that workplace accommodations during pregnancy, especially the availability of paid maternity leave, were significantly associated with women's likelihood of maintaining health insurance coverage postpartum. These results were robust when stratifying by full- versus part-time work status, suggesting that the association between paid leave availability and women's insurance outcomes is not confined to full-time workers.

This research builds upon previous literature indicating comprehensive maternity leave policies, including paid leave and longer leave duration, to be associated with population-level increases in women's employment rates in countries such as Norway and Sweden.[18,31] Continuity of employment may be particularly important to the U.S. context, given the large proportion of reproductive-age women who receive health insurance coverage directly through their employers. Switching to a different employer may lead to ''churning'' that may bring changes in health insurance networks and care providers, thereby disrupting care continuity.[11] This theoretical possibility is supported by our analysis, which suggests that returning to the same employer mediates the association between paid maternity leave availability and loss of private health insurance—that is, while paid leave availability significantly predicts a lower likelihood of private insurance loss, this association may be due to women with paid leave being more likely to return to their original employers postpartum and, as a consequence, keeping the private insurance coverage they had with that employer.

In differentiating between paid and unpaid maternity leave, we also add to the extant knowledge by showing the strength of association between women's outcomes and paid leave in particular—associations that are not significant when only unpaid maternity leave is available. The U.S. remains one of only three countries in the world with no national policy guaranteeing at least some paid leave following childbirth, leaving as many as 90% of women with

TABLE 2. Access to Workplace Accommodations by Socio-demographic Characteristics ($N = 700$)

	Unmet Pregnancy Accommodation ($n = 227$)	*P*	Unpaid Maternity Leave Available ($n = 507$)	*P*	Paid Maternity Leave Available ($n = 444$)	*P*
Age, yrs		**0.039**		0.347		0.551
18–24	16.8		21.5		23.4	
25–29	29.2		27.7		28.5	
30–34	37.1		31.0		30.2	
35 or older	17.0		19.8		17.9	
Race/ethnicity		0.441		0.627		0.356
White, non-Hispanic	68.7		65.4		60.0	
Black/African-American, non-Hispanic	10.2		11.5		14.1	
Hispanic/Latina	17.1		17.5		19.2	
Other/Missing	4.0		5.7		6.7	
Education		0.891		0.128		**0.045**
High school or less	23.9		23.2		20.9	
Some college/Associate's degree	28.9		27.7		29.3	
Bachelor's degree	26.5		28.0		28.4	
Graduate education/degree	20.6		21.1		21.4	
Income		0.673		**0.001**		**<0.001**
≤$15,000 to $44,700	27.9		22.3		23.3	
$44,701–$75,300	34.3		29.9		27.1	
$75,301 and above	37.8		47.8		49.7	
Census region		0.331		0.699		0.113
Northeast	17.8		17.8		16.5	
Midwest	26.2		23.4		23.5	
South	32.9		39.7		42.2	
West	23.1		19.2		17.9	
Married at time of childbirth	78.6	**0.047**	75.8	**0.006**	72.5	0.481
Employment status postpartum						
Returned to work	70.2	**0.007**	82.7	**<0.001**	80.1	**<0.001**
Returned to the same employer	61.4	**0.020**	76.3	**0.004**	86.5	**<0.001**
First-time mother	43.6	0.509	47.6	0.370	49.1	0.121
Complex pregnancy*	32.0	0.349	34.9	0.722	38.4	0.128
NICU stay	21.1	0.722	19.6	0.892	21.9	0.217

*Complex pregnancy refers to any of the following conditions being present before pregnancy: depression, Type 1 or 2 diabetes, high blood pressure, or obesity (BMI $\geq 30\ kg/m^2$).
Note: Bolded values are statistically significant at $P < 0.05$.

no access to paid family leave.[32,33] In addition to direct associations with maternal and infant health, supportive workplace policies such as the availability of paid family leave may also improve women's and children's access to health care services by facilitating continuity in women's employment and health insurance coverage at a critical time during the life course.

These findings have important implications for policy and practice. In particular, public policy approaches may ameliorate loss of health insurance coverage for women during the postpartum period, a crucial time for both maternal recovery and infant development. Compared with their international counterparts, women in the U.S. face a uniquely complex health insurance system. The ACA creates new opportunities for access to private health insurance through health insurance exchanges, employer and individual demand for coverage, and premium subsidies. Overall, these new coverage options improve the likelihood that a postpartum woman would have access to health insurance, but the transition between different types of coverage can be difficult. As many as 40% of adults experience churning between Medicaid, subsidized health insurance coverage through state exchanges, and uninsurance in a given year, which may lead to gaps in coverage and interruptions in access to health care services, as well as incurring high administrative costs.[34,35] Our analysis indicates that expanding family-friendly workplace policies may be one way of reducing insurance churning and gaps in coverage among women who are employed during their pregnancies. Paid maternity leave, in particular, is directly associated with retaining health insurance coverage, and may indicate both the values and priorities of particular employers as well as more robust state-level policies providing social welfare protection.

More supportive employers that offer benefits such as paid maternity leave may reap the rewards of this support via employee retention, while employees may gain more stable access to health care via continuous insurance eligibility. Although some direct costs are incurred by providing employees with paid family leave, nearly 10% of employers in states with paid leave policies, such as California, reported cost savings after paid leave legislation was passed, due to a reduction in cost shifting (ie, employees using paid sick leave and vacation days in the absence of paid family leave).[36] For employers seeking to balance the costs and benefits of family-friendly workplace policies, the results of this study may provide useful information on factors that contribute to women's employment-related decisions postpartum.

Both employer-based and public policies that prioritize work-family balance, therefore, could play an important role in promoting continuity in health insurance coverage, access to care between pregnancies,[29,37] postpartum mental health and adjustment,[38] and overall health and well-being.[39]

Study Strengths and Limitations

The *Listening to Mothers III* survey is unique in the level of detail regarding women's experiences of employer accommodations during pregnancy and provides the only recent data on a national sample of U.S. childbearing women. However, these data are

TABLE 3. Insurance Outcomes by Workplace Accommodation ($N = 700$)

	Lost private insurance ($n = 45$)					
	Model 1			Model 2†		
Workplace policies	AOR	95% CI		AOR	95% CI	
Unmet accommodation while pregnant	0.636	0.26	1.59	0.568	0.23	1.40
Unpaid maternity leave available	1.683	0.62	4.59	2.352	0.82	6.77
Paid maternity leave available	0.434*	0.21	0.89	0.573	0.26	1.27
	Lost public insurance ($n = 37$)					
	Model 1			Model 2†		
	AOR	95% CI		AOR	95% CI	
Unmet accommodation while pregnant	0.702	0.23	2.10	0.670	0.21	2.12
Unpaid maternity leave available	0.497	0.21	1.15	0.555	0.25	1.24
Paid maternity leave available	0.275*	0.09	0.85	0.324*	0.11	0.94
	Became uninsured ($n = 67$)					
	Model 1			Model 2†		
	AOR	95% CI		AOR	95% CI	
Unmet accommodation while pregnant	0.626	0.29	1.36	0.577	0.25	1.33
Unpaid maternity leave available	1.085	0.53	2.20	1.331	0.66	2.68
Paid maternity leave available	0.253***	0.12	0.54	0.318**	0.15	0.68

Note: All models adjusted for age, race/ethnicity, education, income, Census region, marital status, mode of delivery, parity, pregnancy complexity, and NICU stay.
*$P < 0.05$.
**$P < 0.01$.
***$P < 0.001$.
†Adjusted for return to the same employer postpartum.

limited in how they can be applied to the specific questions examined in this study. For example, survey questions asked only whether respondents' employers addressed their requests for accommodation, rather than the employer's broad policies on accommodations for pregnant employees. As previous studies show, the degree to which such accommodations are available can vary according to each individual employee's relationship with her supervisor, which potentially introduces an unobserved confounder into our analyses.[16] Future studies using surveys that include questions on both women's experiences and employer policies for workplace accommodations during pregnancy may provide detail that was beyond the scope of this study. In addition, the survey contained no information on the industry and occupation of respondents, the size and type of their employers, or spousal employment and insurance, all of which may play a role in women's decisions to return to work postpartum.[31] Recall bias is also possible, as all survey responses were based on retrospective self-report.

In addition, although the sample size was sufficient to detect statistically meaningful differences between groups for main outcomes, statistical interpretation was limited by available sample size for certain outcomes and exposures. For each of the insurance outcomes, available samples sizes ($n = 37$ to 67) limited the power of the analyses. In addition, sample size was not sufficient to analyze the impact of specific types of pregnancy-related workplace accommodations on employment and insurance outcomes. Changes in duties, more frequent breaks, and flexible scheduling are different enough in terms of availability and potential impact on employment outcomes that the aggregate variable may not capture more nuanced relationships. Moreover, endogeneity may be a concern in the logistic regression models, as the same unobservable factors that influence women's choice of employer—for example, generosity of benefits—may also determine whether they have access to insurance benefits postpartum. Future research using a prospective design may be better able to account for these challenges and produce causal estimates of the impact of workplace policies on health outcomes for pregnant employees.

Despite these limitations, the policy debates currently underway at the federal, state, local, and individual employer levels will benefit from the information this study provides. We present the first national data to examine the associations between workplace policies and health insurance coverage for women who gave birth in the post-ACA era. Our aim is for this study to serve as a basis for policy discussions and further research addressing the relationship between family-friendly work policies, employment, and health insurance coverage during major life transitions such as having a child.

CONCLUSION

Women who had access to workplace accommodations during pregnancy, especially paid maternity leave, were significantly more likely to keep their health insurance coverage after giving birth. Such accommodations may also influence the retention of skilled labor, a high priority for employers. Future research, possibly using larger samples and a prospective design, may provide more detailed analyses and causal estimates of the effects of workplace policies on women's access to health care postpartum, along with their overall health and well-being. Employers and policymakers may consider measures to expand access to workplace accommodations for pregnant women, including paid maternity leave, with the aim of improving employee retention and productivity, access to health care services, and continuity of care among childbearing women in the United States.

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