OBSTETRICS & GYNECOLOGY

NOTICE: This document contains correspondence generated during peer review and subsequent revisions but before transmittal to production for composition and copyediting:

- Comments from the reviewers and editors (email to author requesting revisions)
- Response from the author (cover letter submitted with revised manuscript)*

**The corresponding author has opted to make this information publicly available.*

Personal or nonessential information may be redacted at the editor's discretion.

Questions about these materials may be directed to the *Obstetrics & Gynecology* editorial office: obgyn@greenjournal.org.

Date: Dec 05, 2019
To: "Jamie Roberta Daw" [redacted]
From: "The Green Journal" em@greenjournal.org
Subject: Your Submission ONG-19-2013

RE: Manuscript Number ONG-19-2013

Racial and Ethnic Disparities in Perinatal Insurance Coverage A Cross-Sectional Study of the Pregnancy Risk Assessment Monitoring System, 2015-2017

Dear Dr. Daw:

Your manuscript has been reviewed by the Editorial Board and by special expert referees. Although it is judged not acceptable for publication in Obstetrics & Gynecology in its present form, we would be willing to give further consideration to a revised version.

If you wish to consider revising your manuscript, you will first need to study carefully the enclosed reports submitted by the referees and editors. Each point raised requires a response, by either revising your manuscript or making a clear and convincing argument as to why no revision is needed. To facilitate our review, we prefer that the cover letter include the comments made by the reviewers and the editor followed by your response. The revised manuscript should indicate the position of all changes made. We suggest that you use the "track changes" feature in your word processing software to do so (rather than strikethrough or underline formatting).

Your paper will be maintained in active status for 14 days from the date of this letter. If we have not heard from you by Dec 19, 2019, we will assume you wish to withdraw the manuscript from further consideration.

REVIEWER COMMENTS:

Reviewer #1: Daw and colleagues present a cross sectional study of PRAMS data evaluating racial and ethnic disparities in perinatal insurance coverage. I have the following questions/comments for the authors:

1- The abstract is clear and well written.

2- The PRAMS survey data is well administered through the CDC and affords the authors with a representative sample for the purposes of answering their interesting question.

3- Line 137 - The use the term "churning" is interesting. I think I know what you mean by this but it is not again referenced or explained and seems slangy. Is this a term that has become used in this area to discuss coverage changes academically? If so, define it in the text.

4- The use of previously used definitions for groups is appreciated to allow for comparison across studies.

5- The tables and figures are well designed and do aid in the understanding of the presented data.

6- Line 278 - The authors discuss not finding these differences in the higher socioeconomic group just above this section but this statement is not adjusted to account for the differences being the lower of the 3 economic strata. Please amend to acknowledge this finding.

7- Line 314-325, after comma - This is a more complex issue than can be thoroughly explored in the context of this paper and is not what this study was designed to prove. Bringing this into your discussion at this point in the paper distracts from the salient points that were identified.

8- Limitations are appropriately identified.

9- The implications for policy and practice could be more succinct. The editorial feel of this section could be minimized with increased brevity.

10- Line 407 - I would attribute this policy proposal differently so as not to distract from the point. Use the actual governmental terms.

Reviewer #2:

Study Summary:
This study's objectives were to report the association between insurance status and race/ethnicity in women participating in the CDC's Pregnancy Risk Assessment and Monitoring System (PRAMS) survey & insurance gaps that occurred in these patient populations. PRAMS surveys a representative sample of women who delivered live-born infants, via mail and telephone post-partum. Information includes demographic data, insurance status, healthcare utilization, healthcare outcomes before/during/after pregnancy & this study limited data to women with complete insurance information. This PRAM sample includes 107,921 women. The study defined insurance status at the following time points: preconception (month prior to conception), primary insurance for delivery and insurer at time of survey administration post-partum.

All racial/ethnic groups had higher rates of uninsured women compared to Non-Hispanic White women. Non-Hispanic White women had lowest rates of insurance disruption (~25%), followed by Non-Hispanic Black women (~45%), Hispanic English speaking women (~48%), Indigenous women (~50%) & Hispanic Spanish speaking women (~80%). In adjusted models, lower income Hispanic women & Indigenous women had higher predicted probabilities of being uninsured at pre-conception & post-partum compared to Non-Hispanic White women. Racial/ethnic differences in insurance status were attenuated by economic status (i.e. higher economic status decreased the racial/ethnic insurance disparities). The authors concluded that racial/ethnic differences in insurance coverage and insurance gaps may affect access to perinatal care and maternal-child health.

Overall Evaluation:
The authors have produced a generally well-written manuscript that contains information important to ACOG and its readers. My comments below do not represent major concerns, but are issues that warrant comment as the study as currently presented may have some flaws that affect the validity of some of its statements. Nonetheless, the manuscript serves to close current knowledge gaps in the literature regarding the association of race/ethnicity on both insurance status and insurance stability relative to pregnancy (pre-conception/delivery/post-partum).

Concerns

Abstract & Introduction: No concerns

Methods Section:
1. The authors note in the Discussion the 10 states not included in the PRAMS survey; it would be good to mention these specific states in the Methods section as well as the differences in length/type of coverage offered by those states compared to states that did participate in PRAMS.

2. I believe that the authors should strongly consider deleting the word 'churning' from the heading in line 138 unless the term can be better defined.

3. It was helpful that Lines 168-1179 explained the justification of the Hispanic Spanish speaking versus English speaking categories as a proxy for immigration status. It would be useful for the authors to cite literature in this paragraph defending use of language as a proxy for immigration status.

4. In line 154, the authors stated that they considered Indian Health Service coverage for Indigenous women to be in the 'uninsured' category. This warrants statements supporting that decision. Some might argue that this choice skews the data regarding insurance coverage for Indigenous women, as most Native Americans are covered by HIS and would seemingly have access to care. Given the potential for increasing the uninsured in this group, it would seem reasonable to also run the data including women with IHS coverage in one of the insured groups.

Results:
1. Post-partum survey responses included the timespan from 2-6 months post-partum. Given that, as the author's note, Medicaid coverage ends after 2 months post-partum, how do the authors think the lack of uniformity regarding time for reporting post-partum insurance coverage may have affected the results?

2. Was there a time difference in post-partum insurance responses between ethnic/racial groups? If there were group differences, how could this have affected the results?

3. Line 219: states that non-Hispanic White women had the lowest rates of uninsured at pre-conception (and 225 says the findings were similar post-partum). Is the <1% difference in the uninsured group comparing non-Hispanic White women and Asian/Pacific Islander women statistically significant? (the proportions seem quite similar)

4. See comment #4 under Methods; Again, the uninsured rates/point estimates for the Indigenous group of women may be grossly over-estimated if Indian Health Service coverage is considered "uninsured".

5. Data presentation that starts with Table numbers and Figures in the 1st sentences of each paragraph is a bit unusual;

but I defer to the editors regarding whether this formatting of the Results section requires editing or is acceptable as is.

Discussion:
1. The discussion is overly long and detailed. The word count is >1300 words and the journal limit is 750; would recommend shortening the Discussion section. Many points are valid and worthwhile but the section would benefit from further editing.

Reviewer #3:

Overall: This study utilizes the PRAMS database to document racial and ethnic disparities in insurance coverage for perinatal care. This is a straightforward study, but nevertheless one that makes an important and novel point, especially in terms of interruptions in coverage (as opposed to looking at a single point in time).

Strengths of the study include a focused research question, nationwide data, and a large, diverse study population. Weaknesses included self-reported insurance status, which may be prone to recall bias, and self-reported race and ethnicity status.

Introduction:
1. Several of the sentences in the first paragraph of the introduction do not have supporting citations - I would put your citations at the relevant sentence, not all at the end of the paragraph.

2. The introduction is a bit long - could some of this information be shifted to the discussion? In particular, while I appreciate the final paragraph in terms of stating a research question, some of this information could be condensed or shifted to the methods section.

Methods:
1. Does the Indian Health Service provide prenatal care? Or are these women truly 'uninsured'?

2. What did you use for weighting (line 182)? The included sampling weights?

3. As data are from states with different Medicaid eligibility criteria (both due to income and due to rules governing non-citizens, for instance), did you consider including fixed effects by state? Alternately, would you consider including a variable for whether a subject was eligible for Medicaid based on state of residence?

Results:
1. This section gets very long - summarizing the key results in the text, and leaving some of this information to the figures/tables, would be helpful. The figures are fantastic!

2. Please avoid the word 'meaningful' - I would use 'statistically significant'.

Discussion:
1. Some more information here (perhaps from the introduction) to document why having continuous insurance coverage is helpful would be appropriate here.

2. Another important point is just because a woman has Medicaid, she may still be subject to discontinuities in care, especially as many state plans have moved to HMOs and limit where women can be seen during pregnancy. Plans often will change providers mid-pregnancy, and thus, while a woman may be continuously insured, she may still experience disruptions in care. To the authors' credit, this is explained as a limitation of the study, but you could expand on this idea further, especially as these disruptions are also likely not random.

3. One final limitation is that some patients may have started their pregnancy in one state and ended in another, leaving them open to differential eligibility rules or to drop out of the survey sample. This is a 'disruption' in insurance that should 'count' as a disruption, but could also lead to sample selection bias.

STATISTICAL EDITOR COMMENTS:

The Statistical Editor makes the following points that need to be addressed:

lines 50-52: Did all 40 States have complete implementation of ACA-Medicaid during all years 2015-2017? If not, then should separately analyze those States with complete vs incomplete implementation or introduce another variable in the

analysis.

lines 131-134: If the unweighted sample was 107,921, then that sample cannot represent 5,963,153 women to the precision of an individual woman.

lines 146-147: Was this rate (88.3%) from all women in this category, or did this represent a sample of women in that category?

Table 1: Need units for age.

Fig 2: Just as a suggestion, why not format this figure like Fig 1, with histograms showing total of 100% for each racial/ethnic group?

Figs 1, 2, 3: Should include a concise description in the figure legends of the key statistical differences across ethnic/racial groups.

EDITOR COMMENTS:

1. The Editors of Obstetrics & Gynecology are seeking to increase transparency around its peer-review process, in line with efforts to do so in international biomedical peer review publishing. If your article is accepted, we will be posting this revision letter as supplemental digital content to the published article online. Additionally, unless you choose to opt out, we will also be including your point-by-point response to the revision letter. If you opt out of including your response, only the revision letter will be posted. Please reply to this letter with one of two responses:
A. OPT-IN: Yes, please publish my point-by-point response letter.
B. OPT-OUT: No, please do not publish my point-by-point response letter.

2. As of December 17, 2018, Obstetrics & Gynecology has implemented an "electronic Copyright Transfer Agreement" (eCTA) and will no longer be collecting author agreement forms. When you are ready to revise your manuscript, you will be prompted in Editorial Manager (EM) to click on "Revise Submission." Doing so will launch the resubmission process, and you will be walked through the various questions that comprise the eCTA. Each of your coauthors will receive an email from the system requesting that they review and electronically sign the eCTA.

Please check with your coauthors to confirm that the disclosures listed in their eCTA forms are correctly disclosed on the manuscript's title page.

3. Standard obstetric and gynecology data definitions have been developed through the reVITALize initiative, which was convened by the American College of Obstetricians and Gynecologists and the members of the Women's Health Registry Alliance. Obstetrics & Gynecology has adopted the use of the reVITALize definitions. Please access the obstetric and gynecology data definitions at https://www.acog.org/About-ACOG/ACOG-Departments/Patient-Safety-and-Quality-Improvement/reVITALize. If use of the reVITALize definitions is problematic, please discuss this in your point-by-point response to this letter.

4. Because of space limitations, it is important that your revised manuscript adhere to the following length restrictions by manuscript type: Original Research reports should not exceed 22 typed, double-spaced pages (5,500 words). Stated page limits include all numbered pages in a manuscript (i.e., title page, précis, abstract, text, references, tables, boxes, figure legends, and print appendixes) but exclude references.

5. Titles in Obstetrics & Gynecology are limited to 100 characters (including spaces). Do not structure the title as a declarative statement or a question. Introductory phrases such as "A study of..." or "Comprehensive investigations into..." or "A discussion of..." should be avoided in titles. Abbreviations, jargon, trade names, formulas, and obsolete terminology also should not be used in the title. Titles should include "A Randomized Controlled Trial," "A Meta-Analysis," or "A Systematic Review," as appropriate, in a subtitle. Otherwise, do not specify the type of manuscript in the title.

6. Specific rules govern the use of acknowledgments in the journal. Please note the following guidelines:

* All financial support of the study must be acknowledged.
* Any and all manuscript preparation assistance, including but not limited to topic development, data collection, analysis, writing, or editorial assistance, must be disclosed in the acknowledgments. Such acknowledgments must identify the entities that provided and paid for this assistance, whether directly or indirectly.
* All persons who contributed to the work reported in the manuscript, but not sufficiently to be authors, must be acknowledged. Written permission must be obtained from all individuals named in the acknowledgments, as readers may infer their endorsement of the data and conclusions. Please note that your response in the journal's electronic author form verifies that permission has been obtained from all named persons.
* If all or part of the paper was presented at the Annual Clinical and Scientific Meeting of the American College of

Obstetricians and Gynecologists or at any other organizational meeting, that presentation should be noted (include the exact dates and location of the meeting).

7. The most common deficiency in revised manuscripts involves the abstract. Be sure there are no inconsistencies between the Abstract and the manuscript, and that the Abstract has a clear conclusion statement based on the results found in the paper. Make sure that the abstract does not contain information that does not appear in the body text. If you submit a revision, please check the abstract carefully.

In addition, the abstract length should follow journal guidelines. The word limits for different article types are as follows: Original Research articles, 300 words. Please provide a word count.

8. Only standard abbreviations and acronyms are allowed. A selected list is available online at http://edmgr.ovid.com /ong/accounts/abbreviations.pdf. Abbreviations and acronyms cannot be used in the title or précis. Abbreviations and acronyms must be spelled out the first time they are used in the abstract and again in the body of the manuscript.

9. The journal does not use the virgule symbol (/) in sentences with words. Please rephrase your text to avoid using "and/or," or similar constructions throughout the text. You may retain this symbol if you are using it to express data or a measurement.

10. In your Abstract, manuscript Results sections, and tables, the preferred citation should be in terms of an effect size, such as odds ratio or relative risk or the mean difference of a variable between two groups, expressed with appropriate confidence intervals. When such syntax is used, the P value has only secondary importance and often can be omitted or noted as footnotes in a Table format. Putting the results in the form of an effect size makes the result of the statistical test more clinically relevant and gives better context than citing P values alone.

If appropriate, please include number needed to treat for benefits (NNTb) or harm (NNTh). When comparing two procedures, please express the outcome of the comparison in U.S. dollar amounts.

Please standardize the presentation of your data throughout the manuscript submission. For P values, do not exceed three decimal places (for example, "P = .001"). For percentages, do not exceed one decimal place (for example, 11.1%").

11. Please review the journal's Table Checklist to make sure that your tables conform to journal style. The Table Checklist is available online here: http://edmgr.ovid.com/ong/accounts/table_checklist.pdf.

12. The American College of Obstetricians and Gynecologists' (ACOG) documents are frequently updated. These documents may be withdrawn and replaced with newer, revised versions. If you cite ACOG documents in your manuscript, be sure the reference you are citing is still current and available. If the reference you are citing has been updated (ie, replaced by a newer version), please ensure that the new version supports whatever statement you are making in your manuscript and then update your reference list accordingly (exceptions could include manuscripts that address items of historical interest). If the reference you are citing has been withdrawn with no clear replacement, please contact the editorial office for assistance (obgyn@greenjournal.org). In most cases, if an ACOG document has been withdrawn, it should not be referenced in your manuscript (exceptions could include manuscripts that address items of historical interest). All ACOG documents (eg, Committee Opinions and Practice Bulletins) may be found via the Clinical Guidance & Publications page at https://www.acog.org/Clinical-Guidance-and-Publications/Search-Clinical-Guidance.

13. Figures 1–3: Please upload as separate figure files on Editorial Manager. If possible, please upload the original figure file (eps, tiff, jpeg), rather than pasting into a Word document.

14. Authors whose manuscripts have been accepted for publication have the option to pay an article processing charge and publish open access. With this choice, articles are made freely available online immediately upon publication. An information sheet is available at http://links.lww.com/LWW-ES/A48. The cost for publishing an article as open access can be found at http://edmgr.ovid.com/acd/accounts/ifauth.htm.

Please note that if your article is accepted, you will receive an email from the editorial office asking you to choose a publication route (traditional or open access). Please keep an eye out for that future email and be sure to respond to it promptly.

15. If you choose to revise your manuscript, please submit your revision through Editorial Manager at http://ong.editorialmanager.com. Your manuscript should be uploaded in a word processing format such as Microsoft Word. Your revision's cover letter should include the following:

* A confirmation that you have read the Instructions for Authors (http://edmgr.ovid.com/ong/accounts/authors.pdf), and
* A point-by-point response to each of the received comments in this letter.

If you submit a revision, we will assume that it has been developed in consultation with your co-authors and that each author has given approval to the final form of the revision.

Again, your paper will be maintained in active status for 14 days from the date of this letter. If we have not heard from you

by Dec 19, 2019, we will assume you wish to withdraw the manuscript from further consideration.

Sincerely,

Nancy C. Chescheir, MD
Editor-in-Chief

2018 IMPACT FACTOR: 4.965
2018 IMPACT FACTOR RANKING: 7th out of 83 ob/gyn journals

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Dear Editors,

Thank you for the opportunity to revise our manuscript. We believe that our paper has been substantially improved after revisions in response to the comments from the Reviewers and Editors. Our responses to each comment and the associated changes are listed below. All changes can also be reviewed in the "Track Changes" version of the revised manuscript.

Thank you again for your continued consideration of our manuscript,

Jamie Daw, PhD (corresponding author)

REVIEWER COMMENTS:

Reviewer #1:

Daw and colleagues present a cross sectional study of PRAMS data evaluating racial and ethnic disparities in perinatal insurance coverage. I have the following questions/comments for the authors:

1- The abstract is clear and well written.

2- The PRAMS survey data is well administered through the CDC and affords the authors with a representative sample for the purposes of answering their interesting question.

3- Line 137 - The use the term "churning" is interesting. I think I know what you mean by this but it is not again referenced or explained and seems slangy. Is this a term that has become used in this area to discuss coverage changes academically? If so, define it in the text.

Response: To avoid confusion, we removed the word "churning" from the manuscript.

4- The use of previously used definitions for groups is appreciated to allow for comparison across studies.

5- The tables and figures are well designed and do aid in the understanding of the presented data.

6- Line 278 - The authors discuss not finding these differences in the higher socioeconomic group just above this section but this statement is not adjusted to account for the differences being the lower of the 3 economic strata. Please amend to acknowledge this finding.

Response: Thank you for flagging this. We added more detail on the findings for the highest SES group to the Results, see page 12: "*For the highest income bracket, (≥400% FPL), we found higher uninsurance rates for Indigenous women at each time point. We did not find statistically significant racial-ethnic differences in uninsurance for Black*

non-Hispanic or Hispanic women in the highest income bracket." Given that Indigenous disparities persisted in the highest income bracket, we did not modify the opening sentence of the discussion.

7- Line 314-325, after comma - This is a more complex issue than can be thoroughly explored in the context of this paper and is not what this study was designed to prove. Bringing this into your discussion at this point in the paper distracts from the salient points that were identified.

Response: Thanks for this note and the suggestion to keep our discussion focused directly on our findings. As part of our extensive edits to the discussion section, we removed these lines.

8- Limitations are appropriately identified.

9- The implications for policy and practice could be more succinct. The editorial feel of this section could be minimized with increased brevity.

Response: In response to this comment and those of the other reviewer's, we removed editorial language and edited the discussion for brevity.

10- Line 407 - I would attribute this policy proposal differently so as not to distract from the point. Use the actual governmental terms.

Response: We removed the mention of the Department of Homeland Security's public charge rule as part of our edits to the discussion.

Reviewer #2:

Study Summary:
This study's objectives were to report the association between insurance status and race/ethnicity in women participating in the CDC's Pregnancy Risk Assessment and Monitoring System (PRAMS) survey & insurance gaps that occurred in these patient populations. PRAMS surveys a representative sample of women who delivered live-born infants, via mail and telephone post-partum. Information includes demographic data, insurance status, healthcare utilization, healthcare outcomes before/during/after pregnancy & this study limited data to women with complete insurance information. This PRAM sample includes 107,921 women. The study defined insurance status at the following time points: preconception (month prior to conception), primary insurance for delivery and insurer at time of survey administration post-partum.

All racial/ethnic groups had higher rates of uninsured women compared to Non-Hispanic White women. Non-Hispanic White women had lowest rates of insurance disruption (~25%), followed by Non-Hispanic Black women (~45%), Hispanic English speaking women (~48%), Indigenous women (~50%) & Hispanic Spanish speaking women (~80%). In adjusted models, lower income Hispanic women & Indigenous women had higher predicted probabilities of being uninsured at pre-conception & post-partum compared to Non-Hispanic White women. Racial/ethnic differences in insurance status were attenuated by economic status (i.e. higher economic status decreased the racial/ethnic insurance disparities). The authors concluded that racial/ethnic differences in insurance coverage and insurance gaps may affect access to perinatal care and maternal-child health.

Overall Evaluation:
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Concerns:

Abstract & Introduction: No concerns

Methods Section:
1. The authors note in the Discussion the 10 states not included in the PRAMS survey; it would be good to mention these specific states in the Methods section as well as the differences in length/type of coverage offered by those states compared to states that did participate in PRAMS.

> **Response:** We provide the list of excluded states under the Limitations section on page 16: "*the 2015-2017 PRAMS included data from 40 states, excluding Arizona, California, Florida, Idaho, Indiana, Minnesota, Mississippi, Nevada, North Carolina and South Carolina.*"

In response to this comment, we have also added the median Medicaid eligibility thresholds for parents and adults in included and excluded states to this section to help readers better generalizability, see page 14: *"The median income thresholds for Medicaid eligibility in 2019 are also similar in included and excluded states (138% FPL and 102% FPL for low-income parents, respectively, and 206% and 199% for pregnant women, respectively).[32]"*.

2. I believe that the authors should strongly consider deleting the word 'churning' from the heading in line 138 unless the term can be better defined.

Response: We removed the word 'churning' from the heading and throughout the manuscript per this suggestion and in response to point #3 from Reviewer #1.

3. It was helpful that Lines 168-1179 explained the justification of the Hispanic Spanish speaking versus English speaking categories as a proxy for immigration status. It would be useful for the authors to cite literature in this paragraph defending use of language as a proxy for immigration status.

Response: Thanks for this comment. In response, we added an additional explanation and citations relevant to using language as a proxy for nativity/acculturation, see page 8: *"Language is one of the most frequently used, and strongest predictors of, acculturation[15], and has been used as a proxy for nativity or acculturation in other studies of health disparities among Hispanic populations in the U.S.[16]"*

4. In line 154, the authors stated that they considered Indian Health Service coverage for Indigenous women to be in the 'uninsured' category. This warrants statements supporting that decision. Some might argue that this choice skews the data regarding insurance coverage for Indigenous women, as most Native Americans are covered by HIS and would seemingly have access to care. Given the potential for increasing the uninsured in this group, it would seem reasonable to also run the data including women with IHS coverage in one of the insured groups.

Response: Thanks for this noting this concern, this is an important point to clarify. The IHS provides a system of health care delivery, largely primary care, not health insurance. Indigenous people who rely solely on IHS often lack access to needed services, and do not have insurance to obtain health care at non-IHS providers. Thus, individuals who rely solely on IHS for care without any form of health insurance coverage are classified by the U.S. Census as uninsured. This is also how insurance is classified in major national surveys such as the National Health Interview Survey and in previous analyses of the PRAMS.

In response to this comment, we added additional references and explanation regarding this on page 8: *"Consistent with the U.S. Census[18], other national surveys[19], and previous analyses of the PRAMS[15], women who reported only Indian Health Service (IHS) were also classified as uninsured. The only exception was Alaska, where the IHS response option on the PRAMS included other state-specific programs, and thus was classified as Medicaid.[15]"*

Results:

1. Post-partum survey responses included the timespan from 2-6 months post-partum. Given that, as the author's note, Medicaid coverage ends after 2 months post-partum, how do the authors think the lack of uniformity regarding time for reporting post-partum insurance coverage may have affected the results?

> **Response:** This is an important question. As the reviewer also notes in point #2 below, if there is differential timing of the survey response across race-ethnicity categories, this could bias the results. For example, if more non-Hispanic white women return the survey at two months (while still eligible for pregnancy Medicaid) than non-Hispanic black women, this may result in a difference in insurance status which is only a function of the timing of the survey. See our response below to point #2 below.

2. Was there a time difference in post-partum insurance responses between ethnic/racial groups? If there were group differences, how could this have affected the results?

> **Response:** The PRAMS begins reaching out to women in the second month after birth, so very few women return the mail survey within this time period. Overall 97% of women completed the survey 3 or more months after delivery, after which pregnancy Medicaid coverage would have ended. We now note this in the Methods, see page 6: *"Nearly all women (97.1%) completed the survey three or more months after childbirth."*
>
> There was a significant difference in the distribution of women completing the survey within 2 months across race-ethnicity categories (chi-square test, p-value<0.05), however, these differences are small in magnitude and not large enough to account for the disparities found.

Race-ethnicity	**% Completed <= 2 months**
White non-Hispanic	3.3
Black non-Hispanic	3.0
Hispanic, Spanish	1.3
Hispanic, English	1.6
Asian/Pacific Islander	1.8
Indigenous	1.4
Other/Mixed/Unknown	2.9

3. Line 219: states that non-Hispanic White women had the lowest rates of uninsured at pre-conception (and 225 says the findings were similar post-partum). Is the <1% difference in the uninsured group comparing non-Hispanic White women and Asian/Pacific Islander women statistically significant? (the proportions seem quite similar)

> **Response:** Thanks for noting this confusing language. In response to this comment, we modified the sentence to be clear we are not suggesting that the difference between non-Hispanic White women and Asian/Pacific Islander women is statistically significant. See

page 10: *"The unadjusted rate of uninsurance at preconception was 9.4% (95% CI: 9.0-9.8) among white non-Hispanic women."*

4. See comment #4 under Methods; Again, the uninsured rates/point estimates for the Indigenous group of women may be grossly over-estimated if Indian Health Service coverage is considered "uninsured".

Response: Please see response to point #4 under Methods above. We adhere to the insurance classification approach taken by the U.S. Census Bureau, the National Center for Health Statistics and the Centers for Disease Control and Prevention.

5. Data presentation that starts with Table numbers and Figures in the 1st sentences of each paragraph is a bit unusual; but I defer to the editors regarding whether this formatting of the Results section requires editing or is acceptable as is.

Response: In response to this comment, we modified this presentation and instead use parenthesized references to the Figures/Tables. This also helped with shortening the length of the results section, as per Reviewer #3's suggestion.

Discussion:
1. The discussion is overly long and detailed. The word count is >1300 words and the journal limit is 750; would recommend shortening the Discussion section. Many points are valid and worthwhile but the section would benefit from further editing.

Response: Thanks for this thoughtful suggestion to improve the readability of our manuscript. We edited the discussion for clarity and brevity, editing the section from approximately 1700 to under 900 words.

Reviewer #3:

Overall: This study utilizes the PRAMS database to document racial and ethnic disparities in insurance coverage for perinatal care. This is a straightforward study, but nevertheless one that makes an important and novel point, especially in terms of interruptions in coverage (as opposed to looking at a single point in time).

Strengths of the study include a focused research question, nationwide data, and a large, diverse study population. Weaknesses included self-reported insurance status, which may be prone to recall bias, and self-reported race and ethnicity status.

Introduction:
1. Several of the sentences in the first paragraph of the introduction do not have supporting citations - I would put your citations at the relevant sentence, not all at the end of the paragraph.

> **Response:** Thanks for noting this. We rearranged citations throughout the manuscript from the end of sentences to the relevant locations within sentences.

2. The introduction is a bit long - could some of this information be shifted to the discussion? In particular, while I appreciate the final paragraph in terms of stating a research question, some of this information could be condensed or shifted to the methods section.

> **Response:** Thanks for this suggestion. We removed the text in the introduction outlining the contributions of this manuscript. The introduction is now under 250 words.

Methods:
1. Does the Indian Health Service provide prenatal care? Or are these women truly 'uninsured'?

> **Response:** Please see response #4 (Methods) and #4 (Results) to reviewer #2 above. We adhere to the insurance classification approach taken by the U.S. Census Bureau, the National Center for Health Statistics and the Centers for Disease Control and Prevention.

2. What did you use for weighting (line 182)? The included sampling weights?

> **Response:** We have included this information in the Methods on page 9: *"Design features and survey weights provided by the CDC were applied with Stata's survey commands to account for the complex survey design."*

3. As data are from states with different Medicaid eligibility criteria (both due to income and due to rules governing non-citizens, for instance), did you consider including fixed effects by state? Alternately, would you consider including a variable for whether a subject was eligible for Medicaid based on state of residence?

> **Response:** Thanks for identifying this important point. We did include state fixed effects in the adjusted models, but this was omitted from the methods in error. As the reviewer

points out, inclusion of state indicators will control for fixed differences across states, including differences in Medicaid programs.

Results:
1. This section gets very long - summarizing the key results in the text, and leaving some of this information to the figures/tables, would be helpful. The figures are fantastic!

Response: Thanks for this comment. We edited the results section for length and made references to the tables where possible, for example on page 10, we removed the detailed demographic statistics from the text and replaced with *"Table 1 presents the demographic characteristics of the sample."*

2. Please avoid the word 'meaningful' - I would use 'statistically significant'.

Response: We removed this word.

Discussion:
1. Some more information here (perhaps from the introduction) to document why having continuous insurance coverage is helpful would be appropriate here.

Response: We moved text about the role of insurance continuity from the introduction to the first paragraph of the discussion.

2. Another important point is just because a woman has Medicaid, she may still be subject to discontinuities in care, especially as many state plans have moved to HMOs and limit where women can be seen during pregnancy. Plans often will change providers mid-pregnancy, and thus, while a woman may be continuously insured, she may still experience disruptions in care. To the authors' credit, this is explained as a limitation of the study, but you could expand on this idea further, especially as these disruptions are also likely not random.

Response: This is an important point. We have added an additional limitation that gets more directly at this. See page 14: *"Second, we are not able to examine within-plan changes that could affect the continuity of care, for example if a woman's provider is removed from her insurers network over the course of pregnancy."*

3. One final limitation is that some patients may have started their pregnancy in one state and ended in another, leaving them open to differential eligibility rules or to drop out of the survey sample. This is a 'disruption' in insurance that should 'count' as a disruption, but could also lead to sample selection bias.

Response: We are not aware of available estimates on how many women change their state of residence during pregnancy or shortly after, however, the CDC refers to this is a "rare" event in the PRAMS procedural manual. If there was differential moving rates across race-ethnicity categories this could bias our results, however, again we believe this number of women would be very small.

STATISTICAL EDITOR COMMENTS:

The Statistical Editor makes the following points that need to be addressed:

1. lines 50-52: Did all 40 States have complete implementation of ACA-Medicaid during all years 2015-2017? If not, then should separately analyze those States with complete vs incomplete implementation or introduce another variable in the analysis.

> **Response:** We removed the two sentences that mentioned the implementation of the ACA. The goal of the study is to document racial disparities given the most recent data available (2015-2017, which is after the main implementation of the ACA in 2014). Examining differences across state Medicaid expansion status would require a different approach, which we feel is outside the scope of the present study.
>
> We agree that it is important to account for state differences in Medicaid programs. As noted in our response to Reviewer #3, Point #3, we did include state fixed effects in the adjusted models, but this was omitted from the methods in error. As the reviewer points out, inclusion of state indicators will control for fixed differences across states, including differences in Medicaid programs.

2. lines 131-134: If the unweighted sample was 107,921, then that sample cannot represent 5,963,153 women to the precision of an individual woman.

> **Response:** We removed this sentence.

3. lines 146-147: Was this rate (88.3%) from all women in this category, or did this represent a sample of women in that category?

> **Response:** This rate was for all women where we had data from both types of responses. We modified the sentence to clarify, see page 7: *"For all women in the sample with both birth certificate and self-reported responses for delivery, 88.3% had concordant responses."*

4. Table 1: Need units for age.

> **Response**: Units for age (years) added to Table 1.

5. Fig 2: Just as a suggestion, why not format this figure like Fig 1, with histograms showing total of 100% for each racial/ethnic group?

> **Response:** Thanks for the suggestion. We tried this alternate formatting, but after review, we felt the original format was a clearer visual depiction of the data.

6. Figs 1, 2, 3: Should include a concise description in the figure legends of the key statistical differences across ethnic/racial groups.

Response: Figures 1 and 2 are purely descriptive and we did not test for statistical differences across ethnic/racial groups for these measures. Figure 3 includes 95% confidence intervals that can help readers understand where statistical differences across ethnic/racial groups are found (the point estimates are also included in Appendix 4).

We are happy to provide additional information if the reviewer expands their comment to include specific details on how they envision the incorporation of statistical differences into the figure legends, where appropriate.

EDITOR COMMENTS:

1. The Editors of Obstetrics & Gynecology are seeking to increase transparency around its peer-review process, in line with efforts to do so in international biomedical peer review publishing. If your article is accepted, we will be posting this revision letter as supplemental digital content to the published article online. Additionally, unless you choose to opt out, we will also be including your point-by-point response to the revision letter. If you opt out of including your response, only the revision letter will be posted. Please reply to this letter with one of two responses:

A. OPT-IN: Yes, please publish my point-by-point response letter.
B. OPT-OUT: No, please do not publish my point-by-point response letter.

Response: OPT-IN

2. As of December 17, 2018, Obstetrics & Gynecology has implemented an "electronic Copyright Transfer Agreement" (eCTA) and will no longer be collecting author agreement forms. When you are ready to revise your manuscript, you will be prompted in Editorial Manager (EM) to click on "Revise Submission." Doing so will launch the resubmission process, and you will be walked through the various questions that comprise the eCTA. Each of your coauthors will receive an email from the system requesting that they review and electronically sign the eCTA.

Please check with your coauthors to confirm that the disclosures listed in their eCTA forms are correctly disclosed on the manuscript's title page.

Response: We confirm that the disclosure listed on the authors' eCTA forms are correctly disclosed on the manuscript's title page.

3. Standard obstetric and gynecology data definitions have been developed through the reVITALize initiative, which was convened by the American College of Obstetricians and Gynecologists and the members of the Women's Health Registry Alliance. Obstetrics & Gynecology has adopted the use of the reVITALize definitions. Please access the obstetric and gynecology data definitions at https://urldefense.proofpoint.com/v2/url?u=https-3A__www.acog.org_About-2DACOG_ACOG-2DDepartments_Patient-2DSafety-2Dand-2DQuality-2DImprovement_reVITALize&d=DwIGaQ&c=G2MiLlal7SXE3PeSnG8W6_JBU6FcdVjSsBSbw6gcR0U&r=GYQOtyiKCKsjyyl_fXffq3VjB88lhFwRKDlWjtbjCVw&m=LxkoiCjBI59oETdsSZwxgkWXEVR0nXDhBV0NggMuuVk&s=z3uiRaT3n3onGmJOQ-8EGfBKMa9iNnZ9zomHELEvA4o&e= . If use of the reVITALize definitions is problematic, please discuss this in your point-by-point response to this letter.

Response: No issues identified.

4. Because of space limitations, it is important that your revised manuscript adhere to the following length restrictions by manuscript type: Original Research reports should not exceed 22 typed, double-spaced pages (5,500 words). Stated page limits include all numbered pages in a

manuscript (i.e., title page, précis, abstract, text, references, tables, boxes, figure legends, and print appendixes) but exclude references.

> **Response:** We confirm that our report conforms to these guidelines. The revised manuscript includes 17 pages and 2,617 words, excluding references.

5. Titles in Obstetrics & Gynecology are limited to 100 characters (including spaces). Do not structure the title as a declarative statement or a question. Introductory phrases such as "A study of..." or "Comprehensive investigations into..." or "A discussion of..." should be avoided in titles. Abbreviations, jargon, trade names, formulas, and obsolete terminology also should not be used in the title. Titles should include "A Randomized Controlled Trial," "A Meta-Analysis," or "A Systematic Review," as appropriate, in a subtitle. Otherwise, do not specify the type of manuscript in the title.

> **Response:** We revised the title to “Racial and Ethnic Disparities in Perinatal Insurance Coverage: A Cross-Sectional Study”.

6. Specific rules govern the use of acknowledgments in the journal. Please note the following guidelines:

* All financial support of the study must be acknowledged.
* Any and all manuscript preparation assistance, including but not limited to topic development, data collection, analysis, writing, or editorial assistance, must be disclosed in the acknowledgments. Such acknowledgments must identify the entities that provided and paid for this assistance, whether directly or indirectly.
* All persons who contributed to the work reported in the manuscript, but not sufficiently to be authors, must be acknowledged. Written permission must be obtained from all individuals named in the acknowledgments, as readers may infer their endorsement of the data and conclusions. Please note that your response in the journal's electronic author form verifies that permission has been obtained from all named persons.
* If all or part of the paper was presented at the Annual Clinical and Scientific Meeting of the American College of Obstetricians and Gynecologists or at any other organizational meeting, that presentation should be noted (include the exact dates and location of the meeting).

> **Response:** We confirm that our manuscript conforms to these guidelines.

7. The most common deficiency in revised manuscripts involves the abstract. Be sure there are no inconsistencies between the Abstract and the manuscript, and that the Abstract has a clear conclusion statement based on the results found in the paper. Make sure that the abstract does not contain information that does not appear in the body text. If you submit a revision, please check the abstract carefully.

In addition, the abstract length should follow journal guidelines. The word limits for different article types are as follows: Original Research articles, 300 words. Please provide a word count.

Response: We confirm that our abstract conforms to these guidelines.

8. Only standard abbreviations and acronyms are allowed. A selected list is available online at https://urldefense.proofpoint.com/v2/url?u=http-3A__edmgr.ovid.com_ong_accounts_abbreviations.pdf&d=DwIGaQ&c=G2MiLlal7SXE3PeSnG8W6_JBU6FcdVjSsBSbw6gcR0U&r=GYQOtyiKCKsjyyl_fXffq3VjB88lhFwRKDlWjtbjCVw&m=LxkoiCjBI59oETdsSZwxgkWXEVR0nXDhBV0NggMuuVk&s=s-nMQvlvQQiOZoyUiwD7ARWPJCcHVJt1ZNT-n81kk28&e= . Abbreviations and acronyms cannot be used in the title or précis. Abbreviations and acronyms must be spelled out the first time they are used in the abstract and again in the body of the manuscript.

Response: We request permission to use the following non-standard abbreviations, used frequently in the body text, so not to detract from the readability of the manuscript:

- Pregnancy Risk Surveillance and Monitoring System (PRAMS)
- Centers for Disease Control and Prevention (CDC)

9. The journal does not use the virgule symbol (/) in sentences with words. Please rephrase your text to avoid using "and/or," or similar constructions throughout the text. You may retain this symbol if you are using it to express data or a measurement.

Response: Thank you for this note. We have avoided the use of the virgule symbol in the body text except when using it to express a measure, for example, Asian/Pacific Islander.

10. In your Abstract, manuscript Results sections, and tables, the preferred citation should be in terms of an effect size, such as odds ratio or relative risk or the mean difference of a variable between two groups, expressed with appropriate confidence intervals. When such syntax is used, the P value has only secondary importance and often can be omitted or noted as footnotes in a Table format. Putting the results in the form of an effect size makes the result of the statistical test more clinically relevant and gives better context than citing P values alone.

If appropriate, please include number needed to treat for benefits (NNTb) or harm (NNTh). When comparing two procedures, please express the outcome of the comparison in U.S. dollar amounts.

Please standardize the presentation of your data throughout the manuscript submission. For P values, do not exceed three decimal places (for example, "P = .001"). For percentages, do not exceed one decimal place (for example, 11.1%").

Response: We present effect sizes with confidence intervals and do not present P values in the body text or main tables. P values in the Supplement are limited to three decimal places. We reviewed the manuscript to ensure that all results expressed in percentages do not exceed one decimal place.

11. Please review the journal's Table Checklist to make sure that your tables conform to journal style. The Table Checklist is available online here: https://urldefense.proofpoint.com/v2/url?u=http-

3A__edmgr.ovid.com_ong_accounts_table-5Fchecklist.pdf&d=DwIGaQ&c=G2MiLlal7SXE3PeSnG8W6_JBU6FcdVjSsBSbw6gcR0U&r=GYQOtyiKCKsjyyl_fXffq3VjB88lhFwRKDlWjtbjCVw&m=LxkoiCjBI59oETdsSZwxgkWXEVR0nXDhBV0NggMuuVk&s=gAYnTxu_QXuoSFl3oInxAaZtTZzAE95nwCGR3n7ief0&e= .

Response: We confirm that our tables conform to these guidelines.

12. The American College of Obstetricians and Gynecologists' (ACOG) documents are frequently updated. These documents may be withdrawn and replaced with newer, revised versions. If you cite ACOG documents in your manuscript, be sure the reference you are citing is still current and available. If the reference you are citing has been updated (ie, replaced by a newer version), please ensure that the new version supports whatever statement you are making in your manuscript and then update your reference list accordingly (exceptions could include manuscripts that address items of historical interest). If the reference you are citing has been withdrawn with no clear replacement, please contact the editorial office for assistance (obgyn@greenjournal.org). In most cases, if an ACOG document has been withdrawn, it should not be referenced in your manuscript (exceptions could include manuscripts that address items of historical interest). All ACOG documents (eg, Committee Opinions and Practice Bulletins) may be found via the Clinical Guidance & Publications page at https://urldefense.proofpoint.com/v2/url?u=https-3A__www.acog.org_Clinical-2DGuidance-2Dand-2DPublications_Search-2DClinical-2DGuidance&d=DwIGaQ&c=G2MiLlal7SXE3PeSnG8W6_JBU6FcdVjSsBSbw6gcR0U&r=GYQOtyiKCKsjyyl_fXffq3VjB88lhFwRKDlWjtbjCVw&m=LxkoiCjBI59oETdsSZwxgkWXEVR0nXDhBV0NggMuuVk&s=9fPAZZXBIoQXBIRXyQhjg1evIzxdsLcvdmqEcJGB9-c&e= .

Response: We reviewed all ACOG documents cited to ensure we include the most recent version.

13. Figures 1–3: Please upload as separate figure files on Editorial Manager. If possible, please upload the original figure file (eps, tiff, jpeg), rather than pasting into a Word document.

Response: We submitted separate high-resolution figure files on Editorial Manager.

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* A point-by-point response to each of the received comments in this letter.

Response: We confirm that we read the Instructions for Authors.