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Low-Income Fathers' Access to Health Insurance

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Abstract

We examine the prevalence and correlates of health insurance status among low-income fathers, a group not previously studied in this context. In a sample of 1,653 low-income fathers from a national urban birth cohort study, 29% had private, 14% had public, and 58% had no insurance. Privately insured fathers had greater levels of human capital than did publicly insured fathers; the latter more closely resembled uninsured fathers than they did privately insured fathers. Multinomial logistic regression analysis indicates that being older, being employed, being married, and having a job offering health insurance all increase the likelihood of having private (vs. no) insurance, and that being disabled and married to or cohabiting with the child's mother increase the likelihood of having public (vs. no) insurance. Public policy should focus on increasing access to health insurance among low-income men, which may improve their health, productivity, and ability to support themselves and their children.

Keywords

Health insurance; low-income fathers; physical health; men's health; mental health

In the United States, 45.7 million people—more than 15% of the population—lacked health insurance coverage in 2007.¹ Uninsurance rates are particularly high among young adults,² especially men.³ Working-age men have higher rates of uninsurance than any other adult group (older men, working-aged women, and older women). In 2006, 22% of non-elderly adult men were uninsured compared with 18% of non-elderly adult women.¹ Among adults with family incomes less than 200% of the federal poverty level (FPL), the rates are much higher: in 2003, 46% of non-elderly men were uninsured, compared with 38% of non-elderly women, and 54% of men aged 21–35 had no coverage, compared with 42% of women aged 21–35. For the younger group, the gender disparity was due almost entirely to higher rates of public insurance among women.⁴

Why are low-income working-aged men so vulnerable to uninsurance? One reason is that the United States has minimal public health insurance for men. For working-aged adult men, there are two major pathways for eligibility for public insurance: having a disability that is severe

enough to qualify for Social Security disability benefits, or living in a household in which one's own dependent children reside and being poor enough to meet state eligibility requirements for Medicaid or the State Children's Health Insurance Program (SCHIP), which are much stricter for parents than for children. Another reason that so many low-income working-age men are uninsured is that private insurance is often unavailable to individuals in low-paying low-skilled jobs.⁵

Being uninsured can have adverse effects on health,^{6,7,8} and men's high uninsurance rates may provide a partial explanation for their poor health status relative to women. Death rates at every age are higher for men than for women, as are the prevalence rates of hypertension, high serum cholesterol, unhealthy weight, and other health conditions.⁹ Gender differences in health status are substantial among young and middle-aged adults. For example, in the U.S. in 2001–2004, 7.0% of men aged 20–34 had hypertension, compared with 2.7% of women in the same age group, and 21.2% of men aged 35–44 had high serum cholesterol, compared with 11.4% among women aged 35–44.⁹ Men with low socioeconomic status are particularly disadvantaged in terms of health.¹⁰ In 2004, death rates for men with less than a high school education were over three times those of men with at least some college education.⁹ Employed men in the lowest income quartile are over three times more likely to die from chronic obstructive pulmonary disease, and over twice as likely to die from diabetes or stroke, as employed men in the highest income quartile.¹¹

Fathers' health insurance can improve family health and well-being in many ways. It can foster men's health and potentially reduce gender health disparities by increasing men's use of preventive care, resulting in earlier diagnosis and treatment of serious health conditions.^{12,13,14} Compared with those who are uninsured, insured men have higher rates of screening for prostate-specific antigens,¹⁵ cholesterol,¹⁶ and blood pressure.¹⁶ Health insurance also is an important financial resource, particularly for low-income families. In 2004, uninsured individuals in the U.S. were about twice as likely as those with insurance to report having problems paying medical bills in the past year, with about one-third of the uninsured reportedly having spent less on other basic needs such as food and heat in order to pay medical bills.¹⁷ Medical expenses are a leading cause of bankruptcy, and parental health insurance has been identified as an important means of avoiding impoverishment from medical out-of-pocket expenses for families.¹⁸ Finally, parents' health insurance coverage improves children's continuity of coverage^{19,20} and utilization of health services.^{21,22}

The importance of fathers' contributions (financial, social, and emotional) to their children's development and well being is increasingly being recognized.²³ Fathers with low earnings potential may have difficulty contributing to the family's material circumstances. Fathers with few job skills may be obliged to work long hours in low-paying jobs that involve emotional stress or health hazards. They are unlikely to have access to employer-sponsored health insurance and, unless seriously disabled, are unlikely to qualify for public health insurance. Uninsurance can compound existing financial difficulties and have adverse health consequences, which may result in reduced work activity. During such cycles, few financial, social, and emotional resources may be available for their children.

Little is known about the health insurance status of fathers, particularly those who are financially disadvantaged. A key reason is that most information on health insurance status comes from surveys, which generally provide incomplete information about non-resident fathers, who are disproportionately poor.²⁴ In this study, we redress this knowledge gap by presenting data on the insurance status of fathers who participated in a national birth cohort study and examining the prevalence and correlates of public, private, and no insurance in this population. The distinction between public and private insurance is important, as potential policy solutions are different for the two types of coverage.

Methods

Data

Births were randomly selected from birth logs in 75 hospitals in 20 U.S. cities (in 15 states) with populations over 200,000 as part of the Fragile Families and Child Wellbeing study, a national longitudinal birth cohort survey that is representative of the U.S. urban population. Non-marital births were oversampled. While still in the hospital after giving birth, mothers were approached by a professional survey interviewer and screened for eligibility. Mothers were eligible for the study if they and their newborn's father were at least 18 years old (this age restriction did not apply in approximately one third of the hospitals, where younger mothers were considered emancipated minors), if they were able to complete the interview in either English or Spanish, if the father of the newborn was living, and if they were not planning to place the child for adoption. If eligible, the mothers were asked to participate in a survey about the conditions and capabilities of new parents. Fathers, who were eligible for the study if their newborn's mother completed an interview, were also asked to participate. Informed consent was administered to all respondents.

A total of 4,898 mothers (86% of those eligible) and 3,830 fathers (78% of those eligible) were interviewed between the spring of 1998 and fall of 2000.²⁵ Both parents were re-interviewed (whether or not the father completed an initial interview) when the child was approximately 12–18 months old. A total of 3,367 fathers completed follow-up interviews. Attrition was associated with socioeconomic status. For example, 67% of the fathers who completed follow-up interviews had at least a high school education, compared with 62% of those who did not complete follow-up interviews (a statistically significant difference).

The analyses were based on fathers whose reported household income was 200% of the FPL or less at the time of the follow-up interview. Of the 3,367 fathers who completed follow-up interviews, 1,933 met this condition. Of those 1,933 fathers, 14 were excluded from the analyses because the father reported that he had both private and public health insurance, 88 were excluded because they were incarcerated at the time of the follow-up interview, and 178 were excluded because of missing data on covariates. The analysis sample consisted of the remaining 1,653 fathers.

Measures

In the follow-up interview, the father was asked if he was covered by Medicaid or received health insurance from another public, federal, or state assistance program. He was then asked if he was covered by private health insurance. This information was used to classify fathers as having either public insurance or private insurance at the time of the follow-up. Fathers who reported that they did not have public health insurance and did not have private health insurance were coded as having no insurance at the time of the follow-up. Fathers were not asked about their insurance status in the baseline interview.

The other variables were classified as *father characteristics* and *family characteristics*. The father characteristics represent demographic and socioeconomic factors that are associated with insurance status in low-income populations.^{26,27} These included age (in years), race/ethnicity (Hispanic and non-Hispanic Black, vs. other), employment (full-time and part-time, vs. not employed), education (high-school graduate vs. less than high school), nativity (foreign-born vs. U.S.-born), whether the father's baseline employer offered health insurance (to control, to the extent possible, for availability of private insurance at baseline), military service (ever), incarceration (any history), and very low household income (less than or equal to 100% of the FPL). Also included were measures of physical and mental health: self-reported suboptimal overall health status (good, fair, or poor, vs. very good or excellent), disability that

limited the father's ability to work for pay, and major depression in the past 12 months according to the Composite International Diagnostic Interview Short Form (CIDI-SF) Version 1.0 November 1998,²⁸ which was embedded in the father's follow-up interview. Following procedures outlined by the developers of the CIDI-SF to identify experience of major depressive episodes, nine standard questions about depressive symptoms were asked and fathers whose response was yes to at least three of those were coded as depressed.²⁹ Other than race/ethnicity, nativity, and whether the father's baseline employer offered health insurance (which were established at baseline) all father characteristics came from the father's follow-up interview. For the few cases with missing data on race/ethnicity, mothers' postpartum reports of the father's race/ethnicity were used. For the offer of employer-sponsored health insurance measure, fathers who did not complete a baseline interview were coded as zero, but a flag variable indicating that the father did not complete a baseline interview was also included.

Based on past research demonstrating interdependencies between family members' health and insurance status,³⁰ the mother's and child's health status were included in the analysis, as were measures of relationship status (married and cohabiting, vs. neither), the mother's employment (full-time and part-time, vs. not employed), and the mother's health insurance status (separate variables for whether the mother had public health insurance and whether she had private insurance that was not through the father). A mother was coded as having suboptimal physical and/or mental health if she reported that her overall health status was less than very good and/or she met the diagnostic criteria for major depression in the past 12-months according to CIDI-SF, which was embedded in the mother's follow-up interview. The child health measure was based on maternal reports of the child's health status and coded the same way as for mothers and fathers. All of these family characteristics were established during follow-up interviews (from fathers for relationship status, from mothers for the others).

Statistical analyses

Stata/SE version 9.2 software (StataCorp LP, College Station, Texas) was used to conduct all statistical analyses. Characteristics of the sample were examined by fathers' insurance status. T-tests were conducted to identify significant differences in characteristics by insurance status.

Multinomial logistic regression analysis was used to estimate the associations between fathers' characteristics and their health insurance status and between family characteristics and fathers' health insurance status. Relative risk ratios (RRRs) and p-values are presented. All models include indicators for the father's state of residence at the time of the follow-up interview, to control for state policies and economic and labor market conditions that might affect fathers' individual and family characteristics as well as their health insurance status (results for these indicators not shown).

Results

As shown in Table 1, over a third (35%) of the fathers reported that they were in suboptimal health, 15% were disabled, and 8% had experienced a depressive episode in the past 12 months. Only 60% of the fathers completed high school. Fewer than half (40%) had been offered health insurance by their baseline employer. The vast majority (85%) were Black or Hispanic. Over half (55%) had household incomes below the FPL (the remainder had incomes between 100–200% of the FPL). Three quarters of the fathers were employed at least part-time. Most (70%) were living with their children's mothers (married or cohabiting).

Of the 1,653 fathers, 474 (29%) had private insurance, 228 (14%) had public insurance, and 951 (58%) had no insurance. The last figure is slightly higher than the national figure for low-income young men cited earlier (54%). In contrast, 20% of the 1,653 mothers in this sample

had private insurance (either through the father or themselves), 44% were publicly insured, and 37% were uninsured; 20% of the children had private insurance, 66% were publicly insured, and 14% were uninsured (most of these figures not shown in tables). Thus, fathers had much higher rates of uninsurance than the mothers and children. Notably, fathers' uninsurance is a risk factor for children not having insurance. Of the 228 children who were uninsured at follow-up, 68% had fathers without insurance and the other 32% had fathers who had health insurance (not shown in tables).

Table 1 includes the results from t-tests that indicate significant differences between pairs of the three insurance groups (fathers with private, public, and no insurance). While past research indicates that uninsured and insured men differ in many ways, it has not generally distinguished between privately and publicly insured men.³¹ As expected, we find that there are many differences between the private and uninsured groups and between the private and public groups. We also find that the public group more closely resembles the uninsured group than it does the group of privately insured fathers.

Compared with privately insured fathers, uninsured fathers tend to report poorer health, are more likely to be disabled, and have lower levels of human capital (they are younger, less educated, less likely to have served in the military, less likely to have been offered health insurance at baseline, more likely to have a history of incarceration, more likely to have income below 100% of the FPL, less likely to be employed, and less likely to be married to the child's mother). Also, they are more likely to be Hispanic. The mothers are more likely to be on public insurance, less likely to be employed, and less likely to have their own private health insurance. Finally, they are more likely to have a child in suboptimal health. Thus, uninsured fathers have greater immediate health needs than privately insured fathers, and they also have much lower earnings capacity.

Compared with publicly insured fathers, uninsured fathers are younger, less educated, less likely to be disabled, more likely to be foreign-born, less likely to be Black, more likely to be Hispanic, and less likely to live with the child's mother. The results for disability, nativity, Hispanic ethnicity, and living arrangements are consistent with lack of eligibility for Medicaid. Additionally, the mothers are more likely to have suboptimal physical or mental health and less likely to be on public insurance. This last finding highlights interdependency in parents' insurance status.

Even in this low-income sample, fathers with private insurance differ significantly from those with public insurance in many ways. They tend to have greater levels of human capital (they are older, more educated, more likely to have had an offer of employer insurance at baseline, less likely to have an incarceration history, less likely to have income below the FPL, more likely to be employed, and more likely to be married). They are also less likely to be disabled or depressed. Finally, they are less likely to be Black and more likely to be foreign-born, and the mother is less likely to have public insurance and more likely to have her own private insurance.

In the cases where both privately and publicly insured fathers differ significantly from those who are uninsured, we find that uninsured fathers are younger and less educated than insured fathers; that uninsured fathers are less likely than publicly insured fathers, but more likely than privately insured fathers, to be disabled; and that uninsured fathers and publicly insured fathers are more likely to be associated with mothers who have public insurance, compared with fathers who are privately insured.

Additional analyses (results not shown) indicate that fathers with multiple risk factors for being uninsured (unmarried, unemployed, and less than a high school education) constitute a substantial proportion of the uninsured. Seventy-eight percent of the 167 fathers who were

unmarried, unemployed, and had a low level of education were uninsured. Even among low-income fathers who are better positioned to have coverage, many do not. Of the 230 fathers who were married, employed, and graduates of high school, over one third (35%) were uninsured. For the uninsured fathers in the last group, there is evidence of considerable unmet need: 62% reported having suboptimal health, 57% were disabled, and 59% were depressed.

Table 2 presents the results of a multinomial logistic regression model that assesses the association of each characteristic with the father's insurance status, controlling for all of the other characteristics. The analysis indicates whether the bivariate associations persist taking all other variables into account, and indicates the magnitude of those effects. Results are presented for the likelihood of private insurance and for the likelihood of public insurance, with no insurance as the reference outcome in both cases. Because no insurance is the reference outcome, the RRRs represent the change in private (or public) insurance status relative to no insurance for a unit change in a given characteristic, holding the others constant. For example, being disabled more than doubles the probability that a father will have public rather than no insurance coverage. Having suboptimal rather than excellent or very good health makes a father 35% less likely to have public insurance coverage than to be uninsured. In keeping with the bivariate associations from Table 1, many paternal and family characteristics differ significantly (using $p < .05$ unless indicated otherwise) between fathers with private rather than no insurance and between fathers with public rather than no insurance. However, education, race/ethnicity, military service, depression, and the child's physical health, which were significant in some of the bivariate comparisons in Table 1, are not independently associated with the father's insurance status in the multivariate context (although some of these factors may operate through the father's employment). The characteristics that differentiate privately insured fathers from uninsured fathers are not necessarily the same characteristics that differentiate publicly insured fathers from uninsured fathers. These differences again highlight the importance of separately analyzing privately and public insured fathers rather than pooling them together to contrast them with those who are uninsured.

Age, employment (full- or part-time), having had (at baseline) an employer offer health insurance, being married to the focal child's mother, and the mother having her own private insurance all increase the likelihood that the father had private (vs. no) insurance. Being foreign-born, being very poor, ever having been incarcerated, and having a child whose mother has public health insurance all decrease the likelihood that the father had private (vs. no) insurance. The strongest associations were for employment ($RRR=4.61$, $p < .001$ for full-time; $RRR=3.12$, $p < .001$ for part-time). The majority of these results are consistent with the corresponding bivariate associations from Table 1.

Being foreign-born and the mother having suboptimal physical and/or mental health decreased the likelihood that the father had public (vs. no) insurance. Notably, being in suboptimal health themselves also decreased the likelihood of public (vs. no) insurance for these fathers, again suggesting that those with greater need for coverage are falling through the public safety net. Being disabled and being married to or cohabiting with the focal child's mother (vs. not living with her) increased the likelihood that the father had public insurance, which we would expect given the eligibility requirements for public insurance. In addition, the mother being employed and the mother having public health insurance also increased the likelihood of public (vs. no) coverage, although not at conventional levels for the former ($p=.07$). For public insurance, many of the state indicators were highly significant and had large magnitudes. Fathers living in one of the sampled states (Pennsylvania) were over three times as likely as those living in another state (Texas) to be publicly insured (results not shown). However, the small number of states represented in the data and the small samples in certain states preclude our making inferences about the effects of state health policies.

Discussion

This study examined the prevalence and correlates of private, public, and no health insurance among low-income working-aged fathers. While such an objective is straightforward, hard data have proven elusive in the past, perhaps because low-income men, particularly those who are non-resident fathers, have historically been underrepresented in household surveys. Using data on fathers from a recent birth cohort study, we found that over half of low-income fathers have no health insurance, less than one-third have private insurance, and only one in seven have public insurance. These figures compare to national rates of 24%, 67%, and 9%, respectively, for fathers aged 19–34 years that were recently calculated from the 2006 Current Population Survey³² (which is household-based and therefore underrepresents non-residential fathers).²⁵ The low rate of private insurance in our sample is not surprising, given that many low-income men do not have jobs that offer insurance and that those who do have jobs offering insurance are likely to have difficulty paying their share of the cost.³³ Even given the higher rate of public insurance for low-income fathers in our sample than for young men nationally, however, the rate is low. Of the fathers in our sample without private health insurance, less than one-fifth received public insurance and the other four-fifths were uninsured. The low rate of public coverage for fathers is consistent with the evolution of public health insurance in the U.S. and the fact that current coverage policies are targeted toward single mothers with children.³⁴

The scant previous research on health insurance coverage among economically disadvantaged men has focused on *any* insurance coverage and studied small geographic areas.³¹ Such an analysis, while informative, may not be generalizable and obscures the different pathways by which low-income men obtain coverage. We found some notable differences in correlates of public versus private health insurance, compared with no insurance. Consistent with previous research that did not use low-income samples, we found that being older, having previously had a job that offered health benefits, and being employed are positively associated,³⁵ and that being an immigrant is negatively associated,^{36,37} with private insurance coverage among men. We also found that even among low-income men, the poorest and those with incarceration histories are less likely than their counterparts to have private insurance, which is consistent with findings by others vis-à-vis labor market outcomes.^{38,39} The key correlates of public health insurance among low-income fathers are disability (one of the eligibility characteristics for public insurance for men) and the mother having public insurance. Interestingly, a self-report of suboptimal physical health (net of disability) *decreases* the likelihood of public insurance, suggesting that many low-income men with health problems obtain public insurance only when they reach the point of being disabled enough to qualify.

We took a preliminary look at associations between health status of family members and the fathers' insurance coverage. We found that reported child physical health is not independently associated with the father's private (vs. no) insurance coverage. We also found that the mother's poor physical or mental health reduces the likelihood that the father has public (vs. no) insurance. Past research has found that men are more likely to be labor force participants when they have a family member who has both a physical and mental illness.⁴⁰ This could reduce the likelihood that they are eligible for public insurance. Further research is needed to explore interdependencies between the health of family members and insurance status.

This study has several limitations. The sample was based on urban births. Patterns in health insurance status for non-urban fathers may look different. Follow-up survey non-response was associated with lower educational attainment, suggesting that the rate of private insurance we found among low-income fathers may be an overestimate and that our findings may not be fully representative of the population of urban low-income fathers. Our measures capture health insurance coverage at one point in time, rather than the duration of time spent in each insurance

status or the dynamics of changes in insurance status. Finally, this is a descriptive study, which depicts correlations between the variables but does not identify causal factors.

Prospects for insurance coverage have worsened since 2000. The fraction of employers offering health benefits has decreased sharply, from 69% to 60%.⁴¹ The decline has been driven to a large extent by reductions in coverage offered by smaller and lower-wage firms, where low-income individuals tend to work.³³ As the economy stalls, state Medicaid programs will face challenges as the eligible population grows and tax revenues decline.⁴¹ Compounding the problem are federal rule changes taking place in 2008 that are expected to reduce federal Medicaid spending by limiting reimbursement to certain providers and restricting the scope of services eligible for federal matching funds. These trends do not bode well for low-income fathers' ability to maintain or obtain health insurance.

The findings from this study have broad policy implications. Our finding of significant state differentials in coverage for fathers suggests that the public sector has the capacity to address the high rate of uninsurance among low-income men. Expanding public insurance eligibility for parents and encouraging take-up among men would increase coverage rates for fathers. Because uninsured and publicly insured fathers share many of the same characteristics, outreach efforts to encourage take-up among those who are already eligible for public coverage and those newly eligible under an expansion can be targeted largely to the same groups. This strategy may also result in increased enrollment among children.^{43,44} Our findings also suggest that making employer-sponsored coverage more widely available and improving employment opportunities, both of which may require government involvement, are necessary for increasing health insurance coverage among low-income fathers.

In summary, the rate of uninsurance among urban low-income fathers in the U.S. is extremely high and represents a pressing public health concern. Most low-income fathers are employed and live with their child's mother. However, they have low earnings capacity and many report suboptimal health. Together, these facts suggest substantial unmet need for health care in this population along with financial instability. Continued efforts to increase health insurance coverage among working-aged men, a largely overlooked group in health policy, are necessary to improve the health of the current and future generations.

Notes

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Table 1
CHARACTERISTICS OF LOW-INCOME FATHERS BY HEALTH INSURANCE STATUS

	Private (n = 474)	Public (n = 228)	uninsured (n = 951)	All Fathers (n = 1653)
Father's characteristics				
Suboptimal health	.30 [*]	.32	.38	.35
Disabled	.09 ^{*,**}	.29 [*]	.15	.15
Depressed	.06 ^{**}	.11	.08	.08
Age (mean, in years)	29.25 ^{*,**}	27.98 [*]	26.95	27.75
At least high school education	.72 ^{*,**}	.62 [*]	.54	.60
Immigrant	.20 ^{**}	.14 [*]	.23	.21
Military	.16 [*]	.12	.11	.12
Baseline employer offered insurance	.60 ^{*,**}	.32	.33	.40
Incarceration history	.12 ^{*,**}	.23	.21	.19
Income ≤100% federal poverty level	.40 ^{*,**}	.60	.61	.55
Did not complete initial interview	.05	.09	.08	.08
Race/ethnicity				
Black	.47 ^{**}	.60 [*]	.46	.48
Hispanic	.33 [*]	.27 [*]	.41	.37
White and Other	.20	.13	.13	.15
Employment				
Full-time	.86 ^{*,**}	.57	.61	.68
Part-time	.06 [*]	.07	.07	.07
Not employed	.08 ^{*,**}	.36	.32	.25
Family's characteristics				
Mother suboptimal physical/mental health	.47	.43 [*]	.51	.49
Child suboptimal health	.12 [*]	.15	.18	.15
Mother employed	.49 [*]	.44	.42	.45
Mother has public insurance	.30 ^{*,**}	.66 [*]	.45	.44
Mother has own private insurance	.23 ^{*,**}	.11	.11	.14
Relationship status				
Married	.39 ^{*,**}	.26	.20	.27
Cohabiting	.38 ^{*,**}	.46	.44	.43
Neither married nor cohabiting	.23 [*]	.28 [*]	.34	.30

* Significantly different from uninsured group at the 5% level.

** Significantly different from public insurance group at the 5% level.

Table 2
 MULTINOMIAL LOGISTIC REGRESSION ESTIMATES OF ASSOCIATIONS BETWEEN FATHERS' INDIVIDUAL AND FAMILY CHARACTERISTICS AND FATHERS' INSURANCE STATUS (N = 1653)^a

	Private		Public	
	RRR ^b	p-value	RRR ^b	p-value
Father's characteristics				
Suboptimal health	0.82	.18	0.65	.01
Disabled	0.84	.43	2.46	.00
Depressed	1.14	.64	1.43	.14
Age (years)	1.04	.00	1.01	.26
At least high school education	1.29	.19	1.12	.34
Immigrant	0.63	.02	0.64	.03
Military	1.01	.97	1.20	.52
Baseline employer offered insurance	2.04	.00	1.04	.80
Incarceration history	0.66	.03	0.99	.94
Income ≤100% federal poverty level	0.62	.00	0.94	.76
Did not complete initial interview	0.81	.42	0.98	.96
Race/Ethnicity				
Black	0.96	.78	1.05	.82
Hispanic	0.75	.11	0.91	.72
Employment				
Full-time	4.61	.00	1.26	.21
Part-time	3.12	.00	1.16	.73
Family's characteristics				
Mother suboptimal physical/mental health	0.87	.23	0.74	.03
Child suboptimal health	0.78	.16	1.05	.80
Mother employed	1.04	.81	1.23	.07
Mother has public insurance	0.74	.00	2.47	.00
Mother has own private insurance	1.75	.03	1.51	.24
Relationship status				
Married	2.05	.01	2.63	.00
Cohabiting	1.15	.35	1.70	.01

^a Model includes indicators for the father's state of residence (estimates not shown).

^b The base outcome in the model is no insurance; therefore, the RRR compares private insurance and public insurance to no insurance.

RRR = relative risk ratio