

Time constraints and healthcare usage: Do children suffer health consequences because of working mothers' busy schedules?

Brian C. Cadena
Alexandra M. Resch

University of Michigan

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Abstract

Using the 1996 panel of the Survey of Income and Program Participation, we examine the effect of increased employment among former welfare recipients on the health and healthcare usage of their children. Our analysis finds little evidence of negative effects. We do find that insurance matters in that children with health insurance coverage are more likely to receive regular care within certain categories. Although the transition from welfare to work may have affected children's healthcare utilization, our analysis suggests that it did so primarily by changing insurance eligibility rather than by increasing time constraints.

1 Introduction

Much of the previous literature regarding welfare reform and child health has focused on health insurance coverage. Critics of welfare reform feared that the low-wage jobs attained by women leaving welfare would pay enough to disqualify them from Medicaid, but either would not offer insurance or would insufficiently subsidize insurance to allow women to afford the premiums. While there was much support for work requirements for single mothers, there has also been support to keep children insured. The SCHIP program was passed in 1997 to offset any potential loss of Medicaid by children whose mothers left welfare for work.

Maintaining insurance coverage, however, does not guarantee that children will receive the care they need. Mothers working in low-wage jobs, often with inflexible hours and little or no available sick leave, may find it difficult to find time to take their child to the doctor. This could result in a lower likelihood of having a usual source of care and in less regular preventive care usage, negative outcomes already associated with a lack of insurance coverage.

Our primary research question is the following: How did the movement of mothers from welfare to work affect the health and healthcare utilization of their children, independent of its effect on insurance status? We use the 1996 panel of the Survey of Income and Program Participation (SIPP) to construct a sample of children in households recently receiving AFDC/TANF around the time of welfare reform and follow them through 2000. We provide a link between two active literatures: the effects of insurance coverage on insurance take-up and health care utilization and the effects of welfare reform and mother's work on children. Given that insurance eligibility and coverage are so strongly tied to work and income, researchers were previously unable to separately identify the effects of work hours and the effects of insurance. Welfare reform provides exogenous variation in mother's work hours while SCHIP provides some consistency in health insurance coverage, allowing us to focus on the effects of mother's work hours on her child's health care utilization.

Without the benefit of panel data, this causal question would be difficult to address with any reliability. Several factors could jointly determine a mother's employment and the child's use of medical care. For example, if a child has a chronic medical condition, his mother may be unable to work while caring for him. Highly motivated mothers with solid parenting skills are more likely to choose both to work and to seek proper medical care. These and other potential simultaneity problems combine to yield an ambiguously signed bias to any estimates of this question using cross-sectional analyses. By using panel data and fixed-effect models we are able to control for these concerns and other time-invariant characteristics of the parent and the child, leading to more credible estimates of the direct effect of maternal work on child health outcomes. Because of the SCHIP program, state-sponsored medical insurance covered a significant fraction of children during times of high and low employment by their mothers, allowing us sufficient within-child variation.

We examine several dependent variables, including a subjective measure of the child's health, whether the child received regular medical and dental care, whether the child received emergency/urgent care, and whether and how frequently the child took prescription medication. We regress the dependent variables on indicators for the child's insured status, measures of the mother's labor decisions, household income and other demographic controls. The panel nature of our data allows us to include child-level fixed effects that control for time-invariant characteristics of the mother or child such as knowledge and perceptions of the medical care system and chronic medical conditions. Our analysis finds little evidence of negative effects of maternal employment on health outcomes. We do find that insurance matters in that children with health insurance coverage are more likely to receive regular care within certain categories. Although the transition from welfare to work may have affected children's healthcare utilization, our analysis suggests that it did so primarily by changing insurance eligibility rather than by increasing time constraints.

2 Previous Literature

Cutler and Gruber (1996) and Ham and Shore-Sheppard (2005) focus on the link between increased Medicaid eligibility and take-up of Medicaid and the crowd-out of private insurance. Cutler and Gruber use Current Population Survey (CPS) data and find large take-up effects and also significant evidence of crowd-out. Ham and Shore-Sheppard replicate their analysis using the 1984-1993 panels of the SIPP. They find significant but smaller take-up effects and little evidence of crowd-out. They attribute the discrepancy between the two studies partly to the different time periods covered by the questions in the two surveys.

Currie and Gruber (1996) examine take-up of Medicaid using the CPS, but also examine child health outcomes using the National Health Interview Survey (NHIS). They show that the increases in Medicaid take-up are roughly half of the increase in eligibility and then examine the effects of increased coverage on health care usage. In particular, they show that eligibility for Medicaid is associated with a significantly lower probability of having had no doctor's visit in the past year and increased likelihood of hospitalization in the past year. They use the Vital Statistics to examine the effects of Medicaid expansion on child mortality. Using variation in eligibility by state, year and child age, they find that increased eligibility is associated with significantly lower child mortality and that the result is particularly strong when focusing on what they term "internal causes" rather than "external causes" including accidents and violence.

DeLeire, Levine, and Levy (2005) document that rates of uninsuredness rise for women during the 1990s but particularly for low-skilled women. Using CPS data and variation in the timing of welfare waivers by state, they find that welfare reform is not driving these decreases in insurance coverage. They find that welfare reform is associated with increases in private health insurance for low-skilled women and with no change in public coverage.

The Spring 1997 issue of *The Future of Children* focused on the transition from welfare to work and includes several articles on child outcomes. Moffitt and Slade document the

discrepancy between the insurance status of mothers leaving welfare and that of their children who are covered at higher rates. Zaslow and Emig review the existing literature on the effects of maternal employment on children, focusing in particular on low income families. They report positive results for child development, including physical measures such as height and weight and also language skills, but note that certain types of employment are better than others. Full time work is associated with better outcomes than part time work, perhaps suggesting that stability and increased income outweigh the costs associated with added constraints on the mother's time. Moore and Driscoll examine the effects of mother's work on child development outcomes using AFDC recipients in the NLSY. They find generally positive results including decreased behavioral problems and increased math scores in certain subgroups. These articles note that they are identifying effects off voluntary moves from welfare to work, so the effects of mandated moves to work associated with PRWORA may differ.

Dunifon, Kalil, and Bajracharya (2005) use the Women's Employment Study to examine the effect of various job characteristics on child behaviors. They find that, of several job characteristics which they describe as "non-family-friendly", only long commute times are associated with increases in negative behavior and decreases in positive behavior. Irregular or nonstandard hours were not found to have negative effects.

The eligibility and utilization studies suggest that insurance coverage is important for children's health care usage and also for health outcomes. The studies examining the effects of mother's work on child outcomes are mixed, with many finding positive effects on child development. The question of how increased work hours affect children's health care remains open.

3 Results

3.1 Data

The data come from the 1996 panel of the Survey of Income and Program Participation (SIPP). We combined calculations from the core files in each wave with data from the Medical Expenses and Utilization of Health Care Topical Module in waves 3, 6, 9 and 12. We selected a sample of children younger than fifteen years old at the time of the first wave, living with mothers ages 18-54 who received cash welfare benefits during at least one month of the first wave's reference period. By establishing these selection criteria we attempted to select women likely to experience exogenous changes in work over the next four years. Work requirements target these families, and they do experience dramatic increases in maternal employment over the sample period, rising from 6.5 hours/week in 1996 to 16.4 hours/week in 1999. This combination of facts suggests that policy changes rather than endogenous choices drive a large amount of the variation in employment.

The topical modules are administered from November through February, asking questions about current health and health care utilization over the previous twelve months, roughly calendar years 1996-1999. Because the majority of these questions ask about the previous year, we create backward-looking averages of several monthly variables from the core files. For example, we calculate for each child the fraction of months in the past year he/she was without health insurance, his/her mother's average weekly hours worked, and his/her average family monthly income (measured in 2000 dollars). The resulting yearly panel dataset contains information on 2,232 children in 1,037 families over four years.

Table 1 contains descriptive information for the children in our sample. These children tend to be healthy, with a mean reported health status slightly better than "very good." They visit the doctor and dentist a few times each year, and rarely require hospitalization. On other measures, however, these children are more likely to be disadvantaged. Their

mothers tend to have low levels of education, and more than half of the children belong to racial or ethnic minority groups. These children also spend a good deal of time uncovered by health insurance; on average, a child is not covered in seventeen percent of the months when we can observe him/her. These children's households have few resources, with average monthly incomes less than \$2,000. This group of families, living on the margin, are exactly who we would expect to be affected most by increasing demands on their time.

3.2 Cross-Sectional Analysis

Table 2 presents results from analyses that treat the data as if they came from repeated cross-sections, adjusting the standard errors for potential correlation within families. We examine seven outcomes including current health status and six measures of health care utilization. In addition to measures of maternal work and income, we include a series of racial/ethnic dummies (omitted category is white, non-hispanic), education dummies (less than high school degree omitted), age dummies for young children, and measures of how each child was covered through insurance over the past year (uninsured omitted).

The results in column 2 are consistent with the hypothesis that maternal work crowds out other valuable uses of a mother's time, such as taking her children to the doctor. None of the other columns, however, provide evidence that missed doctor's visits lead to increased hospitalizations, or other health problems.

The cross-sectional results in this table reveal some other noteworthy patterns, but they also suggest reasons to use caution in interpreting them. For example, racial and ethnic minorities visit medical and dental providers and use prescription drugs far less frequently than do white children. It is unlikely that race has a direct causal effect on service provider utilization. More likely, race and ethnicity are serving as proxies for other unobserved characteristics of children and their mothers. These factors could include geographical access to medical care, willingness to engage in the formal medical care system, or any number of

other possibilities.

Column 1 presents a somewhat counterintuitive result - children covered by public insurance over the past year tend to be in poorer health than uninsured children. We would expect children covered by insurance, all else equal, to be in better health because they are more likely to get the care they need. These estimates suggest a different process. If applying for and receiving public health insurance requires navigating a tricky or time-consuming bureaucratic process, parents who expect to need the coverage will be more likely to obtain coverage for their children. Healthier children will end up disproportionately uninsured, while those who tend to need medical care will be covered.

Similarly, children whose mothers work more tend to be healthier. The point estimate suggests that, on average, a child whose mother works 20 hours more per week will be 0.06 points closer to excellent health . While this finding could be interpreted as evidence that maternal work improves the health of children, there are alternative explanations. Mothers could be willing to work more when their children are healthy, or some other factor (e.g. maternal motivation) could lead to better children's outcomes and increased employment.

3.3 Fixed Effects Models

Each of these examples suggests that the results in this table should not be interpreted as measuring the causal effect of the right hand side variables on any of the outcomes. Fixed effects models represent an alternative methodology that can provide estimates less prone to the influence of omitted variables. In particular, fixed effect models remove any influence of time-invariant unobserved characteristics. Many of the problems outlined in the previous section fall into this category. For example, the influences on our outcomes from a general mistrust of doctors, a higher propensity toward illness, limited geographical access to medical facilities, or general motivation are likely to be approximately constant over a short time horizon.

This approach allows us to compare one child's outcomes during a time period in which her mother works many hours per week to that same child's outcomes during time periods of lower employment. The results of these models are shown in Table 3. These estimates continue to support the hypothesis that the increased demands on women's time created by welfare reform adversely affected their children's usage of the healthcare system. Although the precision of the estimate decreases, the point estimate continues to represent a statistically significantly negative effect at the ten percent level. In a year when a child's mother works twenty hours more than another year, the child visits a medical provider on average 0.4 fewer times. Compared to an average of 2.7 annual visits, this represents a sizeable decrease in contact with the healthcare system. Again, though, there is no evidence that these missed visits have any short-term consequences leading to serious health problems requiring hospitalization.

While the fixed effects models do a good job of controlling for time-invariant unobserved characteristics, they are still vulnerable to a particular type of simultaneity bias. Suppose that the health status of children, rather than remaining fairly constant over time, varied a great deal from period to period. In particular, suppose that a child experienced a negative health shock in one year, requiring her mother to limit her work hours in order to care for her. Because this example represents a one-time shock to the child's health rather than a chronic condition, the fixed effects models are unable to absorb this unobserved factor. We are concerned that this exact scenario could be contributing to the observed negative relationship between maternal work and children's medical visits.

The type of health shock required to cause a reduction in a mother's labor supply would likely require frequent, almost daily contact with the healthcare system. In other words, reverse causation should be most problematic to the estimates in Table 3 during years when children experience exceptional contact with the healthcare system. To address this issue, we repeat the analyses of Table 3, throwing out children in any family in which a child needed

to see a medical provider more than twenty-five times in any given year. Twenty-five visits represents the ninety-ninth percentile of healthcare usage in our sample; so the experiences of these families, some of whom require more than one hundred annual visits, are truly anomalous.

Table 4 details the results of this analysis on the restricted sample. Removing the outliers dramatically reduces the magnitude of the point estimate for the effect of maternal work on medical provider visits. The resulting coefficient becomes statistically insignificant. In addition, taking the point estimate at face value, an increase in maternal work of twenty hours is only associated with 0.1 fewer visits, or only a quarter of the effect suggested by the analysis on the full-sample.

While there is no guarantee that the negative correlation among the outliers results from reverse causation, the arguments outlined above imply that the restricted sample provides more reliable estimates of causal relationships. As additional evidence for this claim, compare the coefficients on insurance coverage in column 2 of Tables 3 and 4. With the outliers included, the point estimates are near zero with large standard errors. When the outliers are omitted, there is a strong relationship between insurance coverage and medical provider usage in the expected direction. This dramatic change suggests that even the fixed effects models do a poor job of controlling for unobserved factors in health care utilization among those who require especially frequent medical care.

4 Policy Implications

Maternal work has the potential to affect the health and healthcare utilization of children through a number of channels. We have focused on the increasing scarcity of a mother's time and the extent to which this time crunch affects a variety of outcomes. When we control for time invariant unobserved factors and base our analysis on the ninety-nine percent of children who do not require more than two doctor's visits per month, we find no evidence

that maternal work crowds out time spent taking children to the doctor.

This finding certainly does not rule out the possibility that welfare reform broadly affected children's health. As maternal work increased after welfare reform, so did the fraction of the previous year that children spend uninsured. We do find evidence that medical insurance and medical usage are closely linked. Similarly, this finding does not imply that policymakers should be uninterested in this issue. In order to meet the demanding requirements of parenting and employment, mothers may be choosing jobs with flexible or variable hours. To the extent that these jobs provide lower pay and fewer benefits, policymakers may still be interested in addressing this aspect of families transition from welfare to work.

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Table 1. Health, Health Utilization and Demographic Characteristics

	Mean	Standard Deviation	Number of Valid Observations
Report of current health status (1 = excellent, 5 = poor)	1.96	0.94	7098
Frequency of medical provider visits in past year	2.69	6.75	7098
Frequency of dental visits in past year	0.98	1.77	7098
Hospital stays in past 12 months	0.04	0.18	7098
Number of nights spent in hospital	0.32	5.25	7098
Prescription medication use in the past year	0.34	0.47	7098
Report of daily prescription medication use	0.29	0.45	2389
Average hours per week mother worked in past 12 months	11.16	14.75	7074
African American	37%	0.48	7098
Hispanic origin	24%	0.43	7098
Other race	5%	0.23	7098
Mother has less than HS Degree	43%	0.49	7074
Mother has exactly HS Degree	32%	0.47	7074
Mother has more than HS Degree	25%	0.44	7074
Fraction of year mother was married	25%	0.42	7074
0-2 years old	7%	0.26	7098
3-5 years old	22%	0.41	7098
Fraction of past 12 months with public insurance coverage	0.72	0.37	7098
Fraction of past year with private insurance coverage (only)	0.11	0.27	7098
Fraction of past 12 months without insurance coverage	0.17	0.29	7098
Average monthly household income (in \$100's)	19.9	18.0	7098

Source: Authors' calculations using the 1996 Panel of the SIPP.

Note: The sample is limited to children younger than fifteen years old at the time of the first wave, living with mothers ages 18-54 who received cash welfare benefits during at least one month of the first wave's reference period.

Table 2. Cross-sectional regressions of health and health care outcomes on maternal work

	(1)	(2)	(3)	(4)	(5)	(6)	(7)
	OLS	OLS	OLS	Tobit	Tobit	Linear Probability Model	Linear Probability Model
	Report of current health status (1 = excellent, 5 = poor)	Frequency of medical provider visits in past year	Frequency of dental visits in past year	Hospital stays in past 12 months	Number of nights spent in hospital	Prescription medication use in the past year	Report of daily prescription medication use
Average hours per week mother worked in past 12 months	-0.003* (0.001)	-0.019* (0.008)	0.001 (0.002)	-0.000 (0.006)	-0.112 (0.139)	0.000 (0.001)	-0.002+ (0.001)
African American	0.020 (0.049)	-1.286** (0.292)	-0.233** (0.079)	-0.092 (0.185)	2.242 (3.956)	-0.153** (0.023)	-0.019 (0.031)
Hispanic origin	-0.018 (0.058)	-1.687** (0.313)	-0.270** (0.086)	-0.233 (0.210)	-3.820 (4.479)	-0.143** (0.026)	0.032 (0.045)
Other race	-0.042 (0.088)	-0.490 (0.655)	-0.012 (0.185)	-0.567+ (0.339)	-13.318 (13.831)	-0.100* (0.049)	0.013 (0.066)
Mother has exactly HS Degree	-0.001 (0.055)	0.089 (0.315)	0.064 (0.071)	0.134 (0.168)	2.755 (3.942)	0.015 (0.022)	0.026 (0.036)
Mother has more than HS Degree	-0.096+ (0.054)	0.484+ (0.293)	0.259** (0.091)	-0.082 (0.197)	-1.675 (4.207)	0.075** (0.026)	0.053 (0.038)
Fraction of year mother was married	-0.053 (0.051)	0.294 (0.320)	0.021 (0.081)	0.263 (0.194)	4.147 (4.585)	0.003 (0.024)	-0.012 (0.039)
0-2 years old	-0.092+ (0.052)	1.965** (0.490)	-0.999** (0.056)	0.913** (0.196)	17.054** (5.556)	0.111** (0.026)	-0.170** (0.033)
3-5 years old	-0.088** (0.033)	0.270 (0.180)	-0.451** (0.047)	-0.137 (0.176)	-1.759 (4.144)	0.058** (0.016)	-0.170** (0.024)
Fraction of past year with private insurance coverage (only)	0.049 (0.077)	0.527 (0.598)	0.293* (0.126)	-0.895* (0.413)	-14.850 (9.191)	0.089* (0.036)	-0.043 (0.065)
Fraction of past year with public insurance coverage	0.142* (0.057)	1.181* (0.535)	0.558** (0.087)	0.140 (0.274)	0.130 (5.910)	0.187** (0.024)	0.013 (0.051)
Average monthly household income (in \$100's)	-0.001 (0.001)	-0.003 (0.005)	0.002 (0.002)	-0.001 (0.004)	0.021 (0.084)	0.000 (0.000)	0.001 (0.001)
Constant	1.975** (0.071)	2.544** (0.608)	0.726** (0.110)	-4.012** (0.331)	-83.549** (19.838)	0.241** (0.033)	0.314** (0.056)
Observations	7074	7074	7074	7074	7074	7074	2382
R-squared	0.01	0.02	0.05			0.05	0.04

Standard errors in parentheses - adjusted for clustering at the family level
+ significant at 10%; * significant at 5%; ** significant at 1%

Source: Authors' calculations using the 1996 Panel of the SIPP.

Notes: Standard errors are block-bootstrapped at the family level for non-linear models. Daily prescription use data only available for children who reported any prescription drug use.

Table 3. Fixed Effects regressions of health and health care outcomes on maternal work

	(1)	(2)	(3)	(4)	(5)	(6)	(7)
	Report of current health status (1 = excellent, 5 = poor)	Frequency of medical provider visits in past year	Frequency of dental visits in past year	Hospital stays in past 12 months	Number of nights spent in hospital	Prescription medication use in the past year	Report of daily prescription medication use
Average hours per week mother worked in past 12 months	-0.001 (0.002)	-0.019+ (0.010)	0.003 (0.003)	-0.000 (0.000)	0.003 (0.009)	-0.000 (0.001)	-0.002 (0.002)
Fraction of year mother was married	-0.202* (0.092)	-0.081 (0.572)	0.372+ (0.226)	0.006 (0.020)	0.300 (0.243)	-0.007 (0.047)	0.057 (0.076)
0-2 years old	0.091 (0.083)	2.700** (0.625)	-0.608** (0.094)	0.042* (0.019)	0.182 (0.823)	0.083+ (0.047)	0.076 (0.070)
3-5 years old	0.007 (0.047)	0.534+ (0.285)	-0.248** (0.065)	-0.005 (0.009)	-0.325 (0.331)	0.034 (0.026)	0.000 (0.035)
Fraction of past year with private insurance coverage (only)	0.191* (0.095)	0.012 (0.680)	0.341* (0.152)	-0.006 (0.014)	-0.140 (0.383)	0.059 (0.049)	-0.049 (0.078)
Fraction of past year with public insurance coverage	0.078 (0.070)	-0.072 (0.808)	0.525** (0.111)	0.007 (0.012)	0.275 (0.491)	0.130** (0.034)	-0.091 (0.065)
Average monthly household income (in \$100's)	0.000 (0.001)	0.006 (0.009)	-0.000 (0.003)	0.000 (0.000)	0.006 (0.005)	-0.000 (0.001)	0.002* (0.001)
Constant	1.935** (0.072)	2.539** (0.747)	0.550** (0.134)	0.023 (0.015)	-0.014 (0.536)	0.237** (0.037)	0.318** (0.071)
Observations	7074	7074	7074	7074	7074	7074	2382
Number of clusters (individual children)	2228	2228	2228	2228	2228	2228	1317

Standard errors in parentheses - block bootstrapped at the family level

+ significant at 10%; * significant at 5%; ** significant at 1%

Source: Authors' calculations using the 1996 Panel of the SIPP.

Notes: Standard errors are block-bootstrapped at the family level for non-linear models. Daily prescription use data only available for children who reported any prescription drug use.

Table 4. Fixed Effects regressions of health and health care outcomes on maternal work

	(1)	(2)	(3)	(4)	(5)	(6)	(7)
	Report of current health status (1 = excellent, 5 = poor)	Frequency of medical provider visits in past year	Frequency of dental visits in past year	Hospital stays in past 12 months	Number of nights spent in hospital	Prescription medication use in the past year	Report of daily prescription medication use
Average hours per week mother worked in past 12 months	-0.002 (0.002)	-0.005 (0.007)	0.002 (0.003)	-0.000 (0.000)	0.010 (0.008)	-0.000 (0.001)	-0.001 (0.002)
Fraction of year mother was married	-0.171+ (0.098)	0.001 (0.302)	0.252 (0.190)	0.007 (0.019)	0.051 (0.113)	-0.029 (0.050)	0.067 (0.079)
0-2 years old	0.089 (0.084)	1.595** (0.392)	-0.610** (0.094)	0.046** (0.017)	0.727 (0.642)	0.077 (0.048)	0.010 (0.070)
3-5 years old	-0.002 (0.048)	0.367+ (0.192)	-0.288** (0.066)	-0.001 (0.009)	-0.007 (0.056)	0.022 (0.027)	-0.015 (0.039)
Fraction of past year with private insurance coverage (only)	0.191+ (0.100)	0.660* (0.296)	0.389* (0.158)	-0.002 (0.013)	0.318 (0.247)	0.063 (0.049)	-0.098 (0.078)
Fraction of past year with public insurance coverage	0.076 (0.072)	0.874** (0.194)	0.516** (0.114)	0.011 (0.011)	0.645 (0.435)	0.135** (0.033)	-0.105+ (0.059)
Average monthly household income (in \$100's)	0.000 (0.001)	-0.002 (0.004)	-0.000 (0.003)	0.000 (0.000)	0.002 (0.003)	-0.001 (0.001)	0.002* (0.001)
Constant	1.911** (0.073)	1.334** (0.233)	0.552** (0.137)	0.012 (0.014)	-0.537 (0.427)	0.231** (0.036)	0.319** (0.066)
Observations	6677	6677	6677	6677	6677	6677	2162
Number of clusters (individual children)	2120	2120	2120	2120	2120	2120	1221

Standard errors in parentheses - block bootstrapped at the family level

+ significant at 10%; * significant at 5%; ** significant at 1%

Source: Authors' calculations using the 1996 Panel of the SIPP.

Notes: Daily prescription use data only available for children who reported any prescription drug use. These results omit from the sample children whose medical provider use was in the top one percent of the sample (more than 25 visits), during at least one wave.