

TRENDS

Covering Kids: Variation In Health Insurance Coverage Trends By State, 1996–2002

Despite nationwide improvements, variation persists in levels of children's coverage among states.

by Lynn A. Blewett, Michael Davern, and Holly Rodin

ABSTRACT: We estimated state-specific changes in health insurance coverage rates for children between 1996–1998 and 2001–2002. We found considerable variation in the changing distribution of health insurance coverage for children across states, with significant increases in public program coverage in twenty-nine states and significant decreases in uninsured children in twenty-seven. Children in families with incomes below 200 percent of the federal poverty level were the most likely to enroll in public programs. We provide an overview of state outreach and administrative simplification efforts and raise concerns about the persistent variation in children's health insurance coverage across states.

IN RECENT YEARS state and national efforts have been targeted to increasing health insurance coverage for children through the implementation of the State Children's Health Insurance Program (SCHIP), Medicaid program expansions, and outreach efforts to promote public program awareness and enrollment. In this paper we use data from the Current Population Survey Demographic Supplement (CPS-DS) to document changes in health insurance coverage for children between 1996 and 2002 in the fifty states and the District of Columbia. We describe state efforts to increase enrollment of children in public programs; analyze the changing distribution of coverage for children; and conclude by discussing states' continued fiscal pressures as they struggle to maintain existing programs and services.

■ **Factors affecting public program enrollment.** SCHIP, passed as part of the Bal-

anced Budget Act (BBA) of 1997, represents the largest expansion of public health insurance programs since the 1965 passage of Medicare and Medicaid. As of June 2004, SCHIP insured approximately 3.7 million children.¹ Combined with the larger Medicaid program, SCHIP and Medicaid represent an important source of health insurance coverage for children, covering almost one in every four children in 2002 (23.9 percent).²

Section 1931 of the Social Security Act, enacted under the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996, also presented new opportunities for states to increase public program enrollment of children. These new provisions increased administrative flexibility and opportunities to streamline eligibility and enrollment. States could raise income eligibility levels and earned-income disregards, eliminate certain asset tests, and extend coverage to

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two-parent working families.³ States could also provide presumptive eligibility for children up to a year old.⁴ Karl Kronebusch and Brian Elbel found that some of these administrative changes, including presumptive eligibility and self-declaration of income, had a sizable impact on increasing children's enrollment in public programs.⁵

State outreach efforts also played a role in increasing coverage for children.⁶ State spending on outreach is eligible for the federal SCHIP match, and almost all states employed outreach programs, including television, radio, and print advertising, as well as activities in targeted enrollment sites such as schools, community clinics, and other provider-based settings.⁷

National outreach efforts were largely funded by the Robert Wood Johnson Foundation (RWJF) with its four-year, \$55 million Covering Kids campaign to increase enrollment in Medicaid and SCHIP. As part of this effort, the Covering Kids and Families program coordinates an annual Back-to-School campaign. The 2002 campaign included 1,200 outreach and enrollment activities, resulting in 39,000 news stories, with corporate partners providing additional outreach.⁸ Genevieve Kenney and colleagues found increased familiarity with Medicaid and SCHIP programs and eligibility requirements among parents of low-income children.⁹

■ **Evidence of increasing coverage for children.** The distribution of health insurance coverage for children is changing, as documented by public program enrollment and national survey data. It should be noted that Medicaid/SCHIP administrative counts of the number of people enrolled do not often agree with the survey estimates of Medicaid coverage.¹⁰ Also, the national surveys cited below use different measures of health insurance coverage, which makes comparisons across surveys difficult. Despite these differences, all of the data point to similar trends: an increase in public program enrollment and a decrease or stable rate of uninsurance for children.

A study using data from the National Health Interview Survey (NHIS) shows a de-

cline in the proportion of uninsured children between 1997 and 2002, from 13.9 percent to 10.1 percent. At the same time, public coverage for children increased from 62.1 percent to 69.3 percent for children in poor families (under 100 percent of poverty), and from 24.3 percent to 42.2 percent for children in near-poor families (100–199 percent of poverty).¹¹

The most current data from the CPS-DS show that from 2000 to 2003, uninsurance among children remained stable, while that among adults increased. There was also a more than 4.7 percent increase in public health insurance coverage for all children.¹² The Urban Institute's analysis of data from the National Survey of America's Families (NSAF) show a decrease in the uninsurance rate of nearly 6 percent for children in low-income families from 1999 to 2002, as well as an overall decrease in the number of uninsured children, from 9.6 to 7.8 million.¹³

Finally, the nationally representative Community Tracking Study (CTS) Household Survey shows that between 1998–1999 and 2000–2001, uninsurance among children declined by nearly 20 percent, and public coverage for low-income children (under 200 percent of poverty) increased from 28.9 percent to 36.7 percent.¹⁴ A recent update found that these trends continued from 2001 to 2003, with the uninsurance rate of low-income children falling an additional 4.3 percent to 11.4 percent and public coverage for low-income children increasing to 49.3 percent.¹⁵

Our analysis examines trends in private health insurance coverage, public coverage, and uninsurance at the state level, controlling for economic and other factors, to illustrate how the distribution of coverage for children has changed over time. We extend previous analyses by examining the dynamics in coverage and presenting state-level comparative data on the impact for two time periods, 1996–1998 and 2001–2002. Our analysis focuses on aggregate rates of change in health insurance coverage at the state level. We do not decompose the variation across states by program-specific characteristics; we acknowledge the need for additional research in this area, to

better understand the local dynamics that affect health coverage.

Study Data And Methods

■ **Data.** We use data on children age eighteen and younger from the CPS-DS for two time periods: 1996–1998 and 2001–2002.¹⁶ In 2000 the CPS-DS greatly altered how health insurance coverage data were obtained by adding a verification question. This question directly asks respondents who did not report having a specific type of coverage whether they are uninsured. Although it would be preferable to have verified data for 1996–1998, the only way to ensure consistent measurement between the two time periods is to “unverify” the data for 2001–2002.¹⁷

■ **Variables.** The dependent variable is the child’s type of health insurance coverage, classified as public, private, or uninsured. Public coverage includes all children reported as being covered by Medicaid, SCHIP, state programs, and Medicare.¹⁸ Private coverage includes children covered by employer-based, privately purchased, and military health insurance. We classify children as being covered by public insurance if they have both private and public coverage in both time periods, because surveys tend to undercount the Medicaid population and people on Medicaid tend to report that they have some type of public insurance.¹⁹ The uninsured category includes all children for whom a specific type of coverage is not reported.

■ **Analysis.** The explanatory variables in our model include characteristics of children and the families with whom they live. Children’s characteristics include age, health status, sex, poverty level, urban or rural residence, race, Hispanic ethnicity, and native-born status. Family characteristics include work status, highest education achieved by any family member, parents’ marital status, and age of family reference person. Also included are state dummy variables and state

time-period interaction variables. Although additional variables could be added to further refine the model, their addition would not greatly alter the robust results we obtained.

We estimated a multinomial logistic regression predicting whether a child was uninsured, covered by public insurance, or covered by private insurance for each time period. We included family economic and demographic characteristics along with the child’s demographic characteristics as covariates. We used

Stata version 7’s multinomial logistic regression procedure to adjust the parameter estimates for the complex sample design of the CPS, with the lowest level of identifiable geography as the stratum and the household as the cluster.²⁰

Using the coefficients derived from the multinomial logistic regression model, we

formed two counterfactuals using a generalization of the “recycled probabilities” methodology.²¹ This procedure allows one to compare mean rates of uninsurance between the two time periods, controlling for significant factors likely to influence rates of uninsurance. The method of recycled probabilities produces adjusted health insurance coverage rates that take into account factors such as age, income, education, employment, and access to employer coverage. The procedure enables apples-to-apples comparisons within states from one time period to another, controlling for other relevant variables that may influence coverage rates. For a multinomial logistic regression model with a categorical dependent variable (being uninsured, privately insured, or publicly insured), the method of recycled probabilities is the appropriate statistical tool to construct adjusted averages.

We examined adjusted and unadjusted differences in the overall rates of public coverage, private coverage, and uninsurance between the two time periods. To compute significance tests for differences between the rates of uninsurance, we used an extension of the delta method to obtain estimates of the standard er-

“Given the current government fiscal environment, we do not anticipate any new influx of revenue to support coverage expansions.”

rors of the differences in recycled means (specific to each respondent-characteristic).²²

Study Results

Exhibit 1 provides the unadjusted and adjusted rates of change in health insurance coverage for children, by state. The adjusted rates are based on the recycled rate of change in private coverage, public coverage, and uninsurance, controlling for family and child characteristics likely to influence coverage. Using the adjusted results, we found significant decreases in the percentage of uninsured children between the two time periods for twenty-seven states and significant increases in the number of children enrolled in public insurance in twenty-nine states. We found fewer states with significant changes in the percentage of children with private health insurance coverage: Twelve states had a significant decrease in private coverage for children, while five states had a significant increase.

Exhibit 2 shows the unadjusted and adjusted rates of health insurance coverage for children. The lowest 2001–2002 adjusted uninsurance rates were in Vermont, Rhode Island, and Wisconsin; the highest were in Texas and Arizona. The overall adjusted change in the percentage of uninsured children, from 14.4 percent to 12.7 percent, was not statistically significant.

Exhibit 3 represents the results of our analysis of factors associated with the change in health insurance by type of coverage. We found the largest increase in public program coverage for children with incomes below 200 percent poverty (significant at the .05 level). There was also a significant decrease (at the .01 level) in the percentage of uninsured children with incomes below 100 percent of poverty but no significant decrease in uninsurance for those with incomes of 100–199 percent of poverty.

Discussion

Although some progress has been made in reducing the number of uninsured children, there is still considerable variation in the coverage rates across states, even controlling for individual sociodemographic, employment, and other characteristics. Also, there is an

early indication that gains made during recent years are starting to slip. Given the current government fiscal environment, we do not anticipate any new influx of revenue to support coverage expansions. However, without additional financial support, the gains that have been made are not likely to be sustained.

■ **State rollbacks.** Although state revenues improved somewhat in 2004, twenty-two states still report cost overruns in Medicaid.²³ And even though children are typically not a large part of the Medicaid outlays (representing 49 percent of Medicaid enrollees but only 16 percent of Medicaid spending), children's programs are not protected from budget cuts, as evidenced by recent state action.²⁴

As part of its fiscal year 2004 budget, Massachusetts capped enrollment in its Children's Medical Security Plan (CMSP) and raised premiums, resulting in an estimated increase of 20 percent in the number of uninsured children.²⁵ As of November 2003, six states had enacted SCHIP enrollment freezes, which may increase inequities in coverage among children. Higher-income children have retained coverage, while lower-income children and eligible newborns have lost coverage.²⁶ In another recent study, seven of thirteen state officials interviewed indicated that their states had drastically cut funding for outreach programs.²⁷

These cuts are starting to show up in recent enrollment data. New data from the Centers for Medicare and Medicaid Services (CMS) show a decline in SCHIP enrollment of 200,000 children, from 3.9 to 3.7 million children between June 2003 and March 2004.²⁸ During the first six months (June–December 2003), Texas alone accounted for 52 percent of the decline.²⁹ This followed major legislative action in Texas that restricted eligibility, placed limits on enrollment, and increased premiums and cost sharing for SCHIP.³⁰

We can anticipate more cuts in 2004. The state fiscal relief provided by Congress—\$10 billion in general fiscal relief for unrestricted purposes and \$10 billion in a temporary increase in the federal matching payments to states—expired 30 June 2004.³¹ As part of the relief package, states were required to main-

EXHIBIT 1
Unadjusted And Adjusted Changes In Rates Of Health Insurance Coverage For
Children Age 18 And Under, By Type Of Coverage, Calendar Years 1996–1998 To
2001–2002

State	Change in private coverage (%)		Change in public coverage (%)		Change in uninsured (%)	
	Unadjusted	Adjusted	Unadjusted	Adjusted	Unadjusted	Adjusted
AL	0.6	-2.8	2.5	7.0****	-3.1	-4.2****
AK	-6.1**	1.5	6.5**	1.9	-0.4	-3.3****
AZ	5.4	0.1	0.9	2.6**	-6.3***	-2.7**
AR	-3.8	-3.1	13.2****	11.9****	-9.5****	-8.8****
CA	2.6**	-1.8	-0.8	3.0	-1.9**	-1.1
CO	0.0	3.3	0.9	-0.7	-0.8	-2.6***
CT	2.5	-1.1	-0.9	0.9	-1.5	0.2
DE	6.1	1.5	-3.7	-1.2	-2.4	-0.2
DC	1.5	-2.2	2.8	5.2***	-4.3	-2.9***
FL	0.6	-2.9	1.7	4.7****	-2.4	-1.8
GA	1.9	-1.6	-0.9	1.6	-0.9	0.0
HI	-0.3	-4.0**	-4.0	-1.4	4.3**	5.3****
ID	-2.5	-4.3**	3.6	6.6****	-1.1	-2.3**
IL	0.8	-2.4	-3.3	-0.6	2.5**	2.9***
IN	-4.2	-4.5***	4.4**	4.8****	-0.2	-0.3
IA	-0.1	-0.2	4.7**	5.0****	-4.6***	-4.8****
KS	-2.4	-3.2**	4.1	5.9****	-1.7	-2.7****
KY	-0.6	-3.0	2.3	5.1****	-1.7	-2.1**
LA	1.7	1.9	7.1**	4.6***	-8.8****	-6.6****
ME	-7.4**	-7.0***	14.8****	14.1****	-7.4****	-7.1****
MD	2.7	-1.9	-3.7	0.8	1.0	1.1
MA	1.6	-2.5	0.6	4.6***	-2.2	-2.1****
MI	-0.2	0.2	-0.1	-1.3	0.3	1.1
MN	7.0**	3.2**	-6.8***	-3.5***	-0.3	0.3
MS	-6.9**	-12.5****	13.8****	18.2****	-6.9***	-5.7****
MO	1.5	-1.3	5.6**	7.3****	-7.1****	-6.0****
MT	3.1	3.6**	-2.7	-2.4	-0.5	-1.2
NE	-4.0	-4.7***	5.8**	5.2****	-1.9	-0.5
NV	1.6	3.8**	-0.1	1.3	-1.4	-5.1****
NH	2.2	0.2	-0.3	0.8	-1.8	-0.9
NJ	1.3	0.2	2.1	2.6**	-3.4**	-2.8***
NM	-2.7	-7.4****	7.3**	11.5****	-4.6**	-4.1***
NY	0.9	-3.7**	2.0	5.8****	-3.0***	-2.2**
NC	-2.8	-0.6	5.3**	4.2***	-2.5	-3.6****
ND	-3.3	-2.2	5.6**	4.1***	-2.3	-1.9**
OH	-0.9	-3.0	2.3	4.4***	-1.4	-1.4**
OK	-2.1	-1.4	7.6***	6.8****	-5.5**	-5.5****
OR	-0.8	-1.8	1.7	2.6**	-0.9	-0.7
PA	-1.0	-1.7	-1.1	0.8	2.2	0.9
RI	-5.6	-6.6***	9.4***	10.7****	-3.8**	-4.1****

EXHIBIT 1
Unadjusted And Adjusted Changes In Rates Of Health Insurance Coverage For
Children Age 18 And Under, By Type Of Coverage, Calendar Years 1996–1998 To
2001–2002 (cont.)

State	Change in private coverage (%)		Change in public coverage (%)		Change in uninsured (%)	
	Unadjusted	Adjusted	Unadjusted	Adjusted	Unadjusted	Adjusted
SC	0.1	1.1	8.6***	4.9***	-8.7****	-6.0****
SD	0.7	-1.5	-1.0	0.5	0.3	1.0
TN	5.3	4.5**	1.9	1.9	-7.1***	-6.4****
TX	-1.2	-0.6	2.6**	2.2	-1.4	-1.6
UT	-5.0	-3.7***	5.1**	3.3***	-0.2	0.4
VT	-4.1	-1.9	5.8	4.7***	-1.7	-2.8****
VA	3.5	0.4	-4.0	-0.5	0.5	0.1
WA	-2.6	-1.4	-0.8	-0.7	3.4	2.1***
WV	-5.7	-3.4	5.8	4.6***	-0.1	-1.2
WI	-2.9	-0.6	3.2	2.1	-0.3	-1.6***
WY	-5.4	-6.4****	5.2**	6.6****	0.2	-0.2
Total	0.2	-1.5	1.4****	3.1**	-1.7****	-1.6

SOURCE: Current Population Survey, 1997–1999 and 2002–2003 Annual Demographic Supplements.

** $p < .05$ *** $p < .01$ **** $p < .001$

tain Medicaid eligibility levels that were in effect as of 2 September 2003. However, states are no longer restricted from making changes to Medicaid program eligibility to achieve budget savings. To balance state budgets, policymakers will face the choice of raising taxes to increase program revenue, eliminating existing coverage programs, or reducing program eligibility or benefits, or both.³²

■ **Related issues.** Our study also highlights the potential benefit of a more thorough examination of state program policies, the role of employer-sponsored insurance (ESI), and implications of public program expansions' crowding out private insurance. It will be difficult to tease out the specific effects of SCHIP on reducing the number of uninsured children, given the complexities of isolating the impact of SCHIP and all of the other factors affecting the change in coverage occurring at the same time, including the extent of state and national outreach, Medicaid program changes, and the type of SCHIP program implemented. For example, of the twenty-nine state programs with significant increases in public program participation in our analysis, the type of SCHIP pro-

gram is fairly evenly distributed: Eleven states implemented a Medicaid expansion program; ten, a separate SCHIP program; and eight, a combined program.³³

Recent research has highlighted the variation of ESI across states largely because of individual employment and labor-market characteristics as well as other community contextual effects.³⁴ State variation in ESI also helps explain the persistent state variation in coverage rates. And in terms of policy solutions, states have had little impact on employers' decisions to offer health insurance coverage—leaving the public programs such as SCHIP and Medicaid to fill the gaps.³⁵

There is also ongoing concern among policymakers about the degree to which public coverage crowds out private employer-based or individual coverage when new or expanded public programs are made available.³⁶ Our analysis indicates that there may be some limited substitution; ten states had a significant decrease in private coverage and a corresponding significant increase in public coverage. Yet, interestingly, five states showed a significant increase in private coverage, with

EXHIBIT 2
Unadjusted And Adjusted Rates Of Health Insurance Coverage For Children Age 18
And Under, By Type Of Coverage, Calendar Years 2001–2002

State	Private coverage (%)		Public coverage (%)		Uninsured (%)	
	Unadjusted	Adjusted	Unadjusted	Adjusted	Unadjusted	Adjusted
AL	66.0	64.6	23.4	26.2	10.6	9.2
AK	59.3	64.1	28.0	25.7	12.7	10.3
AZ	59.1	59.3	22.6	21.3	18.4	19.4
AR	52.2	52.8	35.0	33.3	12.8	13.9
CA	58.0	58.1	25.7	25.5	16.3	16.5
CO	73.6	76.5	11.7	10.2	14.7	13.3
CT	75.2	77.5	15.7	13.7	9.2	8.8
DE	71.1	74.7	17.6	14.6	11.3	10.7
DC	45.2	45.8	43.3	42.5	11.5	11.7
FL	59.9	59.4	23.3	24.0	16.8	16.5
GA	61.9	61.4	23.3	23.4	14.8	15.2
HI	69.3	69.0	20.4	19.8	10.3	11.2
ID	63.1	63.2	22.9	24.3	14.1	12.5
IL	68.6	69.0	18.6	18.5	12.8	12.6
IN	72.9	73.2	15.4	15.0	11.7	11.7
IA	75.1	78.6	18.4	15.7	6.5	5.7
KS	73.1	73.3	17.7	18.6	9.2	8.1
KY	60.8	63.6	25.7	24.8	13.5	11.6
LA	55.1	59.2	31.6	27.0	13.3	13.9
ME	62.4	66.2	30.0	27.6	7.5	6.2
MD	76.8	77.5	11.6	11.1	11.6	11.4
MA	70.6	69.9	22.6	24.2	6.9	5.9
MI	69.2	71.8	22.3	19.5	8.5	8.7
MN	77.8	80.2	15.4	13.8	6.8	5.9
MS	47.6	46.0	39.9	42.1	12.5	11.9
MO	69.5	71.4	24.3	23.5	6.3	5.1
MT	63.7	68.4	22.3	19.6	14.0	12.0
NE	69.8	70.9	22.6	20.4	7.6	8.7
NV	68.8	72.1	12.1	12.8	19.1	15.1
NH	77.5	77.8	15.5	14.6	7.0	7.6
NJ	72.0	74.1	15.8	14.2	12.1	11.7
NM	43.8	43.5	39.8	40.2	16.3	16.3
NY	59.3	60.2	29.3	29.0	11.4	10.8
NC	60.0	62.7	26.3	25.3	13.7	12.0
ND	71.8	71.6	19.1	19.1	9.1	9.3
OH	71.0	71.1	20.1	20.7	8.9	8.2
OK	59.0	59.1	26.2	25.4	14.8	15.5
OR	64.7	67.3	22.8	21.5	12.5	11.2
PA	70.3	71.7	19.1	19.0	10.5	9.3
RI	67.0	71.0	27.5	24.5	5.5	4.5
SC	60.9	65.1	29.7	24.2	9.4	10.6
SD	72.6	78.1	17.9	13.8	9.5	8.2
TN	59.2	61.4	32.8	31.4	8.0	7.2
TX	52.9	55.9	24.1	22.0	23.1	22.1
UT	72.3	73.1	16.5	15.1	11.2	11.8

EXHIBIT 2
Unadjusted And Adjusted Rates Of Health Insurance Coverage For Children Age 18
And Under, By Type Of Coverage, Calendar Years 2001–2002 (cont.)

State	Private coverage (%)		Public coverage (%)		Uninsured (%)	
	Unadjusted	Adjusted	Unadjusted	Adjusted	Unadjusted	Adjusted
VT	57.4	62.5	36.9	33.4	5.7	4.0
VA	75.2	79.3	12.9	11.0	11.9	9.7
WA	63.2	65.7	23.3	22.7	13.4	11.6
WV	52.6	56.1	36.8	34.7	10.6	9.2
WI	74.4	76.7	19.8	18.5	5.9	4.8
WY	65.8	68.1	20.3	19.1	13.9	12.7
Total	63.8	65.0	23.0	22.2	13.2	12.7

SOURCE: Current Population Survey, 1997–1999 and 2002–2003 Annual Demographic Supplements.

EXHIBIT 3
Factors Associated With Adjusted Change In Health Insurance Coverage For Children
Age 18 And Under, By Type Of Coverage, Calendar Years 1996–1998 To 2001–2002

Characteristic	Percent change, type of coverage		
	Private	Public	Uninsured
Age (child)			
6–18 years	-1.4	3.0**	-1.6
Under 6 years	-1.8	3.6**	-1.7**
Total	-1.5	3.1**	-1.6
Health status (child)			
Excellent, very good, good	-1.5	3.1**	-1.6
Fair, poor	-2.0	4.7**	-2.7***
Sex (child)			
Female	-1.5	3.2**	-1.6
Male	-1.5	3.1**	-1.6
Poverty level (family)			
<50%	-1.8	6.4***	-4.6**
50–99%	-2.4	6.6***	-4.2**
<100%	-2.2**	6.5***	-4.4***
100–199%	-3.0	5.5***	-2.6
200–299%	-1.7	2.8**	-1.1
300%+	-0.5	0.9**	-0.4
Race/ethnicity (child)			
White	-1.4	2.8**	-1.4
Black	-2.1	5.0***	-2.8***
American Indian	-1.5	4.9***	-3.4**
Asian/Pacific Islander	-1.5	2.2	-0.7
Non-Hispanic	-1.5	2.9**	-1.4
Hispanic	-1.7	4.2**	-2.4

EXHIBIT 3
Factors Associated With Change In Health Insurance Coverage For Children Age 18
And Under, By Type Of Coverage, Calendar Years 1996–1998 To 2001–2002 (cont.)

Characteristic	Percent change, type of coverage		
	Private	Public	Uninsured
Born in U.S. (child)			
No	-0.8	3.3***	-2.5
Yes	-1.6	3.1**	-1.6
Rural/urban (child)			
Rural	-2.2	4.7***	-2.5**
Urban	-1.4	2.8**	-1.4
Work status (family)			
Only part-time adult workers	-2.3	5.2***	-3.0**
Any adult working full time	-1.4	2.7**	-1.3
All adults unemployed	-2.2	5.7***	-3.5***
All adults out of labor force	-2.4	6.0****	-3.6***
Highest education (family)			
Less than high school	-1.5	5.7***	-4.1***
High school graduate	-2.2	4.7**	-2.4
Some college	-1.8	3.1**	-1.3
College degree or more	-0.7	1.2**	-0.5
Age of reference person (family)			
15–24 years	-2.1	5.7***	-3.6***
25–34 years	-2.0	4.0**	-1.9
35–44 years	-1.4	2.5**	-1.2
45–54 years	-1.2	2.4**	-1.2
55–64 years	-1.2	3.6***	-2.5
65+ years	-1.5	5.2***	-3.7**
Marital status (family)			
No married adults	-2.1	4.9***	-2.8**
Married adults	-1.4	2.7**	-1.3

SOURCE: Current Population Survey, 1997–1999 and 2002–2003 Annual Demographic Supplements.

p* < .05 *p* < .01 *****p* < .001

three of these showing a comparable decrease in levels of uninsurance.

■ **Policy recommendations.** Our research has highlighted the impact that new programs and policies have had on increasing health insurance coverage for children. But it has also demonstrated great variation in these gains by state. Providing a more equitable distribution of coverage of children across states will require not only additional revenue but a concerted bipartisan commitment from policymakers. Perhaps such an effort could initially target coverage for all low-income children (below 200 percent of poverty). Such an

effort would require new state and federal financial support, an increase in federally mandated minimum eligibility levels, and innovations to get and keep children enrolled.

We recommend, initially, that national policymakers consider extending federal fiscal relief to states to support and maintain states' progress toward reducing the number of uninsured children and to explicitly move toward more equitable coverage of children across states, starting with children in families with the lowest incomes.

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