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Submitted for the Record of the Hearing,
“The Children’s Health Insurance Program in Action: A State’s Perspective on CHIP”

Before the Committee on Finance
United States Senate

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I appreciate the opportunity to provide a statement on the State Children’s Health Insurance Program (SCHIP). A principal research associate and health economist at The Urban Institute, I have been at the Urban Institute for over 20 years, where I have been a lead researcher on numerous evaluations, including two major evaluations of SCHIP: a congressionally-mandated evaluation for the U.S. Department of Health and Human Services and an evaluation supported by a number of private foundations. The views expressed here are my own and do not necessarily reflect the views of the Urban Institute or its sponsors.

Background. The State Children’s Health Insurance Program (SCHIP) is up for reauthorization this year. SCHIP was created in 1997 to increase insurance coverage of children whose families earn too much to qualify for Medicaid, but still cannot afford private health insurance. It was funded as a capped block grant to states, providing \$40 billion in federal funds over a ten-year period that were matched by state funds. Numerous studies have assessed SCHIP along a number of different objective standards, and the evidence strongly indicates that SCHIP has been a success¹:

- SCHIP resulted in coverage expansions for children in all states despite being an optional program.
- SCHIP prompted enrollment- and renewal-simplification efforts and new investments in outreach, many of which were adopted by Medicaid programs as well.²
- SCHIP, though smaller than Medicaid, has become an important part of the coverage patchwork for children, providing coverage to over 4 million children on any given day and to more than 6 million children over the course of the year.
- SCHIP, together with Medicaid, contributed to coverage gains for poor and near-poor children over the last decade.³
- SCHIP achieved coverage gains for children without inducing large-scale crowd out of employer coverage.⁴

¹ G. Kenney and J. Yee, “SCHIP at a Crossroads: Experiences to Date and Challenges Ahead,” *Health Affairs* 26, no. 2 (2007): 356-369.

² G. Kenney and D. Chang, “The State Children’s Health Insurance Program: Successes, Shortcomings, and Challenges,” *Health Affairs* 23, no. 5 (2004): 51–62; T. Selden, J. Hudson, J. Banthin, “Tracking Changes in Eligibility and Coverage Among Children, 1996-2002,” *Health Affairs* 23, no. 5 (2004): 39-50.

³ L. Dubay and G. Kenney, “Gains in Children’s Health Insurance Coverage but Additional Progress Needed,” *Pediatrics* 114, no. 5 (2004): 1338-1340; L. Dubay, I. Hill, and G. Kenney, “Five Things Everyone Should Know about SCHIP,” *Assessing the New Federalism Policy Brief A-55* (Washington: Urban Institute, 2002); J.S. Schiller, M. Martinez, and P. Barnes, “Early Release of Selected Estimates Based on Data from the 2005 National Health Interview Survey,” June 2006, www.cdc.gov/nchs/data/nhis/earlyrelease/insur200606.pdf (accessed 16 April 2007); T.M. Selden, J.L. Hudson, and J.S. Banthin, “Tracking Changes in Eligibility and Coverage among Children, 1996–2002,” *Health Affairs* 23, no. 5 (2004): 39–50; J.P. Vistnes and J.A. Rhoades, “Changes in Children’s Health Insurance Status, 1996-2005: Estimates for the U.S. Civilian Noninstitutionalized Population under Age 18,” Statistical Brief #141 (Rockville, MD: Agency for Healthcare Research and Quality, 2006).

⁴ C. Bansak and S. Raphael, “The Effects of State Policy Design Features on Take-up and Crowd-out Rates for the State Children’s Health Insurance Program,” *Journal of Policy Analysis and Management* 26, no. 1 (2006): 149-175; P. Cunningham, J. Hadley, and J. Reschovsky, “The Effects of SCHIP on Children’s Health Insurance Coverage:

- SCHIP led to improvements in children’s access to needed health care and produced access improvements for children in different types of programs and circumstances (e.g., age, race/ethnicity, health status etc.).⁵
- SCHIP helped narrow, but did not eliminate racial and ethnic gaps in coverage and access to care among children.⁶

While SCHIP faces many important programmatic challenges related to its funding level and formula, the close to two million uninsured children who are eligible for SCHIP but are not yet enrolled, and quality monitoring and improvement,⁷ I focus on three issues—crowd out, the coverage of children with family incomes above 200 percent of the federal poverty level (FPL), and the coverage of parents. My main points are the following:

- First, the weight of the evidence on crowd out indicates that it has been a smaller problem than was feared when SCHIP was enacted. Moreover, most children currently covered under SCHIP do not have parents with employer-sponsored insurance coverage. Thus, funding shortfalls under SCHIP would produce higher uninsurance rates among children, since so few enrollees have access to affordable private coverage.
- Second, relatively few SCHIP enrollees have family incomes above 200 percent of the FPL, and most of these pay premiums for SCHIP coverage and do not have parents with employer-sponsored coverage. Thus, restricting SCHIP eligibility to children with family incomes below 200 percent of the FPL would raise uninsurance rates among children.
- Third, while relatively few parents are covered under SCHIP, reducing coverage for parents under SCHIP would lower their access to needed health care and have adverse effects on the health, well-being, and insurance coverage of their children. Given that more than 7 million low-income parents are uninsured and given that they have very little

Early Evidence from the Community Tracking Survey,” *Medical Care Research and Review* 59, no. 4 (2002): 359-383; A. Davidoff, G. Kenney, and L. Dubay, “Effects of the State Children’s Health Insurance Program Expansions on Children with Chronic Health Conditions,” *Pediatrics* 116, no. 1 (2005): e34-e42; L. Dubay and G. Kenney, “The Impact of SCHIP on Insurance Coverage,” Draft Manuscript; J. Gruber and K. Simon, “Crowd-Out Ten Years Later: Have Recent Public Insurance Expansions Crowded Out Private Health Insurance?” NBER Working Paper 12858 (Cambridge, MA: National Bureau of Economic Research, 2007); J. Hudson, T. Selden, and J. Banthin, “The Impact of SCHIP on Insurance Coverage of Children,” *Inquiry* 42, no. 3 (2005): 232-254; A. Lo Sasso and T. Buchmueller, “The Effect of the State Children’s Health Insurance Program on Health Insurance Coverage,” *Journal of Health Economics* 23, no. 5 (2004): 1059-1082.

⁵ Davidoff, Kenney, and Dubay, op cit.; G. Kenney, “The Impacts of SCHIP on Children Who Enroll: Findings from Ten States,” *Health Services Research*, in press; P. Szilagyi et al., “Improved Asthma Care After Enrollment in the State Children’s Health Insurance Program in New York,” *Pediatrics* 117, no. 2 (2006): 486-496; see Kenney and Yee (2007) for additional literature on access and use improvements under SCHIP.

⁶ For example, see A.W. Dick et al., “SCHIP’s Impact in Three States: How Do the Most Vulnerable Children Fare?” *Health Affairs* 23, no. 5 (2004): 63-75; L.P. Shone et al., “Reduction in Racial and Ethnic Disparities after Enrollment in the State Children’s Health Insurance Program,” *Pediatrics* 115, no. 6 (2005): e697–e705.

⁷ See Kenney and Yee (2007), cited in Footnote 1 above, for a discussion of these other important issues facing the program at reauthorization.

access to employer-sponsored insurance, serious consideration should be given to expanding such coverage instead of restricting SCHIP coverage for parents.

Crowd Out Under SCHIP. When SCHIP was created, there was concern that many families would drop employer coverage in order to enroll their children in the new program⁸, a phenomenon known as “crowd out.” As a consequence, the SCHIP statute included anti-crowd out provisions and the Congressional Budget Office (CBO) baseline for SCHIP assumed a crowd out rate of 40 percent. In response, most states required waiting periods for children with employer-sponsored coverage to avoid crowd out.⁹ The difficulty with assessing the extent of crowd out is that it is impossible to know what would have happened to children’s coverage in the absence of SCHIP, given the other changes that were going on in the economy and the private insurance market, such as the shift of jobs toward smaller employers and the service sector, which are less likely to offer employer coverage, and the high growth in the cost of family health insurance premiums in absolute terms and relative to income. In the absence of any public policy changes, such employment shifts and the premium growth that has outstripped wage growth since the late 1990s would have led to continued declines in private insurance coverage.¹⁰ Therefore, separating the effects of policy changes implemented coincidentally with these trends is methodologically challenging.

Numerous econometric studies have attempted to examine the extent to which eligibility expansions to children under SCHIP have substituted for employer coverage on a national level, by controlling for potentially confounding changes occurring over the same time period.¹¹ These studies have produced estimates that range from 0 to 70 percent, demonstrating how sensitive the estimates are to the data and methodological approach and how imprecise the estimates are. The only longitudinal study that has examined crowd out under SCHIP at a national level found estimates in a much lower band, between 0 and 25 percent.¹² In addition, the one study that examined crowd out at the employer-level found that SCHIP expansions had no effect on offers of family coverage and only a small effect on the employer’s contribution toward family coverage.¹³

⁸ United States House of Representatives, Committee on Ways and Means, Subcommittee on Health, Hearing on “Children’s Access to Health Coverage,” 8 April 1997.

⁹ A.W. Lutzky and I. Hill, *Has the Jury Reached a Verdict? States Early Experiences with Crowd Out under SCHIP*. Occasional Paper No. 47 (Washington, DC: The Urban Institute, 2001).

¹⁰ G. Claxton et al., “Health Benefits In 2006: Premium Increases Moderate, Enrollment In Consumer-Directed Health Plans Remains Modest,” *Health Affairs* 25, no. 6 (2006): w476-w485; J. Gabel et al., “Health Benefits In 2005: Premium Increases Slow Down, Coverage Continues To Erode,” *Health Affairs* 24, no. 5 (2005): 1273-1280; J. Gabel et al., “Health Benefits In 2003: Premiums Reach Thirteen-Year High As Employers Adopt New Forms Of Cost Sharing,” *Health Affairs* 22, no. 5 (2003): 117-126; J. Holahan, “Changes in Employer-Sponsored Health Insurance Coverage,” *Snapshots of America’s Families III*, No. 9 (Washington, DC: The Urban Institute, 2003); S. Zuckerman, “Gains in Public Health Insurance Coverage Offset Reductions in Employer Coverage among Adults.” *Snapshots of America’s Families III*, No. 8 (Washington, DC: The Urban Institute, 2003).

¹¹ See references in Footnote 4.

¹² L. Dubay and L. Blumberg, “The National Impact of the SCHIP on Insurance Coverage of Children: A Longitudinal Analysis,” Working Paper (Washington, DC: The Urban Institute, 2007).

¹³ T. Buchmueller et al., “The Effect of SCHIP Expansions on Health Insurance Decisions by Employers,” *Inquiry* 42, no. 3 (2005): 218-231.

Moreover, very few SCHIP enrollees drop employer-sponsored coverage in order to enroll in the program.¹⁴ Estimates from a congressionally-mandated evaluation of 10 states that account for over 62 percent of all SCHIP enrollees in the nation conducted for The Office of the Assistant Secretary for Planning and Evaluation at the Department of Health and Human Services indicate that only 28 percent of children newly enrolling in SCHIP had had employer-sponsored coverage in the preceding six months and that only half of them, or 14 percent overall, could have retained that coverage (Figure 1).

Employer-sponsored insurance (ESI) is not a viable alternative for many SCHIP enrollees, since most do not have parents with employer-sponsored insurance coverage.¹⁵ An estimated 37 percent of all SCHIP enrollees in the nation live in families where at least one parent has employer-sponsored coverage and only 25 percent of all SCHIP enrollees live in families where all parents present (i.e., one parent in single-parent families and both parents in two-parent families) have employer coverage (Figure 2). In addition, no information is available to assess the affordability or quality (i.e., in terms of benefits) of the ESI coverage that is available.

Uninsurance rates among low-income children are much lower than those among other low-income populations that are less likely to be eligible for Medicaid and SCHIP coverage (Figure 3). In particular, low-income parents are nearly twice as likely as low-income children to be without health insurance coverage. Likewise, the uninsured rate for low-income people age 19 through 21 is more than two times as high as the uninsured rate for low-income children under age 18. In addition, the uninsured rate for low-income non-citizen children, another group with very limited access to public insurance programs, is more than 2.5 times as high as for low-income citizen children (Figure 3). The higher rates of uninsurance among these groups are suggestive of what uninsurance rates might have been for low-income citizen children, had SCHIP and Medicaid not been available to them.

In summary, the weight of the evidence on crowd out indicates that it has been a smaller problem than was feared when SCHIP was enacted. While crowd out is an inevitable by-product of any effort to expand coverage, it is likely that alternative policy approaches, which do not include anti-crowd out measures such as those implemented under SCHIP, would lead to more crowd out than was observed under SCHIP.¹⁶ Although econometric studies have not produced a definitive crowd out estimate, very few SCHIP enrollees drop employer coverage to enroll in SCHIP and most children currently covered under SCHIP do not have parents with employer-sponsored

¹⁴ A. Sommers et al., "Substitution of SCHIP for Private Coverage: Results from a 2002 Evaluation in Ten States," *Health Affairs* 26, no. 2 (2007): 529-537; J. Nogle and E. Shenkman, *Florida KidCare Program Evaluation Report, 2003*, January 2004, <http://www.ichp.ufl.edu/documents/KidCareReportYear5Final.pdf> (accessed 16 April 2007); D. Hughes, J. Angeles, and E. Stilling, *Crowd-Out in the Health Families Program: Does it Exist?* (San Francisco: Institute for Health Policy Studies, University of California, August 2002).

¹⁵ A. Sommers, S. Zuckerman, and L. Dubay, "The Relationship Between SCHIP and Private Coverage Among SCHIP Enrollees." In G. Kenney, C. Trenholm, et al., "The Experiences of SCHIP Enrollees and Disenrollees in Ten States: Findings from the Congressionally Mandated SCHIP Evaluation," report prepared for the Assistant Secretary of Planning and Evaluation, U.S. Department of Health and Human Services (Princeton, N.J.: Mathematica Policy Research and the Urban Institute, 2005); G. Kenney and A. Cook, "Coverage Patterns Among SCHIP-Eligible Children and Their Parents," *Health Policy Online* No. 15 (Washington, DC: The Urban Institute, 2007); R.A. Allison et al., "Do Children Enrolling in Public Health Insurance Have Other Options?" *Kansas Health Institute Research Brief 03-2* (Topeka, KS: KHI, 2003).

¹⁶ J. Gruber, Letter to U.S. Representative John Dingell, 28 February 2007.

insurance. Thus, funding shortfalls under SCHIP would produce higher uninsurance among children since so few SCHIP enrollees have access to affordable private coverage. Key policy questions going forward will be whether the provision of wrap-around benefits (e.g., dental and mental health services), which is not currently permitted under the SCHIP statute, and greater reliance on premium assistance programs could give states even more effective tools to limit crowd out.

Coverage of Children above 200 percent of the FPL under SCHIP. While the majority of uninsured children are low-income, a sizeable number of uninsured children have incomes above 200 percent of the FPL, and most of these higher-income children are not eligible for public coverage.¹⁷ Overall, an estimated 2.5 million uninsured children live in families with incomes above 200 percent of the Federal Poverty Level (Figure 4). About half of the uninsured children with incomes above 200 percent of the FPL have family incomes between 200 and 300 percent of the FPL. The risk of uninsurance declines with family income—nearly 10 percent of children with incomes between 200 and 300 percent of the FPL lack health insurance coverage compared with five percent of those with incomes between 300 and 400 percent of the FPL, and three percent of the children with incomes above 400 percent of the FPL. Most uninsured children with incomes between 200 and 300 percent of the FPL do not have parents with employer-sponsored insurance coverage.¹⁸ Moreover, in most states, private non-group insurers are not required to issue insurance policies to individuals with health problems, further limiting coverage options for children losing SCHIP eligibility.

As of July 2006, 16 states had income thresholds above 200 percent of the FPL for children under SCHIP.¹⁹ According to the Congressional Research Service, about 9 percent of all children enrolled in SCHIP in FY 2006 had family incomes above 200 percent of the FPL.²⁰ Recent evidence suggests that most SCHIP enrollees with incomes above 200 percent of the FPL do not have parents with employer-sponsored insurance coverage.²¹ Almost all SCHIP enrollees with incomes above 200 percent of the FPL pay premiums for SCHIP coverage, as most states use sliding-scale premium schedules that require families with higher incomes to contribute more toward their child's coverage compared to families with incomes below 200 percent of the FPL. The level of premiums varies across states, reflecting differences in the cost of living and other factors.²²

¹⁷ J. Holahan, A. Cook and L. Dubay, *Characteristics of the Uninsured: Who is Eligible for Public Coverage and Who Needs Help Affording Coverage?* (Washington, DC: Kaiser Family Foundation, 2007).

¹⁸ Estimates based on Urban Institute Tabulations of the 2006 Annual Social and Economic Supplement (ASEC) to the Current Population Survey (CPS) indicate that only 13.5 percent of uninsured children in this income group have a parent with employer-sponsored coverage, although tabulations of the February Contingent Work Supplement and March ASEC Supplement to the 2005 CPS indicate that 49 percent of uninsured children with incomes between 200 and 299 percent of the FPL live in families where there is an offer of employer-sponsored insurance coverage.

¹⁹ Most states report their eligibility thresholds net of disregards. When disregards are taken into account, it appears that 37 states have gross income thresholds that are above 200 percent of the FPL.

²⁰ C. Peterson and E. Herz, *Estimates of SCHIP Child Enrollees Up to 200% of Poverty, Above 200% of Poverty, and of SCHIP Adult Enrollees* (Washington, DC: Congressional Research Service, 13 March 2007).

²¹ An estimated 30 percent of SCHIP enrollees with incomes between 200 and 300 percent of the FPL live in families where all parents who are present have employer coverage [based on methodology in Kenney and Cook (2007)].

²² G. Kenney, J. Hadley, and F. Blavin, "Effects of Public Premiums on Children's Health Insurance Coverage: Evidence from 1999 to 2003," *Inquiry* 43, no. 4 (2007): 345-361.

In summary, restricting SCHIP eligibility to children in families with incomes below 200 percent of the FPL would lead to higher uninsurance rates among children, since many of the families with incomes between 200 and 300 percent of the FPL who have children enrolled in SCHIP would find it difficult, if not impossible, to obtain affordable private coverage that meets their child's health care needs. Adopting broader Medicaid/SCHIP eligibility policies that encompass higher income children may also raise enrollment among the millions of low-income uninsured children who are eligible for Medicaid and SCHIP but not yet enrolled.²³ A key policy challenge for states will be to determine a premium schedule that minimizes the public subsidies that go to higher-income families, while at the same time maximizing take-up among the higher-income children who are uninsured.

Coverage of Parents Under SCHIP. Of the over 10 million parents who are uninsured, more than two-thirds have incomes below 200 percent of the FPL.²⁴ The risk of being uninsured is much higher for low-income parents than for higher-income parents—fully 42 percent of poor parents and 33 percent of near-poor parents lack coverage compared to 16 percent of parents with incomes between 200 and 300 percent of the FPL and 5 percent of those with incomes that are above 300 percent of the FPL.²⁵

SCHIP funds are used to cover parents in nine states, with parents constituting 6.8 percent of all SCHIP enrollees in 2006 (0.5 million enrolled at any time in FY2006).²⁶ Without the higher federal matching rate available under SCHIP compared to Medicaid, it is not clear how many of these states would continue to provide expanded coverage for parents. While public coverage has grown for parents over the last decade, coverage is still very limited, with the median eligibility level under Medicaid/SCHIP at just 65 percent of the FPL for parents, compared with 200 percent of the FPL for children.²⁷ Only about a third of all low-income uninsured parents appear to be eligible for Medicaid or SCHIP coverage.²⁸

While most low-income uninsured parents are from working families, only a quarter live in a family that has an offer of employer-sponsored coverage. Poor uninsured parents are much less likely than those in families with incomes between 100 and 200 percent of the FPL to have such an offer in their family—just 15 percent of poor parents live in families that have an offer of employer-based coverage (Figure 5).

A substantial number of low-income uninsured parents have one or more health problems—29 percent indicate that they are in poor or fair physical or mental health or that they have a

²³ Selden, Hudson, and Banthin, op cit.

²⁴ Kaiser Commission on Medicaid and the Uninsured, *Health Insurance Coverage in America 2005 Data Update* (Washington, DC: Kaiser Family Foundation, 2006).

²⁵ Ibid.

²⁶ Peterson and Herz, op cit.

²⁷ D. Cohen Ross, L. Cox, and C. Marks, *Resuming the Path to Health Coverage for Children and Parents: A 50 State Update on Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and SCHIP in 2006*, (Washington, DC: Kaiser Family Foundation, 2007).

²⁸ Urban Institute tabulations of the 2005 Current Population Survey which adjust for underreporting of public coverage and take into account immigration status among income-eligible parents.

functional limitation.²⁹ Since many uninsured parents have chronic health care problems, finding non-group health insurance coverage that addresses their health care needs may be very difficult. Not having insurance introduces real access barriers for many uninsured parents. Low-income uninsured parents go without care at high rates—two-thirds did not see a doctor in the past year, almost 90 percent received no dental care, and over half did not have a usual source for health care.³⁰

In addition, there are many connections among the insurance coverage, health status, and use of services of parents and their children. First, covering parents increases receipt of primary health care among their children.³¹ When parents have health insurance for themselves, they may be more effective at obtaining health care services on behalf of their children. Second, expanding eligibility for public programs to parents has been shown to increase public coverage and to reduce uninsurance among children.³² Third, a parent's health status affects the child's health status, health care use and well-being.³³ For example, children with depressed parents are less likely to receive preventive care and more likely to have unmet health needs and to have increased mental health problems.³⁴

While relatively few parents are covered under SCHIP, reducing coverage for parents under SCHIP would lower their access to needed health care and also have adverse effects on the health, well being, and insurance coverage of their children. Given that such a large share of low-income parents are uninsured and do not have access to employer-sponsored insurance, instead of restricting SCHIP coverage for parents, serious consideration should be given to expanding such coverage.

In summary, the research evidence strongly indicates that SCHIP has been a success, leading to improvements in insurance coverage and access to care among low-income children, without crowding out employer coverage on a large scale. The research also clearly indicates that reductions in program funding or eligibility, either to children or their parents, would have adverse effects on the health and well-being of children.

²⁹ Urban Institute analysis of the 2004 Medical Expenditure Panel Survey.

³⁰ Ibid.

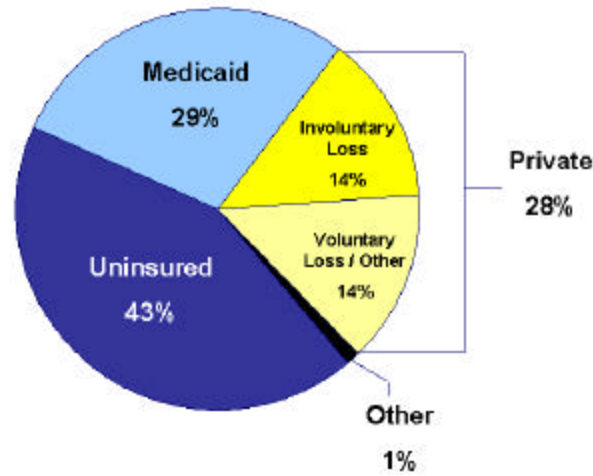
³¹ A. Davidoff et al., "The Effect of Parents' Insurance Coverage on Access to Care for Low-Income Children," *Inquiry* 40, no. 3 (2003): 254-268; Committee on the Consequences of Uninsurance, Institute of Medicine, *Health Insurance Is a Family Matter* (Washington, DC: National Academy Press, 2002); L. Ku and M. Broaddus, *Coverage of Parents Helps Children, Too* (Washington: Center on Budget and Policy Priorities, 2006).

³² B. Wolfe et al., "SCHIP Expansion and Parental Coverage: An Evaluation of Wisconsin's BadgerCare," *Journal of Health Economics* 25, no. 6 (2006): 1170-1192; B.D. Sommers, "Insuring Children or Insuring Families: Do Parental and Sibling Coverage Lead to Improved Retention of Children in Medicaid and CHIP?" *Journal of Health Economics* 25, no. 6 (2006): 1154-1169; A. Aizer and J. Grogger, "Parental Medicaid Expansions and Health Insurance Coverage," NBER Working Paper 9907, August 2003; L. Dubay and G. Kenney, "Expanding Public Health Insurance to Parents: Effects on Children's Coverage Under Medicaid," *Health Services Research* 38, no. 5 (2003): 1283-1301.

³³ Committee on the Consequences of Uninsurance, Institute of Medicine, op cit.

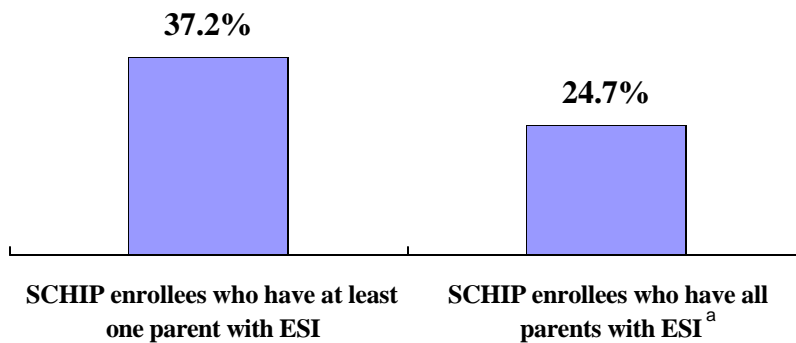
³⁴ Ibid; G. Fairbrother et al., "How do Stressful Family Environments Relate to Reported Access and Use of Health Care by Low-income Children?" *Medical Care Research and Review* 62, no. 2 (2005): 205-230; M. Olfson et al., "Parental Depression, Child Mental Health Problems, and Health Care Utilization," *Medical Care* 41, no. 6 (2003): 716-721.

Figure 1: Coverage of Recent Enrollees in the State Children’s Health Insurance Program (SCHIP) during the Six Months before Enrollment, Ten States, 2002



Source: A. Sommers et al., “Substitution of SCHIP for Private Coverage: Results from a 2002 Evaluation in 10 States.” *Health Affairs* 2007, 26(2): 529-537.

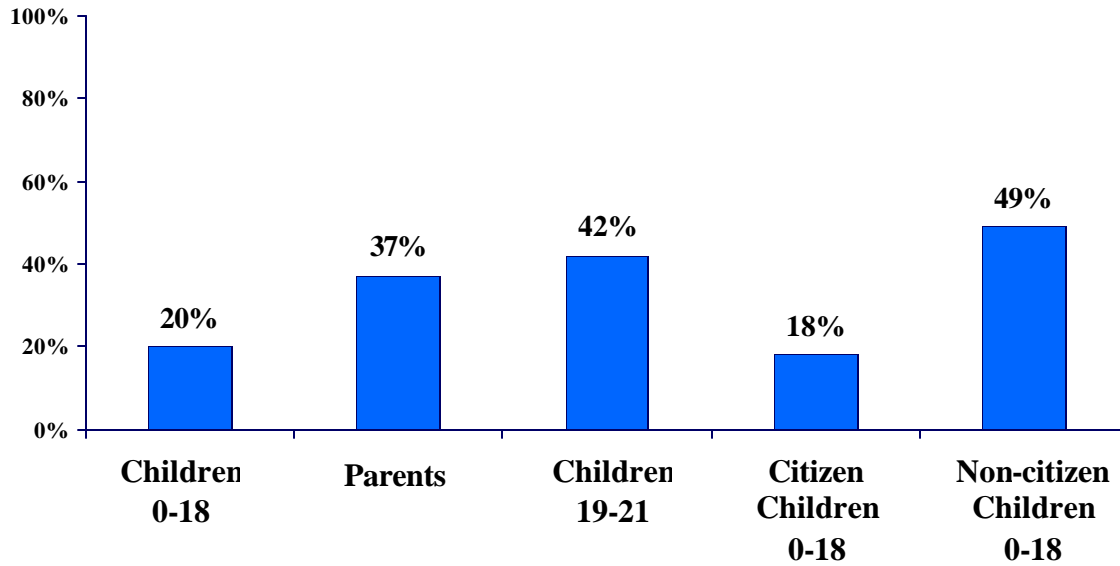
Figure 2. Employer-Sponsored Insurance (ESI) among Parents of SCHIP Enrollees



Source: Urban Institute tabulations of the 2005 Annual Social and Economic Supplement to the Current Population Survey.

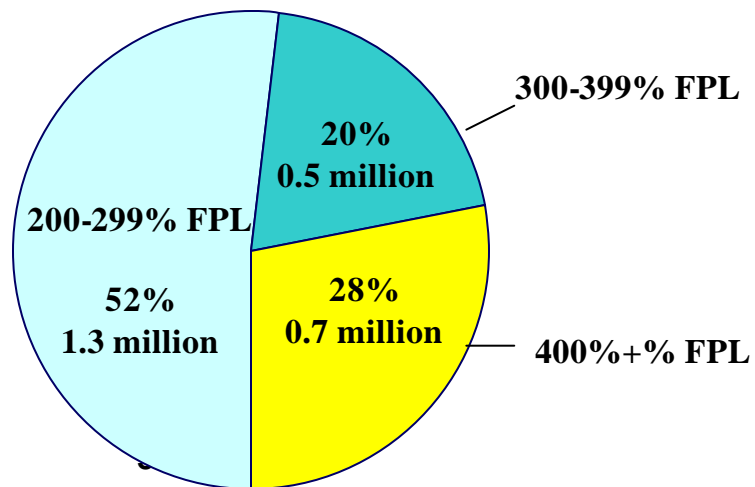
^a Where both parents have ESI in two-parent families and where one parent has ESI in single-parent families.

Figure 3. Uninsurance Rates for Low-Income Children and Parents



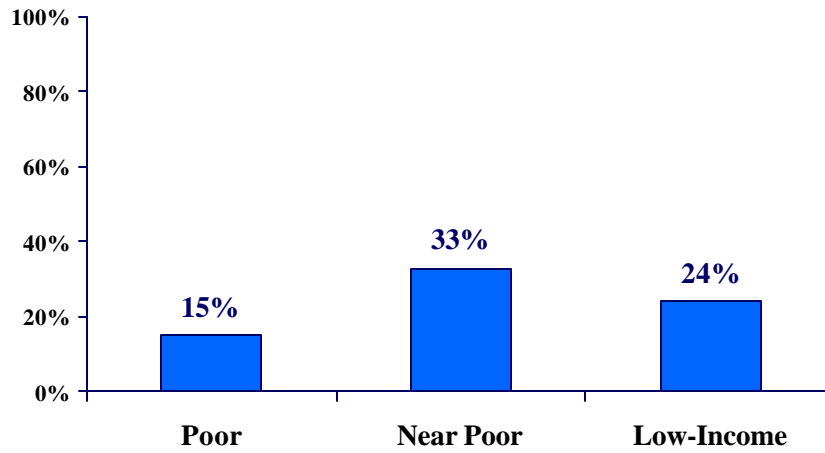
Source: Urban Institute tabulations of the 2006 Annual Social and Economic Supplement to the CPS.

Figure 4. Composition of Uninsured Children Above 200 Percent of Poverty



Source: Urban Institute tabulations of the 2006 Annual Social and Economic Supplement to the CPS.
Note: Data may not sum to 100 percent due to rounding.

Figure 5. Share of Low-Income Uninsured Parents in Health Insurance Units that Have an Offer of Employer Coverage



Source: Urban Institute analysis of the February 2005 Contingent Work Supplement of the Current Population Survey (CPS) and the March 2005 Annual Social and Economic (ASEC) Supplement of the CPS