WELFARE REFORM PROPOSALS

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WELFARE REFORM PROPOSALS

HEARING

BEFORE THE

SUBCOMMITTEE ON HUMAN RESOURCES

OF THE

COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED FOURTEENTH CONGRESS

FIRST SESSION

JULY 15, 2015

Serial No. 114–HR06

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WELFARE REFORM PROPOSALS

WEDNESDAY, JULY 15, 2015

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HUMAN RESOURCES,
Washington, DC.

The Subcommittee met, pursuant to notice, at 10:32 a.m., in Room 1100, Longworth House Office Building, Hon. Charles Boustany [Chairman of the Subcommittee] presiding.

[The advisory announcing the hearing follows:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HUMAN RESOURCES

FOR IMMEDIATE RELEASE
Wednesday, July 8, 2015
No. HR–06

CONTACT: (202) 225–3625

Chairman Boustany Announces Hearing on Welfare Reform Proposals

Congressman Charles Boustany (R–LA), Chairman of the Subcommittee on Human Resources of the Committee on Ways and Means, today announced that the Subcommittee will hold a hearing on welfare reform proposals, specifically involving the reauthorization of the Temporary Assistance for Needy Families (TANF) program. **The hearing will take place on Wednesday, July 15, 2015, in 1100 Longworth House Office Building, beginning at 10:30 a.m.**

In view of the limited time available to hear witnesses, oral testimony at this hearing will be from invited witnesses only. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Please Note: Any person(s) and/or organization(s) wishing to submit for the hearing record must follow the appropriate link on the hearing page of the Committee website and complete the informational forms. From the Committee homepage, *http://waysandmeans.house.gov*, select "Hearings." Select the hearing for which you would like to submit, and click on the link entitled, "Click here to provide a submission for the record." Once you have followed the online instructions, submit all requested information. ATTACH your submission as a Word document, in compliance with the formatting requirements listed below, **by the close of business on Thursday, July 29, 2015**. Finally, please note that due to the change in House mail policy, the U.S. Capitol Police will refuse sealed-package deliveries to all House Office Buildings. For questions, or if you encounter technical problems, please call (202) 225–1721 or (202) 225–3625.

FORMATTING REQUIREMENTS:

The Committee relies on electronic submissions for printing the official hearing record. As always, submissions will be included in the record according to the discretion of the Committee. The Committee will not alter the content of your submission, but we reserve the right to format it according to our guidelines. Any submission provided to the Committee by a witness, any supplementary materials submitted for the printed record, and any written comments in response to a request for written comments must conform to the guidelines listed below. Any submission or supplementary item not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All submissions and supplementary materials must be provided in Word format and MUST NOT exceed a total of 10 pages, including attachments. Witnesses and submitters are advised that the Committee relies on electronic submissions for printing the official hearing record.

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit materials not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. All submissions must include a list of all clients, persons, and/or organizations on whose behalf the witness appears. A supplemental sheet must accompany each submission listing the name, company, address, telephone, and fax numbers of each witness.

The Committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202–225–1721 or 202–226–3411 TDD/TTY in advance of the event (four business days notice is requested). Questions with regard to special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

Note: All Committee advisories and news releases are available online at *http://www.waysandmeans.house.gov/*.

Chairman BOUSTANY. The Subcommittee will come to order. I would like to welcome our Members, witnesses, and guests to this morning's hearing on welfare reform re-authorization proposals.

On April 30th, this Subcommittee held a hearing on ideas to improve TANF to help more families find work and escape poverty. We had an excellent panel of witnesses who shared their ideas, and since that time Members and staff have been discussing ways that we might work together to improve our Nation's welfare system.

Today our hearing will focus on specific proposals to improve the lives of families on welfare by better promoting work and helping families in need move up the economic ladder. Work is the only way for people to really escape from poverty and achieve the American Dream, and we are eager to help more families succeed at doing just that.

The Ways and Means Committee discussion draft released last Friday is designed to focus on outcomes, helping people get jobs and stay employed, and to help more people move from welfare to self-sufficiency. In short, this discussion draft revitalizes the work requirement for people collecting welfare benefits; provides States more options to help people prepare to leave welfare for employment; holds States accountable for getting adults off welfare and into jobs; prevents the work requirements from being waived; ends the TANF marriage penalty, among other key reforms; and maintains funding for the TANF program going forward.

I would like to thank Ranking Member Doggett and his staff for working with us on this draft. We are doing this the right way, holding constructive hearings, working in a bipartisan way on draft legislation, and soliciting expert and public comment as the work continues. So we will welcome our witnesses' comments, and we will be working together to incorporate that feedback as this legislation progresses.

I would also like to thank the many Members who have joined me in introducing specific bills to improve how the TANF program works. Whether it is ensuring more adults on welfare are engaged in work and activities, providing additional flexibility so these activities meet people's specific needs, or just setting a goal of reducing poverty through more employment, those bills are important markers of our path to helping families find work, escape poverty, and achieve the American Dream.

We are joined by several additional Members today, including Congressman Paulsen and Congressman Renacci, who are former Members of this Subcommittee, and we certainly welcome them back. And I appreciate everyone's contributions to this effort.

So, with that, I would like to now yield to the Ranking Member of the Subcommittee, Mr. Doggett, for the purposes of an opening statement.

Mr. DOGGETT. Thank you very much, Mr. Chairman. We are pleased today to get additional input on the Temporary Assistance for Needy Families program, and how it may be reformed. This program has limped along over short periods of time for a number of years. On Friday afternoon there was a discussion draft issued, as the Chairman has indicated, and I think that is what it is, a discussion draft that justifies considerably more discussion to see how it might achieve the objectives, many of which we share and some of which we still have divergent opinions on.

I think there is a recognition that TANF is more hole than safety net at present, and its flaws need to be mended. There should be a recognition that, since the Welfare Reform Act of the nineties that I voted in favor of, much of the objective of that Act has not been fulfilled, and that a significant amount of dollars have essentially been used by the States during the ups and downs of the budget, and the economy, to simply use the Federal dollars to supplant what the States were or should have been doing, rather than to expand innovative programs and do more to get people into the workforce.

I think that an objective of this bill is not just about work, but about opportunity, especially an opportunity to work into the middle class, and that the concept of just finding any dead-end job for someone who is currently receiving temporary assistance, rather than finding opportunity to work and advance within our society, is not where we need to be going.

Of the provisions that I have reviewed in the discussion draft, I think some of the most hopeful are those concerning vocational education, secondary education, and job readiness activities, which would all be permitted under the TANF work requirements in the discussion draft. Those programs are essential to be included, because they do help prepare people for an opportunity up, rather than just a subsistence level of participation.

On the average, the States are only spending about half of the funds that they receive today in TANF on core purposes of TANF, such as financial assistance, child care, and work assistance. In many States, like Texas, that percentage is much lower. While the inherently flawed nature of any block grant program is what allows this situation to occur, I think we can move TANF forward with stronger requirements to achieve more targeted spending. States should be spending at least half of their funds on these core purposes.

I do think that there are some reforms in the discussion draft concerning State matching, and the State approach to these funds that are constructive, that I support, and I would only like to see them enhanced.

The maximum monthly benefit under the program for a family of three now is only 28 percent of the poverty level. In Texas, the benefits are less than 20 percent of the poverty level. As children across the country face homelessness, not one State in 2014 provided a benefit amount equal to the fair market value of rent in that State.

This is truly a temporary subsistence program. And with these deficiencies in mind, I look forward to working with our experts to further evaluate if a specific percentage of State spending toward financial assistance alone should be required, as well.

There are some ideas that we have explored in hearings over the last year for innovation. One of those is social impact partnership projects. I am pleased that we will be hearing about—more about the experience of Utah, which has been a leader on social impact partnerships. Any way that we can constructively get the involvement of the private sector and of foundations, and can focus on outcomes, I think is constructive.

I certainly agree with Ms. Cox, in her testimony, that these social impact partnerships, as they relate to the limited amount of TANF funds, should only serve actual participants—actual recipients of TANF funds. And I think we need to be cautious in moving in this area to be sure that dollars that are essential for providing services are not consumed in consultant and lawyer fees to set up these new arrangements.

There is, in short, Mr. Chairman, much that we agree with in the discussion draft, but much that remains to be discussed and improved if we are to achieve genuine reform in the way this system works. And I look forward to working with you on it.

Chairman BOUSTANY. I thank the gentleman, and I would agree. I think there is much fertile ground that we can cover to get to good reforms, with the objective being moving people up the opportunity ladder into the middle class. So I think—I appreciate the spirit of cooperation.

We have a very distinguished panel here today. I would like to introduce our panel, and I want to thank our panel for being here today to provide expert testimony.

First, we have Kristen Cox, Executive Director, Governor's Office of Management and Budget for the State of Utah. Second, Lieutenant Colonel David Kelly, Program Secretary of The Salvation Army National Headquarters. Third, at this time I would now yield to the gentleman from Minnesota, Mr. Paulsen, to introduce the next witness, Mr. Boyd Brown.

Mr. PAULSEN. Thank you, Mr. Chairman, and I want to thank you also for holding this important hearing, and letting me introduce our next witness.

Boyd Brown has over 18 years of experience overseeing a wide range of programs serving low-income families, individuals with disabilities, and ex-offenders. Boyd has extensive program management experience, including oversight of several large-scale TANF employment programs in Minnesota's two largest counties.

He is currently the Area Director of Employment and Training at Goodwill-Easter Seals Minnesota, whose main programs provide employment services specifically designed for people with disabilities, disadvantages, and other barriers to work. Last year, Goodwill-Easter Seals provided more than 63,000 services to more than 35,000 people, helping them find employment and achieve independence.

Prior to joining Goodwill-Easter Seals in Minnesota, Boyd worked for Dakota County and for the State of Minnesota's ombudsman office for mental health and developmental disabilities,

coordinating several different initiatives that led to public policy changes in the area of health care and disabilities.

I think, Mr. Chairman, Boyd's experience and knowledge will be a valuable perspective for this hearing, for the Committee, as it looks at ways to reform and improve TANF. I thank Boyd for being here, and sharing his perspective, his ideas, and his experience with Members of the Committee, and I thank you.

Chairman BOUSTANY. I thank the gentleman. Next, we have LaDonna Pavetti, Vice President for Family Income Support Policy, Center on Budget and Policy Priorities. And I am also pleased to—I just found out there is a family connection to Lake Arthur, Louisiana, a small town in my district. So glad you are here.

And last, and certainly not least, Grant Collins, Senior Vice President, Fedcap Rehabilitation Services, Incorporated, Workforce Development, and Executive Director, WeCARE Region II, Fedcap.

Thank you all for being here. We have your written testimony. I would ask you to try to keep your oral remarks to 5 minutes, so we can move forward with the question period.

And with that, Ms. Cox, thank you. You may start with your testimony.

Ms. COX. And will you give me the warning, because I am blind?

Chairman BOUSTANY. I sure will.

Ms. COX. Okay, great.

Chairman BOUSTANY. I will give you a warning at 4 minutes, and then you will have a minute to wrap up there.

Ms. COX. Perfect, thank you.

Chairman BOUSTANY. Thank you.

STATEMENT OF KRISTEN COX, EXECUTIVE DIRECTOR, GOVERNOR'S OFFICE OF MANAGEMENT AND BUDGET, STATE OF UTAH

Ms. COX. So, Mr. Chairman, Members of the Committee, and Ranking Member Doggett, thanks for having me.

Utah has a big—a deep, rich history around TANF. And before this job, I ran the Department of Workforce Services, which administers TANF, as well as almost 100 other Federal and State programs, safety net programs and workforce development programs. So I think we have a very unique perspective on integrating safety net programs, those challenges that are inherent across safety net programs, as well as the importance of work through the way our department is established.

Through that lens I want to talk about four issues that are relevant to the discussion draft. One I will touch on lightly, and, for me, it is the goal of aligning safety net programs toward a common goal and objective. Ninety-nine percent of our TANF recipients receiving Federal funds—I mean financial assistance—are on other public assistance programs, primarily Medicaid and SNAP, with different eligibility requirements, different work requirements. Some can do transitional services, some cannot. It is not very cost-efficient.

It is cumbersome for us, as a State. And it is, more importantly, very cumbersome for our clients, who are trying to navigate multiple safety net programs that don't seem to have a cohesive strategy or goal. So, while I recognize the focus of today is on TANF,

which is fantastic, I hope it is part of a broader discussion on overall reform.

My second point is on accountability. In Utah we are very excited to see this going toward more of an outcome-driven system. When I ran the Department of Workforce Services, there was a time that I refused to even look at the participation rate, because it was driving our systems more than employment was, and put the whole focus on employment outcomes, instead. We think it is a great direction to go.

But in the written testimony I have outlined a few areas that I think still merit discussion and refinement, moving forward in this direction. For example, we think cost per service delivery should absolutely be fundamental to this discussion. How do you include positive exits? For example, if somebody exits for increased income due to marriage, as you are trying to eliminate the marriage penalty, should that count as a positive closure or not? Same thing with SSI or SSDI. Those are topics that need discussion.

Some of the lag indicators that we are seeing in the performance measures could take 14 to 17 months. It is difficult to budget in that scenario. Do I budget a portion of my funds ongoing at one time, not knowing if I am going to get dinged on the performance measure?

A few other challenges: Should States be held accountable if somebody exits for non-compliance and they are sanctioned? How do we deal with the national new-hire directory, so that States can get credit for people who get work out of State?

So, I have listed a number of areas that I think still merit some consideration, but we think the direction is absolutely going in the right direction.

The third point has to do with State flexibility. With the increased accountability, which we think is fantastic, we think States should have maximum flexibility. So we definitely support eliminating the distinction between non-core and core activities, and think that is the right thing to do for States.

I would suggest, though, that there are two areas that you may want to tighten up, and that is if we are going to open up more freedom for education and vocational training after 24 months, we think it should be training in jobs in demand, and then should be a rigorous review for what kind of training people enter into, and what taxpayers pay for, as well as when we look at subsidized employment and some of those grants, that we make sure that those are going into the private sector and government entities are not benefitting from the subsidized employment initiatives.

My final point, really, is around this evidence-based evaluation.

Chairman BOUSTANY. We are at the 4-minute mark now.

Ms. COX. Okay, thank you. We totally support that. We are a little concerned with a lot of language around the random control trials. While that is the gold standard, they are not always appropriate, and sometimes not even ethical in government situations. So, having flexibility around the full continuum of evidence-based interventions—exponential research, propensity scoring, other options that are more nimble and more operational—we want to make sure States have that flexibility.

And going to the social impact bonds, as well, we have listed comments on the pros and cons of social impact bonds. They, from my perspective, are a great catalyst, but not necessarily a panacea. They cost money and time and they are hard to scale, but they can help reinforce the need for good data decisions, and understanding the cost-to-value ratio in our services.

I would add with this last point I am excited to see this increased focus on the work. It is the way out for people. And, personally, not—I am going to put my personal hat on for a second. Being blind, for years I was on Social Security disability in a time in life when I thought work would never be a possibility for me. Work is the thing that brings dignity to somebody's life. It brings responsibility, a sense of contribution, and it is not a punishment when we ask people to work and require that they work, it is a way to transform lives. And I will be open for questions. Thank you.

[The prepared statement of Ms. Cox follows:]

July 15, 2015

PREPARED TESTIMONY FOR THE RECORD of the:
U. S. HOUSE COMMITTEE ON WAYS AND MEANS, SUBCOMMITTEE ON HUMAN RESOURCES
HEARING ON WELFARE REFORM PROPOSALS
Offered by Kristen Cox, Executive Director
Governor's Office of Management and Budget, State of Utah

Thank you, Chairman Boustany, Ranking Member Doggett and members of the Committee. I appreciate the opportunity to appear before you today to share my observations relative to the reauthorization of the Temporary Assistance for Needy Families (TANF) program. I am Kristen Cox, Executive Director of Utah's Governor's Office of Management and Budget.

The Temporary Assistance for Needy Families (TANF) block grant as legislated through the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 was last fully reauthorized in the year 2005. As modifications to the TANF program are considered in the context of another more permanent reauthorization, we in Utah are appreciative of the opportunity to inform the discussion as viewed through the prism of our state's administrative, operational, and evaluative TANF experience.

Utah's TANF program is administered through the Department of Workforce Services—a department which integrates a multitude of programs such as TANF, Supplemental Nutrition Assistance Program (SNAP), childcare, weatherization, and other safety net programs. The department also administers a variety of workforce development programs authorized under the Workforce Investment Opportunities Act. The confluence of both safety net and workforce programs provides Utah with a unique perspective on the importance of work and employment as an ultimate objective for our customers.

Utah will expend approximately $67.8 million in total funds for base TANF program operations in state fiscal year 2015. Base TANF program operations are primarily comprised of core welfare reform activities such as financial assistance, supportive services, work activities, and child care. Utah has invested in identifying and securing administrative efficiencies; has leveraged synergies with community partners; and has worked to bring evaluative rigor to the TANF program design, selection, and implementation process. It is through these and other state initiatives that Utah offers the following perspective on TANF reauthorization.

Utah's approach to reauthorization includes nine key principles:

- Reauthorization should promote and focus on outcomes rather than just activities—holding states and individuals accountable for results and progress.
- Other safety net programs should be modified in order to align with and support self-sufficiency and poverty reduction.

- Outcome measures should address cost for service delivery as well as employment outcomes.
- The implementation of evidence-based practices needs to be practical and allow for the full continuum of practice in this field.
- Individual responsibility is key to helping people become self-sufficient.
- Programs should exhibit high expectations for what people can do—low expectations for people are often self-fulfilling.
- States should be given maximum flexibility in order to customize programs and deliver results.
- TANF recipients who are capable of work should be held to the same standard as the taxpayers who pay for the program.
- TANF reauthorization should facilitate or otherwise promote greater coordination with other public benefit programs where appropriate.

Fundamental to any effort to reducing poverty is creating a consistent, clear, and unifying goal across all safety net programs. Optimally, the goal is to align programs designed to support low-income individuals in a way that meets both the individual program objective (e.g., providing health care or food) and to promote the overall objective to help people become self-sufficient through employment wherever possible. Unfortunately, too many low income programs have competing policy objectives and focus on a specific area of concern—resulting in the perpetuation of poverty across current and future generations. Social safety net programs seek to achieve a myriad of objectives under varying criteria for program eligibility with siloed definitions for what constitutes successful recipient outcomes.

For example, the Supplemental Nutrition Assistance Program (SNAP) is designed to provide access to nutritious food and reduce food insecurity to low-income populations, with common eligibility thresholds set at 100 percent of poverty (net income) and grants benefits to able-bodied adults without dependent children under certain work requirement contingencies. Conversely, eligibility for both TANF financial assistance benefits and traditional Medicaid program benefits require non-elderly, able-bodied adults to be parents of dependent children with gross incomes well below the federal poverty threshold. It should be noted that Utah has long been engaged with the Centers for Medicare and Medicaid Services around negotiating the ability to impose work requirements on able-bodied adults without dependent children in the Medicaid expansion population.

In addition, TANF allows states to offer customers transition programs when they attain employment—allowing them to stabilize their employment and benefit from earned income prior to cutting benefits. However, transitional services are not always allowed under other safety net programs that a family may be receiving at the time of employment. Families are aware of this negative cliff effect and often forego raises or other employment opportunities so as not to lose existing benefits.

Administrative isolationism as practiced by these various public benefit programs causes target populations to be stratified in a manner that may not always be appropriate. Data on Utahans enrolled in social safety net programs reveals that over 99% of family employment program

participants were simultaneously enrolled in one or more additional public benefit programs in state fiscal year 2015. The considerable overlap of people and needs suggest that there are opportunities for greater program coordination.

Utah has already adopted an integrated approach to both eligibility services and program administration. This integration has resulted in better cost efficiencies and customer interventions. For example, the implementation of common standards and efficiency strategies have significantly reduced the cycle time on new applications, conserved millions of dollars in state and federal resources, and have ultimately resulted in the expedited delivery of benefits to needy customers. Utah's initiatives to provide services to families in intergenerational poverty includes the integration of a multitude of programs along with TANF to help parents and children move out of the poverty cycle. In Utah, we believe that more could be done to assist this effort if all safety net programs aligned and supported common goals and administrative requirements.

TANF Reauthorization Should Emphasize State Accountability for the Achievement of Successful Employment Outcomes

While work promotion and job preparation are only statutorily articulated in one of the four purposes of TANF, the ability to secure and retain stable employment is in most cases by definition a precondition to self-sufficiency. Given the fundamental role that workforce readiness and job skills play in determining the long-run success of post-TANF participants, states should be incentivized to invest in and expand TANF-supported interventions that are most likely to produce positive labor market outcomes.

One of Utah's primary administrative tools for evaluating the cost and quality of TANF services on a per client basis tracks the ratio of positive case closures for employment-related reasons against the operational expense of the program. This metric provides us the ability to monitor performance in terms of what is arguably the most successful TANF outcome (secured employment) and also allows for the evaluation of program return on investment as aggregate operational expenses are also considered.

While Utah supports the direction of more accountability for outcomes, we believe there are issues around the performance measures as written in the discussion-draft TANF reauthorization bill that merit further discussion and refinement.

Questions to consider include:

- Should individuals who exit the program because of increased income due to marriage or SSDI/SSI count as a positive exit?
- Should individuals who exit the program because they were sanctioned count against a state?
- How do states deal with the disregarded earned income within the context of the fourth quarter measure as currently contemplated?
- Should the focus be on increased earnings or retention?

- Does the general public usually receive increased earnings within the fourth quarter of employment, or is this expectation arbitrary?
- Can states game the fourth quarter measure by placing people in part-time employment that moves into full-time employment—naturally resulting in increased earnings?
- How will states be able to manage budgets and operations against performance measures that could lag anywhere from 11 to 20 months?
- Is the current weighting of lag indicators at 60 percent the correct approach—or should the focus be placed on the second quarter measures/employment attainment?
- Should states be allowed to use the National New Hire Directory in order to capture employment information for recipients who obtain out-of-state employment?

Utah has recently deployed excess TANF reserves to support community partners in providing local level interventions consistent with the four purposes of TANF. For many of these contracts, grant recipients must demonstrate that program enrollees achieve specific and quantifiable outcomes. Further, for grants supporting services around job preparation and employment, Utah has the ability to confirm that contract requirements were met using wage record matches of program participants on a pre/post intervention basis.

TANF Reauthorization Should Allow for More State Flexibility in Identifying What to Count as Participation

TANF customers differ in what they need to successfully gain and retain employment. For example, Utah's *Third Annual Report on Intergenerational Poverty, Welfare Dependency and the Use of Public Assistance* highlights that nearly 20 percent of TANF recipients are part of intergenerational poverty families. These families often need more aggressive and intensive services as compared to individuals who face situational poverty. In Utah, 70 percent of recipients are on TANF for seven to nine months and obviously need less intensive services. Because there is no one-size fits all approach, reauthorization of TANF should recognize this reality by eliminating the distinction between core and non-core work activities.

Eliminating this distinction may generate discussions around the value of education as compared to employment—that is a work first model as compared to an education model. The job of any state should be to find the "sweet spot" or the point at which an individual can attain employment as efficiently as possible. For some, this may require a more costly set of services, while others may attain employment for very little investment. Requiring states to report both customer employment outcomes along with the cost for delivering the service would provide transparency into the relationship between value and costs. States would be required to justify expenditures and manage demand for services, service delivery, and costs in relationship to one another. Doing so would provide insight into the value derived for dollars invested and help curb unnecessary expenditures and avoid allowing people to languish in services for too long.

States should also be allowed to only invest money into training that is limited to occupations in demand. With limited resources, training dollars should be focused in areas where employment is available and probable. In addition, any efforts to promote subsidized employment should be limited to private sector jobs and not include government positions.

TANF Reauthorization Should Emphasize the Implementation of a Full Continuum of Evidence-based Practices and Provide States with Resources for Developing Self-generated Data/Research to Guide Program Implementation Decisions

The TANF block grant allows states the flexibility to be uniquely responsive to the individual needs of their respective TANF populations. However, as block grant spending on interventions in areas other than basic assistance, childcare, and work-related activities increase as a share of total TANF expenditures, an evidence-based justification for TANF-supported programs becomes critical. Not only does the use of empirically driven research findings to inform program selection and implementation decisions ensure that customers will receive services that will maximize the probability of achieving successful outcomes, such findings help to clarify the goals and objectives of a given program intervention from the onset. Another benefit and natural consequence of using evidence-based justification for programs is that the return on the investment of public dollars will be optimized. Provisions such as those that create a repository of data and evidence-based research findings or measures that promote state demonstration projects and the subsequent rigorous evaluations of the effectiveness of such projects would serve well in shifting the paradigm from theoretical to empirical data when it comes to TANF program implementation. Utah has proactively engaged in research and evaluation of its TANF and other programs; however, more could be done to reinforce and strengthen the effort.

States should be provided the flexibility to use a continuum of evidence-based research tools. Random control trials may be the gold standard in many settings; however, they are expensive, time intensive, and not always appropriate in a government setting. For example, quasi-experimental research methods share similarities with the traditional experimental design or randomized controlled trial but specifically lack the element of random assignment to treatment or control. This is common in environments like government where the selection cannot be randomized. In addition, on-the-ground decisions often require more nimble evaluations that can provide confidence in one intervention over another while still providing empirical evidence. Operationalizing evidenced-based practices requires a common sense, practical, and realistic model—a model in which a variety of tools are available along with the funding to support the appropriate infrastructure and expertise.

While social impact bonds, as contemplated in the discussion-draft reauthorization bill, are one way to help cultivate a mind-set of evidence-based interventions, they do have drawbacks. Utah currently administers one social impact bond in the area of early childhood intervention and is developing a model for a social impact bond option for helping to reduce recidivism among prison inmates or parolees with co-occurring mental health and substance abuse challenges. Developing a social impact bond can be costly, time intensive, and take a significant period of time to develop. As a result, they are hard to scale in a fashion that, as of yet, has significant impact. Finally, investors do require a return on their investment. How this payback is structured can impact real and tangible costs for programs as some of the agreements center on cost avoidance rather than real reductions in operating budgets. This additional cost should be weighed against requiring government programs to implement the same level of rigor and the

requirement to produce outcomes. Social impact bonds provide interesting opportunities to improve government and can serve as catalysts for change; however, Utah believes they play a limited role and will not be the panacea for systemic government reform. When it comes to social impact bonds with a TANF reauthorization, we would encourage that allowable social impact bond projects be limited to those that directly impact TANF customers and related purposes in order to maximize available funding.

TANF Reauthorization Should Support Individual Responsibility and Work

Utah's unique and integrated service delivery model provides a broad and deep perspective on why work and work requirements matter. While Utah advocates for state flexibility with current core and noncore activities, we still believe the ultimate objective should be to help people become employed as quickly as possible. What follows are specific data points that emphasize this perspective.

Public assistance programs with work requirements observe increased income among recipients. For example, the nationwide rate of employment among TANF adults more than tripled between 1992 and 2010 (6.6 percent in 1992 to 22.3 percent in 2010). Increased income is a significant reason for individuals to discontinue receiving public assistance in Utah–especially among those experiencing intergenerational poverty. Among intergenerational poverty adults with public assistance (includes TANF, Food Stamps, and Medicaid) during 2012 who did not receive assistance in 2013, 35 percent had increased earned income.

Work effort requirements make it more likely for recipients of government services to search for and obtain employment. Work requirements create a dual motivation for individuals and lead to better long-term outcomes as compared to programs with no work requirements. Continued attachment to the workforce increases experience and skills—usually through employer-paid training and development. Improved skills often lead to employment opportunities with higher incomes.

Work requirements help people get back to work faster and with higher earnings. Individuals receiving unemployment insurance benefits are more likely to get back to work faster and obtain jobs with higher wages when there are structured work requirements. Utah's re-employment efforts, along with work search requirements, resulted in Utah having one of the lowest benefit duration rates in the country. This is supported by Department of Labor research conducted in 2014. For example, the duration rates for Nevada claimants in the study participating in structured work effort requirements had a 1.8-week reduced duration of UI benefits—saving the UI trust fund $2.60 for every dollar invested.

Encouraging recipients to participate in their own progress through work efforts lead to measurable engagement—which then leads to higher job placements. For example, prior to Texas implementing Medicaid sanctions for TANF recipients who did not meet their participation requirements, approximately 40 percent of those with work requirements participated in work activities. After implementation, the program saw an immediate increase in those participating—up to 60 percent. More importantly, the entered employment rate went from

approximately 60 percent to 82 percent in one year, with high retention rates. Because many TANF customers are dual eligible, it is likely that the same positive impacts would occur if a broader base of Medicaid recipients were encouraged to meet work requirements.

Work effort requirements could support individuals in obtaining their high school equivalent and improved skills in order to help individuals secure employment. Median annual earnings in Utah for adults (ages 25 plus) with high school completion during 2012 were $7,500 more than for adults without high school completion. The unemployment rate in Utah among individuals with less than high school completion was 12.4 percent in 2012 as compared to 7.6 percent among high school graduates.

An expectation that people who can work do work reassures taxpayers that funds are used wisely and fairly. As safety net programs consume a significant portion of state and federal budgets, taxpayers have the right to expect that individuals accessing public funds are doing what they can to help themselves and contribute to the community.

Government interventions and services are ultimately affected by the recipient's willingness to engage and take action.

Chairman BOUSTANY. Thank you very much, Ms. Cox.
Mr. Kelly, you may proceed.

STATEMENT OF LIEUTENANT COLONEL DAVID KELLY, PROGRAM SECRETARY, THE SALVATION ARMY NATIONAL HEADQUARTERS

Mr. KELLY. Thank you for the opportunity to share with you today.

This year the Salvation Army is celebrating its 150th year of ministry to the world, now serving in 126 countries. Our mission remains to tell people of the love of God expressed through Jesus, and to meet human needs in His name without discrimination. While many probably only know us for Christmas kettles, thrift stores, and rehab centers, each year we also serve 30 million individuals and provide 50 million meals and 10 million nights of shelter.

I admit, though, that, despite this quantity of assistance, in the past several years we have done some soul searching about whether or not, in the midst of all of our efforts, we are sufficiently focused on finding long-term solutions for those who are coming to us for assistance.

The outcome of this self-evaluation is a renewed determination to support life-transforming opportunities for those who come for material assistance. That doesn't mean we are going to abandon our efforts to feed and shelter, to provide character-building programs for youth, daycare, summer camps, or disaster assistance, but it does mean that we are going to intentionally carve out resources, both personnel and financial, to help families move out of poverty, to make the transition from serving to solving.

This new initiative, piloted in some locations over the past 3 years, and now being rolled out nationally, is called Pathway of Hope. It is an approach that provides enhanced services to families who desire a path out of inter-generational poverty. Food pantries, soup kitchens, daycares, they are all going to continue, but we are going to make a focused effort to actually help families move further than they have moved before.

Once engaged in the program, teams will walk alongside families as part of a partnership effort to facilitate changes and provide support. Pathway of Hope families meet regularly with Salvation Army caseworkers to develop goals and implement an individual plan that will increase their self-sufficiency and hope for the future. Trained staff will complete assessments with the families to tailor service delivery to their specific needs.

Our pilot programs are filled with measurable outcomes, and there is reason for optimism about the potential impact this will have. I share that with you because the legislation we are looking at today seems to blend well with the success we are finding these past several years.

We believe that any new legislation should make provision for the following key elements.

We affirm the elimination of what is commonly referred to as the "marriage penalty" in every State. It is difficult to fathom any positive societal impact coming from indirectly encouraging the breakdown of a two-parent family. Extensive research shows the long-

term negative impact the family breakdown has upon a child's future educationally, economically, and in future opportunities. The marriage penalty produces only a small, short-term savings, but the long-term cost, both to the family and to the budget, is enormous.

Number two, I am very encouraged to note the reference to improving and customizing individual opportunity plans. Educators long ago understood the value of individualized plans for children struggling to keep up in school. These individual plans have helped countless children overcome challenges, catch up and thrive in academic settings. And educators understand that early intervention is not only good for the children, but saves significant cost later.

An equivalent approach in addressing families in poverty will have a similar positive impact. While it may be less expensive in the short term to just treat everyone exactly the same, that approach has not proven to be successful. And the addition of customized individual opportunity plans is a great step, from our perspective.

Number three, allow more education to count toward activity hours. We find that most individuals in poverty have an excellent employment record, and simply don't have the education needed to progress to a higher, more sustainable economic level. Education is a critical step to finding a stable job at a livable wage.

And fourth, fund pilot projects. This is a key provision, and consistent with the success we have experienced with Pathway of Hope programs and other initiatives. It makes good business sense to experiment, identify best practices, and remain somewhat fluid during initial implementation, as new ideas evolve. I should add, though, that in the same way we are implementing Pathway of Hope while maintaining our financial commitment to much-needed programs, we urge you not to decrease funding for TANF, but rather, consider the pilot programs as an additional step.

The Congressional Record will show that on December 15, 1982, a Salvation Army officer came to Washington to testify about homelessness and poverty at a congressional hearing just like this one. That officer was my father, then Major Paul Kelly.

I pray that we will get this right, that we will mold the best possible legislation and together make meaningful improvements to how we address poverty in this generation.

If the next generation is here to testify in 30 years, let it be to celebrate that we have dramatically improved how we help those in greatest need. Thank you.

[The prepared statement of Mr. Kelly follows:]

Testimony by Lt. Colonel David Kelly
Program Secretary
The Salvation Army National Headquarters

House Ways and Means Committee
Subcommittee on Human Resources
July 15, 2015

Good morning. My name is Lt. Colonel David Kelly and I am the Program Secretary for The Salvation Army's National Headquarters. I would like to take this opportunity to thank the House Ways and Means Committee Chairman Paul Ryan, Human Resources Subcommittee Chairman Charles Boustany and the rest of the committee members for inviting me to be with you today. We are so grateful for the opportunity to be part of this important conversation on how to help families in need of temporary assistance transition into and thrive in the work force.

This year, The Salvation Army is celebrating its 150th year of ministry to the world. We are at work in 126 countries and still expanding. Our mission has remained constant for our entire existence- to tell people of the love of God expressed through Jesus, and to meet human needs in His name, without discrimination.

While many only know us for Christmas kettles, thrift stores and rehabilitation centers, the breadth of service is much broader.

- We serve nearly 30,000,000 people annually
- We provide over 10,000,000 nights of shelter each year
- We serve 60,000,000 meals per year
- Services can be found at over 7,000 locations around the U.S.

While we excel at providing a large quantity of services, we have done some very real soul searching and self-examination these past five years to assess whether in the midst of our service, we are sufficiently helping those in need to find long terms solutions to the challenges they face, particularly in the area of poverty. An outcome of this self-evaluation is a renewed determination to apply the same life transforming goals to those who come for material assistance, as we have always applied to those who come into our rehab centers.

This does not mean we will abandon our efforts to feed, and shelter; to provide character building programs for youth, summer camps, and disaster assistance. It does mean that we will carve out resources (both personnel and financial) to focus on helping families move out of

poverty. This new initiative, piloted in some locations several years ago, and now being rolled out nationally, is called Pathway of Hope.

Pathway of Hope is an approach to providing targeted services to families with a desire to take action to break the cycle of crisis and enable a path out of intergenerational poverty. It is rooted in a case management approach, focusing on client needs through a strength-based lens. Pathway of Hope will allow us to increase our impact by:

- Empowering vulnerable families to take action to overcome their barriers by utilizing their strengths
- Optimizing The Salvation Army's resources to take action to overcome their barriers
- Catalyzing community collaboration in response to clients' goals

Pathway of Hope is built on a strengths-based approach combined with increasing hope which can help families overcome barriers and progress along a "path" to sufficiency. In other words, families look at what resources are already available to them intrinsically and externally to overcome their challenges. Throughout the process, unique tools are utilized to complement these theories and measure established outcomes.

Through Pathway of Hope, The Salvation Army will also expand and deepen its network of community resources and increase collaboration to help families achieve their goals.

Best practices include a holistic team approach and positive engagement with families at an early stage. Teams will walk alongside families as a partner to facilitate change, celebrating small victories as well as larger achievements throughout their journey.

Pathway of Hope families typically come from our emergency assistance programs, have at least one child in their care, and are ready and willing to make a change. In addition to having immediate needs met, Pathway of Hope families meet regularly with Salvation Army case workers to develop goals and implement a plan that will increase their self-sufficiency. Case workers complete assessments with the families to tailor service delivery to the specific needs. All of the assessment tools are available to case workers online through a client data management system.
The following tools are used to create Personal Action Plans and measure a family's outcomes.

STEP	DESCRIPTION	TOOLS
1	**Selection**	• **The URICA assessment:** This tool will be used to assess the client's desire to make change in their lives. • **The Working Together Agreement:** This document outlines the Pathway of Hope programmatic expectations for both program clients and the caseworker.
2	**Intake**	• **Release of Information:** Keep your client's information and situation confidential! Receive permission to speak or release information to other agencies concerning a Pathway client's situation using this tool. • **Required Intake Fields:** Caseworkers are to use the intake fields on their client tracking system.

3	**Assessment**	• **Herth Hope Index:** This tool helps us to measure client's level of hope, a key outcome for the Pathway of Hope. • **Personal Strengths Assessment:** This tool helps us identify the positive resources and abilities that our clients already have rather than focusing on "what's wrong". It can be used in partnering with clients to achieve their goals. • **Client Sufficiency Matrix:** The matrix evaluates sufficiency in domains grouped into four clusters: Basic Needs, Health/Disability, Basic Functions, and Family. The tool can be used to assess barriers that the client may be facing and as an indicator for many of the Pathway of Hope outcomes. • **Spiritual Needs Assessment:** ***Optional for client***. Examines the spiritual life and religious needs of the client.
4	**Action Planning**	• **Personal Action Plan**: This tool works with the strengths assessment and continues the collaborative relationship. Use the Pathway of Hope client's dreams and aspirations from the strengths assessment to motivate them toward improving their current situation.
5	**Case Management**	• Administer the Herth Hope Index and Client Sufficiency Matrix every 3 months while active in case management • **Client Referral Tracking Form:** This form helps track external services that were referred to clients • **Case notes:** This form provides a common area to track observations of clients
6	**Transition**	• **Completion Form:** This tool allows clients to reflect on the goals they have achieved through the Pathway of Hope while providing additional ideas to achieve longer term aspirations • **Exit Surveys:** These surveys will help us evaluate progress from the Pathway of Hope client's perspective
7	**Post Completion Follow-up**	• **Follow-up Surveys:** These surveys will help us evaluate progress from the Pathway of Hope client's perspective • Administer the Herth Hope Index and Client Sufficiency Matrix 3, 6, and 12 months post completion

By tracking client outcomes we will be able to pinpoint services that increase the likelihood of families achieving self-sufficiency and improve the lives of those we serve. Individualized case management services are effective because case workers are able to support families emotionally, spiritually and physically. Case workers also give clients the tools to cope with crises as they arise and work to prevent a crisis from occurring.

The Pathway of Hope approach has initiated a number of shifts by The Salvation Army in order to meet the growing needs of people impacted by poverty, the changing communities in which they live, and address external funder increased expectations to deliver outcomes vs. outputs. By utilizing a shared approach and outcomes, The Salvation Army will demonstrate a significant impact on families and communities it serves across the United States.

We have set an ambitious goal of raising $200,000,000 in the next five years to roll out this program nationwide. We are convinced that this new effort will dramatically alter the life trajectory of hundreds of thousands of families. It is not just those families that will be better because of it, but our whole society will be enhanced as people reach their full potential.

All across the country there are programs and organizations that have come to the same conclusion. We will continue to serve those in need, in Jesus name, without any form of discrimination, but we will also bring all of our energy and resources to bear in helping families become economically independent. We cannot stop serving….there will always be some who need assistance. However, we need to stop providing only enough support and service to keep them alive but in poverty, and start providing sufficient support for them to move out of poverty.

We are very pleased that leadership is seriously examining the long term path forward for how we care for those in greatest need. A well-developed plan that works to improve the lives of individuals by getting them into jobs that pay enough to no longer be eligible for public benefits is the best path forward. The Salvation Army is eager to be a partner in this strategic planning. For the sake of those we both serve, and those actively moving from poverty, we fully support the following elements included in the proposed TANF reauthorization.

1. **Extension of TANF funding while alternative approaches are developed and tested.** However, funding at the same level for 5 years clearly indicates a reduction in funding due to inflation and we would encourage you to consider the impact of increasing State responsibility while simultaneously cutting available funding.

2. **Elimination of what is commonly referred to as the marriage penalty, in every state**. It is difficult to fathom the positive societal impact that comes from indirectly encouraging the absence of a two parent family. As I understand it, one of the goals of the TANF program is “Encourage the formation and maintenance of two-parent families”. Clearly any indirect “marriage penalty” works at cross purposes to this goal.

3. **Improved and customized individual opportunity plans.** Educators long ago understood the value of individualized plans for children struggling to keep up in school which have helped countless children overcome challenges, catch up, and thrive in academic settings. An equivalent approach in addressing families in poverty will have a similar positive outcome. While it may be less expensive in the short term to treat everyone exactly the same, that approach has not produced the long term transformations all of us are seeking. By individualizing opportunity plans a person can get what they need to become self-sufficient because they are in control of the plan.

4. **Allowance of more education to count towards activity hours.** Education is shown to improve the long term financial outcomes of individuals and education is a critical step to finding a stable job at a livable wage.

5. **Funding pilot projects testing ways to better help TANF recipients enter, retain, and advance in employment, with high quality evaluations.** This provision is consistent with the success of our own Pathway of Hope program and other initiatives. It makes good business sense to experiment, identify best practices, and remain somewhat fluid during initial implementation as new ideas evolve. We also agree with requiring states to strategically plan their implementation and rollout of pilot projects. We have learned the importance of carefully preparing units to implement enhanced case management services.

Conclusion

The Salvation Army is part of the community, a collaborator with both government and non-government entities seeking to serve those in need. We are very grateful for this opportunity to participate in the process of addressing this specific legislation and particularly for discussing those who are working to improve their lives and provide a better future for their children. Again, we thank you for starting the conversation on improving the outcomes of families receiving Temporary Assistance for Needy Families.

"In these days of difficulty, we Americans everywhere must and shall choose the path of social justice...the path of faith, the path of hope, and the path of love toward our fellow man."
October 2, 1932 (FDR Memorial)

Chairman BOUSTANY. Thank you, Mr. Kelly.
Mr. Brown, you may proceed.

STATEMENT OF BOYD A. BROWN, JR., J.D., AREA DIRECTOR, EMPLOYMENT AND TRAINING, GOODWILL-EASTER SEALS MINNESOTA

Mr. BROWN. Thank you for the opportunity to testify on our experience as a local TANF community-based provider. As Mr. Paulsen mentioned, my name is Boyd Brown, and I am the Area Director of Employment and Training at Goodwill-Easter Seals Minnesota. We are a leading provider of workforce services in our State, and our stores serve as the economic engine for our employment programs. This past year we served 35,000 people with various employment, including 1,500 families who came to us through TANF.

Our recommendations for TANF policy changes are, first, hold providers accountable for what matters most: results. Second, allow providers to document progress toward employment goals, not hours of participation. Third, offer flexibility and allowable activities to meet the unique and individual challenges our families face. And, fourth, include fathers as part of the solution by funding fatherhood initiatives, making the voluntary services of responsible fatherhood a permanent part of TANF. Fathers are part of the solution to stabilizing low-income families.

Next I talk a little bit about Elizabeth's story that was in my written testimony. When our counselor first met Elizabeth, she slept most nights in her car and with her daughter. Elizabeth was adamant that she needed to find a job, and that income was the quickest way to secure housing. She had dropped out of school in the 10th grade. To her, education was a luxury she could not afford. Elizabeth's initial employment plan included 6 weeks of job search, and she gave 100 percent to finding that job, but to no avail.

Usually, the next step in the process is unpaid work or volunteering. But her counselor knew this would not lead Elizabeth to long-term stable employment. The counselor convinced Elizabeth to include GED preparation in her plan, even though it wasn't counted in the work participation rate. While attending GED classes, Elizabeth was couch-hopping from one friend's home to the next. Thirteen months later, she completed her GED. Elizabeth said, other than the birth of her daughter, it was the proudest day of her life.

Three days later, she landed a job at Target, and the following week enrolled at a community college, pursuing a two-year human services degree. She moved into her own apartment. Her work hours increased, and she discontinued assistance in late 2014. She will graduate in June of 2016, and plans to pursue a BA to become a social worker.

So, what does Elizabeth's story tell us? First, education and training are important. Research shows that additional education can yield substantial earning gains, which means that participants with more education will need less government assistance to meet their basic needs. Elizabeth's story also tells us that the one-size-fits-all approach dictated by the work participation rate with its

core and non-core activities doesn't work for many participants, including Elizabeth.

And after spending, on average, 53 percent of their time on documentation and verification, our TANF career counselors simply do not have the time to provide the needed family supports that change outcomes. Elizabeth's story illustrates that, with time, meaningful and productive relationships develop that lead to success.

Elizabeth's is only one story. We serve many people who are homeless, who have serious mental illness, other disabilities, who have criminal records, and little work experience. We succeed by building strong relationships with employers, and responding flexibly to the very different needs and situations of the people we serve.

In my written testimony I describe multiple innovative Minnesota TANF programs. One I will highlight here is the Father Project. The Father Project offers voluntary services for low-income dads to help them support their children, both financially and emotionally. More than 90 percent of the 1,500 dads enrolled reported that the project helped increase their commitment to financially support their family, increased their child support payments, and 481 obtained jobs. A return on investment study demonstrated a return of $3.41 for every dollar invested in the Father Project.

In conclusion, by focusing on outcomes and not process, adding flexibility and activities allowed, and reducing the documentation demand, we can increase employment outcomes and move families off of assistance and out of poverty. We believe in accountability. However, hold us accountable for the outcomes that matter, which are getting people into jobs and off of assistance.

So, thank you for the opportunity to share our experience as a TANF provider. We appreciate the Committee's interest in hearing from the field, and are happy to serve as a resource to you as we look to increase both effectiveness and efficiency of how TANF is implemented across the Nation. Thank you.

[The prepared statement of Mr. Brown follows:]



Together, we prepare people for work.

Written testimony of

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Subcommittee on Human Resources

Hearing on

"Temporary Assistance for Needy Families (TANF) Reform Proposals"

July 15, 2015

Introduction

Thank you for the opportunity to testify on the implementation of Temporary Assistance for Needy Families (TANF) services at the local level from the perspective of a community-based organization. My name is Boyd Brown and I'm the Area Director for Employment and Training at Goodwill-Easter Seals Minnesota (GESM).

My testimony today will cover three broad topics. First, I will provide an "on the ground" description of TANF services in Minnesota. Then, I will provide an overview of innovative programs and practices in Minnesota that should be considered in any TANF reforms. Lastly, I will conclude with a discussion of specific challenges that current TANF policies create around documentation and verification requirements as well as the limitations on allowable work participation activities.

The TANF program in Minnesota is the Minnesota Family Investment Program (MFIP).

Goodwill-Easter Seals has been a leading provider of workforce related services in Minnesota since 1919. This past year, we served 30,000 people with low incomes, disabilities and other barriers to employment throughout Minnesota and in western Wisconsin. We are a local affiliate of both Goodwill Industries International and Easter Seals, Inc. Our organization's mission is "To Eliminate Barriers to Employment and Independence." Goodwill-Easter Seals provides individuals with the skills and training they need to obtain and maintain employment, to advance in their careers and to improve or achieve independence and self-sufficiency. Since 1997 GESM has been a large-scale provider of TANF services in Hennepin and Ramsey Counties, the two largest counties in Minnesota, which include the cities of Minneapolis and St Paul. In Hennepin County, we have consistently met or exceeded our performance measures for TANF providers and have been recognized for outstanding achievement in participant work participation rate, outstanding agency performance and outstanding performance in rate of unsubsidized employment multiple time overs multiple years. We have met all pay-for-performance measures for exceeding the outcome measure of having 40% of participants discontinue MFIP assistance due to unsubsidized employment. Additionally, Goodwill-Easter Seals has been an employment services provider for Ramsey County since 2013 and has a long history of being the provider-of-choice in Ramsey County for specialized Minnesota Family Investment Program (MFIP) services, including supported work, integrated services models serving persons with disabilities, Supplemental Security Income (SSI) Advocacy and sanction outreach services.

Of the 30,000 people served by Goodwill-Easter Seals in 2014, 1,500 came to us through our TANF services (628 in Hennepin County and 871 in Ramsey County). We successfully placed 395 of those parents in employment and helped 289 discontinue assistance because of employment. The remaining families have either left MFIP for other reasons (e.g. left the county) or are continuing to engage in MFIP services.

"On the Ground" TANF implementation in Minnesota

Minnesota delivers TANF services through the Minnesota Family Investment Program (MFIP). MFIP is a state-supervised, county-administered program overseen by the Minnesota Department of Human Services. Most MFIP families are eligible to receive cash assistance for a maximum of 60 months over their lifetime.

MFIP families are placed on one of two tracks: the standard track for families who are expected to meet the federal work participation requirements, or the Family Stabilization Services (FSS) track for new refugees, victims of family violence, and families in which a member has serious functioning impairments. Goodwill-Easter Seals has experience providing both tracks of services. Family Stabilization Services is solely state-funded and the families served in that track are not included in the federal work participation rate calculation. Their activities also are often focused on addressing barriers to employment.

Counties refer families to an employment services agency, such as Goodwill-Easter Seals. Families have a choice of providers but will often go to the one recommended by the county based on geography. Once connected to Goodwill-Easter Seals, individuals meet with their assigned career counselor to complete an assessment of their situation and identify barriers, review the rules and expectations of MFIP, and create an individualized employment plan. Participants meet with their career counselor on a regular basis, at least once per month for the duration of their time receiving MFIP assistance. The Goodwill-Easter Seals' career counselor caseload can range from 50 – 85 families at any given time. Goodwill-Easter Seals significantly subsidizes our MFIP contracts to ensure smaller caseloads. Many employment services providers report caseloads closer to 100 families or more.

Participants typically move into job search activities according to their respective plan, either primarily searching for employment or in combination with short-term education and training. Part of our success as a provider can be attributed to our work in developing relationships with employers and remaining connected with them even after placement. We have dedicated Career Specialists who work in tandem with the career counselor and who study labor market trends, build relationships with employers, assist participants in obtaining career clothing, driving them to interviews and ultimately placing participants into employment. The Career Specialist allows the career counselors to remain focused on ensuring participants meet MFIP requirements. Goodwill-Easter Seals funds these dedicated positions with our own social enterprise retail-generated funding. Most, if not all, Minnesota MFIP providers do not have the funding to cover the cost of these positions. We find it to be a critical piece for meeting employment outcomes.

When a participant is reaching 6 weeks and their job search hours are about to expire, the career counselor begins to look at other activity options including paid or unpaid work experience and/or education and training to supplement the hours spent job searching. During the process, participants can be diverted to other programs if they have medical issues that need special attention, are determined to be eligible for Family Stabilization Services, are sanctioned, or reach their sixty month

limit and do not receive an extension. People also voluntarily close their cases. Finally, if someone obtains a job that is above the defined income level that qualifies for MFIP, they will be transitioned off the program after two months.

Innovations

Goodwill-Easter Seals and the State of Minnesota are known for innovative TANF programming. We have participated in several Federal and State evaluations and pilot projects to learn more about "what works" in assisting individuals reach self-sufficiency. All of these innovative programs have these features in common:

- Meet participants "where they are" and develop personally meaningful goals that fully engage participants and their families in the process.
- Understand that each family is unique so that the services and supports needed for success will be different for every family
- Allow the time and resources needed for staff to fully engage participants and their families in services.
- Allow significant flexibility in activities and reduce documentation and verification requirements to allow maximum time and resources towards services and supports needed to reach employment outcomes.

Families Achieving Success Today (FAST) – Goodwill-Easter Seals is the lead and fiscal agent of a partnership of agencies providing Integrated Services to MFIP Families with Serious Disabilities in Ramsey County, Minnesota. This program was part of the TANF/SSI Disability Transition Project (TSDTP), funded by the Administration of Children and Families, U.S. Department of Health and Human Services and Social Security Administration. The Collaborative uses an integrated, multidisciplinary approach, providing comprehensive services including employment, adult and children's mental health, culturally appropriate health education, advocacy, informal counseling, and guidance that help lead families to self-sufficiency.

The project uses evidence-based practices – the Individualized Placement & Support Model (IPS), from the mental health field, and motivational interviewing – to increase employment and self-sufficiency among TANF recipients with disabilities. The IPS supported employment design has been shown to help people who have serious mental illness, but it had not previously been tested within a TANF program. Through the one-year evaluation, the Study found that FAST group participants participated more in work activities, had higher levels of employment levels and higher annual wages than their control group counterparts. This study has shown much promise in serving families with multiple and significant challenges, but much is still to be learned to improve long-term employment outcomes.

Goodwill-Easter Seals and Ramsey County continue the FAST program today continuing to serve families with significant disabilities. Additionally, Goodwill-Easter Seals, in partnership with Ramsey County, has

implemented FAST II which is the same integrated service model while incorporating culturally specific interventions serving African Americans and American Indians. The goal of the project is to increase engagement and employment outcomes of enrolled African American and American Indian families.

Lifelong Learning Initiative – Goodwill-Easter Seals is participating in a new Ramsey County project called Lifelong Learning Initiative (LLI) which may potentially be part of the Job Search Assistance (JSA) evaluation supported by the Administration of Children and Families, U.S. Department of Health and Human Services. The evaluation would explore whether bringing practices based on the findings of brain-science and the conditions that strengthen our ability to make decisions, set priorities and manage stress is more effective for TANF recipients in helping them secure employment and reduce public benefit receipt than the standard set of employment services.

The initiative uses enhanced coaching methods to guide TANF participants in identifying their individualized self-sufficiency goals and then leading through the progression of steps for strengthening the executive functioning skills listed above in order to achieve those goals. Executive skill development and coaching are evidence-based interventions rooted in the science of the brain.

Minnesota Subsidized Transitional Employment Demonstration (MSTED) –MSTED is a newly-created demonstration and evaluation of subsidized employment to learn whether subsidized work can increase the number of participants moving from TANF into permanent unsubsidized employment. This project is part of the Administration of Children and Families, U.S. Department of Health and Human Services' Subsidized Transitional Employment Demonstration (STED) evaluation. Participants are placed in either a structured work experience paying an average of $9.00 with a non-profit/private sector employer for a 24 hour work week for a total of 8 weeks or into a wage subsidy job with a private sector/private non-profit employer paying a wage subsidy up to $15.00 an hour for an initial 8 week assignment with an option of an additional 8 weeks, with the expectation that the employer providing the wage subsidy job will hire the participant at the end of the wage subsidy. The demonstration is focused on participants with limited work history and on TANF for 6 months or more.

Moving Forward Project – The Moving Forward Project provides one-on-one assistance for participants with a criminal record. The Career Specialist provides information about industry and job specific criminal record restrictions to provide and guide appropriate job leads. Also, Career Specialists assist participants with the expungement process. The flexible nature of the program allows our staff to meet participants at convenient community locations and engage participants in setting personally meaningful and relevant goals. This project served 72 families in 2014, with a 53% placement rate and 86% 90 day and 78% 180 day retention rate with an average wage of $9.77 per hour.

Stable Families Initiative -- The Stable Families Initiative Enhanced Employment Services program provides intensive, individualized employment services to chronically homeless TANF parents. This voluntary complement to traditional TANF services provides holistic and long-term support—with particular focus on increasing housing and financial stability—through collaborations with shelter and housing advocates, county eligibility staff, and other community agencies. All services and support

provided to participants are guided by self-identified and -developed goal plans. The Stable Families initiative has engaged 72 families while placing 33 participants in employment since July 2014.

Responsible Fatherhood –Goodwill-Easter Seals' FATHER Project is currently funded through a Responsible Fatherhood grant with the U.S. Department of Health and Human Services.

The FATHER Project offers services for low-income dads to help them support their children, both financially and emotionally. The FATHER Project provides a holistic framework for all low-income fathers to enhance their own capacity as involved, economically self-sufficient and socially empowered parents and citizens. We work with each participant to help them gain the skills and support needed to enter the workforce, strengthen parenting skills, and ultimately become leaders within their families and their communities. Savings to tax payers include:

- From 2012 – 2014, over 1,500 dads enrolled in the FATHER Project across 5 sites in Minnesota.
- Over 90% of these fathers reported that the Project helped increase their commitment to financially supporting their family
- In the last fiscal year, participants have increased their child support payments in Minnesota's three largest counties (Hennepin, Ramsey and Dakota). Rates among project participants in Dakota County alone jumped from 36 percent in 2013 to 47 percent in the first quarter of 2014 and again to 74 percent in the second quarter. In Hennepin County, FATHER Project participants paid 56.5% of child support that was owed, despite significant barriers to employment.
- 481 obtained job placements with an average wage of $10.92. Almost half of those fathers who were placed had a criminal background
- "Return on Investment" study by Wilder Research (2010) demonstrated a conservative long-term financial return of $3.41 for each dollar invested in the FATHER Project.

As you consider reforms, we urge you to make Responsible Fatherhood a permanent program under TANF. Fathers should be seen as part of the solution for stabilizing low-income families.

TANF Policy Challenges

Paperwork, Documentation and Verification Requirements

Our career counselors are overwhelmed by the amount of paperwork and time needed to document and verify participation hours. These requirements were created in the Deficit Reduction Act of 2005. Our career counselors are spending more time checking for signatures, verifying job search and school attendance, completing paperwork and updating employment plans than they are spending with their participants. Our Hennepin County MFIP team participated in a University of Minnesota, Humphrey Institute of Public Policy study that measured the amount of time career counselors spend on documentation versus direct participant services. The study found on average that career counselors working in the state MFIP program spend 53 percent of their time on documentation and 47 percent of

their time on direct services with their participants.[1] Having only half of the counselor's time available to meet the individualized needs of each family, hampers our ability to assist families in reaching employment goals. Our experience tells us that progress not detailed time logs move someone forward: we are more interested in grades and mastery of materials than in attendance sheets for education programs and more interested in follow up on job leads and applications than in the exact hours in those activities. The information that matters to us from medical and behavioral health professionals is in the type and amount of work that people with serious health problems can manage, not how many hours of appointments fill their calendars. Counselors find that they spend the majority of their meeting time with participants contacting schools, child care providers, medical providers, and government workers in an attempt to meet documentation and verification requirements.

While we acknowledge that documenting results is important, we believe we could improve employment outcomes by reducing the documentation demand. To illustrate how more time to meet the individual's needs leads to success, here is Claire's story.

> Claire is a 24-year old raising her six year old daughter on her own because the girl's father is in prison. Claire and her daughter were in a homeless shelter when she was referred to our Moving Forward project. Claire had been in and out of a number of fast food jobs. Convictions of check forgery and terroristic threats as a juvenile as well as the lack of a high school degree meant she saw few other employment options. Her career counselor, recognizing Claire needed more services than the counselor was able to provide, referred her to a supplementary program focusing on individualized, intensive job search assistance for individuals with a criminal record, another GESM program, the Moving Forward Project.
>
> The Moving Forward staff person worked intensively with Claire on increasing her employability and overcoming barriers to employment. This included guiding her through every step of the process to get her criminal record successfully expunged and placing her in paid work experience at a Goodwill store. Her work placement at Goodwill's E-Commerce division allowed her to strengthen her work skills and add a non-food service job to her resume. The small success experiences fueled her motivation: she got a GED while working part-time, got her driver's license, bought a car and moved out of the homeless shelter. She found herself a $9 an hour job as a driver for an auto parts store, is continuing to receive job support coaching and has held that job for more than a year now.

Work Participation Activity Limitations

We believe the work participation rate with its core and noncore activities dictate a cookie cutter, one-size fits all approach to obtaining employment. Additionally, there are numerous limitations in policy

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[1] Dani Indovino, Amy Kodet, Bridget Olson, and Jeff Streier, *The Flexibility Myth: How Organizations Providing MFIP Services are Faring Under New Federal Regulations,* Hubert H. Humphrey Institute of Public Affairs, University Of Minnesota, 2008

that prevent them from acting in the best interest of participants. These limitations include time limits put on certain activities such as a six week job search, inability for some people to count trainings or school towards work participation, or barriers certain people may have towards employment.

To illustrate this point, here is the story of Barbara, who lived in Hennepin County and was referred to our Stable Families Initiative which specifically serves TANF Families experiencing homelessness.

> Barbara, homeless and living in a Minneapolis shelter, was struggling with finding employment through job search and was having significant difficulty in maintaining the required participation hours. She was enrolled in the Stable Families initiative where the career specialist was able to meet with her on a regular basis. During a home visit, the worker saw boarded up windows and destroyed doors. Thanks to training in addressing domestic violence and the ability to meet outside the office, the worker learned Barbara was homeless because of repeated instances of property damage. Her partner would shoot out windows, destroy walls and doors and physically batter Barbara. She was in sanction trouble with her MFIP employment counselor because she was not meeting her job search hours. But Barbara, who had experienced abuse and violence in her family as well as with her partner, had learned to mistrust people and had not shared information about the violence with her employment counselor. While she was not eligible for child care assistance because her son's father was technically available to care for the boy, Barbara feared for her son's safety when she was not around. Her Stable Families worker gave her information about her options, helped her get a Family Violence waiver on MFIP and a court order for no contact. Her abuser has moved out of state. Barbara now has an apartment for herself and preschool son and without the violence of her son's father, is able to maintain this apartment. Barbara qualified for child care assistance and began engaging in job search, found a $12 an hour job as an administrative assistant and scheduler for a company that provides transit services to people with disabilities. The job provides regular, reliable full-time employment. She earns enough to no longer need a housing subsidy and is receiving reduced MFIP benefits because of her earnings.

Education and Training

We believe that for our participants and for Minnesota's economy we need to go beyond a "work first" policy. Unemployment is high among low-income and less-educated individuals and the employment prospects for less-educated individuals are more limited than ever before. By 2020, 65 percent of all jobs will require postsecondary education and training beyond high school, with 35 percent requiring a bachelor's degree and 30 percent requiring some college or an associate's degree.[2] At the current rate, the United States will have 5 million fewer workers with these education levels than the economy will need, according to the study. Additionally, "by the year 2020, fully 74% of all the jobs in Minnesota will

[2] Anthony P. Carnevale, Nicole Smith, and Jeff Strohl, *Recovery: Job Growth and Education Requirements through 2020,* Georgetown Center on Education and the Workforce, 2013.

require some postsecondary education. Half of these jobs will require a bachelor's degree or beyond; half will require a certificate, diploma or associate's degree."[3] However, just over 40 percent of working age Minnesotans attained a degree beyond a high school diploma/GED in 2013.[4]

Research shows that additional education or training can yield substantial earnings gains – which mean that participants with more education or training will need less government assistance to meet their basic needs. Some recent studies find that one additional year of schooling can lead to earnings gains averaging 10 to 15 percent per year. [5] Shorter-term post-secondary training, e.g., certificate programs that require less than two years of training, also has been shown to have valuable returns. This is what our state's economy needs to thrive. Baby Boomers are retiring in record numbers and we need to replace those skilled workers if our economy is to flourish. We help employers by offering employees who are ready to work. It's hard to reach significant employment outcomes without more flexibility with education and training. To illustrate the importance of education and training, here are Sandy and Elizabeth's stories:

> Sandy came to us as a 24 year old mother. She was working part-time in a minimum wage job requiring a 30 minute commute each way and looking for an additional fast food job near to home in order to try to make ends meet and get off assistance. We were able to help her enroll in a Red Cross Certified Nurse Assistant training. Having her do that training fulltime for up to eight weeks required her to leave the part-time retail job. But it resulted in her getting a fulltime $14 an hour job two blocks from her home at a group home the week after finishing that training.
>
> When the career counselor met Elizabeth for the first time, she and her young daughter slept most nights in her car. Elizabeth was adamant that she needed to find a job and that income was the quickest way to secure housing. However, from our experience we know that securing employment without basic needs being met is an up-hill battle. In addition to housing, Elizabeth had dropped out of school in the 10th grade and had not stepped foot in a classroom since that time. In her mind, continuing her education was a luxury she could not afford. Elizabeth's initial plan included 6 weeks of job search and she gave 100% in finding a job but to no avail. Generally, the next step after 6 weeks of job search is unpaid work or volunteering, but the counselor knew this would not be the right course to obtaining long-term, stable employment. The counselor convinced Elizabeth to include GED preparation in her plan. Even though GED classes would not count toward the required Work Participation Rate, the counselor knew that it would be needed to secure employment and off assistance.

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[3] Ibid.

[4] U.S. Census Bureau, 2009-2013 American Community Survey

[5] C. Goldin and L.F. Katz, *The Race between Education and Technology*, The Belknap Press. Cambridge, MA, 2008.

> For the next 13 months, Elizabeth attended GED classes and continued in her fruitless attempts at finding a job. Elizabeth continued to struggle with housing primarily "couch hopping" while working toward her GED. At one point, she moved in with an abusive partner, showing up with 2 black eyes at the counselor's office. She quickly landed back to couch hopping while finishing up her GED classes.
>
> After 13 months, Elizabeth had completed her GED! Other than the birth of her daughter, she said it was the proudest day of her life. Three days later, she got a part-time job at Target, and the following week she enrolled at Century College pursuing a Human Service AA degree. After obtaining her job, she was able to move into an efficiency apartment. Her work hours increased from 15-20 hours per week to 30+ so she is over-income for MFIP and closed late 2014. She completed her first year as of June 2015 and will graduate June 2016. She eventually will transfer into a Bachelors Program and wants to be a Social Worker. With more work hours, she has now moved out of her efficiency and now is in a 2 bedroom apartment.

Outcome versus Process Measures

We believe in accountability. However, hold us accountable for the outcomes that matter – getting people into jobs and off of assistance. We recommend that TANF policy changes to measure meaningful outcomes related to employment and self-sufficiency and place less emphasis on process measures, such as participation hours. By focusing on these process measures, the policy is creating perverse incentives for career counselors and participants alike, who become obliged to do things like take a lower paying job for more hours rather than a higher paying job that may only be part-time. It also lessens the ability for participants to enroll in meaningful education or training programs that would increase their earning potential. Additionally, it ignores other activities and services that may be the key to employment.

To illustrate this point, here is Laura's story.

> Laura worked in the health industry for 30 years until she was physically disabled from a car accident. After the car accident she started experiencing significant mental health symptoms, such as anxiety and depression. In addition to the changes in her mental and physical health, Laura experienced several deaths within her family, including her daughter. She is now raising her grandson, Ben, and in order to care for him her physical and mental health needed to be stabilized. Additionally, Ben has significant physical and mental health issues including sickle cell anemia, depression and anxiety. His sickle cell anemia treatment includes blood transfusions every two weeks.
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> Stabilization services were provided to Laura and her grandson in the form of adult mental health therapy, children's mental health therapy and Health Navigator services. Since participating in the FAST program, Laura was able to secure employment in the Health Care field and is now employed at two part-time positions. Ben is also doing well, is still receiving services and continues to make progress in school. Since securing employment, Laura continues to

experience life crises, such as the loss of a family member through violence, and has continued to participate and receive ongoing supports from the adult mental health therapist, the health navigator and the career specialist. She has used a variety of services to regain her ability to secure and maintain employment. This employment in turn is helping to improve her mental health, so all of the services (including employment) complement each other, and this could all have fallen apart with the absence of any one of these services.

Conclusion

In summary, we recommend the following TANF policy changes to ensure families have the services and supports needed to meet their employment goals and move out of poverty:

- Hold TANF providers accountable for outcomes and not process.
- Allow TANF providers to document progress towards employment goals and not hours of participation.
- Offer flexibility in allowable employment plan activities to meet the unique and individual needs and challenges our families face.
- Include fathers as part of the solution by adequately supporting Fatherhood initiatives to provide the skills and support needed to enter the workforce, strengthen parenting skills, and ultimately become leaders within their families and their communities.

Again, thank you for the opportunity to share our experience as a TANF provider in the state of Minnesota. We appreciate the committee's interest in hearing from the field and are happy to serve as a resource to you as we look to increase both the effectiveness and efficiency of how TANF is implemented across the nation through reform efforts.

Chairman BOUSTANY. Thank you, Mr. Brown.
Ms. Pavetti, you may proceed.

STATEMENT OF LADONNA PAVETTI, VICE PRESIDENT FOR FAMILY INCOME SUPPORT POLICY, CENTER ON BUDGET AND POLICY PRIORITIES

Ms. PAVETTI. Thank you for the invitation to testify today. In my recent testimony, I presented data showing how few poor families TANF serves and how little TANF does to help poor families find work and escape poverty. In my testimony today I will focus on ways in which the draft bill could help improve TANF's performance in these areas, and I also will suggest additional changes to address some of TANF's fundamental flaws.

States have long identified the complexity and rigidity of TANF's countable work activities as hindering their ability to operate an effective work program. The draft bill makes many improvements that address those issues. We fully support the changes in the bill that will expand recipients' access to education and training, encourage States to address the needs of TANF recipients with significant employment barriers, and remove the disincentives for serving two-parent families.

I encourage the Committee to go further by eliminating the 30 percent cap on vocational education, which, in this economy, doesn't seem to make any sense.

The draft bill's elimination of the caseload reduction credit is a positive change, as it lessens the incentive for States to continually reduce their TANF caseloads and not serve people in need. But it effectively raises the target work participation rate that States must meet, and it will increase the burden on States to place a greater share of families in work activities.

While the proposed work activity changes will enable States to count more people toward meeting the rate, a sizeable gap will likely remain, which could encourage States to further restrict access to the program. So I think we need to be paying attention to this access issue.

The draft bill's requirements that States failing to meet the work rate must increase their State spending is a significant improvement over the current penalty structure. One change we would suggest is requiring States to reinvest those additional resources to the core purposes of TANF. We believe that States should be held accountable for employment outcomes, but we are concerned that the details, as outlined in the draft, may be unworkable, and we are hoping that this is an area where we can actually have some conversation.

I believe it is realistic and appropriate to hold States accountable for employment and retention, but I worry that the short-term measurement limit and the limited assistance that TANF programs usually provide—that it may not be realistic to hold them accountable for advancement. As an alternative, I suggest measuring median earnings at one point in time to encourage States to place recipients in higher-paying jobs to really go toward meeting the goal of reducing poverty.

We are concerned that the proposed penalty structure for these new outcome measures are too onerous and too complex. The long

lag time required to gather and report the data poses substantial challenges. And the penalty is harsher than any initial penalty currently, and it appears that States may have no opportunity to remedy the problem before block grant funds are withheld. I also worry that, because the penalties are too onerous, what States would do is negotiate very low rates, and we wouldn't see sort of the employment outcomes and the push toward high outcomes that you may want to see.

So, I would propose an alternative approach that emphasizes improvement and focuses directly on States that fail to meet their negotiated goals. First, require States to develop a program improvement plan, and provide technical assistance to help them do so. And second, require States to increase their State funds and target them to work activities, just as required for the work participation rate.

Implementing an outcome measure will not be easy for States, nor will it be costless. Most States currently have no data on employment outcomes which they can use to set meaningful outcome targets. And to fill that gap, what I recommend is starting with a benchmark year in which States would be required to report on outcomes, but wouldn't face any penalties. That would allow them to have some benchmarks that they could use to negotiate targets for the future, and to really build on and make improvements.

A key flaw of the TANF block grant is that permissible use of the funds is so broad that States spread them across many areas of the budget. TANF reauthorization provides a key opportunity to reclaim some of those funds, and it is one that shouldn't be missed. We believe requiring States to spend a substantial—a specific share of their TANF resources on core purposes is essential for improving TANF work programs. There are several possible approaches here.

First, all States could be required to spend a specified share of TANF funds on core activities, as Representative Doggett suggested. Alternatively, States that fail to meet the rate could actually—benchmarked could be required to move those additional funds to those purposes.

The draft bill adds a new purpose on reducing poverty. And, while this is a laudable goal, TANF can't reduce poverty if it fails to reach poor families. So one of the suggestions I would make is that we actually add a third outcome measure, and that is access to the program. If families aren't served by the program, we can't reduce poverty, and they can't have access to the services that the program is likely to show.

So, I think that TANF reform is long overdue, and I am looking forward to working with the Committee to see how we can move forward to make positive changes. So thank you.

[The prepared statement of Ms. Pavetti follows:]

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July 15, 2015

Testimony of LaDonna Pavetti, Ph. D., Vice President, Family Income Support Policy, Before the House Ways and Means Committee, Subcommittee on Human Resources

Welfare Reform Proposals

Thank you for the invitation to testify today. I am LaDonna Pavetti, Vice President for Family Income Support at the Center on Budget and Policy Priorities, a policy institute located here in Washington. I conducted some of the very first studies on the implementation of welfare reform and now spend most of my time working with state and county TANF administrators and local and state non-profit organizations to improve the program.

In recent testimony, I provided information showing how few families are reached by TANF and how little TANF does to help poor families find work and escape poverty. My testimony today will focus on the extent to which the Committee Discussion draft bill on TANF reauthorization posted last week will likely improve TANF's performance in these areas. I also will suggest additional changes to address some of TANF's fundamental flaws.

The draft legislation improves the structure of TANF work activities but does not go far enough. In order to operate high-quality work programs, states need to devote more resources and to be freed from onerous reporting requirements that dampen rather than strengthen the quality of services provided. They also should be rewarded for improving program access. Better work programs will do little to reduce poverty if very few household heads have access to them.

Work Participation Changes Represent Important Improvements

States have long identified the complexity and rigidity of TANF's countable work activities as hindering their ability to operate an effective work program. The draft bill makes many improvements that address those issues, though we have some additional suggestions.

First, the bill includes changes in what counts toward the work rate that will expand recipients' access to basic education, skills training, and vocational education, while updating TANF work preparation requirements to better match employers' needs. These changes include extending the

countable duration of vocational education to 24 months, eliminating the distinction between "core" and "noncore" activities, and increasing opportunities for participants under age 26 who have not completed high school to do so (or to obtain a GED). These changes will lift the disincentives that have often led states to limit these activities due to concerns about harming their work participation rates.

Second, the bill includes changes to better serve families with the greatest barriers to employment. Allowing participation in job readiness activities to count toward the work rate may encourage states to place recipients in activities that will address personal and family challenges that hinder their ability to find jobs and retain work over the long term. Providing states with partial credit for recipients who participate for at least half of the required hours encourages states to engage recipients who may not be able to participate for the full 20 or 30 hours due to personal or family challenges. The new mandates that the state conduct assessments and the greater detail required in the renamed Individual Opportunity Plans should also improve work programs.

The bill also eliminates the marriage penalty by striking the separate two-parent work rate and hours requirements. This will permit states to treat single- and two-parent families the same and will reduce states' disincentive to serve two-parent families.

The draft bill indicates that it remains an open issue whether to adjust the 30 percent cap on vocational education's contribution to meeting the work rate. I encourage the Committee to eliminate the cap. Retaining it contradicts other changes in the bill, such as expanding access to education and training activities, simplifying the tracking of work activities, and adding a new TANF program goal of reducing poverty.

When Congress created TANF almost 19 years ago, it assumed that if recipients entered the labor market quickly, a first job would lead to a better job and recipients would eventually work their way out of poverty. This has not happened: individuals who start out in low-wage jobs often see little earnings growth over time and many remain poor. In the current economy, jobs that pay higher wages and offer the greatest growth opportunities require some post-secondary education and training. A substantial share of TANF recipients are young adults who would reap the benefits of additional education and training for many years to come. Arbitrary caps serve no reasonable purpose in an economy that places a high value on a skilled labor force.

Another open issue under the draft bill is how to verify participation in work activities. While states and local providers can best suggest ways to support their efforts to help TANF recipients improve their employment and earnings prospects, we would like to highlight the importance of this issue. States spend inordinate amounts of time gathering information on every hour that participants spend in program activities — time better spent helping recipients set and achieve their goals. Limited resources should not be used for purposes that contribute little to improving family outcomes.

The draft bill's elimination of the caseload reduction credit is a positive change, as it lessens the incentive for states to continually reduce their TANF caseloads. But it effectively raises the target work participation rate that a state must meet, significantly increasing the burdens on states to place a greater share of families in work activities. While the positive changes identified above will enable

states to count more people toward meeting the rate, a sizable gap will likely remain for many states. As discussed below, we are concerned that these additional demands with no additional resources could increase the pressure on states to *not* serve families in their TANF cash assistance programs.

Finally, the draft bill's requirement that states failing to meet the work rate must increase their state spending is a significant improvement over the current penalty structure. The one change we would suggest is requiring states to reinvest those additional resources in the core purposes of TANF (which we elaborate on below).

Measuring Outcomes Is Step in Right Direction, But Details Need Refining

We have long advocated for measuring employment outcomes in TANF. The primary measure of TANF's success should be whether families leave the program with employment and on a path to earn enough to provide for their families, *not* simply whether they participate in a pre-defined set of activities that may or may not prepare them for employment and help them move out of poverty. The draft bill moves in this direction by proposing to hold states accountable for three outcomes for individuals required to participate in work activities that leave TANF: (1) employment two quarters after exit; (2) employment four quarters after exit; and (3) the change in median earnings between quarters two and four. These measures evaluate employment, retention, and advancement, respectively. Although we believe it is important to move in this direction, we believe that the details as outlined in the draft bill need careful scrutiny and refinement.

The employment and retention measures included in the draft bill mirror those in the Workforce Investment and Opportunity Act (WIOA), while the advancement measure is unique to TANF. Alignment of TANF and WIOA is an important goal, but it is important to acknowledge at the outset that assessing the outcomes for all TANF leavers is very different than assessing the outcomes for WIOA participants. In TANF, these outcomes will provide information on how all TANF leavers, regardless of their participation in a TANF work program, are faring while in WIOA they represent how individuals who have completed a WIOA program are faring. WIOA is also a voluntary program while TANF is mandatory. An important positive aspect of holding states accountable for these outcomes is that it will encourage states to keep TANF recipients engaged in TANF work programs until they are ready to find and sustain employment. As under WIOA, states will negotiate targets for each measure with HHS. Because most states do not have any historical data on employment outcomes for TANF leavers, states are likely to require substantial technical assistance to develop meaningful performance goals.

The draft bill's proposed earnings gain measure, which looks to the change in median earnings between the second and fourth quarters after leaving TANF, is problematic and should be revised to mirror the WIOA measure which measures median earnings at one point in time. Given the short-term nature of TANF employment services, it is unrealistic to expect an increase in median earnings in such a short time period. In addition, an increase in median earnings could reflect differences in the characteristics of individuals employed in the second and fourth quarters rather than any real increase in earnings. While the WIOA measure does not measure advancement and is a crude measure of the level of earnings, it will provide some indication of the median earnings of families when they leave TANF.

We believe that an outcome measure that assesses the circumstances of all TANF recipients at some future point in time (e.g., one year later after they are observed on TANF) would be more informative than one that just measures outcomes for leavers. A measure that looks at the employment and work activity status one year later would give states better information on how their caseload as a whole is faring, including who is employed, who is participating in work activities, and who is not working or participating in program activities. We will provide details on how such a measure could be constructed in our detailed comments on the Committee Discussion Draft.

We are concerned that the proposed penalty structure for these new outcome measures is too onerous and too complex. There inherently needs to be a lag period between the year in which performance is measured and when a determination is made on whether the performance goals have been reached. As currently drafted, the potential penalty at 10 percent of the block grant amount is harsher than any initial penalty and it appears that states may have no opportunity to remedy the problem before the funds are withheld. I would propose an alternative, two-pronged approach that focuses directly on states that fail to meet their negotiated goals: (1) provide technical assistance to develop a program improvement plan and (2) require states to increase their state maintenance-of-effort amount and to target a set portion of spending to work activities (or core welfare reform activities). In addition to keeping the block grant at its current level, this revised approach would simplify the penalty structure for states. Under this formulation, failure to meet the 50 percent work participation rate target or failure to meet the established outcome benchmarks would trigger an increase in the required maintenance-of-effort level. This approach would shift the focus to program improvement and require states to devote more state resources to their TANF program, without shrinking the block grant further or creating uncertainty for states.

Implementing an outcome measure is not costless. Only a few states gather information on recipients' earnings when they leave TANF, so states would need to develop new processes for obtaining data on recipients' earnings and following them over time. This would require states to shift resources currently used for other purposes and would most likely increase their overall administrative costs.

Need to Do More on TANF Funding and Spending

A major shortcoming of the draft bill is that it provides no additional funding for TANF even though the block grant has lost 30 percent of its value since its creation. In addition, the bill requires states to earn part of their existing block grant funds, imposes additional reporting requirements on states with no additional funding for those activities, and repurposes the Contingency Fund which some states have used to fund regular TANF activities.

Two spending provisions in the discussion draft aim to address some of the funding issues that have arisen in TANF: eliminating third-party maintenance-of-effort contributions and restricting TANF funds to families with incomes below 200 percent of poverty. We support both changes. Allowing states to claim third-party maintenance-of-effort funds has enabled them to reduce state spending on poor families; allowing states to define "needy families" has, in some cases, enabled them to shift TANF funds away from the poorest families. Changing these provisions will help to hold states accountable for contributing their fair share to help families improve their employment and earnings prospects.

A key flaw of the TANF block grant is that the permissible uses of the funds are so broad that states spread them across many areas of the budget. TANF reauthorization provides a key opportunity to reclaim some of those funds — one that should not be missed.

The draft bill notes that agreement was not reached on whether to require states to spend a specific share of their TANF resources on core purposes. Such a requirement, we believe, is essential for improving TANF work programs and participants' employment outcomes; it also provides an opportunity to reclaim some of the TANF funds that have been diverted to other purposes.

In many states, TANF funding decisions are made outside of the TANF agency, so without a mandate, TANF administrators would likely find it difficult to obtain the funds needed to fully implement the program changes envisioned in the draft plan. There are several possible approaches here. First, all states could be required to spend a specified share of their TANF funds (e.g., 50 percent) on basic assistance, work activities, and work supports. States could be given several years to reach that level of spending so they have time to adjust their funding. Alternatively, states that fail to meet either the work participation rate or their outcome benchmarks could be required to spend additional state funds in their TANF programs *and* to devote those additional funds to TANF's core purposes until the state reaches a specified share of spending.

Improved Access Needed to Make Progress Towards Reducing Poverty

The draft bill adds a new purpose to TANF: reducing poverty. While this is certainly a laudable goal, TANF cannot reduce poverty if it fails to reach poor families.

As my previous testimony explained, TANF serves only 26 families for every 100 families in poverty; in a growing number of states, it serves fewer than *10* families for every 100 families in poverty. The draft bill includes a few provisions that will lessen the incentive for states to avoid serving families in need or those with the greatest barriers, such as eliminating the caseload reduction credit and providing partial credit for recipients who do not participate for the full number of hours. But these do not go far enough.

The problem is that TANF lacks a meaningful accountability measure on how effectively a state's TANF program provides a safety net for very poor families, and the draft bill does not include one. We suggest holding states accountable for adequate access to TANF benefits on a par with the two other performance measures (the work participation rate and the new outcomes measure).

The best way to achieve this would be to add a third accountability measure that specifically measures access to TANF and to attach similar consequences to state failures. The TANF-to-Poverty ratio that we use is one option, but others could be considered.

There are other, more modest ways to encourage states to serve more families in need, such as considering a state's performance in this area either in negotiating with states over their outcome measures or in considering a state's penalty relief request if the state fails to meet the 50 percent

work participation rate. At a minimum, Congress could instruct HHS to produce an annual report that measures access to the program; USDA's annual report for SNAP program could be a model.

TANF reform is long overdue. The draft bill doesn't go far enough but it provides a strong starting point for bringing about meaningful change in a program that currently reaches few poor families and does very little to help the families move out of poverty. A whole generation of children has grown up under the current TANF structure – we should move forward expeditiously to ensure that the next generation has access to a more robust TANF program that both reaches more families in need and provides more meaningful education, training and work opportunities that give families a reasonable chance of moving out of poverty.

Chairman BOUSTANY. Thank you, Ms. Pavetti.
Mr. Collins, you may proceed.

STATEMENT OF GRANT E. COLLINS II, SENIOR VICE PRESIDENT, FEDCAP REHABILITATION SERVICES, INCORPORATED, WORKFORCE DEVELOPMENT; AND EXECUTIVE DIRECTOR, WECARE REGION II, FEDCAP

Mr. COLLINS. Good morning, Chairman Boustany, Ranking Member Doggett, and distinguished Members of the Committee. I am pleased to appear before you today to discuss the next phase of welfare reform.

I am currently the Senior Vice President of Fedcap Rehabilitation Services, Incorporated's Workforce Development practice area. Fedcap is an 80-year-old non-profit human service company that specializes in addressing the economic well-being of those with barriers to work. My comments today will center around the provisions found in H.R. 2968 and H.R. 2952 on casework, employment, and retention, as much of what we do is consistent with these bills.

Fedcap administers a wide range of employment programs, including placement services for the court-involved individual re-entering the workforce, placing veterans as well as public assistance recipients. We also provide employment services for recipients with a wide range of health claims, which we deliver through a comprehensive case management model called WeCARE, Wellness Comprehensive Assessment Rehabilitation and Employment.

A group often exempted from participation in most States, each year we place thousands into employment, as we consistently exceed our contractual goals for job placement, while also achieving a job retention rate at 6 months of just over 73 percent. To achieve these outcomes we employ a strength-based assessment model, where we focus on what our program participants can do, rather than focusing on their weaknesses. Engagement really begins with our receptionist. However, relationship-building is established with our case managers, whom we refer to as our ambassadors of self-sufficiency.

Our unique approach to case management begins with a set of mental tools. Henry Ford once said, "Whether you think you can or think you can't, you are right." Mr. Ford was referring to what is commonly known as the Pygmalion Effect, or self-fulfilling prophecy. In short, what you expect is what you get, so we expect success and shift paradigms up front. Since we expect our participants to work, we refer to them as job-seekers from that point forward.

Core to our success is our belief that, number one, there are jobs; number two, that people are better off working; number three, people do want to work. Let me discuss each briefly.

Number one, there are jobs. We remind our job seekers that, despite the unemployment rate, one job is all they need, and that employers have openings.

Number two, people are better off working. There are many reasons why we work. Work adds to a person's self-esteem, it improves their lifestyle. Work can provide opportunity and hope for the future. There is a platform when each of us can add to an employer's business or to our communities, or advance a cause, and work is

the way we keep our minds and skills sharp. It is one of the primary ways we manifest our potential. There is a certain dignity that comes from work that only work can provide.

And, number three, people want to work. A pathway to the best job for a person can be reached from taking a job now.

Work is the focus of our initial face-to-face meetings. Case managers conduct one of several assessments, starting with an impromptu mock interview on the spot. Within the first few minutes, we look to see if the job seeker is employer-ready. With a sense of urgency, we get the job seeker placed immediately, or track them quickly, often the same day, into a second, more formal assessment called the Diagnostic Vocational Evaluation, or DVE. The DVE is a battery of assessment tools that is designed to help the job seeker understand their work-based strengths. The outcome of the DVE is the basis for the development of the job seeker's individual plan for employment, which includes, among other things, the top three jobs they are looking to obtain.

The plan is established, agreed upon, and signed by the job seeker and case manager. We then fortify this with an action plan that clearly identifies the job seeker's short-term and long-term goals. The initial work activity, and weekly hours are assigned, similar to what is proposed in the TANF reauthorization draft.

Except for a few work activities, most assignments are no more than 12 weeks in length. To extend the activity beyond 12 weeks, a comprehensive employment plan review and new plan with new goals must be established. The draft TANF reauthorization envisions this same approach, meeting every 3 months to review progress and to determine next steps.

We also provide case management even after employment begins. Once the individual is employed, we typically meet with them no less than monthly for up to 6 months. This is consistent with the focus on the outcomes in the draft, and is one way to get States to follow recipients after they leave for work, to make sure they don't come right back.

Personal responsibility is at the core of the TANF program. Effective case management, regular progress reviews, clear, practical action plans for employment and retention can often provide the necessary engagement to help more job seekers establish their own employment futures.

I, along with the other members of this panel, stand ready to work with you to make economic independence for America's neediest families a reality. I would be happy to answer any questions you might have.

[The prepared statement of Mr. Collins follows:]

Grant E. Collins II
Senior Vice President, Fedcap Rehabilitation Services, Inc.

Before the

Committee on Ways and Means
Subcommittee on Human Resources

Welfare Reform Reauthorization
July 15, 2015

Good morning, Chairman Boustany, Ranking Member Doggett, and distinguished members of the Committee I am pleased to appear before you today to discuss the next phase of welfare reform.

I am currently the senior vice president of Fedcap Rehabilitation Services, Inc.'s workforce development practice area. Fedcap is a non-profit human services company that specializes in addressing the economic well-being of those with barriers to work. My comments today will center around the provisions found in H.R. 2968 and H.R. 2952 on casework, employment and retention as much of what we do is consistent with these bills.

Fedcap administers a wide range of employment programs including placement services for the court involved individual re-entering the workforce, placing veterans as well as public assistance recipients. We also provide employment service for those with reported mental health and other barriers which we deliver through comprehensive case management that helps these individuals reach their highest levels of self-sufficiency. Each year we place thousands into employment and in one of our largest programs called WeCARE (Wellness, Comprehensive, Assessment Rehabilitation and Employment), we continue to consistently exceed our originally established performance goals for job placement by 34 percent while maintaining a job retention rate at 6-months of just over 73 percent.

To achieve these outcomes we employ a strength based assessment model where we seek to learn what our program participants can do rather than focusing on their weaknesses. This is one of several aspects of successful engagement that I will be discussing with you today.

Engagement really begins with our receptionist however relationship building is established with our case managers whom we refer to as our "Ambassadors of Self-Sufficiency". They serve as the first line of contact, conveying in words, and in action the very intent of program. These front line experts do more than simply intake and assessment if they are going to be effective. Successful case management begins with an understanding that the person engaging with you has just been faced with making a significant lifestyle change. Our front line ambassadors know that they are the key to helping that person see opportunity.

Our unique approach to case management begins with a set of mental tools. Henry Ford once said, "Whether you think you can or think you can't you are right." Mr. Ford was referring to what is commonly known as the Pygmalion effect or self-fulfilling prophecy. In short, what you expect is what you get so we expect success and shift paradigms upfront. Since we expect our participants to work we refer to them as "jobseekers" from that point forward. Core to our success is our belief that (1) there are jobs (2) people are better off working (3) people do want to work. Let me discuss each briefly. (1) There are jobs: We remind our jobseekers that despite the unemployment rate one job is all they need and that employers have openings; (2) People are better off working: there are many reasons why we work, work adds to a person's self-esteem, it improves their lifestyle, work can provide opportunity and hope for the future, work is a platform where each of us can add to an employer's business or our communities or advance a cause, and work is a way to keep our minds and skills sharp and its one of the primary ways we manifest our potential. There is a certain dignity that comes from work that only work can provide; and (3) People want to work: A pathway to the best job for a person can be gained from taking a job now.

In our initial face-to-face meeting our case managers conduct one of several assessments-they conduct a mock interview on the spot! Within the first few minutes we look to see if the jobseeker is "employer ready". With a sense of urgency we get the jobseeker placed immediately or track them quickly, often the same day, into a second more formal assessment called a diagnostic vocational evaluation or DVE. The DVE is a battery of assessment tools that is designed to help the jobseeker understand their work-based strengths. The outcome of the DVE is the basis for development of the jobseeker's individual plan for employment which includes among other things the top three jobs they are looking to obtain. The plan is established, agreed upon and signed by the job seeker and case manager. We then fortify this with an action plan that clearly identifies the jobseeker's short and long term goals, the initial work activity assigned, the hours assigned as well as identifying a full range of work supports that might be needed similar to what is proposed in the TANF reauthorization draft.

For the exception of a few work activities, most assignments are no more than 12 weeks in length. To extend an activity beyond 12 weeks a comprehensive employment plan review and a new plan with new goals must be established. The draft TANF reauthorization envisions this same approach-meeting every three months to review progress and determine next steps.

We also provide case management and seek progress reviews even after the employment begins. Once an individual is employed we typically meet with them once per week for the first two months (in their off hours), and no less than monthly for the next four months. This is consistent with the focus on outcomes in the draft and is one way to get states to follow recipients after they leave for work to make sure they don't come right back.

While we believe that our philosophy might be unique, the idea of assessments and employment plans is not unique, however, there are elements of delivery that make them effective. In my previous work I have seen the value of well communicated employment plans. For example, whether it was in Wisconsin under an AFDC waiver, or in Minnesota as the state established the new work expectations under the Minnesota Family Investment Program (MFIP), communicating engagement expectations through plans such as these is how the Temporary Assistance for Needy Families (TANF) program ushered in the reciprocal responsibility required over its predecessor welfare program Aid to Families with Dependent Children (AFDC) in which welfare was an entitlement. Working in these states I saw first-hand the changes in policy and how solid case management practices established clear expectations on the front line.

Personal responsibility is at the core of the TANF program. Effective case management, regular progress reviews, clear, practical action plans for employment and retention can often provide the necessary engagement to help more people establish their own employment futures.

I along with the other members of this panel stand ready to work with you to make economic independence for America's neediest families a reality.

I would be happy to answer any questions you have.

Chairman BOUSTANY. Thank you, Mr. Collins, and thank you all for your testimony. We will now go to a question and answer phase of this hearing. Let me start by asking Ms. Cox a question.

You have administered the TANF and workforce systems in your prior role, and you now administer an office focused on creating more value for every tax dollar invested. And, to me, that sounds like focusing tax dollars on results, and not just paying for a process, but to try to really get an outcome, and hopefully, a favorable outcome.

The TANF statute requires States to ensure 50 percent of their welfare caseload participates in work or activities. And while this measures how a State is engaging welfare recipients in activities while receiving benefits, we don't currently measure how well the States are doing in helping welfare recipients leave TANF for work, and hopefully meaningful work.

This discussion draft would reserve a portion of the TANF block grant to pay States based on their success in achieving three goals: moving TANF recipients off of welfare into work; keeping these former welfare recipients in work; and helping them increase their earnings over time. All, we think, are laudable goals.

How do you think changing the TANF program from one that focuses solely on process to one that focuses more on these types of outcomes might encourage States to move more people into jobs and really, actually, help them move up the economic ladder? And what are some of the pitfalls we need to look at, going forward in this?

Ms. COX. So, what you just said is music to my ears. Having been in government for a while, I struggle sometimes with the lack of outcome and accountability that we have on programs that are being funded by taxpayers, and should have impacts for people. It can be very process-focused, and very bureaucratic. And, at the end of the day, we don't know if we have made a difference or an impact.

So, when we—when I took over the TANF program, it was completely participation-driven, and there wasn't—what is her—here, down here, what she talked about, you know, they may not even have the employment data. So, you know, like I said in my testimony, we—I said I am not looking at participation. I want employment outcomes. And it shifted the culture, that that is what we were about. And then can we design participation activities that actually lead to employment outcomes, rather than just sitting people in services, so that we can get the participation credit? So we are all about that.

A few cautions that I think would be important to continue to vet. One, the idea—I think it is 30 or 40 percent would be on increased earnings in the fourth quarter. I don't know if that is arbitrary, I don't know if the general public generally, within the fourth quarter, receives increased earnings or not. I think it is a good aspirational concept to consider, but I don't know what the trend is in the general population. Is that within a State's or a provider's ability? States could potentially game it. You could put them in part-time employment, knowing that it will move to full-time in the fourth quarter, so your earnings increase, but you have never really made a big difference in their actual earnings, long-

term. So there are different ways that that could be gamed, and I think that is an area that merits consideration.

The lag issue is one of the other issues I would want to explore. When I budget or do long-term contracts, I look at ongoing versus one-time funding. And if I don't know if I am going to have that money in 17 months, I am not sure how to budget for that. Now, if I am talking a 3 percent, it is, you know, 3, 3, 4, a total of 10, that is not going to make or break my budget. But it would potentially impact how I would set up contracts, et cetera. So working through that lag, and giving States a little bit more immediate feedback if they are going to hit that or not is going to be something I think that we need to continue to discuss and work through.

So there are other issues there, but I don't think any of them are insurmountable. I would offer this counter-comment. I like the fact that money may get lost. A lot of our Federal—maybe nobody else will agree with me on this, but a lot of our Federal programs threaten lost money. Right? And you go through a lot of corrective action plans, and yada, yada. But, generally speaking, there is not a real consequence. There just isn't. And these funds should be considered precious, scarce resources, and I think it is fair to say, if people don't perform, there is a consequence to it. Now, maybe they should have some technical assistance and a chance to improve. But at some point there needs to be a real consequence if we are not performing.

Chairman BOUSTANY. Well, I thank you for bringing the value of your experience to bear on this. It is really helpful to us.

Mr. Doggett.

Mr. DOGGETT. Thank you very much.

Dr. Pavetti, as you know, the discussion draft leaves open for discussion this question of how much the States are devoting to the core purposes of cash aid, child care, and work activities. How do you feel that should be—that blank should be filled in, and why?

Ms. PAVETTI. I definitely think that there needs to be a requirement that States spend a certain share of their funds on core purposes. And if there isn't, I don't think you will see meaningful change. There are some States that spend as little as 1 percent of their TANF funds on work programs. And to expect that we can increase—reduce poverty if they are spending so little, I think, is unrealistic.

So, I really think there are two ways. I think one is to require all States to get there, and to give them sort of a time to get there. And the other is to—you know, in the draft bill there already are expectations that States will have to spend more State money if they don't meet those requirements. And so that would also be—rather than that—just being able to go anywhere in the State budget, that that really be directed to State core purposes.

But I think it is one of the huge failures of TANF, that so many of the funds have been pulled away from families who really are the most needy, and this is an opportunity to reclaim those funds. And it would be a shame if we didn't actually get those back.

Mr. DOGGETT. When welfare reform was originally approved back in the nineties, wasn't one of the objectives—and I think you make reference to this—people would work their way not only just

to work, but to work their way out of poverty, and work into the middle class? And how well has that objective been satisfied?

Ms. PAVETTI. So what we know about the work—about work and earnings among TANF recipients is that, one, we have very little recent data on employment among TANF recipients. We have data from the early years, but most States don't collect that data and don't report it. So we really don't even know where the starting point is in setting these benchmarks, because we don't know how many get employed. So that is one thing I think we need to think about.

But for those who do get employed and start out in low-wage jobs, there was an expectation that people would move up. But that is really—if you look at the experiments, you don't see sort of increases in earnings over time. What you see is some increases in employment. And where the programs really fall short is in stable employment.

So, right now there are lots of people who get jobs, but they don't hold them. And if people are going to increase their earnings and increase them over time, there are two things that make a difference. One is holding on to jobs, and the other is having the education and the skills that are demanded in the labor market, so that they can move up.

So I think Boyd talked in his testimony about a very compelling example of why education really does make a difference. So I think that the education and training—we have evidence that there is a lag, there is an initial—there is—that gain isn't immediate. But when you compare people who are in those training programs, usually 2 years out their earnings gains are much greater than people who don't participate in them.

So I think we need to be really encouraging States to move in that direction.

Mr. DOGGETT. If there are no new dollars, which is the case with this proposal, no additional funds added, and if a State can continue to devote only 1 percent to work—in the case of one of the States you mentioned—how realistic are the provisions in the bill that there be an individual opportunity plan and State counseling with the recipient every 3 months?

Ms. PAVETTI. I think that is pretty unrealistic, that States will be able to do that. I think it is the right thing to do, but I am not sure how you do it without resources. So I think that it is really something that needs to be paid attention to.

I think the other thing that is important is sort of thinking about—what happens in TANF is that we sort of—we provide a little bit of services to everybody, including people who may not need any services, and really thinking about how can you take what resources are there, and really concentrate them on the people who need the most help. And I think the work participation rate, and the way it is designed, and the focus on hours really does encourage this across the board, serve everybody, even if they don't need it.

So, I think there is—both we should temper our expectations, if the money isn't there, but also really think about can you use the resources that are used better, and not spread them so thin?

Mr. DOGGETT. You probably covered this already. But, in short, what do you think are the most important changes that need to be made in the draft?

Ms. PAVETTI. I think the most important changes—there are two. I do think that the elimination of the core/non-core distinction is pretty—is quite important for States, because it gives them much more flexibility, and it helps on the education and training aspects. And the other is I think the movement to outcome measures is hugely important. I don't think the details are quite right in the draft, and that we really need to think those through. But I do think actually adding outcome measures will change the way States think about what they do, and will change their behavior.

Mr. DOGGETT. Thank you.

Thank you, Mr. Chairman.

Chairman BOUSTANY. Mr. Young.

Mr. YOUNG. Thank you, Chairman, and thank you to all of our witnesses here today.

I will begin with where I am headed with a question. It will be addressed to Mr. Kelly of the Salvation Army and Mr. Brown of Goodwill, and that is, can better casework reduce poverty and increase employment? Your organizations are on the front line of our efforts to reduce poverty. As Chairman Ryan likes to say, "The Federal Government is the rear guard, but you are the vanguard of this effort, clearly."

I am sure those you work with who are receiving TANF benefits often also receive other benefits and services. I have experienced this on the ground throughout my State of Indiana. And in many cases, the individual must meet with multiple case workers, and visit different offices to receive these benefits and meet the different requirements of each program. They may also have to make repeat visits to these various case workers, as their circumstances change over time.

Now, as I think of the served population, these are people who lack the resources, they lack the time, oftentimes. They are under great stress. And moving from caseworker to caseworker, office to office, through a constellation of different programs, can not only be mind-numbing, but problematic and a deterrent, even, to seeking the assistance that they require.

It is burdensome, it is confusing, it is unworkable, it is insensitive, it is irresponsible, and unacceptable. So we have to coordinate our efforts to solve poverty, and that starts with good casework, to my mind.

And so, this week I introduced the Coordinating Assistance for TANF Recipients Act. This would provide funds for States to test better ways of helping recipients move through welfare and into work and self-sufficiency. This bill, which is now part of the larger Ways and Means discussion draft we are focusing on here today, would provide funding to test and evaluate various efforts along these lines.

So, back to the original question. Mr. Kelly, we will begin with you, sir. How might supporting more coordinated casework bring dignity and opportunity to more welfare recipients by helping them move into work and out of poverty?

Mr. KELLY. Well, first, let me say I think that is a great observation. And we would add to that that our experience with those who are living day to day in poverty are suffering from a severe lack of hope, that they have essentially given up. And part of that giving-up process is the despair that comes from going from office to office without, really, a coordinated, centralized way to help them in the process. So, we would, I think, be advocates of a more thoughtful, strategic approach to how we are caring for people.

I would also say we need to help all parties keep in mind what our actual goal is. Our actual goal is not a job that they have, either temporarily or part-time or barely allows them to get through a day. We are looking to move people out of poverty. I assume that is what everyone's goal is. And you can't do that without a large amount of coordination, both within the casework field, and in terms of the involvement of the client themselves.

Mr. YOUNG. Mr. Brown. Yes, sir.

Mr. BROWN. Thank you for the question, Mr. Young. Actually, I think you are right on point. And, actually, in Minnesota we have had several initiatives actually looking at coordinating casework disciplines. And one I want to particularly mention is Families Achieving Success Today that was actually part of a randomized control trial through the U.S. Department of Human Services, where we were integrating adult mental health, children's mental health, along with TANF financial worker, the financial assistance piece, as well as child care, in a collocated, collaborative effort.

It was a 1-year study, so it showed promising efforts. We don't have anything beyond that. But we do know that, having those services together in one spot absolutely improved their access to—our families' access to services, as well as improved their outcomes.

One note of caution I would give is that we have been part of these types of collaborative casework models in the past. However, they did not include employment, and we did not see the results that we wanted to see. This particular one, Families Achieving Success Today, all the providers, whether it is mental health, whether it is health care, they were all on board, that employment is what we are trying to achieve with the families we were serving, and we saw great success with that. So thank you.

Mr. YOUNG. Perhaps that program will move from the promising phase to proven, or will identify a variant to that, will be a better model, and so forth.

I recognize I am out of time, so I will yield back.

Chairman BOUSTANY. I thank the gentleman. Mrs. Noem.

Mrs. NOEM. Thank you, Mr. Chairman.

Mr. Collins, I wanted to visit with you about a loophole that currently exists within the TANF program. And, as you know, the TANF program states that it must engage 50 percent of adults on welfare in worker activities related to work. South Dakota, my home State, does a great job of this, but many other States are failing to engage to the same level.

Under current rules, the loophole says—it is called the Excess Spending Loophole—that States can reduce the share of people they have to engage in work by simply looking for spending of nonprofits, charities, food banks, other third parties, and the States, and how much they are spending on poor families. They then add

up all this third-party spending, and report it as if it was actually spending that the State was engaging in. And, by reporting this excess spending to HHS, they reduce the number of welfare recipients that they are required to help.

In fact, in some cases, States have reduced their 50 percent work participation requirement to a 0 percent. And, you know, through this bill that we have proposed, the TANF Accountability and Integrity Improvement Act, that I have introduced and which is a part of this discussion draft that the Committee has put together on TANF reforms, it would put a stop to some of those activities.

I was wondering if you could give me some feedback on that loophole, if you think that these recommendations to fixing that problem are good in the discussion draft, and if you think that it will be effective in making sure that some of the States implement changes that would reflect more of what is done in my home State of South Dakota?

Mr. COLLINS. Thank you, Congresswoman, for that, and for your leadership on this particular part of the discussion draft.

As you are well aware, the current TANF purposes do allow for such excess maintenance of effort to be applied against the work participation rate. And, as you rightly mention, there are numerous ways in which this can be done, including volunteer hours of Boy Scout leaders, as well as coaches and Shriners and—it is, really, almost endless, the number of ways in which the rate can be essentially avoided, by providing all of these excess maintenance of effort opportunities.

So, I believe this is probably one of the more far-reaching components of the discussion draft, being able to put a stop to this. It eviscerated the work participation rate, as we know it. Whether you agree on what work activities we are to do, the idea of having to engage with someone is the start of a conversation that will allow them to propel forward.

If you provide such loopholes, the incentive for States to really go and reach out to people and engage them productively goes away. So I think that what has been envisioned for the discussion draft is exactly what is needed right now.

Mrs. NOEM. While you worked at HHS, did you see some States engaging in these activities, or some States that were, potentially, the worst offenders?

Mr. COLLINS. So, to be fair, I would—most States participated in it to some degree or another. It is unfortunate, because it really did reduce the work requirement. I would like to commend all those States, post-DRA, that actually did meet the 50 percent work participation rate.

I agree with my colleague, Ms. Cox, that the activities really should be an on-ramp to employment. So it is not really about putting people in activities for activities sake, but that, really, the pressure that the rate was supposed to provide, really, was only 50 percent. And, if you think about it, that is half. I mean we can do far better than that.

Mrs. NOEM. Yes, I saw you nodding your head. Since I have a little bit of time left, when they were talking about the Families Achieving Success program today, did you have some experience

with that program, as well, or some feedback to give on the success of that study?

Mr. COLLINS. I have just some familiarity with the strong case management approach that the State of Minnesota takes. They are very serious about how they engage with participants.

I was nodding my head, because I run a program in New York City that sees 80,000 people a year that does something very similar.

Mrs. NOEM. Okay. And it has been a successful program?

Mr. COLLINS. It has been a very successful program. This is a program where most States would have exempted these participations altogether, because they pose some health challenges to the organization. We see that, after 485,000 independent medical assessments we have been able to do over the 10 years—not my company, but the program itself—half of everyone can actually work. And a third, while they might be sick today, can heal, and those too can work, as well. And very few people end up on Federal disability.

Mrs. NOEM. What was the name of the program in——

Mr. COLLINS. It is called WeCARE, Wellness, Employment, Comprehensive Assessment, Rehabilitation, and Employment.

Mrs. NOEM. Thank you.

Mr. COLLINS. You are welcome.

Mrs. NOEM. I yield back, Mr. Chairman.

Chairman BOUSTANY. I thank the gentlelady. We will now go to Mr. Davis.

Mr. DAVIS. Thank you very much, Mr. Chairman, and I want to thank the witnesses for being here.

You know, I was just thinking that I believe that work is love made visible. Therefore, I am delighted with the focus of this hearing. I have advocated for improvements to TANF and the fatherhood grants to increase the economic well-being of parents, especially non-custodial fathers, since Fathers Day 2007. The draft bill before us contains many of the tenets of the Responsible Fatherhood Act, which is supported by numerous national organizations, including the National Fatherhood Initiative, Concerned Black Men National, the Center for Family Policy and Practice, One Hundred Fathers, Incorporated, the Children's Defense Fund, and others.

I applaud the bill for increasing access to education and training, and focusing on actual employment, including subsidized employment. I look forward to working with you, Mr. Chairman and the Ranking Member, to consider additional provisions to support non-custodial fathers and families, such as lifting the 30 percent cap on education, limiting the marriage penalty for Fiscal Year 2007 until enactment, ensuring that participation in healthy marriage or fatherhood programs is voluntary, and making clear to States that they can provide non-custodial parents the same work supports as custodial parents.

Further, I would like to work with you, Mr. Chairman and the Ranking Member, to include provisions that would better support kinship caregivers. I know that many Members of this Subcommittee come from States with high percentages of grandparents raising grandchildren. And I believe Louisiana has the second-highest percentage of grandchildren in the care of grandparents in the

Nation, with North Carolina, Texas, South Dakota, Georgia, and Illinois having high rates, as well. I am preparing to introduce a bill to improve supports for kinship caregivers, mainly through increased notice, improved data, and State reporting to improve services and supports within TANF.

Mr. Brown, I know that your organization has been advocating for fathers' engagement in children and family well-being. And I hear that your organization works with low-income fathers, often those with criminal backgrounds, to help them support their children, both financially and emotionally, and to provide them skills to become economically self-sufficient and socially empowered parents and citizens. Could you elaborate a little bit on that program, and what do you think Federal funds really do for it, and how might we improve?

Mr. BROWN. Sure. Thank you for the question, Mr. Davis. Yes. So we have been part of the fatherhood initiative—our Father Project has been in existence for well over a decade. We have been funded by the Fatherhood—responsible fatherhood funding through the Federal Government for the past 5 years, and been part of the study, as well.

We find that fathers are an important part of the solution to—for low-income families and moving people out of poverty. Our work, working with fathers, it is a wide array of services, including parenting—parenting classes, co-parenting, relationship-building. Because, even if you don't get along with your partner, you need to be there for your children. And so, really working with families on how can they co-parent, even if they don't get along, or they are not together any longer, that is a big part of our initiative.

Employment. Of course, we are a workforce development agency. Employment is a key. We want to increase child support for the families from the non-custodial, to the custodial parent, making sure that those children's needs are met. So I think it is an extremely important part of TANF and moving people out of poverty. So I commend you on making sure to include fathers and fatherhood initiatives in the TANF reform.

Mr. DAVIS. Thank you very much.

Mr. BROWN. Thank you.

Mr. DAVIS. Thank you, Mr. Chairman. And I am pleased that each one of the witnesses puts an emphasis on the engagement of fathers, and I appreciate that very much.

Chairman BOUSTANY. I thank the gentleman. We will go to Mr. Holding next.

Mr. HOLDING. Thank you, Mr. Chairman. During the course of this year, and the hearings that we have had, and where I have learned about TANF and some other programs, it is striking how bureaucracy can somehow get in the way of results. And, under TANF, States are required to have 50 percent of their caseload engaged in work or activities to prepare for work. That is, an adult must be in specified activities, work, job search, training for a number of hours a week. I have learned that.

But I have also learned, however, there is a marriage penalty in TANF, and one that encourages States to not serve two-parent families, and that can penalize individuals on TANF if they marry. And I am kind of stunned at that. So, under current TANF law,

it establishes a separate, higher participation standard that applies to two-parent families. So these families must meet additional work requirements beyond that of a single-parent family. Of course, we all want two-parent families.

So, I have introduced the TANF Marriage Penalty Elimination Act last week to address this issue by ending the separate and higher requirement for two-parent families. And I am grateful that this has been included as a provision in our Ways and Means discussion draft which we released on Friday.

So, first to you, Mr. Kelly, do you think this is a step in the right direction, to treat single parents and married parents equally in the TANF program? And can you flesh out why that is—if you feel so inclined?

Mr. KELLY. I would say, based on our experience, that the key is to start from wherever that family happens to find themselves. So we can't start from the premise that, you know, if it is a single-parent family, well, it would be great if both parents were there, because that is just not always possible. And you can't start the other way, either. You always have to start with where they are.

So, as our caseworkers have met with families that are in need, you don't go in with a pre-conceived notion of something that is ideal. You start with where they are, and go from there. Having said that, I don't think there is any question that it has been proven to be healthier for children to grow up in an environment where both parents are involved. You know, we all have our idea of what the ideal family construct is, but I think statistics are pretty clear that we are better served when both are involved.

In our own study, it has become clear that a child that grows up in poverty is 32 times more likely to be in poverty as an adult. So, the sooner we begin to engage, the better off we are going to be. But we would be very supportive of a philosophy moving forward where we are encouraging involvement of a two-parent family, but from the perspective of understanding where people find themselves at that moment when they come to us, that effective case management is going to be case management where we identify the needs of the family at that time, and build an individualized plan that helps them to move forward.

Mr. HOLDING. Ms. Cox, in the minute that I have remaining, if and why do you think it is important that we take measures to eliminate the marriage penalty, and ensure that TANF is supporting or encouraging two-parent families?

Ms. COX. Absolutely, we think it is going in the right direction.

The one question I have around this, though, is if you want—you know, tell me how you measure me, and I will tell you how I behave. Right? So, if in the outcome measures that you are going to be looking at, how do you count leaving TANF for increased income because of marriage? And I think that is a point to think through, as we look at performance measures, and making sure that, if people leave because of that—and we want to encourage that—that States aren't penalized because of that in the actual denominator-numerator formula in the performance measures.

Mr. HOLDING. Good, thank you.

Mr. Chairman, I yield back.

Chairman BOUSTANY. The gentleman yields back. Mr. Dold, you are recognized.

Mr. DOLD. Thank you, Mr. Chairman. And I certainly want to thank you for holding this important hearing. I want to thank our witnesses for your testimony and for your insights. We certainly appreciate that.

I believe—and, Ms. Cox, you stated in your testimony that work is—well, it is transforming lives. And I believe that the best way out of poverty is a job. And while moving welfare recipients into employment is the central goal of TANF, some welfare recipients have a difficult time transitioning from welfare into work.

In some cases, employers may be reluctant to hire welfare recipients if they have limited work experience or other barriers to work. That is why I recently introduced the Accelerating Individuals Into the Workforce Act. This bill, which now has been incorporated into the larger TANF discussion draft which we are reviewing today, would provide funds for States to test methods of subsidizing employment for TANF recipients to better help these individuals find jobs and become self-sufficient.

In addition to providing funds for subsidized jobs, the bill requires a high-quality evaluation of each project to determine whether the project was effective in helping welfare recipients move into and stay in work.

Mr. Collins, do you think that providing short-term partial wage subsidies to employers might be a way to encourage them to hire welfare recipients and keep them as employees over the long term?

Ms. Cox, if you have something to say, you can jump in there, too, and then we will go right back to Mr. Collins.

Ms. COX. Oh, okay, sorry. We actually did a study to look at what participation activities correlated to employment outcomes. And this was on the top four, "Subsidized Employment." Again, my caution is not to do it for government entities. And, you know, it should go to the private sector, for sure.

But the other piece to be aware of is WOTC, the Work Opportunity Tax Credit that employers could already benefit from, from getting certain populations that are vulnerable into employment. So how to subsidize employment, correlate or work with WOTC, so that some employers aren't double-dipping. Just something to be mindful of, as well.

Mr. DOLD. Okay. Mr. Collins.

Mr. COLLINS. Congressman, the details on that will matter. I will tell you one of my biggest concerns is presenting someone to an employer as if, for example, they are a discounted individual. So we would have to be careful about how that subsidy is represented for that individual. Most employers have told me over the years that they are just looking for somebody who wants to work, and they are less concerned about the credits and such that go along with the individual if they, in fact, can do the work.

So, I think it is a great opportunity, as I do many other work activities. There is more than one way to get there.

Mr. DOLD. Sure.

Mr. COLLINS. So I think having subsidized employment be a part of the arsenal, if you will, is a great opportunity.

Mr. DOLD. Well, so, can you talk to me a little bit more about some of those other barriers? I mean, obviously, I am a small business person, and obviously, what we find is once people get in, and you have an opportunity to take a look at how they are working, they do a great job. What are some of the barriers in trying to get some of these people that are down on their luck into the workforce, so that they have that opportunity?

Mr. COLLINS. It is a great question. Most of it is their self-view, whether or not they believe that an employer will be willing to accept their background, or whether or not they have enough education. A lot of it is the perception of how they see themselves.

If we are able to get them to overcome that, whether it is through on-the-job training and/or subsidized employment, or whatever form of engagement, really, all we are trying to do is to get them, really, to see themselves in a different light, and one in which they understand what employers are looking for, and then be able to sort of show those skills and abilities at that point. On-the-job practices, which I would refer to subsidized employment as being, is a great way to do that.

Mr. DOLD. Well, and part of that—really, what we are trying to do is we are trying to make sure that there is an easy on-ramp into employment. And giving employers an opportunity to say there are training costs that are going to go into there, and that on-the-job training is potentially some of the best, that is really what, hopefully, this program is trying to do. What would you anticipate some of the complaints or some of the issues from some small businesses to be?

Mr. COLLINS. I would be concerned about the cliff effect of what would happen after the subsidy ran out, and whether or not they are willing to continue the employment of that individual, or if—whether or not they would be interested in, essentially, going and finding another individual who came with a subsidy. Because it does keep their costs down.

So, again, it is all in the details of how this gets rolled out, so that we avoid that. But that would be my biggest concern.

Mr. DOLD. Thank you, Mr. Chairman. My time has expired.

Chairman BOUSTANY. The gentleman's time has expired. We will go to Mr. Crowley next.

Mr. CROWLEY. Thank you, Mr. Chairman. And I want to thank you with the full sincerity—I think I can speak for the entire side of my aisle—for holding this hearing today, and for working in a bipartisan way on the discussion draft that was released last week. So thank you, Mr. Chairman.

There are a lot of improvements we can make to the TANF program. But for too long now, we have just been simply renewing it with short-term extensions. So I appreciate the chance to take a serious look at what we can do and do better.

There is some good progress in the discussion draft, as I said. It moves the focus of the program more significantly toward actual poverty reduction. And I am glad that the bill includes some of the program improvements that my Democratic colleagues and I have been advocating for years now. But I have to say that I am disappointed at what is not in the bill, and namely no new funding for child care.

Child care can make the difference that enables a parent to work, put food on the table, and lift themselves and their families out of poverty, knowing that their child is being adequately cared for. We have had a lot of focus on work participation in TANF. But, as I have said before, work participation has to go hand in hand with ensuring there is adequate access to child care. Working parents need to know that their children are being safely cared for while they are looking for work or are working.

Dr. Pavetti, do you agree that a greater investment in child care would be a significant help to move people out of poverty through the TANF program?

Ms. PAVETTI. Absolutely. I think that, for many families—and it really varies by State, how much States have devoted their resources to child care, but in some places there is a long waiting list for child care, and families can't get child care to be able to go to work. And I think, without it, we are putting kids at risk, and we are making it so much harder for families to do what they want to do, which is either to go to school or to go to work to be able to provide for their families.

So, I think child care is absolutely essential, and I agree with you, that there is a desperate need for more resources to actually fund child care.

Mr. CROWLEY. And would you agree that child care should be considered as part of a TANF reauthorization?

Ms. PAVETTI. Yes, because I think that it is hard to sort of imagine that you are going to put more people to work, and you don't have more funds for child care, because it just doesn't add up that you can—you know, child care is much more costly than grants, so you can't just say instead of being on TANF they will get child care. It just doesn't work.

So, it will create a bottleneck, and it will make—again, it will put kids at risk. Because if families feel that they have to go to work, and they don't have the adequate child care, they will piece it together, and it is the kids in the families who will be harmed by that.

Mr. CROWLEY. Thank you. The child care assistance provided by TANF and other Federal programs is critical. In the majority of States, including my home State of New York, child care costs an average of more than the cost of a year at college. The Federal assistance provided through TANF is a tremendous help to working families, who still pay almost 60 percent of the cost of child care.

But the Federal investment of child care assistance has failed to keep pace with the need and, in fact, is serving fewer children today than it did in the last decade. I have authored the Child First Act to increase the Federal investment in child care, and to close this gap. I will soon be reintroducing this legislation, which will provide the funding needed to serve more than 2.6 million children over 10 years, as recommended in the President's budget. This funding is an investment in successful child care programs, yes. But also in the parents and families that are trying their hardest to lift themselves out of poverty.

Now, I know some might claim we can't add new funding. But those objections didn't stand in the way when my colleagues on the other side added $610 billion to the deficit through permanent tax

cuts for businesses without being paid for. If we want to seriously help families find work and escape poverty, then we should seriously consider increasing child care funding as a part of this reauthorization.

I hope my colleagues on the Subcommittee and the full Committee will look at this issue very closely. I look forward to working with all of you on this, and on other areas in need of improvement, such as further improving access to vocational education and lifting barriers that block hard-working legal immigrant families from participating in these programs.

Let's take this opportunity and really improve, strengthen, and move the TANF program forward for today's families. Thank you, Mr. Chairman.

Chairman BOUSTANY. I thank the gentleman. His time has expired, and we will go to Mr. Smith next.

Mr. SMITH. Thank you, Mr. Chairman. The TANF program currently has four purposes, which are generally to provide help to needy families; independence from welfare through job preparation, work, and marriage; to prevent unmarried births; and, four, to encourage the formation and support of two-parent families. While each of these purposes touches on poverty, none explicitly sets a goal for the program to reduce poverty by promoting work, instead of simply treating the symptoms of poverty day to day.

That is why, last week, I introduced the Reducing Poverty Through Employment Act, to explicitly highlight the connection between poverty reduction and work. My bill would add a new purpose to TANF, which is to reduce poverty by increasing employment entry, retention, and advancement. The same provision is also in the larger TANF discussion draft that is the focus of the hearing today.

Mr. Brown, you talk about the importance of employment goals, and how setting these goals helps people escape poverty over the long term. Do you think adding this purpose to TANF will help others put a greater focus on employment, as well?

Mr. BROWN. Thank you for the question, Mr. Smith. Yes, I do agree with you. Both professionally and personally I have dedicated my career to helping people move out of poverty, and I think TANF is definitely an important part of that. However, what I would say is that TANF is really a small part of the solution, because most people coming off of TANF are not out of poverty.

What I would like to really look at in your language is around entry, retention, and advancement. I think those are key, you are correct, entry into employment, retention, and advancement. With TANF, people, when they make a certain amount of income, they go off. And a lot of times the retention and advancement is missing. And we need to dedicate more time, more resources to really working with them to help them advance, continue to move on that career pathway.

The other thing I would suggest in regard to this is education and training is key to moving people out of poverty. So, in addition to employment, retention, and advancement, I would say that education and training is also a key component to getting people to really—to family-sustaining wages. So thank you.

Mr. SMITH. Thank you very much. Thank you, Mr. Chairman.

Chairman BOUSTANY. The gentleman yields back. We will next go to Mr. Renacci.

Mr. RENACCI. Thank you, Mr. Chairman. Thank you for allowing me to be part of this hearing. And I want to thank the witnesses, also, for being here and for your testimony.

Mr. Brown, your story about Elizabeth kind of touched home, because I was—I had met with Stark—or actually, Summit County Department of Jobs and Family Services, which is a large county in my district. I met with their Executive Director because he had indicated to me that it was very difficult to meet some of the requirements of TANF, but it is also very difficult when many of these individuals don't have their GED, and there is the education requirement.

So we know the current TANF law really requires States to engage 50 percent of adults on welfare in certain work activities, and some activities only count for certain people, or for a brief period of time. In addition, if someone works 1 hour less than a number required, the State gets no credit for that person's participation at all. And these were kind of the issues that he brought up to me, and that his staff brought up to me.

Last week I introduced a Preparing More Welfare Recipients for Work Act, which is folded into the larger Committee discussion draft that would address this by making a number of changes, such as giving States partial credit for individuals who participate for less than the full hours required under current law; eliminating some of the restrictions on how long participation in certain activities can count toward the State requirement; and allowing participation in some educational activities to count for more individuals and for longer periods than under current law, which I think is really important, and touches somewhat on your Elizabeth's story, Mr. Brown.

Do you think this added flexibility would help you better serve those families you are serving now?

Mr. BROWN. Yes, I would absolutely agree with you, that this is definitely a step in the right direction. However, what I would say also is, beyond just more flexibility, we really want to focus more on outcomes.

So, for example, if someone is in education, they are in a community college or they are working on a GED, we are really focusing on those education hours. So we are counting those hours, getting logs in on those hours. How important, really, is that? Really, what is important is what kind of progress are they making in that education. Are they finishing those classes? Are they getting credits? Are they getting those degrees, or completing those degrees? We really want to focus what we are doing on progress and outcomes versus process.

The other thing I would mention is that, even with that flexibility and the activities that you are asking us to do, one of the other things that that leads to is just more documentation and verification of those activities. It doesn't alleviate that concern. When 53 percent of our counselors' time is really chasing after documentation and verification of those activities, that leaves a lot less time to really be looking at what does this person need to gain self-sufficiency, to meet those employment goals.

So, really, what I would like to see is that, if you are going to ask us to report back on activities, it is more on what really matters. How are they approaching and progressing and meeting those goals?

Employment is another example. So they are out job searching. What does that really tell us, unless we know what are those leads, what employers have they actually connected with and interviewed with? What employers have our counselors engaged with that can lead to employment with those folks? Just verifying hours is not helpful in meeting those families' goals.

Mr. RENACCI. Mr. Kelly, your thoughts on some of the flexibility?

Mr. KELLY. I think, as referenced earlier, that we have seen significant improvements in the education field, based predominantly on some flexibility and the ability to create individual progress plans for people. I don't know how we can get away from that as being one of the significant steps as we move forward. So some of that flexibility, I think, is absolutely required.

I think everybody sitting at the panel has used the word "outcomes" and "accountability" in some form. So even those of us who feel as though some additional assistance is necessary or can be tinkered with in one way or the other, we are all in agreement that we should run this in a highly professional, businesslike way, and you can't do that without having significant accountability steps in place.

So, we need outcome measures, clearly-defined outcome measures, but not without enough flexibility to help the individual needs of the people involved.

Mr. RENACCI. Thank you, Mr. Chairman. I yield back.

Chairman BOUSTANY. I thank the gentleman.

At this time I would like to take a moment to congratulate our current Legislative Assistant on the Subcommittee, Levi Stoep. Levi is leaving us today to begin law school. And, Levi, I just want to say well done, and best of luck for the future. Thank you for the great work.

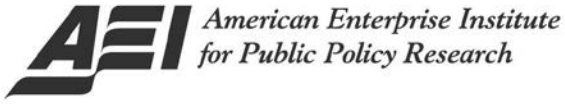
I want to thank all of you for being here today to provide testimony before the Subcommittee. It has been very, very valuable in our efforts to move forward in this TANF reauthorization. I want to thank the Members for their participation and the great work in putting this legislative draft together.

Members may have additional questions that come up, and we will submit those in writing. And we would ask that you try to respond within 2 weeks so we can make this part of the completed record.

And, with that, the Subcommittee now stands adjourned.

[Whereupon, at 11:58 a.m., the Subcommittee was adjourned.]

[Submissions for the Record follow:]



Statement to the Subcommittee on Human Resources, House Committee on Ways and Means on Discussion Draft to Reauthorize TANF

Comments on the House Ways and Means TANF Reauthorization Discussion Draft

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American Enterprise Institute

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The views expressed in this document are those of the authors alone and do not necessarily represent those of the American Enterprise Institute.

Thank you for the opportunity to comment on the House Ways and Means discussion draft to reauthorize the Temporary Assistance for Needy Families (TANF) program. This statement represents our personal views and is based on our combined experience administering and now studying welfare programs in the United States. Collectively, we bring extensive and varying experience with the TANF program, including how it works and what improvements can be made.

First, we believe PRWORA and the creation of the TANF program was a success. It transformed the relationship between low-income, mostly unmarried-mother families and the government programs designed to help them. By shifting from an entitlement program to a block grant, TANF provides states with a great deal of flexibility to design programs that meet the needs of their low-income residents, while making it clear that work is the best way out of poverty. The program's work requirements and emphasis on reducing government dependency make it clear that welfare policy in the U.S. centers on work, while providing support to help people find and sustain employment.

The result of this historic shift in policy was overwhelmingly positive. Welfare caseloads declined as unmarried mothers increased their labor force participation and employment rates. According to data from the Current Population Survey (CPS), labor force participation among never-married mothers in the U.S. increased from 59.9 percent in 1995 (the year before PRWORA was passed) to a peak of 73.8 percent in 2001. Although the strong economy of the late 1990s played an important role, labor force participation among this group was still 69.9 percent in 2013. This increase in labor force participation led to substantial declines in the official measure of poverty among never-married mothers. In 1995, the poverty rate among this group was 51 percent. By 2001 it declined to 38.5 percent and even after the Great Recession, the poverty rate among never-married mothers remains below that of 1995 (43 percent in 2013).[1]

Though TANF was largely a success, it can still be improved. We welcome the opportunity to comment on the House Ways and Means discussion draft. Although we support many of the proposed reforms, our main concerns are outlined below, followed by recommendations for consideration.

- **Elimination of the distinction between core and non-core activities**

We believe that the proposal to eliminate core and non-core activities will reduce the focus on work. This focus has been central to increasing employment and reducing dependence among TANF recipients since the passage of PRWORA. Currently, recipients of ongoing TANF assistance with children under 6 are required to participate in at least 20 hours of work-related activity per week and recipient families with older children are required to participate in at least 30 hours of work-related activity per week. The first 20 hours must be in core activities, which include

[1] Based on author calculations using data from the Current Population Survey, Annual Social and Economic Supplement (ASEC).

subsidized and unsubsidized employment, work experience programs, on-the-job training, community-service programs, vocational education (but only for 12 months lifetime), and job search and job readiness training for up to 6 weeks per year but for no more than 4 consecutive weeks (12 weeks in poor economic times). Non-core activities include education and training directly related to employment, as well as job search and job readiness once the 6 week limit (or 12 week limit) is reached.

We believe that the elimination of core and non-core activities shifts the focus of TANF away from a work-first model. The proposed change will make it easier for states to engage TANF recipients in education and job readiness training for longer periods of time. This concerns us mainly because an education-focused approach has been shown to be less effective than a work-first approach at increasing employment, earnings, and reducing welfare receipt.[2] We understand that limits on activities are included in the discussion draft, but even with these limits, states will be allowed to more easily shift to an education-focused approach over a work-first approach.

Because of these concerns, we recommend that the distinction between core and non-core activities be maintained. Some states may have requested more flexibility in determining activities, but we believe the potential negative consequences outweigh the interest in increasing operational flexibility.

- **Allowing secondary education and vocational education for longer periods of time**

We also believe that the expansion of allowable educational activities (i.e., for recipients placed in secondary education/equivalent up to age 26 and vocational education for 24 months) will diminish the program's effectiveness in increasing employment among TANF recipients.

Evaluation evidence and educational achievement data show that rates of completion in these programs are low. For example, the NEWWS found that few welfare-to-work program participants who entered these programs actually obtained their general education degree (GED).[3] The NEWWS cost/benefit analysis found that mandatory GED and adult education programs failed to increase income over control groups and were not cost effective for the government.[4] In terms of vocational education, federal government data show that less than 30 percent of first-time degree and certificate seeking students at 2-year colleges actually complete their program.[5]

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[2] See Hamilton, G. et al (2001), National Evaluation of Welfare-to-Work Strategies, How Effective Are Different Welfare-to-Work Approaches? Five-Year Adult and Child Impacts for Eleven Programs http://www.mdrc.org/sites/default/files/full_391.pdf

[3] Ibid.

[4] Greenberg, D., Deitch, V. and Hamilton, G, (2009). Welfare-to-Work Program Benefits and Costs, A Synthesis of the Research, http://www.mdrc.org/sites/default/files/full_611.pdf.

[5] See data from the National Center for Education Statistics, http://nces.ed.gov/programs/coe/indicator_cva.asp

We agree that education credentials can be beneficial, but without stronger evidence that these programs result in positive outcomes for TANF participants, we urge the subcommittee to reconsider.

- **Outcome measures**

We support an increased focus on outcome measures, but we do not believe outcome measures can fully counter-balance the elimination of core and non-core activities. We prefer that core and non-core activities be maintained, along with the introduction of outcome measures.

We suggest replacing the earnings growth measure with a job placement measure. The earnings growth measure is problematic because TANF agencies have little control over wages once a person leaves TANF, and because wages are unlikely to increase in such a short time period. The remaining outcome measures hold states accountable for employment among people who leave TANF, which is positive, but offer little accountability for states to initially place people into employment. We understand that the measures are used in the WIOA program, but WIOA is different than TANF because it does not provide an ongoing benefit.

A job placement measure would hold states accountable for moving people from TANF to work. Defined as the number of TANF recipients in a given quarter that obtained unsubsidized employment as a percentage of the total number of TANF recipients subject to work requirements (with appropriate exclusions), it is different than the percentage of former TANF recipients who are employed 2 quarters after exit. A job placement measure, defined this way, will have the dual incentive of keeping caseloads low and encouraging job placements. The legislation should allow the Secretary of DHHS enough flexibility in setting the job placement measure that appropriate exclusions for who is counted are possible. Data sources, such as the new hire database, should make calculation of this measure possible at the state level.

We also caution the subcommittee on how they legislate the targets. We recommend a more data-driven approach similar to what the Department of Labor requires for WIOA.[6] States should be required to present a data-driven methodology that specifies how and why they selected the proposed targets. We also urge the subcommittee to consider how the business cycle will affect the outcome measures and provide states with enough flexibility in the legislation to allow them to request exceptions if their targets are missed due to economic circumstances over which they have little control.

- **Verification of activities**

We believe (especially if core and non-core activities are eliminated) that any softening of verification requirements will lead to less employment and increased dependency. In our

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[6] See page 10 for a discussion of negotiating WIOA performance targets, http://wdr.doleta.gov/directives/attach/TEGL/TEGL_30-14.pdf.

experience, the requirement to participate in activities and to have that participation rigorously tracked was a key driver of increased employment among TANF recipients. We understand the administrative burden this may place on some states, but we believe the necessity of ensuring that recipients engage in the required number of hours outweighs these concerns.

- **Review of Individual Opportunity Plans**

Conceptually, we agree that Individual Opportunity Plans and the process described in the discussion draft can be useful for some TANF participants. However, we believe that specific details regarding the plan's structure, how often it must be reviewed, and who receives it, should be determined by the states. Without flexibility at the state level, it could result in bureaucratic overreach from DHHS into how state TANF programs are administered.

Additionally, if the requirement for Individual Opportunity Plans as written is maintained, we believe states may be left open to legal action from private entities. Although we prefer an alternative that provides states with more flexibility, if the requirement is included as written, we suggest adding language that bars, in association with these plans, private right of action, damages, and remedies against the state.

Additional Items for Consideration

We are in alignment with the subcommittee's discussion draft in several areas, though we also recommend several changes that could strengthen it.

- **Work participation rate**

We support returning the work participation rate to a real requirement. However, if the caseload reduction credit is eliminated, we would prefer some emphasis on decreasing dependency (and thus caseloads) in other parts of the bill. An outcome measure on job placements (as proposed above) and job retention could accomplish this goal. We also support the ability of states to receive partial credit for individuals who have some, but not all, of the required hours.

- **Demonstration projects**

Another positive addition is the availability of funding for demonstration projects with rigorous evaluation requirements. This will greatly advance knowledge in the field. However, because a large federal evaluation of subsidized jobs programs is currently ongoing[7], a demonstration project that aims to increase the use of quality child care for TANF recipient families is preferred over subsidized jobs.

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[7] The Administration for Children and Families is currently sponsoring a multi-year, multi-site study of subsidized and transitional employment for low-income populations, http://www.acf.hhs.gov/programs/opre/research/project/subsidized-and-transitional-employment-demonstration-sted.

In addition, we prefer even stronger language on the desire to use random assignment experiments. We understand that random assignment may not always be possible, but in our experience it could be used much more widely at the state level and it may require legislation to ensure this happens. There is a great deal of expertise in the field to help states conduct random assignment experiments. Cost and small sample sizes should not be sufficient reasons for not doing random assignment experiments, and demonstration projects should be designed accordingly.

- **What Works Clearinghouse**

A welcome addition is also the creation of the What Works Clearinghouse. However, more emphasis is needed on encouraging states to utilize evidence-based programs in their welfare-to-work programs more broadly (not just the demonstration projects). For example, instead of eliminating core and non-core activities, states could be allowed to count job readiness or education/training activities for longer periods of time if the state is using an evidence-based program.

- **Fiscal requirements**

We fully support strengthening the TANF fiscal requirements.

- **Healthy marriage and fatherhood programs**

We support the grants for healthy marriage and fatherhood programs, as well as the requirement for a rigorous evaluation. We recommend language that requires a random assignment evaluation unless the Secretary determines it is not possible. States should be required to do a random assignment experiment unless they can make a strong case against it.

- **Eliminating the marriage penalty in the 2-parent work participation rate**

We support eliminating the higher work participation rate for 2-parent TANF families.

- **Cap on educational activities**

We believe that the 30 percent cap on the percentage of recipients who can be engaged in full-time vocational education activities should be maintained. This will incentivize states to only allow those who are making significant progress toward a degree or certificate to be engaged in vocational education activities.

- **Creating a floor on the share of TANF funds for child care, cash assistance, and work activities**

With the caveat that it should not shift the focus away from employment, we favor providing states with maximum flexibility in allocating their TANF funds to the activities and programs they deem most effective and valuable.

- **Retroactive penalties / corrective action plans / statute of limitations**

Language in the bill is needed to address how current work participation rate penalties and corrective action plans will be addressed moving forward. Will states be given a fresh start, or will states still be at risk for failing to meet requirements for past years under the former law?

We also recommend that language be inserted into the bill that requires the Secretary of DHHS to transmit the work participation rates back to the states in a timelier manner. Currently, there is a 2 to 3 year delay in the official transmittal of work participation rates back to the states. This should be shortened to 6 months following submittal of work participation rate data by the states. In addition, there is also currently no statute of limitations that is applied to ACF's ability to investigate and impose penalties. We recommend requiring DHHS to reimburse states for costs incurred if the failure to meet the work participation rate is not resolved within 2 years after the official work participation rates are posted. It is difficult for states (especially when administrations change) to address these issues many years after the initial violation takes place. The federal agency should be held accountable for resolving these issues in a timely fashion.

Again, thank you for the opportunity to comment.

Robert Doar is the Morgridge Fellow in Poverty Studies at AEI. He was Commissioner for the State of New York Office of Temporary and Disability Assistance and Commissioner for the City of New York Human Resources Administration. He has over two decades of experience directly administering TANF and related welfare-to-work programs.

Angela Rachidi is a research fellow in Poverty Studies at AEI. She was Deputy Commissioner for Evaluation and Research at the City of New York Human Resources Administration. She has over 10 years of experience studying welfare policy and conducting program evaluations of TANF-related work programs.

Maura Corrigan is a visiting fellow in Poverty Studies at AEI. She is a former Director of the Michigan Department of Human Services and former Chief Justice of the Michigan Supreme Court. She has over 23 years of experience with under-served populations, including families who participated in Michigan's child welfare and welfare-to-work programs.

America FORWARD

Welfare Reform Proposals: Comments from America Forward

July 17, 2015

Mr. Charles Boustany, Chairman
Subcommittee on Human Resources
House Ways and Means Committee
1102 Longworth House Office Building
Washington, DC 20515

Mr. Lloyd Doggett, Ranking Member
Subcommittee on Human Resources
House Ways and Means Committee
1102 Longworth House Office Building
Washington, DC 20515

Dear Chairman Boustany and Ranking Member Doggett,

Thank you for the opportunity to comment on the Subcommittee's Discussion Draft of welfare reauthorization legislation containing authority for Social Impact Demonstration Projects.

America Forward is New Profit's nonpartisan policy initiative that unites national policymakers with social entrepreneurs to advance a public policy agenda that champions innovative and effective solutions to our country's most pressing social problems. America Forward works with policymakers to foster social entrepreneurship, spur innovation, identify more effective and efficient solutions, reward results, and catalyze partnerships across sectors. **New Profit** is a pioneering venture philanthropy fund that aims to break down barriers to opportunity in America by transforming the way we educate our children, propel people towards social and financial stability, and create healthy communities.

America Forward advances its efforts through the leadership of the **America Forward Coalition**, a network of more than 70 innovative, impact-oriented organizations, working in more than 14,000 communities nationwide, dedicated to driving systemic change in workforce development, education, early childhood, youth development, and poverty alleviation. Our Coalition members share a commitment to innovating to achieve better results, using data to track progress and ensure accountability, leveraging resources across silos and sectors to improve the lives of the people they serve, and are achieving measurable outcomes in communities across the country every day.

Members of the America Forward Coalition applaud the inclusion of the Social Impact Demonstration Project authority (Section 10, subsection 3) in the welfare reform discussion draft released by the House Ways and Means Human Resources Subcommittee last week. This new authority would provide for funding to promote a variety of pay for performance approaches and also test social innovation financing of pay for performance strategies. In times of tighter budgets and greater demand for social services, we must work together to direct government resources to the most efficient programs that measurably improve people's lives. These demonstration projects have the potential to incentivize more efficient use of government resources to reward what works, linking government dollars to positive outcomes, and leveraging those dollars to attract private capital into the social services sector. America Forward appreciates the opportunity to comment on the draft legislation. We welcome the opportunity to discuss these comments, which are provided in an effort to strengthen the potential of the projects and to ensure their effective implementation.

America FORWARD

Comments/Suggested Changes

General Feasibility Study Requirement
The requirement of a feasibility study is a helpful activity as feasibility studies serve an important purpose in the development of a social impact demonstration project.

America Forward suggests that consideration be given to allowing the utilization of currently underway or completed federally funded feasibility studies in place of a requirement of new feasibility studies so that states and localities need not undertake a duplicative process to understand how such a project could be implemented in their area.

Section A, subsection iii and Section D, subsection i: Feasibility Study Required and Requests for Funding for Feasibility Studies
The current application requirements listed, (I-XXIII) and (I-X) respectively, for states or local governments to submit as part of their feasibility study and application for feasibility study funding contain items that would be learned during a feasibility study itself. Depending on the expected level of detail, some of these application requirements will be difficult for states or local governments to know with any level of certainty. The goal of the feasibility study itself would be to research and articulate many of these data points in greater depth.

America Forward suggests that the language be clearer about the expected level of detail of these feasibility study and funding application requirements so that the feasibility study and funding applications are not so burdensome that states or local governments are not able successfully submit the required elements, as feasibility studies are integral to robust social impact demonstration projects.

Pg. 49, section D, subsection iii: Feasibility Study Required
The requirement of 'rigorous evidence demonstrating that the intervention can be expected to produce the desired outcomes' as an element that states or local governments must include in their feasibility study is important but may be limiting. The present number of interventions that map to the outcomes specifically laid out in the language is not significantly high. In particular, there are certain sectors, such as child welfare, for which rigorously evaluated interventions that could help to advance the child welfare related required outcomes articulated in the discussion draft are in short supply.

America Forward suggests the following language: "rigorous evidence demonstrating that the intervention can be expected to produce the desired outcome OR, IF THE INTERENTION HAS NOT YET UNDERGONE RIGOROUS EVALUATION, THAT THERE BE A REQUIREMENT OF IDENTIFICATION OF OTHER COMPELLING DATA AND THE ABILITY TO ENGAGE IN RIGOROUS EXPERIMENTAL OR QUASI-EXPERIMETAL EVALUATIONS TO BUILD THE EVIDENCE IN THE FIELD"

Pg. 65, section D, subsection v: Submission of Feasibility Study Required
The current language requires states or local governments to complete a feasibility study and submit the study to the 'Council' within 6 months of receipt of feasibility study funding. There are not a large number of feasibility studies that have been completed to date on which to base an average. However, one very recent data point comes from the most recent Social Innovation Fund Pay for Success grantees that are working on feasibility studies with over 40 states and localities, and which have an average timeline for feasibility study completion of 9 to 12 months. As a result, the 'not later than 6 month' requirement is aggressive and may be difficult for state and local governments to adhere to.

America FORWARD

America Forward suggests the following language change: "Not later than 9 months after the receipt of feasibility study funding"

Pg. 75, section F, subsection iii: Qualifications of Council Members

The current language requires that individuals have all three qualifications to be considered as potential 'Council' members. Given the nascent nature of pay for performance generally and in the social services space particularly, it may be difficult to find individuals both inside and outside of government who fit all three of the current qualification requirements.

America Forward suggests the following language change: "are experienced in finance, economics, pay for performance or EVAULATION METHODS/statistics; OR".

Thank you for the opportunity to comment on the Discussion Draft. America Forward would be happy to provide clarification of any of the points raised or provide any additional information you request. Please do not hesitate to contact Nicole Truhe, Government Affairs Director of America Forward at Nicole_truhe@newprofit.org if you would like to discuss these comments further.

Sincerely,

Nicole Truhe
Government Affairs Director, America Forward
1400 Eye Street, NW Ste 400
Washington, DC 20004

America FORWARD

America Forward Pay for Success Task Force Members

America's Promise Alliance
AppleTree Institute
AVANCE
Bottom Line
City Year, Inc.
College Forward
College Possible
Compact Working Capital
Connecticut Center for Social Innovation
Corporation for Supportive Housing
Enterprise Community Solutions
Family Independence Initiative
First Place for Youth
Institute for Child Success
Invest in Outcomes
New Classrooms
Opportunity Nation
REDF
Roca, Inc.
Root Cause
Save the Children
Save the Children Action Network
Single Stop
Social Enterprise Alliance
Social Finance
The Children's Aid Society
The Corps Network
Third Sector Capital Partners
Twin Cities RISE!
Waterford Institute
Year Up
YouthBuild USA
Youth Villages

AMERICA WORKS

August 3, 2015

Honorable Paul Ryan
Chairman
Committee on Ways And Means
U.S. House of Representatives
Washington, D.C. 20515

Dear Chairman Ryan:

We are writing to advise you of our views of the draft re-authorization of the TANF program. In two months, the program popularly known as "welfare reform" will expire after 20 years.

We are very concerned that one provision will be extremely detrimental to the past 20 years and throw the country back into the abyss of having welfare recipients in endless training which does not lead to work.

This provision removes the distinction between "core and non-core" activities and allows training and education to substitute for work activities. This is precisely what the Family Support Act did in 1986, which led to massive increases in welfare nationwide.

America Works was founded in the 1980s on the principles of Work First. People from all over the country and around the world visited our program and were amazed that welfare recipients did not need years of training in order to achieve good jobs. We worked closely with Newt Gingrich on the original bill, explaining to staff the need to limit training and focus on work. The 1996 law was in part based upon the experiences of America Works.

Unlimited training will reverse the past 20 years of success. While there are parts of the draft that are commendable (see attached) we are extremely worried that there are people unlike those of us at America Works do not know, remember or have read the studies showing that job focused not training focus has been most successful in leading to employment.

We are prepared to meet with you and your staff to discuss this further.

Sincerely,

Peter Cove
Founder

Dr. Lee Bowes
Chief Executive Officer

America Works of New York, Inc., 228 East 45th Street, 16th Floor, New York, NY 10017 (212) 599-5627 FAX (212) 599-5174

Addendum

1. The provision eliminating the caseload reduction credit, and prohibiting HHS from implementing waivers to federal work requirements is a good change. While the caseload reduction credit kept states focused on employment and closing cases in the early years, in later years it obviated state obligations to continue to engage participants. The 50% standard work participation rate is a better measure at this time.

2. The provision where state outcome measures related to penalties for non-performance are to be negotiated with HHS can result in pressure by states for low targets. On the other hand, the changes related to failure to meet targets are good if implemented however in practice HHS does little to enforce the penalties today. A national standard range should be set. The prospect of penalties is helpful in focusing state efforts on full engagement. The discussion draft's elimination of excess MOU also falls into this category of positive change.

3. We tend to think that partial credit for reduced hours of activity will lessen the urgency and effort that TANF recipients must contribute if they are to find and succeed in a new job, especially for those who have limited work experience. The current rules make for a version of a simulated work-week so that participants make their child care and other arrangements comparable to those that will be required once employed. This is "learning by doing".

4. We concur with- - permitting job search for one half of required hours after three months. The six week limit is unrealistic and not common practice.

5. We applaud the added wage subsidy funding and evaluation.



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Raquel Hatter, President *Tracy Wareing Evans, Executive Director*

House of Representatives

Committee on Ways and Means

Subcommittee on Human Resources

Hearing

On Welfare Reform Proposals

July 15, 2015

Comments for the Record by

American Public Human Services Association (APHSA)

Tracy Wareing Evans, Executive Director

Contact: Mary Brogdon, (202) 682-0100, x236, mbrogdon@aphsa.org



July 29, 2015

Honorable Charles Boustany
Chairman
House Ways and Means Human Resources Subcommittee
1129 Longworth House Office Building
Washington, DC 20515

Honorable Lloyd Doggett
Ranking Member
House Ways and Means Human Resources Subcommittee
1129 Longworth House Office Building
Washington, DC 20515

Dear Chairman Boustany and Ranking Member Doggett:

The American Public Human Services Association is pleased to respond to the Committee's Discussion Draft on TANF Reauthorization released July 10. The Discussion Draft is very thoughtful and reflects a strong understanding of the TANF program's strengths and weaknesses identified over the years. We are especially glad to see that the reforms in the Committee's Discussion Draft include a renewed focus on what matters most – meaningfully engaging parents to support them in becoming and staying employed, overcoming their barriers to self-sufficiency, and supporting their family's wellbeing. TANF is a complex program and our comments below are intended to improve the Discussion Draft.

With and through our members, we respectfully submit the following detailed comments for your consideration. They represent our high-level consensus positions and recommendations on key issues that, together with the many strengths in the Discussion Draft, can undergird the next stage of TANF's critical role in growing capacity and enabling opportunity for those the program serves.

We also want to emphasize that beyond the particulars outlined below, it is important to keep in mind that many of the Committee's proposals would require states to make major changes to the way they administer their TANF-funded programs – changes that cannot be implemented too swiftly if successful transitions are to be made in IT support, community partnerships, state and local funding arrangements, and the general administration of TANF's diverse array of services. As the Committee revises and refines the Discussion Draft, we encourage you to prioritize this need, and to recognize and address that need where appropriate in the final legislation. Secondly, given that TANF intersects with a number of other key programs and services (such as workforce programs, adult education, and child care assistance), we urge the Committee to discuss proposals related to TANF reauthorization with the Committee on Education and Workforce and consider its input.

Comments on Section 5

Section 5 – Individual Opportunity Plans: Support with reservations

We are generally supportive of Section 5, particularly due to the new language, which recognizes that TANF participants are unique individuals with challenges but also with strengths and resources. This new language also recognizes that addressing participants' immediate needs is essential to their path toward employment and self-sufficiency, and that reassessment and redirection are often necessary. **However, we are concerned that the language describing the contents of the Individual Opportunity Plan is more prescriptive than current law, and does not seem to leave much room for state flexibility.** Requiring such comprehensive assessments of all adult recipients of TANF cash assistance will require states to increase the amount of time spent on assessment, and in effect increase its cost. States should retain the flexibility to customize assessment to account for their caseload demographics, current regional labor markets, and other contextual factors. **We would support added flexibility that would allow states to adopt alternative approaches to the goals described in Section 5,** such as equivalent plans negotiated between the Administration for Children and Families (ACF) and individual states, or through issuing less prescriptive, more general guidance in the legislation.

Comments on Section 6

Section 6(a) – Eliminate credit toward the WPR for caseload size and excess state spending: Oppose

We are wary of seeing Section 6(a) implemented before learning the impacts of the other changes in participation that counts toward the work rate. Until states have experience implementing the proposed improvements to calculating the Work Participation Rate (WPR), neither the states nor the federal government will know what benchmarks are realistic. Rather than immediately implement a change that could drastically impact some states' WPRs and the structures they have established over the years to support their current TANF policies, **we urge that the changes in Section 6(c) be implemented first to gauge their impacts.** If those changes have the intended positive effects, we may support the phasing out of credit for caseload size and excess state spending pursuant to a trigger mechanism contained in the legislation.

This is one of several examples of mechanisms that states have found necessary to take best advantage of TANF's declining purchasing power and flexibility in recent years, and which may become less necessary with well-structured changes this new legislation could potentially provide – but as stated above, only with sufficient time to make this kind of significant transition.

Section 6(b) – Excludes work performed by individuals receiving atypical benefit payments from counting toward the WPR: Oppose

TANF funding is a block grant, not simply an allocation to administer a cash assistance program. The exclusion created in Section 6(b) fails to recognize that each family served through TANF funds is unique and has different needs. This proposed change might create a disincentive to serve families whose circumstances call for anything other than traditional cash assistance, such as low-wage working parents in need of assistance as they transition to self-sufficiency, or non-custodial parents who may not qualify to receive traditional cash assistance but whose work and earnings are critical to the self-sufficiency and well-being of their families. For these reasons, we oppose the provision and urge the Committee to remove it from the legislation.

Section 6(c) – Improves counting of hours of work participation: Support with recommendations

Section 6(c) contains positive changes regarding activities that count toward the WPR such as allowing partial credit toward the work rate for participants who partially complete the required hours of work activities, expanding the period when job search can count toward the work rate, and raising the age limit for individuals whose satisfactory secondary school attendance can count as meeting the work rate. We support these changes since they allow states to respond to the differences across and within their populations and environments, and focus on engaging TANF participants in appropriate work activities that will actually help each individual become work-ready and gainfully employed, rather than focus on engaging them in a narrow range of activities that "count."

We also support Sections 6(c) because it extends the time limit on vocational education training from 12 months to 24 months, and increases the age limit for participants deemed to be engaged in work through secondary school attendance. Completing secondary education and vocational educational training is critical to helping many TANF participants become eligible, competitive workers. However, currently only 30 percent of families counting toward states' participation rates may do so through participation in vocational educational training and secondary school attendance. The most recent data available from the Department of Health and Human Services indicated that over 40 percent of adults receiving TANF assistance had less than 12 years of formal education, and less than 6 percent had any post-secondary education. Clearly, if the 30 percent cap is not increased, the intended impact of these changes will not be fully realized. **We urge that the final legislation also increase the cap on the proportion of families counting toward participation rates who do so through vocational educational training and secondary school attendance.**

Section 6(d) – Revises the penalty structure for failure to meet work participation rate: Support with recommendations

We are pleased to see the thrust of Section 6(d), which revises the penalty structure for states failing to meet their work participation rate. Requiring states that fall short to invest more in their TANF programs is a far more reasonable and constructive system than penalizing states by reducing their federal funds. The current penalty structure contains a mechanism for penalty relief for corrective compliance, and we urge the Committee to include such a mechanism in the new legislation. We would like to add that, while we understand that some process measures may be necessary, requiring extensive documentation and verification of work participation hours has proven to be unnecessarily burdensome and limits the degree to which front line workers can meaningfully and effectively engage with TANF participants working toward employment and self-sufficiency. **We support any changes that would ease the administrative burdens and provide for greater state flexibility in verifying participation hours. We strongly encourage the Committee to move away from the current system that contradicts the movement toward outcome measures that the Committee has embraced.**

Comments on Section 7

Section 7 – Promotes increased employment, retention, and advancement among former TANF recipients: Support certain elements but with strong reservations overall

As we and other stakeholders have testified before your Subcommittee, the current TANF accountability system focuses too much on process and does not contribute constructively to achieving successful

outcomes. While many of the current process measures remain in place, the Discussion Draft's new structure for holding states accountable for employment outcomes is a step in the right direction that could lead to an effective transition to a more fully outcome-based program. **Employment, retention, and increased earnings during the year following program exit are important outcomes that should be measured. However, they are not sufficient on their own.** These indicators are impacted by various other factors that the TANF program itself and its participants cannot directly affect, and should be carefully tested before they are used as the basis for any penalty structure. Further, many states do not have the necessary or timely access to relevant data and various data bases lack all the data needed for the significant number of TANF participants in certain categories of work – such as seasonal employment like retail sales and landscaping – or occupations in which they are considered self-employed such as construction or child care.

On their own, employment, retention, and increase in earnings do not capture all of the elements of a family's progression toward TANF's goals. Additionally, such short-term measures are not sufficient to understand the true and full impact of the TANF program on a family's self-sufficiency and wellbeing. Increase in earnings especially is not an indicator that can be measured in the short-term. These three indicators alone simply will not allow states to measure the impact of all the opportunities and supports they offer, and furthermore, such a limited number of indicators fails to reflect the far more inclusive indicators in the Workforce Innovation and Opportunity Act (WIOA). **We recommend including additional performance indicators that measure short-term, interim, and long-term outcomes and that capture other elements that together provide a more complete understanding of the TANF program's impacts, and that are better aligned with WIOA.**

We believe states should be held accountable for achieving successful outcomes, but we are strongly opposed to the penalty structure established in Section 7. Such a severe penalty system for falling short of any performance targets is problematic in multiple ways. In short, a penalty structure that withholds federal funds without giving states the opportunity to take corrective actions would have serious negative impacts on states and ultimately the families they serve. **We strongly urge that any penalties related to performance measures negotiated pursuant to this section should be imposed in arrears, rather than in advance, and states should be afforded the opportunity for corrective action to avoid any such penalties. Any such system must also be tested and underwritten by sound data and performance benchmarks. Again, we strongly suggest alignment with related changes made recently in WIOA wherever feasible.**

We are very encouraged by the potential opportunities in portions of this legislation to move us toward an outcomes-based model for performance and accountability, but feel that the problematic areas identified above must be modified to remain within that frame. Properly structured and phased in, an outcomes framework is something many states would find very attractive in place of the current penalty-based approach.

Comments on Section 8

Sections 8(a) – Excludes third-party contributions and state spending on medical services from counting toward state spending requirements: Oppose

We cannot support the provisions of Section 8 that exclude third party contributions and spending on medical services from counting toward state spending requirements. States and localities frequently

form partnerships and collaborations with third parties such as non-profit organizations in order to meet the many needs of TANF participants. These collaborative efforts support continuums of care that result in better outcomes for participants. Excluding third party contributions would remove an extra incentive for states to actively collaborate with third parties that broaden supports for families working toward self-sufficiency. Additionally, in some states third party contributions currently make up a large portion of their spending requirement that cannot be easily replaced. When states face significant deficits they benefit greatly by being able to count third party contributions and spending on medical services.

State spending on medical services for TANF participants should be counted toward states' spending requirements. This spending is necessary to ensure that TANF participants receive the services and treatment they need in order to be work-ready. Some states directly fund mental health and substance abuse services for TANF recipients. Substance abuse and mental health issues are serious barriers to becoming and remaining employed that a significant number of TANF participants face. State spending on treatment for these and other medical issues often fill the gaps in Medicaid coverage and access. Such medical spending should count toward state spending requirements since it directly assists TANF participants on their path toward self-sufficiency.

Such spending is an example of many kinds of other investments states and their partners make to help achieve all of TANF's goals, particularly those focusing on preparing participants for sustained success in the workplace, preventing and reducing out-of-wedlock pregnancies, and building greater overall family strength and stability.

Sections 8(b and c) – Prohibits use of federal TANF funds and excludes state TANF funds for families with income greater than twice the poverty line: Cannot support current language; discussion needed

A number of states have raised serious concerns about the provisions of Section 8, which prohibit the use of federal TANF funds for families with income greater than twice the poverty line, and exclude state TANF funds used to serve families in this category from being counted toward state spending requirements. The families and individuals who receive TANF-funded services are diverse, as are states and even the areas within states. The level of income needed for a family to meet even its most basic needs varies depending on its unique circumstances, location, and economic conditions. The TANF program is meant to include the flexibility necessary for states to serve their neediest families. We would like to explore with the Committee its thinking on proposing this limit and examine alternatives that might address those concerns yet retain the flexibility that has been, and will continue to be, required to serve the full range of families that can be strengthened through TANF services.

Comments on Section 9

Section 9 – Eliminates the separate work rate for two-parent families: Support with recommendations

Eliminating the 90 percent work rate for two-parent families is a wise decision. It will remove the disincentive to serve those families. Such a high participation rate requirement is unrealistic and burdensome. **Considering this, we ask that final legislation also relieve states from any penalties yet to be imposed for failing to meet the two-parent work rate in years prior to the effective date of this TANF reauthorization.**

Comments on Section 10

Sections 10 – Improving Opportunity Fund: <u>Support with reservations</u>

APHSA and its members are very pleased to see the Committee's decision to explore innovative approaches to better serve and support greater outcomes for TANF participants through the creation of four competitive grants for demonstration projects. These opportunities reflect a priority that has been urged by our members for years. However, we are troubled that no new funding would be provided for these projects, but rather would be redirected from states' Contingency Funds. While the nation as a whole has recovered from the recession, many states are still recovering now and depend on their Contingency Funds to adequately serve their poorest families. Furthermore, taking money from states' contingency funds would have serious consequences in the event of an economic downturn or other trigger. **We urge the Committee to find alternative sources of additional funds that do not diminish the capacity and effectiveness of TANF and of other human services programs that help build families' capacity and ability to sustain a better future.**

Again, we want to emphasize that the general direction of the Committee's Discussion Draft is a positive one, and many of its proposals respond well to the calls for strengthening TANF that our members have been sounding for many years. With the modifications we have outlined and the necessary resources, we believe this legislation could help produce some of the most significant forward movement in TANF, and for the families it serves, since the program began.

Please feel free to contact Mary Brogdon, Director of the Center for Workforce Engagement, at 202.682.0100 x236 with any questions or requests for additional information regarding these important changes.

Sincerely,



Tracy Wareing Evans
Executive Director

Cc:

Honorable Paul Ryan
Chairman
House Committee on Ways and Means
1129 Longworth House Office Building
Washington, DC

Honorable Sander Levin
Ranking Member
House Committee on Ways and Means
1129 Longworth House Office Building
Washington, DC



BISHOP TRIBAL COUNCIL

REMOVING BARRIERS TO ECONOMIC DEVELOPMENT ON INDIAN LANDS
Testimony submitted to the House Committee on Ways & Means
Subcommittee on Human Resources
Re: TANF Reauthorization

The Bishop Paiute Tribe is grateful for the opportunity to provide testimony to the House Committee on Ways & Means with respect to the reauthorization of the Temporary Assistance for Needy Families program.

The Bishop Paiute Tribe is located at the foot of the Eastern Sierra Nevada Mountains in California's Owens Valley. With 2,000 enrolled members, the Bishop Paiute Tribe is the 5th largest Tribe in the state of California.

As you know, the Temporary Assistance for Needy Families (TANF) program grants Tribes the right to administer their own Tribal TANF programs on their reservations to serve Tribal members who would otherwise be served by the state in which they live (42 U.S.C. Section 612). At Bishop Paiute, we are served by the Owens Valley Career Development Center (OVCDC), a tribal consortium which administers the TANF program and is headquartered on the Bishop Paiute Reservation. The TANF program administered by OVCDC is the third largest Tribal TANF program in the country, serving individuals and families in six California counties and providing funds for employment training, job counseling and other career services to help tribal members prepare for the labor market. While OVCDC provides cash assistance to nearly 700 individuals and families, the majority of their TANF services are dedicated to job training programs.

The TANF law and its implementing guidance, codified in 2 CFR 225, greatly limit allowable expenses. Section 37 of the OMB Circular is particularly troubling in that it essentially *prohibits Tribal TANF prog ramsfrom recouping fair market rental value for office space to run TANF programs on tribal lands.*

The regulations regarding fair market rental rates for the administration of Tribal TANF on Tribal lands are inconsistent with the regulations that govern other Department of Health and Human Services programs, namely at the Indian Health Service (IHS). Under other HHS programs, which operate pursuant to the Indian Self Determination and Education Assistance Act of l975 (ISDEAA), a Tribe can charge and recoup fair market rents for space on their reservation that is utilized for IHS facilities. In fact, this is the case for Bishop Paiute; down the street from the headquarters of the Owens Valley Career Development Center are the Tribe's Indian

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Health Service buildings, for which the Tribe charges and recoups the fair market rents for the property.

ISDEAA expressly allows Tribal governments to use Federal funds to lease Tribal facilities for the administration of ISDEAA funded programs at fair market value. Subsequent amendments to the Act in 1988 and 1994 affirm that right. The purpose ofISDEAA is to recognize the unique circumstances of Tribal governments and to encourage Tribal participation in the administration of these programs. This assists in retaining economic development opportunities on reservations.

In the case of Bishop Paiute and the Owens Valley Career Development Center, HHS not only denied the tribe's right to recoup fair market rates for the administration of its tribal TANF program, it also levied more than $1.7 million in penalties on the tribe. This leaves the tribe with two options - either charge little or nothing for the utilization of the office space, or use funds to lease office space off the reservation. This undermines the intent of ISDEAA.

Failing to allow tribes to charge fair market rents for the placement of TANF facilities on tribal lands can result in the diversion of scarce resources toward facilities owned by non-Indian landowners that are far removed from reservation communities and target populations. While some tribes have chosen to provide facility space rent-free, not all tribes have the financial ability to make such arrangements. In our case, the proposed "allowable rent" under the alternative calculation is less than one-tenth of the actual market rate for the property.

Solution
Despite language in the Statement of Managers accompanying the FY 15 omnibus appropriations bill that directs the Secretary of Health and Human Services to review this policy to ensure that it meets the needs of tribal governments, the Administration has failed to address this issue.

In developing recommendations for TANF Reauthorization, we ask that the Ways & Means Committee consider our request to include Rep. Paul Cook's legislation, H.R. 3026, the "Tribal TANF Fairness Act of 2015", that clarifies that tribes may recoup fair market rents, as validated by a third party audit, for TANF facilities located on Indian lands.

Thank you for the opportunity to comment on this subject, and we look forward to working with you.

Sincerely,

Gerald Howard
Chairman



"We fail to see that some are mired in desperate and degrading poverty, with no way out, while others have not the faintest idea of what to do with their possessions, vainly showing off their supposed superiority..." -Pope Francis

RECIPIENT IMPACT STATEMENT

Welfare Reform Proposal by The House Human Resources Subcommittee of the House Ways and Means Committee

Boustany Announces Hearing on Welfare Reform Proposals
JULY 15, 2015
HEARING HUMAN RESOURCES WELFARE REFORM

Congressman Charles Boustany (R-LA), Chairman of the Subcommittee on Human Resources of the Committee on Ways and Means, today announced that the Subcommittee will hold a hearing on welfare reform proposals, specifically involving the reauthorization of the Temporary Assistance for Needy Families (TANF) program.

The hearing will take place on Wednesday, July 15, 2015, in 1100 Longworth House Office Building, beginning at 10:30 A.M.

The subcommittee invites witnesses and other interested parties to submit testimony and comments on the following Committee Discussion Draft of welfare reauthorization legislation: COMMITTEE DISCUSSION DRAFT

Kevin Aslanian, Executive Director
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Dear Chairperson Boustany:

As an antidote to poverty for families with children in America, the TANF program has failed. As a result of the callous treatment families endure from the state governors, legislators and TANF administrators, millions of children will endure lifelong problems, including profound health issues.

Several years ago, a *60 Minutes* segment on the CBS network, presented the tough journey of a homeless family, living in the southern United States, who could only qualify for SNAP. The TANF program was not even mentioned as a benefit to help poor and homeless families. This Committee should enact a TANF reform bill that would be consistent with Pope Francis's recent encyclical letter wherein he wrote: *"We fail to see that some are mired in desperate and degrading poverty, with no way out, while others have not the faintest idea of what to do with their possessions, vainly showing off their supposed superiority…"*

No family in the United States should have a TANF grant less than 100% of the federal poverty level. See **TABLE #1** that reveals the average TANF payment level is less than 25% of the federal poverty level.

The TANF program has been a federal "bonanza" for States who are charged with assisting parents of poor children get on the road to self-sufficiency. In 2015, only 30% of the total TANF block grant and State MOE funding is used to meet the family's basic survival needs, such as rent, utilities and clothing. TANF money is a great source of funding for the welfare industry and bureaucracy who receive 70% of TANF money while only 30% goes to payments to impoverished families. As contrast, the previous Aid to Families With Dependent Children (AFDC) Program paid 70% of the AFDC funds for direct benefits payments to families. AFDC was funded with 50% federal dollars and 50% state dollars.
TABLE #2 reveals the how States fleece the TANF program.

Since the inception of TANF, California has been able to fleece the TANF program out of $23 billion while TANF/CalWORKs children lead the nation in child poverty. Today, the average grant is about 30% of the federal poverty level. See **TABLES #3.**

How do States manage to use less than 30% of the federal TANF allocation and the State Maintenance of Effort (MOE) for cash assistance? States are operating inhumane and punitive public assistance programs. Most states impose full family sanctions upon families with children whose parent has allegedly not participated in the state employment programs even if the individual did not have child-care or transportation. States do this to meet the Work Participation Rates (WPR) through caseload reductions as well as eliminating families out of the numerator for the WPR calculations.

Many children who are subjected to full family sanctions end up in the foster care system accused of negligence. In reality, it's "State induced *economic* negligence" because parents cannot meet their child's basic needs due to the sanctions. A lot of the TANF dollars are used by States to fund their foster care program – aiding the TANF children. We now have "TANF government children" in the foster care system that would have been with their natural parents when we had the AFDC program.

What is the fiscal difference between TANF and foster care? In California, CalWORKs (TANF) costs on the average $200 a month per child while costing $2,200 a month for a child in foster care.

TABLE # 1

In 2015, the Federal Poverty Level for a Family of Three is $1,674 a month

States	TANF (3 Children)	Percentage of Federal Poverty Level		States	TANF (3 Children)	Percentage of Federal Poverty Level
Alabama	$215	13%		Missouri	$292	17%
Alaska	$656	39%		Montana	$504	30%
Arizona	$278	17%		Nebraska	$364	22%
Arkansas	$204	12%		Nevada	$383	23%
California	$694	41%		New Hampsh.	$675	40%
Colorado	$404	24%		New Jersey	$424	25%
Connecticut	$576	34%		New Mexico	$447	27%
Delaware	$428	26%		New York	$900	54%
DC	$270	16%		North Carolina	$272	16%
Florida	$303	18%		North Dakota	$310	19%
Georgia	$280	17%		Ohio	$434	26%
Hawaii	$763	46%		Oklahoma	$241	14%
Idaho	$309	18%		Oregon	$477	28%
Illinois	$284	17%		Pennsylvania	$403	24%
Indiana	$256	15%		Rhode Island	$554	33%
Iowa	$426	25%		South Carolina	$216	13%
Kansas	$375	22%		South Dakota	$681	41%
Kentucky	$262	16%		Tennessee	$232	14%
Louisiana	$240	14%		Texas	$179	11%
Maine	$386	23%		Utah	$498	30%
Maryland	$733	44%		Vermont	$710	42%
Massachusetts	$633	38%		Virginia	$389	23%

Michigan	$420	25%	Washington	$478	29%
Minnesota	$532	32%	West Virginia	$340	20%
Mississippi	$170	10%	Wisconsin	$550	33%
			Wyoming	$561	34%

TABLE #2

Federal Fiscal Year	Total Federal TANF and State MOE Funds	Total Spent for Payments to Poor Families with Children	Percentage of TANF dollars Going to Cash Assistance to TANF Families	Children Living in Deep Poverty - 50% of the federal poverty level	Children Living Below 100% of the Federal Poverty Level
1997	$19,603,114,268	$13,901,705,312	71%	2,640,694	6,269,998.00
1998	$22,772,430,582	$13,927,623,731	61%	2,519,906	6,001,292.00
1999	$26,954,983,262	$13,165,747,213	49%	2,283,492	5,601,860.00
2000	$28,275,174,613	$11,180,400,974	40%	2,108,912	5,212,228.00
2001	$28,499,551,177	$10,143,465,544	36%	2,153,071	5,197,115.00
2002	$28,372,057,418	$9,408,233,518	33%	2,266,480	5,434,762.00
2003	$29,056,889,945	$10,218,545,347	35%	2,441,227	5,760,902.00
2004	$28,541,831,816	$10,389,421,895	36%	2,579,276	6,003,736.00
2005	$28,439,900,706	$10,739,000,687	38%	2,568,050	5,975,370.00
2006	$28,445,736,836	$9,906,038,682	35%	2,554,450	5,973,777.00
2007	$30,006,456,645	$9,068,930,860	30%	2,577,614	6,041,259.00
2008	$30,989,868,539	$8,648,970,019	28%	2,663,741	6,173,802.00
2009	$33,534,692,301	$9,323,502,540	28%	2,877,916	6,590,502.00
2010	$35,848,113,846	$10,699,142,042	30%		

There is no reason why Congress should not DEMAND that states use at least 70% of the funding for payments to needy families (cash assistance) rather than allowing states to use 70% of the TANF funds to pay for bureaucratic costs, especially when Congress has appropriated billions for employment and childcare programs in the past two years. These funds must first be used for those in the highest need – TANF recipients.

The other major reform needed in the TANF program is to assure that the TANF is a program helping "poor families" and not "greedy states". USDA keeps track of the number

The other major reform needed in the TANF program is to assure that the TANF is a program helping "poor families" and not "greedy states".

of people potentially eligible for SNAP and how many receiving SNAP. TANF has no similar information. It seems like Congress and States don't care that there are families suffering in deep poverty that should be eligible for TANF but cannot overcome the path to eligibility that is loaded with landmines that are often insurmountable.

Is the State Welfare Agency the Right Entity for Employment Services for the Poor of America?

We encourage the House to end the welfare office responsibility to find jobs for welfare recipients. The welfare department is not the jobs department. TANF mandates that the welfare department perform the "jobs" function. Recently, Congress enacted the Workforce Investment Program. Section 2 of PL. 113-128 states:

> *The purposes of this Act are the following:*
>
> *(1) To increase, for individuals in the United States, particularly those individuals with barriers to employment, access to and opportunities for the employment, education, training, and support services they need to succeed in the labor market.*
> *(3) To improve the quality and labor market relevance of workforce investment, education, and economic development efforts to provide America's workers with the skills and credentials necessary to secure and advance in employment with family-sustaining wages and to provide America's employers with the skilled workers the employers need to succeed in a global economy.*

Welfare recipients are also Americans and they should have the same opportunities to be assisted by the state employment professionals and not be subjected to the segregated employment programs operated by the welfare officials of the various states.

Congress authorized over $3.3 billion a year to operate employment programs for Americans in the most recently reauthorized WIA act P.L. 113-128. In California there is another estimated $5.6 billion employment programs for Californians.

Welfare recipients are also Americans and they should have the same opportunities to be assisted by the state employment professionals and not be subjected to the ***segregated employment programs*** operated by the welfare officials of the various states.

Section-By-Section Analysis The Ways & Means Committee "Discussion Draft"

SECTION 3. EXTENSION OF PROGRAM – Page 2, Line 7

RECIPIENT IMPACT STATEMENT: None.

CCWRO POSITION – Support

CCWRO RECOMMENDATIONS – None

SECTION 4. NO WAIVER OF WORK REQUIREMENT – Page 3, Line 19

RECIPIENT IMPACT STATEMENT: Historically most waivers issued by HHS has had a negative impact on the beneficiaries of the AFDC and now TANF program.

CCWRO POSITION – Support

CCWRO RECOMMENDATIONS – None

SECTION 5. INDIVIDUAL OPPORTUNITY PLANS – Page 4, Line 11

RECIPIENT IMPACT STATEMENT: Opportunity plans, employment plans or contracts, rarely give beneficiaries an opportunity to elect a path to self-sufficiency. A family has less chance of becoming self-sufficient when the entire process gives the government all of the decision-making and the beneficiary has no say in it. Many will NOT achieve independence when the whole process starts with making the individual totally dependent on the whims of the state welfare agency. If the individual is going to achieve independence, Congress needs to trust the individual to make decisions on how to achieve self-sufficiency. Currently, participants must either obey the state welfare agency, who believe they know best how to achieve self-sufficiency, or be sanctioned and face the loss of all TANF benefits.

Many will NOT achieve independence when the whole process starts with making the individual totally dependent on the whims of the state welfare agency. If the individual is going to achieve independence, Congress needs to trust the individual to make decisions on how to achieve self-sufficiency.

Under this proposal, the opportunity plan is developed in consultation with the beneficiary, but given §408(b)(2), the desires of the participant will not be reflected in the plan. First of all, the beneficiary, or the individual as stated in this bill, would sign the plan presented by the TANF department or face the total loss of "all" TANF benefits in many states. This does not present a landscape of fair "consultation".

Moreover, the information being gathered pursuant to §403(b) is meaningless if the individual does not have verified access to the services. In California, 50% of the participants do not receive transportation assistance even though the law mandates that the state agency pay for transportation. **See TABLE # 4**. The reason is very simple. There is no requirement for the state or local agency to verify that the individual has transportation or childcare before being required to participant in an activity or be sanctioned.

CCWRO POSITION – Support if amended

CCWRO RECOMMENDATIONS – In order to make the consultation process more effective we suggest the following amendment:

On page 5, line 25, after the word "employment" insert:

> *The plan shall allow the agency to suggest the employment activity that the agency determines is appropriate for the individual. The plan shall also state other activities that the state agency provides in its state plan. The proposed plan shall be mailed to individual and the individual shall select the activity offered by the state agency or another activity in the state plan.*

The activity selected by the individual shall be approved unless the state agency has documentary evidence that the activity selected by the participant would not enhance the individuals' employability;

The state agency shall verify, through documentary evidence, that the individual actually has the needed supportive services before requiring the individual to participate in any activity that would be subject to the penalties under section 408(b)(3).

SECTION 6. STRENGTHENING REQUIREMENTS TO ENGAGE RECIPIENTS IN WORK AND WORK PREPARATION ACTIVITIES

SECTION 6(a), (b) ELIMINATION OF CREDIT TOWARD WORK PARTICIPATION REQUIREMENT FOR CASELOAD SIZE AND EXCESS STATE SPENDING & COUNTING OF WORK PERFORMED BY INDIVIDUALS RECEIVING ATYPICAL BENEFIT PAYMENTS – Page 8 Line 4 and Line 10

RECIPIENT IMPACT STATEMENT: This is a good change for beneficiaries in that it would make sure that the state gets credit for "positive outcomes" – moving families to self-sufficiency and not into deep poverty. Currently, states are rewarded for terminating cases and imposing full-family sanctions that leave the family in deep poverty. States have also become masters of 101 ways to prevent a family in need from receiving TANF benefits.

This is a good change for beneficiaries in that it would make sure that the state gets credit for "positive outcomes" – moving families to self-sufficiency and into deep poverty.

With this change states would have to think about positive terminations – hopefully. The fact that states do not have to spend a specified amount of the TANF and TANF MOE funds for cash assistance still leaves the door wide open for states to use funds for themselves and not for the TANF recipients.

CCWRO POSITION – Support

CCWRO RECOMMENDATIONS- None

SECTION 6(c)(1) - ELIMINATION OF DISTINCTION BETWEEN CORE AND NON-CORE ACTIVITIES – Page 10, Line 13

RECIPIENT IMPACT STATEMENT: This change would simplify the program and encourage state agencies to offer individuals more options that would help them in their efforts to achieve self-sufficiency. States that may give TANF participants a choice would now be able to make a choice.

CCWRO POSITION – Support

CCWRO RECOMMENDATIONS - None

SECTION 6(c)(2) ALLOWING STATES TO RECEIVE PARTIAL CREDIT FOR PARTIAL ENGAGEMEMNT – Page 10, Line 20

RECIPIENT IMPACT STATEMENT: This change would finally recognize the efforts of the individual to meet the federal WPR, even if it is a partial effort. All efforts should be recognized.

CCWRO POSITION – Support

CCWRO RECOMMENDATIONS – None

SECTION 6(c)(3) STATE OPTION TO REQUEST ALTERNATIVE WORK PARTICIPATION CALCULATION — Page 11, Line 16

RECIPIENT IMPACT STATEMENT: From the perspective of the TANF beneficiary the best outcome of the TANF program is to obtain the tools needed to become self-sufficient through a self-sufficiency path selected by the individual and not the state welfare bureaucrat.

Congress should also be aware that this does not happen overnight. First of all, families living on a fixed income that is less than 25% of the federal poverty rate, are in deep poverty. They are competing for jobs with people who are dressed, have a computer, cell phone, car and money for transportation. Most TANF beneficiaries lack many of these resources.

CCWRO POSITION – Support if amended as set forth below

CCWRO RECOMMENDATIONS – The TANF recipients are the customers of this program. We believe that TANF recipient evaluation of the performance of the state welfare agency should be given adequate weight.

California's Welfare-to-Work (WtW) program spends about $2.2 billion a year on work and childcare programs and less than 2 to 3% of the participants find employment that results in the termination of TANF benefits.

On the other hand, the WtW program sanctions over 50% of the unduplicated participants. **See TABLE # 4**.

SECTION 6(c)(5) MODIFICATION OF RULE PROVIDING FOR PARTICIPATION BY REASON OF SECONDARY SCHOOL PARTICIPATION – Page 13, Line 20

Jobs yielding income that would support a family demand workers with education higher than a high school diploma. Most TANF recipients lack high school diplomas.

RECIPIENT IMPACT STATEMENT: Education is the only real effective antidote to poverty in the 21st century. **This proposal is a very small step in helping TANF recipients to achieve self-sufficiency through education.** As recent history has shown us, jobs yielding incomes that allow for self-sufficiency have migrated to other countries. Jobs yielding income that would support a family demand workers with education higher than a high school diploma. Most TANF recipients lack high school diplomas.

We would suggest that rather than having a 2-year ceiling on education, states be required to have a program that provides *at least two-years of secondary school education* and allow states to approve more than two years at their option.

CCWRO POSITION – Support if amended as stated below.

CCWRO RECOMMENDATIONS – Amend the bill as follows:

On page 14, strike lines 8 through 11 and in lieu thereof insert:

> *(6) The individual who maintains satisfactory attendance at secondary school or the equivalent for at least 24 months and, at the state's option, for a longer period provided the participant is making satisfactory progress as defined by the secondary education entity that the individual is attending.*

OPEN ISSUE

SECTION 6(c)(6) WHETHER TO ADJUST CURRENT CAP ON SHARE OF WORK PARTICIPATION RATE THAT CAN BE SATISFIED BY PARTICIPATION IN EDUCATION – Page 14, Line 8

RECIPIENT IMPACT STATEMENT: Education is the most effective way to help TANF recipients achieve self-sufficiency. As recent history has shown us, jobs yielding incomes that allow for self-sufficiency have migrated to other counties.

Individuals should have a right to decide the best path to self-sufficiency and Congress should provide states with the flexibility to accommodate the individu-

als' decision how to overcome deep poverty that the majority of TANF recipient endure today – they live on a cash assistance of 25% of the federal poverty level.

CCWRO POSITION – Support lifting the cap.

CCWRO RECOMMENDATIONS – Remove all caps. If workfare and job search have no caps, then education should not have a cap. Let the beneficiaries decide and not Washington – "the bureaucrats what best for the TANF individuals".

SECTION 6(c)(4) MODIFICATION OF COUNTING JOB SEARCH AS WORK - Page 14, Line 8

RECIPIENT IMPACT STATEMENT: This change would increase the job search period to three months. We have seen many job search programs that require individuals without a high school diploma, non-English speakers or individuals with a felony record to look for jobs that they are not equipped to do or jobs that do not exist. It makes more sense if the state submits quarterly plans to the HHS regional office for approval, showing the availability of jobs so that the individual is not merely submitting applications and getting a piece of paper signed just to satisfy the state and local workfare bureaucrats. This is burdensome on small business owners, who have to take applications for jobs that do not exist, just to make sure that the individual, who is also a customer of the small business, satisfies the welfare agency's need for paper proof that the individual applied for a job.

This is burdensome on small business owners, who have to take applications for jobs that do not exist, just to make sure that the individual, who is also a customer of the small business, satisfies the welfare agency's need for paper proof that the individual applied for a job.

CCWRO POSITION – Oppose unless amended.

CCWRO RECOMMENDATIONS – Amend the law to require that States demonstrate with objective statistical information that the job search being performed by individuals to meet the federal WPR are for jobs that actually exists and that states are not "gaming the system" by forcing individuals looking for jobs that do not exist.

SECTION 6(c)(7) REQUIREMENT TO REVIEW INDIVIDUAL OPPORTUNITY PLANS FOR INDIVIDUALS INVOLVED IN JOB READINESS ACTIVITIES FOR LONGER THAN THREE MONTHS– Page 14, Line 12

RECIPIENT IMPACT STATEMENT: This is a positive change, but, from the perspective of the individual, the current draft is meaningless. This section simply requires the State to "certify" that more job search would be good for the person

after the three months of, often frivolous, job search, that is a total waste of taxpayer dollars. Under the federal AFDC Work Incentive Program (WIN), California had a 3-day job search that yielded more employment than today's glorified job clubs and never ending job search programs. Although job search is cheaper than training and education, it does not lead to self-sufficiency.

Finally, it is puzzling that the state agency is required to determine if the participant can be sanctioned pursuant to section 408(b)(3). The insertion of 408(b)(3) implies that the individual has done something wrong by not finding a job after looking for work for three months – when there was no finding by the state agency that there were any available jobs in the first place that the participant could perform and all barriers to self-sufficiency have been identified and verifiably removed.

CCWRO POSITION – OPPOSE unless amended as stated below.

CCWRO RECOMMENDATIONS – Amend the bill as follows:

On page 15, strike lines 3 through 8 and in lieu thereof insert:

> "unless *the individual certifies in writing that continued participation in such an activity would support and prepare the individual for employment or in the alternative it would not. The individual shall make a choice between the two options in writing.*
>
> *The state agency shall provide objective evidence that the additional job search would yield self-sufficiency. The state agency shall provide quarterly reports of the number of individuals who participated in the job search activity and the number of participants finding employment that yielded income over 100% of the federal poverty level. If two consecutive quarterly reports show that the state agency has not met this standard, then the state shall no longer be allowed to operate a job search program more than three months."*

SECTION 6(c)(9) INCREASE IN TIME LIMIT ON COUNTING VOCATIONAL EDUCATION TRAINING AS WORK – Page 15. Line 19

RECIPIENT IMPACT STATEMENT: This would be beneficial to TANF beneficiaries.

CCWRO POSITION – Support

CCWRO RECOMMENDATIONS – As stated above, states should have flexibility to go beyond this 24-month limit. One-size does not fit all.

OPEN ISSUE

SECTION 6(c)(10) HOW TO VERIFY PARTICIPATION ACTIVITIES- Page 15, Line 23

RECIPIENT IMPACT STATEMENT: How to verify TANF activities? From the perspective of the TANF beneficiary, participation alone is not much benefit, if it is done just to meet the desires of the statute to show that TANF recipients are doing something that has no positive outcomes for the beneficiary. From the perspective of the beneficiary, a positive outcome is getting the necessary tools to obtain and retain employment that would propel the family out of poverty and into self-sufficiency.

The TANF program has time limits. Time limits impede the ability of beneficiaries to acquire the tools needed to obtain and retain employment that would pay more than the poverty level. The purpose of the employment program is to remove the barriers that the beneficiary has preventing her or him from getting a job that pays a family wage. The removal of those barriers cannot be done the same way for all beneficiaries. Each individual, just like each state, has different needs and barriers. Some need extensive education, while others need a refresher course. Transportation is generally a major problem for finding and maintaining a job for TANF recipients. Yet most states do thing to address this major barrier except for sometimes paying for public transportation, if the beneficiary is lucky.

In California about 50% of the beneficiaries actually participating do not receive transportation services. **See TABLE # 4.** Moreover, there is nothing in the federal law that says the beneficiary shall receive transportation. In America today, thousands and thousands of families endure full-family sanctions because they did not have money for transportation and could not use their TANF grant to pay for transportation after paying for rent and utilities, with the TANF grants being 25% of the federal poverty level.

Often beneficiaries who find employment and become self-sufficient, do not report it to the welfare department because of the relationship of the welfare system and the individuals – the state agency is the overbearing parent always threatening "sanctions" and the individual just can't wait to get out of the horrible relationship. This is not to say that there are not individuals who adore their state employment worker. But as a general rule they don't, thus they do not tell the welfare system that they got a job. On the other hand, if the statute would man-

date that individuals who meet the provisions of the opportunity plan and provide evidence of self-sufficiency, they should be given an incentive for reporting and achieving the milestone of self-sufficiency that is meaningful.

CCWRO POSITION – Support if the participation rates are based on achieving the benchmarks of the individual's "opportunity plan" by 50% and having 50% of those eligible for TANF to be participating in the TANF program and require states to provide meaningful bonuses to individuals who become self-sufficient and report that to the state agency.

CCWRO RECOMMENDATIONS – The discussion draft has a proposal for an "opportunity plan". The TANF program has two primary goals: (1) assistance to needy families; and (2) getting the TANF recipients to become self-sufficient by meeting the benchmarks of the TANF opportunity plan.

SECTION 6(d) PENALTY FOR FAILURE TO SATISFY MINIMUM PARTICIPATION RATES – Page 16, Line

RECIPIENT IMPACT STATEMENT: We would oppose this provision unless it protects the individuals that the program is supposed to serve from being punished through reduction of cash assistance payments because of the failure of the State to meet the federal minimum participation rates. The children suffer the most by having States reduce the already low payment levels of payments to families.

CCWRO POSITION – Support if amended as stated below.

CCWRO RECOMMENDATIONS – Amend the bill as follows:

> *On page 17, between lines 11 and 12 insert:*
>
> *"(C) In no event shall payments to families in the form of cash assistance be reduced that have any explicit or implied connection to the state's failure to meet the requirements of this section."*

SECTION 6(e) REPORT OF NON-ENGAGEMENT OF NON-WORKING RECIPIENTS Page 17, Line 16

RECIPIENT IMPACT STATEMENT: Many beneficiaries are not engaged because the state agency has failed to assure that they have childcare and transportation services. While Congress wants to *"verify"* participation, there is no requirement that state agencies *"verify"* that the individual actually has supportive

services before being required to participate in an activity and be subject to the provisions of Section 408(b)(2).

CCWRO POSITION – Support if amended.

CCWRO RECOMMENDATIONS – Amend the bill to include monthly sanction reports to let the public know the number of children enduring TANF-caused government *economic child abuse* that often leads to the destruction of the family with children ending up in foster care.

The report should also document whether or not supportive services were actually available before the individual was asked to engage and did not engage.

In California, local welfare workers tell participants that the county will pay for childcare. However, before childcare can be paid, the provider must be approved by Trust line[1]. If the provider fails Trust line, the provider is not paid for his/her work. Thus, the community learns that the welfare office does not speak the truth when they say they will pay for childcare and refuse to work as a childcare provider unless paid in advance. In California, and I believe in most states, childcare payments cannot be advanced.

Congress should know that just because there are millions of dollars appropriated for TANF recipients for childcare, does not mean the individuals actually receive childcare.

SECTION 6(f) PURPOSES OF TANF PROGRAM TO INCLUDE REDUCING POVERTY – Page 19, Line 13

RECIPIENT IMPACT STATEMENT: The reason that the TANF program has been a bonanza for States in that the TANF money can be used for anything rather than families who meet the rigorous eligibility and work requirements of the TANF program. This has caused extreme undue hardship upon impoverished families of America while showering states with federal money that is minimally used to relieve poverty and it is generally used to provide "aid to state bureaucracies".

CCWRO POSITION – Support if amended.

CCWRO RECOMMENDATIONS – Limit the purpose of the using the TANF money for the families who meet the eligibility requirements and are required to

[1] TrustLine is a California's registry of license-exempt childcare providers who have been through a criminal background screening and clearance process.

participate in employment programs and are subject to the provisions of 408(b)(3).

OPEN ISSUE

SECTION 6(h) ELIGIBILITY OF INDIVIDUALS CONVICTED OF DRUG-RELATED CRIMES – Page 20, Lines 8-9

RECIPIENT IMPACT STATEMENT: Children are always better off with their natural parents, even with a natural parent who has done wrong and done the time.

The denial of TANF benefits to parents who have criminal convictions and have served time in jail or prison should not continue to be punished because such continued punishment has a negative impact on the children. Moreover, by denying aid to the parent, the parent is also being denied the opportunity to receive case management and assistance in becoming self-sufficient.
CCWRO POSITION – See below.

CCWRO RECOMMENDATIONS – This policy has always been anti-family and anti-child resulting in government-induced *economic child abuse*. It should be repealed. Every child needs a parent, and no child should be punished because his or her parent did wrong, paid the price and now wants to do right.

SECTION 7. PROMOTING INCREASED EMPLOYMENT, RETENTION, AND ADVANCEMENT AMONG FORMER TANF RECIPIENTS – Page 21, Line 1.

RECIPIENT IMPACT STATEMENT: Former TANF recipients would be very happy to get assistance.

CCWRO POSITION – Support if amended

CCWRO RECOMMENDATIONS – This section should specify the amount of money to be used to pay for case management services, which should be no more than 50%. The remaining funds should be used to aid former TANF recipients with supportive services, such as childcare, transportation and other ancillary needs

SECTION 8. STRENGTHENING TANF FINANCIAL REQUIREMENTS

SECTION 8(a)(1). No Counting of Third-Party Spending to Meet State Spending Requirements – Page 28, Line 15

RECIPIENT IMPACT STATEMENT: This would have a positive impact on TANF recipients in that it stops the States from "gaming the system" and pretending to count money that does not reach TANF recipients, in that, the beneficiaries of those funds do not have to meet the TANF eligibility and work requirements.

CCWRO POSITION – Support

CCWRO RECOMMENDATIONS – None

SECTION 8(a)(2). No Counting of Spending on Medical Services to Meet State Spending Requirement – Page 29, Line 23

RECIPIENT IMPACT STATEMENT: This would have a positive impact on TANF recipients in that it stops the States from "gaming the system" and pretending to count money that does not reach TANF recipients in that the beneficiaries of those funds do not have to meet the TANF eligibility and work requirements.

CCWRO POSITION – Support

CCWRO RECOMMENDATIONS – None

SECTION 8(c). Prohibition on Use of Federal TANF Funds for Families with Income Greater Than Twice the Poverty Line – Page 30, Line 9

RECIPIENT IMPACT STATEMENT: This would have a positive impact on TANF recipients in that is stops the States from "gaming the system" and pretending to count money that does not reach TANF recipients in that the beneficiaries of those funds do not have to meet the TANF eligibility and work requirements.

CCWRO POSITION – Support

CCWRO RECOMMENDATIONS – This section should be amended to include the State TANF Maintenance of Efforts to prevent the States from finding another way to game the system.

OPEN ISSUE

SECTION 8(e). HOW SHOULD STATES USE THE TANF FUNDS? Page 32, Lines 20-23

RECIPIENT IMPACT STATEMENT: States have been fleecing the TANF program and gaming the system for decades. The name of this program is "Temporary Assistance to Needy Families" and not "Aid to Needy States".

The program has been functioning as a program that provides "*aid to needy, and often greedy, states*".

The program has been functioning as a program that provides "aid to needy, and often greedy, states". California's budget reveals that TANF has contributed over $1.5 billion a year to the state general fund while the average family on TANF/CalWORKs is getting cash assistance that is equal to about 30% of the federal poverty level. **See TABLE #3** showing the history of California's budget for the TANF program. This is from the Governor's proposed budget. Taking from poor children and families is not a California phenomenon. It is something done by majority of the States.

CCWRO POSITION – See recommendation below.

CCWRO RECOMMENDATIONS – Limit TANF expenditures to TANF-eligible recipients who are required to meet the TANF work requirements. The federal TANF grant and the State Maintenance of Efforts (MOE) funds shall be used by states as follows:

Expenditures	Floor –Percentage of Federal TANF and State MOE funds
Cash Assistance – Payments to Needy Families	70%
Child care- There is already the Child Care Block Grant available for TANF. 10% should be more than sufficient	10%
Work activities	10%
Administration	10%

Any funds not used by the state in any year shall be returned to the federal government and used to pay of the U.S. public debt. In 2013 states failed to use over $3 billion. In 2014 there were about $1.5 billion not used. There are some who are advocating for the increase of the TANF block grant. We would support increasing the TANF block grant if states had to do a 100% match and use 70%

In 2013 states failed to use over $3 billion. In 2014 there were about $1.5 billion not used. There are some who are advocating for the increase of the TANF block grant. We would support increasing the TANF block grant if states had to do a 100% match and use 70% for cash assistance. We do not support "welfare for state government".

for cash assistance. We do not support "welfare for state government".

The administrative costs of other means-tested programs and employment programs:

Program	Administration Costs
SNAP, formerly known as food stamps	5% for state and local SNAP agencies
Supplemental Security Income (SSI)	Less than 1%
Unemployment Insurance that includes a work program (in 2010 according to the GATO institute)	$134 billion in benefits and administrative cost of 5.9 billion = .004%

SECTION 8(f)(2). LIMITS ON ACCESS TO ASSISTANCE IN CASINOS, STRIP CLUBS, AND LIQUOR STORES – Page 33, Line 5

RECIPIENT IMPACT STATEMENT: These federal restrictions have already been implemented in California. The major problem facing TANF recipients is that with "Electronic Benefits Transfer" banks have been fleecing TANF recipients by charging fees to use the banks' ATM machine to access their funds.

Calendar Year	TANF Recipient Payments to Banks in the Form of Surcharges and Fees
2011	$20,234,150
2012	$19,377,374
2013	$18,875,475
2014	$19,595,619

CCWRO POSITION – see below

CCWRO RECOMMENDATIONS – Prohibit the state agency from requiring any TANF individual from being required to pay any fee or surcharge to any bank to access their TANF benefits.

SECTION 9. ELIMINATION OF THE MARRIAGE PENALTY – Page 35, Line 9

RECIPIENT IMPACT STATEMENT: This is a good step in supporting marriage. Congress should go one more step and prohibit the use of any TANF funds or TANF MOE funds for state TANF policies that results in a penalty for being married.

CCWRO POSITION – Support

CCWRO RECOMMENDATIONS – Prohibit the use of any TANF funds or TANF MOE funds for state TANF policies that results in a penalty for being married.

OPEN ISSUE

SECTION 11(b). REQUIRE SECRETARY OF HHS, USDA, HUD AND OTHER SECRETARIES TO REPORT TO CONGRESS ON BARRIERS TO IMPROVING PROGRAM COORDINATION AND HOW TO DEVELOP CROSS-PROGRAM ACCOUNTABILITY – Page 92, Line 3

RECIPIENT IMPACT STATEMENT: The major barriers for beneficiaries to assistance lies in the fact that each program has different eligibility requirements. Recipients must complete and file multiple applications when it can be done more efficiently through horizontal integration. This means that if a person is eligible for TANF, then they should also be eligible for SNAP, WIC if the child is at the WIC age, Section 8, childcare, school meals and other programs, if otherwise eligible.

Recipient would OPPOSE putting these programs in one pot to be administered by the welfare office or another office that is not in business of running all of these programs. Lumping programs together into one pot would mean beneficiaries would receive benefits, but the outcomes would not yield maximum benefits to the beneficiary as the program has potential to deliver.

CCWRO POSITION – None

CCWRO RECOMMENDATIONS – The Secretaries should review their programs and try to align the eligibility requirements to streamline and *simplify the administration of the program designed for the same beneficiary*. They should report to Congress annually what statutory eligibility requirements impede the simplification of the programs designed to assist low-income persons and families.

SECTION 13. RESEARCH AND EVALUATION – Page 108, Line 12

RECIPIENT IMPACT STATEMENT: There is very little research as to why so many families who live in deep poverty, are able to eat, but are homeless and receive no cash assistance. The barriers to participation in the TANF program should be extensively reviewed to spot barriers to participation similar to the way USDA identified barriers to participation in the SNAP program, unless it is the intent of Congress to enact a program and then erect barriers between the program and its intended beneficiaries. A family eligible for TANF and SNAP should leave the welfare office with both SNAP and TANF, if otherwise eligible.

The barriers to participation in the TANF program should be extensively reviewed to spot barriers to participation similar to the way USDA identified barriers to participation in the SNAP program, unless it is the intent of Congress to enact a program and then erect barriers between the program and its intended beneficiaries.

CCWRO POSITION – Support

CCWRO RECOMMENDATIONS – Research should also identify barriers that families eligible for TANF not receiving TANF benefits.

SECTION 13(h). DEVELOPMENT OF WHAT WORKS CLEARINGHOUSE OF PROVEN AND PROMISING APPROACHES TO MOVE WELFARE RECIPIENTS INTO WORK– Page 111, Line 10

RECIPIENT IMPACT STATEMENT: This section would only look at what works and fails to look on the other side of the coin – *what does not work*. Many TANF state policies, such as full-family sanctions, are financially deadly to poor families. Full family sanctions help states meet their work participation rates by sentencing

families to a lifetime of poverty. If the family is not in the numerator, then they cannot impact the denominator.

CCWRO POSITION – Support

CCWRO RECOMMENDATIONS – Develop best practices for the improvement of the TANF program to benefits the individuals and children. Upon completion, circulate the best practices to the states.

OPEN ISSUE

SECTION 15(b). CHANGE TERMINALOGY FROM FROM VOCATIONAL AND EDUCATION TRAINING TO CAREER AND TECHNICAL EDUCATION TRAINING – Page 117, Line 5

RECIPIENT IMPACT STATEMENT: The constant changing of names of a program is confusing to TANF beneficiaries. Any education or training program is designed for career development. The only reason that TANF recipients would enroll in any educational or training program is to have a career, to become self-sufficient. Welfare moms do not go to college to have fun. They are not invited to parties because they have kids to take care of. Any welfare mom participating in an educational or training, is doing so to achieve self-sufficiency. They are heroes!

CCWRO POSITION – Oppose

CCWRO RECOMMENDATIONS –

RECIPIENT SUGGESTIONS TO MAKE THE PROGRAM FAMILY/CHILD FRIENDLY

Some ideas that the Ways and Means Committee may want to consider are:

1. Provide employment services and supportive services to parents who have timed out.

2. The time limits shall never be applied to children.

3. Any month that the parent works and meets the federal WPRs should not count towards the 60-month time clock.

4. All states shall have a 60-month time clock.

5. Parents who are not being aided should not be in the numerator. Current law requires that the States include parents in the numerator even when they are not being aided and are not provided with any employment services.

TABLE #3

AUXILIARY TABLES*

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Includes charts, graphs and additional history regarding various CDSS local assistance programs.

Public Assistance Programs Average Monthly Grants 1
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Historical CalWORKs and TANF Funding Chart*

	FY 2008-09	FY 2009-10	FY 2010-11	FY 2011-12
Total TANF Grant/Required MOE	**$ 6,583,092,000**	**$ 6,584,132,000**	**$ 6,950,599,000**	**$ 6,580,797,000**
CalWORKs Program[1]	**5,341,526,077**	**5,341,519,431**	**5,576,729,520**	**5,269,004,000**
Grants	3,275,881,220	3,406,732,000	3,674,460,000	3,260,513,000
Administration	579,578,620	590,571,121	619,727,897	652,927,039
Services	829,198,822	798,905,700	784,790,383	826,832,008
Child Care	542,554,111	440,639,196	388,502,665	409,314,953
Substance Abuse/Mental Health Svcs	114,313,304	104,671,414	109,248,575	119,417,000
County Share of Admin/Svcs[2]	27,214,878	8,368,000		
Tribal TANF[3]	71,001,000	69,750,000	69,073,000	73,743,000
Performance Incentives (budgeted)				
Probation				
Student Aid Commission				
KinGAP	**114,052,000**	**107,687,000**	**91,033,000**	**56,454,000**
ARRA Subsidized Employment - ECF		**158,508,000**	**200,348,000**	
ARRA Non-Recurrent Short-Term Benefits ECF		**176,233,000**	**18,775,000**	
Non-MOE/TANF in CDSS	**(196,041,000)**	**(179,056,000)**	**(158,118,000)**	**(163,597,000)**
Additional TANF/MOE Expenditures in CDSS	**271,073,000**	**299,394,000**	**303,620,000**	**291,131,000**
Other MOE Eligible Expenditures	**714,079,000**	**668,044,000**	**641,575,000**	**682,620,000**
State Support	**28,131,000**	**27,687,000**	**29,180,000**	**29,019,000**
Total Expenditures	**6,343,821,077**	**6,892,156,000**	**6,772,215,520**	**6,238,374,000**
Federal TANF	3,560,047,000	4,041,842,000	3,810,007,000	3,391,395,000
General Fund (MOE)[4]	2,715,820,000	2,712,840,000	3,103,684,000	1,689,030,000
Other State Funds (Employment Training Funding)	35,000,000	20,000,000		
County Funds[4]	133,454,000	117,474,000	113,097,000	1,157,949,000
Total TANF transfers	**442,017,000**	**440,818,000**	**440,163,000**	**444,672,000**
Non-CalWORKs Transfers[5]	169,793,000	186,921,000	197,931,808	192,242,450
CalWORKs/Tribal TANF Transfers and Reserves	272,224,000	253,897,000	242,231,192	252,429,550
TANF Grant/Required MOE	6,583,092,000	6,584,132,000	6,950,599,000	6,580,797,000
Prior Year TANF Carry Forward[6]	119,532,000	117,100,000	233,398,000	158,450,000
Excess MOE Needed to Fund Programs				
Single Allocation Reappropriation (AB 1477)				
ARRA - Emergency Contingency Funds	259,212,000	370,195,000	125,626,000	
ARRA - Subsidized Employment		159,386,000	215,348,000	
ARRA - Non-Recurring ECF Un-spent Performance Incentives		176,233,000	27,225,000	
High Performance Bonus				
Total Available Funding	**6,961,836,000**	**7,407,046,000**	**7,552,196,000**	**6,739,247,000**
Total Funding Needed	**6,785,838,077**	**7,332,974,000**	**7,212,378,520**	**6,683,046,000**
NET TANF Carry-Over Funds[6]	75,498,000	74,072,000	91,187,000	56,201,000
CalWORKs Contribution to the Gen-eral	**$ 1,268,997,000**	**$ 1,262,046,000**	**$ 1,234,159,808**	**$ 1,222,447,450**

Please see Notes Associated with the CalWORKs and TANF Funding Chart for additional information.

Historical CalWORKs and TANF Funding Chart*

	FY 2012-13	FY 2013-14	FY 2014-15 Revised Budget	FY 2015-16 Governor's Budget
Total TANF Grant/Required MOE	**$ 6,584,722,000**	**$ 6,575,412,000**	**$ 6,578,959,000**	**$ 6,572,248,000**
CalWORKs Program[1]	**5,076,484,000**	**5,285,017,000**	**5,503,947,000**	**5,607,783,000**
Grants Admin-	3,155,806,000	3,117,515,000	3,200,769,000	3,241,950,000
stration Ser-	643,265,561	746,813,504	779,020,271	801,636,168
vices	819,383,597	931,663,610	1,021,629,035	1,050,754,650
Child Care	330,464,842	362,418,886	375,922,694	386,836,182
Substance Abuse/Mental Health Svcs	127,564,000	126,606,000	126,606,000	126,606,000
County Share of Admin/Svcs[2]				
Tribal TANF[3]	69,045,000	80,168,000	75,945,000	83,951,000
Performance Incentives (budgeted)				
Probation				
Student Aid Commission	803,754,000	541,712,000	377,406,000	286,320,000
KinGAP	**69,044,000**	**73,319,000**	**74,977,000**	**78,523,000**
ARRA Subsidized Employment - ECF				
ARRA Non-Recurrent Short-Term Benefits ECF				
Non-MOE/TANF in CDSS	**(163,874,000)**	**(339,006,000)**	**(599,719,000)**	**(596,209,000)**
Additional TANF/MOE Expenditures in CDSS	**308,402,000**	**311,414,000**	**343,540,000**	**371,502,000**
Other MOE Eligible Expenditures	**522,617,000**	**468,067,000**	**540,382,000**	**561,016,000**
State Support	**29,703,000**	**29,999,000**	**29,900,000**	**29,796,000**
Total Expenditures	**6,715,175,000**	**6,450,690,000**	**6,346,378,000**	**6,422,682,000**
Federal TANF	3,470,035,000	3,389,838,000	3,387,456,000	3,378,309,000
General Fund (MOE)[4]	2,056,417,000	1,653,982,000	1,202,909,000	1,262,417,000
Other State Funds (Employment Training Funding)				
County Funds[4]	1,188,723,000	1,406,870,000	1,756,013,000	1,781,956,000
Total TANF transfers	**440,136,000**	**451,931,000**	**446,794,000**	**454,547,000**
Non-CalWORKs Transfers[5]	192,243,000	192,242,773	192,119,000	192,119,000
CalWORKs/Tribal TANF Transfers and Reserves	247,893,000	259,688,227	254,675,000	262,428,000
TANF Grant/Required MOE	6,584,722,000	6,575,412,000	6,578,959,000	6,572,248,000
Prior Year TANF Carry Forward[6]	245,245,000	107,951,000	199,470,000	99,038,000
Excess MOE Needed to Fund Programs	394,236,000	219,258,000	113,781,000	205,943,000
Single Allocation Reappropriation (AB 1477)	80,000,000			
ARRA - Emergency Contingency Funds				
ARRA - Subsidized Employment				
ARRA - Non-Recurring ECF Un-				
spent Performance Incentives				
High Performance Bonus				
Total Available Funding	**7,304,203,000**	**6,902,621,000**	**6,892,210,000**	**6,877,229,000**
Total Funding Needed	**7,155,311,000**	**6,902,621,000**	**6,793,172,000**	**6,877,229,000**
NET TANF Carry-Over Funds[6]	148,892,000	-	99,038,000	
CalWORKs Contribution to the General Fund[7]	$ 1,896,060,000	$ 1,586,754,773	$ 1,528,424,000	$ 1,489,480,000

California TANF/CalWORKs
Annual Involuntary Contributions to the California State General Fund

State Fiscal Year	Amount of Annual TANF/CalWORKs Involuntary Contribution
FY 98-99	$708,502,000
FY 99-00	$745,249,000
FY 00-01	$1,021,913,000
FY 01-02	$1,126,647,000
FY 02-03	$1,088,940,000
FY 03-04	$1,163,238,000
FY 04-05	$1,087,321,000
FY 05-06	$1,299,448,000
FY 06-07	$1,184,134,000
FY 07-08	$1,745,291,000
FY 08-09	$1,268,997,000
FY 09-10	$1,262,291,000
FY 10-11	$ 1,234,159,808
FY 11-12	$ 1,222,447,450
FY 12-13	$1,896,060,000
FY 13-14	$1,586,754,773
FY 14-15	$1,522,729,000
FY- 15-16	$1,777,001,000
Total TANF Contribution to the California General Fund Since the Repeal of AFDC	$22,941,123,031

TABLE #4

CalWORKs Welfare-to-Work Monthly Activity Report
WTW 25 For May, 2015 - STATEWIDE

PART A. ENROLLMENT DATA		
1.	Enrollees	179,488
2.	Exemptions	84,847
3.	Removed from the Assistance Unit	0
	a. Sanctions	58,810
4.	Entered employment	9,353
5.	Terminations due to employment	4,614
PART B. ACTIVITIES		
6.	Appraisal	11,360
7.	Assessment	5,710
8.	Reappraisal	949
9.	Job search & job readiness assistance	14,231
10.	Unsubsidized employment	64,741
11.	Self-employment	5,143
12.	Subsidized private sector employment	1,776
13.	Subsidized public sector employment	2,442
14.	On-the-job training (OJT)	226
15.	Grant-based on-the-job training (OJT)	1
16.	Work-study	1,955
17.	Supported work or transitional employment	140
18.	Work experience	2,874
19.	Community service	4,914
20.	Job skills training directly related to employment	4,816
21.	Vocational education training	18,714
22.	Education directly related to employment	3,518
23.	Adult basic education	5,953
24.	Satisfactory progress in a secondary school	201
25.	Other activities	6,228
27.	Providing childcare to community services participants	0
27.	Mental health services	6,247
28.	Substance abuse services	1,480
29.	Domestic abuse services	3,259
	a. Granted DV Waiver	2,721
30.	Number of individuals 6-29 (Unduplicated)	122,173
	a. Self-Initiated Education Program	6,883
PART C. NONPARTICIPATION STATUS		
31.	Noncompliance	30,412
32.	Good cause for not participating in WTW	16,562
PART D. SUPPORTIVE SERVICES		
33.	Transportation	67,872
34.	Ancillary services	13,292
35.	Post-employment/Job-retention services	9,119
36.	Post CalWORKs 60-month time limit services	2,876
CCWRO DATA ANALYSIS		
Unduplicated Participants Not Receiving Transportation – 54,301 Persons		44%
Unduplicated Participants Sanctioned		48%
Unduplicated Participants Finding Employment that Terminates TANF		4%

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July 21, 2015

Comments on Committee Discussion Draft on TANF Reauthorization

We thank you for the opportunity to provide comments on the Discussion Draft. The Center on Budget and Policy Priorities is a nonpartisan research and policy institute. We pursue federal and state policies designed to reduce poverty. We have deep expertise in programs and policies that help low-income people, and have worked on TANF issues at the national and federal level since the inception of TANF.

Below we provide comments of two kinds. First, we address three key issues that are either inadequately addressed or problematic in the Discussion Draft: (1) inadequate funding and targeting of existing resources; (2) holding states accountable for program access; and (3) the design of the newly proposed outcome measure. Then we provide comments on specific sections where we think improvements could be made or there appear to be errors in the drafting language.

Additional resources are needed in TANF

A major shortcoming of the draft bill is that it provides no additional funding for TANF even though the block grant has lost 30 percent of its value since its creation. Instead, the bill actually reduces federal funds through the outcome measure penalty and repurposing of the Contingency Fund while at the same time imposing additional reporting requirements on states with no additional funding for those activities. The block grant should be increased to retain its original value, and should be indexed for inflation for future years.

A key flaw of the TANF block grant that is not addressed in the Discussion Draft is that the permissible uses of the funds are so broad that states spread them across many areas of the budget. TANF reauthorization provides a key opportunity to reclaim some of those funds — one that should not be missed. The Discussion Draft notes that agreement was not reached on whether to require states to spend a specific share of their TANF resources on core purposes. As we note in the detailed comments below, we believe such a requirement is essential for improving TANF work programs and participants' employment outcomes; it also provides an opportunity to reclaim some of the TANF funds that have been diverted to other purposes.

Another change to bring more of the federal funds back to core TANF purposes is to stop allowing states to spend funds for uses that are not within the TANF purposes. Under the TANF law,

certain uses that were "authorized under prior law" were grandfathered in as permissible spending despite not falling within the purposes of TANF. Over time, in some states the amount of spending under this basis has ballooned. This practice should be ended.

Hold states accountable for serving families in need

The draft bill adds a new purpose to TANF: reducing poverty. While a laudable goal, TANF cannot reduce poverty if it fails to reach poor families. TANF serves only 26 families for every 100 families in poverty; in a growing number of states, it serves fewer than *10* families for every 100 families in poverty. Nothing in the current TANF law or the Committee Discussion Draft holds states accountable for providing needy families with access to cash assistance or work-related services. We urge that states should be held accountable for their performance here with some type of an access measure that is on par with the other two performance measures of the WPR and employment outcomes. One approach would be to use something like the ratio of the families on TANF to families in poverty.

While the draft bill includes some provisions that will lessen the incentive for states to avoid serving families in need such as eliminating the caseload reduction credit, we are concerned that the effectively higher work participation rates as well as the new outcome measure could provide new incentives for states to exclude families that are not likely to boost state performance on those measures. For example, states may increase barriers to getting on assistance in the first instance since they will be held to employment outcomes for all of the families that receive assistance.

To fulfill the Committee's intent of making TANF as a more effective vehicle for reducing poverty, it is important that states not be permitted to mandate onerous upfront work requirements that exclude from TANF the very families that need the most assistance. To end this practice, we recommend that states be required to complete an assessment and individual opportunity plan *before* they can require families to participate in work activities.

Hold states accountable for realistic and meaningful outcome measures for TANF leavers

Outcome measures can provide important information on how TANF recipients fare over time, but there are some complicated design issues. Given that most states do not collect this type of information now, we believe it is important to consider all of the design issues carefully, to talk with states about their concerns and to build in time to allow states to gather the information they will need to set realistic targets.

We oppose the proposed penalty structure from the Discussion Draft and suggest an alternate approach. We generally have not included detailed comments on drafting here; while we have many concerns about the proposal as drafted, we anticipate that there will be significant changes and therefore are focusing our comments here on the substantive issues that the proposal raises.

Revising proposed outcome measures

The draft legislation includes three outcome measures for TANF leavers: (1) employment two quarters after exit; (2) employment four quarters after exit; (3) change in median income between the second and fourth quarters. These measures are intended to measure employment, retention and advancement. We suggest dropping one and modifying one, per our discussion below.

Employment two quarters after exit. This measure will provide information on the share of recipients who leave TANF who are employed two quarters after exit. It is the same measure that WIOA will use and is a reasonable way to measure employment among TANF leavers. We agree with using this measure.

Employment four quarters after exit. This measure is intended to provide information on employment retention but it is a weak measure of retention. A true measure of retention would look at employment in the fourth quarter *for individuals employed in the second quarter* after exit. The measure in the Discussion Draft would provide information on how the share of leavers who are employed changes over time, but not on whether recipients who were employed in the second quarter remain employed in the fourth quarter. Since it does not provide a good measure of retention and it creates an additional two-quarter time lag, we recommend dropping it from the outcome measures.

Change in median earnings. For the same reason that measuring employment in the fourth quarter does not measure job retention, the change in median earnings does not measure wage progression. Gathering information on median earnings will, however, provide useful information on the earnings of TANF leavers. We recommend measuring median earnings only in the second quarter; this is the same as the WIOA measure.

One option for getting a better understanding of job retention and advancement among TANF leavers would be to require HHS to conduct an in-depth study of employment and earnings over an extended period among TANF leavers. If such as study is undertaken, we would recommend that it be conducted in several states using the same methodology.

Gathering data and timing for establishing state-specific outcome goals

Very few states currently gather data on employment outcomes or earnings for TANF leavers so there is no baseline information available for states to use to set goals for which they will be held accountable. Shortly after welfare reform was implemented a number of states conducted studies of TANF leavers but those studies are outdated and are not comparable to one another. In order for states to develop meaningful outcome measures for which they will be held accountable we recommend that the first year after enactment be designated as a baseline measurement year. States would be required to report on outcomes for TANF leavers and the data would be used to establish benchmarks and negotiate outcome goals, but states would not be required to meet any specific performance standards. We also suggest that bill language explicitly state that factors to be considered in negotiation of goals include economic conditions, characteristics of recipients, and the extent to which needy families are served in the state's TANF program.

As currently written, the draft legislation does not build in any lag time for states to receive and process employment outcome data. The time it takes to obtain employment data varies by state, but we expect most states will receive employment data about two quarters after the exit quarter. This

means that there will be roughly a one-year lag between the exit month and when a state is able to obtain employment data for the second quarter after exit and it would take another two quarters to receive the fourth quarter employment data if that measure is kept. Assuming a FY 2016 start date, states would not have second quarter employment and earnings data for all families that exit in that year until the last quarter of FY 2017. HHS will then need time during FY 2018 to process the data and negotiate outcome goals with states. This suggests that the first year states could be held accountable for employment and earnings outcomes is FY 2019 (for those families that left TANF in FY 2016).

Changing penalty structure for outcome measures

We oppose the penalty structure included in the Discussion Draft – both because it effectively reduces the block grant whose value has already eroded by 30 percent and because it does not encourage states to take concrete steps to improve their performance. The legislation proposes to hold back a portion of the block grant and require that states earn it back by meeting the outcome measure goals. The portion held back is 4 percent for 2018 and 10 percent in 2019 and 2020. (It is not clear how the sequencing works and whether this is a drafting, timing or concept issue but it seems that the funds will be held back before the state can establish whether it has met the targets.) States that fail to meet their negotiated targets would have an opportunity to re-earn the withheld funds if they meet their targets in the subsequent year. The concept, sequence or time lags necessarily involved make this approach extremely problematic; it will not provide states with enough time to allocate additional state funds to make up for the withheld funds.

Moreover, reducing the federal block grant funds that states will have to work with will impede rather than further improving work programs and employment outcomes. There is no new funding provided in the bill, but there are numerous increased obligations on states. We propose an alternate penalty approach that focuses on program improvement and increased investment in work programs. Following the WIOA structure, if states fail to meet their negotiated outcomes, they would first be required to develop a program improvement plan with technical assistance from HHS. If their performance does not improve, in the next year they would be required to increase spending on work programs by a specified share of their block grant (e.g., five percent) until they reach a specified share of spending on work activities. Under our alternate approach, states that do not achieve the outcome targets would not lose federal funds, and much of the current proposed legislative language would no longer apply. Instead, states would lose some flexibility on how to spend their federal funds, with a directive that a portion of the federal funds must be spent on work programs.

Which TANF leavers should outcome measures apply to?

We agree with the approach of the Discussion Draft that employment and earnings outcomes should be tracked for all adult TANF recipients who were required to engage in work activities while they were on TANF. (The drafting could be improved here to clarify that the adult received assistance and was considered a work-eligible individual for the WPR purposes.) We believe it is important to pick up all such TANF leavers. Families leave TANF for a host of reasons – increased earnings, being sanctioned for non-participation, reaching a time limit, getting married, qualifying for disability benefits, no longer having an eligible child, etc.. Some families may leave without ever

participating in a work program while others may have participated for an extended period. If the goal is to hold states accountable for increasing engagement in work activities, connecting parents to work and reducing poverty, it is import to have information on all leavers' employment status and earnings. If some groups of leavers are excluded from outcome measures (for example, those who leave due to sanctions or time limits), we will have an incomplete picture of how TANF recipients are faring. Policies such as time limits and sanctions have been billed as tools to promote work so there is no policy reason to exclude these individuals from an analysis of employment and earnings among TANF leavers.

Comments by section

Section 5, p. 5-7, Individual Opportunity Plan
We support the Discussion Draft's increasing obligations on states to conduct assessments and adding detail to the re-named IOP. There are several other places in these comments where we refer back to things that might be integrated with or clarified in the IOP section.

Section 6(b), Page 8-10 – Counting Work Participation of Individuals receiving Atypical Benefit Payments
While we understand the goals of this provision, the conception and application seems complicated and states with similar programs could fall on different sides of the criteria laid out here. Some states have different eligibility policies for some groups of recipients than others, including time-limited disregards of earnings or requiring participation in work activities as a condition of eligibility after a period of TANF receipt. It is important to ensure that these programs (which have been designed to achieve specific policy goals) are not impacted by this provision.

Section 6(c)(2), Page 11, line 3 – Partial credit.
We support allowing partial credit and this uniform half credit if half of the hours are met approach is a reasonable way to do this. As drafted, language does not extend this provision to MOE.
After "part," insert "or any other State program funded with qualified State expenditures (as defined in section 409(a)(7)(B)(i))"

Section 6(c)(3), Page 12, line 13 – Alternative work participation calculation
As drafted, language does not extend this provision to MOE.
After "part," insert "or any other State program funded with qualified State expenditures (as defined in section 409(a)(7)(B)(i))"

Section 6(c)(4), p. 13, line 15 – Counting job search as work
We agree with the intent of allowing 3 months of stand-alone participation in job search count toward all hours of the work rate, and outside of that 3-month window, allowing participation in job search to only count for up to half of the hours of engagement. However, we suggest some changes to the drafting. Job search might be combined with another activity either before or after a period of stand-alone job search and a state should be able to get credit for these partial job search hours (for up to half of the hours of engagement) either way. As drafted, the language suggests a rigid sequence of full-time job search first followed by partial job search; that may not always be the best approach. Similarly, the language should clarify that the 3-month clock runs only if all of the hours of participation are in job search.

Suggest revisions, p. 13, lines 8-19 as follows (shown with underscore and strike-thorough):
"(A) COUNTING OF JOB SEARCH AS WORK.—~~After the p~~Participation of an individual in an activity described in subsection (d)(6) of this section of a State program funded under this part or any other State program funded with qualified State expenditures (as defined in section 409(a)(7)(B)(i)) may count as all hours of participation in a work activity ~~has been counted~~ for 3 months~~, as participation in a work activity~~. For any other months, participation by the individual in such an activity shall count towards not more than half of the hours of participation in work activities by the individual."

Section 6(c)(6), Page 14, line 8-11 – *Open question: whether to adjust current 30 percent cap on those who can participate in education*
We urge that the current cap on when participation in education can count toward the WPR be lifted. Retaining it contradicts other changes in the bill, such as expanding access to education and training activities, simplifying the tracking of work activities, and adding a new TANF program goal of reducing poverty.

Section 6(c)(6), Page 14-15 – Job readiness activities
Suggest adding a new subsection here that deems participation in activities set forth in the IOP to be engaged in work without regard to the number of hours of participation. For individuals with disabilities or other barriers, an appropriate IOP may might have fewer than 20 or 30 hours of participation. So longs as the individual complies with what is included in the plan, this should be considered engaged in work (similar to satisfactory secondary school attendance).

Section 6(c)(10), Page 15, line 23-4 – *Open issue – how to verify participation in activities*
As several witnesses have noted in the TANF hearings this year, verification of hours of participation consumes substantial staff time and fundamentally alters the relationship between case managers and recipients. Instead of providing the support that recipients need to succeed in implementing their plan, case managers spend more than half of their time tracking down documentation to verify every hour of participation. With the elimination of the caseload reduction credit, almost every state will be required to do more to achieve a 50 percent work participation rate – and they will be required to do so with no additional money. One way to free up staff time to engage more families in work activities is to reduce the time that staff currently spend verifying participation.

In order to maximize the time staff can spend working with recipients to help them develop and execute the Individual Opportunity Plans included in the draft legislation, we recommend that Congress require HHS to promulgate regulations that simplify current verification requirements and reduce the staff burden for gathering documentation. As an example, instead of requiring states to gather documentation for classroom and homework hours for students in a postsecondary education program, they could be required to verify full-time enrollment in good standing at regular intervals (e.g., every three months). There are some activities, such as work experience, where collecting time sheets to document hours of participation may still be appropriate. HHS should be required to consider each type of activity separately and to develop standards that take into account the nature of the activity and how it might vary from one locale to the next.

We also suggest that language be added or strengthened in Section 5 on the IOP be to make it clear that the plan should include a list of the activities the recipient will be required to engage in to meet their required hours of participation.

Section 6(c) – add a provision to include persons in subsidized employment in WPR
The WPR improvements should also include a provision to allow subsidized job participants to count in the Work Participation Rate. States should be allowed to count persons receiving TANF or MOE-funded subsidized employment in the work rate even if they are not otherwise receiving "assistance." Since job subsidies are defined as non-assistance, states get no WPR credit now unless the family is otherwise receiving assistance, such as a reduced cash assistance benefit. Language that would accomplish this has already been included at Sec. 110(b) in H.R. 3005 introduced by Rep. Danny Davis and could be incorporated here.

Section 6(d), p. 16 – Penalty for failing to meet WPR
We support this change in penalty approach. We are concerned that the references to "the succeeding fiscal year" and "preceding fiscal year" may not match the reality that the reporting and analyzing of the data are not instantaneous and can involve a multi-year lag time between the year for which the work participation rate is measured and the time that HHS notifies a state that it has failed to meet the minimum rate thus triggering penalty consequences. Moreover, if a state appeals a determination that it has failed the rate or seeks other penalty relief or enters into corrective compliance as available under the law, the time at which the obligation to pay the penalty (or, in this case, increase the MOE) does not arise until after these processes are completed. It would be best to ensure that the references to the fiscal year do not result in triggering an increased MOE obligation for a year that is prior to the time at which HHS notifies a state that it has failed to meet the work rate or at which a penalty would otherwise be due.

Section 6(e), p. 17 – Report on state engagement of recipients not working in unsubsidized employment.
This report largely duplicates the type of information that states already report as part of the data reporting requirements, so it is largely unnecessary. And, because it may not exactly match the current reporting requirements, this additional report would become an additional burden. It will not exactly match because the work participation data reporting applies to "work eligible individuals" as defined by HHS rules pursuant to directives from Congress in the Deficit Reduction Act of 2005. The language in the proposed provision refers to adults and minor child head of household who "received" assistance. Work-eligible individuals include parents in the household who do not receive assistance, such as persons who are excluded due to a sanction, an adult-only time limits, or other disqualifying penalty. This report would therefore require to largely overlapping but technically different sets of data to be reported. Moreover, the time frames in the proposed language are not reasonable, requiring an apparently instantaneous report at the end of the fiscal year on which the state is reporting. Given all of the additional things that will be required of states under this bill with no new resources, adding a redundant report should be dropped from the bill.

Section 6(f), p. 19 – Adding new goal of poverty reduction
We support the addition of this new goal, but note that it refers to reducing poverty rather than specifically focusing on reducing child poverty. Under the TANF block grant, the wording of the goals shapes how the funds can be spent. We are concerned that this new goal, without adding the

focus on reducing child poverty, could further expand ways that TANF funds could be spent without regard to whether there is a family with a child.
Page 19, line 21, after "reduce," insert "child"

Section 6(h), p. 20 – *Open issue for individuals convicted of drug-related crimes*
We urge the Committee to use this opportunity to entirely repeal the ban on TANF (and SNAP) receipt by individuals who have been convicted of drug-related crimes. Over the years, a number of states have opted out, or partially opted out of this ban for their TANF programs because of the unfair treatment of those who have already paid their debt to society, and because it treats those with drug-related convictions more harshly than those with convictions for rape or murder. Most recently, Alabama opted out as part of a criminal justice reform bill. Full repeal of this ban would be the simplest and cleanest way to do this. However, if the Committee does not fully repeal the ban, but instead, narrows it, drafting and design is important so that states that previously have fully or partly opted out are not required to go through that process again (that is, so this does not create a step backwards for many states.) While we urge full rather than partial repeal, language in the REDEEM Act pending in Congress is a model for partial repeal without adversely affecting states that have already acted in this area.

Section 8 (a), p. 28-9. No counting of third-party spending as MOE
We support this change, and allowing a phase-in period, but suggest that the language "goods and services" is more narrow than the scope of what can count as third-party MOE under the current federal rules at 45 CFR 263.2(e) and the 2004 policy guidance that authorized third-party MOE. Suggest broadening to match the scope of the HHS language.
P. 28, line 1-2, after "all," strike "goods and services" and insert "expenditures for benefits or services including cash donations and in-kind contributions"
P. 28, line 8, after "such, strike "goods and services" and insert "expenditures for benefits or services including cash donations and in-kind contributions"

Section 8(e), p. 32 – Open Issue on whether to create a floor on share of spending on core activities
We urge the Committee to require a floor, such as 50 percent, on TANF and MOE spending on the core activities of work, child care and basic assistance. The Discussion Draft adds a number of new obligations on states – mandating assessments and IOPs, engaging a larger share of recipients in work activities, adding new outcome measure and reporting requirements. Yet it adds no new resources; indeed, repurposing of the Contingency Fund and reduction of the block grants under the proposed outcome measure will mean fewer resources. If states are to step up their work program performance, they will need to invest more resources in work activities and work supports such as child care and transportation. If states are to further the new goal of poverty reduction, families must have access to benefits and services to improve their employment prospects and family outcomes. While some most states already spend over 50 percent of state and federal TANF funds on these core services, nearly half of states do not. And the states that have used block grant funds in other areas of the state budget will not be able to pull the funds back to welfare reform core purposes absent a mandate such as a minimum floor.

Section 9, p. 35-37. Elimination of marriage penalty.
We support eliminating the separate two-parent work participation rate and hourly requirement. We also suggest additional provisions to lift the marriage penalty that a number of states continue to impose under TANF. A number of states have carried over "deprivation" requirements from the former AFDC program, even though they have flexibility to drop such provisions under TANF. Specifically, some states have continued the work history test, or the "working less than 100 hours" rule, that applied under AFDC as an element of demonstrating that a child in a two-parent family was deprived of parental support due to the unemployment of a parent. If marriage penalties are truly to be eliminated, states should be prohibited from applying additional eligibility requirements, such as these deprivation policies, to two-parent families. Instead, states should be required to serve two-parent families under the same policies that apply to single-parent families.

Section 10, p. 40, Subsidized employment demonstration projects
We recommend that the restriction that federal funds cannot exceed 50 percent of the wages received by a recipient during the period be removed. There is no evidence to suggest that this restriction will produce better impacts than other models. In addition, we are concerned that this restriction may discourage states from developing subsidized employment programs for individuals with the most significant employment barriers where larger subsidies may need to be provided to get employers to hire the program participants. When the TANF Emergency Funds were available, states experimented with a number of different approaches to providing wage subsidies and different approaches are now being tested through two different demonstration projects. Until we have evidence of the most effective models of subsidized employment, we believe states should be able to decide how to structure their programs, including how much of the wages should be paid over the course of a year.

Section 16, p. 117 – Effective Date
We think there is a mistake in the reference for one of the exceptions to the overall effective date. We believe that instead of 5(l), the intended section for the exception was likely 6(i) which has a separate effective date, and accelerated effective date option, for the work participation rate changes.

Other issues

Strengthen the Family Violence Option and Integrate with the New Assessment and IOP Provisions

There has long been a disconnect between the FVO provisions and other federal requirements including the work requirements. This reauthorization of TANF and the beefed up assessment and IOP provisions represent an opportunity to integrate the Family Violence Option service plans and waivers with the new IOP and work participation rate calculation. Under the current law and rules, a state that has chosen the FVO must screen and identify domestic violence victims and refer to appropriate services. Any federally-recognized FVO waivers must be part of an individualized services plan and must include employment goals, consistent with protections for the victim of domestic violence. Under the TANF rules at 45 CFR 260.50 et seq., a FVO waiver from a state's work requirements is only granted if it would be more difficult for an individual to except domestic violence or if it unfairly penalizes such individuals. Otherwise, the FVO plan must be designed to lead to work. The FVO must be reviewed every six months.

Some FVO waivers and plan might include modified or more flexible work activities and some may provide an exemption from any work participation for a period of time. Under current law and rules, the work participation rate is calculated without making any allowance for modified work requirements as part of a FVO service plan, or for a waiver from work requirements. An FVO waiver, while requiring extensive development and documentation, does not remove that individual from the work rate calculation. (Waivers could come into play only with respect to WPR penalty relief after a state has failed the work rate.) And under current law, there is no flexibility for barrier removal activities, or modified hours, but that could change with the new job readiness component.

We suggest directly incorporating the FVO into the new IOP and work rate calculation. The FVO service plan and activity modifications should be part of the IOP. When the FVO waiver includes an exemption from work participation, the adult should be excluded from the work rate. And when, the FVO waiver and service plan includes modified activities or hours, compliance with the plan should be deemed as engaged in work for WPR purposes, subject to six-month (or three) reviews. Both of these options would give states incentives to better utilize the federal FVO evaluation and review provisions.

Penalties for not meeting the Work Participation Rate in recent years

The Discussion Draft does not address what happens to penalties that are in the pipeline for the WPR for years since 2007. Some states are in various stages of penalty relief requests or corrective compliance plans, and the work rates that states have achieved for years after 2012 have not yet been finalized. We suggest that Congress let states start fresh here with a clean slate under the new rules; any penalties for WPR failures from 2007-2015 should be waived.

While the Discussion Draft broadens what can count toward the work rate and redesigns the penalty structure prospectively, it also makes the work rates harder to meet by eliminating the caseload reduction credit and certain worker supplement approaches. It would be unreasonable to require states to achieve corrective compliance under these new rules and yet be subject to the old penalty structure of block grant reductions. And with no new resources, and many new obligations, states should focus on moving forward, not spending time, energy and resources to address past failures under old requirements that Congress has agreed should be changed.



July 17, 2015

Elizabeth Lower-Basch,
Director of Income and Work Supports, Center for Law and Social Policy

Comments on Discussion Draft of TANF Reauthorization Bill
Subcommittee on Human Resources, Committee on Ways and Means
U.S. House of Representatives

Thank you for the opportunity to share the Center for Law and Social Policy's (CLASP's) views on the subcommittee's discussion draft bill to reauthorize the Temporary Assistance for Needy Families (TANF) program for fiscal years (FYs) 2016-2020. CLASP advocates for public policies that reduce poverty, improve the lives of poor people, and create ladders to economic security for all, regardless of race, gender or geography. We have extensive experience working on income and work support programs at both the federal and state levels.

In this response, we build upon the testimony for the record we submitted for the April 30, 2015 hearing on improving TANF, as well as previous recommendations regarding TANF reauthorization. In our testimony, we emphasized that TANF has a dual mission:

- To alleviate poverty and prevent material hardship among children and families, especially those who are particularly vulnerable due to circumstances such as disability, domestic violence, or homelessness; and
- To create effective pathways to economic security, including access to quality education and training programs and individualized services for those with barriers to employment.

In these comments, we assess the discussion draft bill primarily by whether it would make states more or less likely to accomplish these goals with their TANF programs. We will provide additional technical comments directly to the subcommittee staff. In our previous testimony, we identified two primary reasons why TANF has not been effective: (1) the block grant funding structure of TANF means less money in real terms has been available for income support and work programs, and (2) the Work Participation Rate (WPR), which has been the primary performance measure for TANF, does not provide states an incentive to operate effective programs, particularly for the most disadvantaged workers with children.

Overall, the discussion draft takes significant steps forward in improving the WPR to give states credit for the range of activities that would support TANF recipients in obtaining and succeeding in employment. In particular, the bill would give states greater flexibility to serve individuals with barriers to employment and other disabilities, and would recognize the realities of today's labor market in counting more education and training activities toward the rate. This section

includes many recommendations we have previously made, and we strongly applaud the changes to the WPR.

However, the draft does not partner this new flexibility with additional federal resources to expand services. Because providing appropriate services for highly needy individuals with major barriers to work is expensive, the experience in other workforce programs, as well as TANF, is that without clearly targeted resources and carefully designed incentives, employment measures can have the unintended consequence of encouraging "creaming" – failing to serve the most vulnerable families. This is particularly worrisome in TANF, where some states have a history of such exclusion, yet where excluding the neediest families directly contradicts the core anti-poverty purpose. Moreover, in addition to the lack of resources, the elimination of some tools that states have previously used to meet the WPR may make it challenging for some states to meet the rate. We remain concerned that states failing to meet the new rate may respond by restricting access to cash assistance for the most vulnerable families, rather than by expanding services. We therefore provide some recommendations for how to build on the discussion draft to strengthen both parts of TANF's dual mission.

Goals of TANF

For the first time, the draft discussion bill explicitly adds poverty reduction as a goal of TANF, although only through the mechanism of employment. This is an important step towards signaling the centrality of poverty reduction to TANF. However, without incentives to ensure that states provide a meaningful safety net to poor families with children, this addition is largely symbolic. As discussed more in the performance measurement section, we would support including measures to ensure states do not respond to budgetary and performance measurement pressures by denying assistance to poor families.

One example of such a measure is the TANF/poverty ratio. The Center on Budget and Policy Priorities has calculated that in 2013, for every 100 poor families with children in the U.S. only 26 received TANF assistance, down from 68 when TANF was created.[1] In 9 states, less than 10 families receive TANF for every 100 poor families with children.[2] Moreover, the families that do receive assistance remain deeply poor due to inadequate benefit levels. In 2014, for a family of three with no other income, every state's TANF benefits were an amount that totaled less than 50 percent of the poverty line. In 34 states, such a family would qualify for benefits worth less than 30 percent of the poverty line[3].

Block grant structure

The bill makes minimal changes to the block grant structure and federal funding. It does not adjust the overall block grant, which has declined by 32 percent due to inflation since 1996, and has also not been adjusted for population growth. It also does not restore the supplemental grants (provided until FY 2012) for 17 states that were disadvantaged by the original funding formula. Overall, we are concerned that the declining block grant funding combined with higher expectations for services for those who receive assistance will lead states to further restrict access for families.

Moreover, the bill eliminates the contingency fund and redirects the resources for targeted grants, leaving no source of resources to respond to economic downturns. The recent recession vividly demonstrated the challenges of a block grant structure. TANF generally failed to respond to spiking unemployment, suggesting the need for **more** resources, not fewer. Because the proposal eliminates the contingency fund without replacing its role, there will be no aspect of TANF funding designed to respond to greater economic need. While we see the proposed discretionary grants as generally positive, they should not trade off against the core need for a funding strategy that can respond to economic distress, whether state-specific or national.

We strongly urge the Committee to increase the block grant by at least $5 billion to bring the grant up to the real value it had in 1996, and to include an inflation adjustment going forward. In addition, we urge funding for a new contingency fund that could be used for cash assistance or subsidized employment in times of economic downturn.

Uses of Funds

In addition to the declining real value of the federal block grant, one of the major reasons why TANF spending on core services, including cash assistance, work programs, and child care, has been limited is that the great flexibility of the TANF block grant, and the required state spending under the maintenance of effort (MOE) requirement, means these activities must compete against a wide range of other services. Under current law, states have full flexibility to define a "needy" family, and some have set income standards for some TANF- or MOE-funded services at significantly higher levels. The draft discussion bill limits TANF and MOE expenditures to families with incomes under 200% of the poverty line at the time of application for assistance in order to direct services to low-income families. While we are generally supportive of this provision as it applies to services and benefits provided directly from TANF, we would recommend clarifying that the provision does not apply to transfers to the Child Care and Development Block Grant (CCDBG). As states seek to manage CCDBG funds to ensure smooth access to and transition out of CCDBG (with no "cliff" effect) and to implement the new CCDBG reauthorization with its goals of quality and access for working families, having separate requirements from TANF will make it harder to create a successful unified system. We are also interested in learning from states whether there are other services where this limit would have unanticipated ill effects. (We make further comments related to this issue in the section on program alignment at the end of the testimony.).

The discussion draft bill also includes a placeholder for an unresolved issue of whether to set a floor and require states to spend a minimum amount of their TANF/MOE funds on core activities including cash assistance, work activities, and child care. At the hearing, a minimum level of 50 percent was suggested. We strongly support limiting state legislatures' ability to divert TANF funding from these core purposes, while recognizing that such a requirement might need to be phased in over time, as nearly half of the states currently fall below that proposed floor. Since states currently spend on average just 6 percent of their combined TANF/MOE funds on cash assistance, 8 percent on work activities, and 16 percent on child care[4], a 50 percent floor would both help remove the incentive for states to limit access to cash assistance and increase the available resources for workforce training and child care, enabling states to meet the new

performance goals. In addition, we would recommend all additional MOE funds that states are required to expend as part of a penalty should be limited to these core areas.

One new use of funds that would be allowable under the bill is transfers to Title IV-B, which funds child welfare services. While we strongly support adequate funding for child welfare activities, adding them to TANF as an allowable use of funds is likely to put additional pressure on the block grant; therefore we cannot recommend this provision.

Finally, another approach the Committee could consider as part of targeting state funds more effectively to the core activities is narrowing the provision in current law that allows spending on activities authorized by state AFDC and Emergency Assistance plans prior to the 1996 TANF legislation. After almost 20 years, this would be an opportune time to reassess the rationale for grandfathering prior uses.

MOE Requirement

The discussion draft bill attempts to strengthen the MOE requirement to ensure continued state investment in the purposes of TANF by preventing states from claiming third party (non-governmental expenditures) as MOE, with this limitation phased in over several years. This practice allows states to meet the MOE requirement without actually spending state or local dollars on needy families, and therefore we support this change. At the same time, it is worth noting that the elimination of the contingency fund takes away the incentive many states had to spend at higher levels of MOE (in order to access the contingency fund, states had to spend at the 100 percent MOE level, rather than 75 percent or 80 percent). We do not know whether, on net, these provisions will result in any increase in state MOE spending when implemented.

Work participation rate improvements

We applaud provisions in the draft bill to more effectively support work by lifting restrictions that limit states' ability to receive credit towards the WPR for engaging TANF recipients in meaningful work-related activities. CLASP has called for these changes for many years and enthusiastically supports them. These changes bring the TANF statute into far closer alignment with the evidence around effective workforce development activities, and with the key elements of the recent bipartisan workforce reauthorization, the Workforce Innovation and Opportunity Act (WIOA).

One set of changes would make it easier for states to provide individualized services for individuals with barriers to employment, including disabilities. The bill would allow job readiness activities to count as work-related activities, as long as they were determined appropriate as part of the new Individual Opportunity Plans. While the bill does not offer a definition for job readiness, this would presumably allow for the counting of activities such as mental health services or safe housing for an individual experiencing domestic violence, as well as activities in service plans mandated under transitional housing, child welfare, or justice systems. This would be an important improvement over current law, under which barrier-removal activities such as mental health services and substance abuse treatment are only countable toward the work participation rate as part of "job search/job readiness" and therefore

only countable for a few weeks per year. A significant share of TANF recipients experience such conditions, and these individuals are particularly poorly served by the "one-size-fits-all" approach many states have adopted in response to the WPR restrictions.[5] In addition, states could get half credit for individuals participating at least half of the required hours, and possibly get full partial credit if their tracking systems are up to standard.

Several changes would expand states' ability to receive credit for engaging recipients in education and training activities – all of which are consistent with the most up-to-date evidence about what works, as well as with the bipartisan WIOA reauthorization. These include: removing the distinction between "core and non-core" activities—which would allow increased counting of job skills training and education related to employment—and allowing vocational education to be counted for up to 24 months, rather than the 12 months currently countable. The bill would also expand the provision allowing teen parents to meet the work requirements through high school attendance, or the equivalent, or education related to employment to young adults through age 25. This is critical because having a high school diploma or its equivalent is strongly linked to employment and is a prerequisite to postsecondary education. Postsecondary credentials open doors to good jobs and wages, and available data clearly demonstrates significantly lower annual wages for adult full-time workers with a high school diploma or less. These changes increase the likelihood that states will allow welfare recipients to participate in education and training programs that will help them to permanently escape poverty.

The draft raises the question of whether to lift the cap on the share of recipients who can be counted as participating based on vocational education and high school attendance. We urge Congress to do so, because otherwise states may feel compelled to keep restrictions. The Congressional Research Service (CRS) has estimated that 32.2 percent of work-eligible individuals in TANF are 24 and under.[6]

Finally, the bill would allow job search to count for up to half the required hours of participation without time limit (and for three months as a stand-alone activity). While it is not productive to send people to full-time job search over and over,[7] it makes sense for states to receive credit for clients who combine job search with part-time work or training.

The discussion draft also eliminates the separate and higher work participation rate for two-parent families. This rate was so unachievable that 25 states and the District of Columbia have opted not to provide any assistance to two-parent families through TANF.[8] We strongly support this provision, which contributes to family stability and reduces the marriage penalty.

Taking advantage of the increased flexibility to implement high-quality training and job readiness activities will require more resources than most states currently spend on work activities. While some resources may be available from non-TANF sources, it is important to recognize that those funding streams (such as WIOA) have also frequently been capped or reduced over the last decade. Therefore, states must be both enabled and encouraged to spend more of their TANF and MOE funds on work-related services.

One way to do this would be to simplify the tracking and verification of hours of participation, which is left as an open question in the discussion draft. It is essential that this change be

included, particularly because monitoring and tracking participation consumes a great deal of state resources. As mentioned in the hearing, one study of employment counselors in Minnesota found that they spent 53 percent of their TANF time on documentation activities such as verifying, collecting, and reporting information for WPRs, and 47 percent on direct service activities such as creating employment plans, identifying barriers to work, and assisting with job search.[9] Given the lack of additional funds, if Congress expects states to take seriously the new expectations in the bill regarding assessment and case management, states must be able to spend less time documenting participation and more time helping participants succeed. Both caseworkers and participants would welcome the reduced burden of documentation.

Another important and welcome change to the WPR is the replacement of the current penalty structure—which takes federal funds away from states that fail to meet the target rates—with a revised penalty requiring states that fail the rates to invest more of their own funds through an increased MOE requirement. As noted before, states should be required to invest these additional funds in cash assistance, work services, or child care.

State Incentives and Penalties

At the same time the bill broadens in a very positive way the activities that can be included as work participation, it also includes provisions that will make it significantly harder for states to meet the work participation rate. While we support some of the provisions individually, we are concerned that without additional resources or incentives to serve needy people, an unintended consequence will be that states exclude more families from TANF. We have some suggestions here and would be pleased to discuss more options with the Committee.

Specifically, the bill would eliminate the caseload reduction credit (CRC), which lowers the target rate states must achieve. This is a major change. In FY 2012, the most recent year for which WPR data are available, only 11 states would have met the WPR without the benefit of the CRC. Thirteen states would have fallen 20 points or more short of their target rate.[10]

CLASP has long had concerns about the CRC and the incentives it provides to reduce cash assistance caseloads, regardless of need. Under none of the stated goals of TANF is it plausible to consider someone a success who leaves assistance without any source of income, yet states receive as much credit toward the WPR for someone who is sanctioned off or reaches the time limit without work as for someone who earns enough to no longer need assistance. However, we are concerned states may respond to the loss of the CRC in undesirable ways, given that this change is not paired with additional funding or minimum expectations for serving needy families.

In addition, the bill requires HHS to determine how to exclude from WPR calculations the people who receive assistance under programs that provide a minimal benefit under different rules "solely or primarily" created to boost state's WPR. In 2010, the Government Accountability Office reported that 23 states were operating worker supplement programs,[11] although it is not clear that all of them would be affected by the language in the bill. It is important to recognize that states may operate cash assistance under different rules for purposes other than the WPR, such as to serve caregiver relatives caring for children who would otherwise

be in foster care, or to assist newly employed workers with the additional costs incurred by going to work. Congress should be careful not to unduly restrict such efforts.

As noted earlier, even with the expanded activities allowable under the discussion bill, it is likely to remain easier and cheaper for a state to improve its WPR by serving fewer families who need assistance than to raise the WPR by running a more effective program. The cost of providing high-quality assessments, case management, and appropriate activities has often discouraged states from providing appropriate services to low-income families with significant barriers to employment. Simple math shows it is far cheaper to create procedures that make it hard for the most disadvantaged families to get help in the first place, to exempt them from participation requirements, or simply to allow them to be sanctioned off the rolls than it is to provide intensive services. Therefore, we recommend these provisions that raise the target rate states must achieve be phased in over a few years, giving states an opportunity to revamp their services. In addition, as discussed below, we believe performance measures should include indicators of access to cash assistance as well as indicators of states' effectiveness in serving those who receive such assistance.

There is increasing consensus that the effectiveness of public programs should be measured, as much as possible, by their effects on outcomes for the populations they are designed to serve. CLASP has long argued Congress should replace the WPR with outcome-based performance measures that will help foster and improve the effectiveness of these programs. At the same time we have urged proceeding carefully and thoughtfully, lest we replace the WPR with outcome measures that also have perverse consequences, including discouraging states from providing TANF assistance to families where the parents face barriers to employment.

The draft bill creates new performance measures, based on employment of welfare leavers in the 2nd and 4th quarters. Starting in 2018, a portion of the states' block grants would be withheld and could only be earned back by achieving target goals in these measures. The penalties for not meeting targets in the draft are draconian compared to other federal education and workforce programs with measures, targets, and sanctions. For example, under WIOA, the penalty for not meeting performance goals is 5 percent of the Governor's set-aside, which is a small percentage of the total WIOA funding.

Such high-stakes performance measures, particularly using indicators that have not previously been collected and benchmarked, create large incentives for "creaming" (e.g., denying service to harder-to-serve populations) and other ways of manipulating measures in ways that are unrelated to actual performance. Evaluations of programs for the most disadvantaged participants confirm that programs with proven impacts are likely to have outcomes that appear disappointing when compared to programs serving people with recent work history. For example, MDRC evaluated New York City's Personal Roads to Individual Development and Employment (PRIDE) program, an initiative that provided specialized work experience and job search services to individuals who had previously been exempted from work requirements due to disability, but who did not qualify for federal disability benefits. This program increased employment rates by more than 25 percent compared to a control group – but only a third of the recipients assigned to PRIDE ever worked in formal jobs during the two years after assignment, and only 3 percent

worked every quarter of those two years.[12] Therefore, a program that includes such individuals will achieve much lower outcomes than one that screens them out and denies them services.

Therefore, while supportive of the overall desire to incorporate outcome-based measures into the TANF system, CLASP makes the following recommendations:

- Revise proposed outcome measures to match the comparable WIOA performance measures so that states do not have to calculate slightly different measures for overlapping populations;
- Collect data and set baselines for performance on new measures before requiring states to commit to target rates;
- Take into account the populations served, either through a regression model, as used under WIOA, or by asking states to describe subgroups within their TANF population and set different targets for each rate;
- Include measures of states' performance in providing access to benefits, such as the TANF-to-poverty ratio, as well as employment measures;
- Instead of penalizing states that fail to achieve their targets with a loss of a portion of their the block grant, the sanction should instead be increased MOE requirements (as under the revised WPR penalty) and/or reduced flexibility to use TANF and MOE funds to support services other than cash assistance, work activities, and child care; and
- Congress should give states the ability to add additional performance measures, such as "Measurable Skill Gains," the interim measure of progress tracked under WIOA.

CLASP will separately provide additional technical comments on the specific measures proposed in the draft bill and how better to align them with the performance measures under WIOA. As currently written, we have deep concerns about both the details of the measures and the significant funding gap caused by the lag between when funds will be withheld and the period when the data will be available to measure state performance.

Alignment with other programs

WIOA. The draft bill strongly encourages states to include TANF in a Combined Plan under WIOA, an approach that generally makes sense since TANF is a required one-stop partner under WIOA unless the Governor opts out. The suggestion above for performance measures to be aligned across TANF and WIOA is even more important in the context of such joint planning, as separate measures make it far more difficult for programs to align. In addition, we would be glad to work with the Committee staff on technical changes to the proposed opt-out provision in this draft; the current version actually entails more intensive alignment and coordination with workforce programs than would Combined Planning itself, so it inadvertently undercuts the Governor's opt-out authority.

CCDBG. Consistent with the broad interest in program alignment reflected in the draft bill, we recommend that the Committee consider requiring that the provision of the bipartisan CCDBG reauthorization apply to child care funded directly through TANF, as well as through transfers to CCDBG. This would ensure that all children, including the most vulnerable children on TANF, receive the appropriate protections from CCDBG including health and safety requirements and

provisions that ensure stability of care. Should this provision be included, the CCDBG federal eligibility limit of 85 percent of median income limit would apply to these funds as well, rather than the new 200% of poverty limit under TANF.

Discretionary grants

In general, the purposes of the proposed discretionary grants are valuable. Our one concern, as noted earlier, is the elimination of the contingency fund with no provision for another approach to adding resources for economic downturns. We have two specific comments: on the case management demonstrations and the Social Impact Bond demonstrations.

While the TANF caseload is heterogeneous, and no one strategy will work for everyone, there are certainly multi-need families that would likely benefit from a close relationship with a skilled case manager. In addition, research suggests that the effectiveness of case management strategies depends on the availability of services – that is, case managers succeed by providing a trusting relationship that helps families choose, access, and succeed in services, not by substituting for services.[13] For example, if a parent is caring for a disabled child and does not have a high school education, the case manager can give her hope and a sense of practical goals that will enable her to move through these issues, but the case manager cannot substitute for a high-quality and reliable child care setting and an effective education and training pathway. For this reason, we believe these demonstrations will be far more likely to show success if the bill includes provisions we have suggested elsewhere to strengthen services, including more resources for states and changes in state incentives.

We are very pleased the case management, subsidized employment, two-generation, and in-demand sectoral employment pilots are all targeted to very needy families and individuals, whether current TANF recipients, recent recipients, or (as in the case of subsidized employment) certain unemployed and low-income people. We would recommend the Social Impact Bond demonstration include similar language, targeting the resources to TANF recipients or recent recipients. As we noted in a recent paper summarizing the status of Social Impact Bond-financed initiatives[14], while this funding mechanism has the potential to expand the scope of effective public programs for the poorest and most-vulnerable citizens using private capital, there are significant up-front costs for project development, which this bill would provide federal funding to support. TANF funds should not be used to support the costs of projects that would not benefit needy families.

Conclusion

Thank you very much for your attention to these important issues regarding the TANF program and, in particular, for the Committee's commitment to improving the work participation rate and the pathways to work for the nation's most vulnerable families. We appreciate the opportunity to comment on both the draft bill's strengths and the areas where it could go further and achieve greater success. We stand ready to work with the Committee to provide any information and assistance that would be helpful.

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July 24, 2015

The Honorable Charles Boustany, Chairman
The Honorable Lloyd Doggett
Subcommittee on Human Resources
U.S. House of Representatives
Washington DC 20515

Re: Comments on the TANF Reauthorization Draft

The Child Welfare League of America (CWLA) appreciates the opportunity to send our recommendations on the draft Temporary Assistance for Needy Families (TANF) reauthorization.

As a child welfare organization we recognize the role that the TANF block grant plays in funding child welfare services in most of the states and jurisdictions. We know that surveys over the past fifteen years have consistently shown that states have drawn approximately 20 percent of their total federal child welfare funds from the TANF block grant.

While the link between child welfare and welfare assistance is clear in financial terms we also recognize that the TANF block grant is vital in another significant way that is sometimes overlooked. TANF is significant in its role to assist some of the most vulnerable families in our country, especially those families in poverty and deep poverty. This is important if we are to make continued progress in reducing child maltreatment and in increasing permanency for the more than 600,000 children who experience out of home placements during the year.

As recently highlighted in a 2014 ***Child Welfare Journal*** article, ***Child Maltreatment Entrenched by Poverty; How Financial Need is Linked to Poorer Outcomes in Family Preservation:***

> *"Departments of Social Services and localities that may not be adequately supporting families in reducing the risk of maltreatment may be able to better serve those families most at risk by implementing more structurally-focused policy and services that alleviate poverty, addressing those families' material and economic need."*

CWLA sees the TANF block grant as vital to addressing child welfare issues beyond the use of TANF as a source of federal funds for child welfare services but also as a critical tool to provide basic cash assistance and related supports including child care and work supports.

CWLA supports a strong safety net for our most vulnerable families and their children. This TANF reauthorization offers Congress the ability to reassert the TANF block grant as a key source of financial support and as a tool to help alleviate the impact of poverty. Although there are a number of actions we support in relationship to the reauthorization of TANF including the need to increase the TANF block grant above the current $16.5 billion (because it has lost more than 30 percent of its value due to inflation) and the need to increase the mandatory child care fund (which would leverage matching state child care funds), for the most part we focus our remarks on provisions you have included in the draft legislation:

Individual Opportunity Plans

This section of the bill sets up a process for evaluation and goals for the individual adult receiving cash assistance. We suggest that as part of "C" under content of the assessment plan that directs states to describe state assistance and services to be provided to the adult, states also outline how the agency will coordinate with other agencies the family may be involved with including the child welfare and the child protection agencies.

In this same section of the draft bill under "E" where the obligations of the individual are outlined including specific benchmarks to be met by the adult that the state also outline a similar set of measurable benchmarks and service the state will meet as part of the individual plan. This is intended to address any potential support services that may have waiting lists or are not available.

Again under this same section of the draft bill under "H" and more generally in regard to the issue of substance use. We suggest that any state that requires drug testing as a part of the assessment or as part of overall eligibility determination, be required to provide any required or needed treatment services. Substance use can be a significant factor in child welfare cases but if needed treatment is not available we are failing to provide key services that will assist adults in obtaining and keeping a job or families staying together.

Elimination of Caseload Credit

We support elimination of the caseload credit because it has placed too much emphasis on reduction of cash assistance caseloads since 1996. The overall goal of TANF should include not just assisting adults to find permanent and productive work but it must also include the provision of needed assistance for vulnerable families. Incentives that reward decreasing caseloads in times of great need as was the case during the recession of 2008-09 should not be a goal but in such instances the main goal must be to assist and protect families. We recognize the interaction this caseload reduction credit has on state work targets but caseload reduction in and of itself is a false test of success for this human service program.

Improved Counting Hours/Work
We support improvements in how and what qualifies as work. We support allowing states to count as partial work credits for adults who may not be able to meet the full number of hours but who are working. We also support the broader definition of work that a state may be able to count.

As part of this we support the expanded way in which states can count vocation education as meeting the work requirements, the extension to 26 for adults seeking their GED or high school degrees and we suggest that a cap on how many adults are counted under the vocation education provisions be removed.

Penalty Provisions
We believe that any penalties assessed on states should be redirected into program improvement plans. If a state is failing to successfully move adults into work or failing to meet their targets, revenue from penalties assessed would be better utilized in working with that state in developing more effective strategies around assistance and work.

Purposes of the Act
CWLA supports the inclusion of poverty reduction as one of the purposes of the act as we did more than a decade ago. We feel this is an important step in helping to focus TANF on assistance for poor families.

CWLA also suggests that in addition to adding to the purposes that states being rewarded for increasing the number of poor families (or at least the number of families in deep poverty) receiving assistance. When AFDC was converted into the TANF block grant in 1996 over 65 percent of poor families were receiving cash assistance through AFDC. In recent years that percentage has shrunk to approximately 26 percent of poor families receiving cash assistance.

Individuals Convicted of a Drug Related Crime
In response to your request for comment we suggest that the current blanket prohibition on assistance to anyone with a past conviction of a drug related crime should be eliminated. In the ongoing bipartisan efforts to review past legislative mandates in the criminal justice system we feel this ban should also be viewed in the same light. If we are to offer assistance to people, adults and families in the greatest need we must recognize the need for second chances.

Open Issue of Minimum Spending on Child Care, Cash Assistance and Work Activities
CWLA supports a minimum level of TANF funds for core services originally covered under TANF, i.e. cash assistance, child care and work support activity as it relates to eventual employment.

We do not know what that proper level of funding would be but could be based on earlier historic spending levels in a specific state along with a review of what percentage of poor families are receiving cash assistance. Clearly if a state is using very little or no funding

for cash assistance they are not provide a key part of the safety net for vulnerable families.

CWLA knows that TANF can be a key source of flexible funds for child welfare but child welfare agencies and more importantly families are not helped if a set of fragile families are pushed into the child welfare system because they were not able to access a crucial part of the human services safety net.

Elimination of Marriage Penalty
We support the elimination of the separate and often times too rigorous work requirements and standards for married families. The current work requirements have often failed to take into account the challenges that many of these families experience due to the areas of the country they live in or because of some of the personal challenges that these families may be living with.

Improving Opportunities Funds
We support these demonstration projects. We also propose that such case management coordination specifically include how case coordination will involve child welfares services (including child protection) substance abuse services and housing services if the adult and/or family are involved with those human service agencies. Eligibility and other restrictions such as child welfare directives on the termination of parental rights, eligibility requirements connected to eligibility for housing subsidies and other program requirements can sometime create cross purposes and goals between these services and agencies.

Grants to Improve Child Well-Being By Supporting Two Parent Married Families and Responsible Fatherhood
We urge the Committee to increase the amount available to tribal governments and consortia to at least $5 million, more than doubling the total now permitted. Many of these governments and consortia are of very limited financial resources and $2 million for an important initiative such as for prevention of child abuse and neglect, the provision of supportive services to children in out-of-home care and improved case management are too important to be underfunded.

Under the section that promotes responsible fatherhood we urge the committee to also allow the funding of activities that promote fatherhood involvement in child welfare cases. Some initial work has been conducted in this area and we need to extend the outreach to fathers and the father's family when a child is in state custody and such involvement is appropriate.

Additional Concerns:
In regard to data collection we suggest that states, through TANF in coordination with the child welfare agency collect data on the number of children in child only families that are in state custody while receiving child-only grants. In addition the state should indicate if these children are also counted as part of their AFCARS data as in the out-of-home care category.

We also propose that under the TANF program, if a state also has a Title IV-E subsidized guardianship program that families be informed of their options including the options available under Title IV-E, the supports available and the benefit levels provided under TANF compared to Title IV-E. Information is required under Title IV-E but not under the TANF program.

We also propose that the law assure that work and other requirements do not apply to kinship placements and that states specify in state TANF plans the treatment of kinship caregivers, including: kinship caregiving definitions (relative, fictive kin, and caregiver); detailing the caseworker training related to kinship caregivers; and how relative caregivers' benefits are affected by the temporary presence of the biological parent.

We appreciate this opportunity to offer these comments to the subcommittee and look forward to working with Subcommittee members. If you need additional information feel free to contact John Sciamanna at jsciamanna@cwla.org.

Sincerely,

Christine James Brown

Chris James-Brown
President and CEO

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EQUIFAX®

July 29, 2015

Subcommittee on Human Resources
Committee on Ways & Means
Re: Committee Discussion Draft of welfare reauthorization legislation

Thank you for this opportunity to comment on the Committee Discussion Draft of welfare reauthorization legislation. We would like to focus our comments specifically on the open issue in Section 6(c)(10), "How to verify participation in activities."

Today, Equifax Workforce Solutions assists 37 state TANF programs with program integrity and eligibility efforts by providing current employment and income verifications from The Work Number database. As a component of those verifications, we have the capability to provide average hours worked per pay period and pay cycle detail. Combined, this data provides guidance to hours worked per pay period for the individual.

In addition to the verification services we provide to state TANF programs, agencies also benefit from having wage data instantly available -direct from the employer- so applicants can easily be qualified and verified without having to go back to their employer to get pay stubs, documentation, etc., which can be a long and drawn out process. The accuracy of The Work Number data also helps caseworkers process more cases, thus increasing the agencies efficiency because they are no longer having to wait on additional documentation to clear cases and determine eligibility.

With the thousands of employers who provide Equifax Workforce Solutions with pay-period detail every time they run a payroll, we have over 31.5 million current employment records that provide hourly work information. In addition, we have millions of historical payroll records that have this same detail which can be used to alert agencies of changes or verify hours from prior work periods.

With our plan to more than double the number of data-contributing employers in the next two years, collecting hours worked detail is a priority that will provide increased benefit to the agencies that require the information for eligibility purposes.

Thank you again for this opportunity to participate in the process of addressing this specific legislation and particularly for discussing the verifications process. Equifax Workforce Solutions stands committed to helping state and federal agencies make eligibility determinations, reduce improper payments, improve service, and increase overall program integrity. We look forward to working with the committee as they continue to address the reauthorization of the TANF program.

Respectfully submitted,

Nick Stowell
Director, Government Relations



FIRST FOCUS

First Focus
Bruce Lesley, President
Statement for the Record

U.S. House of Representatives Committee On Ways and Means
Hearing on Welfare Reform Proposals

July 14, 2015

Chairman Ryan, Ranking Member Doggett and Members of the House Committee on Ways and Means, thank you for the opportunity to submit this statement for the record.

First Focus is a bipartisan children's advocacy organization dedicated to making children and families a priority in federal policy and budget decisions. Our organization is committed to ensuring that all of our nation's children have equal opportunity to reach their full potential.

Child poverty in the U.S. remains high, with 14.7 million or 19.9 percent of children living below the poverty line in 2013. The child poverty rate remains significantly higher than for other age groups. Very young children experience the brunt of poverty, with nearly one-half of children under the age of 3 living in poor or low-income households.

For children of color, the poverty rate is even more alarming with 38 percent of African American children, 33 percent of Hispanic children, and 36.8 percent of American Indian and Native Alaskan children falling into this category. Furthermore, poverty is a particularly serious problem for children, who suffer negative effects for the rest of their lives after living in poverty for even a short time.

Child poverty carries a high price tag for our nation in terms of its human toll and fiscal costs. Poor and lower-income children are significantly more likely to experience gaps in their cognitive development as a result of economic insecurity and toxic stress in the lives of their parents and caregivers. It is well documented that exposure to toxic stress, including child abuse, neglect and violence and burdens associated with poverty, such as food and housing insecurity, impede early brain development and academic success, resulting in educational inequalities and an increased school drop-out rate. High school dropouts are at an increased risk of engaging in criminal conduct and becoming incarcerated in our criminal justice system.

Simply put, poverty often robs children of the opportunity to enter school prepared to learn, and increases the chance that children will perform poorly throughout school or drop out of school, and experience unstable employment and poverty as adults. In real terms, child poverty sets children along a tragic trajectory to adult poverty.

Beyond consequences for individual children, child poverty negatively affects the entire nation through increased expenditures on criminal justice and healthcare and through lost revenue and economic output.

The Temporary Assistance for Needy Families (TANF) program is the primary cash assistance program for low-income families with children. Currently, the majority of TANF recipients are children and most TANF caseloads are "child-only," meaning only the child in the household is receiving assistance. These cases occur when there is no parent in the household or the parent(s) in the household is ineligible for TANF.

However, the effectiveness of TANF in reducing child poverty has been eroding over time. Much of this is due to the fact that TANF is legislatively fixed as a capped block grant, meaning that it does not change when a state's caseload increases or decreases. This has made TANF unable to respond to increased need during the recession.

In 1996, TANF could provide assistance to 68 out of very 100 families in poverty. By 2010, the ratio fell to 27 families.[1] TANF caseloads have continued to drop since the recession, despite the fact that need has not decreased. Child poverty rates continue to be higher than before the recession, yet in 2013, a little more than 1.7 million families received TANF nationally, down from 1.9 million in 2006.

The overall block grant has fallen in value by 32 percent due to inflation since 1996. In addition, the supplemental grants that expired in 2011 have not been restored. These grants went to 17 states that had relatively low spending per child in poverty or had experienced high population growth in the early 1990s.[2]

This has serious repercussions for the well-being of America's children. The potential of TANF to lift children out of poverty is illustrated in the following statistic: For children living in a family with an income below $25,000 who received a $3,000 annual income boost when they were under age 6 earned 17 percent more as adults and worked 135 more hours per year after age 25 than similarly-situated children whose families didn't receive the income boost. This signifies the importance of income early in a child's life, and how a loss in that income may result in detrimental effects on a child's earning potential and ability to break the cycle of poverty.[3]

Clearly improvements to TANF are needed – and we urge this Committee to concentrate its efforts on serving and lifting more children and families out of poverty and toward economic security.

We support changes in the discussion draft that aim to incentivize states to increase employment rates and earnings gains among participants, rather than simply reduction of caseloads. This includes changes to the activities that count towards the work participation rate such as basic education, skills training, and vocational education. In theory, these changes could improve the long-term economic security of children and families served by TANF, by providing an opportunity for parents to obtain higher earning jobs.

However, we are concerned that these proposed changes do not go nearly far enough, and without further improvements and increased resources, these changes would not result in reduced poverty for children and families served by TANF.

First Focus urges the Committee to significantly increase resources for TANF to meet increased need. In addition, we have several recommendations to improve TANF's ability to address child poverty and improve economic security for families:

First, as a nation, we cannot afford – either morally or economically – to have 1 in 5 of our nation's children and nearly 2 in 5 African-American children living in poverty. Therefore, reducing child poverty should be an explicit goal of the TANF program, and as mentioned previously, the program should be evaluated based on its ability to serve the needs of low-income children.

Specifically, we recommend the inclusion of language from H.R. 2408, the Child Poverty Reduction Act, which establishes a child poverty target and would set the goal of reducing child poverty in half in ten years and eliminating it in twenty years. The United Kingdom did this in 1999 and, on a tri-partisan basis, they have successfully cut their child poverty rate dramatically and our country should make this a clear priority as well.

By setting a target, it will hold states accountable to take concrete steps to reduce child poverty through implementation of TANF and other measures. It institutionalizes the goal of reducing child poverty, and will be an impetus for public debate around the most effective interventions and policy solutions needed to achieve this target.

Second, any changes in the manner in which states are evaluated in promoting work and reducing poverty and dependence on public assistance take into account the percentage of children and families in need being served. States should be incentivized to serve a target percentage of families in need and rewarded based on this outcome.

Third, we recommend creating Children's Fair Share Grants, which would ensure a more equitable funding system for states by indexing the TANF block grant amount to inflation and the child population, and instituting a minimum floor of funding per poor child in poverty at the state level based on the national average of TANF spending. Such a reform would address a major flaw in the current TANF block grant formula, which is that funding does not follow the need and where states are granted widely disparate resources for families in poverty based on spending levels allocated 20 years ago.

Fourth, we recognize that TANF is one of the primary funding sources for childcare subsidies to low-income parents to enable them to complete school and job training programs and secure stable employment. Childcare assistance helps low-income parents obtain gainful employment, leading to increased earnings and ultimately furthering the goals of the TANF program. However, federal TANF funds used for childcare, including direct spending and transfers to the Child Care and Development Grant Program (CCDBG), have significantly declined, largely because TANF funding has not been adjusted for inflation since its creation, causing it to lose one-third of its value.

The TANF program has always recognized the close connection between parental work and their ability to secure appropriate childcare. We urge this Committee to significantly increase funding for the TANF program and continue to allow states to designate funding for childcare purposes. We note that research has shown high-quality childcare, Head Start and early Head Start to be two-generational programs in that they enable parents to maintain stable employment to provide for

their families, and provide young children with a stimulating environment during their earliest years when science has shown their brain development is most rapid. Significantly increasing funding for TANF and Head Start provide a twofold benefit, enabling parents to work and preparing young children to succeed in school and life.

Finally, we also recognize that in recent years, TANF has become a major source of funding for child welfare but not necessarily for wraparound or intervention services. A large portion of flexible funding used by states is used for foster care funding and services and kinship placements.

These services are critical for vulnerable children and families, and therefore we urge that any reform to TANF should do no harm to the child welfare system, and ensure that child welfare is funded adequately and augment support for preventive and early intervention services.

In this same vein, we are supportive of allowing funds to be transferred to Title IV-B, which can be used for preventive and early intervention services for families at-risk of entering the child welfare system. However, given the very limited resources of TANF and the incentives in this legislation to shift funds towards improving employment outcomes, we recognize that realistically, many states would have difficulty in transferring funds to Title IV-B without causing harm to other TANF participants, including children in families receiving cash assistance.

To conclude, TANF's funding structure differs greatly from state to state. Yet children are consistently the majority of TANF recipients, which means that any changes made to the TANF program will impact them greatly. We strongly urge the Committee that any changes made to TANF do no harm to children who already receive funds. We are very concerned that without increased resources, the proposed changes in the discussion draft are likely to result in loss of funds to child recipients. Therefore, reducing child poverty should be an explicit goal of the TANF program, which will ensure that the program is evaluated based on its ability to continue to serve children already receiving funds, as well as serving additional children in need.

We appreciate your consideration of these recommendations, and we look forward to working with you on this and other proposals to improve the well-being of America's children.

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[1] Floyd, I., Pavetti L. and Schott, L. TANF Continues to Weaken as a Safety Net. Washington, D.C.: Center on Budget and Policy Priorities; 2015.

[2] The Supplemental Grants, which were negotiated by Senator Kay Bailey Hutchison (R-TX) as a "compromise" to be added to the TANF bill were make available to the states of Alabama, Alaska, Arkansas, Arizona, Colorado, Florida, Georgia, Idaho, Louisiana, Mississippi, Montana, Nevada, New Mexico, North Carolina, Tennessee, Texas, and Utah each year for fiscal years 1998 through 2001 if the states had lower spending per person in poverty in AFDC and related programs or had experienced high population growth in previous years. This following a "Children's Fair Share" amendment by Senators Bob Graham (D-FL) and Dale Bumpers (D-AR), which would have pushed to end the "inequity" in the TANF funding formula over five years

[3] Greg J. Duncan and Katherine Magnuson, "The Long Reach of Early Childhood Poverty," *Pathways*, Winter 2011, http://www.stanford.edu/group/scspi/_media/pdf/pathways/winter_2011/PathwaysWinter11_Duncan.pdf.

July 20, 2015

To: Honorable Members of Congress

From: Patty Howell, Ed.M., A.G.C., President, Healthy Relationships California

In Re. TANF Reauthorization Legislation, SEC. 403. [42 U.S.C. 603] (a) GRANTS.

I write to share a perspective on the field of Healthy Marriage and Responsible Fatherhood programs which I believe is important for your consideration.

During the past decade, Congress has appropriated $150,000,000 per year for Healthy Marriage and Responsible Fatherhood programs, most of which has been distributed through a series of demonstration grants from the Administration for Children and Families to approximately grantee organizations around the country. Some of these organizations, such as Healthy Relationships California, have conducted highly successful projects reaching tens of thousands of people with well-documented positive impact on their lives.[1] Other grantee organizations have doubtless had positive impact though without such extensive documentation.

We are about to enter a new era: We are on the brink of collecting a large amount of data from across the entire field of relationship skills programs, which I believe will bring a powerful new understanding and confidence about the value of Healthy Marriage and Responsible Fatherhood work. The most recent funding announcements (HHS-2015-ACF-OFA-FM-0985 and HHS-2015-ACF-OFA-FK-0993) have challenged the next round of grantees to implement rigorous 5-year impact evaluation studies as a requirement of funding, and thereby utilize systematically the same survey instruments to collect data from all program participants of all

[1] Howell, P., Krafsky, K.J., McAllister, S., & Collins, D. (2013). *Impact Report: Research on the Impact of Relationship and Marriage Education Programs in California.* Leucadia, CA: Healthy Relationships California. Downloadable pdf at : www.RelationshipsCA.org

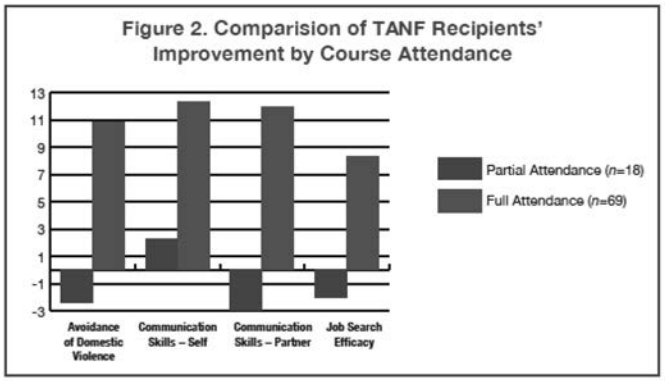
grantee organizations throughout this period of time. Furthermore, those organizations who receive the largest level of this funding will be required to implement a Random-Controlled Trial, along with oversight from OPRE and Mathematica Policy Research.

This strong commitment by the Administration for Children and Families to systematic data collection for the next five years across all of the nation's Healthy Marriage and Responsible Fatherhood grantees will give this field far more data than ever before, and **these data will enable comprehensive analyses of overall effectiveness, and penetrating analyses of the comparative effectiveness of different interventions and dosage levels across many different populations.**

I believe the impact of this over the next five years will result in a significant maturity across the entire field of Healthy Marriage and Responsible Fatherhood work and the Relationship Education programs that form the backbone of this work. From these data, grantees, ACF, and Congress will know what works, and how it works, and all of us will gain both fuller understandings and fuller confidence in these means for helping couples form and maintain healthy marriages, in engaging fathers with their children, in restoring damaged families, and in helping people become economically self-sufficient. In short: **I believe these five years of data will reveal the impact of Relationship Education programs as a powerful preventive investment in helping reduce the numerous social burdens that TANF funds have heretofore largely been used to address post hoc.**

My confidence in this comes partially from a project our organization undertook through Healthy Marriage funding that enabled us to conduct with Riverside County (California) Department of Public Social Services a pilot study on the impact of a 16-hour Relationship

Education course[2] on Riverside TANF clients. Our data found **positive results across all 8 variables associated with successful relationships at work and at home**[3]—**Problem-Solving Skills, Avoidance of Domestic Violence, Relationship Efficacy, Communication Skills, Emotional Control, Work Efficacy and Job Efficacy**. Data further revealed heightened effectiveness for those who completed the course in comparison with those who did not. (See chart above.[4]) Because of its applicability for this population, and the high attendance rates along with strong participant outcomes, Riverside County has since brought this curriculum in-house by having us train their Employment Counselors to teach this course as one of the official employment-support programs for their county TANF recipients. Additionally, through our ACF-grant-supported work, we have also been able to bring this curriculum to TANF agencies in three other California counties.



[2] World Class Relationships for Work & Home.
[3] Larsen-Rife, D., Ph.D. & Pugliese, J., Ph.D. "Special Report on Healthy Relationships Pilot Project with Temporary Assistance for Needy Families (TANF) Recipients", pp. 47-51, in *Impact Report*, op. cit.
[4] Ibid.

These results, along with the heartfelt testimonials of TANF counselors[5] are, in my estimation, just a glimpse into what five years of ACF data will reveal about the impact and value of Healthy Marriage and Responsible Fatherhood funding. Some programs and practices, likely, will not hold up to the bright light of rigorous research; others surely will and they should be brought to scale.

Recognizing as we do, the tremendous economic and social costs from people who are dependent upon public funds, who aren't able to get and keep a job, whose families are in turmoil, whose health is jeopardized, whose kids face an uncertain future, and the yearly multi-billion dollar ramifications of all of this for taxpayers, I believe that Relationship Education holds an important key to unsticking what have been intractable and extremely expensive social problems.

As the data unfold from our work over the next five years, and these data illuminate the preventive value of Relationship Education programs funded through Healthy Marriage and Responsible Fatherhood appropriations, I believe it will be important and even critical for Congress to move to a significantly higher level of funding for this work so we can scale effective practices on a nationwide basis, and I ask that you do so.

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[5] **Sample testimonials from instructor training in World Class Relationships for Work & Home of Riverside TANF/Department of Public Social Services (DPSS) Counselors include:**

- *"**Why did I not have this knowledge when I began my work for DPSS years ago! It would have changed the way I did everything!**"* (David, Morena Valley, CA)
- "*I am excited to learn this program and am extremely excited to share it with the people I work for*."(Sylvia, Hemet, CA)
- "*This class in WCR-WH has changed and will continue to change my life, my family's life and my work environment. I now feel rejuvenated and excited about work. This is a feeling I haven't had in over ten years."*(Laverne, Riverside, CA)
- *"**This workshop is life-changing! I am excited to place these tools in the hands of our customers.♥♥♥**"* (Darlene, Thermal, CA)
- *"**This program should be included in the Induction Training for new employees.** It not only exceeded my expectations for a tool to help our customers but also enhanced my personal needs and professional growth."*(Bill, DPSS Administrator, Riverside, CA)

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INSTITUTE *for* CHILD SUCCESS

Comments for the Record of the

Hearing on Welfare Reform Proposals

In the Subcommittee on Human Resources of the Committee on Ways and Means

On July 15, 2015

Bryan Boroughs, J.D., M.P.P.
General Counsel and Director of Legislative Affairs, Institute for Child Success

Megan Golden, J.D.
Senior Fellow, Institute for Child Success

Introduction

The Institute for Child Success is excited by the progress of discussions in Congress surrounding Pay for Success financing models (often called Social Impact Bonds) to advance the well being of young children. We thank Chairman Boustany and Representatives Young and Delaney for their leadership in including related provisions in the discussion draft of reauthorization legislation discussed during your July 15 hearing. We were also excited to see that the provisions encompassed a range of outcomes, especially including education and health outcomes, that are sometimes overlooked when working to advance the self-sufficiency of needy families. Indeed, failing to meet a basic threshold for those outcomes will often preclude improved workforce outcomes for families.

The Institute for Child Success respectfully submits the following written comments to the hearing record for your consideration. In these comments, we begin with an overview of our perspective on the benefits of Pay for Success financing. We then discuss the substantial benefits of federal involvement, the reasons that legislation is necessary for meaningful federal engagement, and the ways in which this legislation responds to that need. Finally, we include two technical suggestions based on our experience working in this field over the last few years.

Benefits of Pay for Success Financing (or, Social Impact Bonds)

Pay for Success financing is a model that can help effective interventions scale up to improve outcomes for young children, while saving governments money. The fundamental structure is well known to many, so we will only provide a very brief overview here. That most basic theoretical structure involves four pieces:

- An intervention that has been tested, and has demonstrated that it produces outcomes and that its benefits exceed its costs;
- Investors that provide the upfront capital required to bring the intervention up to a larger scale;
- A government entity that agrees to repay the investor – using funds saved for some or all of those payments – if the agreed-upon outcomes are realized; and
- An independent evaluator that determines whether the intervention accomplishes the pre-determined outcomes and, therefore, the government should make payments to the investor.

Because of the novelty and complexity of these arrangements, a third-party intermediary has also been involved in many of the Pay for Success contracts entered into to-date.

Pay for Success financing provides a number of benefits over traditional government mechanisms for selecting and scaling up interventions, including:

- It allows governments to shift resources towards effective prevention and early intervention;

- It draws on expertise and energy from outside investors, who ultimately bear much of the financial risk if a program is ultimately not effective at scale;
- A rigorous cost and savings analysis is necessary to even consider a Pay for Success arrangement, increasing the ability of the government to select interventions wisely;
- Outcome tracking is a centerpiece at every step, allowing the necessary tracking processes to be "baked in" to an intervention from the very beginning; and
- While Pay for Success *does not* privatize critical government services (such as remedial education, criminal justice, or the like), it *does* hold the potential to reduce the overloaded demand on many of those services, allowing them to better fulfill their missions.

Pay for Success and Effective Early Childhood Interventions

As we discussed in our January brief on this topic, Pay for Success is particularly well suited to help scale effective early childhood interventions.[1] Many interventions exist today with long-term outcomes that are independently compelling, result in significant cost savings to governmental entities, and produce outcomes that advance TANF's goal of improving family self-sufficiency and improving workforce engagement. Those outcomes include:

- More economically independent mothers,
- Reduced incarceration rates,
- Fewer teen pregnancies,
- Fewer closely spaced second births and fewer preterm second births,
- Fewer injury-related visits to the emergency room,
- Reductions in child maltreatment,
- Less youth crime,
- Higher achievement in school or careers, and
- Increased lifetime earnings.

Yet despite wide agreement that we should develop and implement these effective early childhood interventions broadly, it is very challenging to do so. Many governmental agencies are working to implement effective early childhood interventions, but those efforts are far from full-scale. Two barriers stand out:

1) **Resources are tied up in responding to problems, leaving little room for prevention.** Governments are busy putting out fires – that is, responding to problems after they happen –

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[1] Institute for Child Success. *Pay for Success Financing for Early Childhood Programs: A Path Forward*. 2014. Available at: http://www.instituteforchildsuccess.org/mydocuments/pay_for_success_financing_for_early_childhood_program2.pdf.

and after more cost-effective responses are no longer an option. Given the fiscal pressure faced by all governmental entities, government is rarely able to devote sufficient up-front resources to developing or implementing effective methods to prevent problems in the first place, even if those approaches would save money in the long run. For instance, the Institute of Medicine has documented the costs of failing to focus on prevention, finding that many mental, emotional, and behavioral disorders in young people are preventable, but that prevention remains underfunded.[2]

2) **The costs of wide-scale implementation are immediate, but the payback takes time.** Although many programs will deliver both social and financial returns, those benefits take time. Governments often find it difficult to afford investments with delayed returns.

Pay for Success can help address both of those barriers. Governments are able to implement tested interventions without immediately burdening the budget, since the model allows government to wait until the relevant outcomes are met before payments must be made. If those interventions are ultimately effective at scale, then the resulting cost-savings can be used to help repay the investors' principal and any premium that is agreed to at the outset. Moreover, if the interventions do not produce the agreed-upon outcomes, and the government doesn't realize the cost savings as a result, then the investors (who bear the financial risk) and are not repaid.

It is important to note here: all parties benefit from having investors who are mindful of the outcomes and want the program to succeed. The interventions that are currently best suited to Pay for Success financing have already been rigorously tested at a smaller scale. Much of the risk, then, relates to the difficulties inherent in scaling a program to a significantly larger size and serving different populations, which are challenges with which many investors have significant expertise. In other words, while the investors bear the risk of failure, they can also help reduce that risk.

Why Does the Federal Government Need to Get Involved

One of the questions that often arises in discussions about Pay for Success is this: Why is it important for the federal government to get involved? The simple answer is that many effective interventions produce positive results and save money at both the federal and state or local levels, and - for many of those - the federal government has a significant interest. For example, some two-generation early childhood interventions result in the improved birth spacing and more economically self-sufficient mothers, and therefore reduce dependency on programs like TANF. Congress should, therefore,

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[2] National Research Council (US) and Institute of Medicine (US) Committee on the Prevention of Mental Disorders and Substance Abuse Among Children, Youth, and Young Adults. *Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities*. 2009. Available at http://www.ncbi.nlm.nih.gov/books/NBK32775/

position federal programs to foster and leverage those outcomes. If it does so as structured in the discussion draft, both states and the federal government will benefit.

In addition, the federal attention and support for outcome-based payments will incentivize jurisdictions around the country to increase accountability for outcomes in government programs. Identifying the most effective programs and tracking their outcomes requires capacity and effort. This legislation will support and incentivize jurisdictions to build that capacity. The result will be more cost-effective government programs and better outcomes for our communities and our country.

Why Do We Need Legislative Action to Encourage Pay for Success

The typical appropriations process presents two significant barriers that prevent agencies from engaging in meaningful Pay for Success deals, both of which are addressed by the discussion draft. First, federal appropriations typically have to be "obligated" by September 30 of any given fiscal year. What we've learned over the last few years is that many of these deals take more than one year to develop to the contract-signing phase. Knowing that the money may vanish after months of diligent work, but before a deal is finalized, is a substantial hurdle.

Second, federally appropriated dollars typically have to be disbursed within 5-years after the fiscal year in which they are appropriated (under 31 U.S.C 1552(a)). Many Pay for Success contracts are best suited to something a little longer than a 5-year window, if only because most programs take a couple of years to reach scale, and long-term outcomes may take several years to be fully measured after that. As an example, the first Social Impact bond out of the United Kingdom was a 6-year contract.

Both of those barriers require Congressional action, but the fix is relatively simple and is handled in the discussion draft. However, there is a larger challenge the federal government will face as it engages in Pay for Success deals, and that is a challenge of human capital. Federal entities are generally not experienced in this field, and we need to develop that expertise in a deliberate fashion. The discussion draft creates an Executive Advisory Group that includes officials from several agencies. Through that mechanism, we can begin building expertise throughout the federal systems, allowing us to operate more sustainably in this field going forward.

What are the Limitations and Challenges of Pay for Success

As with any exciting new model, it is easy to lose sight of the limitations and challenges. There are some problems for which Pay for Success is simply not a solution. For example, it does not provide a sound model for funding programs, or for encouraging better evaluation of programs, that are already operating at scale. It also is not yet well-suited to fund untested innovations (though, a robust Pay for Success mechanism might encourage novel innovations to look to robust evaluation early).

Similarly, Pay for Success might not make the most sense for those specific services in those rare circumstances where success is nearly guaranteed, because the model does involve premium payments in exchange for investors bearing the risk of failure. In a case where there is very little risk, then the investment would be less beneficial from a financial perspective. Even in that scenario, however, Pay for Success financing may provide governments the fiscal relief they need to help shift resources from remediation towards prevention by enabling them to pay at the end of the project rather than at the beginning.

Moreover, Pay for Success financing deals are just very difficult to put together, from a technical perspective, so they are currently only appropriate for large-scale projects where the benefits exceed the transaction costs.

What are some of the technical challenges of Pay for Success financing?

- **Identifying rigorously tested interventions:** We have to find and develop interventions with rigorous evidence of outcomes. There are many interesting interventions out there with great confidence in, but little proof of, their results. So the first hurdle is identifying the rigorously tested programs, and then also encouraging promising programs to develop the kind of evidence that investors and governments need. The discussion draft wisely emphasizes the importance of feasibility studies to address both of these issues.

- **Identifying governmental entities:** One difficulty here flows from the fact that cost savings, especially from early childhood interventions, often cross governmental domains - from Medicaid to juvenile justice to education. It is sometimes difficult to find a single agency that reaps enough of the benefits to afford the full costs of a successful program. The discussion draft addresses this issue in two ways. First, the Executive Advisory Group is a single entity that can look at benefits across the federal government and, second, the legislation is created to support state and municipal deals that have a federal component.

- **Identifying appropriate outcome metrics:** We have to be very cautious to identify outcome metrics with which the service providers, the investors, and the government are all comfortable. This is one of the most challenging elements, particularly with respect to concerns over creating perverse incentives. PFS financing should avoid the danger that providers will "game the system" by determining outcomes compared to a control group or a matched comparison group. If the evaluation is well designed, any changes in how outcomes are counted will affect both the program group and the control group and thus will not translate into better results. This challenge is also why building expertise and collaboration within the federal contracting system – as the discussion draft proposes – is critical to long-term success.

- **Building the system to measure success:** As mentioned above, a centerpiece of Pay for Success financing is rigorous and ongoing outcome measurement, which is challenging for even the best-resourced programs. Pay for Success, however, builds that evaluation into the model from beginning to end, and in such a way that it cannot get lost in the shuffle – investors only invest, and only get a return, if successes are measured and verified by an independent evaluator. The discussion draft supports that model by expressly requiring that the evaluation mechanisms be identified at the beginning.

Given these difficulties, why is so much progress happening anyway?

- **Investors are asking for it:** We frequently hear from bank executives that their high-net-worth clients increasingly seek investments that are in line with their values. More and more, the industry is focusing on generating both direct financial returns *and* positive social outcomes.

- **Governments are looking for more cost-effective strategies to achieve public goals:** Governments – at all levels, but including the Federal Government through TANF and other programs – spend a tremendous amount of resources responding to crisis situations and providing remediation services. Those governments would normally have to sacrifice some of those critical services to invest resources in early interventions. Pay for Success allows governments breathing room to pay for interventions, in full or part, out of the long-term savings they produce. Moreover, Pay for Success financing helps governments move in a direction they are increasingly interested in: toward analyzing benefits and costs of specific strategies and choosing the ones that produce the best value for taxpayers.

Two proposed technical modifications to the discussion draft

On July 17, the Institute for Child Success joined the comments and proposed edits submitted by the America forward coalition. We would also like to submit the following two additional comments, informed by our work in this field over the last few years.

- **Regarding the terminology and requirements of the feasibility studies:** As described starting on page 49 of the draft, the feasibility study sounds more like the result of a fully completed deal negotiation, ready for signatures. The feasibility studies we've seen, instead, often address many/most of those criteria, but in a conditional form. For example, a feasibility study we conducted in South Carolina included a few different potential deal structures. While those proposals had been reviewed by potential parties to the deal, none had committed to exact outcomes, payment schedules, or the like.

  One possible solution, rather than saying the feasibility study "must contain the following," it could say that it must "address the following criteria." A solution in the opposite direction would be to refer to the study, instead, as a proposal or a proposed deal. The former seems

better, however, because it would allow the federal government's involvement to be considered during deal development and negotiation.

- **Contract vs. agreement:** the Federal Acquisition Reform Act of 1996, or the other guidelines that govern federal contracts, did not contemplate Social Impact Bonds or Pay for Success financing structures. Many of those guidelines may not be appropriate for this type of transaction, but describing them as "contracts" may trigger those requirements.

  One possible solution would be to refer to the final deal as an "agreement," "award," or something similar.

Conclusion

Pay for Success Financing is a very promising model for improving social outcomes and government efficiency. The Institute for Child Success is very encouraged by the attention this financing model has received by our elected officials at the federal level, and we are even more encouraged by the introduction of legislation like the proposed discussion draft. This financing model is challenging, especially for the federal government, but has tremendous potential for improving our collective fiscal position while directly improving social outcomes. We look forward to continued work with the Subcommittee and Congress on this issue in the weeks and months to come. Thank you for the consideration of these comments.

About the Institute for Child Success

The Institute for Child Success is a research and policy organization that leads public and private partnerships to align and improve resources for the success of young children. ICS supports those focused on early childhood development, healthcare, and education—all to coordinate, enhance, and improve those efforts for the maximum effect in the lives of young people. For more information: www.instituteforchildsuccess.org.

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July 25, 2015

Comments on House Ways and Means Committee Subcommittee on Human Resources Discussion Draft on TANF Reauthorization

Deborah Harris
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Thank you for the opportunity to comment on the Human Resources Subcommittee TANF Reauthorization Discussion Draft. I submit these comments on behalf of the Massachusetts Law Reform Institute (MLRI), the Massachusetts Welfare Coalition, and low-income clients of legal services programs in Massachusetts. MLRI leads advocacy efforts in Massachusetts to improve basic benefits and increase economic security for very needy individuals and families.

We support many of the provisions in the discussion draft, including elimination of the caseload reduction credit and the two-parent work participation rate, the changes in countable activities, and the strengthened assessment requirement. In the following comments, we focus on other provisions in the Discussion Draft and in current law that we think should be modified in order to help TANF serve the most disadvantaged families more effectively.

Despite improvements, the work participation rate continues to pressure states to deny assistance to families where the parent has a disability or other major barriers to employment.

The WPR rewards states for *not* providing basic cash assistance to families with major barriers to employment. This includes families where the parent has a severe disability but does not receive SSI, families who are in crisis (due to homelessness or some other reason), and families where the parent is not proficient in English, is not literate, lacks recent work experience, or does not have a high school degree.

Massachusetts has resisted the pressure to deny assistance to these families somewhat better than many other states. The state has historically recognized that the Supplemental Security Income (SSI) standard, which regards an individual as disabled only if she or he cannot engage in *any* substantial gainful activity, is not the appropriate standard for a parent who must provide for her children's basic needs. Massachusetts has therefore developed an alternative disability standard that is applied by the state's Disability Evaluation Service using medical and vocational criteria similar to but slightly less stringent than SSI's. The state's Disability Evaluation Service also

determines parents disabled if they meet the SSI standard but have not been approved for SSI, including those who are waiting for a decision from the Social Security Administration. Parents who are determined disabled are not subject to work requirements and are not sanctioned if they participate voluntarily but are unable to meet all of a program's requirements. As a result, about 27% of the families receiving TANF cash assistance in Massachusetts are headed by a parent with a severe disability who is not receiving SSI.

Under the Discussion Draft, Massachusetts would be under greater pressure to impose strict work requirements on parents with disabilities because it could no longer reduce the work participation rate through the caseload reduction credit (as the state did some years ago) and could no longer raise its WPR through a worker supplement program (as it is doing currently). While we appreciate and generally support the reasons for eliminating the caseload reduction credit and excluding the state's worker supplement programs from WPR calculations, we are concerned that these changes would add to the pressure Massachusetts is already under to subject parents with disabilities to the same the work requirements as parents who do not have identified limitations, setting them up for failure and the loss of assistance for themselves and their children.

Improvements in the Discussion Draft, while welcome, do not adequately ameliorate the pressure on states to deny assistance to "work eligible" families who are unable to meet one-size-fits-all work activity requirements.

- **The hours requirements remain too stringent for many families with severe barriers to employment.** About half of the parents determined disabled under the Massachusetts state standard have mental impairments – including anxiety disorders, severe depression, and cognitive impairments. About 20% are approved on the basis of severe musculoskeletal impairments. Many suffer from a combination of impairments. *A 30-hour or even a 20-hour per week activity requirement risks aggravating stress and is inappropriate or impractical for many of these families.* Similarly, homeless families cannot focus on housing search, getting their children to schools and medical appointments that are no longer nearby, and helping their children though the trauma of homelessness if they are subject to strict hours requirements. Allowing states partial credit for families participating for fewer than the minimum required hours, although a welcome provision in the Discussion Draft, would not sufficiently mitigate the disincentive to serve these families since the state would have to engage 100% of the families with barriers for at least half of federally required hours in order to achieve a 50% WPR for them.

- **The bill should be revised to give states credit for serving *more* parents with disabilities and other barriers to employment, rather than fewer such parents.** For example, states could be given a credit against the WPR for families determined – in accordance with reasonable state standards – to have major barriers to employment. Alternatively, or in addition, states could be encouraged to design programs for these parents with reduced hours requirements tailored to what the parent can realistically do, consistent with the Discussion Draft provisions on assessment.

- **At a minimum, individuals who are applying for SSI or in the SSI appeals process should not be considered "work eligible."**

The cap on the share of the work participation rate that can be satisfied by participation in training or education should be eliminated.

Massachusetts' economy, like that of the rest of the country, is increasingly knowledge-based. More than 40% of TANF cash assistance adults in Massachusetts lack a high school diploma or GED. About 20% are not proficient in English. Families are less likely to become self-supporting if they are pushed into unstable low-wage jobs or unpaid community service than if they have help to address these deficits. If the cap is not changed or is only lifted, then it is also important to eliminate the provision that counts young parents maintaining satisfactory school attendance toward the cap. This has been an issue for Massachusetts, which has an excellent school program for parenting teens receiving TANF cash assistance. When the young parents in that program are added to the number of countable individuals in vocational education, Massachusetts exceeds the cap if participants in its worker supplement program are not counted in the work participation rate.

The bill should require HHS to allow more flexibility in how participation hours are counted.

Current rules require the state to track each participant's hours of participation. This is an enormous burden on programs that provide services, results in sanctions of parents who are doing their best to comply, and penalizes states that focus on helping participants succeed rather than documenting hours. We urge Congress to direct the Secretary to revise current rules in the following ways:

- **Allowing for holidays and days of program closure.** Current regulations allow only 10 holidays per year. However, many nonprofit and public employers are closed for more than 10 days per year, especially if they close for the week between Christmas and New Year. Similarly, many education and training programs, job search programs, and job readiness programs are closed for more than 10 days per year, including holidays, semester breaks, and days when the program is closed for staff training or other reasons. During the past winter in Massachusetts, schools and many employers were closed for seven or more days because of weather. On several days, the Governor directed non-essential employees to stay home. Public transportation in the Boston area stopped working and roads throughout the state were impassible or dangerous. The Secretary should be directed to allow states to count days when the employer or program is closed, or alternatively, to calculate monthly compliance excluding such days.

- **Allowing for excused absences.** Current regulations allow only 80 hours of excused absences – including vacation and sick time – over the course of a year, and no more

than 16 hours in any given month. This is more rigid than the absence rules of many employers. Parents get sick and should be encouraged to stay home rather than infect others in the workplace. Children get sick too, and parents need to stay home to care for them. Parents also need to go to medical appointments for themselves and their children, attend school conferences, and deal with breakdowns in transportation or child care arrangements. Massachusetts workers by law can earn and use 40 hours a year of sick time in addition to vacation time. The bill should direct the Secretary to allow states to count a reasonable amount of sick time, in addition to a reasonable amount of personal time, including vacation.

- **Reducing the documentation burden.** Current regulations allow states to project hours for up to six months based on current information on work hours for individuals in paid employment. This is similar to and dovetails with the SNAP (food stamp) Simplified Reporting option, which allows states to require SNAP recipients to report earnings only twice a year (unless their income goes over a specified limit). The bill should similarly direct the Secretary to reduce the documentation burden for persons in other activities that can be expected to last more than a month – including participation in training and education programs. Once an individual is enrolled in program that meets the hours requirement, the state should be allowed to count that individual for the requisite number of hours for the duration of the program provided the state verifies continued participation at appropriate intervals.

- **Standardizing the number of hours per month.** Under current rules, the number of hours each month varies depending on the number of days in the month, adding to the documentation burden. The Secretary should be directed to allow states to require the same number of hours each month, 80 hours a month instead of 20 hours a week or 120 hours a month instead of 30 hours a week. This would retain a clear federal standard but would be easier to administer than the current rule.

A strategy other than (or in addition to) a floor on spending is necessary to redirect TANF and MOE funds to cash assistance, work supports and child care.

The TANF cash assistance caseload in Massachusetts has dropped by 30% since October 2012, due to a combination of an improving economy, harsher implementation of state work requirements and time limits, and state agency business process changes that make it harder for families in need to access and maintain benefits. The caseload is now less than have of what it was in 1996. The state has not invested the "savings" from the caseload decline in long overdue increases in benefits (which have lost nearly half their value to inflation since the late 1980s) and also has not invested in services to help families address severe barriers to employment. Instead, increasing amounts of TANF and MOE are used for worthwhile programs other than the cash assistance program. Center on Budget and Policy Priorities calculations show that the Massachusetts TANF-to-poverty ratio is now less than half of what it was in 1996.

However, unlike many other states, Massachusetts is already spending about 30% of TANF and MOE on cash assistance and work activities (though that will decline if the caseload continues to

decline) and is already spending an additional 30% of TANF and MOE on child care in addition to the 20% of the block grant that is transferred from TANF to CCDF. Thus, a 50% floor (which we understand was suggested at the hearing) would likely not redirect funds to cash assistance or work supports in Massachusetts if the floor includes child care spending.

Moreover, a floor will not be effective in redirecting funds to cash assistance and work supports for the neediest families as long as the WPR continues to penalize states for providing those benefits to persons with disabilities and other barriers to employment. Rather than risk a penalty, states may create worker supplement or other programs that comply with the new requirements but only help families at higher income levels. This is especially likely if the state anticipates that it will be difficult to increase MOE to satisfy a penalty.

One alternative would be to require states to take incremental steps towards a TANF-to-poverty ratio of at least 75 TANF cash assistance families for every 100 families in poverty, the national ratio in 1994-1995 according to the Center on Budget and Policy Priorities. Other ways to achieve the goal of directing funds back to serving the families with the greatest need should also be considered.

States should be allowed to use sampling or other methods to comply with the proposed prohibition on claiming TANF or MOE for families with incomes at or above 200% of the federal poverty line.

The Discussion Draft reasonably allows states to claim spending for *programs* that provide benefits or services to families with incomes at or above 200% of the federal poverty line as long as the *family's* income is below 200% FPL when the family applies. Thus, states would be able to claim at least some of the spending for programs that seek to reduce "cliff effects" by having higher income limits or by phasing out the benefit amount or raising co-pays incrementally for families with higher incomes. Encouraging states to support such programs with TANF and MOE is especially important in a high cost state like Massachusetts where a 200% FPL limit for programs would exclude many families who are struggling to survive.

However, we anticipate that Massachusetts and other states may have difficulty tracking and reporting each family's income data at the time of application. We therefore suggest that the bill expressly allow states to use a sample rather than individual case data to determine the amount that can be claimed for families below 200% FPL who are served in programs that also serve families with higher incomes. States should also be allowed to establish that a family in the sample has income below 200% FPL by doing a match with the SNAP caseload (as is done to verify eligible for the National School Lunch Program) or through a match with other data sources such as the state's quarterly wage data. Because sampling would likely determine income at a point in time after application rather than at the time of application, the bill language should be revised to allow a claim for families whose incomes are below 200% FPL at any point during the sample period as well as families whose incomes are below 200% FPL at the time of application.

States should be held accountable but the outcome measures and penalties should be revised.

We support the inclusion of outcome measures to assess how individuals fare after they leave TANF. This could have a salutary effect in Massachusetts where a short 24-month time limit, work sanctions, procedural case closings, and lack of investment in work supports pushes many families off assistance before they able to support themselves. However, under the Discussion Draft, a state could count a family towards the performance target even if the parent is employed only a few hours a week. There should be a minimum amount of earnings that will count towards the performance target, which should bear some relationship to the state minimum wage times the number of hours required for a family to count towards the WPR. For similar reasons, the Discussion Draft's proposed earnings gain measure should be revised to measure earnings at a point in time and should give states credit only for families who meet specified earnings levels such as, at a minimum, the federal poverty level. We support the concept of setting performance goals that allow for variations among states' economic conditions, wages and cost. However, we are concerned that allowing each state to negotiate its own target will prompt some states to try to set the bar low to avoid the risk of penalties and will make it impossible to compare performance states. The bill should therefore direct the Secretary to develop standard measures, which could be state specific, such as a percentage of median income.

Although such performance measures could discourage states from pushing families off assistance who cannot support themselves, focusing only on employment success could create an incentive to states to make it harder for families who have major barriers to employment to access cash assistance in the first place. Outcome measures should therefore also be designed to discourage states from denying assistance to these parents. The TANF-to-poverty ratio could be one such measure.

We share the concern of others that the penalty structure in the draft needs to be revised. As drafted, the bill would hold back a portion of the block grant and require states to earn back the withheld amount by meeting outcome measure goals. This risks penalizing *families*, who will ultimately suffer if block grant funds are reduced. We suggest that instead of such a draconian penalty the bill would authorize the Secretary to require the state to submit a corrective action plan setting forth the steps the state will take to address the failure. The bill could authorize the Secretary to reduce the amount the state can claim for administrative expenses it the state fails submit and comply with a corrective action plan. The bill could also authorize the Secretary to require the state to increase its investment in cash assistance, work supports and childcare. The Food and Nutrition Service of the Department of Agriculture uses a similar penalty process to enforce compliance with SNAP (food stamp) rules.

The Family Violence Option should be redesigned to allow states to exclude domestic violence survivors from the work participation rate denominator in appropriate circumstances.

Studies in Massachusetts have determined that as many as two-thirds of all TANF cash assistance recipients are survivors of or currently experiencing domestic violence. However, for FFY 12, Massachusetts reported having granted only 25 good cause domestic violence waivers. Most other states also reported having granted very few domestic violence waivers. One reason for this is that granting a domestic violence waiver only helps the state to the extent that the state can show that but for the waiver the state would have met the WPR or would not have failed to comply with the five-year limit. States should be allowed to exclude from the WPR calculation families who qualify for a domestic violence waiver from the work requirement. The bill could limit the number of such exclusions and could require the Individual Opportunity Plan to detail the grounds for the waiver and a timeline for review of it.

Additional funding is needed.

The block grant has lost 30% of its value since it was established. The freeze on funding is one reason that TANF cash assistance benefits in most states have not kept pace with inflation. Cash assistance benefits are so low that families who receive them live from crisis to crisis. TANF cannot help families move towards economic security if it does not first meet their basic needs. Low benefit levels are also a factor in the increasing numbers of very poor families who are over-income for their state's cash assistance program yet face similar survival challenges. The block should be increased, should be indexed to inflation for future years, and at least some of the increases should be directed to states that increase their cash assistance benefits and cover more of the state's poorest families with children.

The drug felon bar should be eliminated.

Massachusetts has opted out of the drug felon bar for SNAP and has limited it for TANF cash assistance recipients so that it only applies to persons who were incarcerated for the felony and released from prison within the previous year. Although the remaining bar is a real issue for the very few families who are affected and potentially interferes with their rehabilitation and return to society, the main problem with the remaining bar in Massachusetts is that adds yet another rule to an already overly complicated program and does not serve any of the primary goals of TANF. We therefore recommend that the drug felon bar be eliminated.

Thank you very much for your consideration of these comments and for the Committee's commitment to making TANF do a better job of helping the nation's neediest families achieve economic stability.

MCDERMOTT CENTER dba HAYMARKET CENTER
COMPREHENSIVE ALCOHOL & DRUG TREATMENT PROGRAMS
FOUNDED IN 1975 BY MSGR. IGNATIUS MCDERMOTT AND DR. JAMES WEST

July 16, 2015

The Honorable Charles Boustany, Chair
Subcommittee on Human Resources of the Committee on Ways and Means

Re: Julia Carson Responsible Fatherhood and Healthy Families Act of 2015: Support

Dear Chairman Boustany:

Haymarket Center, Chicago's largest provider of substance use disorders and mental health treatment, strongly supports the Julia Carson Responsible Fatherhood and Healthy Families Act of 2015 (the Act). Located in Illinois' 7th District, represented by the Honorable Danny K. Davis, we are proud of Representative Davis's leadership on responsible fatherhood issues. We believe the Act will make significant improvements in the ability of federal programs to encourage and support responsible fatherhood and healthy families through enhancing supports–and reducing barriers—for families to increase upward economic mobility; to maintain healthy, non-violent family relationships; and to improve child support and cooperative parenting. We also believe the Act can play an important role in helping families to break negative cycles, so that a new generation will have better access to the opportunities that will give them success in life.

As a recipient of a Pathways to Responsible Fatherhood grant, Haymarket Center has helped 1,200 families in the past four years. We hope to build on the successes of this program and the lessons learned to operate a New Pathways grant program in the five years to come. Provisions of the Act, if passed, will enhance the ability of fathers and families in our program to achieve success. Specific provisions of the Act we particularly support include reforms to TANF, modernizing child support enforcement program, adjustments to the SNAP program, and enhancements to the fatherhood and healthy marriage grant programs.

Reforms to Temporary Assistance for Needy Families (TANF)

Clients of Haymarket Center, who come from every congressional district in Illinois, frequently need the help provided by TANF. Over 90% of them are unemployed, 75% are homeless, and 92% have criminal justice histories. Helping these individuals find jobs poses significant challenges. Subsidized employment has been a powerful tool to provide them with job experience they can use to move into permanent, stable employment. The Act's provisions to expand subsidized employment and job training are welcome enhancements.

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Modernizing Child Support Enforcement Program

Child support is an important component of responsible fatherhood and healthy families. Yet fathers who have faced substance use, incarceration, loss of a job, or other serious challenges can avoid connecting with their families due to child support enforcement and fear of further legal difficulties. The Act provides sensible reforms that recognize the realities of many of these fathers, while still encouraging and providing a path for fathers to return to responsible payment of child support. These reforms also recognize the value of education in helping fathers and families to improve their economic upward mobility.

Adjustments to Supplemental Nutrition Assistance Program (SNAP)

Ensuring that child support payments do not result in loss of food assistance will remove a negative incentive for mothers not to seek child support and is a reasonable adjustment.

Enhancements to the Fatherhood and Healthy Marriage Grant Program

Enhancements to this grant program respond to the realities of clients served in the current program, similar to clients of Haymarket Center. Haymarket serves nearly 16,000 clients annually from communities of Chicago with the highest drug arrest and murder rates in the nation. Of these, approximately 30% are fathers who have abandoned or are separated from their children because of their substance use and who are unlikely to participate in any fatherhood program unless their substance use is stabilized. With high levels of unemployment and homelessness, our clients are often unable to provide for their children's needs. In addition, 91% of the fathers we served in the Pathways to Responsible Fatherhood grant were unmarried with multiple children from different women from whom they have separated. Most lack parenting skills to be a good father.

Therefore, while the Act retains a focus on healthy marriages, addition of "healthy relationships" takes into account the types of clients Haymarket serves most often, where there isn't a marriage but there is still an urgent need to help men and women who have a child learn to communicate and share responsibility for the child. The proposed new language also recognizes the challenges and extra needs of "low-income fathers and other low-income noncustodial parents," which we hope leads to stronger supports for these individuals and the providers seeking to help them.

In our current project, ending in September, Haymarket has already served 1,200 of these individuals. Through the grant, over 72% of fathers reported increased contact with their children, 85% improved relationships with their children, 86% improved communication and conflict resolution skills; and 89% improved parenting skills. Key lessons learned that will guide services for a New Pathways project, if awarded, include addressing fathers' fear and lack of skills to reconnect with their children and mothers of their children; reluctance of mothers to include fathers who are entering recovery from substance use disorders in co-parenting of their child; and the need for on-going support once fathers leave the program. These are Haymarket's

examples, and other providers nationally no doubt have similar positive outcomes from this valuable program. The Act will ensure funding for this valuable program through 2020, ensuring that thousands of fathers and families nationally can benefit from the types of support Haymarket was able to provide in the past four years.

We thank the committee for its excellent work in developing the Julia Carson Responsible Fatherhood and Healthy Families Act of 2015 and wish to record our strong support for the Act. We also appreciate the opportunity to provide comment, and look forward to passage and implementation of the Act.

Sincerely,



Dan Lustig, Psy.D., MISA II, CRADC
Vice President of Clinical Services.



July 24, 2015

The Honorable Charles Boustany, Chairman,
Ways and Means Human Resources Subcommittee
U.S. House of Representatives
Washington, DC

Dear Mr. Chairman:

On Behalf of the Board and Members of the National Fatherhood Leaders, I am submitting comments for consideration of the *Improving Opportunity in The American Welfare Act 2015*. The National Fatherhood Leaders Group (NFLG) is a coalition of national and community-based fatherhood organizations, individual fatherhood practitioners and others interested in fatherhood and family strengthening. Our mission is to raise awareness of the importance of two involved parents in the lives of children and to strengthen the capacity of the responsible fatherhood field. NFLG is a 501(c) (3) tax-exempt nonprofit membership-based organization.

We are aware that 40 percent of children in the United States are born to unmarried parents, and often both parents have low incomes. Many children who grow up without their fathers struggle and are vulnerable to a number of negative risk factors. The public costs of father absence on children are substantial, including poverty, low academic achievement, juvenile delinquency and early pregnancy.

NFLG offers the collective voice of the responsible fatherhood field to help policymakers, practitioners, community and faith-based organizations, child advocates and other groups, understand the importance of providing fathers with the services and supports they need to act responsibly.

NFLG COMMENTS

THE IMPROVING OPPORTUNITY IN THE AMERICAN WELFARE ACT 2015

REQUIRE

1. HHS Office of Family Assistance provide pre-proposal technical assistance in advance of submission of TANF responsible fatherhood and healthy marriage/relationship education grants applications. This will level the playing field and improve the competitive balance of all who seek funding.



2. All TANF funded responsible fatherhood programs to establish parenting plans, including co-parenting and parenting time agreements, for non-married parents to include access and visitation.

3. Remove the requirement for matching funds. This could have the unintended consequence of co-opting the ability of community organizations that have developed and provided fatherhood and healthy marriage/relationship education programs by established and large organizations with significant capacity to raise private funds. State funding for fatherhood and healthy marriage/relationship education programming could be subsumed and diminished within existing programs that will not emphasize the specific programming and specialized case managements and social support services that are essential to the success of these uniquely focused programs.

4. HHS Office of Family Assistance to continue to implement and refine social experiments on responsible fatherhood and healthy marriage/relationship education along the lines of the research cycle employed by National Institutes of Health and the Institute for Education Science of the Department of Education.

5. Increase funding levels by 100% to expand fatherhood and healthy marriage/relationship education programs to insure substantive increases in the expanding knowledge base for serving non-custodial fathers and individuals and couples who grew up in vulnerable families. Given current indicators of effectiveness, funding should be increased to insure that programming variety allows for the complexity of American family life for our most needy children and their parents.

6. Allow for continued delivery and refinement of new, modified and improved fatherhood and healthy marriage and relationship education curricular and programming developments as well as promising practices and current evidence informed models. In some instances research is funded in ways that marginalize programs developed by community agencies and groups that seek to incorporate and attend to the unique characteristics of participants that university based programs often cannot reach. Narrowing the range of program models that are funded diminishes the importance of tailored programs. Manualized approaches that emphasize 'treatment fidelity' at the cost of establishing attunement to the needs of program participants cannot be the standard the fatherhood and healthy marriage/relationship education programs. The integration of theory, research, **and** *(field)* practice are the keys to programming that will produce effective and significant results for program participants. While many programs will



demonstrate effectiveness, comparative studies of program models and implementation strategies can differentiate which programs for which populations.

ENCOUARGE

1. HHS Office of Family Assistance to clearly define what constitutes a responsible fatherhood program.

2. HHS Office of Family Assistance to establish uniform standard benchmarks regarding responsible fatherhood program activities (e.g. program length, outcome metrics).

3. HHS Office of Family Assistance to establish criteria for the use of responsible fatherhood curriculums selection (e.g. what does evidenced-based mean? Does the curriculum have an assessment package?) Are responsible fatherhood education programs or job training programs?

4. HHS Office and Family Assistance to emphasize completion of responsible fatherhood parenting education components to have equal emphasis in performance/outcomes as it does for increases in child support payments and employment efforts. Research on non-custodial parents suggest that knowledge of good parenting practices, visitation and access combined with attitude improvements, influences responsible parenting behaviors toward child support and work.

5. HHS Office of Family Assistance to provide timely feedback to grantees regarding program performance. This information should also be made available online.

6. HHS Office of Family Assistance to provide specific guidelines regarding allowable program support services and program incentives. Specifically food for workshops and other community activities.

7. HHS Office of Family Assistance to provide specific guidelines for media campaigns. For example, should media campaigns be used for the recruitment only of fathers and/or for the promotion of responsible fatherhood community at large to create an environment that is more receptive to fathers and contributors to the success of families?



8. HHS Office of Family Assistance to develop best practice (with a clear definition of best practice) tool kits and other materials that provide guidance to the implementation of the programs.

9. HHS Office and Family Assistance to develop efficient processes in client intake and enrollment data. Specifically a streamlined process that would lessen the paperwork of grantees. Some grantees reported that current HHS procedures can take up to several weeks to complete because of the low reading levels of clients being served. The newly created and implemented FaMLE Crossties' and Form is a major step in this direction.

Respectfully Submitted,

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House Ways and Means Committee Subcommittee on Human Resources Welfare Reform Proposals Hearing

Testimony for the Record
Submitted by Kermit Kaleba, Federal Policy Director

July 21, 2015

National Skills Coalition – a broad-based coalition of business leaders, union affiliates, education and training providers, community-based organizations, and public workforce agencies advocating for policies that invest in the skills of U.S. workers – is pleased to submit the following written testimony for the record on the discussion draft of the "Improving Opportunity in America Welfare Reauthorization Act of 2015."

We wish to commend Chairman Boustany and other members of the House Ways and Means Committee for their commitment to modernizing and strengthening the Temporary Assistance for Needy Families (TANF) program. TANF is one of the nation's most important safety net programs, providing cash assistance and other supports that have helped millions of low-income families weather periods of financial hardship. But it is a program that is held back by a number of restrictive requirements that have hindered the adoption of practices and strategies which could help more TANF recipients transition into well-paying and sustainable employment.

Last year, Congress took important – and bipartisan – action to update the nation's workforce investment systems through passage of the Workforce Innovation and Opportunity Act (WIOA), legislation that reflects the growing recognition that in order to adequately address the skills needs of workers, jobseekers, and employers, we must do a better job of coordinating across multiple education, training, and supportive services programs. National Skills Coalition strongly supports the vision and goals of WIOA, and we believe that Congress should work to ensure that other federal investments in our nation's workforce are aligned with this vision.

We are therefore encouraged to see that the discussion draft includes a range of proposed policy changes that will expand access to employment, education, and training for TANF recipients, including extending the lifetime limits on participation in vocational educational training; lifting statutory caps on the percentage of individuals in education and training that may be counted toward state work participation rates; and adopting new performance indicators for

individuals transitioning off of TANF that should create better incentives for states to focus on long-term outcomes for TANF participants. We are also supportive of efforts under the draft legislation to stimulate innovative training strategies through the new "Improving Opportunity Fund," and of new requirements that would encourage states to include TANF as part of their broader workforce development planning.

At the same time, we are concerned that the draft legislation does not go far enough in bringing TANF in line with the realities of the 21st century economy, and in particular the need to ensure that all Americans – including TANF recipients – have access to the fullest possible range of high quality education and training services aligned to the skill requirements of local and regional industries. We therefore offer the following recommendations for strengthening the proposed legislation.

- **Increase funding for the state basic assistance grant.** The discussion draft proposes setting funding for the state basic assistance grant for Fiscal Years 2016-2020 at just under $16.6 billion, which represents a modest increase over current levels but is approximately 30 percent below funding authorized under the Personal Responsibility and Work Opportunity Act in 1996, when adjusted for inflation. This continued erosion of TANF's purchasing power has contributed to a significant decline not only in the number of individuals directly receiving assistance – the most recent data indicates that a monthly average of 3.9 million individuals received TANF benefits in Fiscal Year 2014, compared to the 11.4 million individuals receiving welfare assistance in 1997 – but also a significant decrease in the percentage of families with children in poverty who are receiving any cash assistance under the program, with the Center on Budget and Policy Priorities estimating that only one-quarter of such families received cash assistance in 2013.[1] While we recognize that in the current fiscal climate Congress must balance multiple competing and compelling interests, we believe that the positive changes outlined in the proposed legislation would be even more effective if TANF were to be funded at a level that corresponds with the actual scale of need.

- **Eliminate the "all-families" work participation rate**. National Skills Coalition strongly supports the proposed elimination of the "two-parent" work participation rate under section 9, but we are disappointed that the discussion draft maintains the all-families work participation rate as the central performance measure for state TANF programs. The problems with the work participation rate are well-documented and well-understood: it puts substantial pressure on work-eligible TANF recipients to participate in low-paying work activities that are unlikely to contribute to longer-term success in the labor market; creates administrative burdens for TANF agencies and service providers who must

[1] http://www.cbpp.org/research/family-income-support/tanf-continues-to-weaken-as-a-safety-net

document work participation; and provides limited incentives for states to develop and implement meaningful career pathways for TANF recipients.

The discussion draft points a better way forward. Under proposed section 7, states will now be required to negotiate performance levels relating to employment and median earnings of TANF leavers, similar to the performance indicators that are applied to the six core programs under the Workforce Innovation and Opportunity Act (WIOA). These measures would not only provide a better measure of TANF's success in helping recipients transition out of poverty and into family-sustaining employment, but would support greater alignment with other federal workforce and education investments. Rather than applying these measures to a relatively small percentage of the state basic assistance grant, the committee should seize this opportunity to jettison the work participation rate entirely and instead measure performance by how well state TANF programs are meeting the long-term employment needs of participants. The committee could also consider giving states the option to elect either work participation rates or the outcome indicators under section 7 as their primary performance measures.

In the event that the committee does not accept the recommendation to eliminate the work participation rate altogether, we would encourage the committee to consider steps that would reduce the administrative burdens on states and service providers in tracking participation. In particular, while we strongly support the committee's efforts to expand access to education and training programs, we are concerned that the current requirements relating to verification of work participation will make it difficult for community colleges, community-based organizations, and other training providers to enroll and serve TANF recipients. To alleviate these concerns, the committee could consider language that would allow successful participation in key federally-supported programs – including adult and youth training programs under WIOA Title I, adult education programs under WIOA Title II, and training services under the Supplemental Nutrition Assistance Program (SNAP) – to be automatically counted as meeting the minimum hour requirements. This step would make it easier for TANF recipients to obtain the skills and credentials they need to succeed in the labor market, while also reducing duplication of services at the state and local levels.

We note that the proposed performance indicator under section 7 relating to median earnings for TANF leavers is different from the WIOA indicator, in that it would measure earnings changes between the second and fourth quarters after program exit, rather than simply measuring median earnings during the second quarter after exit. To avoid confusion and ensure that states are able to better align investments under WIOA and TANF, we would encourage the committee to adopt a performance accountability framework that is as

closely aligned with WIOA measures as is practicable, including considering interim indicators of progress such as measurable skills gains

We would also respectfully encourage the committee to consider eliminating section 4 of the discussion draft, which would prohibit the Department of Health and Human Services from authorizing or approving waivers to the work requirements under TANF. While we recognize that this provision is intended to clarify Congressional intent with respect to work requirements, we believe it is important to maintain at least some administrative flexibility to support innovative strategies that allow states to achieve the broader purposes of poverty reduction and improved employment outcomes. We believe that eliminating any options for waivers may also undercut the committee's efforts under section 11 of the discussion draft to promote greater coordination and planning between TANF and other federal workforce programs.

- **Eliminate the current cap on vocational educational training**. The discussion draft leaves as an "open question" the possibility of lifting the current statutory cap on vocational educational training and secondary school attendance that may be counted towards a state's work participation rate. In the event the committee opts to retain the work participation rate as a measure of state performance, we strongly urge the committee to lift the cap on these activities.

  According to the most recent data available from HHS, 41 percent of adults receiving TANF assistance in Fiscal Year 2012 had fewer than 12 years of formal education, and only 5.7 percent of adults had any form of postsecondary education. In an economy where as many as 80 percent of all new job openings will require at least some education and training beyond the secondary level[2], it makes little sense to impose restrictions on TANF recipients that limit their ability to access these skills. Lifting the cap will give states greater flexibility to design TANF programs that reflect the educational needs of participants, including through career pathways models that align adult education, job training, and supportive services to help low-skilled individuals transition into and advance in high-demand occupations.

- **Ensure that training grants under the proposed "Improving Opportunity Fund" are well-coordinated to state and local workforce investments.** Section 10 of the discussion draft proposes to replace the current TANF contingency fund with a range of competitive grants to support demonstration projects, including $75 million to support training in in-demand occupations ass defined under section 3 of WIOA.

[2] http://www.nationalskillscoalition.org/resources/publications/file/middle-skill-fact-sheets-2014/NSC-United-States-MiddleSkillFS-2014.pdf

National Skills Coalition strongly supports federal investments in high-quality job training, and we believe that the proposed training grant program – if implemented appropriately – provides a useful tool to improve connections between TANF and other workforce programs. We would recommend that the committee strengthen the existing language by explicitly encouraging states to propose strategies that are aligned with new programmatic requirements under WIOA, including the development and implementation of industry or sector partnerships as defined under section 3(26) of WIOA, and career pathways programs as defined under section 3(7) of WIOA. Given the relatively high percentage of TANF recipients who lack a high school diploma or recognized equivalent, we would also encourage the committee to include explicit linkages to adult education programs funded under WIOA Title II. Adding such language would send an important signal to states about the importance of leveraging and coordinating investments across programs, while also helping connect TANF recipients to workforce strategies that have demonstrated effectiveness in meeting the needs of low-skilled, low-income individuals.

Again, we applaud the Committee for their efforts to improve and modernize the TANF program, and we look forward to working with you to ensure that the final legislation supports meaningful opportunities for TANF recipients to fully transition into family-supporting employment.

July 15, 2015

Written Testimony of Cynthia Dungey
Director
Ohio Department of Job and Family Services
U.S. House Ways and Means Committee
Subcommittee on Human Resources

Chairman Boustany, Ranking Member Doggett, and members of the committee:

Thank you for the opportunity to submit testimony to help inform the committee's consideration of welfare reform and legislation to reauthorize the Temporary Assistance for Needy Families (TANF) program. As the director of Ohio's Department of Job and Family Services, I am responsible for managing a number of vital programs that directly impact the lives of Ohioans who rely on TANF, the Supplemental Nutrition Assistance Program (SNAP), job training and employment services, child care, unemployment insurance, child welfare and adoption, adult protective services, and child support programs. Our mission is to improve the well-being of Ohio's workforce and families by ensuring the safety of Ohio's most vulnerable citizens, and promoting long-term self-sufficiency.

A job is the best anti-poverty program, yet too many individuals are trapped in a cycle of poverty. As the economy continues to improve, we cannot afford to have a significant portion of our population in the shadows. Helping these families find meaningful employment is both an economic issue and a moral obligation. In May, Ohio's unemployment rate was 5.2 percent and OhioMeansJobs.com, the state's online job bank, listed more than 206,000 help wanted ads. However, too many Ohioans are unable to take advantage of the improving economy. Nearly 24,000 Ohioans drop out of

high school every year, increasing the likelihood they will not obtain the skills necessary for sustainable employment. At the same time, others struggle to find reliable transportation, stable housing and affordable child care.

Accountability and personal responsibility are important cornerstones of the TANF program and fully embraced by Ohio. In recent years, the state has worked diligently to improve our work participation rate and provide job training and work experiences to adults receiving cash assistance. Ohio's all-family work participation rate improved from 25 percent in December 2010 to 58 percent in March 2015. In addition, the state has increased investments in work support programs, including expanding access to child care assistance for families up to 300 percent of the federal poverty level. We've worked within the rubric of the current system, but simply meeting the work participation rate isn't indicative of actually getting people jobs or the education they need to be successful in the workforce. The next crucial step is ensuring that TANF recipients overcome barriers to employment and develop the in-demand skills local employers seek.

As a county-administered state, with 88 counties representing urban, rural and suburban communities, Ohio is a microcosm of the nation and the perfect laboratory for a new way to work – a new approach to the challenges facing low-income and chronically unemployed individuals.

A New Way to Work

Ohio Governor John Kasich recently signed into law the state's biennial budget, which includes an unprecedented focus on helping Ohioans rise up and out of poverty

and into jobs. The Governor has established a statewide framework that will transform the network of human service and workforce programs to find a *New Way to Work* for the more than 1.8 million Ohioans in poverty, starting first with 16- to 24-year-olds, where early intervention can have the greatest impact.

Ohio is ending the siloed, fragmented approach that for far too long treated "symptoms" of poverty instead of seeking a cure for the underlying challenges faced by low-income Ohioans. We are pushing traditional program boundaries by integrating components of the Ohio Works First TANF program with employment programs under the newly reauthorized Workforce Innovation and Opportunity Act (WIOA) to create a better coordinated, person-centered case management system. The state's Comprehensive Case Management and Employment Program will provide an individualized employment plan appropriate to each person's unique needs in order to remove barriers and make stronger connections to employment. This strategy leverages the strengths of both the workforce and human services systems in a way that focuses on people, not programs.

A number of states and localities have experimented with reforms to better integrate services and align the workforce system to address the needs of TANF recipients and other low-income workers. Lessons learned, highlighting both the benefits and challenges of these initiatives, are well documented. However, Ohio is embarking on this reform in the new era created by WIOA.

WIOA reauthorized national workforce programs for the first time in 16 years and set the stage for a new round of state and local innovation. The law provides opportunities for employment and training activities to be extended to TANF recipients

and for developing innovative, job-driven programs that align services across the TANF and workforce systems. For example, TANF is now a required partner in the local one-stop workforce system, and there is an increased focus on serving low-income individuals with barriers to employment, including out-of-school youth and individuals receiving public assistance. This increases the overlap between targeted populations under both WIOA and TANF.

As we approach the 20th anniversary of the passage of the Personal Responsibility and Workforce Opportunity Act (PRWORA), there is a similar opportunity to make changes to the TANF program to give states flexibility to integrate services and improve employment outcomes for recipients.

Obstacles to Success

From a TANF perspective, there are two major obstacles to TANF-WIOA coordination: 1) Work participation rates are process measures focused on attendance, not outcomes, and 2) strict federal rules, not individual needs, drive work activities.

Rules governing federal work participation requirements have become overly prescriptive and have fundamentally distorted the way caseworkers interact with TANF clients. Federal law holds states accountable for meeting work participation rates, but that accountability has a ripple effect and impacts decisions individual caseworkers make about activities to which TANF clients are assigned. Instead of spending time identifying what clients need and how to get them employed, caseworkers are incentivized to manage to a process to meet the rate. One caseworker I spoke with referred to the work participation rate as a “numbers game.” Another caseworker said

every once in a while he will “take a kick in the teeth” on work participation to do the right thing for a client. Understanding clients’ complex problems and helping them build a path forward is a human-resource-intensive activity. High-quality interactions between caseworkers and clients are the linchpin to identifying barriers and helping individuals become work-ready. Policies that require caseworkers to do mathematical gymnastics to match countable hours to assigned activities are counterproductive and waste a precious resource: their time.

Work participation rules also have led to a proliferation of work experience programs, many of which unfortunately amount to sheltered workshops where clients are given menial tasks disconnected from the skills needed in the job market. Taxpayer dollars are being used to pay outside contractors that specialize in developing and running these “work experience” programs for the sake of saying a client “worked” for their check and counting them toward the rate. It’s hard to believe such programs were a part of Congress’ original vision for welfare reform in 1996.

Finally, federally prescribed work participation rules provide a strong disincentive for workforce development agencies to work with TANF clients. Navigating the rules around what counts and for how long is simply too burdensome. Instead, workforce agencies are inclined to direct their services toward individuals with more work experience and higher skill levels. In short, the current cookie-cutter approach does not effectively move people into jobs, long-term stability or independence from government assistance.

In order to focus on jobs, Ohio is overhauling our case management system and aligning performance metrics with WIOA. Our standards will not be about an individual’s

core and non-core hours and number of consecutive weeks in an activity. Our standards, and ultimately our success, will hinge on metrics tied to improvements in job entry, job retention, earnings and educational outcomes for low-income Ohioans. The state has been a leader in implanting these measures within many of our workforce programs already.

Recommendations

Ohio is not suggesting that Congress reduce the emphasis on personal responsibility or eliminate minimum-hour requirements for individuals to participate in work activities. Yet, TANF has strayed from its original commitment under PRWORA "to increase the flexibility of states in operating a program designed to achieve the purposes of (the Act)" and "end the dependence of needy parents on government benefits by promoting job preparation, work, and marriage." To return to that commitment, we recommend changing a number of federal TANF rules that make it difficult to customize case management based on an individual's employment readiness needs. Specifically, these include the following:

- **Removing the distinction between "core" and "non-core" activities**. Education and training are important pre-cursors to getting a good job. Removing the distinction between "core" and "non-core" activities allows for an individualized service approach to more effectively move clients toward work. For example, a TANF recipient who needs adult basic education and is required to complete 30 hours of activity may be assigned 10 hours to work on his or her education (a "non-core" activity) and 20 hours to attend a work experience program solely because it

is a “core” activity. Activities are assigned and constructed around counting that person toward the work participation rate, not because they address underlying challenges and needs that will enable them to be successful in the workforce.

- **Increasing the vocational education training time limit from 12 to 36 months.** Many individuals require remedial education or lengthier support to get a certification or credential they need to meet employer skill requirements. For example, let’s say a TANF work-required mom with an 8th grade education wants to get her GED and become trained as a phlebotomist. If it takes her longer than 12 months to obtain her GED, she already has used up her 12-month allowance for training (basic skills education linked to training counts toward the time limit). The time it takes to go from an 8th grade education to a GED varies. Someone at an eight-grade level might receive 100 instructional hours over an 18-month period and progress one grade level. Another student might receive the same number of hours over six months and progress two grade levels. Extending the time limit allows recipients additional time to get their GED and complete the vocational education training necessary to get a job. This is particularly important in Ohio, where approximately 30 percent of those in poverty who are age 25 and older do not have a high school education. (*Ohio 2014 Poverty Report*)
- **Increasing job search and job readiness time limits from six to 12 weeks, and removing the four-consecutive-week limit.** The hardest-to-serve individuals require additional time to gain the skills they need to be job-ready. For example, clients may need significant job readiness preparation and soft skills training before they are ready to meaningfully engage in job searching and interviewing with

employers. After spending four weeks on job readiness, they've used up their consecutive-week limits. Arbitrary time limits on job search and job readiness make it harder to successfully connect them to sustainable employment.

- **Removing the 16-hour monthly cap on good-cause hours (but maintaining the 80-hour annual cap) credited toward work participation.** This would provide more flexibility for individuals with situational extenuating circumstances. For example, a mom with children ages 3 and 6 has a high likelihood of being in a situation where one or both children are ill and unable to attend child care or school for more than two days in any given month. Removing the monthly cap would allow that mom to take care of her sick children without negatively impacting her benefit or the state's work participation rate.

A number of these issues are addressed in TANF reauthorization bills under consideration by the committee, in particular the elimination of the distinction between core and non-core activities and increasing the time allowed for job search activities. Ohio supports reforms that enable us to make these changes and that give us more flexibility to tailor our programs and services to successfully move more low-income individuals into work.

Ohio stands ready to work with the committee and its staff to help inform these and other reforms to the TANF program. If you have any questions or would like more details about Ohio's *New Way to Work* initiative, please feel free to contact me directly. Thank you for your time and consideration.

ReadyNation
Strengthening business through
effective investments in children and youth

July 17, 2015

The Honorable Charles Boustany
U.S. House of Representatives
1431 Longworth House Office Building
Washington, DC 20515

The Honorable Todd Young
U.S. House of Representatives
1007 Longworth House Office Building
Washington, DC 20515

The Honorable John Delaney
U.S. House of Representatives
1632 Longworth House Office Building
Washington, DC 20515

Dear Chairman Boustany, Representative Young, and Representative Delaney:

We applaud you and members of the House Ways and Means Subcommittee on Human Resources for including language authorizing Social Impact Demonstration Projects in the recently released draft bill reauthorizing the Temporary Assistance for Needy Families (TANF) program. We thank you for your leadership in ensuring the inclusion of this critical language to authorize and provide resources for the development of "pay for success" (PFS) social impact finance projects by state and local governments, which will reduce taxpayer burden and increase program effectiveness. Encouraging partnerships between private, philanthropic and public sectors to improve social programs through mechanisms such as the Social Impact Demonstration Projects will increase collaboration among stakeholders to solve social problems while ensuring that taxpayer money is spent wisely only on interventions that can demonstrate promised outcomes.

ReadyNation is the preeminent business membership organization whose purpose is to ensure the U.S. has the most productive competitive workforce in the world and enable our nation to regain self-generated sustainable economic growth – through maximizing the life-success of young children. Members of ReadyNation have led the way in developing and establishing PFS projects to scale up high-quality early childhood interventions that produce positive returns for young children and their families, for taxpayers, and for local, state, and the federal, governments.

ReadyNation respectfully submits the following recommendations in the hope that the final legislation will encompass all worthy social impact finance project areas and grant the flexibility needed to deliver the greatest value in promised outcomes.

We suggest amending section 10 of the draft bill as follows:

- Evidence-based early childhood education and home visiting programs have been proven (or, in some cases, have the promise) to improve maternal and infant health outcomes, school readiness, and future life success. In the interest of encompassing all worthy social impact project areas, we recommend including the following changes:
  - **Page 46, line 7,** inserting a new paragraph (V), and reordering paragraphs (V) through

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ReadyNation is a membership organization of business leaders under the umbrella non-profit Council for a Strong America.

(XXI) accordingly, to read: "(V) Improving school readiness and child academic achievement, and reducing special education assignments, grade retention, suspension or expulsions."; and,

- **Page 46, line 11,** revising (VII) to read: "(VII) Improving prenatal, neonatal, maternal and early child health among low-income or at-risk families and individuals."

- In many jurisdictions, the term "prison" isn't inclusive of juvenile facilities or detention centers. Therefore, we feel it important to specify the inclusion of juvenile correctional facilities or detention centers.
  - **Page 47, line 16,** revising (XVII) by replacing with the following:
    - "(XIV) Reducing juvenile or criminal offending, including reducing recidivism among individuals adjudicated as having committed a juvenile offense or adult crime."

- As the draft bill acknowledges, randomized control trials will not be possible in (or applicable to) all interventions due to the covariates and project conditions. It may be that quasi-experimental methodologies, such as those that compare the historical treatment of non-treatment and treatment groups, are necessary. Moreover, because the federal government is not at risk in PFS arrangements -- neither the Treasury Department will make outcome success payments nor will federal agencies from their own funds – without confirmation by a qualified independent evaluation that cost avoidance savings occurred, we do not believe that research design methodologies used by evaluators should be discussed in the legislation. This is the responsibility of the agency head and the intermediary.
  - **Page 52, line 19,** revising (XXII) by striking, "where available, well-implemented randomized control trials" and replacing it with:
    - "scientifically recognized, rigorous research design methodologies for assessing intervention effectiveness and impact, including for promising social interventions that have not yet been rigorously tested".

- Generally, we would encourage committee members to consider that there are promising new approaches to achieving the desired outcomes set forth in the legislation that may not yet have been rigorously tested. Therefore, we encourage incorporating language similar to that used in the reauthorization of the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program that distinguishes between evidence-based and promising programs.
  - **Page 49, line 4,** revising (III) as follows:
    - ``(III) Rigorous evidence demonstrating that the intervention, or combination of integrated interventions, can be expected to produce the desired outcomes, or the model conforms to a promising and new approach to achieving the outcomes specified in paragraph (3)(B)(ii), has been developed or identified by a national organization or institution of higher education, and will be evaluated through well-designed and rigorous process."; or,
    - "(III) Rigorous evidence demonstrating that the intervention, or combination of integrated interventions, can be expected to produce the desired outcomes or, if the intervention has not undergone sufficient rigorous testing, other compelling data demonstrating the promise of the intervention to produce the desired outcome".

General Comments for Consideration:

- There certainly can be no objection to requiring submission of the feasibility studies the investors used in their decision-making process, but it should be noted that if there are no investors willing to put their money at risk, there will be no discussion of a PFS project. Hence, the most important evidence of project success, and the most important standard for federal government funding contemplated in this draft bill, is the presence and commitment of private sector for-profit or non-profit investors. Generally, we ask that you consider including in the evidence standard sections of the bill the presence of committed private investors, whether individuals, businesses, or philanthropies, as overriding evidence of prospective project success;

- The provisions establishing the Federal Interagency Council on Social Impact Partnerships (FICSIP) could be interpreted as providing the Council with general PFS policy authority for the entire federal government. This is unnecessary for the legislation's purposes and dangerous for PFS development. If the sections are left in, other agencies will look to FICSIP for guidance on whether to participate in a PFS project, and state agencies' decisions will be shaped by FICSIP policies. If FICSIP over-regulates or its membership becomes controlled by anti-PFS interests, PFS progress will be halted or indefinitely delayed. We recommend language establishing prohibitions that clarify: (a) the responsibility, authority and policy scope of FICSIP is strictly limited to the disbursement of funds provided for under the Act; and, (b) any government agency may determine on its own whether to participate in a PFS project to the extent its enabling statutes permit; and,

- There is a risk that the standards FICSIP requires to obtain funds under the legislation will become the standards applied to PFS projects generally, particularly by state agencies. We recommend language clarifying that the standards imposed by FICSIP for funding under the legislation not be interpreted in ways that prevent philanthropic, private and state agencies on their own to engage in a PFS project on the basis of the standards they judge to be sufficient.

ReadyNation recognizes the important steps that this legislation would take and commends you for your leadership. We look forward to working with you on this and other initiatives to improve the life-success of young children and families in the future.

Sincerely,



Sara Watson
Director
ReadyNation

SOCIAL FINANCE

Welfare Reform Proposals: Comments from Social Finance

July 22, 2015

Mr. Charles Boustany, Chairman
Subcommittee on Human Resources
House Ways and Means Committee
1102 Longworth House Office Building
Washington, DC 20515

Mr. Lloyd Doggett, Ranking Member
Subcommittee on Human Resources
House Ways and Means Committee
1102 Longworth House Office Building
Washington, DC 20515

Dear Chairman Boustany and Ranking Member Doggett,

Thank you for the opportunity to comment on the Subcommittee's Discussion Draft of welfare reauthorization legislation containing authority for Social Impact Demonstration Projects.

Social Finance, Inc. is a 501(c)(3) nonprofit organization dedicated to mobilizing capital to drive social progress. Co-founded in January 2011 by David Blood, Sir Ronald Cohen, and Tracy Palandjian, Social Finance believes that everyone deserves the opportunity to thrive and that impact investing can play a catalytic role in creating these opportunities. Social Finance is committed to designing public-private partnerships that are focused on resolving complex social challenges. Through these partnerships, we aim to direct capital to high-quality interventions to facilitate greater access for vulnerable populations. Core to our mission is the advancement of Pay for Success (PFS) projects in the United States through comprehensive advisory work, transaction development, performance management, and market education. Additionally, Social Finance has two sister organizations, Social Finance United Kingdom and Social Finance Israel, which comprise Social Finance's Global Network.

Social Finance strongly supports the inclusion of the Social Impact Demonstration Project authority (Section 10, subsection 3) in the welfare reform discussion draft released by the House Ways and Means Human Resources Subcommittee this week. This legislation supports the exciting momentum around Pay for Success that we are seeing in the field among state and local governments, nonprofit service providers, and impact investors, and reflects the strong knowledge and support of Pay for Success at the Federal level. Based on our on-the-ground experience in developing Pay for Success projects, we offer the below comments for your consideration. We believe these changes would significantly strengthen the legislation to ensure its effective implementation and to measurably improve the lives of Americans:

Section B, subsection ii: Required Outcomes for Social Impact Partnership Project
The current languages states that "a project must produce measurable, clearly defined outcomes that result in social benefit and Federal savings".

We recommend that the language be revised to encourage projects to produce outcomes that result in social benefit and value to the government, rather than requiring savings to the Federal government. The language requiring savings may unintentionally restrict the types of projects and outcomes that are supported and could prevent projects which produce significant value to the government over the long-term. For example, increased educational achievement or

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improvements to veterans' wellbeing have value for the Federal government even if they cannot prove direct impact on a Federal budget line item.

Section A, subsection iii and Section D, subsection i: Feasibility Study Required and Requests for Funding for Feasibility Studies
The current language includes requirements for applying for feasibility study funding and the feasibility study for states or local governments.

We recommend that the feasibility study requirements and the application for feasibility study funding requirements for states and local governments include suggested topics to address in the feasibility study without requiring specific level of detail on those topics, to avoid making the requirements so burdensome that states or local governments cannot access this Federal resource. Our experience in developing Pay for Success projects is that the feasibility study is used to identify topics such as potential service providers, preliminary operation plans and potential project intermediaries. Detailed decisions on these topics are more thoroughly addressed in the development stage of the project after all parties are committed to executing a PFS contract. For example, establishing the payment structure or defining payment thresholds cannot be finalized before engaging with investors during the project development stage.

Section D, subsection iii: Feasibility Study Required - Evidence
The feasibility study requirements include "rigorous evidence demonstrating that the intervention can be expected to produce the desired outcomes".

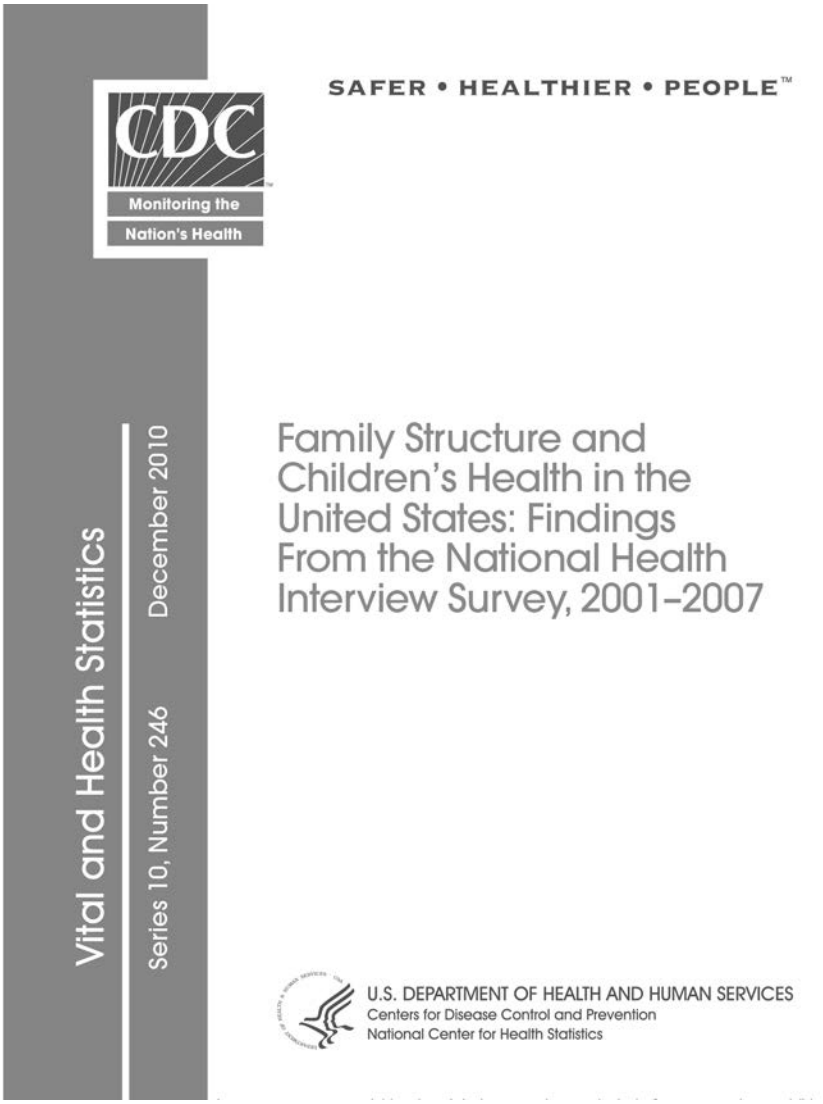
We appreciate the requirement for strong evidence for interventions being supported in a Pay for Success project. However, the current language may unintentionally restrict projects which are helping to build the evidence base for a sector or intervention. Instead, the language should allow for other forms of compelling data and the ability to engage in rigorous experimental or quasi-experimental evaluations to build the evidence in the field. The child welfare sector, for example, has very limited interventions with rigorous evidence and Pay for Success could expand highly impactful programs while building the evidence base for the sector. In addition, an intervention may have compelling programmatic data paired with quasi-experimental studies but have not yet had the resources to fund a randomized experiment, which could be funded through a Pay for Success project.

Thank you for the opportunity to comment on the Discussion Draft. Social Finance would be happy to provide clarification of any of the points raised to provide additional information.

Sincerely,



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Monitoring the Nation's Health
Vital and Health Statistics
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Family Structure and Children's Health in the United States: Findings From the National Health Interview Survey, 2001–2007
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Disease Control and Prevention
National Center for Health Statistics

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Family Structure and Children's Health in the United States: Findings From the National Health Interview Survey, 2001–2007

Data From the National Health Interview Survey

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Disease Control and Prevention
National Center for Health Statistics

Hyattsville, Maryland
December 2010
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Abstract

Objectives

This report presents statistics from the 2001–2007 National Health Interview Survey (NHIS) on selected measures of physical health and limitations, access to or utilization of health care, and behavior or emotional well-being for children under age 18 by family structure, sex, age, race, Hispanic origin, parent's education, family income, poverty status, home tenure status, health insurance coverage, place of residence, and region.

Source of Data

NHIS is a multistage probability sample survey conducted annually by interviewers of the U.S. Census Bureau for the Centers for Disease Control and Prevention's National Center for Health Statistics, and is representative of the civilian noninstitutionalized population of the United States. Information about one randomly selected child per family is collected in a face-to-face interview with an adult proxy respondent familiar with the child's health.

Highlights

Children in nuclear families were generally less likely than children in nonnuclear families to be in good, fair, or poor health; to have a basic action disability; to have learning disabilities or attention deficit hyperactivity disorder; to lack health insurance coverage; to have had two or more emergency room visits in the past 12 months; to have receipt of needed prescription medication delayed during the past 12 months due to lack of affordability; to have gone without needed dental care due to cost in the past 12 months; to be poorly behaved; and to have definite or severe emotional or behavioral difficulties during the past 6 months. Children living in single-parent families had higher prevalence rates than children in nuclear families for the various health conditions and indicators examined in this report. However, when compared with children living in other nonnuclear families, children in single-parent families generally exhibited similar rates with respect to child health, access to care, and emotional or behavioral difficulties.

Keywords: health and limitations • access to care • emotional or behavioral difficulties

Family Structure and Children's Health in the United States: Findings From the National Health Interview Survey, 2001–2007

by Debra L. Blackwell, Ph.D., Division of Health Interview Statistics

Introduction

As divorce rates remain high and cohabitation becomes more commonplace, an increasing number of U.S. children will spend a larger proportion of their lives in a nontraditional family. The proportion of U.S. children likely to live part of their childhood in a married stepfamily increased from about one-seventh in the early 1970s to one-quarter in the early 1980s; if unmarried stepfamilies are also included, the proportions would be higher (1). In 1990, 3.5% of U.S. children lived with a parent and his or her cohabiting partner (2), while in 2002, 6% lived with a cohabiting parent and partner (3). Graefe and Lichter estimated that about one of four children will live in a family headed by a cohabiting couple at some point during their childhood (4). Using different data, Bumpass and Lu concluded that 40% of children would live in a cohabiting couple family during childhood (5). Additionally, the U.S. Census Bureau estimated that in 2004, 10 million children under age 18, or 14% of all children, were living in households consisting of a biological or adoptive parent and another unrelated adult (6), while the Centers for Disease Control and Prevention's (CDC) National Center for Health Statistics (NCHS) reported that 35.8% of all births in 2004 were to unmarried women (7).

In view of the changing family structure distribution, new categories of families such as unmarried families or unmarried stepfamilies need to be studied so that the health characteristics of children in nontraditional families can be identified (1,8,9). Previous researchers have reported that children living in nontraditional families are disadvantaged financially, and are more likely to experience deleterious outcomes with respect to school (e.g., higher drop-out rates, poorer academic performance), behavior (e.g., delinquency, promiscuity), and mental health (9–17). A small number of published studies have found that children in two-parent families are more advantaged than children in other types of families with respect to health status or access to health care (18–21). However, these analyses were based on

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survey data that did not collect information on cohabitation and parent-child relationships (e.g., biological, step, etc.), making the identification of nontraditional family types impossible.

The National Health Interview Survey (NHIS), a multi-purpose health survey conducted by NCHS, initiated an important step in identifying nontraditional families with the implementation of a new household rostering system and marital status variables in 1997. Detailed family structure variables distinguished between married parent families (with biological or adoptive children), unmarried parent families (with biological or adoptive children), parent-stepparent families (with children), and parent-cohabiting partner families (with children). Thus, NHIS data provide an opportunity to investigate the association of family structure with the health status and characteristics of U.S. children.

This report presents national prevalence estimates for selected health status and access to health care indicators among children by type of family structure. Because the association between children's health and family structure is likely to be modified by personal (e.g., sex, age, race/ethnicity), social (parental education), and economic (e.g., family income, poverty status, home tenure status, and health insurance coverage) characteristics, these factors are also controlled for in the report's detailed tables.

The family structure indicator used in this report consists of seven mutually exclusive categories that take into account parental marital status as well as the type of relationship between children aged 0–17 and any parents present in the family. Because NHIS defines children as family members who are aged 0–17 and adults as family members who are aged 18 and over, adult children (those aged 18 and over) are considered related adults regardless of their relationship (biological, adoptive, step, or foster) to their parents.

- A *nuclear family* consists of one or more children living with two parents who are married to one another and are each biological or adoptive parents to all children in the family.
- A *single-parent family* consists of one or more children living with a single adult (male or female, related or unrelated to the child or children).
- An *unmarried biological or adoptive family* consists of one or more children living with two parents who are not married to one another and are each biological or adoptive parents to all children in the family.
- A *blended family* consists of one or more children living with a biological or adoptive parent and an unrelated stepparent who are married to one another.
- A *cohabiting family* consists of one or more children living with a biological or adoptive parent and an unrelated adult who are cohabiting with one another.
- An *extended family* consists of one or more children living with at least one biological or adoptive parent and a related adult who is not a parent (e.g., a grandparent). Any of the previously described family types that contained an adult child are categorized as an extended family.
- An *"other" family* consists of one or more children living with related or unrelated adults who are not biological or adoptive parents. Children being raised by their grandparents are included in this category, as are foster children living with at least two adults.

Data Source

Data from the 2001–2007 NHIS are pooled to provide national estimates for a broad range of health status indicators and measures of access to health care by family structure for the U.S. civilian noninstitutionalized population of children under age 18. Pooled analyses are typically done to increase sample sizes for small populations (e.g., unmarried biological or adoptive and cohabiting families). Weighted estimates from such an analysis can be interpreted as either an estimate for the midpoint of the study period or as an "average" across the study period (22). Data from the 2001–2007 NHIS were selected for this analysis because the 2000 NHIS does not contain complete family structure information, and the 2008 NHIS was not available at the time these analyses were conducted. The family structure indicator used for this report is obtained from the 2001–2007 in-house Person or Family data files; a public-use version is also available but it combines all unmarried biological or adoptive families and cohabiting families into a single category. Most health estimates are derived from the 2001–2007 public-use Sample Child data files of the annual NHIS Basic Module; the remaining health estimates are derived from the 2001–2007 public-use Person data files. These estimates, which users can replicate with NHIS public-use data, are shown in Tables 1–66 for various subgroups of the population, including those defined by sex, age, race and Hispanic origin, parent's education, family income, poverty status, home tenure status, health insurance coverage, place of residence, and region. Appendix I contains brief technical notes and Appendix II contains definitions of terms used in this report.

NHIS has been an important source of information about health and health care in the United States since it was first conducted in 1957. Its main objective is to monitor the health of the civilian noninstitutionalized U.S. population through the collection and analysis of data on a broad range of health topics. Persons in long-term care institutions (e.g., nursing homes; hospitals for the chronically ill, disabled, or mentally handicapped; wards for abused or neglected children), correctional facilities (e.g., prisons or jails, juvenile detention centers, halfway houses), active duty Armed Forces personnel (although their civilian family members are included), and U.S. nationals living in foreign countries are excluded from the sampling frame. More information on sample design can be found in "Design and Estimation for the National Health Interview Survey, 1995–2004" (23).

The NHIS questionnaire, called the Basic Module or Core, is repeated annually and consists of three main components: the Family Core, the Sample Child Core, and the Sample Adult Core (the latter is not used for this report). The Family Core collects information about all family members regarding household composition and sociodemographic characteristics, along with basic indicators of health status, activity limitations, and utilization of health care services. All members of the household aged 17 and over who are at home at the time of the interview are invited to participate and respond for themselves. For children and adults not at home during the interview, information is provided by a knowledgeable adult family member aged 18 and over residing in the household. Although considerable effort is made to ensure accurate reporting, the information from both proxies and self-respondents may be inaccurate because the respondent is unaware of relevant information, has forgotten it, does not wish to reveal it to an interviewer, or does not understand the intended meaning of the question. Note that NHIS does not obtain independent evaluations directly from doctors or other health care professionals.

The Sample Child Core obtains additional information on the health of one randomly selected child aged 0–17 in the family; a knowledgeable adult in the family (usually a parent) provides proxy responses for the sample child. The Sample Child Core is the primary data source for this report, while information regarding demographic characteristics is derived from the Family Core.

The interviewed sample for the 2001–2007 NHIS consisted of a total of 244,572 households, which yielded 630,884 persons in 249,570 families. There were 90,566 children aged 0–17 who were eligible for the Sample Child questionnaire. Data were collected for 82,553 children, a conditional response rate of 91.1%. The average final response rate for the Sample Child component during 2001–2007 was 79.3% (24–30). However, detailed family structure information was not available in the first and second quarters of 2004, so these sample child cases were omitted, and case weights for the sample child observations in the third and fourth quarters of 2004 were doubled to obtain an appropriate estimate of the U.S. child population for 2004. This adjustment yields a total of 83,849 observations for analysis. This sample results in a weighted, annualized estimate of 73.2 million children in the United States during 2001–2007.

Limitations of the Data

NHIS obtains information from respondents via an in-person interviewing process, with a typical interview averaging about 1 hour. No clinical measurements are taken. As a result, all NHIS data are based on subjective reports obtained from respondents who stated that they were knowledgeable about all family members' health status, access to medical care, and personal information. The NHIS interviewer has no way of verifying whether these family respondents are, in fact, knowledgeable. In addition, respondents may experience recall problems or have different cultural definitions of illness, either of which could result in inaccurate responses. Furthermore, as with all surveys, respondents may simply underreport characteristics or conditions that they consider undesirable. It is thus likely that some of the prevalence estimates presented in this report are conservative.

Despite the fact that multiple years of data were used for this analysis, cell counts in some of the more detailed cross-classification tables are small, particularly when a "rare" family structure is crossed with a "rare" health condition. The resulting percentages have relatively large standard errors that make the detection of statistically significant relationships difficult; some relationships between family structure and child health may thus go undetected as a result. Percentages with a relative standard error greater than 30% are identified by an asterisk in all tables; readers should use caution when attempting to interpret these statistics. For this reason, percentages indicated by an asterisk in the tables are not discussed in the text or shown in any figures in this report. In addition, frequencies may also be underestimates due to item nonresponse and unknowns, both of which are excluded from the tables. See Appendix I for more information about the number of unknowns with respect to each health characteristic.

NHIS is a cross-sectional survey that does not obtain retrospective information from adult respondents regarding their marital histories or living arrangements. The family structure indicator used in this report cannot account for children's transitions into and out of different families, nor can it be used to estimate health outcomes for children who have ever lived in a particular type of family (e.g., cohabiting or single-parent families). Thus, we cannot distinguish between family structure *per se* and family instability, that is, repeated transitions into and out of different family types (15). Family structure, as measured in this report, is the type of family in which the sample child was living at the time of interview. Consequently, the tables in this report can only be used to understand the extent to which selected child health outcomes and family structure vary together; causality or directionality in the family structure and child health relationship cannot be determined from NHIS data. Lastly, while the tables show estimates by various age groups, the prevalence estimates presented in the tables are not age-adjusted.

Methods

Estimation Procedures

Estimates presented in this report were weighted to provide national health estimates; the record weight of the sample child was used to generate all estimates. These weights were calibrated by NCHS staff to produce numbers consistent with the population estimates of the United States by age, sex, and race/ethnicity, and are based on population projections from the U.S. Census Bureau for noninstitutionalized civilians. Because 7 years of NHIS data were utilized, each weight was divided by seven before analyzing the data, in

order to annualize the resulting estimates.

The weights from the 2001 and 2002 NHIS were based on projections from the 1990 census, while the weights from the 2003–2007 NHIS were based on projections from the 2000 census. Prior to the release of the 2003 data, NCHS staff compared estimates for a number of health characteristics using the 1990 census-based weights and the 2000 census-based weights and found that health estimates were extremely consistent regardless of the weighting schema used (26). Thus, the change in the census-based population controls used to create the 2003–2007 NHIS case weights should have little impact on data analyses that utilize the combined 2001–2007 data.

For each health measure, weighted frequencies and weighted percentages are shown for all children according to their family structure. Estimates are further disaggregated by various sociodemographic characteristics, such as sex, age, race and Hispanic origin, parent's education, family income, poverty status, home tenure status, health insurance coverage, place of residence, and region. All counts are expressed in thousands. Counts for children of unknown status with respect to family structure and each health characteristic of interest are not shown separately in the tables, nor are they included in the calculation of percentages, in order to make the presentation of the data more straightforward. In most instances, the percentage unknown is small (typically less than 1%).

Additionally, some of the sociodemographic variables that are used to delineate various subgroups of the population have unknown values. Again, for most of these variables, the percentage unknown is small. Health estimates for children with these unknown sociodemographic characteristics are not shown in the tables. Readers should refer to Appendix I for more information on the quantities of cases with unknown or missing values. The 2001–2007 NHIS Imputed Family Income/Personal Earnings Files were used to minimize the exclusion of cases with incomplete information regarding family income and poverty status.

Variance Estimation and Significance Testing

NHIS data are based on a sample of the population and are therefore subject to sampling error. Standard errors are reported to indicate the reliability of the estimates. Estimates and standard errors were calculated using SUDAAN software that takes into account the complex sampling design of NHIS. The Taylor series linearization method was used for variance estimation in SUDAAN (31).

Standard errors are shown for all percentages in the tables but not for the frequencies. Estimates with relative standard errors of greater than 30% are considered unreliable and are indicated with an asterisk. The statistical significance of differences between point estimates was evaluated using two-sided *t* tests at the 0.05 level and assuming independence. Terms such as "greater than," "less than," "more likely," "less likely," "increased," "decreased," "compared with," or "opposed to" indicate a statistically significant difference between estimates, whereas "similar," "no difference," or "comparable" indicate that the estimates are not statistically different. A lack of commentary about any two estimates should not be interpreted to mean that a *t* test was performed and the difference found to be not significant. These statistical tests did not take multiple comparisons into account.

Measurement of Family Structure

NHIS is a cross-sectional, household-based survey that obtains information from its respondents at a specific time. It does not obtain detailed relationship histories from respondents because this would be beyond the scope of the survey. The household composition portion of the survey contains several filter questions at the outset of the interview that ask whether all persons in the household live and eat together or if any of them have another residence where they usually live. Persons who do not routinely live and eat together as well as those who may regularly visit but maintain a residence elsewhere are not included in the interview. Individuals drift into and out of cohabiting unions gradually over time (32), so the use of these filter questions may result in more accurate estimates of some nontraditional families. A household roster is then completed and the relationships of all family members to the "family reference person"—typically the person who owns or rents the home—are established. To facilitate completion of the roster, respondents are given a flash card listing 17 possible family relationships; "spouse (husband/wife)" and "unmarried partner" are listed as separate items. Current marital status is obtained for all family members aged 14 and over; respondents self-report whether they are currently married, widowed, divorced, separated, never married, or living with a partner, and they identify which family member is their spouse or partner. Also, for each family member aged 17 and under, several questions ascertain whether one or both parents are present in the household and the nature of the relationship between the parent or parents and child (i.e., biological, adoptive, step, or foster).

Family structure is measured by a variable with seven mutually exclusive categories (see the family structure description in the Introduction) that takes into account parental marital status and the type of relationship (e.g., biological, adoptive, step) between children aged 0–17 and any parents present in the family. Children aged 17 and under who are emancipated minors are excluded from the analysis. A related family member is someone who is connected by ancestry, marriage, or legal adoption to the child or children. In the case of **nuclear** and **unmarried biological or adoptive families**, both parents must be biological or adoptive to all children in the family. **Single-parent families** may consist of one or more children living with a single parent (male or female) who may or may not be biologically related to the child or

children in the family. **Blended families** (i.e., parent and stepparent) are those in which the two adults present are married to one another and at least one child in the family is the biological or adopted child of one adult and the stepchild of the other adult. **Cohabiting families** consist of one or more children residing with a biological (or adoptive) parent and that parent's cohabiting partner who is unrelated to the child or children. Families with one or more children living with at least one biological or adoptive parent and one or more related adults, such as a grandparent or an adult sibling, are referred to as an **extended family**. Note that NHIS defines persons aged 18 and over as adults. As a result, any of the family types described previously with one or more adult children are considered extended families. This will result in smaller counts and percentages of the remaining family types, particularly nuclear families, and to a lesser extent, single-parent families. Lastly, a family with one or more children living with two or more related or unrelated adults (none of whom is a biological or adoptive parent to that child) is considered, for the purposes of this report, as an **"other" family**. Children being raised by their grandparents would be included in this category, as would foster children (as long as a minimum of two adults are present).

Measurement of Health Outcomes

This report examines children's health in three broad categories: physical health or limitations, access to or utilization of health care, and behavior or emotional well-being. In all instances, a knowledgeable adult (typically a parent) provided information on behalf of all sample children aged 0–17. Note that the second footnote in each table contains the verbatim text of the survey question that was the source of the estimates in the table, along with other pertinent information. Unless otherwise noted, questionnaire items and response categories did not change across the 2001–2007 surveys.

Information regarding good, fair, or poor health status [i.e., less than optimal health (33–37)], and impairments that limited crawling, walking, running, or playing was obtained from separate questions in the Family Core that asked about the child's current (i.e., at the time of the interview) health. Information regarding receipt of special education or Early Intervention Services (EIS) was also obtained from the Family Core, and was based on current as well as previous enrollment. Chronic condition status was based on a series of separate questions in the Sample Child Core that asked whether a doctor or health professional had ever said that the sample child had Down syndrome, muscular dystrophy, cystic fibrosis, sickle cell anemia, autism, diabetes, arthritis, congenital heart disease, or any other heart condition. Likewise, prevalence estimates of ever having asthma, mental retardation, or any developmental delay were obtained from separate questions in the Sample Child Core that asked whether a doctor or other health professional had ever said that the sample child had these conditions. Frequency and percentage estimates of mental retardation and any developmental delay were combined for this analysis.

Information regarding hay fever, allergies (respiratory, skin, or digestive), and ear infections was obtained for sample children of all ages and was based on the 12-month period prior to the interview; information regarding frequent headaches or migraines was also based on the 12-month period prior to the interview, but was obtained only for sample children aged 3–17. Information on vision problems was obtained from a Sample Child Core question that asked whether the sample child had any "trouble seeing." If the child was aged 2 and over, the interviewer added "even when wearing glasses or contact lenses." Prevalence estimates of learning disabilities or attention deficit hyperactivity disorder (ADHD) were derived from separate questions in the Sample Child Core. Respondents were asked whether a representative from a school or a health professional had ever said that the sample child aged 3–17 had a learning disability. Similarly, respondents were asked whether a doctor or health professional had ever said that the sample child aged 3–17 had ADHD or attention deficit disorder (ADD). Frequency and percentage estimates of learning disabilities and ADHD or ADD were combined for this analysis.

Basic action disability (Tables 27–28) is a new summary measure that takes into account four basic domains or functions that a child needs in order to participate in age-appropriate activities (38,39). These domains consist of sensory functions (e.g., hearing, vision), movement (e.g., walking, running, playing), cognitive functioning (e.g., ability to remember, learning disabilities, mental retardation, Down syndrome, autism), and emotional or behavioral functions (ADHD, emotional, or behavioral difficulties). Accordingly, children aged 4–17 were considered to have a basic action disability if they had any one of the following: a lot of trouble hearing or deafness; trouble seeing; limitations in their ability to crawl, walk, run, or play; difficulty remembering; mental retardation; Down syndrome; autism; a learning disability; ADHD; or definite or severe emotional or behavioral difficulties [from the Strengths and Difficulties Questionnaire (SDQ)]. Information regarding difficulty remembering came from a Family Core question; all other information was obtained from questions in the Sample Child Core.

Data on the number of school days missed were obtained from a question in the Sample Child Core that asked how many school days the sample child aged 5–17 missed in the past 12 months due to illness or injury. (Tables in this report utilize a cut-point of six or more days.) Information regarding use of prescription medications was based on a question in the Sample Child Core that asked whether the sample child aged 0–17 had a problem for which he or she had regularly taken prescription medication for at least 3 months.

Information regarding health care insurance coverage was obtained from various questions in the Family Core about type of coverage at the time of interview. Information about having a usual place of health care was obtained

from a question in the Sample Child Core that asked whether there was a place (e.g., doctor's office, health clinic, etc.) that the sample child "usually" went when he or she was sick or the parent or guardian needed advice about the child's health. Information regarding emergency room (ER) visits was obtained from a Sample Child Core question that asked the number of times during the past 12 months that the sample child had gone to a hospital ER about his or her health, including those times that resulted in a hospital admission. In addition, information regarding receipt of medical checkups was obtained from another question in the Sample Child Core that asked whether the sample child had received a "well-child check-up—that is, a general check-up when he or she was not sick or injured" during the past 12 months. Note that children under age 1 are not included in the tables showing medical checkups. The Sample Child Core also obtained information regarding the child's contacts with "an optometrist, ophthalmologist, or eye doctor (someone who prescribes glasses)" during the past 12 months.

NHIS contains several questions that obtain information regarding delaying medical care during the past 12 months due to cost or affordability concerns. Having medical care delayed due to concerns over cost was obtained from a question in the Family Core; all children aged 0–17 are shown in the resulting tables. In addition, the Sample Child Core included questions that asked whether the child "needed prescription medication but didn't get it because [the family] couldn't afford it" and whether the child "needed eyeglasses but didn't get them because [the family] couldn't afford it." These questions were asked of sample children aged 2–17.

Information regarding dental care was obtained from separate questions in the Sample Child Core that asked when the sample child had last visited any kind of dentist (including orthodontists, oral surgeons, or other dental specialists), and whether the sample child had needed dental care (including checkups) during the past 12 months but had not received it due to concerns over cost. Note that only children aged 2–17 were included in the dental care tables. Information regarding behavior and emotional well-being was obtained from several questions from the SDQ that were included in the Sample Child Cores in 2001–2007. The SDQ is a behavioral screening questionnaire for children aged 4–17 that includes questions on both positive and negative behaviors as well as follow-up questions about the impact of these behaviors on the child and his or her family (40).

Data presented in this report are based only on those questions included in all 7 years of the 2001–2007 Sample Child Cores. Five behavior questions were asked of sample children aged 4–17 and were based on the 6-month period prior to the interview. Response categories for the five questions included "Not true," "Somewhat true," and "Certainly true" (as well as "Refused" or "Don't know"). The tables in this report include those cases where it was "certainly true" that the sample child was often unhappy, depressed, or tearful; "not true" that the sample child was generally well-behaved and usually did what adults requested; "certainly true" that the sample child had many worries or often seemed worried; "not true" that the sample child had a good attention span and saw chores or homework through to the end; and "certainly true" that the sample child got along better with adults than with other (age-appropriate) children.

The final SDQ question asked whether, "overall," the sample child had difficulties with emotions, concentration, behavior, or being able to get along with other people. Response categories included "No," "Yes, minor difficulties," "Yes, definite difficulties," "Yes, severe difficulties," "Refused," or "Don't know." Tables 63–64 show children with definite or severe emotional or behavioral difficulties. Tables 65–66 are based on two questions in the Sample Child Core that asked, "During the past 12 months, have you seen or talked to a mental health professional such as a psychiatrist, psychologist, psychiatric nurse, or clinical social worker about [child's name]'s health?" and, for sample children who had seen or talked with a general doctor or pediatrician during the past 12 months, "Did you see or talk with this general doctor because of an emotional or behavioral problem that [child's name] may have?" Only children with definite or severe emotional or behavioral difficulties are included in these tables.

Further Information

Readers interested in NHIS data can obtain the latest information about NHIS by periodically checking the NCHS website: http://www.cdc.gov/nchs/nhis.htm. The website features downloadable public-use data and documentation for recent surveys, as well as important information about any modifications or updates to the data or documentation. Readers wishing access to in-house NHIS data should contact the NCHS Research Data Center via http://www.cdc.gov/rdc/.

Researchers may also wish to join the NHIS electronic mailing list. To do so, visit http://www.cdc.gov/subscribe.html. Fill in the appropriate information and click the "National Health Interview Survey (NHIS) researchers" box, followed by the "Subscribe" button at the bottom of the page. The list consists of approximately 3,000 persons worldwide who receive e-mail about NHIS surveys (e.g., new releases of data or modifications to existing data), publications, and conferences.

Selected Results

This section includes selected graphs and a discussion of results based on the estimates shown in Figures 1–28 and Tables 1–66. Results are shown for three broad categories: physical health or limitations, access to or utilization of health care, and behavior or emotional well-being.

In addition, the results presented below utilize the following shorthand terms in describing mutually exclusive family types (see Appendix II):

- A *nuclear family* consists of one or

more children living with two parents who are married to one another and are each biological or adoptive parents to all children in the family.

- A *single-parent family* consists of one or more children living with a single adult (male or female, related or unrelated to the child or children).
- An *unmarried biological or adoptive family* consists of one or more children living with two parents who are not married to one another and are each biological or adoptive parents to all children in the family.
- A *blended family* consists of one or more children living with a biological or adoptive parent and an unrelated stepparent who are married to one another.
- A *cohabiting family* consists of one or more children living with a biological or adoptive parent and an unrelated adult who are cohabiting with one another.
- An *extended family* consists of one or more children living with at least one biological or adoptive parent and a related adult who is not a parent (e.g., grandparent, adult sibling). Any of the previously described family types that contained an adult child are categorized as an extended family. As a result, counts and percentages of the remaining family types—in particular, nuclear families and single-parent families—will be smaller.
- An *"other" family* consists of one or more children living with related or unrelated adults who are not biological or adoptive parents. Children being raised by their grandparents are included in this category, as well as foster children.

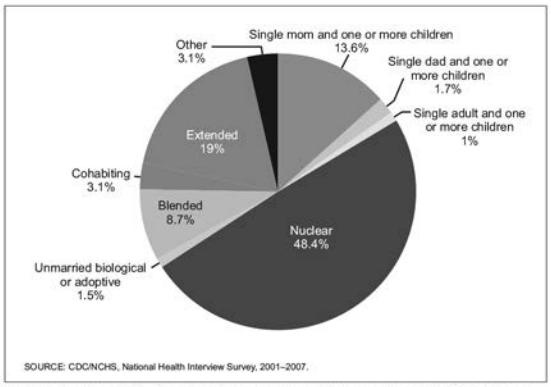


Figure 1. Percent distribution of family structure for children under age 18: United States, 2001–2007

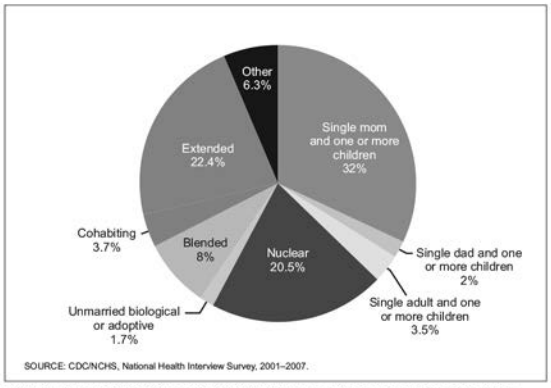


Figure 2. Percent distribution of family structure for non-Hispanic black children under age 18: United States, 2001–2007

Family Structure Characteristics

The percent distribution of family structure for U.S. children in 2001–2007 is shown in Figure 1. These percentages can be interpreted as either an estimate for the midpoint of the study period or as an "average" across the study period. Note that single-parent families are disaggregated into single mother, single father, and single adult (such as an adult sibling, aunt or uncle, or grandparent) in order to facilitate comparisons with previous publications. Roughly 48% of all children were living in a "traditional" nuclear family, and approximately 2% of children lived in an unmarried biological or adoptive family. In other words, one-half of all children lived with two biological or adoptive parents in 2001–2007. In addition, roughly 14% of children lived with a single mother (either biological or adoptive) in 2001–2007, while nearly 2% lived with a single father and 1% lived with a related or unrelated single

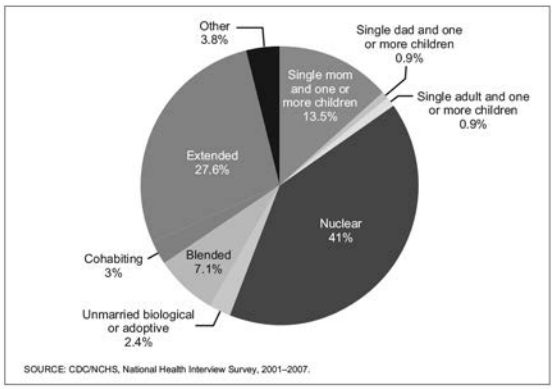


Figure 3. Percent distribution of family structure for Hispanic children under age 18: United States, 2001–2007

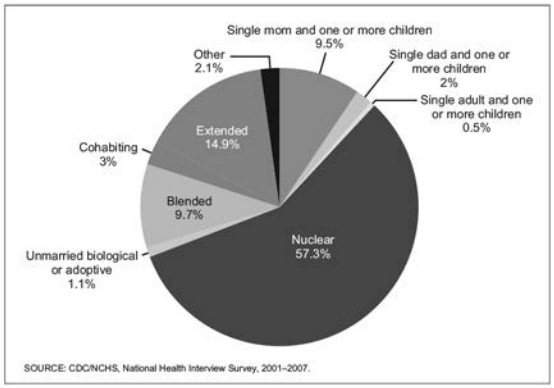


Figure 4. Percent distribution of family structure for non-Hispanic white children under age 18: United States, 2001–2007

adult. Approximately 19% of children resided with a biological or adoptive parent and another adult relative (such as an adult sibling or a grandparent) in an extended family in 2001–2007, 9% resided with a biological or adoptive parent and stepparent in a blended family, and 3% lived with a biological or adoptive parent and that parent's cohabiting partner. Lastly, other families consisting of one or more children living with two or more related or unrelated adults who are not biological or adoptive parents made up approximately 3% of the distribution. Only 0.1% of children could not be assigned to a designated category.

The results in Figure 1 change considerably when the percent distribution of family structure is disaggregated by race/ethnicity or poverty status, the two correlates of family structure mentioned most commonly in the literature (41). Figures 2–4 show percent distributions of family structure for non-Hispanic black, Hispanic, and non-Hispanic white children. Fifty-seven percent of non-Hispanic white children lived in nuclear families, compared with 21% of non-Hispanic black children and 41% of Hispanic children. In contrast, non-Hispanic black and Hispanic children were more likely than non-Hispanic white children to live in single-parent or extended families. For example, 10% of non-Hispanic white children lived with a single mother, compared with 14% of Hispanic children and 32% of non-Hispanic black children. A similar picture emerges if family structure is disaggregated by poverty status (Figures 5–7). Thirty-three percent of poor children (those in families with income below the poverty threshold) lived in single-mother families, compared with 18% of near poor children (those in families with income of 100% to less than 200% of the poverty threshold) and 6% of not poor children (those in families with income 200% of the poverty threshold or greater). Poor children were also much less likely to be living in nuclear families: 25% of poor children lived in nuclear families, while 37% of near poor, and 61% of not poor children lived in nuclear families.

Figure 8 shows the percent distribution of family structure across the 7-year study period. Note that in this figure (and in the remainder of the report), children living with single mothers, single fathers, and single adults are combined into the single-parent category described in the Introduction. While the trend lines appear relatively flat, there are nevertheless measurable changes in the distributions during the study period. For example, the percentage of nuclear families declined

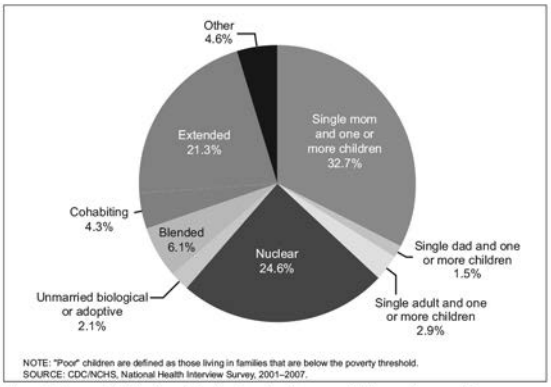


Figure 5. Percent distribution of family structure for poor children under age 18: United States, 2001–2007

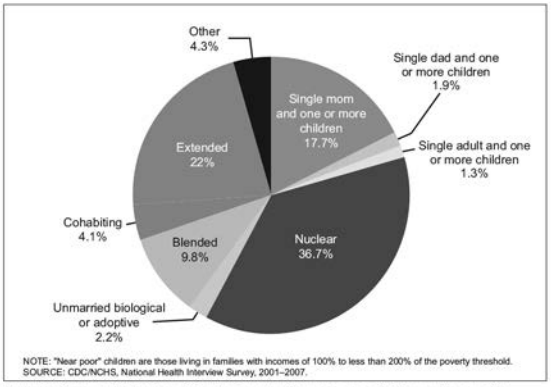


Figure 6. Percent distribution of family structure for near poor children under age 18: United States, 2001–2007

from 49.6% in 2001 to 47.3% in 2007; blended families also declined from 9.8% in 2001 to 8.3% in 2007. On the other hand, the percentage of other families more than doubled during the study period, from 1.7% in 2001 to 3.7% in 2007.

Measures of Physical Health and Limitations

Health status and chronic conditions

Overall, 12.6 million U.S. children under age 18 (17.2%) were in good, fair, or poor health (Tables 1–2) and 1.8 million U.S. children under age 18 (2.5%) had one or more chronic conditions (Tables 3–4).

- As Figure 9 illustrates, children in nuclear (12%) and blended (17.5%) families were least likely to be in good, fair, or poor health, while children in other families (30%) were most likely to be in good, fair, or poor health. Children in single-parent families (3.2%) were more likely to have one or more chronic conditions than children in nuclear (2.2%), unmarried biological or adoptive (1.9%), or extended (2.4%) families, and were comparable to children living in the remaining family types (Figure 10).
- Nearly 22% of Hispanic children living in nuclear families were in good, fair, or poor health compared with Hispanic children living in single-parent (28.8%), unmarried biological or adoptive (27.8%), extended (30.8%), or other (35.4%) families. Non-Hispanic white children in nuclear families (9.2%) were least likely to be in good, fair, or poor health relative to non-Hispanic white children in the remaining family types. Likewise, non-Hispanic black children in nuclear families (16.7%) were least likely to be in good, fair, or poor health relative to non-Hispanic black children in the remaining family types.
- Among poor families, children in nuclear families (27.1%) were less likely to be in good, fair, or poor health than children in extended (36.4%) or other (40.4%) families. Among near poor families, 19.2% of children in nuclear families were in good, fair, or poor health compared with 22.5% of children in single-parent families, 23.3% in blended families, 26.4% in extended families, and 32.9% in other families. Among not poor families, children in nuclear families (8.5%) were least likely to be in good, fair, or poor health. Children living in not poor single-parent families (3.3%) were more likely to have one or more chronic conditions than

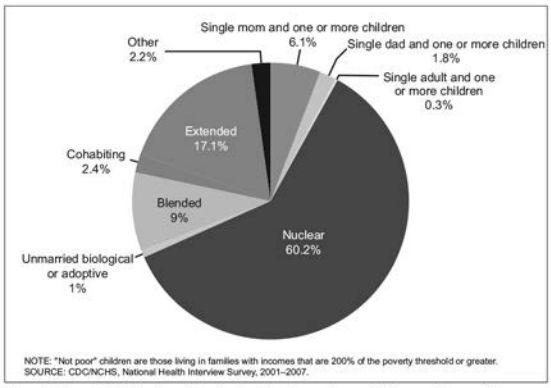


Figure 7. Percent distribution of family structure for not poor children under age 18: United States, 2001–2007

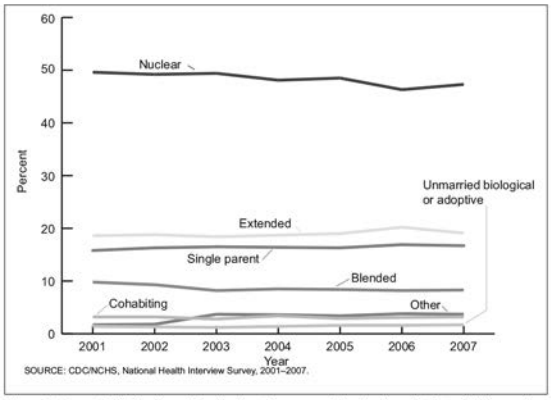


Figure 8. Percent distribution of family structure across the study period for children under age 18: United States, 2001–2007

children in not poor nuclear (2.3%) or extended (2.2%) families. Family structure was unrelated to the prevalence of chronic conditions among children living in poor or near poor families.

- Family structure was unrelated to the prevalence of chronic conditions among children whose more highly educated parent was either a high school dropout or a high school graduate or equivalent. However, when at least one parent had more than a high school diploma, children in nuclear families (2.3%) were less likely than children in single-parent (3.6%) or cohabiting (4.3%) families to have one or more chronic conditions.
- Among children with private health insurance, those living in nuclear families (9%) were least likely to be in good, fair, or poor health. Among children with Medicaid, those living in extended (32.5%) and other (35.3%) families were most likely to be in good, fair, or poor health.

Asthma, hay fever, and allergies

In the past 12 months, 9 million U.S. children under age 18 (12.7%) had ever had asthma, 7.2 million children (9.9%) had hay fever, 8.4 million U.S. children (11.6%) had respiratory allergies, and 8.8 million children (12%) had digestive or skin allergies (Tables 5–12).

- Children living with biological or adoptive parents—either in nuclear families or unmarried biological or adoptive families—were less likely to have ever suffered from asthma than children in the remaining family types (Figure 11).
- Children in single-parent families were more likely than children in nuclear families to have asthma regardless of their gender, race/ethnicity, parent's education, family's poverty status, place of residence, or region.
- Among children with private health insurance, those living in nuclear families (10.4%) were less likely to have asthma than children in single-parent (15.3%), unmarried biological or adoptive (15.5%), blended (13.7%), extended (13.9%), or other (18.7%) families. Among children with Medicaid, those living in nuclear (11.4%) and unmarried biological or adoptive (9.3%) families were less likely to have asthma than children in single-parent (20%), blended (15.3%), cohabiting (16.5%), extended (16.4%), or other (17%) families.
- Children living in unmarried biological or adoptive families (5.8%) were least likely to have hay fever in the past 12 months (Figure 12). Children in unmarried

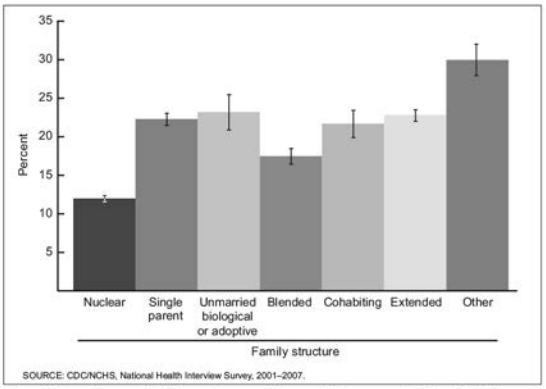


Figure 9. Percentages of children under age 18 in good, fair, or poor health, by family structure: United States, 2001–2007

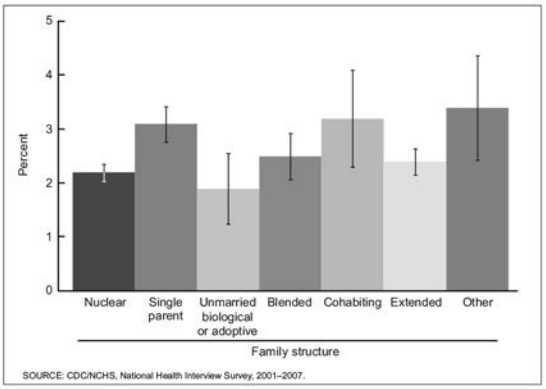


Figure 10. Percentages of children under age 18 with one or more selected chronic conditions, by family structure: United States, 2001–2007

biological or adoptive families (8.4%) were also less likely to have respiratory allergies in the past 12 months than children in nuclear (11.3%), single-parent (12.8%), blended (12%), extended (11.2%), or other (12.8%) families, and were comparable to children in cohabiting families (Figure 13).

- Among Hispanic children, those in unmarried biological or adoptive families (5.6%) were less likely than children in single-parent (8.2%) or blended (8.8%) families to have hay fever. Among non-Hispanic white children, those in unmarried biological or adoptive families (7.2%) were less likely than children in nuclear (11.2%), single-parent (12%), blended (10.9%), extended (12.2%), or other (11.4%) families to have hay fever. Family structure was unrelated to the prevalence of hay fever among non-Hispanic black children.
- Family structure was unrelated to the prevalence of hay fever among children whose more highly educated parent was a high school dropout. When at least one parent was either a high school graduate or had more than a high school diploma, children in unmarried biological or adoptive families were less likely to have hay fever than children in nuclear, single-parent, blended, or extended families.
- Among near poor families, children living in cohabiting families (5.4%) were less likely to have hay fever than children living in single-parent (9.2%), blended (8.7%), or other (10.4%) families. Among not poor families, children living in unmarried biological or adoptive families (5.8%) were least likely to have hay fever. Children living in unmarried biological or adoptive families that owned or were buying their homes were also least likely to have hay fever (6.3%). Among families that rented their homes, children in unmarried biological or adoptive families (5.7%) were less likely than children in single-parent (8.3%), blended (8.1%), or other (9.7%) families to have hay fever.
- Family structure was unrelated to the prevalence of respiratory allergies among Hispanic children. Non-Hispanic white children in unmarried biological or adoptive families (9%) were less likely to have respiratory allergies in the past 12 months than non-Hispanic white children in nuclear (12.2%), single-parent (15.5%), blended (13.4%), extended (14.1%), or other (15.3%) families. Among non-Hispanic black children, those in cohabiting families (7.7%) were less likely to have respiratory allergies than children in single-parent families (11.1%).

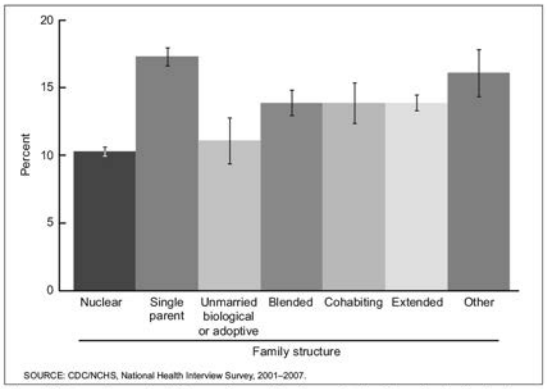


Figure 11. Percentages of children under age 18 who ever had asthma, by family structure: United States, 2001–2007

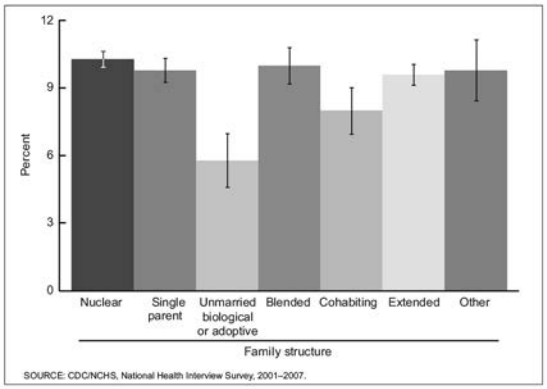


Figure 12. Percentages of children under age 18 who had hay fever in the past 12 months, by family structure: United States, 2001–2007

- When the more highly educated parent was a high school dropout, children in nuclear families (7.2%) were less likely to have respiratory allergies in the past 12 months than children in single-parent families (9.1%). When at least one parent was a high school graduate, children in unmarried biological or adoptive families (7.1%) were less likely to have respiratory allergies than children in single-parent (11.2%) or extended (10.1%) families. When at least one parent had more than a high school diploma, children in unmarried biological or adoptive families (10.8%) were less likely than children in single-parent (15.3%) or other (20%) families to have respiratory allergies.
- Among poor families, children in nuclear families (9.2%) were less likely to have respiratory allergies than children in single-parent families (11.8%). Among near poor families, children in unmarried biological or adoptive families (6.9%) were less likely to have respiratory allergies than children living in single-parent (12.9%), blended (10.6%), or other (13%) families. Among not poor families, children in unmarried biological or adoptive families (8.6%) were less likely to have respiratory allergies than children in the remaining family types, with the exception of other families.
- Among children living in large metropolitan statistical areas (MSAs), children in unmarried biological or adoptive families (5.4%) were least likely to have respiratory allergies. Among children living in small MSAs, children in unmarried biological or adoptive families (10%) were less likely to have respiratory allergies than children in single-parent families (14.1%). Family structure was unrelated to the prevalence of respiratory allergies among children who did not live in an MSA.
- Children in single-parent families (13.1%) were more likely to have digestive or skin allergies in the past 12 months than children in nuclear (11.8%) or extended (11.4%) families, and were comparable to children living in the remaining family types.
- Hispanic children living in single-parent families (10.4%) were more likely than Hispanic children in nuclear (8.7%) or extended (8.2%) families to have digestive or skin allergies. Family structure was unrelated to the prevalence of digestive or skin allergies among non-Hispanic children.
- Among poor families, children living in unmarried biological or adoptive families (6.2%) were less likely than children in single-parent

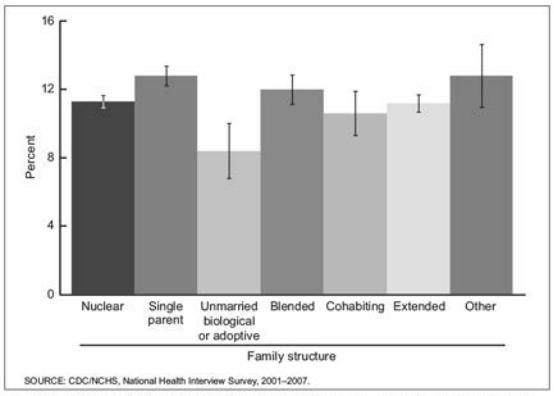


Figure 13. Percentages of children under age 18 who had respiratory allergies in the past 12 months, by family structure: United States, 2001–2007

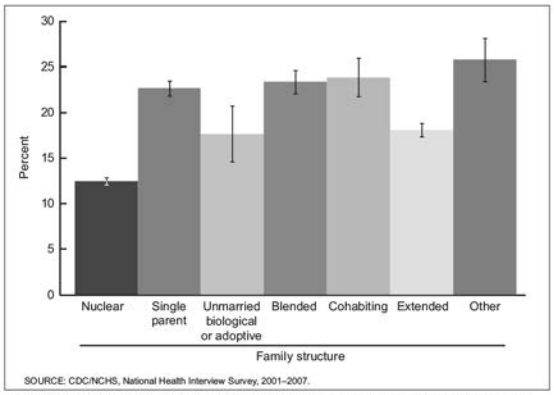


Figure 14. Percentages of children aged 4–17 who had a basic action disability, by family structure: United States, 2001–2007

(13.2%), blended (12%), extended (11%), or other (11.1%) families to have digestive or skin allergies. Family structure was unrelated to the prevalence of digestive or skin allergies among children living in near poor or not poor families.

Headaches or migraines and ear infections

Overall, nearly 3.7 million U.S. children aged 3–17 (6%) had frequent headaches or migraines in the past 12 months, while 4.2 million U.S. children under age 18 (5.8%) had three or more ear infections the past 12 months (Tables 13–16).

- Children aged 3–17 in nuclear families (4.5%) were less likely to have frequent headaches or migraines in the past 12 months than children in single-parent (8%), blended (6.6%), cohabiting (7.6%), extended (7.1%), or other (7.6%) families, and were comparable to children living in unmarried biological or adoptive families.
- Among children aged 12–17, those in nuclear families (7.6%) were less likely to have headaches or migraines than children in single-parent (11.6%), cohabiting (12.8%), extended (9.7%), or other (11.4%) families.
- Hispanic children living in nuclear families (4%) were less likely to have frequent headaches or migraines than children in single-parent (7.9%), blended (5.9%), cohabiting (7.4%), or extended (5.8%) families. Non-Hispanic white children living in nuclear families (4.8%) were less likely to have frequent headaches or migraines than children in nonnuclear families, with the exception of unmarried biological or adoptive families. Non-Hispanic black children living in nuclear families (4.1%) were less likely to have frequent headaches or migraines than those in single-parent (7.7%), blended (6.5%), extended (7.2%), or other (9.5%) families.
- Among poor families, children in nuclear families (6.6%) were less likely to have frequent headaches or migraines than children in single-parent (8.8%) or other (13.2%) families. Among near poor families, children in nuclear families (5.4%) were less likely than children in single-parent (8.5%) or extended (7.3%) families to have frequent headaches or migraines. Among not poor families, children in nuclear families (4.1%) were less likely than children in single-parent (6.6%), blended (6.4%), cohabiting (7.3%),

or extended (6.7%) families to have frequent headaches or migraines.

- Among children of all ages, those in unmarried biological or adoptive families (8.3%) were more likely to have three or more ear infections in the past 12 months than children in nuclear (5.9%), single-parent (6%), blended (5.1%), extended (5.4%), or other (5.3%) families, and were comparable to children living in cohabiting families.
- Hispanic children living in unmarried biological or adoptive families (9.1%) were more likely than Hispanic children in nuclear (5.8%), single-parent (5.9%), blended (4.8%), or extended (5.6%) families to have three or more ear infections in the past 12 months. Non-Hispanic white children in unmarried biological or adoptive families (9.4%) were more likely than non-Hispanic white children in nuclear (6.4%), blended (5.4%), or extended (6%) families to have three or more ear infections. Family structure was unrelated to the prevalence of ear infections among non-Hispanic black children.
- Among children living in the Northeast, those in unmarried biological or adoptive families (12.9%) were more likely to have three or more ear infections in the past 12 months than children in nuclear (5.9%), single-parent (4.7%), blended (5.9%), extended (5%), or other (6%) families. Among children in the South, those in unmarried biological or adoptive families (8.8%) were more likely to have three or more ear infections than children in blended (5.4%) or other (4.9%) families. Family structure was unrelated to the prevalence of ear infections in the Midwest and West regions of the United States.

Developmental delays and limitations

Overall, 2.6 million U.S. children under age 18 (3.6%) had mental retardation or any developmental delay; 1.4 million U.S. children under age 18 (1.9%) had an impairment or health problem that limited their crawling, walking, running, or playing; and 1.3 million U.S. children under age 18 (1.8%) received special education or EIS for an emotional or behavioral problem. In addition, 1.7 million U.S. children under age 18 (2.3%) experienced vision problems and 9.7 million U.S. children aged 4–17 (17.2%) had a basic action disability (Tables 17–26).

- Children living in nuclear families (3%) were less likely than children in single-parent (4.6%), blended (3.8%), cohabiting (4.5%), extended (3.6%), or other (6.6%) families to have mental retardation or any developmental delay, and were comparable to children living in unmarried biological or adoptive families. Children in other families had the highest prevalence rates of mental retardation or any developmental delay.
- Among Hispanic children, those in nuclear families (2.4%) were less likely than children in single-parent (4.2%) or other (5.1%) families to have mental retardation or any developmental delay. Among non-Hispanic white children, those living in nuclear families (3.3%) were less likely to have mental retardation or any developmental delay than children living in single-parent (4.9%), cohabiting (5.5%), or other (7.7%) families. Among non-Hispanic black children, those in nuclear families (2.8%) were less likely than children in single-parent families (4.1%) to have mental retardation or any developmental delay.
- Children in nuclear families (1.4%) were less likely than children in single-parent (2.7%), blended (2.6%), extended (2%), or other (2.6%) families to have an impairment or health problem that limited their crawling, walking, running, or playing, and were comparable to children living in unmarried biological or adoptive families or cohabiting families.
- When the more highly educated parent was a high school dropout, children in nuclear families (1.1%) were less likely than children in single-parent families (3%) to have an impairment or problem limiting activity. When at least one parent was a high school graduate, children in nuclear families (1.8%) were less likely than children in single-parent (2.6%) or blended (3.9%) families to have an impairment or problem limiting activity. When at least one parent had more than a high school diploma, children in nuclear families (1.4%) were less likely to have such an impairment or health problem than children in single-parent (2.7%), blended (2%), or extended (2.1%) families.
- Among poor families, children living in nuclear families (1.7%) were less likely to have impairments or health problems limiting activity than children in single-parent (3.2%), blended (4.5%), or extended (2.7%) families. Among near poor families, children in nuclear families (2%) were less likely to have impairments or health problems limiting activity than children in single-parent families (2.9%). Among not poor families, children living in nuclear families (1.3%) were less likely to have impairments or health problems limiting activity than children in single-parent (2%), blended (2%), or extended (1.7%) families.
- Less than 1% of children living in nuclear families received special education or EIS for an emotional or behavioral problem compared with 3.3% of children in single-parent families, 2.3% of children in blended families, 3.3% of children in cohabiting families, 2.1% of children in extended families, and 5.2% of children in other families. Children living in nuclear families were comparable to those living in unmarried biological or adoptive families regarding the receipt of special education or EIS. Children in other families were most likely to receive special education or EIS for an emotional or behavioral problem.
- Among children with Medicaid, those living in nuclear families (1.5%) were less likely to receive special education or EIS for emotional or behavioral problems

than children in single-parent (4.4%), blended (3.7%), cohabiting (4.6%), extended (3.3%), or other (8%) families. With the exception of children living in unmarried biological or adoptive families, children with Medicaid living in other families were most likely to receive special education or EIS for an emotional or behavioral problem.

- Children living in nuclear families (1.8%) were less likely than children in single-parent (3.2%), blended (2.6%), cohabiting (3.6%), extended (2.6%), or other (3%) families to have vision problems, and were comparable to children living in unmarried biological or adoptive families. Among children aged 5–17, those in nuclear families (2.2%) were less likely than children in single-parent (3.8%), blended (3.2%), cohabiting (4.4%), extended (3.1%), or other (3.4%) families to have vision problems, even when wearing glasses or contact lenses.
- Among poor families, children in nuclear families (2.6%) were less likely to have vision problems than children in single-parent families (4%). Family structure was not related to vision problems among children living in near poor families. Among not poor families, children in nuclear families (1.6%) were less likely than children in single-parent (2.5%), blended (2.4%), or extended (2.5%) families to have vision problems.
- Children aged 4–17 living in nuclear families (12.5%) were less likely than children in single-parent (22.7%), unmarried biological or adoptive (17.7%), blended (23.4%), cohabiting (23.9%), extended (18.1%), or other (25.8%) families to have a basic action disability (Figure 14).
- When the more highly educated parent was a high school dropout, children in nuclear families (11.3%) were less likely than children in single-parent (23.9%), blended (21.5%), cohabiting (25.8%), or extended (15.9%) families to have a basic action disability. When at least one parent was a high school graduate, children in nuclear families (14.4%) were less likely than children in single-parent (22.7%), blended (25.4%), cohabiting (22.4%), or extended (19.4%) families to have a basic action disability. When at least one parent had more than a high school diploma, children in nuclear families (12.3%) were least likely to have such a disability.
- Among children with Medicaid health insurance, those living in nuclear families (16.8%) were less likely to have a basic action disability than children in single-parent (26.7%), blended (28.1%), cohabiting (25.5%), extended (22.8%), or other (32.3%) families.

Learning disabilities and missed school days

Overall, 6.9 million U.S. children aged 3–17 (11.4%) had a learning disability or ADHD. In addition, 8.1 million U.S. children aged 5–17 (15.8%) missed 6 or more days of school in the past 12 months due to illness or injury (Tables 27–30).

- Children aged 3–17 living in nuclear families (8.1%) were less likely than children in single-parent (14.9%), blended (16.1%), cohabiting (15.6%), extended (12.1%), or other (19%) families to have a learning disability or ADHD (Figure 15), and were comparable to those living in unmarried biological or adoptive families.
- Roughly 11% of boys living in nuclear families had a learning disability or ADHD compared with 20.4% of boys in single-parent families, 21.5% in blended families, 19.9% in cohabiting families, 15.7% in extended families, and 22.7% in other families. Five percent of girls living in nuclear families had a learning disability or ADHD compared with 9.5% of girls in single-parent families, 10.5% in blended families, 11% in cohabiting families, 8.1% in extended families, and 15% in other families.
- Among Hispanic children, those in nuclear families (6.6%) were less likely than children in single-parent (11.3%), blended (11.7%), extended (8.1%), or other (11.4%) families to have a learning disability or ADHD. Among non-Hispanic white children, those living in nuclear families (9%) were less likely to have a learning disability or ADHD than children living in single-parent (17.4%), blended (18%), cohabiting (18.2%), extended (15.1%), or other (22.3%) families. Among non-Hispanic black children, those in nuclear families (5.8%) were less likely than children in single-parent (13.2%), blended (12.1%), cohabiting (13.7%), extended (11.4%), or other (20.2%) families to have a learning disability or ADHD.
- Children with private health insurance living in nuclear families (7.8%) were less likely to have a learning disability or ADHD than children with private health insurance living in single-parent (13%), blended (15.6%), cohabiting (15.6%), extended (10.8%), or other (14.1%) families. Children with Medicaid living in nuclear families (11.1%) were less likely to have a learning disability or ADHD than children with Medicaid living in single-parent (17.3%), blended (19.5%), cohabiting (16.4%), extended (15.9%), or other (24.6%) families. Similarly, 5.7% of uninsured children living in nuclear families had a learning disability or ADHD compared with 14.1% of uninsured children living in single-parent families, 12.9% in blended families, 13.2% in cohabiting families, 9.8% in extended families, and 12.2% in other families.
- Children in nuclear families were generally less likely than children in the remaining family types to have a learning disability or ADHD regardless of parent's education, income, poverty status, place of residence, or region.
- Children aged 5–17 living in nuclear families (13.3%) were less likely to miss school for 6 or more days in the past 12 months due to illness or injury than children aged 5–17 living in single-parent (19.7%),

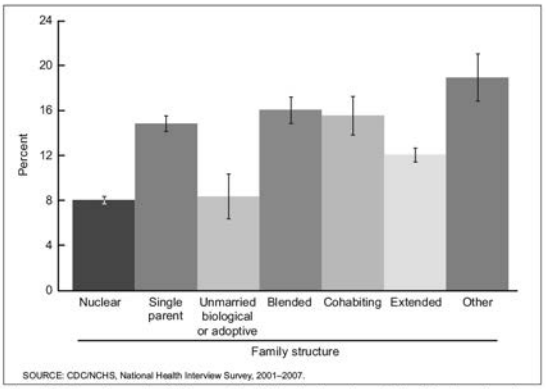


Figure 15. Percentages of children aged 3–17 who had ever been told of having a learning disability or ADHD, by family structure: United States, 2001–2007

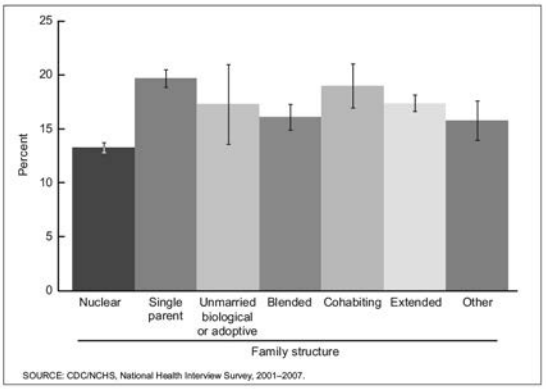


Figure 16. Percentages of children aged 5–17 who missed 6 or more days of school in the past 12 months due to illness or injury, by family structure: United States, 2001–2007

blended (16.1%), cohabiting (19%), extended (17.4%), or other (15.8%) families, and were comparable to children living in unmarried biological or adoptive families (Figure 16).

- Among Hispanic children, 10.5% of those in nuclear families missed 6 or more school days in the past 12 months compared with 19.9% of children in single-parent families, 13.5% in blended families, 17.7% in cohabiting families, and 13.5% in extended families. Among non-Hispanic white children, 14.8% of those in nuclear families missed 6 or more school days in the past 12 months compared with 23.5% of children in single-parent families, 18% in blended families, 21.2% in cohabiting families, 21.5% in extended families, and 19.3% in other families. Among non-Hispanic black children, 7.6% of those in nuclear families missed 6 or more school days in the past 12 months compared with 14.2% of children in single-parent families, 11.1% in blended families, 14.1% in extended families, and 12.8% in other families.
- When the more highly educated parent was a high school dropout, 13.1% of children living in nuclear families missed 6 or more days of school in the past 12 months compared with 24.4% of children in single-parent families, 22.3% in blended families, and 19.9% in cohabiting families. When at least one parent was a high school graduate, children in nuclear families (16%) were less likely than children in extended families (20.1%) to miss 6 or more school days. When at least one parent had more than a high school diploma, 12.7% of children in nuclear families missed 6 or more days of school compared with 18.9% of children in single-parent families, 21% in unmarried biological or adoptive families, 15.2% in blended families, 17.8% in cohabiting families, and 17.3% in extended families.
- Among poor families, children in nuclear families (16.3%) were less likely than children in single-parent (22.3%) or blended families (22.3%) to miss 6 or more days of school in the past 12 months. Among near poor families, children in nuclear families (13.9%) were less likely than children in single-parent (20.6%), blended (18.2%), cohabiting (19.3%), or extended (17.5%) families to miss 6 or more days of school. Among not poor families, children in nuclear families

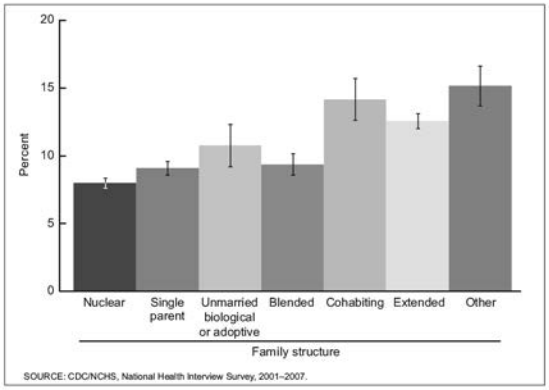


Figure 17. Percentages of children under age 18 who did not have health insurance, by family structure: United States, 2001–2007

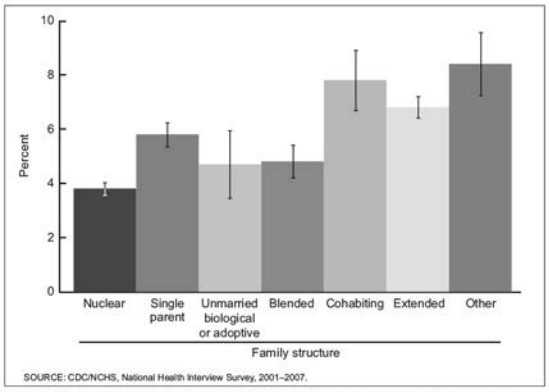


Figure 18. Percentages of children under age 18 without a usual place of health care, by family structure: United States, 2001–2007

(12.8%) were less likely than children in single-parent (15.9%), cohabiting (18%), or extended (17.1%) families to miss 6 or more school days.

Measures of Access to or Utilization of Health Care

Lack of health insurance coverage

Overall, 7 million U.S. children under age 18 (9.6%) lacked health insurance coverage (Tables 31–32).

- Children living in nuclear families (8%) were less likely than children in single-parent (9.1%), unmarried biological or adoptive (10.8%), blended (9.4%), cohabiting (14.2%), extended (12.6%), or other (15.2%) families to lack health insurance coverage (Figure 17).
- Among children under age 5, 6% of those living in nuclear families lacked health insurance coverage compared with 8.9% of children in unmarried biological or adoptive families, 12.6% of children in cohabiting families, 11.6% of children in extended families, and 12.6% of children in other families. Among children aged 5–17, 8.9% of children living in nuclear families lacked health insurance coverage compared with 13.9% of children in unmarried biological or adoptive families, 14.8% of children in cohabiting families, 12.8% of children in extended families, and 16% of children in other families.
- Hispanic children in single-parent families (12.5%) were less likely to lack health insurance coverage than Hispanic children in nuclear (19.9%), unmarried biological or adoptive (18.8%), blended (17.6%), cohabiting (18.5%), extended (22.9%), or other (26.3%) families. However, non-Hispanic children in nuclear families (5.7%) were less likely to lack health insurance coverage than non-Hispanic children in single-parent (8.4%), blended (7.9%), cohabiting (13.3%), extended (8.6%), or other (12%) families.
- Among children living in families with a combined family income less than $20,000 in the previous calendar year, 9.7% in single-parent families did not have health insurance coverage compared with 20.8% in nuclear families, 15.6% in blended families, 14.9% in cohabiting families, 16.9% in extended families, and 16.1% in other families. Similar percents with respect to lacking health insurance coverage were obtained for children living in poor families or when the

more highly educated parent did not graduate from high school.

- Among children living in the West, those in unmarried biological or adoptive families (16.7%) were more likely than children in nuclear (10.2%), single-parent (11.5%), or blended (11%) families to lack health insurance coverage. This pattern was not apparent in the remaining three regions of the United States.

Lack of usual place of care

Overall, 3.7 million U.S. children under age 18 (5%) lacked a usual place of health care (Tables 33–34).

- Children living in nuclear families (3.8%) were less likely than children in single-parent (5.8%), blended (4.8%), cohabiting (7.8%), extended (6.8%), or other (8.4%) families to lack a usual place of health care, and were comparable to children living in unmarried biological or adoptive families (Figure 18).
- Hispanic children living in nuclear families (9.9%) were less likely than Hispanic children in cohabiting (13.9%), extended (13.2%), or other (15.9%) families to lack a usual place of health care. Non-Hispanic white children living in nuclear families (2.2%) were less likely than non-Hispanic white children in single-parent (5.3%), blended (3.6%), cohabiting (7.6%), extended (3.4%), or other (6.6%) families to lack a usual place of health care. Family structure was unrelated to lacking a usual place of health care among non-Hispanic black children.
- When the more highly educated parent was a high school dropout, children living in nuclear families (14.5%) were more likely to lack a usual place of health care than children in single-parent (8.3%), unmarried biological or adoptive (6.8%), or blended (7%) families. However, when at least one parent was a high school graduate, children in nuclear families (5%) were less likely to lack a usual place of health care than children in cohabiting (7.5%) or extended (6.3%) families. Similarly, when at least one parent had more than a high school diploma, children in nuclear families (2.4%) were less likely to lack a usual place of care than children in single-parent (4.4%), blended (4.3%), cohabiting (6.2%), or extended (3.9%) families. Similar patterns of percentages with respect to lacking a usual place of health care were obtained for children living in poor, near poor, and not poor families.
- Children living in nuclear families that owned or were buying their homes (2.6%) were less likely to lack a usual place of health care than children in single-parent (4.8%), blended (3.6%), cohabiting (6.6%), extended (5.1%) or other (6.4%) families that owned or were buying their homes. Children living in nuclear families that rented their homes (8.5%) were more likely to lack a usual place of health care than children in single-parent (6.3%) or unmarried biological or adoptive (4.5%) families that rented, but were less likely to lack a usual place of health care than children in extended (10.7%) or other (13.2%) families that rented their homes.
- Among children living in the Northeast, 1.3% of those in nuclear families lacked a usual place of health care compared with 2.5% of children in extended families. Among children living in the Midwest, 2.6% of those in nuclear families lacked a usual place of health care compared with 4.2% of children in single-parent families, 5.5% of children in cohabiting families, and 4.6% of children in extended families. Among children living in the South, 4.7% of those in nuclear families lacked a usual place of health care compared with 7.3% of children in single-parent families, 10.2% of children in cohabiting families, 8.1% of children in extended families, and 9.8% of children in other families. Among children living in the West, 5.7% of those in nuclear families lacked a usual place of health care compared with 8.2% of single-parent families, 8.7% of children in blended families, 9.8% of children in cohabiting families, 9.6% of children in extended families, and 12% of children in other families.

Prescription medication usage

Overall, 9.4 million U.S. children under age 18 (12.9%) had a problem that required regular use of a prescription medication for at least 3 months (Tables 35–36).

- Children in unmarried biological or adoptive families (9.2%) were least likely to have had a problem requiring the regular use of a prescription medication for at least 3 months (Figure 19).
- Among young children under age 5, 11% of those living in single-parent families had a problem that required regular use of a prescription medication for at least 3 months compared with 7.2% of children in nuclear families, 6.1% in unmarried biological or adoptive families, 6.8% in blended families, and 7.5% in extended families.
- Hispanic children living in unmarried biological or adoptive families (6.2%) were less likely to have a problem requiring regular use of a prescription medication than Hispanic children in single-parent (11%), blended (9.5%), or other (11.9%) families. Among non-Hispanic white children, those living in unmarried biological or adoptive families (11.4%) were less likely to have a problem requiring regular use of a prescription medication than children in single-parent (18.6%), blended (17.7%), extended (17.1%), or other (19%) families. Non-Hispanic black children living in nuclear families (10.2%) were less likely to have a problem requiring prescription medication than non-Hispanic black children in other families (15.1%).
- Among poor families, children in nuclear families (9.1%) were less likely than children in single-parent (15.5%), blended (15%), extended (11.6%), or other (14.5%) families to have a problem requiring prescription medication. Among near

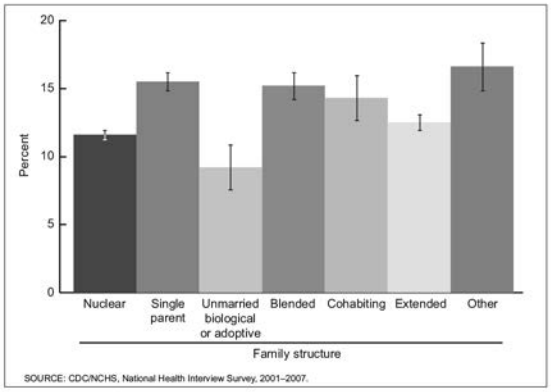


Figure 19. Percentages of children under age 18 with a problem for which prescription medications were used for at least 3 months, by family structure: United States, 2001–2007

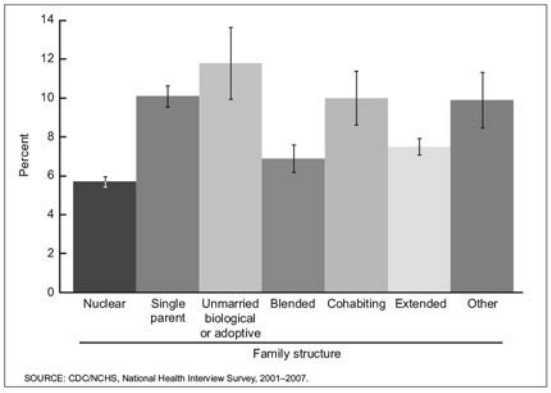


Figure 20. Percentages of children under age 18 who had two or more visits to the emergency room in the past 12 months, by family structure: United States, 2001–2007

poor families, children in nuclear families (9.7%) were less likely than children in single-parent (15.7%), blended (15.3%), cohabiting (15.1%), or other (16.9%) families to have a problem requiring prescription medication. Among not poor families, children in unmarried biological or adoptive families (7.9%) were least likely to have a problem requiring prescription medication.

- Children living in unmarried biological or adoptive families that owned or were buying their homes (10.6%) were less likely to have a problem requiring prescription medication than children in single-parent (16.3%), blended (15.7%), or other (19.2%) families that owned or were buying their homes. Children living in unmarried biological or adoptive families that rented their homes (8%) were less likely to have a problem requiring prescription medication than children in single-parent (15%), blended (14%), cohabiting (13.5%), or extended (11%) families that rented their homes.
- Among children with private health insurance, children in unmarried biological or adoptive families were least likely to have a problem requiring prescription medication. Among children with Medicaid, 12% of children in nuclear families had a problem that required prescription medication compared with 17.1% of children in single-parent families, 16.5% in blended families, 15.5% in cohabiting families, 14.3% in extended families, and 20.3% in other families.

Receipt of medical care

Overall, 5.2 million U.S. children under age 18 (7.2%) had two or more visits to a hospital ER in the past 12 months; 19.4 million U.S. children aged 1–17 (28.4%) did not have a medical checkup in the past 12 months; and 14.9 million U.S. children aged 2–17 (23%) saw or talked with an eye doctor during the past 12 months. In addition, nearly 2.8 million U.S. children under age 18 (3.8%) had medical care delayed during the past 12 months due to concerns over the cost, 1.8 million U.S. children aged 2–17 (2.8%) did not receive needed prescription medication due to lack of affordability, and 1.4 million U.S. children aged 2–17 (2.2%) did not get needed eyeglasses due to lack of affordability (Tables 37–48).

- Children living in nuclear families (5.7%) were least likely to have two or more ER visits in the past 12 months (Figure 20).
- Among children under age 5, 7.2% of those in nuclear families had two

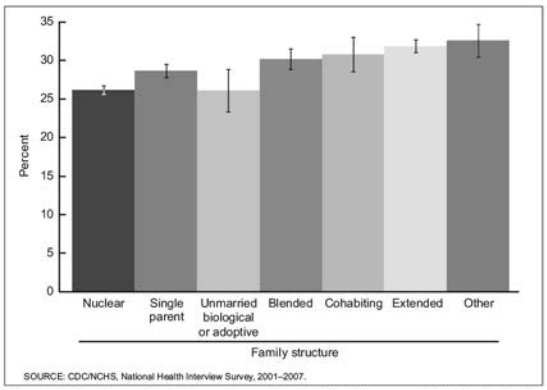


Figure 21. Percentages of children under age 18 who did not have a medical checkup in the past 12 months, by family structure: United States, 2001–2007

or more ER visits in the past 12 months compared with 17% of children in single-parent families, 13.1% in unmarried biological or adoptive families, 10.4% in blended families, 15% in cohabiting families, 12% in extended families, and 15% in other families. Among older children aged 12–17, 4.9% of those in nuclear families had two or more ER visits in the past 12 months compared with 8.3% of children in single-parent families, 8.5% in cohabiting families, 5.8% in extended families, and 9.4% in other families.

- Among children with private health care insurance, 5% of those in nuclear families had two or more ER visits in the past 12 months compared with 6.7% of children in single-parent families, 10.9% in unmarried biological or adoptive families, and 5.8% in extended families. Among children covered by Medicaid, 8.8% of those in nuclear families had two or more ER visits in the past 12 months compared with 13.5% of children in single-parent families, 12.7% in unmarried biological or adoptive families, 13.8% in cohabiting families, and 11.3% in extended families.
- Children living in nuclear families (26.2%) were less likely to lack a medical checkup in the past 12 months than children in single-parent (28.7%), blended (30.2%), cohabiting (30.8%), extended (31.9%), or other (32.6%) families, and were comparable to children living in unmarried biological or adoptive families (Figure 21).
- Nearly 15% of children under age 5 living in nuclear families did not have a medical checkup in the past 12 months compared with 19.8% of children in the same age group living in cohabiting families and 19.3% of children in the same age group living in extended families.
- Among Hispanic children, those in single-parent families (30.2%) were less likely to lack a medical checkup in the past 12 months than children in nuclear (34%), cohabiting (37.4%), extended (38.3%), or other (39.3%) families. Among non-Hispanic white children, those in unmarried biological or adoptive families (23.3%) were less likely to lack a medical checkup than children in single-parent (32.9%), blended (31.5%), cohabiting (32.6%), extended (31%), or other (34.8%) families. Among non-Hispanic black children, those in unmarried biological or adoptive families (14.4%) were less likely to lack a medical checkup than children in nuclear (21.1%), single-parent (22.4%), blended (23.5%), extended (24.5%), or other (24.9%) families.
- Among poor families, 26.5% of children living in unmarried biological or adoptive families did not have a medical checkup in the past 12 months compared with 37.1% of children living in nuclear families, 35.9% in extended families, and 36% in other families. Among not poor families, 23% of children living in nuclear families did not have a medical checkup in the past 12 months compared with 28% of children in single-parent families, 29.9% in blended families, 29.9% in cohabiting families, 28.5% in extended families, and 28.3% in other families.
- Children living in unmarried biological or adoptive families (12.5%) were less likely to have seen or spoken with an eye doctor during the past 12 months than children in nuclear (22.7%), single-parent (23.6%), blended (23.8%), cohabiting (20.4%), extended (24%), or other (22.3%) families.
- Among young children aged 2–4, 4% of those living in unmarried biological or adoptive families had seen an eye doctor in the past 12 months compared with 6.4% of children in nuclear families and 6.9% of children in single-parent families. Among children aged 5–11, 13.5% of those in unmarried biological or adoptive families had seen an eye doctor in the past 12 months compared with 23% of children in nuclear families, 23.7% in single-parent families, 24.8% in blended families, 21.1% in cohabiting families, 20% in extended families, and 23.1% in other families. Among older children aged 12–17, children in nuclear families (34%) were more likely to have seen an eye doctor in the past 12 months than children in

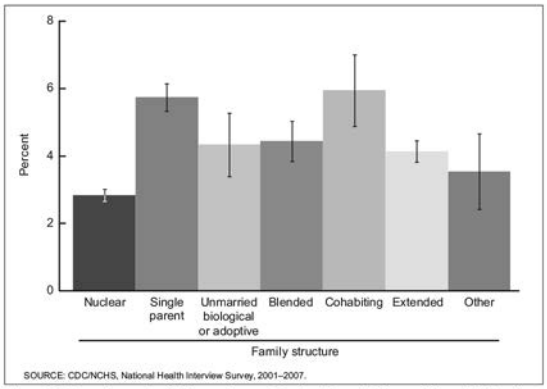


Figure 22. Percentages of children under age 18 who had medical care delayed during the past 12 months due to concerns over cost, by family structure: United States, 2001–2007

single-parent (29.7%), blended (28.6%), cohabiting (27%), extended (31.7%), or other (26.7%) families.

- Children living in cohabiting families (5.9%) were more likely to have medical care delayed during the past 12 months due to concerns over cost than children in nuclear (2.8%), blended (4.4%), extended (4.1%), or other (3.5%) families, and were comparable to children living in single-parent or unmarried biological or adoptive families (Figure 22).
- Family structure was unrelated to delays in receiving medical care due to concerns over cost among children whose more highly educated parent was a high school dropout. When at least one parent had more than a high school diploma, children in nuclear families (2.4%) were less likely to have medical care delayed due to cost than children in single-parent (6.8%), unmarried biological or adoptive (5.2%), blended (3.7%), cohabiting (5.8%), or extended (3.9%) families.
- Among children with private health insurance, those in nuclear families (1.7%) were less likely than children in single-parent (4.1%), blended (2.4%), or extended (2.4%) families to have medical care delayed due to concerns over cost. Among children with Medicaid, family structure was unrelated to delays in receiving medical care due to concerns over cost. Among uninsured children, those in other families (9.9%) were less likely to have medical care delayed due to concerns over cost than children in nuclear (14.2%), single-parent (25.5%), blended (20.6%), cohabiting (18.1%), or extended (15.2%) families.
- Children aged 2–17 living in nuclear families (1.8%) were least likely to have receipt of needed prescription medication delayed during the past 12 months due to lack of affordability.
- Among Hispanic children, those in nuclear families (3.5%) were less likely to have receipt of needed prescription medication delayed due to lack of affordability than children in single-parent (5%), cohabiting (6.7%), or extended (5%) families. Among non-Hispanic white children, those in nuclear families (1.4%) were less likely to have receipt of needed prescription medication delayed due to lack of affordability than children in single-parent (4.7%), blended (2.4%), cohabiting (4.2%), or extended (2.9%) families. Among non-Hispanic black children, those in other families (2.3%) were less likely to have receipt of needed prescription medication delayed due to lack of affordability than children in single-parent (4%) or blended (4.5%) families.
- Children living in nuclear families that owned or were buying their homes (1.3%) were less likely to have prescription medication delayed due to lack of affordability than children in single-parent (3.4%), blended (2.3%), cohabiting (4.1%), or extended (2.8%) families that owned or were buying their homes. Children living in unmarried biological or adoptive families that rented their homes (2.6%) were less likely to have prescription medication delayed due to lack of affordability than children in single-parent (5.1%), blended (4.7%), cohabiting (4.6%), or extended (5.5%) families that rented their homes.
- Among children with private health insurance coverage, 1% of those in nuclear families had prescription medication delayed due to lack of affordability compared with 3.2% of children in single-parent families, 1.9% of children in blended families, and 2% of children in extended families. Among children covered by Medicaid, 1.6% of those in other families had prescription medication delayed due to lack of affordability compared with 2.6% of children in nuclear families, 3.8% of children in single-parent families, 3.7% of children in blended families, 3.6% of children in cohabiting families, and 4% of children in extended families. Among uninsured children, 14.8% of those in single-parent families had prescription medication delayed due to lack of affordability compared with 8.2% of children in nuclear families, 9.3% of children in blended families, 10% of children in extended families, and 9.7% of children in other families.
- Children aged 2–17 living in nuclear families (1.3%) were less likely to

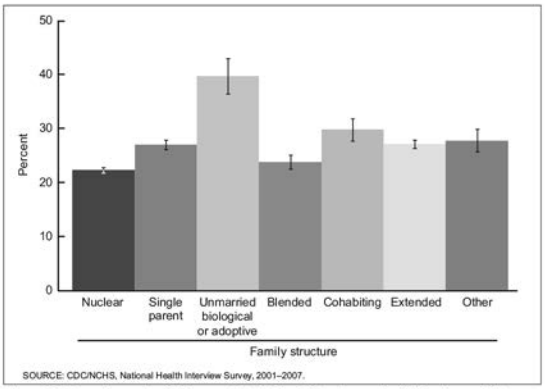


Figure 23. Percentages of children aged 2–17 who did not see a dentist in the past 12 months, by family structure: United States, 2001–2007

have receipt of needed eyeglasses delayed during the past 12 months due to lack of affordability than children living in single-parent (3.4%), blended (2.7%), cohabiting (2.8%), extended (2.9%), or other (2.5%) families, and were comparable to children living in unmarried biological or adoptive families.

- Among Hispanic children, 2.5% of those living in nuclear families were delayed in receiving needed eyeglasses in the past 12 months compared with 3.7% of children in extended families. Among non-Hispanic white children, 1.1% of those in nuclear families were delayed in receiving needed eyeglasses compared with 3.7% of children in single-parent families, 2.4% in blended families, 2.7% in cohabiting families, and 2.3% in extended families. Among non-Hispanic black children, 1.3% of those in nuclear families were delayed in receiving needed eyeglasses compared with 3.1% of children in single-parent families, 2.8% in blended families, and 3.2% in extended families.
- Among children with private health insurance coverage, 2.9% of those in single-parent families were delayed in receiving needed eyeglasses in the past 12 months compared with 0.7% of children in nuclear families, 1.8% of children in blended families, and 1.7% of children in extended families. Among children covered by Medicaid, 3.4% of those in extended families were delayed in receiving needed eyeglasses compared with 1.9% of children in nuclear and 1.9% in other families. Among uninsured children, 9.1% of those in single-parent and also in blended families were delayed in receiving needed eyeglasses compared with 5.7% of children in nuclear families; children in single-parent families (but not those in blended families) were also more likely to experience delays in receiving needed eyeglasses than children in cohabiting families (5.6%).

Dental care

Overall, 15.9 million U.S. children aged 2–17 (24.6%) had not seen a dentist in the past 12 months, and 4.2 million U.S. children aged 2–17 (6.4%) did not receive needed dental care in the past 12 months due to cost (Tables 49–52).

- Children aged 2–17 living in unmarried biological or adoptive families (39.6%) were least likely to have seen a dentist in the past 12 months (Figure 23).
- Among children aged 12–17, 13.3% of those in nuclear families had not seen a dentist in the past 12 months compared with 22.3% of children in single-parent families, 22% in unmarried biological or adoptive families, 18.1% in blended families, 25.1% in cohabiting families, 20.9% in extended families, and 25.3% in other families.
- Among Hispanic children aged 2–17, 29.9% of those in single-parent families had not seen a dentist in the past 12 months compared with 35% of children in nuclear families, 41.2% in unmarried biological or adoptive families, 37.2% in cohabiting families, 36.8% in extended families, and 40.2% in other families. Among non-Hispanic white children aged 2–17, 18.8% of those in nuclear families had not seen a dentist in the past 12 months compared with 24.4% of children in single-parent families, 43.1% in unmarried biological or adoptive families, 22.4% in blended families, 27.8% in cohabiting families, and 23.6% in other families. Among non-Hispanic black children, 26.7% of those living in nuclear families had not seen a dentist in the past 12 months compared with 31.5% of children in extended families.
- Among children with private health insurance, 18.2% of those in nuclear families did not see a dentist within the past 12 months compared with 19.9% of children in single-parent families, 35.6% of children in unmarried biological or adoptive families, and 20.2% of children in blended families. Among children with Medicaid, 23.4% of those in other families did not see a dentist within the past 12 months compared with 30% of children in nuclear families, 29% of children in single-parent families, 38.3% of children in unmarried biological or adoptive families, 31.1% of children in cohabiting families, and 30.6% of

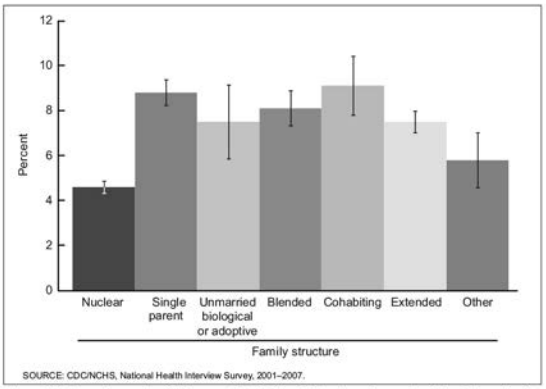


Figure 24. Percentages of children aged 2–17 who did not receive needed dental care in the past 12 months due to cost, by family structure: United States, 2001–2007

children in extended families. Among uninsured children, 42.9% of those in blended families did not see a dentist within the past 12 months compared with 49.4% of children in nuclear families, 55% of children in unmarried biological or adoptive families, 54.6% of children in extended families, and 55.3% of children in other families. Overall, 50% of uninsured children did not see a dentist within the past 12 months.

- Children aged 2–17 living in nuclear families (4.6%) were less likely than children of the same age in single-parent (8.8%), unmarried biological or adoptive (7.5%), blended (8.1%), cohabiting (9.1%), or extended (7.5%) families to lack receipt of needed dental care in the past 12 months due to cost, and were comparable to children living in other families (Figure 24).
- Nearly 8% of Hispanic children living in nuclear families did not receive needed dental care due to cost compared with 10.7% of Hispanic children living in blended families and 9.3% in extended families. Among non-Hispanic white children, 3.9% of those living in nuclear families did not receive needed dental care due to cost compared with 10.3% of children in single-parent families, 7.2% in unmarried biological or adoptive families, 8.1% in blended families, 10.4% in cohabiting families, and 6.6% in extended families. Among non-Hispanic black children, 3.4% of those living in cohabiting families did not receive needed dental care due to cost compared with 6.7% of children in single-parent families, 6.5% in blended families, and 6.5% in extended families.
- Among poor families, 5.3% of children living in other families did not receive needed dental care due to cost compared with 9.3% of children in nuclear families, 9.1% in single-parent families, 11.5% in blended families, 11.8% in cohabiting families, and 10.3% in extended families. Among near poor families, 8.7% of children living in nuclear families did not receive needed dental care due to cost compared with 10.6% of children in single-parent families, 12.1% in blended families, and 10.9% in extended families. Among not poor families, 3.1% of children living in nuclear families did not receive needed dental care due to cost compared with 6.9% of children in single-parent families, 5.9% in blended families, 8.1% in cohabiting families, and 4.9% in extended families.

Measures of Behavior or Emotional Well-being

During the past 6 months, approximately 1.7 million U.S. children aged 4–17 (3%) were often unhappy, depressed, or tearful; 2 million U.S. children aged 4–17 (3.6%) were generally not well-behaved or did not usually do what adults requested; 3.3 million U.S. children aged 4–17 (5.9%) had many worries or often seemed worried; 6.2 million U.S. children aged 4–17 (11.2%) generally exhibited a poor attention span or did not usually see chores and homework through to the end; and 6.3 million U.S. children aged 4–17 (11.3%) certainly got along better with adults than children. Lastly, 2.9 million U.S. children aged 4–17 (5.1%) had definite or severe emotional or behavioral difficulties and 1.1 million U.S. children aged 4–17 with definite or severe emotional or behavioral difficulties had no contact with a mental health professional or general doctor for an emotional or behavioral problem during the last 12 months (39.9%) (Tables 53–66).

- Two percent of children aged 4–17 living in nuclear families were often unhappy, depressed, or tearful during the past 6 months compared with 4.4% of children in single-parent families, 3.7% of children in blended families, 3.4% of children in extended families, and 4.9% of children in other families, and were comparable to children living in unmarried biological or adoptive families or cohabiting families.
- Among Hispanic children, 3% of those in nuclear families were often unhappy, depressed, or tearful during the past 6 months compared with 4.9% of children in single-parent families and 5.6% in blended families. Among non-Hispanic white children, 1.7% of those in nuclear families were often unhappy, depressed, or tearful during the past

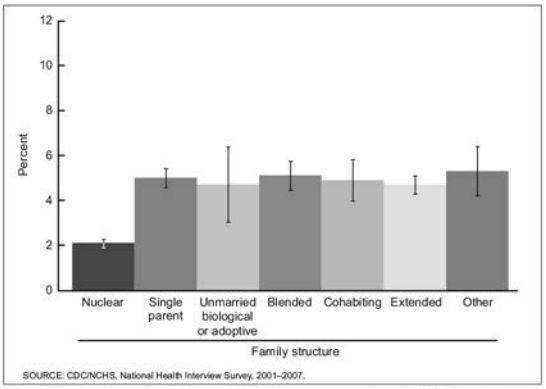


Figure 25. Percentages of children aged 4–17 who were generally not well behaved or did not usually do who adults requested in the past 6 months, by family structure: United States, 2001–2007

6 months compared with 4.1% of children in single-parent families, 3.1% in blended families, and 3.3% in extended families. Among non-Hispanic black children, 2.2% of those in nuclear families were often unhappy, depressed, or tearful during the past 6 months compared with 4.2% of children in single-parent families and 5.1% in other families.

- When the more highly educated parent was a high school dropout, 3.7% of children living in nuclear families were often unhappy, depressed, or tearful during the past 6 months compared with 6.7% of children in single-parent families and 7.7% in blended families. When at least one parent was a high school graduate, children in nuclear families (2.3%) were less likely than children in single-parent (3.7%), blended (4.2%), or extended (3.4%) families to often exhibit unhappy, depressed, or tearful behavior. When at least one parent had more than a high school diploma, 1.8% of children in nuclear families were often unhappy, depressed, or tearful compared with 3.7% of children in single-parent families, 2.9% in blended families, and 3.1% in extended families. Similar percentages for often exhibiting unhappy, depressed, or tearful behavior are obtained when family structure is disaggregated by poverty status.
- About 2% of children aged 4–17 in nuclear families were generally not well-behaved or did not usually do what adults requested during the past 6 months compared with 5% of children in single-parent families, 4.7% of children in unmarried biological or adoptive families, 5.1% of children in blended families, 4.9% of children in cohabiting families, 4.7% of children in extended families, and 5.3% of children in other families (Figure 25).
- Among Hispanic children, 3.5% of those in nuclear families were generally not well-behaved or did not usually do what adults requested during the past 6 months compared with 6% of children in single-parent families, 5.7% in blended families, and 5.1% in extended families. Among non-Hispanic white children, 1.8% of those in nuclear families were generally not well-behaved or did not usually do what adults requested during the past 6 months compared with 4.1% of children in single-parent families, 5.1% in blended families, 3.7% in cohabiting families, 4.2% in extended families, and 4.9% in other families. Among non-Hispanic black children, 2% of those in nuclear families were generally not well-behaved or did not usually do what adults requested during the past 6 months compared with 5.9% of children in single-parent families, 4.5% in blended families, 8% in cohabiting families, 5.7% in extended families, and 6.8% in other families.
- Among poor families, 4.2% of children in nuclear families were generally not well-behaved or did not usually do what adults requested during the past 6 months compared with 6.8% of children in single-parent families, 8.3% in blended families, 7% in extended families, and 8.7% in other families. Among near poor families, 2.7% of children in nuclear families were generally not well-behaved or did not usually do what adults requested compared with 5% of children in single-parent families, 5.9% in blended families, 6.2% in cohabiting families, and 5.1% in extended families. Among not poor families, 1.8% of children in nuclear families were generally not well-behaved or did not usually do what adults requested compared with 3% of children in single-parent families, 4.2% in blended families, 3.4% in cohabiting families, 3.7% in extended families, and 3.7% in other families.
- Children aged 4–17 living in nuclear families (4.1%) were less likely than children in single-parent (8.5%), blended (7.3%), cohabiting (7.6%), extended (6%), or other (9.8%) families to have many worries or often seem worried during the past 6 months, and were comparable to children living in unmarried biological or adoptive families (Figure 26).
- Among Hispanic children, 4.5% of those in nuclear families had many worries or often seemed worried during the past 6 months compared

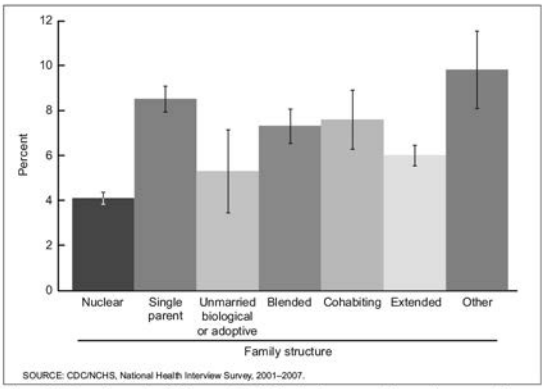


Figure 26. Percentages of children aged 4–17 who had many worries or often seemed worried in the past 6 months, by family structure: United States, 2001–2007

with 8.1% of children in single-parent families, 7.6% in blended families, 6.2% in extended families, and 7.9% in other families. Among non-Hispanic white children, 4.1% of those in nuclear families had many worries or often seemed worried compared with 10.5% of children in single-parent families, 7.7% in blended families, 8.4% in cohabiting families, 6.5% in extended families, and 12.4% in other families. Among non-Hispanic black children, 3.3% of those in nuclear families had many worries or often seemed worried compared with 5.5% of children in single-parent families, 5.2% in extended families, and 7.3% in other families.

- Children living in nuclear families that owned or were buying their homes (3.9%) were less likely to have many worries or often seem worried than children in single-parent (8.6%), blended (6.7%), cohabiting (8.5%), extended (5.2%), or other (10%) families that owned or were buying their homes. Children living in nuclear families that rented their homes (5.3%) were less likely to have many worries or often seem worried than children in single-parent (8.4%), blended (8.6%), extended (8.3%), or other (8.6%) families that rented their homes.
- Nearly 8% of children aged 4–17 in nuclear families generally exhibited a poor attention span or did not usually see chores and homework through to the end during the past 6 months compared with 14.7% of children in single-parent families, 15.6% of children in blended families, 16% of children in cohabiting families, 11.9% of children in extended families, and 18% of children in other families, and were comparable to children living in unmarried biological or adoptive families.
- Ten percent of boys living in nuclear families generally exhibited a poor attention span or did not usually see chores and homework through to the end during the past 6 months compared with 18.1% of boys in single-parent families, 19.6% in blended families, 18.8% in cohabiting families, 14.4% in extended families, and 21.4% in other families. Nearly 6% of girls living in nuclear families generally exhibited a poor attention span or did not usually see chores and homework through to the end during the past 6 months compared with 11.4% of girls in single-parent families, 11.4% in blended families, 12.9% in cohabiting families, 9.3% in extended families, and 14.4% in other families.
- When the more highly educated parent was a high school dropout, 8.4% of children living in nuclear families generally exhibited a poor attention span or did not usually see chores and homework through to the end compared with 15% of children in single-parent families, 17.5% in blended families, 16.2% in cohabiting families, and 11.3% in extended families. When at least one parent was a high school graduate, children in nuclear families (9.8%) were less likely than children in single-parent (14.9%), blended (16.6%), cohabiting (16.1%), or extended (13.9%) families to generally exhibit a poor attention span or not usually see chores and homework through to the end. When at least one parent had more than a high school diploma, 7.4% of children in nuclear families generally exhibited a poor attention span or did not usually see chores and homework through to the end compared with 14.2% of children in single-parent families, 14.9% in blended families, 15.9% in cohabiting families, 11.2% in extended families, and 24% in other families.
- About 9% of children aged 4–17 in nuclear families certainly got along better with adults than children during the past 6 months compared with 13.8% of children in single-parent families, 12.4% of children in blended families, 12.5% of children in cohabiting families, 13% of children in extended families, and 15.2% of children in other families, and were comparable to children living in unmarried biological or adoptive families.
- Among Hispanic children, 12.7% of those in nuclear families certainly got along better with adults than children during the past 6 months compared with 17.5% of children in single-parent families and 19.5% in other families. Among non-Hispanic

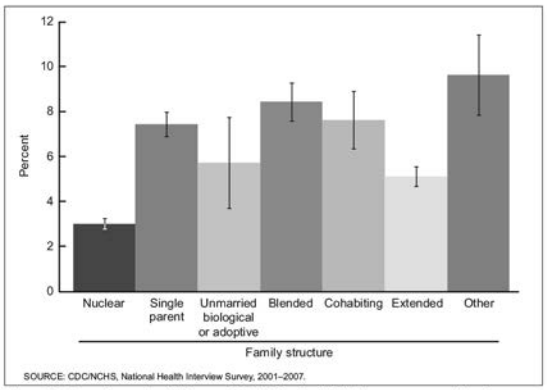


Figure 27. Percentages of children aged 4–17 who had definite or severe emotional or behavioral difficulties, by family structure: United States, 2001–2007

white children, 7.6% of those in nuclear families certainly got along better with adults than children during the past 6 months compared with 11.4% of children in single-parent families, 12.0% in blended families, 11.3% in cohabiting families, 11.7% in extended families, and 14% in other families. Family structure was not related to the extent to which non-Hispanic black children certainly got along better with adults than children during the past 6 months.

- When the more highly educated parent was a high school dropout, 13% of children living in nuclear families certainly got along better with adults than children during the past 6 months compared with 19.7% of children in single-parent families. When at least one parent was a high school graduate, 8.5% of children in unmarried biological or adoptive families certainly got along better with adults than children during the past 6 months compared with 13.6% of children in single-parent families, 14.2% in blended families, and 14% in extended families. When at least one parent had more than a high school diploma, 8.1% of children living in nuclear families certainly got along better with adults than children during the past 6 months compared with 11.5% of children in single-parent families, 11.3% in blended families, 11.8% in extended families, and 15.1% in other families.
- As Figure 27 illustrates, children aged 4–17 living in nuclear families (3%) were less likely to have definite or severe emotional or behavioral difficulties than children in single-parent (7.4%), unmarried biological or adoptive (5.7%), blended (8.4%), cohabiting (7.6%), extended (5.1%), or other (9.6%) families.
- Nearly 4% of boys living in nuclear families had definite or severe emotional or behavioral difficulties compared with 9.3% of boys in single-parent families, 7.7% in unmarried biological or adoptive families, 10.8% in blended families, 9.6% in cohabiting families, 6.2% in extended families, and 9.7% in other families. Two percent of girls living in nuclear families had definite or severe emotional or behavioral difficulties compared with 5.5% of girls in single-parent families, 5.9% in blended families, 5.4% in cohabiting families, 3.9% in extended families, and 9.5% in other families.
- Among Hispanic children, 2.1% of those in nuclear families had definite or severe emotional or behavioral difficulties compared with 5.8% of children in single-parent families, 6.8% in blended families, 5.7% in extended families, and 7.1% in other families. Among non-Hispanic white children, 3.3% of those in nuclear families had definite or severe emotional or behavioral difficulties compared with 8.2% of children in single-parent families, 8.5% in unmarried biological or adoptive families, 9% in blended families, 7.6% in cohabiting families, 6.4% in extended families, and 11.1% in other families. Among non-Hispanic black children, 2.3% of those in nuclear families had definite or severe emotional or behavioral difficulties compared with 6.4% of children in single-parent families, 6.8% in blended families, 7.3% in cohabiting families, 5.5% in extended families, and 9.4% in other families.
- Among children living in poor families, 3.8% of those in nuclear families had definite or severe emotional or behavioral difficulties during the past 6 months compared with 8.9% of children in single-parent families, 9.4% in blended families, 7.2% in cohabiting families, 6.6% in extended families, and 9.7% in other families. Among children living in near poor families, 3.1% of those in nuclear families had definite or severe emotional or behavioral difficulties compared with 7.6% of children in single-parent families, 11.1% in blended families, 9.5% in cohabiting families, 5.4% in extended families, and 11% in other families. Among children living in not poor families, 2.9% of those in nuclear families had definite or severe emotional or behavioral difficulties compared with 5.4% of children in single-parent families, 7.2% in blended families, 6.7% in cohabiting

families, 4.5% in extended families, and 8.5% in other families.

- Among children with private health insurance, 2.8% of those living in nuclear families had definite or severe emotional or behavioral difficulties during the past 6 months compared with 5.6% of children in single-parent families, 7.4% in blended families, 5.8% in cohabiting families, and 4.2% in extended families. Among children with Medicaid, 4.6% of those living in nuclear families had definite or severe emotional or behavioral difficulties during the past 6 months compared with 9.5% of children in single-parent families, 11.3% in blended families, 10.1% in cohabiting families, 7.6% in extended families, and 13.4% in other families. Among uninsured children, 2% of those living in nuclear families had definite or severe emotional or behavioral difficulties during the past 6 months compared with 7.2% of children in single-parent families, 9.3% in blended families, 5.6% in cohabiting families, 4% in extended families, and 5.1% in other families.
- Among children aged 4–17 with definite or severe emotional or behavioral difficulties, 27.8% of those in other families had no contact with a mental health professional or general doctor for an emotional or behavioral problem during the last 12 months compared with 39.9% of children with definite or severe emotional or behavioral difficulties in nuclear families, 40.2% of children with such difficulties in single-parent families, and 43.5% of children with such difficulties in extended families.

Conclusion

The findings presented in this report indicate that children living in nuclear families—that is, in families consisting of two married adults who are the biological or adoptive parents of all children in the family—were generally healthier, more likely to have access to health care, and less likely to have definite or severe emotional or behavioral difficulties than children living in nonnuclear families. For example, children in nuclear families were generally less likely than children in nonnuclear families to be in good, fair, or poor health; to have a basic action disability; or to have learning disabilities or ADHD. They were also less likely than children in nonnuclear families to lack health insurance coverage, to have had two or more ER visits in the past 12 months, to have receipt of needed prescription medication delayed during the past 12 months due to lack of affordability, or to have gone without needed dental care in the past 12 months due to cost. Additionally, children living in nuclear families were less likely to be poorly behaved or to have definite or severe emotional or behavioral difficulties during the past 6 months than children living in nonnuclear family types.

These findings are consistent with previous research that concluded that children living with two parents were advantaged relative to children living in other types of families (18–21). Using data from the Child Health Supplement of the 1988 NHIS, Dawson (18,19) reported that children living with two biological parents were less likely to experience behavioral or emotional problems than children living in other family types. Dawson found small and inconsistent differences in prevalence estimates by family structure for most chronic conditions and indicators of physical health, but noted that children living in households with two parents were less likely to have had chronic asthma in the past 12 months than children living in households without fathers (18). Heck and Parker (20) found that children in two-parent families were less likely than children living with single mothers to have unmet health care needs and more likely to have employer-sponsored health insurance. Bramlett and Blumberg (21) reported that children living with two biological parents were more likely than children in single-mother or grandparent-only families to be in excellent or very good health and less likely to have asthma-related health issues during the past year, to have ADHD, or to have moderate to severe emotional or behavior problems.

Relative to children living in nuclear families, children in single-parent families clearly had higher prevalence rates for the various health conditions and indicators examined in this report. However, when compared to children living in other nonnuclear families, children living in single-parent families generally exhibited comparable prevalence rates with respect to child health, access to care, and emotional or behavioral difficulties. This report combined children living with single mothers, single fathers, or some other related single adult into one category because the vast majority of single adult families in 2001–2007 were headed by mothers. If single-parent families were disaggregated by type of parent (i.e., mother, father, or some other adult), it is possible that children living in single-mother families might have slightly higher rates of health problems and less access to health care than children in single-father families, as well as other nonnuclear families, as earlier research (18–21) has found.

Children living in blended (i.e., stepparent), cohabiting, unmarried biological or adoptive, extended, and other families were generally disadvantaged relative to children in nuclear families, and were, for the most part, comparable to children living in single-parent families regarding most health status and access to care measures. However, few, if any, consistent patterns emerged in the prevalence estimates of children living in nonnuclear families. Interestingly, children living in unmarried biological families share some of the health characteristics of both nuclear and cohabiting families. Results in this report suggest that children in unmarried biological families generally fared well in terms of the prevalence of asthma, hay fever, and allergies and they were also least likely to have had a problem requiring the regular use of a prescription medication for at least 3 months. Conversely, they were more likely than children in the remaining family types to have three or more ear infections in the past 12 months and

least likely to have seen a dentist or had contact with an eye doctor in the past 12 months. Regarding some health measures, however, results were inconclusive due to the relatively small number of children in unmarried biological families. Additional research is needed to determine whether this particular family type is consistently and positively associated with indicators of child health, access to care, and behavioral or emotional well-being.

The association of children's health status, access to or utilization of care, and emotional well-being with family structure was mitigated in some instances by the introduction of various personal, social, and economic characteristics. Yet differences in child health and access to care by family structure generally persisted regardless of population subgroup, with children living in nuclear families remaining advantaged relative to children in nonnuclear families.

The findings in this report cannot be used to infer that family structure "caused" a particular child health outcome or that a child health outcome "caused" family structure. In fact, previous research has shown that causality may flow in both directions; that is, family structure may have consequences for child health outcomes, while children's health may have consequences for family structure (42,43). Ideally, a methodological approach should be used that more accurately reflects how children's health may select them into particular family structures, which, in turn, may have ramifications for their health outcomes. However, the cross-sectional design of NHIS and the lack of information in the data about marriage or union onset or duration makes this task impossible. However, there are certainly different ways to model family structure that are beyond the scope of this report. For example, analysts may wish to distinguish between mother-stepfather and father-stepmother families. Moreover, although the date at which marriages or unions began cannot be determined from NHIS, it is possible to determine whether single mothers have ever been married. It may make a difference whether children are living with a never- versus ever-married mother (44). A postdivorce mother may have more goods and resources (e.g., alimony and child support payments) available to her than a never-married mother. No attempt was made in the current analysis to determine the marital status of single parents (formerly married versus never married) or to distinguish between mother-stepfather, father-stepmother, mother-cohabiting male partner, or father-cohabiting female partner families. The 2001–2007 NHIS data do allow for these possibilities, however.

Despite the data limitations discussed previously, the findings summarized in this report remain important, particularly given the sweeping changes in family formation and living arrangements currently taking place in the United States. This report is based on 7 years of NHIS survey data that contain numerous child health and access to health care measures for a sample of nearly 84,000 children. In addition, this study incorporates a detailed indicator of family structure that takes into account both parental marital status and the nature of parent-child relationships (e.g., biological, step, etc.), making the identification of nontraditional families possible. Very few nationally representative data sources contain reliable measures of both family structure and child health. Thus, NHIS provides a unique opportunity to understand the complicated relationships that exist between family structure and child health in the United States today.

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Table 1. Frequencies of children under age 18 who were in good, fair, or poor health, by family structure and by selected characteristics: United States, 2001–2007

Selected characteristics	All children under age 18 in good, fair, or poor health	Family structure[1]						
		Nuclear	Single parent	Unmarried biological or adoptive	Blended	Cohabiting	Extended	Other
	Number in thousands[2]							
Total[3]	12,604	4,246	2,668	246	1,105	493	3,166	680
Sex								
Male	6,670	2,247	1,393	135	611	267	1,675	342
Female	5,934	1,999	1,275	111	494	225	1,491	338
Age								
0–4 years	3,071	1,181	553	124	219	138	724	132
5–17 years	9,533	3,065	2,115	122	887	355	2,442	548
5–11 years	4,749	1,713	1,057	86	443	205	998	247
12–17 years	4,784	1,352	1,058	36	443	149	1,443	302
Hispanic origin and race[4]								
Hispanic or Latino	3,630	1,233	608	92	225	110	1,177	185
Mexican or Mexican American	2,669	998	331	61	159	77	898	144
Not Hispanic or Latino	8,973	3,013	2,060	154	880	383	1,989	495
White, single race	5,461	2,308	886	99	623	247	1,074	223
Black or African American, single race	2,654	364	1,019	42	212	93	690	234
Parent's education[5]								
Less than high school diploma	3,063	813	780	70	172	133	1,030	64
High school diploma or GED[6]	3,546	1,094	768	93	385	174	967	65
More than high school diploma	5,248	2,307	928	82	535	180	1,094	122
Family income[7]								
Less than $20,000	3,887	765	1,684	83	206	158	808	182
$20,000–$34,999	2,935	931	641	66	289	122	712	173
$35,000–$54,999	2,447	939	240	55	282	103	678	150
$55,000–$74,999	1,389	619	65	26	159	55	373	93
$75,000 or more	1,945	993	38	*16	169	55	593	81
Poverty status[8]								
Poor	4,168	898	1,480	79	243	171	1,047	250
Near poor	3,697	1,146	766	88	374	146	948	228
Not poor	4,739	2,202	423	79	488	175	1,171	202
Home tenure status[9]								
Owned or being bought	6,810	2,867	738	83	658	173	1,877	414
Rented	5,424	1,262	1,838	152	407	299	1,225	240
Some other arrangement	298	97	82	*10	30	*14	48	*18
Health insurance coverage[10]								
Private	5,250	2,423	706	69	552	136	1,221	143
Medicaid	5,400	1,169	1,622	150	384	263	1,400	412
Other	232	79	50	*2	40	*7	39	*14
Uninsured	1,642	562	274	26	124	82	467	106
Place of residence[11]								
Large MSA	4,402	1,189	1,157	87	330	170	1,198	270
Small MSA	5,632	2,197	1,007	104	451	190	1,410	272
Not in MSA	2,570	859	504	55	324	133	557	138
Region								
Northeast	2,157	730	507	50	144	78	539	109
Midwest	2,758	941	610	48	278	121	619	140
South	4,806	1,532	1,073	78	505	176	1,151	291
West	2,884	1,043	478	70	178	117	856	140

* Estimate has a relative standard error of greater than 30% and should be used with caution because it does not meet the standards of reliability or precision.

– Quantity zero.

[1]A nuclear family consists of one or more children living with two parents who are married to one another and are biological or adoptive parents to all children in the family. A single-parent family consists of one or more children living with a single adult (male or female, related or unrelated). An unmarried biological or adoptive family consists of one or more children living with two parents who are not married to one another and are biological or adoptive parents to all children in the family. A blended family consists of one or more children living with a biological or adoptive parent and an unrelated stepparent who are married to one another. A cohabiting family consists of one or more children living with a biological or adoptive parent and an unrelated adult who are cohabiting with one another. An extended family consists of one or more children living with at least one biological or adoptive parent and a related adult. An "other" family consists of one or more children living with

related or unrelated adults who are not biological or adoptive parents.

[2]Data are based on household interviews of a sample of the civilian noninstitutionalized population. Respondent-assessed health status is obtained from a question in the Family Core section of the survey that asked, "Would you say [child's name] health in general was excellent, very good, good, fair, or poor?" A knowledgeable adult provided information on behalf of child respondents. Unknowns with respect to health status and family structure are not included in the column labeled "All children under age 18 in good, fair, or poor health" (see Appendix I).

[3]Includes other races not shown separately and children with unknown parent's education, family income, poverty status, or health insurance. Additionally, numbers within selected characteristics may not add to totals because of rounding.

[4]Persons of Hispanic or Latino origin may be of any race or combination of races. Similarly, the category "Not Hispanic or Latino" refers to all persons who are not of Hispanic or Latino origin, regardless of race. To be concise, the text uses shorter versions of the terms shown in the table. For example, the category, "Not Hispanic or Latino black or African American, single race" in the tables is referred to as "non-Hispanic black" in the text.

[5]Refers to the education level of the parent with the higher level of education, regardless of that parent's age.

[6]GED is General Educational Development high school equivalency diploma.

[7]Information on family income and poverty status is obtained from the 2001–2007 National Health Interview Survey Imputed Family Income/Personal Earnings Files.

[8]Based on family income and family size using the U.S. Census Bureau's poverty thresholds for the previous calendar year. "Poor" persons are defined as below the poverty threshold. "Near poor" persons have incomes of 100% to less than 200% of the poverty threshold. "Not poor" persons have incomes that are 200% of the poverty threshold or greater.

[9]Based on a question in the Family Core that asked whether the family's house or apartment is owned or being bought, rented, or occupied by some other arrangement (see Appendix II).

[10]Classification of health insurance coverage is based on a hierarchy of mutually exclusive categories. Persons with more than one type of health insurance were assigned to the first appropriate category in the hierarchy. The category "Uninsured" includes persons who had no coverage as well as those who had only Indian Health Service coverage or had only a private plan that paid for one type of service such as accidents or dental care (see Appendix II).

[11]MSA is metropolitan statistical area. Large MSAs have a population size of 1 million or more; small MSAs have a population size of less than 1 million. "Not in MSA" consists of persons not living in a metropolitan statistical area.

SOURCE: CDC/NCHS, National Health Interview Survey, 2001–2007.

Table 2. Percentages (with standard errors) of children under age 18 who were in good, fair, or poor health, by family structure and by selected characteristics: United States, 2001–2007

Selected characteristics	All children under age 18 in good, fair, or poor health	Family structure[1]					
		Nuclear	Single parent	Unmarried biological or adoptive	Blended	Cohabiting	Extended	Other
	Percent[2] (standard error)							
Total[3]	17.2 (0.20)	12.0 (0.24)	22.3 (0.48)	23.2 (1.41)	17.5 (0.61)	21.7 (1.09)	22.8 (0.44)	30.0 (1.23)
Sex								
Male	17.9 (0.26)	12.4 (0.32)	23.5 (0.68)	24.0 (1.89)	18.9 (0.94)	22.8 (1.59)	23.3 (0.59)	29.6 (1.72)
Female	16.6 (0.27)	11.6 (0.33)	21.1 (0.64)	22.2 (2.12)	16.0 (0.87)	20.6 (1.49)	22.3 (0.62)	30.4 (1.85)
Age								
0–4 years	15.3 (0.33)	10.5 (0.36)	21.9 (1.09)	19.0 (1.65)	15.8 (1.36)	22.3 (2.19)	23.1 (0.87)	25.1 (2.34)
5–17 years	18.0 (0.23)	12.7 (0.29)	22.4 (0.51)	29.9 (2.56)	17.9 (0.70)	21.5 (1.30)	22.8 (0.49)	31.4 (1.43)
5–11 years	16.9 (0.29)	11.8 (0.35)	21.5 (0.70)	29.0 (2.89)	17.3 (0.97)	20.9 (1.73)	24.3 (0.83)	29.8 (2.01)
12–17 years	19.3 (0.31)	14.1 (0.46)	23.4 (0.72)	32.3 (5.19)	18.6 (1.01)	22.5 (1.93)	21.9 (0.60)	32.9 (2.14)
Hispanic origin and race[4]								
Hispanic or Latino	26.3 (0.46)	21.9 (0.61)	28.8 (1.03)	27.8 (2.37)	22.9 (1.45)	26.7 (2.49)	30.8 (0.82)	35.4 (2.35)
Mexican or Mexican American	28.2 (0.58)	24.6 (0.75)	28.4 (1.42)	27.3 (2.44)	23.8 (1.77)	29.1 (3.16)	33.3 (1.02)	37.0 (2.81)
Not Hispanic or Latino	15.1 (0.21)	10.1 (0.25)	20.9 (0.53)	21.1 (1.72)	16.5 (0.68)	20.6 (1.20)	19.8 (0.51)	28.4 (1.45)
White, single race	12.5 (0.23)	9.2 (0.27)	17.0 (0.64)	21.1 (2.10)	14.8 (0.75)	18.7 (1.41)	16.5 (0.61)	24.6 (2.03)
Black or African American, single race	24.9 (0.55)	16.7 (0.99)	25.6 (0.91)	23.8 (3.49)	24.9 (1.81)	23.6 (2.70)	28.8 (1.11)	34.7 (2.46)
Parent's education[5]								
Less than high school diploma	32.7 (0.63)	29.2 (1.07)	33.4 (1.22)	30.0 (2.85)	33.9 (2.63)	28.5 (2.45)	35.8 (1.10)	36.9 (4.99)
High school diploma or GED[6]	21.8 (0.41)	18.7 (0.61)	22.6 (0.84)	23.5 (2.21)	21.5 (1.29)	21.3 (1.84)	25.7 (0.83)	26.8 (3.87)
More than high school diploma	11.7 (0.20)	8.7 (0.23)	16.4 (0.57)	19.1 (2.34)	13.5 (0.67)	18.6 (1.62)	15.7 (0.51)	26.2 (3.37)
Family income[7]								
Less than $20,000	30.0 (0.52)	25.8 (0.99)	28.7 (0.75)	26.9 (2.59)	31.2 (2.55)	30.0 (2.62)	37.5 (1.29)	38.0 (2.68)
$20,000–$34,999	23.2 (0.50)	20.2 (0.74)	20.7 (0.89)	23.2 (2.61)	25.5 (1.68)	22.8 (2.44)	28.9 (1.30)	33.2 (2.73)
$35,000–$54,999	17.4 (0.43)	14.3 (0.57)	13.3 (0.95)	21.3 (2.93)	18.0 (1.42)	19.0 (2.29)	24.1 (0.97)	29.0 (2.81)
$55,000–$74,999	12.8 (0.43)	9.9 (0.52)	10.2 (1.56)	22.4 (5.42)	13.2 (1.25)	18.5 (3.36)	17.7 (1.22)	30.6 (4.27)
$75,000 or more	8.6 (0.28)	6.6 (0.28)	6.9 (1.42)	17.1 (4.71)	9.6 (0.93)	15.0 (2.50)	13.8 (0.79)	18.2 (2.54)
Poverty status[8]								
Poor	30.9 (0.55)	27.1 (1.03)	29.5 (0.86)	28.3 (2.85)	29.4 (2.33)	29.8 (2.61)	36.4 (1.18)	40.4 (2.60)
Near poor	22.7 (0.53)	19.2 (0.77)	22.5 (0.91)	24.3 (2.52)	23.3 (1.58)	21.8 (2.11)	26.4 (0.98)	32.9 (2.52)
Not poor	11.0 (0.21)	8.5 (0.23)	11.9 (0.59)	18.8 (2.18)	12.5 (0.68)	17.1 (1.43)	15.8 (0.54)	21.1 (1.58)
Home tenure status[9]								
Owned or being bought	13.8 (0.22)	10.2 (0.25)	17.1 (0.71)	21.2 (2.53)	15.4 (0.73)	18.7 (1.63)	19.4 (0.50)	27.2 (1.44)
Rented	24.6 (0.38)	19.8 (0.64)	25.4 (0.66)	23.8 (1.74)	21.4 (1.25)	23.5 (1.48)	31.2 (0.87)	35.9 (2.36)
Some other arrangement	21.0 (1.35)	16.2 (1.89)	23.2 (2.57)	35.1 (10.06)	22.3 (5.23)	*30.0 (12.20)	23.4 (3.49)	*30.8 (9.51)
Health insurance coverage[10]								
Private	11.6 (0.19)	9.0 (0.23)	14.4 (0.57)	18.4 (2.21)	13.6 (0.68)	15.8 (1.56)	16.4 (0.50)	20.8 (2.13)
Medicaid	28.6 (0.44)	24.9 (0.81)	28.6 (0.79)	26.9 (2.12)	26.7 (1.61)	25.9 (1.84)	32.5 (0.91)	35.3 (1.87)
Other	14.5 (1.06)	10.3 (1.21)	19.5 (2.88)	*14.6 (7.41)	18.8 (3.57)	*13.3 (6.11)	16.0 (2.24)	27.6 (7.42)
Uninsured	23.4 (0.64)	19.9 (1.03)	25.2 (1.45)	22.5 (3.97)	21.0 (2.31)	25.5 (2.92)	27.1 (1.17)	31.0 (2.86)
Place of residence[11]								
Large MSA	21.0 (0.41)	14.2 (0.51)	24.9 (0.80)	23.0 (2.19)	21.3 (1.38)	25.8 (2.12)	26.6 (0.80)	33.9 (2.23)
Small MSA	14.6 (0.26)	10.7 (0.30)	19.4 (0.69)	22.6 (2.24)	14.2 (0.84)	18.4 (1.58)	19.7 (0.58)	28.0 (1.81)
Not in MSA	18.9 (0.50)	13.5 (0.62)	23.6 (1.17)	24.8 (3.15)	20.2 (1.14)	23.1 (2.08)	25.5 (1.32)	27.6 (2.40)
Region								
Northeast	16.5 (0.47)	11.0 (0.53)	23.6 (1.20)	27.8 (3.74)	17.8 (1.84)	22.2 (2.86)	20.6 (0.97)	32.9 (3.32)
Midwest	16.0 (0.40)	10.8 (0.50)	21.5 (0.94)	17.0 (2.46)	17.3 (1.23)	19.9 (2.14)	22.5 (1.03)	31.2 (3.04)
South	18.0 (0.32)	12.6 (0.39)	22.3 (0.76)	23.9 (2.44)	19.0 (0.97)	20.8 (1.81)	23.8 (0.73)	29.6 (1.77)
West	17.9 (0.47)	13.3 (0.54)	22.0 (1.07)	25.8 (2.88)	14.3 (1.14)	25.5 (2.24)	23.5 (0.87)	27.7 (2.47)

* Estimate has a relative standard error of greater than 30% and should be used with caution because it does not meet the standards of reliability or precision.

– Quantity zero.

[1]A nuclear family consists of one or more children living with two parents who are married to one another and are biological or adoptive parents to all children in the family. A single-parent family consists of one or more children living with a single adult (male or female, related or unrelated). An unmarried biological or adoptive family consists of one or more children living with two parents who are not married to one another and are biological or adoptive parents to all children in the family. A blended family consists of one or more children living with a biological or adoptive parent and an unrelated stepparent who are married to one another. A cohabiting family consists of one or more children living with a biological or adoptive parent and an unrelated adult who are cohabiting with one another. An extended family consists of one or more children living with at least one biological or adoptive parent and a related adult. An "other" family consists of one or more children living with related or unrelated adults who are not biological or adoptive parents.

[2]Data are based on household interviews of a sample of the civilian noninstitutionalized population. Respondent-assessed health status is obtained from a question in the Family Core section of the survey that asked, "Would you say [child's name] health in general was excellent, very good, good, fair, or poor?" A knowledgeable adult provided information on behalf of child respondents. Unknowns with respect to health status and family structure are not included in the column labeled "All children under age 18 in good, fair, or poor health" (see Appendix I).

[3]Includes other races not shown separately and children with unknown parent's education, family income, poverty status, or health insurance. Additionally, numbers within selected characteristics may not add to totals because of rounding.

[4]Persons of Hispanic or Latino origin may be of any race or combination of races. Similarly, the category "Not Hispanic or Latino" refers to all persons who are not of Hispanic or Latino origin, regardless of race. To be concise, the text uses shorter versions of the terms shown in the table. For example, the category "Not Hispanic or Latino black or African American, single race" in the tables is referred to as "non-Hispanic black" in the text.

[5]Refers to is the education level of the parent with the higher level of education, regardless of that parent's age.

[6]GED is General Educational Development high school equivalency diploma.

[7]Information on family income and poverty status is obtained from the 2001–2007 National Health Interview Survey Imputed Family Income/Personal Earnings Files.

[8]Based on family income and family size using the U.S. Census Bureau's poverty thresholds for the previous calendar year. "Poor" persons are defined as below the poverty threshold. "Near poor" persons have incomes of 100% to less than 200% of the poverty threshold. "Not poor" persons have incomes that are 200% of the poverty threshold or greater.

[9]Based on a question in the Family Core that asked whether the family's house or apartment is owned or being bought, rented, or occupied by some other arrangement (see Appendix II).

[10]Classification of health insurance coverage is based on a hierarchy of mutually exclusive categories. Persons with more than one type of health insurance were assigned to the first appropriate category in the hierarchy. The category "Uninsured" includes persons who had no coverage as well as those who had only Indian Health Service coverage or had only a private plan that paid for one type of service such as accidents or dental care (see Appendix II).

[11]MSA is metropolitan statistical area. Large MSAs have a population size of 1 million or more; small MSAs have a population size of less than 1 million. "Not in MSA" consists of persons not living in a metropolitan statistical area.

SOURCE: CDC/NCHS, National Health Interview Survey, 2001–2007.

Table 3. Frequencies of children under age 18 who have ever been told they have one or more chronic conditions, by family structure and by selected characteristics: United States, 2001–2007

Selected characteristics	All children under age 18 ever told of having one or more chronic conditions	Family structure[1]						
		Nuclear	Single parent	Unmarried biological or adoptive	Blended	Cohabiting	Extended	Other
	Number in thousands[2]							
Total[3]	1,820	790	366	20	159	72	335	76
Sex								
Male	1,049	454	224	12	83	40	196	40
Female	771	337	142	*9	76	32	139	*37
Age								
0–4 years	406	198	57	*5	39	*15	72	*20
5–17 years	1,414	593	310	15	121	58	263	56
5–11 years	739	361	152	*8	67	25	102	*25
12–17 years	675	232	157	*7	54	33	161	31
Hispanic origin and race[4]								
Hispanic or Latino	266	90	54	*5	13	*16	79	10
Mexican or Mexican American	173	54	32	*4	*10	*8	58	*6
Not Hispanic or Latino	1,554	701	313	15	146	57	256	66
White, single race	1,152	599	173	*9	125	41	161	44
Black or African American, single race	288	63	113	*6	15	*10	68	15
Parent's education[5]								
Less than high school diploma	194	48	55	*5	*10	*14	59	*3
High school diploma or GED[6]	405	126	98	*4	47	17	104	*8
More than high school diploma	1,176	614	203	11	101	42	170	*35
Family income[7]								
Less than $20,000	403	72	184	*6	*24	*21	80	15
$20,000–$34,999	307	91	84	*3	*25	*20	62	*22
$35,000–$54,999	317	135	62	*5	30	*13	64	*9
$55,000–$74,999	290	155	*22	*3	36	*10	55	*9
$75,000 or more	503	337	14	*3	45	*9	74	*22
Poverty status[8]								
Poor	404	75	157	*5	30	*21	93	*23
Near poor	370	119	90	*5	29	*25	80	21
Not poor	1,046	597	119	10	100	26	161	*33
Home tenure status[9]								
Owned or being bought	1,227	654	135	8	113	30	230	58
Rented	551	125	224	12	41	40	97	11
Some other arrangement	37	*10	*6	*–	*5	*3	*5	*8
Health insurance coverage[10]								
Private	1,058	617	134	*8	105	23	152	*19
Medicaid	607	122	196	*10	42	40	144	53
Other	35	15	*7	*–	*2	*4	*7	*1
Uninsured	118	34	29	*3	*10	*5	32	*4
Place of residence[11]								
Large MSA	507	184	136	*6	36	19	96	*30
Small MSA	956	445	162	10	89	37	176	36
Not in MSA	358	161	69	*5	34	16	63	10
Region								
Northeast	303	158	46	*5	25	*13	47	*10
Midwest	540	249	103	*8	59	*24	83	*14
South	668	250	156	*5	59	23	148	27
West	309	134	62	*3	*16	*13	57	*25

* Estimate has a relative standard error of greater than 30% and should be used with caution because it does not meet the standards of reliability or precision.

– Quantity zero.

[1] A nuclear family consists of one or more children living with two parents who are married to one another and are biological or adoptive parents to all children in the family. A single-parent family consists of one or more children living with a single adult (male or female, related or unrelated). An unmarried biological or adoptive family consists of one or more children living with two parents who are not married to one another and are biological or adoptive parents to all children in the family. A blended family consists of one or more children living with a biological or adoptive parent and an unrelated stepparent who are married to one another. A cohabiting family consists of one or more children living with a biological or adoptive parent and an unrelated adult who are cohabiting with one

another. An extended family consists of one or more children living with at least one biological or adoptive parent and a related adult. An "other" family consists of one or more children living with related or unrelated adults who are not biological or adoptive parents.

[2]Data are based on household interviews of a sample of the civilian noninstitutionalized population. Prevalence of one or more chronic conditions is based on a series of separate questions that asked whether a doctor or health professional had ever said that the selected child had Down syndrome, muscular dystrophy, cystic fibrosis, sickle cell anemia, autism, diabetes, arthritis, congenital heart disease, or any other heart condition. A knowledgeable adult provided information on behalf of child respondents. Unknowns with respect to chronic conditions and family structure are not included in the column labeled "All children under age 18 ever told of having one or more chronic conditions" (see Appendix I).

[3]Includes other races not shown separately and children with unknown parent's education, family income, poverty status, or health insurance. Additionally, numbers within selected characteristics may not add to totals because of rounding.

[4]Persons of Hispanic or Latino origin may be of any race or combination of races. Similarly, the category "Not Hispanic or Latino" refers to all persons who are not of Hispanic or Latino origin, regardless of race. To be concise, the text uses shorter versions of the terms shown in the table. For example, the category "Not Hispanic or Latino black or African American, single race" in the tables is referred to as "non-Hispanic black" in the text.

[5]Refers to the education level of the parent with the higher level of education, regardless of that parent's age.

[6]GED is General Educational Development high school equivalency diploma.

[7]Information on family income and poverty status is obtained from the 2001–2007 National Health Interview Survey Imputed Family Income/Personal Earnings Files.

[8]Based on family income and family size using the U.S. Census Bureau's poverty thresholds for the previous calendar year. "Poor" persons are defined as below the poverty threshold. "Near poor" persons have incomes of 100% to less than 200% of the poverty threshold. "Not poor" persons have incomes that are 200% of the poverty threshold or greater.

[9]Based on a question in the Family Core that asked whether the family's house or apartment is owned or being bought, rented, or occupied by some other arrangement (see Appendix II).

[10]Classification of health insurance coverage is based on a hierarchy of mutually exclusive categories. Persons with more than one type of health insurance were assigned to the first appropriate category in the hierarchy. The category "Uninsured" includes persons who had no coverage as well as those who had only Indian Health Service coverage or had only a private plan that paid for one type of service such as accidents or dental care (see Appendix II).

[11]MSA is metropolitan statistical area. Large MSAs have a population size of 1 million or more; small MSAs have a population size of less than 1 million. "Not in MSA" consists of persons not living in a metropolitan statistical area.

SOURCE: CDC/NCHS, National Health Interview Survey, 2001–2007.

Table 4. Percentages (with standard errors) of children under age 18 who have ever been told they had one or more chronic conditions, by family structure and by selected characteristics: United States, 2001–2007

Selected characteristics	All children under age 18 ever told of having one or more chronic conditions	Family structure[1]						
		Nuclear	Single parent	Unmarried biological or adoptive	Blended	Cohabiting	Extended	Other
	Percent[2] (standard error)							
Total[3]	2.5 (0.07)	2.2 (0.10)	3.1 (0.20)	1.9 (0.40)	2.5 (0.26)	3.2 (0.55)	2.4 (0.15)	3.4 (0.59)
Sex								
Male	2.8 (0.11)	2.5 (0.15)	3.8 (0.30)	2.0 (0.55)	2.6 (0.36)	3.4 (0.77)	2.7 (0.23)	3.4 (0.71)
Female	2.2 (0.10)	2.0 (0.13)	2.4 (0.23)	*1.8 (0.58)	2.4 (0.40)	2.9 (0.78)	2.1 (0.19)	3.3 (0.97)
Age								
0–4 years	2.0 (0.13)	1.8 (0.15)	2.2 (0.36)	*0.8 (0.28)	2.8 (0.75)	*2.4 (1.08)	2.3 (0.32)	*3.9 (1.20)
5–17 years	2.7 (0.09)	2.5 (0.12)	3.3 (0.22)	3.7 (0.93)	2.4 (0.27)	3.5 (0.63)	2.5 (0.17)	3.2 (0.69)
5–11 years	2.6 (0.12)	2.5 (0.16)	3.1 (0.32)	*2.7 (0.95)	2.6 (0.40)	2.5 (0.67)	2.5 (0.31)	*3.0 (1.05)
12–17 years	2.7 (0.12)	2.4 (0.20)	3.5 (0.31)	*6.2 (2.26)	2.2 (0.37)	4.9 (1.21)	2.4 (0.20)	3.3 (0.90)
Hispanic origin and race[4]								
Hispanic or Latino	1.9 (0.12)	1.6 (0.16)	2.5 (0.35)	*1.6 (0.57)	1.3 (0.39)	*3.8 (1.66)	2.1 (0.21)	1.9 (0.51)
Mexican or Mexican American	1.8 (0.13)	1.3 (0.16)	2.7 (0.53)	*1.9 (0.80)	*1.6 (0.53)	*2.8 (1.22)	2.1 (0.25)	*1.5 (0.53)
Not Hispanic or Latino	2.6 (0.08)	2.4 (0.11)	3.2 (0.22)	2.1 (0.52)	2.7 (0.31)	3.0 (0.56)	2.6 (0.19)	3.8 (0.76)
White, single race	2.6 (0.10)	2.4 (0.13)	3.3 (0.31)	*2.0 (0.63)	3.0 (0.37)	3.1 (0.72)	2.5 (0.23)	4.8 (1.24)
Black or African American, single race	2.7 (0.18)	2.9 (0.42)	2.8 (0.32)	*3.3 (1.32)	1.7 (0.44)	*2.4 (0.77)	2.9 (0.39)	2.2 (0.61)
Parent's education[5]								
Less than high school diploma	2.1 (0.17)	1.7 (0.26)	2.4 (0.37)	*2.3 (0.99)	*2.0 (0.74)	*2.9 (1.45)	2.0 (0.28)	*1.7 (0.84)
High school diploma or GED[6]	2.5 (0.15)	2.2 (0.24)	2.9 (0.33)	*1.1 (0.50)	2.6 (0.59)	2.1 (0.58)	2.8 (0.32)	*3.2 (1.30)
More than high school diploma	2.6 (0.09)	2.3 (0.12)	3.6 (0.31)	2.5 (0.68)	2.6 (0.30)	4.3 (0.94)	2.4 (0.21)	*7.5 (2.50)
Family income[7]								
Less than $20,000	3.1 (0.18)	2.4 (0.35)	3.1 (0.27)	*2.1 (0.88)	3.6 (1.06)	*4.0 (1.38)	3.7 (0.46)	3.1 (0.82)
$20,000–$34,999	2.4 (0.17)	2.0 (0.24)	2.7 (0.35)	*1.1 (0.64)	*2.2 (0.67)	*3.7 (1.44)	2.5 (0.39)	*4.3 (1.47)
$35,000–$54,999	2.3 (0.16)	2.1 (0.22)	3.4 (0.56)	*1.9 (0.83)	1.9 (0.41)	*2.3 (0.80)	2.3 (0.34)	*1.7 (0.63)
$55,000–$74,999	2.7 (0.20)	2.5 (0.27)	*3.4 (1.03)	*2.6 (1.38)	3.0 (0.65)	*3.4 (1.23)	2.6 (0.54)	*2.9 (0.98)
$75,000 or more	2.2 (0.13)	2.3 (0.16)	2.5 (0.73)	*3.1 (1.88)	2.5 (0.53)	*2.5 (1.01)	1.7 (0.24)	*4.9 (2.13)
Poverty status[8]								
Poor	3.0 (0.19)	2.3 (0.34)	3.1 (0.30)	*1.6 (0.89)	3.7 (1.03)	*3.6 (1.29)	3.3 (0.40)	*3.7 (1.19)
Near poor	2.3 (0.16)	2.0 (0.24)	2.7 (0.38)	*1.5 (0.65)	1.8 (0.48)	*3.8 (1.24)	2.2 (0.32)	3.0 (0.81)
Not poor	2.4 (0.09)	2.3 (0.12)	3.3 (0.34)	2.5 (0.72)	2.6 (0.34)	2.6 (0.57)	2.2 (0.20)	*3.4 (1.05)
Home tenure status[9]								
Owned or being bought	2.5 (0.09)	2.3 (0.12)	3.1 (0.33)	2.1 (0.58)	2.6 (0.34)	3.2 (0.75)	2.4 (0.18)	3.8 (0.77)
Rented	2.5 (0.12)	2.0 (0.19)	3.1 (0.25)	1.9 (0.56)	2.2 (0.45)	3.2 (0.80)	2.5 (0.27)	1.6 (0.48)
Some other arrangement	2.6 (0.59)	*1.7 (0.58)	*1.6 (0.54)	*–	*3.7 (1.86)	*5.9 (4.64)	*2.7 (1.02)	*12.9 (9.11)
Health insurance coverage[10]								
Private	2.3 (0.09)	2.3 (0.12)	2.7 (0.29)	*2.0 (0.62)	2.6 (0.34)	2.7 (0.64)	2.0 (0.19)	*2.7 (1.21)
Medicaid	3.2 (0.16)	2.6 (0.28)	3.5 (0.30)	*1.8 (0.54)	2.9 (0.61)	4.0 (1.04)	3.3 (0.31)	4.5 (0.89)
Other	2.2 (0.37)	2.0 (0.50)	*2.6 (0.96)	*–	*0.8 (0.49)	*7.2 (4.50)	*2.8 (0.99)	*1.6 (1.22)
Uninsured	1.7 (0.18)	1.2 (0.23)	2.7 (0.51)	*2.7 (1.63)	*1.7 (0.64)	*1.5 (0.78)	1.9 (0.42)	*1.1 (0.59)
Place of residence[11]								
Large MSA	2.4 (0.13)	2.2 (0.20)	2.9 (0.28)	*1.6 (0.64)	2.3 (0.45)	2.9 (0.71)	2.1 (0.23)	*3.8 (1.29)
Small MSA	2.5 (0.10)	2.2 (0.12)	3.1 (0.32)	2.1 (0.60)	2.8 (0.40)	3.6 (1.04)	2.5 (0.21)	3.7 (0.84)
Not in MSA	2.6 (0.16)	2.5 (0.26)	3.2 (0.45)	*2.1 (0.94)	2.2 (0.51)	2.8 (0.73)	2.9 (0.47)	2.0 (0.55)
Region								
Northeast	2.3 (0.16)	2.4 (0.25)	2.1 (0.32)	*2.6 (1.18)	3.1 (0.82)	*3.7 (1.90)	1.8 (0.26)	*3.0 (0.94)
Midwest	3.1 (0.18)	2.9 (0.24)	3.6 (0.48)	*2.7 (0.95)	3.7 (0.68)	*3.9 (1.26)	3.0 (0.39)	*3.2 (1.78)
South	2.5 (0.12)	2.0 (0.15)	3.2 (0.32)	*1.6 (0.62)	2.2 (0.34)	2.7 (0.68)	3.1 (0.30)	2.8 (0.64)
West	1.9 (0.13)	1.7 (0.17)	2.9 (0.39)	*1.0 (0.50)	*1.3 (0.50)	*2.8 (0.89)	1.6 (0.21)	*4.8 (1.64)

* Estimate has a relative standard error of greater than 30% and should be used with caution because it does not meet the standards of reliability or precision.

– Quantity zero.

[1]A nuclear family consists of one or more children living with two parents who are married to one another and are biological or adoptive parents to all children in the family. A single-parent family consists of one or more children living with a single adult (male or female, related or unrelated). An unmarried biological or adoptive family consists of one or more children living with two parents who are not married to one another and are biological or adoptive parents to all children in the family. A blended family consists of one or more children living with a biological or adoptive parent and an unrelated stepparent who are married to one another. A cohabiting family consists of one or more children living with a biological or adoptive parent and an unrelated adult who are cohabiting with one another. An extended family consists of one or more children living with at least one biological or adoptive parent and a related adult. An "other" family consists of one or more children living with

related or unrelated adults who are not biological or adoptive parents.

[2]Data are based on household interviews of a sample of the civilian noninstitutionalized population. Prevalence of one or more chronic conditions is based on a series of separate questions that asked whether a doctor or health professional had ever said that the selected child had Down syndrome, muscular dystrophy, cystic fibrosis, sickle cell anemia, autism, diabetes, arthritis, congenital heart disease, or any other heart condition. A knowledgeable adult provided information on behalf of child respondents. Unknowns with respect to chronic conditions and family structure are not included in the column labeled "All children under age 18 ever told of having one or more chronic conditions" (see Appendix I).

[3]Total includes other races not shown separately and children with unknown parent's education, family income, poverty status, or health insurance.

[4]Persons of Hispanic or Latino origin may be of any race or combination of races. Similarly, the category "Not Hispanic or Latino" refers to all persons who are not of Hispanic or Latino origin, regardless of race. To be concise, the text uses shorter versions of the terms shown in the table. For example, the category "Not Hispanic or Latino black or African American, single race" in the tables is referred to as "non-Hispanic black" in the text.

[5]Refers to the education level of the parent with the higher level of education, regardless of that parent's age.

[6]GED is General Educational Development high school equivalency diploma.

[7]Information on family income and poverty status is obtained from the 2001–2007 National Health Interview Survey Imputed Family Income/Personal Earnings Files.

[8]Based on family income and family size using the U.S. Census Bureau's poverty thresholds for the previous calendar year. "Poor" persons are defined as below the poverty threshold. "Near poor" persons have incomes of 100% to less than 200% of the poverty threshold. "Not poor" persons have incomes that are 200% of the poverty threshold or greater.

[9]Based on a question in the Family Core that asked whether the family's house or apartment is owned or being bought, rented, or occupied by some other arrangement (see Appendix II).

[10]Classification of health insurance coverage is based on a hierarchy of mutually exclusive categories. Persons with more than one type of health insurance were assigned to the first appropriate category in the hierarchy. The category ""Uninsured" includes persons who had no coverage as well as those who had only Indian Health Service coverage or had only a private plan that paid for one type of service such as accidents or dental care (see Appendix II).

[11]MSA is metropolitan statistical area. Large MSAs have a population size of 1 million or more; small MSAs have a population size of less than 1 million. "Not in MSA" consists of persons not living in a metropolitan statistical area.

SOURCE: CDC/NCHS, National Health Interview Survey, 2001–2007.

Table 5. Frequencies of children under age 18 who have ever been told they have asthma, by family structure and by selected characteristics: United States, 2001–2007

Selected characteristics	All children under age 18 who have ever been told they have asthma	Family structure[1]						
		Nuclear	Single parent	Unmarried biological or adoptive	Blended	Cohabiting	Extended	Other
	Number in thousands[2]							
Total[3]	9,299	3,631	2,071	118	879	315	1,920	364
Sex								
Male	5,496	2,210	1,173	74	502	203	1,146	188
Female	3,802	1,421	898	44	377	112	774	175
Age								
0–4 years	1,571	630	372	51	100	76	292	50
5–17 years	7,728	3,001	1,699	67	780	239	1,628	314
5–11 years	3,890	1,662	900	46	412	131	596	143
12–17 years	3,838	1,339	799	21	368	108	1,032	171
Hispanic origin and race[4]								
Hispanic or Latino	1,611	518	394	26	127	60	426	61
Mexican or Mexican American	912	326	168	13	68	33	266	38
Not Hispanic or Latino	7,687	3,113	1,677	92	752	255	1,494	303
White, single race	5,130	2,510	780	53	563	149	930	147
Black or African American, single race	1,862	327	756	28	140	71	407	132
Parent's education[5]								
Less than high school diploma	1,180	215	456	22	66	69	330	22
High school diploma or GED[6]	2,105	628	545	50	244	110	497	30
More than high school diploma	5,669	2,781	975	46	565	132	1,070	101
Family income[7]								
Less than $20,000	2,012	291	1,102	32	101	75	335	77
$20,000–$34,999	1,667	438	520	32	166	83	332	96
$35,000–$54,999	1,692	619	273	28	256	88	368	60
$55,000–$74,999	1,341	674	98	13	151	43	302	60
$75,000 or more	2,586	1,609	79	13	206	26	583	71
Poverty status[8]								
Poor	2,016	330	945	27	121	86	419	88
Near poor	2,147	554	583	47	247	106	480	131
Not poor	5,135	2,747	542	44	512	124	1,021	145
Home tenure status[9]								
Owned or being bought	5,888	2,962	657	49	560	110	1,305	244
Rented	3,204	605	1,361	67	291	199	575	106
Some other arrangement	179	56	51	*2	22	*6	32	*12
Health insurance coverage[10]								
Private	5,420	2,795	750	58	556	101	1,032	128
Medicaid	3,012	536	1,132	52	220	168	707	197
Other	184	79	35	*–	23	*5	38	*3
Uninsured	657	213	152	*7	77	41	133	33
Place of residence[11]								
Large MSA	2,768	807	868	37	226	80	614	135
Small MSA	4,900	2,205	892	62	450	138	994	159
Not in MSA	1,631	619	311	*19	202	97	311	71
Region								
Northeast	1,929	795	443	31	144	48	400	66
Midwest	2,137	868	510	36	198	65	375	86
South	3,363	1,247	766	30	354	130	689	147
West	1,870	721	353	21	183	72	456	65

* Estimate has a relative standard error of greater than 30% and should be used with caution because it does not meet the standards of reliability or precision.

– Quantity zero.

[1] A nuclear family consists of one or more children living with two parents who are married to one another and are biological or adoptive parents to all children in the family. A single-parent family consists of one or more children living with a single adult (male or female, related or unrelated). An unmarried biological or adoptive family consists of one or more children living with two parents who are not married to one another and are biological or adoptive parents to all children in the family. A blended family consists of one or more children living with a biological or adoptive parent and an unrelated stepparent who are married to one another. A cohabiting family consists of one or more children living with a biological or adoptive parent and an unrelated adult who are cohabiting with one

another. An extended family consists of one or more children living with at least one biological or adoptive parent and a related adult. An "other" family consists of one or more children living with related or unrelated adults who are not biological or adoptive parents.

[2]Data are based on household interviews of a sample of the civilian noninstitutionalized population. Ever told had asthma is based on the question, "Has a doctor or other health professional ever told you that [child's name] had asthma?" A knowledgeable adult provided information on behalf of child respondents. Unknowns with respect to asthma and family structure are not included in the column labeled "All children under age 18 who have ever been told they have asthma" (see Appendix I).

[3]Total includes other races not shown separately and children with unknown parent's education, family income, poverty status, or health insurance. Additionally, numbers within selected characteristics may not add to totals because of rounding.

[4]Persons of Hispanic or Latino origin may be of any race or combination of races. Similarly, the category "Not Hispanic or Latino" refers to all persons who are not of Hispanic or Latino origin, regardless of race. To be concise, the text uses shorter versions of the terms shown in the table. For example, the category "Not Hispanic or Latino black or African American, single race" in the tables is referred to as "non-Hispanic black" in the text.

[5]Refers to the education level of the parent with the higher level of education, regardless of that parent's age.

[6]GED is General Educational Development high school equivalency diploma.

[7]Information on family income and poverty status is obtained from the 2001–2007 National Health Interview Survey Imputed Family Income/Personal Earnings Files.

[8]Based on family income and family size using the U.S. Census Bureau's poverty thresholds for the previous calendar year. "Poor" persons are defined as below the poverty threshold. "Near poor" persons have incomes of 100% to less than 200% of the poverty threshold. "Not poor" persons have incomes that are 200% of the poverty threshold or greater.

[9]Based on a question in the Family Core that asked whether the family's house or apartment is owned or being bought, rented, or occupied by some other arrangement (see Appendix II).

[10]Classification of health insurance coverage is based on a hierarchy of mutually exclusive categories. Persons with more than one type of health insurance were assigned to the first appropriate category in the hierarchy. The category ""Uninsured" includes persons who had no coverage as well as those who had only Indian Health Service coverage or had only a private plan that paid for one type of service such as accidents or dental care (see Appendix II).

[11]MSA is metropolitan statistical area. Large MSAs have a population size of 1 million or more; small MSAs have a population size of less than 1 million. "Not in MSA" consists of persons not living in a metropolitan statistical area.

SOURCE: CDC/NCHS, National Health Interview Survey, 2001–2007.

Table 6. Percentages (with standard errors) of children under age 18 who have ever been told they have asthma, by family structure and by selected characteristics: United States, 2001–2007

Selected characteristics	All children under age 18 who have ever been told they have asthma	Family structure[1]						
		Nuclear	Single parent	Unmarried biological or adoptive	Blended	Cohabiting	Extended	Other
	Percent[2] (standard error)							
Total[3]	12.7 (0.16)	10.3 (0.20)	17.3 (0.41)	11.1 (1.04)	13.9 (0.57)	13.9 (0.91)	13.9 (0.35)	16.1 (1.06)
Sex								
Male	14.7 (0.23)	12.2 (0.30)	19.8 (0.61)	13.3 (1.53)	15.6 (0.78)	17.3 (1.41)	16.0 (0.52)	16.3 (1.40)
Female	10.7 (0.21)	8.3 (0.27)	14.9 (0.52)	8.7 (1.38)	12.2 (0.82)	10.3 (1.10)	11.6 (0.48)	15.9 (1.64)
Age								
0–4 years	7.8 (0.23)	5.6 (0.27)	14.8 (0.79)	7.8 (1.00)	7.2 (0.93)	12.3 (1.63)	9.3 (0.58)	9.5 (1.45)
5–17 years	14.6 (0.20)	12.5 (0.27)	18.0 (0.47)	16.4 (2.14)	15.8 (0.66)	14.5 (1.08)	15.2 (0.42)	18.1 (1.29)
5–11 years	13.8 (0.27)	11.5 (0.34)	18.3 (0.66)	15.6 (2.33)	16.1 (0.97)	13.4 (1.34)	14.5 (0.67)	17.3 (1.62)
12–17 years	15.5 (0.30)	13.9 (0.45)	17.7 (0.66)	18.6 (4.70)	15.5 (0.92)	16.2 (1.85)	15.6 (0.53)	18.8 (2.01)
Hispanic origin and race[4]								
Hispanic or Latino	11.7 (0.31)	9.2 (0.42)	18.7 (0.90)	7.9 (1.29)	12.9 (1.14)	14.5 (2.09)	11.2 (0.55)	11.6 (1.57)
Mexican or Mexican American	9.6 (0.34)	8.0 (0.47)	14.4 (1.10)	5.8 (1.45)	10.2 (1.31)	12.3 (2.51)	9.9 (0.64)	9.9 (1.62)
Not Hispanic or Latino	13.0 (0.18)	10.5 (0.23)	17.1 (0.45)	12.6 (1.39)	14.1 (0.64)	13.8 (1.00)	14.9 (0.43)	17.4 (1.29)
White, single race	11.8 (0.21)	10.1 (0.25)	15.1 (0.61)	11.2 (1.75)	13.4 (0.71)	11.2 (1.10)	14.3 (0.55)	16.1 (1.82)
Black or African American, single race	17.5 (0.43)	15.0 (0.89)	19.0 (0.71)	16.0 (2.77)	16.5 (1.59)	18.1 (2.40)	17.1 (0.84)	19.8 (2.10)
Parent's education[5]								
Less than high school diploma	12.6 (0.44)	7.7 (0.63)	19.5 (0.98)	9.3 (2.03)	13.0 (1.93)	14.8 (2.11)	11.5 (0.73)	12.5 (2.76)
High school diploma or GED[6]	13.0 (0.31)	10.7 (0.51)	16.0 (0.70)	12.7 (1.93)	13.7 (1.15)	13.5 (1.42)	13.2 (0.61)	12.3 (3.22)
More than high school diploma	12.6 (0.20)	10.5 (0.24)	17.3 (0.58)	10.8 (1.55)	14.3 (0.68)	13.7 (1.38)	15.3 (0.52)	21.7 (3.31)
Family income[7]								
Less than $20,000	15.6 (0.39)	9.8 (0.66)	18.8 (0.60)	10.3 (2.01)	15.3 (1.74)	14.2 (1.72)	15.5 (0.87)	16.3 (2.25)
$20,000–$34,999	13.2 (0.41)	9.5 (0.57)	16.8 (0.79)	11.2 (2.10)	14.6 (1.53)	15.6 (2.26)	13.5 (0.95)	18.4 (2.26)
$35,000–$54,999	12.1 (0.40)	9.5 (0.46)	15.1 (1.05)	11.0 (2.58)	16.4 (1.36)	16.4 (2.05)	13.1 (0.83)	11.6 (1.81)
$55,000–$74,999	12.3 (0.44)	10.8 (0.54)	15.4 (1.71)	11.6 (2.88)	12.6 (1.16)	14.6 (2.77)	14.3 (1.04)	19.5 (4.17)
$75,000 or more	11.5 (0.28)	10.8 (0.33)	14.3 (1.76)	13.5 (3.38)	11.7 (0.92)	7.0 (1.46)	13.5 (0.62)	16.1 (2.58)
Poverty status[8]								
Poor	14.9 (0.40)	10.0 (0.69)	18.9 (0.66)	9.6 (2.12)	14.6 (1.73)	14.9 (1.86)	14.6 (0.84)	14.4 (2.07)
Near poor	13.2 (0.38)	9.3 (0.50)	17.2 (0.79)	12.9 (2.25)	15.4 (1.42)	15.8 (1.95)	13.4 (0.80)	18.7 (2.30)
Not poor	11.9 (0.19)	10.6 (0.24)	15.3 (0.65)	10.6 (1.45)	13.2 (0.65)	12.1 (1.21)	13.8 (0.46)	15.3 (1.49)
Home tenure status[9]								
Owned or being bought	12.0 (0.19)	10.5 (0.24)	15.3 (0.62)	12.5 (1.94)	13.1 (0.66)	11.9 (1.31)	13.5 (0.41)	16.0 (1.25)
Rented	14.6 (0.29)	9.5 (0.43)	18.8 (0.55)	10.5 (1.30)	15.3 (1.08)	15.6 (1.34)	14.7 (0.66)	16.0 (1.97)
Some other arrangement	12.7 (1.05)	9.3 (1.41)	14.3 (2.17)	*7.5 (4.36)	16.3 (3.77)	*12.7 (5.90)	15.7 (2.82)	*19.8 (8.89)
Health insurance coverage[10]								
Private	12.0 (0.19)	10.4 (0.24)	15.3 (0.59)	15.5 (1.84)	13.7 (0.66)	11.7 (1.31)	13.9 (0.46)	18.7 (2.24)
Medicaid	16.0 (0.35)	11.4 (0.61)	20.0 (0.65)	9.3 (1.45)	15.3 (1.33)	16.5 (1.52)	16.4 (0.70)	17.0 (1.45)
Other	11.5 (0.89)	10.3 (1.41)	13.6 (2.24)	*–	10.9 (2.37)	*9.3 (3.97)	15.5 (2.30)	*6.7 (2.69)
Uninsured	9.4 (0.42)	7.6 (0.59)	14.0 (1.22)	6.6 (1.97)	13.1 (1.84)	12.7 (2.21)	7.7 (0.68)	9.7 (1.94)
Place of residence[11]								
Large MSA	13.2 (0.29)	9.6 (0.38)	18.7 (0.66)	9.8 (1.53)	14.7 (1.14)	12.2 (1.49)	13.6 (0.57)	17.1 (2.08)
Small MSA	12.7 (0.22)	10.7 (0.28)	17.3 (0.63)	13.4 (1.70)	14.2 (0.80)	13.4 (1.37)	13.9 (0.51)	16.3 (1.50)
Not in MSA	12.0 (0.37)	9.7 (0.47)	14.6 (0.87)	8.7 (2.49)	12.6 (1.12)	16.9 (1.93)	14.2 (0.92)	14.2 (1.97)
Region								
Northeast	14.8 (0.41)	12.1 (0.54)	20.7 (1.01)	17.2 (2.80)	18.0 (1.65)	13.6 (1.93)	15.3 (0.84)	20.4 (2.79)
Midwest	12.4 (0.35)	10.0 (0.40)	18.0 (0.90)	12.7 (2.46)	12.3 (1.13)	10.7 (1.76)	13.6 (0.86)	19.2 (2.95)
South	12.6 (0.26)	10.2 (0.34)	15.9 (0.62)	9.2 (1.63)	13.3 (0.88)	15.3 (1.54)	14.2 (0.56)	14.9 (1.48)
West	11.6 (0.30)	9.2 (0.38)	16.3 (0.87)	7.8 (1.48)	14.7 (1.26)	15.7 (2.10)	12.5 (0.65)	12.8 (1.98)

* Estimate has a relative standard error of greater than 30% and should be used with caution because it does not meet the standards of reliability or precision.

– Quantity zero.

[1] A nuclear family consists of one or more children living with two parents who are married to one another and are biological or adoptive parents to all children in the family. A single-parent family consists of one or more children living with a single adult (male or female, related or unrelated). An unmarried biological or adoptive family consists of one or more children living with two parents who are not married to one another and are biological or adoptive parents to all children in the family. A blended family consists of one or more children living with a biological or adoptive parent and an unrelated stepparent who are married to one another. A cohabiting family consists of one or more children living with a biological or adoptive parent and an unrelated adult who are cohabiting with one

another. An extended family consists of one or more children living with at least one biological or adoptive parent and a related adult. An "other" family consists of one or more children living with related or unrelated adults who are not biological or adoptive parents.

[2]Data are based on household interviews of a sample of the civilian noninstitutionalized population. Ever told had asthma is obtained from the question, "Has a doctor or other health professional ever told you that [child's name] had asthma?" A knowledgeable adult provided information on behalf of child respondents. Unknowns with respect to asthma and family structure are not included in the column labeled "All children under age 18 who have ever been told they have asthma" (see Appendix I).

[3]Includes other races not shown separately and children with unknown parent's education, family income, poverty status, or health insurance.

[4]Persons of Hispanic or Latino origin may be of any race or combination of races. Similarly, the category "Not Hispanic or Latino" refers to all persons who are not of Hispanic or Latino origin, regardless of race. To be concise, the text uses shorter versions of the terms shown in the table. For example, the category "Not Hispanic or Latino black or African American, single race" in the tables is referred to as "non-Hispanic black" in the text.

[5]Refers to the education level of the parent with the higher level of education, regardless of that parent's age.

[6]GED is General Educational Development high school equivalency diploma.

[7]Information on family income and poverty status is obtained from the 2001–2007 National Health Interview Survey Imputed Family Income/Personal Earnings Files.

[8]Based on family income and family size using the U.S. Census Bureau's poverty thresholds for the previous calendar year. "Poor" persons are defined as below the poverty threshold. "Near poor" persons have incomes of 100% to less than 200% of the poverty threshold. "Not poor" persons have incomes that are 200% of the poverty threshold or greater.

[9]Based on a question in the Family Core that asked whether the family's house or apartment is owned or being bought, rented, or occupied by some other arrangement (see Appendix II).

[10]Classification of health insurance coverage is based on a hierarchy of mutually exclusive categories. Persons with more than one type of health insurance were assigned to the first appropriate category in the hierarchy. The category ""Uninsured" includes persons who had no coverage as well as those who had only Indian Health Service coverage or had only a private plan that paid for one type of service such as accidents or dental care (see Appendix II).

[11]MSA is metropolitan statistical area. Large MSAs have a population size of 1 million or more; small MSAs have a population size of less than 1 million. "Not in MSA" consists of persons not living in a metropolitan statistical area.

SOURCE: CDC/NCHS, National Health Interview Survey, 2001–2007.

Table 7. Frequencies of children under age 18 with hay fever in the past 12 months, by family structure and by selected characteristics: United States, 2001–2007

Selected characteristics	All children under age 18 with hay fever in the past 12 months	Family structure[1]						
		Nuclear	Single parent	Unmarried biological or adoptive	Blended	Cohabiting	Extended	Other
	Number in thousands[2]							
Total[3]	7,232	3,632	1,171	61	634	181	1,331	222
Sex								
Male	3,963	2,023	639	37	339	87	722	118
Female	3,268	1,609	533	24	295	94	609	105
Age								
0–4 years	912	517	121	22	59	27	130	35
5–17 years	6,320	3,115	1,050	39	574	154	1,200	187
5–11 years	2,963	1,649	475	29	270	76	373	91
12–17 years	3,356	1,467	575	*10	305	77	827	96
Hispanic origin and race[4]								
Hispanic or Latino	1,047	430	172	19	87	28	272	40
Mexican or Mexican American	692	299	89	14	61	21	185	23
Not Hispanic or Latino	6,185	3,202	999	43	547	153	1,059	182
White, single race	4,889	2,782	619	34	461	102	787	104
Black or African American, single race	826	172	313	*6	55	30	188	63
Parent's education[5]								
Less than high school diploma	582	160	152	12	31	35	181	*10
High school diploma or GED[6]	1,276	464	245	18	145	59	322	*24
More than high school diploma	5,158	3,001	725	31	450	86	818	46
Family income[7]								
Less than $20,000	1,005	215	490	17	41	36	163	43
$20,000–$34,999	1,030	364	295	19	99	34	173	48
$35,000–$54,999	1,352	600	230	13	145	47	261	57
$55,000–$74,999	1,105	595	83	*6	142	27	223	29
$75,000 or more	2,739	1,858	74	*6	207	37	512	45
Poverty status[8]								
Poor	990	252	395	*14	50	35	193	49
Near poor	1,354	476	314	23	140	36	293	73
Not poor	4,888	2,904	462	24	444	110	844	100
Home tenure status[9]								
Owned or being bought	5,404	3,109	537	25	464	92	1,029	149
Rented	1,656	449	598	36	153	86	269	65
Some other arrangement	150	64	34	*–	*11	*2	29	*8
Health insurance coverage[10]								
Private	5,072	3,003	594	24	455	75	855	66
Medicaid	1,465	352	455	32	103	75	326	123
Other	134	69	23	*1	*10	*3	20	*9
Uninsured	549	204	99	*5	64	26	127	23
Place of residence[11]								
Large MSA	1,859	774	424	17	138	48	390	68
Small MSA	3,998	2,166	527	35	353	85	739	93
Not in MSA	1,375	692	220	*10	143	48	202	61
Region								
Northeast	1,250	638	210	*7	90	29	257	20
Midwest	1,564	819	258	17	135	35	259	41
South	2,656	1,305	438	21	263	68	444	116
West	1,762	871	266	16	145	49	371	45

* Estimate has a relative standard error of greater than 30% and should be used with caution because it does not meet the standards of reliability or precision.

– Quantity zero.

[1]A nuclear family consists of one or more children living with two parents who are married to one another and are biological or adoptive parents to all children in the family. A single-parent family consists of one or more children living with a single adult (male or female, related or unrelated). An unmarried biological or adoptive family consists of one or more children living with two parents who are not married to one another and are biological or adoptive parents to all children in the family. A blended family consists of one or more children living with a biological or adoptive parent and an unrelated stepparent who are married to one another. A cohabiting family consists of one or more children living with a biological or adoptive parent and an unrelated adult who are cohabiting with one another. An extended family consists of one or more children living with at least one biological or adoptive parent and a related adult. An "other" family consists of one or more children living with

related or unrelated adults who are not biological or adoptive parents.

[2]Data are based on household interviews of a sample of the civilian noninstitutionalized population. Prevalence of hay fever is based on the question, "During the past 12 months, has [child's name] had hay fever?" A knowledgeable adult provided information on behalf of child respondents. Unknowns with respect to hay fever and family structure are not included in the column labeled "All children under age 18 with hay fever in the past 12 months" (see Appendix I).

[3]Includes other races not shown separately and children with unknown parent's education, family income, poverty status, or health insurance. Additionally, numbers within selected characteristics may not add to totals because of rounding.

[4]Persons of Hispanic or Latino origin may be of any race or combination of races. Similarly, the category "Not Hispanic or Latino" refers to all persons who are not of Hispanic or Latino origin, regardless of race. To be concise, the text uses shorter versions of the terms shown in the table. For example, the category "Not Hispanic or Latino black or African American, single race" in the tables is referred to as "non-Hispanic black" in the text.

[5]Refers to the education level of the parent with the higher level of education, regardless of that parent's age.

[6]GED is General Educational Development high school equivalency diploma.

[7]Information on family income and poverty status is obtained from the 2001–2007 National Health Interview Survey Imputed Family Income/Personal Earnings Files.

[8]Based on family income and family size using the U.S. Census Bureau's poverty thresholds for the previous calendar year. "Poor" persons are defined as below the poverty threshold. "Near poor" persons have incomes of 100% to less than 200% of the poverty threshold. "Not poor" persons have incomes that are 200% of the poverty threshold or greater.

[9]Based on a question in the Family Core that asked whether the family's house or apartment is owned or being bought, rented, or occupied by some other arrangement (see Appendix II).

[10]Classification of health insurance coverage is based on a hierarchy of mutually exclusive categories. Persons with more than one type of health insurance were assigned to the first appropriate category in the hierarchy. The category ""Uninsured" includes persons who had no coverage as well as those who had only Indian Health Service coverage or had only a private plan that paid for one type of service such as accidents or dental care (see Appendix II).

[11]MSA is metropolitan statistical area. Large MSAs have a population size of 1 million or more; small MSAs have a population size of less than 1 million. "Not in MSA" consists of persons not living in a metropolitan statistical area.

SOURCE: CDC/NCHS, National Health Interview Survey, 2001–2007.

Table 8. Percentages (with standard errors) of children under age 18 with hay fever in the past 12 months, by family structure and by selected characteristics: United States, 2001–2007

Selected characteristics	All children under age 18 with hay fever in the past 12 months	Family structure[1]						
		Nuclear	Single parent	Unmarried biological or adoptive	Blended	Cohabiting	Extended	Other
	Percent[2] (standard error)							
Total[3]	9.9 (0.15)	10.3 (0.22)	9.8 (0.32)	5.8 (0.73)	10.0 (0.49)	8.0 (0.63)	9.6 (0.28)	9.8 (0.83)
Sex								
Male	10.6 (0.21)	11.2 (0.31)	10.8 (0.47)	6.6 (1.13)	10.5 (0.73)	7.4 (0.81)	10.1 (0.38)	10.2 (1.18)
Female	9.2 (0.19)	9.4 (0.27)	8.9 (0.42)	4.9 (0.86)	9.6 (0.67)	8.6 (1.00)	9.1 (0.40)	9.4 (1.13)
Age								
0–4 years	4.6 (0.18)	4.6 (0.24)	4.8 (0.46)	3.4 (0.64)	4.3 (0.74)	4.3 (0.95)	4.2 (0.39)	6.8 (1.39)
5–17 years	12.0 (0.19)	13.0 (0.29)	11.2 (0.37)	9.6 (1.60)	11.6 (0.59)	9.3 (0.80)	11.2 (0.34)	10.7 (0.99)
5–11 years	10.5 (0.24)	11.4 (0.35)	9.7 (0.48)	9.7 (1.91)	10.6 (0.83)	7.8 (0.93)	9.1 (0.50)	11.0 (1.38)
12–17 years	13.6 (0.27)	15.3 (0.47)	12.8 (0.56)	*9.2 (2.81)	12.8 (0.82)	11.6 (1.48)	12.5 (0.45)	10.4 (1.36)
Hispanic origin and race[4]								
Hispanic or Latino	7.6 (0.24)	7.6 (0.38)	8.2 (0.55)	5.6 (1.06)	8.8 (1.01)	6.7 (1.16)	7.1 (0.39)	7.7 (1.17)
Mexican or Mexican American	7.3 (0.29)	7.4 (0.47)	7.7 (0.70)	6.1 (1.33)	9.1 (1.19)	7.8 (1.53)	6.9 (0.45)	6.1 (1.16)
Not Hispanic or Latino	10.5 (0.17)	10.8 (0.25)	10.2 (0.36)	5.9 (0.95)	10.3 (0.56)	8.3 (0.74)	10.6 (0.36)	10.4 (1.02)
White, single race	11.2 (0.20)	11.2 (0.27)	12.0 (0.53)	7.2 (1.34)	10.9 (0.65)	7.8 (0.85)	12.2 (0.48)	11.4 (1.40)
Black or African American, single race	7.8 (0.31)	7.9 (0.65)	7.9 (0.50)	*3.4 (1.28)	6.5 (1.01)	7.6 (1.48)	7.9 (0.60)	9.3 (1.65)
Parent's education[5]								
Less than high school diploma	6.2 (0.28)	5.7 (0.52)	6.5 (0.58)	5.3 (1.50)	6.2 (1.18)	7.6 (1.44)	6.3 (0.50)	*5.7 (2.12)
High school diploma or GED[6]	7.9 (0.26)	7.9 (0.45)	7.2 (0.48)	4.6 (1.05)	8.1 (0.84)	7.2 (1.04)	8.6 (0.51)	*9.8 (2.96)
More than high school diploma	11.5 (0.20)	11.4 (0.26)	12.9 (0.51)	7.1 (1.31)	11.4 (0.67)	8.9 (0.97)	11.8 (0.43)	10.0 (2.08)
Family income[7]								
Less than $20,000	7.8 (0.27)	7.3 (0.58)	8.4 (0.43)	5.5 (1.48)	6.2 (1.06)	6.8 (1.19)	7.6 (0.62)	9.0 (1.81)
$20,000–$34,999	8.2 (0.32)	7.9 (0.52)	9.5 (0.63)	6.6 (1.68)	8.7 (1.06)	6.3 (1.47)	7.0 (0.58)	9.2 (1.73)
$35,000–$54,999	9.6 (0.32)	9.2 (0.48)	12.7 (0.96)	5.0 (1.30)	9.3 (1.05)	8.6 (1.61)	9.3 (0.62)	11.1 (1.88)
$55,000–$74,999	10.2 (0.39)	9.6 (0.53)	13.2 (1.61)	*5.2 (2.08)	11.9 (1.23)	9.1 (2.37)	10.6 (0.82)	9.3 (1.92)
$75,000 or more	12.2 (0.28)	12.4 (0.35)	13.3 (1.58)	*6.9 (2.34)	11.8 (1.06)	10.1 (1.83)	11.9 (0.56)	10.1 (2.17)
Poverty status[8]								
Poor	7.3 (0.28)	7.6 (0.64)	7.9 (0.48)	*5.2 (1.56)	6.1 (1.15)	6.0 (1.12)	6.7 (0.54)	8.0 (1.61)
Near poor	8.3 (0.29)	8.0 (0.50)	9.2 (0.58)	6.3 (1.40)	8.7 (0.91)	5.4 (1.42)	8.2 (0.60)	10.4 (1.59)
Not poor	11.3 (0.20)	11.2 (0.26)	13.1 (0.63)	5.8 (1.06)	11.4 (0.66)	10.7 (1.25)	11.4 (0.42)	10.5 (1.24)
Home tenure status[9]								
Owned or being bought	11.0 (0.19)	11.1 (0.25)	12.5 (0.58)	6.3 (1.18)	10.9 (0.63)	9.9 (1.09)	10.7 (0.36)	9.8 (0.97)
Rented	7.5 (0.22)	7.1 (0.39)	8.3 (0.39)	5.7 (0.97)	8.1 (0.73)	6.8 (0.81)	6.9 (0.43)	9.7 (1.69)
Some other arrangement	10.6 (1.13)	10.9 (1.85)	9.7 (1.62)	*–	*8.2 (3.08)	*5.1 (3.07)	14.3 (2.80)	*13.9 (5.35)
Health insurance coverage[10]								
Private	11.2 (0.19)	11.2 (0.26)	12.1 (0.52)	6.4 (1.20)	11.2 (0.64)	8.7 (1.11)	11.5 (0.41)	9.6 (1.46)
Medicaid	7.8 (0.24)	7.5 (0.47)	8.0 (0.44)	5.7 (1.10)	7.2 (0.89)	7.4 (0.93)	7.6 (0.47)	10.6 (1.24)
Other	8.4 (0.82)	9.0 (1.36)	8.9 (1.97)	*6.4 (6.27)	*4.8 (1.85)	*4.8 (2.75)	8.1 (1.74)	*18.0 (6.96)
Uninsured	7.8 (0.35)	7.2 (0.58)	9.1 (0.91)	*4.4 (1.69)	10.9 (1.65)	8.2 (1.73)	7.4 (0.60)	6.7 (1.32)
Place of residence[11]								
Large MSA	8.9 (0.25)	9.2 (0.39)	9.1 (0.48)	4.5 (0.93)	8.9 (0.90)	7.3 (1.23)	8.7 (0.44)	8.5 (1.37)
Small MSA	10.4 (0.21)	10.6 (0.29)	10.2 (0.49)	7.5 (1.37)	11.1 (0.75)	8.2 (0.95)	10.4 (0.42)	9.5 (1.15)
Not in MSA	10.1 (0.39)	10.9 (0.59)	10.3 (0.81)	*4.4 (1.36)	8.9 (0.89)	8.3 (1.32)	9.2 (0.71)	12.4 (2.12)
Region								
Northeast	9.6 (0.34)	9.7 (0.48)	9.8 (0.82)	*3.6 (1.17)	11.2 (1.46)	8.2 (1.35)	9.8 (0.61)	6.1 (1.36)
Midwest	9.1 (0.28)	9.5 (0.40)	9.1 (0.62)	6.1 (1.74)	8.4 (0.95)	5.7 (1.12)	9.4 (0.65)	9.2 (2.12)
South	10.0 (0.25)	10.7 (0.38)	9.1 (0.48)	6.6 (1.40)	9.9 (0.77)	8.1 (1.07)	9.2 (0.46)	11.8 (1.40)
West	10.9 (0.34)	11.1 (0.50)	12.3 (0.76)	5.9 (1.16)	11.6 (1.05)	10.6 (1.58)	10.2 (0.57)	8.9 (1.46)

* Estimate has a relative standard error of greater than 30% and should be used with caution because it does not meet the standards of reliability or precision.

– Quantity zero.

[1]A nuclear family consists of one or more children living with two parents who are married to one another and are biological or adoptive parents to all children in the family. A single-parent family consists of one or more children living with a single adult (male or female, related or unrelated). An unmarried biological or adoptive family consists of one or more children living with two parents who are not married to one another and are biological or adoptive parents to all children in the family. A blended family consists of one or more children living with a biological or adoptive parent and an unrelated stepparent who are married to one another. A cohabiting family consists of one or more children living with a biological or adoptive parent and an unrelated adult who are cohabiting with one another. An extended family consists of one or more children living with at least one biological or adoptive parent and a related adult. An "other" family consists of one or more children living with

related or unrelated adults who are not biological or adoptive parents.

[2]Data are based on household interviews of a sample of the civilian noninstitutionalized population. Prevalence of hay fever is based on the question, "During the past 12 months, has [child's name] had hay fever?" A knowledgeable adult provided information on behalf of child respondents. Unknowns with respect to hay fever and family structure are not included in the column labeled "All children under age 18 with hay fever in the past 12 months" (see Appendix I).

[3]Total includes other races not shown separately and children with unknown parent's education, family income, poverty status, or health insurance.

[4]Persons of Hispanic or Latino origin may be of any race or combination of races. Similarly, the category "Not Hispanic or Latino" refers to all persons who are not of Hispanic or Latino origin, regardless of race. To be concise, the text uses shorter versions of the terms shown in the table. For example, the category "Not Hispanic or Latino black or African American, single race" in the tables is referred to as "non-Hispanic black" in the text.

[5]Refers to the education level of the parent with the higher level of education, regardless of that parent's age.

[6]GED is General Educational Development high school equivalency diploma.

[7]Information on family income and poverty status is obtained from the 2001–2007 National Health Interview Survey Imputed Family Income/Personal Earnings Files.

[8]Based on family income and family size using the U.S. Census Bureau's poverty thresholds for the previous calendar year. "Poor" persons are defined as below the poverty threshold. "Near poor" persons have incomes of 100% to less than 200% of the poverty threshold. "Not poor" persons have incomes that are 200% of the poverty threshold or greater.

[9]Based on a question in the Family Core that asked whether the family's house or apartment is owned or being bought, rented, or occupied by some other arrangement (see Appendix II).

[10]Classification of health insurance coverage is based on a hierarchy of mutually exclusive categories. Persons with more than one type of health insurance were assigned to the first appropriate category in the hierarchy. The category ""Uninsured" includes persons who had no coverage as well as those who had only Indian Health Service coverage or had only a private plan that paid for one type of service such as accidents or dental care (see Appendix II).

[11]MSA is metropolitan statistical area. Large MSAs have a population size of 1 million or more; small MSAs have a population size of less than 1 million. "Not in MSA" consists of persons not living in a metropolitan statistical area.

SOURCE: CDC/NCHS, National Health Interview Survey, 2001–2007.

Table 9. Frequencies of children under age 18 with respiratory allergies in the past 12 months, by family structure and by selected characteristics: United States, 2001–2007

Selected characteristics	All children under age 18 with respiratory allergies in the past 12 months	Family structure[1]						
		Nuclear	Single parent	Unmarried biological or adoptive	Blended	Cohabiting	Extended	Other
	Number in thousands[2]							
Total[3]	8,418	3,973	1,523	89	754	240	1,551	289
Sex								
Male	4,688	2,239	847	49	439	135	832	146
Female	3,731	1,733	676	40	314	105	719	143
Age								
0–4 years	1,506	776	240	43	97	57	235	58
5–17 years	6,912	3,197	1,283	46	657	183	1,316	231
5–11 years	3,568	1,839	649	33	336	100	488	125
12–17 years	3,344	1,358	634	13	321	83	828	107
Hispanic origin and race[4]								
Hispanic or Latino	1,132	445	191	24	82	36	302	52
Mexican or Mexican American	746	325	97	12	64	22	194	31
Not Hispanic or Latino	7,286	3,528	1,332	65	672	204	1,249	238
White, single race	5,661	3,040	803	42	564	155	916	140
Black or African American, single race	1,088	221	441	17	74	31	231	73
Parent's education[5]								
Less than high school diploma	722	201	213	14	39	30	215	*10
High school diploma or GED[6]	1,647	574	381	28	182	85	377	*19
More than high school diploma	5,787	3,187	860	46	526	124	951	93
Family income[7]								
Less than $20,000	1,435	276	727	31	63	53	220	65
$20,000–$34,999	1,358	444	398	21	138	48	244	66
$35,000–$54,999	1,514	681	230	15	177	62	296	54
$55,000–$74,999	1,281	675	87	*14	155	34	259	57
$75,000 or more	2,831	1,897	81	8	221	43	533	47
Poverty status[8]								
Poor	1,401	305	588	27	74	56	274	76
Near poor	1,676	545	438	25	171	52	355	90
Not poor	5,341	3,122	497	36	509	132	922	123
Home tenure status[9]								
Owned or being bought	6,099	3,369	640	38	550	112	1,166	225
Rented	2,113	526	838	48	182	114	349	55
Some other arrangement	186	70	43	*2	*16	*15	32	*9
Health insurance coverage[10]								
Private	5,521	3,200	664	33	512	97	925	90
Medicaid	2,126	471	715	47	157	104	466	167
Other	158	66	31	*1	26	*4	26	*4
Uninsured	600	233	111	*7	58	34	130	28
Place of residence[11]								
Large MSA	2,123	851	493	20	170	58	438	92
Small MSA	4,555	2,327	726	46	390	122	825	119
Not in MSA	1,740	795	304	22	194	61	287	79
Region								
Northeast	1,398	686	262	11	107	26	268	37
Midwest	1,830	897	327	23	155	61	302	65
South	3,748	1,697	716	32	377	110	659	156
West	1,442	692	218	*22	115	43	321	31

* Estimate has a relative standard error of greater than 30% and should be used with caution because it does not meet the standards of reliability or precision.

– Quantity zero.

[1] A nuclear family consists of one or more children living with two parents who are married to one another and are biological or adoptive parents to all children in the family. A single-parent family consists of one or more children living with a single adult (male or female, related or unrelated). An unmarried biological or adoptive family consists of one or more children living with two parents who are not married to one another and are biological or adoptive parents to all children in the family. A blended family consists of one or more children living with a biological or adoptive parent and an unrelated stepparent who are married to one another. A cohabiting family consists of one or more children living with a biological or adoptive parent and an unrelated adult who are cohabiting with one

another. An extended family consists of one or more children living with at least one biological or adoptive parent and a related adult. An "other" family consists of one or more children living with related or unrelated adults who are not biological or adoptive parents.

[2]Data are based on household interviews of a sample of the civilian noninstitutionalized population. Prevalence of respiratory allergies is based on the question, "During the past 12 months, has [child's name] had any kind of respiratory allergy?" A knowledgeable adult provided information on behalf of child respondents. Unknowns with respect to respiratory allergies and family structure are not included in the column labeled "All children under age 18 with respiratory allergies in the past 12 months" (see Appendix I).

[3]Includes other races not shown separately and children with unknown parent's education, family income, poverty status, or health insurance. Additionally, numbers within selected characteristics may not add to totals because of rounding.

[4]Persons of Hispanic or Latino origin may be of any race or combination of races. Similarly, the category "Not Hispanic or Latino" refers to all persons who are not of Hispanic or Latino origin, regardless of race. To be concise, the text uses shorter versions of the terms shown in the table. For example, the category "Not Hispanic or Latino black or African American, single race" in the tables is referred to as "non-Hispanic black" in the text.

[5]Refers to the education level of the parent with the higher level of education, regardless of that parent's age.

[6]GED is General Educational Development high school equivalency diploma.

[7]Information on family income and poverty status is obtained from the 2001–2007 National Health Interview Survey Imputed Family Income/Personal Earnings Files.

[8]Based on family income and family size using the U.S. Census Bureau's poverty thresholds for the previous calendar year. "Poor" persons are defined as below the poverty threshold. "Near poor" persons have incomes of 100% to less than 200% of the poverty threshold. "Not poor" persons have incomes that are 200% of the poverty threshold or greater.

[9]Based on a question in the Family Core that asked whether the family's house or apartment is owned or being bought, rented, or occupied by some other arrangement (see Appendix II).

[10]Classification of health insurance coverage is based on a hierarchy of mutually exclusive categories. Persons with more than one type of health insurance were assigned to the first appropriate category in the hierarchy. The category ""Uninsured" includes persons who had no coverage as well as those who had only Indian Health Service coverage or had only a private plan that paid for one type of service such as accidents or dental care (see Appendix II).

[11]MSA is metropolitan statistical area. Large MSAs have a population size of 1 million or more; small MSAs have a population size of less than 1 million. "Not in MSA" consists of persons not living in a metropolitan statistical area.

SOURCE: CDC/NCHS, National Health Interview Survey, 2001–2007.

Table 10. Percentages (with standard errors) of children under age 18 with respiratory allergies in the past 12 months, by family structure and by selected characteristics: United States, 2001–2007

Selected characteristics	All children under age 18 with respiratory allergies in the past 12 months	Family structure[1]						
		Nuclear	Single parent	Unmarried biological or adoptive	Blended	Cohabiting	Extended	Other
	Percent[2] (standard error)							
Total[3]	11.6 (0.15)	11.3 (0.22)	12.8 (0.35)	8.4 (0.99)	12.0 (0.53)	10.6 (0.79)	11.2 (0.31)	12.8 (1.12)
Sex								
Male	12.6 (0.21)	12.4 (0.31)	14.3 (0.53)	8.7 (1.28)	13.7 (0.77)	11.6 (1.16)	11.6 (0.42)	12.6 (1.38)
Female	10.5 (0.21)	10.1 (0.29)	11.2 (0.46)	8.0 (1.51)	10.2 (0.69)	9.6 (1.08)	10.8 (0.47)	12.9 (1.76)
Age								
0–4 years	7.5 (0.23)	6.9 (0.30)	9.6 (0.71)	6.6 (1.20)	7.1 (0.93)	9.3 (1.31)	7.5 (0.55)	11.1 (1.77)
5–17 years	13.1 (0.19)	13.3 (0.28)	13.6 (0.40)	11.2 (1.64)	13.3 (0.61)	11.1 (0.97)	12.3 (0.38)	13.3 (1.35)
5–11 years	12.7 (0.25)	12.7 (0.35)	13.2 (0.55)	11.0 (1.92)	13.1 (0.86)	10.2 (1.30)	11.9 (0.62)	15.1 (1.66)
12–17 years	13.5 (0.27)	14.2 (0.44)	14.1 (0.59)	11.8 (3.21)	13.5 (0.84)	12.6 (1.47)	12.6 (0.49)	11.6 (1.73)
Hispanic origin and race[4]								
Hispanic or Latino	8.2 (0.25)	7.9 (0.38)	9.1 (0.61)	7.2 (1.93)	8.3 (0.91)	8.8 (1.39)	7.9 (0.42)	9.9 (1.60)
Mexican or Mexican American	7.9 (0.30)	8.0 (0.46)	8.4 (0.81)	5.5 (1.33)	9.6 (1.17)	8.3 (1.69)	7.2 (0.46)	8.1 (1.67)
Not Hispanic or Latino	12.3 (0.18)	11.9 (0.25)	13.6 (0.41)	8.9 (1.12)	12.6 (0.60)	11.0 (0.91)	12.5 (0.41)	13.6 (1.38)
White, single race	13.0 (0.21)	12.2 (0.27)	15.5 (0.60)	9.0 (1.46)	13.4 (0.71)	11.8 (1.16)	14.1 (0.54)	15.3 (2.07)
Black or African American, single race	10.2 (0.35)	10.1 (0.70)	11.1 (0.58)	9.5 (2.05)	8.7 (1.10)	7.7 (1.63)	9.7 (0.64)	10.9 (1.72)
Parent's education[5]								
Less than high school diploma	7.7 (0.34)	7.2 (0.59)	9.1 (0.68)	5.9 (1.68)	7.7 (1.51)	6.6 (1.33)	7.5 (0.64)	*5.8 (2.32)
High school diploma or GED[6]	10.1 (0.29)	9.8 (0.47)	11.2 (0.62)	7.1 (1.30)	10.2 (0.97)	10.4 (1.46)	10.1 (0.54)	7.9 (2.34)
More than high school diploma	12.9 (0.20)	12.1 (0.26)	15.3 (0.54)	10.8 (1.88)	13.3 (0.68)	12.9 (1.29)	13.7 (0.49)	20.0 (3.83)
Family income[7]								
Less than $20,000	11.1 (0.36)	9.3 (0.68)	12.5 (0.51)	9.9 (1.90)	9.6 (1.39)	10.1 (1.83)	10.2 (0.71)	13.7 (2.25)
$20,000–$34,999	10.8 (0.34)	9.6 (0.52)	12.9 (0.69)	7.3 (1.66)	12.2 (1.34)	9.0 (1.60)	9.9 (0.83)	12.7 (2.02)
$35,000–$54,999	10.8 (0.34)	10.4 (0.49)	12.7 (0.94)	5.9 (1.50)	11.3 (1.07)	11.5 (1.75)	10.5 (0.71)	10.4 (1.88)
$55,000–$74,999	11.8 (0.41)	10.9 (0.48)	13.8 (1.62)	*12.2 (4.95)	12.9 (1.39)	11.6 (2.46)	12.3 (1.05)	18.5 (4.14)
$75,000 or more	12.6 (0.28)	12.7 (0.36)	14.5 (1.86)	8.7 (2.49)	12.6 (0.97)	11.8 (2.02)	12.4 (0.56)	10.7 (2.17)
Poverty status[8]								
Poor	10.4 (0.37)	9.2 (0.67)	11.8 (0.57)	9.8 (2.06)	9.0 (1.37)	9.8 (1.84)	9.5 (0.72)	12.4 (2.06)
Near poor	10.3 (0.32)	9.1 (0.49)	12.9 (0.64)	6.9 (1.39)	10.6 (1.12)	7.9 (1.47)	9.9 (0.74)	13.0 (2.12)
Not poor	12.4 (0.20)	12.0 (0.25)	14.1 (0.64)	8.6 (1.71)	13.1 (0.68)	12.9 (1.23)	12.5 (0.45)	12.9 (1.39)
Home tenure status[9]								
Owned or being bought	12.4 (0.19)	12.0 (0.25)	14.9 (0.62)	9.6 (1.89)	12.9 (0.64)	12.1 (1.22)	12.1 (0.39)	14.7 (1.53)
Rented	9.6 (0.25)	8.3 (0.42)	11.6 (0.43)	7.6 (1.09)	9.6 (0.89)	9.0 (0.93)	8.9 (0.53)	8.3 (1.44)
Some other arrangement	13.1 (1.17)	11.8 (1.65)	12.0 (1.84)	*8.6 (4.28)	*11.6 (3.56)	*32.3 (12.20)	15.4 (3.03)	*15.8 (6.26)
Health insurance coverage[10]								
Private	12.2 (0.19)	11.9 (0.25)	13.6 (0.56)	8.9 (1.33)	12.6 (0.65)	11.3 (1.33)	12.4 (0.44)	13.1 (2.55)
Medicaid	11.3 (0.31)	10.0 (0.57)	12.7 (0.54)	8.4 (1.57)	11.0 (1.11)	10.3 (1.18)	10.8 (0.62)	14.4 (1.37)
Other	9.9 (0.84)	8.6 (1.13)	12.2 (2.29)	*9.6 (8.25)	12.3 (2.97)	*7.1 (3.79)	10.5 (2.05)	*7.7 (3.91)
Uninsured	8.6 (0.39)	8.2 (0.68)	10.2 (0.97)	*6.3 (2.15)	9.9 (1.64)	10.6 (2.04)	7.6 (0.63)	8.0 (1.96)
Place of residence[11]								
Large MSA	10.2 (0.27)	10.2 (0.42)	10.6 (0.51)	5.4 (0.94)	11.0 (1.02)	8.8 (1.28)	9.7 (0.50)	11.5 (2.34)
Small MSA	11.9 (0.22)	11.4 (0.29)	14.1 (0.59)	10.0 (1.81)	12.3 (0.79)	11.8 (1.29)	11.6 (0.45)	12.2 (1.28)
Not in MSA	12.8 (0.38)	12.5 (0.58)	14.3 (0.80)	10.0 (2.22)	12.1 (1.00)	10.6 (1.40)	13.2 (0.87)	15.8 (2.33)
Region								
Northeast	10.8 (0.36)	10.4 (0.54)	12.3 (0.88)	6.3 (1.62)	13.3 (1.71)	7.5 (1.44)	10.3 (0.66)	11.1 (2.18)
Midwest	10.7 (0.30)	10.4 (0.40)	11.6 (0.70)	8.2 (1.94)	9.7 (1.02)	10.0 (1.53)	11.0 (0.78)	14.6 (3.68)
South	14.1 (0.28)	13.9 (0.41)	14.9 (0.58)	9.9 (1.59)	14.2 (0.86)	13.0 (1.51)	13.7 (0.54)	15.9 (1.66)
West	9.0 (0.27)	8.9 (0.39)	10.0 (0.73)	*8.0 (2.44)	9.2 (0.92)	9.4 (1.40)	8.8 (0.57)	6.2 (1.27)

* Estimate has a relative standard error of greater than 30% and should be used with caution because it does not meet the standards of reliability or precision.

– Quantity zero.

[1] A nuclear family consists of one or more children living with two parents who are married to one another and are biological or adoptive parents to all children in the family. A single-parent family consists of one or more children living with a single adult (male or female, related or unrelated). An unmarried biological or adoptive family consists of one or more children living with two parents who are not married to one another and are biological or adoptive parents to all children in the family. A blended family consists of one or more children living with a biological or adoptive parent and an unrelated stepparent who are married to one another. A cohabiting family consists of one or more children living with a biological or adoptive parent and an unrelated adult who are cohabiting with one another. An extended family consists of one or more children living with at least one biological or adoptive parent and a related adult. An "other" family consists of one or more children living with related or unrelated adults who are not biological or adoptive parents.

[2]Data are based on household interviews of a sample of the civilian noninstitutionalized population. Prevalence of respiratory allergies is based on the question, "During the past 12 months, has [child's name] had any kind of respiratory allergy?" A knowledgeable adult provided information on behalf of child respondents. Unknowns with respect to respiratory allergies and family structure are not included in the column labeled "All children under age 18 with respiratory allergies in the past 12 months" (see Appendix I).

[3]Includes other races not shown separately and children with unknown parent's education, family income, poverty status, or health insurance.

[4]Persons of Hispanic or Latino origin may be of any race or combination of races. Similarly, the category "Not Hispanic or Latino" refers to all persons who are not of Hispanic or Latino origin, regardless of race. To be concise, the text uses shorter versions of the terms shown in the table. For example, the category "Not Hispanic or Latino black or African American, single race" in the tables is referred to as "non-Hispanic black" in the text.

[5]Refers to the education level of the parent with the higher level of education, regardless of that parent's age.

[6]GED is General Educational Development high school equivalency diploma.

[7]Information on family income and poverty status is obtained from the 2001–2007 National Health Interview Survey Imputed Family Income/Personal Earnings Files.

[8]Based on family income and family size using the U.S. Census Bureau's poverty thresholds for the previous calendar year. "Poor" persons are defined as below the poverty threshold. "Near poor" persons have incomes of 100% to less than 200% of the poverty threshold. "Not poor" persons have incomes that are 200% of the poverty threshold or greater.

[9]Based on a question in the Family Core that asked whether the family's house or apartment is owned or being bought, rented, or occupied by some other arrangement (see Appendix II).

[10]Classification of health insurance coverage is based on a hierarchy of mutually exclusive categories. Persons with more than one type of health insurance were assigned to the first appropriate category in the hierarchy. The category ""Uninsured" includes persons who had no coverage as well as those who had only Indian Health Service coverage or had only a private plan that paid for one type of service such as accidents or dental care (see Appendix II).

[11]MSA is metropolitan statistical area. Large MSAs have a population size of 1 million or more; small MSAs have a population size of less than 1 million. "Not in MSA" consists of persons not living in a metropolitan statistical area.

SOURCE: CDC/NCHS, National Health Interview Survey, 2001–2007.

Table 11. Frequencies of children under age 18 with digestive or skin allergies in the past 12 months, by family structure and by selected characteristics: United States, 2001–2007

Selected characteristics	All children under age 18 with digestive or skin allergies in the past 12 months	Family structure[1]						
		Nuclear	Single parent	Unmarried biological or adoptive	Blended	Cohabiting	Extended	Other
	Number in thousands[2]							
Total[3]	8,753	4,171	1,568	119	783	262	1,582	268
Sex								
Male	4,369	2,117	740	70	416	131	779	116
Female	4,384	2,054	829	49	367	131	803	152
Age								
0–4 years	2,727	1,473	377	78	209	109	415	67
5–17 years	6,026	2,698	1,192	40	573	154	1,167	201
5–11 years	3,366	1,706	657	34	320	100	461	89
12–17 years	2,660	993	535	*7	253	54	706	112
Hispanic origin and race[4]								
Hispanic or Latino	1,231	487	219	27	93	46	313	46
Mexican or Mexican American	738	300	109	19	56	28	200	27
Not Hispanic or Latino	7,521	3,685	1,349	91	689	216	1,268	222
White, single race	5,327	3,017	639	55	540	147	802	125
Black or African American, single race	1,509	328	590	30	110	45	325	81
Parent's education[5]								
Less than high school diploma	762	172	240	17	35	53	228	*16
High school diploma or GED[6]	1,675	535	390	39	232	77	387	14
More than high school diploma	6,092	3,460	882	63	511	129	961	86
Family income[7]								
Less than $20,000	1,491	257	793	22	76	56	231	56
$20,000–$34,999	1,461	475	397	36	141	67	283	60
$35,000–$54,999	1,614	745	244	27	182	72	292	53
$55,000–$74,999	1,319	745	73	20	160	32	245	*44
$75,000 or more	2,868	1,948	62	13	224	36	530	55
Poverty status[8]								
Poor	1,507	287	659	17	99	61	315	68
Near poor	1,868	632	462	43	187	88	375	81
Not poor	5,377	3,252	447	58	497	113	892	118
Home tenure status[9]								
Owned or being bought	5,902	3,405	545	42	528	103	1,110	170
Rented	2,607	666	975	74	228	156	430	77
Some other arrangement	217	95	47	*3	18	*3	32	*19
Health insurance coverage[10]								
Private	5,605	3,348	631	47	516	88	878	97
Medicaid	2,297	467	788	58	196	128	524	137
Other	215	114	43	*1	*19	*6	31	*2
Uninsured	617	236	104	13	52	40	140	31
Place of residence[11]								
Large MSA	2,478	941	640	42	211	67	488	90
Small MSA	4,770	2,494	681	57	425	133	850	130
Not in MSA	1,505	736	248	19	147	62	244	49
Region								
Northeast	1,633	771	308	22	111	44	334	44
Midwest	2,150	1,043	399	38	204	68	332	66
South	3,024	1,420	564	31	301	94	510	104
West	1,946	937	298	27	167	57	406	54

* Estimate has a relative standard error of greater than 30% and should be used with caution because it does not meet the standards of reliability or precision.

– Quantity zero.

[1]A nuclear family consists of one or more children living with two parents who are married to one another and are biological or adoptive parents to all children in the family. A single-parent family consists of one or more children living with a single adult (male or female, related or unrelated). An unmarried biological or adoptive family consists of one or more children living with two parents who are not married to one another and are biological or adoptive parents to all children in the family. A blended family consists of one or more children living with a biological or adoptive parent and an unrelated stepparent who are married to one another. A cohabiting family consists of one or more children living with a biological or adoptive parent and an unrelated adult who are cohabiting with one

another. An extended family consists of one or more children living with at least one biological or adoptive parent and a related adult. An "other" family consists of one or more children living with related or unrelated adults who are not biological or adoptive parents.

[2]Data are based on household interviews of a sample of the civilian noninstitutionalized population. Prevalence of digestive or skin allergies is based on separate questions, "During the past 12 months, has [child's name] had any kind of food or digestive allergy?" and "During the past 12 months, has [the sample child] had eczema or any kind of skin allergy?" A knowledgeable adult provided information on behalf of child respondents. Unknowns with respect to digestive or skin allergies and family structure are not included in the column labeled "All children under age 18 with digestive or skin allergies in the past 12 months" (see Appendix I).

[3]Includes other races not shown separately and children with unknown parent's education, family income, poverty status, or health insurance. Additionally, numbers within selected characteristics may not add to totals because of rounding.

[4]Persons of Hispanic or Latino origin may be of any race or combination of races. Similarly, the category "Not Hispanic or Latino" refers to all persons who are not of Hispanic or Latino origin, regardless of race. To be concise, the text uses shorter versions of the terms shown in the table. For example, the category "Not Hispanic or Latino black or African American, single race" in the tables is referred to as "non-Hispanic black" in the text.

[5]Refers to the education level of the parent with the higher level of education, regardless of that parent's age.

[6]GED is General Educational Development high school equivalency diploma.

[7]Information on family income and poverty status is obtained from the 2001–2007 National Health Interview Survey Imputed Family Income/Personal Earnings Files.

[8]Based on family income and family size using the U.S. Census Bureau's poverty thresholds for the previous calendar year. "Poor" persons are defined as below the poverty threshold. "Near poor" persons have incomes of 100% to less than 200% of the poverty threshold. "Not poor" persons have incomes that are 200% of the poverty threshold or greater.

[9]Based on a question in the Family Core that asked whether the family's house or apartment is owned or being bought, rented, or occupied by some other arrangement (see Appendix II).

[10]Classification of health insurance coverage is based on a hierarchy of mutually exclusive categories. Persons with more than one type of health insurance were assigned to the first appropriate category in the hierarchy. The category ""Uninsured" includes persons who had no coverage as well as those who had only Indian Health Service coverage or had only a private plan that paid for one type of service such as accidents or dental care (see Appendix II).

[11]MSA is metropolitan statistical area. Large MSAs have a population size of 1 million or more; small MSAs have a population size of less than 1 million. "Not in MSA" consists of persons not living in a metropolitan statistical area.

SOURCE: CDC/NCHS, National Health Interview Survey, 2001–2007.

Table 12. Percentages (with standard errors) of children under age 18 with digestive or skin allergies in the past 12 months, by family structure and by selected characteristics: United States, 2001–2007

Selected characteristics	All children under age 18 with digestive or skin allergies in the past 12 months	Family structure[1]						
		Nuclear	Single parent	Unmarried biological or adoptive	Blended	Cohabiting	Extended	Other
	Percent[2] (standard error)							
Total[3]	12.0 (0.15)	11.8 (0.21)	13.1 (0.37)	11.2 (0.96)	12.4 (0.55)	11.6 (0.87)	11.4 (0.32)	11.8 (0.98)
Sex								
Male	11.7 (0.22)	11.7 (0.31)	12.5 (0.52)	12.4 (1.43)	12.9 (0.80)	11.2 (1.17)	10.9 (0.44)	10.0 (1.20)
Female	12.3 (0.22)	11.9 (0.31)	13.8 (0.52)	9.8 (1.23)	11.9 (0.76)	12.0 (1.27)	12.0 (0.47)	13.7 (1.54)
Age								
0–4 years	13.6 (0.31)	13.1 (0.40)	14.9 (0.85)	12.0 (1.22)	15.2 (1.42)	17.6 (2.14)	13.3 (0.71)	12.7 (2.00)
5–17 years	11.4 (0.18)	11.2 (0.25)	12.7 (0.40)	9.9 (1.52)	11.6 (0.59)	9.3 (0.86)	10.9 (0.36)	11.6 (1.13)
5–11 years	12.0 (0.25)	11.8 (0.34)	13.4 (0.59)	11.4 (1.92)	12.6 (0.89)	10.1 (1.14)	11.2 (0.59)	10.9 (1.38)
12–17 years	10.7 (0.24)	10.3 (0.38)	11.9 (0.54)	*6.1 (2.00)	10.6 (0.82)	8.2 (1.33)	10.7 (0.45)	12.2 (1.77)
Hispanic origin and race[4]								
Hispanic or Latino	8.9 (0.25)	8.7 (0.40)	10.4 (0.66)	8.2 (1.23)	9.5 (1.04)	11.2 (1.68)	8.2 (0.43)	8.8 (1.35)
Mexican or Mexican American	7.8 (0.29)	7.4 (0.41)	9.3 (0.88)	8.5 (1.57)	8.4 (1.20)	10.4 (1.77)	7.4 (0.50)	7.0 (1.45)
Not Hispanic or Latino	12.7 (0.18)	12.4 (0.24)	13.7 (0.42)	12.6 (1.28)	13.0 (0.62)	11.7 (1.00)	12.7 (0.41)	12.7 (1.19)
White, single race	12.2 (0.21)	12.1 (0.27)	12.3 (0.57)	11.7 (1.54)	12.9 (0.70)	11.2 (1.20)	12.4 (0.51)	13.8 (1.78)
Black or African American, single race	14.2 (0.41)	15.0 (0.90)	14.8 (0.69)	17.4 (2.75)	13.0 (1.48)	11.3 (1.81)	13.6 (0.87)	12.0 (1.82)
Parent's education[5]								
Less than high school diploma	8.1 (0.33)	6.2 (0.54)	10.3 (0.73)	7.3 (1.63)	7.0 (1.37)	11.5 (1.78)	7.9 (0.56)	*9.0 (2.93)
High school diploma or GED[6]	10.3 (0.31)	9.1 (0.48)	11.5 (0.62)	9.8 (1.49)	13.0 (1.14)	9.4 (1.32)	10.3 (0.60)	5.8 (1.72)
More than high school diploma	13.6 (0.20)	13.1 (0.26)	15.7 (0.58)	14.7 (1.74)	12.9 (0.71)	13.4 (1.37)	13.8 (0.50)	18.6 (3.17)
Family income[7]								
Less than $20,000	11.5 (0.35)	8.7 (0.61)	13.6 (0.54)	7.2 (1.37)	11.5 (1.64)	10.5 (1.86)	10.8 (0.74)	11.6 (1.98)
$20,000–$34,999	11.6 (0.39)	10.3 (0.62)	12.8 (0.69)	12.8 (2.15)	12.5 (1.38)	12.6 (2.01)	11.5 (0.87)	11.6 (1.92)
$35,000–$54,999	11.5 (0.38)	11.4 (0.51)	13.5 (0.98)	10.5 (1.76)	11.7 (1.13)	13.3 (1.94)	10.3 (0.82)	10.2 (1.80)
$55,000–$74,999	12.1 (0.41)	12.0 (0.50)	11.4 (1.44)	17.0 (3.92)	13.4 (1.45)	10.8 (2.00)	11.7 (1.01)	14.4 (3.83)
$75,000 or more	12.8 (0.28)	13.0 (0.36)	11.2 (1.59)	14.0 (3.26)	12.7 (1.15)	9.8 (1.87)	12.3 (0.61)	12.4 (2.27)
Poverty status[8]								
Poor	11.2 (0.36)	8.7 (0.64)	13.2 (0.60)	6.2 (1.47)	12.0 (1.71)	10.6 (1.86)	11.0 (0.79)	11.1 (1.94)
Near poor	11.5 (0.35)	10.6 (0.59)	13.6 (0.71)	12.0 (1.82)	11.7 (1.16)	13.2 (1.82)	10.5 (0.68)	11.7 (2.20)
Not poor	12.5 (0.20)	12.5 (0.26)	12.6 (0.65)	13.8 (1.61)	12.8 (0.72)	11.1 (1.11)	12.1 (0.43)	12.4 (1.41)
Home tenure status[9]								
Owned or being bought	12.0 (0.19)	12.1 (0.24)	12.7 (0.60)	10.6 (1.62)	12.4 (0.67)	11.2 (1.37)	11.5 (0.39)	11.2 (1.12)
Rented	11.9 (0.26)	10.5 (0.46)	13.5 (0.47)	11.6 (1.20)	12.1 (1.00)	12.3 (1.18)	11.0 (0.57)	11.6 (1.76)
Some other arrangement	15.3 (1.17)	15.9 (1.82)	13.3 (1.90)	*10.0 (6.08)	13.8 (3.15)	*6.2 (3.64)	15.8 (3.15)	*32.2 (10.07)
Health insurance coverage[10]								
Private	12.4 (0.19)	12.4 (0.25)	12.9 (0.58)	12.8 (1.67)	12.7 (0.68)	10.1 (1.28)	11.8 (0.44)	14.2 (2.14)
Medicaid	12.2 (0.31)	10.0 (0.52)	13.9 (0.55)	10.3 (1.30)	13.7 (1.28)	12.7 (1.43)	12.2 (0.64)	11.7 (1.26)
Other	13.5 (1.02)	14.8 (1.59)	16.9 (2.58)	*5.2 (3.76)	8.8 (2.29)	*10.0 (4.06)	12.9 (2.13)	*4.0 (2.06)
Uninsured	8.8 (0.40)	8.4 (0.67)	9.6 (0.96)	11.5 (2.79)	8.9 (1.53)	12.5 (2.21)	8.1 (0.67)	9.2 (2.00)
Place of residence[11]								
Large MSA	11.9 (0.28)	11.2 (0.41)	13.8 (0.58)	11.2 (1.52)	13.7 (1.12)	10.1 (1.45)	10.8 (0.53)	11.3 (1.92)
Small MSA	12.4 (0.21)	12.2 (0.29)	13.2 (0.58)	12.4 (1.45)	13.4 (0.83)	12.9 (1.36)	11.9 (0.47)	13.3 (1.36)
Not in MSA	11.1 (0.34)	11.5 (0.49)	11.7 (0.82)	8.7 (2.11)	9.2 (0.89)	10.8 (1.69)	11.1 (0.83)	9.8 (1.75)
Region								
Northeast	12.6 (0.36)	11.7 (0.49)	14.4 (0.88)	12.3 (2.34)	13.9 (1.49)	12.5 (2.54)	12.8 (0.71)	13.2 (2.35)
Midwest	12.5 (0.31)	12.0 (0.39)	14.1 (0.80)	13.5 (2.19)	12.7 (1.15)	11.2 (1.75)	12.1 (0.82)	14.8 (2.67)
South	11.4 (0.24)	11.6 (0.34)	11.8 (0.54)	9.6 (1.64)	11.3 (0.85)	11.1 (1.38)	10.5 (0.49)	10.6 (1.34)
West	12.1 (0.35)	12.0 (0.52)	13.7 (0.90)	9.9 (1.55)	13.4 (1.18)	12.3 (1.70)	11.2 (0.64)	10.7 (2.06)

* Estimate has a relative standard error of greater than 30% and should be used with caution because it does not meet the standards of reliability or precision.

– Quantity zero.

[1] A nuclear family consists of one or more children living with two parents who are married to one another and are biological or adoptive parents to all children in the family. A single-parent family consists of one or more children living with a single adult (male or female, related or unrelated). An unmarried biological or adoptive family consists of one or more children living with two parents who are not married to one another and are biological or adoptive parents to all children in the family. A blended family consists of one or more children living with a biological or adoptive parent and an unrelated stepparent who are married to one another. A cohabiting family consists of one or more children living with a biological or adoptive parent and an unrelated adult who are cohabiting with one

another. An extended family consists of one or more children living with at least one biological or adoptive parent and a related adult. An "other" family consists of one or more children living with related or unrelated adults who are not biological or adoptive parents.

[2]Data are based on household interviews of a sample of the civilian noninstitutionalized population. Prevalence of digestive or skin allergies is based on separate questions, "During the past 12 months, has [child's name] had any kind of food or digestive allergy?" and "During the past 12 months, has [child's name] had eczema or any kind of skin allergy?" A knowledgeable adult provided information on behalf of child respondents. Unknowns with respect to digestive or skin allergies and family structure are not included in the column labeled "All children under age 18 with digestive or skin allergies in the past 12 months" (see Appendix I).

[3]Includes other races not shown separately and children with unknown parent's education, family income, poverty status, or health insurance.

[4]Persons of Hispanic or Latino origin may be of any race or combination of races. Similarly, the category "Not Hispanic or Latino" refers to all persons who are not of Hispanic or Latino origin, regardless of race. To be concise, the text uses shorter versions of the terms shown in the table. For example, the category "Not Hispanic or Latino black or African American, single race" in the tables is referred to as "non-Hispanic black" in the text.

[5]Refers to the education level of the parent with the higher level of education, regardless of that parent's age.

[6]GED is General Educational Development high school equivalency diploma.

[7]Information on family income and poverty status is obtained from the 2001–2007 National Health Interview Survey Imputed Family Income/Personal Earnings Files.

[8]Based on family income and family size using the U.S. Census Bureau's poverty thresholds for the previous calendar year. "Poor" persons are defined as below the poverty threshold. "Near poor" persons have incomes of 100% to less than 200% of the poverty threshold. "Not poor" persons have incomes that are 200% of the poverty threshold or greater.

[9]Based on a question in the Family Core that asked whether the family's house or apartment is owned or being bought, rented, or occupied by some other arrangement (see Appendix II).

[10]Classification of health insurance coverage is based on a hierarchy of mutually exclusive categories. Persons with more than one type of health insurance were assigned to the first appropriate category in the hierarchy. The category ""Uninsured" includes persons who had no coverage as well as those who had only Indian Health Service coverage or had only a private plan that paid for one type of service such as accidents or dental care (see Appendix II).

[11]MSA is metropolitan statistical area. Large MSAs have a population size of 1 million or more; small MSAs have a population size of less than 1 million. "Not in MSA" consists of persons not living in a metropolitan statistical area.

SOURCE: CDC/NCHS, National Health Interview Survey, 2001–2007.

Table 13. Frequencies of children aged 3–17 with frequent headaches or migraines in the past 12 months, by family structure and by selected characteristics: United States, 2001–2007

Selected characteristics	All children aged 3–17 with frequent headaches or migraines in the past 12 months	Family structure[1]						
		Nuclear	Single parent	Unmarried biological or adoptive	Blended	Cohabiting	Extended	Other
	Number in thousands[2]							
Total[3]	3,662	1,295	849	24	362	147	837	149
Sex								
Male	1,766	627	425	14	180	62	392	67
Female	1,896	668	424	10	183	85	445	82
Age								
3–4 years	51	21	*6	*1	*4	*3	*9	*6
5–17 years	3,611	1,274	842	22	358	144	828	143
5–11 years	1,311	548	320	*11	150	59	186	37
12–17 years	2,300	726	522	12	208	85	642	105
Hispanic origin and race[4]								
Hispanic or Latino	613	182	143	*7	49	26	181	25
Mexican or Mexican American	393	125	77	*5	33	12	121	21
Not Hispanic or Latino	3,049	1,113	705	17	313	121	656	124
White, single race	2,245	976	394	*6	253	87	466	63
Black or African American, single race	614	72	264	*6	48	25	143	56
Parent's education[5]								
Less than high school diploma	500	126	156	*6	22	32	152	*7
High school diploma or GED[6]	900	271	234	*5	103	44	231	*11
More than high school diploma	2,118	896	410	*12	236	71	451	43
Family income[7]								
Less than $20,000	860	138	439	*4	46	39	139	56
$20,000–$34,999	738	194	226	*10	63	35	175	34
$35,000–$54,999	719	280	123	*5	101	26	160	24
$55,000–$74,999	457	192	36	*1	62	*24	127	*14
$75,000 or more	889	491	25	*2	90	23	237	*21
Poverty status[8]								
Poor	880	170	369	*4	51	41	177	67
Near poor	901	251	259	*11	90	37	217	37
Not poor	1,881	874	221	*8	222	69	442	45
Home tenure status[9]								
Owned or being bought	2,335	1,028	318	10	237	70	583	89
Rented	1,235	236	506	13	112	76	246	46
Some other arrangement	80	28	23	*–	*11	*–	*5	*14
Health insurance coverage[10]								
Private	2,029	938	319	*7	223	68	438	35
Medicaid	1,176	223	416	*9	100	54	284	91
Other	68	27	9	*1	*12	*7	*9	*3
Uninsured	383	106	103	*6	27	18	102	20
Place of residence[11]								
Large MSA	1,019	255	315	13	107	38	244	47
Small MSA	1,788	722	363	8	152	63	418	62
Not in MSA	855	318	171	*2	103	46	175	40
Region								
Northeast	591	216	136	*5	44	27	142	*21
Midwest	868	319	211	*6	104	32	174	23
South	1,456	494	364	*6	154	50	316	72
West	747	265	138	*8	61	38	205	32

* Estimate has a relative standard error of greater than 30% and should be used with caution because it does not meet the standards of reliability or precision.

– Quantity zero.

[1]A nuclear family consists of one or more children living with two parents who are married to one another and are biological or adoptive parents to all children in the family. A single-parent family consists of one or more children living with a single adult (male or female, related or unrelated). An unmarried biological or adoptive family consists of one or more children living with two parents who are not married to one another and are biological or adoptive parents to all children in the family. A blended family consists of one or more children living with a biological or adoptive parent and an unrelated stepparent who are married to one another. A cohabiting family consists of one or more children living with a biological or adoptive parent and an unrelated adult who are cohabiting with one

another. An extended family consists of one or more children living with at least one biological or adoptive parent and a related adult. An "other" family consists of one or more children living with related or unrelated adults who are not biological or adoptive parents.

[2]Data are based on household interviews of a sample of the civilian noninstitutionalized population. Having frequent headaches or migraines is based on aquestion that asked, "During the past 12 months, has [child's name] had frequent or severe headaches, including migraines?" A knowledgeable adult provided information on behalf of child respondents. Unknowns with respect to frequent headaches or migraines and family structure are not included in the column labeled "All children aged 3–17 with frequent headaches or migraines in the past 12 months" (see Appendix I).

[3]Total includes other races not shown separately and children with unknown parent's education, family income, poverty status, or health insurance. Additionally, numbers within selected characteristics may not add to totals because of rounding.

[4]Persons of Hispanic or Latino origin may be of any race or combination of races. Similarly, the category "Not Hispanic or Latino" refers to all persons who are not of Hispanic or Latino origin, regardless of race. In order to be concise, the text uses shorter versions of the terms shown in the table. For example, the category "Not Hispanic or Latino black or African American, single race" in the tables is referred to as "non-Hispanic black" in the text.

[5]Parent's education is the education level of the parent with the higher level of education, regardless of that parent's age.

[6]GED is General Educational Development high school equivalency diploma.

[7]Information on family income and poverty status is obtained from the 2001–07 National Health Interview Survey Imputed Family Income/Personal Earnings Files.

[8]Poverty status is based on family income and family size using the U.S. Census Bureau's poverty thresholds for the previous calendar year. "Poor" persons are defined as below the poverty threshold. "Near poor" persons have incomes of 100% to less than 200% of the poverty threshold. "Not poor" persons have incomes that are 200% of the poverty threshold or greater.

[9]Home tenure status is based on a question in the Family Core that asked whether the family's house or apartment is owned or being bought, rented, or occupied by some other arrangement. See Appendix II for more information.

[10]Classification of health insurance coverage is based on a hierarchy of mutually exclusive categories. Persons with more than one type of health insurance were assigned to the first appropriate category in the hierarchy. The category "Uninsured" includes persons who had no coverage as well as those who had only Indian Health Service coverage or had only a private plan that paid for one type of service such as accidents or dental care (see Appendix II).

[11]MSA is metropolitan statistical area. Large MSAs have a population size of 1,000,000 or more; small MSAs have a population size of less than 1,000,000. "Not in MSA" consists of persons not living in a metropolitan statistical area.

SOURCE: CDC/NCHS, National Health Interview Survey, 2001–2007.

Table 14. Percentages (with standard errors) of children aged 3–17 with frequent headaches or migraines in the past 12 months, by family structure and by selected characteristics: United States, 2001–2007

Selected characteristics	All children aged 3–17 with frequent headaches or migraines in the past 12 months	Family structure[1]						
		Nuclear	Single parent	Unmarried biological or adoptive	Blended	Cohabiting	Extended	Other
	Percent[2] (standard error)							
Total[3]	6.0 (0.12)	4.5 (0.16)	8.0 (0.32)	4.1 (0.81)	6.6 (0.42)	7.6 (0.75)	7.1 (0.27)	7.6 (0.81)
Sex								
Male	5.6 (0.16)	4.2 (0.21)	8.1 (0.45)	4.3 (1.19)	6.4 (0.54)	6.2 (0.87)	6.4 (0.36)	6.6 (1.12)
Female	6.4 (0.18)	4.8 (0.22)	7.9 (0.43)	3.7 (1.05)	6.8 (0.64)	9.1 (1.34)	7.8 (0.41)	8.7 (1.23)
Age								
3–4 years	0.6 (0.10)	0.5 (0.12)	*0.5 (0.20)	*0.7 (0.68)	*0.7 (0.37)	*1.2 (0.84)	*0.8 (0.29)	*2.7 (1.52)
5–17 years	6.8 (0.14)	5.3 (0.18)	8.9 (0.36)	5.5 (1.11)	7.3 (0.46)	8.7 (0.88)	7.7 (0.30)	8.2 (0.91)
5–11 years	4.7 (0.16)	3.8 (0.20)	6.5 (0.43)	*3.6 (1.19)	5.9 (0.59)	6.0 (1.02)	4.5 (0.37)	4.6 (0.90)
12–17 years	9.3 (0.22)	7.6 (0.33)	11.6 (0.56)	10.5 (2.59)	8.7 (0.69)	12.8 (1.59)	9.7 (0.42)	11.4 (1.51)
Hispanic origin and race[4]								
Hispanic or Latino	5.5 (0.21)	4.0 (0.33)	7.9 (0.60)	*3.7 (1.19)	5.9 (0.87)	7.4 (1.46)	5.8 (0.40)	5.9 (1.32)
Mexican or Mexican American	5.2 (0.26)	3.8 (0.39)	7.8 (0.81)	*3.8 (1.50)	5.9 (1.03)	5.4 (1.51)	5.6 (0.47)	6.9 (1.69)
Not Hispanic or Latino	6.1 (0.14)	4.6 (0.18)	8.0 (0.37)	4.2 (1.04)	6.7 (0.46)	7.6 (0.87)	7.5 (0.34)	8.0 (0.99)
White, single race	6.1 (0.17)	4.8 (0.20)	8.3 (0.51)	*2.5 (0.88)	6.9 (0.54)	7.5 (1.01)	8.0 (0.44)	7.7 (1.32)
Black or African American, single race	6.9 (0.31)	4.1 (0.52)	7.7 (0.54)	*6.4 (2.32)	6.5 (1.05)	7.7 (1.88)	7.2 (0.66)	9.5 (1.75)
Parent's education[5]								
Less than high school diploma	6.6 (0.33)	5.6 (0.62)	7.9 (0.71)	*4.9 (1.65)	5.1 (1.08)	8.0 (1.83)	6.6 (0.59)	*5.0 (2.11)
High school diploma or GED[6]	6.6 (0.26)	5.5 (0.37)	7.9 (0.60)	*2.4 (0.93)	6.7 (0.77)	6.4 (1.19)	7.4 (0.53)	*6.4 (2.88)
More than high school diploma	5.6 (0.15)	4.2 (0.18)	8.0 (0.46)	5.3 (1.57)	6.8 (0.53)	8.5 (1.19)	7.2 (0.38)	10.5 (2.51)
Family income[7]								
Less than $20,000	8.3 (0.33)	6.2 (0.64)	8.9 (0.48)	*2.7 (1.25)	8.7 (1.43)	9.4 (1.75)	8.0 (0.76)	14.3 (2.48)
$20,000–$34,999	7.1 (0.34)	5.4 (0.54)	8.0 (0.60)	*6.6 (2.20)	6.5 (1.03)	7.7 (1.92)	8.6 (0.85)	7.5 (1.75)
$35,000–$54,999	6.1 (0.28)	5.4 (0.43)	7.2 (0.78)	*3.4 (1.30)	7.5 (0.96)	5.7 (1.46)	6.7 (0.61)	5.4 (1.47)
$55,000–$74,999	5.0 (0.30)	3.8 (0.34)	5.9 (1.30)	*2.3 (1.64)	5.9 (0.92)	9.0 (2.52)	6.8 (0.69)	*5.0 (1.82)
$75,000 or more	4.6 (0.20)	3.9 (0.25)	4.7 (0.93)	*4.2 (2.44)	5.6 (0.69)	6.7 (1.81)	6.1 (0.49)	*5.2 (1.59)
Poverty status[8]								
Poor	8.1 (0.35)	6.6 (0.69)	8.8 (0.54)	*3.1 (1.51)	7.7 (1.30)	9.1 (1.77)	7.7 (0.80)	13.2 (2.29)
Near poor	6.7 (0.28)	5.4 (0.46)	8.5 (0.60)	*5.4 (1.66)	6.6 (0.95)	6.8 (1.59)	7.3 (0.62)	6.2 (1.23)
Not poor	5.1 (0.14)	4.1 (0.17)	6.6 (0.48)	3.5 (1.03)	6.4 (0.50)	7.3 (1.12)	6.7 (0.34)	5.3 (1.02)
Home tenure status[9]								
Owned or being bought	5.5 (0.14)	4.4 (0.17)	7.9 (0.51)	3.8 (1.01)	6.3 (0.49)	8.4 (1.33)	6.9 (0.32)	6.6 (0.82)
Rented	7.1 (0.24)	5.1 (0.44)	8.2 (0.41)	4.3 (1.25)	7.0 (0.78)	7.3 (0.97)	7.8 (0.54)	8.4 (1.72)
Some other arrangement	7.2 (0.99)	6.4 (1.55)	7.6 (1.61)	*–	*10.0 (3.21)	*–	*2.7 (1.12)	*30.0 (11.68)
Health insurance coverage[10]								
Private	5.2 (0.14)	4.2 (0.18)	7.0 (0.43)	*3.4 (1.07)	6.2 (0.48)	8.7 (1.39)	6.4 (0.31)	5.6 (1.19)
Medicaid	8.0 (0.29)	6.4 (0.53)	8.8 (0.53)	*3.1 (1.10)	8.5 (1.01)	6.7 (1.10)	8.8 (0.65)	9.3 (1.34)
Other	5.3 (0.76)	4.6 (1.07)	4.5 (1.16)	*19.0 (17.24)	*7.1 (2.41)	*13.3 (6.74)	*4.2 (1.39)	*6.0 (3.07)
Uninsured	6.2 (0.34)	4.3 (0.50)	10.1 (1.08)	*7.9 (2.87)	5.1 (1.18)	6.4 (1.46)	6.8 (0.68)	6.8 (1.63)
Place of residence[11]								
Large MSA	5.9 (0.22)	3.9 (0.27)	7.8 (0.51)	6.2 (1.78)	8.1 (0.91)	6.9 (1.23)	6.5 (0.45)	7.0 (1.54)
Small MSA	5.5 (0.16)	4.3 (0.21)	7.8 (0.48)	3.3 (0.96)	5.5 (0.52)	7.0 (1.11)	6.7 (0.37)	7.3 (1.19)
Not in MSA	7.4 (0.32)	6.0 (0.37)	9.1 (0.79)	*1.9 (1.01)	7.4 (0.93)	9.3 (1.72)	9.4 (0.80)	9.0 (1.71)
Region								
Northeast	5.3 (0.26)	4.0 (0.34)	7.1 (0.73)	*4.4 (1.97)	6.1 (1.14)	9.0 (2.04)	6.1 (0.52)	*7.4 (2.26)
Midwest	6.0 (0.24)	4.5 (0.32)	8.4 (0.68)	*3.6 (1.37)	7.5 (0.90)	6.2 (1.45)	7.3 (0.61)	5.9 (1.37)
South	6.6 (0.22)	5.0 (0.29)	8.6 (0.53)	*3.5 (1.74)	6.7 (0.66)	6.9 (1.08)	7.8 (0.50)	8.4 (1.24)
West	5.6 (0.24)	4.2 (0.28)	7.1 (0.67)	*4.7 (1.45)	5.5 (0.77)	9.5 (1.92)	6.6 (0.56)	7.6 (1.96)

* Estimate has a relative standard error of greater than 30% and should be used with caution because it does not meet the standards of reliability or precision.

– Quantity zero.

[1]A nuclear family consists of one or more children living with two parents who are married to one another and are biological or adoptive parents to all children in the family. A single-parent family consists of one or more children living with a single adult (male or female, related or unrelated). An unmarried biological or adoptive family consists of one or more children living with two parents who are not married to one another and are biological or adoptive parents to all children in the family. A blended family consists of one or more children living with a biological or adoptive parent and an unrelated stepparent who are married to one another. A cohabiting family consists of one or more children living with a biological or adoptive parent and an unrelated adult who are cohabiting with one another. An extended family consists of one or more children living with at least one biological or adoptive parent and a related adult. An "other" family consists of one or more children living with

related or unrelated adults who are not biological or adoptive parents.

[2]Data are based on household interviews of a sample of the civilian noninstitutionalized population. Having frequent headaches or migraines is based on a question that asked, "During the past 12 months, has [child's name] had frequent or severe headaches, including migraines?" A knowledgeable adult provided information on behalf of child respondents. Unknowns with respect to frequent headaches or migraines and family structure are not included in the column labeled "All children aged 3–17 with frequent headaches or migraines in the past 12 months" (see Appendix I).

[3]Includes other races not shown separately and children with unknown parent's education, family income, poverty status, or health insurance.

[4]Persons of Hispanic or Latino origin may be of any race or combination of races. Similarly, the category "Not Hispanic or Latino" refers to all persons who are not of Hispanic or Latino origin, regardless of race. To be concise, the text uses shorter versions of the terms shown in the table. For example, the category "Not Hispanic or Latino black or African American, single race" in the tables is referred to as "non-Hispanic black" in the text.

[5]Refers to the education level of the parent with the higher level of education, regardless of that parent's age.

[6]GED is General Educational Development high school equivalency diploma.

[7]Information on family income and poverty status is obtained from the 2001–2007 National Health Interview Survey Imputed Family Income/Personal Earnings Files.

[8]Based on family income and family size using the U.S. Census Bureau's poverty thresholds for the previous calendar year. "Poor" persons are defined as below the poverty threshold. "Near poor" persons have incomes of 100% to less than 200% of the poverty threshold. "Not poor" persons have incomes that are 200% of the poverty threshold or greater.

[9]Based on a question in the Family Core that asked whether the family's house or apartment is owned or being bought, rented, or occupied by some other arrangement (see Appendix II).

[10]Classification of health insurance coverage is based on a hierarchy of mutually exclusive categories. Persons with more than one type of health insurance were assigned to the first appropriate category in the hierarchy. The category "'Uninsured" includes persons who had no coverage as well as those who had only Indian Health Service coverage or had only a private plan that paid for one type of service such as accidents or dental care (see Appendix II).

[11]MSA is metropolitan statistical area. Large MSAs have a population size of 1 million or more; small MSAs have a population size of less than 1 million. "Not in MSA" consists of persons not living in a metropolitan statistical area.

SOURCE: CDC/NCHS, National Health Interview Survey, 2001–2007.

Table 15. Frequencies of children under age 18 with three or more ear infections in the past 12 months, by family structure and by selected characteristics: United States, 2001–2007

Selected characteristics	All children under age 18 with three or more ear infections in the past 12 months	Family structure[1]						
		Nuclear	Single parent	Unmarried biological or adoptive	Blended	Cohabiting	Extended	Other
	Number in thousands[2]							
Total[3]	4,249	2,097	715	88	323	158	748	120
Sex								
Male	2,249	1,111	378	50	168	83	401	59
Female	2,000	986	337	38	155	75	348	61
Age								
0–4 years	2,176	1,206	308	67	147	76	324	49
5–17 years	2,073	892	407	21	177	82	424	71
5–11 years	1,465	713	263	14	134	54	244	43
12–17 years	607	178	144	*6	43	28	180	28
Hispanic origin and race[4]								
Hispanic or Latino	803	328	125	30	47	28	213	30
Mexican or Mexican American	536	242	64	18	32	14	144	22
Not Hispanic or Latino	3,446	1,769	589	57	276	130	535	89
White, single race	2,787	1,598	363	44	228	105	388	61
Black or African American, single race	441	70	184	10	38	15	104	20
Parent's education[5]								
Less than high school diploma	627	169	182	20	39	38	167	*12
High school diploma or GED[6]	947	301	182	37	105	56	252	*13
More than high school diploma	2,571	1,621	327	30	178	61	323	31
Family income[7]								
Less than $20,000	939	214	445	24	42	42	153	19
$20,000–$34,999	721	240	150	25	76	37	158	35
$35,000–$54,999	820	418	83	25	82	48	133	30
$55,000–$74,999	619	397	16	*8	56	19	105	18
$75,000 or more	1,150	827	20	*6	68	*12	199	18
Poverty status[8]								
Poor	916	220	356	19	44	47	202	29
Near poor	938	311	219	31	101	49	184	43
Not poor	2,393	1,567	139	38	178	62	362	48
Home tenure status[9]								
Owned or being bought	2,761	1,671	206	30	216	55	495	87
Rented	1,364	379	477	53	95	100	235	25
Some other arrangement	120	45	31	*4	*13	*2	16	*8
Health insurance coverage[10]								
Private	2,450	1,594	222	30	187	38	353	27
Medicaid	1,352	333	411	47	94	91	303	74
Other	100	49	17	*–	*11	*1	17	*6
Uninsured	334	120	63	10	30	28	72	11
Place of residence[11]								
Large MSA	1,094	426	249	22	79	40	242	36
Small MSA	2,270	1,262	316	49	153	77	364	48
Not in MSA	884	409	149	17	91	41	142	35
Region								
Northeast	739	386	100	23	48	30	132	20
Midwest	994	504	180	18	73	40	157	21
South	1,690	760	337	29	143	63	309	48
West	826	447	98	18	59	24	150	31

* Estimate has a relative standard error of greater than 30% and should be used with caution because it does not meet the standards of reliability or precision.
– Quantity zero.
[1]A nuclear family consists of one or more children living with two parents who are married to one another and are biological or adoptive parents to all children in the family. A single-parent family consists of one or more children living with a single adult (male or female, related or unrelated). An unmarried biological or adoptive family consists of one or more children living with two parents who are not married to one another and are biological or adoptive parents to all children in the family. A blended family consists of one or more children living with a biological or adoptive parent and an unrelated stepparent who are married to one another. A cohabiting family consists of one or more children living with a biological or adoptive parent and an unrelated adult who are cohabiting with one another. An extended family consists of one or more children living with at least one biological or adoptive parent and a related adult. An "other" family consists of one or more children living with

related or unrelated adults who are not biological or adoptive parents.

[2]Data are based on household interviews of a sample of the civilian noninstitutionalized population. Prevalence of ear infections is based on a question that asked, "During the past 12 months, has [child's name] had three or more ear infections?" A knowledgeable adult provided information on behalf of child respondents. Unknowns with respect to ear infections and family structure are not included in the column labeled "All children under age 18 with three or more ear infections in the past 12 months" (see Appendix I).

[3]Includes other races not shown separately and children with unknown parent's education, family income, poverty status, or health insurance. Additionally, numbers within selected characteristics may not add to totals because of rounding.

[4]Persons of Hispanic or Latino origin may be of any race or combination of races. Similarly, the category "Not Hispanic or Latino" refers to all persons who are not of Hispanic or Latino origin, regardless of race. To be concise, the text uses shorter versions of the terms shown in the table. For example, the category "Not Hispanic or Latino black or African American, single race" in the tables is referred to as "non-Hispanic black" in the text.

[5]Refers to the education level of the parent with the higher level of education, regardless of that parent's age.

[6]GED is General Educational Development high school equivalency diploma.

[7]Information on family income and poverty status is obtained from the 2001–2007 National Health Interview Survey Imputed Family Income/Personal Earnings Files.

[8]Based on family income and family size using the U.S. Census Bureau's poverty thresholds for the previous calendar year. "Poor" persons are defined as below the poverty threshold. "Near poor" persons have incomes of 100% to less than 200% of the poverty threshold. "Not poor" persons have incomes that are 200% of the poverty threshold or greater.

[9]Based on a question in the Family Core that asked whether the family's house or apartment is owned or being bought, rented, or occupied by some other arrangement (see Appendix II).

[10]Classification of health insurance coverage is based on a hierarchy of mutually exclusive categories. Persons with more than one type of health insurance were assigned to the first appropriate category in the hierarchy. The category ""Uninsured" includes persons who had no coverage as well as those who had only Indian Health Service coverage or had only a private plan that paid for one type of service such as accidents or dental care (see Appendix II).

[11]MSA is metropolitan statistical area. Large MSAs have a population size of 1 million or more; small MSAs have a population size of less than 1 million. "Not in MSA" consists of persons not living in a metropolitan statistical area.

SOURCE: CDC/NCHS, National Health Interview Survey, 2001–2007.

Table 16. Percentages (with standard errors) of children under age 18 with three or more ear infections in the past 12 months, by family structure and by selected characteristics: United States, 2001–2007

Selected characteristics	All children under age 18 with three or more ear infections in the past 12 months	Family structure[1]						
		Nuclear	Single parent	Unmarried biological or adoptive	Blended	Cohabiting	Extended	Other
	Percent[2] (standard error)							
Total[3]	5.8 (0.11)	5.9 (0.16)	6.0 (0.27)	8.3 (0.84)	5.1 (0.35)	7.0 (0.64)	5.4 (0.22)	5.3 (0.58)
Sex								
Male	6.0 (0.15)	6.1 (0.22)	6.4 (0.36)	8.9 (1.19)	5.2 (0.51)	7.1 (0.95)	5.6 (0.31)	5.1 (0.69)
Female	5.6 (0.15)	5.7 (0.22)	5.6 (0.37)	7.6 (1.11)	5.0 (0.50)	6.9 (0.92)	5.2 (0.32)	5.5 (0.93)
Age								
0–4 years	10.8 (0.27)	10.7 (0.36)	12.2 (0.73)	10.3 (1.16)	10.6 (1.05)	12.2 (1.72)	10.4 (0.61)	9.4 (1.48)
5–17 years	3.9 (0.10)	3.7 (0.15)	4.3 (0.27)	5.0 (1.11)	3.6 (0.34)	5.0 (0.62)	4.0 (0.22)	4.1 (0.61)
5–11 years	5.2 (0.16)	4.9 (0.22)	5.3 (0.39)	4.8 (1.26)	5.2 (0.55)	5.5 (0.79)	5.9 (0.42)	5.2 (0.90)
12–17 years	2.4 (0.12)	1.9 (0.17)	3.2 (0.35)	*5.5 (2.35)	1.8 (0.33)	4.3 (0.99)	2.7 (0.24)	3.0 (0.83)
Hispanic origin and race[4]								
Hispanic or Latino	5.8 (0.20)	5.8 (0.29)	5.9 (0.55)	9.1 (1.39)	4.8 (0.72)	6.8 (1.22)	5.6 (0.37)	5.9 (1.02)
Mexican or Mexican American	5.7 (0.24)	6.0 (0.34)	5.5 (0.67)	8.2 (1.47)	4.8 (0.84)	5.3 (1.30)	5.3 (0.44)	5.7 (1.22)
Not Hispanic or Latino	5.8 (0.12)	6.0 (0.18)	6.0 (0.30)	7.9 (1.05)	5.2 (0.39)	7.0 (0.74)	5.3 (0.28)	5.1 (0.68)
White, single race	6.4 (0.15)	6.4 (0.20)	7.0 (0.43)	9.4 (1.47)	5.4 (0.45)	7.9 (0.94)	6.0 (0.38)	6.7 (1.14)
Black or African American, single race	4.1 (0.23)	3.2 (0.41)	4.6 (0.42)	5.5 (1.41)	4.4 (0.90)	3.7 (1.06)	4.3 (0.47)	3.0 (0.77)
Parent's education[5]								
Less than high school diploma	6.7 (0.30)	6.1 (0.47)	7.8 (0.71)	8.6 (1.77)	7.6 (1.49)	8.1 (1.49)	5.8 (0.51)	*6.7 (2.43)
High school diploma or GED[6]	5.8 (0.22)	5.1 (0.32)	5.4 (0.42)	9.4 (1.40)	5.9 (0.74)	6.9 (1.08)	6.7 (0.48)	*5.2 (1.74)
More than high school diploma	5.7 (0.14)	6.1 (0.19)	5.8 (0.36)	7.0 (1.19)	4.5 (0.41)	6.3 (0.98)	4.6 (0.29)	6.7 (1.79)
Family income[7]								
Less than $20,000	7.3 (0.28)	7.2 (0.57)	7.6 (0.42)	7.7 (1.38)	6.3 (1.18)	8.0 (1.32)	7.1 (0.63)	4.0 (0.88)
$20,000–$34,999	5.7 (0.25)	5.2 (0.36)	4.8 (0.46)	8.7 (1.63)	6.7 (0.85)	6.8 (1.40)	6.4 (0.64)	6.8 (1.48)
$35,000–$54,999	5.8 (0.25)	6.4 (0.35)	4.6 (0.59)	9.7 (2.06)	5.3 (0.76)	8.9 (1.57)	4.7 (0.54)	5.8 (1.36)
$55,000–$74,999	5.7 (0.28)	6.4 (0.40)	2.5 (0.68)	*7.3 (2.21)	4.6 (0.84)	6.4 (1.75)	5.0 (0.59)	5.8 (1.62)
$75,000 or more	5.1 (0.19)	5.5 (0.25)	3.5 (0.90)	*6.0 (2.40)	3.9 (0.57)	*3.3 (1.08)	4.6 (0.40)	4.0 (1.13)
Poverty status[8]								
Poor	6.8 (0.27)	6.6 (0.53)	7.1 (0.45)	6.7 (1.41)	5.4 (0.99)	8.2 (1.50)	7.0 (0.59)	4.7 (1.25)
Near poor	5.8 (0.23)	5.2 (0.33)	6.4 (0.49)	8.5 (1.69)	6.3 (0.76)	7.3 (1.30)	5.1 (0.53)	6.2 (1.14)
Not poor	5.5 (0.13)	6.0 (0.18)	3.9 (0.34)	9.1 (1.25)	4.6 (0.42)	6.1 (0.84)	4.9 (0.32)	5.0 (0.78)
Home tenure status[9]								
Owned or being bought	5.6 (0.13)	5.9 (0.18)	4.8 (0.38)	7.6 (1.17)	5.1 (0.41)	6.0 (0.90)	5.1 (0.26)	5.7 (0.70)
Rented	6.2 (0.19)	5.9 (0.32)	6.6 (0.35)	8.4 (1.11)	5.0 (0.63)	7.9 (0.96)	6.0 (0.43)	3.7 (0.77)
Some other arrangement	8.4 (1.02)	7.6 (1.40)	8.9 (1.71)	*15.3 (9.40)	*9.4 (3.02)	*5.5 (3.35)	7.7 (2.03)	*13.6 (8.95)
Health insurance coverage[10]								
Private	5.4 (0.13)	5.9 (0.18)	4.5 (0.32)	8.0 (1.27)	4.6 (0.40)	4.3 (0.79)	4.7 (0.28)	4.0 (0.78)
Medicaid	7.2 (0.24)	7.1 (0.44)	7.3 (0.44)	8.5 (1.27)	6.6 (0.80)	8.9 (1.12)	7.0 (0.47)	6.3 (0.92)
Other	6.3 (0.78)	6.4 (1.17)	6.8 (1.88)	*–	*4.9 (1.98)	*2.3 (2.27)	6.8 (1.59)	*10.7 (6.45)
Uninsured	4.8 (0.30)	4.3 (0.41)	5.8 (0.91)	8.9 (2.53)	5.1 (1.28)	8.7 (1.84)	4.2 (0.45)	3.4 (0.90)
Place of residence[11]								
Large MSA	5.2 (0.18)	5.1 (0.28)	5.4 (0.37)	5.9 (1.08)	5.1 (0.63)	6.1 (1.22)	5.4 (0.37)	4.6 (1.01)
Small MSA	5.9 (0.15)	6.1 (0.21)	6.1 (0.41)	10.5 (1.34)	4.8 (0.50)	7.4 (0.98)	5.1 (0.31)	5.0 (0.80)
Not in MSA	6.5 (0.25)	6.4 (0.34)	7.0 (0.76)	7.4 (2.12)	5.7 (0.70)	7.1 (1.26)	6.5 (0.61)	7.1 (1.39)
Region								
Northeast	5.7 (0.25)	5.9 (0.38)	4.7 (0.50)	12.9 (2.68)	5.9 (1.22)	8.5 (1.95)	5.0 (0.50)	6.0 (1.60)
Midwest	5.8 (0.21)	5.8 (0.31)	6.4 (0.48)	6.4 (1.32)	4.6 (0.62)	6.7 (1.23)	5.7 (0.54)	4.7 (1.12)
South	6.3 (0.19)	6.2 (0.28)	7.0 (0.50)	8.8 (1.58)	5.4 (0.55)	7.5 (1.05)	6.4 (0.42)	4.9 (0.78)
West	5.1 (0.22)	5.7 (0.31)	4.5 (0.54)	6.5 (1.31)	4.7 (0.69)	5.3 (1.21)	4.1 (0.34)	6.1 (1.52)

* Estimate has a relative standard error of greater than 30% and should be used with caution because it does not meet the standards of reliability or precision.

– Quantity zero.

[1]A nuclear family consists of one or more children living with two parents who are married to one another and are biological or adoptive parents to all children in the family. A single-parent family consists of one or more children living with a single adult (male or female, related or unrelated). An unmarried biological or adoptive family consists of one or more children living with two parents who are not married to one another and are biological or adoptive parents to all children in the family. A blended family consists of one or more children living with a biological or adoptive parent and an

unrelated stepparent who are married to one another. A cohabiting family consists of one or more children living with a biological or adoptive parent and an unrelated adult who are cohabiting with one another. An extended family consists of one or more children living with at least one biological or adoptive parent and a related adult. An "other" family consists of one or more children living with related or unrelated adults who are not biological or adoptive parents.

[2]Data are based on household interviews of a sample of the civilian noninstitutionalized population. Prevalence of ear infections is based on a question that asked, "During the past 12 months, has [child's name] had three or more ear infections?" A knowledgeable adult provided information on behalf of child respondents. Unknowns with respect to ear infections and family structure are not included in the column labeled "All children under age 18 with three or more ear infections in the past 12 months" (see Appendix I).

[3]Includes other races not shown separately and children with unknown parent's education, family income, poverty status, or health insurance. Additionally, numbers within selected characteristics may not add to totals because of rounding.

[4]Persons of Hispanic or Latino origin may be of any race or combination of races. Similarly, the category "Not Hispanic or Latino" refers to all persons who are not of Hispanic or Latino origin, regardless of race. To be concise, the text uses shorter versions of the terms shown in the table. For example, the category "Not Hispanic or Latino black or African American, single race" in the tables is referred to as "non-Hispanic black" in the text.

[5]Refers to the education level of the parent with the higher level of education, regardless of that parent's age.

[6]GED is General Educational Development high school equivalency diploma.

[7]Information on family income and poverty status is obtained from the 2001–2007 National Health Interview Survey Imputed Family Income/Personal Earnings Files.

[8]Based on family income and family size using the U.S. Census Bureau's poverty thresholds for the previous calendar year. "Poor" persons are defined as below the poverty threshold. "Near poor" persons have incomes of 100% to less than 200% of the poverty threshold. "Not poor" persons have incomes that are 200% of the poverty threshold or greater.

[9]Based on a question in the Family Core that asked whether the family's house or apartment is owned or being bought, rented, or occupied by some other arrangement (see Appendix II).

[10]Classification of health insurance coverage is based on a hierarchy of mutually exclusive categories. Persons with more than one type of health insurance were assigned to the first appropriate category in the hierarchy. The category ""Uninsured" includes persons who had no coverage as well as those who had only Indian Health Service coverage or had only a private plan that paid for one type of service such as accidents or dental care (see Appendix II).

[11]MSA is metropolitan statistical area. Large MSAs have a population size of 1 million or more; small MSAs have a population size of less than 1 million. "Not in MSA" consists of persons not living in a metropolitan statistical area.

SOURCE: CDC/NCHS, National Health Interview Survey, 2001–2007.

Table 17. Frequencies of children under age 18 who have ever been told they have mental retardation or any developmental delay, by family structure and by selected characteristics: United States, 2001–2007

Selected characteristics	All children under age 18 ever told they have mental retardation or any developmental delay	Family structure[1]						
		Nuclear	Single parent	Unmarried biological or adoptive	Blended	Cohabiting	Extended	Other
	Number in thousands[2]							
Total[3]	2,635	1,066	546	29	242	102	500	151
Sex								
Male	1,690	730	339	19	140	63	315	84
Female	946	336	207	*10	102	39	185	67
Age								
0–4 years	574	291	91	*11	39	*17	88	37
5–17 years	2,062	775	455	18	203	85	412	114
5–11 years	1,166	522	251	*13	103	46	170	61
12–17 years	896	253	205	*5	99	39	242	53
Hispanic origin and race[4]								
Hispanic or Latino	401	136	89	*7	29	*10	103	27
Mexican or Mexican American	251	98	45	*2	20	*5	62	20
Not Hispanic or Latino	2,235	930	458	21	213	92	397	124
White, single race	1,678	813	254	17	175	73	276	70
Black or African American, single race	384	60	163	*4	23	*14	86	33
Parent's education[5]								
Less than high school diploma	265	52	90	*2	18	21	79	*2
High school diploma or GED[6]	588	157	150	14	75	36	145	*11
More than high school diploma	1,653	856	273	*12	144	42	271	54
Family income[7]								
Less than $20,000	590	78	305	*8	41	28	99	32
$20,000–$34,999	530	149	131	*7	71	27	107	38
$35,000–$54,999	512	246	64	*7	53	24	93	25
$55,000–$74,999	342	178	30	*4	33	*10	60	26
$75,000 or more	662	416	17	*2	44	*13	141	*29
Poverty status[8]								
Poor	613	89	256	*7	56	28	138	40
Near poor	664	225	163	*10	76	32	116	42
Not poor	1,359	753	128	*12	110	42	246	68
Home tenure status[9]								
Owned or being bought	1,729	902	191	*10	161	35	324	106
Rented	851	153	342	18	71	64	162	40
Some other arrangement	51	*11	*10	*–	*9	*3	*13	*5
Health insurance coverage[10]								
Private	1,346	783	157	*6	128	31	216	25
Medicaid	1,048	208	344	18	85	59	216	118
Other	77	36	*9	*1	*7	*3	20	*–
Uninsured	160	38	35	*4	*21	*9	46	*8
Place of residence[11]								
Large MSA	757	246	225	*8	63	19	152	45
Small MSA	1,347	636	221	14	99	49	259	70
Not in MSA	531	185	101	*7	80	34	89	36
Region								
Northeast	551	243	122	*13	22	28	103	*19
Midwest	687	292	132	*8	74	29	109	44
South	923	341	210	*6	98	36	185	47
West	474	190	83	*1	48	*9	103	40

* Estimate has a relative standard error of greater than 30% and should be used with caution because it does not meet the standards of reliability or precision.

– Quantity zero.

[1]A nuclear family consists of one or more children living with two parents who are married to one another and are biological or adoptive parents to all children in the family. A single-parent family

consists of one or more children living with a single adult (male or female, related or unrelated). An unmarried biological or adoptive family consists of one or more children living with two parents who are not married to one another and are biological or adoptive parents to all children in the family. A blended family consists of one or more children living with a biological or adoptive parent and an unrelated stepparent who are married to one another. A cohabiting family consists of one or more children living with a biological or adoptive parent and an unrelated adult who are cohabiting with one another. An extended family consists of one or more children living with at least one biological or adoptive parent and a related adult. An "other" family consists of one or more children living with related or unrelated adults who are not biological or adoptive parents.

[2]Data are based on household interviews of a sample of the civilian noninstitutionalized population. Prevalence of mental retardation or any developmental delay is based on separate questions, "Has a doctor or health professional ever told you that [child's name] had mental retardation?" and "Has a doctor or health professional ever told you that [child's name] had any other developmental delay?" A knowledgeable adult provided information on behalf of child respondents. Unknowns with respect to mental retardation or any developmental delay and family structure are not included in the column labeled "All children under age 18 ever told they have mental retardation or any developmental delay" (see Appendix I).

[3]Includes other races not shown separately and children with unknown parent's education, family income, poverty status, or health insurance. Additionally, numbers within selected characteristics may not add to totals because of rounding.

[4]Persons of Hispanic or Latino origin may be of any race or combination of races. Similarly, the category "Not Hispanic or Latino" refers to all persons who are not of Hispanic or Latino origin, regardless of race. To be concise, the text uses shorter versions of the terms shown in the table. For example, the category "Not Hispanic or Latino black or African American, single race" in the tables is referred to as "non-Hispanic black" in the text.

[5]Refers to the education level of the parent with the higher level of education, regardless of that parent's age.

[6]GED is General Educational Development high school equivalency diploma.

[7]Information on family income and poverty status is obtained from the 2001–2007 National Health Interview Survey Imputed Family Income/Personal Earnings Files.

[8]Based on family income and family size using the U.S. Census Bureau's poverty thresholds for the previous calendar year. "Poor" persons are defined as below the poverty threshold. "Near poor" persons have incomes of 100% to less than 200% of the poverty threshold. "Not poor" persons have incomes that are 200% of the poverty threshold or greater.

[9]Based on a question in the Family Core that asked whether the family's house or apartment is owned or being bought, rented, or occupied by some other arrangement (see Appendix II).

[10]Classification of health insurance coverage is based on a hierarchy of mutually exclusive categories. Persons with more than one type of health insurance were assigned to the first appropriate category in the hierarchy. The category ""Uninsured" includes persons who had no coverage as well as those who had only Indian Health Service coverage or had only a private plan that paid for one type of service such as accidents or dental care (see Appendix II).

[11]MSA is metropolitan statistical area. Large MSAs have a population size of 1 million or more; small MSAs have a population size of less than 1 million. "Not in MSA" consists of persons not living in a metropolitan statistical area.

SOURCE: CDC/NCHS, National Health Interview Survey, 2001–2007.

Table 18. Percentages (with standard errors) of children under age 18 who have ever been told they have mental retardation or any developmental delay, by family structure and by selected characteristics: United States, 2001–2007

Selected characteristics	All children under age 18 ever told they have mental retardation or any developmental delay	Family structure[1]						
		Nuclear	Single parent	Unmarried biological or adoptive	Blended	Cohabiting	Extended	Other
	Percent[2] (standard error)							
Total[3]	3.6 (0.09)	3.0 (0.12)	4.6 (0.25)	2.7 (0.57)	3.8 (0.32)	4.5 (0.60)	3.6 (0.21)	6.6 (0.77)
Sex								
Male	4.5 (0.14)	4.0 (0.19)	5.7 (0.38)	3.4 (0.85)	4.3 (0.46)	5.4 (0.87)	4.4 (0.30)	7.2 (1.15)
Female	2.6 (0.11)	2.0 (0.13)	3.4 (0.32)	*1.9 (0.73)	3.3 (0.45)	3.6 (0.74)	2.8 (0.26)	6.0 (1.01)
Age								
0–4 years	2.9 (0.15)	2.6 (0.19)	3.6 (0.45)	*1.6 (0.51)	2.8 (0.61)	*2.8 (0.95)	2.8 (0.35)	7.0 (1.56)
5–17 years	3.9 (0.11)	3.2 (0.15)	4.8 (0.29)	4.4 (1.24)	4.1 (0.37)	5.1 (0.73)	3.8 (0.24)	6.5 (0.88)
5–11 years	4.1 (0.16)	3.6 (0.20)	5.1 (0.42)	*4.4 (1.36)	4.0 (0.56)	4.7 (0.85)	4.1 (0.38)	7.4 (1.34)
12–17 years	3.6 (0.16)	2.6 (0.21)	4.5 (0.39)	*4.6 (2.66)	4.2 (0.49)	5.8 (1.30)	3.7 (0.31)	5.8 (1.12)
Hispanic origin and race[4]								
Hispanic or Latino	2.9 (0.16)	2.4 (0.23)	4.2 (0.50)	*2.2 (0.86)	2.9 (0.62)	*2.3 (0.78)	2.7 (0.26)	5.1 (1.19)
Mexican or Mexican American	2.7 (0.18)	2.4 (0.28)	3.9 (0.70)	*0.7 (0.41)	3.1 (0.83)	*1.7 (0.75)	2.3 (0.27)	5.1 (1.39)
Not Hispanic or Latino	3.8 (0.11)	3.1 (0.13)	4.6 (0.28)	2.9 (0.73)	4.0 (0.37)	5.0 (0.69)	4.0 (0.27)	7.1 (0.91)
White, single race	3.9 (0.12)	3.3 (0.15)	4.9 (0.38)	3.7 (1.03)	4.1 (0.43)	5.5 (0.87)	4.3 (0.36)	7.7 (1.20)
Black or African American, single race	3.6 (0.23)	2.8 (0.43)	4.1 (0.42)	*2.4 (1.21)	2.7 (0.71)	*3.5 (1.17)	3.6 (0.44)	4.8 (1.24)
Parent's education[5]								
Less than high school diploma	2.8 (0.20)	1.9 (0.31)	3.9 (0.46)	*1.1 (0.71)	3.5 (0.97)	4.6 (1.10)	2.8 (0.35)	*1.2 (0.73)
High school diploma or GED[6]	3.6 (0.18)	2.7 (0.27)	4.4 (0.45)	3.5 (1.02)	4.2 (0.60)	4.5 (0.96)	3.9 (0.40)	*4.4 (1.79)
More than high school diploma	3.7 (0.12)	3.2 (0.14)	4.8 (0.37)	*2.9 (0.97)	3.6 (0.39)	4.4 (0.96)	3.9 (0.30)	11.6 (2.41)
Family income[7]								
Less than $20,000	4.6 (0.23)	2.6 (0.39)	5.2 (0.37)	*2.6 (1.01)	6.2 (1.27)	5.3 (1.33)	4.6 (0.53)	6.7 (1.73)
$20,000–$34,999	4.2 (0.24)	3.2 (0.34)	4.2 (0.47)	*2.5 (1.07)	6.2 (1.02)	5.1 (1.46)	4.3 (0.61)	7.3 (1.55)
$35,000–$54,999	3.7 (0.21)	3.8 (0.32)	3.5 (0.55)	*2.8 (1.39)	3.4 (0.66)	4.4 (1.13)	3.3 (0.42)	4.9 (1.29)
$55,000–$74,999	3.1 (0.22)	2.9 (0.26)	4.8 (1.29)	*3.9 (2.10)	2.8 (0.66)	*3.4 (1.61)	2.8 (0.44)	8.5 (2.10)
$75,000 or more	2.9 (0.16)	2.8 (0.18)	3.0 (0.87)	*2.2 (1.82)	2.5 (0.49)	*3.7 (1.36)	3.3 (0.38)	6.6 (1.93)
Poverty status[8]								
Poor	4.5 (0.25)	2.7 (0.40)	5.1 (0.40)	*2.4 (1.05)	6.8 (1.38)	4.8 (1.23)	4.8 (0.56)	6.5 (1.65)
Near poor	4.1 (0.22)	3.8 (0.36)	4.8 (0.53)	*2.8 (1.08)	4.8 (0.71)	4.8 (1.23)	3.2 (0.37)	6.0 (1.20)
Not poor	3.1 (0.11)	2.9 (0.13)	3.6 (0.36)	*2.8 (0.97)	2.8 (0.32)	4.1 (0.84)	3.3 (0.27)	7.2 (1.23)
Home tenure status[9]								
Owned or being bought	3.5 (0.11)	3.2 (0.14)	4.4 (0.40)	*2.6 (0.96)	3.8 (0.37)	3.7 (0.69)	3.4 (0.24)	7.0 (0.95)
Rented	3.9 (0.17)	2.4 (0.25)	4.7 (0.32)	2.9 (0.73)	3.7 (0.61)	5.1 (0.90)	4.1 (0.41)	5.9 (1.34)
Some other arrangement	3.6 (0.56)	*1.9 (0.65)	*3.0 (1.00)	*–	*6.5 (2.52)	*6.8 (4.93)	6.3 (1.84)	*8.4 (4.58)
Health insurance coverage[10]								
Private	3.0 (0.10)	2.9 (0.13)	3.2 (0.31)	*1.7 (0.70)	3.2 (0.36)	3.6 (0.85)	2.9 (0.24)	3.6 (0.89)
Medicaid	5.6 (0.23)	4.4 (0.41)	6.1 (0.43)	3.3 (0.86)	5.9 (0.83)	5.8 (1.00)	5.0 (0.46)	10.1 (1.31)
Other	4.8 (0.62)	4.7 (0.97)	*3.7 (1.17)	*5.0 (4.96)	*3.4 (1.35)	*5.4 (3.28)	8.3 (2.16)	*–
Uninsured	2.3 (0.21)	1.3 (0.25)	3.2 (0.71)	*3.2 (2.12)	3.6 (1.07)	*3.0 (1.08)	2.7 (0.40)	*2.2 (0.87)
Place of residence[11]								
Large MSA	3.6 (0.17)	2.9 (0.21)	4.8 (0.41)	*2.1 (0.86)	4.1 (0.78)	2.9 (0.72)	3.4 (0.31)	5.6 (1.16)
Small MSA	3.5 (0.13)	3.1 (0.16)	4.3 (0.38)	3.0 (0.83)	3.1 (0.40)	4.8 (1.01)	3.6 (0.30)	7.2 (1.13)
Not in MSA	3.9 (0.22)	2.9 (0.27)	4.7 (0.52)	*3.1 (1.51)	5.0 (0.64)	5.8 (1.12)	4.1 (0.58)	7.3 (1.94)
Region								
Northeast	4.2 (0.25)	3.7 (0.33)	5.7 (0.67)	*7.4 (2.25)	2.7 (0.66)	8.0 (2.03)	3.9 (0.56)	*5.9 (1.87)
Midwest	4.0 (0.20)	3.4 (0.24)	4.6 (0.57)	*2.9 (1.04)	4.6 (0.69)	4.7 (1.26)	3.9 (0.50)	9.8 (2.31)
South	3.5 (0.14)	2.8 (0.18)	4.4 (0.35)	*1.8 (0.87)	3.7 (0.46)	4.2 (0.92)	3.8 (0.35)	4.8 (0.97)
West	2.9 (0.18)	2.4 (0.23)	3.8 (0.52)	*0.4 (0.31)	3.8 (0.81)	*2.0 (0.68)	2.8 (0.31)	7.9 (1.62)

* Estimate has a relative standard error of greater than 30% and should be used with caution because it does not meet the standards of reliability or precision.

– Quantity zero.

[1] A *nuclear* family consists of one or more children living with two parents who are married to one another and are biological or adoptive parents to all children in the family. A single-parent family consists of one or more children living with a single adult (male or female, related or unrelated). An unmarried biological or adoptive family consists of one or more children living with two parents who

are not married to one another and are biological or adoptive parents to all children in the family. A blended family consists of one or more children living with a biological or adoptive parent and an unrelated stepparent who are married to one another. A cohabiting family consists of one or more children living with a biological or adoptive parent and an unrelated adult who are cohabiting with one another. An extended family consists of one or more children living with at least one biological or adoptive parent and a related adult. An "other" family consists of one or more children living with related or unrelated adults who are not biological or adoptive parents.

[2]Data are based on household interviews of a sample of the civilian noninstitutionalized population. Prevalence of mental retardation or any developmental delay is based on separate questions, "Has a doctor or health professional ever told you that [child's name] had mental retardation?" and "Has a doctor or health professional ever told you that [child's name] had any other developmental delay?" A knowledgeable adult provided information on behalf of child respondents. Unknowns with respect to mental retardation or any developmental delay and family structure are not included in the column labeled "All children under age 18 ever told they have mental retardation or any developmental delay" (see Appendix I).

[3]Includes other races not shown separately and children with unknown parent's education, family income, poverty status, or health insurance.

[4]Persons of Hispanic or Latino origin may be of any race or combination of races. Similarly, the category "Not Hispanic or Latino" refers to all persons who are not of Hispanic or Latino origin, regardless of race. To be concise, the text uses shorter versions of the terms shown in the table. For example, the category "Not Hispanic or Latino black or African American, single race" in the tables is referred to as "non-Hispanic black" in the text.

[5]Refers to the education level of the parent with the higher level of education, regardless of that parent's age.

[6]GED is General Educational Development high school equivalency diploma.

[7]Information on family income and poverty status is obtained from the 2001–2007 National Health Interview Survey Imputed Family Income/Personal Earnings Files.

[8]Based on family income and family size using the U.S. Census Bureau's poverty thresholds for the previous calendar year. "Poor" persons are defined as below the poverty threshold. "Near poor" persons have incomes of 100% to less than 200% of the poverty threshold. "Not poor" persons have incomes that are 200% of the poverty threshold or greater.

[9]Based on a question in the Family Core that asked whether the family's house or apartment is owned or being bought, rented, or occupied by some other arrangement (see Appendix II).

[10]Classification of health insurance coverage is based on a hierarchy of mutually exclusive categories. Persons with more than one type of health insurance were assigned to the first appropriate category in the hierarchy. The category ""Uninsured" includes persons who had no coverage as well as those who had only Indian Health Service coverage or had only a private plan that paid for one type of service such as accidents or dental care (see Appendix II).

[11]MSA is metropolitan statistical area. Large MSAs have a population size of 1 million or more; small MSAs have a population size of less than 1 million. "Not in MSA" consists of persons not living in a metropolitan statistical area.

SOURCE: CDC/NCHS, National Health Interview Survey, 2001–2007.

Table 19. Frequencies of children under age 18 with an impairment or health problem that limits crawling, walking, running, or playing, by family structure and by selected characteristics: United States, 2001–2007

Selected characteristics	All children under age 18 with an impairment that limits crawling, walking, running, or playing	Family structure[1]						
		Nuclear	Single parent	Unmarried biological or adoptive	Blended	Cohabiting	Extended	Other
	Number in thousands[2]							
Total[3]	1,402	510	326	21	164	39	283	59
Sex								
Male	721	256	170	*11	89	17	149	30
Female	680	254	156	10	75	22	134	29
Age								
0–4 years	250	128	40	*5	*10	*10	36	*22
5–17 years	1,151	382	286	17	153	29	247	36
5–11 years	488	185	115	14	82	17	63	*12
12–17 years	663	198	171	*2	72	*12	184	24
Hispanic origin and race[4]								
Hispanic or Latino	215	61	48	*5	17	*3	67	*13
Mexican or Mexican American	138	47	19	*4	*12	*2	48	*7
Not Hispanic or Latino	1,187	449	278	16	146	36	216	46
White, single race	882	400	151	*9	121	29	154	18
Black or African American, single race	214	27	96	*5	21	*4	46	*15
Parent's education[5]								
Less than high school diploma	169	31	69	*3	*13	*4	48	*2
High school diploma or GED[6]	374	108	88	*9	70	*14	83	*2
More than high school diploma	798	371	154	*9	80	19	148	*17
Family income[7]								
Less than $20,000	364	49	185	*3	35	*12	62	*19
$20,000–$34,999	287	79	88	*6	31	*7	59	16
$35,000–$54,999	280	120	33	*7	44	*11	60	*5
$55,000–$74,999	182	99	14	*3	26	*3	29	*7
$75,000 or more	289	164	*5	*2	28	*5	73	*13
Poverty status[8]								
Poor	364	57	159	*2	37	*11	79	*19
Near poor	381	117	97	*10	50	*14	76	18
Not poor	656	337	70	*9	76	*14	129	*22
Home tenure status[9]								
Owned or being bought	866	399	105	*14	108	12	193	35
Rented	497	99	212	*7	46	27	84	22
Some other arrangement	38	*12	*8	*–	*10	*–	*6	*2
Health insurance coverage[10]								
Private	709	362	102	*7	88	*10	132	*7
Medicaid	556	112	190	*10	62	19	119	44
Other	31	13	*9	*–	*2	*1	*5	*1
Uninsured	105	23	24	*3	*12	*9	28	*6
Place of residence[11]								
Large MSA	387	96	126	*5	48	*9	88	*16
Small MSA	726	323	133	*12	64	20	146	28
Not in MSA	288	91	67	*4	52	*10	48	*15
Region								
Northeast	212	75	45	*2	*15	*11	52	*12
Midwest	387	156	94	*3	51	*9	61	*13
South	501	170	121	*10	70	13	97	20
West	301	109	65	*6	27	*6	73	*14

* Estimate has a relative standard error of greater than 30% and should be used with caution because it does not meet the standards of reliability or precision.
– Quantity zero.

[1]A nuclear family consists of one or more children living with two parents who are married to one another and are biological or adoptive parents to all children in the family. A single-parent family consists of one or more children living with a single adult (male or female, related or unrelated). An unmarried biological or adoptive family consists of one or more children living with two parents who are not married to one another and are biological or adoptive parents to all children in the family. A blended family consists of one or more children living with a biological or adoptive parent and an unrelated stepparent who are married to one another. A cohabiting family consists of one or more children living with a biological or adoptive parent and an unrelated adult who are cohabiting with one another. An extended family consists of one or more children living with at least one biological or adoptive parent and a related adult. An "other" family consists of one or more children living with related or unrelated adults who are not biological or adoptive parents.

[2]Data are based on household interviews of a sample of the civilian noninstitutionalized population. Prevalence of impairments or health problems resulting in activity limitations is based on a question that asked, "Does [child's name] have an impairment or health problem that limits [his/her] ability to crawl, walk, run, or play?" A knowledgeable adult provided information on behalf of child respondents. Unknowns with respect to impairments and family structure are not included in the column labeled "All children under age 18 with an impairment that limits crawling, walking, running, or playing." (see Appendix I).

[3]Includes other races not shown separately and children with unknown parent's education, family income, poverty status, or health insurance. Additionally, numbers within selected characteristics may not add to totals because of rounding.

[4]Persons of Hispanic or Latino origin may be of any race or combination of races. Similarly, the category "Not Hispanic or Latino" refers to all persons who are not of Hispanic or Latino origin, regardless of race. To be concise, the text uses shorter versions of the terms shown in the table. For example, the category "Not Hispanic or Latino black or African American, single race" in the tables is referred to as "non-Hispanic black" in the text.

[5]Refers to the education level of the parent with the higher level of education, regardless of that parent's age.

[6]GED is General Educational Development high school equivalency diploma.

[7]Information on family income and poverty status is obtained from the 2001–2007 National Health Interview Survey Imputed Family Income/Personal Earnings Files.

[8]Based on family income and family size using the U.S. Census Bureau's poverty thresholds for the previous calendar year. "Poor" persons are defined as below the poverty threshold. "Near poor" persons have incomes of 100% to less than 200% of the poverty threshold. "Not poor" persons have incomes that are 200% of the poverty threshold or greater.

[9]Based on a question in the Family Core that asked whether the family's house or apartment is owned or being bought, rented, or occupied by some other arrangement (see Appendix II).

[10]Classification of health insurance coverage is based on a hierarchy of mutually exclusive categories. Persons with more than one type of health insurance were assigned to the first appropriate category in the hierarchy. The category ""Uninsured" includes persons who had no coverage as well as those who had only Indian Health Service coverage or had only a private plan that paid for one type of service such as accidents or dental care (see Appendix II).

[11]MSA is metropolitan statistical area. Large MSAs have a population size of 1 million or more; small MSAs have a population size of less than 1 million. "Not in MSA" consists of persons not living in a metropolitan statistical area.

SOURCE: CDC/NCHS, National Health Interview Survey, 2001–2007.

Table 20. Percentages (with standard errors) of children under age 18 with an impairment or health problem that limits crawling, walking, running, or playing, by family structure and by selected characteristics: United States, 2001–2007

Selected characteristics	All children under age 18 with an impairment that limits crawling, walking, running, or playing	Family structure[1]						
		Nuclear	Single parent	Unmarried biological or adoptive	Blended	Cohabiting	Extended	Other
	Percent[2] (standard error)							
Total[3]	1.9 (0.06)	1.4 (0.08)	2.7 (0.17)	2.0 (0.45)	2.6 (0.26)	1.7 (0.31)	2.0 (0.13)	2.6 (0.45)
Sex								
Male	1.9 (0.09)	1.4 (0.12)	2.9 (0.25)	*1.9 (0.65)	2.8 (0.40)	1.4 (0.36)	2.1 (0.18)	2.5 (0.64)
Female	1.9 (0.09)	1.5 (0.11)	2.6 (0.24)	2.1 (0.61)	2.4 (0.43)	2.0 (0.51)	2.0 (0.18)	2.6 (0.59)
Age								
0–4 years	1.2 (0.10)	1.1 (0.14)	1.6 (0.27)	*0.7 (0.34)	*0.7 (0.25)	*1.6 (0.61)	1.1 (0.19)	*4.3 (1.31)
5–17 years	2.2 (0.08)	1.6 (0.10)	3.0 (0.21)	4.1 (1.03)	3.1 (0.33)	1.8 (0.36)	2.3 (0.16)	2.1 (0.43)
5–11 years	1.7 (0.10)	1.3 (0.12)	2.3 (0.27)	4.8 (1.35)	3.2 (0.51)	1.8 (0.45)	1.5 (0.20)	*1.5 (0.54)
12–17 years	2.7 (0.12)	2.1 (0.17)	3.8 (0.31)	*2.0 (1.06)	3.0 (0.44)	*1.8 (0.59)	2.8 (0.23)	2.6 (0.60)
Hispanic origin and race[4]								
Hispanic or Latino	1.6 (0.10)	1.1 (0.14)	2.3 (0.31)	*1.6 (0.50)	1.7 (0.50)	*0.8 (0.36)	1.7 (0.20)	*2.5 (0.87)
Mexican or Mexican American	1.5 (0.12)	1.2 (0.16)	1.6 (0.32)	*1.7 (0.63)	*1.8 (0.55)	*0.6 (0.45)	1.8 (0.25)	*1.7 (0.82)
Not Hispanic or Latino	2.0 (0.07)	1.5 (0.09)	2.8 (0.20)	2.2 (0.61)	2.7 (0.30)	1.9 (0.37)	2.2 (0.16)	2.6 (0.52)
White, single race	2.0 (0.09)	1.6 (0.11)	2.9 (0.28)	*1.9 (0.69)	2.9 (0.35)	2.2 (0.48)	2.4 (0.22)	1.9 (0.55)
Black or African American, single race	2.0 (0.16)	1.2 (0.26)	2.4 (0.29)	*3.1 (1.65)	2.5 (0.73)	*1.1 (0.51)	1.9 (0.28)	2.2 (0.64)
Parent's education[5]								
Less than high school diploma	1.8 (0.14)	1.1 (0.20)	3.0 (0.38)	*1.2 (0.54)	*2.5 (0.95)	*0.9 (0.42)	1.7 (0.24)	*1.2 (0.68)
High school diploma or GED[6]	2.3 (0.15)	1.8 (0.24)	2.6 (0.32)	*2.2 (0.84)	3.9 (0.66)	*1.7 (0.52)	2.2 (0.27)	*1.0 (0.76)
More than high school diploma	1.8 (0.08)	1.4 (0.09)	2.7 (0.25)	*2.2 (0.73)	2.0 (0.28)	2.0 (0.50)	2.1 (0.19)	*3.6 (1.42)
Family income[7]								
Less than $20,000	2.8 (0.17)	1.6 (0.30)	3.2 (0.26)	*0.9 (0.57)	5.2 (1.31)	*2.3 (0.74)	2.9 (0.38)	4.0 (1.19)
$20,000–$34,999	2.3 (0.17)	1.7 (0.25)	2.8 (0.38)	*2.1 (0.89)	2.7 (0.59)	*1.4 (0.56)	2.4 (0.37)	3.0 (0.80)
$35,000–$54,999	2.0 (0.16)	1.8 (0.22)	1.8 (0.35)	*2.6 (1.30)	2.8 (0.74)	*2.1 (0.71)	2.1 (0.35)	*0.9 (0.43)
$55,000–$74,999	1.7 (0.16)	1.6 (0.21)	2.2 (0.65)	*2.9 (1.75)	2.2 (0.57)	*1.1 (0.84)	1.4 (0.28)	*2.1 (0.86)
$75,000 or more	1.3 (0.10)	1.1 (0.11)	*0.9 (0.43)	*2.5 (2.15)	1.6 (0.40)	*1.3 (0.86)	1.7 (0.25)	*2.9 (1.39)
Poverty status[8]								
Poor	2.7 (0.17)	1.7 (0.32)	3.2 (0.31)	*0.7 (0.60)	4.5 (1.08)	*2.0 (0.70)	2.7 (0.34)	*3.1 (0.94)
Near poor	2.3 (0.16)	2.0 (0.27)	2.9 (0.33)	*2.8 (0.94)	3.1 (0.70)	*2.0 (0.63)	2.1 (0.28)	2.6 (0.64)
Not poor	1.5 (0.07)	1.3 (0.09)	2.0 (0.26)	*2.2 (0.77)	2.0 (0.30)	*1.4 (0.42)	1.7 (0.17)	*2.3 (0.71)
Home tenure status[9]								
Owned or being bought	1.8 (0.08)	1.4 (0.09)	2.4 (0.26)	3.5 (1.04)	2.5 (0.34)	1.3 (0.38)	2.0 (0.16)	2.3 (0.51)
Rented	2.3 (0.12)	1.5 (0.20)	2.9 (0.23)	*1.2 (0.38)	2.4 (0.50)	2.1 (0.48)	2.1 (0.24)	3.3 (0.96)
Some other arrangement	2.7 (0.63)	*2.0 (0.62)	*2.3 (0.87)	*–	*7.3 (4.15)	*–	*3.1 (1.33)	*2.8 (2.00)
Health insurance coverage[10]								
Private	1.6 (0.07)	1.3 (0.09)	2.1 (0.23)	*2.0 (0.79)	2.2 (0.31)	*1.2 (0.43)	1.8 (0.17)	*1.1 (0.40)
Medicaid	2.9 (0.15)	2.4 (0.28)	3.4 (0.28)	*1.9 (0.59)	4.3 (0.87)	1.9 (0.46)	2.8 (0.27)	3.8 (0.76)
Other	1.9 (0.40)	1.7 (0.44)	*3.6 (1.83)	*–	*0.8 (0.55)	*2.0 (1.40)	*2.1 (0.99)	*1.6 (1.22)
Uninsured	1.5 (0.16)	0.8 (0.17)	2.2 (0.47)	*3.0 (1.61)	*2.0 (0.63)	*2.7 (1.15)	1.6 (0.32)	*1.7 (1.01)
Place of residence[11]								
Large MSA	1.9 (0.12)	1.1 (0.14)	2.7 (0.28)	*1.4 (0.48)	3.1 (0.69)	*1.3 (0.43)	2.0 (0.21)	*2.0 (0.63)
Small MSA	1.9 (0.09)	1.6 (0.11)	2.6 (0.26)	*2.6 (0.86)	2.0 (0.31)	1.9 (0.52)	2.0 (0.19)	2.8 (0.74)
Not in MSA	2.1 (0.16)	1.4 (0.21)	3.2 (0.39)	*1.7 (0.86)	3.2 (0.53)	*1.8 (0.60)	2.2 (0.35)	*3.1 (1.05)
Region								
Northeast	1.6 (0.13)	1.1 (0.17)	2.1 (0.33)	*1.2 (0.93)	*1.9 (0.63)	*3.1 (1.10)	2.0 (0.27)	*3.7 (1.44)
Midwest	2.2 (0.16)	1.8 (0.20)	3.3 (0.43)	*1.1 (0.46)	3.2 (0.73)	*1.4 (0.55)	2.2 (0.32)	*2.8 (1.04)
South	1.9 (0.10)	1.4 (0.13)	2.5 (0.25)	*2.9 (1.10)	2.6 (0.34)	1.6 (0.47)	2.0 (0.22)	2.0 (0.54)
West	1.9 (0.13)	1.4 (0.17)	3.0 (0.41)	*2.4 (0.86)	2.1 (0.46)	*1.3 (0.54)	2.0 (0.24)	*2.8 (1.11)

* Estimate has a relative standard error of greater than 30% and should be used with caution because it does not meet the standards of reliability or precision.

– Quantity zero.

[1]A nuclear family consists of one or more children living with two parents who are married to one another and are biological or adoptive parents to all children in the family. A single-parent family consists of one or more children living with a single adult (male or female, related or unrelated). An unmarried biological or adoptive family consists of one or more children living with two parents who

are not married to one another and are biological or adoptive parents to all children in the family. A blended family consists of one or more children living with a biological or adoptive parent and an unrelated stepparent who are married to one another. A cohabiting family consists of one or more children living with a biological or adoptive parent and an unrelated adult who are cohabiting with one another. An extended family consists of one or more children living with at least one biological or adoptive parent and a related adult. An "other" family consists of one or more children living with related or unrelated adults who are not biological or adoptive parents.

[2]Data are based on household interviews of a sample of the civilian noninstitutionalized population. Prevalence of impairments or health problems resulting in activity limitations is based on a question that asked, "Does [child's name] have an impairment or health problem that limits [his/her] ability to crawl, walk, run, or play?" A knowledgeable adult provided information on behalf of child respondents. Unknowns with respect to impairments and family structure are not included in the column labeled "All children under age 18 with an impairment that limits crawling, walking, running, or playing." (see Appendix I).

[3]Includes other races not shown separately and children with unknown parent's education, family income, poverty status, or health insurance.

[4]Persons of Hispanic or Latino origin may be of any race or combination of races. Similarly, the category "Not Hispanic or Latino" refers to all persons who are not of Hispanic or Latino origin, regardless of race. To be concise, the text uses shorter versions of the terms shown in the table. For example, the category "Not Hispanic or Latino black or African American, single race" in the tables is referred to as "non-Hispanic black" in the text.

[5]Refers to the education level of the parent with the higher level of education, regardless of that parent's age.

[6]GED is General Educational Development high school equivalency diploma.

[7]Information on family income and poverty status is obtained from the 2001–2007 National Health Interview Survey Imputed Family Income/Personal Earnings Files.

[8]Based on family income and family size using the U.S. Census Bureau's poverty thresholds for the previous calendar year. "Poor" persons are defined as below the poverty threshold. "Near poor" persons have incomes of 100% to less than 200% of the poverty threshold. "Not poor" persons have incomes that are 200% of the poverty threshold or greater.

[9]Based on a question in the Family Core that asked whether the family's house or apartment is owned or being bought, rented, or occupied by some other arrangement (see Appendix II).

[10]Classification of health insurance coverage is based on a hierarchy of mutually exclusive categories. Persons with more than one type of health insurance were assigned to the first appropriate category in the hierarchy. The category ""Uninsured" includes persons who had no coverage as well as those who had only Indian Health Service coverage or had only a private plan that paid for one type of service such as accidents or dental care (see Appendix II).

[11]MSA is metropolitan statistical area. Large MSAs have a population size of 1 million or more; small MSAs have a population size of less than 1 million. "Not in MSA" consists of persons not living in a metropolitan statistical area.

SOURCE: CDC/NCHS, National Health Interview Survey, 2001–2007.

Table 21. Frequencies of children under age 18 receiving special education or EIS for an emotional or behavioral problem, by family structure and by selected characteristics: United States, 2001–2007

Selected characteristics	All children under age 18 receiving special education or EIS for an emotional or behavioral problem	Family structure[1]						
		Nuclear	Single parent	Unmarried biological or adoptive	Blended	Cohabiting	Extended	Other
	Number in thousands[2]							
Total[3]	1,335	296	393	16	147	75	290	118
Sex								
Male	976	217	302	*12	97	58	212	78
Female	359	79	91	*4	50	18	78	40
Age								
0–4 years	88	35	18	*2	*3	*5	*14	*12
5–17 years	1,247	261	375	*14	144	70	277	106
5–11 years	599	151	202	*11	60	35	99	41
12–17 years	648	110	173	*3	84	35	178	65
Hispanic origin and race[4]								
Hispanic or Latino	192	36	59	*5	*13	*5	57	*18
Mexican or Mexican American	96	25	18	*2	*9	*1	25	*14
Not Hispanic or Latino	1,143	259	334	*10	134	70	234	100
White, single race	787	227	177	*8	110	53	157	55
Black or African American, single race	280	16	128	*2	18	*12	65	38
Parent's education[5]								
Less than high school diploma	205	17	89	*1	*11	21	61	*5
High school diploma or GED[6]	342	63	119	*6	48	16	82	*6
More than high school diploma	697	216	165	*9	86	37	143	42
Family income[7]								
Less than $20,000	389	31	239	*3	*14	*15	63	24
$20,000–$34,999	283	46	73	*3	32	*29	68	33
$35,000–$54,999	233	56	50	*4	39	14	52	18
$55,000–$74,999	154	58	*18	*3	*21	*5	34	*14
$75,000 or more	276	105	*14	*2	*41	*12	74	28
Poverty status[8]								
Poor	398	38	202	*3	*19	*15	87	34
Near poor	339	51	107	*5	46	31	67	32
Not poor	598	206	84	*8	83	30	137	51
Home tenure status[9]								
Owned or being bought	774	226	122	*5	99	24	200	98
Rented	523	60	260	*11	43	49	82	18
Some other arrangement	36	*8	*11	*–	*5	*2	*8	*2
Health insurance coverage[10]								
Private	548	189	119	*3	82	*16	122	19
Medicaid	666	73	247	*9	53	47	144	93
Other	25	*12	*7	*1	*3	*1	*1	*1
Uninsured	91	20	21	*3	*9	*11	22	*5
Place of residence[11]								
Large MSA	396	64	164	*4	25	18	92	29
Small MSA	662	168	163	*9	76	36	154	57
Not in MSA	277	63	67	*3	47	21	45	31
Region								
Northeast	313	77	100	*8	24	18	66	21
Midwest	331	72	74	*3	45	*22	74	40
South	465	94	156	*4	54	24	97	36
West	226	53	62	*1	*23	11	54	21

* Estimate has a relative standard error of greater than 30% and should be used with caution because it does not meet the standards of reliability or precision.

– Quantity zero.

[1]A nuclear family consists of one or more children living with two parents who are married to one another and are biological or adoptive parents to all children in the family. A single-parent family consists of one or more children living with a single adult (male or female, related or unrelated). An unmarried biological or adoptive family consists of one or more children living with two parents who

are not married to one another and are biological or adoptive parents to all children in the family. A blended family consists of one or more children living with a biological or adoptive parent and an unrelated stepparent who are married to one another. A cohabiting family consists of one or more children living with a biological or adoptive parent and an unrelated adult who are cohabiting with one another. An extended family consists of one or more children living with at least one biological or adoptive parent and a related adult. An "other" family consists of one or more children living with related or unrelated adults who are not biological or adoptive parents.

[2]Data are based on household interviews of a sample of the civilian noninstitutionalized population. Receipt of special education or early intervention services (EIS) is based on two questions in the Family Core that asked if any children under age 18 in the family received Special Education or EIS and, if so, whether he or she received these services because of an emotional or behavioral problem. A knowledgeable adult provided information on behalf of child respondents. Unknowns with respect to receipt of special education and family structure are not included in the column labeled "All children under age 18 receiving special education or EIS for an emotional or behavioral problem" (see Appendix I).

[3]Includes other races not shown separately and children with unknown parent's education, family income, poverty status, or health insurance. Additionally, numbers within selected characteristics may not add to totals because of rounding.

[4]Persons of Hispanic or Latino origin may be of any race or combination of races. Similarly, the category "Not Hispanic or Latino" refers to all persons who are not of Hispanic or Latino origin, regardless of race. To be concise, the text uses shorter versions of the terms shown in the table. For example, the category "Not Hispanic or Latino black or African American, single race" in the tables is referred to as "non-Hispanic black" in the text.

[5]Refers to the education level of the parent with the higher level of education, regardless of that parent's age.

[6]GED is General Educational Development high school equivalency diploma.

[7]Information on family income and poverty status is obtained from the 2001–2007 National Health Interview Survey Imputed Family Income/Personal Earnings Files.

[8]Based on family income and family size using the U.S. Census Bureau's poverty thresholds for the previous calendar year. "Poor" persons are defined as below the poverty threshold. "Near poor" persons have incomes of 100% to less than 200% of the poverty threshold. "Not poor" persons have incomes that are 200% of the poverty threshold or greater.

[9]Based on a question in the Family Core that asked whether the family's house or apartment is owned or being bought, rented, or occupied by some other arrangement (see Appendix II).

[10]Classification of health insurance coverage is based on a hierarchy of mutually exclusive categories. Persons with more than one type of health insurance were assigned to the first appropriate category in the hierarchy. The category ""Uninsured" includes persons who had no coverage as well as those who had only Indian Health Service coverage or had only a private plan that paid for one type of service such as accidents or dental care (see Appendix II).

[11]MSA is metropolitan statistical area. Large MSAs have a population size of 1 million or more; small MSAs have a population size of less than 1 million. "Not in MSA" consists of persons not living in a metropolitan statistical area.

SOURCE: CDC/NCHS, National Health Interview Survey, 2001–2007.

Table 22. Percentages (with standard errors) of children under age 18 receiving special education or EIS for an emotional or behavioral problem, by family structure and by selected characteristics: United States, 2001–2007

Selected characteristics	All children under age 18 receiving special education or EIS for an emotional or behavioral problem	Family structure[1]						
		Nuclear	Single parent	Unmarried biological or adoptive	Blended	Cohabiting	Extended	Other
	Percent[2] (standard error)							
Total[3]	1.8 (0.06)	0.8 (0.06)	3.3 (0.20)	1.5 (0.42)	2.3 (0.29)	3.3 (0.52)	2.1 (0.15)	5.2 (0.61)
Sex								
Male	2.6 (0.10)	1.2 (0.10)	5.1 (0.33)	*2.1 (0.64)	3.0 (0.48)	4.9 (0.92)	3.0 (0.25)	6.8 (0.94)
Female	1.0 (0.07)	0.5 (0.06)	1.5 (0.21)	*0.8 (0.52)	1.6 (0.31)	1.6 (0.45)	1.2 (0.18)	3.6 (0.77)
Age								
0–4 years	0.4 (0.05)	0.3 (0.06)	0.7 (0.18)	*0.3 (0.20)	*0.2 (0.12)	*0.9 (0.51)	*0.4 (0.13)	*2.2 (0.77)
5–17 years	2.4 (0.08)	1.1 (0.08)	4.0 (0.25)	*3.3 (1.02)	2.9 (0.37)	4.2 (0.69)	2.6 (0.19)	6.1 (0.75)
5–11 years	2.1 (0.11)	1.0 (0.10)	4.1 (0.36)	*3.6 (1.18)	2.4 (0.53)	3.6 (0.71)	2.4 (0.28)	4.9 (0.92)
12–17 years	2.6 (0.13)	1.1 (0.13)	3.8 (0.33)	*2.6 (2.02)	3.5 (0.50)	5.2 (1.33)	2.7 (0.26)	7.1 (1.14)
Hispanic origin and race[4]								
Hispanic or Latino	1.4 (0.12)	0.6 (0.12)	2.8 (0.40)	*1.6 (0.77)	*1.3 (0.52)	*1.2 (0.52)	1.5 (0.21)	*3.4 (1.11)
Mexican or Mexican American	1.0 (0.12)	0.6 (0.15)	1.6 (0.40)	*0.9 (0.51)	*1.4 (0.72)	*0.6 (0.56)	0.9 (0.18)	*3.7 (1.44)
Not Hispanic or Latino	1.9 (0.08)	0.9 (0.06)	3.4 (0.23)	*1.4 (0.50)	2.5 (0.33)	3.8 (0.63)	2.3 (0.20)	5.7 (0.72)
White, single race	1.8 (0.09)	0.9 (0.07)	3.4 (0.32)	*1.7 (0.69)	2.6 (0.39)	4.0 (0.80)	2.4 (0.27)	6.0 (1.01)
Black or African American, single race	2.6 (0.18)	0.7 (0.19)	3.2 (0.34)	*0.9 (0.77)	2.1 (0.62)	*3.1 (1.06)	2.7 (0.35)	5.7 (1.18)
Parent's education[5]								
Less than high school diploma	2.2 (0.19)	0.6 (0.15)	3.8 (0.50)	*0.3 (0.18)	*2.1 (0.84)	4.6 (1.14)	2.1 (0.33)	*3.1 (1.67)
High school diploma or GED[6]	2.1 (0.14)	1.1 (0.15)	3.5 (0.38)	*1.6 (0.72)	2.7 (0.52)	2.0 (0.52)	2.2 (0.29)	*2.6 (1.12)
More than high school diploma	1.6 (0.08)	0.8 (0.07)	2.9 (0.28)	*2.0 (0.78)	2.2 (0.37)	3.9 (1.00)	2.0 (0.23)	9.2 (2.19)
Family income[7]								
Less than $20,000	3.0 (0.18)	1.0 (0.20)	4.1 (0.32)	*1.1 (0.54)	*2.0 (0.69)	*2.8 (0.92)	2.9 (0.38)	5.1 (1.08)
$20,000–$34,999	2.2 (0.19)	1.0 (0.20)	2.3 (0.29)	*1.0 (0.66)	2.9 (0.73)	5.4 (1.61)	2.7 (0.53)	6.3 (1.46)
$35,000–$54,999	1.7 (0.13)	0.9 (0.14)	2.7 (0.52)	*1.7 (1.05)	2.5 (0.59)	2.6 (0.73)	1.8 (0.35)	3.5 (0.97)
$55,000–$74,999	1.4 (0.16)	0.9 (0.16)	2.9 (0.85)	*2.8 (2.09)	*1.7 (0.55)	*1.9 (1.01)	1.6 (0.37)	*4.5 (1.50)
$75,000 or more	1.2 (0.11)	0.7 (0.08)	*2.4 (0.88)	*1.7 (1.61)	*2.3 (0.71)	*3.2 (1.44)	1.7 (0.29)	6.4 (1.87)
Poverty status[8]								
Poor	2.9 (0.19)	1.1 (0.22)	4.0 (0.36)	*1.1 (0.59)	*2.3 (0.72)	*2.5 (0.84)	3.0 (0.49)	5.6 (1.23)
Near poor	2.1 (0.15)	0.9 (0.16)	3.1 (0.37)	*1.4 (0.75)	2.8 (0.61)	4.5 (1.31)	1.9 (0.28)	4.6 (1.00)
Not poor	1.4 (0.07)	0.8 (0.07)	2.4 (0.28)	*1.8 (0.78)	2.1 (0.39)	3.0 (0.68)	1.8 (0.20)	5.4 (1.01)
Home tenure status[9]								
Owned or being bought	1.6 (0.07)	0.8 (0.06)	2.8 (0.32)	*1.3 (0.67)	2.3 (0.37)	2.6 (0.66)	2.1 (0.20)	6.4 (0.87)
Rented	2.4 (0.12)	0.9 (0.14)	3.6 (0.27)	*1.7 (0.56)	2.3 (0.45)	3.9 (0.79)	2.1 (0.24)	2.7 (0.63)
Some other arrangement	2.5 (0.52)	*1.3 (0.63)	*3.0 (1.02)	*–	*3.5 (2.11)	*4.4 (4.30)	*4.0 (1.35)	*4.0 (3.89)
Health insurance coverage[10]								
Private	1.2 (0.07)	0.7 (0.06)	2.4 (0.29)	*0.7 (0.37)	2.0 (0.35)	*1.9 (0.61)	1.6 (0.18)	2.7 (0.72)
Medicaid	3.5 (0.17)	1.5 (0.23)	4.4 (0.32)	*1.7 (0.62)	3.7 (0.74)	4.6 (0.96)	3.3 (0.38)	8.0 (1.08)
Other	1.5 (0.32)	*1.5 (0.51)	*2.6 (1.03)	*5.0 (4.96)	*1.5 (0.68)	*2.0 (2.03)	*0.2 (0.21)	*2.0 (1.53)
Uninsured	1.3 (0.17)	0.7 (0.20)	1.9 (0.45)	*2.7 (2.03)	*1.5 (0.73)	*3.5 (1.27)	1.3 (0.28)	*1.4 (0.73)
Place of residence[11]								
Large MSA	1.9 (0.11)	0.8 (0.11)	3.5 (0.33)	*1.0 (0.65)	1.6 (0.44)	2.8 (0.65)	2.0 (0.24)	3.7 (0.71)
Small MSA	1.7 (0.09)	0.8 (0.07)	3.1 (0.29)	*2.0 (0.67)	2.4 (0.44)	3.5 (0.89)	2.1 (0.24)	5.9 (1.04)
Not in MSA	2.0 (0.16)	1.0 (0.15)	3.1 (0.49)	*1.2 (0.92)	2.9 (0.58)	3.7 (1.07)	2.1 (0.36)	6.3 (1.51)
Region								
Northeast	2.4 (0.17)	1.2 (0.16)	4.7 (0.56)	*4.3 (1.69)	3.0 (0.76)	5.0 (1.34)	2.5 (0.43)	6.3 (1.62)
Midwest	1.9 (0.14)	0.8 (0.12)	2.6 (0.36)	*1.1 (0.64)	2.8 (0.60)	*3.7 (1.33)	2.7 (0.38)	9.1 (2.00)
South	1.7 (0.11)	0.8 (0.09)	3.2 (0.33)	*1.2 (0.75)	2.0 (0.48)	2.9 (0.77)	2.0 (0.27)	3.6 (0.78)
West	1.4 (0.11)	0.7 (0.11)	2.9 (0.39)	*0.2 (0.25)	1.9 (0.55)	2.4 (0.66)	1.5 (0.20)	4.1 (0.94)

* Estimate has a relative standard error of greater than 30% and should be used with caution because it does not meet the standards of reliability or precision.

– Quantity zero.

[1]A nuclear family consists of one or more children living with two parents who are married to one another and are biological or adoptive parents to all children in the family. A single-parent family consists of one or more children living with a single adult (male or female, related or unrelated). An unmarried biological or adoptive family consists of one or more children living with two parents who

are not married to one another and are biological or adoptive parents to all children in the family. A blended family consists of one or more children living with a biological or adoptive parent and an unrelated stepparent who are married to one another. A cohabiting family consists of one or more children living with a biological or adoptive parent and an unrelated adult who are cohabiting with one another. An extended family consists of one or more children living with at least one biological or adoptive parent and a related adult. An "other" family consists of one or more children living with related or unrelated adults who are not biological or adoptive parents.

[2]Data are based on household interviews of a sample of the civilian noninstitutionalized population. Receipt of special education or early intervention services (EIS) is based on two questions in the Family Core that asked if any children under age 18 in the family received Special Education or EIS and, if so, whether he or she received these services because of an emotional or behavioral problem. A knowledgeable adult provided information on behalf of child respondents. Unknowns with respect to receipt of special education and family structure are not included in the column labeled "All children under age 18 receiving special education or EIS for an emotional or behavioral problem" (see Appendix I).

[3]Includes other races not shown separately and children with unknown parent's education, family income, poverty status, or health insurance.

[4]Persons of Hispanic or Latino origin may be of any race or combination of races. Similarly, the category "Not Hispanic or Latino" refers to all persons who are not of Hispanic or Latino origin, regardless of race. To be concise, the text uses shorter versions of the terms shown in the table. For example, the category "Not Hispanic or Latino black or African American, single race" in the tables is referred to as "non-Hispanic black" in the text.

[5]Refers to the education level of the parent with the higher level of education, regardless of that parent's age.

[6]GED is General Educational Development high school equivalency diploma.

[7]Information on family income and poverty status is obtained from the 2001–2007 National Health Interview Survey Imputed Family Income/Personal Earnings Files.

[8]Based on family income and family size using the U.S. Census Bureau's poverty thresholds for the previous calendar year. "Poor" persons are defined as below the poverty threshold. "Near poor" persons have incomes of 100% to less than 200% of the poverty threshold. "Not poor" persons have incomes that are 200% of the poverty threshold or greater.

[9]Based on a question in the Family Core that asked whether the family's house or apartment is owned or being bought, rented, or occupied by some other arrangement (see Appendix II).

[10]Classification of health insurance coverage is based on a hierarchy of mutually exclusive categories. Persons with more than one type of health insurance were assigned to the first appropriate category in the hierarchy. The category ""Uninsured" includes persons who had no coverage as well as those who had only Indian Health Service coverage or had only a private plan that paid for one type of service such as accidents or dental care (see Appendix II).

[11]MSA is metropolitan statistical area. Large MSAs have a population size of 1 million or more; small MSAs have a population size of less than 1 million. "Not in MSA" consists of persons not living in a metropolitan statistical area.

SOURCE: CDC/NCHS, National Health Interview Survey, 2001–2007.

Table 23. Frequencies of children under age 18 with vision problems, by family structure and by selected characteristics: United States, 2001–2007

Selected characteristics	All children under age 18 with vision problems	Family structure[1]						
		Nuclear	Single parent	Unmarried biological or adoptive	Blended	Cohabiting	Extended	Other
	Number in thousands[2]							
Total[3]	1,706	634	378	20	166	81	360	67
Sex								
Male	897	352	196	*11	93	39	169	38
Female	810	282	182	*9	73	42	191	29
Age								
0–4 years	180	101	21	*3	*7	*8	31	*9
5–17 years	1,526	533	357	17	159	73	329	58
5–11 years	708	303	155	*11	78	33	105	24
12–17 years	818	230	202	*6	81	40	224	35
Hispanic origin and race[4]								
Hispanic or Latino	339	110	73	*5	25	18	91	16
Mexican or Mexican American	213	80	38	*1	22	*7	57	8
Not Hispanic or Latino	1,367	523	305	15	141	63	269	51
White, single race	973	449	152	*11	113	40	182	27
Black or African American, single race	291	34	137	*4	20	*18	57	22
Parent's education[5]								
Less than high school diploma	275	58	94	*2	14	28	75	*4
High school diploma or GED[6]	422	136	105	*7	50	27	90	*7
More than high school diploma	952	440	164	*11	100	26	190	*21
Family income[7]								
Less than $20,000	424	76	225	*3	*14	27	64	15
$20,000–$34,999	368	122	86	*8	44	*22	71	*15
$35,000–$54,999	320	123	40	*2	43	17	75	*20
$55,000–$74,999	212	94	*18	*5	26	*7	55	*6
$75,000 or more	383	219	*9	*2	39	*7	96	*11
Poverty status[8]								
Poor	438	86	198	*2	20	29	84	18
Near poor	444	142	92	*9	54	26	93	29
Not poor	824	405	88	*8	92	26	183	20
Home tenure status[9]								
Owned or being bought	1,039	483	115	*12	108	32	242	47
Rented	626	134	247	*8	55	48	115	18
Some other arrangement	38	*14	16	*–	*2	*1	*3	*2
Health insurance coverage[10]								
Private	917	434	126	*7	105	26	203	*16
Medicaid	545	110	208	*10	39	41	98	39
Other	38	*14	*6	*–	*5	*4	*8	*–
Uninsured	202	74	38	*3	*17	*10	49	*11
Place of residence[11]								
Large MSA	546	158	144	*4	50	31	131	28
Small MSA	825	362	163	9	76	21	168	24
Not in MSA	336	113	71	*7	39	29	62	*15
Region								
Northeast	302	145	62	*1	*11	*10	61	*13
Midwest	442	159	104	*6	47	24	86	*16
South	638	213	146	*10	72	26	142	29
West	324	117	67	*3	35	21	72	9

* Estimate has a relative standard error of greater than 30% and should be used with caution because it does not meet the standards of reliability or precision.
– Quantity zero.
[1]A nuclear family consists of one or more children living with two parents who are married to one another and are biological or adoptive parents to all children in the family. A single-parent family consists of one or more children living with a single adult (male or female, related or unrelated). An unmarried biological or adoptive family consists of one or more children living with two parents who are not married to one another and are biological or adoptive parents to all children in the family. A blended family consists of one or more children living with a biological or adoptive parent and an unrelated stepparent who are married to one another. A cohabiting family consists of one or more children living with a biological or adoptive parent and an unrelated adult who are cohabiting with one another. An extended family consists of one or more children living with at least one biological or adoptive parent and a related adult. An "other" family consists of one or more children living with related or unrelated adults who are not biological or adoptive parents.

[2]Data are based on household interviews of a sample of the civilian noninstitutionalized population. Having vision problems is based on a question that asked, "Does [child's name] have any trouble seeing [if he/she is 2 or more years of age] even when wearing glasses or contact lenses?" A knowledgeable adult provided information on behalf of child respondents. Unknowns with respect to vision problems and family structure are not included in the column labeled "All children under age 18 with vision problems" (see Appendix I).

[3]Includes other races not shown separately and children with unknown parent's education, family income, poverty status, or health insurance. Additionally, numbers within selected characteristics may not add to totals because of rounding.

[4]Persons of Hispanic or Latino origin may be of any race or combination of races. Similarly, the category "Not Hispanic or Latino" refers to all persons who are not of Hispanic or Latino origin, regardless of race. To be concise, the text uses shorter versions of the terms shown in the table. For example, the category "Not Hispanic or Latino black or African American, single race" in the tables is referred to as "non-Hispanic black" in the text.

[5]Refers to the education level of the parent with the higher level of education, regardless of that parent's age.

[6]GED is General Educational Development high school equivalency diploma.

[7]Information on family income and poverty status is obtained from the 2001–2007 National Health Interview Survey Imputed Family Income/Personal Earnings Files.

[8]Based on family income and family size using the U.S. Census Bureau's poverty thresholds for the previous calendar year. "Poor" persons are defined as below the poverty threshold. "Near poor" persons have incomes of 100% to less than 200% of the poverty threshold. "Not poor" persons have incomes that are 200% of the poverty threshold or greater.

[9]Based on a question in the Family Core that asked whether the family's house or apartment is owned or being bought, rented, or occupied by some other arrangement (see Appendix II).

[10]Classification of health insurance coverage is based on a hierarchy of mutually exclusive categories. Persons with more than one type of health insurance were assigned to the first appropriate category in the hierarchy. The category ""Uninsured" includes persons who had no coverage as well as those who had only Indian Health Service coverage or had only a private plan that paid for one type of service such as accidents or dental care (see Appendix II).

[11]MSA is metropolitan statistical area. Large MSAs have a population size of 1 million or more; small MSAs have a population size of less than 1 million. "Not in MSA" consists of persons not living in a metropolitan statistical area.

SOURCE: CDC/NCHS, National Health Interview Survey, 2001–2007.

Table 24. Percentages (with standard errors) of children under age 18 with vision problems, by family structure and by selected characteristics: United States, 2001–2007

Selected characteristics	All children under age 18 with vision problems	Family structure[1]						
		Nuclear	Single parent	Unmarried biological or adoptive	Blended	Cohabiting	Extended	Other
	Percent[2] (standard error)							
Total[3]	2.3 (0.07)	1.8 (0.09)	3.2 (0.19)	1.9 (0.43)	2.6 (0.25)	3.6 (0.49)	2.6 (0.16)	3.0 (0.43)
Sex								
Male	2.4 (0.10)	1.9 (0.14)	3.3 (0.27)	*1.9 (0.64)	2.9 (0.36)	3.3 (0.68)	2.4 (0.20)	3.3 (0.68)
Female	2.3 (0.10)	1.6 (0.12)	3.0 (0.26)	*1.9 (0.58)	2.4 (0.33)	3.9 (0.69)	2.9 (0.26)	2.6 (0.53)
Age								
0–4 years	0.9 (0.08)	0.9 (0.12)	0.9 (0.20)	*0.5 (0.19)	*0.5 (0.22)	*1.3 (0.51)	1.0 (0.22)	*1.7 (0.64)
5–17 years	2.9 (0.09)	2.2 (0.12)	3.8 (0.24)	4.1 (1.07)	3.2 (0.31)	4.4 (0.63)	3.1 (0.20)	3.4 (0.53)
5–11 years	2.5 (0.12)	2.1 (0.16)	3.1 (0.30)	*3.6 (1.10)	3.1 (0.42)	3.3 (0.72)	2.6 (0.28)	2.9 (0.73)
12–17 years	3.3 (0.14)	2.4 (0.19)	4.5 (0.35)	*5.6 (2.58)	3.4 (0.46)	6.0 (1.14)	3.4 (0.27)	3.8 (0.77)
Hispanic origin and race[4]								
Hispanic or Latino	2.5 (0.13)	2.0 (0.19)	3.5 (0.39)	*1.4 (0.74)	2.5 (0.49)	4.4 (1.25)	2.4 (0.24)	3.1 (0.77)
Mexican or Mexican American	2.3 (0.15)	2.0 (0.23)	3.3 (0.48)	*0.4 (0.29)	3.2 (0.69)	*2.8 (1.05)	2.1 (0.27)	2.2 (0.60)
Not Hispanic or Latino	2.3 (0.08)	1.8 (0.10)	3.1 (0.22)	2.1 (0.53)	2.6 (0.28)	3.4 (0.53)	2.7 (0.21)	2.9 (0.51)
White, single race	2.2 (0.10)	1.8 (0.12)	2.9 (0.29)	*2.4 (0.76)	2.7 (0.33)	3.0 (0.55)	2.8 (0.27)	3.0 (0.75)
Black or African American, single race	2.7 (0.19)	1.5 (0.31)	3.5 (0.35)	*2.1 (0.83)	2.3 (0.54)	*4.5 (1.37)	2.4 (0.34)	3.3 (0.82)
Parent's education[5]								
Less than high school diploma	2.9 (0.20)	2.1 (0.31)	4.0 (0.46)	*0.7 (0.54)	2.8 (0.80)	6.0 (1.57)	2.6 (0.34)	*2.5 (1.35)
High school diploma or GED[6]	2.6 (0.15)	2.3 (0.24)	3.1 (0.38)	*1.8 (0.65)	2.8 (0.49)	3.3 (0.70)	2.4 (0.27)	*3.0 (1.68)
More than high school diploma	2.1 (0.09)	1.7 (0.11)	2.9 (0.25)	*2.6 (0.83)	2.5 (0.31)	2.7 (0.58)	2.7 (0.24)	*4.6 (1.42)
Family income[7]								
Less than $20,000	3.3 (0.20)	2.6 (0.38)	3.8 (0.30)	*1.0 (0.69)	2.2 (0.65)	5.1 (1.23)	3.0 (0.49)	3.1 (0.81)
$20,000–$34,999	2.9 (0.19)	2.7 (0.34)	2.8 (0.30)	*2.7 (0.95)	3.9 (0.75)	4.2 (1.24)	2.9 (0.40)	*2.9 (0.91)
$35,000–$54,999	2.3 (0.15)	1.9 (0.20)	2.2 (0.45)	*0.7 (0.43)	2.7 (0.55)	3.2 (0.83)	2.7 (0.40)	*3.9 (1.22)
$55,000–$74,999	1.9 (0.20)	1.5 (0.22)	*2.9 (1.00)	*4.5 (2.30)	2.2 (0.53)	*2.3 (0.92)	2.6 (0.45)	*2.0 (0.86)
$75,000 or more	1.7 (0.11)	1.5 (0.13)	*1.6 (0.70)	*2.2 (1.52)	2.2 (0.42)	*2.0 (0.84)	2.2 (0.28)	*2.6 (1.08)
Poverty status[8]								
Poor	3.2 (0.21)	2.6 (0.39)	4.0 (0.34)	*0.9 (0.67)	2.4 (0.70)	5.0 (1.34)	2.9 (0.43)	2.9 (0.79)
Near poor	2.7 (0.16)	2.4 (0.27)	2.7 (0.30)	*2.5 (0.78)	3.3 (0.60)	3.9 (1.01)	2.6 (0.36)	4.2 (1.01)
Not poor	1.9 (0.08)	1.6 (0.10)	2.5 (0.30)	*2.0 (0.74)	2.4 (0.30)	2.6 (0.51)	2.5 (0.21)	2.1 (0.55)
Home tenure status[9]								
Owned or being bought	2.1 (0.08)	1.7 (0.10)	2.7 (0.28)	*3.0 (0.97)	2.5 (0.29)	3.5 (0.72)	2.5 (0.19)	3.1 (0.56)
Rented	2.8 (0.14)	2.1 (0.22)	3.4 (0.25)	*1.3 (0.40)	2.9 (0.47)	3.8 (0.71)	2.9 (0.33)	2.7 (0.71)
Some other arrangement	2.7 (0.49)	*2.4 (0.81)	4.6 (1.16)	*–	*1.8 (1.16)	*1.4 (1.38)	*1.3 (0.70)	*3.6 (2.51)
Health insurance coverage[10]								
Private	2.0 (0.09)	1.6 (0.10)	2.6 (0.26)	*1.8 (0.63)	2.6 (0.31)	3.0 (0.69)	2.7 (0.24)	*2.4 (0.74)
Medicaid	2.9 (0.15)	2.4 (0.29)	3.7 (0.31)	*1.8 (0.58)	2.7 (0.54)	4.1 (0.81)	2.3 (0.25)	3.4 (0.64)
Other	2.4 (0.48)	*1.8 (0.66)	*2.5 (0.96)	*–	*2.4 (1.35)	*7.0 (4.91)	*3.2 (1.28)	*–
Uninsured	2.9 (0.23)	2.6 (0.38)	3.4 (0.48)	*2.7 (1.98)	*2.8 (0.89)	*3.1 (1.06)	2.8 (0.46)	*3.2 (1.16)
Place of residence[11]								
Large MSA	2.6 (0.13)	1.9 (0.18)	3.1 (0.29)	*1.0 (0.63)	3.3 (0.49)	4.6 (0.91)	2.9 (0.30)	3.5 (0.77)
Small MSA	2.1 (0.09)	1.8 (0.13)	3.2 (0.28)	2.0 (0.59)	2.4 (0.33)	2.0 (0.57)	2.3 (0.20)	2.5 (0.63)
Not in MSA	2.5 (0.20)	1.8 (0.21)	3.3 (0.49)	*3.1 (1.29)	2.5 (0.56)	5.1 (1.23)	2.8 (0.49)	*2.9 (0.91)
Region								
Northeast	2.3 (0.17)	2.2 (0.26)	2.9 (0.37)	*0.6 (0.37)	*1.4 (0.43)	*2.8 (0.94)	2.3 (0.38)	*4.0 (1.51)
Midwest	2.6 (0.17)	1.8 (0.21)	3.7 (0.44)	*2.2 (0.86)	2.9 (0.59)	3.9 (0.94)	3.1 (0.41)	*3.6 (1.22)
South	2.4 (0.12)	1.7 (0.13)	3.0 (0.31)	*3.0 (1.06)	2.7 (0.37)	3.1 (0.77)	2.9 (0.29)	3.0 (0.61)
West	2.0 (0.14)	1.5 (0.17)	3.1 (0.42)	*1.1 (0.59)	2.8 (0.56)	4.6 (1.32)	2.0 (0.27)	1.8 (0.48)

* Estimate has a relative standard error of greater than 30% and should be used with caution because it does not meet the standards of reliability or precision.

– Quantity zero.

[1] A nuclear family consists of one or more children living with two parents who are married to one another and are biological or adoptive parents to all children in the family. A single-parent family consists of one or more children living with a single adult (male or female, related or unrelated). An unmarried biological or adoptive family consists of one or more children living with two parents who are not married to one another and are biological or adoptive parents to all children in the family. A blended family consists of one or more children living with a biological or adoptive parent and an unrelated stepparent who are married to one another. A cohabiting family consists of one or more children living with a biological or adoptive parent and an unrelated adult who are cohabiting with one

another. An extended family consists of one or more children living with at least one biological or adoptive parent and a related adult. An "other" family consists of one or more children living with related or unrelated adults who are not biological or adoptive parents.

[2]Data are based on household interviews of a sample of the civilian noninstitutionalized population. Having vision problems is based on a question that asked, "Does [child's name] have any trouble seeing [if he/she is 2 or more years of age] even when wearing glasses or contact lenses?" A knowledgeable adult provided information on behalf of child respondents. Unknowns with respect to vision problems and family structure are not included in the column labeled "All children under age 18 with vision problems" (see Appendix I).

[3]Includes other races not shown separately and children with unknown parent's education, family income, poverty status, or health insurance.

[4]Persons of Hispanic or Latino origin may be of any race or combination of races. Similarly, the category "Not Hispanic or Latino" refers to all persons who are not of Hispanic or Latino origin, regardless of race. To be concise, the text uses shorter versions of the terms shown in the table. For example, the category "Not Hispanic or Latino black or African American, single race" in the tables is referred to as "non-Hispanic black" in the text.

[5]Refers to the education level of the parent with the higher level of education, regardless of that parent's age.

[6]GED is General Educational Development high school equivalency diploma.

[7]Information on family income and poverty status is obtained from the 2001–2007 National Health Interview Survey Imputed Family Income/Personal Earnings Files.

[8]Based on family income and family size using the U.S. Census Bureau's poverty thresholds for the previous calendar year. "Poor" persons are defined as below the poverty threshold. "Near poor" persons have incomes of 100% to less than 200% of the poverty threshold. "Not poor" persons have incomes that are 200% of the poverty threshold or greater.

[9]Based on a question in the Family Core that asked whether the family's house or apartment is owned or being bought, rented, or occupied by some other arrangement (see Appendix II).

[10]Classification of health insurance coverage is based on a hierarchy of mutually exclusive categories. Persons with more than one type of health insurance were assigned to the first appropriate category in the hierarchy. The category ""Uninsured" includes persons who had no coverage as well as those who had only Indian Health Service coverage or had only a private plan that paid for one type of service such as accidents or dental care (see Appendix II).

[11]MSA is metropolitan statistical area. Large MSAs have a population size of 1 million or more; small MSAs have a population size of less than 1 million. "Not in MSA" consists of persons not living in a metropolitan statistical area.

SOURCE: CDC/NCHS, National Health Interview Survey, 2001–2007.

Table 25. Frequencies of children aged 4–17 with a basic action disability, by family structure and by selected characteristics: United States, 2001–2007

Selected characteristics	All children aged 4–17 with a basic action disability	Family structure[1]						
		Nuclear	Single parent	Unmarried biological or adoptive	Blended	Cohabiting	Extended	Other
	Number in thousands[2]							
Total[3]	9,705	3,259	2,243	85	1,213	424	2,012	470
Sex								
Male	6,041	2,050	1,375	58	773	261	1,252	273
Female	3,663	1,208	868	27	440	163	760	197
Age								
4–17 years	9,705	3,259	2,243	85	1,213	424	2,012	470
4–11 years	4,616	1,751	1,103	57	621	224	670	189
12–17 years	5,089	1,508	1,139	27	592	200	1,342	281
Hispanic origin and race[4]								
Hispanic or Latino	1,414	428	313	21	146	54	383	68
Mexican or Mexican American	893	302	160	12	101	27	244	46
Not Hispanic or Latino	8,291	2,831	1,929	63	1,067	369	1,629	402
White, single race	6,262	2,515	1,117	47	896	272	1,202	213
Black or African American, single race	1,528	165	674	13	126	69	318	162
Parent's education[5]								
Less than high school diploma	1,201	231	426	14	86	91	338	*15
High school diploma or GED[6]	2,421	653	633	34	361	142	562	37
More than high school diploma	5,607	2,368	1,058	37	754	182	1,083	125
Family income[7]								
Less than $20,000	2,151	280	1,176	19	141	81	344	111
$20,000–$34,999	1,817	416	563	23	229	119	364	102
$35,000–$54,999	1,898	642	307	20	321	102	407	99
$55,000–$74,999	1,345	557	116	13	224	50	318	67
$75,000 or more	2,494	1,365	80	*8	298	72	579	92
Poverty status[9]								
Poor	2,150	311	998	18	171	86	439	127
Near poor	2,363	567	641	32	326	140	499	158
Not poor	5,192	2,380	604	35	716	198	1,073	186
Home tenure status[9]								
Owned or being bought	6,284	2,697	815	42	805	185	1,412	329
Rented	3,201	505	1,360	42	373	232	558	129
Some other arrangement	200	50	66	*1	33	*7	36	*8
Health insurance coverage[10]								
Private	5,403	2,427	824	27	770	168	1,071	117
Medicaid	3,165	510	1,159	45	306	185	671	290
Other	217	88	36	*1	35	*13	37	*8
Uninsured	897	231	221	13	101	56	221	54
Place of residence[11]								
Large MSA	2,717	708	825	21	277	108	613	165
Small MSA	5,063	1,962	991	43	602	210	1,059	196
Not in MSA	1,924	588	426	21	333	106	340	108
Region								
Northeast	1,710	626	378	18	130	75	412	70
Midwest	2,444	826	577	23	314	98	457	148
South	3,744	1,190	912	23	559	167	713	180
West	1,807	616	376	20	210	83	430	72

* Estimate has a relative standard error of greater than 30% and should be used with caution because it does not meet the standards of reliability or precision.

– Quantity zero.

[1]A nuclear family consists of one or more children living with two parents who are married to one another and are biological or adoptive parents to all children in the family. A single-parent family consists of one or more children living with a single adult (male or female, related or unrelated). An unmarried biological or adoptive family consists of one or more children living with two parents who are not married to one another and are biological or adoptive parents to all children in the family. A blended family consists of one or more children living with a biological or adoptive parent and an unrelated stepparent who are married to one another. A cohabiting family consists of one or more children living with a biological or adoptive parent and an unrelated adult who are cohabiting with one another. An extended family consists of one or more children living with at least one biological or adoptive parent and a related adult. An "other" family consists of one or more children living with related or unrelated adults who are not biological or adoptive parents.

[2]Data are based on household interviews of a sample of the civilian noninstitutionalized population. Children were considered to have a basic action disability if they had any one of the following

problems: a lot of trouble hearing or deafness; trouble seeing; limitations in their ability to crawl, walk, run, or play; difficulty remembering; mental retardation; Down syndrome; autism; a learning disability; attention deficit hyperactivity disorder; or definite or severe emotional or behavioral difficulties. A knowledgeable adult provided information on behalf of child respondents. Unknowns with respect to this measure and family structure are not included in the column labeled "All children aged 4–17 with a basic action disability" (see Appendix I).

[3]Includes other races not shown separately and children with unknown parent's education, family income, poverty status, or health insurance. Additionally, numbers within selected characteristics may not add to totals because of rounding.

[4]Persons of Hispanic or Latino origin may be of any race or combination of races. Similarly, the category "Not Hispanic or Latino" refers to all persons who are not of Hispanic or Latino origin, regardless of race. To be concise, the text uses shorter versions of the terms shown in the table. For example, the category "Not Hispanic or Latino black or African American, single race" in the tables is referred to as "non-Hispanic black" in the text.

[5]Refers to the education level of the parent with the higher level of education, regardless of that parent's age.

[6]GED is General Educational Development high school equivalency diploma.

[7]Information on family income and poverty status is obtained from the 2001–2007 National Health Interview Survey Imputed Family Income/Personal Earnings Files.

[8]Based on family income and family size using the U.S. Census Bureau's poverty thresholds for the previous calendar year. "Poor" persons are defined as below the poverty threshold. "Near poor" persons have incomes of 100% to less than 200% of the poverty threshold. "Not poor" persons have incomes that are 200% of the poverty threshold or greater.

[9]Based on a question in the Family Core that asked whether the family's house or apartment is owned or being bought, rented, or occupied by some other arrangement (see Appendix II).

[10]Classification of health insurance coverage is based on a hierarchy of mutually exclusive categories. Persons with more than one type of health insurance were assigned to the first appropriate category in the hierarchy. The category ""Uninsured" includes persons who had no coverage as well as those who had only Indian Health Service coverage or had only a private plan that paid for one type of service such as accidents or dental care (see Appendix II).

[11]MSA is metropolitan statistical area. Large MSAs have a population size of 1 million or more; small MSAs have a population size of less than 1 million. "Not in MSA" consists of persons not living in a metropolitan statistical area.

SOURCE: CDC/NCHS, National Health Interview Survey, 2001–2007.

Table 26. Percentages (with standard errors) of children aged 4–17 with a basic action disability, by family structure and by selected characteristics: United States, 2001–2007

Selected characteristics	All children aged 4–17 with a basic action disability	Family structure[1]						
		Nuclear	Single parent	Unmarried biological or adoptive	Blended	Cohabiting	Extended	Other
	Percent[2] (standard error)							
Total[3]	17.2 (0.20)	12.5 (0.26)	22.7 (0.52)	17.7 (1.88)	23.4 (0.78)	23.9 (1.27)	18.1 (0.45)	25.8 (1.43)
Sex								
Male	21.0 (0.30)	15.3 (0.40)	28.3 (0.77)	22.0 (2.72)	29.3 (1.16)	28.2 (1.87)	21.7 (0.67)	29.4 (2.03)
Female	13.3 (0.26)	9.6 (0.33)	17.3 (0.66)	12.6 (2.42)	17.3 (1.01)	19.2 (1.65)	14.2 (0.58)	22.0 (2.02)
Age								
4–17 years	17.2 (0.20)	12.5 (0.26)	22.7 (0.52)	17.7 (1.88)	23.4 (0.78)	23.9 (1.27)	18.1 (0.45)	25.8 (1.43)
4–11 years	14.5 (0.26)	10.6 (0.30)	20.3 (0.68)	15.7 (1.95)	22.1 (1.16)	20.0 (1.46)	14.5 (0.63)	20.6 (1.76)
12–17 years	20.8 (0.32)	15.9 (0.48)	25.6 (0.76)	24.3 (4.68)	25.0 (1.09)	30.5 (2.35)	20.6 (0.61)	31.0 (2.24)
Hispanic origin and race[4]								
Hispanic or Latino	13.8 (0.37)	10.5 (0.55)	18.7 (1.00)	14.0 (2.47)	18.8 (1.56)	17.3 (2.25)	13.4 (0.63)	17.8 (2.21)
Mexican or Mexican American	12.8 (0.43)	10.3 (0.64)	17.5 (1.32)	11.6 (2.46)	19.4 (1.90)	13.2 (2.21)	12.3 (0.73)	16.4 (2.58)
Not Hispanic or Latino	18.0 (0.24)	12.9 (0.29)	23.5 (0.59)	19.5 (2.52)	24.2 (0.88)	25.3 (1.46)	19.7 (0.56)	27.9 (1.69)
White, single race	18.4 (0.28)	13.6 (0.33)	24.7 (0.79)	22.9 (3.42)	25.7 (1.02)	25.6 (1.80)	21.6 (0.72)	28.4 (2.29)
Black or African American, single race	18.6 (0.55)	10.3 (0.88)	21.5 (0.95)	16.7 (4.27)	18.1 (1.80)	23.5 (2.92)	17.2 (0.99)	28.9 (2.70)
Parent's education[5]								
Less than high school diploma	17.3 (0.54)	11.3 (0.85)	23.9 (1.20)	12.8 (3.24)	21.5 (2.64)	25.8 (2.74)	15.9 (0.92)	*11.5 (3.64)
High school diploma or GED[6]	19.2 (0.44)	14.4 (0.63)	22.7 (0.98)	18.4 (3.22)	25.4 (1.57)	22.4 (2.01)	19.4 (0.85)	22.9 (5.17)
More than high school diploma	16.1 (0.26)	12.3 (0.31)	21.9 (0.72)	20.0 (3.18)	22.7 (0.98)	23.5 (1.99)	18.3 (0.63)	33.7 (3.99)
Family income[7]								
Less than $20,000	23.0 (0.54)	14.3 (0.96)	26.1 (0.81)	16.6 (3.78)	29.4 (2.75)	22.7 (2.68)	21.7 (1.21)	30.3 (3.15)
$20,000–$34,999	18.9 (0.53)	13.0 (0.80)	21.1 (0.97)	17.8 (3.48)	25.4 (2.03)	28.9 (3.00)	19.3 (1.17)	24.3 (2.79)
$35,000–$54,999	17.6 (0.48)	13.6 (0.65)	18.8 (1.19)	16.1 (3.83)	25.2 (1.69)	24.0 (2.70)	18.3 (1.00)	23.7 (3.04)
$55,000–$74,999	15.8 (0.52)	12.1 (0.61)	20.0 (2.20)	26.2 (6.74)	22.1 (1.82)	19.6 (3.26)	17.8 (1.22)	25.5 (4.81)
$75,000 or more	13.9 (0.37)	11.8 (0.41)	16.3 (2.07)	*15.9 (5.05)	19.7 (1.48)	22.3 (3.02)	15.9 (0.80)	25.6 (3.42)
Poverty status[8]								
Poor	21.9 (0.54)	13.6 (0.93)	26.1 (0.92)	15.0 (3.78)	28.2 (2.57)	21.6 (2.76)	20.9 (1.10)	27.1 (3.07)
Near poor	19.1 (0.47)	13.5 (0.75)	22.4 (1.02)	18.6 (3.41)	25.5 (1.73)	28.1 (2.78)	18.0 (0.95)	27.9 (2.94)
Not poor	15.2 (0.24)	12.2 (0.30)	18.9 (0.77)	18.6 (2.95)	21.7 (0.94)	22.6 (1.77)	17.2 (0.59)	23.5 (1.97)
Home tenure status[9]								
Owned or being bought	16.0 (0.24)	12.5 (0.29)	21.1 (0.79)	19.0 (2.92)	22.6 (0.91)	23.8 (1.83)	17.6 (0.54)	26.3 (1.73)
Rented	20.2 (0.41)	12.5 (0.60)	23.8 (0.71)	17.1 (2.56)	24.8 (1.54)	24.6 (1.82)	19.4 (0.88)	25.3 (2.72)
Some other arrangement	19.9 (1.51)	13.1 (2.01)	23.7 (2.85)	*7.2 (7.01)	35.5 (6.95)	*20.2 (9.01)	21.4 (3.45)	*18.4 (7.11)
Health insurance coverage[10]								
Private	15.1 (0.24)	12.1 (0.29)	18.9 (0.70)	15.6 (2.72)	22.5 (0.97)	22.7 (1.97)	16.5 (0.55)	19.9 (2.59)
Medicaid	23.9 (0.47)	16.8 (0.89)	26.7 (0.87)	19.3 (2.93)	28.1 (1.90)	25.5 (2.05)	22.8 (0.99)	32.3 (2.16)
Other	18.2 (1.31)	16.3 (2.09)	17.8 (3.19)	*9.2 (9.24)	21.0 (3.80)	*28.5 (8.69)	19.2 (3.12)	*20.4 (9.50)
Uninsured	15.6 (0.57)	10.1 (0.79)	23.2 (1.58)	18.8 (4.91)	20.2 (2.43)	22.0 (2.96)	15.7 (1.02)	18.8 (2.75)
Place of residence[11]								
Large MSA	17.3 (0.38)	11.9 (0.52)	22.2 (0.84)	12.4 (2.41)	22.1 (1.46)	21.1 (2.03)	17.5 (0.78)	26.1 (2.55)
Small MSA	16.9 (0.29)	12.9 (0.35)	22.5 (0.78)	19.6 (2.91)	23.2 (1.13)	25.5 (2.06)	18.1 (0.61)	24.7 (2.01)
Not in MSA	18.1 (0.49)	12.1 (0.61)	24.2 (1.33)	22.7 (5.30)	25.1 (1.50)	24.3 (2.26)	19.2 (1.16)	27.5 (3.20)
Region								
Northeast	16.7 (0.50)	12.7 (0.60)	21.1 (1.25)	21.3 (4.91)	19.5 (1.92)	27.6 (3.41)	18.7 (1.08)	26.9 (3.66)
Midwest	18.5 (0.45)	12.9 (0.54)	24.7 (1.19)	18.7 (4.20)	24.3 (1.62)	20.9 (2.44)	20.3 (1.08)	40.7 (3.68)
South	18.3 (0.33)	13.4 (0.45)	23.2 (0.80)	18.5 (3.47)	25.6 (1.20)	25.4 (2.15)	18.8 (0.76)	22.4 (1.97)
West	14.5 (0.40)	10.7 (0.51)	20.6 (1.07)	14.0 (2.80)	20.1 (1.79)	22.3 (2.43)	14.9 (0.77)	18.2 (2.41)

* Estimate has a relative standard error of greater than 30% and should be used with caution because it does not meet the standards of reliability or precision.

– Quantity zero.

[1]A nuclear family consists of one or more children living with two parents who are married to one another and are biological or adoptive parents to all children in the family. A single-parent family consists of one or more children living with a single adult (male or female, related or unrelated). An unmarried biological or adoptive family consists of one or more children living with two parents who are not married to one another and are biological or adoptive parents to all children in the family. A blended family consists of one or more children living with a biological or adoptive parent and an unrelated stepparent who are married to one another. A cohabiting family consists of one or more children living with a biological or adoptive parent and an unrelated adult who are cohabiting with one another. An extended family consists of one or more children living with at least one biological or adoptive parent and a related adult. An "other" family consists of one or more children living with related or unrelated adults who are not biological or adoptive parents.

[2]Data are based on household interviews of a sample of the civilian noninstitutionalized population. Children were considered to have a basic action disability if they had any one of the following

problems: a lot of trouble hearing or deafness; trouble seeing; limitations in their ability to crawl, walk, run, or play; difficulty remembering; mental retardation; Down syndrome; autism; a learning disability; attention deficit hyperactivity disorder; or definite or severe emotional or behavioral difficulties. A knowledgeable adult provided information on behalf of child respondents. Unknowns with respect to this measure and family structure are not included in the column labeled "All children aged 4–17 with a basic action disability" (see Appendix I).

[3]Includes other races not shown separately and children with unknown parent's education, family income, poverty status, or health insurance.

[4]Persons of Hispanic or Latino origin may be of any race or combination of races. Similarly, the category "Not Hispanic or Latino" refers to all persons who are not of Hispanic or Latino origin, regardless of race. To be concise, the text uses shorter versions of the terms shown in the table. For example, the category "Not Hispanic or Latino black or African American, single race" in the tables is referred to as "non-Hispanic black" in the text.

[5]Refers to the education level of the parent with the higher level of education, regardless of that parent's age.

[6]GED is General Educational Development high school equivalency diploma.

[7]Information on family income and poverty status is obtained from the 2001–2007 National Health Interview Survey Imputed Family Income/Personal Earnings Files.

[8]Based on family income and family size using the U.S. Census Bureau's poverty thresholds for the previous calendar year. "Poor" persons are defined as below the poverty threshold. "Near poor" persons have incomes of 100% to less than 200% of the poverty threshold. "Not poor" persons have incomes that are 200% of the poverty threshold or greater.

[9]Based on a question in the Family Core that asked whether the family's house or apartment is owned or being bought, rented, or occupied by some other arrangement (see Appendix II).

[10]Classification of health insurance coverage is based on a hierarchy of mutually exclusive categories. Persons with more than one type of health insurance were assigned to the first appropriate category in the hierarchy. The category ""Uninsured" includes persons who had no coverage as well as those who had only Indian Health Service coverage or had only a private plan that paid for one type of service such as accidents or dental care (see Appendix II).

[11]MSA is metropolitan statistical area. Large MSAs have a population size of 1 million or more; small MSAs have a population size of less than 1 million. "Not in MSA" consists of persons not living in a metropolitan statistical area.

SOURCE: CDC/NCHS, National Health Interview Survey, 2001–2007.

Table 27. Frequencies of children aged 3–17 who have ever been told they have a learning disability or ADHD, by family structure and by selected characteristics: United States, 2001–2007

Selected characteristics	All children aged 3–17 who have ever been told they have a learning disability or ADHD	Family structure[1]						
		Nuclear	Single parent	Unmarried biological or adoptive	Blended	Cohabiting	Extended	Other
	Number in thousands[2]							
Total[3]	6,922	2,315	1,571	48	883	302	1,431	371
Sex								
Male	4,654	1,561	1,062	34	602	199	968	229
Female	2,269	754	509	15	282	103	464	142
Age								
3–4 years	207	73	49	*2	*27	*9	30	*17
5–17 years	6,715	2,242	1,522	46	856	293	1,401	354
5–11 years	3,092	1,149	744	28	434	147	451	138
12–17 years	3,624	1,093	778	19	422	146	950	216
Hispanic origin and race[4]								
Hispanic or Latino	941	297	204	14	97	31	251	47
Mexican or Mexican American	584	207	98	7	67	19	155	31
Not Hispanic or Latino	5,981	2,018	1,367	34	786	271	1,181	324
White, single race	4,604	1,823	826	24	662	209	879	180
Black or African American, single race	1,040	103	449	*7	89	45	228	119
Parent's education[5]								
Less than high school diploma	819	154	280	*5	66	68	237	*9
High school diploma or GED[6]	1,736	475	463	24	246	95	401	32
More than high school diploma	4,010	1,679	739	19	562	133	775	103
Family income[7]								
Less than $20,000	1,500	194	811	*9	107	49	248	83
$20,000–$34,999	1,263	282	389	11	172	84	251	74
$35,000–$54,999	1,335	445	229	16	219	73	281	74
$55,000–$74,999	979	396	83	*7	164	37	233	58
$75,000 or more	1,845	999	59	*5	221	59	420	82
Poverty status[8]								
Poor	1,498	219	681	*9	131	51	314	95
Near poor	1,640	381	451	17	237	95	345	113
Not poor	3,784	1,715	440	22	516	156	772	163
Home tenure status[9]								
Owned or being bought	4,535	1,927	582	22	592	134	1,010	270
Rented	2,235	349	945	26	272	163	391	90
Some other arrangement	136	33	43	*1	19	*6	27	*7
Health insurance coverage[10]								
Private	3,845	1,724	591	15	562	123	740	89
Medicaid	2,334	383	818	23	228	132	511	239
Other	149	66	18	*1	24	*8	26	*7
Uninsured	580	139	142	*10	68	38	147	36
Place of residence[11]								
Large MSA	1,827	485	555	13	173	67	412	123
Small MSA	3,698	1,393	722	25	465	165	769	159
Not in MSA	1,397	437	294	*11	245	71	251	89
Region								
Northeast	1,260	447	277	17	98	62	304	56
Midwest	1,744	579	388	13	239	66	334	125
South	2,699	881	658	*8	400	122	503	127
West	1,219	407	249	10	146	53	290	63

* Estimate has a relative standard error of greater than 30% and should be used with caution because it does not meet the standards of reliability or precision.

– Quantity zero.

[1]A nuclear family consists of one or more children living with two parents who are married to one another and are biological or adoptive parents to all children in the family. A single-parent family consists of one or more children living with a single adult (male or female, related or unrelated). An unmarried biological or adoptive family consists of one or more children living with two parents who are not married to one another and are biological or adoptive parents to all children in the family. A blended family consists of one or more children living with a biological or adoptive parent and an

unrelated stepparent who are married to one another. A cohabiting family consists of one or more children living with a biological or adoptive parent and an unrelated adult who are cohabiting with one another. An extended family consists of one or more children living with at least one biological or adoptive parent and a related adult. An "other" family consists of one or more children living with related or unrelated adults who are not biological or adoptive parents.

[2]Data are based on household interviews of a sample of the civilian noninstitutionalized population. Prevalence of learning disability or ADHD is based on separate questions, "Has a representative from a school or a health professional ever told you that [child's name] had a learning disability?" and "Has a doctor or health professional ever told you that [child's name] had Attention Deficit Hyperactivity Disorder (ADHD) or Attention Deficit Disorder (ADD)?" A knowledgeable adult provided information on behalf of child respondents. Unknowns with respect to learning disability or ADHD and family structure are not included in the column labeled "All children aged 3–17 who have ever been told they have a learning disability or ADHD" (see Appendix I).

[3]Includes other races not shown separately and children with unknown parent's education, family income, poverty status, or health insurance. Additionally, numbers within selected characteristics may not add to totals because of rounding.

[4]Persons of Hispanic or Latino origin may be of any race or combination of races. Similarly, the category "Not Hispanic or Latino" refers to all persons who are not of Hispanic or Latino origin, regardless of race. To be concise, the text uses shorter versions of the terms shown in the table. For example, the category "Not Hispanic or Latino black or African American, single race" in the tables is referred to as "non-Hispanic black" in the text.

[5]Refers to the education level of the parent with the higher level of education, regardless of that parent's age.

[6]GED is General Educational Development high school equivalency diploma.

[7]Information on family income and poverty status is obtained from the 2001–2007 National Health Interview Survey Imputed Family Income/Personal Earnings Files.

[8]Based on family income and family size using the U.S. Census Bureau's poverty thresholds for the previous calendar year. "Poor" persons are defined as below the poverty threshold. "Near poor" persons have incomes of 100% to less than 200% of the poverty threshold. "Not poor" persons have incomes that are 200% of the poverty threshold or greater.

[9]Based on a question in the Family Core that asked whether the family's house or apartment is owned or being bought, rented, or occupied by some other arrangement (see Appendix II).

[10]Classification of health insurance coverage is based on a hierarchy of mutually exclusive categories. Persons with more than one type of health insurance were assigned to the first appropriate category in the hierarchy. The category ""Uninsured" includes persons who had no coverage as well as those who had only Indian Health Service coverage or had only a private plan that paid for one type of service such as accidents or dental care (see Appendix II).

[11]MSA is metropolitan statistical area. Large MSAs have a population size of 1 million or more; small MSAs have a population size of less than 1 million. "Not in MSA" consists of persons not living in a metropolitan statistical area.

SOURCE: CDC/NCHS, National Health Interview Survey, 2001–2007.

Table 28. Percentages (with standard errors) of children aged 3–17 who have ever been told they have a learning disability or ADHD, by family structure and by selected characteristics: United States, 2001–2007

Selected characteristics	All children aged 3–17 who have ever been told they have a learning disability or ADHD	Family structure[1]						
		Nuclear	Single parent	Unmarried biological or adoptive	Blended	Cohabiting	Extended	Other
	Percent[2] (standard error)							
Total[3]	11.4 (0.17)	8.1 (0.20)	14.9 (0.43)	8.4 (1.22)	16.1 (0.71)	15.6 (1.05)	12.1 (0.37)	19.0 (1.28)
Sex								
Male	14.9 (0.26)	10.6 (0.32)	20.4 (0.66)	10.8 (1.80)	21.5 (1.10)	19.9 (1.60)	15.7 (0.58)	22.7 (1.85)
Female	7.6 (0.20)	5.4 (0.25)	9.5 (0.50)	5.5 (1.54)	10.5 (0.79)	11.0 (1.32)	8.1 (0.46)	15.0 (1.75)
Age								
3–4 years	2.6 (0.24)	1.6 (0.23)	4.3 (0.83)	*1.1 (0.97)	*4.9 (1.65)	*3.2 (1.63)	2.6 (0.49)	*7.7 (2.86)
5–17 years	12.7 (0.19)	9.3 (0.24)	16.2 (0.47)	11.5 (1.68)	17.4 (0.74)	17.8 (1.19)	13.1 (0.41)	20.4 (1.38)
5–11 years	11.0 (0.24)	7.9 (0.29)	15.2 (0.64)	9.4 (1.71)	17.0 (1.08)	15.0 (1.40)	11.0 (0.61)	16.8 (1.74)
12–17 years	14.6 (0.28)	11.4 (0.42)	17.3 (0.65)	16.8 (4.00)	17.7 (1.00)	22.0 (2.18)	14.4 (0.53)	23.6 (2.12)
Hispanic origin and race[4]								
Hispanic or Latino	8.4 (0.29)	6.6 (0.43)	11.3 (0.78)	7.9 (1.83)	11.7 (1.33)	8.9 (1.41)	8.1 (0.49)	11.4 (1.75)
Mexican or Mexican American	7.7 (0.35)	6.3 (0.50)	9.9 (1.04)	6.1 (1.70)	12.0 (1.74)	8.4 (1.70)	7.2 (0.56)	10.3 (2.06)
Not Hispanic or Latino	12.0 (0.20)	8.4 (0.23)	15.6 (0.48)	8.6 (1.57)	16.9 (0.80)	17.1 (1.24)	13.5 (0.46)	21.0 (1.51)
White, single race	12.5 (0.23)	9.0 (0.26)	17.4 (0.68)	9.4 (2.13)	18.0 (0.94)	18.2 (1.57)	15.1 (0.61)	22.3 (2.06)
Black or African American, single race	11.7 (0.42)	5.8 (0.60)	13.2 (0.76)	*7.7 (2.70)	12.1 (1.47)	13.7 (2.37)	11.4 (0.82)	20.2 (2.34)
Parent's education[5]								
Less than high school diploma	10.8 (0.44)	6.9 (0.65)	14.2 (0.97)	*4.0 (1.33)	15.2 (2.32)	17.1 (2.13)	10.4 (0.79)	*7.0 (3.10)
High school diploma or GED[6]	12.8 (0.37)	9.7 (0.53)	15.7 (0.79)	10.8 (2.30)	16.1 (1.33)	13.7 (1.67)	12.8 (0.71)	18.7 (4.74)
More than high school diploma	10.7 (0.21)	7.9 (0.23)	14.5 (0.60)	8.5 (1.99)	16.2 (0.87)	16.0 (1.69)	12.4 (0.51)	25.3 (3.72)
Family income[7]								
Less than $20,000	14.5 (0.43)	8.8 (0.73)	16.5 (0.68)	*6.6 (2.30)	20.4 (2.34)	11.9 (2.02)	14.3 (0.97)	21.3 (2.73)
$20,000–$34,999	12.1 (0.43)	7.9 (0.62)	13.9 (0.79)	7.2 (2.04)	17.8 (1.86)	18.7 (2.50)	12.3 (1.00)	16.3 (2.46)
$35,000–$54,999	11.4 (0.39)	8.5 (0.50)	13.5 (1.04)	10.2 (2.86)	16.2 (1.36)	15.7 (2.17)	11.8 (0.85)	16.6 (2.62)
$55,000–$74,999	10.7 (0.43)	7.9 (0.48)	13.6 (1.84)	*11.0 (4.34)	15.6 (1.65)	13.8 (2.83)	12.5 (1.06)	21.2 (4.68)
$75,000 or more	9.5 (0.29)	7.9 (0.33)	11.3 (1.75)	*8.3 (3.48)	13.9 (1.32)	17.3 (2.77)	10.9 (0.64)	21.0 (3.16)
Poverty status[8]								
Poor	13.9 (0.44)	8.5 (0.73)	16.3 (0.78)	*6.2 (2.32)	19.9 (2.22)	11.3 (2.05)	13.7 (0.92)	18.8 (2.64)
Near poor	12.2 (0.39)	8.1 (0.59)	14.8 (0.82)	8.4 (2.24)	17.4 (1.46)	17.3 (2.25)	11.6 (0.83)	19.0 (2.74)
Not poor	10.3 (0.20)	8.0 (0.24)	13.2 (0.65)	9.6 (2.02)	14.9 (0.83)	16.7 (1.56)	11.7 (0.48)	19.1 (1.82)
Home tenure status[9]								
Owned or being bought	10.8 (0.20)	8.2 (0.23)	14.5 (0.67)	8.6 (1.87)	15.8 (0.80)	16.0 (1.54)	11.9 (0.45)	20.0 (1.58)
Rented	12.8 (0.32)	7.6 (0.45)	15.3 (0.57)	8.3 (1.67)	16.9 (1.37)	15.5 (1.49)	12.4 (0.68)	16.5 (2.31)
Some other arrangement	12.3 (1.10)	7.7 (1.52)	14.4 (2.29)	*5.0 (4.99)	17.3 (4.24)	*16.6 (8.28)	15.2 (2.83)	*16.2 (6.60)
Health insurance coverage[10]								
Private	9.9 (0.19)	7.8 (0.23)	13.0 (0.59)	7.5 (1.70)	15.6 (0.84)	15.6 (1.72)	10.8 (0.44)	14.1 (2.36)
Medicaid	15.9 (0.40)	11.1 (0.72)	17.3 (0.71)	7.9 (1.80)	19.5 (1.67)	16.4 (1.69)	15.9 (0.85)	24.6 (1.96)
Other	11.6 (1.11)	11.1 (1.85)	8.5 (1.98)	*9.2 (9.24)	13.9 (2.92)	*15.8 (6.29)	12.6 (2.49)	*15.4 (8.48)
Uninsured	9.5 (0.46)	5.7 (0.58)	14.1 (1.31)	*12.2 (3.90)	12.9 (1.96)	13.2 (2.21)	9.8 (0.86)	12.2 (2.27)
Place of residence[11]								
Large MSA	10.7 (0.30)	7.4 (0.40)	13.9 (0.67)	6.1 (1.62)	13.1 (1.21)	12.0 (1.57)	10.9 (0.61)	18.3 (2.29)
Small MSA	11.4 (0.23)	8.3 (0.28)	15.4 (0.66)	9.5 (1.88)	16.8 (1.02)	18.5 (1.82)	12.3 (0.51)	18.8 (1.74)
Not in MSA	12.2 (0.43)	8.3 (0.49)	15.6 (1.05)	*10.0 (3.43)	17.6 (1.41)	14.4 (1.69)	13.5 (1.07)	20.5 (3.02)
Region								
Northeast	11.4 (0.38)	8.2 (0.47)	14.5 (1.00)	16.3 (4.17)	13.7 (1.70)	20.4 (2.85)	13.2 (0.88)	19.4 (2.85)
Midwest	12.2 (0.36)	8.2 (0.40)	15.6 (0.97)	8.4 (2.31)	17.3 (1.39)	12.9 (2.00)	14.0 (0.95)	32.8 (3.65)
South	12.2 (0.29)	9.0 (0.37)	15.6 (0.67)	*5.3 (1.89)	17.4 (1.14)	16.8 (1.81)	12.4 (0.60)	14.7 (1.61)
West	9.1 (0.34)	6.4 (0.37)	12.8 (0.84)	6.3 (1.63)	13.3 (1.65)	13.2 (1.89)	9.4 (0.66)	14.9 (2.33)

* Estimate has a relative standard error of greater than 30% and should be used with caution because it does not meet the standards of reliability or precision.

– Quantity zero.

[1]A nuclear family consists of one or more children living with two parents who are married to one another and are biological or adoptive parents to all children in the family. A single-parent family consists of one or more children living with a single adult (male or female, related or unrelated). An unmarried biological or adoptive family consists of one or more children living with two parents who are not married to one another and are biological or adoptive parents to all children in the family. A blended family consists of one or more children living with a biological or adoptive parent and an unrelated stepparent who are married to one another. A cohabiting family consists of one or more children living with a biological or adoptive parent and an unrelated adult who are cohabiting with one

another. An extended family consists of one or more children living with at least one biological or adoptive parent and a related adult. An "other" family consists of one or more children living with related or unrelated adults who are not biological or adoptive parents.

[2]Data are based on household interviews of a sample of the civilian noninstitutionalized population. Prevalence of learning disability or ADHD is based on separate questions, "Has a representative from a school or a health professional ever told you that [child's name] had a learning disability?" and "Has a doctor or health professional ever told you that [child's name] had Attention Deficit Hyperactivity Disorder (ADHD) or Attention Deficit Disorder (ADD)?" A knowledgeable adult provided information on behalf of child respondents. Unknowns with respect to learning disability or ADHD and family structure are not included in the column labeled "All children aged 3–17 who have ever been told they have a learning disability or ADHD" (see Appendix I).

[3]Includes other races not shown separately and children with unknown parent's education, family income, poverty status, or health insurance.

[4]Persons of Hispanic or Latino origin may be of any race or combination of races. Similarly, the category "Not Hispanic or Latino" refers to all persons who are not of Hispanic or Latino origin, regardless of race. To be concise, the text uses shorter versions of the terms shown in the table. For example, the category "Not Hispanic or Latino black or African American, single race" in the tables is referred to as "non-Hispanic black" in the text.

[5]Refers to the education level of the parent with the higher level of education, regardless of that parent's age.

[6]GED is General Educational Development high school equivalency diploma.

[7]Information on family income and poverty status is obtained from the 2001–2007 National Health Interview Survey Imputed Family Income/Personal Earnings Files.

[8]Based on family income and family size using the U.S. Census Bureau's poverty thresholds for the previous calendar year. "Poor" persons are defined as below the poverty threshold. "Near poor" persons have incomes of 100% to less than 200% of the poverty threshold. "Not poor" persons have incomes that are 200% of the poverty threshold or greater.

[9]Based on a question in the Family Core that asked whether the family's house or apartment is owned or being bought, rented, or occupied by some other arrangement (see Appendix II).

[10]Classification of health insurance coverage is based on a hierarchy of mutually exclusive categories. Persons with more than one type of health insurance were assigned to the first appropriate category in the hierarchy. The category ""Uninsured" includes persons who had no coverage as well as those who had only Indian Health Service coverage or had only a private plan that paid for one type of service such as accidents or dental care (see Appendix II).

[11]MSA is metropolitan statistical area. Large MSAs have a population size of 1 million or more; small MSAs have a population size of less than 1 million. "Not in MSA" consists of persons not living in a metropolitan statistical area.

SOURCE: CDC/NCHS, National Health Interview Survey, 2001–2007.

Table 29. Frequencies of children aged 5–17 who missed 6 or more school days in the past 12 months due to illness or injury, by family structure and by selected characteristics: United States, 2001–2007

Selected characteristics	All children aged 5–17 who missed 6 or more school days in the past 12 months due to illness or injury	Family structure[1]						
		Nuclear	Single parent	Unmarried biological or adoptive	Blended	Cohabiting	Extended	Other
	Number in thousands[2]							
Total[3]	8,144	3,127	1,797	68	777	303	1,810	261
Sex								
Male	4,067	1,566	870	46	402	146	899	137
Female	4,077	1,561	928	23	375	157	911	123
Age								
5–17 years	8,144	3,127	1,797	68	777	303	1,810	261
5–11 years	4,006	1,807	812	45	416	159	657	109
12–17 years	4,139	1,319	985	24	361	145	1,153	151
Hispanic origin and race[4]								
Hispanic or Latino	1,247	383	305	15	97	48	353	48
Mexican or Mexican American	812	276	159	8	61	31	243	34
Not Hispanic or Latino	6,897	2,744	1,493	54	681	255	1,458	213
White, single race	5,562	2,488	997	35	587	207	1,120	129
Black or African American, single race	938	111	409	*8	72	27	245	66
Parent's education[5]								
Less than high school diploma	1,094	243	386	10	80	64	290	*21
High school diploma or GED[6]	2,042	656	466	25	221	110	543	21
More than high school diploma	4,724	2,224	853	33	476	125	968	46
Family income[7]								
Less than $20,000	1,767	298	934	14	110	63	286	63
$20,000–$34,999	1,514	415	461	25	140	81	323	68
$35,000–$54,999	1,555	599	247	*11	218	73	340	66
$55,000–$74,999	1,155	550	84	*13	136	40	298	34
$75,000 or more	2,153	1,264	71	*5	174	46	564	29
Poverty status[8]								
Poor	1,746	338	766	*14	117	71	357	83
Near poor	1,930	520	547	29	213	86	447	88
Not poor	4,468	2,269	484	26	448	146	1,006	89
Home tenure status[9]								
Owned or being bought	5,343	2,546	693	36	528	133	1,234	172
Rented	2,605	535	1,039	32	230	161	535	74
Some other arrangement	180	45	64	*–	17	*4	38	*12
Health insurance coverage[10]								
Private	4,704	2,323	692	26	487	108	1,000	68
Medicaid	2,493	493	911	30	195	133	587	145
Other	133	47	26	*–	*13	*16	24	*8
Uninsured	791	259	164	*11	78	44	194	39
Place of residence[11]								
Large MSA	2,158	665	606	24	172	78	528	84
Small MSA	4,279	1,791	835	31	381	149	988	103
Not in MSA	1,707	670	357	*13	224	75	294	73
Region								
Northeast	1,591	613	366	*13	106	51	404	38
Midwest	1,905	767	412	*17	202	79	377	52
South	2,890	1,069	666	*17	321	100	605	112
West	1,758	677	354	21	148	74	425	59

* Estimate has a relative standard error of greater than 30% and should be used with caution because it does not meet the standards of reliability or precision.

– Quantity zero.

[1]A nuclear family consists of one or more children living with two parents who are married to one another and are biological or adoptive parents to all children in the family. A single-parent family consists of one or more children living with a single adult (male or female, related or unrelated). An unmarried biological or adoptive family consists of one or more children living with two parents who are not married to one another and are biological or adoptive parents to all children in the family. A blended family consists of one or more children living with a biological or adoptive parent and an unrelated stepparent who are married to one another. A cohabiting family consists of one or more children living with a biological or adoptive parent and an unrelated adult who are cohabiting with one another. An extended family consists of one or more children living with at least one biological or adoptive parent and a related adult. An "other" family consists of one or more children living with related or unrelated adults who are not biological or adoptive parents.

[2]Data are based on household interviews of a sample of the civilian noninstitutionalized population. Number of missed school days is obtained from a question that asked, "During the past 12 months, about how many days did [child's name] miss school because of illness or injury?" A knowledgeable adult provided information on behalf of child respondents. Unknowns with respect to missed school days and family structure are not included in the column labeled "All children aged 5–17 who missed 6 or more school days in the past 12 months due to illness or injury" (see Appendix I).

[3]Includes other races not shown separately and children with unknown parent's education, family income, poverty status, or health insurance. Additionally, numbers within selected characteristics may not add to totals because of rounding.

[4]Persons of Hispanic or Latino origin may be of any race or combination of races. Similarly, the category "Not Hispanic or Latino" refers to all persons who are not of Hispanic or Latino origin, regardless of race. To be concise, the text uses shorter versions of the terms shown in the table. For example, the category "Not Hispanic or Latino black or African American, single race" in the tables is referred to as "non-Hispanic black" in the text.

[5]Refers to the education level of the parent with the higher level of education, regardless of that parent's age.

[6]GED is General Educational Development high school equivalency diploma.

[7]Information on family income and poverty status is obtained from the 2001–2007 National Health Interview Survey Imputed Family Income/Personal Earnings Files.

[8]Based on family income and family size using the U.S. Census Bureau's poverty thresholds for the previous calendar year. "Poor" persons are defined as below the poverty threshold. "Near poor" persons have incomes of 100% to less than 200% of the poverty threshold. "Not poor" persons have incomes that are 200% of the poverty threshold or greater.

[9]Based on a question in the Family Core that asked whether the family's house or apartment is owned or being bought, rented, or occupied by some other arrangement (see Appendix II).

[10]Classification of health insurance coverage is based on a hierarchy of mutually exclusive categories. Persons with more than one type of health insurance were assigned to the first appropriate category in the hierarchy. The category ""Uninsured" includes persons who had no coverage as well as those who had only Indian Health Service coverage or had only a private plan that paid for one type of service such as accidents or dental care (see Appendix II).

[11]MSA is metropolitan statistical area. Large MSAs have a population size of 1 million or more; small MSAs have a population size of less than 1 million. "Not in MSA" consists of persons not living in a metropolitan statistical area.

SOURCE: CDC/NCHS, National Health Interview Survey, 2001–2007.

Table 30. Percentages (with standard errors) of children aged 5–17 who missed 6 or more school days in the past 12 months due to illness or injury, by family structure and by selected characteristics: United States, 2001–2007

Selected characteristics	All children aged 5–17 who missed 6 or more school days in the past 12 months due to illness or injury	Family structure[1]						
		Nuclear	Single parent	Unmarried biological or adoptive	Blended	Cohabiting	Extended	Other
	Percent[2] (standard error)							
Total[3]	15.8 (0.22)	13.3 (0.29)	19.7 (0.50)	17.3 (2.26)	16.1 (0.74)	19.0 (1.24)	17.4 (0.46)	15.8 (1.12)
Sex								
Male	15.5 (0.29)	12.9 (0.40)	19.4 (0.68)	21.4 (3.34)	16.5 (1.07)	17.4 (1.62)	16.8 (0.65)	16.2 (1.57)
Female	16.2 (0.29)	13.7 (0.40)	20.0 (0.69)	12.6 (2.62)	15.7 (0.99)	20.7 (1.90)	18.1 (0.64)	15.3 (1.64)
Age								
5–17 years	15.8 (0.22)	13.3 (0.29)	19.7 (0.50)	17.3 (2.26)	16.1 (0.74)	19.0 (1.24)	17.4 (0.46)	15.8 (1.12)
5–11 years	14.6 (0.29)	12.8 (0.37)	17.1 (0.64)	15.8 (2.47)	16.7 (1.12)	16.6 (1.49)	16.6 (0.74)	13.8 (1.51)
12–17 years	17.1 (0.31)	14.0 (0.44)	22.5 (0.75)	21.2 (5.00)	15.5 (0.92)	22.5 (2.16)	18.0 (0.58)	17.6 (1.65)
Hispanic origin and race[4]								
Hispanic or Latino	13.5 (0.37)	10.5 (0.54)	19.9 (1.04)	11.2 (2.70)	13.5 (1.33)	17.7 (2.63)	13.5 (0.63)	13.9 (1.98)
Mexican or Mexican American	12.9 (0.45)	10.4 (0.65)	19.2 (1.36)	9.3 (2.48)	12.8 (1.59)	17.3 (3.17)	13.4 (0.77)	13.6 (2.15)
Not Hispanic or Latino	16.3 (0.25)	13.8 (0.33)	19.6 (0.56)	20.4 (3.08)	16.5 (0.84)	19.2 (1.40)	18.8 (0.57)	16.3 (1.32)
White, single race	17.8 (0.30)	14.8 (0.37)	23.5 (0.81)	21.8 (3.78)	18.0 (0.99)	21.2 (1.73)	21.5 (0.72)	19.3 (2.08)
Black or African American, single race	12.4 (0.46)	7.6 (0.81)	14.2 (0.74)	*12.5 (4.24)	11.1 (1.47)	10.5 (2.06)	14.1 (1.02)	12.8 (1.83)
Parent's education[5]								
Less than high school diploma	17.5 (0.60)	13.1 (1.01)	24.4 (1.31)	11.5 (3.16)	22.3 (2.83)	19.9 (2.78)	15.1 (0.90)	19.5 (5.40)
High school diploma or GED[6]	17.7 (0.44)	16.0 (0.72)	18.0 (0.84)	17.0 (3.51)	16.8 (1.47)	19.5 (2.05)	20.1 (0.88)	14.7 (3.97)
More than high school diploma	14.8 (0.26)	12.7 (0.32)	18.9 (0.70)	21.0 (4.19)	15.2 (0.85)	17.8 (1.89)	17.3 (0.66)	13.2 (2.72)
Family income[7]								
Less than $20,000	21.0 (0.56)	17.0 (1.18)	23.0 (0.78)	14.4 (3.99)	25.7 (2.90)	20.5 (2.85)	19.7 (1.23)	19.6 (2.42)
$20,000–$34,999	17.4 (0.55)	14.7 (0.96)	18.6 (0.93)	24.2 (5.51)	17.3 (1.58)	22.2 (3.05)	18.5 (1.29)	18.3 (2.63)
$35,000–$54,999	15.7 (0.50)	14.2 (0.69)	15.8 (1.14)	*11.0 (3.50)	18.2 (1.71)	18.8 (2.57)	16.6 (0.99)	16.8 (2.67)
$55,000–$74,999	14.7 (0.52)	13.3 (0.68)	15.2 (1.80)	27.9 (7.67)	14.1 (1.52)	17.0 (3.23)	17.9 (1.27)	15.0 (2.92)
$75,000 or more	12.9 (0.34)	11.9 (0.42)	15.0 (1.91)	*11.0 (4.39)	12.2 (1.20)	15.3 (2.81)	16.3 (0.78)	8.7 (1.73)
Poverty status[8]								
Poor	19.8 (0.56)	16.3 (1.14)	22.3 (0.85)	*13.7 (4.18)	22.3 (2.52)	20.8 (2.99)	18.5 (1.16)	20.3 (2.70)
Near poor	17.2 (0.50)	13.9 (0.77)	20.6 (1.00)	20.9 (4.49)	18.2 (1.67)	19.3 (2.63)	17.5 (1.05)	17.2 (2.23)
Not poor	14.2 (0.25)	12.8 (0.32)	15.9 (0.69)	16.5 (3.21)	14.3 (0.84)	18.0 (1.67)	17.1 (0.62)	12.2 (1.43)
Home tenure status[9]								
Owned or being bought	14.7 (0.25)	13.0 (0.31)	18.7 (0.75)	19.6 (3.67)	15.7 (0.91)	18.0 (1.77)	16.4 (0.53)	15.0 (1.28)
Rented	18.3 (0.43)	15.0 (0.79)	20.2 (0.67)	15.8 (2.70)	16.6 (1.20)	19.7 (1.80)	20.2 (0.92)	16.4 (2.04)
Some other arrangement	20.1 (1.60)	13.8 (2.38)	25.5 (2.94)	*–	21.3 (5.75)	*16.5 (11.37)	23.0 (3.90)	*28.9 (12.19)
Health insurance coverage[10]								
Private	14.2 (0.24)	12.7 (0.31)	16.8 (0.69)	18.1 (3.96)	15.1 (0.85)	15.6 (1.65)	16.2 (0.55)	12.1 (1.60)
Medicaid	21.2 (0.50)	18.5 (1.00)	23.2 (0.81)	16.1 (3.30)	20.5 (1.93)	21.5 (2.13)	22.1 (1.08)	18.4 (1.78)
Other	12.3 (1.21)	9.6 (1.64)	14.5 (2.80)	*–	*8.5 (2.67)	37.5 (10.95)	13.7 (2.79)	*20.9 (8.01)
Uninsured	15.0 (0.59)	12.5 (0.94)	18.8 (1.37)	20.3 (5.55)	16.1 (2.44)	18.6 (3.24)	14.8 (1.03)	15.4 (2.73)
Place of residence[11]								
Large MSA	15.1 (0.37)	12.5 (0.57)	17.8 (0.75)	18.3 (3.53)	14.5 (1.29)	17.6 (2.26)	16.3 (0.75)	14.6 (1.93)
Small MSA	15.6 (0.30)	13.0 (0.39)	20.3 (0.79)	17.0 (3.23)	15.7 (0.97)	20.0 (1.84)	17.9 (0.65)	14.6 (1.55)
Not in MSA	17.5 (0.58)	15.2 (0.69)	22.1 (1.25)	*16.6 (6.03)	18.4 (1.79)	18.5 (2.51)	17.9 (1.10)	19.9 (2.71)
Region								
Northeast	16.9 (0.52)	13.7 (0.67)	21.8 (1.25)	19.5 (5.44)	16.6 (1.96)	20.2 (3.11)	19.5 (1.10)	16.3 (2.95)
Midwest	15.7 (0.45)	13.2 (0.58)	19.3 (1.12)	18.2 (5.31)	16.9 (1.69)	18.7 (2.67)	17.6 (1.00)	14.9 (2.48)
South	15.5 (0.38)	13.3 (0.53)	18.3 (0.72)	16.3 (4.45)	15.8 (1.13)	16.6 (1.82)	17.2 (0.78)	15.5 (1.63)
West	15.5 (0.41)	12.9 (0.56)	20.9 (1.18)	16.5 (3.45)	15.4 (1.41)	22.7 (2.79)	16.0 (0.89)	16.9 (2.57)

* Estimate has a relative standard error of greater than 30% and should be used with caution because it does not meet the standards of reliability or precision.

– Quantity zero.

[1]A nuclear family consists of one or more children living with two parents who are married to one another and are biological or adoptive parents to all children in the family. A single-parent family consists of one or more children living with a single adult (male or female, related or unrelated). An unmarried biological or adoptive family consists of one or more children living with two parents who are not married to one another and are biological or adoptive parents to all children in the family. A blended family consists of one or more children living with a biological or adoptive parent and an unrelated stepparent who are married to one another. A cohabiting family consists of one or more children living with a biological or adoptive parent and an unrelated adult who are cohabiting with one

another. An extended family consists of one or more children living with at least one biological or adoptive parent and a related adult. An "other" family consists of one or more children living with related or unrelated adults who are not biological or adoptive parents.

[2]Data are based on household interviews of a sample of the civilian noninstitutionalized population. Number of missed school days is obtained from a question that asked, "During the past 12 months, about how many days did [child's name] miss school because of illness or injury?" A knowledgeable adult provided information on behalf of child respondents. Unknowns with respect to missed school days and family structure are not included in the column labeled "All children aged 5–17 who missed 6 or more school days in the past 12 months due to illness or injury" (see Appendix I).

[3]Includes other races not shown separately and children with unknown parent's education, family income, poverty status, or health insurance.

[4]Persons of Hispanic or Latino origin may be of any race or combination of races. Similarly, the category "Not Hispanic or Latino" refers to all persons who are not of Hispanic or Latino origin, regardless of race. To be concise, the text uses shorter versions of the terms shown in the table. For example, the category "Not Hispanic or Latino black or African American, single race" in the tables is referred to as "non-Hispanic black" in the text.

[5]Refers to the education level of the parent with the higher level of education, regardless of that parent's age.

[6]GED is General Educational Development high school equivalency diploma.

[7]Information on family income and poverty status is obtained from the 2001–2007 National Health Interview Survey Imputed Family Income/Personal Earnings Files.

[8]Based on family income and family size using the U.S. Census Bureau's poverty thresholds for the previous calendar year. "Poor" persons are defined as below the poverty threshold. "Near poor" persons have incomes of 100% to less than 200% of the poverty threshold. "Not poor" persons have incomes that are 200% of the poverty threshold or greater.

[9]Based on a question in the Family Core that asked whether the family's house or apartment is owned or being bought, rented, or occupied by some other arrangement (see Appendix II).

[10]Classification of health insurance coverage is based on a hierarchy of mutually exclusive categories. Persons with more than one type of health insurance were assigned to the first appropriate category in the hierarchy. The category ""Uninsured" includes persons who had no coverage as well as those who had only Indian Health Service coverage or had only a private plan that paid for one type of service such as accidents or dental care (see Appendix II).

[11]MSA is metropolitan statistical area. Large MSAs have a population size of 1 million or more; small MSAs have a population size of less than 1 million. "Not in MSA" consists of persons not living in a metropolitan statistical area.

SOURCE: CDC/NCHS, National Health Interview Survey, 2001–2007.

Table 31. Frequencies of children under age 18 without any health insurance, by family structure and by selected characteristics: United States, 2001–2007

Selected characteristics	All children under age 18 without health insurance	Family structure[1]						
		Nuclear	Single parent	Unmarried biological or adoptive	Blended	Cohabiting	Extended	Other
	Number in thousands[2]							
Total[3]	7,008	2,823	1,088	114	591	321	1,727	343
Sex								
Male	3,561	1,418	506	67	301	163	926	180
Female	3,447	1,405	582	47	290	159	801	163
Age								
0–4 years	1,504	673	173	58	96	78	361	65
5–17 years	5,504	2,150	915	57	495	243	1,366	278
5–11 years	2,785	1,283	425	39	258	134	554	93
12–17 years	2,719	868	490	18	237	109	813	185
Hispanic origin and race[4]								
Hispanic or Latino	2,693	1,117	262	62	172	76	867	136
Mexican or Mexican American	2,104	916	172	45	126	51	684	109
Not Hispanic or Latino	4,315	1,706	826	52	419	245	860	207
White, single race	2,879	1,291	456	32	323	195	484	98
Black or African American, single race	850	157	278	12	69	30	229	76
Parent's education[5]								
Less than high school diploma	2,058	818	269	37	102	98	697	37
High school diploma or GED[6]	1,877	718	292	42	218	107	461	40
More than high school diploma	2,669	1,254	455	36	255	112	510	48
Family income[7]								
Less than $20,000	1,829	616	563	32	102	78	361	77
$20,000–$34,999	2,073	835	343	35	186	93	480	102
$35,000–$54,999	1,654	705	139	29	172	87	438	83
$55,000–$74,999	720	324	28	13	65	35	227	*28
$75,000 or more	732	343	15	*6	66	28	221	54
Poverty status[8]								
Poor	2,041	731	461	30	121	85	509	104
Near poor	2,575	986	395	43	244	109	674	125
Not poor	2,391	1,107	232	42	226	127	544	113
Home tenure status[9]								
Owned or being bought	3,624	1,653	346	37	315	110	983	181
Rented	3,148	1,066	705	75	262	197	698	145
Some other arrangement	178	79	33	*2	*10	*8	33	*11
Place of residence[10]								
Large MSA	2,264	804	398	51	158	96	644	112
Small MSA	3,314	1,386	461	51	302	142	816	155
Not in MSA	1,430	633	229	13	130	82	266	76
Region								
Northeast	701	248	124	13	70	34	178	34
Midwest	1,108	452	178	22	103	71	231	51
South	3,256	1,327	538	35	281	147	762	167
West	1,944	797	249	45	137	69	556	92

* Estimate has a relative standard error of greater than 30% and should be used with caution because it does not meet the standards of reliability or precision.

– Quantity zero.

[1]A nuclear family consists of one or more children living with two parents who are married to one another and are biological or adoptive parents to all children in the family. A single-parent family consists of one or more children living with a single adult (male or female, related or unrelated). An unmarried biological or adoptive family consists of one or more children living with two parents who are not married to one another and are biological or adoptive parents to all children in the family. A blended family consists of one or more children living with a biological or adoptive parent and an unrelated stepparent who are married to one another. A cohabiting family consists of one or more children living with a biological or adoptive parent and an unrelated adult who are cohabiting with one another. An extended family consists of one or more children living with at least one biological or adoptive parent and a related adult. An "other" family consists of one or more children living with related or unrelated adults who are not biological or adoptive parents.

[2]Data are based on household interviews of a sample of the civilian noninstitutionalized population. Health insurance coverage is obtained from a question in the Family Core that asked, "[Are you/Is anyone] covered by health insurance or some other kind of health care plan?" A knowledgeable adult provided information on behalf of child respondents. Children with only Indian Health Service coverage are also considered uninsured (see Appendix II). Unknowns with respect to health insurance coverage and family structure are not included in the column labeled "All children under age 18 without health insurance" (see Appendix I).

[3]Includes other races not shown separately and children with unknown parent's education, family income, poverty status, or health insurance. Additionally, numbers within selected characteristics may not add to totals because of rounding.

[4]Persons of Hispanic or Latino origin may be of any race or combination of races. Similarly, the category "Not Hispanic or Latino" refers to all persons who are not of Hispanic or Latino origin, regardless of race. To be concise, the text uses shorter versions of the terms shown in the table. For example, the category "Not Hispanic or Latino black or African American, single race" in the tables is referred to as "non-Hispanic black" in the text.

[5]Refers to the education level of the parent with the higher level of education, regardless of that parent's age.

[6]GED is General Educational Development high school equivalency diploma.

[7]Information on family income and poverty status is obtained from the 2001–2007 National Health Interview Survey Imputed Family Income/Personal Earnings Files.

[8]Based on family income and family size using the U.S. Census Bureau's poverty thresholds for the previous calendar year. "Poor" persons are defined as below the poverty threshold. "Near poor" persons have incomes of 100% to less than 200% of the poverty threshold. "Not poor" persons have incomes that are 200% of the poverty threshold or greater.

[9]Based on a question in the Family Core that asked whether the family's house or apartment is owned or being bought, rented, or occupied by some other arrangement (see Appendix II).

[10]MSA is metropolitan statistical area. Large MSAs have a population size of 1 million or more; small MSAs have a population size of less than 1 million. "Not in MSA" consists of persons not living in a metropolitan statistical area.

SOURCE: CDC/NCHS, National Health Interview Survey, 2001–2007.

Table 32. Percentages (with standard errors) of children under age 18 without any health insurance, by family structure and by selected characteristics: United States, 2001–2007

Selected characteristics	All children under age 18 without health insurance	Family structure[1]						
		Nuclear	Single parent	Unmarried biological or adoptive	Blended	Cohabiting	Extended	Other
	Percent[2] (standard error)							
Total[3]	9.6 (0.17)	8.0 (0.23)	9.1 (0.31)	10.8 (0.96)	9.4 (0.49)	14.2 (0.94)	12.6 (0.33)	15.2 (0.91)
Sex								
Male	9.6 (0.22)	7.8 (0.30)	8.6 (0.40)	12.1 (1.37)	9.3 (0.69)	13.9 (1.32)	13.0 (0.45)	15.7 (1.35)
Female	9.7 (0.21)	8.2 (0.29)	9.7 (0.43)	9.4 (1.31)	9.4 (0.67)	14.6 (1.34)	12.1 (0.45)	14.8 (1.27)
Age								
0–4 years	7.5 (0.23)	6.0 (0.29)	6.9 (0.57)	8.9 (1.12)	7.0 (0.81)	12.6 (1.72)	11.6 (0.67)	12.6 (1.73)
5–17 years	10.4 (0.20)	8.9 (0.28)	9.7 (0.35)	13.9 (1.70)	10.0 (0.58)	14.8 (1.10)	12.8 (0.37)	16.0 (1.08)
5–11 years	9.9 (0.26)	8.9 (0.33)	8.7 (0.47)	13.2 (1.92)	10.1 (0.81)	13.7 (1.38)	13.6 (0.61)	11.4 (1.30)
12–17 years	11.0 (0.26)	9.0 (0.40)	10.9 (0.50)	16.0 (3.58)	10.0 (0.81)	16.5 (1.85)	12.4 (0.44)	20.2 (1.60)
Hispanic origin and race[4]								
Hispanic or Latino	19.6 (0.40)	19.9 (0.61)	12.5 (0.69)	18.8 (1.95)	17.6 (1.27)	18.5 (2.10)	22.9 (0.73)	26.3 (2.00)
Mexican or Mexican American	22.3 (0.52)	22.6 (0.77)	14.8 (1.01)	20.0 (2.27)	18.9 (1.59)	19.3 (2.51)	25.6 (0.91)	28.5 (2.44)
Not Hispanic or Latino	7.3 (0.18)	5.7 (0.23)	8.4 (0.33)	7.2 (1.03)	7.9 (0.52)	13.3 (1.05)	8.6 (0.35)	12.0 (1.04)
White, single race	6.6 (0.20)	5.2 (0.24)	8.8 (0.48)	6.7 (1.17)	7.7 (0.61)	14.8 (1.35)	7.5 (0.42)	10.8 (1.33)
Black or African American, single race	8.0 (0.32)	7.2 (0.75)	7.0 (0.43)	6.7 (1.81)	8.1 (1.12)	7.7 (1.34)	9.7 (0.65)	11.4 (1.53)
Parent's education[5]								
Less than high school diploma	22.0 (0.59)	29.4 (1.30)	11.5 (0.71)	15.9 (2.29)	20.2 (2.33)	21.2 (2.29)	24.4 (0.92)	20.7 (3.81)
High school diploma or GED[6]	11.6 (0.33)	12.3 (0.56)	8.6 (0.55)	10.6 (1.42)	12.2 (1.11)	13.1 (1.59)	12.4 (0.60)	16.4 (3.00)
More than high school diploma	6.0 (0.15)	4.7 (0.18)	8.1 (0.41)	8.3 (1.40)	6.5 (0.48)	11.6 (1.36)	7.4 (0.34)	10.4 (2.10)
Family income[7]								
Less than $20,000	14.2 (0.41)	20.8 (1.03)	9.7 (0.45)	10.5 (1.58)	15.6 (1.72)	14.9 (2.05)	16.9 (0.94)	16.1 (1.90)
$20,000–$34,999	16.5 (0.44)	18.2 (0.80)	11.1 (0.65)	12.4 (1.93)	16.3 (1.38)	17.5 (2.16)	19.6 (0.94)	19.8 (2.27)
$35,000–$54,999	11.8 (0.37)	10.8 (0.52)	7.7 (0.76)	11.1 (2.26)	11.1 (1.16)	16.0 (2.12)	15.7 (0.82)	16.1 (2.17)
$55,000–$74,999	6.6 (0.32)	5.2 (0.42)	4.4 (1.20)	11.0 (3.16)	5.4 (0.97)	12.0 (2.71)	10.9 (0.92)	9.1 (2.61)
$75,000 or more	3.3 (0.17)	2.3 (0.20)	2.7 (0.69)	*6.0 (4.19)	3.7 (0.76)	7.6 (1.95)	5.2 (0.40)	12.2 (2.00)
Poverty status[8]								
Poor	15.2 (0.47)	22.1 (1.21)	9.2 (0.50)	10.8 (1.92)	14.7 (1.60)	14.9 (2.11)	17.8 (0.90)	17.0 (1.87)
Near poor	15.9 (0.40)	16.5 (0.67)	11.6 (0.63)	11.9 (1.79)	15.2 (1.30)	16.3 (1.89)	19.0 (0.78)	18.2 (1.94)
Not poor	5.5 (0.15)	4.3 (0.19)	6.6 (0.45)	9.9 (1.53)	5.8 (0.50)	12.5 (1.26)	7.4 (0.35)	11.9 (1.29)
Home tenure status[9]								
Owned or being bought	7.4 (0.18)	5.9 (0.21)	8.1 (0.49)	9.5 (1.49)	7.4 (0.54)	11.9 (1.31)	10.3 (0.37)	12.0 (1.03)
Rented	14.3 (0.31)	16.7 (0.62)	9.8 (0.39)	11.9 (1.27)	13.9 (1.02)	15.6 (1.32)	17.9 (0.67)	21.8 (1.93)
Some other arrangement	12.6 (1.10)	13.4 (1.85)	9.3 (1.72)	*6.8 (4.20)	*7.8 (2.95)	*18.3 (8.28)	16.5 (2.77)	*19.2 (6.40)
Place of residence[10]								
Large MSA	10.9 (0.28)	9.6 (0.44)	8.6 (0.43)	13.6 (1.81)	10.3 (0.89)	14.8 (1.81)	14.4 (0.58)	14.2 (1.30)
Small MSA	8.6 (0.22)	6.8 (0.27)	8.9 (0.48)	11.0 (1.37)	9.5 (0.76)	13.8 (1.36)	11.5 (0.45)	16.0 (1.43)
Not in MSA	10.5 (0.54)	9.9 (0.70)	10.8 (0.81)	5.8 (1.40)	8.2 (0.85)	14.3 (1.88)	12.3 (0.97)	15.3 (2.20)
Region								
Northeast	5.4 (0.26)	3.8 (0.34)	5.8 (0.53)	7.2 (2.05)	8.7 (1.55)	9.7 (1.99)	6.9 (0.60)	10.2 (1.73)
Midwest	6.4 (0.25)	5.2 (0.35)	6.3 (0.52)	7.6 (1.49)	6.4 (0.90)	11.7 (1.96)	8.5 (0.61)	11.4 (1.82)
South	12.2 (0.33)	10.9 (0.46)	11.2 (0.56)	10.8 (1.67)	10.6 (0.76)	17.5 (1.62)	15.9 (0.58)	17.0 (1.53)
West	12.1 (0.40)	10.2 (0.51)	11.5 (0.72)	16.7 (2.36)	11.0 (1.06)	14.9 (1.89)	15.4 (0.75)	18.4 (1.88)

* Estimate has a relative standard error of greater than 30% and should be used with caution because it does not meet the standards of reliability or precision.
– Quantity zero.

[1]A nuclear family consists of one or more children living with two parents who are married to one another and are biological or adoptive parents to all children in the family. A single-parent family consists of one or more children living with a single adult (male or female, related or unrelated). An unmarried biological or adoptive family consists of one or more children living with two parents who are not married to one another and are biological or adoptive parents to all children in the family. A blended family consists of one or more children living with a biological or adoptive parent and an unrelated stepparent who are married to one another. A cohabiting family consists of one or more children living with a biological or adoptive parent and an unrelated adult who are cohabiting with one another. An extended family consists of one or more children living with at least one biological or adoptive parent and a related adult. An "other" family consists of one or more children living with related or unrelated adults who are not biological or adoptive parents.

[2]Data are based on household interviews of a sample of the civilian noninstitutionalized population. Health insurance coverage status is obtained from a question in the Family Core that asked, "[Are you/Is anyone] covered by health insurance or some other kind of health care plan?" A knowledgeable adult provided information on behalf of child respondents. Children with only Indian Health Service coverage are also considered uninsured (see Appendix II). Unknowns with respect to health insurance coverage and family structure are not included in the column labeled "All children under age 18 without health insurance" (see Appendix I).

[3]Includes other races not shown separately and children with unknown parent's education, family income, poverty status, or health insurance.

[4]Persons of Hispanic or Latino origin may be of any race or combination of races. Similarly, the category "Not Hispanic or Latino" refers to all persons who are not of Hispanic or Latino origin, regardless of race. To be concise, the text uses shorter versions of the terms shown in the table. For example, the category "Not Hispanic or Latino black or African American, single race" in the tables is referred to as "non-Hispanic black" in the text.

[5]Refers to the education level of the parent with the higher level of education, regardless of that parent's age.

[6]GED is General Educational Development high school equivalency diploma.

[7]Information on family income and poverty status is obtained from the 2001–2007 National Health Interview Survey Imputed Family Income/Personal Earnings Files.

[8]Based on family income and family size using the U.S. Census Bureau's poverty thresholds for the previous calendar year. "Poor" persons are defined as below the poverty threshold. "Near poor" persons have incomes of 100% to less than 200% of the poverty threshold. "Not poor" persons have incomes that are 200% of the poverty threshold or greater.

[9]Based on a question in the Family Core that asked whether the family's house or apartment is owned or being bought, rented, or occupied by some other arrangement (see Appendix II).

[10]MSA is metropolitan statistical area. Large MSAs have a population size of 1 million or more; small MSAs have a population size of less than 1 million. "Not in MSA" consists of persons not living in a metropolitan statistical area.

SOURCE: CDC/NCHS, National Health Interview Survey, 2001–2007.

Table 33. Frequencies of children under age 18 without a usual place of health care, by family structure and by selected characteristics: United States, 2001–2007

Selected characteristics	All children under age 18 without a usual place of health care	Family structure[1]						
		Nuclear	Single parent	Unmarried biological or adoptive	Blended	Cohabiting	Extended	Other
	Number in thousands[2]							
Total[3]	3,678	1,340	687	50	301	176	935	189
Sex								
Male	1,944	705	338	21	167	104	500	109
Female	1,734	635	349	29	134	72	436	80
Age								
0–4 years	604	265	87	20	38	34	142	19
5–17 years	3,074	1,075	600	30	263	142	794	171
5–11 years	1,379	590	253	*21	105	68	290	51
12–17 years	1,696	485	347	*9	158	74	504	120
Hispanic origin and race[4]								
Hispanic or Latino	1,506	558	189	27	89	57	503	83
Mexican or Mexican American	1,188	459	129	17	63	44	408	68
Not Hispanic or Latino	2,172	782	497	23	211	119	433	106
White, single race	1,379	559	273	13	154	99	220	60
Black or African American, single race	493	89	189	*4	43	16	124	28
Parent's education[5]								
Less than high school diploma	1,109	402	193	16	36	55	385	23
High school diploma or GED[6]	917	293	195	*21	91	61	238	*17
More than high school diploma	1,406	629	249	13	169	60	271	*16
Family income[7]								
Less than $20,000	1,061	327	371	16	40	49	216	42
$20,000–$34,999	992	367	189	14	79	43	245	54
$35,000–$54,999	756	255	86	*13	79	48	227	47
$55,000–$74,999	408	165	29	*5	54	*21	117	18
$75,000 or more	462	225	12	*2	49	*16	130	28
Poverty status[8]								
Poor	1,173	382	319	12	47	50	308	54
Near poor	1,208	400	206	25	112	60	334	71
Not poor	1,298	557	162	12	142	66	294	65
Home tenure status[9]								
Owned or being bought	1,775	746	205	*20	152	61	493	97
Rented	1,780	540	453	29	142	110	419	87
Some other arrangement	100	40	27	*1	*5	*5	17	*4
Health insurance coverage[10]								
Private	1,001	460	179	*6	122	32	175	27
Medicaid	685	158	207	*17	49	38	171	45
Other	54	*14	*12	*1	*9	*6	*13	*–
Uninsured	1,910	705	285	26	120	99	564	113
Place of residence[11]								
Large MSA	1,305	429	267	24	94	58	364	69
Small MSA	1,695	662	277	*19	145	84	429	78
Not in MSA	679	249	143	*7	61	34	143	42
Region								
Northeast	234	89	40	*5	*12	*12	67	9
Midwest	583	227	120	*4	48	33	127	23
South	1,646	574	348	17	132	86	391	97
West	1,216	449	178	24	109	45	350	61

* Estimate has a relative standard error of greater than 30% and should be used with caution because it does not meet the standards of reliability or precision.

– Quantity zero.

[1] A nuclear family consists of one or more children living with two parents who are married to one another and are biological or adoptive parents to all children in the family. A single-parent family consists of one or more children living with a single adult (male or female, related or unrelated). An unmarried biological or adoptive family consists of one or more children living with two parents who are not married to one another and are biological or adoptive parents to all children in the family. A blended family consists of one or more children living with a biological or adoptive parent and an unrelated stepparent who are married to one another. A cohabiting family consists of one or more children living with a biological or adoptive parent and an unrelated adult who are cohabiting with one

another. An extended family consists of one or more children living with at least one biological or adoptive parent and a related adult. An "other" family consists of one or more children living with related or unrelated adults who are not biological or adoptive parents.

[2]Data are based on household interviews of a sample of the civilian noninstitutionalized population. Having a usual place of health care is obtained from a question that asked, "Is there a place that [child's name] USUALLY goes when [he/she] is sick or you need advice about [his/her] health?" A knowledgeable adult provided information on behalf of child respondents. Unknowns with respect to usual place of health care and family structure are not included in the column labeled "All children under age 18 without a usual place of health care" (see Appendix I).

[3]Includes other races not shown separately and children with unknown parent's education, family income, poverty status, or health insurance. Additionally, numbers within selected characteristics may not add to totals because of rounding.

[4]Persons of Hispanic or Latino origin may be of any race or combination of races. Similarly, the category "Not Hispanic or Latino" refers to all persons who are not of Hispanic or Latino origin, regardless of race. To be concise, the text uses shorter versions of the terms shown in the table. For example, the category "Not Hispanic or Latino black or African American, single race" in the tables is referred to as "non-Hispanic black" in the text.

[5]Refers to the education level of the parent with the higher level of education, regardless of that parent's age.

[6]GED is General Educational Development high school equivalency diploma.

[7]Information on family income and poverty status is obtained from the 2001–2007 National Health Interview Survey Imputed Family Income/Personal Earnings Files.

[8]Based on family income and family size using the U.S. Census Bureau's poverty thresholds for the previous calendar year. "Poor" persons are defined as below the poverty threshold. "Near poor" persons have incomes of 100% to less than 200% of the poverty threshold. "Not poor" persons have incomes that are 200% of the poverty threshold or greater.

[9]Based on a question in the Family Core that asked whether the family's house or apartment is owned or being bought, rented, or occupied by some other arrangement (see Appendix II).

[10]Classification of health insurance coverage is based on a hierarchy of mutually exclusive categories. Persons with more than one type of health insurance were assigned to the first appropriate category in the hierarchy. The category "Uninsured" includes persons who had no coverage as well as those who had only Indian Health Service coverage or had only a private plan that paid for one type of service such as accidents or dental care (see Appendix II).

[11]MSA is metropolitan statistical area. Large MSAs have a population size of 1 million or more; small MSAs have a population size of less than 1 million. "Not in MSA" consists of persons not living in a metropolitan statistical area.

SOURCE: CDC/NCHS, National Health Interview Survey, 2001–2007.

Table 34. Percentages (with standard errors) of children under age 18 without a usual place of health care, by family structure and by selected characteristics: United States, 2001–2007

Selected characteristics	All children under age 18 without a usual place of health care	Family structure[1]						
		Nuclear	Single parent	Unmarried biological or adoptive	Blended	Cohabiting	Extended	Other
	Percent[2] (standard error)							
Total[3]	5.0 (0.11)	3.8 (0.14)	5.8 (0.27)	4.7 (0.76)	4.8 (0.37)	7.8 (0.68)	6.8 (0.24)	8.4 (0.71)
Sex								
Male	5.2 (0.15)	3.9 (0.20)	5.7 (0.39)	3.8 (0.75)	5.2 (0.54)	8.9 (1.07)	7.0 (0.33)	9.5 (1.09)
Female	4.9 (0.15)	3.7 (0.20)	5.8 (0.36)	5.7 (1.36)	4.3 (0.45)	6.6 (0.82)	6.5 (0.33)	7.3 (0.90)
Age								
0–4 years	3.0 (0.16)	2.4 (0.18)	3.5 (0.64)	3.1 (0.63)	2.7 (0.63)	5.5 (0.99)	4.5 (0.40)	3.6 (0.84)
5–17 years	5.8 (0.14)	4.5 (0.19)	6.4 (0.29)	7.4 (1.69)	5.3 (0.43)	8.7 (0.86)	7.4 (0.28)	9.8 (0.89)
5–11 years	4.9 (0.17)	4.1 (0.22)	5.1 (0.38)	7.2 (2.16)	4.1 (0.49)	7.0 (0.98)	7.1 (0.45)	6.2 (1.05)
12–17 years	6.8 (0.20)	5.0 (0.28)	7.7 (0.46)	*7.8 (2.39)	6.6 (0.66)	11.2 (1.54)	7.6 (0.35)	13.1 (1.36)
Hispanic origin and race[4]								
Hispanic or Latino	10.9 (0.30)	9.9 (0.44)	9.0 (0.67)	8.1 (1.37)	9.1 (0.99)	13.9 (1.79)	13.2 (0.57)	15.9 (1.60)
Mexican or Mexican American	12.6 (0.39)	11.3 (0.56)	11.1 (0.98)	7.5 (1.46)	9.5 (1.25)	16.4 (2.39)	15.2 (0.73)	17.4 (1.92)
Not Hispanic or Latino	3.7 (0.12)	2.6 (0.14)	5.1 (0.29)	3.2 (0.92)	4.0 (0.40)	6.4 (0.74)	4.3 (0.25)	6.1 (0.77)
White, single race	3.2 (0.13)	2.2 (0.15)	5.3 (0.38)	2.8 (0.68)	3.6 (0.46)	7.6 (1.00)	3.4 (0.26)	6.6 (1.13)
Black or African American, single race	4.6 (0.28)	4.1 (0.58)	4.8 (0.50)	*2.1 (0.86)	5.0 (0.88)	4.2 (0.94)	5.2 (0.52)	4.2 (0.90)
Parent's education[5]								
Less than high school diploma	11.8 (0.42)	14.5 (0.84)	8.3 (0.84)	6.8 (1.57)	7.0 (1.27)	11.8 (1.60)	13.4 (0.71)	13.1 (3.11)
High school diploma or GED[6]	5.6 (0.24)	5.0 (0.36)	5.8 (0.48)	*5.3 (1.64)	5.1 (0.71)	7.5 (1.12)	6.3 (0.47)	*7.1 (2.13)
More than high school diploma	3.1 (0.11)	2.4 (0.13)	4.4 (0.32)	3.1 (0.72)	4.3 (0.43)	6.2 (1.03)	3.9 (0.25)	*3.4 (1.37)
Family income[7]								
Less than $20,000	8.2 (0.31)	11.0 (0.73)	6.3 (0.42)	5.1 (1.06)	6.1 (1.07)	9.3 (1.35)	10.1 (0.75)	8.9 (1.39)
$20,000–$34,999	7.9 (0.30)	8.0 (0.51)	6.1 (0.54)	5.0 (1.26)	6.9 (0.95)	8.0 (1.32)	10.0 (0.74)	10.5 (1.56)
$35,000–$54,999	5.4 (0.24)	3.9 (0.31)	4.8 (0.62)	*5.1 (2.36)	5.1 (0.84)	8.9 (1.74)	8.1 (0.64)	9.1 (1.68)
$55,000–$74,999	3.8 (0.26)	2.6 (0.31)	4.5 (0.98)	*4.4 (1.96)	4.5 (0.91)	7.1 (2.12)	5.6 (0.63)	5.8 (1.67)
$75,000 or more	2.1 (0.14)	1.5 (0.17)	2.2 (0.64)	*1.8 (1.05)	2.8 (0.57)	*4.3 (1.39)	3.0 (0.30)	6.4 (1.62)
Poverty status[8]								
Poor	8.7 (0.34)	11.6 (0.79)	6.4 (0.49)	4.4 (1.08)	5.7 (1.00)	8.7 (1.34)	10.7 (0.72)	8.8 (1.30)
Near poor	7.4 (0.26)	6.7 (0.41)	6.1 (0.51)	7.0 (1.86)	7.0 (0.96)	9.0 (1.46)	9.3 (0.55)	10.2 (1.49)
Not poor	3.0 (0.11)	2.1 (0.14)	4.6 (0.39)	3.0 (0.79)	3.6 (0.40)	6.5 (0.94)	4.0 (0.25)	6.8 (1.05)
Home tenure status[9]								
Owned or being bought	3.6 (0.12)	2.6 (0.14)	4.8 (0.48)	*5.1 (1.64)	3.6 (0.39)	6.6 (0.97)	5.1 (0.26)	6.4 (0.82)
Rented	8.1 (0.23)	8.5 (0.43)	6.3 (0.34)	4.5 (0.75)	7.5 (0.80)	8.7 (0.98)	10.7 (0.55)	13.2 (1.54)
Some other arrangement	7.1 (0.81)	6.7 (1.35)	7.8 (1.71)	*3.8 (3.04)	*4.0 (1.78)	*10.4 (5.29)	8.6 (1.81)	*7.4 (3.12)
Health insurance coverage[10]								
Private	2.2 (0.09)	1.7 (0.11)	3.7 (0.32)	*1.7 (0.60)	3.0 (0.41)	3.7 (0.72)	2.4 (0.18)	3.9 (1.03)
Medicaid	3.6 (0.18)	3.4 (0.31)	3.7 (0.38)	*3.1 (1.13)	3.4 (0.56)	3.7 (0.62)	4.0 (0.35)	3.9 (0.59)
Other	3.4 (0.60)	*1.8 (0.60)	*4.6 (1.43)	*6.4 (6.27)	*4.0 (1.88)	*10.6 (4.51)	*5.3 (1.72)	*–
Uninsured	27.4 (0.67)	25.0 (1.12)	26.3 (1.45)	22.3 (3.54)	20.3 (1.99)	31.1 (3.30)	32.8 (1.27)	33.3 (3.07)
Place of residence[11]								
Large MSA	6.2 (0.21)	5.1 (0.32)	5.8 (0.39)	6.5 (1.21)	6.1 (0.75)	8.9 (1.45)	8.1 (0.44)	8.7 (1.05)
Small MSA	4.4 (0.14)	3.2 (0.17)	5.4 (0.37)	*4.1 (1.36)	4.6 (0.47)	8.1 (1.01)	6.0 (0.32)	8.0 (1.06)
Not in MSA	5.0 (0.34)	3.9 (0.38)	6.7 (0.87)	*3.0 (0.96)	3.8 (0.83)	5.9 (1.15)	6.5 (0.68)	8.5 (1.76)
Region								
Northeast	1.8 (0.16)	1.3 (0.21)	1.9 (0.35)	*2.7 (1.38)	*1.4 (0.48)	*3.3 (1.17)	2.5 (0.36)	2.9 (0.83)
Midwest	3.4 (0.20)	2.6 (0.24)	4.2 (0.47)	*1.5 (0.58)	3.0 (0.55)	5.5 (1.30)	4.6 (0.48)	5.1 (1.30)
South	6.2 (0.22)	4.7 (0.28)	7.3 (0.50)	5.1 (1.05)	5.0 (0.55)	10.2 (1.22)	8.1 (0.42)	9.8 (1.18)
West	7.6 (0.27)	5.7 (0.34)	8.2 (0.66)	8.9 (2.35)	8.7 (1.22)	9.8 (1.57)	9.6 (0.53)	12.0 (1.75)

* Estimate has a relative standard error of greater than 30% and should be used with caution because it does not meet the standards of reliability or precision.

– Quantity zero.

[1]A nuclear family consists of one or more children living with two parents who are married to one another and are biological or adoptive parents to all children in the family. A single-parent family consists of one or more children living with a single adult (male or female, related or unrelated). An unmarried biological or adoptive family consists of one or more children living with two parents who are not married to one another and are biological or adoptive parents to all children in the family. A blended family consists of one or more children living with a biological or adoptive parent and an

unrelated stepparent who are married to one another. A cohabiting family consists of one or more children living with a biological or adoptive parent and an unrelated adult who are cohabiting with one another. An extended family consists of one or more children living with at least one biological or adoptive parent and a related adult. An "other" family consists of one or more children living with related or unrelated adults who are not biological or adoptive parents.

[2]Data are based on household interviews of a sample of the civilian noninstitutionalized population. Having a usual place of health care is obtained from a question that asked, "Is there a place that [child's name] USUALLY goes when [he/she] is sick or you need advice about [his/her] health?" A knowledgeable adult provided information on behalf of child respondents. Unknowns with respect to usual place of health care and family structure are not included in the column labeled "All children under age 18 without a usual place of health care" (see Appendix I).

[3]Includes other races not shown separately and children with unknown parent's education, family income, poverty status, or health insurance.

[4]Persons of Hispanic or Latino origin may be of any race or combination of races. Similarly, the category "Not Hispanic or Latino" refers to all persons who are not of Hispanic or Latino origin, regardless of race. To be concise, the text uses shorter versions of the terms shown in the table. For example, the category "Not Hispanic or Latino black or African American, single race" in the tables is referred to as "non-Hispanic black" in the text.

[5]Refers to the education level of the parent with the higher level of education, regardless of that parent's age.

[6]GED is General Educational Development high school equivalency diploma.

[7]Information on family income and poverty status is obtained from the 2001–2007 National Health Interview Survey Imputed Family Income/Personal Earnings Files.

[8]Based on family income and family size using the U.S. Census Bureau's poverty thresholds for the previous calendar year. "Poor" persons are defined as below the poverty threshold. "Near poor" persons have incomes of 100% to less than 200% of the poverty threshold. "Not poor" persons have incomes that are 200% of the poverty threshold or greater.

[9]Based on a question in the Family Core that asked whether the family's house or apartment is owned or being bought, rented, or occupied by some other arrangement (see Appendix II).

[10]Classification of health insurance coverage is based on a hierarchy of mutually exclusive categories. Persons with more than one type of health insurance were assigned to the first appropriate category in the hierarchy. The category "Uninsured" includes persons who had no coverage as well as those who had only Indian Health Service coverage or had only a private plan that paid for one type of service such as accidents or dental care (see Appendix II).

[11]MSA is metropolitan statistical area. Large MSAs have a population size of 1 million or more; small MSAs have a population size of less than 1 million. "Not in MSA" consists of persons not living in a metropolitan statistical area.

SOURCE: CDC/NCHS, National Health Interview Survey, 2001–2007.

Table 35. Frequencies of children under age 18 with a problem for which prescription medication has been used regularly for at least 3 months, by family structure and by selected characteristics: United States, 2001–2007

Selected characteristics	All children under age 18 with a problem requiring prescription medication for at least 3 months	Family structure[1]						
		Nuclear	Single parent	Unmarried biological or adoptive	Blended	Cohabiting	Extended	Other
	Number in thousands[2]							
Total[3]	9,427	4,078	1,854	98	962	323	1,736	376
Sex								
Male	5,384	2,328	1,062	62	578	205	947	203
Female	4,043	1,751	792	36	384	118	789	174
Age								
0–4 years	1,564	813	277	40	94	52	235	53
5–17 years	7,863	3,265	1,577	58	868	271	1,500	323
5–11 years	3,715	1,710	781	41	427	145	465	146
12–17 years	4,148	1,555	796	*17	441	126	1,036	177
Hispanic origin and race[4]								
Hispanic or Latino	1,102	378	232	20	94	39	278	62
Mexican or Mexican American	651	248	95	14	59	23	167	44
Not Hispanic or Latino	8,324	3,701	1,622	77	868	284	1,458	314
White, single race	6,517	3,265	967	54	744	206	1,108	173
Black or African American, single race	1,292	222	549	20	86	48	265	102
Parent's education[5]								
Less than high school diploma	853	162	335	*15	60	52	214	*14
High school diploma or GED[6]	1,980	616	466	40	238	99	483	38
More than high school diploma	6,264	3,294	969	43	656	166	1,029	108
Family income[7]								
Less than $20,000	1,753	297	931	28	91	68	267	71
$20,000–$34,999	1,575	427	472	26	189	76	294	91
$35,000–$54,999	1,677	674	274	24	238	88	310	69
$55,000–$74,999	1,356	694	103	*7	174	44	278	55
$75,000 or more	3,064	1,986	73	12	269	47	586	90
Poverty status[8]								
Poor	1,722	302	774	25	124	73	333	90
Near poor	2,024	582	532	39	245	101	406	118
Not poor	5,681	3,195	547	33	593	149	996	168
Home tenure status[9]								
Owned or being bought	6,610	3,495	704	42	670	138	1,267	293
Rented	2,589	513	1,083	51	265	172	433	71
Some other arrangement	198	61	64	*5	19	*9	30	*10
Health insurance coverage[10]								
Private	5,907	3,290	745	34	640	118	982	99
Medicaid	2,837	565	970	54	237	157	616	238
Other	226	105	35	*–	36	*13	28	*9
Uninsured	439	115	102	*9	47	34	101	30
Place of residence[11]								
Large MSA	2,384	815	666	19	210	75	498	103
Small MSA	5,035	2,457	841	56	453	163	903	162
Not in MSA	2,007	807	347	23	299	85	335	111
Region								
Northeast	1,748	780	362	22	110	66	347	60
Midwest	2,391	1,078	461	33	262	75	377	104
South	3,819	1,620	778	28	425	131	677	160
West	1,468	600	253	14	164	51	334	52

* Estimate has a relative standard error of greater than 30% and should be used with caution because it does not meet the standards of reliability or precision.

– Quantity zero.

[1]A nuclear family consists of one or more children living with two parents who are married to one another and are biological or adoptive parents to all children in the family. A single-parent family

consists of one or more children living with a single adult (male or female, related or unrelated). An unmarried biological or adoptive family consists of one or more children living with two parents who are not married to one another and are biological or adoptive parents to all children in the family. A blended family consists of one or more children living with a biological or adoptive parent and an unrelated stepparent who are married to one another. A cohabiting family consists of one or more children living with a biological or adoptive parent and an unrelated adult who are cohabiting with one another. An extended family consists of one or more children living with at least one biological or adoptive parent and a related adult. An "other" family consists of one or more children living with related or unrelated adults who are not biological or adoptive parents.

[2]Data are based on household interviews of a sample of the civilian noninstitutionalized population. Use of prescription medication is based on a question asked, "Does [child's name] now have a problem for which [he/she] has regularly taken prescription medication for at least three months?" A knowledgeable adult provided information on behalf of child respondents. Unknowns with respect to prescription medication usage and family structure are not included in the column labeled "All children under age 18 with a problem requiring prescription medication for at least 3 months" (see Appendix I).

[3]Includes other races not shown separately and children with unknown parent's education, family income, poverty status, or health insurance. Additionally, numbers within selected characteristics may not add to totals because of rounding.

[4]Persons of Hispanic or Latino origin may be of any race or combination of races. Similarly, the category "Not Hispanic or Latino" refers to all persons who are not of Hispanic or Latino origin, regardless of race. To be concise, the text uses shorter versions of the terms shown in the table. For example, the category "Not Hispanic or Latino black or African American, single race" in the tables is referred to as "non-Hispanic black" in the text.

[5]Refers to the education level of the parent with the higher level of education, regardless of that parent's age.

[6]GED is General Educational Development high school equivalency diploma.

[7]Information on family income and poverty status is obtained from the 2001–2007 National Health Interview Survey Imputed Family Income/Personal Earnings Files.

[8]Based on family income and family size using the U.S. Census Bureau's poverty thresholds for the previous calendar year. "Poor" persons are defined as below the poverty threshold. "Near poor" persons have incomes of 100% to less than 200% of the poverty threshold. "Not poor" persons have incomes that are 200% of the poverty threshold or greater.

[9]Based on a question in the Family Core that asked whether the family's house or apartment is owned or being bought, rented, or occupied by some other arrangement (see Appendix II).

[10]Classification of health insurance coverage is based on a hierarchy of mutually exclusive categories. Persons with more than one type of health insurance were assigned to the first appropriate category in the hierarchy. The category "Uninsured" includes persons who had no coverage as well as those who had only Indian Health Service coverage or had only a private plan that paid for one type of service such as accidents or dental care (see Appendix II).

[11]MSA is metropolitan statistical area. Large MSAs have a population size of 1 million or more; small MSAs have a population size of less than 1 million. "Not in MSA" consists of persons not living in a metropolitan statistical area.

SOURCE: CDC/NCHS, National Health Interview Survey, 2001–2007.

Table 36. Percentages (with standard errors) of children under age 18 with a problem for which prescription medication has been used regularly for at least 3 months, by family structure and by selected characteristics: United States, 2001–2007

Selected characteristics	All children under age 18 with a problem requiring prescription medication for at least 3 months	Family structure[1]						
		Nuclear	Single parent	Unmarried biological or adoptive	Blended	Cohabiting	Extended	Other
	Percent[2] (standard error)							
Total[3]	12.9 (0.16)	11.6 (0.21)	15.5 (0.40)	9.2 (1.00)	15.2 (0.60)	14.3 (1.01)	12.5 (0.36)	16.6 (1.06)
Sex								
Male	14.4 (0.23)	12.9 (0.31)	17.9 (0.59)	11.0 (1.45)	17.9 (0.88)	17.5 (1.56)	13.2 (0.49)	17.5 (1.50)
Female	11.3 (0.21)	10.2 (0.28)	13.2 (0.53)	7.2 (1.40)	12.4 (0.81)	10.8 (1.14)	11.8 (0.52)	15.6 (1.44)
Age								
0–4 years	7.8 (0.24)	7.2 (0.31)	11.0 (0.73)	6.1 (0.98)	6.8 (0.96)	8.3 (1.48)	7.5 (0.51)	10.1 (1.96)
5–17 years	14.8 (0.20)	13.6 (0.28)	16.7 (0.46)	14.2 (2.06)	17.6 (0.72)	16.5 (1.23)	14.0 (0.43)	18.5 (1.24)
5–11 years	13.2 (0.26)	11.8 (0.34)	15.9 (0.62)	13.8 (2.25)	16.7 (1.05)	14.8 (1.50)	11.3 (0.63)	17.7 (1.76)
12–17 years	16.7 (0.30)	16.2 (0.48)	17.6 (0.66)	15.2 (4.51)	18.5 (0.97)	19.0 (2.08)	15.7 (0.58)	19.3 (1.72)
Hispanic origin and race[4]								
Hispanic or Latino	8.0 (0.25)	6.7 (0.36)	11.0 (0.72)	6.2 (1.18)	9.5 (1.02)	9.4 (1.48)	7.3 (0.45)	11.9 (1.73)
Mexican or Mexican American	6.9 (0.29)	6.1 (0.41)	8.2 (0.88)	6.2 (1.50)	8.9 (1.19)	8.5 (1.79)	6.2 (0.51)	11.3 (1.87)
Not Hispanic or Latino	14.1 (0.19)	12.5 (0.24)	16.5 (0.46)	10.6 (1.34)	16.3 (0.68)	15.3 (1.17)	14.5 (0.46)	18.0 (1.27)
White, single race	15.0 (0.23)	13.1 (0.27)	18.6 (0.67)	11.4 (1.83)	17.7 (0.81)	15.6 (1.44)	17.1 (0.63)	19.0 (1.72)
Black or African American, single race	12.1 (0.37)	10.2 (0.70)	13.8 (0.64)	11.6 (2.40)	10.1 (1.25)	12.1 (2.11)	11.1 (0.68)	15.1 (1.90)
Parent's education[5]								
Less than high school diploma	9.1 (0.37)	5.8 (0.50)	14.3 (0.86)	6.4 (1.87)	11.7 (1.80)	11.3 (1.83)	7.5 (0.71)	*7.9 (2.40)
High school diploma or GED[6]	12.2 (0.32)	10.5 (0.49)	13.7 (0.68)	10.1 (1.80)	13.3 (1.14)	12.1 (1.58)	12.9 (0.65)	15.5 (3.53)
More than high school diploma	14.0 (0.21)	12.5 (0.25)	17.2 (0.61)	10.0 (1.57)	16.6 (0.77)	17.2 (1.67)	14.8 (0.54)	23.3 (3.10)
Family income[7]								
Less than $20,000	13.5 (0.36)	10.0 (0.70)	15.9 (0.57)	9.0 (1.95)	13.8 (1.80)	13.0 (2.05)	12.4 (0.88)	14.8 (1.81)
$20,000–$34,999	12.5 (0.37)	9.3 (0.57)	15.3 (0.77)	9.2 (2.02)	16.7 (1.54)	14.1 (2.19)	12.0 (0.88)	17.5 (2.38)
$35,000–$54,999	11.9 (0.37)	10.3 (0.48)	15.2 (1.01)	9.4 (2.43)	15.2 (1.34)	16.3 (2.33)	11.0 (0.72)	13.3 (2.12)
$55,000–$74,999	12.5 (0.43)	11.1 (0.54)	16.3 (1.82)	*6.2 (2.16)	14.5 (1.49)	15.1 (3.00)	13.2 (1.11)	17.9 (3.40)
$75,000 or more	13.6 (0.31)	13.3 (0.37)	13.1 (1.71)	13.2 (3.45)	15.3 (1.17)	12.7 (2.69)	13.6 (0.62)	20.3 (3.35)
Poverty status[8]								
Poor	12.8 (0.38)	9.1 (0.67)	15.5 (0.64)	9.0 (2.09)	15.0 (1.93)	12.7 (1.98)	11.6 (0.83)	14.5 (1.86)
Near poor	12.4 (0.37)	9.7 (0.54)	15.7 (0.77)	10.9 (2.14)	15.3 (1.32)	15.1 (1.96)	11.3 (0.77)	16.9 (2.13)
Not poor	13.1 (0.20)	12.3 (0.25)	15.4 (0.65)	7.9 (1.24)	15.3 (0.74)	14.6 (1.47)	13.5 (0.48)	17.6 (1.76)
Home tenure status[9]								
Owned or being bought	13.4 (0.19)	12.4 (0.24)	16.3 (0.66)	10.6 (1.80)	15.7 (0.72)	14.9 (1.51)	13.1 (0.44)	19.2 (1.39)
Rented	11.8 (0.27)	8.1 (0.42)	15.0 (0.51)	8.0 (1.17)	14.0 (1.02)	13.5 (1.29)	11.0 (0.61)	10.6 (1.51)
Some other arrangement	13.9 (1.18)	10.3 (1.51)	18.0 (2.18)	*17.0 (9.32)	14.3 (3.45)	*19.0 (12.52)	14.6 (3.02)	*17.8 (6.42)
Health insurance coverage[10]								
Private	13.0 (0.19)	12.2 (0.24)	15.2 (0.61)	9.1 (1.46)	15.8 (0.75)	13.7 (1.63)	13.2 (0.48)	14.4 (1.81)
Medicaid	15.1 (0.34)	12.0 (0.63)	17.1 (0.61)	9.7 (1.60)	16.5 (1.41)	15.5 (1.56)	14.3 (0.70)	20.3 (1.63)
Other	14.1 (1.05)	13.7 (1.43)	13.8 (2.41)	*–	16.7 (3.13)	*22.9 (8.07)	11.5 (1.97)	*17.2 (7.57)
Uninsured	6.3 (0.34)	4.1 (0.42)	9.4 (1.02)	*8.0 (2.42)	7.9 (1.38)	10.6 (2.13)	5.9 (0.64)	8.9 (1.95)
Place of residence[11]								
Large MSA	11.4 (0.28)	9.7 (0.40)	14.4 (0.60)	5.0 (0.98)	13.6 (1.11)	11.3 (1.57)	11.0 (0.54)	12.9 (1.45)
Small MSA	13.1 (0.23)	12.0 (0.29)	16.3 (0.64)	12.2 (1.73)	14.3 (0.84)	15.8 (1.60)	12.6 (0.50)	16.6 (1.66)
Not in MSA	14.8 (0.42)	12.6 (0.53)	16.3 (0.98)	10.2 (2.59)	18.7 (1.34)	14.8 (1.86)	15.3 (1.07)	22.3 (2.53)
Region								
Northeast	13.4 (0.39)	11.8 (0.51)	17.0 (0.97)	12.2 (2.84)	13.6 (1.45)	18.6 (3.03)	13.2 (0.88)	18.3 (2.76)
Midwest	13.9 (0.37)	12.4 (0.45)	16.3 (0.91)	11.6 (2.37)	16.3 (1.35)	12.4 (1.86)	13.7 (0.87)	23.3 (2.90)
South	14.3 (0.26)	13.3 (0.36)	16.2 (0.63)	8.7 (1.58)	16.0 (0.94)	15.5 (1.74)	14.0 (0.60)	16.2 (1.51)
West	9.1 (0.29)	7.7 (0.38)	11.6 (0.75)	5.2 (1.25)	13.1 (1.10)	11.1 (1.57)	9.2 (0.60)	10.2 (1.93)

* Estimate has a relative standard error of greater than 30% and should be used with caution because it does not meet the standards of reliability or precision.

– Quantity zero.

[1]A nuclear family consists of one or more children living with two parents who are married to one another and are biological or adoptive parents to all children in the family. A single-parent family consists of one or more children living with a single adult (male or female, related or unrelated). An unmarried biological or adoptive family consists of one or more children living with two parents who are not married to one another and are biological or adoptive parents to all children in the family. A blended family consists of one or more children living with a biological or adoptive parent and an

unrelated stepparent who are married to one another. A cohabiting family consists of one or more children living with a biological or adoptive parent and an unrelated adult who are cohabiting with one another. An extended family consists of one or more children living with at least one biological or adoptive parent and a related adult. An other family consists of one or more children living with related or unrelated adults who are not biological or adoptive parents.

[2]Data are based on household interviews of a sample of the civilian noninstitutionalized population. Use of prescription medication is based on a question asked, "Does [child's name] now have a problem for which [he/she] has regularly taken prescription medication for at least three months?" A knowledgeable adult provided information on behalf of child respondents. Unknowns with respect to prescription medication usage and family structure are not included in the column labeled "All children under age 18 with a problem requiring prescription medication for at least 3 months" (see Appendix I).

[3]Includes other races not shown separately and children with unknown parent's education, family income, poverty status, or health insurance.

[4]Persons of Hispanic or Latino origin may be of any race or combination of races. Similarly, the category "Not Hispanic or Latino" refers to all persons who are not of Hispanic or Latino origin, regardless of race. To be concise, the text uses shorter versions of the terms shown in the table. For example, the category "Not Hispanic or Latino black or African American, single race" in the tables is referred to as "non–Hispanic black" in the text.

[5]Refers to the education level of the parent with the higher level of education, regardless of that parent's age.

[6]GED is General Educational Development high school equivalency diploma.

[7]Information on family income and poverty status is obtained from the 2001–2007 National Health Interview Survey Imputed Family Income/Personal Earnings Files.

[8]Based on family income and family size using the U.S. Census Bureau's poverty thresholds for the previous calendar year. "Poor" persons are defined as below the poverty threshold. "Near poor" persons have incomes of 100% to less than 200% of the poverty threshold. "Not poor" persons have incomes that are 200% of the poverty threshold or greater.

[9]Based on a question in the Family Core that asked whether the family's house or apartment is owned or being bought, rented, or occupied by some other arrangement (see Appendix II).

[10]Classification of health insurance coverage is based on a hierarchy of mutually exclusive categories. Persons with more than one type of health insurance were assigned to the first appropriate category in the hierarchy. The category "Uninsured" includes persons who had no coverage as well as those who had only Indian Health Service coverage or had only a private plan that paid for one type of service such as accidents or dental care (see Appendix II).

[11]MSA is metropolitan statistical area. Large MSAs have a population size of 1 million or more; small MSAs have a population size of less than 1 million. "Not in MSA" consists of persons not living in a metropolitan statistical area.

SOURCE: CDC/NCHS, National Health Interview Survey, 2001–2007.

Table 37. Frequencies of children under age 18 who made two or more visits to a hospital ER in the past 12 months, by family structure and by selected characteristics: United States, 2001–2007

Selected characteristics	All children under age 18 who made two or more visits to hospital ER in the past 12 months	Family structure[1]						
		Nuclear	Single parent	Unmarried biological or adoptive	Blended	Cohabiting	Extended	Other
	Number in thousands[2]							
Total[3]	5,239	1,992	1,200	125	438	227	1,035	222
Sex								
Male	2,815	1,122	661	64	199	109	560	100
Female	2,424	870	539	61	239	118	475	122
Age								
0–4 years	2,004	804	425	85	144	92	375	78
5–17 years	3,235	1,187	775	39	294	135	660	145
5–11 years	1,729	716	405	*24	164	79	282	59
12–17 years	1,505	471	370	*15	131	56	377	86
Hispanic origin and race[4]								
Hispanic or Latino	1,014	347	203	31	63	52	266	51
Mexican or Mexican American	593	232	84	15	31	26	164	39
Not Hispanic or Latino	4,225	1,645	997	94	375	175	768	171
White, single race	2,856	1,359	468	51	289	117	485	87
Black or African American, single race	1,011	155	452	25	63	34	220	62
Parent's education[5]								
Less than high school diploma	934	230	313	29	41	68	232	20
High school diploma or GED[6]	1,382	390	337	54	163	73	349	16
More than high school diploma	2,700	1,357	490	42	224	84	443	61
Family income[7]								
Less than $20,000	1,527	278	763	34	79	59	251	63
$20,000–$34,999	1,085	341	265	40	101	72	211	56
$35,000–$54,999	974	412	112	34	129	43	202	41
$55,000–$74,999	607	296	35	*9	64	34	138	*31
$75,000 or more	1,046	665	25	*8	65	*19	233	31
Poverty status[8]								
Poor	1,511	302	644	29	92	66	294	85
Near poor	1,378	397	335	56	140	82	297	70
Not poor	2,349	1,293	221	40	205	79	444	67
Home tenure status[9]								
Owned or being bought	2,864	1,404	308	45	268	84	621	134
Rented	2,211	542	846	73	159	139	378	74
Some other arrangement	146	41	43	*6	*11	*4	26	*15
Health insurance coverage[10]								
Private	2,452	1,332	328	41	225	44	429	54
Medicaid	2,156	411	759	71	159	140	485	131
Other	128	68	21	*2	*12	*10	14	*1
Uninsured	485	178	91	11	39	31	100	34
Place of residence[11]								
Large MSA	1,649	506	484	45	114	68	349	83
Small MSA	2,473	1,100	463	49	200	99	467	95
Not in MSA	1,117	386	253	31	124	60	219	44
Region								
Northeast	1,005	379	240	25	74	40	212	34
Midwest	1,217	506	273	36	101	60	199	*43
South	2,158	770	535	39	200	87	434	93
West	859	336	152	25	64	39	190	52

* Estimate has a relative standard error of greater than 30% and should be used with caution because it does not meet the standards of reliability or precision.

– Quantity zero.

[1]A nuclear family consists of one or more children living with two parents who are married to one another and are biological or adoptive parents to all children in the family. A single-parent family consists of one or more children living with a single adult (male or female, related or unrelated). An unmarried biological or adoptive family consists of one or more children living with two parents who are not married to one another and are biological or adoptive parents to all children in the family. A blended family consists of one or more children living with a biological or adoptive parent and an

unrelated stepparent who are married to one another. A cohabiting family consists of one or more children living with a biological or adoptive parent and an unrelated adult who are cohabiting with one another. An extended family consists of one or more children living with at least one biological or adoptive parent and a related adult. An "other" family consists of one or more children living with related or unrelated adults who are not biological or adoptive parents.

[2]Data are based on household interviews of a sample of the civilian noninstitutionalized population. Information regarding emergency room (ER) visits is obtained from a question that asked, "During the past 12 months, how many times has [child's name] gone to a hospital emergency room about [his/her] health? (This includes emergency room visits that resulted in a hospital admission.)" A knowledgeable adult provided information on behalf of child respondents. Unknowns with respect to ER visits and family structure are not included in the column labeled "All children under age 18 who made two or more visits to hospital ER in the past 12 months" (see Appendix I).

[3]Includes other races not shown separately and children with unknown parent's education, family income, poverty status, or health insurance. Additionally, numbers within selected characteristics may not add to totals because of rounding.

[4]Persons of Hispanic or Latino origin may be of any race or combination of races. Similarly, the category "Not Hispanic or Latino" refers to all persons who are not of Hispanic or Latino origin, regardless of race. To be concise, the text uses shorter versions of the terms shown in the table. For example, the category "Not Hispanic or Latino black or African American, single race" in the tables is referred to as "non–Hispanic black" in the text.

[5]Refers to the education level of the parent with the higher level of education, regardless of that parent's age.

[6]GED is General Educational Development high school equivalency diploma.

[7]Information on family income and poverty status is obtained from the 2001–2007 National Health Interview Survey Imputed Family Income/Personal Earnings Files.

[8]Based on family income and family size using the U.S. Census Bureau's poverty thresholds for the previous calendar year. "Poor" persons are defined as below the poverty threshold. "Near poor" persons have incomes of 100% to less than 200% of the poverty threshold. "Not poor" persons have incomes that are 200% of the poverty threshold or greater.

[9]Based on a question in the Family Core that asked whether the family's house or apartment is owned or being bought, rented, or occupied by some other arrangement (see Appendix II).

[10]Classification of health insurance coverage is based on a hierarchy of mutually exclusive categories. Persons with more than one type of health insurance were assigned to the first appropriate category in the hierarchy. The category "Uninsured" includes persons who had no coverage as well as those who had only Indian Health Service coverage or had only a private plan that paid for one type of service such as accidents or dental care (see Appendix II).

[11]MSA is metropolitan statistical area. Large MSAs have a population size of 1 million or more; small MSAs have a population size of less than 1 million. "Not in MSA" consists of persons not living in a metropolitan statistical area.

SOURCE: CDC/NCHS, National Health Interview Survey, 2001–2007.

Table 38. Percentages (with standard errors) of children under age 18 who made two or more visits to a hospital ER in the past 12 months, by family structure and by selected characteristics: United States, 2001–2007

Selected characteristics	All children under age 18 who made two or more visits to hospital ER in the past 12 months	Family structure[1]						
		Nuclear	Single parent	Unmarried biological or adoptive	Blended	Cohabiting	Extended	Other
	Percent[2] (standard error)							
Total[3]	7.2 (0.13)	5.7 (0.16)	10.1 (0.33)	11.8 (1.13)	6.9 (0.43)	10.1 (0.84)	7.5 (0.26)	9.9 (0.87)
Sex								
Male	7.6 (0.18)	6.2 (0.24)	11.2 (0.49)	11.4 (1.33)	6.2 (0.50)	9.3 (1.12)	7.9 (0.38)	8.7 (0.98)
Female	6.8 (0.17)	5.1 (0.21)	9.0 (0.43)	12.2 (1.89)	7.7 (0.69)	10.9 (1.24)	7.2 (0.36)	11.0 (1.46)
Age								
0–4 years	10.0 (0.25)	7.2 (0.30)	17.0 (0.82)	13.1 (1.29)	10.4 (1.09)	15.0 (1.99)	12.0 (0.65)	15.0 (1.90)
5–17 years	6.1 (0.14)	4.9 (0.20)	8.3 (0.34)	9.7 (2.10)	6.0 (0.46)	8.2 (0.84)	6.2 (0.27)	8.3 (0.99)
5–11 years	6.2 (0.19)	5.0 (0.25)	8.3 (0.46)	8.2 (2.36)	6.4 (0.72)	8.0 (1.09)	6.9 (0.46)	7.2 (1.07)
12–17 years	6.1 (0.20)	4.9 (0.29)	8.3 (0.49)	*13.5 (4.45)	5.5 (0.57)	8.5 (1.33)	5.8 (0.33)	9.4 (1.63)
Hispanic origin and race[4]								
Hispanic or Latino	7.4 (0.24)	6.2 (0.34)	9.7 (0.68)	9.4 (1.42)	6.4 (0.78)	12.7 (2.18)	7.0 (0.38)	9.9 (1.52)
Mexican or Mexican American	6.3 (0.26)	5.7 (0.39)	7.2 (0.73)	6.9 (1.41)	4.7 (0.82)	9.9 (2.18)	6.1 (0.43)	10.2 (1.81)
Not Hispanic or Latino	7.2 (0.15)	5.6 (0.18)	10.2 (0.37)	12.9 (1.52)	7.0 (0.50)	9.5 (0.89)	7.7 (0.33)	9.9 (1.06)
White, single race	6.6 (0.17)	5.5 (0.20)	9.1 (0.51)	10.9 (1.71)	6.9 (0.53)	8.9 (1.07)	7.5 (0.42)	9.6 (1.65)
Black or African American, single race	9.6 (0.34)	7.1 (0.62)	11.5 (0.60)	14.6 (2.54)	7.4 (1.13)	8.8 (1.54)	9.3 (0.69)	9.3 (1.34)
Parent's education[5]								
Less than high school diploma	10.0 (0.42)	8.3 (0.87)	13.5 (0.85)	12.5 (2.23)	8.1 (1.47)	14.8 (2.32)	8.1 (0.56)	11.4 (2.93)
High school diploma or GED[6]	8.5 (0.26)	6.7 (0.40)	10.0 (0.62)	13.7 (2.18)	9.1 (0.90)	8.9 (1.22)	9.3 (0.52)	6.5 (1.90)
More than high school diploma	6.0 (0.14)	5.1 (0.17)	8.7 (0.44)	9.8 (1.50)	5.7 (0.51)	8.7 (1.16)	6.4 (0.36)	13.2 (2.89)
Family income[7]								
Less than $20,000	11.9 (0.36)	9.4 (0.70)	13.2 (0.52)	11.0 (1.84)	12.1 (1.86)	11.3 (1.83)	11.7 (0.83)	13.2 (1.73)
$20,000–$34,999	8.6 (0.32)	7.4 (0.50)	8.6 (0.62)	14.0 (2.05)	8.9 (1.16)	13.5 (1.88)	8.6 (0.65)	10.8 (1.88)
$35,000–$54,999	7.0 (0.28)	6.3 (0.39)	6.2 (0.66)	13.2 (3.17)	8.3 (0.93)	8.0 (1.70)	7.2 (0.54)	8.0 (1.59)
$55,000–$74,999	5.6 (0.30)	4.8 (0.35)	5.6 (1.03)	*7.8 (2.99)	5.3 (0.90)	11.6 (2.80)	6.6 (0.66)	*10.2 (3.80)
$75,000 or more	4.7 (0.18)	4.5 (0.23)	4.5 (0.93)	*8.9 (3.62)	3.7 (0.67)	5.1 (1.53)	5.4 (0.41)	7.1 (1.54)
Poverty status[8]								
Poor	11.3 (0.39)	9.2 (0.82)	13.0 (0.58)	10.3 (2.01)	11.2 (1.69)	11.5 (1.99)	10.3 (0.74)	13.8 (1.90)
Near poor	8.5 (0.28)	6.7 (0.43)	9.9 (0.62)	15.5 (2.44)	8.8 (1.01)	12.4 (1.72)	8.3 (0.58)	10.1 (1.99)
Not poor	5.5 (0.13)	5.0 (0.17)	6.3 (0.44)	9.6 (1.45)	5.3 (0.47)	7.8 (1.02)	6.0 (0.31)	7.1 (0.96)
Home tenure status[9]								
Owned or being bought	5.8 (0.14)	5.0 (0.17)	7.2 (0.48)	11.5 (2.16)	6.3 (0.52)	9.1 (1.26)	6.5 (0.30)	8.8 (1.07)
Rented	10.1 (0.24)	8.6 (0.42)	11.8 (0.44)	11.6 (1.19)	8.4 (0.78)	11.0 (1.17)	9.7 (0.54)	11.2 (1.36)
Some other arrangement	10.4 (1.03)	7.0 (1.17)	12.1 (2.01)	*21.7 (9.46)	*8.6 (3.05)	*9.5 (6.64)	12.6 (2.71)	*25.1 (9.86)
Health insurance coverage[10]								
Private	5.4 (0.13)	5.0 (0.17)	6.7 (0.40)	10.9 (1.69)	5.5 (0.46)	5.1 (0.95)	5.8 (0.32)	7.9 (1.80)
Medicaid	11.5 (0.30)	8.8 (0.50)	13.5 (0.53)	12.7 (1.77)	11.1 (1.15)	13.8 (1.46)	11.3 (0.57)	11.3 (1.21)
Other	8.0 (0.76)	8.9 (1.22)	8.3 (1.72)	*13.2 (8.84)	5.6 (1.62)	*18.3 (7.14)	5.6 (1.35)	*1.7 (1.65)
Uninsured	7.0 (0.43)	6.3 (0.82)	8.4 (1.00)	10.1 (2.56)	6.7 (1.42)	9.7 (1.97)	5.8 (0.56)	10.0 (1.59)
Place of residence[11]								
Large MSA	7.9 (0.22)	6.1 (0.31)	10.5 (0.52)	12.0 (1.51)	7.4 (0.75)	10.4 (1.38)	7.8 (0.43)	10.5 (1.79)
Small MSA	6.5 (0.16)	5.4 (0.21)	9.0 (0.48)	10.6 (1.72)	6.3 (0.63)	9.7 (1.25)	6.6 (0.33)	9.8 (1.20)
Not in MSA	8.2 (0.36)	6.1 (0.43)	11.9 (0.83)	14.2 (3.06)	7.7 (0.95)	10.5 (1.84)	10.0 (0.89)	8.9 (1.26)
Region								
Northeast	7.8 (0.28)	5.8 (0.36)	11.3 (0.78)	13.7 (2.63)	9.2 (1.30)	11.4 (2.57)	8.1 (0.59)	10.5 (2.14)
Midwest	7.1 (0.28)	5.8 (0.34)	9.7 (0.64)	12.5 (2.27)	6.3 (0.93)	10.1 (1.77)	7.3 (0.63)	9.6 (2.67)
South	8.1 (0.24)	6.3 (0.31)	11.2 (0.57)	12.2 (1.90)	7.5 (0.69)	10.3 (1.25)	9.0 (0.50)	9.5 (1.05)
West	5.3 (0.20)	4.3 (0.26)	7.1 (0.59)	9.3 (2.40)	5.1 (0.67)	8.6 (1.59)	5.3 (0.38)	10.4 (1.84)

* Estimate has a relative standard error of greater than 30% and should be used with caution because it does not meet the standards of reliability or precision.

– Quantity zero.

[1]A nuclear family consists of one or more children living with two parents who are married to one another and are biological or adoptive parents to all children in the family. A single–parent family

consists of one or more children living with a single adult (male or female, related or unrelated). An unmarried biological or adoptive family consists of one or more children living with two parents who are not married to one another and are biological or adoptive parents to all children in the family. A blended family consists of one or more children living with a biological or adoptive parent and an unrelated stepparent who are married to one another. A cohabiting family consists of one or more children living with a biological or adoptive parent and an unrelated adult who are cohabiting with one another. An extended family consists of one or more children living with at least one biological or adoptive parent and a related adult. An "other" family consists of one or more children living with related or unrelated adults who are not biological or adoptive parents.

[2]Data are based on household interviews of a sample of the civilian noninstitutionalized population. Information regarding emergency room (ER) visits is obtained from a question that asked, "During the past 12 months, how many times has [child's name] gone to a hospital emergency room about [his/her] health? (This includes emergency room visits that resulted in a hospital admission.)" A knowledgeable adult provided information on behalf of child respondents. Unknowns with respect to ER visits and family structure are not included in the column labeled "All children under age 18 who made two or more visits to hospital ER in the past 12 months" (see Appendix I).

[3]Includes other races not shown separately and children with unknown parent's education, family income, poverty status, or health insurance. Additionally, numbers within selected characteristics may not add to totals because of rounding.

[4]Persons of Hispanic or Latino origin may be of any race or combination of races. Similarly, the category "Not Hispanic or Latino" refers to all persons who are not of Hispanic or Latino origin, regardless of race. To be concise, the text uses shorter versions of the terms shown in the table. For example, the category "Not Hispanic or Latino black or African American, single race" in the tables is referred to as "non–Hispanic black" in the text.

[5]Refers to the education level of the parent with the higher level of education, regardless of that parent's age.

[6]GED is General Educational Development high school equivalency diploma.

[7]Information on family income and poverty status is obtained from the 2001–2007 National Health Interview Survey Imputed Family Income/Personal Earnings Files.

[8]Based on family income and family size using the U.S. Census Bureau's poverty thresholds for the previous calendar year. "Poor" persons are defined as below the poverty threshold. "Near poor" persons have incomes of 100% to less than 200% of the poverty threshold. "Not poor" persons have incomes that are 200% of the poverty threshold or greater.

[9]Based on a question in the Family Core that asked whether the family's house or apartment is owned or being bought, rented, or occupied by some other arrangement (see Appendix II).

[10]Classification of health insurance coverage is based on a hierarchy of mutually exclusive categories. Persons with more than one type of health insurance were assigned to the first appropriate category in the hierarchy. The category "Uninsured" includes persons who had no coverage as well as those who had only Indian Health Service coverage or had only a private plan that paid for one type of service such as accidents or dental care (see Appendix II).

[11]MSA is metropolitan statistical area. Large MSAs have a population size of 1 million or more; small MSAs have a population size of less than 1 million. "Not in MSA" consists of persons not living in a metropolitan statistical area.

SOURCE: CDC/NCHS, National Health Interview Survey, 2001–2007.

Table 39. Frequencies of children aged 1–17 who did not have a medical checkup in the past 12 months, by family structure and by selected characteristics: United States, 2001–2007

Selected characteristics	All children aged 1–17 who did not have a medical checkup in the past 12 months	Family structure[1]						
		Nuclear	Single parent	Unmarried biological or adoptive	Blended	Cohabiting	Extended	Other
	Number in thousands[2]							
Total[3]	19,414	8,609	3,278	222	1,810	656	4,145	693
Sex								
Male	9,872	4,429	1,565	120	925	347	2,151	335
Female	9,542	4,180	1,713	102	885	308	1,994	358
Age								
1–4 years	2,532	1,320	332	75	163	100	469	73
5–17 years	16,882	7,290	2,946	147	1,647	555	3,677	621
5–11 years	8,385	4,283	1,412	104	800	309	1,246	233
12–17 years	8,497	3,007	1,535	43	847	247	2,431	388
Hispanic origin and race[4]								
Hispanic or Latino	4,450	1,794	605	93	281	147	1,344	186
Mexican or Mexican American	3,486	1,463	395	70	214	98	1,093	153
Not Hispanic or Latino	14,963	6,816	2,673	129	1,529	509	2,801	507
White, single race	11,394	5,779	1,647	87	1,260	405	1,916	300
Black or African American, single race	2,262	426	845	21	188	75	548	159
Parent's education[5]								
Less than high school diploma	3,469	1,176	693	63	188	163	1,123	63
High school diploma or GED[6]	4,794	1,736	975	86	569	242	1,125	60
More than high school diploma	10,364	5,645	1,437	73	1,031	245	1,821	112
Family income[7]								
Less than $20,000	3,784	934	1,594	58	186	156	699	158
$20,000–$34,999	3,901	1,473	890	62	341	140	826	169
$35,000–$54,999	4,120	1,845	495	62	453	172	925	170
$55,000–$74,999	2,844	1,465	172	25	357	90	645	91
$75,000 or more	4,765	2,893	129	15	473	97	1,051	107
Poverty status[8]								
Poor	4,087	1,125	1,359	60	223	165	951	204
Near poor	5,010	1,885	954	85	473	197	1,186	231
Not poor	10,317	5,600	965	78	1,115	294	2,008	258
Home tenure status[9]								
Owned or being bought	12,948	6,715	1,322	103	1,243	263	2,855	446
Rented	5,956	1,694	1,824	114	537	380	1,193	213
Some other arrangement	410	155	114	*5	21	*12	77	*27
Health insurance coverage[10]								
Private	10,902	5,808	1,335	83	1,149	238	2,084	206
Medicaid	4,511	1,162	1,316	89	360	258	1,056	270
Other	373	158	78	*3	42	*10	67	*16
Uninsured	3,555	1,465	535	48	257	146	905	198
Place of residence[11]								
Large MSA	5,356	2,034	1,093	82	403	202	1,303	240
Small MSA	9,355	4,431	1,392	95	852	286	2,026	273
Not in MSA	4,703	2,145	793	45	555	168	816	181
Region								
Northeast	1,739	782	290	29	126	56	382	75
Midwest	4,553	2,160	785	56	447	163	804	138
South	7,675	3,230	1,449	54	820	253	1,554	314
West	5,447	2,437	755	82	417	184	1,405	167

* Estimate has a relative standard error of greater than 30% and should be used with caution because it does not meet the standards of reliability or precision.

– Quantity zero.

[1] A nuclear family consists of one or more children living with two parents who are married to one another and are biological or adoptive parents to all children in the family. A single-parent family consists of one or more children living with a single adult (male or female, related or unrelated). An unmarried biological or adoptive family consists of one or more children living with two parents who are not married to one another and are biological or adoptive parents to all children in the family. A blended family consists of one or more children living with a biological or adoptive parent and an

unrelated stepparent who are married to one another. A cohabiting family consists of one or more children living with a biological or adoptive parent and an unrelated adult who are cohabiting with one another. An extended family consists of one or more children living with at least one biological or adoptive parent and a related adult. An "other" family consists of one or more children living with related or unrelated adults who are not biological or adoptive parents.

[2]Data are based on household interviews of a sample of the civilian noninstitutionalized population. Information regarding receipt of medical checkup is obtained from a question that asked, "During the past 12 months, did [child's name] receive a well child check-up—that is, a general check-up when [he/she] was not sick or injured?" A knowledgeable adult provided information on behalf of child respondents. Unknowns with respect to receipt of medical checkups and family structure are not included in the column labeled "All children aged 1–17 who did not have a medical checkup in the past 12 months" (see Appendix I).

[3]Includes other races not shown separately and children with unknown parent's education, family income, poverty status, or health insurance. Additionally, numbers within selected characteristics may not add to totals because of rounding.

[4]Persons of Hispanic or Latino origin may be of any race or combination of races. Similarly, the category "Not Hispanic or Latino" refers to all persons who are not of Hispanic or Latino origin, regardless of race. To be concise, the text uses shorter versions of the terms shown in the table. For example, the category "Not Hispanic or Latino black or African American, single race" in the tables is referred to as "non–Hispanic black" in the text.

[5]Refers to the education level of the parent with the higher level of education, regardless of that parent's age.

[6]GED is General Educational Development high school equivalency diploma.

[7]Information on family income and poverty status is obtained from the 2001–2007 National Health Interview Survey Imputed Family Income/Personal Earnings Files.

[8]Based on family income and family size using the U.S. Census Bureau's poverty thresholds for the previous calendar year. "Poor" persons are defined as below the poverty threshold. "Near poor" persons have incomes of 100% to less than 200% of the poverty threshold. "Not poor" persons have incomes that are 200% of the poverty threshold or greater.

[9]Based on a question in the Family Core that asked whether the family's house or apartment is owned or being bought, rented, or occupied by some other arrangement (see Appendix II).

[10]Classification of health insurance coverage is based on a hierarchy of mutually exclusive categories. Persons with more than one type of health insurance were assigned to the first appropriate category in the hierarchy. The category "Uninsured" includes persons who had no coverage as well as those who had only Indian Health Service coverage or had only a private plan that paid for one type of service such as accidents or dental care (see Appendix II).

[11]MSA is metropolitan statistical area. Large MSAs have a population size of 1 million or more; small MSAs have a population size of less than 1 million. "Not in MSA" consists of persons not living in a metropolitan statistical area.

SOURCE: CDC/NCHS, National Health Interview Survey, 2001–2007.

Table 40. Percentages (with standard errors) of children aged 1–17 who did not have a medical checkup in the past 12 months, by family structure and by selected characteristics: United States, 2001–2007

Selected characteristics	All children aged 1–17 who did not have a medical checkup in the past 12 months	Family structure[1]						
		Nuclear	Single parent	Unmarried biological or adoptive	Blended	Cohabiting	Extended	Other
	Percent[2] (standard error)							
Total[3]	28.4 (0.28)	26.2 (0.36)	28.7 (0.55)	26.1 (1.69)	30.2 (0.81)	30.8 (1.36)	31.9 (0.52)	32.6 (1.30)
Sex								
Male	28.2 (0.36)	26.2 (0.48)	27.6 (0.75)	26.9 (2.34)	30.1 (1.09)	31.9 (1.89)	31.9 (0.71)	31.1 (1.72)
Female	28.5 (0.36)	26.1 (0.48)	29.7 (0.75)	25.1 (2.37)	30.4 (1.16)	29.7 (1.89)	31.8 (0.72)	34.1 (1.98)
Age								
1–4 years	15.8 (0.40)	14.6 (0.48)	15.8 (1.13)	16.8 (1.73)	14.7 (1.35)	19.8 (2.38)	19.3 (0.96)	18.0 (2.47)
5–17 years	32.2 (0.32)	30.5 (0.44)	31.5 (0.61)	36.2 (2.80)	33.8 (0.92)	34.2 (1.61)	34.8 (0.58)	36.0 (1.47)
5–11 years	30.1 (0.40)	29.8 (0.53)	29.0 (0.82)	35.3 (3.16)	31.8 (1.31)	31.9 (2.00)	30.7 (0.89)	28.5 (2.00)
12–17 years	34.6 (0.42)	31.6 (0.64)	34.3 (0.84)	38.7 (5.37)	35.9 (1.26)	37.7 (2.48)	37.3 (0.70)	42.8 (2.16)
Hispanic origin and race[4]								
Hispanic or Latino	34.6 (0.50)	34.0 (0.70)	30.2 (1.11)	35.4 (2.74)	30.2 (1.62)	37.4 (2.64)	38.3 (0.88)	39.3 (2.48)
Mexican or Mexican American	39.6 (0.60)	38.3 (0.83)	35.8 (1.49)	39.5 (3.19)	33.9 (2.02)	39.0 (3.02)	44.4 (1.05)	43.4 (3.02)
Not Hispanic or Latino	26.9 (0.32)	24.7 (0.41)	28.3 (0.62)	21.9 (2.13)	30.2 (0.92)	29.3 (1.54)	29.5 (0.62)	30.7 (1.55)
White, single race	27.8 (0.38)	24.9 (0.45)	32.9 (0.84)	23.3 (2.51)	31.5 (1.06)	32.6 (1.98)	31.0 (0.79)	34.8 (2.33)
Black or African American, single race	22.7 (0.62)	21.1 (1.11)	22.4 (0.90)	14.4 (2.73)	23.5 (1.90)	20.5 (2.55)	24.5 (1.18)	24.9 (2.15)
Parent's education[5]								
Less than high school diploma	40.0 (0.72)	45.6 (1.25)	31.3 (1.34)	32.9 (3.22)	39.8 (2.95)	37.1 (2.79)	42.8 (1.16)	41.6 (5.55)
High school diploma or GED[6]	31.5 (0.51)	31.5 (0.83)	30.1 (0.99)	26.8 (2.92)	33.6 (1.68)	31.5 (2.20)	32.2 (0.89)	28.4 (4.55)
More than high school diploma	24.6 (0.32)	22.9 (0.39)	26.4 (0.72)	21.5 (2.68)	27.4 (0.96)	27.1 (1.93)	27.2 (0.72)	25.2 (3.50)
Family income[7]								
Less than $20,000	31.7 (0.59)	34.8 (1.19)	28.8 (0.79)	24.1 (2.71)	31.1 (2.55)	33.0 (2.80)	35.3 (1.29)	36.0 (2.93)
$20,000–$34,999	33.0 (0.60)	34.5 (0.99)	29.9 (1.02)	27.4 (3.29)	32.1 (1.91)	27.8 (2.64)	36.0 (1.27)	34.0 (2.92)
$35,000–$54,999	31.3 (0.55)	30.3 (0.80)	28.1 (1.23)	28.9 (3.71)	30.2 (1.69)	33.7 (3.01)	35.1 (1.15)	35.4 (3.05)
$55,000–$74,999	27.8 (0.63)	25.2 (0.77)	27.7 (2.29)	25.6 (5.29)	31.3 (1.87)	31.5 (3.74)	32.2 (1.44)	31.2 (4.89)
$75,000 or more	22.5 (0.44)	20.6 (0.49)	23.9 (2.18)	20.7 (4.94)	28.0 (1.53)	27.3 (3.13)	25.6 (0.97)	25.2 (3.45)
Poverty status[8]								
Poor	32.8 (0.63)	37.1 (1.31)	28.8 (0.93)	26.5 (3.08)	29.6 (2.41)	31.5 (2.83)	35.9 (1.24)	36.0 (2.64)
Near poor	33.0 (0.56)	34.0 (0.92)	29.2 (0.98)	29.1 (3.15)	31.4 (1.85)	31.6 (2.55)	35.6 (1.08)	35.7 (2.78)
Not poor	25.3 (0.32)	23.0 (0.38)	28.0 (0.89)	23.1 (2.27)	29.9 (0.98)	29.9 (1.82)	28.5 (0.68)	28.3 (1.99)
Home tenure status[9]								
Owned or being bought	27.8 (0.33)	25.4 (0.40)	31.4 (0.89)	30.3 (3.09)	30.6 (1.02)	29.7 (2.09)	31.2 (0.63)	30.8 (1.55)
Rented	29.4 (0.44)	29.6 (0.76)	26.7 (0.67)	23.2 (1.90)	30.1 (1.47)	32.2 (1.80)	33.2 (0.91)	34.9 (2.39)
Some other arrangement	31.2 (1.55)	28.5 (2.45)	33.7 (2.88)	*24.5 (9.15)	16.9 (4.05)	*27.5 (9.47)	39.5 (3.85)	52.8 (9.95)
Health insurance coverage[10]								
Private	25.5 (0.32)	23.0 (0.39)	28.1 (0.76)	27.4 (2.89)	29.5 (0.99)	28.9 (1.94)	29.0 (0.69)	31.2 (2.46)
Medicaid	26.2 (0.47)	27.3 (0.91)	24.7 (0.80)	20.4 (2.19)	27.5 (1.74)	27.7 (2.13)	27.4 (0.91)	25.0 (1.72)
Other	25.4 (1.29)	22.9 (1.81)	31.8 (3.47)	*23.1 (10.17)	21.3 (3.82)	*19.1 (6.32)	29.7 (3.15)	33.0 (8.30)
Uninsured	53.0 (0.79)	54.5 (1.31)	50.4 (1.64)	47.0 (4.58)	44.7 (2.68)	47.5 (3.57)	54.9 (1.41)	61.4 (3.22)
Place of residence[11]								
Large MSA	27.5 (0.45)	26.4 (0.68)	24.8 (0.76)	27.1 (2.55)	27.6 (1.43)	32.6 (2.24)	30.9 (0.85)	32.3 (2.41)
Small MSA	25.9 (0.38)	23.1 (0.45)	27.9 (0.84)	25.0 (2.50)	28.2 (1.16)	29.8 (2.05)	30.0 (0.72)	29.9 (1.83)
Not in MSA	36.8 (0.86)	35.8 (1.04)	38.8 (1.52)	26.5 (4.59)	36.8 (1.67)	30.5 (2.89)	39.9 (1.52)	38.4 (2.77)
Region								
Northeast	14.1 (0.47)	12.6 (0.61)	14.0 (0.89)	19.2 (3.43)	16.3 (1.68)	17.1 (3.37)	15.3 (0.93)	23.9 (3.39)
Midwest	28.3 (0.54)	26.7 (0.74)	29.0 (1.11)	24.9 (3.80)	29.7 (1.68)	29.0 (2.73)	30.9 (1.05)	33.1 (3.24)
South	30.9 (0.51)	28.6 (0.63)	31.6 (0.95)	21.5 (2.65)	32.7 (1.32)	31.5 (2.11)	34.6 (0.89)	34.0 (1.89)
West	36.0 (0.58)	33.5 (0.80)	36.3 (1.23)	37.0 (3.33)	34.7 (1.68)	42.0 (2.97)	41.0 (1.10)	35.1 (2.70)

* Estimate has a relative standard error of greater than 30% and should be used with caution because it does not meet the standards of reliability or precision.
– Quantity zero.
[1] A nuclear family consists of one or more children living with two parents who are married to one another and are biological or adoptive parents to all children in the family. A single-parent family consists of one or more children living with a single adult (male or female, related or unrelated). An unmarried biological or adoptive family consists of one or more children living with two parents who

are not married to one another and are biological or adoptive parents to all children in the family. A blended family consists of one or more children living with a biological or adoptive parent and an unrelated stepparent who are married to one another. A cohabiting family consists of one or more children living with a biological or adoptive parent and an unrelated adult who are cohabiting with one another. An extended family consists of one or more children living with at least one biological or adoptive parent and a related adult. An "other" family consists of one or more children living with related or unrelated adults who are not biological or adoptive parents.

[2]Data are based on household interviews of a sample of the civilian noninstitutionalized population. Information regarding receipt of medical checkup is obtained from a question that asked, "During the past 12 months, did [child's name] receive a well child check-up—that is, a general check-up when [he/she] was not sick or injured?" A knowledgeable adult provided information on behalf of child respondents. Unknowns with respect to receipt of medical checkups and family structure are not included in the column labeled "All children aged 1–17 who did not have a medical checkup in the past 12 months" (see Appendix I).

[3]Includes other races not shown separately and children with unknown parent's education, family income, poverty status, or health insurance. Additionally, numbers within selected characteristics may not add to totals because of rounding.

[4]Persons of Hispanic or Latino origin may be of any race or combination of races. Similarly, the category "Not Hispanic or Latino" refers to all persons who are not of Hispanic or Latino origin, regardless of race. To be concise, the text uses shorter versions of the terms shown in the table. For example, the category "Not Hispanic or Latino black or African American, single race" in the tables is referred to as "non–Hispanic black" in the text.

[5]Refers to the education level of the parent with the higher level of education, regardless of that parent's age.

[6]GED is General Educational Development high school equivalency diploma.

[7]Information on family income and poverty status is obtained from the 2001–2007 National Health Interview Survey Imputed Family Income/Personal Earnings Files.

[8]Based on family income and family size using the U.S. Census Bureau's poverty thresholds for the previous calendar year. "Poor" persons are defined as below the poverty threshold. "Near poor" persons have incomes of 100% to less than 200% of the poverty threshold. "Not poor" persons have incomes that are 200% of the poverty threshold or greater.

[9]Based on a question in the Family Core that asked whether the family's house or apartment is owned or being bought, rented, or occupied by some other arrangement (see Appendix II).

[10]Classification of health insurance coverage is based on a hierarchy of mutually exclusive categories. Persons with more than one type of health insurance were assigned to the first appropriate category in the hierarchy. The category "Uninsured" includes persons who had no coverage as well as those who had only Indian Health Service coverage or had only a private plan that paid for one type of service such as accidents or dental care (see Appendix II).

[11]MSA is metropolitan statistical area. Large MSAs have a population size of 1 million or more; small MSAs have a population size of less than 1 million. "Not in MSA" consists of persons not living in a metropolitan statistical area.

SOURCE: CDC/NCHS, National Health Interview Survey, 2001–2007.

Table 41. Frequencies of children aged 2–17 who saw or talked with an eye doctor during the past 12 months, by family structure and by selected characteristics: United States, 2001–2007

Selected characteristics	All children aged 2–17 who saw or talked with an eye doctor in the past 12 months	Family structure[1]						
		Nuclear	Single parent	Unmarried biological or adoptive	Blended	Cohabiting	Extended	Other
	Number in thousands[2]							
Total[3]	14,932	7,002	2,608	88	1,361	416	2,999	458
Sex								
Male	7,170	3,422	1,200	43	659	178	1,446	222
Female	7,761	3,580	1,407	44	702	238	1,553	236
Age								
2–4 years	765	437	115	12	47	33	96	25
5–17 years	14,167	6,565	2,493	76	1,314	383	2,903	433
5–11 years	6,366	3,318	1,160	40	632	206	820	190
12–17 years	7,801	3,247	1,333	36	681	178	2,083	243
Hispanic origin and race[4]								
Hispanic or Latino	2,129	783	406	20	193	61	581	87
Mexican or Mexican American	1,342	520	213	11	123	40	374	61
Not Hispanic or Latino	12,803	6,219	2,202	68	1,168	355	2,419	371
White, single race	9,798	5,320	1,286	48	956	247	1,740	202
Black or African American, single race	1,984	402	763	*13	147	66	456	137
Parent's education[5]								
Less than high school diploma	1,312	347	378	14	76	74	392	*31
High school diploma or GED[6]	3,004	1,077	668	29	326	145	715	44
More than high school diploma	10,180	5,570	1,455	44	949	194	1,865	102
Family income[7]								
Less than $20,000	2,236	444	1,113	18	103	86	380	92
$20,000–$34,999	2,289	703	689	27	213	79	465	113
$35,000–$54,999	2,687	1,137	470	23	338	101	519	98
$55,000–$74,999	2,369	1,261	174	*10	276	73	510	64
$75,000 or more	5,352	3,456	162	*10	432	77	1,125	90
Poverty status[8]								
Poor	2,255	503	913	15	129	91	484	120
Near poor	2,971	917	767	40	325	109	669	144
Not poor	9,705	5,583	927	33	907	215	1,846	194
Home tenure status[9]								
Owned or being bought	10,966	6,002	1,136	41	991	196	2,279	320
Rented	3,655	872	1,384	45	349	212	671	122
Some other arrangement	279	113	83	*1	21	*7	40	*13
Health insurance coverage[10]								
Private	10,122	5,660	1,237	40	925	182	1,953	124
Medicaid	3,479	801	1,152	43	277	177	756	274
Other	313	151	54	*–	35	*7	54	*13
Uninsured	990	386	163	*5	122	50	219	45
Place of residence[11]								
Large MSA	3,745	1,416	913	26	303	105	836	145
Small MSA	8,001	4,091	1,184	36	669	192	1,620	209
Not in MSA	3,185	1,494	511	25	389	119	543	104
Region								
Northeast	3,034	1,446	544	20	190	82	689	62
Midwest	3,950	1,996	663	28	369	106	679	108
South	5,258	2,344	977	19	522	148	1,038	210
West	2,690	1,216	423	21	280	79	593	77

* Estimate has a relative standard error of greater than 30% and should be used with caution because it does not meet the standards of reliability or precision.
– Quantity zero.
[1]A nuclear family consists of one or more children living with two parents who are married to one another and are biological or adoptive parents to all children in the family. A single–parent family consists of one or more children living with a single adult (male or female, related or unrelated). An unmarried biological or adoptive family consists of one or more children living with two parents who are not married to one another and are biological or adoptive parents to all children in the family. A blended family consists of one or more children living with a biological or adoptive parent and an

unrelated stepparent who are married to one another. A cohabiting family consists of one or more children living with a biological or adoptive parent and an unrelated adult who are cohabiting with one another. An extended family consists of one or more children living with at least one biological or adoptive parent and a related adult. An "other" family consists of one or more children living with related or unrelated adults who are not biological or adoptive parents.

[2]Data are based on household interviews of a sample of the civilian noninstitutionalized population. Information regarding contacts with an eye doctor were obtained from a question that asked, "During the past 12 months, have you seen or talked with an optometrist, opthalmologist, or eye doctor (someone who prescribes eye glasses) about [child's name]'s health?" A knowledgeable adult provided information on behalf of child respondents. Unknowns with respect to contacts with eye doctors and family structure are not included in the column labeled "All children aged 2–17 who saw or talked with an eye doctor in the past 12 months" (see Appendix I).

[3]Includes other races not shown separately and children with unknown parent's education, family income, poverty status, or health insurance. Additionally, numbers within selected characteristics may not add to totals because of rounding.

[4]Persons of Hispanic or Latino origin may be of any race or combination of races. Similarly, the category "Not Hispanic or Latino" refers to all persons who are not of Hispanic or Latino origin, regardless of race. To be concise, the text uses shorter versions of the terms shown in the table. For example, the category "Not Hispanic or Latino black or African American, single race" in the tables is referred to as "non–Hispanic black" in the text.

[5]Refers to the education level of the parent with the higher level of education, regardless of that parent's age.

[6]GED is General Educational Development high school equivalency diploma.

[7]Information on family income and poverty status is obtained from the 2001–2007 National Health Interview Survey Imputed Family Income/Personal Earnings Files.

[8]Based on family income and family size using the U.S. Census Bureau's poverty thresholds for the previous calendar year. "Poor" persons are defined as below the poverty threshold. "Near poor" persons have incomes of 100% to less than 200% of the poverty threshold. "Not poor" persons have incomes that are 200% of the poverty threshold or greater.

[9]Based on a question in the Family Core that asked whether the family's house or apartment is owned or being bought, rented, or occupied by some other arrangement (see Appendix II).

[10]Classification of health insurance coverage is based on a hierarchy of mutually exclusive categories. Persons with more than one type of health insurance were assigned to the first appropriate category in the hierarchy. The category "Uninsured" includes persons who had no coverage as well as those who had only Indian Health Service coverage or had only a private plan that paid for one type of service such as accidents or dental care (see Appendix II).

[11]MSA is metropolitan statistical area. Large MSAs have a population size of 1 million or more; small MSAs have a population size of less than 1 million. "Not in MSA" consists of persons not living in a metropolitan statistical area.

SOURCE: CDC/NCHS, National Health Interview Survey, 2001–2007.

Table 42. Percentages (with standard errors) of children aged 2–17 who saw or talked with an eye doctor during the past 12 months, by family structure and by selected characteristics: United States, 2001–2007

Selected characteristics	All children aged 2–17 who saw or talked with an eye doctor in the past 12 months	Family structure[1]						
		Nuclear	Single parent	Unmarried biological or adoptive	Blended	Cohabiting	Extended	Other
	Percent[2] (standard error)							
Total[3]	23.0 (0.23)	22.7 (0.32)	23.6 (0.51)	12.5 (1.47)	23.8 (0.80)	20.4 (1.08)	24.0 (0.48)	22.3 (1.18)
Sex								
Male	21.6 (0.30)	21.6 (0.44)	22.0 (0.68)	11.6 (1.94)	22.5 (1.07)	16.9 (1.41)	22.3 (0.62)	21.3 (1.61)
Female	24.5 (0.31)	23.9 (0.44)	25.3 (0.72)	13.4 (2.18)	25.1 (1.10)	24.1 (1.66)	25.8 (0.69)	23.4 (1.67)
Age								
2–4 years	6.3 (0.27)	6.4 (0.37)	6.9 (0.67)	4.0 (1.16)	5.9 (1.21)	7.9 (1.69)	5.3 (0.61)	7.8 (2.11)
5–17 years	26.9 (0.26)	27.4 (0.39)	26.6 (0.58)	18.6 (2.25)	26.7 (0.89)	23.5 (1.28)	27.2 (0.54)	25.0 (1.33)
5–11 years	22.7 (0.33)	23.0 (0.47)	23.7 (0.79)	13.5 (2.10)	24.8 (1.22)	21.1 (1.65)	20.0 (0.76)	23.1 (1.84)
12–17 years	31.6 (0.38)	34.0 (0.61)	29.7 (0.82)	32.2 (5.36)	28.6 (1.21)	27.0 (2.02)	31.7 (0.70)	26.7 (1.92)
Hispanic origin and race[4]								
Hispanic or Latino	17.7 (0.40)	16.0 (0.57)	21.2 (0.94)	8.6 (1.67)	22.0 (1.58)	16.3 (1.94)	17.5 (0.73)	19.5 (2.06)
Mexican or Mexican American	16.3 (0.49)	14.7 (0.66)	20.1 (1.27)	7.5 (1.91)	20.8 (1.88)	16.5 (2.42)	16.2 (0.86)	18.6 (2.40)
Not Hispanic or Latino	24.2 (0.26)	24.0 (0.37)	24.2 (0.59)	14.3 (2.01)	24.1 (0.89)	21.3 (1.24)	26.4 (0.60)	23.1 (1.40)
White, single race	25.1 (0.30)	24.4 (0.40)	26.1 (0.85)	15.8 (2.47)	24.9 (1.01)	20.4 (1.45)	28.9 (0.79)	23.9 (1.99)
Black or African American, single race	21.0 (0.53)	21.1 (1.06)	21.3 (0.83)	*10.6 (3.29)	19.4 (1.87)	19.3 (2.71)	21.5 (1.02)	22.4 (2.17)
Parent's education[5]								
Less than high school diploma	16.2 (0.51)	14.4 (0.89)	18.1 (1.05)	9.1 (2.24)	16.8 (2.34)	17.6 (2.47)	16.0 (0.91)	21.5 (5.47)
High school diploma or GED[6]	20.7 (0.42)	20.7 (0.69)	21.4 (0.88)	10.9 (2.32)	20.1 (1.55)	19.7 (1.91)	21.5 (0.84)	22.4 (4.62)
More than high school diploma	25.4 (0.29)	24.2 (0.37)	27.5 (0.76)	15.9 (2.60)	26.4 (0.98)	22.3 (1.64)	28.7 (0.71)	23.9 (2.83)
Family income[7]								
Less than $20,000	20.1 (0.49)	18.1 (1.00)	21.3 (0.69)	9.9 (2.30)	18.4 (2.23)	19.1 (2.35)	20.5 (1.12)	22.0 (2.34)
$20,000–$34,999	20.6 (0.52)	18.0 (0.85)	23.6 (0.96)	14.1 (3.27)	21.1 (1.76)	16.5 (2.28)	21.4 (1.14)	23.9 (2.73)
$35,000–$54,999	21.5 (0.51)	20.1 (0.79)	27.0 (1.32)	12.2 (3.10)	23.7 (1.81)	20.8 (2.32)	20.5 (1.04)	21.1 (2.65)
$55,000–$74,999	24.3 (0.60)	23.1 (0.78)	28.2 (2.29)	12.5 (3.64)	25.2 (1.79)	26.4 (3.45)	26.3 (1.38)	23.0 (3.44)
$75,000 or more	26.3 (0.40)	25.9 (0.51)	30.4 (2.67)	15.5 (4.48)	26.4 (1.45)	21.9 (2.56)	28.2 (0.87)	21.8 (2.84)
Poverty status[8]								
Poor	19.4 (0.52)	17.9 (1.00)	20.6 (0.78)	8.6 (2.33)	18.6 (2.06)	18.4 (2.36)	19.6 (1.04)	22.2 (2.48)
Near poor	20.7 (0.47)	18.0 (0.80)	24.2 (0.98)	16.3 (3.24)	22.7 (1.85)	18.7 (2.17)	21.0 (0.99)	23.0 (2.40)
Not poor	25.0 (0.30)	24.4 (0.38)	27.1 (0.88)	11.5 (1.87)	25.2 (0.96)	22.4 (1.63)	27.0 (0.66)	21.9 (1.71)
Home tenure status[9]								
Owned or being bought	24.6 (0.28)	23.9 (0.37)	27.5 (0.86)	13.9 (2.39)	25.3 (1.03)	22.9 (1.65)	25.8 (0.58)	22.7 (1.42)
Rented	19.4 (0.37)	16.9 (0.64)	21.2 (0.63)	11.6 (1.93)	20.8 (1.34)	18.9 (1.41)	19.8 (0.82)	21.2 (2.20)
Some other arrangement	23.2 (1.50)	23.9 (2.41)	25.9 (2.75)	*5.4 (3.83)	18.4 (3.90)	*17.3 (7.61)	21.4 (3.85)	*26.4 (8.90)
Health insurance coverage[10]								
Private	24.8 (0.28)	23.9 (0.37)	26.5 (0.80)	15.8 (2.73)	24.8 (0.93)	22.7 (1.83)	27.7 (0.65)	19.3 (1.91)
Medicaid	21.9 (0.44)	20.8 (0.86)	22.9 (0.75)	12.3 (2.12)	22.4 (1.76)	20.3 (1.70)	21.4 (0.91)	26.5 (1.84)
Other	22.9 (1.35)	24.0 (2.24)	23.5 (3.29)	*–	18.9 (3.44)	*12.8 (4.94)	25.1 (3.16)	27.0 (8.09)
Uninsured	15.3 (0.56)	15.0 (0.94)	15.7 (1.23)	*5.0 (1.91)	22.1 (2.77)	16.5 (2.55)	13.8 (0.92)	14.2 (2.24)
Place of residence[11]								
Large MSA	20.5 (0.39)	19.8 (0.61)	21.7 (0.75)	10.5 (2.12)	21.9 (1.39)	18.1 (1.66)	20.9 (0.77)	20.6 (1.86)
Small MSA	23.3 (0.31)	22.7 (0.43)	24.4 (0.79)	11.3 (1.90)	23.2 (1.08)	20.7 (1.73)	24.9 (0.66)	23.6 (1.84)
Not in MSA	26.1 (0.58)	26.4 (0.81)	26.0 (1.28)	18.7 (4.64)	26.7 (1.89)	22.4 (2.13)	27.5 (1.31)	22.5 (2.76)
Region								
Northeast	25.9 (0.52)	24.8 (0.80)	27.5 (1.31)	15.6 (3.79)	25.7 (2.04)	26.5 (3.24)	28.6 (1.12)	21.2 (2.99)
Midwest	25.9 (0.49)	26.4 (0.70)	25.4 (1.14)	15.3 (3.40)	25.7 (1.80)	19.6 (1.96)	27.3 (1.21)	26.9 (2.96)
South	22.3 (0.38)	22.1 (0.53)	22.2 (0.75)	9.5 (2.51)	21.8 (1.27)	19.2 (1.81)	24.2 (0.80)	23.3 (1.81)
West	18.7 (0.43)	17.8 (0.61)	20.9 (1.15)	10.8 (2.22)	24.2 (1.48)	19.0 (1.96)	18.0 (0.85)	16.9 (2.08)

* Estimate has a relative standard error of greater than 30% and should be used with caution because it does not meet the standards of reliability or precision.

– Quantity zero.

[1] A nuclear family consists of one or more children living with two parents who are married to one another and are biological or adoptive parents to all children in the family. A single-parent family consists of one or more children living with a single adult (male or female, related or unrelated). An unmarried biological or adoptive family consists of one or more children living with two parents who are not married to one another and are biological or adoptive parents to all children in the family. A blended family consists of one or more children living with a biological or adoptive parent and an

unrelated stepparent who are married to one another. A cohabiting family consists of one or more children living with a biological or adoptive parent and an unrelated adult who are cohabiting with one another. An extended family consists of one or more children living with at least one biological or adoptive parent and a related adult. An "other" family consists of one or more children living with related or unrelated adults who are not biological or adoptive parents.

[2]Data are based on household interviews of a sample of the civilian noninstitutionalized population. Information regarding contacts with an eye doctor were obtained from a question that asked, "During the past 12 months, have you seen or talked with an optometrist, opthalmologist, or eye doctor (someone who prescribes eye glasses) about [child's name]'s health?" A knowledgeable adult provided information on behalf of child respondents. Unknowns with respect to contacts with eye doctors and family structure are not included in the column labeled "All children aged 2–17 who saw or talked with an eye doctor in the past 12 months" (see Appendix I).

[3]Includes other races not shown separately and children with unknown parent's education, family income, poverty status, or health insurance.

[4]Persons of Hispanic or Latino origin may be of any race or combination of races. Similarly, the category "Not Hispanic or Latino" refers to all persons who are not of Hispanic or Latino origin, regardless of race. To be concise, the text uses shorter versions of the terms shown in the table. For example, the category "Not Hispanic or Latino black or African American, single race" in the tables is referred to as "non–Hispanic black" in the text.

[5]Refers to the education level of the parent with the higher level of education, regardless of that parent's age.

[6]GED is General Educational Development high school equivalency diploma.

[7]Information on family income and poverty status is obtained from the 2001–2007 National Health Interview Survey Imputed Family Income/Personal Earnings Files.

[8]Based on family income and family size using the U.S. Census Bureau's poverty thresholds for the previous calendar year. "Poor" persons are defined as below the poverty threshold. "Near poor" persons have incomes of 100% to less than 200% of the poverty threshold. "Not poor" persons have incomes that are 200% of the poverty threshold or greater.

[9]Based on a question in the Family Core that asked whether the family's house or apartment is owned or being bought, rented, or occupied by some other arrangement (see Appendix II).

[10]Classification of health insurance coverage is based on a hierarchy of mutually exclusive categories. Persons with more than one type of health insurance were assigned to the first appropriate category in the hierarchy. The category "Uninsured" includes persons who had no coverage as well as those who had only Indian Health Service coverage or had only a private plan that paid for one type of service such as accidents or dental care (see Appendix II).

[11]MSA is metropolitan statistical area. Large MSAs have a population size of 1 million or more; small MSAs have a population size of less than 1 million. "Not in MSA" consists of persons not living in a metropolitan statistical area.

SOURCE: CDC/NCHS, National Health Interview Survey, 2001–2007.

Table 43. Frequencies of children under age 18 who had medical care delayed during the past 12 months due to concerns over cost, by family structure and by selected characteristics: United States, 2001–2007

Selected characteristics	All children under age 18 who had medical care delayed in the past 12 months due to concerns over cost	Family structure[1]						
		Nuclear	Single parent	Unmarried biological or adoptive	Blended	Cohabiting	Extended	Other
	Number in thousands[2]							
Total[3]	2,775	986	686	45	279	134	564	80
Sex								
Male	1,415	511	331	23	143	74	299	34
Female	1,360	476	355	22	137	59	265	46
Age								
0–4 years	606	258	109	22	57	30	116	*14
5–17 years	2,169	728	577	23	222	104	448	66
5–11 years	1,038	413	260	17	112	46	166	23
12–17 years	1,132	315	317	*7	110	57	282	*44
Hispanic origin and race[4]								
Hispanic or Latino	603	207	107	13	49	27	182	18
Mexican or Mexican American	435	168	62	11	33	18	132	*13
Not Hispanic or Latino	2,172	779	579	32	230	107	383	63
White, single race	1,628	649	370	27	189	86	265	*42
Black or African American, single race	370	59	176	*3	27	*13	81	12
Parent's education[5]								
Less than high school diploma	455	130	111	10	30	33	138	*4
High school diploma or GED[6]	697	216	164	13	102	45	149	*7
More than high school diploma	1,552	639	383	22	147	56	270	*34
Family income[7]								
Less than $20,000	680	157	332	8	46	30	97	*10
$20,000–$34,999	744	250	220	18	62	35	141	17
$35,000–$54,999	673	255	101	15	97	45	142	*18
$55,000–$74,999	334	144	20	*2	49	*13	86	*20
$75,000 or more	343	180	*12	*2	25	*11	99	*15
Poverty status[8]								
Poor	673	176	263	*8	52	34	127	*13
Near poor	964	297	253	18	105	48	203	*41
Not poor	1,138	513	171	19	122	52	235	*27
Home tenure status[9]								
Owned or being bought	1,547	682	225	21	153	49	353	64
Rented	1,148	282	436	24	121	71	199	14
Some other arrangement	64	19	24	*–	*3	*4	*12	*2
Health insurance coverage[10]								
Private	980	446	201	12	97	24	176	*24
Medicaid	585	133	197	16	57	41	119	*22
Other	32	*5	*8	*–	*4	*10	*5	*–
Uninsured	1,171	402	277	17	122	58	261	34
Place of residence[11]								
Large MSA	834	240	248	17	78	43	180	*29
Small MSA	1,396	540	315	18	135	53	302	33
Not in MSA	545	206	123	*11	67	38	82	18
Region								
Northeast	349	112	86	*6	42	24	76	*2
Midwest	679	258	164	13	64	33	121	*26
South	1,061	371	289	12	119	40	194	37
West	687	246	147	14	54	37	173	*15

* Estimate has a relative standard error of greater than 30% and should be used with caution because it does not meet the standards of reliability or precision.

– Quantity zero.

[1]A nuclear family consists of one or more children living with two parents who are married to one another and are biological or adoptive parents to all children in the family. A single-parent family consists of one or more children living with a single adult (male or female, related or unrelated). An unmarried biological or adoptive family consists of one or more children living with two parents who are not married to one another and are biological or adoptive parents to all children in the family. A blended family consists of one or more children living with a biological or adoptive parent and an

unrelated stepparent who are married to one another. A cohabiting family consists of one or more children living with a biological or adoptive parent and an unrelated adult who are cohabiting with one another. An extended family consists of one or more children living with at least one biological or adoptive parent and a related adult. An "other" family consists of one or more children living with related or unrelated adults who are not biological or adoptive parents.

[2]Data are based on household interviews of a sample of the civilian noninstitutionalized population. Information regarding the delay of medical care due to cost is obtained from a question in the Family Core that asked, "During the past 12 months, [have/has] [you/anyone in the family] delayed seeking medical care because of worry about the cost?" In the event of an affirmative response, the affected family member(s) was (were) identified. A knowledgeable adult provided information on behalf of child respondents. Unknowns with respect to delays in receipt of medical care due to cost and family structure are not included in the column labeled "All children under age 18 who had medical care delayed in the past 12 months due to concerns over cost" (see Appendix I).

[3]Includes other races not shown separately and children with unknown parent's education, family income, poverty status, or health insurance. Additionally, numbers within selected characteristics may not add to totals because of rounding.

[4]Persons of Hispanic or Latino origin may be of any race or combination of races. Similarly, the category "Not Hispanic or Latino" refers to all persons who are not of Hispanic or Latino origin, regardless of race. To be concise, the text uses shorter versions of the terms shown in the table. For example, the category "Not Hispanic or Latino black or African American, single race" in the tables is referred to as "non–Hispanic black" in the text.

[5]Refers to the education level of the parent with the higher level of education, regardless of that parent's age.

[6]GED is General Educational Development high school equivalency diploma.

[7]Information on family income and poverty status is obtained from the 2001–2007 National Health Interview Survey Imputed Family Income/Personal Earnings Files.

[8]Based on family income and family size using the U.S. Census Bureau's poverty thresholds for the previous calendar year. "Poor" persons are defined as below the poverty threshold. "Near poor" persons have incomes of 100% to less than 200% of the poverty threshold. "Not poor" persons have incomes that are 200% of the poverty threshold or greater.

[9]Based on a question in the Family Core that asked whether the family's house or apartment is owned or being bought, rented, or occupied by some other arrangement (see Appendix II).

[10]Classification of health insurance coverage is based on a hierarchy of mutually exclusive categories. Persons with more than one type of health insurance were assigned to the first appropriate category in the hierarchy. The category "Uninsured" includes persons who had no coverage as well as those who had only Indian Health Service coverage or had only a private plan that paid for one type of service such as accidents or dental care (see Appendix II).

[11]MSA is metropolitan statistical area. Large MSAs have a population size of 1 million or more; small MSAs have a population size of less than 1 million. "Not in MSA" consists of persons not living in a metropolitan statistical area.

SOURCE: CDC/NCHS, National Health Interview Survey, 2001–2007.

Table 44. Percentages (with standard errors) of children under age 18 who had medical care delayed during the past 12 months due to concerns over cost, by family structure and by selected characteristics: United States, 2001–2007

Selected characteristics	All children under age 18 who had medical care delayed in the past 12 months due to concerns over cost	Family structure[1]						
		Nuclear	Single parent	Unmarried biological or adoptive	Blended	Cohabiting	Extended	Other
	Percent[2] (standard error)							
Total[3]	3.8 (0.09)	2.8 (0.11)	5.7 (0.25)	4.3 (0.57)	4.4 (0.37)	5.9 (0.64)	4.1 (0.19)	3.5 (0.68)
Sex								
Male	3.8 (0.13)	2.8 (0.16)	5.6 (0.34)	4.1 (0.75)	4.4 (0.52)	6.3 (1.03)	4.2 (0.27)	2.9 (0.71)
Female	3.8 (0.13)	2.8 (0.15)	5.9 (0.36)	4.4 (0.90)	4.4 (0.54)	5.4 (0.82)	4.0 (0.27)	4.2 (1.16)
Age								
0–4 years	3.0 (0.16)	2.3 (0.19)	4.3 (0.51)	3.3 (0.57)	4.2 (0.75)	4.9 (1.00)	3.7 (0.40)	*2.7 (1.09)
5–17 years	4.1 (0.11)	3.0 (0.14)	6.1 (0.29)	5.7 (1.16)	4.5 (0.41)	6.3 (0.80)	4.2 (0.22)	3.8 (0.82)
5–11 years	3.7 (0.14)	2.9 (0.17)	5.3 (0.38)	5.6 (1.34)	4.4 (0.54)	4.7 (0.81)	4.0 (0.35)	2.7 (0.72)
12–17 years	4.6 (0.17)	3.3 (0.23)	7.0 (0.44)	*5.9 (2.25)	4.6 (0.64)	8.6 (1.68)	4.3 (0.28)	4.8 (1.41)
Hispanic origin and race[4]								
Hispanic or Latino	4.4 (0.18)	3.7 (0.25)	5.1 (0.45)	4.0 (0.87)	5.0 (0.72)	6.5 (1.14)	4.8 (0.35)	3.3 (0.85)
Mexican or Mexican American	4.6 (0.22)	4.1 (0.31)	5.3 (0.59)	4.8 (1.19)	4.9 (0.88)	6.6 (1.38)	4.9 (0.43)	*3.4 (1.02)
Not Hispanic or Latino	3.7 (0.11)	2.6 (0.12)	5.9 (0.29)	4.4 (0.72)	4.3 (0.42)	5.8 (0.74)	3.8 (0.23)	3.6 (0.84)
White, single race	3.7 (0.13)	2.6 (0.14)	7.1 (0.46)	5.7 (1.04)	4.5 (0.49)	6.5 (0.97)	4.1 (0.29)	*4.7 (1.44)
Black or African American, single race	3.5 (0.20)	2.7 (0.42)	4.4 (0.34)	*1.6 (0.68)	3.1 (0.64)	*3.2 (0.99)	3.4 (0.43)	1.8 (0.48)
Parent's education[5]								
Less than high school diploma	4.8 (0.25)	4.7 (0.43)	4.7 (0.46)	4.3 (1.25)	5.8 (1.57)	7.1 (1.34)	4.8 (0.47)	*2.2 (1.01)
High school diploma or GED[6]	4.3 (0.20)	3.7 (0.32)	4.8 (0.43)	3.3 (0.76)	5.7 (0.84)	5.5 (1.02)	4.0 (0.34)	*2.9 (1.53)
More than high school diploma	3.5 (0.11)	2.4 (0.12)	6.8 (0.39)	5.2 (1.02)	3.7 (0.38)	5.8 (1.07)	3.9 (0.26)	*7.4 (2.74)
Family income[7]								
Less than $20,000	5.3 (0.23)	5.3 (0.47)	5.7 (0.33)	2.6 (0.69)	7.0 (1.26)	5.7 (1.31)	4.5 (0.48)	*2.0 (0.68)
$20,000–$34,999	5.9 (0.26)	5.4 (0.39)	7.1 (0.60)	6.3 (1.43)	5.5 (0.83)	6.6 (1.69)	5.7 (0.54)	3.3 (0.81)
$35,000–$54,999	4.8 (0.23)	3.9 (0.30)	5.6 (0.70)	5.8 (1.44)	6.2 (0.95)	8.2 (1.80)	5.0 (0.53)	*3.6 (1.13)
$55,000–$74,999	3.1 (0.24)	2.3 (0.24)	3.2 (0.85)	*2.2 (1.26)	4.1 (0.84)	*4.4 (1.74)	4.1 (0.59)	*6.6 (3.72)
$75,000 or more	1.5 (0.12)	1.2 (0.13)	*2.2 (0.71)	*1.8 (1.24)	1.4 (0.41)	*2.9 (1.52)	2.3 (0.31)	*3.3 (1.51)
Poverty status[8]								
Poor	5.0 (0.24)	5.3 (0.49)	5.2 (0.39)	*3.0 (0.91)	6.3 (1.08)	5.9 (1.46)	4.4 (0.47)	*2.1 (0.74)
Near poor	5.9 (0.27)	5.0 (0.36)	7.4 (0.57)	5.0 (1.09)	6.6 (1.03)	7.1 (1.58)	5.7 (0.47)	*5.9 (1.86)
Not poor	2.6 (0.10)	2.0 (0.11)	4.8 (0.40)	4.5 (0.96)	3.1 (0.36)	5.1 (0.89)	3.2 (0.23)	2.8 (0.83)
Home tenure status[9]								
Owned or being bought	3.1 (0.11)	2.4 (0.12)	5.2 (0.40)	5.4 (1.09)	3.6 (0.41)	5.3 (0.99)	3.7 (0.22)	4.2 (0.98)
Rented	5.2 (0.19)	4.4 (0.30)	6.0 (0.34)	3.8 (0.66)	6.4 (0.83)	5.6 (0.80)	5.1 (0.39)	2.1 (0.53)
Some other arrangement	4.5 (0.58)	3.2 (0.83)	6.8 (1.46)	*–	*2.4 (1.47)	*8.2 (5.15)	*6.0 (2.05)	*2.7 (1.90)
Health insurance coverage[10]								
Private	2.2 (0.09)	1.7 (0.10)	4.1 (0.34)	3.2 (0.87)	2.4 (0.30)	2.8 (0.73)	2.4 (0.20)	*3.5 (1.74)
Medicaid	3.1 (0.16)	2.8 (0.29)	3.5 (0.31)	2.8 (0.68)	4.0 (0.72)	4.1 (0.76)	2.8 (0.26)	*1.9 (0.60)
Other	2.0 (0.46)	*0.6 (0.30)	*3.2 (0.98)	*–	*2.0 (0.99)	*17.7 (8.53)	*2.2 (1.25)	*–
Uninsured	16.7 (0.57)	14.2 (0.83)	25.5 (1.47)	15.2 (2.87)	20.6 (2.50)	18.1 (2.96)	15.2 (0.98)	9.9 (1.93)
Place of residence[11]								
Large MSA	4.0 (0.17)	2.9 (0.24)	5.3 (0.34)	4.4 (0.92)	5.0 (0.67)	6.5 (1.37)	4.0 (0.30)	*3.6 (1.47)
Small MSA	3.6 (0.13)	2.6 (0.15)	6.1 (0.42)	3.9 (0.80)	4.2 (0.58)	5.1 (0.79)	4.2 (0.28)	3.4 (0.87)
Not in MSA	4.0 (0.24)	3.2 (0.26)	5.8 (0.69)	*4.8 (1.47)	4.2 (0.64)	6.6 (1.45)	3.7 (0.49)	3.7 (1.06)
Region								
Northeast	2.7 (0.17)	1.7 (0.21)	4.0 (0.51)	*3.4 (1.44)	5.3 (1.48)	6.8 (1.85)	2.9 (0.39)	*0.7 (0.46)
Midwest	3.9 (0.22)	3.0 (0.24)	5.8 (0.55)	4.6 (1.07)	4.0 (0.65)	5.4 (1.46)	4.4 (0.47)	*5.9 (2.60)
South	4.0 (0.16)	3.0 (0.20)	6.0 (0.38)	3.7 (0.95)	4.5 (0.58)	4.7 (0.81)	4.0 (0.31)	3.7 (0.78)
West	4.3 (0.21)	3.1 (0.25)	6.8 (0.66)	5.2 (1.21)	4.3 (0.62)	8.1 (1.42)	4.8 (0.40)	*3.0 (1.16)

* Estimate has a relative standard error of greater than 30% and should be used with caution because it does not meet the standards of reliability or precision.
– Quantity zero.
[1]A nuclear family consists of one or more children living with two parents who are married to one another and are biological or adoptive parents to all children in the family. A single–parent family consists of one or more children living with a single adult (male or female, related or unrelated). An unmarried biological or adoptive family consists of one or more children living with two parents who are not married to one another and are biological or adoptive parents to all children in the family. A blended family consists of one or more children living with a biological or adoptive parent and an

unrelated stepparent who are married to one another. A cohabiting family consists of one or more children living with a biological or adoptive parent and an unrelated adult who are cohabiting with one another. An extended family consists of one or more children living with at least one biological or adoptive parent and a related adult. An "other" family consists of one or more children living with related or unrelated adults who are not biological or adoptive parents.

[2]Data are based on household interviews of a sample of the civilian noninstitutionalized population. Information regarding the delay of medical care due to cost is obtained from a question in the Family Core that asked, "During the past 12 months, [have/has] [you/anyone in the family] delayed seeking medical care because of worry about the cost?" In the event of an affirmative response, the affected family member(s) was (were) identified. A knowledgeable adult provided information on behalf of child respondents. Unknowns with respect to delays in receipt of medical care due to cost and family structure are not included in the column labeled "All children under age 18 who had medical care delayed in the past 12 months due to concerns over cost" (see Appendix I).

[3]Includes other races not shown separately and children with unknown parent's education, family income, poverty status, or health insurance.

[4]Persons of Hispanic or Latino origin may be of any race or combination of races. Similarly, the category "Not Hispanic or Latino" refers to all persons who are not of Hispanic or Latino origin, regardless of race. To be concise, the text uses shorter versions of the terms shown in the table. For example, the category "Not Hispanic or Latino black or African American, single race" in the tables is referred to as "non–Hispanic black" in the text.

[5]Refers to the education level of the parent with the higher level of education, regardless of that parent's age.

[6]GED is General Educational Development high school equivalency diploma.

[7]Information on family income and poverty status is obtained from the 2001–2007 National Health Interview Survey Imputed Family Income/Personal Earnings Files.

[8]Based on family income and family size using the U.S. Census Bureau's poverty thresholds for the previous calendar year. "Poor" persons are defined as below the poverty threshold. "Near poor" persons have incomes of 100% to less than 200% of the poverty threshold. "Not poor" persons have incomes that are 200% of the poverty threshold or greater.

[9]Based on a question in the Family Core that asked whether the family's house or apartment is owned or being bought, rented, or occupied by some other arrangement (see Appendix II).

[10]Classification of health insurance coverage is based on a hierarchy of mutually exclusive categories. Persons with more than one type of health insurance were assigned to the first appropriate category in the hierarchy. The category "Uninsured" includes persons who had no coverage as well as those who had only Indian Health Service coverage or had only a private plan that paid for one type of service such as accidents or dental care (see Appendix II).

[11]MSA is metropolitan statistical area. Large MSAs have a population size of 1 million or more; small MSAs have a population size of less than 1 million. "Not in MSA" consists of persons not living in a metropolitan statistical area.

SOURCE: CDC/NCHS, National Health Interview Survey, 2001–2007.

Table 45. Frequencies of children aged 2–17 who did not receive needed prescription medication during the past 12 months due to lack of affordability, by family structure and by selected characteristics: United States, 2001–2007

Selected characteristics	All children aged 2–17 who did not receive needed prescription medication in the past 12 months due lack of affordability	Family structure[1]						
		Nuclear	Single parent	Unmarried biological or adoptive	Blended	Cohabiting	Extended	Other
	Number in thousands[2]							
Total[3]	1,838	553	501	24	171	88	447	55
Sex								
Male	921	256	247	15	112	45	217	28
Female	917	297	254	*9	60	42	230	26
Age								
2–4 years	293	110	70	*7	*15	21	61	*9
5–17 years	1,546	442	432	18	156	67	385	46
5–11 years	705	249	197	12	73	24	133	17
12–17 years	840	194	235	*5	83	43	252	29
Hispanic origin and race[4]								
Hispanic or Latino	530	172	96	12	43	25	165	16
Mexican or Mexican American	391	147	57	*9	36	18	112	14
Not Hispanic or Latino	1,308	381	405	*12	128	63	282	38
White, single race	880	299	234	*9	93	51	177	18
Black or African American, single race	334	55	144	*2	34	11	74	14
Parent's education[5]								
Less than high school diploma	419	106	111	*6	30	28	134	*5
High school diploma or GED[6]	523	153	142	*7	56	34	124	*8
More than high school diploma	840	295	231	*12	84	25	184	*8
Family income[7]								
Less than $20,000	614	119	286	*7	32	33	119	19
$20,000–$34,999	520	168	134	*6	53	*17	127	15
$35,000–$54,999	389	138	62	*5	56	23	95	*10
$55,000–$74,999	165	52	*14	*6	20	*9	56	*8
$75,000 or more	150	76	*5	*–	*9	*6	50	*3
Poverty status[8]								
Poor	612	135	233	*8	36	32	146	21
Near poor	633	192	159	*7	70	22	161	23
Not poor	594	226	110	*10	65	34	139	10
Home tenure status[9]								
Owned or being bought	887	329	143	*14	91	35	247	29
Rented	892	206	334	10	79	52	186	24
Some other arrangement	54	*15	23	*–	*2	*–	*13	*1
Health insurance coverage[10]								
Private	626	231	150	*6	72	*20	140	*6
Medicaid	538	102	192	*8	46	32	142	17
Other	*14	*7	*4	*–	*1	*–	*1	*1
Uninsured	652	210	154	*11	51	35	160	31
Place of residence[11]								
Large MSA	618	143	189	*11	66	33	156	18
Small MSA	869	310	225	*10	57	31	218	20
Not in MSA	351	100	88	*3	48	24	72	16
Region								
Northeast	218	51	74	*3	*15	*11	57	*7
Midwest	343	97	93	*4	37	17	82	*14
South	851	266	240	*10	91	36	188	19
West	426	138	94	*8	28	24	120	14

* Estimate has a relative standard error of greater than 30% and should be used with caution because it does not meet the standards of reliability or precision.
– Quantity zero.

[1]A nuclear family consists of one or more children living with two parents who are married to one another and are biological or adoptive parents to all children in the family. A single-parent family consists of one or more children living with a single adult (male or female, related or unrelated). An unmarried biological or adoptive family consists of one or more children living with two parents who are not married to one another and are biological or adoptive parents to all children in the family. A blended family consists of one or more children living with a biological or adoptive parent and an unrelated stepparent who are married to one another. A cohabiting family consists of one or more children living with a biological or adoptive parent and an unrelated adult who are cohabiting with one another. An extended family consists of one or more children living with at least one biological or adoptive parent and a related adult. An "other" family consists of one or more children living with related or unrelated adults who are not biological or adoptive parents.

[2]Data are based on household interviews of a sample of the civilian noninstitutionalized population. Information regarding not receiving prescription medication due to lack of affordability is based on a question that asked, "During the past 12 months, was there any time when [child's name] needed prescription medication, but didn't get it because you couldn't afford it?" A knowledgeable adult provided information on behalf of child respondents. Unknowns with respect to not receiving prescription medication and family structure are not included in the column labeled "All children aged 2–17 who did not receive needed prescription medication in the past 12 months due to lack of affordability" (see Appendix I).

[3]Includes other races not shown separately and children with unknown parent's education, family income, poverty status, or health insurance. Additionally, numbers within selected characteristics may not add to totals because of rounding.

[4]Persons of Hispanic or Latino origin may be of any race or combination of races. Similarly, the category "Not Hispanic or Latino" refers to all persons who are not of Hispanic or Latino origin, regardless of race. To be concise, the text uses shorter versions of the terms shown in the table. For example, the category "Not Hispanic or Latino black or African American, single race" in the tables is referred to as "non-Hispanic black" in the text.

[5]Refers to the education level of the parent with the higher level of education, regardless of that parent's age.

[6]GED is General Educational Development high school equivalency diploma.

[7]Information on family income and poverty status is obtained from the 2001–2007 National Health Interview Survey Imputed Family Income/Personal Earnings Files.

[8]Based on family income and family size using the U.S. Census Bureau's poverty thresholds for the previous calendar year. "Poor" persons are defined as below the poverty threshold. "Near poor" persons have incomes of 100% to less than 200% of the poverty threshold. "Not poor" persons have incomes that are 200% of the poverty threshold or greater.

[9]Based on a question in the Family Core that asked whether the family's house or apartment is owned or being bought, rented, or occupied by some other arrangement (see Appendix II).

[10]Classification of health insurance coverage is based on a hierarchy of mutually exclusive categories. Persons with more than one type of health insurance were assigned to the first appropriate category in the hierarchy. The category "Uninsured" includes persons who had no coverage as well as those who had only Indian Health Service coverage or had only a private plan that paid for one type of service such as accidents or dental care (see Appendix II).

[11]MSA is metropolitan statistical area. Large MSAs have a population size of 1 million or more; small MSAs have a population size of less than 1 million. "Not in MSA" consists of persons not living in a metropolitan statistical area.

SOURCE: CDC/NCHS, National Health Interview Survey, 2001–2007.

Table 46. Percentages (with standard errors) of children aged 2–17 who did not receive needed prescription medication during the past 12 months due to lack of affordability, by family structure and by selected characteristics: United States, 2001–2007

Selected characteristics	All children aged 2–17 who did not receive needed prescription medication in the past 12 months due to lack of affordability	Family structure[1]						
		Nuclear	Single parent	Unmarried biological or adoptive	Blended	Cohabiting	Extended	Other
	Percent[2] (standard error)							
Total[3]	2.8 (0.08)	1.8 (0.09)	4.5 (0.24)	3.4 (0.72)	3.0 (0.26)	4.3 (0.52)	3.6 (0.19)	2.6 (0.37)
Sex								
Male	2.8 (0.11)	1.6 (0.12)	4.5 (0.32)	4.2 (1.11)	3.8 (0.42)	4.3 (0.70)	3.3 (0.25)	2.7 (0.54)
Female	2.9 (0.11)	2.0 (0.14)	4.5 (0.35)	*2.6 (0.86)	2.1 (0.31)	4.3 (0.80)	3.8 (0.29)	2.6 (0.52)
Age								
2–4 years	2.4 (0.17)	1.6 (0.18)	4.2 (0.56)	*2.2 (0.76)	*1.9 (0.57)	5.0 (1.20)	3.4 (0.54)	*2.8 (0.98)
5–17 years	2.9 (0.09)	1.8 (0.11)	4.6 (0.26)	4.3 (1.10)	3.2 (0.29)	4.1 (0.57)	3.6 (0.20)	2.6 (0.40)
5–11 years	2.5 (0.11)	1.7 (0.13)	4.0 (0.36)	4.2 (1.23)	2.9 (0.39)	2.4 (0.51)	3.2 (0.30)	2.0 (0.49)
12–17 years	3.4 (0.14)	2.0 (0.19)	5.2 (0.37)	*4.6 (2.35)	3.5 (0.47)	6.5 (1.24)	3.8 (0.26)	3.2 (0.62)
Hispanic origin and race[4]								
Hispanic or Latino	4.4 (0.20)	3.5 (0.28)	5.0 (0.52)	5.4 (1.52)	4.9 (0.73)	6.7 (1.35)	5.0 (0.38)	3.7 (0.77)
Mexican or Mexican American	4.7 (0.25)	4.1 (0.36)	5.3 (0.68)	5.6 (1.63)	6.1 (1.00)	7.3 (1.80)	4.8 (0.44)	4.3 (1.00)
Not Hispanic or Latino	2.5 (0.09)	1.5 (0.10)	4.4 (0.27)	*2.5 (0.76)	2.6 (0.29)	3.7 (0.57)	3.1 (0.21)	2.4 (0.42)
White, single race	2.3 (0.10)	1.4 (0.10)	4.7 (0.38)	*2.8 (1.01)	2.4 (0.31)	4.2 (0.74)	2.9 (0.29)	2.1 (0.56)
Black or African American, single race	3.5 (0.21)	2.9 (0.49)	4.0 (0.36)	*1.8 (1.41)	4.5 (0.86)	3.2 (0.87)	3.5 (0.42)	2.3 (0.69)
Parent's education[5]								
Less than high school diploma	5.1 (0.29)	4.4 (0.50)	5.3 (0.64)	*3.5 (1.39)	6.7 (1.28)	6.6 (1.45)	5.4 (0.48)	*3.2 (1.99)
High school diploma or GED[6]	3.6 (0.19)	2.9 (0.31)	4.5 (0.42)	*2.5 (0.88)	3.5 (0.61)	4.6 (0.94)	3.7 (0.37)	*4.0 (1.68)
More than high school diploma	2.1 (0.09)	1.3 (0.09)	4.4 (0.33)	*4.4 (1.39)	2.3 (0.30)	2.9 (0.59)	2.8 (0.24)	*2.0 (0.80)
Family income[7]								
Less than $20,000	5.5 (0.25)	4.8 (0.52)	5.5 (0.38)	*3.9 (1.43)	5.7 (1.15)	7.3 (1.46)	6.4 (0.65)	4.5 (1.05)
$20,000–$34,999	4.7 (0.23)	4.3 (0.41)	4.6 (0.41)	*3.2 (1.41)	5.3 (0.90)	*3.5 (1.16)	5.8 (0.56)	3.1 (0.92)
$35,000–$54,999	3.1 (0.19)	2.4 (0.28)	3.6 (0.55)	*2.7 (1.10)	4.0 (0.67)	4.6 (1.21)	3.7 (0.46)	*2.2 (0.72)
$55,000–$74,999	1.7 (0.19)	1.0 (0.17)	*2.2 (0.68)	*7.1 (3.60)	1.8 (0.54)	*3.2 (1.45)	2.9 (0.61)	*2.8 (1.09)
$75,000 or more	0.7 (0.08)	0.6 (0.10)	*1.0 (0.57)	*–	*0.6 (0.26)	*1.8 (1.16)	1.2 (0.22)	*0.7 (0.34)
Poverty status[8]								
Poor	5.2 (0.25)	4.8 (0.50)	5.2 (0.42)	*4.6 (1.68)	5.2 (1.01)	6.4 (1.32)	5.9 (0.58)	4.0 (1.00)
Near poor	4.4 (0.21)	3.7 (0.36)	5.0 (0.45)	*2.7 (1.04)	4.9 (0.71)	3.7 (1.02)	5.1 (0.46)	3.6 (0.85)
Not poor	1.5 (0.07)	1.0 (0.08)	3.2 (0.34)	*3.4 (1.26)	1.8 (0.27)	3.5 (0.77)	2.0 (0.21)	1.2 (0.30)
Home tenure status[9]								
Owned or being bought	2.0 (0.08)	1.3 (0.09)	3.4 (0.32)	*4.7 (1.42)	2.3 (0.29)	4.1 (0.88)	2.8 (0.20)	2.1 (0.38)
Rented	4.7 (0.18)	4.0 (0.34)	5.1 (0.34)	2.6 (0.70)	4.7 (0.63)	4.6 (0.70)	5.5 (0.43)	4.2 (0.92)
Some other arrangement	4.5 (0.71)	*3.2 (1.15)	7.1 (1.62)	*–	*1.8 (1.06)	*–	6.7 (1.96)	*2.1 (2.08)
Health insurance coverage[10]								
Private	1.5 (0.08)	1.0 (0.08)	3.2 (0.29)	*2.3 (1.04)	1.9 (0.30)	*2.4 (0.74)	2.0 (0.20)	*0.9 (0.39)
Medicaid	3.4 (0.17)	2.6 (0.32)	3.8 (0.34)	*2.2 (0.74)	3.7 (0.61)	3.6 (0.72)	4.0 (0.38)	1.6 (0.37)
Other	*1.0 (0.33)	*1.1 (0.63)	*1.9 (0.76)	*–	*0.6 (0.48)	*–	*0.6 (0.33)	*1.3 (1.30)
Uninsured	10.1 (0.40)	8.2 (0.66)	14.8 (1.18)	*11.4 (3.43)	9.3 (1.39)	11.7 (2.19)	10.0 (0.76)	9.7 (1.82)
Place of residence[11]								
Large MSA	3.4 (0.16)	2.0 (0.19)	4.5 (0.34)	*4.5 (1.40)	4.8 (0.74)	5.7 (1.24)	3.9 (0.35)	2.6 (0.56)
Small MSA	2.5 (0.11)	1.7 (0.13)	4.6 (0.38)	*3.0 (1.01)	2.0 (0.28)	3.3 (0.63)	3.3 (0.24)	2.2 (0.55)
Not in MSA	2.9 (0.18)	1.8 (0.20)	4.5 (0.62)	*2.4 (1.20)	3.3 (0.56)	4.4 (0.99)	3.7 (0.53)	3.5 (0.96)
Region								
Northeast	1.9 (0.16)	0.9 (0.18)	3.7 (0.53)	*2.1 (1.45)	2.1 (0.61)	3.6 (1.04)	2.3 (0.34)	*2.2 (1.05)
Midwest	2.2 (0.15)	1.3 (0.17)	3.5 (0.44)	*2.0 (0.86)	2.6 (0.45)	3.0 (0.84)	3.3 (0.41)	*3.6 (1.10)
South	3.6 (0.14)	2.5 (0.17)	5.4 (0.44)	*4.9 (1.73)	3.8 (0.48)	4.7 (0.90)	4.4 (0.35)	2.1 (0.43)
West	3.0 (0.17)	2.0 (0.21)	4.6 (0.51)	*4.2 (1.40)	2.5 (0.49)	5.6 (1.38)	3.6 (0.37)	3.1 (0.78)

* Estimate has a relative standard error of greater than 30% and should be used with caution because it does not meet the standards of reliability or precision.
– Quantity zero.

[1]A nuclear family consists of one or more children living with two parents who are married to one another and are biological or adoptive parents to all children in the family. A single-parent family consists of one or more children living with a single adult (male or female, related or unrelated). An unmarried biological or adoptive family consists of one or more children living with two parents who are not married to one another and are biological or adoptive parents to all children in the family. A blended family consists of one or more children living with a biological or adoptive parent and an unrelated stepparent who are married to one another. A cohabiting family consists of one or more children living with a biological or adoptive parent and an unrelated adult who are cohabiting with one another. An extended family consists of one or more children living with at least one biological or adoptive parent and a related adult. An "other" family consists of one or more children living with related or unrelated adults who are not biological or adoptive parents.

[2]Data are based on household interviews of a sample of the civilian noninstitutionalized population. Information regarding not receiving prescription medication due to lack of affordability is based on a question that asked, "During the past 12 months, was there any time when [child's name] needed prescription medication, but didn't get it because you couldn't afford it?" A knowledgeable adult provided information on behalf of child respondents. Unknowns with respect to not receiving prescription medication and family structure are not included in the column labeled "All children aged 2–17 who did not receive needed prescription medication in the past 12 months due to lack of affordability" (see Appendix I).

[3]Includes other races not shown separately and children with unknown parent's education, family income, poverty status, or health insurance.

[4]Persons of Hispanic or Latino origin may be of any race or combination of races. Similarly, the category "Not Hispanic or Latino" refers to all persons who are not of Hispanic or Latino origin, regardless of race. To be concise, the text uses shorter versions of the terms shown in the table. For example, the category "Not Hispanic or Latino black or African American, single race" in the tables is referred to as "non-Hispanic black" in the text.

[5]Refers to the education level of the parent with the higher level of education, regardless of that parent's age.

[6]GED is General Educational Development high school equivalency diploma.

[7]Information on family income and poverty status is obtained from the 2001–2007 National Health Interview Survey Imputed Family Income/Personal Earnings Files.

[8]Based on family income and family size using the U.S. Census Bureau's poverty thresholds for the previous calendar year. "Poor" persons are defined as below the poverty threshold. "Near poor" persons have incomes of 100% to less than 200% of the poverty threshold. "Not poor" persons have incomes that are 200% of the poverty threshold or greater.

[9]Based on a question in the Family Core that asked whether the family's house or apartment is owned or being bought, rented, or occupied by some other arrangement (see Appendix II).

[10]Classification of health insurance coverage is based on a hierarchy of mutually exclusive categories. Persons with more than one type of health insurance were assigned to the first appropriate category in the hierarchy. The category "Uninsured" includes persons who had no coverage as well as those who had only Indian Health Service coverage or had only a private plan that paid for one type of service such as accidents or dental care (see Appendix II).

[11]MSA is metropolitan statistical area. Large MSAs have a population size of 1 million or more; small MSAs have a population size of less than 1 million. "Not in MSA" consists of persons not living in a metropolitan statistical area.

SOURCE: CDC/NCHS, National Health Interview Survey, 2001–2007.

Table 47. Frequencies of children aged 2–17 who needed but did not get eyeglasses during the past 12 months due to lack of affordability, by family structure and by selected characteristics: United States, 2001–2007

Selected characteristics	All children aged 2–17 who needed but did not get eyeglasses in the past 12 months due to lack of affordability	Family structure[1]						
		Nuclear	Single parent	Unmarried biological or adoptive	Blended	Cohabiting	Extended	Other
	Number in thousands[2]							
Total[3]	1,413	400	379	15	152	58	357	52
Sex								
Male	650	181	178	*6	74	29	168	13
Female	763	219	201	*8	78	29	189	39
Age								
2–4 years	50	29	*5	*1	*1	*2	*7	*4
5–17 years	1,363	371	374	*14	151	55	350	48
5–11 years	478	152	134	*5	50	19	102	*15
12–17 years	886	218	241	*9	101	36	248	33
Hispanic origin and race[4]								
Hispanic or Latino	377	120	64	*7	35	15	122	*13
Mexican or Mexican American	283	101	40	*3	27	8	90	*12
Not Hispanic or Latino	1,036	280	315	*8	117	43	235	39
White, single race	708	237	180	*5	93	33	139	20
Black or African American, single race	253	25	112	*3	21	*7	67	*17
Parent's education[5]								
Less than high school diploma	280	77	78	*2	12	14	94	*4
High school diploma or GED[6]	390	114	110	*–	50	16	91	*9
More than high school diploma	693	209	177	*12	87	26	166	*16
Family income[7]								
Less than $20,000	419	75	200	*2	22	15	93	12
$20,000–$34,999	416	117	110	*5	54	15	103	*12
$35,000–$54,999	307	97	57	*3	40	17	82	*12
$55,000–$74,999	153	60	*7	*4	25	*7	41	*9
$75,000 or more	117	50	*5	*1	*11	*3	38	*7
Poverty status[8]								
Poor	436	92	171	*4	24	18	113	*15
Near poor	484	123	120	*3	74	15	128	22
Not poor	492	185	88	*8	54	26	116	*15
Home tenure status[9]								
Owned or being bought	769	278	127	*9	89	18	215	33
Rented	593	108	234	*5	61	37	134	14
Some other arrangement	46	*13	17	*–	*2	*3	*7	*4
Health insurance coverage[10]								
Private	538	178	138	*2	67	18	122	*12
Medicaid	409	72	139	*6	32	21	119	20
Other	16	*3	*6	*–	*3	*1	*2	*1
Uninsured	447	148	95	*5	51	17	113	20
Place of residence[11]								
Large MSA	444	110	129	*6	42	27	116	15
Small MSA	639	194	175	*5	69	13	159	24
Not in MSA	330	97	75	*4	41	17	82	*14
Region								
Northeast	182	38	60	*3	15	*8	47	*10
Midwest	326	96	101	*2	37	20	64	*6
South	599	172	159	*5	70	22	143	29
West	306	94	59	*4	30	*8	103	*8

* Estimate has a relative standard error of greater than 30% and should be used with caution because it does not meet the standards of reliability or precision.

– Quantity zero.

[1]A nuclear family consists of one or more children living with two parents who are married to one another and are biological or adoptive parents to all children in the family. A single-parent family

consists of one or more children living with a single adult (male or female, related or unrelated). An unmarried biological or adoptive family consists of one or more children living with two parents who are not married to one another and are biological or adoptive parents to all children in the family. A blended family consists of one or more children living with a biological or adoptive parent and an unrelated stepparent who are married to one another. A cohabiting family consists of one or more children living with a biological or adoptive parent and an unrelated adult who are cohabiting with one another. An extended family consists of one or more children living with at least one biological or adoptive parent and a related adult. An "other" family consists of one or more children living with related or unrelated adults who are not biological or adoptive parents.

[2]Data are based on household interviews of a sample of the civilian noninstitutionalized population. Information regarding not having eyeglasses due to lack of affordability is based on a question that asked, "During the past 12 months, was there any time when [child's name] needed eyeglasses, but didn't get them because you couldn't afford them?" A knowledgeable adult provided information on behalf of child respondents. Unknowns with respect to not having eyeglasses and family structure are not included in the column labeled "All children aged 2–17 who needed but did not get eyeglasses in the past 12 months due to lack of affordability" (see Appendix I).

[3]Includes other races not shown separately and children with unknown parent's education, family income, poverty status, or health insurance. Additionally, numbers within selected characteristics may not add to totals because of rounding.

[4]Persons of Hispanic or Latino origin may be of any race or combination of races. Similarly, the category "Not Hispanic or Latino" refers to all persons who are not of Hispanic or Latino origin, regardless of race. To be concise, the text uses shorter versions of the terms shown in the table. For example, the category "Not Hispanic or Latino black or African American, single race" in the tables is referred to as "non-Hispanic black" in the text.

[5]Refers to the education level of the parent with the higher level of education, regardless of that parent's age.

[6]GED is General Educational Development high school equivalency diploma.

[7]Information on family income and poverty status is obtained from the 2001–2007 National Health Interview Survey Imputed Family Income/Personal Earnings Files.

[8]Based on family income and family size using the U.S. Census Bureau's poverty thresholds for the previous calendar year. "Poor" persons are defined as below the poverty threshold. "Near poor" persons have incomes of 100% to less than 200% of the poverty threshold. "Not poor" persons have incomes that are 200% of the poverty threshold or greater.

[9]Based on a question in the Family Core that asked whether the family's house or apartment is owned or being bought, rented, or occupied by some other arrangement (see Appendix II).

[10]Classification of health insurance coverage is based on a hierarchy of mutually exclusive categories. Persons with more than one type of health insurance were assigned to the first appropriate category in the hierarchy. The category "Uninsured" includes persons who had no coverage as well as those who had only Indian Health Service coverage or had only a private plan that paid for one type of service such as accidents or dental care (see Appendix II).

[11]MSA is metropolitan statistical area. Large MSAs have a population size of 1 million or more; small MSAs have a population size of less than 1 million. "Not in MSA" consists of persons not living in a metropolitan statistical area.

SOURCE: CDC/NCHS, National Health Interview Survey, 2001–2007.

Table 48. Percentages (with standard errors) of children aged 2–17 who needed but did not get eyeglasses during the past 12 months due to lack of affordability, by family structure and by selected characteristics: United States, 2001–2007

Selected characteristics	All children aged 2–17 who needed but did not get eyeglasses in the past 12 months due to lack of affordability	Family structure[1]						
		Nuclear	Single parent	Unmarried biological or adoptive	Blended	Cohabiting	Extended	Other
	Percent[2] (standard error)							
Total[3]	2.2 (0.07)	1.3 (0.08)	3.4 (0.21)	2.1 (0.61)	2.7 (0.30)	2.8 (0.40)	2.9 (0.17)	2.5 (0.43)
Sex								
Male	2.0 (0.09)	1.1 (0.10)	3.3 (0.28)	*1.7 (0.77)	2.5 (0.37)	2.8 (0.57)	2.6 (0.24)	1.3 (0.36)
Female	2.4 (0.11)	1.5 (0.12)	3.6 (0.30)	*2.5 (0.96)	2.8 (0.46)	2.9 (0.52)	3.1 (0.24)	3.8 (0.78)
Age								
2–4 years	0.4 (0.06)	0.4 (0.09)	*0.3 (0.13)	*0.2 (0.19)	*0.1 (0.13)	*0.6 (0.36)	*0.4 (0.13)	*1.2 (0.43)
5–17 years	2.6 (0.09)	1.5 (0.10)	4.0 (0.24)	*3.4 (1.04)	3.1 (0.34)	3.4 (0.49)	3.3 (0.20)	2.8 (0.50)
5–11 years	1.7 (0.09)	1.1 (0.10)	2.7 (0.29)	*1.8 (0.72)	2.0 (0.38)	2.0 (0.43)	2.5 (0.28)	*1.8 (0.65)
12–17 years	3.6 (0.15)	2.3 (0.19)	5.3 (0.38)	*7.8 (3.16)	4.2 (0.58)	5.4 (0.98)	3.8 (0.27)	3.6 (0.74)
Hispanic origin and race[4]								
Hispanic or Latino	3.1 (0.17)	2.5 (0.22)	3.3 (0.43)	*3.1 (1.30)	4.0 (0.77)	4.1 (0.91)	3.7 (0.31)	*3.0 (0.92)
Mexican or Mexican American	3.4 (0.22)	2.9 (0.28)	3.8 (0.56)	*2.2 (1.09)	4.6 (1.00)	3.4 (0.98)	3.9 (0.40)	*3.7 (1.23)
Not Hispanic or Latino	2.0 (0.08)	1.1 (0.08)	3.4 (0.23)	*1.6 (0.65)	2.4 (0.32)	2.5 (0.44)	2.6 (0.20)	2.4 (0.48)
White, single race	1.8 (0.10)	1.1 (0.09)	3.7 (0.34)	*1.7 (0.90)	2.4 (0.38)	2.7 (0.54)	2.3 (0.25)	2.4 (0.66)
Black or African American, single race	2.7 (0.18)	1.3 (0.34)	3.1 (0.31)	*2.1 (1.25)	2.8 (0.64)	*2.0 (0.71)	3.2 (0.40)	*2.8 (0.86)
Parent's education[5]								
Less than high school diploma	3.4 (0.23)	3.2 (0.36)	3.7 (0.54)	*1.4 (0.92)	2.6 (0.74)	3.3 (0.88)	3.8 (0.41)	*2.5 (1.31)
High school diploma or GED[6]	2.7 (0.17)	2.2 (0.25)	3.5 (0.39)	*–	3.1 (0.59)	2.2 (0.63)	2.7 (0.29)	*4.5 (2.00)
More than high school diploma	1.7 (0.08)	0.9 (0.08)	3.3 (0.28)	*4.2 (1.42)	2.4 (0.37)	3.0 (0.59)	2.6 (0.24)	*3.7 (1.31)
Family income[7]								
Less than $20,000	3.8 (0.22)	3.1 (0.40)	3.8 (0.32)	*1.0 (0.92)	4.0 (1.03)	3.4 (0.84)	5.0 (0.63)	2.8 (0.78)
$20,000–$34,999	3.7 (0.22)	3.0 (0.37)	3.8 (0.38)	*2.7 (1.29)	5.4 (0.92)	3.1 (0.85)	4.7 (0.54)	*2.6 (0.92)
$35,000–$54,999	2.5 (0.19)	1.7 (0.19)	3.3 (0.59)	*1.4 (1.11)	2.8 (0.67)	3.5 (0.93)	3.2 (0.44)	*2.6 (1.28)
$55,000–$74,999	1.6 (0.16)	1.1 (0.19)	*1.1 (0.47)	*4.6 (2.85)	2.2 (0.59)	*2.7 (1.06)	2.1 (0.43)	*3.1 (1.31)
$75,000 or more	0.6 (0.08)	0.4 (0.08)	*1.0 (0.47)	*2.0 (2.02)	*0.7 (0.31)	*0.9 (0.57)	1.0 (0.18)	*1.7 (1.14)
Poverty status[8]								
Poor	3.7 (0.22)	3.3 (0.45)	3.8 (0.36)	*2.3 (1.28)	3.4 (0.85)	3.5 (0.95)	4.5 (0.53)	*2.8 (0.91)
Near poor	3.4 (0.19)	2.4 (0.26)	3.8 (0.40)	*1.2 (0.64)	5.2 (0.90)	2.5 (0.66)	4.0 (0.43)	3.5 (1.04)
Not poor	1.3 (0.07)	0.8 (0.07)	2.6 (0.32)	*2.7 (1.20)	1.5 (0.26)	2.6 (0.57)	1.7 (0.18)	*1.6 (0.64)
Home tenure status[9]								
Owned or being bought	1.7 (0.08)	1.1 (0.08)	3.1 (0.32)	*3.2 (1.25)	2.3 (0.35)	2.1 (0.53)	2.4 (0.19)	2.3 (0.53)
Rented	3.1 (0.15)	2.1 (0.20)	3.6 (0.27)	*1.3 (0.54)	3.7 (0.59)	3.3 (0.55)	4.0 (0.38)	2.4 (0.70)
Some other arrangement	3.8 (0.73)	*2.7 (1.11)	5.4 (1.29)	*–	*1.5 (1.15)	*7.8 (4.80)	*3.9 (1.73)	*7.2 (3.41)
Health insurance coverage[10]								
Private	1.3 (0.07)	0.7 (0.07)	2.9 (0.31)	*1.0 (0.58)	1.8 (0.29)	2.3 (0.57)	1.7 (0.17)	*1.9 (0.69)
Medicaid	2.6 (0.16)	1.9 (0.27)	2.8 (0.27)	*1.7 (0.80)	2.6 (0.59)	2.4 (0.59)	3.4 (0.38)	1.9 (0.56)
Other	1.2 (0.31)	*0.4 (0.20)	*2.6 (1.05)	*–	*1.4 (1.18)	*2.7 (2.68)	*0.8 (0.49)	*1.2 (1.20)
Uninsured	6.9 (0.36)	5.7 (0.52)	9.1 (0.93)	*5.0 (2.72)	9.1 (1.62)	5.6 (1.33)	7.1 (0.64)	6.2 (1.52)
Place of residence[11]								
Large MSA	2.4 (0.12)	1.5 (0.17)	3.0 (0.27)	*2.3 (1.08)	3.0 (0.53)	4.7 (0.85)	2.9 (0.28)	2.0 (0.55)
Small MSA	1.9 (0.09)	1.1 (0.10)	3.6 (0.34)	*1.6 (0.74)	2.4 (0.39)	1.4 (0.39)	2.4 (0.20)	2.7 (0.70)
Not in MSA	2.7 (0.21)	1.7 (0.18)	3.8 (0.54)	*2.7 (1.73)	2.8 (0.74)	3.3 (0.93)	4.2 (0.62)	*2.9 (1.05)
Region								
Northeast	1.6 (0.14)	0.7 (0.13)	3.0 (0.47)	*2.6 (1.87)	2.1 (0.59)	*2.7 (0.87)	1.9 (0.33)	*3.3 (1.43)
Midwest	2.1 (0.17)	1.3 (0.17)	3.9 (0.47)	*1.2 (0.80)	2.6 (0.71)	3.7 (0.94)	2.6 (0.41)	*1.4 (0.79)
South	2.5 (0.12)	1.6 (0.14)	3.6 (0.34)	*2.6 (1.33)	2.9 (0.43)	2.8 (0.68)	3.3 (0.29)	3.2 (0.71)
West	2.1 (0.15)	1.4 (0.16)	2.9 (0.39)	*1.9 (0.96)	2.6 (0.68)	1.9 (0.56)	3.1 (0.36)	*1.7 (0.63)

* Estimate has a relative standard error of greater than 30% and should be used with caution because it does not meet the standards of reliability or precision.

– Quantity zero.

[1]A nuclear family consists of one or more children living with two parents who are married to one another and are biological or adoptive parents to all children in the family. A single-parent family

consists of one or more children living with a single adult (male or female, related or unrelated). An unmarried biological or adoptive family consists of one or more children living with two parents who are not married to one another and are biological or adoptive parents to all children in the family. A blended family consists of one or more children living with a biological or adoptive parent and an unrelated stepparent who are married to one another. A cohabiting family consists of one or more children living with a biological or adoptive parent and an unrelated adult who are cohabiting with one another. An extended family consists of one or more children living with at least one biological or adoptive parent and a related adult. An "other" family consists of one or more children living with related or unrelated adults who are not biological or adoptive parents.

[2]Data are based on household interviews of a sample of the civilian noninstitutionalized population. Information regarding not having eyeglasses due to lack of affordability is based on a question that asked, "During the past 12 months, was there any time when [child's name] needed eyeglasses, but didn't get them because you couldn't afford them?" A knowledgeable adult provided information on behalf of child respondents. Unknowns with respect to not having eyeglasses and family structure are not included in the column labeled "All children aged 2–17 who needed but did not get eyeglasses in the past 12 months due to lack of affordability" (see Appendix I).

[3]Includes other races not shown separately and children with unknown parent's education, family income, poverty status, or health insurance.

[4]Persons of Hispanic or Latino origin may be of any race or combination of races. Similarly, the category "Not Hispanic or Latino" refers to all persons who are not of Hispanic or Latino origin, regardless of race. To be concise, the text uses shorter versions of the terms shown in the table. For example, the category "Not Hispanic or Latino black or African American, single race" in the tables is referred to as "non-Hispanic black" in the text.

[5]Refers to the education level of the parent with the higher level of education, regardless of that parent's age.

[6]GED is General Educational Development high school equivalency diploma.

[7]Information on family income and poverty status is obtained from the 2001–2007 National Health Interview Survey Imputed Family Income/Personal Earnings Files.

[8]Based on family income and family size using the U.S. Census Bureau's poverty thresholds for the previous calendar year. "Poor" persons are defined as below the poverty threshold. "Near poor" persons have incomes of 100% to less than 200% of the poverty threshold. "Not poor" persons have incomes that are 200% of the poverty threshold or greater.

[9]Based on a question in the Family Core that asked whether the family's house or apartment is owned or being bought, rented, or occupied by some other arrangement (see Appendix II).

[10]Classification of health insurance coverage is based on a hierarchy of mutually exclusive categories. Persons with more than one type of health insurance were assigned to the first appropriate category in the hierarchy. The category "Uninsured" includes persons who had no coverage as well as those who had only Indian Health Service coverage or had only a private plan that paid for one type of service such as accidents or dental care (see Appendix II).

[11]MSA is metropolitan statistical area. Large MSAs have a population size of 1 million or more; small MSAs have a population size of less than 1 million. "Not in MSA" consists of persons not living in a metropolitan statistical area.

SOURCE: CDC/NCHS, National Health Interview Survey, 2001–2007.

Table 49. Frequencies of children aged 2–17 who did not see a dentist within the past 12 months, by family structure and by selected characteristics: United States, 2001–2007

Selected characteristics	All children aged 2–17 who did not see a dentist in the past 12 months	Family structure[1]						
		Nuclear	Single parent	Unmarried biological or adoptive	Blended	Cohabiting	Extended	Other
	Number in thousands[2]							
Total[3]	15,883	6,831	2,954	275	1,345	600	3,325	554
Sex								
Male	8,373	3,554	1,557	148	712	326	1,801	275
Female	7,510	3,277	1,397	127	633	274	1,523	279
Age								
2–4 years	6,638	3,650	906	185	461	220	1,061	155
5–17 years	9,246	3,181	2,047	90	884	380	2,264	399
5–11 years	4,787	1,908	1,054	66	458	215	909	177
12–17 years	4,459	1,273	993	24	427	165	1,354	222
Hispanic origin and race[4]								
Hispanic or Latino	4,128	1,706	570	93	248	137	1,199	176
Mexican or Mexican American	3,014	1,287	340	62	191	93	902	139
Not Hispanic or Latino	11,756	5,125	2,384	182	1,098	464	2,126	378
White, single race	7,973	4,095	1,199	129	857	333	1,165	194
Black or African American, single race	2,655	506	1,018	42	181	107	650	151
Parent's education[5]								
Less than high school diploma	3,101	990	706	65	164	159	963	53
High school diploma or GED[6]	4,180	1,451	909	103	452	234	977	54
More than high school diploma	7,979	4,358	1,196	106	708	203	1,323	85
Family income[7]								
Less than $20,000	3,733	882	1,654	77	178	154	655	133
$20,000–$34,999	3,592	1,352	794	77	318	166	746	140
$35,000–$54,999	3,473	1,586	342	75	378	146	810	136
$55,000–$74,999	2,089	1,184	84	32	228	59	451	50
$75,000 or more	2,997	1,828	79	14	244	75	663	95
Poverty status[8]								
Poor	3,917	984	1,428	75	227	166	870	166
Near poor	4,606	1,715	891	94	422	206	1,084	194
Not poor	7,360	4,132	634	105	696	229	1,372	194
Home tenure status[9]								
Owned or being bought	9,066	4,732	851	102	809	195	2,038	339
Rented	6,360	1,917	2,002	161	495	385	1,205	195
Some other arrangement	388	157	95	*11	30	*14	66	14
Health insurance coverage[10]								
Private	7,728	4,304	929	89	751	175	1,343	138
Medicaid	4,627	1,150	1,449	132	330	269	1,062	235
Other	280	107	70	*4	29	*17	45	*8
Uninsured	3,187	1,259	490	51	232	138	850	167
Place of residence[11]								
Large MSA	5,024	1,805	1,172	93	347	191	1,216	198
Small MSA	7,680	3,697	1,208	131	611	241	1,574	218
Not in MSA	3,180	1,329	574	50	388	168	534	137
Region								
Northeast	2,262	1,018	434	54	137	72	477	69
Midwest	3,280	1,434	663	72	306	161	565	78
South	6,602	2,735	1,345	85	609	249	1,295	284
West	3,740	1,644	511	64	294	118	986	123

* Estimate has a relative standard error of greater than 30% and should be used with caution because it does not meet the standards of reliability or precision.

– Quantity zero.

[1]A nuclear family consists of one or more children living with two parents who are married to one another and are biological or adoptive parents to all children in the family. A single-parent family consists of one or more children living with a single adult (male or female, related or unrelated). An unmarried biological or adoptive family consists of one or more children living with two parents who are not married to one another and are biological or adoptive parents to all children in the family. A blended family consists of one or more children living with a biological or adoptive parent and an

unrelated stepparent who are married to one another. A cohabiting family consists of one or more children living with a biological or adoptive parent and an unrelated adult who are cohabiting with one another. An extended family consists of one or more children living with at least one biological or adoptive parent and a related adult. An "other" family consists of one or more children living with related or unrelated adults who are not biological or adoptive parents.

[2]Data are based on household interviews of a sample of the civilian noninstitutionalized population. Information regarding last dental visit is obtained from a question that asked, "About how long has it been since [child's name] last saw a dentist? Include all types of dentists, such as orthodontists, oral surgeons, and all other dental specialists, as well as dental hygienists." A knowledgeable adult provided information on behalf of child respondents. Unknowns with respect to last dental visit and family structure are not included in the column labeled "All children aged 2–17 who did not see a dentist in the past 12 months" (see Appendix I).

[3]Includes other races not shown separately and children with unknown parent's education, family income, poverty status, or health insurance. Additionally, numbers within selected characteristics may not add to totals because of rounding.

[4]Persons of Hispanic or Latino origin may be of any race or combination of races. Similarly, the category "Not Hispanic or Latino" refers to all persons who are not of Hispanic or Latino origin, regardless of race. To be concise, the text uses shorter versions of the terms shown in the table. For example, the category "Not Hispanic or Latino black or African American, single race" in the tables is referred to as "non-Hispanic black" in the text.

[5]Refers to the education level of the parent with the higher level of education, regardless of that parent's age.

[6]GED is General Educational Development high school equivalency diploma.

[7]Information on family income and poverty status is obtained from the 2001–2007 National Health Interview Survey Imputed Family Income/Personal Earnings Files.

[8]Based on family income and family size using the U.S. Census Bureau's poverty thresholds for the previous calendar year. "Poor" persons are defined as below the poverty threshold. "Near poor" persons have incomes of 100% to less than 200% of the poverty threshold. "Not poor" persons have incomes that are 200% of the poverty threshold or greater.

[9]Based on a question in the Family Core that asked whether the family's house or apartment is owned or being bought, rented, or occupied by some other arrangement (see Appendix II).

[10]Classification of health insurance coverage is based on a hierarchy of mutually exclusive categories. Persons with more than one type of health insurance were assigned to the first appropriate category in the hierarchy. The category "Uninsured" includes persons who had no coverage as well as those who had only Indian Health Service coverage or had only a private plan that paid for one type of service such as accidents or dental care (see Appendix II).

[11]MSA is metropolitan statistical area. Large MSAs have a population size of 1 million or more; small MSAs have a population size of less than 1 million. "Not in MSA" consists of persons not living in a metropolitan statistical area.

SOURCE: CDC/NCHS, National Health Interview Survey, 2001–2007.

Table 50. Percentages (with standard errors) of children aged 2–17 who did not see a dentist within the past 12 months, by family structure and by selected characteristics: United States, 2001–2007

Selected characteristics	All children aged 2–17 who did not see a dentist in the past 12 months	Family structure[1]						
		Nuclear	Single parent	Unmarried biological or adoptive	Blended	Cohabiting	Extended	Other
	Percent[2] (standard error)							
Total[3]	24.6 (0.25)	22.2 (0.32)	26.9 (0.52)	39.6 (1.98)	23.7 (0.78)	29.7 (1.28)	27.0 (0.47)	27.7 (1.29)
Sex								
Male	25.4 (0.32)	22.5 (0.43)	28.7 (0.76)	40.0 (2.72)	24.5 (1.06)	31.3 (1.85)	28.2 (0.66)	27.2 (1.79)
Female	23.8 (0.31)	21.9 (0.44)	25.2 (0.68)	39.1 (2.94)	22.8 (1.12)	28.0 (1.74)	25.7 (0.64)	28.2 (1.80)
Age								
2–4 years	55.1 (0.58)	53.5 (0.74)	55.0 (1.46)	62.9 (3.00)	58.3 (2.36)	54.9 (3.16)	59.4 (1.39)	49.5 (3.92)
5–17 years	17.7 (0.24)	13.3 (0.30)	22.0 (0.51)	22.4 (2.31)	18.1 (0.74)	23.4 (1.33)	21.5 (0.46)	23.6 (1.31)
5–11 years	17.2 (0.33)	13.3 (0.39)	21.7 (0.78)	22.6 (2.74)	18.0 (1.08)	22.3 (1.68)	22.6 (0.80)	21.8 (1.79)
12–17 years	18.2 (0.32)	13.3 (0.43)	22.3 (0.69)	22.0 (4.19)	18.1 (1.08)	25.1 (2.15)	20.9 (0.55)	25.3 (1.81)
Hispanic origin and race[4]								
Hispanic or Latino	34.6 (0.52)	35.0 (0.77)	29.9 (1.11)	41.2 (3.15)	28.3 (1.63)	37.2 (2.78)	36.8 (0.86)	40.2 (2.62)
Mexican or Mexican American	36.9 (0.67)	36.4 (0.90)	32.4 (1.55)	41.0 (3.35)	32.2 (2.04)	39.2 (3.42)	39.8 (1.06)	42.8 (3.08)
Not Hispanic or Latino	22.4 (0.26)	19.8 (0.34)	26.3 (0.59)	38.8 (2.49)	22.8 (0.88)	28.0 (1.43)	23.5 (0.55)	24.1 (1.46)
White, single race	20.5 (0.30)	18.8 (0.36)	24.4 (0.79)	43.1 (3.20)	22.4 (0.98)	27.8 (1.77)	19.5 (0.64)	23.6 (2.04)
Black or African American, single race	28.5 (0.60)	26.7 (1.21)	28.7 (0.96)	35.9 (4.56)	24.1 (2.03)	31.7 (2.89)	31.5 (1.13)	25.4 (2.27)
Parent's education[5]								
Less than high school diploma	38.5 (0.70)	41.4 (1.21)	34.0 (1.32)	41.0 (3.88)	37.0 (2.83)	37.9 (2.84)	39.9 (1.15)	36.9 (5.26)
High school diploma or GED[6]	29.1 (0.49)	27.9 (0.75)	29.3 (0.98)	39.6 (3.39)	28.0 (1.59)	32.1 (2.12)	30.0 (0.89)	28.3 (4.49)
More than high school diploma	20.0 (0.27)	18.9 (0.33)	22.7 (0.70)	38.5 (3.40)	19.8 (0.92)	23.5 (1.95)	20.5 (0.60)	20.2 (2.96)
Family income[7]								
Less than $20,000	34.0 (0.59)	36.1 (1.24)	31.9 (0.82)	43.5 (3.94)	32.6 (2.63)	34.9 (2.93)	36.3 (1.29)	33.2 (2.72)
$20,000-$34,999	32.5 (0.59)	34.9 (0.94)	27.4 (1.03)	41.0 (3.88)	31.9 (2.06)	35.1 (2.92)	34.8 (1.28)	29.9 (2.69)
$35,000-$54,999	28.0 (0.54)	28.1 (0.80)	19.7 (1.26)	40.6 (4.27)	26.7 (1.52)	30.2 (2.72)	32.5 (1.13)	29.8 (2.86)
$55,000-$74,999	21.5 (0.55)	21.7 (0.78)	13.6 (1.72)	38.7 (7.12)	20.8 (1.65)	21.5 (3.46)	23.6 (1.23)	18.3 (3.99)
$75,000 or more	14.8 (0.35)	13.7 (0.42)	14.8 (1.97)	22.2 (5.17)	14.9 (1.29)	21.5 (3.15)	16.8 (0.74)	23.4 (3.05)
Poverty status[8]								
Poor	34.1 (0.60)	35.2 (1.18)	32.4 (0.94)	44.1 (4.10)	33.1 (2.56)	34.3 (2.89)	35.9 (1.18)	31.9 (2.73)
Near poor	32.4 (0.54)	33.8 (0.89)	28.3 (0.97)	39.0 (3.78)	29.7 (1.75)	35.4 (2.76)	34.7 (1.09)	31.4 (2.53)
Not poor	19.0 (0.26)	18.1 (0.33)	18.6 (0.74)	37.3 (3.09)	19.4 (0.92)	23.9 (1.73)	20.3 (0.55)	22.4 (1.82)
Home tenure status[9]								
Owned or being bought	20.5 (0.27)	18.9 (0.33)	20.7 (0.79)	35.0 (3.34)	20.7 (0.92)	22.7 (1.80)	23.3 (0.55)	24.4 (1.51)
Rented	34.1 (0.44)	37.3 (0.82)	30.8 (0.71)	41.7 (2.53)	30.0 (1.51)	34.7 (1.84)	36.2 (0.93)	35.6 (2.45)
Some other arrangement	32.2 (1.67)	32.8 (2.70)	29.6 (2.75)	67.6 (11.04)	26.2 (5.15)	35.7 (10.62)	35.7 (4.07)	29.1 (7.71)
Health insurance coverage[10]								
Private	19.0 (0.26)	18.2 (0.32)	19.9 (0.69)	35.6 (3.03)	20.2 (0.90)	21.7 (1.83)	19.2 (0.54)	21.7 (2.14)
Medicaid	29.4 (0.50)	30.0 (0.91)	29.0 (0.82)	38.3 (3.08)	26.9 (1.75)	31.1 (1.93)	30.6 (0.96)	23.4 (1.67)
Other	20.5 (1.29)	17.0 (1.73)	30.5 (3.38)	*44.3 (13.53)	15.6 (3.07)	33.1 (8.85)	20.9 (3.02)	*17.8 (7.67)
Uninsured	50.0 (0.76)	49.4 (1.23)	47.6 (1.69)	55.0 (5.00)	42.9 (2.86)	46.6 (3.57)	54.6 (1.38)	55.3 (3.32)
Place of residence[11]								
Large MSA	27.7 (0.43)	25.3 (0.66)	28.1 (0.83)	37.9 (3.04)	25.3 (1.47)	33.4 (2.18)	30.8 (0.81)	28.9 (2.24)
Small MSA	22.5 (0.32)	20.6 (0.41)	25.0 (0.79)	42.2 (3.19)	21.3 (1.01)	26.2 (1.90)	24.5 (0.66)	25.1 (1.77)
Not in MSA	26.3 (0.72)	23.5 (0.77)	29.4 (1.47)	36.6 (4.37)	26.8 (1.86)	31.7 (2.57)	27.6 (1.31)	30.7 (2.92)
Region								
Northeast	19.4 (0.48)	17.5 (0.72)	21.9 (1.14)	42.6 (4.52)	18.5 (1.87)	23.3 (2.57)	20.1 (0.97)	24.1 (3.23)
Midwest	21.7 (0.49)	19.0 (0.62)	25.6 (0.99)	40.3 (3.99)	21.4 (1.76)	30.0 (2.86)	23.0 (1.05)	19.7 (2.57)
South	28.2 (0.45)	25.9 (0.57)	30.7 (0.90)	43.3 (3.86)	25.7 (1.22)	32.8 (2.17)	30.6 (0.81)	32.6 (2.08)
West	26.2 (0.47)	24.1 (0.63)	25.4 (1.11)	33.1 (3.53)	25.6 (1.50)	28.3 (2.44)	30.5 (0.95)	27.3 (2.50)

* Estimate has a relative standard error of greater than 30% and should be used with caution because it does not meet the standards of reliability or precision.

– Quantity zero.

[1] A nuclear family consists of one or more children living with two parents who are married to one another and are biological or adoptive parents to all children in the family. A single-parent family consists of one or more children living with a single adult (male or female, related or unrelated). An unmarried biological or adoptive family consists of one or more children living with two parents who are not married to one another and are biological or adoptive parents to all children in the family. A blended family consists of one or more children living with a biological or adoptive parent and an unrelated stepparent who are married to one another. A cohabiting family consists of one or more children living with a biological or adoptive parent and an unrelated adult who are cohabiting with one

another. An extended family consists of one or more children living with at least one biological or adoptive parent and a related adult. An "other" family consists of one or more children living with related or unrelated adults who are not biological or adoptive parents.

[2]Data are based on household interviews of a sample of the civilian noninstitutionalized population. Information regarding last dental visit is obtained from a question that asked, "About how long has it been since [child's name] last saw a dentist? Include all types of dentists, such as orthodontists, oral surgeons, and all other dental specialists, as well as dental hygienists." A knowledgeable adult provided information on behalf of child respondents. Unknowns with respect to last dental visit and family structure are not included in the column labeled "All children aged 2–17 who did not see a dentist in the past 12 months" (see Appendix I).

[3]Includes other races not shown separately and children with unknown parent's education, family income, poverty status, or health insurance.

[4]Persons of Hispanic or Latino origin may be of any race or combination of races. Similarly, the category "Not Hispanic or Latino" refers to all persons who are not of Hispanic or Latino origin, regardless of race. To be concise, the text uses shorter versions of the terms shown in the table. For example, the category "Not Hispanic or Latino black or African American, single race" in the tables is referred to as "non-Hispanic black" in the text.

[5]Refers to the education level of the parent with the higher level of education, regardless of that parent's age.

[6]GED is General Educational Development high school equivalency diploma.

[7]Information on family income and poverty status is obtained from the 2001–2007 National Health Interview Survey Imputed Family Income/Personal Earnings Files.

[8]Based on family income and family size using the U.S. Census Bureau's poverty thresholds for the previous calendar year. "Poor" persons are defined as below the poverty threshold. "Near poor" persons have incomes of 100% to less than 200% of the poverty threshold. "Not poor" persons have incomes that are 200% of the poverty threshold or greater.

[9]Based on a question in the Family Core that asked whether the family's house or apartment is owned or being bought, rented, or occupied by some other arrangement (see Appendix II).

[10]Classification of health insurance coverage is based on a hierarchy of mutually exclusive categories. Persons with more than one type of health insurance were assigned to the first appropriate category in the hierarchy. The category "Uninsured" includes persons who had no coverage as well as those who had only Indian Health Service coverage or had only a private plan that paid for one type of service such as accidents or dental care (see Appendix II).

[11]MSA is metropolitan statistical area. Large MSAs have a population size of 1 million or more; small MSAs have a population size of less than 1 million. "Not in MSA" consists of persons not living in a metropolitan statistical area.

SOURCE: CDC/NCHS, National Health Interview Survey, 2001–2007.

Table 51. Frequencies of children aged 2–17 who did not receive needed dental care in the past 12 months due to cost, by family structure and by selected characteristics: United States, 2001–2007

Selected characteristics	All children aged 2–17 who did not receive needed dental care in the past 12 months due to cost	Family structure[1]						
		Nuclear	Single parent	Unmarried biological or adoptive	Blended	Cohabiting	Extended	Other
	Number in thousands[2]							
Total[3]	4,168	1,421	978	53	467	188	942	120
Sex								
Male	2,022	687	457	28	217	95	490	48
Female	2,146	734	521	25	250	92	452	72
Age								
2–4 years	364	167	70	11	21	13	72	*8
5–17 years	3,804	1,254	908	42	446	174	869	111
5–11 years	1,790	693	416	27	223	82	315	35
12–17 years	2,014	561	492	15	223	92	555	76
Hispanic origin and race[4]								
Hispanic or Latino	1,044	379	160	27	94	38	309	37
Mexican or Mexican American	784	306	101	18	70	27	233	28
Not Hispanic or Latino	3,124	1,042	818	26	372	149	633	83
White, single race	2,270	857	510	22	311	126	397	46
Black or African American, single race	561	89	241	*4	49	12	138	28
Parent's education[5]								
Less than high school diploma	776	209	181	21	46	54	256	*8
High school diploma or GED[6]	1,129	367	262	13	143	65	265	*12
More than high school diploma	2,150	841	496	19	273	67	413	*41
Family income[7]								
Less than $20,000	1,083	216	502	14	74	53	199	25
$20,000–$34,999	1,091	362	293	19	107	48	235	27
$35,000–$54,999	1,025	393	145	11	152	51	243	31
$55,000–$74,999	481	209	22	*6	74	*15	129	*25
$75,000 or more	488	242	*16	*3	59	*20	135	*12
Poverty status[8]								
Poor	1,108	262	407	14	81	59	256	29
Near poor	1,427	442	336	22	174	50	347	56
Not poor	1,633	716	236	17	212	79	338	35
Home tenure status[9]								
Owned or being bought	2,330	978	334	22	260	72	591	73
Rented	1,705	395	611	31	200	101	325	43
Some other arrangement	105	39	31	*–	*5	*5	22	*3
Health insurance coverage[10]								
Private	1,645	695	313	11	222	43	327	*35
Medicaid	1,102	245	363	22	99	64	278	31
Other	65	*14	21	*–	*7	*10	*12	*2
Uninsured	1,346	466	278	20	138	69	321	52
Place of residence[11]								
Large MSA	1,256	364	335	25	120	54	309	49
Small MSA	2,012	751	429	20	218	78	470	45
Not in MSA	900	306	214	*7	129	55	163	26
Region								
Northeast	512	170	117	*8	55	29	125	*8
Midwest	923	304	236	10	106	50	186	*32
South	1,674	586	422	12	198	64	340	52
West	1,060	361	203	24	107	46	291	28

* Estimate has a relative standard error of greater than 30% and should be used with caution because it does not meet the standards of reliability or precision.

– Quantity zero.

[1]A nuclear family consists of one or more children living with two parents who are married to one another and are biological or adoptive parents to all children in the family. A single-parent family

consists of one or more children living with a single adult (male or female, related or unrelated). An unmarried biological or adoptive family consists of one or more children living with two parents who are not married to one another and are biological or adoptive parents to all children in the family. A blended family consists of one or more children living with a biological or adoptive parent and an unrelated stepparent who are married to one another. A cohabiting family consists of one or more children living with a biological or adoptive parent and an unrelated adult who are cohabiting with one another. An extended family consists of one or more children living with at least one biological or adoptive parent and a related adult. An "other" family consists of one or more children living with related or unrelated adults who are not biological or adoptive parents.

[2]Data are based on household interviews of a sample of the civilian noninstitutionalized population. Information regarding receipt of dental care is obtained from a question that asked, "During the past 12 months, was there any time when [child's name] needed [dental care, including check-ups] but didn't get it because you couldn't afford it?" A knowledgeable adult provided information on behalf of child respondents. Unknowns with respect to receipt of dental care and family structure are not included in the column labeled "All children aged 2–17 who did not receive needed dental care in the past 12 months due to cost" (see Appendix I).

[3]Includes other races not shown separately and children with unknown parent's education, family income, poverty status, or health insurance. Additionally, numbers within selected characteristics may not add to totals because of rounding.

[4]Persons of Hispanic or Latino origin may be of any race or combination of races. Similarly, the category "Not Hispanic or Latino" refers to all persons who are not of Hispanic or Latino origin, regardless of race. To be concise, the text uses shorter versions of the terms shown in the table. For example, the category "Not Hispanic or Latino black or African American, single race" in the tables is referred to as "non-Hispanic black" in the text.

[5]Refers to the education level of the parent with the higher level of education, regardless of that parent's age.

[6]GED is General Educational Development high school equivalency diploma.

[7]Information on family income and poverty status is obtained from the 2001–2007 National Health Interview Survey Imputed Family Income/Personal Earnings Files.

[8]Based on family income and family size using the U.S. Census Bureau's poverty thresholds for the previous calendar year. "Poor" persons are defined as below the poverty threshold. "Near poor" persons have incomes of 100% to less than 200% of the poverty threshold. "Not poor" persons have incomes that are 200% of the poverty threshold or greater.

[9]Based on a question in the Family Core that asked whether the family's house or apartment is owned or being bought, rented, or occupied by some other arrangement (see Appendix II).

[10]Classification of health insurance coverage is based on a hierarchy of mutually exclusive categories. Persons with more than one type of health insurance were assigned to the first appropriate category in the hierarchy. The category "Uninsured" includes persons who had no coverage as well as those who had only Indian Health Service coverage or had only a private plan that paid for one type of service such as accidents or dental care (see Appendix II).

[11]MSA is metropolitan statistical area. Large MSAs have a population size of 1 million or more; small MSAs have a population size of less than 1 million. "Not in MSA" consists of persons not living in a metropolitan statistical area.

SOURCE: CDC/NCHS, National Health Interview Survey, 2001–2007.

Table 52. Percentages (with standard errors) of children aged 2–17 who did not receive needed dental care in the past 12 months due to cost, by family structure and by selected characteristics: United States, 2001–2007

Selected characteristics	All children aged 2–17 who did not receive needed dental care in the past 12 months due to cost	Family structure[1]						
		Nuclear	Single parent	Unmarried biological or adoptive	Blended	Cohabiting	Extended	Other
	Percent[2] (standard error)							
Total[3]	6.4 (0.13)	4.6 (0.16)	8.8 (0.34)	7.5 (1.00)	8.1 (0.47)	9.1 (0.80)	7.5 (0.29)	5.8 (0.74)
Sex								
Male	6.1 (0.17)	4.3 (0.21)	8.3 (0.44)	7.4 (1.41)	7.4 (0.60)	9.0 (1.12)	7.6 (0.40)	4.6 (0.73)
Female	6.8 (0.19)	4.9 (0.22)	9.3 (0.50)	7.7 (1.42)	8.9 (0.75)	9.3 (1.13)	7.5 (0.40)	7.1 (1.28)
Age								
2–4 years	3.0 (0.18)	2.4 (0.23)	4.2 (0.54)	3.8 (1.09)	2.6 (0.75)	3.3 (0.95)	4.0 (0.52)	*2.6 (0.83)
5–17 years	7.2 (0.15)	5.2 (0.19)	9.6 (0.38)	10.2 (1.53)	9.0 (0.53)	10.6 (0.95)	8.1 (0.32)	6.4 (0.86)
5–11 years	6.4 (0.19)	4.8 (0.22)	8.5 (0.52)	9.2 (1.62)	8.7 (0.71)	8.4 (1.09)	7.7 (0.52)	4.2 (0.76)
12–17 years	8.1 (0.22)	5.8 (0.31)	10.9 (0.55)	13.1 (3.50)	9.3 (0.81)	13.9 (1.69)	8.4 (0.40)	8.4 (1.51)
Hispanic origin and race[4]								
Hispanic or Latino	8.7 (0.28)	7.7 (0.43)	8.3 (0.64)	11.8 (2.09)	10.7 (1.16)	10.4 (1.63)	9.3 (0.50)	8.2 (1.21)
Mexican or Mexican American	9.5 (0.36)	8.6 (0.53)	9.5 (0.84)	12.2 (2.28)	11.9 (1.48)	11.2 (2.09)	10.1 (0.62)	8.6 (1.43)
Not Hispanic or Latino	5.9 (0.14)	4.0 (0.17)	8.9 (0.38)	5.5 (1.07)	7.7 (0.52)	8.9 (0.92)	6.9 (0.34)	5.1 (0.90)
White, single race	5.8 (0.17)	3.9 (0.18)	10.3 (0.55)	7.2 (1.60)	8.1 (0.61)	10.4 (1.20)	6.6 (0.43)	5.4 (1.52)
Black or African American, single race	5.9 (0.30)	4.7 (0.64)	6.7 (0.49)	*3.2 (1.10)	6.5 (1.03)	3.4 (1.01)	6.5 (0.62)	4.5 (0.98)
Parent's education[5]								
Less than high school diploma	9.5 (0.39)	8.7 (0.64)	8.6 (0.80)	13.1 (2.66)	10.3 (1.71)	12.7 (1.95)	10.4 (0.70)	*5.5 (1.87)
High school diploma or GED[6]	7.8 (0.30)	7.0 (0.48)	8.4 (0.59)	4.9 (1.14)	8.8 (0.91)	8.8 (1.34)	8.0 (0.51)	*6.3 (2.26)
More than high school diploma	5.4 (0.15)	3.6 (0.16)	9.4 (0.48)	6.7 (1.60)	7.6 (0.61)	7.7 (1.09)	6.3 (0.39)	9.5 (2.76)
Family income[7]								
Less than $20,000	9.7 (0.34)	8.8 (0.67)	9.6 (0.49)	7.9 (1.94)	13.3 (1.83)	11.8 (2.01)	10.7 (0.88)	6.1 (1.12)
$20,000–$34,999	9.8 (0.35)	9.3 (0.63)	10.0 (0.68)	9.8 (2.08)	10.7 (1.18)	10.1 (2.27)	10.8 (0.77)	5.6 (1.14)
$35,000–$54,999	8.2 (0.31)	6.9 (0.43)	8.3 (0.89)	6.2 (1.76)	10.6 (1.16)	10.3 (1.99)	9.6 (0.75)	6.6 (1.45)
$55,000–$74,999	4.9 (0.34)	3.8 (0.35)	3.5 (0.92)	*7.1 (3.24)	6.8 (1.12)	*5.4 (1.83)	6.7 (0.94)	*8.8 (4.06)
$75,000 or more	2.4 (0.16)	1.8 (0.17)	*3.1 (1.11)	*4.2 (2.66)	3.6 (0.66)	*5.8 (1.76)	3.4 (0.39)	*2.9 (1.00)
Poverty status[8]								
Poor	9.5 (0.36)	9.3 (0.74)	9.1 (0.56)	8.0 (2.13)	11.5 (1.56)	11.8 (2.02)	10.3 (0.82)	5.3 (1.05)
Near poor	9.9 (0.33)	8.7 (0.52)	10.6 (0.71)	8.9 (1.77)	12.1 (1.19)	8.5 (1.58)	10.9 (0.74)	8.9 (2.02)
Not poor	4.2 (0.13)	3.1 (0.15)	6.9 (0.52)	6.0 (1.55)	5.9 (0.53)	8.1 (1.16)	4.9 (0.34)	3.9 (0.70)
Home tenure status[9]								
Owned or being bought	5.2 (0.14)	3.9 (0.16)	8.0 (0.49)	7.5 (1.63)	6.6 (0.55)	8.3 (1.26)	6.7 (0.33)	5.2 (0.96)
Rented	9.0 (0.26)	7.6 (0.45)	9.3 (0.46)	7.8 (1.32)	11.9 (1.02)	9.0 (1.00)	9.6 (0.57)	7.5 (1.16)
Some other arrangement	8.7 (1.01)	8.2 (1.75)	9.7 (2.00)	*–	*4.4 (2.27)	*12.0 (6.19)	11.5 (2.45)	*5.0 (2.79)
Health insurance coverage[10]								
Private	4.0 (0.13)	2.9 (0.15)	6.7 (0.44)	4.2 (1.22)	5.9 (0.52)	5.3 (1.04)	4.6 (0.29)	*5.3 (1.82)
Medicaid	6.9 (0.26)	6.4 (0.50)	7.2 (0.48)	6.5 (1.29)	8.0 (1.02)	7.3 (1.06)	7.8 (0.61)	3.0 (0.61)
Other	4.7 (0.74)	*2.1 (0.68)	8.9 (2.17)	*–	*3.9 (1.69)	*19.0 (8.69)	*5.5 (2.04)	*3.4 (2.44)
Uninsured	20.8 (0.63)	18.1 (0.97)	26.8 (1.58)	21.3 (4.26)	24.9 (2.39)	22.9 (2.91)	20.2 (1.12)	16.6 (2.29)
Place of residence[11]								
Large MSA	6.8 (0.22)	5.1 (0.32)	7.9 (0.48)	10.1 (1.96)	8.6 (0.94)	9.2 (1.46)	7.7 (0.46)	6.8 (1.69)
Small MSA	5.8 (0.17)	4.2 (0.20)	8.8 (0.52)	6.5 (1.30)	7.5 (0.65)	8.4 (1.11)	7.2 (0.39)	5.1 (0.82)
Not in MSA	7.4 (0.38)	5.4 (0.41)	10.9 (0.91)	*5.2 (2.12)	8.8 (1.02)	10.4 (1.81)	8.2 (0.86)	5.6 (1.25)
Region								
Northeast	4.4 (0.26)	2.9 (0.32)	5.9 (0.68)	*6.0 (2.58)	7.4 (1.15)	9.1 (2.02)	5.2 (0.59)	*2.8 (0.96)
Midwest	6.0 (0.27)	4.0 (0.29)	9.0 (0.72)	5.3 (1.50)	7.4 (0.94)	9.1 (1.77)	7.4 (0.67)	*7.8 (2.78)
South	7.1 (0.22)	5.5 (0.28)	9.5 (0.58)	5.9 (1.60)	8.3 (0.74)	8.3 (1.18)	7.9 (0.47)	5.8 (0.89)
West	7.4 (0.30)	5.3 (0.37)	10.0 (0.74)	12.3 (2.35)	9.3 (1.09)	10.9 (1.76)	8.8 (0.62)	6.1 (1.16)

* Estimate has a relative standard error of greater than 30% and should be used with caution because it does not meet the standards of reliability or precision.

– Quantity zero.

[1]A nuclear family consists of one or more children living with two parents who are married to one another and are biological or adoptive parents to all children in the family. A single-parent family

consists of one or more children living with a single adult (male or female, related or unrelated). An unmarried biological or adoptive family consists of one or more children living with two parents who are not married to one another and are biological or adoptive parents to all children in the family. A blended family consists of one or more children living with a biological or adoptive parent and an unrelated stepparent who are married to one another. A cohabiting family consists of one or more children living with a biological or adoptive parent and an unrelated adult who are cohabiting with one another. An extended family consists of one or more children living with at least one biological or adoptive parent and a related adult. An "other" family consists of one or more children living with related or unrelated adults who are not biological or adoptive parents.

[2]Data are based on household interviews of a sample of the civilian noninstitutionalized population. Information regarding receipt of dental care is obtained from a question that asked, "During the past 12 months, was there any time when [child's name] needed [dental care, including check-ups] but didn't get it because you couldn't afford it?" A knowledgeable adult provided information on behalf of child respondents. Unknowns with respect to receipt of dental care and family structure are not included in the column labeled "All children aged 2–17 who did not receive needed dental care in the past 12 months due to cost" (see Appendix I).

[3]Includes other races not shown separately and children with unknown parent's education, family income, poverty status, or health insurance.

[4]Persons of Hispanic or Latino origin may be of any race or combination of races. Similarly, the category "Not Hispanic or Latino" refers to all persons who are not of Hispanic or Latino origin, regardless of race. To be concise, the text uses shorter versions of the terms shown in the table. For example, the category "Not Hispanic or Latino black or African American, single race" in the tables is referred to as "non-Hispanic black" in the text.

[5]Refers to the education level of the parent with the higher level of education, regardless of that parent's age.

[6]GED is General Educational Development high school equivalency diploma.

[7]Information on family income and poverty status is obtained from the 2001–2007 National Health Interview Survey Imputed Family Income/Personal Earnings Files.

[8]Based on family income and family size using the U.S. Census Bureau's poverty thresholds for the previous calendar year. "Poor" persons are defined as below the poverty threshold. "Near poor" persons have incomes of 100% to less than 200% of the poverty threshold. "Not poor" persons have incomes that are 200% of the poverty threshold or greater.

[9]Based on a question in the Family Core that asked whether the family's house or apartment is owned or being bought, rented, or occupied by some other arrangement (see Appendix II).

[10]Classification of health insurance coverage is based on a hierarchy of mutually exclusive categories. Persons with more than one type of health insurance were assigned to the first appropriate category in the hierarchy. The category "Uninsured" includes persons who had no coverage as well as those who had only Indian Health Service coverage or had only a private plan that paid for one type of service such as accidents or dental care (see Appendix II).

[11]MSA is metropolitan statistical area. Large MSAs have a population size of 1 million or more; small MSAs have a population size of less than 1 million. "Not in MSA" consists of persons not living in a metropolitan statistical area.

SOURCE: CDC/NCHS, National Health Interview Survey, 2001–2007.

Table 53. Frequencies of children aged 4–17 who were often unhappy, depressed, or tearful during the past 6 months, by family structure and by selected characteristics: United States, 2001–2007

Selected characteristics	All children aged 4–17 who were often unhappy, depressed, or tearful in the past 6 months	Family structure[1]						
		Nuclear	Single parent	Unmarried biological or adoptive	Blended	Cohabiting	Extended	Other
	Number in thousands[2]							
Total[3]	1,666	526	430	*9	190	51	371	89
Sex								
Male	758	237	190	*6	92	28	167	37
Female	908	289	240	*3	98	22	204	52
Age								
4–17 years	1,666	526	430	*9	190	51	371	89
4–11 years	783	295	198	*7	91	25	141	26
12–17 years	883	231	232	*2	99	26	230	63
Hispanic origin and race[4]								
Hispanic or Latino	386	120	81	*2	43	16	104	20
Mexican or Mexican American	257	91	39	*1	27	*11	69	19
Not Hispanic or Latino	1,279	406	349	*7	147	35	267	69
White, single race	858	314	182	*5	108	30	183	*35
Black or African American, single race	285	35	131	*1	27	*4	60	28
Parent's education[5]								
Less than high school diploma	326	74	118	*2	31	13	84	*4
High school diploma or GED[6]	382	104	101	*5	60	*14	97	*–
More than high school diploma	855	346	176	*2	95	22	182	*31
Family income[7]								
Less than $20,000	443	60	240	*2	30	*8	79	23
$20,000–$34,999	362	108	99	*4	45	12	75	*18
$35,000–$54,999	296	96	59	*1	46	*11	67	*16
$55,000–$74,999	213	79	*16	*–	28	*6	65	*19
$75,000 or more	353	183	*15	*1	41	*13	86	*13
Poverty status[8]								
Poor	489	86	215	*4	41	*9	103	30
Near poor	420	100	116	*1	52	*14	102	*34
Not poor	756	340	98	*4	96	27	166	25
Home tenure status[9]								
Owned or being bought	1,002	406	153	*2	110	25	248	57
Rented	623	109	264	*7	77	24	119	23
Some other arrangement	36	*10	*12	*–	*3	*1	*2	*8
Health insurance coverage[10]								
Private	798	328	153	*4	90	*18	183	*23
Medicaid	610	114	226	*5	62	18	136	49
Other	34	*17	*7	*–	*5	*2	*3	*–
Uninsured	218	67	42	*1	33	*13	45	16
Place of residence[11]								
Large MSA	538	148	165	*4	49	17	115	*40
Small MSA	795	284	185	*3	87	22	181	33
Not in MSA	332	94	80	*2	53	*11	75	17
Region								
Northeast	316	99	87	*3	32	*11	73	9
Midwest	325	87	97	*2	35	*10	69	*26
South	600	186	170	*3	73	*16	118	34
West	425	154	75	*1	50	14	110	*20

* Estimate has a relative standard error of greater than 30% and should be used with caution because it does not meet the standards of reliability or precision.
– Quantity zero.
[1]A nuclear family consists of one or more children living with two parents who are married to one another and are biological or adoptive parents to all children in the family. A single-parent family consists of one or more children living with a single adult (male or female, related or unrelated). An unmarried biological or adoptive family consists of one or more children living with two parents who

are not married to one another and are biological or adoptive parents to all children in the family. A blended family consists of one or more children living with a biological or adoptive parent and an unrelated stepparent who are married to one another. A cohabiting family consists of one or more children living with a biological or adoptive parent and an unrelated adult who are cohabiting with one another. An extended family consists of one or more children living with at least one biological or adoptive parent and a related adult. An "other" family consists of one or more children living with related or unrelated adults who are not biological or adoptive parents.

[2]Data are based on household interviews of a sample of the civilian noninstitutionalized population. Prevalence of the behavior shown in this table is obtained from a question that asked, "During the past 6 months, has [child's name] often been unhappy, depressed, or tearful?" Response categories included "not true," "somewhat true," "certainly true," "refused," and "don't know;" only "certainly true" cases are represented in this table. A knowledgeable adult provided information on behalf of child respondents. Unknowns with respect to this behavior and family structure are not included in the column labeled "All children aged 4–17 who were often unhappy, depressed, or tearful in the past 6 months" (see Appendix I).

[3]Includes other races not shown separately and children with unknown parent's education, family income, poverty status, or health insurance. Additionally, numbers within selected characteristics may not add to totals because of rounding.

[4]Persons of Hispanic or Latino origin may be of any race or combination of races. Similarly, the category "Not Hispanic or Latino" refers to all persons who are not of Hispanic or Latino origin, regardless of race. To be concise, the text uses shorter versions of the terms shown in the table. For example, the category "Not Hispanic or Latino black or African American, single race" in the tables is referred to as "non-Hispanic black" in the text.

[5]Refers to the education level of the parent with the higher level of education, regardless of that parent's age.

[6]GED is General Educational Development high school equivalency diploma.

[7]Information on family income and poverty status is obtained from the 2001–2007 National Health Interview Survey Imputed Family Income/Personal Earnings Files.

[8]Based on family income and family size using the U.S. Census Bureau's poverty thresholds for the previous calendar year. "Poor" persons are defined as below the poverty threshold. "Near poor" persons have incomes of 100% to less than 200% of the poverty threshold. "Not poor" persons have incomes that are 200% of the poverty threshold or greater.

[9]Based on a question in the Family Core that asked whether the family's house or apartment is owned or being bought, rented, or occupied by some other arrangement (see Appendix II).

[10]Classification of health insurance coverage is based on a hierarchy of mutually exclusive categories. Persons with more than one type of health insurance were assigned to the first appropriate category in the hierarchy. The category "Uninsured" includes persons who had no coverage as well as those who had only Indian Health Service coverage or had only a private plan that paid for one type of service such as accidents or dental care (see Appendix II).

[11]MSA is metropolitan statistical area. Large MSAs have a population size of 1 million or more; small MSAs have a population size of less than 1 million. "Not in MSA" consists of persons not living in a metropolitan statistical area.

SOURCE: CDC/NCHS, National Health Interview Survey, 2001–2007.

Table 54. Percentages (with standard errors) of children aged 4–17 who were often unhappy, depressed, or tearful during the past 6 months, by family structure and by selected characteristics: United States, 2001–2007

Selected characteristics	All children aged 4–17 who were often unhappy, depressed, or tearful in the past 6 months	Family structure[1]						
		Nuclear	Single parent	Unmarried biological or adoptive	Blended	Cohabiting	Extended	Other
	Percent[2] (standard error)							
Total[3]	3.0 (0.10)	2.0 (0.11)	4.4 (0.27)	*1.9 (0.60)	3.7 (0.32)	2.9 (0.48)	3.4 (0.23)	4.9 (0.84)
Sex								
Male	2.7 (0.12)	1.8 (0.14)	4.0 (0.33)	*2.2 (1.00)	3.5 (0.45)	3.1 (0.75)	2.9 (0.28)	4.0 (0.75)
Female	3.3 (0.16)	2.3 (0.18)	4.8 (0.40)	*1.5 (0.55)	3.9 (0.47)	2.7 (0.60)	3.8 (0.37)	5.9 (1.55)
Age								
4–17 years	3.0 (0.10)	2.0 (0.11)	4.4 (0.27)	*1.9 (0.60)	3.7 (0.32)	2.9 (0.48)	3.4 (0.23)	4.9 (0.84)
4–11 years	2.5 (0.12)	1.8 (0.14)	3.7 (0.32)	*2.0 (0.74)	3.2 (0.43)	2.2 (0.49)	3.1 (0.36)	2.9 (0.60)
12–17 years	3.6 (0.17)	2.5 (0.20)	5.3 (0.44)	*1.8 (0.86)	4.2 (0.48)	3.9 (0.99)	3.6 (0.31)	7.1 (1.59)
Hispanic origin and race[4]								
Hispanic or Latino	3.8 (0.20)	3.0 (0.29)	4.9 (0.54)	*1.4 (0.54)	5.6 (0.96)	5.0 (1.27)	3.7 (0.35)	5.4 (1.26)
Mexican or Mexican American	3.7 (0.25)	3.2 (0.36)	4.2 (0.69)	*0.8 (0.40)	5.2 (1.03)	*5.6 (1.74)	3.5 (0.43)	6.7 (1.67)
Not Hispanic or Latino	2.8 (0.11)	1.9 (0.12)	4.3 (0.31)	*2.2 (0.85)	3.3 (0.33)	2.4 (0.51)	3.3 (0.28)	4.8 (1.03)
White, single race	2.5 (0.12)	1.7 (0.13)	4.1 (0.38)	*2.4 (1.20)	3.1 (0.35)	2.8 (0.67)	3.3 (0.35)	*4.8 (1.73)
Black or African American, single race	3.5 (0.26)	2.2 (0.39)	4.2 (0.48)	*1.5 (0.95)	3.8 (0.91)	*1.3 (0.63)	3.3 (0.47)	5.1 (1.21)
Parent's education[5]								
Less than high school diploma	4.8 (0.31)	3.7 (0.45)	6.7 (0.75)	*2.1 (1.67)	7.7 (1.80)	3.8 (1.06)	4.0 (0.46)	*3.1 (1.52)
High school diploma or GED[6]	3.1 (0.18)	2.3 (0.25)	3.7 (0.42)	*2.5 (0.96)	4.2 (0.70)	*2.2 (0.72)	3.4 (0.39)	*–
More than high school diploma	2.5 (0.12)	1.8 (0.13)	3.7 (0.37)	*1.2 (0.71)	2.9 (0.33)	2.9 (0.78)	3.1 (0.35)	*8.4 (3.35)
Family income[7]								
Less than $20,000	4.8 (0.28)	3.1 (0.46)	5.4 (0.45)	*1.9 (1.17)	6.3 (1.49)	*2.4 (0.86)	5.1 (0.74)	6.4 (1.27)
$20,000–$34,999	3.8 (0.27)	3.4 (0.47)	3.8 (0.43)	*3.2 (1.60)	5.0 (0.93)	2.9 (0.88)	4.0 (0.56)	*4.3 (1.58)
$35,000–$54,999	2.8 (0.20)	2.1 (0.28)	3.7 (0.68)	*1.0 (0.83)	3.6 (0.60)	*2.5 (0.82)	3.0 (0.46)	*3.8 (1.26)
$55,000–$74,999	2.5 (0.27)	1.7 (0.23)	*2.7 (0.98)	*–	2.8 (0.61)	*2.5 (1.34)	3.7 (0.88)	*7.4 (4.26)
$75,000 or more	2.0 (0.15)	1.6 (0.17)	*3.1 (1.28)	*2.5 (1.88)	2.7 (0.57)	*4.1 (1.78)	2.4 (0.38)	*3.7 (1.29)
Poverty status[8]								
Poor	5.0 (0.31)	3.8 (0.58)	5.7 (0.50)	*3.5 (1.95)	6.9 (1.43)	*2.3 (0.92)	4.9 (0.66)	6.6 (1.63)
Near poor	3.4 (0.23)	2.4 (0.29)	4.1 (0.44)	*0.8 (0.48)	4.1 (0.66)	*2.8 (0.85)	3.7 (0.55)	*6.2 (2.19)
Not poor	2.2 (0.10)	1.8 (0.12)	3.1 (0.39)	*2.0 (0.86)	2.9 (0.35)	3.1 (0.78)	2.7 (0.26)	3.1 (0.70)
Home tenure status[9]								
Owned or being bought	2.6 (0.11)	1.9 (0.12)	4.0 (0.41)	*0.9 (0.53)	3.1 (0.35)	3.3 (0.84)	3.1 (0.27)	4.6 (1.07)
Rented	4.0 (0.20)	2.7 (0.31)	4.7 (0.37)	*2.8 (1.05)	5.1 (0.69)	2.6 (0.57)	4.2 (0.48)	4.5 (0.85)
Some other arrangement	3.6 (0.90)	*2.6 (1.00)	*4.6 (1.45)	*–	*2.8 (2.09)	*3.0 (2.18)	*1.4 (0.74)	*17.7 (11.79)
Health insurance coverage[10]								
Private	2.2 (0.11)	1.6 (0.12)	3.5 (0.35)	*2.1 (0.90)	2.6 (0.33)	*2.4 (0.74)	2.8 (0.28)	*4.0 (1.95)
Medicaid	4.6 (0.24)	3.8 (0.45)	5.3 (0.45)	*2.1 (1.01)	5.7 (0.84)	2.4 (0.60)	4.7 (0.54)	5.5 (1.07)
Other	2.8 (0.62)	3.2 (0.92)	*3.3 (1.60)	*–	*2.8 (1.53)	*4.8 (4.68)	*1.5 (0.77)	*–
Uninsured	3.8 (0.31)	3.0 (0.46)	4.4 (0.82)	*1.2 (0.94)	6.7 (1.52)	*5.3 (1.75)	3.3 (0.49)	5.8 (1.28)
Place of residence[11]								
Large MSA	3.5 (0.20)	2.5 (0.25)	4.5 (0.41)	*2.7 (0.98)	3.9 (0.69)	3.4 (0.85)	3.3 (0.36)	*6.4 (2.05)
Small MSA	2.7 (0.13)	1.9 (0.15)	4.2 (0.42)	*1.2 (0.66)	3.4 (0.42)	2.7 (0.72)	3.1 (0.32)	4.2 (0.88)
Not in MSA	3.1 (0.23)	1.9 (0.27)	4.6 (0.67)	*2.3 (1.99)	4.1 (0.70)	*2.6 (1.02)	4.3 (0.65)	4.1 (0.99)
Region								
Northeast	3.1 (0.23)	2.0 (0.30)	4.9 (0.64)	*4.0 (1.76)	4.8 (1.03)	*4.1 (1.54)	3.4 (0.55)	3.7 (1.06)
Midwest	2.5 (0.21)	1.4 (0.17)	4.2 (0.58)	*1.8 (1.11)	2.7 (0.53)	*2.0 (0.77)	3.1 (0.52)	*7.1 (3.10)
South	3.0 (0.15)	2.1 (0.18)	4.4 (0.42)	*2.2 (1.56)	3.4 (0.50)	*2.5 (0.79)	3.2 (0.30)	4.2 (0.84)
West	3.5 (0.23)	2.7 (0.30)	4.2 (0.64)	*0.5 (0.26)	4.8 (0.71)	3.8 (1.01)	3.9 (0.52)	*5.3 (1.76)

* Estimate has a relative standard error of greater than 30% and should be used with caution because it does not meet the standards of reliability or precision.

– Quantity zero.

[1]A nuclear family consists of one or more children living with two parents who are married to one another and are biological or adoptive parents to all children in the family. A single-parent family consists of one or more children living with a single adult (male or female, related or unrelated). An unmarried biological or adoptive family consists of one or more children living with two parents who are not married to one another and are biological or adoptive parents to all children in the family. A blended family consists of one or more children living with a biological or adoptive parent and an

unrelated stepparent who are married to one another. A cohabiting family consists of one or more children living with a biological or adoptive parent and an unrelated adult who are cohabiting with one another. An extended family consists of one or more children living with at least one biological or adoptive parent and a related adult. An "other" family consists of one or more children living with related or unrelated adults who are not biological or adoptive parents.

[2]Data are based on household interviews of a sample of the civilian noninstitutionalized population. Prevalence of the behavior shown in this table is obtained from a question that asked, "During the past 6 months, has [child's name] often been unhappy, depressed, or tearful?" Response categories included "not true," "somewhat true," "certainly true," "refused," and "don't know;" only "certainly true" cases are represented in this table. A knowledgeable adult provided information on behalf of child respondents. Unknowns with respect to this behavior and family structure are not included in the column labeled "All children aged 4–17 who were often unhappy, depressed, or tearful in the past 6 months" (see Appendix I).

[3]Includes other races not shown separately and children with unknown parent's education, family income, poverty status, or health insurance.

[4]Persons of Hispanic or Latino origin may be of any race or combination of races. Similarly, the category "Not Hispanic or Latino" refers to all persons who are not of Hispanic or Latino origin, regardless of race. To be concise, the text uses shorter versions of the terms shown in the table. For example, the category "Not Hispanic or Latino black or African American, single race" in the tables is referred to as "non-Hispanic black" in the text.

[5]Refers to the education level of the parent with the higher level of education, regardless of that parent's age.

[6]GED is General Educational Development high school equivalency diploma.

[7]Information on family income and poverty status is obtained from the 2001–2007 National Health Interview Survey Imputed Family Income/Personal Earnings Files.

[8]Based on family income and family size using the U.S. Census Bureau's poverty thresholds for the previous calendar year. "Poor" persons are defined as below the poverty threshold. "Near poor" persons have incomes of 100% to less than 200% of the poverty threshold. "Not poor" persons have incomes that are 200% of the poverty threshold or greater.

[9]Based on a question in the Family Core that asked whether the family's house or apartment is owned or being bought, rented, or occupied by some other arrangement (see Appendix II).

[10]Classification of health insurance coverage is based on a hierarchy of mutually exclusive categories. Persons with more than one type of health insurance were assigned to the first appropriate category in the hierarchy. The category "Uninsured" includes persons who had no coverage as well as those who had only Indian Health Service coverage or had only a private plan that paid for one type of service such as accidents or dental care (see Appendix II).

[11]MSA is metropolitan statistical area. Large MSAs have a population size of 1 million or more; small MSAs have a population size of less than 1 million. "Not in MSA" consists of persons not living in a metropolitan statistical area.

SOURCE: CDC/NCHS, National Health Interview Survey, 2001–2007.

Table 55. Frequencies of children aged 4–17 who were generally not well-behaved or did not usually do what adults requested during the past 6 months, by family structure and by selected characteristics: United States, 2001–2007

Selected characteristics	All children aged 4–17 who were generally not well-behaved in the past 6 months	Family structure[1]						
		Nuclear	Single parent	Unmarried biological or adoptive	Blended	Cohabiting	Extended	Other
	Number in thousands[2]							
Total[3]	2,028	553	492	23	262	87	515	96
Sex								
Male	1,196	337	294	16	145	50	294	60
Female	832	216	198	*6	118	37	221	36
Age								
4–17 years	2,028	553	492	23	262	87	515	96
4–11 years	1,084	357	268	*11	145	53	208	42
12–17 years	944	197	224	*12	117	34	307	54
Hispanic origin and race[4]								
Hispanic or Latino	466	140	100	*6	44	16	144	15
Mexican or Mexican American	318	111	52	*2	33	*9	98	*13
Not Hispanic or Latino	1,562	413	392	16	218	71	371	80
White, single race	1,018	339	182	*13	179	39	231	36
Black or African American, single race	414	32	182	*2	32	23	104	38
Parent's education[5]								
Less than high school diploma	438	75	160	*6	42	23	127	*4
High school diploma or GED[6]	522	126	117	*12	83	31	145	*8
More than high school diploma	940	351	178	*5	133	31	227	17
Family income[7]								
Less than $20,000	576	75	285	*6	43	26	108	33
$20,000–$34,999	458	101	145	*7	48	27	109	*22
$35,000–$54,999	376	117	42	*5	79	*13	101	*18
$55,000–$74,999	249	95	*15	*4	38	*11	72	*15
$75,000 or more	369	167	*5	*1	54	*10	125	*8
Poverty status[8]								
Poor	623	94	257	*7	50	27	147	40
Near poor	532	112	141	*7	75	31	141	26
Not poor	872	347	94	*9	138	29	227	30
Home tenure status[9]								
Owned or being bought	1,150	396	146	*9	159	34	341	64
Rented	817	141	329	13	94	50	161	29
Some other arrangement	50	*10	17	*1	*8	*3	*9	*3
Health insurance coverage[10]								
Private	927	357	140	*5	141	21	238	24
Medicaid	811	126	295	13	82	44	191	59
Other	35	*4	*9	*1	*7	*4	*8	*2
Uninsured	245	63	47	*3	29	18	72	*11
Place of residence[11]								
Large MSA	671	158	217	*6	72	28	159	30
Small MSA	933	280	186	*12	125	32	253	45
Not in MSA	424	115	89	*5	65	27	102	21
Region								
Northeast	344	89	86	*7	36	16	97	*14
Midwest	426	121	109	*1	62	18	91	25
South	808	187	225	*7	111	37	193	48
West	450	157	72	*7	53	16	135	*10

* Estimate has a relative standard error of greater than 30% and should be used with caution because it does not meet the standards of reliability or precision.
– Quantity zero.
[1]A nuclear family consists of one or more children living with two parents who are married to one another and are biological or adoptive parents to all children in the family. A single-parent family consists of one or more children living with a single adult (male or female, related or unrelated). An unmarried biological or adoptive family consists of one or more children living with two parents who

are not married to one another and are biological or adoptive parents to all children in the family. A blended family consists of one or more children living with a biological or adoptive parent and an unrelated stepparent who are married to one another. A cohabiting family consists of one or more children living with a biological or adoptive parent and an unrelated adult who are cohabiting with one another. An extended family consists of one or more children living with at least one biological or adoptive parent and a related adult. An "other" family consists of one or more children living with related or unrelated adults who are not biological or adoptive parents.

[2]Data are based on household interviews of a sample of the civilian noninstitutionalized population. Prevalence of the behavior shown in this table is obtained from a question that asked, "During the past 6 months, has [child's name] been generally well-behaved, usually does what adults request?" Response categories included "not true," "somewhat true," "certainly true," "refused," and "don't know;" only "not true" cases are represented in this table. A knowledgeable adult provided information on behalf of child respondents. Unknowns with respect to this behavior and family structure are not included in the column labeled "All children aged 4–17 who were generally not well-behaved in the past 6 months" (see Appendix I).

[3]Includes other races not shown separately and children with unknown parent's education, family income, poverty status, or health insurance. Additionally, numbers within selected characteristics may not add to totals because of rounding.

[4]Persons of Hispanic or Latino origin may be of any race or combination of races. Similarly, the category "Not Hispanic or Latino" refers to all persons who are not of Hispanic or Latino origin, regardless of race. To be concise, the text uses shorter versions of the terms shown in the table. For example, the category "Not Hispanic or Latino black or African American, single race" in the tables is referred to as "non-Hispanic black" in the text.

[5]Refers to the education level of the parent with the higher level of education, regardless of that parent's age.

[6]GED is General Educational Development high school equivalency diploma.

[7]Information on family income and poverty status is obtained from the 2001–2007 National Health Interview Survey Imputed Family Income/Personal Earnings Files.

[8]Based on family income and family size using the U.S. Census Bureau's poverty thresholds for the previous calendar year. "Poor" persons are defined as below the poverty threshold. "Near poor" persons have incomes of 100% to less than 200% of the poverty threshold. "Not poor" persons have incomes that are 200% of the poverty threshold or greater.

[9]Based on a question in the Family Core that asked whether the family's house or apartment is owned or being bought, rented, or occupied by some other arrangement (see Appendix II).

[10]Classification of health insurance coverage is based on a hierarchy of mutually exclusive categories. Persons with more than one type of health insurance were assigned to the first appropriate category in the hierarchy. The category "Uninsured" includes persons who had no coverage as well as those who had only Indian Health Service coverage or had only a private plan that paid for one type of service such as accidents or dental care (see Appendix II).

[11]MSA is metropolitan statistical area. Large MSAs have a population size of 1 million or more; small MSAs have a population size of less than 1 million. "Not in MSA" consists of persons not living in a metropolitan statistical area.

SOURCE: CDC/NCHS, National Health Interview Survey, 2001–2007.

Table 56. Percentages (with standard errors) of children aged 4–17 who were generally not well-behaved or did not usually do what adults requested during the past 6 months, by family structure and by selected characteristics: United States, 2001–2007

Selected characteristics	All children aged 4–17 who were generally not well-behaved in the past 6 months	Family structure[1]						
		Nuclear	Single parent	Unmarried biological or adoptive	Blended	Cohabiting	Extended	Other
	Percent[2] (standard error)							
Total[3]	3.6 (0.10)	2.1 (0.11)	5.0 (0.26)	4.7 (1.02)	5.1 (0.39)	4.9 (0.56)	4.7 (0.25)	5.3 (0.67)
Sex								
Male	4.2 (0.14)	2.5 (0.17)	6.1 (0.40)	6.3 (1.70)	5.5 (0.56)	5.4 (0.77)	5.1 (0.38)	6.5 (0.97)
Female	3.0 (0.13)	1.7 (0.15)	4.0 (0.32)	*2.8 (0.90)	4.6 (0.54)	4.4 (0.82)	4.2 (0.32)	4.1 (0.93)
Age								
4–17 years	3.6 (0.10)	2.1 (0.11)	5.0 (0.26)	4.7 (1.02)	5.1 (0.39)	4.9 (0.56)	4.7 (0.25)	5.3 (0.67)
4–11 years	3.4 (0.13)	2.2 (0.14)	5.0 (0.35)	*2.9 (0.88)	5.2 (0.56)	4.7 (0.70)	4.5 (0.37)	4.6 (0.82)
12–17 years	3.9 (0.15)	2.1 (0.18)	5.1 (0.37)	*10.5 (3.22)	4.9 (0.53)	5.3 (0.94)	4.8 (0.34)	6.0 (1.06)
Hispanic origin and race[4]								
Hispanic or Latino	4.6 (0.21)	3.5 (0.30)	6.0 (0.53)	*4.1 (1.63)	5.7 (0.96)	5.2 (1.24)	5.1 (0.40)	4.1 (1.06)
Mexican or Mexican American	4.6 (0.26)	3.8 (0.38)	5.7 (0.77)	*2.3 (0.86)	6.4 (1.23)	*4.2 (1.28)	5.0 (0.49)	*4.6 (1.39)
Not Hispanic or Latino	3.4 (0.11)	1.9 (0.12)	4.8 (0.29)	5.0 (1.29)	5.0 (0.42)	4.9 (0.62)	4.5 (0.31)	5.6 (0.80)
White, single race	3.0 (0.12)	1.8 (0.13)	4.1 (0.39)	*6.0 (1.85)	5.1 (0.48)	3.7 (0.60)	4.2 (0.39)	4.9 (0.89)
Black or African American, single race	5.1 (0.28)	2.0 (0.37)	5.9 (0.47)	*3.1 (1.47)	4.5 (1.03)	8.0 (1.71)	5.7 (0.59)	6.8 (1.58)
Parent's education[5]								
Less than high school diploma	6.4 (0.36)	3.7 (0.44)	9.1 (0.85)	*5.3 (2.11)	10.6 (2.17)	6.6 (1.47)	6.1 (0.58)	*3.5 (1.84)
High school diploma or GED[6]	4.2 (0.21)	2.8 (0.31)	4.2 (0.45)	6.3 (1.88)	5.9 (0.73)	4.9 (0.89)	5.0 (0.45)	*5.0 (2.09)
More than high school diploma	2.7 (0.11)	1.8 (0.12)	3.7 (0.31)	*2.7 (1.39)	4.0 (0.43)	4.0 (0.83)	3.8 (0.35)	4.5 (1.30)
Family income[7]								
Less than $20,000	6.2 (0.30)	3.9 (0.51)	6.4 (0.44)	*5.1 (1.91)	9.2 (1.90)	7.3 (1.56)	6.9 (0.74)	9.1 (2.19)
$20,000–$34,999	4.8 (0.29)	3.2 (0.41)	5.5 (0.53)	*5.3 (1.95)	5.3 (0.98)	6.6 (1.57)	5.8 (0.75)	5.4 (1.57)
$35,000–$54,999	3.5 (0.23)	2.5 (0.30)	2.6 (0.49)	*3.7 (1.97)	6.2 (0.89)	*3.1 (1.03)	4.6 (0.50)	*4.4 (1.37)
$55,000–$74,999	2.9 (0.26)	2.1 (0.27)	*2.6 (0.82)	*7.4 (4.73)	3.7 (0.77)	*4.2 (1.38)	4.1 (0.74)	*5.7 (1.82)
$75,000 or more	2.1 (0.14)	1.4 (0.14)	*1.1 (0.83)	*1.9 (1.35)	3.6 (0.61)	*3.1 (1.18)	3.4 (0.37)	*2.1 (0.73)
Poverty status[8]								
Poor	6.4 (0.32)	4.2 (0.61)	6.8 (0.49)	*6.2 (2.41)	8.3 (1.64)	6.7 (1.45)	7.0 (0.76)	8.7 (1.95)
Near poor	4.3 (0.24)	2.7 (0.31)	5.0 (0.49)	*3.8 (1.53)	5.9 (0.90)	6.2 (1.27)	5.1 (0.50)	4.7 (1.10)
Not poor	2.6 (0.11)	1.8 (0.11)	3.0 (0.33)	*4.5 (1.61)	4.2 (0.42)	3.4 (0.65)	3.7 (0.29)	3.7 (0.76)
Home tenure status[9]								
Owned or being bought	3.0 (0.11)	1.9 (0.11)	3.8 (0.37)	*4.1 (1.45)	4.5 (0.45)	4.4 (0.81)	4.3 (0.30)	5.2 (0.74)
Rented	5.2 (0.21)	3.5 (0.39)	5.8 (0.36)	5.1 (1.48)	6.3 (0.79)	5.4 (0.83)	5.6 (0.50)	5.7 (1.51)
Some other arrangement	5.0 (0.74)	*2.6 (0.84)	6.2 (1.56)	*7.7 (5.58)	*8.3 (3.25)	*7.4 (5.78)	*5.2 (2.07)	*6.3 (5.30)
Health insurance coverage[10]								
Private	2.6 (0.11)	1.8 (0.12)	3.3 (0.32)	*3.2 (1.12)	4.2 (0.42)	2.8 (0.58)	3.7 (0.30)	4.0 (0.99)
Medicaid	6.2 (0.25)	4.2 (0.48)	6.9 (0.46)	5.4 (1.57)	7.6 (1.11)	6.1 (0.98)	6.5 (0.57)	6.6 (1.13)
Other	2.9 (0.57)	*0.8 (0.39)	*4.3 (1.67)	*17.6 (13.32)	*4.1 (1.85)	*8.5 (5.40)	*4.2 (1.65)	*4.2 (3.43)
Uninsured	4.3 (0.31)	2.8 (0.36)	5.0 (0.76)	*4.7 (3.46)	5.8 (1.24)	7.3 (1.88)	5.2 (0.67)	*4.1 (1.30)
Place of residence[11]								
Large MSA	4.3 (0.20)	2.7 (0.27)	5.9 (0.45)	*3.7 (1.60)	5.8 (0.80)	5.4 (1.08)	4.6 (0.38)	4.8 (1.20)
Small MSA	3.1 (0.12)	1.9 (0.13)	4.3 (0.37)	5.4 (1.57)	4.8 (0.53)	3.9 (0.73)	4.3 (0.34)	5.7 (1.05)
Not in MSA	4.0 (0.28)	2.4 (0.31)	5.1 (0.61)	*4.8 (2.37)	4.9 (0.83)	6.2 (1.27)	5.8 (0.83)	5.2 (1.21)
Region								
Northeast	3.4 (0.23)	1.8 (0.22)	4.9 (0.59)	*8.3 (3.20)	5.4 (1.12)	5.9 (1.51)	4.4 (0.58)	*5.2 (2.38)
Midwest	3.2 (0.19)	1.9 (0.22)	4.7 (0.54)	*1.2 (0.90)	4.8 (0.73)	3.8 (0.98)	4.0 (0.54)	6.8 (1.51)
South	4.0 (0.17)	2.1 (0.18)	5.7 (0.45)	*5.7 (2.44)	5.1 (0.62)	5.6 (0.94)	5.1 (0.44)	5.9 (1.05)
West	3.7 (0.21)	2.8 (0.29)	4.0 (0.47)	*4.6 (1.55)	5.1 (0.83)	4.4 (1.24)	4.7 (0.51)	*2.6 (0.79)

* Estimate has a relative standard error of greater than 30% and should be used with caution because it does not meet the standards of reliability or precision.

– Quantity zero.

[1] A nuclear family consists of one or more children living with two parents who are married to one another and are biological or adoptive parents to all children in the family. A single-parent family consists of one or more children living with a single adult (male or female, related or unrelated). An unmarried biological or adoptive family consists of one or more children living with two parents who

are not married to one another and are biological or adoptive parents to all children in the family. A blended family consists of one or more children living with a biological or adoptive parent and an unrelated stepparent who are married to one another. A cohabiting family consists of one or more children living with a biological or adoptive parent and an unrelated adult who are cohabiting with one another. An extended family consists of one or more children living with at least one biological or adoptive parent and a related adult. An "other" family consists of one or more children living with related or unrelated adults who are not biological or adoptive parents.

[2]Data are based on household interviews of a sample of the civilian noninstitutionalized population. Prevalence of the behavior shown in this table is obtained from a question that asked, "During the past 6 months, has [child's name] been generally well-behaved, usually does what adults request?" Response categories included "not true," "somewhat true," "certainly true," "refused," and "don't know;" only "not true" cases are represented in this table. A knowledgeable adult provided information on behalf of child respondents. Unknowns with respect to this behavior and family structure are not included in the column labeled "All children aged 4–17 who were generally not well-behaved in the past 6 months" (see Appendix I).

[3]Includes other races not shown separately and children with unknown parent's education, family income, poverty status, or health insurance.

[4]Persons of Hispanic or Latino origin may be of any race or combination of races. Similarly, the category "Not Hispanic or Latino" refers to all persons who are not of Hispanic or Latino origin, regardless of race. To be concise, the text uses shorter versions of the terms shown in the table. For example, the category "Not Hispanic or Latino black or African American, single race" in the tables is referred to as "non-Hispanic black" in the text.

[5]Refers to the education level of the parent with the higher level of education, regardless of that parent's age.

[6]GED is General Educational Development high school equivalency diploma.

[7]Information on family income and poverty status is obtained from the 2001–2007 National Health Interview Survey Imputed Family Income/Personal Earnings Files.

[8]Based on family income and family size using the U.S. Census Bureau's poverty thresholds for the previous calendar year. "Poor" persons are defined as below the poverty threshold. "Near poor" persons have incomes of 100% to less than 200% of the poverty threshold. "Not poor" persons have incomes that are 200% of the poverty threshold or greater.

[9]Based on a question in the Family Core that asked whether the family's house or apartment is owned or being bought, rented, or occupied by some other arrangement (see Appendix II).

[10]Classification of health insurance coverage is based on a hierarchy of mutually exclusive categories. Persons with more than one type of health insurance were assigned to the first appropriate category in the hierarchy. The category "Uninsured" includes persons who had no coverage as well as those who had only Indian Health Service coverage or had only a private plan that paid for one type of service such as accidents or dental care (see Appendix II).

[11]MSA is metropolitan statistical area. Large MSAs have a population size of 1 million or more; small MSAs have a population size of less than 1 million. "Not in MSA" consists of persons not living in a metropolitan statistical area.

SOURCE: CDC/NCHS, National Health Interview Survey, 2001–2007.

Table 57. Frequencies of children aged 4–17 who had many worries or often seemed worried during the past 6 months, by family structure and by selected characteristics: United States, 2001–2007

Selected characteristics	All children aged 4–17 who had many worries or often seemed worried in the past 6 months	Family structure[1]						
		Nuclear	Single parent	Unmarried biological or adoptive	Blended	Cohabiting	Extended	Other
	Number in thousands[2]							
Total[3]	3,276	1,067	832	25	376	135	665	177
Sex								
Male	1,671	540	440	16	189	67	325	94
Female	1,606	527	392	*9	187	68	339	83
Age								
4–17 years	3,276	1,067	832	25	376	135	665	177
4–11 years	1,638	649	423	18	183	78	216	71
12–17 years	1,639	418	409	*8	193	57	448	105
Hispanic origin and race[4]								
Hispanic or Latino	610	182	135	*7	59	22	176	30
Mexican or Mexican American	418	129	73	*4	42	18	126	27
Not Hispanic or Latino	2,666	885	697	19	317	113	489	147
White, single race	2,055	761	471	*16	267	89	359	92
Black or African American, single race	411	53	170	*2	33	18	95	40
Parent's education[5]								
Less than high school diploma	490	101	161	*7	41	31	143	*5
High school diploma or GED[6]	773	198	216	*9	114	45	184	*8
More than high school diploma	1,832	765	397	*10	218	59	330	52
Family income[7]								
Less than $20,000	793	112	421	*10	56	22	134	38
$20,000–$34,999	691	168	210	*8	85	41	145	35
$35,000–$54,999	620	224	114	*5	88	32	132	24
$55,000–$74,999	456	190	49	*–	65	23	82	*48
$75,000 or more	717	374	37	*2	83	*17	173	31
Poverty status[8]								
Poor	816	133	359	*10	66	24	176	49
Near poor	852	221	240	*8	99	43	188	53
Not poor	1,608	713	233	*8	211	68	301	75
Home tenure status[9]								
Owned or being bought	2,020	838	330	*11	236	66	415	124
Rented	1,174	212	471	14	130	68	237	43
Some other arrangement	71	*13	31	*–	*9	*1	*10	*8
Health insurance coverage[10]								
Private	1,746	735	360	*6	220	52	329	44
Medicaid	1,082	183	380	17	106	49	242	104
Other	58	24	*12	*1	*10	*6	*6	*–
Uninsured	382	122	76	*2	40	29	85	27
Place of residence[11]								
Large MSA	940	255	271	*5	85	34	225	63
Small MSA	1,628	591	387	*13	173	67	317	80
Not in MSA	708	220	173	*8	118	34	122	34
Region								
Northeast	575	184	144	*8	56	24	138	22
Midwest	740	253	185	*5	83	39	126	50
South	1,259	381	357	*8	160	46	245	62
West	702	249	146	*5	77	26	156	42

* Estimate has a relative standard error of greater than 30% and should be used with caution because it does not meet the standards of reliability or precision.
– Quantity zero.
[1]A nuclear family consists of one or more children living with two parents who are married to one another and are biological or adoptive parents to all children in the family. A single-parent family consists of one or more children living with a single adult (male or female, related or unrelated). An unmarried biological or adoptive family consists of one or more children living with two parents who

are not married to one another and are biological or adoptive parents to all children in the family. A blended family consists of one or more children living with a biological or adoptive parent and an unrelated stepparent who are married to one another. A cohabiting family consists of one or more children living with a biological or adoptive parent and an unrelated adult who are cohabiting with one another. An extended family consists of one or more children living with at least one biological or adoptive parent and a related adult. An "other" family consists of one or more children living with related or unrelated adults who are not biological or adoptive parents.

[2]Data are based on household interviews of a sample of the civilian noninstitutionalized population. Prevalence of the behavior shown in this table is obtained from a question that asked, "During the past 6 months, has [child's name] many worries, or often seems worried?" Response categories included "not true," "somewhat true," "certainly true," "refused," and "don't know;" only "certainly true" cases are represented in this table. A knowledgeable adult provided information on behalf of child respondents. Unknowns with respect to this behavior and family structure are not included in the column labeled "All children aged 4–17 who had many worries or often seemed worried in the past 6 months" (see Appendix I).

[3]Includes other races not shown separately and children with unknown parent's education, family income, poverty status, or health insurance. Additionally, numbers within selected characteristics may not add to totals because of rounding.

[4]Persons of Hispanic or Latino origin may be of any race or combination of races. Similarly, the category "Not Hispanic or Latino" refers to all persons who are not of Hispanic or Latino origin, regardless of race. To be concise, the text uses shorter versions of the terms shown in the table. For example, the category "Not Hispanic or Latino black or African American, single race" in the tables is referred to as "non-Hispanic black" in the text.

[5]Refers to the education level of the parent with the higher level of education, regardless of that parent's age.

[6]GED is General Educational Development high school equivalency diploma.

[7]Information on family income and poverty status is obtained from the 2001–2007 National Health Interview Survey Imputed Family Income/Personal Earnings Files.

[8]Based on family income and family size using the U.S. Census Bureau's poverty thresholds for the previous calendar year. "Poor" persons are defined as below the poverty threshold. "Near poor" persons have incomes of 100% to less than 200% of the poverty threshold. "Not poor" persons have incomes that are 200% of the poverty threshold or greater.

[9]Based on a question in the Family Core that asked whether the family's house or apartment is owned or being bought, rented, or occupied by some other arrangement (see Appendix II).

[10]Classification of health insurance coverage is based on a hierarchy of mutually exclusive categories. Persons with more than one type of health insurance were assigned to the first appropriate category in the hierarchy. The category "Uninsured" includes persons who had no coverage as well as those who had only Indian Health Service coverage or had only a private plan that paid for one type of service such as accidents or dental care (see Appendix II).

[11]MSA is metropolitan statistical area. Large MSAs have a population size of 1 million or more; small MSAs have a population size of less than 1 million. "Not in MSA" consists of persons not living in a metropolitan statistical area.

SOURCE: CDC/NCHS, National Health Interview Survey, 2001–2007.

Table 58. Percentages (with standard errors) of children aged 4–17 who had many worries or often seemed worried during the past 6 months, by family structure and by selected characteristics: United States, 2001–2007

Selected characteristics	All children aged 4–17 who had many worries or often seemed worried in the past 6 months	Family structure[1]						
		Nuclear	Single parent	Unmarried biological or adoptive	Blended	Cohabiting	Extended	Other
	Percent[2] (standard error)							
Total[3]	5.9 (0.13)	4.1 (0.16)	8.5 (0.35)	5.3 (1.13)	7.3 (0.47)	7.6 (0.80)	6.0 (0.28)	9.8 (1.05)
Sex								
Male	5.8 (0.17)	4.1 (0.21)	9.2 (0.49)	6.2 (1.59)	7.2 (0.63)	7.3 (1.13)	5.7 (0.37)	10.2 (1.30)
Female	5.9 (0.18)	4.2 (0.22)	7.9 (0.46)	*4.2 (1.59)	7.4 (0.67)	8.0 (1.12)	6.4 (0.42)	9.4 (1.67)
Age								
4–17 years	5.9 (0.13)	4.1 (0.16)	8.5 (0.35)	5.3 (1.13)	7.3 (0.47)	7.6 (0.80)	6.0 (0.28)	9.8 (1.05)
4–11 years	5.2 (0.16)	4.0 (0.20)	7.8 (0.47)	4.9 (1.27)	6.5 (0.60)	7.0 (0.92)	4.7 (0.38)	7.8 (1.14)
12–17 years	6.8 (0.20)	4.4 (0.26)	9.4 (0.51)	*6.7 (2.43)	8.2 (0.67)	8.7 (1.47)	7.0 (0.39)	11.9 (1.80)
Hispanic origin and race[4]								
Hispanic or Latino	6.0 (0.25)	4.5 (0.32)	8.1 (0.72)	*4.4 (1.32)	7.6 (1.03)	7.2 (1.50)	6.2 (0.47)	7.9 (1.60)
Mexican or Mexican American	6.1 (0.33)	4.5 (0.39)	8.0 (1.01)	*3.5 (1.52)	8.1 (1.25)	8.7 (2.04)	6.4 (0.60)	9.7 (2.12)
Not Hispanic or Latino	5.8 (0.15)	4.1 (0.18)	8.6 (0.39)	5.8 (1.54)	7.2 (0.53)	7.7 (0.91)	6.0 (0.33)	10.3 (1.26)
White, single race	6.1 (0.18)	4.1 (0.19)	10.5 (0.56)	7.8 (2.33)	7.7 (0.58)	8.4 (1.15)	6.5 (0.44)	12.4 (2.00)
Black or African American, single race	5.1 (0.31)	3.3 (0.51)	5.5 (0.50)	*2.6 (1.24)	4.8 (1.10)	6.2 (1.77)	5.2 (0.61)	7.3 (1.53)
Parent's education[5]								
Less than high school diploma	7.2 (0.36)	5.1 (0.51)	9.2 (0.83)	*6.6 (2.69)	10.4 (2.11)	8.7 (1.81)	6.8 (0.63)	*4.2 (2.19)
High school diploma or GED[6]	6.2 (0.26)	4.4 (0.37)	7.8 (0.60)	*4.7 (1.70)	8.1 (0.95)	7.1 (1.17)	6.4 (0.53)	*4.9 (2.26)
More than high school diploma	5.3 (0.16)	4.0 (0.19)	8.3 (0.49)	*5.2 (1.75)	6.6 (0.55)	7.7 (1.31)	5.6 (0.39)	14.0 (3.57)
Family income[7]								
Less than $20,000	8.6 (0.35)	5.8 (0.60)	9.5 (0.54)	*8.4 (2.88)	11.8 (1.98)	6.2 (1.43)	8.6 (0.88)	10.8 (1.68)
$20,000–$34,999	7.2 (0.33)	5.3 (0.52)	8.0 (0.59)	*5.8 (2.58)	9.4 (1.36)	10.0 (2.20)	7.7 (0.79)	8.6 (2.05)
$35,000–$54,999	5.8 (0.29)	4.8 (0.40)	7.1 (0.87)	*4.0 (2.23)	6.9 (0.88)	7.6 (1.53)	6.0 (0.67)	5.9 (1.59)
$55,000–$74,999	5.4 (0.34)	4.2 (0.40)	8.4 (1.60)	*–	6.4 (0.94)	8.9 (2.27)	4.6 (0.58)	18.6 (4.84)
$75,000 or more	4.0 (0.19)	3.3 (0.21)	7.8 (1.65)	*4.5 (3.20)	5.5 (0.73)	*5.2 (1.63)	4.8 (0.44)	8.5 (2.17)
Poverty status[8]								
Poor	8.4 (0.37)	5.9 (0.59)	9.5 (0.59)	*8.2 (3.06)	11.0 (1.77)	6.0 (1.40)	8.4 (0.85)	10.6 (1.88)
Near poor	6.9 (0.30)	5.3 (0.48)	8.5 (0.62)	*4.5 (2.01)	7.8 (1.04)	8.7 (1.87)	6.8 (0.58)	9.6 (2.45)
Not poor	4.8 (0.15)	3.7 (0.17)	7.4 (0.56)	*4.2 (1.66)	6.4 (0.52)	7.8 (1.06)	4.9 (0.32)	9.5 (1.38)
Home tenure status[9]								
Owned or being bought	5.2 (0.15)	3.9 (0.17)	8.6 (0.56)	*5.1 (1.74)	6.7 (0.53)	8.5 (1.22)	5.2 (0.30)	10.0 (1.32)
Rented	7.5 (0.26)	5.3 (0.43)	8.4 (0.44)	5.7 (1.54)	8.6 (0.95)	7.3 (1.10)	8.3 (0.64)	8.6 (1.31)
Some other arrangement	7.1 (1.04)	*3.5 (1.12)	11.2 (2.03)	*–	*9.4 (3.38)	*3.3 (2.41)	*5.8 (2.24)	*17.7 (11.79)
Health insurance coverage[10]								
Private	4.9 (0.15)	3.7 (0.17)	8.4 (0.51)	*3.3 (1.34)	6.5 (0.53)	7.0 (1.14)	5.1 (0.32)	7.5 (2.07)
Medicaid	8.2 (0.32)	6.1 (0.58)	8.9 (0.53)	7.2 (1.99)	9.8 (1.20)	6.8 (1.25)	8.3 (0.66)	11.8 (1.52)
Other	4.9 (0.75)	4.4 (1.03)	*6.1 (1.83)	*9.2 (9.24)	*6.1 (2.21)	*13.2 (6.33)	*2.9 (1.54)	*–
Uninsured	6.7 (0.42)	5.5 (0.57)	8.1 (0.99)	*3.7 (1.98)	8.0 (1.56)	11.3 (2.30)	6.1 (0.74)	9.9 (1.82)
Place of residence[11]								
Large MSA	6.0 (0.24)	4.3 (0.31)	7.4 (0.53)	*3.0 (1.04)	6.8 (0.86)	6.8 (1.15)	6.5 (0.51)	10.2 (2.26)
Small MSA	5.5 (0.17)	3.9 (0.21)	8.9 (0.53)	5.9 (1.72)	6.7 (0.65)	8.2 (1.25)	5.4 (0.37)	10.3 (1.36)
Not in MSA	6.7 (0.33)	4.6 (0.37)	9.9 (0.87)	*8.2 (3.67)	9.0 (1.06)	7.6 (1.72)	7.0 (0.77)	8.4 (1.63)
Region								
Northeast	5.7 (0.30)	3.8 (0.35)	8.2 (0.82)	*8.7 (3.34)	8.5 (1.38)	8.7 (2.04)	6.3 (0.76)	8.5 (2.11)
Midwest	5.6 (0.26)	4.0 (0.30)	8.0 (0.76)	*3.9 (2.21)	6.4 (0.80)	8.4 (1.89)	5.6 (0.57)	13.9 (3.25)
South	6.2 (0.22)	4.3 (0.28)	9.1 (0.56)	*6.1 (2.34)	7.4 (0.78)	7.0 (1.17)	6.5 (0.48)	7.8 (1.21)
West	5.7 (0.28)	4.4 (0.35)	8.2 (0.69)	*3.8 (1.46)	7.4 (1.02)	7.0 (1.48)	5.4 (0.45)	11.1 (2.34)

* Estimate has a relative standard error of greater than 30% and should be used with caution because it does not meet the standards of reliability or precision.

– Quantity zero.

[1]A nuclear family consists of one or more children living with two parents who are married to one another and are biological or adoptive parents to all children in the family. A single-parent family consists of one or more children living with a single adult (male or female, related or unrelated). An unmarried biological or adoptive family consists of one or more children living with two parents who are not married to one another and are biological or adoptive parents to all children in the family. A blended family consists of one or more children living with a biological or adoptive parent and an

unrelated stepparent who are married to one another. A cohabiting family consists of one or more children living with a biological or adoptive parent and an unrelated adult who are cohabiting with one another. An extended family consists of one or more children living with at least one biological or adoptive parent and a related adult. An "other" family consists of one or more children living with related or unrelated adults who are not biological or adoptive parents.

[2]Data are based on household interviews of a sample of the civilian noninstitutionalized population. Prevalence of the behavior shown in this table is obtained from a question that asked, "During the past 6 months, has [child's name] many worries, or often seems worried?" Response categories included "not true," "somewhat true," "certainly true," "refused," and "don't know;" only "certainly true" cases are represented in this table. A knowledgeable adult provided information on behalf of child respondents. Unknowns with respect to this behavior and family structure are not included in the column labeled "All children aged 4–17 who had many worries or often seemed worried in the past 6 months" (see Appendix I).

[3]Includes other races not shown separately and children with unknown parent's education, family income, poverty status, or health insurance.

[4]Persons of Hispanic or Latino origin may be of any race or combination of races. Similarly, the category "Not Hispanic or Latino" refers to all persons who are not of Hispanic or Latino origin, regardless of race. To be concise, the text uses shorter versions of the terms shown in the table. For example, the category "Not Hispanic or Latino black or African American, single race" in the tables is referred to as "non-Hispanic black" in the text.

[5]Refers to the education level of the parent with the higher level of education, regardless of that parent's age.

[6]GED is General Educational Development high school equivalency diploma.

[7]Information on family income and poverty status is obtained from the 2001–2007 National Health Interview Survey Imputed Family Income/Personal Earnings Files.

[8]Based on family income and family size using the U.S. Census Bureau's poverty thresholds for the previous calendar year. "Poor" persons are defined as below the poverty threshold. "Near poor" persons have incomes of 100% to less than 200% of the poverty threshold. "Not poor" persons have incomes that are 200% of the poverty threshold or greater.

[9]Based on a question in the Family Core that asked whether the family's house or apartment is owned or being bought, rented, or occupied by some other arrangement (see Appendix II).

[10]Classification of health insurance coverage is based on a hierarchy of mutually exclusive categories. Persons with more than one type of health insurance were assigned to the first appropriate category in the hierarchy. The category "Uninsured" includes persons who had no coverage as well as those who had only Indian Health Service coverage or had only a private plan that paid for one type of service such as accidents or dental care (see Appendix II).

[11]MSA is metropolitan statistical area. Large MSAs have a population size of 1 million or more; small MSAs have a population size of less than 1 million. "Not in MSA" consists of persons not living in a metropolitan statistical area.

SOURCE: CDC/NCHS, National Health Interview Survey, 2001–2007.

Table 59. Frequencies of children aged 4–17 who generally exhibited a poor attention span or did not usually see chores and homework through to the end during the past 6 months, by family structure and by selected characteristics: United States, 2001–2007

Selected characteristics	All children aged 4–17 who generally exhibited a poor attention span in the past 6 months	Family structure[1]						
		Nuclear	Single parent	Unmarried biological or adoptive	Blended	Cohabiting	Extended	Other
	Number in thousands[2]							
Total[3]	6,242	2,036	1,433	50	804	281	1,315	323
Sex								
Male	3,933	1,323	869	35	515	173	821	197
Female	2,309	713	563	15	289	108	494	126
Age								
4–17 years	6,242	2,036	1,433	50	804	281	1,315	323
4–11 years	3,313	1,241	798	35	414	156	518	151
12–17 years	2,928	795	635	15	390	125	797	172
Hispanic origin and race[4]								
Hispanic or Latino	1,039	315	222	17	104	43	267	71
Mexican or Mexican American	713	230	130	*11	76	26	183	58
Not Hispanic or Latino	5,202	1,721	1,211	34	699	238	1,048	252
White, single race	3,812	1,480	684	25	579	173	729	141
Black or African American, single race	1,061	136	438	*6	86	48	261	86
Parent's education[5]								
Less than high school diploma	812	169	262	*8	69	57	237	*9
High school diploma or GED[6]	1,638	438	410	25	235	102	397	31
More than high school diploma	3,480	1,424	677	17	493	122	658	90
Family income[7]								
Less than $20,000	1,375	186	739	*10	92	68	219	61
$20,000–$34,999	1,257	291	378	13	156	78	268	73
$35,000–$54,999	1,256	433	200	14	201	57	281	70
$55,000–$74,999	909	387	62	*7	172	37	193	52
$75,000 or more	1,444	739	54	*6	182	41	354	67
Poverty status[8]								
Poor	1,403	218	628	*11	112	70	285	80
Near poor	1,613	379	427	19	223	85	366	115
Not poor	3,225	1,439	377	20	469	127	665	128
Home tenure status[9]								
Owned or being bought	3,907	1,610	501	19	556	112	872	238
Rented	2,187	390	895	30	224	162	411	75
Some other arrangement	128	24	36	*1	23	*7	29	*8
Health insurance coverage[10]								
Private	3,364	1,469	520	19	502	94	671	89
Medicaid	2,101	331	747	23	216	131	466	189
Other	133	52	26	*–	17	*9	25	*3
Uninsured	629	179	139	*9	68	46	146	42
Place of residence[11]								
Large MSA	1,803	441	561	15	185	100	397	103
Small MSA	3,087	1,147	609	28	382	120	667	133
Not in MSA	1,352	448	262	*7	237	61	251	86
Region								
Northeast	1,004	345	233	14	88	36	255	34
Midwest	1,537	514	360	*12	210	73	277	91
South	2,459	761	585	*10	362	117	496	128
West	1,241	416	254	14	144	56	287	70

* Estimate has a relative standard error of greater than 30% and should be used with caution because it does not meet the standards of reliability or precision.

– Quantity zero.

[1]A nuclear family consists of one or more children living with two parents who are married to one another and are biological or adoptive parents to all children in the family. A single-parent family consists of one or more children living with a single adult (male or female, related or unrelated). An unmarried biological or adoptive family consists of one or more children living with two parents who are not married to one another and are biological or adoptive parents to all children in the family. A blended family consists of one or more children living with a biological or adoptive parent and an

unrelated stepparent who are married to one another. A cohabiting family consists of one or more children living with a biological or adoptive parent and an unrelated adult who are cohabiting with one another. An extended family consists of one or more children living with at least one biological or adoptive parent and a related adult. An "other" family consists of one or more children living with related or unrelated adults who are not biological or adoptive parents.

[2]Data are based on household interviews of a sample of the civilian noninstitutionalized population. Prevalence of the behavior shown in this table is obtained from a question that asked, "During the past 6 months, has [child's name] had a good attention span, sees chores or homework through to the end?" Response categories included "not true," "somewhat true," "certainly true," "refused," and "don't know;" only "not true" cases are represented in this table. A knowledgeable adult provided information on behalf of child respondents. Unknowns with respect to this behavior and family structure are not included in the column labeled "All children aged 4–17 who generally exhibited a poor attention span in the past 6 months" (see Appendix I).

[3]Includes other races not shown separately and children with unknown parent's education, family income, poverty status, or health insurance. Additionally, numbers within selected characteristics may not add to totals because of rounding.

[4]Persons of Hispanic or Latino origin may be of any race or combination of races. Similarly, the category "Not Hispanic or Latino" refers to all persons who are not of Hispanic or Latino origin, regardless of race. To be concise, the text uses shorter versions of the terms shown in the table. For example, the category "Not Hispanic or Latino black or African American, single race" in the tables is referred to as "non-Hispanic black" in the text.

[5]Refers to the education level of the parent with the higher level of education, regardless of that parent's age.

[6]GED is General Educational Development high school equivalency diploma.

[7]Information on family income and poverty status is obtained from the 2001–2007 National Health Interview Survey Imputed Family Income/Personal Earnings Files.

[8]Based on family income and family size using the U.S. Census Bureau's poverty thresholds for the previous calendar year. "Poor" persons are defined as below the poverty threshold. "Near poor" persons have incomes of 100% to less than 200% of the poverty threshold. "Not poor" persons have incomes that are 200% of the poverty threshold or greater.

[9]Based on a question in the Family Core that asked whether the family's house or apartment is owned or being bought, rented, or occupied by some other arrangement (see Appendix II).

[10]Classification of health insurance coverage is based on a hierarchy of mutually exclusive categories. Persons with more than one type of health insurance were assigned to the first appropriate category in the hierarchy. The category "Uninsured" includes persons who had no coverage as well as those who had only Indian Health Service coverage or had only a private plan that paid for one type of service such as accidents or dental care (see Appendix II).

[11]MSA is metropolitan statistical area. Large MSAs have a population size of 1 million or more; small MSAs have a population size of less than 1 million. "Not in MSA" consists of persons not living in a metropolitan statistical area.

SOURCE: CDC/NCHS, National Health Interview Survey, 2001–2007.

Table 60. Percentages (with standard errors) of children aged 4–17 who generally exhibited a poor attention span or did not usually see chores and homework through to the end during the past 6 months, by family structure and by selected characteristics: United States, 2001–2007

Selected characteristics	All children aged 4–17 who generally exhibited a poor attention span in the past 6 months	Family structure[1]						
		Nuclear	Single parent	Unmarried biological or adoptive	Blended	Cohabiting	Extended	Other
	Percent[2] (standard error)							
Total[3]	11.2 (0.17)	7.9 (0.21)	14.7 (0.42)	10.6 (1.54)	15.6 (0.63)	16.0 (1.10)	11.9 (0.38)	18.0 (1.22)
Sex								
Male	13.8 (0.25)	10.0 (0.32)	18.1 (0.65)	13.5 (2.34)	19.6 (0.98)	18.8 (1.57)	14.4 (0.56)	21.4 (1.74)
Female	8.5 (0.21)	5.7 (0.25)	11.4 (0.55)	7.1 (1.76)	11.4 (0.79)	12.9 (1.50)	9.3 (0.51)	14.4 (1.77)
Age								
4–17 years	11.2 (0.17)	7.9 (0.21)	14.7 (0.42)	10.6 (1.54)	15.6 (0.63)	16.0 (1.10)	11.9 (0.38)	18.0 (1.22)
4–11 years	10.5 (0.22)	7.6 (0.26)	14.8 (0.58)	9.7 (1.60)	14.8 (0.88)	14.1 (1.30)	11.3 (0.55)	16.6 (1.55)
12–17 years	12.1 (0.27)	8.4 (0.35)	14.5 (0.61)	13.6 (3.78)	16.5 (0.96)	19.2 (1.96)	12.4 (0.51)	19.4 (1.95)
Hispanic origin and race[4]								
Hispanic or Latino	10.3 (0.33)	7.9 (0.46)	13.4 (0.95)	10.9 (2.60)	13.5 (1.48)	13.9 (2.17)	9.5 (0.53)	18.8 (2.48)
Mexican or Mexican American	10.4 (0.42)	8.0 (0.54)	14.3 (1.37)	10.2 (2.91)	14.7 (1.91)	12.7 (2.50)	9.4 (0.65)	20.8 (3.13)
Not Hispanic or Latino	11.4 (0.20)	7.9 (0.24)	15.0 (0.48)	10.5 (1.89)	15.9 (0.71)	16.4 (1.24)	12.8 (0.47)	17.7 (1.42)
White, single race	11.3 (0.23)	8.1 (0.26)	15.3 (0.67)	12.4 (2.63)	16.7 (0.82)	16.3 (1.52)	13.2 (0.59)	19.0 (2.08)
Black or African American, single race	13.1 (0.49)	8.6 (0.82)	14.2 (0.75)	*7.7 (2.62)	12.4 (1.54)	16.7 (2.52)	14.3 (1.05)	15.7 (2.12)
Parent's education[5]								
Less than high school diploma	11.9 (0.45)	8.4 (0.70)	15.0 (1.02)	*7.5 (2.45)	17.5 (2.49)	16.2 (2.33)	11.3 (0.73)	*7.1 (2.78)
High school diploma or GED[6]	13.1 (0.36)	9.8 (0.51)	14.9 (0.80)	14.0 (2.83)	16.6 (1.24)	16.1 (1.92)	13.9 (0.77)	19.3 (4.92)
More than high school diploma	10.1 (0.21)	7.4 (0.25)	14.2 (0.63)	9.2 (2.26)	14.9 (0.80)	15.9 (1.68)	11.2 (0.52)	24.0 (3.69)
Family income[7]								
Less than $20,000	14.9 (0.45)	9.7 (0.82)	16.6 (0.64)	*8.4 (2.93)	19.4 (2.39)	19.2 (2.67)	14.1 (1.09)	17.3 (2.44)
$20,000–$34,999	13.2 (0.45)	9.2 (0.70)	14.3 (0.85)	10.3 (2.98)	17.5 (1.60)	18.9 (2.80)	14.3 (1.06)	17.7 (2.23)
$35,000–$54,999	11.7 (0.39)	9.3 (0.56)	12.4 (1.02)	11.5 (3.14)	15.8 (1.31)	13.5 (1.97)	12.7 (0.98)	16.9 (2.61)
$55,000–$74,999	10.7 (0.46)	8.5 (0.53)	10.7 (1.83)	*13.6 (5.94)	17.0 (1.51)	14.5 (2.98)	10.9 (0.99)	20.1 (4.54)
$75,000 or more	8.1 (0.27)	6.5 (0.30)	11.3 (2.01)	*11.2 (4.27)	12.1 (1.06)	13.0 (2.43)	9.8 (0.61)	18.6 (3.06)
Poverty status[8]								
Poor	14.5 (0.48)	9.6 (0.85)	16.7 (0.74)	*9.7 (3.29)	18.5 (2.22)	17.7 (2.64)	13.7 (1.06)	17.5 (2.44)
Near poor	13.2 (0.41)	9.1 (0.60)	15.1 (0.86)	11.2 (2.82)	17.5 (1.46)	17.1 (2.56)	13.3 (0.83)	20.8 (2.65)
Not poor	9.5 (0.20)	7.4 (0.24)	12.0 (0.70)	10.6 (2.27)	14.3 (0.75)	14.5 (1.55)	10.8 (0.47)	16.3 (1.63)
Home tenure status[9]								
Owned or being bought	10.1 (0.19)	7.6 (0.23)	13.1 (0.66)	8.6 (2.09)	15.7 (0.76)	14.5 (1.51)	11.0 (0.44)	19.1 (1.54)
Rented	14.0 (0.33)	9.8 (0.56)	15.9 (0.56)	12.1 (2.17)	14.9 (1.15)	17.3 (1.61)	14.4 (0.80)	15.0 (2.05)
Some other arrangement	12.8 (1.32)	6.4 (1.44)	13.0 (2.47)	*10.5 (7.73)	25.2 (5.33)	*19.6 (9.86)	16.8 (3.38)	*18.9 (7.34)
Health insurance coverage[10]								
Private	9.5 (0.20)	7.4 (0.24)	12.1 (0.60)	10.9 (2.30)	14.8 (0.76)	12.8 (1.58)	10.4 (0.46)	15.2 (2.30)
Medicaid	16.0 (0.40)	11.0 (0.72)	17.4 (0.70)	9.9 (2.19)	19.9 (1.49)	18.0 (1.83)	16.0 (0.88)	21.3 (1.84)
Other	11.2 (1.05)	9.7 (1.56)	12.7 (2.34)	*–	10.5 (2.48)	*21.2 (7.29)	13.3 (2.84)	*8.3 (4.23)
Uninsured	11.1 (0.50)	8.0 (0.72)	14.7 (1.37)	*13.4 (4.50)	13.7 (2.05)	18.3 (3.04)	10.5 (0.83)	15.1 (2.39)
Place of residence[11]								
Large MSA	11.6 (0.32)	7.5 (0.41)	15.4 (0.72)	9.2 (2.28)	14.8 (1.19)	19.8 (2.22)	11.5 (0.65)	16.7 (2.27)
Small MSA	10.4 (0.23)	7.6 (0.29)	14.0 (0.64)	13.1 (2.55)	14.7 (0.90)	14.6 (1.65)	11.5 (0.51)	17.2 (1.74)
Not in MSA	12.8 (0.40)	9.3 (0.49)	15.1 (0.90)	*7.3 (3.04)	18.0 (1.34)	14.0 (2.08)	14.3 (1.13)	21.5 (2.51)
Region								
Northeast	10.0 (0.40)	7.1 (0.48)	13.2 (0.93)	16.2 (4.31)	13.3 (1.60)	13.3 (2.64)	11.8 (0.95)	13.3 (2.74)
Midwest	11.7 (0.38)	8.1 (0.44)	15.6 (0.95)	*10.1 (3.17)	16.2 (1.41)	15.6 (2.22)	12.4 (0.89)	25.0 (3.55)
South	12.2 (0.28)	8.6 (0.37)	15.0 (0.68)	*8.0 (2.41)	16.7 (1.00)	17.8 (1.86)	13.2 (0.65)	16.0 (1.57)
West	10.1 (0.33)	7.3 (0.43)	14.2 (0.91)	10.0 (2.72)	13.9 (1.15)	15.1 (2.29)	10.1 (0.65)	18.5 (2.46)

* Estimate has a relative standard error of greater than 30% and should be used with caution because it does not meet the standards of reliability or precision.

– Quantity zero.

[1]A nuclear family consists of one or more children living with two parents who are married to one another and are biological or adoptive parents to all children in the family. A single-parent family consists of one or more children living with a single adult (male or female, related or unrelated). An unmarried biological or adoptive family consists of one or more children living with two parents who

are not married to one another and are biological or adoptive parents to all children in the family. A blended family consists of one or more children living with a biological or adoptive parent and an unrelated stepparent who are married to one another. A cohabiting family consists of one or more children living with a biological or adoptive parent and an unrelated adult who are cohabiting with one another. An extended family consists of one or more children living with at least one biological or adoptive parent and a related adult. An "other" family consists of one or more children living with related or unrelated adults who are not biological or adoptive parents.

[2]Data are based on household interviews of a sample of the civilian noninstitutionalized population. Prevalence of the behavior shown in this table is obtained from a question that asked, "During the past 6 months, has [child's name] had a good attention span, sees chores or homework through to the end?" Response categories included "not true," "somewhat true," "certainly true," "refused," and "don't know;" only "not true" cases are represented in this table. A knowledgeable adult provided information on behalf of child respondents. Unknowns with respect to this behavior and family structure are not included in the column labeled "All children aged 4–17 who generally exhibited a poor attention span in the past 6 months" (see Appendix I).

[3]Includes other races not shown separately and children with unknown parent's education, family income, poverty status, or health insurance.

[4]Persons of Hispanic or Latino origin may be of any race or combination of races. Similarly, the category "Not Hispanic or Latino" refers to all persons who are not of Hispanic or Latino origin, regardless of race. To be concise, the text uses shorter versions of the terms shown in the table. For example, the category "Not Hispanic or Latino black or African American, single race" in the tables is referred to as "non-Hispanic black" in the text.

[5]Refers to the education level of the parent with the higher level of education, regardless of that parent's age.

[6]GED is General Educational Development high school equivalency diploma.

[7]Information on family income and poverty status is obtained from the 2001–2007 National Health Interview Survey Imputed Family Income/Personal Earnings Files.

[8]Based on family income and family size using the U.S. Census Bureau's poverty thresholds for the previous calendar year. "Poor" persons are defined as below the poverty threshold. "Near poor" persons have incomes of 100% to less than 200% of the poverty threshold. "Not poor" persons have incomes that are 200% of the poverty threshold or greater.

[9]Based on a question in the Family Core that asked whether the family's house or apartment is owned or being bought, rented, or occupied by some other arrangement (see Appendix II).

[10]Classification of health insurance coverage is based on a hierarchy of mutually exclusive categories. Persons with more than one type of health insurance were assigned to the first appropriate category in the hierarchy. The category "Uninsured" includes persons who had no coverage as well as those who had only Indian Health Service coverage or had only a private plan that paid for one type of service such as accidents or dental care (see Appendix II).

[11]MSA is metropolitan statistical area. Large MSAs have a population size of 1 million or more; small MSAs have a population size of less than 1 million. "Not in MSA" consists of persons not living in a metropolitan statistical area.

SOURCE: CDC/NCHS, National Health Interview Survey, 2001–2007.

Table 61. Frequencies of children aged 4–17 who certainly got along better with adults than children during the past 6 months, by family structure and by selected characteristics: United States, 2001–2007

Selected characteristics	All children aged 4–17 who certainly got along better with adults than children in the past 6 months	Family structure[1]						
		Nuclear	Single parent	Unmarried biological or adoptive	Blended	Cohabiting	Extended	Other
	Number in thousands[2]							
Total[3]	6,264	2,327	1,339	54	635	219	1,419	271
Sex								
Male	3,215	1,225	650	29	349	96	722	144
Female	3,049	1,102	689	26	286	122	697	127
Age								
4–17 years	6,264	2,327	1,339	54	635	219	1,419	271
4–11 years	3,081	1,296	664	39	292	123	549	118
12–17 years	3,183	1,031	676	16	343	95	870	152
Hispanic origin and race[4]								
Hispanic or Latino	1,409	504	286	18	108	44	376	73
Mexican or Mexican American	953	376	159	12	62	29	257	58
Not Hispanic or Latino	4,855	1,822	1,054	36	527	174	1,044	198
White, single race	3,187	1,384	504	21	415	118	643	103
Black or African American, single race	1,171	205	471	9	87	44	281	75
Parent's education[5]								
Less than high school diploma	1,061	260	344	17	58	61	302	*19
High school diploma or GED[6]	1,597	513	374	15	199	80	397	*20
More than high school diploma	3,306	1,549	543	22	371	77	689	56
Family income[7]								
Less than $20,000	1,481	256	757	16	70	63	263	56
$20,000–$34,999	1,252	361	325	16	130	61	283	77
$35,000–$54,999	1,217	513	164	*11	150	47	282	51
$55,000–$74,999	873	410	54	*7	116	26	222	38
$75,000 or more	1,441	787	40	*5	168	22	369	50
Poverty status[8]								
Poor	1,546	287	650	16	97	65	348	84
Near poor	1,499	455	368	16	140	62	379	79
Not poor	3,219	1,585	321	23	398	92	692	108
Home tenure status[9]								
Owned or being bought	3,862	1,784	424	24	421	86	956	166
Rented	2,247	488	877	29	202	125	438	88
Some other arrangement	136	46	36	*1	*11	*7	*20	*15
Health insurance coverage[10]								
Private	3,367	1,576	465	17	417	84	737	72
Medicaid	1,921	398	694	25	133	94	440	137
Other	143	62	23	*1	15	*5	28	*7
Uninsured	804	287	151	*11	69	34	198	55
Place of residence[11]								
Large MSA	2,012	593	582	19	146	60	512	100
Small MSA	3,034	1,270	531	24	319	100	675	115
Not in MSA	1,218	464	226	*11	169	58	233	56
Region								
Northeast	1,113	383	263	*11	100	40	280	35
Midwest	1,191	444	282	*9	116	40	261	39
South	2,602	966	551	17	313	97	539	118
West	1,358	533	243	17	105	41	339	79

* Estimate has a relative standard error of greater than 30% and should be used with caution because it does not meet the standards of reliability or precision.

– Quantity zero.

[1] A nuclear family consists of one or more children living with two parents who are married to one another and are biological or adoptive parents to all children in the family. A single-parent family consists of one or more children living with a single adult (male or female, related or unrelated). An unmarried biological or adoptive family consists of one or more children living with two parents who

are not married to one another and are biological or adoptive parents to all children in the family. A blended family consists of one or more children living with a biological or adoptive parent and an unrelated stepparent who are married to one another. A cohabiting family consists of one or more children living with a biological or adoptive parent and an unrelated adult who are cohabiting with one another. An extended family consists of one or more children living with at least one biological or adoptive parent and a related adult. An "other" family consists of one or more children living with related or unrelated adults who are not biological or adoptive parents.

[2]Data are based on household interviews of a sample of the civilian noninstitutionalized population. Prevalence of the behavior shown in this table is obtained from a question that asked, "During the past 6 months, did [child's name] get along better with adults than with other [children ages 4–11/youth 12–17]?" Response categories included "not true," "somewhat true," "certainly true," "refused," and "don't know;" only "certainly true" cases are represented in this table. A knowledgeable adult provided information on behalf of child respondents. Unknowns with respect to this behavior and family structure are not included in the column labeled "All children aged 4–17 who certainly got along better with adults than children in the past 6 months" (see Appendix I).

[3]Includes other races not shown separately and children with unknown parent's education, family income, poverty status, or health insurance. Additionally, numbers within selected characteristics may not add to totals because of rounding.

[4]Persons of Hispanic or Latino origin may be of any race or combination of races. Similarly, the category "Not Hispanic or Latino" refers to all persons who are not of Hispanic or Latino origin, regardless of race. To be concise, the text uses shorter versions of the terms shown in the table. For example, the category "Not Hispanic or Latino black or African American, single race" in the tables is referred to as "non-Hispanic black" in the text.

[5]Refers to the education level of the parent with the higher level of education, regardless of that parent's age.

[6]GED is General Educational Development high school equivalency diploma.

[7]Information on family income and poverty status is obtained from the 2001–2007 National Health Interview Survey Imputed Family Income/Personal Earnings Files.

[8]Based on family income and family size using the U.S. Census Bureau's poverty thresholds for the previous calendar year. "Poor" persons are defined as below the poverty threshold. "Near poor" persons have incomes of 100% to less than 200% of the poverty threshold. "Not poor" persons have incomes that are 200% of the poverty threshold or greater.

[9]Based on a question in the Family Core that asked whether the family's house or apartment is owned or being bought, rented, or occupied by some other arrangement (see Appendix II).

[10]Classification of health insurance coverage is based on a hierarchy of mutually exclusive categories. Persons with more than one type of health insurance were assigned to the first appropriate category in the hierarchy. The category "Uninsured" includes persons who had no coverage as well as those who had only Indian Health Service coverage or had only a private plan that paid for one type of service such as accidents or dental care (see Appendix II).

[11]MSA is metropolitan statistical area. Large MSAs have a population size of 1 million or more; small MSAs have a population size of less than 1 million. "Not in MSA" consists of persons not living in a metropolitan statistical area.

SOURCE: CDC/NCHS, National Health Interview Survey, 2001–2007.

Table 62. Percentages (with standard errors) of children aged 4–17 who certainly got along better with adults than children during the past 6 months, by family structure and by selected characteristics: United States, 2001–2007

Selected characteristics	All children aged 4–17 who certainly got along better with adults than children in the past 6 months	Family structure[1]						
		Nuclear	Single parent	Unmarried biological or adoptive	Blended	Cohabiting	Extended	Other
	Percent[2] (standard error)							
Total[3]	11.3 (0.18)	9.1 (0.24)	13.8 (0.44)	11.4 (1.51)	12.4 (0.60)	12.5 (0.98)	13.0 (0.40)	15.2 (1.03)
Sex								
Male	11.3 (0.24)	9.3 (0.31)	13.6 (0.57)	10.9 (2.04)	13.4 (0.90)	10.5 (1.17)	12.7 (0.54)	15.8 (1.49)
Female	11.3 (0.25)	8.9 (0.33)	14.0 (0.63)	12.0 (2.26)	11.3 (0.84)	14.7 (1.50)	13.2 (0.59)	14.5 (1.47)
Age								
4–17 years	11.3 (0.18)	9.1 (0.24)	13.8 (0.44)	11.4 (1.51)	12.4 (0.60)	12.5 (0.98)	13.0 (0.40)	15.2 (1.03)
4–11 years	9.8 (0.22)	8.0 (0.28)	12.4 (0.57)	10.6 (1.61)	10.5 (0.81)	11.2 (1.11)	12.0 (0.60)	13.1 (1.35)
12–17 years	13.2 (0.29)	11.0 (0.41)	15.6 (0.66)	14.2 (3.67)	14.7 (0.92)	14.7 (1.85)	13.6 (0.54)	17.3 (1.56)
Hispanic origin and race[4]								
Hispanic or Latino	14.1 (0.36)	12.7 (0.57)	17.5 (0.97)	12.0 (2.57)	14.1 (1.34)	14.3 (2.05)	13.4 (0.63)	19.5 (2.40)
Mexican or Mexican American	14.0 (0.45)	13.1 (0.70)	17.8 (1.31)	11.4 (2.95)	12.1 (1.44)	14.3 (2.39)	13.2 (0.76)	21.1 (2.96)
Not Hispanic or Latino	10.7 (0.20)	8.4 (0.25)	13.1 (0.49)	11.2 (1.90)	12.1 (0.66)	12.1 (1.09)	12.8 (0.49)	14.0 (1.16)
White, single race	9.5 (0.22)	7.6 (0.26)	11.4 (0.62)	10.4 (2.29)	12.0 (0.76)	11.3 (1.26)	11.7 (0.59)	14.0 (1.65)
Black or African American, single race	14.5 (0.52)	13.0 (1.03)	15.2 (0.79)	11.6 (3.04)	12.6 (1.57)	15.3 (2.72)	15.5 (1.08)	13.6 (1.81)
Parent's education[5]								
Less than high school diploma	15.6 (0.54)	13.0 (0.86)	19.7 (1.19)	15.3 (3.40)	14.8 (2.13)	17.4 (2.59)	14.5 (0.88)	15.8 (4.37)
High school diploma or GED[6]	12.9 (0.38)	11.5 (0.61)	13.6 (0.76)	8.5 (1.89)	14.2 (1.26)	12.6 (1.61)	14.0 (0.75)	12.6 (3.72)
More than high school diploma	9.6 (0.21)	8.1 (0.25)	11.5 (0.55)	11.9 (2.70)	11.3 (0.74)	10.2 (1.36)	11.8 (0.56)	15.1 (3.03)
Family income[7]								
Less than $20,000	16.2 (0.50)	13.4 (0.97)	17.1 (0.74)	13.9 (3.44)	14.9 (2.12)	17.9 (2.66)	17.0 (1.18)	16.1 (1.92)
$20,000–$34,999	13.3 (0.43)	11.5 (0.74)	12.4 (0.76)	12.0 (3.07)	14.6 (1.55)	15.1 (2.56)	15.3 (1.11)	18.6 (2.55)
$35,000–$54,999	11.4 (0.40)	11.0 (0.62)	10.2 (0.97)	*8.7 (2.74)	11.9 (1.16)	11.0 (1.76)	12.9 (0.89)	12.2 (2.18)
$55,000–$74,999	10.4 (0.42)	9.1 (0.53)	9.5 (1.40)	*13.0 (5.26)	11.5 (1.27)	10.4 (1.99)	12.6 (1.05)	14.6 (2.75)
$75,000 or more	8.1 (0.26)	6.9 (0.30)	8.4 (1.53)	*9.3 (3.91)	11.3 (1.15)	6.9 (1.59)	10.3 (0.64)	14.0 (2.53)
Poverty status[8]								
Poor	16.1 (0.52)	12.8 (0.95)	17.3 (0.84)	13.5 (3.59)	16.2 (2.10)	16.5 (2.48)	16.9 (1.13)	18.7 (2.49)
Near poor	12.3 (0.39)	11.0 (0.68)	13.1 (0.73)	9.0 (2.19)	11.1 (1.14)	12.6 (2.12)	13.8 (0.83)	14.2 (1.92)
Not poor	9.6 (0.20)	8.2 (0.25)	10.2 (0.58)	12.3 (2.40)	12.2 (0.74)	10.7 (1.14)	11.3 (0.48)	13.8 (1.49)
Home tenure status[9]								
Owned or being bought	10.0 (0.20)	8.4 (0.25)	11.2 (0.59)	10.9 (2.18)	12.0 (0.72)	11.3 (1.30)	12.1 (0.46)	13.4 (1.17)
Rented	14.4 (0.35)	12.3 (0.63)	15.7 (0.62)	11.7 (2.09)	13.5 (1.06)	13.5 (1.47)	15.4 (0.80)	17.9 (2.06)
Some other arrangement	13.9 (1.40)	12.6 (2.33)	13.0 (2.23)	*9.4 (8.99)	*12.1 (3.72)	*20.5 (9.08)	12.4 (3.54)	*34.1 (11.83)
Health insurance coverage[10]								
Private	9.5 (0.20)	7.9 (0.24)	10.9 (0.56)	9.8 (2.28)	12.3 (0.76)	11.5 (1.37)	11.6 (0.51)	12.4 (1.63)
Medicaid	14.7 (0.40)	13.3 (0.80)	16.3 (0.73)	10.9 (2.12)	12.3 (1.25)	13.1 (1.72)	15.2 (0.84)	15.6 (1.62)
Other	12.1 (1.11)	11.6 (1.80)	11.8 (2.34)	*17.6 (13.32)	9.3 (2.51)	*11.8 (4.87)	14.8 (2.89)	*18.9 (7.42)
Uninsured	14.3 (0.60)	12.9 (0.94)	16.2 (1.31)	16.8 (4.51)	14.0 (2.04)	13.4 (2.51)	14.3 (1.05)	19.9 (2.58)
Place of residence[11]								
Large MSA	13.0 (0.35)	10.2 (0.51)	16.0 (0.72)	11.4 (2.37)	11.8 (1.12)	12.0 (1.52)	14.9 (0.74)	16.2 (1.95)
Small MSA	10.3 (0.24)	8.5 (0.29)	12.2 (0.65)	11.1 (2.03)	12.4 (0.88)	12.4 (1.51)	11.7 (0.51)	14.9 (1.55)
Not in MSA	11.6 (0.43)	9.7 (0.60)	13.1 (1.00)	*12.1 (4.43)	13.0 (1.18)	13.4 (1.97)	13.4 (1.10)	14.1 (1.83)
Region								
Northeast	11.1 (0.39)	7.9 (0.47)	15.1 (1.01)	13.3 (3.74)	15.3 (1.89)	15.0 (2.63)	13.0 (0.94)	13.9 (2.33)
Midwest	9.1 (0.35)	7.0 (0.40)	12.3 (0.89)	*7.2 (2.81)	9.1 (0.98)	8.7 (1.83)	11.8 (0.95)	10.7 (2.18)
South	12.9 (0.32)	11.0 (0.47)	14.2 (0.71)	13.4 (3.08)	14.6 (1.05)	14.9 (1.72)	14.4 (0.66)	14.9 (1.42)
West	11.2 (0.39)	9.5 (0.49)	13.7 (1.05)	12.1 (2.60)	10.2 (0.98)	11.3 (1.76)	12.0 (0.73)	20.9 (2.74)

* Estimate has a relative standard error of greater than 30% and should be used with caution because it does not meet the standards of reliability or precision.
– Quantity zero.
[1] A nuclear family consists of one or more children living with two parents who are married to one another and are biological or adoptive parents to all children in the family. A single-parent family

consists of one or more children living with a single adult (male or female, related or unrelated). An unmarried biological or adoptive family consists of one or more children living with two parents who are not married to one another and are biological or adoptive parents to all children in the family. A blended family consists of one or more children living with a biological or adoptive parent and an unrelated stepparent who are married to one another. A cohabiting family consists of one or more children living with a biological or adoptive parent and an unrelated adult who are cohabiting with one another. An extended family consists of one or more children living with at least one biological or adoptive parent and a related adult. An "other" family consists of one or more children living with related or unrelated adults who are not biological or adoptive parents.

[2]Data are based on household interviews of a sample of the civilian noninstitutionalized population. Prevalence of the behavior shown in this table is obtained from a question that asked, "During the past 6 months, did [child's name] get along better with adults than with other [children ages 4–11/youth 12–17]?" Response categories included "not true," "somewhat true," "certainly true," "refused," and "don't know;" only "certainly true" cases are represented in this table. A knowledgeable adult provided information on behalf of child respondents. Unknowns with respect to this behavior and family structure are not included in the column labeled "All children aged 4–17 who certainly got along better with adults than children in the past 6 months" (see Appendix I).

[3]Includes other races not shown separately and children with unknown parent's education, family income, poverty status, or health insurance. Additionally, numbers within selected characteristics may not add to totals because of rounding.

[4]Persons of Hispanic or Latino origin may be of any race or combination of races. Similarly, the category "Not Hispanic or Latino" refers to all persons who are not of Hispanic or Latino origin, regardless of race. To be concise, the text uses shorter versions of the terms shown in the table. For example, the category "Not Hispanic or Latino black or African American, single race" in the tables is referred to as "non-Hispanic black" in the text.

[5]Refers to the education level of the parent with the higher level of education, regardless of that parent's age.

[6]GED is General Educational Development high school equivalency diploma.

[7]Information on family income and poverty status is obtained from the 2001–2007 National Health Interview Survey Imputed Family Income/Personal Earnings Files.

[8]Based on family income and family size using the U.S. Census Bureau's poverty thresholds for the previous calendar year. "Poor" persons are defined as below the poverty threshold. "Near poor" persons have incomes of 100% to less than 200% of the poverty threshold. "Not poor" persons have incomes that are 200% of the poverty threshold or greater.

[9]Based on a question in the Family Core that asked whether the family's house or apartment is owned or being bought, rented, or occupied by some other arrangement (see Appendix II).

[10]Classification of health insurance coverage is based on a hierarchy of mutually exclusive categories. Persons with more than one type of health insurance were assigned to the first appropriate category in the hierarchy. The category "Uninsured" includes persons who had no coverage as well as those who had only Indian Health Service coverage or had only a private plan that paid for one type of service such as accidents or dental care (see Appendix II).

[11]MSA is metropolitan statistical area. Large MSAs have a population size of 1 million or more; small MSAs have a population size of less than 1 million. "Not in MSA" consists of persons not living in a metropolitan statistical area.

SOURCE: CDC/NCHS, National Health Interview Survey, 2001–2007.

Table 63. Frequencies of children aged 4–17 with definite or severe emotional or behavioral difficulties, by family structure and by selected characteristics: United States, 2001–2007

Selected characteristics	All children aged 4–17 with definite or severe emotional or behavioral difficulties	Family structure[1]						
		Nuclear	Single parent	Unmarried biological or adoptive	Blended	Cohabiting	Extended	Other
	Number in thousands[2]							
Total[3]	2,851	779	729	27	438	135	567	176
Sex								
Male	1,823	526	452	20	287	89	359	91
Female	1,028	254	277	*7	151	46	208	85
Age								
4–17 years	2,851	779	729	27	438	135	567	176
4–11 years	1,422	425	375	17	228	77	221	77
12–17 years	1,429	354	353	*10	210	57	346	99
Hispanic origin and race[4]								
Hispanic or Latino	372	83	97	*6	53	18	87	27
Mexican or Mexican American	216	58	45	*2	31	10	48	22
Not Hispanic or Latino	2,479	696	632	21	385	117	480	148
White, single race	1,834	611	370	18	317	81	354	84
Black or African American, single race	464	37	200	*2	47	21	102	53
Parent's education[5]								
Less than high school diploma	346	50	140	*6	34	24	88	*3
High school diploma or GED[6]	675	136	200	*9	117	40	165	*7
More than high school diploma	1,663	592	347	*12	281	69	305	58
Family income[7]								
Less than $20,000	714	82	399	*6	45	29	113	40
$20,000–$34,999	571	88	189	*6	104	39	112	34
$35,000–$54,999	514	144	78	*9	125	27	100	32
$55,000–$74,999	405	151	35	*5	73	*18	93	*30
$75,000 or more	646	315	28	*1	92	22	149	39
Poverty status[8]								
Poor	705	87	341	*6	57	29	139	45
Near poor	758	131	217	*10	141	47	149	62
Not poor	1,387	560	171	*11	240	59	279	68
Home tenure status[9]								
Owned or being bought	1,748	636	264	*8	288	50	370	133
Rented	1,039	131	448	20	140	84	180	37
Some other arrangement	58	*9	17	*–	*11	*1	*16	*4
Health insurance coverage[10]								
Private	1,425	568	243	*4	254	43	273	*40
Medicaid	1,108	140	411	18	123	74	223	120
Other	60	25	*6	*1	*14	*4	*9	*1
Uninsured	251	45	69	*5	46	14	56	*14
Place of residence[11]								
Large MSA	830	180	272	*6	102	41	165	65
Small MSA	1,418	444	332	*16	200	62	290	75
Not in MSA	602	155	126	*6	136	32	111	36
Region								
Northeast	516	137	129	*9	59	25	130	*28
Midwest	710	176	191	*9	104	36	137	57
South	1,094	303	298	*5	199	46	180	62
West	530	163	111	*4	77	27	120	28

* Estimate has a relative standard error of greater than 30% and should be used with caution because it does not meet the standards of reliability or precision.

– Quantity zero.

[1] A nuclear family consists of one or more children living with two parents who are married to one another and are biological or adoptive parents to all children in the family. A single-parent family consists of one or more children living with a single adult (male or female, related or unrelated). An unmarried biological or adoptive family consists of one or more children living with two parents who are not married to one another and are biological or adoptive parents to all children in the family. A blended family consists of one or more children living with a biological or adoptive parent and an unrelated stepparent who are married to one another. A cohabiting family consists of one or more children living with a biological or adoptive parent and an unrelated adult who are cohabiting with one

another. An extended family consists of one or more children living with at least one biological or adoptive parent and a related adult. An "other" family consists of one or more children living with related or unrelated adults who are not biological or adoptive parents.

[2]Data are based on household interviews of a sample of the civilian noninstitutionalized population. Prevalence of the behavior shown in this table is obtained from a question that asked, "Overall, do you think that [child's name] has difficulties in any of the following areas: emotions, concentration, behavior, or being able to get along with other people?" Response categories included "no," yes, minor difficulties," "yes, definite difficulties," "yes, severe difficulties," "refused," and "don't know;" "yes, definite difficulties" and "yes, severe difficulties" are represented in this table. A knowledgeable adult provided information on behalf of child respondents. Unknowns with respect to this behavior and family structure are not included in the column labeled "All children aged 4–17 with definite or severe emotional or behavioral difficulties" (see Appendix I).

[3]Includes other races not shown separately and children with unknown parent's education, family income, poverty status, or health insurance. Additionally, numbers within selected characteristics may not add to totals because of rounding.

[4]Persons of Hispanic or Latino origin may be of any race or combination of races. Similarly, the category "Not Hispanic or Latino" refers to all persons who are not of Hispanic or Latino origin, regardless of race. To be concise, the text uses shorter versions of the terms shown in the table. For example, the category "Not Hispanic or Latino black or African American, single race" in the tables is referred to as "non-Hispanic black" in the text.

[5]Refers to the education level of the parent with the higher level of education, regardless of that parent's age.

[6]GED is General Educational Development high school equivalency diploma.

[7]Information on family income and poverty status is obtained from the 2001–2007 National Health Interview Survey Imputed Family Income/Personal Earnings Files.

[8]Based on family income and family size using the U.S. Census Bureau's poverty thresholds for the previous calendar year. "Poor" persons are defined as below the poverty threshold. "Near poor" persons have incomes of 100% to less than 200% of the poverty threshold. "Not poor" persons have incomes that are 200% of the poverty threshold or greater.

[9]Based on a question in the Family Core that asked whether the family's house or apartment is owned or being bought, rented, or occupied by some other arrangement (see Appendix II).

[10]Classification of health insurance coverage is based on a hierarchy of mutually exclusive categories. Persons with more than one type of health insurance were assigned to the first appropriate category in the hierarchy. The category "Uninsured" includes persons who had no coverage as well as those who had only Indian Health Service coverage or had only a private plan that paid for one type of service such as accidents or dental care (see Appendix II).

[11]MSA is metropolitan statistical area. Large MSAs have a population size of 1 million or more; small MSAs have a population size of less than 1 million. "Not in MSA" consists of persons not living in a metropolitan statistical area.

SOURCE: CDC/NCHS, National Health Interview Survey, 2001–2007.

Table 64. Percentages (with standard errors) of children aged 4–17 with definite or severe emotional or behavioral difficulties, by family structure and by selected characteristics: United States, 2001–2007

Selected characteristics	All children aged 4–17 with definite or severe emotional or behavioral difficulties	Family structure[1]						
		Nuclear	Single parent	Unmarried biological or adoptive	Blended	Cohabiting	Extended	Other
	Percent[2] (standard error)							
Total[3]	5.1 (0.12)	3.0 (0.14)	7.4 (0.33)	5.7 (1.23)	8.4 (0.51)	7.6 (0.78)	5.1 (0.27)	9.6 (1.08)
Sex								
Male	6.3 (0.18)	3.9 (0.22)	9.3 (0.50)	7.7 (1.91)	10.8 (0.81)	9.6 (1.22)	6.2 (0.39)	9.7 (1.28)
Female	3.7 (0.15)	2.0 (0.16)	5.5 (0.41)	*3.2 (1.36)	5.9 (0.59)	5.4 (1.01)	3.9 (0.36)	9.5 (1.72)
Age								
4–17 years	5.1 (0.12)	3.0 (0.14)	7.4 (0.33)	5.7 (1.23)	8.4 (0.51)	7.6 (0.78)	5.1 (0.27)	9.6 (1.08)
4–11 years	4.5 (0.15)	2.6 (0.16)	6.9 (0.42)	4.6 (1.17)	8.1 (0.78)	6.9 (0.92)	4.8 (0.39)	8.3 (1.18)
12–17 years	5.8 (0.19)	3.7 (0.25)	8.0 (0.47)	*9.1 (3.55)	8.8 (0.70)	8.7 (1.45)	5.3 (0.36)	10.9 (1.83)
Hispanic origin and race[4]								
Hispanic or Latino	3.6 (0.19)	2.1 (0.24)	5.8 (0.61)	*4.1 (1.69)	6.8 (0.98)	5.7 (1.22)	3.0 (0.29)	7.1 (1.62)
Mexican or Mexican American	3.1 (0.22)	2.0 (0.28)	4.9 (0.82)	*1.8 (1.05)	6.0 (0.98)	5.1 (1.41)	2.4 (0.31)	7.6 (2.05)
Not Hispanic or Latino	5.4 (0.14)	3.2 (0.16)	7.7 (0.37)	6.4 (1.63)	8.7 (0.59)	8.0 (0.92)	5.8 (0.34)	10.2 (1.28)
White, single race	5.4 (0.17)	3.3 (0.17)	8.2 (0.52)	8.5 (2.38)	9.0 (0.69)	7.6 (1.11)	6.4 (0.46)	11.1 (1.87)
Black or African American, single race	5.6 (0.31)	2.3 (0.47)	6.4 (0.54)	*3.2 (1.90)	6.8 (1.19)	7.3 (1.68)	5.5 (0.60)	9.4 (1.95)
Parent's education[5]								
Less than high school diploma	5.0 (0.32)	2.5 (0.39)	7.9 (0.72)	*5.4 (2.76)	8.5 (1.86)	6.8 (1.45)	4.1 (0.62)	*2.6 (1.43)
High school diploma or GED[6]	5.4 (0.25)	3.0 (0.32)	7.2 (0.59)	*5.1 (1.88)	8.2 (0.91)	6.4 (1.14)	5.7 (0.51)	*4.3 (2.79)
More than high school diploma	4.8 (0.15)	3.1 (0.16)	7.2 (0.47)	*6.4 (2.00)	8.5 (0.68)	8.9 (1.42)	5.1 (0.37)	15.5 (3.48)
Family income[7]								
Less than $20,000	7.6 (0.34)	4.1 (0.57)	8.9 (0.52)	*5.4 (2.58)	9.3 (1.77)	8.2 (1.60)	7.1 (0.78)	11.0 (2.41)
$20,000–$34,999	5.9 (0.30)	2.7 (0.40)	7.1 (0.62)	*4.4 (1.93)	11.5 (1.36)	9.4 (2.03)	5.9 (0.65)	7.9 (1.80)
$35,000–$54,999	4.7 (0.26)	3.0 (0.33)	4.8 (0.63)	*7.1 (2.84)	9.8 (1.04)	6.4 (1.40)	4.5 (0.52)	7.7 (1.87)
$55,000–$74,999	4.7 (0.33)	3.3 (0.33)	6.0 (1.23)	*9.7 (4.86)	7.2 (1.06)	*6.9 (2.16)	5.2 (0.87)	*11.6 (4.39)
$75,000 or more	3.6 (0.20)	2.7 (0.20)	5.8 (1.56)	*2.3 (2.67)	6.1 (1.00)	6.6 (1.76)	4.1 (0.41)	10.9 (2.51)
Poverty status[8]								
Poor	7.2 (0.34)	3.8 (0.54)	8.9 (0.59)	*5.3 (2.58)	9.4 (1.69)	7.2 (1.48)	6.6 (0.71)	9.7 (2.11)
Near poor	6.1 (0.30)	3.1 (0.39)	7.6 (0.62)	*5.8 (2.17)	11.1 (1.22)	9.5 (1.89)	5.4 (0.63)	11.0 (2.42)
Not poor	4.1 (0.13)	2.9 (0.15)	5.4 (0.47)	*5.9 (1.88)	7.2 (0.63)	6.7 (1.03)	4.5 (0.33)	8.5 (1.34)
Home tenure status[9]								
Owned or being bought	4.5 (0.14)	3.0 (0.15)	6.8 (0.52)	*3.5 (1.39)	8.0 (0.64)	6.4 (1.03)	4.6 (0.30)	10.5 (1.34)
Rented	6.6 (0.25)	3.2 (0.35)	7.8 (0.44)	7.8 (1.99)	9.3 (0.91)	8.9 (1.23)	6.3 (0.57)	7.2 (1.75)
Some other arrangement	5.7 (0.88)	*2.4 (0.95)	6.2 (1.77)	*–	*11.6 (4.11)	*1.8 (1.78)	9.5 (2.72)	*9.1 (5.73)
Health insurance coverage[10]								
Private	4.0 (0.14)	2.8 (0.15)	5.6 (0.44)	*2.4 (0.92)	7.4 (0.62)	5.8 (1.07)	4.2 (0.32)	*6.7 (2.06)
Medicaid	8.3 (0.31)	4.6 (0.51)	9.5 (0.55)	7.6 (2.14)	11.3 (1.18)	10.1 (1.44)	7.6 (0.66)	13.4 (1.64)
Other	5.0 (0.75)	4.6 (1.27)	*2.9 (0.95)	*9.2 (9.24)	8.6 (2.48)	*8.6 (5.34)	*4.8 (1.58)	*2.2 (1.65)
Uninsured	4.4 (0.32)	2.0 (0.35)	7.2 (0.98)	*7.0 (3.71)	9.3 (1.71)	5.6 (1.54)	4.0 (0.53)	5.1 (1.52)
Place of residence[11]								
Large MSA	5.3 (0.22)	3.0 (0.26)	7.3 (0.50)	*3.4 (1.55)	8.1 (0.87)	7.9 (1.29)	4.7 (0.41)	10.2 (2.20)
Small MSA	4.7 (0.17)	2.9 (0.18)	7.5 (0.51)	7.3 (2.10)	7.7 (0.75)	7.5 (1.30)	5.0 (0.35)	9.4 (1.42)
Not in MSA	5.6 (0.28)	3.2 (0.34)	7.1 (0.78)	*6.0 (2.85)	10.3 (1.10)	7.4 (1.39)	6.3 (0.83)	8.8 (1.96)
Region								
Northeast	5.1 (0.29)	2.8 (0.33)	7.2 (0.73)	*10.3 (3.88)	8.8 (1.25)	9.1 (2.14)	5.9 (0.68)	10.6 (2.99)
Midwest	5.3 (0.27)	2.7 (0.25)	8.2 (0.74)	*7.5 (2.92)	8.0 (1.07)	7.7 (1.79)	6.1 (0.67)	15.5 (3.28)
South	5.4 (0.21)	3.4 (0.24)	7.6 (0.53)	*4.3 (2.03)	9.1 (0.84)	7.0 (1.20)	4.7 (0.41)	7.7 (1.32)
West	4.3 (0.21)	2.8 (0.28)	6.1 (0.65)	*2.6 (1.33)	7.4 (1.02)	7.3 (1.35)	4.2 (0.47)	7.2 (1.69)

* Estimate has a relative standard error of greater than 30% and should be used with caution because it does not meet the standards of reliability or precision.

– Quantity zero.

[1] A nuclear family consists of one or more children living with two parents who are married to one another and are biological or adoptive parents to all children in the family. A single-parent family consists of one or more children living with a single adult (male or female, related or unrelated). An unmarried biological or adoptive family consists of one or more children living with two parents who are not married to one another and are biological or adoptive parents to all children in the family. A blended family consists of one or more children living with a biological or adoptive parent and an unrelated stepparent who are married to one another. A cohabiting family consists of one or more children living with a biological or adoptive parent and an unrelated adult who are cohabiting with one

another. An extended family consists of one or more children living with at least one biological or adoptive parent and a related adult. An "other" family consists of one or more children living with related or unrelated adults who are not biological or adoptive parents.

[2]Data are based on household interviews of a sample of the civilian noninstitutionalized population. Prevalence of the behavior shown in this table is obtained from a question that asked, "Overall, do you think that [child's name] has difficulties in any of the following areas: emotions, concentration, behavior, or being able to get along with other people?" Response categories included "no," "yes, minor difficulties," "yes, definite difficulties," "yes, severe difficulties," "refused," and "don't know;" "yes, definite difficulties" and "yes, severe difficulties" are represented in this table. A knowledgeable adult provided information on behalf of child respondents. Unknowns with respect to this behavior and family structure are not included in the column labeled "All children aged 4–17 with definite or severe emotional or behavioral difficulties" (see Appendix I).

[3]Includes other races not shown separately and children with unknown parent's education, family income, poverty status, or health insurance. Additionally, numbers within selected characteristics may not add to totals because of rounding.

[4]Persons of Hispanic or Latino origin may be of any race or combination of races. Similarly, the category "Not Hispanic or Latino" refers to all persons who are not of Hispanic or Latino origin, regardless of race. To be concise, the text uses shorter versions of the terms shown in the table. For example, the category "Not Hispanic or Latino black or African American, single race" in the tables is referred to as "non-Hispanic black" in the text.

[5]Refers to the education level of the parent with the higher level of education, regardless of that parent's age.

[6]GED is General Educational Development high school equivalency diploma.

[7]Information on family income and poverty status is obtained from the 2001–2007 National Health Interview Survey Imputed Family Income/Personal Earnings Files.

[8]Based on family income and family size using the U.S. Census Bureau's poverty thresholds for the previous calendar year. "Poor" persons are defined as below the poverty threshold. "Near poor" persons have incomes of 100% to less than 200% of the poverty threshold. "Not poor" persons have incomes that are 200% of the poverty threshold or greater.

[9]Based on a question in the Family Core that asked whether the family's house or apartment is owned or being bought, rented, or occupied by some other arrangement (see Appendix II).

[10]Classification of health insurance coverage is based on a hierarchy of mutually exclusive categories. Persons with more than one type of health insurance were assigned to the first appropriate category in the hierarchy. The category "Uninsured" includes persons who had no coverage as well as those who had only Indian Health Service coverage or had only a private plan that paid for one type of service such as accidents or dental care (see Appendix II).

[11]MSA is metropolitan statistical area. Large MSAs have a population size of 1 million or more; small MSAs have a population size of less than 1 million. "Not in MSA" consists of persons not living in a metropolitan statistical area.

SOURCE: CDC/NCHS, National Health Interview Survey, 2001–2007.

Table 65. Frequencies of children aged 4–17 with definite or severe emotional or behavioral difficulties who had no contact with a mental health professional or general doctor for an emotional or behavioral problem during the last 12 months, by family structure and by selected characteristics: United States, 2001–2007

Selected characteristics	All children aged 4–17 with definite or severe emotional or behavioral difficulties who had no contact with a mental health professional or general doctor for this type of problem in the past 12 months	Family structure[1]						
		Nuclear	Single parent	Unmarried biological or adoptive	Blended	Cohabiting	Extended	Other
	Number in thousands[2]							
Total[3]	1,133	311	292	*13	170	53	245	49
Sex								
Male	706	203	170	*10	102	34	167	20
Female	427	108	122	*3	67	19	79	29
Age								
4–17 years	1,133	311	292	*13	170	53	245	49
4–11 years	565	171	154	*9	80	33	99	20
12–17 years	568	140	138	*5	90	20	146	29
Hispanic origin and race[4]								
Hispanic or Latino	175	40	42	*1	29	*9	47	*7
Mexican or Mexican American	103	28	20	*–	17	*5	26	*6
Not Hispanic or Latino	958	270	251	*12	141	44	199	42
White, single race	639	228	119	*10	104	29	131	18
Black or African American, single race	245	22	106	*2	27	*9	53	*24
Parent's education[5]								
Less than high school diploma	166	26	66	*–	*8	16	43	*1
High school diploma or GED[6]	297	58	84	*2	52	16	83	*2
More than high school diploma	601	227	124	*5	104	20	116	*6
Family income[7]								
Less than $20,000	300	35	162	*5	*18	16	44	*20
$20,000–$34,999	267	41	92	*5	45	*14	63	*8
$35,000–$54,999	205	62	24	*2	45	*7	55	*10
$55,000–$74,999	142	57	*10	*–	34	*8	30	*3
$75,000 or more	220	117	*5	*1	28	*8	54	*7
Poverty status[8]								
Poor	309	39	143	*5	19	15	65	*22
Near poor	328	59	99	*5	62	17	74	*13
Not poor	496	213	50	*3	88	21	107	14
Home tenure status[9]								
Owned or being bought	651	248	88	*1	112	23	150	29
Rented	454	56	201	*12	53	30	85	*17
Some other arrangement	24	*5	*4	*–	*5	*–	*10	*1
Health insurance coverage[10]								
Private	534	221	79	*1	91	19	115	*8
Medicaid	423	55	163	*11	42	27	91	34
Other	24	*7	*3	*–	*5	*–	*7	*–
Uninsured	151	27	47	*1	31	*7	31	*7
Place of residence[11]								
Large MSA	351	72	122	*1	47	15	75	*19
Small MSA	540	172	115	*10	76	20	126	20
Not in MSA	243	66	55	*2	47	18	44	*10
Region								
Northeast	190	55	43	*3	25	*12	45	*8
Midwest	230	57	76	*5	27	*9	47	*9
South	483	120	131	*2	89	22	96	23
West	230	79	42	*4	29	10	58	*9

* Estimate has a relative standard error of greater than 30% and should be used with caution because it does not meet the standards of reliability or precision.

-- Quantity zero.

[1]A nuclear family consists of one or more children living with two parents who are married to one another and are biological or adoptive parents to all children in the family. A single-parent family consists of one or more children living with a single adult (male or female, related or unrelated). An unmarried biological or adoptive family consists of one or more children living with two parents who are not married to one another and are biological or adoptive parents to all children in the family. A blended family consists of one or more children living with a biological or adoptive parent and an unrelated stepparent who are married to one another. A cohabiting family consists of one or more children living with a biological or adoptive parent and an unrelated adult who are cohabiting with one another. An extended family consists of one or more children living with at least one biological or adoptive parent and a related adult. An "other" family consists of one or more children living with related or unrelated adults who are not biological or adoptive parents.

[2]Data are based on household interviews of a sample of the civilian noninstitutionalized population. Prevalence of having no contacts with either a mental health professional or a general doctor for an emotional or behavioral problem are based on two questions that asked, "During the past 12 months, have you seen or talked to a mental health professional such as a psychiatrist, psychologist, psychiatric nurse, or clinical social worker about [child's name]'s health?" and, for sample children who had seen or talked with a general doctor or pediatrician during the past 12 months, "Did you see or talk with this general doctor because of an emotional or behavioral problem that [child's name] may have?" Only sample children with definite or severe emotional or behavioral difficulties who lacked contacts with either a mental health professional or a general doctor for such a problem are represented in this table. A knowledgeable adult provided information on behalf of child respondents. Unknowns with respect to these contacts and family structure are not included in the column labeled "All children aged 4–17 with definite or severe emotional or behavioral difficulties who had no contact with a mental health professional or general doctor for this type of problem in the past 12 months" (see Appendix I).

[3]Includes other races not shown separately and children with unknown parent's education, family income, poverty status, or health insurance. Additionally, numbers within selected characteristics may not add to totals because of rounding.

[4]Persons of Hispanic or Latino origin may be of any race or combination of races. Similarly, the category "Not Hispanic or Latino" refers to all persons who are not of Hispanic or Latino origin, regardless of race. To be concise, the text uses shorter versions of the terms shown in the table. For example, the category "Not Hispanic or Latino black or African American, single race" in the tables is referred to as "non-Hispanic black" in the text.

[5]Refers to the education level of the parent with the higher level of education, regardless of that parent's age.

[6]GED is General Educational Development high school equivalency diploma.

[7]Information on family income and poverty status is obtained from the 2001–2007 National Health Interview Survey Imputed Family Income/Personal Earnings Files.

[8]Based on family income and family size using the U.S. Census Bureau's poverty thresholds for the previous calendar year. "Poor" persons are defined as below the poverty threshold. "Near poor" persons have incomes of 100% to less than 200% of the poverty threshold. "Not poor" persons have incomes that are 200% of the poverty threshold or greater.

[9]Based on a question in the Family Core that asked whether the family's house or apartment is owned or being bought, rented, or occupied by some other arrangement (see Appendix II).

[10]Classification of health insurance coverage is based on a hierarchy of mutually exclusive categories. Persons with more than one type of health insurance were assigned to the first appropriate category in the hierarchy. The category "Uninsured" includes persons who had no coverage as well as those who had only Indian Health Service coverage or had only a private plan that paid for one type of service such as accidents or dental care (see Appendix II).

[11]MSA is metropolitan statistical area. Large MSAs have a population size of 1 million or more; small MSAs have a population size of less than 1 million. "Not in MSA" consists of persons not living in a metropolitan statistical area.

SOURCE: CDC/NCHS, National Health Interview Survey, 2001–2007.

Table 66. Percentages (with standard errors) of children aged 4–17 with definite or severe emotional or behavioral difficulties who had no contact with a mental health professional or general doctor for an emotional or behavioral problem during the last 12 months, by family structure and by selected characteristics: United States, 2001–2007

Selected characteristics	All children aged 4–17 with definite or severe emotional or behavioral difficulties who had no contact with a mental health professional or general doctor for this type of problem in the past 12 months	Family structure[1]											
		Nuclear		Single parent		Unmarried biological or adoptive		Blended		Cohabiting		Extended		Other	
	Percent[2] (standard error)												
Total[3]	39.9 (1.19)	39.9	(2.18)	40.2	(2.23)	48.2	(11.11)	39.0	(3.18)	39.6	(5.31)	43.5	(2.59)	27.8	(4.95)
Sex															
Male	38.9 (1.42)	38.7	(2.63)	37.8	(2.75)	49.3	(12.96)	36.0	(3.80)	38.4	(6.39)	46.7	(3.10)	22.3	(5.59)
Female	41.6 (2.02)	42.6	(4.00)	44.1	(3.71)	*45.2	(21.20)	44.6	(5.19)	42.2	(9.47)	38.0	(4.24)	33.8	(8.74)
Age															
4–17 years	39.9 (1.19)	39.9	(2.18)	40.2	(2.23)	48.2	(11.11)	39.0	(3.18)	39.6	(5.31)	43.5	(2.59)	27.8	(4.95)
4–11 years	39.9 (1.68)	40.2	(3.06)	41.2	(3.18)	50.1	(12.88)	35.1	(4.44)	43.0	(6.98)	45.1	(4.06)	25.5	(6.33)
12–17 years	39.9 (1.66)	39.6	(3.35)	39.2	(3.15)	*45.2	(20.29)	43.1	(4.28)	35.2	(7.38)	42.5	(3.34)	29.6	(7.33)
Hispanic origin and race[4]															
Hispanic or Latino	47.3 (2.74)	48.6	(5.35)	42.9	(5.59)	*16.2	(10.54)	56.3	(7.41)	53.4	(11.44)	54.0	(4.81)	*24.8	(8.77)
Mexican or Mexican American	47.6 (3.63)	48.6	(6.43)	44.5	(8.70)	*	–	55.6	(9.73)	*46.3	(14.40)	54.4	(6.42)	*27.9	(10.98)
Not Hispanic or Latino	38.8 (1.30)	38.9	(2.38)	39.8	(2.38)	57.9	(12.72)	36.6	(3.42)	37.5	(5.82)	41.6	(2.90)	28.4	(5.65)
White, single race	34.9 (1.50)	37.3	(2.54)	32.3	(2.97)	56.6	(14.42)	33.1	(3.73)	35.8	(6.97)	37.0	(3.37)	21.3	(5.40)
Black or African American, single race	53.1 (2.87)	59.6	(9.97)	53.4	(4.29)	87.0	(13.65)	57.0	(9.43)	*43.4	(13.37)	53.5	(5.52)	45.7	(11.16)
Parent's education[5]															
Less than high school diploma	48.3 (3.43)	51.0	(8.10)	46.8	(4.79)	*	–	*25.1	(8.58)	69.9	(9.89)	49.0	(7.55)	*33.5	(27.44)
High school diploma or GED[6]	44.1 (2.35)	42.2	(5.30)	42.6	(4.18)	*19.8	(13.53)	44.9	(5.77)	38.5	(8.55)	50.3	(4.68)	*29.7	(25.82)
More than high school diploma	36.2 (1.57)	38.4	(2.51)	35.8	(3.17)	*44.1	(15.50)	37.2	(4.07)	29.2	(7.43)	38.2	(3.48)	*9.5	(5.58)
Family income[7]															
Less than $20,000	42.2 (2.30)	42.4	(7.18)	40.6	(2.97)	85.4	(11.08)	40.4	(9.58)	53.6	(10.27)	39.7	(5.60)	49.9	(11.84)
$20,000–$34,999	46.9 (2.77)	46.2	(6.52)	48.8	(4.68)	82.5	(13.16)	43.2	(6.71)	36.9	(10.71)	56.0	(5.80)	*24.0	(11.17)
$35,000–$54,999	39.9 (2.95)	43.2	(5.88)	31.5	(7.03)	*20.4	(15.71)	36.0	(5.22)	*26.6	(9.12)	54.8	(6.17)	*30.5	(11.70)
$55,000–$74,999	35.2 (3.21)	37.8	(5.00)	*27.7	(9.36)	*	–	46.9	(7.60)	*45.0	(16.11)	32.2	(7.14)	*11.4	(6.56)
$75,000 or more	34.1 (2.46)	37.1	(3.59)	*16.4	(8.78)	*31.3	(49.31)	31.1	(7.01)	*37.2	(13.50)	36.3	(4.72)	*18.8	(8.39)
Poverty status[8]															
Poor	44.0 (2.50)	44.9	(7.42)	42.2	(3.45)	88.2	(10.45)	34.1	(8.55)	52.2	(10.68)	46.9	(5.62)	48.5	(11.46)
Near poor	43.4 (2.52)	44.7	(5.86)	45.7	(4.21)	*47.5	(19.16)	44.3	(5.92)	35.3	(9.19)	49.8	(6.03)	*20.7	(7.77)
Not poor	35.9 (1.58)	38.1	(2.49)	29.4	(3.89)	*25.9	(14.78)	37.0	(3.99)	37.0	(7.70)	38.5	(3.40)	20.6	(5.77)
Home tenure status[9]															
Owned or being bought	37.3 (1.51)	39.1	(2.40)	33.4	(3.53)	*8.5	(8.44)	39.2	(3.95)	46.9	(8.53)	40.6	(3.16)	21.6	(4.86)
Rented	43.9 (1.92)	43.0	(5.49)	44.9	(2.91)	63.9	(12.90)	38.1	(5.26)	35.6	(6.57)	47.6	(4.61)	46.8	(12.84)
Some other arrangement	42.2 (7.94)	*53.2	(20.63)	*24.0	(10.67)	*	–	*42.7	(19.67)	*	–	60.3	(14.72)	*26.9	(25.55)
Health insurance coverage[10]															
Private	37.6 (1.67)	38.9	(2.59)	32.5	(3.63)	*17.9	(12.44)	36.1	(4.04)	44.3	(9.34)	42.5	(3.77)	*20.8	(10.18)
Medicaid	38.3 (1.89)	39.1	(5.64)	39.9	(2.98)	63.0	(14.02)	34.7	(5.20)	37.7	(7.28)	40.8	(4.31)	27.9	(5.81)
Other	39.4 (7.62)	*29.3	(11.09)	*51.6	(16.48)	*	–	*38.2	(14.63)	*	–	76.6	(13.17)	*	–
Uninsured	60.2 (3.58)	60.1	(8.49)	68.1	(6.10)	*11.7	(12.14)	66.3	(8.90)	46.7	(13.74)	56.1	(6.80)	*48.6	(15.34)
Place of residence[11]															
Large MSA	42.4 (2.18)	40.1	(4.32)	45.2	(3.52)	*19.7	(13.06)	46.3	(6.07)	37.4	(8.20)	45.3	(4.49)	*29.0	(9.92)
Small MSA	38.2 (1.66)	38.9	(2.96)	34.8	(3.23)	61.4	(14.07)	38.3	(4.77)	33.3	(8.12)	43.9	(3.56)	27.0	(6.47)
Not in MSA	40.3 (2.77)	42.8	(5.10)	43.7	(5.69)	*40.5	(21.75)	34.5	(5.63)	54.5	(11.03)	40.0	(6.76)	*27.3	(9.10)
Region															
Northeast	36.9 (2.74)	40.1	(5.57)	33.2	(4.81)	*34.1	(18.92)	43.2	(8.56)	47.0	(12.33)	34.5	(5.18)	*27.7	(16.81)
Midwest	32.6 (2.36)	32.5	(4.14)	40.3	(4.50)	*49.9	(19.41)	26.1	(5.23)	*24.6	(8.71)	34.7	(5.43)	*16.4	(6.34)
South	44.2 (1.96)	39.7	(3.49)	43.9	(3.59)	*35.5	(21.56)	44.9	(5.07)	47.7	(9.49)	53.7	(4.44)	36.8	(7.95)
West	43.6 (2.66)	48.3	(4.86)	38.1	(5.31)	96.3	(4.00)	37.7	(7.54)	39.3	(9.94)	48.1	(5.25)	*31.5	(9.79)

* Estimate has a relative standard error of greater than 30% and should be used with caution because it does not meet the standards of reliability or precision.

– Quantity zero.

[1]A nuclear family consists of one or more children living with two parents who are married to one another and are biological or adoptive parents to all children in the family. A single-parent family consists of one or more children living with a single adult (male or female, related or unrelated). An unmarried biological or adoptive family consists of one or more children living with two parents who are not married to one another and are biological or adoptive parents to all children in the family. A blended family consists of one or more children living with a biological or adoptive parent and an unrelated stepparent who are married to one another. A cohabiting family consists of one or more children living with a biological or adoptive parent and an unrelated adult who are cohabiting with one another. An extended family consists of one or more children living with at least one biological or adoptive parent and a related adult. An "other" family consists of one or more children living with related or unrelated adults who are not biological or adoptive parents.

[2]Data are based on household interviews of a sample of the civilian noninstitutionalized population. Prevalence of having no contacts with either a mental health professional or a general doctor for an emotional or behavioral problem are based on two questions that asked, "During the past 12 months, have you seen or talked to a mental health professional such as a psychiatrist, psychologist, psychiatric nurse, or clinical social worker about [child's name]'s health?" and, for sample children who had seen or talked with a general doctor or pediatrician during the past 12 months, "Did you see or talk with this general doctor because of an emotional or behavioral problem that [child's name] may have?" Only sample children with definite or severe emotional or behavioral difficulties who lacked contacts with either a mental health professional or a general doctor for such a problem are represented in this table. A knowledgeable adult provided information on behalf of child respondents. Unknowns with respect to these contacts and family structure are not included in the column labeled "All children aged 4–17 with definite or severe emotional or behavioral difficulties who had no contact with a mental health professional or general doctor for this type of problem in the past 12 months" (see Appendix I).

[3]Includes other races not shown separately and children with unknown parent's education, family income, poverty status, or health insurance.

[4]Persons of Hispanic or Latino origin may be of any race or combination of races. Similarly, the category "Not Hispanic or Latino" refers to all persons who are not of Hispanic or Latino origin, regardless of race. To be concise, the text uses shorter versions of the terms shown in the table. For example, the category "Not Hispanic or Latino black or African American, single race" in the tables is referred to as "non-Hispanic black" in the text.

[5]Refers to the education level of the parent with the higher level of education, regardless of that parent's age.

[6]GED is General Educational Development high school equivalency diploma.

[7]Information on family income and poverty status is obtained from the 2001–2007 National Health Interview Survey Imputed Family Income/Personal Earnings Files.

[8]Based on family income and family size using the U.S. Census Bureau's poverty thresholds for the previous calendar year. "Poor" persons are defined as below the poverty threshold. "Near poor" persons have incomes of 100% to less than 200% of the poverty threshold. "Not poor" persons have incomes that are 200% of the poverty threshold or greater.

[9]Based on a question in the Family Core that asked whether the family's house or apartment is owned or being bought, rented, or occupied by some other arrangement (see Appendix II).

[10]Classification of health insurance coverage is based on a hierarchy of mutually exclusive categories. Persons with more than one type of health insurance were assigned to the first appropriate category in the hierarchy. The category "Uninsured" includes persons who had no coverage as well as those who had only Indian Health Service coverage or had only a private plan that paid for one type of service such as accidents or dental care (see Appendix II).

[11]MSA is metropolitan statistical area. Large MSAs have a population size of 1 million or more; small MSAs have a population size of less than 1 million. "Not in MSA" consists of persons not living in a metropolitan statistical area.

SOURCE: CDC/NCHS, National Health Interview Survey, 2001–2007.

Appendix I. Technical Notes on Methods

This report is based on pooled data from the 2001–2007 in-house Sample Child and Person files, which are derived from the Sample Child and Family Core components of the National Health Interview Survey (NHIS). Selected variables from various Household and Family files were also used, most notably the family structure variable used for this report. The latter variable was not available in the first and second quarters of 2004, so the Sample Child case weights for the third and fourth quarters of 2004 were doubled so as to obtain an appropriate estimate of the U.S. child population for that particular year. The Sample Child record weight in the combined 2001–2007 file was divided by 7 in order to obtain weighted estimates that are representative of the U.S. noninstitutionalized child population in a single year (during the study period). Detailed, in-house sample design information was used to produce the most accurate variance estimates possible. However, because a new NHIS sample design was implemented in 2006 (and continued in 2007), it was necessary to create new design effect variables in order to perform variance estimation across the two sample design periods (i.e., 2001–2005 and 2006–2007). These procedures are outlined in Appendix VII of the 2007 NHIS Survey Description (30).

Standard errors, produced by the SUDAAN statistical package, are shown for all percentages in the tables. Frequencies or percentages with relative standard errors greater than 30% are considered unreliable and are indicated with an asterisk. The relative standard errors are calculated as follows:

Relative standard error = (SE/Est)100,

where SE is the standard error of the estimate, and Est is the estimate (percentage or frequency). The reliability of frequencies and their percentages is determined independently, so that it is possible for a particular frequency to be reliable and its associated percentage unreliable, and vice versa. In most instances, however, both estimates were reliable or unreliable simultaneously.

In the tables, all unknown values (respondents coded as "refused," "don't know," or "not ascertained") with respect to each table's variables of interest were removed from the denominators when calculating row percentages. In most instances the overall number of unknowns is quite small, and would not have supported disaggregation by the demographic characteristics included in the table. Because these unknowns are not shown separately, users calculating their own percentages based on the frequencies and population counts presented in the tables may obtain slightly different results. To aid readers' understanding of the data, weighted counts and percentages of unknowns (with respect to the health characteristics shown in each table) are presented in Table I.

Unknowns with respect to several of the demographic characteristics used in each table are not shown due to small cell counts. Table II shows weighted counts and percentages of children in the U.S. population with unknown values with respect to family structure, parental education and home tenure status. Note that the 2001–2007 NHIS Imputed Family Income or Personal Earnings Files were used to minimize missing information with respect to family income and poverty status.

Hypothesis Tests

Two-tailed tests of significance were performed on all the comparisons mentioned in the "Selected Highlights" section of this report (no adjustments were made for multiple comparisons). The test statistic used to determine statistical significance of the difference between two percentages was

$$Z = \frac{|X_a - X_b|}{\sqrt{S_a^2 + S_b^2}},$$

where X_a and X_b are the two percentages being compared, and S_a and S_b are the SUDAAN-calculated standard errors of those percentages. The critical value used for two-sided tests at the 0.05 level of significance was 1.96.

Table I. Weighted counts and percentages of children with unknown information on health characteristics of interest, National Health Interview Survey, 2001–2007

Variable	Count of children (in thousands)	Percent of children
Good, fair, or poor health (children under age 18), Tables 1–2	33	0.04%
Ever told had one or more chronic conditions (children under age 18), Tables 3–4	41	0.06%
Ever told had asthma (children under age 18), Table 5–6	135	0.18%
Hay fever in the past 12 months (children under age 18), Tables 7–8	225	0.31%
Respiratory allergies in the past 12 months (children under age 18), Tables 9–10	242	0.33%
Digestive or skin allergies in the past 12 months (children under age 18), Tables 11–12	176	0.24%
Frequent headaches or migraines in the past 12 months (children aged 3–17), Tables 13–14	68	0.11%
Three or more ear infections in the past 12 months (children under age 18), Tables 15–16	89	0.12%
Ever told had mental retardation or any developmental delay (children under age 18), Tables 17–18	91	0.12%
Had impairment or health problem that limited crawling, walking, running, or playing (children under age 18), Tables 19–20	41	0.06%
Received special education or early intervention services for an emotional or behavioral problem (children under age 18), Tables 21–22	35	0.05%
Vision problems (children under age 18), Tables 23–24	145	0.20%
Ever been told had learning disability or attention deficit hyperactivity disorder (children aged 3–17), Tables 25–26	164	0.27%
Basic actions disability (children aged 4–17), Tables 27–28	792	1.39%
Missed 6 or more school days in past 12 months (children aged 5–17), Tables 29–30	1,484	2.80%
Health insurance coverage (children under age 18), Tables 31–32	280	0.38%
Lacked a usual place of health care (children under age 18), Tables 33–34	180	0.25%
Prescription medication used regularly for at least 3 months (children under age 18), Tables 35–36	100	0.14%
Two or more visits to a hospital emergency room in the past 12 months (children under age 18), Tables 37–38	421	0.58%
No medical checkup in the past 12 months (children under age 18), Tables 39–40	754	1.09%
Saw or talked with an eye doctor in the past 12 months (children aged 2–17), Tables 41–42	377	0.58%
Medical care delayed due to concerns over cost (children under age 18), Tables 43–44	47	0.06%
Did not receive prescription medication during the past 12 months due to lack of affordability (children aged 2–17), Tables 45–46	163	0.25%
Did not get needed eyeglasses during the past 12 months due to lack of affordability (children aged 2–17), Tables 47–48	161	0.25%
Did not see dentist within the past 12 months (children aged 2–17), Tables 49–50	802	1.23%
Dental care delayed due to cost (children aged 2–17), Tables 51–52	163	0.25%
Often unhappy, depressed, or tearful behavior during the past 6 months (children aged 4–17), Tables 53–54	1,259	2.20%
Not well-behaved or did not usually do what adults requested during the past 6 months (children aged 4–17), Tables 55–56	1,204	2.11%
Had many worries or often seemed worried during the past 6 months (children aged 4–17), Tables 57–58	1,282	2.24%
Poor attention span or did not usually see chores and homework through to the end during the past 6 months (children aged 4–17), Tables 59–60	1,387	2.43%
Got along better with adults than children during the past 6 months (children aged 4–17), Tables 61–62	1,706	2.99%
Had definite or severe emotional or behavioral difficulties (children aged 4–17), Tables 63–64	697	1.22%
No contact with a mental health professional or general doctor for an emotional or behavioral problem during the last 12 months (children aged 4–17 with definite or several emotional or behavioral difficulties), Tables 65–66	88	0.31%

Table II. Weighted counts and percentages of children aged 0–17 with unknown information on selected sociodemographic characteristics, National Health Interview Survey, 2001–2007

Variable	Count of children (in thousands)	Percent of children
Family structure	79	0.11%
Parental education	2,408	3.30%
Home tenure status	348	0.48%

NOTE: There are no missing cases with respect to either income or poverty status because the 2001–2007 NHIS Imputed Family Income/Personal Earnings Files were used for this analysis.

Appendix II. Definitions of Selected Terms

Sociodemographic characteristics

Age—The age recorded for each child is the age at the last birthday. Age is recorded in single years and grouped using a variety of age categories depending on the purpose of the table.

Family income—Each member of a family is classified according to the total income of all family members. Family members are all persons within the household related to each other by blood, marriage, cohabitation, or adoption. The income recorded is the total income received by all family members in the previous calendar year. Income from all sources—including wages, salaries, pensions, government payments, child support or alimony, dividends, help from relatives, etc.—is included. Unrelated individuals living in the same household (e.g., roommates) are considered to be separate families and are classified according to their own incomes.

Family structure—A *nuclear family* consists of one or more children living with two parents who are married to one another and are biological or adoptive parents to all children in the family. A *single-parent family* consists of one or more children living with a single adult (male or female, related or unrelated to the child or children). An *unmarried biological or adoptive family* consists of one or more children living with two parents who are not married to one another and are biological or adoptive parents to all children in the family. A *blended family* consists of one or more children living with a biological or adoptive parent and an unrelated stepparent who are married to one another. A *cohabiting family* consists of one or more children living with a biological or adoptive parent and an unrelated adult who are cohabiting with one another. An *extended family* consists of one or more children living with at least one biological or adoptive parent and a related adult who is not a parent (e.g., grandparent, adult sibling). Given the NHIS definition of children as family members aged 0–17 and adults as family members aged 18 and over, adult children (those aged 18 and over) are considered related adults. This will result in smaller counts and percentages of the remaining family types, particularly nuclear families, and to a lesser extent, single-parent families (in part because they are numerically the largest family types). An *"other" family* consists of one or more children living with related or unrelated adults who are not biological or adoptive parents (foster children living with at least two adults as well as children being raised by their grandparents are included in this category). All categories are mutually exclusive.

Health insurance coverage—NHIS respondents were asked about their health insurance coverage at the time of interview. Respondents reported whether they were covered by private insurance (obtained through the employer or workplace, purchased directly, or through a local or community program), Medicare, Medigap (supplemental Medicare coverage), Medicaid, Children's Health Insurance Program (CHIP), Indian Health Service (IHS), military coverage (including VA, TRICARE, or CHAMP–VA), a state-sponsored health plan, another government program, or single-service plans. This information was used to create a health insurance hierarchy for persons under age 65 with four mutually exclusive categories. Persons with more than one type of health insurance were assigned to the first appropriate category in the hierarchy listed below:

Private coverage—Includes persons who had any comprehensive private insurance plan [including health maintenance organizations (HMOs) and preferred provider organizations]. These plans include those obtained through an employer and those purchased directly or through local or community programs.

Medicaid—Includes persons who do not have private coverage, but who have Medicaid and/or other state-sponsored health plans including CHIP.

Other coverage—Includes persons who do not have private or Medicaid (or other public coverage), but who have any type of military health plan (includes VA, TRICARE, and CHAMP–VA) or Medicare. This category also includes persons who are covered by other government programs.

Uninsured—Includes persons who have not indicated that they are covered at the time of interview under private health insurance (from employer or workplace, purchased directly, or through a state, local government or community program), Medicare, Medicaid, CHIP, a state-sponsored health plan, other government programs, or military health plan (includes VA, TRICARE, and CHAMP–VA). This category also includes persons who are only covered by IHS or only have a plan that pays for one type of service such as accidents or dental care.

Weighted frequencies indicate that 0.38% of children were missing information with respect to health insurance coverage.

Hispanic origin and race—The tables in this report are consistent with federal guidelines established in 1997 by the Office of Management and Budget (OMB) regarding the presentation of race and ethnicity statistics in U.S. government publications (45). Hispanic origin and race are two separate and distinct concepts. Hispanic persons may be of any race. Hispanic origin includes persons of Mexican, Puerto Rican, Cuban, Central and South American, or Spanish origins. All tables show Mexican or Mexican-American persons as a subset of Hispanic persons. Other groups are not shown for reasons of confidentiality or statistical reliability.

The category "Not Hispanic or Latino" includes the categories of "White, single race" and "Black or African American, single race." Persons in these categories indicated only a single race group (see the definition of

"Race" in this Appendix for more information). Data are not shown separately for other "Not Hispanic or Latino" single-race persons or those reporting multiple race due to statistical unreliability as measured by the relative standard errors of the estimates, but are included in the total for "Not Hispanic or Latino."

Home tenure status—Based on a question in the Family Core that asked whether the family's house or apartment is owned or is being bought, rented, or occupied by some other arrangement. The latter category includes respondents who may live rent-free with relatives, provide a service (such as child care, maintenance, etc.) in return for rent, or live in group homes or assisted living accommodations. The number of families in this category is very small: in 2001–2007, 1.5% of all sample children lived in families that occupied homes "by some other arrangement" (or 2% of all U.S. children nationally).

Parent's education—This reflects the highest grade in school completed by the sample child's mother or father who are living in the household, regardless of that parent's age. NHIS does not obtain information pertaining to parents not living in the household. If both parents reside in the household but information on one parent's education is unknown, then the other parent's education is used. If both parents reside in the household and education is unknown for both, then parent's education (with respect to the child) is unknown. If neither parent resides in the household, then parent's education is unknown.

Only years completed in a school that advances a person toward an elementary or high school diploma, General Educational Development high school equivalency diploma, college, university, or professional degree are included. Education in other schools and home schooling are counted only if the credits are accepted in a regular school system.

Place of residence—Classified as inside a metropolitan statistical area (MSA) or outside an MSA. Generally, an MSA consists of a county or group of counties containing at least one city or twin cities with a population of 50,000 or more, plus adjacent counties that are metropolitan in character and are economically and socially integrated with the central city. In New England, towns and cities rather than counties are the units used in defining MSAs. The number of adjacent counties included in an MSA is not limited, and boundaries may cross state lines.

OMB defines metropolitan areas according to published standards that are applied to U.S. Census Bureau data. Consequently, the definition of a metropolitan area is periodically revised. For the 2001–2005 NHIS data, the MSA definition was based on 1993 OMB standards using the 1990 census. For the 2006–2007 NHIS, the MSA definition is based on 2003 OMB standards using data from the 2000 census. In the tables for this report, place of residence is based on variables indicating MSA size from the 2001–2003 Person and 2004–2007 Household files. These variables are collapsed into three categories: MSAs with a population of 1 million or more, MSAs with a population of less than 1 million, and areas that are not within an MSA.

Poverty status—Based on family income and family size using the U.S. Census Bureau's poverty thresholds. "Poor" persons are defined as persons whose family incomes are below the poverty threshold. "Near poor" persons have family incomes of 100% to less than 200% of the poverty threshold. "Not poor" persons have family incomes that are 200% of the poverty threshold or greater.

Race—The categories "White, single race" and "Black or African American, single race" refer to persons who indicated only a single race group. Estimates for multiple race combinations are not shown in this report because these generally do not meet the requirements for confidentiality and statistical reliability.

The text in this report uses shorter versions of the new OMB race and Hispanic origin terms for conciseness, while the tables use the complete terms. For example, the category "Not Hispanic or Latino, black or African American, single race" in the tables is referred to as "Non-Hispanic black" in the text.

Region—In the geographic classification of the U.S. population, states are grouped into the four regions used by the U.S. Census Bureau:

Region	*States included*
Northeast	Maine, Vermont, New Hampshire, Massachusetts, Connecticut, Rhode Island, New York, New Jersey, and Pennsylvania;
Midwest	Ohio, Illinois, Indiana, Michigan, Wisconsin, Minnesota, Iowa, Missouri, North Dakota, South Dakota, Kansas, and Nebraska;
South	Delaware, Maryland, District of Columbia, West Virginia, Virginia, Kentucky, Tennessee, North Carolina, South Carolina, Georgia, Florida, Alabama, Mississippi, Louisiana, Oklahoma, Arkansas, and Texas;
West	Washington, Oregon, California, Nevada, New Mexico, Arizona, Idaho, Utah, Colorado, Montana, Wyoming, Alaska, and Hawaii.

Health characteristics or outcomes

Asthma—Includes bronchial asthma, allergic asthma, etc. Asthma is indicated when a doctor or other health professional reported to the family that the sample child has asthma.

Attention deficit hyperactivity disorder (ADHD)—Indicated when a doctor or other health professional reported to the family that the sample child has ADHD. ADHD includes attention deficit disorder.

Basic actions disability—A new summary measure that takes into account four basic domains or functions that a child needs in order to participate in age-appropriate activities (38,39). These domains consist of sensory functions (e.g., hearing, vision), movement (e.g., walking, running, playing), cognitive functioning (e.g., ability to remember, learning disabilities,

mental retardation, Down syndrome, autism), and emotional or behavioral functions (ADHD, emotional or behavioral difficulties). Children aged 4–17 were considered to have a basic action disability if they had any one of the following problems: a lot of trouble hearing or deafness; trouble seeing; limitations in their ability to crawl, walk, run, or play; difficulty remembering; mental retardation; Down syndrome; autism; a learning disability; ADHD; or definite or severe emotional or behavioral difficulties (from the Strengths and Difficulties Questionnaire).

Chronic conditions—Conditions that are not cured, once acquired (such as heart disease, diabetes, and birth defects) are considered chronic from the date of onset. Other conditions must have been present 3 months or longer to be considered chronic. An exception is made for children less than age 1 who have had a condition since birth; these conditions are considered chronic. Questions in the 2001–2007 NHIS Sample Child Cores pertaining to chronic conditions ask whether these conditions were diagnosed by a doctor or a health professional.

Contacts with health professionals—Defined as a visit to or conversation with a doctor or other health professional by anyone in the family about the health of the sample child during the 2 weeks prior to interview. Contacts include home visits, office visits, or telephone calls for medical advice, prescriptions, or test results. A telephone call to schedule an appointment is not included as a contact. An emergency room visit and hospital stays are included as contacts.

Doctor or other health professional—Refers to medical doctors and osteopathic physicians, including general practitioners as well as specialists, psychologists, nurses, physical therapists, chiropractors, etc.

Health status—Obtained from a question in the survey that asked respondents, ''Would you say your health in general was excellent, very good, good, fair, or poor?'' Information was obtained from all respondents, with proxy responses allowed for adults not taking part in the interview and all children under age 18. In this report, the categories ''Good,'' ''Fair,'' and ''Poor'' health are combined into a single category and shown in Tables 1 and 2.

Hospital emergency room (ER) visits—Includes visits to a hospital ER only. Visits for emergency care received at an HMO, outpatient clinic, or urgent care center are not included.

Prescription medicine—Medication that can only be obtained with the approval of a licensed health care provider.

Usual place of health care—Based on a question that asked whether respondents had a place that they usually went to when they were sick or needed advice about their health. These places include a walk-in clinic, doctor's office, clinic, health center, HMO, hospital emergency room or outpatient clinic, or a military or VA health care facility.

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CS215109
T37792 (12/2010)
DHHS Publication No. (PHS) 2011–1574, Series 10, No. 246

10 Recommendations to Prevent Poverty

1. Add relationship education and training workshops to the case management protocols of Temporary Assistance to Needy Family (TANF) clients.
2. Reduce the perceived or actual anti-marriage penalties in welfare programs that would reduce cash benefits if a couple is married.
3. Create public education campaigns in low income communities on the benefits of building and forming healthy families, maintaining healthy families and building social supports.
4. Encourage schools to educate students on the benefits of delaying childbearing until academic achievement goals are reached and a family is formed.
5. Require federally funded family planning clinics to provide classes on forming and maintaining healthy relationships to interested low income clients.

6. Require federally funded family planning clinics to offer voluntary referrals to life planning, literacy, financial and relationship skills education to all interested low income clients.
7. Make voluntary relationship education widely available to interested couples in low income communities.
8. Reduce the barriers of attending these classes by providing meals, childcare and transportation.
9. Fund, create and implement statewide strategy to promote healthy family formation and family strengthening messages to prevent poverty and increase child well-being.
10. Teach relationship, literacy, financial and leadership skills to students to be educated, equipped and empowered with the skills necessary to create emotional and personal safety in the home, workplace and in the community and to advocate for what they need to reach their full potential.

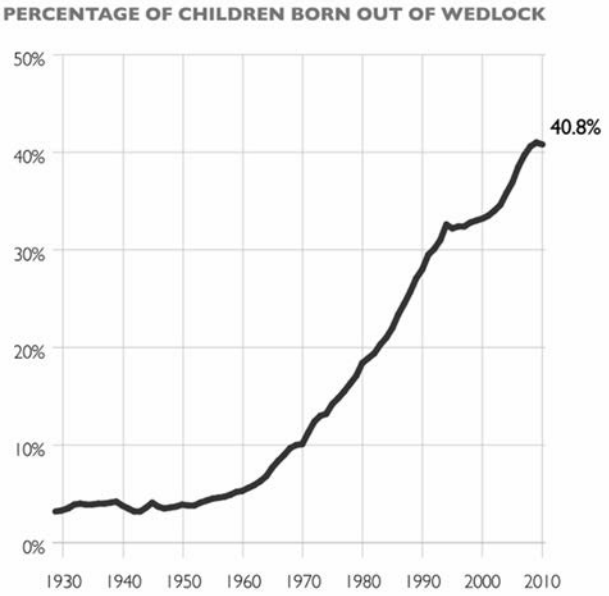
Growth of Out-of-Wedlock Childbearing in the United States, 1929–2010

Throughout most of U.S. history, out-of-wedlock childbearing was rare.

When the federal government's War on Poverty began in 1964, only 6.8 percent of children in the U.S. were born out of wedlock. However, over the next four decades, the number rose rapidly. By 2010, 40.8 percent of births in the U.S. occurred outside of marriage.

Note: Initiated by President Lyndon Johnson in 1964, the War on Poverty led to the creation of more than three dozen welfare programs to aid poor persons. Government has spent $16.7 trillion on means-tested aid to the poor since 1964.

Sources: U.S. Government, U.S. Census Bureau, and National Center for Health Statistics.

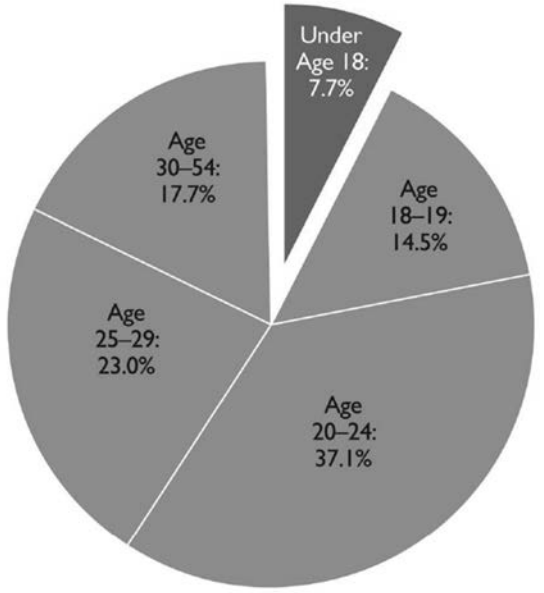


Few Unwed Births Occur to Teenagers

Out-of-wedlock births are often confused erroneously with teen births, but only 8 percent of out-of-wedlock births in the U.S. occur to girls under age 18.

By contrast, some three out of four unwed births occur to young adult women between the ages of 18 and 29.

PERCENTAGE OF OUT-OF-WEDLOCK BIRTHS BY AGE OF MOTHER



Note: Figures have been rounded.

Source: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2006 NHS data.

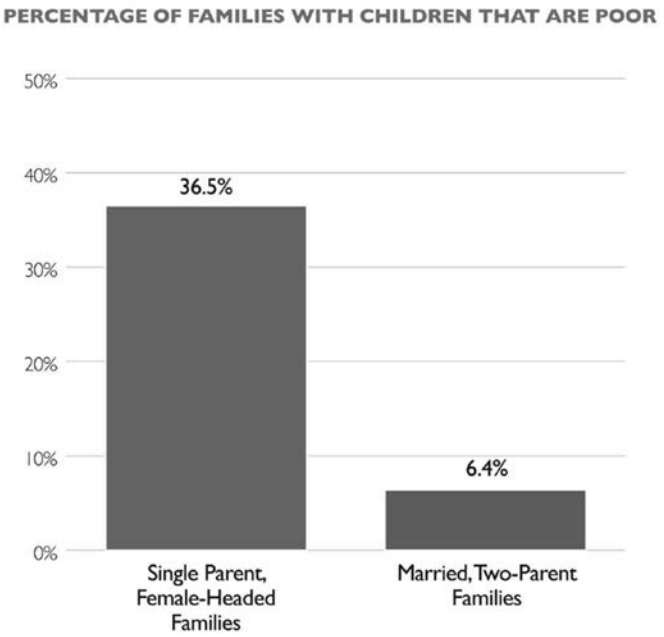
Marriage Drops the Probability of Child Poverty by 82 Percent

The steady rise in out-of-wedlock child bearing is a major cause of high levels of child poverty in the U.S.

In 2008, more than a third (36.5 percent) of single mothers with children were poor, compared to only 6.4 percent of married couples with children.

Single-parent families with children are almost six times more likely to be poor than are married couples.

The higher poverty rate among single-mother families is due both to the lower education levels of the mothers and the lower income because of the absence of the fathers.

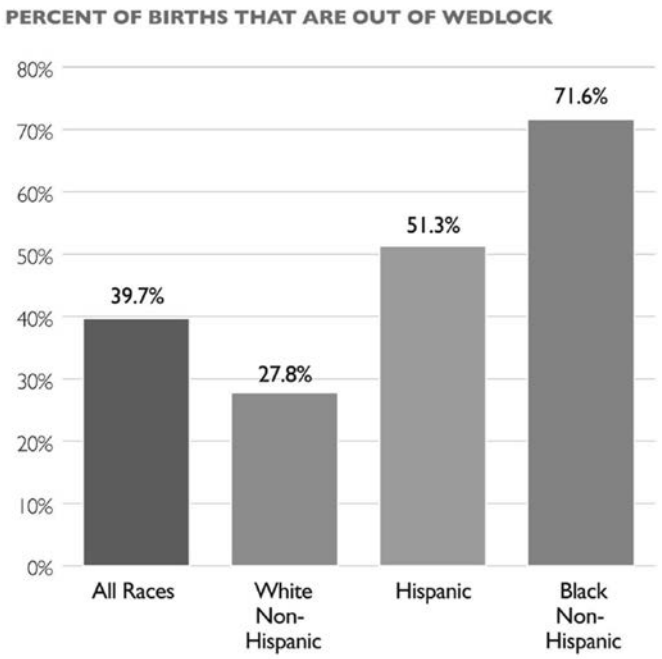


Source: U.S. Census Bureau, American Community Survey, 2006–2008 data.

Unwed Birth Rates Vary Strongly by Race

Out-of-wedlock childbearing varies considerably by race.

In 2006 (the most recent year for which racial breakdown is available), nearly four in 10 births (39.7 percent) in the U.S. occurred outside marriage. The unwed birth rate was lowest among non-Hispanic whites, at just over one in four births (27.8 percent). Among Hispanics, more than half of births were out-of-wedlock. Among blacks, seven out of 10 births were to unmarried women (71.6 percent).



Source: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2006 NHS data.

July 21, 2015

Jessica Bartholow, Antionette Dozier and Michael Herald
Western Center on Law and Poverty

Comments on HR 2959 and the Discussion Draft of TANF Reauthorization Bill

Subcommittee on Human Resources, Committee on Ways and Means
U.S. House of Representatives

The Western Center on Law and Poverty (Western Center) represents Californian's poorest residents in the areas of health, public benefits and housing. One of our areas of subject matter expertise is the Temporary Assistance for Needy Families (TANF) block grant program that is known in California as California Work Opportunity and Responsibility to Kids (CalWORKs) program. This paper includes our initial responses to HR 2959[1] and the Discussion Draft of TANF Reauthorization.[2] While we wish that there had been more time allocated to discussing the current reality of families with children who live in poverty and deep poverty, the increase in family homelessness and maternal depression among low-income mothers, the stagnant poverty rates among black children and scalable best practices to address these issues, we are satisfied that HR 2959 and the Discussion Draft seek to improve program accountability to poor children and their families and hope that our comments are helpful to improve it prior to passage.

Background from a California Perspective

The CalWORKs program was established in 1997, following the passage of the federal personal Responsibility and Work Opportunity Act. It requires eligible parents to be employed or participate in employment training (Welfare-to-Work) while offering supports, including child care and transportation. CalWORKs, once recognized as one of California's most effective programs, now suffers from severe cuts, weakening its ability to help families secure self-sufficient employment in an economy that has few opportunities for low-wage workers to exit poverty.[3]

Since the program's inception, the purchasing power of the benefit and the length of aid available have been dramatically reduced. In 1996, benefits for low-income families were at about 80% of the Federal Poverty Level (FPL). As of January 2015, the maximum cash grant for a family of three is $638/month, just 41% of the FPL. Length of aid for which adults are eligible for benefits through the program has also been reduced over the past decade, from 60 months of lifetime eligibility to just 48 months. In addition, adults' eligibility for welfare-to-work and support services has been reduced from 60 months to 24 months (with some exceptions, including child care). Moreover, these cuts to the program were levied during the worst recession in a generation, when unemployment skyrocketed even those with limited barriers to work remained unemployed for years. Unemployment rates were particularly high for women and minorities.[4] Reversing the fate of these families, who live below half of the poverty rate with little chance of escape, should be a top priority for federal and state elected officials.

Response to Major Provisions in HR 2959 and the TANF Reauthorization Working Draft

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[1] https://www.congress.gov/bill/114th-congress/house-bill/2959/text
[2] http://waysandmeans.house.gov/wp-content/uploads/2015/07/JDG_705_xml.pdf
[3] According to the Public Policy Institute of California, nearly 80% of poor Californians lived in families with at least one adult working and 54.9% of those in poverty, at least one family member report working full time (excluding families comprised exclusively people who were over 65 years of age). http://www.ppic.org/main/publication_show.asp?i=261
[4] "Women's Unemployment at 6 Year Low, but Raises for Black Women," National Women's Law Center (March 2015) http://www.nwlc.org/press-release/womens-unemployment-6-year-low-rises-black-women-nwlc-analysis-shows

We appreciate that the Ways and Means Committee is making TANF Reauthorization a priority. For almost two decades, TANF has been a neglected policy area. Efforts in the past to reauthorize TANF have often ignored what was happening to the families who need assistance at the expense of winning political points. Due to this, opportunities to fully explore how TANF has or has not worked to lift families out of poverty have been few and far between. The Committee's focus on TANF's actual performance is refreshing. Below are our initial comments to HR 2959 and the Discussion Draft and the open policy questions and we look forward to working with the committee in the coming weeks to develop reauthorization policy.

- **Redesign of The TANF Work Participation Measure**

Since its' passage in 1997 TANF has had a mixed record of fulfilling its' promise of providing meaningful opportunities to education, training and employment for low income families. While many TANF recipients have benefited from the changes in the 1997 law, many more families have not benefited. In part this is due to the initial program design of TANF.

State policy choices in implementing TANF have long been shaped by a desire to avoid penalties for failing to meet the 50% work participation requirement. During the first years of TANF, large caseload reductions gave states a credit towards their work participation requirement that made the standard easier to meet. The focus on caseload reduction was accentuated after TANF was reauthorized in the Deficit Reduction Act in early 2006 when caseload credits were limited to caseload reductions after 2005. States, including California, had renewed incentive to reduce caseload or to identify excess Maintenance of Effort (MOE) that could be converted into caseload reduction credit.

Caseload reduction, however, does not always equate to positive outcomes for families. States got a credit whenever anyone leaves the caseload, whether for employment or because they were sanctioned off assistance or they simply quit. States got a caseload reduction credit based on state spending that qualified as MOE even though it often provided little or no assistance to needy families.

Western Center has long supported replacing the caseload reduction credit and the TANF penalty structure with outcome measures that better encourage states to reduce poverty, increase educational achievement, serve those with barriers to employment and increase earnings for TANF recipients. The HR 2959 and the Discussion Draft are clearly a step in the right direction in this regard. Eliminating the caseload reduction construct and replacing it with a straightforward work participation requirement would allow states to get partial credit for persons who are not able to participate fully. It eliminates the excessive work requirements on two parent families and the core/non-core weekly work requirement that functioned as a one size fits all approach to participation.

HR 2959 and the Discussion Draft additionally propose to create a set of performance measures for states that reward states for outcomes that make a difference. It measures the number of recipients who exit TANF for unsubsidized employment and who remain employed for two or four quarters. It measures the increase in median incomes of recipients who exit TANF for unsubsidized employment and who remain employed for four quarters. These are the kind of outcomes that states should be challenged to meet.

HR 2959 and the Discussion Draft also propose a new method of penalizing states for failure to meet work participation. Instead of reductions to the TANF block grant that states would have to backfill with state funding, the penalty would be an increase of 5 percent in state MOE funding each year up to a maximum of 100 percent of MOE. This approach will help states do a better job of improving performance and meet outcomes than the current penalty methodology. States will still have to

increase their spending but it will not suffer from a loss of TANF funds. Thus at a point where the state is being challenged to do more to help recipients succeed it has more resources to accomplish the task. Under the existing system, states have to commit new state resources just to maintain the prior funding level which makes it hard, if not impossible, for states to improve outcomes. Without new resources states are motivated to restrict eligibility, strictly enforce work requirements and impose harsh sanction on families that do not comply with work requirements. The proposal in HR 2959 and the Discussion Draft is fairer. It requires the state to spend more and will relieve some of the pressures that result in harsh outcomes to the families the program is designed to assist, though not all of them.

- **Recommendations for Improving Work Participation Measurement Redesign**

While we believe that these provisions offer a great deal to look forward to, we are concerned about a couple of details. First, we think that there should be more attention to the transition periods that will be required should reauthorization pass.

Second, given the significant changes to TANF proposed in this draft we support eliminating or waiving all prior TANF penalties and corrective compliance plans. Unless this is built into future versions of this bill it will compel states to pursue both corrective compliance plans under the current law and implement the changes proposed in HR 2959 and the Discussion Draft so as to meet the performance measures outlined in the draft. Given the opportunity for assisting recipients in HR 2959 and the Discussion Draft, Western Center supports focusing states on implementing the new provisions rather than trying to resolve the past.

In 2012 and 2013, California made major changes to the welfare to work plan. As we note below, many of the changes are consistent with provisions included in HR 2959 and the Discussion Draft. Among them are partially eliminating the core/non-core requirement, redesigning the upfront engagement of clients, creating a new on-line assessment tool to provide multiple work activity paths built around the needs of recipients and eliminating the bar on person with drug offenses. These improvements were coupled with short time limits for participating under the more relaxed welfare to work rules.

These reforms were implemented in most cases within six months of adoption by the Legislature. This meant that the time clock was ticking on recipients even though the state and the counties which operate our CalWORKs program were still putting the pieces in place. We were building the car while trying to drive it down the freeway. In retrospect, our state did not provide enough lead in time to make the changes made by our Legislature. Changes of the magnitude made in California or that are represented in HR 2959 and the Discussion Draft require state laws to be changed, budgets to be reconfigured, federal and state regulations to be vetted and approved, new forms to be promulgated and significant staff training. Moreover, these changes represent a cultural sea change in our approach to assisting poor families. It is simply unrealistic to think that administrators and staff can not only learn the new rules but learn how to use them in one year. We strongly encourage the committee to adopt a longer phase in for states before the HHS Secretary begins to measure work participation rates or outcome measures.

HR 2959 and the Discussion Draft would establish these new performance measures by reserving a portion of the TANF block grant from states. As Western Center understands the draft if the state did not meet the agreed upon milestones in the first year they would have one additional year to achieve it. But if the state failed in the second year, they would lose the TANF funding. Given that HR 2959 and the Discussion Draft is not proposing any increase in the TANF block grant (the base funding level has remained constant since 1997), reducing funding to states will reduce funding that can be used to provide basic assistance grants, child care and pay for work and educational activities. It may have the effect of limiting state's ability to meet the outcome measures.

Western Center instead proposes to give states work participation credits for positive outcomes. HR 2959 and the Discussion Draft already embrace this concept by providing a credit to states for recipients who achieve partial participation. This concept should be extended to an adult that exits welfare for employment and remains employed for the evaluation period. Western Center supports giving states work participation credits if the state achieves median income gains for former recipients. Western Center supports giving states work participation credit for additional outcomes such as:

- Increasing the percentage of poor families receiving assistance
- Participating in job training or education programs
- Reducing deep poverty among children
- Assisting families with Family Violence Option services , mental health services, learning disabilities, English proficiency and physical disabilities
- Increasing Participation in EITC by TANF recipients
- Moving children & adults unable to work consistently to SSI/SSDI

Finally, while we appreciate the new state performance measures, we believe that the timing of the measures should be reconsidered and drafted to better align with the Workforce Investment and Opportunity Act (WIOA) measures for ease of implementation and, like those measurements, should provide a longer period from which to evaluate success.

As we said above, we applaud HR 2959 and the Discussion Draft for recognizing the need for more meaningful methods of measuring states performance but we do not believe that an additional method of measurement is needed. Instead we support building in the outcome measurements into the existing work participation construct.

- **Work Participation Requirements Proposal in HR 2959 and the Discussion Draft**

The desire of states to avoid penalties by reducing caseload was reinforced by a rigid work requirement and mandatory sanction policies which in many cases have resulted in families falling into even deeper poverty. Since 1997 we have learned much about the debilitating effects of deep poverty on the brain development of young children and its' long term consequences for them as adults. [5] It is in the interest of both families and policymakers to stem the tide of children living in deep poverty.

HR 2959 and the Discussion Draft take some steps that will help families from falling into deep or deeper poverty. They require states to develop much more robust welfare to work plans than are currently required by federal law. California has already started down this path with major changes to our assessment and appraisal of family needs. Since 1997 TANF and, in our state, CalWORKs provided only one path for families, finding a job. While this approach worked for some families, it did not work for most. Instead our state is embracing multiple paths based on the individual needs of the client. In requiring more robust assessments of family needs, HR 2959 and the Discussion Draft take useful steps in this direction.

Another proposal to help–families succeed in TANF in HR 2959 and the Discussion Draft is to eliminate the core/non-core requirement and allow families to participate in services that are best suited to them. Many families who enter TANF are in crisis. They may not be ready for full-time work or may be at risk if they do participate in work. Allowing states to work with recipients to develop a plan that addresses the family as they are is critically important. But under the existing

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[5] "The Long Reach of Childhood Poverty," by Greg J. Duncan and Katherine Magnuson, Stanford Poverty Center https://web.stanford.edu/group/scspi/_media/pdf/pathways/winter_2011/PathwaysWinter11_Duncan.pdf

core/non-core rules states had limited flexibility to meet families where they were. Western Center heartily endorses eliminating the core/non-core requirement.

Changes proposed by HR 2959 and the Discussion Draft to work activities, by expanding vocational education to 24 months will allow persons to get the training they need to get a job with a future. Allowing persons up to age 26 to participate by attending secondary school will help TANF adults gain the basic education they need to become employable or proceed further into education. Western Center supports these proposals.

Creating a new work activity for job readiness will help address a significant gap in the original TANF law and that was reinforced with the implementation of the TANF DRA provisions – many people have significant barriers to overcome before they are ready for either job search or employment. In California we have many recipients who are homeless or at risk of homelessness when they apply for assistance. Before they can participate in activities they need to have their lives stabilized. Many are escaping domestic violence or the end of a troubled relationship. Many have suspended driver's licenses due to unpaid traffic tickets that they cannot afford to pay.[6] Other individuals have barriers such as criminal records that need to be expunged before most employers will hire them. Some people need to have tattoo's removed that reflect one's past gang affiliations. All of these situations and more need to be addressed before persons can be expected to successfully participate in welfare to work activities. Unfortunately, in implementing the TANF DRA provisions, HHS barred states from being able to count these activities towards job/job readiness. HR 2959 and the Discussion Draft need to clarify that those regulations are expressly eliminated and provide states with broad flexibility to identify the activities that count towards job readiness.

Open Issues in HR 2959 and the Discussion Draft

- **Raising cap on number of persons who can meet work rate via education activities**

Education is the key to helping recipients obtain and maintain employment that will help them exit public assistance. Research shows that the higher level of educational achievement that a single mother achieves the more likely she is to be employed.[7] However, TANF currently caps the percentage of the caseload that can be meeting the employment requirements through education at 30 percent. This cap is an arbitrary standard that should be eliminated entirely. HR 2959 and the Discussion Draft propose to eliminate the core/non-core requirement for welfare to work plans. This provision applies to all adults who are required by federal or state law to participate in welfare to work activities.

Imposing a cap on how many of these recipients can participate in education will lead state program administrators to manage entrance into education to avoid breaching the cap. This means that some individuals will not get the opportunity to access education and training to gain a job which leads to self-sufficiency. Since CalWORKs was adopted the state has never exceeded the 30 percent cap and in most years less than 15 percent of recipients participated in educational activities. Still, the 30 percent cap is viewed as a policy statement that education is to be discouraged as a work activity and, we believe, it actively limits opportunities for parents to pursue certificate and degree programs that could eliminate their dependence on the program in the long term.

- **Elimination of marriage penalty**

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[6] "Not Just a Ferguson Problem: How Traffic Courts Drive Inequality in California," (May 2015) http://wclp.org/not-just-a-ferguson-problem-how-traffic-courts-drive-inequality-in-california/

[7] "Various Supports for Low-Income Families Reduce Poverty and Have Long-term Possitive Effects," (July 30, 2013) Arloc Sherman, Danilo Trisi, and Sharon Parrott http://www.cbpp.org/research/various-supports-for-low-income-families-reduce-poverty-and-have-long-term-positive-effects

HR 2959 and the Discussion Draft call for an end to the TANF marriage penalty. While we support this provision, we do not think it goes far enough. Six states, including California, still employ a "child deprivation" test which denies aid to working-two parent homes if they work too many hours.[8] It is unfortunate that a family working 100 hours per week would still be poor enough to qualify for the program, but with wage stagnation at its peak, it happens more frequently now than it did in previous decades. What's worse is that existing law not only punishes families who are working hard to get ahead but receiving a low-wage, but it incentivizes families to split. This is because the same family would be eligible for aid if the primary wage earner left. Western Center has sponsored state legislation to repeal the policy which has received strong bi-partisan support. We encourage Congress to consider removing the ability of all states to employ this rule which disadvantages two-parent, working families.

- **Ending the Bar on Eligibility Of Persons with Prior Drug Convictions**

PRWORA enacted policy barring states from issuing TANF and Supplemental Nutrition Assistance Program (SNAP), benefits to people who were convicted of a drug-related offense after August 22, 1996.[9] Since then, the bar was removed, but states were given an option of whether to keep the restrictions in place. California was one of the states that chose to maintain this discriminating, lifetime bar until April of this year, when the law was repealed for everyone who is complying with their probation and parole. The repeal had editorial support from the New York Times and the Los Angeles Times and was supported by cities, counties, law enforcement and over 100 organizations throughout the state because it would reduce recidivism and crime and support parents who were trying to start over.

According to Pew Center on the States, with few or no job prospects, approximately two-thirds of those released from prison will be rearrested – and almost one-half will be re-incarcerated—within three years of their release. Research shows that 55 percent of incarcerated prisoners will live with their children upon release.[10] Although in some states children of adults who are banned remain eligible to receive TANF, the ban reduces the benefits received by the household. As a result, benefit levels for these families falls almost to a quarter of the Federal Poverty Line.

A report by the Reentry Policy Council of the Council of State Governments credits public benefits and job training as key contributors to successful prisoner reentry and recommends that states opt out of bans against people with prior drug-related felony convictions.[11] The Reentry Policy Council is a bipartisan working group with representatives of national associations of probation and parole, correctional administrators, courts, police, mental health and housing experts, among others.[12] Harvard's Bruce Western said that the costs to restoring access to benefits like SNAP and TANF, "..are offset by increased employment and reduced crime and correctional costs for program participants…Achieving these objectives will yield a sustainable public safety that overcomes the long-term negative consequences of criminal punishment and promotes the economic improvement of poor communities."[13]

A study of women probationers concluded that "women's challenges in the areas of education, family support, and self-efficacy, as well as relationship dysfunction, contributed to

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[8] The Urban Institute Databook shows how many states have 2-parent deprivation policies: http://anfdata.urban.org/databook_tabs/2012/I.B.2.XLSX

[9] The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PL 104- 193). Sec. 115 AB 1260 (Ashburn) – Chapter 284, Statutes of 1997

[10] http://bjs.ojp.usdoj.gov/content/pub/pdf/iptc.pdf

[11] Report of the Re-Entry Policy Council: Charting the Safe and Successful Return of Prisoners to the Community. Council of State Governments. Reentry Policy Council. New York: Council of State Governments. January 2005,

[12] http://www.reentrypolicy.org/about/reentry_policy_council

[13] Western, Bruce. 2008. "From Prison to Work: A Proposal for a National Prisoner Reentry Program." (Washington, DC: The Brookings Institution, 2008) 3-5

employment/financial difficulties and subsequent imprisonment." Research on reoffending patterns among women found that state-sponsored support programs, especially services related to job training, health, education and housing that address short-term economic needs, reduce the odds of recidivism by 83 percent. [14] Several states have found that, by increasing access to poverty ameliorating assistance, they can reduce criminal activity among the re-entry community and, therefore, recidivism.[15] California's Senate Committee on Appropriations analysis asserted that a reduction in recidivism resulting in the repeal of the law will result in a reduction in state corrections costs and local government costs related to jailing and supporting successful re-entry.

We recommend that Congress consider entirely removing this lifetime ban for anyone who has successfully completed or is complying with the conditions of their probation or parole.[16] Continuing to keep the ban in place is only punishing parents who would otherwise participate in Welfare-to-Work as parents who do participate are already not eligible.

Provisions Missing From HR 2959 and the Discussion Draft

While we understand that the Discussion Draft is not intended to be comprehensive and if a Reauthorization is to be successful, it will likely not include all of the proposals we would offer, we think it is important to raise them as this may be our only opportunity before the next reauthorization. Below are additional reforms we would like the committee to consider.

- **TANF Should Establish State Min. Cash Assistance & Support Services Expenditures**

When the AFDC program and the federal entitlement to assistance for poor families were repealed by the passage of TANF, families lost a critical legal protection that prevented many families from falling into deeper poverty. Even without an entitlement to aid, the TANF block grant and the MOE requirement were a source of funding that were intended to be spent to assist the poorest families. Sadly, this did not happen. After TANF was passed, states took advantage of the flexibility on the use of both TANF and MOE funds to significantly shrink funding for basic cash assistance, work activities and child care. States had an incentive to enact rigid eligibility standards and severe sanction policies to reduce the caseload so that funding could be diverted to other state uses.

While California has done better than almost all states in using TANF and MOE funds for their intended purpose, California diverts between $800 million and $1 billion a year from the TANF/MOE funding stream to fund state operations that are not directly provided to CalWORKs families. If these funds were not being diverted the CalWORKs grants in California could be raised so that no family was living in deep poverty and the repeal of the state's Maximum Family Grant Rule could be easily funded. HR 2959 and the Discussion Draft are silent on whether the artificial barriers to success that were promulgated after the DRA (listed below) are to be continued. We believe they should not.

- ACF added child only Safety Net cases into the federal work rate even though the parent has used up the 60 months on aid and is no longer receiving federal assistance.
- ACF narrowly defined allowable work activities including job readiness activities, vocational ESL and limited duration and scope of subsidized employment with private sector.
- ACF denied the ability to count Domestic Violence counseling as work preparation.
- ACF denied the ability for states to make "reasonable accommodations" to federal work requirements under the Americans with Disabilities Act but instructed states to comply with it.
- ACF required disabled and needy grandparents to work, families that California exempts.

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[14] Holtfreter, Kristy, Michael D. Reisig, and Merry Morash. "Poverty, State Capital, And Recidivism Among Women Offenders*." Criminology & Public Policy 3.2 (2004): 185-208. Print. http://olms.cte.jhu.edu/olms/data/resource/6080/HOLTFRETER-POVERTY%20AND%20RECIDIVISM.pdf

[15] http://www.ccjrc.org/pdf/CO_Reducing_Recidivism_Report.pdf

[16] Short of full repeal, we would recommend consideration of the bi-partisan REDEEM Act The REDEEM Act of 2015 S. 675 https://www.congress.gov/bill/114th-congress/senate-bill/675/all-info

- Imposed confusing, burdensome and costly documentation and verification requirements on participants, counties, employers and providers in educational activities.

- **TANF Child Exclusion Laws Should Be Banned**

California is one of 14 states that still employ a Child Exclusion or Family Cap rule in their TANF Program. California's program, however, employs a unique version of the rule, denying basic needs assistance to a child aid based on the facts of their conception. This rule, known as the Maximum Family Grant (MFG) rule and denies aid to a child if any member of the infant's family was on aid when the child was conceived unless their parent was using the specific form of birth control listed in state law (sterilization or inter-uterine devise) and a doctor attests that the baby's conception was due to the failure of that method. Additionally, if a woman becomes pregnant as a result of rape or incest, the MFG rule does not apply provided she reported the incident within 12 months. The stated goal of the MFG policy is to reduce the reproductive options and births among welfare recipients. While decades of research have shown definitively that these types of "child exclusion" rules are not effective in reducing the incidence of births or the caseload in state TANF programs, the rule asserts unacceptable restrictions on women's reproductive freedom, using economic coercion (access to a basic needs grant for their child) to limit contraceptive choice and require disclosure of private reproductive health information. In short, TANF should require that all children in an eligible household be aided and should not allow states to condition financial assistance for a child on its mother's decision to use contraception or to disclose a sexual assault.

- **TANF Should Better Serve Veteran Families and Surviving Family Members**

As far as we can tell, TANF never considered the unique situation of veterans with children and survivors. In California, we have been working to address some of the program oversights and suggest that Congress consider doing the same. These include: (a) honoring VA determinations of disability; (b) referring veterans to veteran service providers; (c) support vocational options for veterans & survivors by clarifying income & resource exemptions for all GI Bill related income.

- **TANF Should Do More to Reduce Infant Mortality & Support Healthy Outcomes**

TANF allows states to determine whether or not it serves pregnant women and at which trimester. This, despite the fact that low-income pregnant women are especially likely to experience discrimination, as employers may refuse to provide the accommodation necessary to enable a woman to work throughout her pregnancy[17] and more likely to be victims of domestic violence.[18] Delaying basic needs cash assistance for very low-income pregnant women not only impacts the health of children born into deep poverty, but it also endangers the health and wellbeing of pregnant women. Not ensuring uninterrupted supportive services to women experiencing multiple stressful situations during their pregnancies may increase complications in their pregnancies and premature labor. Because maternal stress increases pre-term birth, morbidity and the likelihood a child will be born with a short-term or even lifelong disability,[19] Congress should direct states to serve pregnant women and fund them to do so.

- **TANF Should Require States Certain Child Support Standards**

Current TANF law allows states to determine whether and how much child support to pass through to custodial parents and many states have chosen not to pass through any or to only pass through a minimal amount.[20] The Deficit Reduction Act of 2005 (DRA, P.L. 109-171) provides incentives for

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[17] National Women's Law Center and A Better Balance, "It shouldn't be a heavy lift: fair treatment for pregnant workers." 2013. Available online at: http://www.nwlc.org/sites/default/files/pdfs/pregnant_workers.pdf

[18] Bohn, D.K., "Domestic Violence and Pregnancy. Implication for Practice." Journal of Nurse Midwifery 1990 Mar-Apr 35(2):86-98.

[19] http://www.jstor.org/stable/30013020

[20] http://www.clasp.org/resources-and-publications/publication-1/PassThroughFinal061209.pdf, http://anfdata.urban.org/databook_tabs/2010/IV.A.2.xls, and http://www.urban.org/publications/411595.html

states to allow more of the child support collected on behalf of TANF families to go to the family without a reduction in welfare benefits. Under DRA, the federal government shares in the cost of passing through up to $100 per month for a family with one child, and up to $200 per month for a family of two or more children, of collected child support to TANF families. A report by the Congressional Research Services illustrates that the impact of a higher pass-through to TANF families has a significant positive effect on these families. Higher pass-through rates are also expected to increase participation among non-custodial parents. Congress should consider requiring states to maximize child support pass-through and should clarify that child-support paid by a TANF parent to support a child out-side of that TANF household should never be considered available income to the children in the TANF household.

- **TANF Should Require (and Fund) States to Provide Time-Limit Relief During Recession**

Current TANF law allows states to determine whether and how much child support to pass
Federal law allows state to provide aid to low-income parents and children. While federal law allows for 60 months of eligibility for adults, many states restrict families to less months of lifetime eligibility. In California, adults are limited to 48 months in a lifetime and welfare-to-work services to 24 months in a lifetime, with some exceptions. Adult TANF recipients, with some exceptions, must participate in work activities as a condition of receiving cash benefits.

Under TANF, there are no waivers from the work requirement during recessionary times. This means that, during the 18 months of economic recession since the inception of the CalWORKs program, very poor parents with multiple barriers to work were required to participate in employment activities even when unemployment was very high, reaching over 40% in those California communities where CalWORKs participation is concentrated (in the Central Valley).[21] During this time, some CalWORKs recipients reported to our organization about how humiliating it was to report to the mandatory job-search portion of their welfare-to-work program only to spend the day calling companies in search of jobs that everyone knew didn't exist. Requiring participation in welfare-to-work during a recession means that more families face a sanction during unbearable economic times, pushing the family further into deep poverty and impairing the ability of their family to overcome the long-reaching impact of a recession. What's more, making families vulnerable to sanctions related to work during a recession has a negative impact on the economies of already vulnerable communities. According to a report by Beacon Economics reducing CalWORKs expenditures has a negative consequence for local economies in which both program recipients live.[22] These findings are consistent with those published by national economists at Moody's and very strongly assert that reducing safety net benefits during a federally declared recession is not only bad for the long-term health of children served by the program and for the long-term health of our economy. Finally, alleviating families of welfare-to-work requirements during a recession or in a federally declared work-surplus area would relieve caseworkers of the time to oversee their compliance. This is significant because, during a recession, there are more families that seek assistance and less money to serve them with. The cost pressures associated with these dynamics on the program were so significant that, during the last recession, then California Governor Arnold Schwarzenegger actually proposed terminating the program altogether.[23]

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[21] Henry S. Farber, "Job Loss in the Great Recession: Historical Perspective from the Displaced Workers Survey, 1984-2010," (May, 2011) http://www.nber.org/papers/w17040

[22] See Spending on County Human Service programs in California: An Evaluation of Economic Impacts, March 2009, http://cfpic.org/downloads/CFPIC_Beacon_report09.pdf According to this report, every dollar in state funds spent on CalWORKs generates an additional $1.43 in economic stimulus.

[23] In January 2010, California Governor Arnold Schwarzenegger proposed to eliminate the CalWORKs program, then serving 1.9 million, if the federal government did not approve $6.9 billion in additional federal funds and federal flexibilities. http://www.cdss.ca.gov/cdssweb/entres/pdf/CDSS_Budget_Summary.pdf

Western Center would like to see more relief for families who have met their 60 month, especially when any portion of those months were spent during a federally declared recession or in a federally declared work surplus area. The fact that the program has no considerations for economic impacts that result in employment beyond the influence of state, and certainly participants, is one of its cruelest features.

TANF Alone Cannot End Poverty among Families or Protect Children from Long-Term Harm

Most poor families with working-aged adults are working families. Here in California, according to the Public Policy institute of California, 78.2% of low-income people live in a working family. While we support increasing subsidized jobs for low-income families who rely on TANF proposed in the Discussion Draft, it will have little impact in eliminating working-poverty unless federal law makers also pass laws to ensure that a day's work brings an honest wage, one that will pay for the basic costs of living, and that unemployment benefits are available when jobs are not. Until that is accomplished, low-income workers need workplace protections to prevent long-term impacts of poverty, like: Paid Sick Days, Schedule Fairness, Paid Family Leave, and Affordable Child Care.

TANF Reauthorization Should Prioritize Goal of Reducing Child Poverty

In summary, Western Center on Law and Poverty supports many of the accountability measures included in the TANF Reauthorization Discussion Draft and we also support the goal of reauthorizing TANF, rather than simply extending it. Provided the reauthorization can be accomplished without adding additional harmful and mean-spirited measures. While we would have liked to have a more robust conversation about poverty and deep poverty, the impact both are having on families and children, and promising practices to support health and wellbeing of people living in poverty and improve opportunities for low-income families to exit poverty, we are satisfied that, for the most part, the proposals in the working draft will move the program forward in a modestly positive direction. We thank you for your consideration of our comments and respectfully reserve the right to submit additional thoughts and considerations as the reauthorization progresses. Please do not hesitate to contact us should you have any questions at all.

About Western Center on Law and Poverty

For more information about Western Center, go to www.wclp.org. For more information about our TANF Reauthorization priorities or positions, contact us:

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From: Zeva
To: Submissions, Ways and Means
Subject: About welfare
Date: Monday, July 13, 2015 3:17:09 PM

Dear members.

I am writing to tell you a story about when I was on welfare in 1974 and to urge you to fund welfare.

I had a three-year-old whose father abusive to my daughter and me. My family was not able to help. My daughter was traumatized and I could not find child care that fit her needs. Therefore I needed to depend on welfare for 6 months.

Finally I was able to stabilize myself to find a job and a home.

My career put me in contact with many families on welfare. I never saw anybody abuse it. I saw people use it well.

In the long run helping those who need help benefits society and saves money.

Sincerely.
Zeva Longley
San Rafael. Ca

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