

PUBLIC HEALTH INSURANCE EXPANSIONS FOR PARENTS: EVIDENCE FROM WISCONSIN

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ABSTRACT

The State Children's Health Insurance Program federal legislation has provided states with new incentives to expand the availability of public health insurance programs for children. In response, Wisconsin created BadgerCare to expand public health insurance to families with incomes up to 185% of the federal poverty level. As an added incentive for enrolling children, and to help remove barriers to employment for parent, BadgerCare is available to both eligible children and their custodial parents. While this approach has likely been somewhat successful, critics argue that covering parents will encourage the incidence of 'crowding out.' Overall, the inclusion of parents in BadgerCare has resulted in a decline in the percent of uninsured working-age adults in Wisconsin, even while the national percent of uninsured adults was increasing. Using a difference-in-differences approach, the rate of crowding out is estimated at 27% for crowding of employer-sponsored insurance and at 36% for overall crowding out.

INTRODUCTION

Congress has taken several measures to assure access to health insurance for low-income children and pregnant women, beginning with the creation of the Medicaid program in 1965. The most recent attempt to ensure that all children in the U.S. have adequate access to medical care was through the passage of Title XXI, States Children's Health Insurance Program (SCHIP), of the Balanced Budget Act of 1997. Title XXI allows states to receive enhanced federal matching funds to reduce the number of uninsured, low-income children through the following options: 1) they can expand their Medicaid income eligibility threshold, 2) they can create new state programs to insure low-income children not

eligible for Medicaid, or 3) they can use a combination of the two approaches.

The primary advantage for using a Medicaid expansion is that there will be fewer administrative difficulties for expanding an existing program, compared to the creation of a new state program. However, with a new state program, states have greater flexibility in designing their program. First, the new state programs must provide comprehensive coverage, though the set of covered services do not have to be as broad as those covered by Medicaid. For example, states that include dental coverage for Medicaid participants do not have to include dental benefits as part of the new state program. Second, the new state programs have greater flexibility to include cost-sharing measures (such as premiums, copayments, and coinsurance rates), though the out-of-pocket expenses from such measures must not exceed 5% of a family's income. Finally, the new state programs can limit eligibility for those recently enrolled in private policies or with access to private insurance policies. (CMS, 2004)

In 1999, Wisconsin implemented the BadgerCare program in response to the Title XXI legislation. BadgerCare is designed to provide health insurance to low-income families with children. One of the more unique features of BadgerCare is that coverage is provided to parents as well as children in eligible families. The inclusion of parent coverage is intended to encourage enrollment of eligible children as well as to remove barriers to employment for working families. However, this may also serve to enhance the "crowding out" effect as families who otherwise would have enrolled in private health insurance

coverage may choose to enroll in BadgerCare. Another potential criticism of BadgerCare is that it favors parents over otherwise similar childless adults.

The purpose of this paper is to explore the impact that BadgerCare expansions have had on the Wisconsin adult population by: 1) reducing the number of uninsured; and 2) potentially decreasing the number with private insurance. Together, these estimates provide some insight into both the intended goal of reducing uninsurance rates and the extent to which public insurance expansions have crowded out private insurance.

OVERVIEW OF MEDICAID AND BADGERCARE EXPANSIONS

Traditionally, Medicaid was available only to specific populations, such as those who qualified for Aid to Families with Dependent Children (AFDC) payments, low-income aged and disabled people, and those who were “medically needy” (meaning that they had recently incurred large medical expenses, relative to their income). Prior to 1984, low-income children were typically eligible for Medicaid only if they were in families receiving AFDC. Beginning in 1984, the link between AFDC and Medicaid eligibility was relaxed, so that Medicaid eligibility could be expanded to low-income children who did not qualify for AFDC. From 1986 to 1992, there were numerous expansions in Medicaid eligibility for pregnant women and children, which occurred through both federal mandates and optional state expansions.

As of March 31, 1997, the federally mandated eligibility thresholds for Medicaid were 133% of the Federal Poverty Line (FPL) for pregnant women, infants and children less than 6 years old, and 100% FPL for children 6 years old and older born after September 30, 1983. Eight states began enrolling children in Title XXI expansion programs in 1997, 32 states in 1998, 8 states in 1999, and 2 states in 2000 (Mathematica Policy Research, Inc., 2001).

Resulting from these expansions, the average maximum eligibility limit across states for children had increased from approximately 137% FPL in 1997 to 213% FPL in 2002. Parents, however, are only eligible in most states if they would have qualified through the former AFDC program, with more generous coverage typically available only during pregnancy.

Prior to the BadgerCare expansion in 1999, Medicaid coverage was available to: pregnant women and children ages 0-5 with family incomes below 185% FPL; older children born after September 30, 1983, with family incomes below 100% FPL; older children born prior to September 30, 1983, with family incomes below 68% FPL; and nondisabled custodial parents with family incomes below 55% FPL. Under BadgerCare, which was implemented in July 1999, coverage was expanded to both children and their custodial parents with family incomes below 185% FPL. Once enrolled, families can continue to receive coverage as long as family income remains below 200% FPL (Sirica, 2001).

BadgerCare is typically described as a Medicaid expansion, since the existing Medicaid coverage is extended to those gaining eligibility through the BadgerCare expansions. However, BadgerCare was allowed to incorporate features of the new state programs through special waivers from the Health Care Financing Administration. Eligible families with incomes above 150% FPL are charged monthly premiums which are designed not to exceed 3% of the family’s income. In addition, there are restrictions on eligibility for those who become eligible due to the BadgerCare expansions, which do not apply to those who would have been eligible without the expansions in place. First, applicants must have been without health insurance for the previous 3 months to be eligible for BadgerCare. Second, applicants must not have had access to employer-sponsored insurance (ESI), where the employer pays at least 80% of the premium, for 18 months before they can become eligible for

BadgerCare (Sirica, 2001). Finally, applicants must not have access to a state employee health plan, so that state workers cannot decline their employment-related benefits in order to enroll themselves or their dependents in BadgerCare (Alberga, 2001).

These additional restrictions are intended to prevent the crowding out of private insurance. Broadly defined, crowding out refers to those who do not hold private health insurance, but who otherwise would have in the absence of expanded eligibility for public health insurance. The most obvious case of crowding out occurs if individuals simply drop private coverage and enroll in public programs. Crowding out may also occur, though, if some individuals become uninsured as a result of public insurance expansions, but otherwise would have had private insurance. For example, many states have traditionally had different eligibility thresholds for children of different ages. Thus, previous Medicaid expansions may have resulted in some children in a family becoming eligible for Medicaid, while other children in the same family did not. This may give families a financial incentive to change employment-related policies from family to individual coverage. The eligible children may then be enrolled in Medicaid, leaving the non-eligible children and/or spouse uninsured. Because the BadgerCare expansions equalize the income-test for all family members, this type of crowding out would not be expected. However, many employers are more generous in providing single benefits than family benefits. Thus, under BadgerCare, an employee meeting the income-test may be able to switch from family to single coverage through their employer if the employer pays at least 80% of the premium for single coverage, but less than 80% of the premium for family coverage. Other members of the workers family would then be eligible to enroll in BadgerCare, though they may have to be willing to be uninsured during the 3 month waiting period.

Additionally, firms may react to expanded Medicaid eligibility by increasing the employee share of premiums or, in a more

extreme case, by discontinuing individual and/or family health insurance from their benefit package completely. This, again, may result in crowding out for those eligible for BadgerCare.

The presence of crowding out is often interpreted as a shift from private provision to public provision of health insurance, resulting in increased government expense and little gain in social welfare. However, for anyone that enrolls in BadgerCare, including those that 'crowd out,' it can be argued that there must be some gain in welfare from doing so, following a revealed-preference argument. This gain is potentially small for those that have access to ESI where the employer covers the majority of the premium expense. For those that must pay a large share of the premium for ESI, or for those facing non-group coverage, there is a much greater potential gain in premium-savings from switching to BadgerCare; this savings can then be put to other uses. In order to gain eligibility for BadgerCare, applicants must not only meet the income test, but must also not have access to ESI where the employer pays over 80% of the premium. This requirement (assuming that it can be monitored and enforced) prevents participation by those who would gain relatively little savings while shifting the cost of their health care largely to the government.

PREVIOUS STUDIES

Previous studies of the effects of Medicaid expansions on insurance coverage have focused heavily on the issue of crowding out, the extent to which increases in public insurance are offset by reductions in private coverage.

Cutler and Gruber (1996) used March CPS data from 1988-1993 to identify changes in insurance status resulting from eligibility expansions, identified by state-level variation in eligibility thresholds. They found rates of crowding out to be 40% for children and more than 100% for women of child-bearing age. This analysis provides greater rates of crowding

out since it accounts for parents and children who become uninsured, rather than gaining public insurance, but who otherwise would have been covered under private policies.

Other researchers have directly used comparison groups to measure the magnitude of crowding out, based on cross-sectional data. Dubay and Kenney (1997), for example, use a comparison group of men ages 18-44 to measure the magnitude of crowding out for women ages 18-44, based on the 1989 and 1993 March CPS data. They estimate an overall rate of crowding out for women of childbearing age to be 14%, with no evidence of crowding out for women with incomes <100% of poverty, crowding out of 29% for women with incomes 100-133% of poverty, and 59% for women with incomes 134-185% of poverty. Thus, they conclude that crowding out becomes more likely as the eligibility rates expand further.

Shore-Sheppard, Buchmueller, and Jensen (2000) use firm-level data from various surveys taken between 1989 and 1995 to assess employers' responses to Medicaid expansions. They find that firms employing large fractions of low-wage workers were significantly less likely to offer insurance, but that firms' decisions to offer insurance was unaffected by the percentage of workers eligible for Medicaid. They did find that firms with a higher percentage of workers eligible for Medicaid were significantly less likely to offer family coverage. They conclude that crowding out occurs mainly through reduced take-up of employer-sponsored coverage, rather than through reductions in the availability of employer-sponsored coverage, particularly for workers who would be required to contribute directly toward premiums.

Many researchers have also used longitudinal data from the SIPP and NLSY to measure both the magnitude of crowding out and the choice of insurance, both before and after a change in eligibility. Thorpe and Florence (1998) use NLSY data from 1989 to 1994 to show that, although approximately one-third of children enrolled in Medicaid had held private coverage the previous year, only 16% of

children newly enrolled had access to private insurance through a parent's employment at the time of enrollment. Yazici and Kaestner (2000) use NLSY data from 1988 to 1992 to estimate that crowding out accounted for 18.9% of the increased participation in Medicaid for children. Blumberg, Dubay, and Norton (2000) use data from the 1990 SIPP Panel to examine the change in insurance coverage between 1989 and 1992. They estimate that 23% of the movement from private insurance to Medicaid was attributable to crowding out as a result of the expansions.

While using longitudinal data certainly has many advantages in assessing changes in the choice of insurance, there is a much longer lag in the availability of such data, making it currently inaccessible for studying the effects of state programs.

Overall, crowding out is estimated to account for 15-40% of the increased children's enrollment in Medicaid, following the expansions in eligibility which occurred in the late 1980's and early 1990's. For women of child-bearing age, estimates of crowding out are more varied, ranging from 14-100% of the increased enrollment in Medicaid. In comparing the different approaches used, Cutler and Gruber are the only researchers that have used cross-state variation directly to identify the response to changes in Medicaid eligibility. This distinction does appear to have an effect on the estimates of crowding out, since Cutler and Gruber's estimates are noticeably larger than that of other researchers. Part of this difference is due to the fact that Cutler and Gruber explicitly allow for indirect crowding out which results from a gain in Medicaid eligibility for some family members, potentially leaving others in the family uninsured. However, the estimates from their first model, which does not account for such spillover effects, are still greater than those of other researchers.

DATA AND METHODS

Data used in this study comes from the Urban Institute's 'National Survey of American Families' (NSAF). The NSAF has collected detailed information including variables on health care, employment, earnings, and demographics in the years 1997, 1999, and 2002. The data used comes from the 'Adult Pair' files (Urban Institute). For households with children, data is gathered for one randomly chosen child ages 0-5 and a second randomly chosen child ages 6-17 (if such children exist in the household). The data for each child is provided by the 'most knowledgeable adult' (MKA) in the household for each child. Data is also collected for the MKA and their spouse (if one exists). For households without children, data is collected from a randomly chosen adult and their spouse (if one exists) (Abi-Habib, Safir, and Triplett, 2004).

The NSAF oversamples low-income populations which aids in the evaluation of programs affecting these populations specifically. The NSAF also has samples large enough to provide for state-level estimates in 13 states (including Wisconsin), with smaller samples in other states sufficient to produce national-level estimates. (Abi-Habib, Safir, and Triplett, 2004). This provides some advantages over the March CPS data which is designed to produce national-level estimates and state-level comparisons, though the samples are not large enough in each state to provide accurate point-in-time state-level estimates.

Rates of health insurance coverage through Medicaid/BadgerCare, employment-sponsored insurance, and the uninsured, are compared for Wisconsin adults in 1997 and 2002. There are other types of insurance coverage not included in this study. However, these are of less concern. Medicare, for example, is another source of public health insurance, though there is no expectation that BadgerCare expansions would affect either the eligibility or take-up for Medicare. Private

health insurance which is unrelated to employment, such as non-group coverage, is also not measured directly.

The change in each type of coverage (Medicaid/BadgerCare, ESI, or uninsured) is measured both for: 1)parents, and 2)childless adults. The parent group includes all MKA's and their spouses who are identified as parents of one or both of the focal children. MKA's who are not parents of one of the focal children are excluded as it is uncertain whether these individuals have children of their own. For example, some MKA's are identified as the grandparent or older sibling of one of the focal children, though they could possibly have children of their own who are not included in the dataset. The changes for childless adults are treated as a control group since the BadgerCare expansions did not impact their eligibility for public health insurance. For example, the percentage-point change in ESI for the parent group likely was influenced by both the BadgerCare expansions and by other events such as the 2001 recession and general trends in health insurance status. The percentage-point change in ESI for the childless adult group, though, was not influenced by BadgerCare but was influenced by the other events which also influenced the parent group. The difference in these estimates, using a difference-in-differences calculation, thus provides the part of the change in ESI for the parent group which can be attributed to the BadgerCare expansions themselves.

Rates of crowding out are calculated first as the ratio of the change in ESI attributed to BadgerCare to the change in Medicaid/BadgerCare enrollment attributed to BadgerCare. In other words, this measures the percent of the increase in BadgerCare enrollment that can be explained by decreases in ESI, or 'ESI crowding out.' By ignoring non-ESI private plans, though, this measure does ignore some potential sources of crowding out. For example, a family that drops non-group private coverage in order to gain access to BadgerCare would not be reflected as part of the crowding out under this measure.

However, the switch from non-group coverage to public coverage likely represents a large welfare gain to the family which was previously paying the full premium plus any cost-sharing out-of-pocket. This behavior may be problematic from a government finance perspective as the cost of insurance has now been transferred largely to the government. However, this may be less problematic from a social perspective compared to ESI crowding out which generates smaller welfare gains to the families. Essentially, any decline in ESI attributed to BadgerCare expansions adds to the government cost to finance the program, though with reduced benefit to such families. This behavior provides the least social benefit for the cost and, as such, is perhaps a more serious form of crowding out.

An alternate measurement is calculated as one minus the ratio of the change in the number uninsured attributed to BadgerCare to the change in Medicaid/BadgerCare enrollment attributed to BadgerCare. In other words, this measures the percent of the increase in BadgerCare enrollment which is not explained in a decrease in the uninsured. This measure, 'overall crowding out,' identifies all potential sources of crowding out, with no distinction made between crowding out of ESI or non-group coverage. The differences in these two related measurements for crowding out also stem from the fact that enrollment in Medicaid (at least for those eligible without the BadgerCare expansions) and ESI are not mutually exclusive; some individuals do report having both sources of coverage.

RESULTS

Table 1, below, shows the percentages of working age adults in the U.S. and Wisconsin with Medicaid/SCHIP coverage, ESI, and no health insurance. These percentages are shown for both the entire population and the part of the population with family incomes below 200% FPL (near-poor).

There are a few noteworthy differences between the coverage rates in Wisconsin, compared to the nation as a whole. From the 1997 data on working age adults, it is clear that Wisconsin had a smaller percent of the population enrolled in Medicaid, a larger percent covered through ESI, and a smaller percent of uninsured, compared to the nation as a whole. This is true for both the overall population and for the near-poor. This may add to the potential for crowding out, since there is a relatively smaller pool of uninsured (the intended population for BadgerCare expansions) and a relatively larger pool of those covered through ESI (those with the potential for crowding out).

The fact that Wisconsin is one of a few states that have expanded parent coverage under Medicaid/SCHIP programs is also seen in the data in Table 1. For both the overall population and the near-poor, Wisconsin has greater percentage point increases in Medicaid/SCHIP coverage, and greater percentage-point decreases in ESI. The net impact is that Wisconsin has seen a decrease in the incidence of uninsured, working-age adults, while there has been an increase in the uninsured for the nation as a whole.

If the changes in insurance coverage for Wisconsin were only due to BadgerCare expansions, this data could be used to estimate the incidence of crowding out. For example, the decline in ESI for the near-poor (3.9 percentage points) accounts for about 45% of the growth in Medicaid/BadgerCare coverage for the near-poor (8.6 percentage points), indicating a potential for 45% ESI crowding out. Alternatively, the reduction in uninsured rates (4.2 percentage points), accounts for about 49% of the increase in Medicaid/BadgerCare coverage, indicating that the remaining 51% increase is potentially due to overall crowding out. Since these estimates do not account for other factors contributing to changes in health insurance status, they can be considered a rough upper-bound for the true crowding out effect.

In order to control for changes in insurance coverage rates which are unrelated to BadgerCare, the changes in insurance coverage from 1997-2002 are calculated for parents and non-parents (childless adults), as shown in Table 2. The analysis shown in Table 2 is restricted to working-age adults with family incomes below 200% FPL. This is the group which is potentially affected by the expansions.

From Table 2, the growth in Medicaid/BadgerCare coverage was 15.8 percentage points greater for the near-poor parents, compared to the near-poor childless adults. Similarly, there was a greater decline in ESI, by 4.2 percentage points, and a greater decline in the uninsured, by 10.1 percentage points (relative to a small increase for childless adults). Based on this data, ESI crowding out can be calculated as about 26.5% of the increase in Medicaid/BadgerCare enrollment; alternatively, the decline in the uninsured accounts for 63.8% of the growth in Medicaid/BadgerCare, leaving 36.2% of the increase which may be attributed to overall crowding out.

SUMMARY AND CONCLUSIONS

Wisconsin has designed their BadgerCare program to expand public health insurance coverage not only to children, but for the entire family unit. By covering the entire family unit, the state believed that this would provide further incentives for low-income families to enroll in the program and help to reduce uninsurance rates among children. This research examines the impact that this change has had on the insurance status of working-age adults in Wisconsin.

Overall, the inclusion of parents in BadgerCare has resulted in a decline in the percent of uninsured working-age adults in Wisconsin, even while the national percent of uninsured adults was increasing. The rate of crowding out is estimated at 27% for ESI crowding out at 36% overall crowding out. In other words, about one-fourth of the increased

adult enrollment would have had ESI in the absence of the BadgerCare expansions while the remaining three-fourths would not. Additionally, about one-third of the increased adult enrollment would have had some form of health insurance in the absence of the BadgerCare expansions, while the remaining two-thirds would have been uninsured.

Thus, it appears that the inclusion of parents under BadgerCare has had a positive impact on increasing health insurance coverage of adults, and likely for their children as well. This research has focused on the impact of adult health insurance status because this is a somewhat unique feature of BadgerCare, and because the exclusion of childless adults provides a solid natural experiment setting for testing the impact on adult coverage. More research is needed to assess how the inclusion of parent coverage has impacted children's coverage to fully understand this policy change. In addition, more research is needed to determine the causes of crowding out which do occur: is this a response to reduced offers of ESI in benefit packages, reduced generosity of ESI offers (greater premium sharing, for example) or simply a decline in take-up rates among those who are offered ESI. Finally, does the increased access to health care provided through the BadgerCare expansions result in improvements in either health outcomes or promotion of a higher standard of living (by freeing-up resources which can be put to other uses)? If so, how does the welfare gain compare to the social and/or government cost of providing coverage?

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	1997	1999	2002	1997-2002 \square
Medicaid/SCHIP				
U.S.	5.5%	5.7%	6.7%	+1.2 % pts.
WI	3.5%	3.5%	5.6%	+2.1 % pts.
U.S. Near-Poor	16.0%	16.4%	18.8%	+2.8 % pts.
WI Near-Poor	12.1%	11.9%	20.7%	+8.6 % pts.
ESI				
U.S.	71.2%	72.4%	70.6%	-0.6 % pts.
WI	80.1%	81.7%	80.6%	+0.5 % pts.
U.S. Near-Poor	38.6%	41.8%	37.0%	-1.6 % pts.
WI Near-Poor	52.3%	53.5%	48.4%	-3.9 % pts.
Uninsured				
U.S.	16.9%	16.3%	16.9%	0.0 % pts.
WI	9.8%	9.8%	8.6%	-1.2 % pts.
U.S. Near-Poor	36.5%	34.7%	36.8%	+0.3 % pts.
WI Near-Poor	26.8%	26.4%	22.6%	-4.2 % pts.
Sample Sizes				
U.S.	73,160	72,379	68,379	
WI	8,740	9,271	5,363	
U.S. Near-Poor	28,507	22,517	21,487	
WI Near-Poor	3,130	2,501	1,237	
Source: National Survey of American Families, 1997, 1999, and 2002. Urban Institute.				

	1997	2002	1997-2002 \square
Medicaid/SCHIP			
Parents	15.2%	32.6%	+17.4 % pts.
Non-Parents	9.5%	11.2%	+1.7 % pts.
Difference			+15.8 % pts.
ESI			
Parents	54.4%	48.2%	-6.1 % pts.
Non-Parents	50.9%	48.9%	-2.0 % pts.
Difference			-4.2 % pts.
Uninsured			
Parents	25.3%	15.6%	-9.7 % pts.
Non-Parents	27.8%	28.2%	+0.4 % pts.
Difference			10.1 % pts.
Sample Sizes			
Parents	2,104	832	
Non-Parents	877	373	
Source: National Survey of American Families, 1997 and 2002. Urban Institute.			