In this policy brief we examine the health insurance coverage of poor and near-poor children and their caregivers in low-income neighborhoods in three cities: Boston, Chicago, and San Antonio. We highlight Medicaid because it represents the main component of the health care safety net for the pre-retirement-age poor. In 1999, the program provided acute and long-term care to nearly 32 million Americans. Medicaid has been very successful in providing health care coverage to numerous low-income families, who highly value the benefits. Nonetheless, many working and non-working low-income families remain uninsured. In this brief we document wide variation in the percent of families with Medicaid coverage in our cities, with far higher coverage in Boston and Chicago than in San Antonio. We also present evidence on the extent and nature of other types of health insurance coverage among children and caregivers in our study, and we identify those who are at highest risk of having no health care coverage.

Prior to 1999, the number of uninsured individuals had grown for over a decade, despite efforts to extend Medicaid and other public health insurance programs to all of those eligible. This growth was of concern to most policy-makers since a goal of welfare reform was to increase Medicaid coverage. In fact, at the same time that cash assistance was increasingly restricted, the federal government not only required states to preserve Medicaid benefits for needy families, but it also allowed them to offer additional benefits beyond those previously available on a shared federal/state cost basis. States were required to provide Medicaid to children up to age 6 in families with incomes below 133 percent of the federal poverty level (FPL) and children up to age 17 in families with incomes below 100 percent of the FPL.

**Summary**

Medicaid represents the major component of the health care safety net for poor children and their families in the Three-City Study. Relatively few are covered by employer-sponsored plans or other forms of health insurance. The longer families are off welfare, the less likely they are to be covered by any type of health insurance. A larger percentage of Mexican-Americans, compared to other Hispanics or African-Americans, lack coverage, and children in two-parent households are less likely to be covered than children in single-parent households. Parents value Medicaid and go to great lengths to obtain it for their children, but some parents are unable to obtain or afford health coverage for themselves.

Having an employed parent, having two parents in the home, or being Mexican-American are health insurance risk factors for poor children. The longer a family has been off TANF, the less likely they are to be covered by health insurance of any kind.
Increasing participation in Medicaid by needy children has been an ongoing challenge for federal and state governments.

Table 1

<table>
<thead>
<tr>
<th>Percent of Children Covered by Medicaid</th>
<th>All 3 cities</th>
<th>Boston</th>
<th>Chicago</th>
<th>San Antonio</th>
<th>March 2000 CPS</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;100%</td>
<td>77</td>
<td>82</td>
<td>82</td>
<td>64</td>
<td>60</td>
</tr>
<tr>
<td>100–124%</td>
<td>58</td>
<td>86</td>
<td>59</td>
<td>30</td>
<td>42</td>
</tr>
<tr>
<td>125–149%</td>
<td>53</td>
<td>63</td>
<td>61</td>
<td>35</td>
<td>33</td>
</tr>
<tr>
<td>150–199%</td>
<td>54</td>
<td>64</td>
<td>35</td>
<td>5</td>
<td>23</td>
</tr>
</tbody>
</table>

In the Three-City Study, described on page 8, we conducted a household-based, random-sample survey of children 0–4 or 10–14 years of age and their caregivers in low-income neighborhoods. In households with incomes below 200 percent of the FPL, interviewers randomly selected one child in the targeted age range and conducted an in-person interview with that child’s caregiver (the mother in over 90 percent of the cases). Assessments of the children, as well as interviews with them, were also carried out, but these data will not be discussed in this report. Overall, 2,402 child-caregiver pairs were interviewed, including an oversample of those receiving TANF. The interviews were conducted between March and November of 1999. We achieved a response rate of 74 percent. All figures and charts in this report are based on the survey.

The first four columns in Table 1 show Medicaid coverage in our three-city sample overall and for each city separately, and for different income levels. Among the poorest families in our study, those with incomes below 100 percent of the FPL, 82 percent of children are covered in Boston and Chicago, 64 percent in San Antonio, and 77 percent for all three cities combined. Among families with slightly higher incomes, San Antonio lags far behind Boston and Chicago. It is for this income range that Massachusetts and Illinois have introduced greatly expanded optional coverage. In families with incomes between 150 percent and 199 percent of poverty, a category that includes many working poor families, only 5 percent of San Antonio children receive Medicaid compared to 35 percent in Chicago and 64 percent in Boston.

These across-city differences are clearly affected by state policy (see sidebar on Medicaid policies, page 7). Massachusetts has instituted most of the optional coverage allowed by federal law. In contrast, at the time of the interview, Texas had not extended coverage much beyond what was federally required, and this is no doubt the reason that children in low-income neighborhoods in San Antonio have rates of coverage far below those in the other two cities. Illinois has instituted more coverage than Texas but less than Massachusetts.
Clearly, the health care safety net benefits the poorest families most. In fact, low-income parents highly value Medicaid coverage (see “How Families Value Medicaid,” page 6). Still, in the survey, 27 percent of families that qualified for Medicaid on the basis of the most restrictive federal requirements (households below 133 percent of the FPL and with a child under 6) reported that no one in the household was participating in the program. This finding is consistent with national studies showing that many children who qualify for Medicaid are not enrolled. Possible barriers to enrollment may include misinformation or misunderstanding concerning the connection between Medicaid and the receipt of TANF, a complex application and reapplication process that differs from state to state, or fears concerning citizenship and immigration status.

The last column of Table 1 provides national data on health insurance coverage for all children under 15 years of age from the March 2000 Current Population Survey (CPS) conducted by the U.S. Bureau of the Census. The figures indicate that children in the low-income neighborhoods we studied have, on average and across all three cities, substantially higher coverage rates than in the nation as a whole. However, while this is true for Boston and Chicago individually, San Antonio has substantially lower rates of Medicaid coverage overall than do children nationwide. There are several significant differences between our sample and the CPS, including that our sample is urban and the CPS includes both urban and rural residents. Our sample also includes only families with a child 0–4 or 10–14 whereas the CPS does not control for the age of the child. In addition, our sample is heavily African-American and Hispanic. Nonetheless, the CPS gives us a useful national comparison.

The Link Between TANF and Medicaid

The top bars of Figure 1 show that in our total sample, 99 percent of the families in which someone was receiving TANF were also receiving Medicaid. Medicaid use dropped to 73 percent among those in which someone had received cash benefits sometime during the two years preceding the interview and to 53 percent among those that had been off the welfare rolls for more than two years prior to the interview. Among those who had never received cash assistance, 52 percent were enrolled in Medicaid.

Medicaid enrollment among those receiving cash assistance was high in all three of our cities; however, rates of coverage for families no longer receiving cash benefits differed substantially. Figure 1 shows that in Boston, coverage was relatively high even among those families that had not received benefits for over two years (73 percent). In Chicago, the drop-off among those who were no longer receiving assistance was much more pronounced. Only 37 percent of families that had been off for more than two years reported receiving Medicaid. In San Antonio, Medicaid coverage was, in general, lower than in Boston or Chicago among those currently receiving TANF or those who received it within the two years preceding the interview.

Other Types of Health Insurance

Figure 2 shows the extent of non-Medicaid health care coverage for the children in our study, in relation to the family welfare status at the time of the interview. Here we present the average values across the three cities. Since so few families in our sample purchase private plans or have coverage through other sources such as the military, we combine all forms of non-employer-based coverage, including privately purchased plans, into one category labeled “other.” A very small fraction of families report both Medicaid and other insurance so we focus on those who report only non-Medicaid coverage. Figure 2 shows that non-Medicaid coverage is relatively rare among poor and near-poor children. Not surprisingly, almost none of those currently on welfare have non-Medicaid coverage. Coverage...
participation rates. In order to determine whether the low Medicaid coverage among Mexican-Americans in this sample is simply a Texas phenomenon, we compared coverage for African-Americans and Mexican-Americans living in the same city. We found that Mexican-American families had coverage lower than that of other groups in both Chicago and San Antonio.13 Although a lower proportion of African-American families received Medicaid in San Antonio than in Chicago, even in San Antonio their Medicaid use was higher than that of Mexican-American families. It appears that low Medicaid use by Mexican-American families is not solely a reflection of lower overall Medicaid coverage in San Antonio.

Figure 3 provides information on the proportion of families in our sample who reported that their children were not covered by any form of health insurance at the time of the survey. It shows that the longer a family had been off TANF, the greater the likelihood that their children had no health insurance. Twenty-one percent of the families that had been off TANF for more than two years, and 22 percent of those that had never received TANF reported having no health insurance for their children.

Health insurance coverage is often inconsistent for poor families. Eligibility must periodically be reestablished, and breaks in coverage can occur. Parents sometimes are able to cover their children through Medicaid, but not themselves (see “Mothers Without Coverage,” page 6). We asked those individuals who said they currently had health insurance or were covered by Medicaid if there had been a period during the 12 months preceding the interview when their children had not been covered (see Figure 4). Of those children currently receiving cash assistance, 8 percent had been uninsured at some point during the 12 months prior to the interview. Six percent of children in families who were no longer receiving cash assistance but who had some form of health insurance experienced an interruption in coverage during the 12 months preceding the interview. Among those families that had never received cash assistance the number of children who had experienced a break in coverage at some time during the year prior to the survey increased to 16 percent.

Coverage by Race and Hispanic Ethnicity
Figure 5 shows the number of uninsured children by race and Hispanic ethnicity and reveals lower rates of coverage for Mexican-American families. In our sample, 9 percent of non-Hispanic white children and 8 percent of African-American children were uninsured at the time of the survey. Nine percent of other Hispanic children and 6 percent of Puerto Rican children had no health insurance.12 In contrast, 27 percent of Mexican-American children were uninsured.

Eighty-five percent of our Mexican-American sample lives in Texas, a state with low TANF benefits and low Medicaid coverage. Local labor market factors in San Antonio may also play a role, and issues related to citizenship may influence participation rates. In order to determine whether the low Medicaid coverage among Mexican-Americans in this sample is simply a Texas phenomenon, we compared coverage for African-Americans and Mexican-Americans living in the same city. We found that Mexican-American families had coverage lower than that of other groups in both Chicago and San Antonio.13 Although a lower proportion of African-American families received Medicaid in San Antonio than in Chicago, even in San Antonio their Medicaid use was higher than that of Mexican-American families. It appears that low Medicaid use by Mexican-American families is not solely a reflection of lower overall Medicaid coverage in San Antonio.

Figure 4 provides information on the proportion of families in our sample who reported that their children were not covered by any form of health insurance at the time of the survey. It shows that the longer a family had been off TANF, the greater the likelihood that their children had no health insurance. Twenty-one percent of the families that had been off TANF for more than two years, and 22 percent of those that had never received TANF reported having no health insurance for their children.

Health insurance coverage is often inconsistent for poor families. Eligibility must periodically be reestablished, and breaks in coverage can occur. Parents sometimes are able to cover their children through Medicaid, but not themselves (see “Mothers Without Coverage,” page 6). We asked those individuals who said they currently had health insurance or were covered by Medicaid if there had been a period during the 12 months preceding the interview when their children had not been covered (see Figure 4). Of those children currently receiving cash assistance, 8 percent had been uninsured at some point during the 12 months prior to the interview. Six percent of children in families who were no longer receiving cash assistance but who had some form of health insurance experienced an interruption in coverage during the 12 months preceding the interview. Among those families that had never received cash assistance the number of children who had experienced a break in coverage at some time during the year prior to the survey increased to 16 percent.

Coverage by Race and Hispanic Ethnicity
Figure 5 shows the number of uninsured children by race and Hispanic ethnicity and reveals lower rates of coverage for Mexican-American families. In our sample, 9 percent of non-Hispanic white children and 8 percent of African-American children were uninsured at the time of the survey. Nine percent of other Hispanic children and 6 percent of Puerto Rican children had no health insurance.12 In contrast, 27 percent of Mexican-American children were uninsured.

Eighty-five percent of our Mexican-American sample lives in Texas, a state with low TANF benefits and low Medicaid coverage. Local labor market factors in San Antonio may also play a role, and issues related to citizenship may influence participation rates. In order to determine whether the low Medicaid coverage among Mexican-Americans in this sample is simply a Texas phenomenon, we compared coverage for African-Americans and Mexican-Americans living in the same city. We found that Mexican-American families had coverage lower than that of other groups in both Chicago and San Antonio.13 Although a lower proportion of African-American families received Medicaid in San Antonio than in Chicago, even in San Antonio their Medicaid use was higher than that of Mexican-American families. It appears that low Medicaid use by Mexican-American families is not solely a reflection of lower overall Medicaid coverage in San Antonio.

Figure 3 provides information on the proportion of families in our sample who reported that their children were not covered by any form of health insurance at the time of the survey. It shows that the longer a family had been off TANF, the greater the likelihood that their children had no health insurance. Twenty-one percent of the families that had been off TANF for more than two years, and 22 percent of those that had never received TANF reported having no health insurance for their children.

Health insurance coverage is often inconsistent for poor families. Eligibility must periodically be reestablished, and breaks in coverage can occur. Parents sometimes are able to cover their children through Medicaid, but not themselves (see “Mothers Without Coverage,” page 6). We asked those individuals who said they currently had health insurance or were covered by Medicaid if there had been a period during the 12 months preceding the interview when their children had not been covered (see Figure 4). Of those children currently receiving cash assistance, 8 percent had been uninsured at some point during the 12 months prior to the interview. Six percent of children in families who were no longer receiving cash assistance but who had some form of health insurance experienced an interruption in coverage during the 12 months preceding the interview. Among those families that had never received cash assistance the number of children who had experienced a break in coverage at some time during the year prior to the survey increased to 16 percent.
For many poor families the health safety net remains incomplete. Private health insurance is out of reach for many families with low incomes; and since many employer-based policies do not cover dependents, or do so only if the family can afford relatively high additional premiums, even children in families with a working parent may lack coverage.

Coverage by Mother’s Marital Status

Two-parent families have always posed a problem for welfare policy since society expects families that include an able-bodied male to be self-supporting. Yet there are many two-parent families among the working poor, a group in which employer-sponsored health insurance is far from universal and family income is often too high to qualify for Medicaid but too low to allow the purchase of private health care coverage. In our sample, 22 percent of children in two-parent families, compared to 10 percent of those in single-parent families, had no insurance. The main reason is that Medicaid coverage is highest among TANF recipients, but two-parent families’ access to TANF is more restrictive. Current health and welfare policies, then, appear to undermine support for two-parent families by making coverage harder for them to obtain.

Conclusion

Medicaid has become the main source of health insurance coverage for low-income families in the United States. In the low-income neighborhoods in our three cities, it is far more common than employer-based or other private insurance, and it is highly valued by parents. Recent expansions of coverage to children from poor and near-poor families that are not receiving TANF have further solidified the dominant role of government-funded health insurance. Yet there is great variation in low-income families’ coverage. Our report highlights four sources of variation:

1. **State of residence**: Although virtually all TANF-receiving families also receive Medicaid, federal legislation allows states substantial discretion in the extent of coverage they offer to poor and near-poor families that don’t receive TANF. In our study, Massachusetts had the most expansive coverage, Illinois less so, and Texas the least. These different policies were associated with sharp differences in coverage rates across the three cities.

2. **Ethnicity**: Mexican-American families reported much lower levels of Medicaid coverage. Some of this difference reflects the lower coverage rates in Texas. But even when we looked just at San Antonio families, Mexican-Americans had less coverage than African-Americans.

3. **Employment**: In general, access to health insurance declines as caregivers leave welfare and enter the labor force. The longer a family had been off welfare, the less likely their children were to be covered by health insurance. The kinds of jobs many caregivers hold either do not carry health insurance benefits or provide them at a cost that some parents feel they cannot afford.

4. **Household structure**: Children living with both parents were twice as likely as children living with one parent to be without health insurance. The access of low-income two-parent families to

---

**Figure 5**

Percentage of children with no health insurance by race and Hispanic ethnicity

- **White, Non-Hispanic**: 9%
- **African-American**: 8%
- **Mexican-American**: 27%
- **Puerto Rican**: 6%
- **Other Hispanic**: 9%

**Figure 6**

Source of coverage for children who have left welfare

- **Medicaid**: 78%, 67%, 71%, 51%
- **Other**: 15%, 11%, 11%, 23%
- **Employer**: 7%, 5%, 11%, 11%
- **None**: 2%, 3%, 1%, 22%

---

**Our ethnographic interviews made it clear that families value Medicaid highly and go to great lengths to enroll their children.**
Two-parent families have always posed a problem for welfare policy since society expects families that include an able-bodied male to be self-supporting.

Medicaid is more restrictive, and many of the parents have jobs that do not provide coverage.

The findings on employment are particularly relevant for assessing welfare reform, whose main objectives are to promote work and reduce dependence on cash assistance. Neither the state nor federal initiatives included as an objective the denial of health care coverage to needy infants and children. Unfortunately, one unintended consequence of federal and state efforts to restrict cash assistance may be a steeper decline in Medicaid enrollment than we might have otherwise seen.

More generally, our study suggests that each state faces unique problems that reflect the racial and ethnic composition of its poverty population, as well as its economic base. For example, we demonstrated that Mexican-Americans have particularly low levels of health coverage, a situation that complicates the social welfare picture in Illinois, Texas, and other states with large Mexican-American populations. The State Children’s Health Insurance Program (SCHIP) is the most recent attempt to address the problem of health coverage for children. Eventually, every state will implement some version of SCHIP, and children who would otherwise not receive needed health care should gain access to it. States are implementing this new program in different ways, as they do with Medicaid. Local traditions and politics, as well as federal law, shape state plans.

In the years to come, public health professionals and advocates of broader health insurance coverage will have to monitor these experiments to determine which works best within the practical constraints that state and local governments face.

Our study suggests that for poor and near-poor children, having a parent who is employed rather than on welfare is a serious health-insurance risk factor. So is having two parents in the household rather than one. A child’s ethnic group also matters: Mexican-Americans have particularly low levels of health insurance coverage. Given the public support for work, marriage, and equal opportunity, these would seem to be unwanted consequences. Recently, the federal government and the states have extended coverage to children through SCHIP and changes in PWRORA. To reduce the unintended inequities we have described, however, the health insurance safety net for poor American families will require much more attention.

How Families Value Medicaid

Our ethnographic interviews made it clear that families value Medicaid highly and go to great lengths to enroll their children. Many parents expressed satisfaction with the program. Yesenia, one of the Mexican-American mothers who spoke to us, told us that she really likes her asthmatic son’s Medicaid. When we asked about her experiences, she said, “I haven’t had any troubles with Medicaid—it paid for everything.” She explained to us that Medicaid even paid for her son’s trip to the emergency room by ambulance, which would have cost her $288.

Marie, an African-American working mother who has health coverage for herself but not her children through her job, is satisfied with the Medicaid coverage she has managed to obtain for her son and daughter. “I have to admit Medicaid is pretty good here. They’ll go back a couple of months, two or three months, and—or maybe it’s four months—and they’ll pick up any bills that, when you weren’t even covered, you know. Cause I know there was one time with—I don’t know, maybe I’m thinking it was with the twins, maybe it was the twins—but I did have a space there where I was not really covered. I was on pins and needles, but Medicaid did kick in.”

Mothers Without Coverage

Even when mothers are able to obtain health coverage for their children, usually through Medicaid, they often do without care themselves because they are ineligible, cannot afford the deductibles and co-payments, or cannot negotiate the application process. Monica, a Mexican-American mother, had been denied Medicaid and said that she was resigned to being without it. She explained that she does not seek medical care for herself and that “dealing with Medicaid is difficult because they never trust you and every time you go you have to prove that you don’t have a car, what your income is, and that you don’t have any other bank accounts.”

Mary Ruth, a Mexican-American mother of five, also has no insurance for herself. She explained to us that she has tried to get Medicaid several times but has been unable to because DHS (the Department of Human Services) says that her husband is living with her, and that since he is working he should be helping financially. Mary Ruth is actually separated from her husband who comes and goes but does not give her money. For a while, Mary Ruth was working providing home health care, and she hoped to purchase health insurance through her employer, but she hurt her back trying to move a patient and lost her job as a result.

Since then she has been in constant pain, but she cannot afford a medical visit. At present, Mary Ruth cannot work and has trouble keeping her home clean.

Even when an employer offers health insurance, families on tight budgets may find the cost high. We asked Yesenia, the Mexican-American mother who was pleased with her son’s Medicaid, whether her partner’s job offered health insurance. She replied, “Yeah, but I didn’t want anything more taken out of the paycheck.” When we asked how much insurance would have cost, or what else she and her partner had taken into consideration when they decided not to purchase health insurance, she replied, “We didn’t even discuss it—it was too expensive, and Gilbert [her partner] tends to be healthy.” Gilbert’s employer-provided plan would have covered him, but coverage for Yesenia and the children would have cost more. Meanwhile, Yesenia is seriously overweight and needs thyroid medication but, since she lost Medicaid coverage, has been unable to pay for pills.
terms, 29 percent of the sample was receiving TANF at the time of the interview, and another 14 percent had received TANF in the previous two years.


12. Puerto Ricans are concentrated in Northeastern states with more generous Medicaid policies, and they are by birth citizens of the United States.


17. Families of different income levels and family structures were sampled at different rates, but we have survey weights which allow us to generalize our sample to the population of low-income single-mother and two-parent families living in low-income neighborhoods in the city as a whole. We employ these survey weights in all the tabulations reported here. For details on weights and sampling see Pamela Winston et al., Welfare, Children, and Families: A Three-City Study, Overview and Design Report.

Notes

The authors would like to acknowledge the contributions of the co-principal investigators of the Three-City Study for repeated group discussions of the content of this report, which is a collaborative effort, as well as the contributions of the research associates who were most heavily involved in the discussions. They are Linda Burton, P. Lindsay Chase-Lansdale, Andrew Cherlin, Robert Moffitt, William Julius Wilson, Rebekah Levine Coley, and James Quane.


6. Possible explanations for low coverage despite eligibility include state agency or state government culture, changes or lack of changes in administration to accommodate individuals in need of coverage who are now employed full time, lack of knowledge or familiarity with policy changes in eligibility, and new coverage options.

7. Ninety-two percent of the block groups we selected for our sample had poverty rates of 20 percent or more.

8. That is to say, of all the eligible child-caregiver pairs that were identified, we were able to complete interviews with 74 percent of them.

9. All statistics in this report use weights that adjust the statistics to be representative of all children ages 0–4 and 10–14 and their caregivers, in the areas of the cities from which we drew our sample.

State Medicaid Policies

Massachusetts: Medicaid eligibility standards in Massachusetts are very generous. Under a federal 1115 waiver, the state has greatly expanded its coverage of the poor through MassHealth. This program covers pregnant women and infants under 1 year old in families with incomes below 200 percent of the federal poverty level (FPL), and all children up to 19 in families with incomes below 150 percent of the FPL. The state’s Children’s Health Insurance Program (CHIP) is part of MassHealth and was approved in 1998, with a retroactive start date of July 1997. Massachusetts also provides health care coverage to the poor and unemployed through several other state-funded insurance programs, including an uncompensated care pool that provides coverage for hospital care. Consequently, Massachusetts is one of the states with the highest rates of health insurance coverage and most extensive health safety net for the poor.

Illinois: Prior to 1998 Illinois did not extend Medicaid eligibility beyond the federal requirement (133 percent of the FPL up to age 6 and 100 percent of the FPL up to age 16), except for older teenagers in households with incomes below 50 percent of the FPL. The state’s CHIP program, KidCare, began in 1998 and expanded the number of eligible children in families with incomes below 133 percent of poverty. Currently, all children under 19 years of age in these families are covered. Infants under 1 year old are covered in families up to 200 percent of the FPL. Illinois has a medically needy program to assist low-income families who incur large medical expenses.

Texas: Medicaid eligibility in Texas is more restrictive, and the state is one of the leaders in the nation in the percentage of uninsured individuals. The state does not extend Medicaid eligibility to children beyond what is required by federal law. Texas does, however, provide presumptive Medicaid coverage for pregnant women and infants up to 185 percent of poverty. Its CHIP program, which was approved in 1999 and is being implemented this year, covers children up to age 19. The program was not in place during the time of our survey. Texas formally covers the medically needy, but the income and asset limits are low. The state does not have a state-financed health coverage program for families that do not qualify for Medicaid. Rather, it relies on public hospitals run by the counties to provide indigent care. In 1997 the Texas Healthy Kids Corporation, a public/private partnership, began providing health insurance to nearly 1.3 million uninsured children ages 2 through 18. Although this program requires that a family pay a monthly premium for each child covered, it also offers assistance through private funding in paying the premium to families with low incomes. During the 2001 legislative session Texas passed legislation to simplify the application procedure for Medicaid.
Welfare, Children, and Families: A Three-City Study is an ongoing research project in Boston, Chicago, and San Antonio to monitor the consequences of welfare reform for the well-being of children and families. The study comprises three interrelated components: (1) a longitudinal in-person survey of approximately 2,400 families with children 0–4 years of age and 10–14 years of age in low-income neighborhoods, about 40 percent of whom were receiving cash welfare payments when they were first interviewed in 1999. Seventy-seven percent of the families have incomes below the poverty line. Seventy-three percent are headed by single mothers, and 23 percent are headed by two parents. They should be thought of as a random sample in each city of poor and near-poor families with children 0–4 years of age and 10–14 years of age who live in low-income neighborhoods. In Boston and Chicago we sampled approximately equal numbers of African-American, Hispanic, and non-Hispanic white children in poor neighborhoods. Because of the fact that San Antonio does not contain poor neighborhoods that are predominantly non-Hispanic white, we did not sample this group in that city. Our San Antonio sample, therefore, consists entirely of African-Americans and Hispanics. As part of the survey, extensive baseline information was obtained on one child per household and his or her caregiver (usually the mother). The caregivers and children will be reinterviewed periodically. (2) an embedded developmental study of a subset of about 630 children 2–14 years of age in 1999 and their caregivers, consisting of videotaped assessments of children’s behaviors and caregiver-child interactions, observations of child-care settings, and interviews with fathers. (3) an ethnographic study of about 215 families residing in the same neighborhoods as the survey families who will be followed for 12 to 18 months, and periodically thereafter, using in-depth interviewing and participant observation. Unlike the survey, the San Antonio ethnography included non-Hispanic white families. About 45 of the families in the ethnography include a child with a physical or mental disability. A detailed description of the research design can be found in Welfare, Children, and Families: A Three-City Study. Overview and Design Report, available at www.jhu.edu/~welfare or in hard copy upon request.

The principal investigators are Ronald Angel, University of Texas; Linda Burton, Pennsylvania State University; P. Lindsay Chase-Lansdale, Northwestern University; Andrew Cherlin, Johns Hopkins University; Robert Moffitt, Johns Hopkins University; and William Julius Wilson, Harvard University.