State Welfare Reform Policies and Declines in Health Insurance

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A B S T R A C T

Objectives. This study sought to determine whether there is a relationship between state policies on Temporary Assistance to Needy Families (TANF), declines in both TANF and Medicaid caseloads, and the rise in the number of uninsured.

Methods. Extant data sources of state TANF policies, TANF and Medicaid participation, and uninsurance rates were analyzed, with the state as the unit of analysis. The independent variables included state TANF policies that directly address receipt of benefits or relate to health; dependent variables included changes in state TANF enrollment, Medicaid enrollment, and health insurance status since the enactment of the law.

Results. In the bivariate analysis, declines in Medicaid were associated with sanction for work noncompliance, lack of a child care guarantee, and strategies to deter TANF enrollment; this last factor was also associated with increased uninsurance. In the multivariate analysis, lack of a child care guarantee and deterrent strategies predicted TANF declines; deterrent strategies predicted Medicaid decline and uninsurance increases.

Conclusions. This analysis suggests that policies deterring TANF enrollment may contribute to declines in Medicaid and increased uninsurance. To maintain health insurance for the poor, policymakers should consider revising policies that deter TANF enrollment. (*Am J Public Health.* 2000;90: 900–908)

Since the passage of the Personal Responsibility Work Opportunity and Reconciliation Act (PRWORA) of 1996, welfare caseloads have declined by 44% nationally.[1] While federal officials have touted this decline as evidence of success,[2] others have pointed with concern to a concurrent decline in Medicaid enrollment and a rise in the number of uninsured people.[3–6] Indeed, they have wondered whether there is a causal relationship between the decline in Temporary Assistance to Needy Families (TANF) enrollment—the cash assistance program that replaced Aid to Families with Dependent Children (AFDC)—and the reduction in health insurance coverage for poor women and children.

The PRWORA mandated work requirements and lifetime limits on income assistance for poor families with children, administratively separated Medicaid from TANF, and "devolved" considerable autonomy to the states to shape their own policies and programs.[7] While the states were constrained by the broad parameters of the federal legislation (ceilings such as 5-year lifetime limits and work requirements after 2 years), they were free to further restrict benefits and to impose behavioral requirements on recipients through reductions or termination of benefits. Consequently, there are now more than 50 state and county versions of welfare reform,[8] providing an opportunity to study the consequences of the varied policy choices.

Because of the long-standing recognition that lack of health insurance (uninsurance) is a serious national problem, the PRWORA explicitly severed the 30-year link between income assistance and Medicaid. Moreover, since the intention behind decoupling Medicaid from TANF was to maintain Medicaid insurance, provision of transitional Medicaid was built into the federal legislation.[7] Nonetheless, Medicaid enrollment of this population has declined. It is important to learn whether this decline is an inadvertent consequence of TANF design at the local level. We explore this question by conceptually grouping together types of policies to assess whether any patterns emerge regarding state choice of TANF policies and rates of change in health insurance as well as TANF enrollment.

Methods

We used extant data sources for this analysis of state welfare policies and insurance rates, with the state (n=50) as the unit of analysis. The independent variables include state TANF policies that directly address the receipt of benefits and relate to health and for which data are available. These 13 TANF policy variables fall into 4 general categories (Table 1).

Two of the categories of independent variables include policies that make it more difficult either to enroll in TANF or to continue receiving it; it seems plausible that these requirements might affect access to or maintenance of other benefits as well. We call the first category "deterrent"; it comprises policies that deter enrollment by mandating activities that must be performed before an application can be processed. The second category, which we call "restrictive," includes those policies that impose short time limits and maximal penalties on clients for noncompliance.

A third category includes a subset of "family life obligations," which delineate

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TABLE 1—State Policies for Temporary Assistance to Needy Families (TANF)

Policy	Definition	No. of States[a]
Deterrent		
Lump-sum payment	State offers a 1-time cash payment to potential applicants in order to delay application for TANF	20 (AR, CA, CO, FL, IA, ID, KY, MD, ME, MN, MT, NC, OH, SD, TX, UT, VA, WA, WI, WV)
Alternative resources	Potential applicants must seek assistance from alternative resources (e.g., friends, family, charities) before they can apply for TANF.	7 (FL, ID, MD, MT, NY, TX, WI)
Mandatory job search	Potential applicants have to apply for a specified number of jobs prior to being able to apply for TANF.	16 (AL, AR, AZ, GA, ID, IN, KS, MD, MO, NV, NY, OH, OK, OR, SC, WI)
Restrictive		
Time limit reached	State time limit on receipt of benefits has been reached (i.e., as of October 1998).	9 (CT, FL, IN, MA, NE, OR, SC, TN, TX)
Work requirement	Recipients must engage in work as a condition of continued cash assistance ("workfare") prior to the federal cutpoint of 2 years.	28 (AL, AR, AZ, CA, CT, FL, GA, IA, ID, LA, MA, MI, MN, MT, NC, ND, NH, NM, OH, OK, OR, SD, TN, TX, UT, VA, WA, WI)
Initial work sanction	A full-family sanction (i.e., cutoff of the entire TANF benefit) is imposed for an initial noncompliance with work requirements.	15 (AR, FL, ID, KS, MD, MI, MS, NE, OH, OK, SC, TN, VA, WI, WY)
Medicaid sanction	State elected to apply a TANF sanction for work noncompliance to Medicaid receipt (i.e., cutoff of Medicaid).	12 (AL, ID, IN, KS, LA, MI, MS, MT, NM, NV, OH, SC)
Family life obligations		
Immunization/pediatric health	TANF recipients' children must be vaccinated and/or comply with other pediatric health requirements.	27 (AL, AR, AZ, CA, CO, DE, FL, ID, IN, KY, LA, MA, MD, MI, MO, MS, MT, NC, NM, NV, OK, PA, TN, TX, UT, VA, WV)
Family planning	TANF recipients must attend family planning counseling and/or educational activities.	13 (DE, GA, IA, IN, MS, ND, NE, OK, SD, TN, TX, WI, WV)
Child support cooperation	TANF receipt is conditioned on recipients' cooperation with child support collection efforts.	36 (AK, AR, AZ, CA, CO, DE, FL, ID, KS, KY, LA, MA, MD, ME, MI, MO, MS, MT, NC, ND, NE, NH, NM, OH, OK, OR, PA, RI, TN, TX, UT, VA, WA, WI, WV, WY)
Family cap	TANF grant amount remains the same even after a recipient gives birth to a new child.	23 (AR, AZ, CA, CT, DE, FL, GA, ID, IL, IN, MA, MD, MS, NC, ND, NE, NJ, OK, SC, TN, VA, WI, WY)
Supportive		
Child care	State guarantees child care for *current* TANF recipients.	37 (AK, AL, AR, AZ, CA, CO, DE, GA, HI, IA, IL, IN, KS, KY, LA, MA, MD, ME, MI, MO, MT, ND, NE, NH, NJ, NV, NY, OH, OK, OR, RI, SC, TN, UT, VA, VT, WI)
Family violence option	State has adopted the Family Violence Option (FVO).	29 (AK, AL, AZ, CA, CO, DE, FL, GA, IA, KY, LA, MA, MD, MI, MN, MO, NC, ND, NE, NH, NJ, NV, NY, PA, RI, TX, WA, WV, WY)

[a]State postal codes are given in parentheses.
Note. States with positive responses are coded 1 in the analysis; negative responses are coded 0.

parental and childbearing behavioral requirements. Of these, we have selected the ones that bear most directly on health and reproductive decision making. A TANF recipient would need Medicaid (or some form of health insurance) in order to comply with these mandated health behaviors. Have states with these policies maintained higher levels of health insurance for TANF recipients than the nation as a whole? Or do TANF recipients find themselves in a quandary, where lack of insurance precludes their compliance with TANF requirements (e.g., inability to obtain family planning services or to bring child vaccinations up to date)?

We call the fourth cluster of policies "supportive." These are measures intended to redress anticipated problems that might prevent women from complying with TANF requirements, such as domestic violence or lack of child care. Do such measures effectively serve to maintain TANF enrollment, and does this maintenance extend to Medicaid as well?

Finally, this analysis uses the unemployment rate in 1996 as a control variable in an effort to adjust for crude differences in state economies at the time that states chose these policy options.[9]

The dependent variables include percentage change in state TANF enrollment, Medicaid enrollment for TANF recipients (adults and children) and for all adults, and health insurance status (for total population and for children younger than 18 years) since enactment of the PRWORA (Table 2). (Generally, adult enrollees in Medicaid are aged 18 to 64 years; however, some states report enrollees aged 15 to 20 years as a mix of adults and children, and some states report all people younger than 21 years as children.) Percentage change in TANF is reported for individuals (not families or households) between August 1996 and June 1998, by state.[10] The unit of measurement for Medicaid is percentage change in enrollment between 1995 and 1997, by state. The unit of measurement for health insurance coverage data is the change in state uninsurance rates between 1996 and 1998.

The state policy data were obtained from national surveys conducted by the National

TABLE 2—Percentage Change in Enrollment in Temporary Assistance to Needy Families (TANF) (1996–1998) and Medicaid (1995–1997) and Increase in Uninsurance (1996–1998) in the United States, by State

State	% Change in TANF (Recipients)	% Change in Medicaid (TANF)	% Change in Medicaid (Adults)	% Change in Uninsured (Total Population)	% Change in Uninsured (<18 y)
AK	–14	–2.6	–2.1	–3.8	–2.1
AL	–46	–11.9	–4.5	–4.1	–5.1
AR	–43	–11.0	–0.6	3	1.7
AZ	–41	–14.1	3.8	–0.1	–1.3
CA	–22	–15.5	–9.3	–2	–2.6
CO	–43	–14.2	–11.4	1.5	5.9
CT	–32	–5.9	–1.2	–1.6	1.5
DC	–20	–4.4	–3.1	–2.2	–3.3
DE	–27	–11.5	28.8	–1.3	–4.7
FL	–52	–10.8	–0.1	1.4	0.4
GA	–45	–21.7	–6.5	0.3	–3.9
HI	14	4.1	–1.7	–1.4	–4.2
IA	–24	–10.1	0.5	2.3	0.7
ID	–81	–24.0	–12.6	–1.2	–4.4
IL	–25	–8.3	–1.3	–3.7	–4.8
IN	–18	–21.1	–2.4	–3.8	–5.6
KS	–48	–17.7	–9.4	1.1	3
KY	–31	–7.8	–6.7	1.3	3.4
LA	–45	–10.7	–5	1.9	4
MA	–27	–15.6	1.4	2.1	1.2
MD	–38	–15.0	–1.8	–5.2	–9.4
ME	–26	–4.8	–5.3	–0.6	2.5
MI	–33	–15.4	–9.6	–4.3	–3.4
MN	–14	–10.4	–5.8	0.9	–1.6
MO	–35	–14.7	–13	2.7	2.8
MS	–59	–5.2	–3.4	–1.5	–2.8
MT	–26	–9.4	–7.8	–6	–8.7
NC	–39	–2.7	–10.3	1	4
ND	–35	–16.2	–6.6	–4.4	–6.7
NE	–5	5.3	5.8	2.4	4.3
NH	–35	–20.9	–15.2	–1.8	0
NJ	–26	–13.1	–3.9	0.3	5.2
NM	–27	–11.5	–6.3	1.2	0.4
NV	–26	–22.5	–19.8	–5.6	–4.1
NY	–22	–7.6	–4.4	–0.3	1.3
OH	–38	–14.7	–7.8	1.1	1
OK	–38	–15.3	–2.2	–1.3	–1.9
OR	–41	–23.1	0.1	1	5.2
PA	–32	–15.5	–3.1	–1	–1.8
RI	–5	–6.4	–4.1	–0.1	–1.3
SC	–48	–27.7	11.9	1.7	5.9
SD	–38	–11.7	–6.6	–4.8	–6.6
TN	–42	–27.2	–2.2	2.2	8
TX	–44	–12.9	–9.1	–0.2	–0.9
UT	–28	–18.2	–9.6	–1.9	–0.4
VA	–36	–12.2	–5.1	–1.6	–2
VT	–19	–18.5	21.9	1.2	–0.3
WA	–23	–2.7	–1.8	1.2	1.8
WI	–71	–25.7	–11.1	–3.4	–3.5
WV	–58	–13.5	–21.6	–2.3	–1.7
WY	–74	–28.4	–6.2	–3.4	–5.9
US	–32	–12.9	–5.5	–0.7	–0.6

Governors' Association,[11] the Center for Law and Social Policy and the Center on Budget and Policy Priorities,[12,13] and the National Organization for Women Legal Defense and Education Fund.[14,15] Missing data were augmented by our study team via telephone calls to state TANF administrators. TANF information came from published reports from the Administration for Children and Families[10]; Medicaid data were extracted from estimates based on HCFA-2082 reports (the most recent year for which data were available is 1997)[16]; uninsurance data were derived from the Census Bureau Current Population Surveys.[17]

We assessed the bivariate relationship between each dichotomous independent and continuous dependent measure by using a *t* test. We employed linear regression analysis to identify the set of independent factors that contribute to the changes in TANF and Medicaid enrollment and to uninsurance. In these analyses, we regressed each dependent measure onto the set of independent predictors. The resulting regression coefficients in each model represent the unique contribution of each independent measure to the explanation of change in the respective outcome measures.

Results

Certain individual TANF policies were significantly associated with declines in

TABLE 3—Percentage Change in Temporary Assistance to Needy Families (TANF) (1996–1998) and Medicaid Enrollment (1995–1997) and Percentage Change in Population Without Health Insurance (1996–1998), by State TANF Policy

State-Elected Welfare Policy	% Change									
	TANF (Recipients)		Medicaid (TANF)		Medicaid (Adults)		Uninsured (Total Population)		Uninsured (<18 y)	
	Yes[a]	No[b]	Yes[a]	No[b]	Yes[a]	No[b]	Yes[a]	No[b]	Yes[a]	No[b]
Deterrent										
Lump-sum payment	–38.8	–31.5	–12.4	–13.7	–7.2	–2.0*	–0.8	–0.9	–1.0	–0.7
Alternative resources first	–47.7	–32.2*	–15.1	–12.9	–6.7	–3.6	–2.1	–0.6	–3.6	–0.3*
Mandatory job search	–42.4	–30.6*	–18.0	–11.0**	–5.0	–3.6	–0.9	–0.8	–1.1	–0.6
Restrictive										
Time limit reached	–34.3	–34.3	–15.4	–12.7	0.5	–5.0	0.6	–1.1†	2.2	–1.4*
Workfare requirement less than 2 y	–38.1	–29.8	–14.3	–11.8	–5.4	–2.5	–0.7	–1.0	–0.8	–0.8
Initial work sanction (full benefits)	–47.1	–29.0***	–16.3	–11.9†	–3.6	–4.2	–0.6	–0.9	–0.6	–0.9
Sanction applied to Medicaid	–41.3	–32.2	–16.0	–12.3	–6.4	–3.3	–1.6	–0.6	–1.7	–0.5
Family life obligations										
Immunization/pediatric health requirements	–38.4	–29.7	–14.1	–12.2	–5.3	–2.7	–0.9	–0.7	–1.1	–0.5
Family planning requirements	–38.8	–32.8	–14.4	–12.8	–2.8	–4.5	–1.2	–0.7	–1.9	–0.4
Child support cooperation required	–37.8	–25.9*	–13.4	–12.7	–5.0	–1.8	–0.6	–1.4	–0.4	–1.7
Family cap	–40.2	–29.5*	–14.9	–11.8	–1.5	–6.1*	–0.9	–0.8	–1.2	–0.5
Supportive										
Child care *not* guaranteed	–42.4	–31.3*	–13.9	–11.4	–6.5	–3.1*	–0.9	–0.8	–0.5	–1.5
Family violence option *not* adopted	–36.7	–32.7	–12.1	–14.7	–3.0	–4.8	–1.0	–0.8	–0.8	–0.8

[a]Mean percentage change in states that adopted the policy.
[b]Mean percentage change in states that did not adopt the policy.
*$P<.05$; **$P<.01$; ***$P<.001$; †$P=.053$.

TANF enrollment (Table 3). TANF enrollment dropped significantly in states that sanctioned the entire family's cash grant for initial noncompliance with work requirements, states with family caps (i.e., not increasing a grant when additional children are born), states that required cooperation with child support collection efforts, states that did not guarantee child care for TANF recipients, and states that required applicants to seek alternative resources and to document previous job search efforts before applying for TANF.

States that did not guarantee child care to current recipients and those that deterred enrollment by offering lump-sum cash payments to would-be applicants had significantly greater decreases in adult Medicaid enrollment. However, the presence of a family-cap policy was associated with a significantly smaller decline in Medicaid. Sanctioning the entire family's check for initial noncompliance with workfare ($P=.053$) and mandating a job search before one can apply for TANF were significantly associated with Medicaid declines for TANF recipients.

States with shorter lifetime limits fared better regarding uninsurance both for the total population and for children. Those states that required applicants to seek alternative resources prior to enrolling in TANF experienced an increase in uninsurance among children.

A few TANF policies persisted as predictive of TANF enrollment declines in the multiple regression analysis (Table 4); these factors were lack of guaranteed child care to TANF recipients and requiring a job search before one can apply for TANF. Several other factors (i.e., initial work sanction, Medicaid sanction, family cap, child support cooperation) were also associated with TANF declines and were of substantial magnitude, although they did not reach statistical significance. The overall model explained 55% of the variation in TANF change ($F_{14,36}=3.176$; $P<.01$). Although no variables predicted changes in Medicaid enrollment for the total adult population, mandatory job search was significantly associated with declines in Medicaid among TANF recipients ($P<.05$).

Two TANF policies were predictive of changes in uninsurance for the total population as well as for children. Shorter time limits predicted a decrease in uninsurance ($P<.05$, total population; $P<.001$, children), whereas requiring applicants to seek alternative resources was significantly predictive of a rise in uninsurance ($P<.05$, total population; $P<.01$, children). The overall model for change in uninsurance among children explained 44% of the variation ($F_{14,36}=1.987$; $P<.05$).

Discussion

Although a host of state welfare policy choices are individually associated with declines in TANF, 2 persist in predicting change in enrollment in the multivariate analysis. A guarantee of child care is uniquely associated with maintenance of TANF and Medicaid enrollment. On the other hand, mandating a job search prior to enrollment significantly predicts declines in both TANF and Medicaid. Further, the requirement that applicants first seek alternative resources both deterred enrollment in TANF in the bivariate analysis and emerged as predictive of increases in uninsurance for the total population and for children.

This latter group of findings is plausible on its face: policies that deter would-be appli-

TABLE 4—Unstandardized Regression Coefficients (b) for Change in Temporary Assistance to Needy Families (TANF) and Medicaid Enrollment and Population Without Health Insurance, by State TANF Policy Predictors

Predictor State TANF Policy	Understandardized Regression Coefficients (b)				
	TANF Change (Recipients)	Medicaid Change (TANF)	Medicaid Change (Adults)	Uninsurance Change (Total Population)	Uninsurance Change (<18 y)
Time limit reached	5.85	–1.04	3.32	2.56*	5.64***
Workfare	–2.85	–1.92	–1.62	.321	–.021
Initial work sanction	–5.92	–1.03	.934	1.01	1.50
Medicaid sanction	–6.00	–.881	–3.11	–1.38	–1.54
Family cap	–6.73	–.550	3.55	–.830	–1.79
Immunization	–.034	–1.25	–.251	–.201	–.653
Family planning	–3.53	–.074	–.167	–.687	–1.62
Child support cooperation	–9.57	–.601	–2.64	.689	1.47
Child care guarantee	15.08**	.364	3.72	.027	1.20
Family violence option	–1.27	.613	–2.31	.477	.412
Lump-sum payment	–1.32	2.12	–3.47	.780	1.48
Alternative resources	–3.47	–.081	.366	–2.71*	–4.90**
Mandatory job search	–12.69*	–5.71*	–3.67	.913	.737
Unemployment rate—1996	.630	.986	.329	.185	.471
F statistic (*df*)	3.176** (14,36)	1.019 (14,36)	1.078 (14,36)	1.072 (14,36)	1.987* (14,36)
R^2	0.553	0.284	0.295	0.294	0.436

*P<.05; **P<.01; ***P<.001.

cants from enrolling in 1 benefit program spill over to deter enrollment in another. Although the PRWORA resulted in different eligibility criteria for the 2 programs, in fact, 47 states have joint applications for TANF and Medicaid.[13] One example of such a spillover effect occurred in New York City. A successful federal class-action lawsuit (*Reynolds v Giuliani,* 43 F Supp 2d 492 [SD NY 1999]) was filed on behalf of needy individuals and families who were deterred from submitting applications for Medicaid and food stamps at the same time that they were told to seek alternative resources prior to enrolling in TANF.[18] Moreover, the drop in Medicaid and food stamp use was so dramatic in New York that the US Department of Agriculture and the Health Care Finance Administration (HCFA) also investigated and cited the city for noncompliance with federal requirements, as well as the state for failure to effectively monitor the city.[19–22]

Our one seemingly paradoxical finding is the association between shorter time limits and improved insurance status. However, because the shorter time limits were just beginning to take effect at the end of our data collection period (October 1998), a causal relationship is unlikely. It is possible that choice of the shorter time-limit policy is a proxy for some other factor (e.g., provision of transitional Medicaid). The relationship should be reassessed when enough time has elapsed for the policy to have had an impact. This same limitation requires postponing evaluation of other time-sensitive policies, including workfare required in less than 24 months, and providing those who leave TANF with Medicaid and child care beyond the transitional period defined by the federal legislation.

The proportion of the population without health insurance has long been considered a national problem.[23–27] Persistent disparities in health between racial and income groups are thought to derive, in part, from disparate access to health care, secondary to ability to pay.[28–30] The framers of the 1996 welfare reform legislation acknowledged that even welfare reform "successes"—those women leaving TANF for employment—were not likely to find jobs that provide health insurance. They based this assumption on evidence from the preceding AFDC era that demonstrated that most former recipients who obtained subsequent employment found jobs that paid minimum wage and did not offer benefits such as paid vacation, leave time, or health insurance.[31] A recent analysis of welfare recipi-

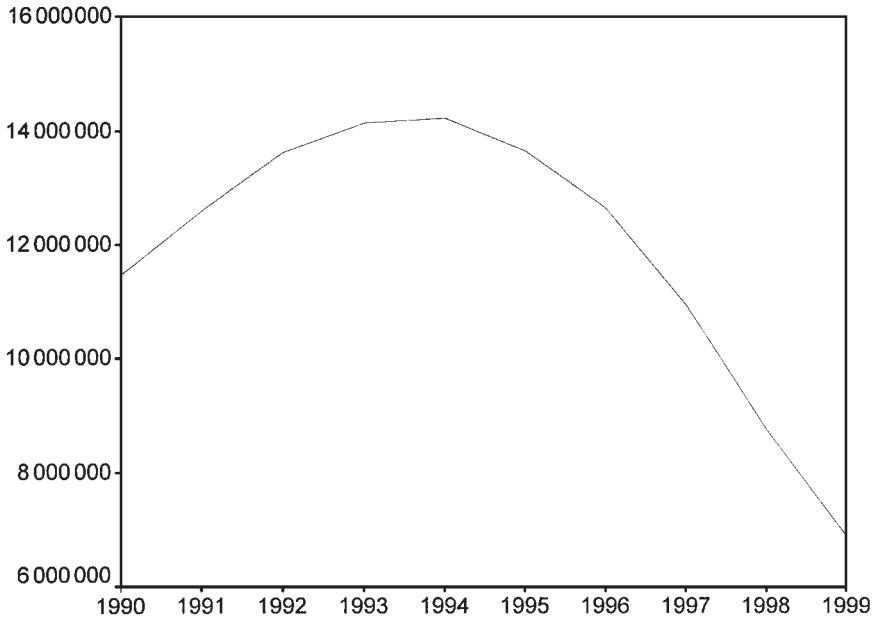

FIGURE 1—AFDC/TANF enrollment (individuals), 1990–1999.

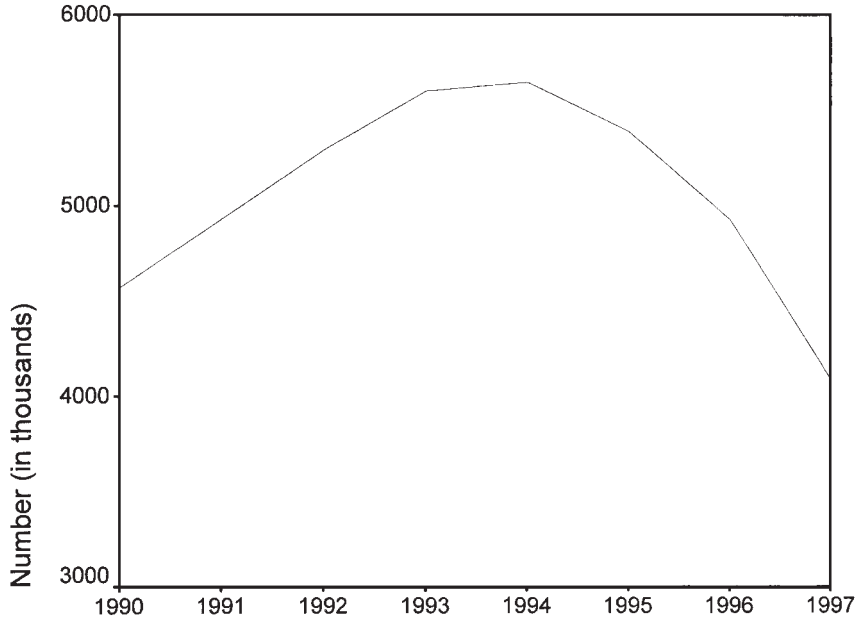

FIGURE 2—Medicaid enrollment (AFDC/TANF recipients), 1990–1997.

ents who left AFDC just prior to implementation of welfare reform demonstrated that slightly more than half found employment, but only a third of these received job-related health insurance.[32] A year after leaving AFDC, roughly half of these women and one third of children were uninsured. Moreover, in general, a decreasing proportion of private-sector employees obtain health insurance as a work-related benefit.[26,33]

Critics of the PRWORA anticipated worsened poverty and loss of health insurance to the children born to women reliant on cash assistance who would soon lose their benefits.[34,35] The State Children' s Health Insurance Program (SCHIP) was established in 1997 to provide health insurance coverage for poor and near-poor children, regardless of their parents' insurance status.[36] Enrollment in SCHIP has been disappointing. Although the HCFA recently announced the enrollment of 2 million children in fiscal year 1999, there are an estimated 11 million uninsured children.[37] Thus far, SCHIP has not offset the declines in the number of children covered by Medicaid or the increase in uninsurance among children.[36]

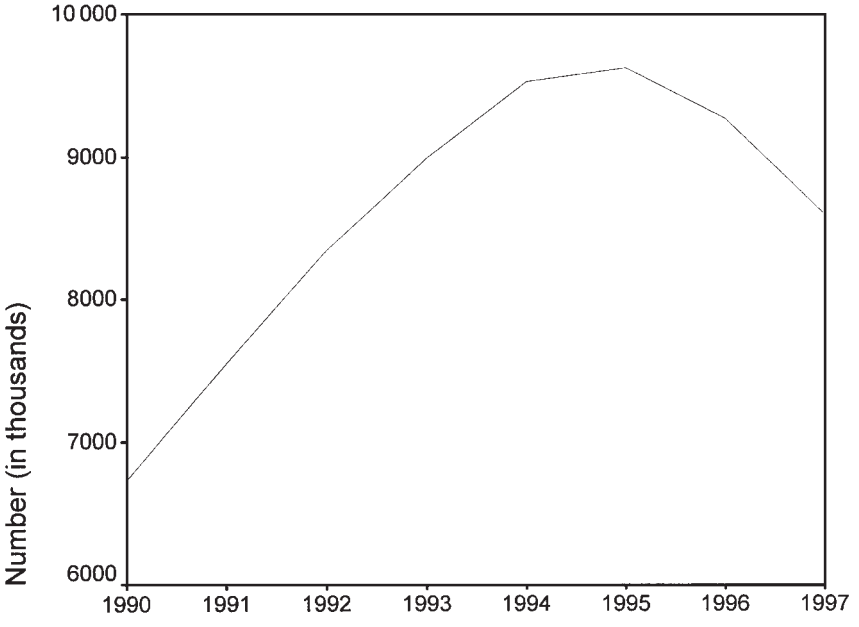

FIGURE 3—Medicaid enrollment (adults), 1990–1997.

Further support for a possible relationship between passage of the PRWORA and a rise in uninsurance derives from trend data for the programs evaluated (Figures 1–5).[10,16–17] AFDC enrollment had already started to decline prior to passage of the law, as almost all states had been granted Section 1115 waivers in the preceding decade to experiment with welfare program components.[38] The slope of the decline, however, changed precipitously after 1996. This connection is not disputed, and many point to it as proof of the program's success.[2] The Medicaid trend data, however, raise more troubling issues. Beginning in the late 1980s, a series of bills to expand Medicaid eligibility criteria for maternity care had been passed at the federal and state levels.[39,40] There had therefore been an upward trend in Medicaid enrollment for pregnant women. Although the rate of decline since 1996 is not nearly as dramatic as that of TANF, it is noteworthy, especially because it has reversed a prior increasing trend. Uninsurance rates for children and the total population had been increasing from 1990 to 1996, with some periods of leveling off; however, a consistent upward trend has continued from around 1996.

This analysis points to areas meriting in-depth research; it should be considered preliminary, as there are several limitations. The time periods reflected in the dependent-variable data (i.e., TANF, Medicaid, uninsurance) are not exactly the same; we were restricted to using data for the time period since the passage of welfare reform to the extent that they were available. Estimates of the uninsured vary depending on the data set used (e.g., CPS, SIPP, NHIS) and may be considered unstable from one year to the next.[41] The policy data are dichotomous (i.e., they simply state whether or not a state adopted the policy) and do not provide a qualitative understanding of how, or to what extent, a policy was implemented programmatically. In fact, recent surveys conducted of state agency administrators (CPS, Maternal and Child Health) have revealed the complicated nature of policy implementation and varying levels of knowledge about TANF.[42]

The state unemployment rate for 1996 is included as a control variable.[43] Other analy-

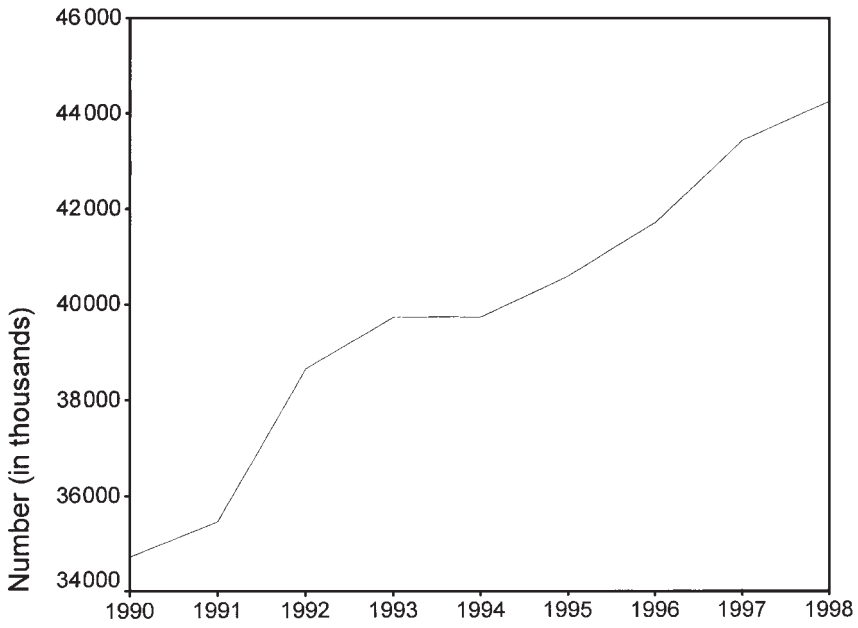

FIGURE 4—Uninsured adults, 1990–1998 (in 1000s).

ses have included other control variables when examining factors influencing Medicaid enrollment and insurance coverage, including employer-based coverage, wages, industry type, percentage of the population in poverty, and state Medicaid eligibility policy. We did not incorporate some of these economic variables, because classification of some measures is less clear-cut (e.g., industry type), and additional data collection would have been required.

Conclusion

Others have reported the chronological relationship between welfare reform, declines in Medicaid, and increases in uninsurance.[4,44,45] What this analysis adds to those observations is an indication that policies deterring TANF enrollment may contribute to these changes. In fact, more than half of the 9 states implementing at least 2 deterrent policies (Arkansas, Florida, Idaho, New York, and Texas)[46] had already been in the top third of states with the highest uninsurance rates in 1996.

The problem may also derive from the philosophic shift regarding governmental support for the poor, and particularly for poor women and children, that underlies the PRWORA. Enrollment in other government benefit programs, such as food assistance, has also declined during this same time period,[20,44,47] even as requests for emergency food assistance across the country have increased sharply.[48,49] Governmentally subsidized child care was the only program that received additional funds, in order to enable women receiving TANF to comply with workfare requirements, and transitional child care was extended to women losing TANF, so that they might work.[50] However, despite widespread recognition of lack of child care, there has been poor uptake of this benefit.[51] We speculate that the message communicated to the poor is the undifferentiated one that, in general, benefit programs are no longer available, although, of course, many factors are at work in such complex social phenomena.

The handful of methodologically acceptable studies of women leaving TANF ("leaver" studies) indicate that although many are indeed finding employment, job retention and persistent poverty appear to be significant problems.[52–54] The data on Medicaid and uninsurance indicate that many of these women are certainly not obtaining jobs that provide health insurance. Efforts intended to ameliorate this situation, such as the establishment of SCHIP and provision of transitional Medicaid, thus far have not succeeded in reversing the rise in uninsurance among poor families with children.

The medical and public health communities need to be aware of these trends and to anticipate the health consequences at the individual and community levels. The importance of this development is reflected in the fact that uninsurance among children has already emerged as a theme of the forthcoming presidential elections.

The PRWORA expires in 2002. There is thus an opportunity in the next year to apply the lessons from the initial experience with welfare reform to reshape the next phase. Although further in-depth research is clearly needed to tease out the multifaceted relationships among state welfare policies, enrollment in Medicaid, and trends in uninsurance,

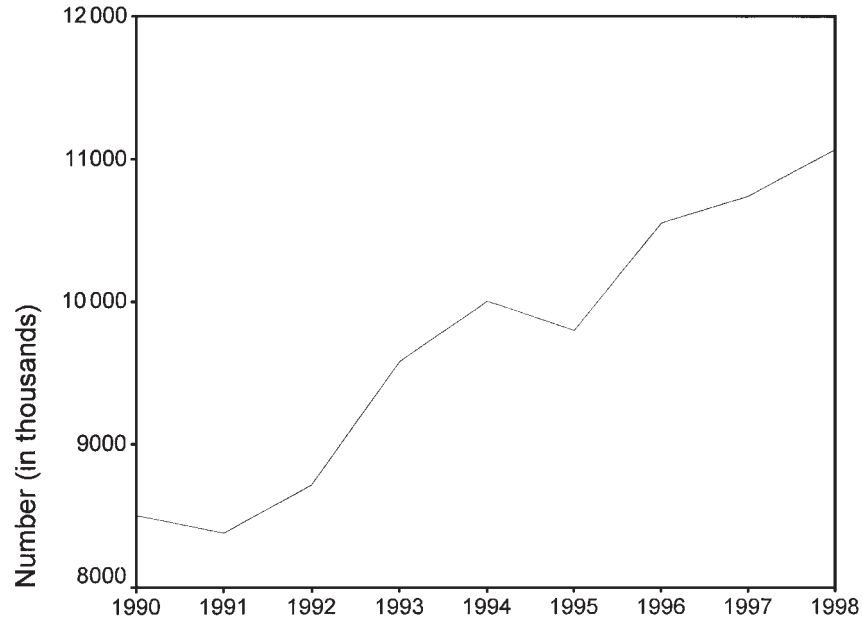

FIGURE 5—Uninsured children (<18 y), 1990–1998.

the short time remaining before legislative reauthorization does not permit definitive answers to these questions. Thus, we should pay attention to these preliminary indications that some policies deterring TANF enrollment may have contributed to the nation's ongoing serious problem of uninsurance. The importance of health insurance coverage warrants action to prevent further declines. □

Contributors

All 3 authors contributed to the conception and design of the study and to the writing and revision of the paper.

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