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The impact of welfare reform on the health insurance coverage, utilization and health of low education single mothers

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ABSTRACT

The Personal Responsibility Work Opportunity and Reconciliation Act (PRWORA) of 1996 imposed time limits on the receipt of welfare cash benefits and mandated cash benefit sanctions for failure to meet work requirements. Many studies examining the health implications of PRWORA have found associated declines in health insurance coverage and healthcare utilization among single mothers but no impact of PRWORA on health outcomes. A limitation of this literature is that most studies cover a time period before time limits were implemented in all states and also before individuals began actually timing out. This work builds on previous studies by exploring this research question using data from the Survey of Income and Program Participation that covers a time period after all states have implemented time limits (1991–2009). We use a difference-in-differences study design that exploits variability in eligibility for cash welfare benefits by marital status and state-level variation in timing of PRWORA implementation to identify the effect of PRWORA. Using ordinary least square regression models, controlling for state-level and federal policies, individual-level demographics and state and year fixed-effects, we find that PRWORA leads to 7 and 5 percentage point increases in self-reported poor health and self-reported disability among white single mothers without a diploma, respectively.

1. Introduction

In 1935 Aid to Families with Dependent Children (AFDC), better known as welfare, was established to provide financial assistance to single mothers of minor children. AFDC enrollment guaranteed a set income for families each month as long as their earnings remained under the eligibility threshold. Starting in the 1960s, AFDC-eligible families were also jointly enrolled in Medicaid. The cost of AFDC was shared between the federal government and the states, with the federal government providing matching funds to each state. States were prohibited from instituting AFDC eligibility criteria that were more stringent than the criteria imposed by the federal government (Patterson and Patterson, 2000).

In 1996 the Personal Responsibility Work Opportunity and Reconciliation Act (PRWORA), also known as welfare reform, replaced AFDC with Temporary Assistance for Needy Families (TANF). TANF differed from AFDC in several ways, including the imposition of work requirements to receive benefits, mandatory benefit sanctions for failure to meet work requirements and a time-limit for benefit receipt. The federal government gave the states authority to set benefit eligibility criteria more stringent than the federally mandated criteria. The funding streams for AFDC and TANF also differed. Rather than providing states with matching funds, the federal government provided states with a block grant or set amount of money that was frozen at 1996 funding levels. The administrative relationship between welfare and Medicaid was also severed; however, Medicaid eligibility criteria was expanded to include families not receiving welfare that otherwise met financial criteria for welfare receipt (Schott, 2012).

In the period immediately after implementation of welfare reform, welfare caseloads declined and employment increased

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among single mothers with low levels of education (Falk, 2013). A trend of declining welfare caseloads that began in the mid 1990s continued after implementation of welfare reform. Between 1994 and 2008, the size of the welfare caseload declined from 5.1 million to 1.7 million. The share of single mothers with low education working rose from 49% in 1995 to 64% in 1999. Average incomes for single mothers increased over the 1990s, although average incomes declined for the lowest earning fifth of single mothers (Jeffrey Grogger et al., 2002). Starting in the early 2000s, employment gains began to reverse among single mothers with low levels of education. In 2003 the proportion of single mothers with low education working declined to 60%. As of 2009, this figure had dropped to 54% (Jeffrey Grogger et al., 2002). The proportion of single mothers neither working nor receiving government cash benefits also increased from 13% to 20% between 1996 and 2008 (Pavetti and Schott, 2011). Additionally, a smaller proportion of income eligible families have obtained welfare benefits. In 1995 the welfare program assisted 75% of families with children living in poverty; as of 2009 that figure had dropped to 28% (Pavetti and Schott, 2011).

Women's health advocates have voiced concern about the potential implications of welfare reform for the health of women. There are several mechanisms by which this policy may have impacted the health of this population. The most often stated mechanisms include loss of health insurance coverage, loss of income and increased psychological stress. Loss of health insurance may result if an individual gets kicked off of welfare or leaves welfare for employment in a firm that does not provide health insurance and fails to complete the administrative process for securing Medicaid coverage. Lack of health insurance coverage has been repeatedly linked to lack of a usual source of care, less receipt of preventive care and delaying of needed medical care (Lavarreda and Cabezas, 2011). Conversely, broadening Medicaid eligibility to encompass individuals who are financially eligible for welfare but not receiving it could have the effect of increasing health insurance coverage and access to health care in low-income mothers (Shore-Sheppard and Ham, 2003). Another potential mechanism by which welfare reform may have impacted health is through reductions in household income; these could result from sanctions or loss of cash benefits, as a consequence of exceeding time limits. A socioeconomic-driven morbidity and mortality gradient has been demonstrated across conditions that are amenable to medical intervention as well as those that are not (Mackenbach et al., 1989). Welfare reform may also increase stress for low-income women. Loss of income or income volatility may result in economic hardship, increasing stress levels. One study of welfare recipients found that sanctioned individuals had increased odds of having a utility shut off within the last year and had increased odds of expecting to experience inadequate housing, food or medical care within the next two months, compared to their non-sanctioned counterparts (Ariel Kalil, 2002). Welfare reform may also have adverse impacts on health as a consequence of increasing employment in this group. Although prior research has shown positive health impacts of employment in married mothers, such may not be the case with this cohort. The impact of employment on health may be moderated by job type and most of these women are relegated to working at low wage, low autonomy and repetitive jobs, the type of jobs that are associated with increased stress levels (Lennon, 1994). These jobs are also less likely to provide sick leave or predictable schedules which may limit the ability to engage in health-promoting behaviors, such as making a doctor's appointment (Brodkin and Marston, 2013).

The majority of studies investigating the health implications of welfare reform have focused on the link between welfare reform and potential mediators of health, such as health insurance coverage and health care utilization. Regarding the impact of welfare reform on health insurance coverage, some studies have found negative impacts, others have found positive impacts and some have found no impact at all (Bitler et al., 2004; DeLeire et al., 2006; Handler et al., 2006). With respect to health care utilization, associated declines in health care utilization have been observed along with increased reports of needing care but finding it unaffordable, in the broader target population (Bitler and Hoynes, 2006; Danziger et al., 2000).

The body of research on the direct health impacts of welfare reform is more limited in volume than the research on the health insurance and health care utilization impacts and it has some challenges with respect to external validity. Some studies have focused on single states or left out states with a large proportion of the affected population, as a consequence of data limitations (Bitler et al., 2004; Kaestner, 2004). Nonetheless, some studies have found positive associations between welfare reform and mortality, while others have found no health impacts of welfare reform at all. An issue for the vast majority of the studies on this topic or any of the previous topics discussed is that they cover a relatively short period of time after welfare reform implementation, during which a key piece of welfare reform, time limits, was not fully implemented (Bitler et al., 2004; Kaestner, 2004).

This study builds on the previous research on the health insurance, health care utilization and health impacts of welfare reform by employing a methodologically rigorous study design and using a nationally representative data set that includes time periods before and after all states have implemented time limits, to address three primary research questions: (1) what impact did welfare reform have on the health insurance coverage?, (2) what impact did welfare reform have on the annual medical provider contact? and (3) what impact did welfare reform have on the health outcomes? We also explored whether the impact of welfare reform, on the outcomes specified above, differed by race/ethnicity.

2. Literature review

Studies using robust methods have explored the relationship between welfare reform, health insurance coverage and in some cases health care utilization, among single mothers; however, the bulk of these studies only covered time periods extending into the early 2000s. These studies used similar quasi-experimental designs, with slight variations in the treatment population, control groups, measures of welfare reform and covariates. Kaestner and Kaushal used data from the March Current Population Survey (1993–2000) and a Difference-In-Differences (DID) study design (Kaestner and Kaushal, 2003). The treatment group was single mothers with 12 years or less education. The two comparison groups were single women without children and married women with children, with 12 years of education or less. They used the post-reform change in welfare caseload size as a proxy for welfare reform implementation. Controlling for individual-level demographic factors, family composition, size of welfare population, Medicaid eligibility criteria and state-level economic indicators, as well as state and year fixed-effects, they found that welfare reform was associated with a 3–4 percentage point reduction in Medicaid coverage and a 0.5 to 2.3 percentage point increase in not having any health insurance, depending on the comparison group used.

Bitler et al. (2004) used data from the Behavior Risk Factor Surveillance Survey (BRFSS) (1991–2000) and used both DID and Difference-in-Difference-in-Differences (DDD) study designs (Bitler et al., 2004). They conducted analyses using several different treatment groups including single women living with children, with 12 or fewer years of education, black single women living with children, all single women with 12 or fewer years of education, all black single women and all Hispanic single women. The