WOMEN'S ISSUE BRIEF
AN UPDATE ON WOMEN'S HEALTH POLICY
THE HENRY J. KAISER FAMILY FOUNDATION

WELFARE, WOMEN, AND HEALTH: The Role of Temporary Assistance for Needy Families

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Many factors affect the health of women and their families, including income, social supports, health insurance, and access to health care. Although it has been long been known that poverty is associated with poor health, the relationship of the nation's welfare program, Temporary Assistance for Needy Families (TANF), to poor women's health is only beginning to be understood. TANF's influence on the health and well-being of poor women is driven by multiple aspects of the program, including access to health insurance, work requirements and training options, links to health care services, and reproductive health provisions. The different avenues through which TANF intersects with health provide multiple opportunities for improving women's health.

Passed by the U.S. Congress in 1996, the TANF program now faces federal reauthorization. After five years of experience with this program, individual states and the nation as a whole have the opportunity to learn from the program's experience with the health of women and their families. These lessons can be useful to state and federal policy makers as they consider future directions for the program, yet grapple with severe economic downturn and difficult choices in spending priorities and resource allocations.

This issue brief highlights what is known about both direct and indirect effects of TANF on women's health—and outlines opportunities for TANF reauthorization to improve and strengthen the program's ability to effectively address the health needs of poor women.

WHAT IS TANF?

TANF replaced the Aid to Families with Dependent Children (AFDC) welfare program in 1996 with a $16.5 billion annual federal block grant in which the federal government sets broad policy requirements and states determine, within those rules, their own policies for providing cash grants to eligible poor families. TANF's reach is broad: the program serves 1.4 million women (90 percent of the adult caseload) and 4.4 million children.

A key feature of federal TANF policy that distinguishes the current welfare program from its predecessor is that benefits for adults and their families are limited to 60 months over a recipient's lifetime. In addition, while the program provides recipients with cash grants, it focuses on employment, emphasizing the importance of work in supporting families.

TANF can influence women's health directly because the funds can be used to provide health services or links to health services. For example, TANF funds may be spent on family planning services and other pregnancy prevention programs. Since TANF funded programs are not necessarily limited to grant recipients, these services may be available to families that receive cash grants as well as those who have not. TANF can also readily link families with Medicaid and Transitional Medicaid Assistance services (TMA)—although loss of Medicaid has been a common experience for many families who have left TANF. In addition, state policies determine how victims of domestic violence will be addressed, whether new babies born to welfare recipients will be included in the calculation of the family's cash grant, and how requirements such as childhood immunization or substance abuse treatment are addressed. Finally, TANF's focus on family formation issues—particularly reducing non-marital childbearing—have implications for women's health and well-being.

Although TANF is an income support and work-focused program, it can also influence women's health in a variety of other indirect ways. For example, the level of the cash grant itself can determine how much material hardship the family experiences. Similarly, the extent of a state's work requirements can affect a family's ability to manage their health problems and ultimately have an impact on health outcomes. Sanctions for

failure to meet program rules, such as reductions in the grant amount, often fall disproportionately on families with health problems who may have trouble meeting requirements and can create greater hardship.[1]

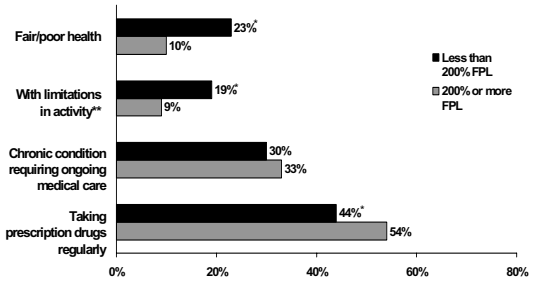
HOW DO POVERTY, WELFARE, & WOMEN'S HEALTH CONNECT?

TANF is a program for the very poor. It serves a disproportionate share of women with health problems and women with children who are chronically ill or disabled. While a health problem may have contributed to a woman's need for welfare in the first place, once a woman enters the TANF program she is soon expected to be engaged in work activities to receive cash assistance. Addressing health problems that serve as barriers to work can improve a participant's success in gaining and maintaining employment. This issue is often compounded by the fact that some TANF mothers face an employability barrier driven by the need to care for their sick or disabled children, and some mothers with ill children also face barriers to work because they are in poor health themselves.

Poor women have poorer health. Compared to higher income women, more than twice as many women under 200 percent of poverty reported experiencing "fair" or "poor" health in 2001, and more than twice as many reported health limitations that reduced participation in school, work, housework, or other activities in the past year (Figure 1).

Figure 1

Differences in Health Status, by Poverty Level, Women Ages 18 to 64, 2001



*Significantly different at p<.05 from reference group (200% or more FPL). The federal poverty level (FPL) was $14,255 for a family of three in 2001.

**Limitations in activity are due to a disability, handicap, or chronic disease that keeps respondents from participating fully in school, work, housework, or other activities.

Source: Henry J. Kaiser Family Foundation, *Kaiser Women's Health Survey*, 2001.

Poor women who receive or leave welfare have greater rates of health problems than other women. Data about the physical and mental health of TANF recipients are largely drawn from national surveys and smaller studies because the federal government generally does not require state TANF agencies to report on the health status of recipients (see Table 1 at the end of the brief for study summaries). These data offer a portrait of a population with significant health problems.

Nearly one-half of TANF recipients report either "poor" general health or "poor" mental health, according to the Urban Institute's National Survey of America's Families (NSAF). Almost 40 percent of long-term TANF recipients—those who received welfare continuously for at least two years—reported "very poor" health. Similarly, according to a General Accounting Office report, 44 percent of TANF recipients have at least one or more physical or mental health impairment, a rate three times greater than those not receiving TANF.[2] Those who leave TANF also have a high rate of health problems. Half of those who left TANF jobless between 1997-1999 reported being in "very poor" health, according to the Urban Institute.[3]

Women with welfare experience (those either currently or formerly receiving benefits) have higher rates of health problems than others:

- *Physical health*. Nearly one-third of women in the four counties that were part of the Manpower Demonstration Research Corporation's Urban Change Project had low physical well-being scores compared to one-tenth of adults nationally.[4] The scores are based on responses to self-assessments that measure such issues as pain interfering with work or limiting the ability to climb stairs.

- *Mental health*. Recent studies have found mental health problems in 20 percent to 35 percent of the women with welfare experience. Over one-quarter of the women with welfare experience in the Urban Change Project scored poorly on measures of mental health—double the national rate for adults of the same age. The NSAF found that over one-third of current recipients scored poorly and over one-fifth scored very poorly on a

mental health scale. Research in an urban Michigan county, the Women's Employment Study (WES), found 35 percent of TANF respondents had some mental health problem, including 25 percent who had a major depressive episode within the year.[5]

- *Substance abuse*. Estimates of drug use vary depending on how drug use is defined and the period of time measured. While higher than the general population, drug use among welfare recipients has been declining, dropping from 30 percent to 21 percent between 1990 and 1998, according to the National Household Survey of Drug Abuse, which measures drug use at any time during the year. Serious drug dependence, however, is limited to about 4.5 percent of recipients compared with 2.1 percent among non-recipients.[6] The Urban Change Project found that about 10 percent of the study population reported any type of drug use in the prior month.

- *Domestic violence*. Women who receive TANF are more likely to be victims of domestic violence than other women. National surveys suggest that, among all women who live with a husband or partner, about 3 percent are physically abused each year.[7] The estimates of abuse for welfare recipients range from 15 to 40 percent during a year, depending on the definition used. For example, in the Urban Change study, over 40 percent of the sample experienced physical or emotional abuse in the prior year; other studies, not limited to urban areas, found between 20 to 30 percent of welfare recipients were victims of abuse in the prior year.[8] Current abuse was severe for 15 percent of TANF participants in the Michigan WES study.

Women's health problems can pose barriers to work. While women who have health problems often work, health issues may present barriers to employment. Data from NSAF found that, for nearly one-third of TANF participants, health problems may pose limits on work. Other studies support this finding. For example, in a three-city study of welfare participants, over one-quarter of the women who were current TANF recipients reported that a health condition prevented them from working.[9] In the Urban Change Project, nearly one-quarter of the women reported having a health condition that limited either the kind or the amount of work they could do, and over one-third of those who were not working responded that health limited their work. In its review of those who left TANF, the GAO found that those who had health impairments were less likely to be employed than those without impairments (39 percent v. 80 percent).

Women with welfare experience often have a child with an illness, disability, or emotional problem. The need to care for a sick child can limit a mother's ability to effectively participate in the workforce. Child care for these children is often very difficult to obtain and can be costly. An estimated 10 to 41 percent of women with welfare experience have children with special health care needs. A California study found that 10 to 12 percent of families who received AFDC had a disabled child.[10] About 15 percent of the women in the Urban Change sample had at least one child with a limiting health condition. About one-quarter of the women in the Michigan WES study had a child with an illness, disability, or emotional problem. In terms of those who transition to work, national data indicate that 41 percent of working mothers who had previously received AFDC for more than two years had at least one child with a chronic health condition, compared with 21 percent of mothers who had never been on welfare.[11]

The health of a child can also influence whether a mother can become or stay employed. In the Urban Change study, one-quarter of TANF mothers who were not working were limited in their ability to work or go to school because of a child's health problem. One state study found the likelihood of leaving welfare decreased significantly when a disabled child was in the household—the inability to leave welfare had the same effect as if the education level of the head of the household were reduced a full four years.[12]

Mothers with ill or disabled children often work, but they work fewer hours than other mothers. The Michigan WES study found that 49 percent of TANF recipients with ill or disabled children worked 20 or more hours per week, compared with 61 percent of mothers whose children did not have health problems. Studies of more than 900 families with chronically ill children (typically

asthma) in Boston and San Antonio found that two-thirds of those recently employed reported missing work due to a child's chronic illness. One-third of the Boston respondents and over two-thirds of the San Antonio respondents said that their children's health posed an important barrier to employment.[13] The barriers to work grow when women with ill or disabled children are in poor health themselves. A GAO study found that among 8 percent of TANF recipients both the adult and a child in the family had an impairment.[14]

TANF POLICIES FOCUSED ON WOMEN'S HEALTH

A number of TANF policies can directly influence women's health. Through Medicaid and Transitional Medicaid Assistance and linkages to other health insurance programs, TANF can help assure that women and their children have access to care. In assessing women's capacity to work, TANF programs can identify health-related barriers and refer recipients to health services, including family planning, substance abuse and mental health services, and domestic violence treatment and prevention. They can also exempt women beset by domestic violence from various TANF participation requirements. In addition, TANF contains provisions that address family formation issues, including permitting states to adopt "family cap" policies and allowing funds to be spent directly on family planning services and on preventing teen pregnancy and non-marital childbearing.

Medicaid and Transitional Medicaid Assistance

For low-income women, particularly those poor enough to qualify for TANF, having health coverage is critical to having access to care—especially in light of the disproportionately high degree of health problems that this population faces. Medicaid coverage had been provided automatically to all persons who received cash assistance under TANF's predecessor program, AFDC. However, under TANF, Medicaid eligibility was severed from welfare program participation in 1996 and tied, instead, to income. This means a poor family does not need to receive welfare to qualify for Medicaid, increasing the potential for more low-income families to secure health coverage.

In practice, Medicaid is available to TANF recipients. In addition, many individuals who leave TANF, particularly those who leave for jobs, qualify for Transitional Medicaid Assistance (TMA). TMA can provide up to a year's health coverage to families with incomes (less child care expenses) below 185 percent of poverty. Further, Medicaid expansions (e.g., for pregnant women and other low-income individuals), including those established for the State Children's Health Insurance Program, have the potential to serve more low-income women.[15]

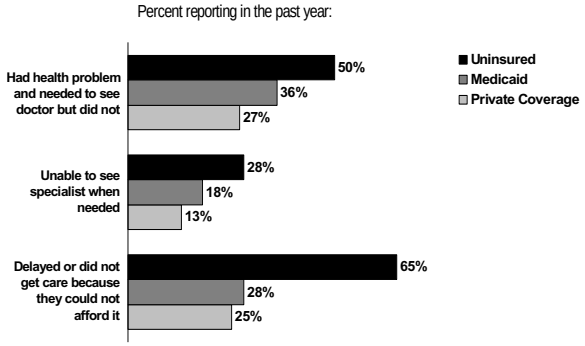
Eligible women and their children often lose Medicaid coverage when they leave TANF. While states are beginning to take advantage of the separation of Medicaid and TANF to provide assistance to more low-income adults and children,[16] a review of women who left TANF in 1997 found that 41 percent were uninsured in 1999, as were 22 percent of their children. Two years after leaving TANF, Medicaid was the source of coverage for 39 percent of the women and 59 percent of their children, while 20 percent of the women had employer-sponsored coverage, which reached 19 percent of their children.[17] A CLASP review of TANF-leaver studies reveals that only about one-quarter to one-third of employed leavers participate in employer-sponsored health insurance.[18] Most women who leave TANF for work are employed in low-wage jobs that provide very few benefits, such as health insurance.

TMA is intended to continue coverage for welfare leavers but only for a subset of recipients and only for a limited time. TMA is available only for certain welfare recipients: those who have been enrolled in Medicaid for at least three of the last six months. The maximum length of receipt is 12 months, and to remain eligible for the full period, families must repeatedly submit income data. Such rules, as well as confusion about eligibility, means families often assume they can only receive Medicaid if they are on welfare. Since TMA is temporary, even the women who get TMA may lose coverage after the 12 month period unless they reside in a state that has expanded coverage to other groups who historically have not been categorically eligible for Medicaid.

Lack of insurance can translate into unaddressed medical needs. Low-income uninsured women are more likely than their low-income insured counterparts to experience barriers to care. Over half of uninsured low-income women reported they had a health problem but delayed or postponed care because they couldn't afford it (Figure 2). In addition, the Kaiser Women's Health Survey found that women without insurance also get essential screening tests at lower rates than those with private coverage.

Figure 2

Barriers to Care for Low-Income Women, by Insurance Status, 2001



Note: Low-income is defined as under 200% of the federal poverty level. The federal poverty level (FPL) was $14,255 for a family of three in 2001.
Source: Henry J. Kaiser Family Foundation, Unpublished estimates from the *Kaiser Women's Health Survey*, 2001.

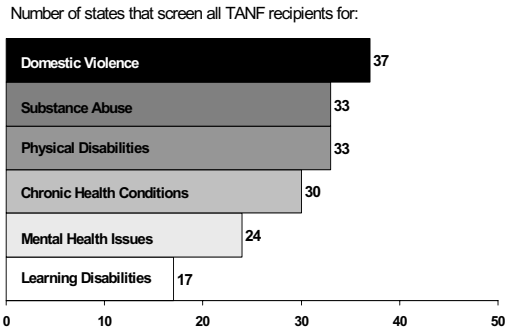
Opportunities to Link to Health Services through TANF

A number of opportunities exist within TANF programs to link recipients to health services. The TANF program requires states to conduct an assessment of recipients, largely to determine employability; however, there is no requirement that the assessment consider health barriers to employment or that it include the health of family members. And, even if a health barrier is identified, there is no requirement to address it.

TANF assessments of recipients offer opportunities to identify barriers to employment, as well as the potential to provide a vital link to health-related services. States report that they have established screening procedures to identify a range of health barriers (Figure 3). Although states are not mandated to follow-up with needed services, most states report offering services that assist clients experiencing domestic violence, substance abuse, mental illness, and disabilities. For example, a Missouri pilot project identifies welfare recipients with substance abuse and mental health problems and links them to treatment services. The project is designed to increase the skills of welfare agency staff in identifying these problems and referring recipients to treatment services.[19] Next steps for states, identified by the U.S. Department of Health and Human Services (HHS) in a report by the Inspector General, could include the expansion of innovative programs particularly for individuals with multiple barriers, as well as expansion of tracking of individuals with barriers with an eye towards the effects of sanction policies.[20]

Figure 3

State Screening Procedures



Source: Office of Inspector General, DHHS, July 2002.

TANF agencies often are part of a family planning referral system and sometimes co-locate services or station health providers in welfare offices. About 25 state family planning agencies have referral systems with the welfare agency, according to a national survey of state family planning administrators; about 15 states report that family planning services are co-located with the welfare agency. In some places, "outstationing" of public health personnel in welfare offices provides outreach and case management services.[21] Probably the most extensive example of that kind of collaboration is in Washington State. Most welfare offices in the state have a staff person who spends up to half-time dedicated to family planning, and a number have full-service family planning clinics co-located with the welfare office.[22]

TANF staff are often trained by state family planning agencies on a range of family planning issues. TANF recipients have also been trained to undertake outreach to other recipients. About 21 states report that their family planning agencies have arranged trainings for staff in welfare offices; trainings vary from information about the scope of unintended pregnancy to advice about how to query a client in order to make an effective referral. In five states, recipients of social service programs, such as WIC (the Special Supplemental Nutrition Program for Women, Infants, and Children) or welfare, have been trained to be "peer educators." A Maine peer educator pilot program trained TANF recipients to work as reproductive health outreach specialists; this activity "counted" towards their TANF work participation requirement.

Employment and training "one-stop" centers that serve TANF and other low-income women can also provide links to health services. For example, the TANF job center in Alaska is a one-stop shop that has a public health outreach worker outstationed for family planning services. In Milwaukee, Wisconsin, YW Works, a community organization, runs a one-stop employment center that serves participants in the state's welfare program, W-2; Planned Parenthood has co-located a clinician onsite.

States determine whether to implement the "family violence option" (FVO), which allows them to exempt victims of violence from certain TANF requirements. Forty states have certified that they use the FVO established in TANF. A state with the FVO is expected to have confidential screening for domestic violence victims, to refer victims for supportive services, and to waive rules, such as time limits and child support requirements, in instances where the imposition of the provision could penalize the domestic violence victim.

Most states establish Individual Responsibility Agreements (IRA) or contracts with clients, many of which include health obligations related to the mother and/or child. A CLASP review of state IRA policies found that 17 states required child immunizations, 10 required substance abuse treatment, 17 required health visits, and nine required family planning visits. Most IRAs establish a particular sanction policy related to the failure to fulfill an obligation.[23] While relatively little is known about the extent to which the IRA agreements trigger sanctions, some state information is available. For example, Delaware has two health-related "adult responsibility" agreements—having a child immunized and attending a family planning session. Among the roughly 5,000 "adult responsibility" sanctions in Delaware over an 18-month period, about one-quarter were because the adult failed to prove a child had been immunized and about one-eighth were because the adult failed to prove she had attended a family planning session. While addressing health concerns is desirable, the potential health consequences of the sanctions must also be weighed in designing effective health interventions through TANF. In addition, the IRA process provides another opportunity to offer families referrals to health services.

TANF Policies Affecting Reproductive Health: Family Cap, Family Planning, and Family Formation

The legislated purposes of TANF indicate the program's potential influence on reproductive health. These TANF purposes shape spending and support for family planning and family formation issues.

Purposes of TANF

From the Personal Responsibility and Work Opportunity Reconciliation Act of 1996

1. Provide assistance to needy families so children can be cared for in their homes or the homes of relatives;
2. End the dependency of needy parents on government benefits by promoting job preparation, work, and marriage;
3. Prevent and reduce the incidence of out-of-wedlock pregnancies and establish annual numerical goals for preventing and reducing the incidence of these pregnancies;
4. Encourage the formation and maintenance of two-parent families.

States determine whether to adopt a "child exclusion" or "family cap" policy on cash grants, although the health implications for families are not known. Under a "family cap," the family's grant does not increase if the family becomes larger due to a child conceived while the family received welfare. According to FY 2000 federal data, at least 4.1 percent of all TANF families (93,000 families) were subject to the family cap in the 21 states with such a policy.[24] Further, according to a recent GAO report, in an average *month* in FY 2000,[25] at least 108,000 families received cash benefits that were limited due to family cap policies—more than the total number of families receiving TANF in the combined states of Alabama, Arkansas, Colorado, Idaho, Maine, Montana, Nebraska, Oregon, Utah, and Wyoming in December 2000.

Limited research exists on the effect of family cap policies. A GAO analysis concluded it was not possible to make conclusions on the impact of family cap on fertility based on the available research. Included in this review was a Rutgers University study of New Jersey's family cap, which estimated that roughly 14,000 births were averted due to the policy between October 1992 and December 1996. In addition, the report estimated that during that period the family cap led to 1,400 abortions that otherwise would not have occurred. Surprisingly little research has looked at the impact of the family cap on the well-being of children.

TANF goals shape how states spend funds. These goals include preventing non-marital births, encouraging marriage, and strengthening two-parent families. The focus on avoiding non-marital births directly relates to reproductive health. In addition, while TANF precludes spending on medical services generally, an explicit exception is made for family planning services.

TANF funds may be spent on programs for welfare recipients, former welfare recipients, and those who have never received welfare. States have taken advantage of this flexibility to expand reproductive health related services to low-income women.

A number of states have used TANF funds to pay for contraceptive services for women. Six states report having used TANF funds for family planning clinical services, including the purchase of longer-lasting contraceptives for low-income women who are not eligible for Medicaid. Additional states are using TANF funds to augment family planning outreach and education programs.[26]

Most states use TANF funds for teen pregnancy prevention programs. According to a 1999 survey by the American Public Human Services Association (APHSA), 46 states used TANF funds for some type of teen pregnancy prevention or non-marital birth prevention initiative. The reporting states offer a mix of statewide and local initiatives ranging from after-school services to media campaigns to teen support and education programs.[27] Some states have used TANF to address the prevention of subsequent births by teen parents, particularly through support for home-visiting programs.[28] While the nation's teen birth rate declined a dramatic 22 percent between 1991 and 2000, it remains the highest of all developed countries. Within TANF, teen parents accounted for 13 percent of all teen TANF recipients; these teen parents are a relatively small fraction of the parents on TANF, with only 138,000 teen parents compared to the over 1.5 million adult recipients—a proportion of about 1 to 11.[29] However, women who began parenting as teenagers comprised 40-50 percent of the welfare caseload (according to a study of AFDC women, when these data were last available).[30]

A number of states have used TANF funds for couples and marriage programs. Some believe that poverty and the need for TANF would diminish if there were more marriages and fewer non-marital births. It is clear from the research that poverty and marital status are linked. A central question is to what extent child poverty is caused by the absence of marriage or by the absence of income. Some European countries with equal or higher rates of non-marital births than the U.S. have lower rates of child poverty—due to some extent to the amount of publicly subsidized income and social support given to single parents.[31] To the extent that there is an association between marriage and poverty and a link between poverty and poor health, the issue of marriage may get merged into discussions regarding health outcomes.

Four states have spent TANF funds to launch activities (for TANF and non-TANF families) specifically designed to promote and strengthen marriage and reduce divorce: Oklahoma ($10 million), Arizona ($1.65 million), Michigan ($1.25 million) and Utah ($600,000).[32] Interest in these and other marriage promotion initiatives[33] is driven, in part, by research that indicates that child outcomes are enhanced when children grow up with both stable, biological parents.

A central question is what set of activities should be funded to promote marriage and reduce non-marital child bearing. A number of efforts have had positive impacts on couples and on health. These encouraging results occurred in programs that did not promote marriage *per se* but that resulted in either a reduction in non-marital births or an increase in marital stability. For example, a number of effective teen pregnancy prevention strategies have been identified,[34] and investments in these strategies would be a major step in addressing non-marital births, since 80 percent of teen births occur outside of marriage. Marriage rates were increased in a welfare demonstration in Minnesota, which also improved marital stability among two-parent families. These effects "were driven largely by the increase in families' incomes," which was achieved through more flexible rules that enabled families to keep more of their welfare income when they worked. The program was also associated with a dramatic reduction in domestic violence.[35]

Another demonstration tested the impact of giving families *all* of the child support collected on their behalf. Welfare families typically receive only a small amount of their child support, with the government keeping the rest to recover costs. The research suggests, that, under certain circumstances, allowing families to receive all the child support collected led to less serious conflict between the parents, fewer health problems for children, and teenagers who did better in school and were more likely to stay out of trouble.[36] Investing in these sorts of interventions as more is learned about the efficacy of other "marriage promotion" strategies can be useful for states.

Some states use TANF funds to pay for expansions of abstinence-unless-married education. Abstinence-unless-married education (a program that is separate from TANF) teaches that "sexual activity outside of the context of marriage is likely to have harmful psychological and physical effects" and precludes information about how to use contraceptives effectively.[37] Three separate federal programs support such education; since 1996, over a half billion dollars in federal and state matching funds have been earmarked for this purpose. TANF funds are sometimes spent on abstinence-unless-married education; the APHSA survey found that 12 states tapped TANF for support of abstinence education.

OTHER TANF POLICIES ALSO AFFECT WOMEN'S HEALTH

As a work-focused program, TANF's employment policies can have health consequences for families, which may or may not be intended. The following highlights a few TANF policies that can influence health and well-being.

States determine the cash grant level awarded to families; adequate financial assistance could ameliorate some of the material hardships experienced by families with health problems. Most states have not raised their cash grant levels since 1995, and some states have reduced their grant levels. For a family of three, grants in the continental U.S. range from $164 in Alabama (less than $2 per day per person) to $645 in California (around $7 per day per person).[38] One-third (34 percent) of welfare recipients report experiencing one or more critical hardships, according to an analysis of 1997 and 1999 NSAF data; critical hardship is defined as a circumstance that immediately threatens a family's health and well-being, such as a lack of food, eviction, or inability to receive medical care.[39]

The federal TANF law sets forth minimum expectations related to work participation, which have associations with the health of low-income families. Current law requires that 50 percent of the TANF caseload participate in work-related activities for 30 hours per week (20 hours per week if the child is under age 6). As noted in the Urban Change Project study, concern about the current requirements is driven by the higher rate of health and non-health barriers in the remaining caseload. The same

concerns arise if those left on the caseload are increasingly caring for ill and disabled children. It is also unclear what effects low-income mothers' work has on their children's development and well-being. In general, higher incomes are associated with improvements in child well-being. A recent report from the Three-City Study found that while entering the workforce did reduce the amount of time that mothers spend with very young children (ages 2 to 4 years), work did not have any significant associations with the children's development in the short-term. For adolescents, there seemed to be a slight pattern of improvement in mental well-being when their mothers went to work.[40]

States must sanction individuals who fail to comply with TANF rules without good cause, but they also define non-compliance and set the length and severity of sanctions. Families with health problems have disproportionately high rates of sanctions. A sanction under TANF typically means that a family's cash grant is cut; it can also mean that the grant is terminated. In the Urban Change study, about one-third of welfare recipients with three or more health barriers experienced a sanction compared to one-quarter of those without health barriers. Furthermore, barriers such as domestic violence, depression, and having a child with a health problem were particularly related to sanctioning. A six-city study of children under age three in families with TANF experience found that sanctions and benefit decreases are associated with significantly increased rates of hospitalizations of young children and of food insecurity. Their rate of hospitalization was 30 percent higher and rate of food insecurity was 50 percent higher than for families whose benefits had not been decreased.[41]

2003 WELFARE REAUTHORIZATION AND BEYOND

Welfare reauthorization presents an opportunity to adjust welfare policy to reflect new knowledge about how the TANF program affects health and well-being. Developments to date suggest that federal changes may provide further flexibility for states to consider health issues in welfare families. At the same time, if a new law is enacted, it may include work and other provisions that create greater requirements for TANF women and their children who have health problems. While the law was considered but did not get reauthorized in 2002, the new 108th Congress is on its way to passing a bill in 2003.

Among the reauthorization opportunities is the chance to address funding levels for TANF and related programs. With no cost of living adjustment, the program is losing its purchasing power; by 2007 it will be able to buy 22 percent less than it could in 1996.[42]

At the same time though, hovering over the reauthorization is the specter of states' fiscal crises. States must now contend with unprecedented budget gaps, with projections for continuing declines in FY 2004[43]. Because of the flexibility of the TANF program, states will face a wide range of choices and decisions for the best use of TANF funds. This has enormous implications for efforts that use TANF funds for health-related services, such as TANF-funded teen pregnancy prevention or family planning services. Until recently, TANF funds were often available for investment in activities related to the TANF purposes. This opportunity existed because caseloads dropped dramatically—56 percent between FY 1996 and FY 2001.[44] However, in many states, the souring of the economy has resulted in caseload increases. While nationally the total caseload continued to decline, TANF caseloads started to rise in 16 states in the last year (December 2001- June 2002).[45] This increase in caseload in these states reflects the difficulties families are facing in the current job market, presenting many states with a distressing scenario - increasing needs for support services during rising unemployment and severe economic downturn.

Another area of legislative debate relates to Transitional Medicaid Assistance; the House-approved TANF reauthorization bill in 2002 called for a one-year extension; the Senate extended the program longer and made program adjustments that would facilitate TMA enrollment and utilization. The two Houses may differ in this way again. Individual states have opportunities to determine eligibility and duration levels for their TMA programs. Yet, due to overall fiscal constraints and the costs of the Medicaid

program, 41 states report plans to cut Medicaid in FY 2003.[46]

Also considered in 2002 and expected to take center stage in the upcoming debates are new work requirements for TANF recipients. The House-passed bill, backed by President Bush, would increase work requirements for most participants from the current level of 30 hours per week to 40 hours. The bill would also increase the percent of the caseload required to work and limit the kinds of activities that "count" as work. If enacted, these new work rules may limit flexibility to address employment barriers, such as substance abuse or mental health problems.

While greater work requirements would affect all women who receive TANF, the workforce participation issues could be particularly troublesome for the 44 percent of TANF recipients with health conditions. When these individuals leave TANF, they are less likely to be employed than those who have no health impairments (39 percent v. 80 percent).[47] In addition, work requirements that increase hours of participation could be especially challenging for mothers of children with severe disabilities, who may not have the resources accessible to simultaneously meet their children's health needs and work requirements.

TANF has great—but often unrealized—potential to improve the health status of women and children. At the same time, some TANF policies present significant challenges to poor women with health problems or with children with disabilities or poor health. Whether or not improvements are made to the TANF program during reauthorization, states will continue to have significant flexibility to make their own welfare funding and policy choices, giving them the opportunity to greatly affect the health of poor women and children. These policies affect low-income women and their families outside of the TANF program as well.

There is much that states could do today to make their TANF programs more likely to bolster the health of women and children, including improving screening, assessment, and referral procedures, particularly for families with multiple barriers to work; creating and improving linkages to health services for low-income women; reassessing their sanctions policies, particularly those that disproportionately affect women with health problems and with disabled or chronically ill children; and investing TANF funds in teen pregnancy prevention and reproductive health services.

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TABLE 1: KEY RESEARCH ON WOMEN'S HEALTH AND WELFARE

STUDY	DATA SOURCE	OVERVIEW
The Impact of Welfare Sanction on the Health of Infants and Toddlers *The Children's Sentinel Nutrition Assessment Program (C-SNAP)* http://dcc2.bumc.bu.edu/csnappublic/Welfaresanctions.htm	Interviews conducted between 8/98 and 12/2000 with 9,469 caregivers of children age 3 and under at medical centers in 6large cities. Findings on welfare sanctions are based on the 2,718 interviews that were with caregivers receiving welfare (or having their benefits terminated).	Investigates the connection between welfare sanctions, health, and food security for children under age three.
Welfare Reform: Outcomes for TANF Recipients with Impairments *General Accounting Office (GAO)* http://www.gao.gov/	Self-reported data from the Census Bureau's Survey of Income and Program Participation (SIPP), a nationally representative survey. The study used a cross-section of responses from 7/97-7/99.	Examines the extent to which TANF recipients with impairments leave TANF and become employed, in comparison to those without impairments.
Welfare, Children, and Families: A Three-City Study *Johns Hopkins University (based). Also the University of Chicago, University of Texas, and Harvard University.* http://www.jhu.edu/~welfare/	Random sample of approximately 2,400 low-income households with children in Boston, Chicago, and San Antonio. The first wave of interviews in this longitudinal study took place from March to December 1999.	Examines how welfare reform affects families, on employment, education, fertility, mobility, social service usage, and child health and development.
Kaiser Women's Health Survey *The Henry J. Kaiser Family Foundation* http://www.kff.org/content/2002/20020507a/	Survey of almost 4,000 women, aged 18 to 64, conducted in 2001. The survey is nationally representative and over-sampled women who were Latina, African-American, low-income, uninsured, or on Medicaid.	Looks at women's health care coverage and access to health care providers.
Project on Devolution and Urban Change (Urban Change Project) *Manpower Demonstration Research Corporation (MDRC)* http://www.mdrc.org/WelfareReform/UrbanChange.htm	Survey conducted in 4 large urban counties in 1997-1998 of almost 4,000 single mothers who, in May 1995, were receiving public benefits (welfare or food stamps) and were living in neighborhoods with high poverty rates or high rates of welfare receipt.	Focuses on welfare reform's effect on low-income families, poor neighborhoods, and local and state institutions.
Women's Employment Study (WES) *University of Michigan Poverty Research and Training Center; School of Social Work* http://www.ssw.umich.edu/poverty/wes/	Random sample of 753 single mothers (ages 18-54) in an urban Michigan county who were receiving welfare in February 1997. Respondents were interviewed 3 times between 1997-2000.	Explores the impediments to employment faced by welfare recipients.
National Survey of America's Families (NSAF) *Urban Institute* http://www.urban.org/Content/Research/NewFederalism/NSAF/Overview/NSAFOverview.htm	Surveys conducted in 1997 and 1999 of 42,000-44,000 households, resulting in information on approximately 109,000 individuals under age 65.	Looks at social, health, and economic characteristics of families containing nonelderly adults and/or children.

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