Health Care
After Welfare:
Insurance for Women Who Have Left the TANF Rolls

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# Health Care After Welfare

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Executive Summary

A number of recent studies have determined that many women who leave the welfare rolls lose their health care coverage (e.g., Families USA 1999; Loprest, 1999). This is significant given the evidence documenting the high prevalence of health and mental health needs of many of these low-income women (e.g., Barusch, 1999; Danziger, et al. 1999; Olson & Pavetti, 1996).

The report summarizes the findings from face-to-face interviews conducted with 215 women from Hillsborough County who left the welfare rolls between January 2000 and August 2000. The purpose of the descriptive study was to identify the health care needs of these women, to determine the degree to which their needs were being met, and to document the type and nature of their health care coverage. Additionally, the study compared the health care access issues of welfare leavers who had a prior mental health contact with those who had not.

Approximately one third of the women had no health care coverage at the time they were interviewed. The likelihood of being uninsured did not differ
across ethnic groups although access to health insurance was associated with physical health status. Women who reported poorer physical health were more likely to have health care coverage compared to those in better health. However, the likelihood of having insurance was not associated with mental health status. Women with a prior mental health contact, who were also in poorer mental health, were no more likely to have health care coverage relative to women who had better mental health status. Furthermore, among those who were working, women with a prior mental health contact were significantly less likely to have employer-based health coverage compared to their non-mental health contact counterparts. Women not currently receiving TANF and who were told about the availability of Transitional Medicaid Assistance when they left the welfare rolls were almost 2.5 times as likely to currently have health care coverage compared to women who were not informed. Somewhat surprisingly, however, these women were no more likely to currently be receiving Medicaid relative to women who reported not knowing about Transitional Medicaid Assistance.

In terms of their health and mental health status, the women in our sample were in poorer health and mental health (based on the SF-12) relative to what would be expected in the general population. Additionally, the rate of unmet needs among these former welfare recipients was approximately 11% for physical health and 27% for mental health.
The findings from this study highlight many of the challenges faced by women leaving the welfare rolls. Additional findings include:

- 31% of the women were uninsured
- between 10% and 27% had unmet health or mental health needs
- 38% reported a chronic health condition or disability
- 35% were in "fair" or "poor" health
- 50% were currently unemployed
- 16% had returned to welfare
- 27% reported work limitations

The findings support the need to find mechanisms to ensure that women who leave the welfare rolls do not lose access to basic health and mental health care. The findings also document the challenges that health and mental health problems pose for many of these women in becoming self-sufficient. While these issues are certainly complex, they will not be resolved unless we continue to search for possible solutions.
Health Care After Welfare: Insurance for Women Who Have Left the TANF Rolls

Background

**National Context.** In August of 1996, Congress passed landmark legislation called the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA, P.L. 104-193). This act dramatically changed the face of welfare as it had existed in this country for over 60 years, by ending the nation’s principal income-support program, Aid to Families with Dependent Children (AFDC), and replacing it with fixed block grants to states. Known as the Temporary Assistance for Needy Families Program (TANF), these grants gave individual states the broad authority to redesign and administer their welfare programs and to modify eligibility determination and benefit levels. The primary goal of this legislation is to assist recipients in becoming economically self-sufficient by, *among other things*, emphasizing work, imposing time limits on cash assistance, strengthening child support enforcement programs, and increasing funding for child care programs (PRWORA, 1996).

One of the more distinctive aspects of this legislation is the work requirement mandating that all recipients be working within two years of receiving aid and that they must engage in community service within two months of receiving benefits if they are not working. Another major aspect of this legislation
is that the PRWORA created a new Section 1931 of the Medicaid law requiring the de-coupling of Medicaid from welfare by repealing the required eligibility connection between welfare and Medicaid (PRWORA, 1996).

While the full impact of this reform on recipients is yet unknown, one effect has been well documented; significant reductions have occurred in the welfare rolls since enactment of the legislation. According to the Department of Health and Human Services (Department of Health and Human Services [DHHS], 1999), welfare caseloads dropped an average of 48% between January 1993 and March 1999. Some individual states have noted even more dramatic declines in caseloads. For example, Wisconsin reported an 88% reduction in their welfare caseloads. Idaho and Florida followed closely with an 86% and a 72% reduction in caseloads, respectively (DHHS, 1999). Additionally, these significant declines in the welfare rolls have been associated with corresponding declines in Medicaid enrollment (Government Accounting Office, 1999) raising concerns regarding the health and well being of former welfare recipients.

Despite efforts on the national level to ensure that women leaving TANF retain health care coverage, numerous studies have documented that many welfare leavers become uninsured. Families USA (1999) reported that in 1997, 675,000 low-income people representing 54% of those who left the welfare rolls, became uninsured as a result of welfare reform.
A number of studies in various states have documented the loss of health care coverage after welfare benefits are terminated. Kauff, Fowler, Fraker, and Milliner-Waddell (2001) conducted telephone interviews with 401 welfare leavers in Iowa and found that 37% had no health insurance at the time they were interviewed and that 60% lacked health care coverage at some point in time since leaving the welfare rolls. Medicaid covered approximately 48% of their respondents. Danziger (2000) noted that almost a third of the leavers in a Michigan study had no health insurance because they had exhausted their transitional Medicaid benefits, and were either not covered by their employer or could not afford the monthly premiums. Garrett and Holahan’s (2000a, 2000b) study of welfare leavers found that while 50% retained Medicaid coverage, 41% became uninsured. Loprest (1999) found that only 34% of adults who left the welfare rolls continued to receive Medicaid benefits. Brauner and Loprest’s (1999) multi-state review, however, found large variability across states in the percentage of former TANF recipients who continued to receive Medicaid benefits ranging from 83% in Wisconsin to 44% in Washington. In contrast, Acker et al.’s (2001) study of welfare leavers in Oregon found that 88% of the women maintained coverage under the Oregon Health Plan for some period of time after leaving the welfare rolls. Despite this finding, a considerable number of women expressed concerns about their ability to maintain health care coverage for themselves and their children after they lose their eligibility. The concern of these women seemed somewhat well founded given that only 40% of the welfare leavers with jobs received employer health care benefits and many of
those who were interviewed indicated that employee contributions to the insurance often made it prohibitively expensive.

The loss of Medicaid coverage among former TANF recipients occurs in spite of the fact that most of these families are eligible to receive Transitional Medicaid Assistance for a period of up to 12 months after leaving the welfare rolls. What accounts for the seeming failure of this federal safeguard to ensure health care coverage for families leaving the welfare rolls? A study by the Government Accounting Office (1998) reported,

“Welfare reform poses additional Medicaid education and enrollment challenges for states. The historic link between Medicaid and cash assistance provided states a strong avenue for ensuring that individuals who were qualified for cash assistance were also enrolled in Medicaid. But as welfare rolls shrink, there is concern that those who qualify for Medicaid may not enroll.” (page 19).

In response to this concern, several letters were issued by Department of Health and Human Services and the Health Care Financing Agency and sent to all State Medicaid Directors and TANF Administrators. The June 5, 1998 letter stated, “With the decoupling of Medicaid and TANF, States need to pay careful attention to their eligibility and enrollment processes…” while a March 22, 1999 letter noted, “The delinkage of Medicaid from cash assistance … has created
challenges and opportunities for providing support for working families.”

Concerns regarding the loss of Medicaid to eligible individuals is supported by Oliphant (2000), who noted that many former TANF recipients were unaware that they could work full-time and still receive Medicaid coverage after leaving welfare and that their caseworkers failed to inform them of their eligibility for Transitional Medicaid Assistance at the time they left the program.

The findings from several studies examining the impact of health care coverage on welfare dependency are mixed. For example Moffitt and Wolfe (1989) found strong evidence that the lack of private insurance contributed to an increased participation in welfare. Additionally, Ellwood and Adams (1990) concluded that the loss of Medicaid likely has a deterrent effect on women leaving the welfare rolls. In contrast, Blank (1989) found no evidence that access to Medicaid benefits had any significant influence on the likelihood of welfare participation.

There is evidence suggesting that being employed does not seem to significantly increase the likelihood of ensuring health care coverage. The Children’s Defense Fund (2000) analysis of over 5000 individuals in 65 cities found that less than one quarter of former recipients who were working had employer-sponsored insurance for themselves and only 11% reported receiving coverage for their families. Because of this, “Former recipients who have jobs are significantly more likely than current recipients to face medical hardships” (page
29). Over 36% of employed welfare leavers without Medicaid benefits reported they could not pay for health care for themselves. Edin and Lein (1997) found that most of the women in their study who were working had no health insurance. On average they noted that “work-reliant” mothers spent over three times as much for medical care ($56/month, approximately 5% of their monthly income) compared to women who were still receiving welfare ($18/month, approximately 2% of their monthly income). They also found that on average, work-reliant mothers were carrying $1,000 in debt, half of which was the result of unpaid medical bills. It is therefore not surprising that poor women are over three times more likely to be uninsured (36%) compared to non-poor women (11%) (American Psychological Association, 1998).

Edin and Lein (1997) found that health insurance was so important that many of the working mothers they interviewed reported taking lower paying jobs because they offered better health care coverage for themselves and their families. A number of these women also indicated that running out of food was “…preferable to going without needed medical care” (page 117). Despite this importance, Edin and Lein (1997) found that between one third and half of the women in each of the four sites indicated that within the past year they had needed to see a doctor but did not because they could not afford it. Boushey and Gundersen’s (2001) national analysis of working welfare leavers who had been off the rolls for more than a year found between 13% and 20% were experiencing “critical hardships” related to access to health care defined by
skipping necessary medical care. They found that higher rates of hardship were associated with working less than full time.

The concerns arising from the lack of health care coverage and serious medical hardship experienced by many former TANF recipients are exacerbated given the growing evidence documenting the high prevalence of health and mental health needs of many of these low-income women (Barusch, 1999; Danziger, et al. 1999; Grant & Dawson, 1996; Loprest & Acs, 1995; Olson & Pavetti, 1996; Salomon, Bassuk, & Brooks, 1996). Olson & Pavetti (1996) estimated the rate of health problems within the welfare population to be between 16% and 31%. Loprest and Acs (1995) found that between 17% and 19% of women receiving TANF had a physical, mental, or other health condition. Danziger et al. (1999) found 20% of mothers on welfare had a health problem. The prevalence of mental health problems among these women was even higher as 36% met criteria for a DSM-IV diagnosis. The rate of physical disability and health problems among a Utah sample of welfare recipients was found to be 53%, while 33% of them had a mental health problem (Barusch, 1999). This growing body of research presents a disturbing picture regarding health and mental health conditions of welfare recipients and raises concerns about the general well being of these women after welfare benefits have been terminated.

**Florida Context.** In Florida, as in other states, welfare reform has dramatically reduced the number of families receiving TANF. Statewide, TANF rolls
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decreased from 108,235 participants in July 1997 to 57,562 participants in December 1998, a 46.8% reduction during this 18-month period (OPPAGA, 2000). In 1999, Florida ranked 44th in the country regarding the percentage of people without health care coverage (19.2%). This percentage was substantially higher among individuals living in households with incomes less than $25,000 a year, the income bracket within which most former welfare recipients reside (US Census Bureau, 2000, September). Families USA (2000, June) reported that 70% of low-income (i.e., below 200% of federal poverty level) nonelderly uninsured adults in the United States reside in 15 states. Florida ranks 6th among these 15 states, with a 41% uninsured rate. They further report that Florida Medicaid enrollments of parents declined 26% (50,451 individuals) between January 1998 and December 1999 (page 6, Table 3), the highest among these 15 states. Parents are currently eligible for Medicaid in Florida if their incomes are below $9,648 per year, which is 68% of the federal poverty level (page 16). Thus, the concerns expressed nationally regarding the well being of former TANF recipients, the availability of health care coverage, and their access to services also seems warranted in Florida.

A study commissioned by the Florida State TANF Board reported, “...large numbers of former welfare participants leave the rolls without knowing that their Medicaid could continue for a year or more...” (Florida Inter-University Welfare Reform Collaborative, 1999, page 146). Interviews with TANF case managers concluded “…most did not …assess whether participants needed transitional
medical services” (Florida Inter-University Welfare Reform Collaborative, 1999, page 61). A recent qualitative study of welfare mothers in the Tampa area concluded that health care was a major concern for these women (Redfern-Vance, 2000). Summarizing her interviews with welfare mothers, Redfern-Vance wrote, “…their Medicaid was cut off, including several [women] who were pregnant.” Additionally, Redfern-Vance noted that the jobs typically available to these women are often part-time and/or temporary and do not include health care coverage.

The impact of these issues on the health care coverage of former TANF recipients was also the focus of a recent study conducted by the Florida Agency for Health Care Administration (2000). The purpose of the study was to estimate the number of welfare leavers who will lose their health care coverage as they transition from welfare to work. Of the 358,280 active TANF recipients on October 1997, 71% were no longer receiving cash assistance as of March 1999. Of the approximately 256,000 welfare leavers, it was estimated that 52% would retain some form of health care coverage. More specifically, 31% would be receiving Medicaid and have some matching income, 10% would be receiving Medicaid and have no matching income, and 11% would have some income and an alternative source of health care coverage. Of concern, however, is the nearly half of the former welfare recipients (48%) who will lose their health care coverage and become uninsured as a result of this transition. It is important to note that these estimates were based on the assumption that economic
conditions would remain stable which, given the recent downturn in the economy, would suggest larger numbers of women will lose their coverage. The study concluded, “Significant opportunities remain for improvement” (page 4). Among the recommendations outlined in the report were the need to create a clear vision regarding the importance of health care coverage, improving the linkage of welfare leavers with transition benefits, simplifying complex rules and policies, and improving the customer perspective within state agencies.

So serious are the concerns regarding access to health care coverage that they have resulted in a class action lawsuit being filed in August 1999 on behalf of low-income families in Florida. The suit, currently in mediation, alleges that the state had failed to de-link welfare and Medicaid which lead to many welfare leavers being illegally denied or terminated from Medicaid (Grant v. Kearney, 99 Civ. 2147 (S.D.Fl., filed August 3, 1999).

The reductions in the welfare rolls coupled with the fact that former recipients have high rates of health and mental health needs but frequently do not receive transitional Medicaid services although eligible, raise questions concerning what are the health care needs of former welfare recipients and the extent to which their needs are being met. Do these welfare leavers have health care coverage? What are their health and mental health needs? If they are receiving health care services, who is paying for it? This descriptive study was designed to begin to understand and address these issues.
In this report we summarize the findings from face-to-face interviews with 215 women residing in Hillsborough County who had left the welfare rolls within the past 18 months. Respondents were sampled to ensure diversity by race/ethnicity and by prior mental health contact to determine which leavers retained health care coverage and to explore what factors are associated with the likelihood of being insured. In addition we summarize the health and mental health status of these women, their service needs, and their overall quality of life in the context of women who have left the welfare rolls.

**Methodology**

**Study Questions.** The primary issues addressed by this study were the identification of the health care needs of women who have left the welfare rolls, the degree to which their needs are being met, and the type and nature of their health care coverage. Additionally, the study examined several broader issues related to welfare reform such as employment histories and barriers to economic self-sufficiency.

Examples of specific study questions include:

- What percentage of former welfare recipients have health care insurance? What type of coverage is it? Are their employers providing health care insurance options to them? Do the children in these families have health care coverage?
• When leaving the welfare rolls, were these recipients informed that they were eligible for transitional Medicaid coverage?

• What are the health, mental health, and substance use needs and status of former TANF recipients? Is the availability of health care coverage associated with better health care status?

• To what extent are these women’s health and mental health care needs being met? What types of health-related needs, if any, are going unmet? Are unmet health care needs associated with employment outcomes such as job turnover?

• Are health care issues a barrier for these women in terms of their economic self-sufficient? What other barriers, if any, affect their ability to become self-sufficient?

• Are there ethnic differences in the likelihood of having health care coverage? Is ethnicity associated with employment outcomes?

Study Participants. In the original concept paper for this study, the proposed sample was 240 former TANF mothers residing in Hillsborough County who transitioned off TANF between January 2000 and August 2000. The final sample included 215 women. A delayed start up and the inability to continue data collection beyond the June 30th contract end date prevented the additional interviews from being completed. The difference in the number of women interviewed with and without a prior mental health contact does not reflect a differential participation rate between the two groups but rather the fact that
women with a prior mental health contact were recruited into the study first followed by those without prior contact. The proposed sampling strategy and actual results are summarized in Table 1. As shown, the sampling frame stratified women on two variables; prior mental health contact (i.e., Yes versus No) and Race/Ethnicity (i.e., White, Black/African American, and Hispanic). The women were stratified on prior mental health contact because women with mental health needs are at greater risk for poorer health-related and economic outcomes and this sampling approach would permit analyses to determine if insurance status was differential for women with varying degrees of mental health needs. The sample was also stratified on race/ethnicity so that ethnic differences in access to health care coverage and service needs could be examined.

To identify prospective study participants, data were obtained from the Department of Children and Families (DCF) on all women in Hillsborough County who left the welfare rolls between January 2000 and August 2000. In addition to contact and demographic information on these women, the data extract included information on the women’s lengths of time on TANF, the number of times they cycled on and off TANF, the most recent reason for leaving the TANF program, and the specific services they received while on TANF. These DCF data were then linked with the Medicaid claims and encounter data obtained from the Florida Health Partnership and Health Maintenance Organizations that is residing at the Louis de la Parte Florida Mental Health Institute (FMHI), to determine
whether or not women had had a prior mental health contact in the past four years. The recruitment and enrollment of women in the study was conducted to ensure an adequate representation of women with and without a prior mental health contact across various ethnic groups.

**Instrumentation and Data Sources.** Data for this study were obtained through face-to-face interviews with former TANF recipients and from existing administrative data sources. An interview protocol was developed for use in this study. The measures and domains included in this protocol are summarized in Table 2. The protocol contained demographic data consistent with the minimum data standards established by the Welfare National Institute of Mental Health (NIMH: Leginski, Croze, Driggers, et al., 1989) regarding client characteristics. In addition, information on family composition (e.g., the number, ages, and gender of children in the family) and presence and type of health care coverage for each

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**Table 1. Proposed Sampling Strategy and Final Results**

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Prior Mental Health Contact</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes (Proposed)</td>
<td>No (Actual)</td>
</tr>
<tr>
<td>White</td>
<td>40/43*</td>
<td>40/25</td>
</tr>
<tr>
<td>Black/African American</td>
<td>40/49</td>
<td>40/37</td>
</tr>
<tr>
<td>Hispanic</td>
<td>40/36</td>
<td>40/20</td>
</tr>
<tr>
<td>Other</td>
<td>0/4</td>
<td>0/1</td>
</tr>
<tr>
<td>Total</td>
<td>120/132</td>
<td>120/83</td>
</tr>
</tbody>
</table>

*Proposed/Actual
Table 2. Measures Included in the TANF Interview Protocol

<table>
<thead>
<tr>
<th>Domains</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Living Situation</td>
<td></td>
</tr>
<tr>
<td>Family Relationships</td>
<td></td>
</tr>
<tr>
<td>Finances</td>
<td></td>
</tr>
<tr>
<td>Work &amp; School Health</td>
<td></td>
</tr>
<tr>
<td>Health</td>
<td></td>
</tr>
<tr>
<td>Barriers to Economic Self- Sufficiency</td>
<td>Self developed.</td>
</tr>
<tr>
<td>Service Needs and Use</td>
<td>Adapted from the SAMHSA Managed Care Multi-site study.</td>
</tr>
</tbody>
</table>

The interview also included psychometrically tested respondent self-report health, mental health, and substance abuse status measures. Additional questions focused on a broad range of respondents’ health
care service needs and use. Particular attention was given to determining the type, if any, of health care insurance that these women had as well as who pays for the services actually used. In addition, given that this is a study examining the availability of health care within the context of welfare reform, data were collected on employment outcomes, support services needed and used (e.g., transportation), barriers to self-sufficiency, and quality of life.

**Study Design.** This descriptive study involved a two-group design (*i.e.*, women with and without a prior mental health contact). Both retrospective interviews with former TANF recipients as well as existing administrative data were used to address health care needs and coverage questions described above. The study design and sampling approach are summarized graphically in Figure 1. Conducting the study in Hillsborough County provided a unique opportunity to examine what impact the County’s Indigent Health Care Plan had on assisting women who have left the rolls in maintaining health care coverage.

**Procedures.** First, the pool of potential study participants was identified using the procedures previously discussed. After this was completed, field interview staff were hired and trained specifically for this study. Pre-notification letters were mailed to eligible women, explaining the purpose and scope of the study, and informing them they would be contacted by a field interviewer to determine their interest in participating in the study. Women not interested in being contacted could call a toll-free number and have their names removed from the
list. Women who did not call were contacted and for those agreeing to participate, signed informed consents were obtained as well as permission to link their interview responses to existing administrative data. The women who participated in the study were paid $20.00 as compensation for their time. Prior to initiating project activities, all proposed study procedures were reviewed by the University of South Florida’s Institutional Review Board to ensure that participants’ rights were adequately protected.
Analysis. The analyses performed were largely descriptive in nature and intended to address the basic questions regarding how many former welfare recipients have health care coverage, what type of insurance they have, how well they are doing, and the degree to which unmet health care needs exist and are associated with insurance coverage and employment outcomes. Several comparative (i.e., inferential) analyses were performed to examine differences among subgroups of women interviewed. For example, differences in the rates of health care coverage among women with and without a prior mental health contact and across racial and ethnic groups were examined. Additional analyses are planned to examine more comprehensively what factors are associated with the likelihood of former welfare mothers having access to health care coverage.

Results

Participant Characteristics. The results are based on interviews conducted with 215 women who had exited the welfare rolls in Hillsborough County between January 2000 and August 2000. Approximately 61% of the women (132) were identified in the Medicaid claims data file as having had a prior mental health contact within the past four years. The remaining 83 women (38.6%) had no prior contact mental health contact within the past four years. Table 3 summarizes participants’ background characteristics, including their race/ethnicity, age, educational level, marital status, household composition, duration of prior welfare receipt, and whether or not they had returned to the welfare rolls. The characteristics are presented separately for women with and without prior mental
Table 3. Participant Characteristics

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>No Prior MH Service Use</th>
<th>Prior MH Service Use</th>
<th>Total (N = 215)</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(n = 83)</td>
<td>(n = 132)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Race/Ethnicity:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>30.1%</td>
<td>32.6%</td>
<td>31.6%</td>
<td>NS</td>
</tr>
<tr>
<td>Black/African American</td>
<td>24.1%</td>
<td>27.3%</td>
<td>26.0%</td>
<td></td>
</tr>
<tr>
<td>Hispanic</td>
<td>1.2%</td>
<td>3.0%</td>
<td>2.3%</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age:</td>
<td></td>
<td></td>
<td></td>
<td>NS</td>
</tr>
<tr>
<td>Mean</td>
<td>33.1</td>
<td>32.2</td>
<td>31.9</td>
<td></td>
</tr>
<tr>
<td>SD</td>
<td>9.01</td>
<td>8.01</td>
<td>8.39</td>
<td></td>
</tr>
<tr>
<td>Range</td>
<td>19 to 55</td>
<td>20 to 53</td>
<td>19 to 55</td>
<td></td>
</tr>
<tr>
<td>Education level:</td>
<td></td>
<td></td>
<td></td>
<td>NS</td>
</tr>
<tr>
<td>Less than HS</td>
<td>28.9%</td>
<td>37.9%</td>
<td>33.4%</td>
<td></td>
</tr>
<tr>
<td>High School or GED</td>
<td>43.4%</td>
<td>28.8%</td>
<td>34.4%</td>
<td></td>
</tr>
<tr>
<td>More than HS</td>
<td>27.7%</td>
<td>33.3%</td>
<td>31.2%</td>
<td></td>
</tr>
<tr>
<td>Marital status:</td>
<td></td>
<td></td>
<td></td>
<td>NS</td>
</tr>
<tr>
<td>Married/Living as married</td>
<td>20.5%</td>
<td>14.4%</td>
<td>16.7%</td>
<td></td>
</tr>
<tr>
<td>Separated, Divorced, Widowed</td>
<td>28.9%</td>
<td>37.1%</td>
<td>34.0%</td>
<td></td>
</tr>
<tr>
<td>Never married</td>
<td>50.6%</td>
<td>48.5%</td>
<td>49.3%</td>
<td></td>
</tr>
<tr>
<td>Duration of prior welfare receipt:</td>
<td></td>
<td></td>
<td></td>
<td>NS</td>
</tr>
<tr>
<td>Less than 6 months</td>
<td>37.8%</td>
<td>38.0%</td>
<td>37.9%</td>
<td></td>
</tr>
<tr>
<td>6 months to 1 year</td>
<td>26.8%</td>
<td>34.9%</td>
<td>31.8%</td>
<td></td>
</tr>
<tr>
<td>1 to 2 years</td>
<td>23.2%</td>
<td>14.7%</td>
<td>18.0%</td>
<td></td>
</tr>
<tr>
<td>Over 3 years</td>
<td>12.2%</td>
<td>12.4%</td>
<td>12.3%</td>
<td></td>
</tr>
<tr>
<td>Had returned to the welfare rolls:</td>
<td></td>
<td></td>
<td></td>
<td>.01</td>
</tr>
<tr>
<td>No</td>
<td>95.2%</td>
<td>83.3%</td>
<td>87.9%</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>4.8%</td>
<td>16.7%</td>
<td>12.1%</td>
<td></td>
</tr>
<tr>
<td>Number of children:</td>
<td></td>
<td></td>
<td></td>
<td>.005</td>
</tr>
<tr>
<td>Mean</td>
<td>2.37</td>
<td>3.02</td>
<td>2.70</td>
<td></td>
</tr>
<tr>
<td>SD</td>
<td>1.42</td>
<td>1.68</td>
<td>1.67</td>
<td></td>
</tr>
<tr>
<td>Range</td>
<td>1 to 8</td>
<td>1 to 9</td>
<td>1 to 9</td>
<td></td>
</tr>
</tbody>
</table>
health contact. The two groups of women did not differ in their racial/ethnic composition. Overall, 31.6% of the women were White NonHispanic, 40.0% Black or African American NonHispanic, 26.0% Hispanic, and the remaining 2.3% were from other minority cultural groups. Collectively, the women’s ages ranged from 19 to 55 years, averaging 31.9 years old (SD = 8.39). No significant difference was found between the ages of women who had prior mental health contact and those that did not. No difference was found in the educational levels between the two groups of women. Approximately a third of the women had not completed high school, about a third had their high school diploma or GED, and about a third had completed some post secondary education or technical school training. The two groups of women also did not differ in terms of the length of time they reported receiving TANF. Almost 38% of the women indicated they received TANF for less than six months, 31.8% reported receiving TANF between six months and one year, 18.0% received TANF between one and two years, while the remaining 12.3% reported receiving TANF for more than three years. A significant difference was found between women who had a prior mental health contact and those who had not regarding whether they had returned to the welfare rolls $\chi^2 (1, N = 215) = 6.73, p = .01$. Approximately 17% of the women with a prior mental health contact were again receiving welfare compared to 4.8% of women without a mental health contact. Examination of the odds ratio revealed that women who had a prior mental health contact were nearly four times more likely to return to the welfare rolls relative to those with no mental health contact. Women with a prior mental health contact also had significantly
more children ($M = 3.02$, $SD = 1.42$) than those without a prior mental health contact ($M = 2.37$, $SD = 1.68$) $t(213) = 2.89$, $p < .005$.

**Access to Health Care Coverage.** At the time they were interviewed, 69.8% of the women reported having health care coverage whereas 30.2% were uninsured. Neither prior mental health service use nor race was associated with the likelihood of having health care coverage. Almost 59% of the respondents indicated that they were told about the availability of Transitional Medicaid Assistance when they left the welfare rolls and no difference was found in terms of notification of this possibility between women with and without a prior mental health contact or race. Of respondents who were told about the availability of Transitional Medicaid Assistance, most reported being notified by their caseworker (73.1%). Of the women with insurance, 67.6% continued to receive Medicaid benefits. Less frequent sources of health care coverage included private insurance (23.0%), the Hillsborough County Health Care Plan (4.3%), and other sources (5.0%). No differences were found in the type of health care coverage between women with and without a prior mental health contact or by race.

The availability of health care coverage for the children of these women was more prevalent as 83.9% of the respondents reported their children had insurance. No differences were found in the likelihood of these children having
health care coverage by the mother’s race, whether she had a prior mental health contact, or the mother’s insurance status.

Among the 104 women who were working, 35.6% indicated receiving health care coverage through their employer. It is important to note, however, that a significant difference was found in the likelihood of having employer-based insurance between women with (28.0%) and without (55.2%) a prior mental health contact, \( \chi^2 (1, N = 104) = 6.74, p < .01 \). Examination of the odds ratio indicates that women with a prior mental health contact were only one third as likely to have employer-based insurance compared to women who had no prior mental health contact.

Among the 187 women who remained off the TANF rolls, there was no significant difference across ethnic groups regarding the likelihood of having health care coverage. Nearly 71% of the White NonHispanic respondents reported having health insurance, as did 70.3% of the Black/African American NonHispanic women, and 63.3% of the Hispanic respondents. Additionally, no difference was found in the likelihood of having health care coverage based on whether or not the respondent had a prior mental health contact among women who were not receiving TANF. Almost 70% of the women who had a prior mental health contact had insurance, as did 69% of women without a mental health contact.
Having health insurance was found to be significantly associated with whether or not women had been informed of Transitional Medicaid Assistance. Women not currently receiving TANF and who were told about the availability of Transitional Medicaid Assistance when they left the welfare rolls were almost 2.5 times as likely to currently have health care coverage compared to women who were not informed $\chi^2 (1, N = 179) = 6.82, p < .01$. Somewhat surprisingly, however, these women were no more likely to currently be receiving Medicaid relative to women who reported not knowing about Transitional Medicaid Assistance.

Having access to health care coverage was almost universally held as important among respondents, as demonstrated by the fact that 98.6% of the women rated health care coverage as “very important”. Given that all but one respondent reported access to health care coverage as “very important”, importance did not differ by race/ethnicity or by whether the respondent had a prior mental health contact.

**Unmet Health, Mental Health, and Substance Abuse Needs.** Unmet needs were measured as follows. Respondents indicated whether they needed physical and mental health services and whether they used these services during the previous six months. Unmet need was calculated by determining the percentage of respondents needing a service who did not use it. While most respondents reported having a physical health service need during the past six
months (79.4%), 10.2% of these women indicated they were unable to obtain the services they needed. The rate of unmet health needs did not differ by whether respondents had (10.9%) or did not have (8.5%) a prior mental health contact. Despite some meaningful discrepancies, no statistically significant differences were found by race because of the small number of women with unmet health needs. Unmet health needs were present among 11.8% of White NonHispanic respondents, 5.8% of Black/African American NonHispanic women, and 14.3% of Hispanic respondents.

With respect to mental health needs, 17.5% of the respondents \( (n = 37) \) reported needing services within the past six months. Of these women, approximately 27% \( (n = 10) \) reported being unable to obtain the mental health services they felt were needed. The rate of unmet mental health needs did not differ by race, although the numbers of women are small. Not surprisingly, however, a significant difference was found in unmet mental health needs based on whether respondents had a prior mental health contact. All of the respondents’ unmet mental health needs were among women with a prior mental health contact whereas none of the women without a prior mental health contact had unmet mental health needs \( \chi^2 (1, N = 211) = 5.22, p < .05. \) It is important to note that the overall number of women reporting unmet mental health needs was small.
Although 26.2% of the women reported having had an alcohol or substance abuse problem at some time in their life, only 1.9% (4 respondents) indicated a current substance abuse problem. Of these four women, one reported that she was unable to obtain needed treatment for her substance abuse problem. Given the small number of women acknowledging a substance abuse need, unmet substance abuse needs were not examined by race, prior mental health contact, or insurance status.

In terms of health care hardships, nearly a third of the respondents (31.9%) indicated that they had postponed going to the doctor at times during the previous six months because of a lack of money. Although no difference was found among respondents based on whether (28.0%) or not (32.6%) they had a prior mental health contact, a significant difference was found based on the respondent’s race $\chi^2 (3, N = 213) = 24.19, p < .005$. Further examination revealed that White NonHispanic (41.3%) and Hispanic (42.8%) respondents were significantly more likely to postpone getting needed medical care than were Black/African American NonHispanic (16.3%) respondents.

**Health Status.** The average score for these women on the physical health component of the SF-12 (Keller, Kosinski, & Ware, 1996) was 44.86 ($SD = 12.75$). Population-based norms are standardized to a mean of 50 ($SD = 10$), suggesting that these women are experiencing significantly more physical problems than a typical person in the general population. Over one third of the
women (38.3%) reported having a serious illness or physical disability and 75.7%
reported experiencing one or more physical symptoms during the past six
months. The types of medical problems these women reported ranged from ear
(15.3%) and nose and throat problems (42.8%) to lung (18.7%), heart (9.3%),
and kidney (15.0%) problems. On average the women reported experiencing 2.5
symptoms during the past six months. There were no differences found in the
likelihood of reporting a serious illness or physical disability, or in the number of
symptoms women reported by either race or prior mental health service use.

The women’s physical health status and number of medical symptoms
reported were found to be associated with whether they had health insurance. In
both cases women with health insurance reported being in significantly poorer
health $t(210) = 2.63, p < .01$, and experiencing an increased number of
symptoms $t(210) = 2.28, p < .05$, compared to women who did not have health
care coverage.

**Mental Health Status.** Respondents’ average score on the mental health
component of the SF-12 (Keller, Kosinski, & Ware, 1996) was 45.18 ($SD =
12.45$). As with the health component, population-based norms are standardized
to a mean of 50 ($SD = 10$), again suggesting that these women were
experiencing significantly more emotional difficulties than typical women in the
general population.
As would be expected, respondents’ scores on the mental health component of the SF-12 were significantly related to whether they had a prior mental health contact $t (212) = 2.21, p < .05$. Women with a prior mental health contact reported being in significantly poorer mental health ($M = 43.71$, $SD = 12.42$) compared to women without a prior mental health contact ($M = 47.54$, $SD = 12.20$). Race/ethnicity was not found to be associated with respondents’ mental health status. In contrast to physical health, women’s scores on the mental health component of the SF-12 were not associated with whether or not they had health insurance.

Mental health status was also examined using the Colorado Symptom Index (CSI: Shern, Wilson, & Coen, 1994). The average score was 28.38 ($SD = 11.84$), considerably lower than the mean score found among a population of adults diagnosed with a serious mental illness ($M = 33.5$), indicating a lower level of psychiatric symptomatology among these women compared to a mental health referent group. Consistent with findings on the mental health component of the SF-12, respondents’ scores on the CSI were also significantly related to whether women had a prior contact with the mental health system $t (183.8) = 2.80, p < .01$. As would be expected, women with a prior mental health contact reported being in significantly poorer mental health ($M = 30.12$, $SD = 12.05$) compared to women without a prior mental health contact ($M = 25.61$, $SD = 10.99$). As was

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1 Degrees of Freedom have been adjusted because of unequal variances between the two groups.
found with the mental health component of the SF-12, women’s scores on the
CSI were not associated with race or whether they had health insurance.

Over 16% of the respondents acknowledged that they currently had an
emotional or psychiatric problem, while 30.0% reported a prior history of
emotional/psychiatric problems. Not surprisingly, women with prior mental
health contact reported significantly higher levels of both current (22.3%) and
lifetime (37.4%) mental health problems compared to women with no prior
contacts (7.3% and 18.3%, respectively) [$\chi^2 (1, N = 213) = 8.20, p < .005 \text{ and } \chi^2$
(1, N = 213) = 8.76, $p < .005$]. Significant racial/ethnic differences were also
found in the percentage of women reporting mental health problems. White
NonHispanic women were significantly more likely to report having a current
(33.3%) or lifetime (50.0%) emotional problem relative to either Black/African
American NonHispanic (5.9% and 18.8%, respectively) or Hispanic respondents
(11.1% and 23.6%, respectively) [$\chi^2 (2, N = 208) = 22.99, p < .001 \text{ and } \chi^2 (2, N =$
208) = 18.96, $p < .001$]. No significant difference was found in the frequency of
mental health problems by insurance status.

Over a quarter of the respondents (26.6%) reported that emotional
problems limited their ability to work. No significant differences in work limitation
due to mental health problems were found by prior mental health service use,
race, or insurance status.
**Economic Status.** Approximately 39.6% of the women were currently employed full-time while an additional 15.6% were employed part time. No differences were found in the likelihood of full- or part-time employment by prior mental health contact, race, or insurance status. Approximately 68% of the women reported working sometime during the past six months. These women averaged 14.26 weeks of work during this period. No significant differences were found in either the rate of having worked or in the average number of weeks worked during the past six months according to whether a woman had previously used a mental health service or her race. The types of jobs respondents most frequently reported included retail sales (18.6%), clerical (14.2%), food service (12.4%), health care (11.5%), telephone sales (6.2%), and childcare (5.3%).

Of those women who were working full or part time, their average monthly income was $1,032.39 ($SD = $536.14). Not surprisingly, the average monthly income for women working part time was $645.58 ($SD = $361.64), much less than the average monthly income of women who were working full time $1,173.88 ($SD = $520.99). No significant differences were found in average monthly income by race or prior mental health service use. In addition to the women’s reported incomes, 75.2% received an Earned Income Tax Credit, 74.1% received assistance in paying for childcare, 44.0% received Food Stamps, and 16.5% received alimony and/or child support. No differences were found in other forms of economic support by race or prior mental health service use.
In terms of economic hardships, most women (87.6%) reported having enough food to eat although 13.4% reported “sometimes” or “often” not having enough to eat. Over a third of the women (36.2%) reported difficulty paying bills “frequently” or “all of the time,” and a similar percentage (37.0%) stated they delayed buying something the family needed because of a lack of money. The presence of economic hardships was not significantly associated with prior mental health service use, race, or insurance status.

**Quality of Life.** Respondents were asked to assess their satisfaction with seven life domains as well as to rate their overall level of satisfaction. These results are summarized in Table 4. Respondents reported being most satisfied with their social relationships as 81.7% indicated they were “moderately” or “very” satisfied. Legal and safety issues ranked second as 73.1% of the women reporting high levels of satisfaction. Almost 66% of the women reported high levels of satisfaction with their housing arrangements, ranking this third. The respondents’ health status ranked fourth, with 64.7% of the women indicating they were satisfied. Recreational and leisure opportunities ranked fifth with 50.5% of the women being satisfied. Nearly half of the respondents (47.9%) reported being satisfied with their employment and educational situation, ranking this sixth. Finances ranked last as only 34.3% of the women were satisfied with their current economic condition. No differences were found in respondents’ quality of life by race, however significant differences were noted on several of the quality of life questions by prior mental health contact. Women with prior mental health
service use were significantly more likely to report lower levels of satisfaction with their housing arrangements ($M = 2.75$, $SD = 1.10$) compared to women with no prior mental health contact ($M = 3.05$, $SD = 1.10$) $t(211) = 1.96$, $p < .05$.

Additionally, these women also reported significantly less satisfaction with their health status ($M = 3.12$, $SD = .99$) compared to women with no prior mental health contacts ($M = 2.64$, $SD = 1.10$) $t(211) = 3.21$, $p < .005$. No significant racial/ethnic differences were found regarding respondents’ level of satisfaction with any of the quality of life domains.

**Table 4. Quality of Life**

<table>
<thead>
<tr>
<th>Life Domain</th>
<th>Mean Rating</th>
<th>Ranking</th>
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<tbody>
<tr>
<td>Housing</td>
<td>2.86</td>
<td>3</td>
</tr>
<tr>
<td>Finances</td>
<td>2.20</td>
<td>7</td>
</tr>
<tr>
<td>Health</td>
<td>2.83</td>
<td>4</td>
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<tr>
<td>Social Relationships</td>
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<tr>
<td>Employment/Education</td>
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</tr>
<tr>
<td>Recreation and Leisure</td>
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</tr>
<tr>
<td>Legal and Safety</td>
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<td>2</td>
</tr>
<tr>
<td>Overall Quality of Life</td>
<td>3.08</td>
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</table>

1Scale: 1=Not at all satisfied; 2=Somewhat satisfied; 3= Moderately satisfied; 4=Very Satisfied

Quality of Life Index (QLI) was developed by summing the responses across the seven life domains and the overall rating in Lehman’s Quality of Life Interview. The average QLI for all respondents was 22.55 ($SD = 5.43$), which is similar to that observed in previous studies in Florida involving welfare.
populations. Prior mental health contact was associated with overall quality of life, such that women with prior mental health contact reported significantly less satisfaction with their overall quality of life ($M = 23.61$, $SD = 5.44$) compared to women with no prior mental health contacts ($M = 21.88$, $SD = 5.34$) $t (211) = 2.28$, $p < .05$. No differences were found across racial/ethnic groups in women’s overall quality of life.

Summary and Discussion

This report summarizes findings of a study examining former welfare recipients’ access to health care, and their health, mental health, and economic status. The findings indicate that women vary in their degree of well being.

Despite the fact that the major policy objective of welfare reform was to promote economic self-sufficiency by emphasizing work and strengthening support services such as child care and transportation to women leaving the welfare rolls (PRWORA, 1996), a substantial percentage of women in our sample reported significant economic hardships. Over half were currently unemployed and 16% had already cycled back onto the welfare rolls. Other participants reported difficulty paying bills (36.2%), and 13.4% lacked enough food to eat. In terms of support services, one third of the women reported existing unmet transportation needs and almost 40% cited the need for childcare.
The economic challenges experienced by many of these women also had health-related implications. Nearly one third reported not seeking needed medical services because of a lack of money, over 37% reported that physical health problems interfered with their ability to work, while 25% indicated that emotional problems limited their ability to work. Additionally, 38% reported a chronic health condition or disability and 35% indicated they were in “fair” or “poor” health.

Notwithstanding these health-related needs, almost one third of the women had no health care coverage at the time they were interviewed. Although likelihood of being uninsured did not differ across ethnic groups, access to coverage was associated with the physical health status of these women. Women who reported poorer physical health were more likely to have insurance than those in better health. This finding is important because it seems to suggest a safety net may be in place as most of the women in need were insured. This, however, was not the case with mental health status. Women with a prior mental health contact (who also reported being in poorer mental health) were no more likely to have health care coverage relative to women who had better mental health status. Furthermore, among working women in our sample, those with a prior mental health contact were significantly less likely to receive employer-based health coverage compared to their non-mental health contact counterparts. While this finding could be related to any number of reasons such as women with increased mental health needs working in lower level jobs, it does
tend to support the diminished priority and access to services for mental health needs compared to physical health needs. Generally, for all the women in our sample, their health and mental health status (based on the SF-12) were poorer than would be expected in a general population and the rate of unmet needs among these former welfare recipients was approximately 11% for physical health and 27% for mental health.

The findings from this study highlight the ongoing economic and health care issues that exist for many women who have left the welfare rolls. Given there are no agreed upon standards, how are we to interpret these findings relative to determining whether welfare reform has met its intended objective (i.e., economic self-sufficiency)? Do these women have adequate supports such as transportation, childcare, and health care coverage necessary to help facilitate self-sufficiency? Are these outcomes “good enough”? Has the legislation adequately achieved its intended goal of economic self-sufficiency for welfare leavers?

While welfare reform may have provided the necessary incentives for some women to leave the welfare rolls and succeed, others are seemingly worse off. As documented by Edin and Lein (1997) many of the “work-reliant” women in their study were seemingly no better off or even worse off after leaving welfare relative to those who continued receiving benefits. Loss of, or reductions in housing subsidies, childcare benefits, access to transportation services, and
Health care coverage eroded the increases in income for these work-reliant women. Working women were more likely to be uninsured, had higher health care costs, and incurred more health-related debt compared to women who remained on the welfare rolls.

There is no doubt that these issues are very complex and that a single solution most likely does not exist. One strategy is to decompose the overall issue into its component parts and examine them and their potential solutions one at a time. Central to this study was the issue of health care. Given health problems are more prevalent among poor people (e.g., Danziger, et al. 1999; Olson & Pavetti, 1996; Salomon, Bassuk, & Brooks, 1996) and given that women in the present study reported their health problems interfered with their ability to work, it seems reasonable to conclude that access to adequate basic health care is a fundamental building block for promoting and maintaining economic self-sufficiency. Therefore, we need to find mechanisms to ensure that women leaving the welfare rolls do not have to choose between having enough food to eat and having access to basic health care. By recognizing the challenges that health and mental health problems pose for women leaving welfare and how they impact the likelihood of these women’s continued and successful employment, access to care should be a priority.

The Earned Income Tax Credit was established to provide an income incentive for women to exit the welfare system. Perhaps the establishment of an
Earned Medical Tax Credit could be explored, through which women could receive tax relief for costs associated with receipt of health care services for themselves and their families or for the purchase of health insurance. Tax credits could be extended to employers who offer their employees health care coverage. Low cost options for former welfare recipients to purchase additional time through Transitional Medicaid Assistance might be established or as Danziger (2000) concluded, perhaps we need to extend these transitional benefits. Whatever the ultimate solution might be we need to keep the search for possible solutions on the front burner.
References


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*Health Affairs*. 19, 175-184.


