

Open Questions:
New Jersey's Family Cap Evaluation

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New Jersey's Family Cap Evaluation: Open Questions

In New Jersey, a welfare family with a newborn received \$64 upon the birth of a child until the state implemented its family cap policy in 1993. An evaluation of the family cap was undertaken to assess whether the family cap reduces the birth rate among welfare recipients. Any state considering a family cap policy should view it in light of not only these findings but also the new 1996 federal welfare law which establishes a lifetime limit on assistance and work requirements on participants. This broader context is explored in CLASP's "Excluded Children: Family Cap in a New Era" and the fact sheet "Cap on Kids"; what follows are highlights of the New Jersey findings and issues raised by the research.

New Jersey's final evaluations regarding the family cap utilize two different methodologies which both conclude that it achieves the intended goal of decreasing births among recipients; however, the decrease in births is accompanied by an increase in abortion and the elimination of the traditional grant increase for many newborns.¹

One analysis, based on statistical trends,² estimates that between October 1992 and December 1996 the family cap led to roughly:

- # 1,400 abortions incurred that otherwise would not have been performed.
- # 14,000 births averted that otherwise would have occurred.

According to state records, between May 1993 and June 1998 the family cap resulted in:

- # 28,000 newborns in poor families excluded from cash aid³; the percent of cases subject to the cap has grown steadily over time and is over 12% of the caseload.

Other research, based on an experimental design, compared outcomes for an experimental group and a control group⁴ and also found birth and abortion impacts between 1993 and 1996; researchers looked separately at on-going cases and new cases:

- # for ongoing welfare cases, members of the experimental group had a birth rate 9 percent lower

than those in the control group; regarding abortion there was no statistical difference between the groups.

for new cases, members of the experimental group had a birth rate 12 percent lower than those in the control group; the abortion rate was 14 percent higher for the experimental group.

Do the research findings mean that the elimination of New Jersey's \$64 traditional incremental increase for newborns caused these reproductive outcomes and that they can be replicated in other states? Both state officials and researchers expressed caution in interpreting the results.

The New Jersey Commissioner suggested that a causal link may not be appropriate and noted:

“These findings indicate that the family cap may have been a factor in women’s reproductive decisions, however, these are complicated, very personal decisions. To think that a woman decides to have a child or not have a child solely because of the small amount of money involved trivializes a very complex issue. But I do think the family cap sends a message that people on welfare must face the same life decisions as everyone else.”⁵

Researchers cautioned about replicability:

“Can these results be used to predict the impact of a family cap on AFDC/TANF births elsewhere? That is a difficult question to answer. The age, race, and the ethnic composition of the caseload, local labor market conditions, the exact size of the anticipated benefits loss, and the availability of family planning and abortion services will all play a role in the outcome. These are all factors that can vary across the states and must be taken into account before the results of this study can be applied elsewhere.”⁶

Does the fact that New Jersey used two different methodologies suggest the findings are conclusive? Because no single methodology can adequately address the multitude of issues inherent in measuring the impact of the family cap, a second methodology that affirms the findings of the first helps enhance the credibility of each.⁷ Thus, it is now possible to assert that a behavior trend follows from the New Jersey family cap policy: abortions increase and births decrease. What remains potentially contentious is the magnitude of these effects. The flaws of each methodology have not been eliminated and the “tweaking” of each could result in a larger or smaller effect within the overall trend. This is an important distinction and its significance is best illustrated by the findings of a draft version of the trend analysis. When researchers originally used a few different statistical assumptions, they concluded that the family cap led to increased abortions and decreased births but the number of projected abortions (240 per year) exceeded the decrease in births (140 per year). In other words, the abortions achieved the

birth reduction. The final report, while finding the same trend of increased abortions/decreased births offers a dramatically different picture based on slightly different assumptions: estimated abortions are one tenth the estimated number of averted births. While the findings regarding the trend on birth rates related to the New Jersey family cap is compelling, the findings regarding the magnitude are less so.

How grave are the flaws in each individual methodology? The Rutgers research has been subject to considerable scrutiny and sophisticated critique. The draft research received not only the traditional peer review but also consideration by staff at the federal and state departments of Health and Human Services. Indeed, HHS, which originally mandated the experimental design negotiated with New Jersey to undertake a subsequent statistical trend analysis out of concern that problems with the experimental design needed to be overcome [Rutgers undertook the trend analysis and paid for it with federal funds that had been planned for a study of the impact of the family cap on affected children]⁸. Because of the attention given the research by the investigative team and outside reviewers, significant effort has been made to improve each. Nevertheless, important questions remain including:

Trend analysis...

- \$ ***Birth data sources likely underestimate actual birth rates:*** What are the implications of relying on state welfare administrative data for birth information? The researchers recognized that Medicaid data may not have recorded all births after the introduction of managed care and, thus, chose not to rely on this data to calculate birth rates. They used state administrative data instead. However, this data may also underestimate the number of births. Women who believed the family cap applied to them may not have notified their caseworkers of a new child. Alternatively, caseworkers may not have recorded these births when there was no need to recompute benefits. While the researchers may have had little choice but to use state administrative data, this data source may well underestimate the actual birth rates.⁹

- \$ ***Birthrates declined before the family cap:*** what are the implications of the decline in the AFDC birthrate which *preceded* the family cap by a number of years? The family cap took effect in August 1993¹⁰. The AFDC birth rate had been declining perceptibly prior to that date. In fact, the birth rate of welfare recipients dropped by nearly 5% in the year *before* even news stories about the “family cap” legislative proposal could have possibly effected the birth rate (the state legislative debate and the term “family cap” was coined in early 1992; since gestation takes 9 months, any potential birth rate change would not appear in the September 1992 data). After clients began to be advised of the family cap rule the birth rate continued its decline - at an even greater rate: 7%.¹¹ However, what contributed to the AFDC birth rate decline *prior* to implementation of the family cap is not known. What caused this decline could be important in the evaluation’s

trend projections which attempt to control for numerous variables; the lack of insight about the birth rate decline *prior* to the family cap, therefore, could affect the capacity to appropriately project its impact in the future.

- \$ ***Fertility declined after the family cap:*** what are the implications of the aging of the caseload on the decline in the AFDC birthrate? The AFDC caseload has been aging, i.e. younger women are less likely to be in the caseload and those who remain tend to be older. The mean age of the caseload has been steadily increasing since the family cap policy took effect.¹² As the mean age of women in the caseload grows, the number of participating women who are fertile declines. Thus, some part of the birthrate decline in the caseload is attributable to the fact that fewer women are of childbearing age. How much of the birthrate decline attributed to the family cap reflects the decline in the fertility of the caseload is not known; neither is it known how much of the aging of the caseload reflects the family cap policy (i.e. younger women leaving the caseload because of the policy).
- \$ ***Family planning utilization rates increased universally:*** what are the implications for the New Jersey family cap of the dramatic increase nationally in the use of family planning services? Since the variables that contributed to that increase are not necessarily known, is it possible to adequately estimate how much the family cap increased utilization above and beyond this already occurring trend?¹³

Experimental-Control Group....

- \$ ***Risk Pool revision results in lower birth rate:*** the final report [but not the earlier draft] included in the denominator all women who left welfare even though their birth status after leaving welfare is unknown. Thus, while this group is added to the denominator (the full universe) they can not influence the numerator (the number of births). The expanded denominator and static numerator has the effect of decreasing the birth rate.¹⁴
- \$ ***Role of Medicaid and Food Stamp availability unknown:*** clients frequently believed a falsehood - that capped children are denied all forms of assistance. While the family cap policy continues Medicaid and food stamps for capped children, the client survey indicates substantial confusion on this subject: 35% of the respondents believed they would receive no additional benefit of any kind.¹⁵ This misinformation could have had effects in two directions. A pregnant woman who believes that her infant is ineligible for any assistance might not believe it necessary to report the birth of the child to the welfare agency (the source of the birth data). Alternatively, a woman who believes that an infant

would lose all major sources of support might view the birth of a child as even more problematic and thus, might chose to abort or to contracept. What is the impact of this basic misunderstanding on the findings? It is not possible to say from the available research. The survey reveals that there was equal confusion among the experimentals and controls. The research, however, does not explicitly measure the effect of the confusion. It is wholly possible that those who were subject to the cap (the experimentals) averted births more than the controls because their perception they would lose Medicaid and food stamps influenced their reproductive behavior.

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Contraceptive utilization findings may be encouraging but the picture is not entirely clear. The experimental group used contraceptive drugs and devices more than the control group in both the new and on-going cases. At the same time, this misses something the experimentals and controls have in common: a decline in utilization of contraceptives since 1993 according to the projections. Why would use of contraceptives decline overall among the AFDC population in the face of the family cap? This appears to be a function of the methodology: included in the projection are those individuals who have left welfare but whose contraceptive utilization is not known. Since these individual's contraceptive status is unknown, they are counted in the denominator but not the numerator: hence, the decline.¹⁶ There is another way to draw the picture that might better inform the lay public about the extent to which FDP influences contraceptive utilization. That snapshot looks only at the contraceptive utilization of those for whom contraceptive data is available - the FDP caseload. This data is not presented in the final report but was included in a draft. What this analysis shows is a significant increase in contraceptive utilization among the experimentals who are new cases.¹⁷ Utilization grew among the experimentals from 10.2% at the outset to 19.2% in 1996. The controls also increased, starting at identical point but ending at 13.7%. A closer review of the controls, however, shows that the group had its highest rate of utilization (16.7) in the mid-point and then utilization dropped. This raises a question: why would birth control users stop using birth control? If it is simply a function of age, that should effect both the experimentals and controls. Could it be that the controls who thought they were subject to the family cap finally realized they were not - so ceased practicing contraception? Could it be, instead, that the controls used over the counter contraceptives so, while they are practicing birth control this does not appear in the data? Another set of questions relates to the comparison of experimentals and controls who were on-going cases. In this group, the controls utilized contraceptives at a higher rate for most of the test period. Why? Again, the absence of an explanation for the apparent behaviors raises questions about the ability of the projections to capture the full picture. The basic picture appears encouraging but numerous questions remain.

New Jersey's Governor, Christie Todd Whitman, in announcing the findings of the Rutgers study

suggested, “Part of the success attributable to New Jersey’s welfare reform and Medicaid programs has been the result of our education efforts that encourage effective family planning methods as the best alternative to unwanted pregnancies, to abortions and to growth in the ranks of children living in poverty...” The effort the Governor was citing is the expanded accessibility to information and counseling that has resulted from the state’s switch to managed care - which is mandated for welfare recipients. As part of orientation to managed care, women are advised of the available family planning services and pregnant women are specifically counseled during the pregnancy about family planning services.¹⁸ The Rutgers study, however, does not examine the role of managed care in contraceptive utilization. Indeed, the role of family planning information was not studied - and welfare staff involved in the implementation of the family cap were not expected to discuss family planning issues with clients. The study’s survey of county staff asked about a range of issues that staff might discuss with clients - family planning was not on the list of issues.

How should states view the social costs of the family cap? The answer to that question rests with two judgments: first, how a state views the “costs” associated with reduced births and second, how the state rates the research findings. The “costs” of a family cap policy include an increase in abortions and a cap on assistance to newborns in poor families. One state might view a single abortion driven by government policy as untenable; another state might view imposition of the cap on a newborn as counter-productive to state investments in early childhood. Other states might want to assess the “trade-offs” between these social costs and reduced births. To conduct such an assessment, however, it is important to have a high degree of confidence in the numbers that describe the magnitude of the effects. Yet, the magnitude of the effects are not necessarily conclusive in New Jersey - and certainly can not be assumed to apply in other states. Further, the New Jersey evaluation did not seek to test the reproductive effects of welfare provisions all states are now implementing: time-limited welfare and work-first requirements.

ENDNOTES

1. The final research findings were issued in three reports:

- # A Cost-Benefit Analysis of New Jersey's Family Development Program: Final Report@
- # AA Final Report on the Impact of New Jersey's Family Development Program: Results from a Pre-post Analysis of the AFDC Case Heads from 1990-1996"
- # AA Final Report on the Impact of New Jersey's Family Development Program Experimental-Control Group Analysis@

2. AA Final Report on the Impact of New Jersey's Family Development Program: Results from a Pre-post Analysis of the AFDC Case Heads from 1990-1996"

3. A Excluded Children: Family Cap in a New Era@CLASP November, 1998

4. AA Final Report on the Impact of New Jersey's Family Development Program Experimental-Control Group Analysis.@The sample size included 2,892 control group members and 5,510 experimental group members. The analysis of births was drawn from the less than 100 births to control group members that took place each quarter and the slightly larger number of births from the experimental group. Thus, for example, in December 1993, a total of 54 births is attributed to the 2,892 control group and a total of 107 births are attributed to the 5,510 experimental group. In other words, during the quarter, less than 2% of each group gave birth. The relative differences between the groups that are reported in the research findings are statistically significant yet it is also useful to appreciate the modest magnitude of the births among the full study group.

5. New Jersey Department of Human Services, Office of Public Information, press release, November 2, 1998

6. AA Final Report on the Impact of New Jersey's Family Development Program: Results from a Pre-post Analysis of the AFDC Case Heads from 1990-1996" p. 165

7. The researchers note the limits of each methodology and the value of using two methodologies which show the same trend/direction and reinforce the findings of the other. Regarding the statistical trends analysis, the authors note that AStatistical estimates, while illuminating, do not, by themselves, prove that the Family Development Program and the family cap caused a reduction in births, an increase in abortions, or any other changes in family formation behavior...Our findings here agree, in direction and implication, with the results of another analysis of the family formation impacts of the Family Development Program...which utilizes a classical experimental design methodology...While the estimated magnitudes of these impacts may vary with differences in methodology and estimates methods, the ultimate outcome

remains the same. The net effect is a reduction in pregnancies and births among women on AFDC in New Jersey; this conclusion is supported by research reported here and elsewhere, and is consistent with expectations derived from economic analyses. (Results from Pre-Post Analysis P.iv,v; 164). Regarding the experimental study, the researchers observe that AThe value of the experimental design as an effective methodology for evaluating the impacts of social policy received careful scrutiny as our evaluation proceeded. Fears that the publicity and media attention that accompanied the introduction of the family cap provision would affect control group decisions, as well as early indications that control group members may not have entirely understood their evaluation status, led US-DHHS staff to fund [the statistical trend analysis]...This pre-post analysis of the AFDC caseload...showed us that our social experiment, while possessing a good deal of internal validity, had begun to lose touch with caseload realities in 1996. Our sample, through attrition and aging, no longer reflected the dynamic welfare population from which it was drawn.@ (Experimental-Control Group Analysis p274).

8. NOW Legal Defense and Education Fund deposition of Rutgers= researchers.

9. Results from a Pre-Post Analysis. Appendix A.1. Figure A.1.5.

10. August 1993 is the first month a family grant=s might be capped in New Jersey, 10 months after the legislation went into effect.

11. The 5% and 7% rates are calculated by averaging the quarterly fertility rates for each year (beginning in December and ending in September of 1991, 1992, and 1993). The pre- family cap rate of 4.8% compares the average of the quarters for the years ending September 1991 and 1992; the post family cap policy compares 1992 and 1993. [Results from a Pre-Post Analysis Table 3.1, p.35]

12. Averaging the quarterly mean ages of household heads (beginning in December and ending in September of 92, 93, 94, and 95) the annual averages indicate mean ages of 31.54; 31.71; 31.97, and 32.24 respectively.

13. Results from a Pre-Post Analysis p. 57 . ATable 3.8 shows the rate of family planning utilization for AFDC payees. Utilization in this context includes all encounters associated with the provision of family planning services, including surgical services, office visits and laboratory services. Utilization increases steadily from March 1994, after a brief decline between September 1993 and March 1994. Available evidence on the national use of family planning services indicate a dramatic increase over this same period. Frost (1996), in her survey of publicly-funded family planning service providers, observes a 30 percent increase from 1983 to 1994.@

14. Experimental-Control Group Analysis p. 35 . The researchers state, AIn response to the federal and state critique of the first draft of this report submitted in April 1998, we have conducted our analyses of all the outcomes, including births and abortions...without removing cases that had exited AFDC from the

quarterly risk pool. The use of such risk pool denominators, we believe, is not appropriate in the cases of birth or abortion outcomes where it is impractical to obtain matchable person-level data on births and abortions that occurred while women were not receiving AFDC payments...Our acquiescence to the use of unadjusted denominators is based on our comparative analyses of these same outcomes with risk pool adjusted denominators. The denominator unadjusted and adjusted analyses produce very similar results. The difficulties in interpretation engendered by the use of unadjusted denominators can be seen in the Tables produced in the Appendix to Chapter 3. Note how the birth and abortion rates decline as a function of denominator stability and fail to reflect AFDC population rates after September 1994. This approach to the denominator was used in all of the measures within the evaluation.

15. Experimental-Control Group Analysis. p.75. Over 1200 current and former clients were surveyed in New Jersey. Experimentals and controls were equally confused. Reports on the family cap in Delaware suggest confusion on the same topic exists there as well. Almost one quarter of the treatment group members and 13% of the control group members believed that Medicaid would be unavailable for capped children [The ABC Evaluation: The Early Economic Impacts of Delaware's A Better Chance Welfare Reform Program (December 1997, Abt Associates)]

16. For new cases, the projected rate of utilization (per 1,000) was 21% higher than the controls over the study period. [Experimental-Control Group Analysis. P. v; Tables 7.14 and 7.21 b&c] Among on-going cases, controls were more likely to use contraceptives in the early years, about 3 % more on average; by early 1996, it is the experimental on-going cases that begin to use contraceptive drugs and devices more often [Experimental-Control Group Analysis p. 180]. While the 21% and 3% figures are statistically significant, both the rate of use among participants and the difference itself are small.

17. AA Draft Final Report on the Impact of New Jersey's Family Development Program: Experimental-Control Group Analysis April 1998. Table 7.9 Contraception Use in New Cases and Table 7.4 Contraception Use in Ongoing Cases.

	New: <i>Experimentals/Controls</i>		Ongoing: <i>Experimentals/Controls</i>	
Oct 92 July 93	10.2%	10.2%	16.6%	19.3%
Aug 93 July 94	13.7%	12%	16.4%	17.3%
Aug 94 July 95	19.4%	16.7%	17.6%	18.2%
Aug 95 July 96	18.2	14.1	11.8%	10.5%

18. CLASP communication with New Jersey Office of Public Information, Department of Human Services, January 1999.