

ISSUE BRIEF

Welfare Reform and Its Impact on Medicaid: An Update

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Welfare Reform and Its Impact on Medicaid

The Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), enacted in August 1996, was hailed as landmark legislation to “end welfare as we know it.”¹ After months of wrangling and two presidential vetoes, radical reform of welfare was accomplished by excising the individual entitlement program of Aid to Families with Dependent Children (AFDC) and replacing it with a state-administered block grant program of Temporary Assistance to Needy Families (TANF). The dramatic changes in welfare have the potential to affect not only the economic but also the social and health status of low-income people. Moreover, this striking reform also provides a living lesson in the devolution of public policy management from the federal government to states and localities.

One of the most contentious elements of the welfare reform debate in 1995 and 1996 revolved around the Medicaid program. Would it be tied to welfare reform and block granted along with cash payments? Should the Medicaid program be considered a health financing program or a welfare program? Should states be given the same flexibility to design and redesign Medicaid programs as was being considered for cash welfare programs? The administration’s response, a presidential veto threat, highlighted its refusal to accept a block grant for Medicaid, leading to final enactment of a bill that maintains existing Medicaid federal and state roles. The automatic eligibility link between welfare and Medicaid programs, however, was severed.

As the first years of TANF unfold, some outcome-based impacts in terms of the number of recipients in both welfare and Medicaid programs are being tallied and analyzed. It is important, two years post-enactment, also to review state implementation processes and changes in administrative mechanisms. Only time and careful research will answer the most important questions about how effective the revised welfare incentives are for pulling recipients into work and, especially, out of poverty and whether recipients’ eligibility for health services through Medicaid is appropriately continued.

The Forum has had a keen interest in the progress of welfare reform, initiating a series of activities, including site visits, to review policy development at both the federal and state levels, to follow state implementation of TANF, and to assess the impacts of welfare reform on Medicaid and other health programs. Capitalizing on

insights gained in recent visits to Kansas and New Jersey, this Forum session looks at progress to date on implementation of state TANF programs, reviews national studies of TANF and its implementation, and begins to examine the special interface between welfare reform and health programs, particularly Medicaid.

WELFARE REFORM UPDATE

The welfare reform legislation converts the old AFDC program into the TANF block grant with fixed funding for income support and work programs. Work requirements are key, and PRWORA requires states to orient their programs around employment. Penalties are levied if a state fails to achieve minimum work participation rates among clients. There is a five-year lifetime cap on receipt of TANF benefits, and states must require most recipients to participate in work or work-related activities within two years in order to receive benefits. States have the option of requiring work immediately and may terminate all assistance for noncompliance. Great flexibility is afforded states to structure their own programs to meet the purposes of TANF. Thus, states define their own criteria for eligibility and services and may expand or deny services entirely to certain groups. In this way, states can define their benefits and expend funds to meet their own priorities. In addition to the primary emphasis on work, PRWORA stresses support for family stability,

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encouragement of two-parent families, reduction of out-of-wedlock pregnancies, and enhanced child support enforcement.

Cash assistance to legal immigrants under both TANF and the federal Supplemental Security Income program are severely curtailed under PRWORA. With the exception of certain groups of refugees and asylees, the act basically bars benefits to immigrants entering the country after the date of enactment for at least five years, requires sponsor-to-alien deeming of income, and limits benefits for those already in the United States in 1996. The conference report noted that the act “makes sweeping reforms relating to benefits for noncitizens, strengthening the principle that immigrants come to America to work, not to collect welfare benefits.”² Prior to welfare reform, Medicaid and AFDC eligibility rules were nearly identical for legal immigrants and citizens, so the modification for welfare represents an extremely restrictive change, with significant consequences for immigrant children and families, for states with significant immigrant populations, and for people who serve the immigrant community.

TANF Programs

The end of the AFDC entitlement program brought TANF programs most clearly characterized by the work requirement, with allowance for time-limited assistance. States are allowed great flexibility in establishing eligibility criteria and deciding the type and amount of assistance, but the primary focus is jobs, work, and responsibility. States may receive performance bonuses for moving welfare recipients into work and reducing illegitimacy; they are required to maintain existing state effort, stress child support enforcement programs, and provide an array of services to support the movement from welfare to work, including child care.

While many questions remain, there is absolutely no doubt that the number of Americans receiving cash welfare assistance has dropped dramatically since TANF replaced AFDC. An administration news release from January 1999 notes welfare caseloads declined to below 8 million recipients, the lowest level in 30 years. This represents a decrease of nearly half of the people on welfare since January 1993 when state-based welfare reform demonstration programs were begun across the nation and there were over 14 million recipients.³ The caseload decline began before the enactment of PRWORA, as noted in the press release, but the decline has accelerated since the law was enacted. The decline reflects both more people leaving welfare and fewer people becoming recipients.

There are various explanations for the decline. The extraordinary strength of the U.S. economy, with unemployment rates at record lows and many new and entry-level jobs available to former or potential welfare recipients certainly cannot be discounted. The TANF work requirements and the continued strength of the economy at this time of radical shift in welfare policy have created propitious conditions for short-term success, measured in the current low welfare caseloads. Advocates credit misunderstanding, misinformation, operational variations, and confusion about welfare under TANF as other important factors. Most observers believe the goal of state TANF officials now must be to identify and capitalize on what is working, address problems, and prepare for future challenges like economic downturn.

Reengineering Welfare

Removing a strong federal role in defining and administering welfare raises questions about how well the states will do with their new-found freedom and flexibility. And the massive devolution of public policy management to states raises additional questions about the appropriate division of responsibilities in our federal system. States’ success meeting the goals of welfare reform will have enormous impact on future debates about the appropriate level of responsibility for administering other social and health programs. So far, the raw numbers look solid. Review of states’ changes in policies, procedures, internal structures, and basic approaches provide a complementary assessment to the numbers themselves. And such review also indicates the extent to which long-term change, rather than short term reaction, is under way.

The title of a 1998 report by the General Accounting Office (GAO) is informative: “States Are Restructuring Programs to Reduce Welfare Dependency.” This report, which reviewed seven states, found them moving to welfare programs that emphasize finding employment as quickly as possible. It says that welfare offices in these states “generally are being transformed into job placement centers.”⁴ The report also noted that states have modified their programs to better support welfare recipients’ self-sufficiency and expanded welfare caseworkers’ priority from eligibility determination to providing work support services.⁵

A larger study of 20 states directed by the Rockefeller Institute of Government, the public policy research arm of the State University of New York, focused on implementing PRWORA. Richard P. Nathan, director of the institute and principal investiga-

tor for the study, has said, “In thirty years of observing welfare policymaking and administration, I have never seen a period of such rapid change. This is not the case in all states, but it is the case—to varying degrees—in *most states*”(emphasis his).⁶ A recent book from the Rockefeller Institute reported on PRWORA implementation and summarized field-research findings to date. In this implementation report, Nathan and his colleagues commented on the rapid bureaucratic change they have observed in welfare agencies:

States are not simply layering on new responsibilities to public employees; in many places they are completely reorganizing how they operate welfare and related social programs. The face of welfare has changed for families as states have altered who is involved in the delivery of welfare benefits and services, what processes they rely on and in what context the program is placed. Our field data show that the Work First philosophy has penetrated many state welfare bureaucracies.⁷

The Rockefeller Institute researchers primarily attributed the change in state welfare agencies to what they deemed the three S’s—signals, services, and sanctions. They suggested that the signals of work versus dependency are big, bold, and have engaged workers, supervisors, and politicians alike; that services delivered are more focused and often more extensive; and that the availability of sanctions provides a previously unavailable enforcement tool.⁸ Their work additionally highlights a second-order devolution to local and community agencies, the crucial role of front-line workers, new efforts to divert individuals from becoming TANF recipients by providing a variety of other cash payments or services, and the growing importance of welfare information systems.

The challenges around information systems are particularly critical. AFDC systems were focused on eligibility and cash payment levels. But TANF requires systems that meet the long-term need to track people through the welfare system, enforce time-limits, provide needed support services, measure employment barriers, and, finally, assess whether this new work-oriented system produces and maintains individuals who are economically stable, independent, and upwardly mobile. There is little current information about what is happening to the millions of people who have left the welfare rolls. Reengineering of information and tracking systems is in a nascent stage, at best. But if the new federalism is to be considered successful by skeptics, it must be accountable through federal monitoring via information about states’ programs. States must have good information systems to provide consistent, high-

quality data about the many facets of their efforts to move people to long-term economic independence.

WELFARE AND MEDICAID

Welfare Reform’s Implications for Medicaid

A proposal by governors to block-grant funding and devolve additional Medicaid authority generated controversy and debate during the congressional deliberations on welfare reform. In the end, this idea was rejected, and PRWORA essentially maintains the federal-state Medicaid program structure as it was created in 1965.

A new section, 1931, of the Social Security Act requires states to continue to provide Medicaid to families who meet the state AFDC income and related eligibility standards that were in effect at the time of PRWORA enactment, regardless of whether they receive TANF. Thus, states are required to maintain an eligibility floor for Medicaid based on old standards they used in AFDC, while developing entirely new TANF rules that may be dramatically differ from AFDC. This delinking of Medicaid from welfare ended the traditional automatic eligibility of welfare recipients for Medicaid, since Medicaid and TANF requirements are now different. In the past, moreover, a single application had been used for both AFDC and Medicaid; under TANF, states may use separate application forms.

States do still have the flexibility to align their TANF and Medicaid rules, so they must rethink and redesign their eligibility systems and decide whether a group of people who were once automatically enrolled will continue to be automatically enrolled. With state emphasis on promoting work and job placement, there is widespread concern about whether this redesign to assure appropriate Medicaid eligibility procedures has taken place. These state decisions about eligibility system design are important, because prior to welfare reform, AFDC receipt had triggered Medicaid enrollment for more than one-third of all Medicaid beneficiaries and about half of all the children on the program.

The experience of states’ attempts to enroll low-income children who are not in families receiving cash benefits is instructive, since this population could be thought of as the first group to have been delinked from Medicaid beginning in the late 1980s. States’ commitment and ability to enroll these children was not uniform

across the nation. States encountered problems in identifying these children and demonstrated varying levels of commitment to outreach and enrollment activities targeted at them. The result is an extremely uneven pattern of enrollment of these nonwelfare children across the country.

The subject of Medicaid eligibility is extremely difficult. Years ago, before many recent confounding complications were added, Medicaid eligibility rules were described in a District Court opinion as “an aggravated assault on the English language, resistant to attempts to understand it.”⁹ The passage of welfare reform and the delinking of Medicaid and welfare add even more complication to this subject. At best, over time, the delinking will allow Medicaid to become a health program, financing medical and health services, rather than the current stigmatized welfare program. But there are many problems to sort out before that ideal can be reached. In the meantime, delinking has removed the automatic protection of Medicaid eligibility for low-income families who receive welfare benefits. And delinking has created the risk that people leaving welfare will inappropriately lose Medicaid coverage, making it difficult to remain employed and stay off welfare.

An important Medicaid provision allows transitional or extended Medicaid benefits, often referred to as transitional medical assistance, or TMA. Under TMA, Medicaid is continued, usually for 12 months, after recipients begin to work and earn income above what would normally make them Medicaid-eligible. This transitional benefit is a critical component for low-income people moving into employment, since low-income workers often do not receive health benefits from employers. TANF has complicated TMA because, under federal law and rules, recipients must have received welfare payments for a period of months before they can receive TMA. By diverting people from cash benefits or radically shortening the period of time people get cash benefits, states are unable to provide Medicaid through TMA. This represents another regulatory and systems problem for states.

From Medicaid’s perspective, the key to successful implementation of welfare reform is ensuring that low-income people do not become lost in the complex maze of new rules associated with welfare *or* Medicaid eligibility. This requires new systems and new procedures. It requires states to carefully review and reconsider the design of their Medicaid program. And in the transition period, it requires that caseworkers who are now focused on work requirements must also know and remember to enroll in Medicaid people who may not be

eligible for, or may be diverted from, TANF. This is quite a tall order.

As noted, PRWORA also made profound changes in the provision of assistance to legal immigrants. Medicaid changes in immigrant eligibility are similar to those applied to TANF, although some Medicaid provisions were later moderated for legal immigrants in the United States before PRWORA was enacted. The primary ban on Medicaid for new legal immigrants and the deeming of sponsor income still remain and have raised enormous concern in the immigrant community. Widespread fear has been reported by both legal and illegal immigrants faced with applying for medical assistance, particularly for their legal children. It appears that many eligible immigrant families may not be seeking Medicaid for themselves or their children because of this very negative signal. A report prepared for the Kaiser Family Foundation on focus groups in California provides striking evidence of the misinformation and fear associated with Medicaid enrollment there.¹⁰ This problem has surely motivated the recent proposal in the president’s fiscal year 2000 budget request to restore Medicaid benefits to legal immigrants who lost them under PRWORA.¹¹

Medicaid Caseload Dynamics

As noted, welfare caseloads are down since the early 1990s, with an increasingly rapid decrease since the passage of welfare reform. Medicaid data reporting lags behind welfare reporting, making comparisons more difficult. However, Medicaid enrollment is also down, but less so than welfare. Using Health Care Financing Administration (HCFA) data from 1995-96 (a period before PRWORA was enacted but instructive because so many states were already using federal waivers to administer welfare programs much like TANF), Marilyn Ellwood and Leighton Ku last year reported early evidence of these declines. They reported a 1.8 percent overall reduction in the number of children and nondisabled adults in Medicaid during this period. This net change reflects a 7.5 percent reduction in AFDC-based Medicaid enrollment and a 5.8 percent increase in noncash-related enrollment. They noted that “this net decline in Medicaid participation is noteworthy, since this is the first downturn in nearly a decade of steadily rising Medicaid participation rates.”¹² Studies in individual states confirm this trend. Ellwood and Ku analyzed state enrollment drops for Medicaid adults and children from January 1995 to January 1998 and found decreases of more than 29 percent in Wisconsin, 19 percent in New York, 18 percent in Florida, and 12 percent in California, for example.¹³

Mark Greenberg last fall reported similar findings and presented information from a series of “exit” studies. In these studies, sometimes referred to as “leavers” studies, some states have analyzed why people are no longer on TANF and have reviewed their Medicaid status. Greenberg reported that, despite an array of approaches, methodologies, and questions asked, the studies that ask about Medicaid provide fairly consistent information:

When families cease receiving AFDC/TANF, Medicaid enrollment goes down. The magnitude of the decline varies between studies, but often, one-third or more of children and most adults in families that have exited are no longer reported to be receiving Medicaid when exiters are surveyed some number of months after leaving.¹⁴

Greenberg recited state findings: South Carolina found 16 percent of children and half of adults had no health care coverage; New Mexico data suggest that one-quarter of children and most adults had neither Medicaid nor employer coverage; Indiana found one-third of children and most adults had no coverage after leaving TANF; Washington discovered one-third of families and 16 percent of children were without coverage; Tennessee reported the highest level of continued coverage, probably because that state’s TennCare program provides 18 months of TMA.

In a 1997 study of three states, GAO showed participation falling in families where welfare benefits were terminated, with Medicaid participation ranging from 84 to 100 percent before termination and from 26 to 61 percent after.¹⁵ And Urban Institute researchers engaged in the major multiyear study of social programs, *Assessing the New Federalism*, have said:

Despite state efforts to maintain Medicaid enrollment for those beneficiaries leaving the cash welfare rolls without obtaining employer-sponsored health insurance, Medicaid enrollment is falling. Yet Medicaid enrollment has not declined as much as cash welfare rolls because of the many ways to remain eligible for Medicaid, especially for children and pregnant women. . . . However, rates of uninsurance for adults, especially women, are likely to increase. These changes imply that the composition of the uninsured will change, with fewer children and more adults. Falling enrollment will depress the rate of growth of Medicaid expenditures.¹⁶

Study results are just beginning to come in, and additional information will be critical to further understanding and response to this phenomena. On the positive side, the news is not as bad as some predicted when PRWORA was enacted, and the Medicaid declines are generally not nearly as great as the welfare

declines. But the results are far from rosy, and there is great cause for concern, particularly because congressional intent was to maintain or even allow expansions of Medicaid, not to inadvertently decrease the number of people receiving the benefits of the program. Many states are increasingly concerned with this issue and are responding in a variety of ways.

Broader State Concerns

While there was a fair amount of national consensus around the need to reform welfare and stress work over cash payments, there was no stated desire to cut the Medicaid program while reforming the welfare cash payment system. In fact, the PRWORA statute gives states new tools to actually expand Medicaid eligibility and develop an entirely health-based program. The fact that Medicaid enrollment might be dropping because of welfare reform should sound an alarm. States certainly want to avoid the unnecessary health and cost consequences of inadequate preventive care and delayed health services, as well as threats to the continued viability of safety net and managed care providers.

In an attempt to learn what public human services administrators and evaluators believe is happening in this dynamically charged environment, Vernon K. Smith, Ph.D., and Mary Jo O’Brien last summer initiated a series of focus groups and a survey of state human service administrators, Medicaid eligibility specialists, and welfare agency analysts. In their October 1998 report, “The Dynamics of Current Medicaid Enrollment Changes,” they identified five themes based on state officials’ views:

- People still link Medicaid to welfare and believe that tougher welfare policies apply to Medicaid.
- Diversion and job emphasis have channeled people away from Medicaid, and the healthy economy has made it easier to find jobs and raised incomes so that some no longer meet income tests for Medicaid.
- Administrative procedures do not always continue Medicaid for eligible children or adults who work their way off welfare.
- People do not know they are eligible for Medicaid, because both they and state workers lack information or are confused.
- Potential beneficiaries often delay applying for Medicaid until there is a medical need.
- State officials are identifying actions to improve their programs, processes, forms, systems and image.

Smith and O'Brien concluded that "there is a significant relationship between what is happening in welfare eligibility and in Medicaid enrollment."¹⁷

Elaine Ryan, an official of the American Public Human Services Association has noted the difficulty of managing Medicaid since welfare reform. Calling for additional statutory or regulatory reform to allow greater state flexibility, she has suggested that new Medicaid standards that are simpler to administer and easier for families to understand must be established.¹⁸ Ellwood and Ku noted that "state officials and advocates are understandably concerned that information about the availability of Medicaid benefits may be overlooked, as local welfare offices focus on increasing employment and reducing dependency."¹⁹

Observers agree that the time is right for serious examination of state health financing programs for low-income people. A confluence of events, including availability of information from new studies, more operational experience with TANF, and the addition of the new State Child Health Insurance Program (CHIP), should help states with an interest in reassessing their programs. States have new responsibilities in at least three critical programs—TANF, CHIP and Medicaid—and review of the interaction of all three is appropriate to assure that states meet client needs and assure appropriate efficiency and effectiveness in these important human services programs.

THE FORUM SESSION

This forum session will review the welfare reform program, examine the status of several studies related to state implementation practices and activities, and explore the initial impact of welfare reform on Medicaid. The Forum will have the help of a number of experts to discuss a series of questions about the status of welfare reform and the impact of welfare reform on the Medicaid program, including:

- What is the status of welfare reform in states? Has the devolution of public policy authority changed the basic nature of welfare programs? In what ways? Is devolution beyond the state to local and community staff appropriate and acceptable? Are interactions between client and caseworker more efficient and productive?
- Should results be measured primarily by declining caseloads? What are the critical concerns that need to be addressed next?

- What kinds of systems have states changed in implementing their TANF programs? Are states better managing their welfare programs? What measures should be used to determine effectiveness and accountability?
- How has welfare reform changed state processes and procedures in determining eligibility for TANF and Medicaid? What is the nature of the differences between eligibility determinations in the two programs? Are states setting up entirely new and separate eligibility processes for Medicaid, or has Medicaid eligibility determination become a poor step sister, crying for attention?
- What do we need to do to avoid unintended Medicaid case declines? Can two systems—welfare and health—work, or should we move back to a more uniform system? Are two eligibility processes a good idea?
- Is there need to focus specific attention on reengineering the Medicaid program in light of welfare reform? What are the primary problems that should be addressed in such a systems reform, and who should be driving this reengineering—directives from the federal level or states themselves?
- What have states done to take advantage of welfare reform to broaden their health programs? Are they thinking more about Medicaid as a health insurance program?
- Can the Medicaid program be transformed from a program stigmatized by its welfare identification into a health program? How long will this take? What changes would be necessary in the law, in management systems, and in caseworker orientation, training, and practice? What other steps are necessary?

Speakers

The first speaker will set the stage for our discussion by providing a status report and update on welfare reform. **Richard P. Nathan, Ph.D.**, brings a unique perspective to our discussion, having spent over 30 years as an observer of and participant in welfare policy. Dr. Nathan is distinguished professor of political science and public policy and director of the Nelson A. Rockefeller Institute of Government, the public policy arm of the State University of New York (SUNY). Before joining SUNY in 1989, he was a professor of public and international affairs at Princeton University and, earlier, a senior fellow at the Brookings Institution. Prior to his academic career, Dr. Nathan worked in

federal service, serving as assistant director of the Office of Management and Budget from 1969 to 1972 and deputy under secretary for welfare reform at the Department of Health, Education, and Welfare in 1972. His SUNY colleague **Frank J. Thompson, Ph.D.**, will also speak, describing their joint work on a new review of TANF and its affect on the social safety net, especially Medicaid. Dr. Thompson is interim provost of Rockefeller College at SUNY Albany.

Vernon J. Smith, Ph.D., and **Mary Jo O'Brien** will describe their recent study of Medicaid eligibility and state processes, "The Dynamics of Current Medicaid Enrollment Changes." Both bring extensive state experience and insight to share with us. Dr. Smith is a principal with Health Management Associates, an organization that he joined in 1997 after many years service in the state of Michigan, where he served as Medicaid director for five years. He was vice-chair of the National Association of State Medicaid Directors from 1994 to 1997 and chaired the governing board of the National Academy of State Health Policy from 1995 to 1998. Ms. O'Brien has recently joined Health Management Associate as a principal. At the time of the study, she was vice president of the Lewin Group, and she previously served as commissioner of the Minnesota Department of Health.

Other commentators will provide additional insight to the forum session. **William Waldman** is executive director of the American Public Human Services Association, the organization which represents directors of state welfare, social service, child care and child support, as well as Medicaid programs. Mr. Waldman will discuss implementation of TANF and its impact on Medicaid from the standpoint of the state officials who have been on the front lines, making the choices, directing change, and fulfilling the requirements in PRWORA. Before beginning his service at APHSA last summer, he served as commissioner of the New Jersey Department of Human Services while TANF was being implemented in that state, and will be able to share those experiences with us as well.

Cindy Mann, director of the State Low-Income Initiatives Project at the Center on Budget and Policy Priorities, will describe her work on the impact of welfare reform on Medicaid. Ms. Mann is an expert on Medicaid and eligibility for welfare and related programs and has written extensively for states and advocates to assist in the redesign and implementation of welfare reform programs. She was involved in congressional deliberations when PRWORA was enacted.

John Monahan, principal deputy assistant secretary with the Administration for Children and Families at the Department of Health and Human Services, has been involved in both the enactment and the implementation of PRWORA. Mr. Monahan will be on hand to provide information about the department's priorities and the ongoing monitoring associated with welfare reform. At the time of the passage of welfare reform, Mr. Monahan served as director of intergovernmental affairs and spent considerable time working on issues related to Medicaid. Prior to joining DHHS, he served on the Clinton/Gore transition team and was counsel to Sen. David Pryor (D-Ark.).

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