WELFARE REFORM AND AMERICA'S POOR:

The Impact of Declining AFDC/TANF Caseloads on Medicaid Enrollments

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ABSTRACT

This paper examines the impact of welfare reform on America's poor. The primary goal of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996 was to promote self-sufficiency through employment. This legislation produced noticeable changes in the American welfare system. The Temporary Assistance for Needy Families program (TANF), the principal reform mechanism, moved people from the welfare rolls into the workforce. The success of the program is often equated with the number of people no longer receiving cash benefits. This equation of success only tells part of the picture.

This analysis examines how declines in AFDC/TANF caseloads have affect other public programs, thereby presenting a more comprehensive picture of the impacts of welfare reform. We particularly wanted to explore how welfare reform mechanisms related to other support programs and thereby derive a more comprehensive assessment of success. In this paper, we explore this topic by analyzing the impact of welfare reform on the poor as it creates change in public healthcare enrollment patterns. More specifically, we examine programmatic and economic variables on the percentage caseload changes in Medicaid enrollment.

In our study, we found that the traditional view of policy interaction effects of one program on another is valid. However, the specificity of how social programs may direct usage of one another is mistaken. The reductions in the cash benefit rolls have led to a significant increase in Medicaid enrollment. We also found that even in a time of a strong economy, Medicaid enrollments are much higher than the enrollment patterns of any other social programs. As a result, we conclude that welfare reform has not had as great an impact on the poor as was predicted with the passage of PRWORA. Moreover, as more people are dropped from welfare

rolls into low-income jobs, there will continue to be a rise in the enrollment patterns of support programs, particularly Medicaid.

INTRODUCTION

Welfare reform has brought about significant changes to the social mechanisms that provide assistance to the poor in America. When welfare reform was implemented in 1996, its mechanism for change, the Temporary Assistance for Needy Families program (TANF), replaced the Aid to Families with Dependent Children program (AFDC). The inability of the AFDC system to respond to overwhelming concerns about rising welfare caseloads, costs, and other social problems over the past three decades precipitated a concerted effort to pass the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) in 1996. The 1996 reform devolved greater control and authority over welfare program administration to states.

Although the passage of PRWORA can be credited with unprecedented caseload reductions, welfare reform has had somewhat of an ambiguous impact on poverty and it has contributed to an increase in the number of persons seeking and obtaining Medicaid. Much of the statistical data lend credence to the arguments of welfare reformists who laud the success of the reform. However, the number of families and children living in poverty continues to be extraordinarily high and those numbers have been steadily increasing since 2000. In addition, welfare reform has been counterproductive in its influence on other social programs. Medicaid enrollment, for example, has substantially increased since the implementation of TANF. These issues raise one important question: How has welfare reform affected other social programs? Although the full impact of welfare reform has yet to be seen, the early findings presented in this research demonstrate that the "success" of the reform may be just a mirage.

WELFARE REFORM

The welfare system under TANF differed from its predecessor, AFDC, in three important respects: new limitations on the time a recipient is eligible for benefits, an overall decrease in welfare caseloads, and mandatory work requirements for eligible program participants. These three changes signaled a significant shift in the purpose and intent of the welfare system in America. Historically, the welfare system has been an entitlement program, where eligible individuals and families were "entitled" to federal support. Welfare reform eliminated this entitlement and instituted several programmatic practices that made the receipt of public assistance a conditional means of support. The most important of these practices was that TANF made it necessary for adults to engage in acceptable state-defined work activities as the means for obtaining and/or maintaining public assistance. The federal government was able to "revolutionize" the welfare system by placing the onus of reform on the states. As a result of "devolution," the states would be in the critical position of administering and assuming responsibility for their welfare programs.

Welfare reform instituted a state-centered welfare system, which differed from the AFDC system that relegated states to a position of being bureaucratic agents of the federal government. The states were awarded millions of dollars through a new federal block grant system to fully assume control over the welfare system. Although the federal government outlined broad policy parameters with PRWORA, it mostly relinquished the authority and responsibility over the development and implementation of welfare programs to the states. This new approach to welfare administration supported the long held belief that state, and in some instances local, agencies ("second order devolution") were most efficient in this capacity because of their close proximity to the people demanding services (Schram 1998; Weaver 2000). With this new

conveyance of authority over welfare programs, the states utilized their block grants to address the social problems that motivated the reform movements of the previous decades.

Welfare Reform and the Issue of Poverty

The issue of poverty has been a conundrum for U.S. policymakers for most of this century. During the mid-70s, the number of persons living in poverty in America was at its lowest point since the 1930s. At that time the poverty rate was just below 12% (U.S. Census Bureau 2002). However, by the 1980s the rate at which people were living below the poverty line began to climb to a high of over 30% (U.S. Census Bureau 2002). When PRWORA was implemented in 1996, one of the problems that policymakers anticipated resolving with the passage of this reform legislation was the poverty dilemma. Although the poverty rate decreased after the implementation of TANF, a noticeable downward trend had already begun in 1993 (U.S. Census Bureau 2002). Welfare reform's objective was to reduce the number of persons on public assistance by providing recipients with the means to escape poverty through work (Mead 1997). The work requirement was seen as the path to economic self-sufficiency. However, the true ability of the reforms to elevate the poor from a position of need becomes questionable in the face of economic instability.

The 1990s demonstrated the power of a strong economy. The unemployment rate was at an all time low because jobs were plentiful. Moreover, per capita incomes had improved for many Americans during the economic boom. Hence, the newly implemented welfare reforms had great success at achieving PRWORA's most pressing objective -- reducing the welfare caseload. But, when the economic indicators began to show signs of an approaching recession around 2000, the effectiveness of welfare reform became an issue of discussion in the ongoing dialogue between welfare advocates and opponents. Recently, the downward trend in welfare

caseload numbers has slowed, as recipients are increasingly unable to leave the welfare program because of financial need. The percentage decrease in TANF caseloads has started to shrink as a sluggish economy continues to exacerbate the problem of poverty in America.

WELFARE REFORM IMPACTS HEALTHCARE FOR THE POOR

As impressive as the declining welfare rolls are, they do not depict the complete picture of poverty. There have been significant changes in other social programs that affect impoverished and low-income people. States have been quite inventive with their eligibility rates and expansions of support programs beyond cash benefits. Therefore, we are compelled to examine the interaction of programs in order to identify the real effects of welfare reform on poverty. In our analysis, we investigated whether PRWORA mechanisms are putting an added burden on other support programs. Between 1996 and 1998, Medicaid enrollment fell by 1.2% (Kaiser Foundation 2001, Moore 1999). This was the first decrease in Medicaid in decades (Moore, 1999). However, that decline was short-lived. By 1999, Medicaid enrollment had increased by 4.4% (Kaiser Foundation 2001). And, by 2001, Medicaid enrollment was larger than ever; up 22.0% since 1999 (Kaiser Foundation 2001). Medicaid is an important issue when discussing poverty and welfare reform for several reasons.

First, and perhaps foremost, Medicaid supports more poor and near-poor Americans than any other social program. Enacted in 1965, Medicaid is a joint federal and state program that

(Insert Figure 1 here)

provides health insurance to people with incomes at or below the federal poverty level (Aston 1997, Gruber 1997, Schneider 1998, Newacheck, Pearl, and Hughes 1998). It has been referred to as "health insurance for the poor" or as most people have understood it to be, a particular "welfare benefit." Medicaid, however, provides coverage for more than just those on welfare (i.e., receiving cash benefits). It also provides medical insurance coverage for the underemployed, elderly, and disabled. For this analysis, we focus on Medicaid enrollment patterns for pregnant women, children and families, excluding the elderly and disabled. To employ some generalizations, we limit our investigation to these target populations because they are the primary consumers of most social program benefits. In 2001, Medicaid caseloads for pregnant women, children, and families soared to 22,986,000 (Kaiser Foundation 2001). This is a significant difference from the Food Stamp Program and TANF. Medicaid is the largest social program in the nation.

Second, Medicaid's basic components have remained intact during welfare reform. PRWORA produced significant changes to the welfare system, but left Medicaid virtually untouched. Its eligibility requirements have stayed the same and it still finances the same group of needy people (women, infants, and children). However, welfare reform *did* finally sever the administrative linkage between cash benefits and medical insurance benefits. This decoupling started in the mid-1980s under the Omnibus Budget Reconciliation Act of 1986 (King 1997, Lin and Lave 1998). It was an effort to diminish the perceived welfare stigma often associated with Medicaid by allowing the states to offer Medicaid benefits to low-income individuals who did not receive cash benefits under welfare.

This unlinking has had mixed effects on Medicaid enrollment and the poor. Medicaid is quite complex and onerous. Its process, accessibility, and requirements are often misunderstood,

making it difficult to increase enrollment. Moreover, its eligibility requirements befuddle most people, including administrators. For example, after the enactment of the PRWORA, administrators disenrolled many people who were dropped from the welfare rolls despite the mandated transition coverage (Moore 1999). This confusion may account for the decline in enrollment between 1996 and 1998.

Third, throughout its 35-year history, there have been incredible expansions in eligibility and services under Medicaid; especially since the mid-1980s, to ensure America's poor received healthcare coverage (Rosenback, Irvin, and Coulam 1999, Lin and Lave 1998, Moffitt and Slade 1997). Impressive changes have been made in the last two decades. Reagan's new federalism gave states immense power and flexibility over social programs. Under the Omnibus Budget Reconciliation Acts (OBRA) of the 1980s, efforts to extend healthcare coverage to needy populations were unparalleled. These reforms and extensions gave states power over the identification and assignment of "needy" to particular sections of their constituency. The reform legislation often targeted pregnant women, children, and infants. In 1981, the OBRA permitted states to provide targeted populations (persons with special needs) with a more comprehensive benefit package. It also allowed states the opportunity to experiment with Medicaid payment plans (Lin and Lave 1998). This was an effort to increase Medicaid's cost-effectiveness (Lin and Lave 1998). Congress passed the Consolidated Omnibus Budget Reconciliation Act in 1985; altering the restrictive nature of Medicaid. States were now able to design benefit packages on a case-by-case basis to insure that the needs of its constituency were met. Later in 1987, OBRA increased the eligibility levels for pregnant women. This change helped borderline poor women needing prenatal care. Finally, in 1990, eligibility was granted to children up to nineteen years of

age and continual care offered to pregnant women up to 60 days post-partum (Lin and Lave 1998).

This flexibility continued in the 1990s. Prior to the 1996 reform legislation, many states employed Section 1115 Waivers to continue their ingenuity to deliver additional support to their needy populations and reduce welfare caseloads. However, by 1997, about 11 million, or 15% percent, of America's children remained uninsured (Lin and Lave 1998). To help eradicate this problem, Congress passed the State Children's Health Insurance Program, Title XXI of the Social Security Act, as part of the Balanced Budget Act of 1997 (P.L. 105-33). This new legislation allows more children to obtain health insurance. Over a ten-year span approximately $48 billion will be distributed to states to cover health insurance for low-income children. CHIP is an expansion of or an addition to preexisting state Medicaid plans. States may opt to simply extend Medicaid, implement or expand a separate state program, or provide a combination of the two. As of 2000, most states had adopted Medicaid expansions or hybrids (Tucker 2000, Aston 1999, Gardner 1998).

CHIP boosted Medicaid enrollment in several ways. It not only increased the number of insured children under Medicaid and Separate State plans, but it identified other eligible Medicaid beneficiaries. Due to its complexity and limited outreach activities, people are often unaware of Medicaid's extensive eligibility and wide range of services. Therefore, many qualified persons do not apply for such benefits. Under the Children's Health Insurance Program, outreach is a mandatory exercise. Outreach activities for CHIP have brought an advantageous positive externality to Medicaid (Landers 2000, Frieden 1999). CHIP applicants can be detected and referred to Medicaid if they qualify under the states' existing eligibility guidelines.

Welfare reform has in many ways changed the way redistribution services support America's poor. Our study demonstrates how welfare mechanisms, while reducing the number of people receiving cash benefits and getting people to work, shifts additional redistribution responsibilities to other social programs, such as Medicaid. Medicaid continues to serve millions of Americans that cannot afford to purchase private healthcare coverage. Welfare reform has been effective at getting people to work; most in low-income positions. These jobs do not offer healthcare benefits and do not provide a means to purchase private insurance. Since the reform legislation, the "working poor" have increased in numbers and Medicaid has been taking up the slack of providing a basic level of healthcare to the poor. Moreover, since welfare reform, the states have been given greater responsibility over the costs incurred by running a program of this magnitude. State governments, during this time of limited financial resources and economic uncertainty, are forced to find ways to deal with skyrocketing Medicaid costs and limited budgets. These are salient issues and they point to the underlying problems with rising Medicaid enrollments that have the potential to create a social crisis. This paper takes a preliminary look at the factors influencing the substantial increase in Medicaid enrollment patterns.

MODEL AND DATA

If we believe that the 1996 reforms have been successful at helping people become economically self-sufficient and are, as a result, helping recipients to leave the rolls, than it stands to reason that there should also be declines in Medicaid enrollment numbers. Current Medicaid enrollment patterns demonstrate that the numbers have not only continued to increase, but they have substantially increased since welfare reform. To test this relationship we developed

a model that sets the change in Medicaid enrollment patterns for pregnant women, children, and families from 1999-2000, *Medicaid*[1], as the dependent variable.

There are several independent variables that are hypothesized to have a significant impact on Medicaid enrollment patterns. The first independent variable, *Welfare*[2], measures the percentage change in the number of AFDC/TANF families from 1995 to 2000. There have been significant percentage decreases in welfare caseloads across the states. If welfare reform was meticulously improving the economic conditions of current and former welfare recipients; we would expect to also see percentage decreases in Medicaid enrollment. According to Medicaid enrollment data, this has not been the case. Welfare caseloads have declined, but Medicaid enrollment has increased, therefore, we predict that percentage decreases in welfare caseload numbers will lead to percentage increases in Medicaid enrollment. This analysis does not limit itself to just the more obvious effects of welfare reform on Medicaid enrollment patterns. The model also incorporates and tests the effects of some programmatic factors that are critical to the reform effort.

The next three independent variables measure the effects of specific programmatic practices and outcomes. The *Work*[3] variable captures the percentage of adult recipients that are participating in state-defined work activities during the 1999 fiscal year. We hypothesize that when work participation rates increase there will be a greater number of employed and economically self-sufficient welfare recipients, hence, there will be a decline in Medicaid enrollments for pregnant women, children, and families. The work component is the most important feature of the TANF program because it is the mechanism for reform. Welfare reform proponents argue that the effectiveness of PRWORA hinges upon the states' ability to effectively implement the mandatory work requirement for all eligible adults. The states responded to this

mandate in various ways. In terms of specific work programmatic requirements, the states established different time frames for mandatory work participation. The states with more stringent work programs were more likely to require immediate work participation and the states with more lenient programs did not set an immediate work requirement. Hence, more severe work programs, coded "1" in the model, will have greater work participation rates and greater percentage decreases in Medicaid enrollment. The *Time*[4] variable captures the impact of work programmatic practices on the dependent variable in 1999. Lastly, the *Adult*[5] variable measures the percentage distribution of TANF adults participating in work activities during the 1998-1999 fiscal year. This variable measures all state-defined work activity, therefore, it includes the distribution across different activities (i.e., unsubsidized employment, job search activities, job training education, work preparation training) considered acceptable for meeting the work requirement. As the percentage distribution of adults participating in all work activities increases, we would expect Medicaid enrollment patterns to reflect this diversification in work activities.

The fifth independent variable, *Income*[6] gauges the influence of economic conditions on the dependent variable. In the model, we utilize *per capita income* estimates as a proxy for economic conditions. A measure of economic condition is critical to this model because it enables us to distinguish the effects of a weakening economy on Medicaid enrollment patterns from the impact of welfare reform on enrollment. We expect that economic conditions will have an inverse relation to the percentage change in Medicaid enrollment numbers because as the economy becomes more unstable the number of those seeking and obtaining Medicaid will increase.

The last independent variable is state policy priorities, *Policy*[7]. State governmental decisions about how to allocate scarce state funds are critical to the effectiveness of welfare

reform. If state governments determine that supporting programs that provide particularized benefits, i.e., welfare, are an important policy priority than scarce state dollars will be utilized for programs of that nature. On the other hand, if state policymakers deem it more important to prioritize more collective policies that extend benefits to the community-at-large, than state funds will be utilized in that manner. We expect to see that state policy decisions that prioritize more particularized policies will contribute to a percentage increase in the number of pregnant women, children, and families enrolling in the Medicaid program.

EMPIRICAL RESULTS

The empirical results of the model demonstrate that welfare reform has had an impact on the Medicaid enrollment patterns. The overall fit of the model to the data was good with an R^2 of about .52. This value indicates that the variables included in the OLS regression equation account for 52% of the unexplained variance in the percentage change in Medicaid enrollments for pregnant women, children, and families.

Table 1 presents the empirical results for the complete model. The unstandardized OLS coefficient estimates are presented in the middle column with their corresponding standard errors. All of the variables have statistical significance at the .05 probability level using one-tailed hypothesis tests. The standardized coefficients are listed in the far right column to correct for state-to-state differences that are inherent in the model.

(Insert Table 1 here)

Upon examining the model more closely, we discovered some interesting results. One of the most significant findings from this empirical analysis of welfare reform's impact on Medicaid enrollment patterns is that the tremendous percentage decreases in welfare caseloads across the 50 states has contributed to a significant increase in Medicaid enrollments. So, contrary to what many would believe, the 1996 reforms have not been as effective at ameliorating the poor economic conditions of current and/or former welfare recipients. The *Welfare* variable, which measured the change in welfare caseloads, supports this finding with a coefficient value of -.347 and a standardized value of -.561. Changes in welfare caseload numbers do have a significant influence on Medicaid enrollment patterns for pregnant women, children, and families.

Programmatic factors also have a significant impact on Medicaid enrollment patterns. Table 1 shows the OLS estimates for work participation rates, *Work*, work participation time frame requirements, *Time*, and the percentage distribution of TANF adults participating in work activities, *Adult*. The significance of the work component to welfare reform suggests that all of these variables will have an impact on Medicaid enrollments. This proves to be the case because all three of the variables are significant. First, if we look at work participation rates, we notice that as the percentage of recipients engaged in work activities increases there is a .237 percent decrease in Medicaid enrollment for pregnant women, children, and families. Moreover, the standardized coefficient of -.401 substantiates this finding. Second, since the presence or absence of immediate work participation requirements, *Time*, is a dichotomous variable, we analyze the empirical results and conclude that states with immediate work requirements will have a 5.645 percent decrease in Medicaid enrollments. And, third, the percentage distribution of TANF adults actually participating in work activities also has an impact on Medicaid enrollments. The

results demonstrate that the percentage distribution of adults participating in certain types of work activities matter. An increase in the percentage distribution of TANF work participants leads to a .233 percent increase in Medicaid enrollments. If TANF work program participants are engaged in work activities that include job search and work preparation training and are not receiving income from employment, the benefits of work and economic independence are not fully realized by the recipient. Therefore, an increase in these other work activities would contribute to a percentage increase in Medicaid enrollments. All three of the work program-related variables behaved as initially predicted. We argued that an increase in the number of people working would contribute to greater economic self-sufficiency, thereby, reducing the percentage of people enrolled in Medicaid. Moreover, to further emphasize the importance of work to welfare reform, we predicted that an increase in the percentage distribution of TANF adults participating in acceptable work activities would have a positive impact on enrollment patterns.

Economic conditions also have an impact on Medicaid enrollment patterns. However, when compared with the other programmatic and policy variables, the per capita measure, *Income*, has a coefficient value of -.001, which indicates that it has a small, but significant, impact on enrollments. As income levels decrease during this period of high unemployment and economic uncertainty, we expected to see an increase in Medicaid enrollments and the findings in Table 1 support that previous assertion.

The last factor that was tested in this model incorporates the influence of state governmental decisions pertaining to how state actors allocate limited state funds in support of their policy priorities. The state policy priorities variable, *Policy*, has an impact on Medicaid enrollment patterns. The coefficient value is 35.359 and is significant. This particular measure

dictates that larger coefficient values, such as this one, indicate state policy priorities that are more particularized in nature. We expected state governments that prioritized policies that provided for particularized benefits would have greater enrollment patterns for pregnant women, children, and families and the results confirm this hypothesis.

CONCLUSION

The Personal Responsibility and Work Opportunity Act of 1996 has produced some significant changes to the American welfare system. It has impacted the poor and near poor citizens of America in vast and various ways. The TANF mechanism provides clear objectives to reduce the number of people dependent upon cash benefits, in hopes of pushing them towards economic self-sufficiency. This analysis finds that welfare reform has caused an increase in the enrollment patterns of other social programs, namely public health insurance. We found that welfare roll declines do not provide an accurate depiction of reform success. Welfare reform has reduced the number of people receiving cash benefits. Many of these former recipients have been forced into low-income jobs that do not offer health benefits or a means to purchase private insurance. The empirical results of the impact of the work component on Medicaid enrollments support this belief.

Although work participation rates have increased and there are more people employed there has not been a decline in Medicaid enrollments. The impetus for reforming the welfare system was to encourage recipients to seek and obtain employment, so that they would become economically independent of public assistance. However, despite the increased participation in work, welfare reform has not significantly improved the economic conditions for America's poor. Therefore, these inadequacies are shifted to other social programs, such as Medicaid.

Consequently, issues of non-cash benefits that supplement the needs of poor or impoverished people must be addressed.

This study involves new theoretical and substantive implications to the field of social policy. The impact of welfare reform mechanisms on poverty provides an overview of how new legislation meets targeted needs as well as performs in an unpredictable society. The increased dialogue regarding the interplay of social programs stimulates additional research questions: How does one policy impact the outcomes of another? Can social policies ever be completely separate?

This analysis highlights the inherent problems in making broad assumptions regarding the changes in one social program independent of the factors associated with other similar programs. This preliminary analysis barely scratches the surface of the intricate relationships between welfare reform and other social programs in America, but it does provide an initial look at the complex issues that exist in this research area. Building upon the foundation established in this paper would necessarily entail a more comprehensive examination of other social programs. It would be important to look at other specific factors pertaining to these programs (i.e., job retention rates, earning levels, etc.). Moreover, it would be beneficial to this focus to include more programmatic aspects of Medicaid (i.e., outreach activities, eligibility requirements, etc.). As welfare reform matures, more data will become available and the empirical results will be better suited for generalization. In the meantime, researchers in the policy field will have to continue to analyze the data that is available in an effort to uncover and explain interesting causal relationships that could possibly have an influence the policy process.

NOTES

1. The data for the percentage change in Medicaid enrollments for pregnant women, children, and families during the years 1999 to 2000 was obtained from the Kaiser Foundation. "Medicaid Enrollment in the 50 states." December 2001, Data Update #4067, available on the website at www.kff.org/content/2002/4067.
2. The percentage change in AFDC/TANF caseload data for the time period 1995 to 1999 comes from the U.S. Department of Health and Human Services, Administration for Children and Families, Office of Planning, Research and Evaluation, available on the DHHS/ACF/OPRE website.
3. The data for the TANF work participation rates for 1999 were obtained from the *Temporary Assistance for Needy Families (TANF) Program*, U.S. Department of Health and Human Services, Administration for Children and Families, Office of Planning, Research and Evaluation, Third Annual Report to Congress, August 2000.
4. The work participation time frame variable is a dichotomous variable. If states require immediate work participation upon receipt of benefits the variable is coded "1" and if there is no immediate requirement the variable is coded "0." The data for this post-reform (1999) variable comes from the *Temporary Assistance for Needy Families (TANF) Program*, U.S. Department of Health and Human Services, Administration for Children and Families, Office of Planning, Research and Evaluation, Third Annual Report to Congress, August 2000.
5. The data for the percentage distribution of TANF adults participating in work activities during the 1998 to 1999 fiscal year was obtained from the *Temporary Assistance for Needy Families (TANF) Program*, U.S. Department of Health and Human Services, Administration for Children and Families, Office of Planning, Research and Evaluation, Third Annual

Report to Congress, August 2000. The percentage distributions of TANF adults participating in work activities include 4 different types of state-defined work activities: unsubsidized employment, job search, work preparation, and job training education.

6. The per capita income data comes from the U.S. Census Bureau, *Statistical Abstract of the United States* for 2000.
7. The state policy priorities variable for 1999 was derived from the procedure described in Jacoby and Schneider (2001). In this paper, we utilize a simplified version of the measure by taking the difference between the percentages of state government expenditures devoted to particularized (i.e, welfare) and collective (i.e., highways) policies. Larger OLS estimates indicate a greater state commitment to particularized benefits and smaller OLS estimates indicate a state-level emphasis on collective goods. The data used to create the variable come from the state government expenditures provided in the *Statistical Abstract of the United States, 2001*.

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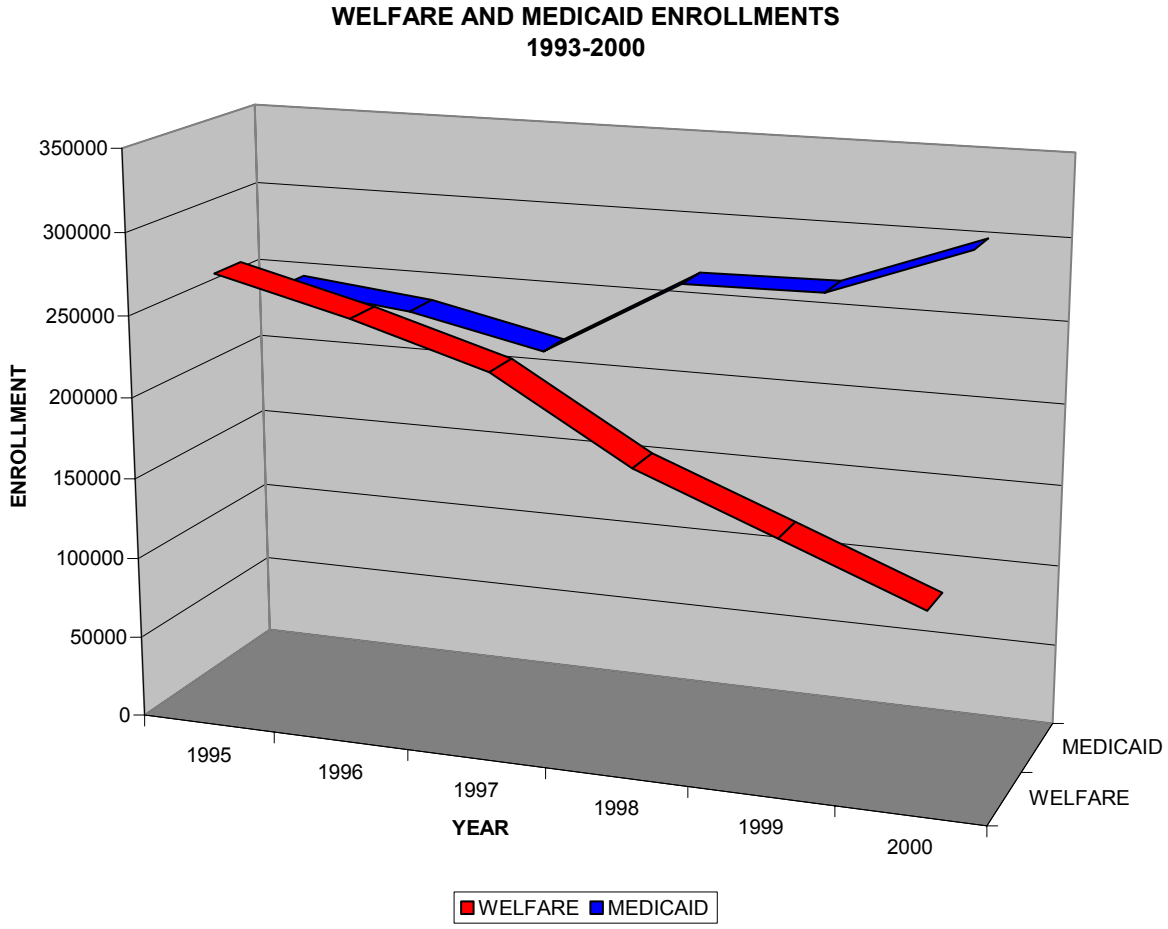
Table 1. Welfare Reform's Impact on Medicaid Enrollment Patterns

	OLS Coefficient Estimates	Standardized OLS Coefficient Estimates
Welfare	-0.347 (0.086)	-0.561
Work	-0.237 (0.093)	-0.401
Time	-5.645 (2.287)	-0.307
Adult	0.233 (0.087)	0.429
Income	-0.001 (0.000)	-0.294
Policy	35.359 (17.833)	0.260
R^2	.517	
Adjusted R^2	.437	
Intercept	9.554	
Number of Observations	43	

* All variables are significant.

Note: The standard errors are shown in parentheses.

FIGURE 1. LINE GRAPH OF AFDC/TANF CASELOADS AND MEDICAID CASELOADS*



*Medicaid caseloads include families, children, and pregnant women. Data are rounded to the nearest one hundred thousand. The AFDC/TANF data are rounded to the nearest ten thousand.