THE IMPACT OF WELFARE REFORM ON MEDICAID POLICY IN THE AMERICAN STATES

Saundra K. Schneider
Michigan State University
February 2007

sks@msu.edu

Prepared for delivery at the
Seventh Annual Conference on State Politics and Policy,
University of Texas at Austin, February 23-24, 2007.

ABSTRACT

This study examines the impact of welfare reform efforts on Medicaid policy within the American states. The empirical analysis reveals that states with the greatest reductions in welfare coverage have also exhibited the largest increases in Medicaid program enrollments, and vice versa. This linkage is tempered by influences stemming from state-specific TANF work provisions, Medicaid policy decisions, and economic conditions. But, the findings show clearly that decreases in cash assistance caseloads are the primary stimulant for increases in state Medicaid recipient populations. These results have important implications for substantive theories of policymaking, scholarly views about the nature of the Medicaid program, and the types of issues that are now confronting American state governments.

The 1996 Welfare Reform Act brought about major changes in the American welfare state. It ended the previously-existing federal entitlement of cash benefits, and, in so doing, promoted a state-centered system of public assistance programs (Weaver 2000; Soss, Schram, Vartanian, and O'Brian 2001). The major goals of this legislation were to minimize poor citizens' reliance on government support and to prepare them for work activities. One of the most noticeable consequences of these changes is reflected in the size of the welfare population. Across the states, welfare caseloads dropped markedly during the late 1990s, and they have remained relatively low since that time (Pear 2004; Haskins 2006). This result is indisputable, and it has been a focus of attention from elected officials, governmental administrators, journalists, and scholars (Schram and Soss 2002).

But, the reductions in public assistance caseloads are not the only effects of welfare reform. Indeed, there have been major repercussions on other aspects of the American social welfare system (e.g., Lens 2002; Rosso 2003; Karoly, Klerman, and Rogowski 2001; Garfinkel 2001; Grogger 2004; Zedlewski and Brauner 1999; Zedlewski 2002). One of the significant consequences occurred in the Medicaid program– the nation's primary health care system for the poor. After an initial dip in Medicaid coverage following the passage of welfare reform, state Medicaid enrollments for low-income women and children increased dramatically (Kaiser Commission on Medicaid and the Uninsured 2003). Such countervailing developments are intrinsically important because of the normative and practical implications associated with cutting cash assistance while expanding health coverage to exactly the same target groups. They are also noteworthy because they represent a reversal of the traditional connection between public assistance and health insurance programs for the poor. For both of these reasons it is

important to understand why this pattern of apparently compensatory policy changes– i.e., welfare rollbacks and Medicaid expansions– occurred.

In the analysis below, I argue that the increases in Medicaid participation represent an example of spillover effects (Jones and Baumgartner 2005, p. 259) emanating from welfare reform. Specifically, I will examine the amount of change in state Medicaid program enrollments for low-income women and children during the late 1990s. The analysis shows clearly that decreases in cash assistance caseloads are the prime stimulant for increases in Medicaid expansion. This is a significant, but unintended, by-product of the 1996 Welfare Reform Act. It has dramatic practical consequences for state governments and policymaking. And, it also has important implications for theories of policymaking and scholarly understandings of policy change.

CHANGING COURSE IN AMERICAN WELFARE POLICY

In summer 1996, the U.S. Congress passed and President Clinton signed the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA-PL-104-93). This legislation tied together the major issues involved underlying the contemporary debate about welfare in the United States: Curtailing unnecessary government regulations; preventing welfare dependence; and saving taxpayer dollars. The PRWORA eliminated the Aid to Families with Dependent Children (AFDC) program and created a new form of public support, called Temporary Assistance for Needy Families (TANF), to take its place.

Welfare Reform as Policy Change

The 1996 welfare reform legislation represents a clear example of policy change. This is what Baumgartner and Jones (1993) describe as a punctuation in the existing equilibrium of programmatic arrangements for addressing societal problems. In such a situation, ongoing policy

monopolies are broken up, symbolic representations of the policy image are altered, and the venues of decisionmaking shift to reflect new lines of authority and responsibility (pp. 39-55). This is exactly what happened with the welfare reform provisions initiated by PRWORA.

A major objective of the 1996 Act was the devolution of welfare policymaking to the states. In so doing, the federal government relinquished much of its direct authority over public assistance policy. Instead, it now relies upon financial stimulants and sanctions to prompt the states into establishing and maintaining their own TANF programs (Gais, Nathan, Lurie, and Kaplan 2001). For their part, the states now have considerable latitude for developing their own welfare systems, as long as their new TANF programs contain certain key elements (i.e., five-year time limits on cash benefits, clear work requirements for program recipients, etc.) and lead to a reduction in welfare caseloads.

The 1996 Welfare Reform Act ended the notion of a *federal* entitlement to cash benefits for the poor by creating fifty separate *state* programs in its place: Each state now determines who receives cash assistance within its jurisdiction. Welfare Reform also eliminated the "open-ended" nature of public assistance by placing work requirements upon, and imposing strict time limits for, the receipt of governmental cash benefits. In sum, the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 transformed the basic federal/state structure of American social welfare policy activity.

Immediate Consequence of Welfare Reform

One of the most obvious results of the 1996 Act has been dramatic reductions in welfare caseloads. This is, perhaps, not surprising since PRWORA gives the states a compelling incentive to encourage welfare recipients to engage in work-related activity and decrease the size

of their respective welfare populations. If any state fails to do so, it risks losing significant amounts of funding from the national government (Lurie 2006).

Nevertheless, the figures are striking: Since the passage of welfare reform, the number of individuals receiving public assistance has dropped by about 8 million, and the percentage of the population relying upon government aid has been cut dramatically (U.S. Department of Health and Human Services 2005). Currently, there are about two million families receiving welfare benefits. This is less than half the number of families that were on public aid before the enactment of the 1996 Welfare Reform provisions (U.S. Department of Health and Human Services 2005). Furthermore, public assistance caseloads have continued to decline in recent years even though the U.S. economy has not improved (Pear 2004). So, by this one narrowly-defined criterion, a central objective of the 1996 Welfare Reform Act has been achieved: Welfare rolls have fallen and remained low across the nation.

Medicaid and Spillover from Welfare Reform

Policy change does not occur in a vacuum. Changes in one program often have dramatic effects in other policy areas (Jones and Baumgartner 2005). Therefore, it is likely that the consequences of welfare reform extend beyond the targeted cash assistance programs, alone. An obvious place to look for these spillover effects is the Medicaid program, which has a close, long-standing tie to cash assistance for the poor.

Medicaid was created in 1965 as the health-care counterpart to the old AFDC program: Individuals who met the eligibility criteria for AFDC automatically qualified for Medicaid coverage (Davison 1980). For many years, state Medicaid developments were a direct response to AFDC changes (Stevens and Stevens 1974). As the AFDC program expanded to cover more

low-income women and children, so, too, did the Medicaid program. Accordingly, there was a positive relationship between the two programs' growth rates within the states.

Extrapolating from the pattern that existed during the first two decades of Medicaid's existence, welfare caseload reductions should be accompanied by comparable decreases in Medicaid participation rates. But, this is definitely *not* what happened in the wake of the 1996 Welfare Reform legislation. Immediately following the implementation of PROWRA, Medicaid enrollments declined as states mistakenly cut women and children from both cash assistance and health insurance benefits (Greenstein and Guyer 2001).[2] But, the initial drop in Medicaid coverage following welfare reform was soon followed by remarkable increases in the Medicaid recipient population. Since 1998, the number of Americans covered by Medicaid has grown steadily, at an average 5.9 % annual growth rate. Over the past few years, total Medicaid enrollments have expanded by nearly one-third (Kaiser Commission on Medicaid and the Uninsured 2006). The main population group contributing to this increase is low-income families, children, and pregnant women. Their Medicaid program enrollments have risen dramatically— over 30% from 1997 to 2001– and they represent the fastest growing category within the Medicaid population (Kaiser Commission on Medicaid and the Uninsured 2004a; 2005).

These national-level figures are dramatic. But, the changes in Medicaid program enrollments for poor families, children, and pregnant women actually vary markedly from one state to the next. Figure 1 shows a dotplot of the percentage change in enrollments from 1999 to 2000. The information in the graph reveals that Medicaid coverage rose sharply in some states (e.g., Idaho, with a 41.4% increase), more modestly in others (e.g., Arizona, with an increase of 13.9%), and only slightly in still other states (e.g., New York, with a 1.1% increase). The figure

also shows that Medicaid program enrollments for low-income families, children, and pregnant women actually decreased in New Hampshire and Virginia by 8.5% and 4.8%, respectively. Hence, there are significant interstate differences in change rates for Medicaid coverage during this time period.

Medicaid is an extremely salient program for state governments. In fact, it is the largest single item in all state budgets (DiIulio and Nathan 1998; Kaiser Commission on Medicaid and the Uninsured 2006a). Therefore, the sheer size and scope of the program warrant an examination of why Medicaid enrollments have increased across the nation, as well as why such variability exists in state Medicaid program coverage. But, it is also important to understand why increases in Medicaid program enrollments correspond to decreases in cash assistance caseloads following the implementation of welfare reform. This represents a significant reversal in the historical patterns of development between the two programs. It is precisely this change in AFDC/TANF and Medicaid program trends which is the central objective of this analysis. And, as we will see, welfare reform played a dominant role in altering the process.

The Impact of Welfare Reform on Medicaid

How did the welfare reform movement of the mid-1990s affect the Medicaid program? It did *not* produce significant changes in the structural elements or general provisions of state Medicaid programs (Schneider 1998).[1] Instead, welfare reform changed how low-income women, children, and families would qualify for coverage under the Medicaid program (Tallon and Brown 1998; Holahan and Bruen 2003; Schneider, Fennel and Long 1998).

In the old AFDC system, the federal government set the basic eligibility requirements for cash assistance. But, welfare reform ended the federal guarantee of cash benefits to certain categorical groups: It shifted the primary responsibility for deciding cash assistance eligibility to

the states. In turn, each state sets the eligibility criteria for its TANF program (within general federal parameters).

Welfare reform also severed the linkage between the receipt of cash assistance and Medicaid services (Ku and Coughlin 1997; Mann 2002). Under the old system, AFDC recipients were automatically eligible for Medicaid services. The 1996 Welfare Reform Act requires states provide Medicaid services to individuals and families who *previously* qualified for AFDC benefits– even if they do not meet the new state-determined TANF provisions (Moore 1999). But, the 1996 Act also "decoupled" the eligibility linkage between the two programs: States now make *separate* eligibility determinations for their TANF and Medicaid programs (Tallon and Brown 1998; Holahan and Bruen 2003; Schneider, Fennel and Long 1998).

The decoupling of TANF and Medicaid eligibility has given states a great deal of flexibility in their Medicaid decisionmaking. It has enabled them to provide Medicaid coverage to poor families who no longer qualify for cash benefits, to add new groups to their Medicaid populations, and to expand program coverage far beyond the traditional cash assistance populations (Ku and Coughlin 1997; Mann 2002). And, I would argue that this is precisely how states made up for the constrictions in their welfare populations that were imposed by the 1996 federal legislation. They adjusted Medicaid eligibility criteria so that poor people who were ineligible for cash assistance could nevertheless be included on the Medicaid rolls. This, in turn, would account for the overall increase in Medicaid participation that occurred during the late 1990s. In effect, one program "picked up the slack" left by the other.

Welfare reform is an intuitively reasonable explanation for the increases in Medicaid program enrollments for low-income women, children, and families. Although the general components of welfare reform have been intensely scrutinized and widely debated, the

consequences of policy change *across* program areas have received far less attention from scholars, the news media, and political actors. Therefore, the empirical analysis presented below will examine whether the apparent negative relationship between the two key welfare programs– AFDC/TANF and Medicaid– stands up to systematic scrutiny.

MODELING POLICY CHANGE IN THE AMERICAN WELFARE SYSTEM

This study will focus directly on the *net* policy changes which occurred following the 1996 Welfare Reform Act. There are two main reasons for this approach. First, net change has clearly been at the center of the debates and discussions about the impact of welfare reform. Government agencies track changes in welfare caseloads in order to determine whether states are complying with federal requirements and to monitor the overall implementation of welfare reform provisions (e.g., Department of Health and Human Services 2003, 2004, 2005). The news media report net caseload declines in their efforts to focus public attention on easily identifiable and understandable elements of welfare policy (Schram and Soss 2002, p. 62). And, prominent political leaders (from both political parties and across the ideological spectrum) have heralded the overall drop in welfare rolls as clear evidence of the "triumph" or "success" of contemporary American social policy efforts (Mink 1998; Miller 1998; Kelly 1999; Weaver 2000).

Second, the focus on net change is fortuitous because it produces a relatively straightforward model specification. It allows us to determine whether overall reductions in one policy area are followed by increases in another. Hence, it is particularly useful in this situation for assessing the general impact of welfare caseload cutbacks on Medicaid program expansions.[2]

The dependent variable in the empirical analysis is the percentage change in the number of families, children, and pregnant women enrolled in Medicaid between 1999 and 2000 within each state– the same information that was depicted graphically back in Figure 1. This variable

provides a readily interpretable measure of the fluctuation in Medicaid enrollments that occurred across the states after the implementation of the 1996 Welfare Reform Act. 1999 is used as the base year for three reasons. First, the PRWORA provisions were not fully implemented until this point (Gais, Nathan, Lurie, and Kaplan 2001); therefore, data from earlier time periods would probably miss some of the legislation's full effects. Second, this timing falls after the initial period of confusion which occurred in the states' responses to welfare reform. Following the passage of PRWORA, a number of states inappropriately removed low-income families from Medicaid when they left public assistance even those these families were still eligible to receive Medicaid benefits (Schlosberg and Ferber 1998). It was not until several years after the full implementation of PRWORA that state Medicaid enrollments settled down to more stable patterns. It is really the latter that are of substantive interest, rather than the first, halting (and incorrect) steps taken by state policymakers. Third, this time frame is used because it captures an important period of Medicaid program developments for low-income women and children. From 1999 to 2000, Medicaid enrollments for poor families rose by 11.6 %. Although the Medicaid program continues to expand after this time period, the rate of Medicaid growth for this particular population group slows quite noticeably in subsequent years (Kaiser Commission on Medicaid and the Uninsured 2006). Hence, the interval from 1999 to 2000 picks up one of the most dramatic and significant periods of Medicaid enrollment increases for poor women and children. The data on 1999-2000 change in state Medicaid populations come from the Kaiser Commission on Medicaid and the Uninsured (2003a).[3]

In order to capture the net change in welfare enrollments, I use the percentage change in state AFDC/TANF caseloads from 1995 to 1999 as the main independent variable in the model. This variable provides a concise measure of the dramatic drop in cash assistance populations

which occurred across the states during this time period. More specifically, it shows the difference between cash assistance enrollments *before* the enactment of welfare reform and *after* the full implementation of the new provisions. The data for this variable come from the U.S. Department of Health and Human Services, Administration for Children and Families, Office of Planning, Research and Evaluation (2005).[4] Again, the main hypothesis is that the changes in state welfare caseloads are strongly related to changes in state Medicaid coverage: Increases in Medicaid enrollments coincide with decreases in cash assistance enrollments.

Of course, welfare participation changes do not comprise the only factor affecting the states' Medicaid populations. States vary significantly in their overall willingness to provide benefits for needy citizens (Peterson and Rom 1990; Soss, Schram, Vartanian, and O'Brien 2001; Volden 2002; Fellows and Rowe 2004). One manifestation of these differing propensities is the stringency of the work requirements for TANF participation: The establishment of harsh work requirements in welfare programs deters the poor from using, and relying upon, social services (Gutmann 1998; Blank 1997; Ellwood 1988).[5]

In order to capture potential effects of the new TANF work requirements, I have included three variables. The first is the work participation rate. This rate is set by the federal government, and it identifies the percentage of welfare recipients that must participate in work activities within each state. If a state does not meet this rate, it loses a substantial portion of its federal financial TANF allocation. Hence, the work participation rate encourages states to involve their welfare populations in work-related activities. Since states can also meet their work participation rates by cutting recipients from the welfare rolls without moving them into work-related activities, it has also had a direct impact on reducing welfare caseloads (Pavetti 2004).[6]

The second TANF work requirement variable is the percentage of TANF adults who are participating in any type of work-*related* activity, broadly defined to include unsubsidized employment, job search activities, job training, etc.[7] The federal government establishes a set of "acceptable" work-related activities, as well as the length of time recipients can be involved in them (in order to qualify for federal funding). But, each state determines the mix of activities it will make available to its welfare population, as well as how it will encourage recipients to engage in these services (Pavetti 2004). The third variable is a dichotomy which operationalizes the timing of work requirements. States must require that welfare recipients work after 24 months of cash assistance, but they can establish shorter time frames, as well. Here, the most stringent state policy is one that requires welfare recipients to participate immediately in work activity. Those states which require work immediately upon the receipt of benefits are scored one; those states that have more lenient (i.e., longer) time frames between the receipt of cash assistance and engaging in work activity are coded zero.

All three of these variables cover the 1999-2000 fiscal year, and the data are obtained from the U.S. Department of Health and Human Services, Administration for Children and Families, Office of Planning, Research and Evaluation (2005). If work requirements for cash assistance have independent effects on social service utilization, then the states with the harshest work provisions should show smaller increases in Medicaid program enrollments, and vice versa.

Particular characteristics of state Medicaid systems could also have direct effects on Medicaid program enrollments. Specifically, Section 1115 Waivers give states the ability to extend Medicaid coverage to previously uninsured population groups and to expand the package of medical benefits available to them (Kaiser Commission on Medicaid and the Uninsured

2003). These waivers reveal a state's propensity to pursue innovative policies and program expansions (Schneider 1997); hence, states which have comprehensive Section 1115 Medicaid waivers should have larger numbers of low-income families enrolled in Medicaid. The use of Section 1115 Waivers is measured with a dummy variable for states that had implemented these waivers in their Medicaid programs by the 1999-2000 fiscal year.[8] The data for this variable are obtained from the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (2007).

Finally, state economic conditions probably affect Medicaid participation. During the last half of the 1990s, states across the country experienced serious economic problems and fiscal distress. While the nation's unemployment rate averaged over 4%, some states (e.g., Alaska, Louisiana, and New Mexico), experienced much greater levels of job insecurity. Such high rates of unemployment might well have a direct impact on Medicaid enrollments since private health insurance coverage is often tied to employment (Bruen and Holahan 2001). For this reason, the analysis will take 1999 state unemployment rates into account. The data are obtained from the *Statistical Abstract of the United States: 2001.*

In addition to general economic conditions, certain specific aspects of economic distress could also contribute to variability in Medicaid program coverage. During the late 1990s, a great deal of attention was focused on the health and welfare of low-income children (Riley and Pernice 1998; Shi, Oliver, and Huang 2000; Volden 2006). This led to the passage of the Children's Health Insurance Program (CHIP) initiative, and broader efforts to use Medicaid as a way to provide benefits to low-income families (Greenstein and Guyer 2001). Many state programs responded to higher incidence of child poverty with expanded Medicaid enrollment efforts. Therefore, the 1999 percentage of children living in low-income households should have

a direct impact on state Medicaid expansions. The data for this variable are obtained from The Kaiser Commission on Medicaid and the Uninsured (2004a).

Table 1 shows summary statistics for all of the variables used in this analysis. There are several other variables which are often employed in models of state politics and policymaking. These include political characteristics of state government (e.g., gubernatorial and/or legislative partisanship, state governmental ideology, etc.), state-level public opinion (e.g., partisanship and ideology of state electorates), and further economic indicators (e.g., per capita income, gross domestic product, etc.). None of these variables showed any significant effects on changes in state Medicaid populations. Therefore, they are not included in the analysis reported below.

EMPIRICAL RESULTS

The effects of the independent variables are estimated using ordinary least squares, and the results are presented in Table 2. Even though the regression equation is quite simple in form, it fits the data quite well. The R^2 is 0.620, indicating that the model accounts for more than 60% of the variance in state Medicaid enrollment increases for poor women and their children.[9]

The leftmost column in Table 2 shows the regression coefficients for the individual variables, along with their standard errors. Most of the independent variables have statistically significant effects. In order to assess the relative impacts of the different variables, the right-hand column of Table 2 shows the standardized regression coefficients. Despite all of their well-known limitations, the latter still provide the most convenient way to compare the effects of continuous independent variables that are measured in different units.

For present purposes, the most important result in Table 2 is the highly significant, negative coefficient for changes in welfare caseloads (-0.372). Cash assistance enrollments are definitely related to Medicaid program enrollments for low-income families: States which have

experienced the greatest *reductions* in TANF caseloads have also had the greatest *increases* in their Medicaid populations. Furthermore, the standardized coefficient for the welfare caseload variable is the largest of all those in the table, at -0.602. In other words, this immediate consequence of welfare reform has the strongest impact of all the various factors considered in this study. Within the states, cutting the welfare rolls clearly leads to greater utilization of *other* social programs. Many poor families may no longer be receiving cash assistance, but they are relying more heavily upon the government for health insurance benefits. This finding provides strong support for the major hypothesis of this study.

The next three coefficients show that the work participation requirements of state TANF systems have strong effects, although the nature of their influence differs from one variable to the next. The coefficients for work participation rates and immediate work requirements are both significant and negative, at -0.291 and -6.839 respectively. This shows that states with the highest work participation rates and those that require recipients to work immediately have smaller increases in their Medicaid program enrollments. Such a result is fully consistent with the argument that stringent program requirements discourage participation in social programs (Pavetti 2004). The coefficient for work-related activity is positive and significant at 0.283. States which encourage their welfare populations to engage in a broad array of work-related activities– i.e., unsubsidized employment, on-the-job training, job skills training, etc.– have experienced greater increases in Medicaid program enrollments for low income women, children, and families.

It is also important to emphasize that the effects of the TANF work requirements are quite strong. The standardized coefficients for work-related activities and work participation rates are the second- and third-largest in the table, at 0.522 and -0.493, respectively. Thus, a

standard deviation increase in each of these variables corresponds to a difference of about one-half a standard deviation (in opposing directions) on the dependent variable.

Standardized coefficients make little sense for dummy variables. But, the nonstandardized coefficient is directly interpretable as a mean difference in values of the dependent variable. So, the coefficient of -6.839 for the immediate work requirement indicates that states which require welfare recipients to work immediately average nearly 7% smaller increases in Medicaid populations than states without such a requirement. By way of comparison, the standard deviation on the dependent variable is 9.190. So, the immediate work requirement typically decreases the size of Medicaid enrollment changes by more than two-thirds of a standard deviation. Taken together, the results for these three variables provide further confirmation for the major hypothesis of this study: Once again, elements of welfare reform (in this case, TANF work requirements) have a profound impact on the Medicaid program.

The implementation of statewide Section 1115 waivers has a predictable effect on Medicaid program coverage (Schneider 1997; Kaiser Commission on Medicaid and the Uninsured 2003). The OLS coefficient for this variable is large and significant at 5.767. This shows that states which have used the flexibility provided by the Section 1115 waiver have been able to expand the scope of their Medicaid programs. The obvious and immediate consequence is that these states have seen greater increases (by almost 6%) in the utilization of Medicaid services by women and children. While these waivers have existed for many years, state policymakers are now clearly using them as a tool for dealing with the requirements imposed by PRWORA and other, related policy changes (Kaiser Commission on Medicaid and the Uninsured 2003). So, this is still more evidence that the Medicaid program is reacting– albeit in a somewhat indirect manner– to welfare reform initiatives.

Finally, state economic conditions also have an impact on Medicaid enrollments. The OLS coefficient for state unemployment rates is statistically significant at 2.383. This result is perfectly consistent with prior expectations (Bruen and Holahan 2001). When general economic conditions deteriorate and jobs are more difficult to find, citizens rely more heavily on government programs to obtain needed assistance. Under such circumstances, the Medicaid program is an obvious source of support.

In a similar vein, the percentage of low-income children also has a positive impact on Medicaid coverage. Although the coefficient for this variable does not quite achieve statistical significance, the direction of influence does conform to prior expectations. States with higher numbers of poor children have tended to increase their Medicaid enrollments for poor families. Taken together, the results for these last two variables suggest that environmental conditions can bring about changes in the Medicaid program. However, their collective impact is not nearly as strong as the various factors that are directly tied to welfare reform and state policymaking.

CONCLUSIONS

The results of the empirical analysis indicate that a variety of factors influence state Medicaid program developments. As we would expect, Medicaid enrollments are affected by the size of the state's welfare population, program requirements for obtaining cash assistance, specific decisions affecting Medicaid program coverage, and general state economic conditions. But, one variable stands out as having the greatest impact on Medicaid expansions for low-income women, children, and families: The reductions in welfare caseloads which accompanied the passage of the 1996 Welfare Reform legislation. This basic finding has important implications for theories of American policymaking, the nature of the Medicaid program, and the political situation confronting state governments. Let us consider each of these in turn.

Theoretical Implications

The welfare reform movement of the mid-1990s was a unique episode in the history of social policy. But, it does illustrate several general principles drawn from theories of policymaking. The reforms themselves represent a punctuation point that altered the previously-existing equilibrium in the American welfare state (Baumgartner and Jones 1993). And, as Baumgartner and Jones point out, this often produces aftershocks that reverberate throughout the entire governmental decision-making process (p. 4). Their work focuses primarily on the national level. But this study demonstrates that the process goes even farther: National decisions also have immediate implications for state governments as well. PRWORA, a piece of *federal* legislation, mandated reductions in the welfare population. The *states* responded immediately by tightening up eligibility requirements and cutting their public assistance rolls. So, the consequences of welfare reform permeate both major levels of government (i.e., national and state) in the American federal system (Soss, Schram, Vartanian, and Obrien 2001).[10]

The impact of welfare reform on Medicaid also illustrates another important principle drawn from theories of the policy process: Dramatic changes in one program will always have effects that are manifested in other, separate, programs which exist within the same general policy domain Heclo 1978; Meier 1985; and Stone 2002). Here, TANF provides resources for basic subsistence, while Medicaid covers health care needs. These are distinct responsibilities, but they are aimed at the same target population.[11] So, even though public officials may cut resources in one program, the basic social problem experienced by that program's target group– i.e., poverty– still exists. Therefore, other programs will have to pursue additional efforts in order to ameliorate the underlying needs. This is exactly what happened in the Medicaid

response to welfare reform. It would be difficult to imagine a clearer example of such an interrelationship between two different governmental programs.

The consequences of welfare reform for Medicaid also illustrate a third theoretical principle: Policy activity often has unintended, but profound, consequences that exist apart from governmental decision-makers' immediate programmatic goals (Peters 1996; Kingdon 2003). A central objective of the welfare reform legislation was to increase the self-sufficiency of low-income populations. In order to accomplish this, a set of regulations and incentives were put into place which were designed to move welfare recipients into work activities and to reduce their reliance on government aid. This, in turn, would reduce government expenditures for social welfare programs (*Republican Contract With America* 1994). But, AFDC/TANF represents one of the smallest components of the American welfare state in terms of the number of people who receive benefits and the amount of money spent on program services.[12] In contrast, Medicaid is very expensive. It is now the single largest public health insurance program in the United States with a price tag of more than $276 billion per year (Kaiser Commission on Medicaid and the Uninsured 2006). Thus, welfare reform produced cuts in one of the least expensive programs, but they were offset by increases in a much more costly program. In fact, states are now spending more to provide resources to the poor than they did in the years prior to the enactment of PRWORA. They are simply devoting more and more of their resources to Medicaid, rather than to cash assistance. Clearly, this ironic situation is an unintended consequence of the welfare reform legislation.

The Nature of Medicaid

The results from this study provide new insights about the role of the Medicaid program. Medicaid and AFDC/TANF have always been closely connected to each other. But, the nature of their relationship has reversed itself over time. From the creation of Medicaid in the mid-1960s through the early 1980s, state Medicaid developments were usually a direct response to AFDC expansions (Stevens and Stevens 1974; Davison 1980). Accordingly, there was a positive relationship between the two programs' growth rates within the states.

Beginning in the 1980s, however, the connection between AFDC and Medicaid eroded. Federal legislation and state administrators' actions interacted to bring about a decoupling process in which Medicaid systems expanded far beyond AFDC in scope, coverage, and impact (Coughlin, Ku, and Holahan 1994; Schneider 1998; Tallon and Brown 1998). Therefore, growth rates were basically unrelated across the two programs during that time period.

This study demonstrates the existence of a new era in the linkage between AFDC/TANF and Medicaid– one in which growth rates within the two programs are now *inversely* related. As we have seen, expansions in Medicaid are due (at least in large part) to constrictions in cash-based welfare, producing a negative empirical relationship between the two programs' post-1996 growth rates. This "compensatory" connection accounts for a significant amount of the variation that exists in Medicaid program coverage.

The finding that welfare reductions lead to increases in Medicaid program enrollments shows how states are trying to achieve two seemingly contradictory public policy objectives: Cut welfare, but continue to help the poor. On the one hand, Americans do not like welfare (Gilens 1999). Therefore, the 1996 welfare reform initiatives were extremely popular in the American electorate (Schneider and Jacoby 2005). On the other hand, most Americans are sympathetic to

the needs of the poor (Gilens 1999) and believe that health care coverage should be available to everyone. This sentiment is especially pronounced when it involves government benefits for the most vulnerable segments of American society, such as pregnant women, single mothers, and children (Skocpol 1992; Duncan and Chase-Lansdale 2001). Therefore, Medicaid (which finances health care services) is a more acceptable alternative to cash assistance policies like AFDC/TANF (Greenstein and Guyer 2001). But, this in turn, places the Medicaid program at the center of the modern American welfare state, a position that its original proponents never intended it to occupy (Stevens and Stevens 1974).

Politics in the States

Increased levels of Medicaid spending place severe constraints on state governments. The Medicaid program already represents their single largest funding commitment (Kaiser Commission on Medicaid and the Uninsured 2004b). Expansions in program enrollments mean that states have to allocate further resources in order to cover health care benefits for the larger Medicaid populations. This puts intense additional pressure on state governments, which are already struggling to recover from the cycle of economic downturns that occurred during the late 1990s.[13]

In order to deal with these problems, many states have implemented a variety of measures designed specifically to stop (or at least slow) the growth in Medicaid enrollments and expenses. These include efforts to freeze (or reduce) provider payments, control the cost of prescription drugs, increase beneficiary co-payments, and invoke taxes on provider reimbursements (Kaiser Commission on Medicaid and the Uninsured 2005). And, after several years of concerted efforts to broaden program coverage, many states have reversed course and are now looking for ways to restrict eligibility and/or cut back on program expansions (Kaiser

Commission on Medicaid and the Uninsured 2005). For its part, the federal government recently passed legislation (the Deficit Reduction Act of 2005) that will enable the states to pursue these program changes more easily, with the ultimate objective of reducing Medicaid expenditures by $11.5 billion over the next five years (Pear 2006; Kaiser Commission on Medicaid and the Uninsured 2006).

In conclusion, the states are left with a fundamental dilemma. Unless there are profound changes to the existing American welfare system, Medicaid will continue to serve as the health care safety net for low-income families. And, the states will have to pay a significant fraction of the program costs which will inevitably increase during the coming years. How can states deal with these problems given their finite resources? Unfortunately, the only feasible course of action is for the states to use the flexibility available to them under existing federal legislation and find ways to stop Medicaid program expansions. In the short run, this will help to alleviate the financial drain that Medicaid imposes on state budgets. In the long run, however, it is likely to create additional health care problems for Medicaid beneficiaries and lead to even greater governmental health care expenses within the states.

NOTES

1. As before, Medicaid still covers two basic categories of needy persons: (1) low-income women and children (formerly referred to as the "AFDC categorical group"); and (2) low-income elderly, blind, and disabled individuals (officially designated as the "Supplemental Security Income categorical group)). In addition, it still finances health care services for individuals and families who meet the eligibility requirements of the federally-defined "optional" groups (i.e., pregnant women and infants with incomes above the federal poverty level, terminally ill persons who are receiving hospice care, etc.).
2. An alternative approach would be to use a time series, cross-sectional model. However, that would be problematic for several reasons. First, it would require an inordinate amount of data which are not currently available across all states and all time points. Second, some of the independent variables lack temporal variability which makes it difficult to use them in time series models. Third, the trajectories of yearly change vary markedly across the states. Therefore, any attempt to represent these yearly changes within a common structure would produce null results, even tough the eventual outcomes *do* conform to clear systematic patterns. For all of these reasons, the approach used in this study is to focus on *net* change.
3. The Kaiser Commission on Medicaid and the Uninsured collects Medicaid enrollment data on families, children and pregnant women from 44 states. The remaining jurisdictions (6 states and the District of Columbia) do not provide data for this subgroup of the Medicaid population. Hence, the dependent variable in this analysis covers only the 44 states for which Kaiser Commission data are available and reported.

4. I examined the same model using different variables to capture changes in welfare reductions and Medicaid expansions across slightly different time periods. Specifically, I looked at the impact of the change in welfare caseloads between 1995 and 2000 on the change in Medicaid program enrollments for low-income pregnant women and children from 2000 to 2001. And, I also looked at the impact of the change in welfare caseloads between 1996 and 1999 on Medicaid enrollments from 1999 to 2000 and the change in welfare caseloads between 1996 and 2000 on Medicaid enrollments from 2000 to 2001. The use of these other change variables produced slightly different parameter estimates for the independent variables and poorer goodness of fit statistics for the overall models. But, the welfare variables still emerged as the most important influences on Medicaid program enrollments in all of these models.
5. Scholars have documented many reasons for this phenomenon. These include poor women's preferences to monitor and supervise their own children (Heymann and Earle 1998; Edin and Lein 1996), their concern over losing health insurance and child care services (Myers 1993; Ellwood 1988), and the basic desire to be able to spend more time with their families (Kahil, Schweingruber, Daniel-Echols, and Breen 2000).
6. This is referred to as the "caseload reduction credit," and it has been used by all states to meet their work participation rates since the passage of PROWORA.
7. Data for broadly-defined work activity rates are not reported for Vermont. Therefore, that state must be excluded from the analysis.
8. Other important characteristics of state Medicaid programs, including Medicaid eligibility levels, Medicaid managed care provisions, Medicaid/SCHIP (State Children's Health Insurance Program) efforts, etc., were examined in preliminary versions of the analysis.

None of these variables exerted significant impacts on state Medicaid enrollments. Hence, they were omitted from the final model.

9. The OLS estimates for this model are quite robust. There are no serious outliers or influential observations affecting the coefficients. And, the regression diagnostics reveal that multicollinearity is not a serious problem; the tolerance levels range from 0.485 to 0.924.

10. Other scholars have shown that welfare reform has had local, as well as state- and nation-level effects (Riccucci 2005).

11. The Medicaid program also covers the health care needs of *other* groups in society– e.g., poor pregnant women without other children– who are ineligible for cash assistance. And, it also serves as the chief financier of long-term, institutionalized care for disabled and elderly Americans. But, the largest group of Medicaid beneficiaries is still comprised of low-income women and their children.

12. Even if one considers only those measures which serve low-income women and children, cash assistance programs like AFDC/TANF still are neither the largest nor the most expensive (Weaver 2000; Noble 1997; Bane and Ellwood 1994).

13. Of course, changes in the Medicaid program also affect the national government. But, Medicaid takes up a much smaller proportion of the federal budget than it does in any of the state's budgets. Therefore, it has unlikely to create the same kind of problems and dilemmas for federal policymakers.

REFERENCES

Bane, Mary Jo, and David Ellwood. 1994. *Welfare Realities: From Rhetoric to Reform*. Cambridge: Harvard University Press.

Blank, Rebecca. 1997. *It Takes a Nation: A New Agenda for Fighting Poverty*. New York: Russell Sage Foundation.

Bruen, Brian, and John Holahan. 2001. “Medicaid Spending Growth Remained Modest in 1998, But Likely Headed Upward.” Washington, DC: The Kaiser Commission on Medicaid and the Uninsured. February.

Coughlin, Teresa A., Leighton Ku, and John Holahan. 1994. *Medicaid Since 1980: Costs, Coverage, and the Shifting Alliance Between the Federal Government and the States*. Washington, DC: Urban Institute Press.

Davison, Stephen M. 1980. *Medicaid Decisions: A Systematic Analysis of the Cost Problem*. Cambridge, MA: Ballinger Publishing Company.

DiIulio, John J., Jr., and Richard P. Nathan. 1998. “Introduction.” In *Medicaid and Devolution: A View From the States*. eds. Frank J. Thompson and John J. DiIulio Jr., Washington, DC: The Brookings Institution, pp. 1-13.

Duncan, Greg J., and P. Lindsay Chase-Lansdale. 2001. “Welfare Reform and Children’s Well-Being.” In *The New World of Welfare*. ed. Rebecca Blank and Ron Haskins. Washington, DC: The Brookings Institution Press.

Edin, K., and L. Lein. 1996. *Making Ends Meet: How Single Mothers Survive Welfare and Low-Wage Work*. New York: Russell Sage Foundation.

Ellwood, David T. 1988. *Poor Support: Poverty in the American Family*. New York: Basic Books.

Fellowes, Matthew C., and Gretchen Rowe. 2004. "Politics and the New American Welfare States." *American Journal of Political Science* 48: 362-373.

Gais, Thomas L., Richard P. Nathan, Irene Lurie, and Thomas Kaplan. 2001. "Implementation of the Personal Responsibility Act of 1996." In *The New World of Welfare*. ed. Rebecca Blank and Ron Haskins. Washington, DC: The Brookings Institution, pp. 35-69.

Garfinkel, Irwin. 2001. "Child Support in the New World of Welfare." In *The New World of Welfare*. ed. Rebecca Blank and Ron Haskins. Washington, DC: The Brookings Institution.

Garrett, Bown, and Sherry Glied. 2000. "Does State AFDC Generosity Affect Child SSI Participation?" *Journal of Policy Analysis and Management* 19: 275-296.

Gilens, Martin. 1999. *Why Americans Hate Welfare*. Chicago: The University of Chicago Press.

Greenstein, Robert, and Jocelyn Guyer. 2001. "Supporting Work Through Medicaid and Food Stamps." In *The New World of Welfare*. eds. Rebecca Blank and Ron Haskins. Washington, DC: The Brookings Institution, pp. 335-369.

Grogger, Jeffrey. 2004. "Welfare Transitions in the 1990s: The Economy, Welfare Policy, and the EITC." *Journal of Policy Analysis and Management* 23: 671-696

Gutmann, Amy. 1998. *Work and Welfare*. Princeton, NJ: Princeton University Press.

Haskins, Ron. 2006. *Work Over Welfare: The Inside Story of the 1996 Welfare Reform Law*. Washington, DC: Brookings Institution Press.

Heymann, S.L., and A. Earle. 1998. "The Work-Family Balance: What Hurdles Are Parents Leaving Welfare Likely to Confront?" *Journal of Policy Analysis and Management* 17: 313-321.

Holahan, John, and Brian Bruen. 2003. "Medicaid Spending: What Factors Contributed to the Growth Between 2000 and 2002?" Washington, DC: Kaiser Commission on Medicaid and the Uninsured. September.

Heclo, Hugh. 2001. "The Politics of Welfare Reform." In *The New World of Welfare*, ed. Rebecca Blank and Ron Haskins. Washington, DC: The Brookings Institution.

Jones, Bryan, and Frank Baumgartner. 2005. *The Politics of Attention: How Government Prioritizes Problems*. Chicago: The University of Chicago Press.

Kaiser Commission on Medicaid and the Uninsured. 2003a. "Medicaid Enrollment in 50 States: December 2002 Data Update." The Henry J. Kaiser Family Foundation.

Kaiser Commission on Medicaid and the Uninsured. 2004a. "Beneath the Surface: Barriers Threaten to Slow Progress on Expanding Health Coverage of Children and Families." The Henry J. Kaiser Family Foundation.

Kaiser Commission on Medicaid and the Uninsured. 2004b. "The Continuing Medicaid Budget Challenge: State Medicaid Spending Growth and Cost Containment in Fiscal Years 2004 and 2005: Results from a 50-State Survey." The Henry J. Kaiser Family Foundation.

Kaiser Commission on Medicaid and the Uninsured. 2005a. "Enrolling Uninsured Low-Income Children in Medicaid and SCHIP." The Henry J. Kaiser Family Foundation.

Kaiser Commission on Medicaid and the Uninsured. 2005b. "In a Time of Growing Need: State Choices Influence Health Coverage Access for Children and Families." The Henry J. Kaiser Family Foundation.

Kaiser Commission on Medicaid and the Uninsured. 2006a. "Deficit Reduction Act of 2005: Implications for Medicaid." The Henry J. Kaiser Family Foundation.

Kaiser Commission on Medicaid and the Uninsured. 2006b. "Medicaid Enrollment and Spending Trends." The Henry J. Kaiser Family Foundation.

Kaiser Commission on Medicaid and the Uninsured. 2006c. *The Medicaid Program at a Glance*. The Henry J. Kaiser Family Foundation (www.kff.org/medicaid/upload/7235pdf).

Karoly, Lynn A., Jacob Alex Klerman, and Jeannette A. Rogowski. 2001. "Effects of the 1996 Welfare Reform Changes on the SSI Program." In *The New World of Welfare*. ed. Rebecca Blank and Ron Haskins. Washington, DC: The Brookings Institution.

Kelly, Michael. 1999. "Assessing Welfare Reform" *Washington Post*, August 4.

Ku, Leighton and Teresa A. Coughlin. 1997 "How the New Welfare Reform Law Affects Medicaid." Washington, DC: The Urban Institute (www.urban.org/url.cfm?ID=30737).

Lens, Vicki. 2002. "TANF: What Went Wrong and What to Do Next." *Social Work* 47 (3): 279-90.

Lurie, Irene. 2006. "State Welfare Policy." In *The State of the States*, ed. Carl E. Van Horn. Washington, DC: Congressional Quarterly Press, pp. 167-191.

Mann, C. 1999. "The Ins and Outs of Delinking: Promoting Medicaid Enrollment of Children Who Are Moving In and Out of the TANF System." Robert Wood Johnson Foundation: Covering Kids Initiative.

Miller, William H. 1998. "Surprise! Welfare Reform is Working." *Industry Week*, March 16.

Mink, Gwendolyn. 1998. *Welfare's End*. Ithaca: Cornell University Press.

Myers, M.K. 1993. "Child Care in JOBS Employment and Training Program: What Difference Does Quality Make?" *Journal of Marriage and the Family* 55: 767-783.

Moore, Judith. 1999. "Welfare Reform and its Impact on Medicaid: An Update." Issue Brief #732. Washington, DC: National Health Policy Forum, February 26.

Noble, Charles. 1997. *Welfare as We Knew It.* New York: Oxford University Press.

Pavotti, LaDonna 2004. "The Challenge of Achieving High Work Participation Rates in Welfare Programs." Washington, DC: The Brookings Institution.

Pear, Robert. 2004. "Despite the Sluggish Economy, Welfare Rolls Actually Shrank." *New York Times*. March 22.

Pear, Robert. 2006. "Budget to Hurt Poor People on Medicaid, Report Says." *New York Times*, January 30.

Peters, B. Guy. 1996. *American Public Policy*. Chatham, NJ: Chatham House Publishers, Inc.

Peterson, Paul E., and Mark C. Rom. 1990. *Welfare Magnets: A New Case for a National Standard*. Washington, DC: The Brookings Institution.

"Republican Contract With America." 1994 U.S. House of Representatives, 104th Congress.

Ricucci, Norma M. 2005. *How Management Matters: Street-Level Bureaucrats and Welfare Reform*. Washington, DC: Georgetown University Press.

Riley, Trish, and Cynthia Pernice. 1998. *How Are States Implementing Children's Health Insurance Plans?* Portland, ME: National Academy for State Health Policy.

Rosso, Randy. 2003. "Characteristics of Food Stamp Households: Fiscal Year 2001." Food and Nutrition Service Report FSP-03-CHAR. Department of Agriculture.

Schlosberg, Claudia, and Joel Ferber. 1998. "Access to Medicaid Since the Personal Responsibility and Work Opportunity Reconciliation Act." *Clearinghouse Review* 31: 528-47.

Schneider, Andy, Kristen Fennel, and Peter Long. 1998. "Medicaid Eligibility for Families and Children." Washington, DC: Kaiser Commission on Medicaid and the Uninsured.

Schneider, Saundra K. 1997. "Medicaid Section 1115 Waivers: Shifting Health Care Reform to the States." *Publius: The Journal of Federalism*: 27: 89-109.

Schneider, Saundra K. 1998. “The Impact of Welfare Reform on Medicaid.” *Publius: The Journal of Federalism* 28: 161-174.

Schneider, Saundra K. 1999. “The Impact of Welfare Reform on Medicaid.” In *Welfare Reform: A Race to the* Bottom? ed. Sanford Schram and Samuel H. Beer. Baltimore, MD: John Hopkins Press.

Schneider, Saundra K. 1993. “Examining the Relationship Between Public Policies: AFDC and Medicaid.” 1993. *Public Administration Review* 53 (July/August): 368-380.

Schneider, Saundra K., and William G. Jacoby. 2005. “Elite Discourse and American Public Opinion: The Case of Welfare Spending.” *Political Research Quarterly* 58: 367-379.

Schram, Sanford F., and Jose Soss. 2002. “Success Stories: Welfare Reform, Policy Discourse, and the Politics of Research.” In *Lost Ground*. Edited by Randy Albelda and Ann Withorn. Cambridge, MA: South End Press.

Shi, Leiyu, Thomas R. Oliver, and Virginia Huang. 2000. “The Children’s Health Insurance Program: Expanding the Framework to Evaluate State Goals and Performance.” *The Milibank Quarterly* 78: 403-6.

Skocpol, Theda. 1992. *Protecting Soldiers and Mothers: The Political Origins of Social Policy in the United States*. Cambridge, MA: Harvard University Press.

Soss, Joe, Sanford F. Schram, Thomas P. Vartanian, and Erin O’Brien. 2001. “Setting the Terms of Relief: Explaining State Policy Choices in the Devolution Revolution.” *American Journal of Political Science* 45: 378-395.

Sparer, Michael S. 1996. *Medicaid and the Limits of State Health Reform*. Philadelphia: Temple University Press.

Stevens, Robert S., and Rosemary Stevens. 1974. *Welfare Medicine in America: A Case Study of Medicaid*. New York: Free Press.

Stone, Deborah. 2002. *Policy Paradox*. New York: W.W. Norton and Company.

Tallon, James R., Jr., and Lawrence D. Brown. 1998. "Who Gets What? Devolution of Eligibility and Benefits in Medicaid." In *Medicaid and Devolution: A View From the States*, ed. Frank J. Thompson and John J. DiIlulio Jr., Washington, DC: Brookings Institution Press.

U.S. Census Bureau. 2001. "Total Unemployed and Insured Unemployed by State: 1980 to 2000." *Statistical Abstract of the United States.*

U.S. Department of Health and Human Services. 2005. "State by State Welfare Caseloads Since 1993," Office of Family Assistance, The Administration for Children and Families (www.acf.hhs.gov/news/stats/case-fam.htm).

U.S. Department of Health and Human Services. 2007."Medicaid Waivers and Demonstrations List." Washington, DC: Centers for Medicare and Medicaid (www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/MWDL/list.asp).

Volden, Craig. 2002. "The Politics of Competitive Federalism: A Race to the Bottom in Welfare Benefits?" *American Journal of Political Science* 46: 352-363.

Volden, Craig. 2006. "States as Policy Laboratories: Emulating Success in the Children's Health Insurance Program." *American Journal of Political Science* 50: 294-312.

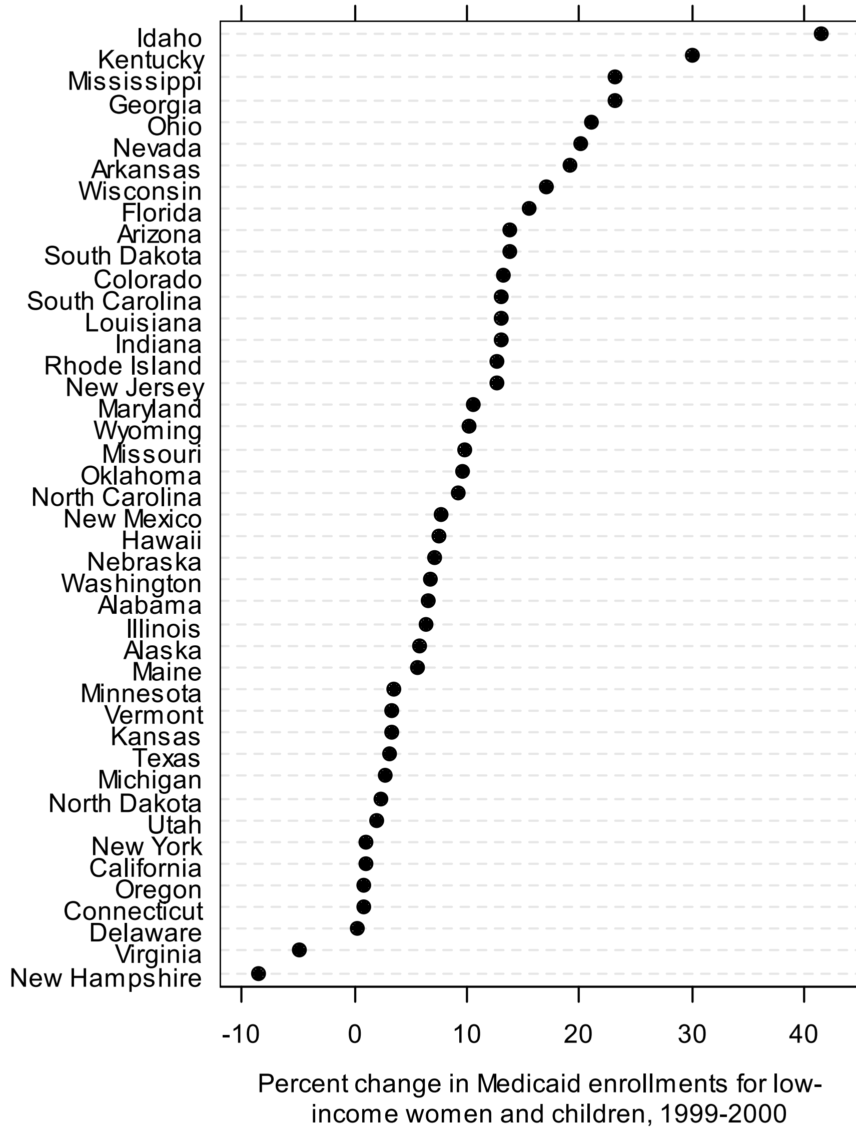
Weaver, R. Kent. 2000. *Ending Welfare as We Know It*. Washington, DC: The Brookings Institution.

Wildavsky, Aaron. 1979. *Speaking Truth to Power*. Boston: Little, Brown.

Zedlewski, S., and S. Brauner. 1999. "Are The Steep Declines in Food Stamp Participation Linked to Falling Welfare Caseloads?" Washington, DC: The Urban Institute.

Zedlewski, S. 2002. "Are Shrinking Caseloads Always a Good Thing? Short Takes on Welfare Policy." Washington, DC: The Urban Institute.

Figure 1: Percentage Change in State Medicaid Enrollments, 1999-2000.



NOTE: Medicaid enrollment data for low-income families, children, and pregnant women are from the Kaiser Commission on Medicaid and the Uninsured (2003a). The total number of states for which data are reported is 44.

Table 1: Summary Statistics for Variables Included in Model of State Medicaid Enrollment Change, 1999-2000.

A. Statistics for Continuous Variables.

	Mean	Standard Deviation	Minimum	Maximum
Change in Medicaid Enrollments for Low-Income Families	9.93	9.95	-8.50	41.40
Change in Welfare Caseloads	-51.49	14.95	-88.89	-18.18
Federal Work Participation Rate	39.30	15.63	11.20	96.70
State Work Activity Rate	43.97	17.02	5.10	87.70
State Unemployment Rate	3.91	0.23	2.20	6.70
Percentage of Children in Low-Income Households	41.58	8.07	28.4	60.10

B. Frequency Distributions for Dummy Variables.

	Implemented (Scored 1)	Not Implemented (Scored 0)
Immediate Work Requirement	24 states (55.8%)	19 states (44.2%)
Medicaid Section 1115 Waiver	14 states (32.6)	29 states (67.4%)

NOTE: The data cover the states included in this analysis. Medicaid enrollment data are not available for six states (Iowa, Massachusetts, Montana, Pennsylvania, Tennessee, and West Virginia); State-defined work activity data are not available for Vermont. Hence, the total number of observations is 43.

Table 2: Influences on State Medicaid Program Enrollments for Families, Children, and Pregnant Women.

Independent Variables	OLS Regression Coefficients	Standardized Coefficients
Welfare Reform		
Change in Welfare Caseloads	-0.372 (0.074)	-0.602
TANF Work Requirements		
Federal Work Participation Rate	-0.291 (0.086)	-0.493
State Work Activity Rate	0.283 (0.081)	0.522
Immediate Work Requirement	-6.839 (2.073)	0.372
Medicaid Policy		
Medicaid Section 1115 Waiver	5.767 (2.114)	0.296
Economic Conditions		
State Unemployment Rate	2.383 (1.213)	0.239
Percentage of Children in Low-Income Households	0.226 (0.148)	0.197
Intercept	-26.778	
R^2	0.620	

Note Table entries are OLS regression coefficients, with standard errors shown in parentheses. Standardized regression coefficients are in the right-hand column of the table. The number of observations is 43.