Extend Gains From Welfare Reform to Texas Medicaid

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Executive Summary

Texas Medicaid is failing. It does not provide medically necessary services and goods to vulnerable Texans. It is consuming an excessive portion of the Texas budget. Fundamental change is needed.

Reasons for the failure of Texas Medicaid are (1) because the federal government, not Texas, administers Texas' program, and (2) because of Medicaid's character as an entitlement. All state Medicaid programs are controlled primarily by Washington with its one-size-fits-all approach. Washington has successfully reformed other welfare programs but not Medicaid.

The same cultural change—adding personal responsibility—that improved other welfare programs will help Medicaid. *How* personal responsibility is infused into Medicaid programs should be left to the states. Changing an entitlement to an exchange means that receipt of welfare support is contingent on some action by those recipients who are able. Such actions include working, volunteering, going to school, attending annual doctor check-ups, paying small premiums or copays, and managing a health savings account. Thirty-six states have received approval, submitted, or considered submission of Section 1115 demonstration waivers related to adding work requirements to their state Medicaid programs for health care *welfare*.

Welfare in the U.S. has needed reform since the federal government took it over in 1929. Presidents Reagan and Clinton made progress, particularly with the 1996 Personal Responsibility and Work Opportunity Reconciliation Act. Personal responsibility became an integral element of federal welfare programs for food and financial assistance, but not health care.

The addition of personal responsibility elements to Texas Medicaid would be consistent with Texas' ethos that emphasizes independence and self-reliance. Using the results of reform in other welfare programs as a guide to what could be accomplished, both Texans and Texas would benefit from infusing Medicaid with elements of personal responsibility.

Key Points

- In 1996, personal responsibility was infused into government welfare programs such as TANF and SNAP.
- Both Texas and Texans can benefit when personal responsibility is added to welfare programs such as Medicaid.
- More than a dozen states have taken the initiative to incorporate personal responsibility elements into their Medicaid programs.
- Texas should seek a Section 1115 waiver to add personal responsibility to its Medicaid program.

Introduction

Medical as well as fiscal failures of Texas Medicaid are described below. The program needs major reform. Various changes to the program have been suggested, with the central theme of making receipt of government support contingent on some action by those recipients who are able. Such actions include working, volunteering, going to school, attending annual doctor check-ups, paying small premiums or copays, and managing a health savings account. Such contingencies would not be applicable to the disabled, aged, blind, pregnant women, or children. An increasing number of states have received, applied for, or considered waivers to allow work requirements in their state programs.

Despite enthusiasm at both federal and state levels, Medicaid work requirements remain controversial (Williams). Opponents claim the covert goal of work requirements is to cut spending rather than uplift individuals, to take coverage away from low-income Americans and to dismantle Obamacare (Meyer; Fishman). Others argue the policy will cause more harm than good, by further complicating an already bureaucratic Medicaid system, making it more difficult for enrollees to become and remain employed, and creating more barriers to care (Meyer; Ende; Katch et al.). These predictions are reminiscent of the 1990s warnings about welfare reform, described in detail below, ominous predictions that never materialized.

Opponents of Medicaid work requirements are also using the legal system seeking to halt reform of Medicaid. In June 2018, the U.S. District Court for the District of Columbia vacated the approval of Kentucky's waiver allowing work requirements on the grounds that the secretary of Health and Human Services "never adequately considered whether Kentucky HEALTH would in fact help the state furnish medical assistance to its citizens." The judge concluded that approval of contingencies for Kentucky Medicaid was "arbitrary and capricious," and that obliging them to work put them "in danger of losing" their health insurance coverage (*Stewart v. Azar* 2018, 2-3). The Center for Medicare and Medicaid Services (CMS) reapproved Kentucky's waiver in November 2018 and was blocked, yet again, with the same opinion from the same court (*Stewart v. Azar* 2019, 3).

In August 2018, three advocacy groups filed suit to prevent Arkansas from adding work requirements to its Medicaid program (DeMillo). On March 27, 2019, the U.S. District Court for the District of Columbia vacated the HHS secretary's approval of Arkansas' work requirement (*Gresham v. Azar*, 4).

Medicaid Needs Reform

Despite five decades of touted fixes by Washington, Medicaid programs continue to fail, including in Texas (Waldman 2017a). Expansion states such as Illinois and New Mexico are in even worse shape, both fiscally and medically (Horton; Boyd).

Over the past five decades, piece by piece, section by section, CMS, the federal health care agency in Washington, has taken over nearly all the "supervision or control over the administration or operation" of every state Medicaid program with its one-size-fits-all mandates (Public Law 89-97, 291; Stout, 2-8). States have limited flexibility to tailor their programs for the unique aspects of their state populations and budgets. Solutions that may work in Rhode Island are unlikely to be effective in the Texas Panhandle. It is neither efficient nor effective to impose mandates uniformly across a nation with 326 million people spread over 3,800,000 square miles.

Spending by state Medicaid programs is largely decided by federal mandates. Expenditures for all other state priorities must accept what funds remain after Medicaid takes the first and biggest bite out of the budget. In Texas, this *crowd-out effect* restricts the state's ability to spend what is needed for education, infrastructure, fire, police, and disaster relief for events such as Hurricane Harvey.

The combination of fewer participating doctors and more patients demanding care has precipitated a crisis in care delivery.

Each year, Medicaid takes a larger bite out of our state budget. In the 2000-01 biennium, Texas Medicaid consumed 20.4 percent of the Texas All Funds budget. By 2018-19, Medicaid's share of the budget had increased nearly 50 percent to 29.6 percent (LBB, 12).

The excessive size of Texas Medicaid has led to significant challenges in properly overseeing its clinical contracts (Batheja). With a budget over $62 billion for the 2018-2019 biennium, this can have profound financial as well as medical consequences.

Medicaid is failing not only fiscally but medically as well. Nationally, less than 70 percent of physicians accept new Medicaid patients (Paradise), while in Texas, only 43 percent do (Texas Medical Association, 66). This means Medicaid patients have limited options and inadequate access to care. Physicians avoid treating Medicaid patients due to the administrative complexity, low reimbursements, and medically non-compliant patients.

A June 2018, five-part exposé by McSwane and Chavez in the *Dallas Morning News* revealed numerous ways that Texas Medicaid failed to provide necessary, sometimes life-sustaining, care. Inadequate medications, insufficient services, and outdated network portals that list nonexistent providers are some of the ways that Texas Medicaid, through its contracted managed care organizations, fails medically vulnerable Texans.

As a result of the ACA, 17.7 million Americans became newly insured, almost all through Medicaid expansion (Haislmaier and Gonshorowski; Hayes). The combination of fewer participating doctors and more patients demanding care has precipitated a crisis in care delivery. Wait times to see a doctor are rising (Merritt Hawkins, 6). This has led to "death by queueing" (VA Office of Inspector General, 11). In the Land of Lincoln, 752 Illinoisans died waiting in line for Medicaid-allowed health care that was not available in time to save them (Horton; DDS).

Medical outcomes in patients covered by Medicaid were often no better than being uninsured and sometimes worse. After surgery, Medicaid enrollees had higher complication rates and greater in-hospital mortality than those with no insurance at all (LaPar et al.). Medicaid recipients infected with Hepatitis C did worse than both privately insured and uninsured patients because promised medications were unauthorized, unavailable, or delayed in delivery (Younossi). And then there is the tragic story of a Texas child, D'Ashon Badawo, who suffered when a Texas Medicaid contracted managed care organization reduced his nursing hours below what was necessary (Evans 2018a). As a result, D'Ashon is now severely brain damaged.

Starting as early as 1967, Washington began a series of legislative and regulatory "fixes" for Medicaid, culminating in federal control of virtually every aspect of all state programs. A partial list is provided below of legislation that expanded Medicaid eligibility, increased benefits, added categories of illness, lowered reimbursement schedules, demanded more irrelevant, unnecessary information on enrollment forms, and extended timelines. Despite all the new, revised regulations, Medicaid outcomes continue to deteriorate.

Congressional Legislation that Expanded Medicaid

- Social Security Amendments of 1967
- Employee Retirement Income Security Act of 1974
- Tax Equity and Fiscal Responsibility Act of 1982
- Omnibus Budget Reconciliation Act of 1985
- Omnibus Budget Reconciliation Act of 1987
- Medicare Catastrophic Coverage Act of 1988
- Omnibus Budget Reconciliation Act of 1990
- National Breast and Cervical Cancer Early Detection Program of 1991
- Omnibus Budget Reconciliation Act of 1992
- Omnibus Budget Reconciliation Act of 1993
- Omnibus Budget Reconciliation Act of 2003
- Affordable Care Act of 2010
- Medicare Access & CHIP Reauthorization Act of 2015

Returning Authority to States

Medicaid programs are essentially federally controlled in all aspects. In order to add personal responsibility to Texas Medicaid, the state should request a waiver that asks CMS for permission to ignore or circumvent Washington's rules that prohibit contingencies, which encourage personal responsibility among recipients, preclude financial empowerment of enrollees, or impede placing limits on government support.

Section 1115 of the 1965 Social Security Act allows for "demonstration project" waivers, through which states may test policies within their Medicaid systems that do not comply with CMS rules. Section 1115 waivers are temporary, typically lasting five years, and may be renewed multiple times (Waldman 2017).

The Obama administration had no appetite for Medicaid reforms that might change the entitlement nature of Medicaid. However, both President Trump and the new CMS administrator, Seema Verma, have signaled interest in substantive reforms, such as allowing states to implement contingencies for able-bodied enrollees through the Section 1115 waiver process (Zoppo et al.; Neale).

On January 20, 2017, President Donald J. Trump issued his first executive order, titled "Minimizing the Economic Burden of the Patient Protection and Affordable Care Act Pending Repeal." Section 2 of the order states:

> *"To the maximum extent permitted by law, the Secretary of Health and Human Services (Secretary) and the heads of all other executive departments and agencies (agencies) with authorities and responsibilities under the [ACA] shall exercise all authority and discretion available to them to waive, defer, grant exemptions from, or delay the implementation of any provision or requirement of the [ACA] that would impose a fiscal burden on any State or a cost, fee, tax, penalty, or regulatory burden on individuals, families, healthcare providers, health insurers, patients, recipients of healthcare services, purchasers of health insurance, or makers of medical devices, products, or medications" (Proclamation No. 13,765).*

These words set the stage for CMS to allow states to mitigate the adverse effects of the ACA, including Medicaid expansion with its massive regulatory burden, attendant escalation of insurance prices, and huge bureaucratic costs.

On January 11, 2018, Brian Neale, former director of the Center for Medicaid and CHIP Services, issued a letter to

state Medicaid directors claiming, "CMS will support state efforts to test incentives that make participation in work or other community engagement a requirement for continued Medicaid eligibility or coverage for certain adult Medicaid beneficiaries…" (Neale, 1).

Current CMS rules establish Medicaid eligibility criteria based on age, medical condition, income, residence, and U.S. citizenship. California ignores the citizenship requirement (Hart). People who qualify by demographic criteria automatically receive Medicaid insurance free of charge. For those who qualify, there is no personal responsibility or any form of contingency to enroll.

The Trump administration reinforced its commitment to personal responsibility and federalism on April 10, 2018, issuing another executive order titled "Reducing Poverty in America by Promoting Opportunity and Economic Mobility." The order specifically addressed the failure of unreformed federal welfare programs to lift Americans out of poverty. Instead, these programs have perpetuated a cycle of poverty and increased dependency on the federal government. The order seeks to reverse these trends: "The Federal Government's role is to clear paths to self-sufficiency, reserving public assistance programs for those who are truly in need … by investing in Federal programs that are effective at moving people into the workforce and out of poverty" (Proclamation No. 13,828).

The approval of 10 state waivers (AZ, AR, IN, KY, ME, MI, NH, OH, UT, and WI) that include a work requirement indicates that CMS intends to follow through with its new commitments with respect to work requirements. With the approval of Wisconsin's waiver request, CMS is allowing non-expansion states to adjust their programs toward personal responsibility. These steps move Medicaid toward cooperative federalism instead of the top-down regulatory structure that has been in force.

The issue of limits on Medicaid benefits remains unclear. If enrollees were personally responsible and there were eligibility or benefits contingencies, then some form of limitations, time or dollar, would also seem reasonable. CMS has explicitly rejected lifetime limits on Medicaid support, a personal responsibility reform requested by several states. On May 7, 2018, the administrator of CMS sent a letter to the Kansas Medicaid director announcing, "[CMS] will not approve this formulation of the state's request to impose a lifetime limit on Medicaid benefits for individuals who are eligible for Medicaid" (Seema 2018a, 1). Two days later, Arizona withdrew its lifetime limit request from its pending 1115 waiver application (Innes).

Arizona had planned to withdraw its lifetime limit request even before the Kansas decision. In April 2018, the director of the Arizona Health Care Cost Containment System sent a letter to Gov. Doug Ducey explaining, "CMS has indicated that expediting the approval of the community engagement requirements will require continued discussion of the maximum lifetime limit post-approval of the community engagement requirements" (Betlach).

The approval of 10 state waivers that include a work requirement indicates that the Center for Medicare and Medicaid Services intends to follow through with its new commitments to state Medicaid flexibility.

Developing an 1115 demonstration project requires considerable amounts of time and state resources. With the number of submitted waiver requests, limited administrative resources to evaluate them, and with intense public scrutiny, negotiations that lead to approval can easily last more than a year. The 1115 waiver applications currently held up in CMS's bureaucratic pipeline are likely to induce hesitation in states that want to submit waivers but have not yet begun the process (Kasich and McCarthy).

The fact that no state really knows what CMS will approve or disapprove highlights a fundamental problem with the waiver process. Waivers give states an opportunity to make meaningful changes to their Medicaid programs, but implementation is dependent on CMS permission. Even when CMS approves, 1115 demonstrations are temporary and subject to constant federal oversight. Having a waiver process is better than not having one, but waivers ultimately perpetuate a system in which Washington controls what were supposed to be state-run medical safety net programs (Schneider and Wachino).

States at the Forefront

Since August 2016, 17 states have submitted Section 1115 waiver applications to CMS, requesting permission to incorporate work requirements into their Medicaid programs

(KFF 2019a). Ten of these states have received CMS approval, including Arizona, Arkansas, Indiana, Kentucky, Maine, Michigan, New Hampshire, Ohio, Utah, and Wisconsin. Waivers from Alabama, Mississippi, Oklahoma, South Dakota, Tennessee, and Virginia are pending.

Table 1 shows the status of these waiver requests and variations in the number of hours per week that states propose to require work activities from able-bodied adults. **Figure 1** shows the status of states' 1115 waivers that include work requirements.

Kansas originally requested work requirements in its December 2017 waiver but later asked CMS to defer its decision on the work requirement component (Mayhew, 5). CMS subsequently approved the other components of Kansas' waiver. Kansas may have withdrawn its work requirement request so as to expedite and ensure the approval of its other waiver components.

Table 1. States requesting Medicaid work requirements via 1115 waivers

State	ACA Expansion	Status	WR
Alabama	No	Pending	35 hrs/wk[6]
Arizona	Yes	Approved	80 hrs/mo
Arkansas	Yes	Approved[2]	80 hrs/mo
Indiana	Yes	Approved	20 hrs/wk[7]
Kansas	No	Withdrawn[3]	20-55 hrs/wk[8]
Kentucky	Yes	Approved[4]	80 hrs/mo
Maine	Yes	Approved[5]	80 hrs/mo
Michigan	Yes	Approved	80 hrs/mo
Mississippi	No	Pending	20 hrs/wk
New Hampshire	Yes	Approved	100 hrs/mo
Ohio	Yes	Approved	20 hrs/wk
Oklahoma	No	Pending	80 hrs/mo
South Dakota	No	Pending	80 hrs/mo[9]
Tennessee	No	Pending	20 hrs/wk[10]
Utah	Yes[1]	Approved	3 mo/yr[11]
Virginia	Yes	Pending	20-80 hrs/mo[12]
Wisconsin	No	Approved	80 hrs/mo[13]

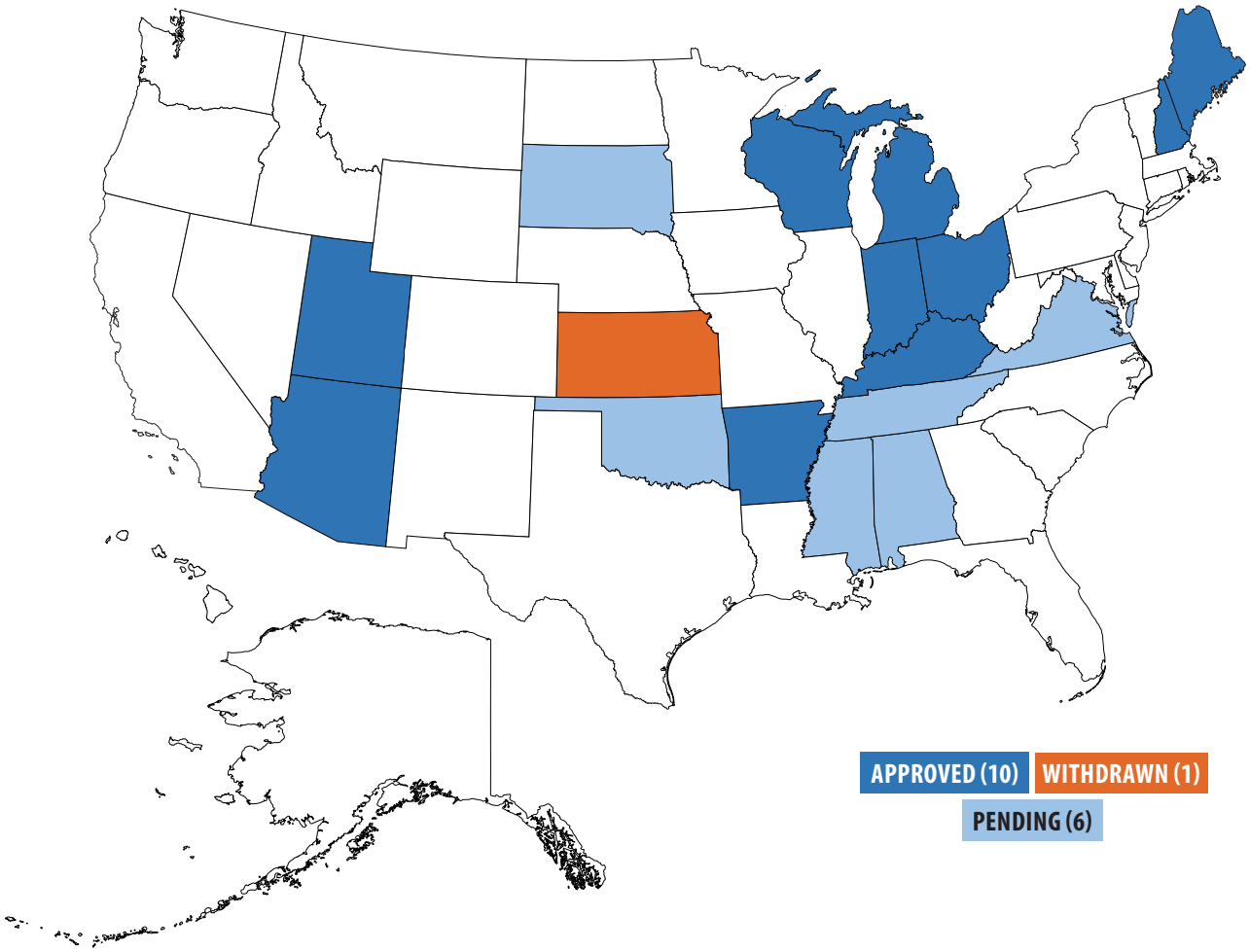
[1]Utah passed legislation requiring expansion and is currently seeking partial Medicaid expansion from CMS (State of Utah).
[2]CMS approved Arkansas' waiver on March 5, 2018 (ADHS 2018a). On March 27, 2019, the U.S. District Court for the District of Columbia vacated CMS' approval (*Gresham v. Azar*, 4).
[3]On December 26, 2017, Kansas submitted an 1115 application to CMS requesting work requirements (KS). On December 18, 2018, CMS approved Kansas' waiver, but the approval did not include work requirements. According to CMS, "The state [had] asked CMS to defer consideration of" the work requirement component, among others (Mayhew, 5).
[4]CMS approved Kentucky's waiver on January 12, 2018, but brought the waiver back under review after the U.S. District Court for the District of Columbia vacated CMS' approval (*Stewart v. Azar*, 2-3). CMS reinstated the approval on November 20, 2018 (Paul Mango, 1). The U.S. District Court for the District of Columbia vacated CMS's second approval on March 27, 2019 (*Stewart v. Azar* 2019, 3).
[5]Maine's waiver was approved on December 21, 2018; Maine refused the terms of CMS' approval and declared it would not implement a work requirement on January 22, 2019 (Seema 2018b, 1; Janet).
[6]Parents and caretaker relatives with a child under age 6 may work 20 hrs/wk (ALM, 5).
[7]For at least eight months of a calendar year (FSSA 2018, 2).
[8]Depends on the number of adults in a household and the presence and age of a child in a household (KS, 11).
[9]Alternatively, enrollees may complete monthly milestones in their individualized employment and training plan (DSS, 4-5).
[10]Enrollees are required to demonstrate compliance for four months per six-month period (DTC, 4).
[11]Enrollees must participate in job search or training within the first three months of enrollment; beneficiaries working 30 hours per week are exempt (UDH 2017, 3).
[12]Virginia will gradually increase the time commitment the longer an enrollee remains in the program, up to 80 hrs/mo (DMAS, 7).
[13]Wisconsin's work requirement is tied to a 48-month time limit on benefits; participation in the work requirement stops the clock on the time limit (DHS 2018a, 4).
Sources: KFF 2019a, KFF 2019b, ALM, AHCCCS 2017, ADHS 2018a, FSSA 2018, KS, Paul Mango, MEHHS, MIHHS, MS, NHDHHS, ODM, OHCA 2018b, DSS, DTC, UDH 2017, DHS 2018a, DMAS

On December 21, 2018, CMS approved Maine's waiver, including a work requirement, but Maine refused the terms of CMS's approval and declared it would not implement a work requirement on January 22, 2019 (Seema 2018b, 1; Mills). Maine elected a new governor in November 2018, transitioning from a red state to a blue state.

After receiving its first approval from CMS on January 12, 2018, Kentucky was scheduled to implement its work requirement on July 1, 2018, but was blocked by a court ruling issued on June 29, 2018 (KFF 2018). The opinion, written by Judge James E. Boasberg of the U.S. District Court for the District of Columbia, deemed CMS's approval of Kentucky's waiver "arbitrary and capricious," and "remand[ed] the matter to HHS for further review" (*Stewart v. Azar*, 3). CMS brought Kentucky's waiver back under review and conducted a 30-day public comment period from July 19 to August 18, 2018 (CMS). CMS approved the waiver a second time on November 20, 2018, but its decision was vacated a second time by the U.S. District Court on March 27, 2019 (*Stewart v. Azar* 2019, 3). Kentucky's Cabinet for Health and Family Services released a statement saying, "Although a setback to our implementation schedule, we believe that we have an excellent record for appeal and are currently considering next steps" (CHFS 2019, 1).

Arkansas was the first state to implement a Medicaid work requirement. Starting June 1, 2018, expansion adults aged 30 to 49 were required to work a minimum 80 hours per month to remain eligible for Medicaid benefits (ADHS 2018b, 1). Expansion adults aged 19 to 29 were being phased in from January through June 2019 (ADHS 2019). Arkansas Works allowed enrollees a three-month grace period per year

Figure 1. Status of state work requirement waivers



Source: Legislative activities compiled by authors.

before disenrolling them for noncompliance (ADHS 2018a, 5). September 2018 was the first month in which Arkansas Works cases began to close due to the work requirement. Of the 116,229 enrollees subject to the work requirement in February 2019, 102,856 met the work requirement and 13,373 did not (ADHS 2019). The rate of compliance steadily rose from 71 percent in June 2018 to 92 percent in December 2018, with a slight decrease to 88 percent in February 2019. Since implementation, Arkansas has closed 18,164 total cases due to noncompliance (ADHS 2019).

On March 27, 2019, the U.S. District Court for the District of Columbia vacated the HHS secretary's decision to approve Arkansas' work requirement waiver, rendering work requirements unlawful in the state (*Gresham v. Azar*, 4). Arkansas' governor has urged the Department of Justice and HHS to appeal the ruling, adding that "If [Arkansas] want[s] to continue the fight for a work requirement, the best course is to appeal. If not, we lose the opportunity to lead nationally in this effort to provide training and work opportunities for those on Medicaid" (Arkansas Governor).

Indiana implemented its work requirement on January 1, 2019. For the first six months of the program, enrollees are not required to demonstrate work activity. Starting July 2019, they will need to demonstrate 20 hours of work per week, which will gradually increase to 80 hours of work per month through July 2020 (FSSA). Due to the six-month grace period, Indiana has not yet released data on the effects of its policy.

New Hampshire notified CMS that it intends to implement its work requirement on March 1, 2019 ("Re: Notice"). Wisconsin announced that "final implementation of [the work requirement] is expected to be at least one year from approval," so the earliest implementation could be October 2019 (DHS 2018b). Work requirements in Arizona, Michigan, and Utah are scheduled to commence no sooner than January 1, 2020 (AHCCCS 2019; HMP; UDH 2019). Ohio intends to implement on January 1, 2021 (Seema 2019, 1).

Most states use CMS guidelines as a foundation for designing their work requirements, but there is a wide range of creativity and innovation as states attempt to put their own unique spin on reform (Neale, 2-9). Unfortunately, the more states expand on the guidelines, the farther they venture outside the box, the more they risk disapproval of their applications. CMS-enforced risk aversion creates a perverse incentive: States avoid bold reforms that could greatly improve access to care for Medicaid patients because of fear of rejection. The recent court rulings on work requirements in Arkansas and Kentucky are likely to discourage states even further.

Eligible Populations

States that expanded Medicaid to low-income adults under the ACA are using their 1115 waivers to apply work requirements to their expansion populations. Non-expansion states (6 out of 17 states with 1115 waiver requests) would generally apply the requirement to able-bodied, adult Medicaid recipients, including some parents and caretakers. However, most non-expansion states would exempt parents of young children and caretakers of elderly or disabled individuals who cannot care for themselves (ALM, 6; DHS 2018a, 10; MS, 4; KS, 10; DSS, 4; OHCA 2018b, 9; DTC, 3).

On October 31, 2018, CMS approved Wisconsin's work requirement waiver—the first from a non-expansion state (DHS 2018a, 1). This action set what might be viewed as a radical precedent, but one that is in keeping with prior welfare reforms. The current administration supports the incorporation of personal responsibility elements into Medicaid programs on principle, not simply as a means to counter exorbitant costs in expansion states. After more than a year of uncertainty, the remaining non-expansion states with pending waivers can rest assured that their waivers will not be denied simply on the basis of nonexpansion. Wisconsin will develop policies relevant to its work requirements for at least a year before implementation (DHS 2018b). The state projects approximately 148,000 childless adults may be affected, not accounting for exemptions (DHS 2018c, 455).

In the remaining non-expansion states, the number of Medicaid recipients who would be required to work varies. The Oklahoma Health Care Authority projects 6,000 enrollees would be required to work, accounting for exemptions (OHCA 2018a, 10). Kansas projected 12,000 able-bodied enrollees would have been affected, less than 3 percent of the state's total Medicaid population (NPR). Mississippi's waiver application states that "current data elements indicate approximately 56,467 individuals could be eligible for workforce training activities," but this number is likely an overestimate as it does not capture data relevant to exemption criteria (MS, 8). Alabama projects 75,000 recipients will be subject to its work requirement, barring exemptions (ALM, 10).

South Dakota's waiver request is unique in that its demonstration proposal is a pilot program limited to its two most populous counties, Minnehaha and Pennington. The state anticipates the work requirement will apply to approximately 1,300 individuals in these areas, and that, "a small number of individuals will lose coverage during the demonstration period as a result of choosing not to participate in the program" (DSS, 10).

All states would apply work requirements to able-bodied adults, beginning with age 19 and ending, depending on the state, with ages 49 to 65. Each state has its own list of exempt populations. Some common exemptions include—

- Pregnant women
- Parents and caretakers
- Physically or mentally disabled individuals
- Medically frail individuals
- Students
- Individuals participating in substance abuse treatment programs
- Individuals recently incarcerated
- Individuals residing in an institution

Some states, such as Ohio and Indiana, plan to offer exemptions for people living in areas with high unemployment, job shortages, lack of public transportation, other socioeconomic hardships that would create a significant barrier to fulfilling the state's work requirements (ODM, 8; FSSA 2018, 18).

Kansas' waiver would have allowed the state to reward disabled beneficiaries who choose to work and facilitate employment opportunities for them (KS, 13). Oklahoma's waiver exempts disabled enrollees from the work requirement but proposes granting them the opportunity to participate voluntarily (OHCA 2018b, 9). These are the only states so far to suggest that employment or work-related activities should be encouraged for disabled Medicaid recipients.

Time Commitments and Qualifying Activities

States vary slightly in how much work or community engagement they would require. The majority would require 20 hours per week (**Table 1**). New Hampshire is an outlier on the stricter side, proposing 25 hours per week (NHDHHS, 20). Utah would only require three months of job search and/or training activities, rather than work, in a

calendar year (UDH 2017, 3). However, Utah would exempt individuals already working 30 hours per week.

Other states are flexible with the number of hours required. Kansas' required hours per week would have depended on beneficiaries' family size and the presence of young children in their households (KS, 11). Maine would have required different hours for different types of community engagement activities—20 hours per week for employment or 24 hours per month for community service (MEHHS, 6). Indiana will allow extra hours completed in a week to rollover within the same month, while New Hampshire will not allow any rollovers (FSSA 2018, 14; NHDHHS, 21).

The types of activities that satisfy work requirements also vary among states. For example, Indiana will allow hours spent homeschooling children to count toward the requirement (FSSA 2018, 13). Arkansas offers classes on health insurance, using the health system, and healthy living that satisfy its work requirement (ADHS 2018a, 20). The majority of states would consider participation in substance abuse treatment programs as fulfilling the time obligation, or grant an exemption to participating beneficiaries. Other states, such as Ohio and Wisconsin, only allow a limited number of employment-related activities (ODM, 8; DHS 2018a, 10).

Almost all states would align their Medicaid work requirements with those for SNAP and TANF beneficiaries.

Penalties, Re-enrollment, and Implementation

In order to enforce work requirements, states penalize noncompliance but offer opportunities to re-enter the program. All states would penalize noncompliance with termination of eligibility. Wisconsin's work requirement is uniquely paired with a 48-month eligibility time limit—meaning certain recipients would be limited to 48 months of benefits. Time during which beneficiaries fail to comply with Wisconsin's work requirements would count toward the time limit, whereas compliance would stop the clock (DHS 2018a, 4).

Arkansas and Kentucky will impose lockout periods for noncompliance or failure to report a change of circumstance that could affect eligibility (ADHS 2018a, 22; Paul Mango, 17). During lockout periods, individuals would be

Table 2. Personal responsibility Medicaid policies requested or adopted by states in addition to work requirements.[1]

	AL	AR	AZ	IN	KS	KY	ME	MI	MS	NH	OH	OK	SD	TN	UT	VA	WI
Copays	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Premiums		✓	✓	✓		✓	✓	✓			✓					✓	✓
Health Incentives			✓	✓		✓		✓			✓		✓			✓	✓
Health Savings Accounts		✓		✓	✓			✓			✓						
Limited Retroactive Eligibility		✓					✓			✓	✓						
Premium Assistance		✓								✓		✓			✓		
Time Limits			✓		✓										✓		✓[2]
Redetermination Penalties				✓		✓					✓						
No Presumptive Eligibility							✓								✓		

[1]This table is not an exhaustive representation of all states with Medicaid policies that promote personal responsibility, as only the 17 states with work requirement waivers were examined and included; states included may have more Medicaid policies that promote personal responsibility than those represented here, as the analysis only includes state work requirement waivers and fact sheets about states' demonstration programs on CMS's state waiver database.
[2]WI's time limit is not a lifelong limit on benefits or eligibility; enrollees who fail to comply with the work requirement for 48 months will be disenrolled and subject to a six-month lockout period, during which they cannot re-enroll under the same eligibility category.
(X) denotes waiver requests that have been withdrawn or denied by CMS.
Sources: AHCCCS 2017, ADHS 2018a, ALM, FSSA 2018, KS, Paul Mango, MEHHS, MIHHS, MS, NHDHHS, ODM, UDH 2017, DHS 2018a, DSS, DMAS, DTC, OHCA 2018b

unable to re-enroll. Lenient states grant grace periods of three to six months, 30-day "opportunity to cure" periods, or a certain number of days from the time of eligibility determination to come into compliance.

CMS established limitations on the duration of lockout periods, meaning lockout periods cannot be indefinite or too long. In an interview with the *Washington Post*, the administrator of CMS stated, "We want to make sure that there's a pathway back into the [Medicaid] program, that there's a way for [participants] to come back in if they're compliant with the requirements" (*Washington Post*).

States offer a number of opportunities to re-enroll once individuals lose their eligibility due to noncompliance. Usually, individuals are required to make up work hours, demonstrate "good cause" for failing to comply, or become eligible for benefits under a different eligibility category. Kentucky and Tennessee would allow reinstatement after completion of a state-approved health literacy or financial literacy course (Paul Mango, 34; DTC, 4). In Kentucky, the re-enrollment course option would only be available to a non-compliant individual once per 12-month benefit period.

Timelines vary as to how states plan to verify compliance with their work requirements. Arkansas requires monthly reporting of compliance, while Indiana will determine compliance annually (ADHS 2018a, 20; FSSA 2018, 15). Arizona proposed conducting bi-annual eligibility redeterminations, against the ACA's limitation on redeterminations to once per year (AHCCCS 2017, 7). Only one state, Mississippi, is requesting enhanced federal matching funds for workforce training programs (MS, 4).

Additional Personal Responsibility Reforms

All 17 states with approved, pending, or withdrawn waiver requests push Medicaid reform well beyond requirements related solely to work. **Table 2** shows the states with proposed or established Medicaid policies that promote personal responsibility for Medicaid recipients, including:

- **Co-pays**—small fees patients are responsible for at point of service.
- **Premiums**—mandatory monthly contributions paid by enrollees.
- **Health incentives**—rewards for exhibiting healthy behaviors, or penalties for demonstrating unhealthy behaviors.
- **Health savings accounts**—savings accounts that may only be used for health-related expenditures, to which beneficiaries and/or the state may make tax-free contributions.
- **Limited retroactive eligibility**—limits the period of time prior to eligibility determination for which health care services are covered by Medicaid, relative to the ACA rule that states must retroactively cover three months.
- **Premium assistance**—use of Medicaid funds to subsidize premiums for qualified health plans offered in the individual market through the Marketplace.
- **Time limits**—maximum time periods for which individuals may receive Medicaid benefits.
- **Redetermination penalties**—penalties for failure to complete eligibility redetermination or provide adequate information for redetermination.
- **No presumptive eligibility**—revokes individuals' ability to receive immediate, temporary Medicaid coverage prior to formally applying for benefits.

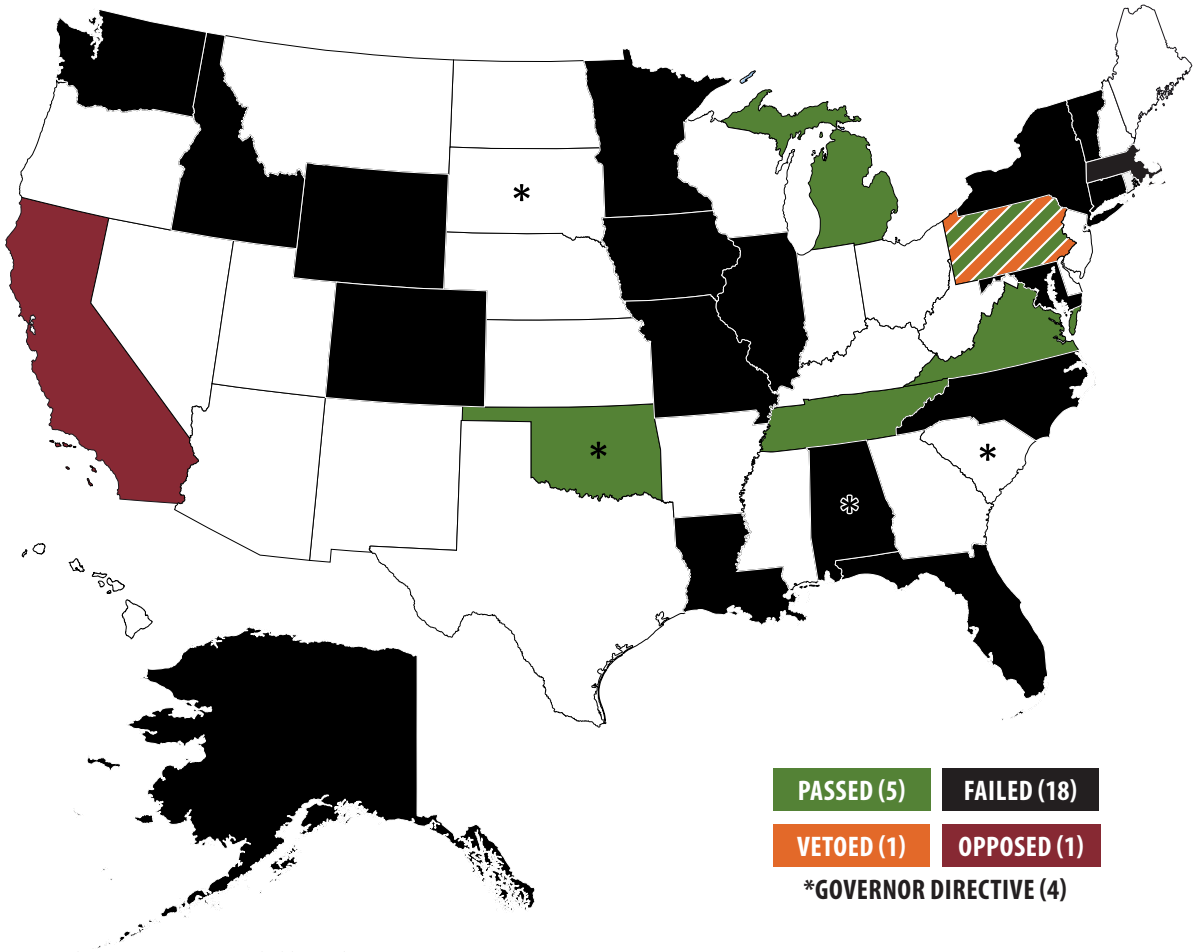
The states differ as to how they seek to cultivate independence and personal responsibility within their Medicaid populations (**Table 2**). No state has stopped at requesting only one action because reforms are aimed at broader thematic goals: promoting self-reliance and economic mobility for Medicaid beneficiaries and transforming Medicaid into a two-way relationship between vulnerable individuals and their communities.

States One Step Back

Some states, including Texas, have yet to submit Section 1115 waivers. Many are debating the decision in their respective state legislatures. In 2018, 23 states considered legislation that would require their Medicaid agencies to develop and submit 1115 waiver applications that would implement work requirements. Waiver legislation failed to pass in 18 states and passed in five states: Michigan, Oklahoma, Pennsylvania, Tennessee, and Virginia (SB 897; HB 2932; HB 2138; HB 1551; HB 5001). Pennsylvania is the only state in which passed legislation was vetoed by the governor; the other four states earned governors' signatures and were enacted.

A legislature is not the only place where waivers can start. The governors of Alabama, Oklahoma, South Carolina, and South Dakota ordered their state Medicaid directors to draft work requirement waivers (Gore; Fallin; Office of the Governor; Daugaard, 16). However, support from the legislature adds strength and momentum to a waiver initiative. Oklahoma is the only state so far in which the governor issued an executive order and legislation was enacted to develop a waiver (Fallin; HB 2932).

Figure 2. State work requirement legislation and governor directives



Source: Legislative activities compiled by authors.

Figure 2 shows state legislative actions and governor directives related to Medicaid work requirements.

Some bills simply *allow* their state Medicaid agencies to include personal responsibility in their waiver applications, rather than *directing* them to do so. For example, one bill in Missouri directs the agency to submit a waiver that "maximize[s] the flexibility of the state to design a patient-centered, sustainable, and cost-effective approach to a market-based health care system" (SB 562). The bill includes a list of reforms the agency "may include" in its waiver, including work requirements, but does not specify which reforms the waiver must include. Similarly, Louisiana amended a bill that originally required a work requirement waiver to establish an in-state planning process to implement work requirements, which "may include submission of a section 1115 waiver…" (HB 3). Strong legislative language is critical to providing state Medicaid agencies with clear direction. It also gives the states an opportunity to clarify exactly which regulations should be waived before they begin the arduous negotiation process with CMS.

California's action is unique. It is the only state to propose legislation to explicitly *prohibit* the Department of Health Care Services (DHCS), its Medicaid agency, from submitting a work requirement waiver. The bill passed the Senate and received "Do pass" recommendations from the Assembly Committees on Health and Appropriations before it was amended to take milder action (SB 1108). The amended bill passed and was signed by the governor, authorizing DHCS to submit a waiver application that "either increase[s] the number of [Medicaid] beneficiaries or enhance[s] the medical assistance provided to beneficiaries" (SB 1108). It also requires that any proposals to offer nonmedical benefits to Medicaid beneficiaries including, but not limited to, employment and housing assistance, must be offered on a voluntary basis, rather than as a condition of eligibility. In effect, the legislation renders work requirements off limits in California.

Several states have considered legislation that would pair work requirements with other personal responsibility reforms, such as cost sharing, lifetime limits, and incentives for healthy behaviors. A few of these states explicitly named

personal responsibility as a reform goal within legislative language. A bill from Idaho sought to establish cost sharing "in order to increase the awareness and responsibility of [M]edicaid participants for the cost of their health care" (HB 464). Virginia's enacted legislation directs the Department of Medical Assistance Services to "include provisions to foster personal responsibility and prepare newly eligible enrollees for participation in commercial health insurance plans … through the State Plan amendments, contracts, or other policy changes" (HB 5001, 112).

The majority of personal responsibility bills failed to pass in their respective state legislatures. Nonetheless, creation of these bills signals states' appetite to consider transforming their Medicaid programs. In fact, reform initiatives are increasingly focused on themes like personal responsibility, self-sufficiency, and community engagement. Pressure from the states to incorporate these principles into Medicaid could eventually lead to major changes at the federal level, particularly changes that give control of their Medicaid programs back to the states, as intended when Medicaid was first established (Public Law 89-97, 291).

Lone Star State in Between

Texas is a "half step" behind the states with submitted waiver requests and a half step ahead of those merely contemplating such a request.

Chapter 537

In 2011, Texas considered submitting a Section 1115 waiver that added personal responsibility to Medicaid. In fact, the 83rd Texas Legislature passed Chapter 537 into law, instructing HHSC to "...seek a waiver under Section 1115 of the federal Social Security Act (42 U.S.C. Section 1315) to the state Medicaid plan" that included welfare reforms such as: "provide [state] flexibility to determine Medicaid eligibility … provide [state] flexibility to design Medicaid benefits … encourage use of the private health benefits coverage market rather than public benefits systems … create a culture of shared financial responsibility, accountability, and participation" (Texas Government Code).

Subsequent to the passage of Chapter 537, the Texas Medicaid Reform Legislative Oversight Committee decided to delay submission of this waiver request with the following rationale: "In light of the current [2012] Medicaid environment, including ongoing implementation of initiatives passed by the 82nd Legislature, uncertainties still surrounding the impact of the ACA ruling, and the need for the 83rd Legislature to meet and determine the direction of the Texas Medicaid program, a new Medicaid 1115 waiver request would be premature at this time" (Nelson).

Additionally, in 2012 when the oversight committee was considering asking for more state flexibility, the Obama administration was tightening CMS's control of Medicaid. Today, the Washington political environment is different. The Trump White House and CMS under Administrator Seema Verma have declared their enthusiasm for states' ideas for transformative changes in Medicaid (Proclamation No. 13,765; Proclamation No. 13,828; Neale).

Are Work Requirements Right for Texas?

Because Texas has not expanded Medicaid to low-income, able-bodied adults under the ACA, few Texas Medicaid recipients are eligible for a work requirement (**Table 3**). CMS's guidance on work requirements provides parameters regarding who might be eligible, including "non-elderly, non-pregnant adult Medicaid beneficiaries who are eligible for Medicaid on a basis other than disability" (Neale, 1).

Children make up nearly 2.9 million of the 3.9 million Texas Medicaid enrollees, or 73 percent (HHSCa). In Texas and other non-expansion states, children as defined as being ages 19 and under, as opposed to expansion states where they are defined as being ages 26 and under. Naturally, children are exempt from any Medicaid work requirements.

Disabled, elderly, and pregnant adults (22 percent of Texas Medicaid enrollees) are also exempt from work requirements (HHSCa). CMS's guidance further prescribes that "states must also create exemptions for individuals determined by the state to be medically frail and … any individuals with acute medical conditions … that would prevent them from complying..." (Neale, 5). In Texas Medicaid, these exemptions would most likely apply to 195 individuals classified as medically needy and 4,752 individuals with breast and cervical cancer (HHSCa).

The remaining non-exempt Texas Medicaid population is low-income parents qualifying for TANF cash assistance. They comprise 133,094 individuals, or 3 percent of the Texas Medicaid population (HHSCa). Furthermore, they already have certain work-related contingencies for receiving TANF benefits, including training for jobs, looking for

Pressure from the states to incorporate community engagement principles into Medicaid could eventually lead to major changes at the federal level.

Table 3. Texas Medicaid demography

Texas Medicaid (February 2019)

	Enrollees	
	Number	**Percent total***
Total Medicaid population	3,927,894	100%
Children (<19 y)	2,872,614	73%
Disability-Related	409,587	10%
Aged & Medicare-Related	372,072	9%
Pregnant Women	136,059	3%
Breast & Cervical Cancer	4,752	<1%
Medically Needy	195**	<1%
TANF Adults***	133,094**	3%

y = years of age. *Sum of percent totals may not equal 100 due to rounding. **Estimated data for January 2019. ***Eligibility group subjectable to a work requirement.
Source: "Medicaid and CHIP Monthly Enrollment by Risk Group (September 2013 - February 2019)"; email exchange with Michael Ghasemi, TX HHSC personnel, April 20, 2019 (Ghasemi).

work, or not quitting a job they already have (HHSCb). According to CMS's work requirement guidance, "individuals enrolled in and compliant with a TANF or SNAP work requirement, as well as individuals exempt from a TANF or SNAP work requirement, must automatically be considered to be complying with the Medicaid work requirements" (Neale, 5).

Because Texas TANF adults are already subject to, or exempt from, a work requirement, it is unclear which Texas Medicaid population would be impacted by a work requirement. Any impact would be small.

Fiscal Impact of a Work Requirement

For the sake of calculating a maximum-impact cost analysis, let us assume briefly that all TANF Medicaid recipients are subject to a work requirement. According to HHSC's Texas Medicaid and CHIP Reference Guide (12th Edition), the average cost of non-disabled, full-benefit adults is $246 per client per month, or $2,952 per client per year (HHSC 2018, 3).

Because Arkansas is the only state so far to have implemented and maintained an active work requirement, yielding data on enrollment effects, we shall use this state as the standard for comparison. The lowest work-requirement compliance rate in Arkansas occurred within the first two months of its implementation (June and July 2018), equaling 71 percent (ADHS 2019). In other words, 29 percent of Medicaid recipients subject to the work requirement did not comply within the first two months of implementation.

Presuming that 29 percent of Texas Medicaid TANF adults do not comply with a work requirement, 38,597 individuals would be eligible for disenrollment. If all of these individuals were disenrolled, Texas Medicaid would save $113,938,344 per year at most. However, for reasons stated above, the majority of TANF Medicaid recipients would likely be considered compliant with, or exempt from, a work requirement.

The administrative costs of implementing a work requirement would not likely differ from state to state, as they primarily involve similar electronic system changes and the cost of outreach and education. In Arkansas, system changes attributable to the work requirement were estimated to cost $23,134,047 from July 2017 through March 2019 (Lee 2019a). Outreach and education efforts included social media and search engine marketing, newspaper advertisements, radio and television advertisements, and advertisements on public transit systems. The estimated cost of these efforts was $44,670 from January through June 2019 (Lee 2019b).

Medical and Psychosocial Effects

A guidance letter dated January 11, 2018, from CMS to state Medicaid directors on community engagement claims that "[the] new policy [is] designed to assist states in their efforts to improve Medicaid enrollee health and well-being through incentivizing work and community engagement" (Neale, 1). The implication that employment and community engagement could improve the health of Medicaid enrollees has sparked debate among supporters and opponents of work requirements.

Because of scientific, statistical, and even ethical difficulties studying the intersection of health with work, there is limited useful scientific data. Most research reports come with provisos and disclaimers that make it difficult to draw any reliable conclusions (Butterworth et al.; Waddell and Burton, ix; Gibson et al. 51; Cook et al.).

Some studies prove the obvious: Being in poor health has a high risk of job loss and unemployment (van Rijn et al., 299; Olesen et al., 6). Other studies report that unemployment is associated with poor health, particularly poor mental health (Waddell and Burton, 32; Paul and Moser). Evidence exists for the converse association: Having a job may improve mental health (van der Noordt et al.; Rueda et al., 547) and possibly physical health as well (Hergenrather et al.). A 2006 literature review commissioned by the United Kingdom Department for Work and Pensions concludes that "there is a strong body of indirect evidence that … work is generally good for your health and well-being, with certain important provisos" (Waddell and Burton, 31). If the job/health association is cause-and-effect, it is unclear which comes first: good health or steady employment.

Access to health insurance is positively associated with acquiring and keeping a job, particularly among Medicaid expansion enrollees (Kasich and Sears, 46; IHPI; Ward and Bridge, 3; Hall et al.). While employment can help some individuals gain health insurance, these opportunities are less common for low-income workers (Antonisse and Garfield). In the Oregon Medicaid Study, having health insurance was associated with lower levels of stress, but there were no statistically significant physical health benefits reported (Baicker et al.).

The inherent challenges of trying to discern the precise relationship between work and health can be boiled down to two unanswered and possibly unanswerable questions. Is the relationship a causal connection or merely an association? If it is cause and effect, which comes first: the chicken or the egg (Virtanen et al., 50; Waddell and Burton, 1)?

While hard to quantify, the psychosocial gains from welfare reform are nonetheless real. Entitlement presumes the individual is a victim, one who expects government to supply all of life's necessities. The infusion of personal responsibility into Medicaid changes the fundamental culture of welfare. Texas recipients who reject victimhood can re-establish personal dignity. Instead of depending on Washington giveaways, Texans can regain independence, self-reliance, and prosperity, rather than merely surviving on government hand-outs.

Welfare Reform in the U.S.

The principles guiding the reforms suggested in this paper have their foundation in decades of private charitable efforts that helped vulnerable Americans get back on their feet while receiving needed assistance. Unfortunately, memory of these efforts has been overwhelmed by the growth of federal welfare programs.

The principles guiding the reforms suggested in this paper have their foundation in decades of private charitable efforts that helped vulnerable Americans get back on their feet while receiving needed assistance.

Government support or welfare can take many forms and has changed greatly over the years. In addition to taxpayersupported, government-distributed food, housing, and financial assistance, there is health care insurance provided through Medicaid. Note that Medicaid is an entitlement with no cost to recipients nor any contingencies.

From colonial times to the early 20th century, assistance for Americans in need was provided primarily through charitable associations, rather than any component of the central government (Olasky, 6). Organizations that provided charity had names such as the New York Association for Improving the Conditions of the Poor, Massachusetts Charitable Fire Society, Hebrew Home for the Aged, and Benevolent Society for the Relief of Poor Widows and Small Children.

Some private charities would screen beneficiaries' willingness to work and to be personally responsible before providing aid. For instance, a person seeking assistance might be asked to chop wood or repair a garment before receiving no-charge food, clothing, or lodging. Those who were unwilling to perform such tasks were less likely to receive assistance than those who were willing. Charities that used these methods considered personal responsibility a necessary prerequisite for receiving assistance, at least for the able-bodied adults.

The word "personal" was considered critical for success in any charitable activity. The beneficiary needed to show his or her willingness to contribute back, while donors had to be personally and directly involved with the recipients of his or her charity. The Boston Fragment Society, which gathered damaged garments for repair by women charity seekers, urged its donors: "Let us penetrate the lanes and by-ways of the city, enter the abodes of poverty and distress, and show the destitute inmates that we sympathize in their sufferings" (Olasky, 14). As impersonal government took over the role of charity provider and welfare distributor, the direct personal contact element was lost to both recipient and donor.

During the Great Depression, the federal government replaced private charitable organizations as the primary provider of assistance to Americans in need. The Roosevelt administration established a series of national welfare programs within the Social Security Act and Amendments, starting in 1935. Since then, public welfare programs have been expanded through a host of federal initiatives, notably President Johnson's War on Poverty and his Great Society program, along with the 1965 amendments to the Social Security Act, that created both Medicare and Medicaid (Social Security Amendments).

As government welfare supplanted private charity, Americans became increasingly dependent on impersonal government instead of highly personal private, community-based activities. Many individuals on welfare struggle to become independent and to break the cycle of poverty, but fail.

Reagan Welfare Reforms

The California Welfare Reform Act of 1971 was the brainchild of Gov. Ronald Reagan, Chief Deputy Director of the California State Department of Public Works Robert Carleson, and Democratic Speaker of the California Assembly Robert Moretti (Carleson). Designed to address the numerous problems within the California public welfare system, the bill raised basic grant levels for families with dependent children. At the same time, Reagan's reform required more private-sector involvement in welfare, increased family- and community-based care for the elderly, tightened verification processes, and established limits on support.

At a 1968 Governor's Conference on Medicaid in San Francisco, Gov. Reagan said, "We should measure welfare's success by how many people leave welfare, not by how many are added." In 1981 at a White House press conference, President Reagan explained, "The whole target of some of our social reforms, like welfare, always should have been to find a way to salvage those people and make them self-sustaining, instead of perpetuating them into the third and fourth generation as wards of the government" (Reagan's Template).

1996 Bipartisan Reform—PRWORA

The Social Security Act of 1935 established the Aid to Families with Dependent Children (AFDC) program, one of the nation's largest efforts to support needy families. States received federal AFDC grants and administered their individual programs, providing cash assistance to families with absent, deceased, incapacitated, or unemployed parents. All 50 states operated AFDC programs (ASPE 2009).

AFDC enrollment began to skyrocket in the 1960s. The total number of AFDC recipients rose from 3 million in 1960 to 11 million in 1973 without a single year of decline in between. The program operated at this capacity with moderate fluctuation throughout the 1980s before reaching an unprecedented peak of 14 million recipients in 1993 (**Figure 3**). Concomitantly, total AFDC expenditures exceeded $39 billion in 1994 (ASPE 2014).

During the 1990s, both Democrats and Republicans began to agree that "welfare is bad for you," and that "getting long-term recipients off the rolls is the only way to reduce public-assistance costs" (Whitman, 1). The Clinton administration sought to mitigate rising AFDC caseloads and expenditures by revolutionizing the nation's approach to welfare. In 1996, the bipartisan Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) was enacted by a Republican-led Congress and Democrat President Clinton, who promised to "end welfare as we know it" (Semuels).

As its name suggests, PRWORA marked a fundamental shift of focus in American welfare programs, moving from entitlements toward work-based support systems. The act replaced AFDC with the Temporary Assistance for Needy Families (TANF) program, designed to provide cash assistance to families, reduce out-of-wedlock pregnancies, and encourage two-parent households. Also among the program's expressed goals was a commitment to "end the dependence of needy parents on government benefits by promoting job preparation, work, and marriage" (Public Law 104-193).

The newly established TANF program included work requirements and a five-year lifetime limit. Heads of households receiving TANF benefits had to work a minimum 20 hours per week in 1997 and 1998, 25 hours per week in 1999, and 30 hours per week in 2000 onward to remain eligible for cash assistance. Qualifying activities included

public- or private-sector employment, work experience, job training, job search, job readiness assistance, community service, vocational training, education, and the provision of child care services to someone participating in a community service program.

In addition, PRWORA implemented work requirements and a time limit for individuals participating in the Food Stamp Program (FSP), renamed the Supplemental Nutrition Assistance Program (SNAP) in 2008. The number of FSP recipients increased rapidly in the early 1990s, reaching 27 million in 1994 (FNS). To address soaring caseloads, PRWORA required able-bodied participants to work or participate in state-approved work programs for at least 20 hours per week to remain eligible for food stamps (Public Law 104-193). Those who did not comply with the work requirement would lose benefits after three months of support per 36-month period. Compliance with the work requirement nullified this time limit.

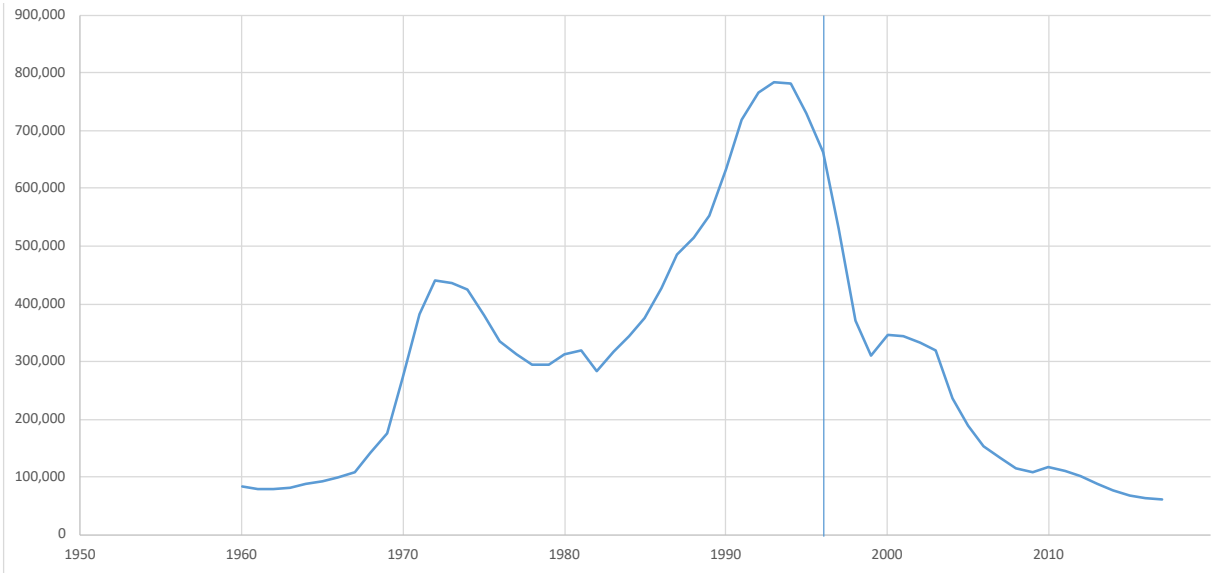
During the run-up to passage of the 1996 welfare reform, detractors of PRWORA predicted disaster. They claimed a work-based safety net would render low-income Americans destitute. People would die of starvation by denial of "food-stamp assistance" to the needy. People would be thrown off welfare rolls and would be unable to find employment. PRWORA would "push more than a million children into poverty" (Edelman).

The exact opposite occurred. Both employment rates and income increased for this population post-PRWORA. From 1994 to 1999, the proportion of adults receiving cash assistance who were employed increased from 8 percent to 28 percent (Strawn et al., 8). For single mothers, the employment rate increased from 58 percent in 1993 to 75 percent in 2000. Among never-married mothers, those most likely to depend on welfare for more than a decade, employment increased from 44 percent to 66 percent over the same period (Haskins 2006, 2).

Gains in employment allowed millions of low-income Americans to achieve independence from government support. From 1994 to 2005, TANF caseloads declined approximately 60 percent (**Figure 3**) (Haskins 2015, 1; OFA). Among the adults who left welfare, nearly 60 percent were employed at any given time. A majority—57 percent in Los Angeles to 90 percent in South Carolina—held at least one job over a period of several months or longer (Acs et al., 24). Employment was not consistently stable for this population. Only 37 percent of welfare leavers worked all four quarters of their first post-exit year.

Nonetheless, welfare leavers and recipients were better off post-PRWORA. The proportion of families in deep poverty—earning less than or equal to half the federal poverty line (FPL)—decreased 35 percent in the late 1990s (Haskins 2015, 3). Child poverty declined between 1994 and 2000 and reached low levels not seen since 1978. A study by University of Michigan scholars found that income gains were higher among poor families than non-poor families in the 1990s. States that implemented work requirements achieved greater income gains for single-parent families (Blank and Schoeni, 307). In fact, they observed that "it is the more-lenient states with softer penalties where children's income seems to have grown the least."

Figure 3. Number of AFDC/TANF recipients, 1960-2017



Source: AFDC and TANF data and reports (OFA).

While not every family earned enough to achieve complete self-sufficiency, many earned enough to significantly decrease their welfare dependency. Female-headed families in the bottom 40 percent of the income distribution went from earning only 30 percent of their income in 1993 to 60 percent in 2000. Furthermore, the welfare portion of their income decreased from 55 to 23 percent over the same period (Haskins 2006, 2). The combination of work requirements and Earned Income Tax Credits (EITC) was crucial to raising the income of these low-income families.

Opponents of PRWORA typically point to income losses among the bottom 10 percent of single-mother families on cash assistance in the years following reform (Murray and Primus). While income data indicates these families were worse off post-PRWORA, consumption data for the same population suggests that their material well-being improved over the same period (Meyer and Sullivan, 1). Others contend that the employment and income gains of the 1990s were not a result of welfare reforms, but of the concurrent economic boom. Discerning the respective effects of each major event on the well-being of low-income Americans has been a challenge, and attempts to do so have produced a variety of conclusions. However, the magnitude of employment and income gains after PRWORA, especially among single-mother families, was unprecedented through previous economic booms and did persist despite the economic downturn of 2008 (Haskins 2015, 2).

Income gains were higher among poor families in the 1990s after states instituted work requirements.

Referring to Obamacare's expansion of Medicaid to the able-bodied, Charles Krauthammer warned that "welfare without work [in] the latest Obama entitlement by decree … would fatally undermine the great bipartisan welfare reform of 1996," referring to PRWORA (Krauthammer, 137). States requesting waivers to infuse personal responsibility by adding work requirements are seeking to extend the successes of welfare reform to Medicaid.

The Benefits of Cultural Transformation

PRWORA was a tectonic shift, a cultural transformation of welfare from an entitlement to an exchange. An entitlement is "a legal obligation of the federal government to make payments to a person, group of people, business, unit of government, or similar entity that meets the eligibility criteria set in law and for which the budget authority is not provided in advance in an appropriation act" (Glossary, 8). Entitlements are one-way streets—beneficiaries are not required to do or give anything in exchange for what they are given. On the other hand, exchanges are two-way streets—each party gives something and each party gets something. PRWORA transformed two major government welfare programs from entitlements to exchanges by requiring SNAP and TANF recipients to work.

For example, enrollment in SNAP is contingent on fulfilling specific work requirements in order to receive vouchers for food at no charge. In order to obtain cash contributions, a TANF beneficiary had to accept that government support is time limited. The *T* stands for temporary—government support is not a lifelong entitlement, unless you are truly, permanently disabled.

Referring to the effects of PRWORA, Haskins testified before Congress that "the pattern is clear: earnings up, welfare down. This is the very definition of reducing welfare dependency" (Haskins 2006, 2). PRWORA's emphasis on personal responsibility changed America's entire approach to and view of welfare. It recognized that low-income people do not want checks in the mail, they want to be self-sufficient and to lead purposeful lives. The trifecta of work requirements, time limits, and the EITC tying financial support to personal effort fundamentally transformed welfare from a government handout to an exchange of value for value. Welfare reform converted dependency into dignity.

Conclusion and Recommendation

Medicaid, the federal government's centralized medical welfare program, is both failing to provide adequate services to medically fragile Texans and is crowding out vital non-medical Texas priorities. Medicaid escaped the reforms of the 1990s that "ended welfare as we know it."

The essence of that reform was changing welfare from an *entitlement*, where recipients have an absolute right to the unlimited benefits, to an *exchange*, where recipients receive limited benefits in return for actions that, for those capable, lead to a lessening or ending of the need to receive government benefits.

To begin effective reform of Texas Medicaid, the Lone Star State must re-establish a degree of independence from the mass of stifling federal mandates. Much can be learned from the Section 1115 waivers submitted by other states. However, Texas should seek to waive whichever regulations will

best serve vulnerable Texans and the Texas budget rather than limiting its waiver request to what may appear acceptable to CMS. A strong case can be made for the addition of all the elements discussed in this paper. Furthermore, Washington has signaled in numerous ways its willingness to consider innovative, locale-specific, state-directed solutions to specific state Medicaid problems.

If the principle of personal responsibility were added to Texas Medicaid, comparable benefits can be anticipated in terms of accessibility and affordability of health care as occurred in nutrition (SNAP) and finance (TANF).

Whether Texas uses the existing Chapter 537 law or starts from scratch, the sooner Texas begins to administer its own Medicaid program, the sooner Texans will have better access to care, the greater the fiscal gains realized, and the closer Texans will come to achieving self-reliance, true independence, and prosperity.

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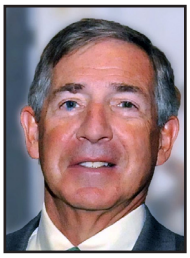

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