Decoupling: Ensuring Access to Entitlements After Welfare Reform

Julia Heald
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Introduction

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) decoupled eligibility for Medicaid from Temporary Aid for Needy Families (TANF). Before welfare reform, eligibility requirements for Medicaid and Aid to Families with Dependent Children (AFDC) were the same and receipt of one entailed receipt of the other. Delinking the programs' eligibility requirements meant that cash welfare's new work requirements and time limits would not affect Medicaid eligibility and that Medicaid would remain an entitlement program. The law allocated $500 million to be distributed among the states to match spending on a range of measures to implement this change.

As expected and intended, PRWORA caused steep drops in cash assistance caseloads. From 1996 to 2000, welfare caseloads declined by 50% (U.S. General Accounting Office 2001). Many politicians and observers, however, were surprised by the simultaneous decline in Medicaid caseloads after 1996. Rachel Klein and Cheryl Fish-Parcham (1999) found that 675,000 people lost Medicaid coverage (despite probable eligibility) and did not receive any other insurance in 1997 as a result of welfare reform. The U.S. Census reports that Medicaid enrollment dropped from 31,451,000 in 1996 to 28,956,000 in 1997 before bottoming out at 27,854,000 in 1998. Enrollment began to rise again slowly in the following years (U.S. Census Bureau). Figure 1 illustrates the steady rise in Medicaid rolls in the early 1990s, the plateau in enrollment 1993-1996, and this drop in enrollment just after welfare reform was enacted. State studies reported that in the late 1990s, Medicaid enrollment for welfare leavers varied widely -- from 44% to 83% (Fagnoni 2001). Medicaid enrollment for TANF recipients decreased in most states...
between 1996 and 1998 but varied: Wyoming experienced a 28.4% decline in enrollment while enrollment in Nebraska increased by 5.3% (Chavkin, Romero, and Wise 2000). This paper seeks to explain why Medicaid enrollment fell as a result of welfare reform or, in other words, why decoupled eligibility for Medicaid and cash assistance was not implemented effectively.

To answer this question, I conducted case studies of four states – two of which increased Medicaid enrollment after PRWORA, and two with substantial Medicaid enrollment declines. I then analyzed each state in terms of R. Kent Weaver’s (2009) five causes of compliance and noncompliance to understand what factors caused decoupled eligibility success and failure. In each case, state political attitudes and objectives played the largest role in determining the states’ outcomes. Other factors were certainly important, but the state’s different ideas about Medicaid itself, implementation, and spending on government programs best explain the variation in implementation success.
State compliance with federal laws and regulations is essential in a federalist system, and this exploration of noncompliance contributes to an understanding of federalism’s inherent implementation and compliance challenges. By focusing exclusively on government rather than recipients of public benefits, this paper also helps to emphasize the fundamental importance of political actors. This study also explores the complexities of policy interaction. The major policy change in the PRWORA was the creation of TANF, but the new program influenced other public benefits like Medicaid and Food Stamps. This analysis of Medicaid enrollment declines also contributes to an understanding of the political motivations for PRWORA. If Medicaid rolls were the result of purely mechanical problems, welfare reform would appear to be primarily driven by a desire to promote work with work incentives like Medicaid. However, the political influences on Medicaid declines suggest that some states, at least, interpreted welfare reform as roll-reducing more than work-incentivizing.

Scholarly literature on implementation can largely be divided into two groups: one emphasizing the technicalities of implementation and the other focusing on the politics of implementation. All agree that implementation is a crucial part of policy that requires more planning and foresight than most policymakers allow for or expect.

I begin with the group focused on the technicalities of implementation rather than the politics. These scholars, like John J. Dilulio and Donald F. Kettl in Fine Print (1995), identify bureaucratic resources and administrative capabilities as crucial parts of implementation. Kettl (2005) favors decentralization as a management strategy but believes that “The federal government particularly has not built the capacity required to effectively manage a government increasingly operated through proxies” (37). Kettl
argues that information technology is a crucial part of policy implementation and should be centralized to facilitate information flows between localities and different levels of government. With Richard Nathan in 1994, DiIulio and Kettl argued that varying state administrative capacities meant that national plans imposed very different responsibilities on different states. For this reason, DiIulio, Nathan, and Kettl argue that uniform results should not be expected in the first years following implementation. Frank J. Thompson (1998) holds lawmakers responsible for implementation problems, but not for political reasons. He writes that policymakers have a “perennial propensity” to “slight implementation issues and underinvest in administration” (268). Thus, according to Thompson, problems with implementation are inevitable because of a general failure to plan for the technicalities of implementation. Kettl states that national government efforts to ensure policy compliance are ultimately counterproductive: “Federal pressures for compliance lead state and local governments to concern themselves with the details rather than the spirit of the rules” (Kettl 1983, 13).

Jeffrey L. Pressman and Aaron Wildavsky’s book, Implementation: How Great Expectations in Washington are Dashed in Oakland; Or, Why It’s Amazing That Federal Programs Work At All (1979), offers the basic illustration of implementation as a primarily political act. They explain that implementation is often overlooked because its complexity and political nature are not immediately apparent: “We are initially surprised because we do not begin to appreciate the number of steps involved, the number of participants whose preferences have to be taken into account, the number of separate decisions that are part of what we think of as a single one” (93). Pressman and Wildavsky studied a program that appeared to have everything going for it — a fully
designed policy, authorized funding, and local endorsement of the program. Nonetheless, the combined weight of a number of individually small delays in decision making and different agencies’ diverging goals served to keep the project from getting off the ground. Delays in making decisions or taking action arose from both disagreements and a lack of enthusiasm, which affected peripheral concerns in particular. These problems occurred at the federal, state, and local levels of government: the federal agency became less of a cheerleader over time as the program ran into unexpected obstacles and local administrators interpreted the federal legislation on their own terms. Pressman and Wildavsky write, “Congress may have written the language, but the administrators were doing the translating” (75).

Pressman and Wildavsky cite Jerome T. Murphy (1971) when arguing that the American system of federalism inherently poses problems for implementation. Murphy studied the implementation of the 1965 Elementary and Secondary Education Act (ESEA) based on a view of the program’s administrators at all levels of government as political actors. Murphy found that executive branch administrators were reluctant to take the extreme step of criticizing state implementation, particularly because the U.S. Office of Education was so dependent on states for programmatic information. At the state level, Murphy found that administrators did not consider themselves compliance officers and were reluctant to interfere with local wishes. He writes, “In the federal system, states have no inherent reason for following federal directives, such as basic criteria, unless they are rewarded or penalized for their action” (57). Thus Murphy concludes (and Pressman and Wildavsky largely agree) that implementation is highly political and problematic at all levels under a federalist system.
Scholars who have researched Medicaid enrollment declines or welfare reform in general can largely be placed in one of these two groups – one focused on the politics of implementation and one on the mechanics. These researchers can be further divided by which level of government they focus on as the source of implementation problems – national, state, or local. I will first review the literature on Medicaid enrollment declines that falls in the group emphasizing technical problems at all three levels of government. It is worth noting that most research on Medicaid enrollment declines after welfare reform has been done by think tanks and policy research institutes and focuses on technical problems at the local level. While most of the results from this research reflect the immediate causes of Medicaid enrollment declines, these researchers did not attempt to find the root causes. I will then survey the literature with a political focus, again at all three levels of government.

Technical Explanations, National Level

This school of thought argues that PRWORA’s creators did not intend to cut Medicaid enrollment but that technical implementation problems caused the drop. Not surprisingly, government agencies indicate that eligibility decoupling was an important part of making work pay by assisting new low-wage workers without employer-provided health benefits (U. S. Department of Health and Human Services 2001; U.S. General Accounting Office, 1999 and 2000). Bowen Garrett and John Holahan agree: “A major intent among policymakers was to ensure that individuals leaving welfare would not lose Medicaid health coverage as well” (Garrett and Holahan 2000, 1).
Although federal legislators sought to make work pay, this school of thought argues that flaws in the legislation limited this impact. John DiIulio, Richard Nathan, and Donald Kettl (1994) found that a “failure to plan, failure to follow through, and failure to have the patience to work out the bugs” were the primary causes of the implementation failures they researched. In their analysis of provisions in PRWORA affecting Medicaid, Sara Rosenbaum and Julie Darnell (1997) did not question federal legislators’ honesty about their intentions with decoupling but the researchers predicted that flaws in the federal legislation would cause problems with Medicaid administration. Rosenbaum and Darnell anticipated problems with Medicaid enrollment resulting from the increased number of required eligibility determinations. PRWORA meant that initial Medicaid eligibility would be determined separately from TANF and that Medicaid eligibility would need to be redetermined when clients ceased receiving cash. They also raised numerous questions facing the Health Care Financing Administration, the Administration for Children and Families in the Department of Health and Human Services, and the Department of Justice resulting from ambiguities in PRWORA. Rosenbaum and Darnell wrote that limiting PRWORA’s negative impact on Medicaid would require “changes in the basic structure of Medicaid” to simplify the program facilitated by “significant reforms in the statute and the infusion of new funding to cover additional eligible persons” (Rosenbaum and Darnell, 1997, 32). Thus Rosenbaum and Darnell argue that defects in the law itself caused Medicaid enrollment drops, and that fixing these issues would best solve the larger problem.

A number of scholars assert or accept that federal legislators did intend to use Medicaid as a work incentive. Fewer attribute Medicaid enrollment drops to the law’s
technical shortcomings. PRWORA was intended to give states power and flexibility in creating welfare programs, and therefore deliberately left some questions open. Furthermore, PRWORA included sections designed to maintain or possibly increase Medicaid eligibility. Decoupling eligibility requirements for TANF and Medicaid allowed welfare leavers to continue health insurance, and Section 1931 gave states the option to expand Medicaid coverage (Smith and Moore 2008). As secretary of the Department of Health and Human Services, former Wisconsin governor Tommy Thompson echoed this logic when wrote he that the surprising drops in Medicaid enrollment were likely caused by problems at the state and local level. He reasoned that because PRWORA did not restrict Medicaid eligibility, the federal statute was not the root cause (Thompson 2001). PRWORA devolved significant power to states to develop welfare programs. “The increased discretion granted to states under TANF meant that the on-the-ground mixture of approaches to welfare reform confronting current and potential TANF recipients would depend heavily on state decisions” (Weaver 2000, 335).

**Technical Explanations, State Level**

Most researchers studying welfare reform implementation at the state level accept that the law was primarily motivated by a desire to increase employment of the poor, not a wish to lessen all government assistance (Holcomb and Martinson 2002; Chavkin, Romero, and Wise 2000).

Sandra K. Schneider (2007) studied Medicaid enrollment changes between 1999 and 2000 relative to welfare enrollment changes between 1995 and 1999. She argues that Medicaid enrollment increased after initial declines because state policymakers
deliberately sought to make up for declines in cash assistance. By expanding Medicaid eligibility, states responded to restricted TANF eligibility and furthered the goal of encouraging the poor to take any work. In 2007, states spent more money on the poor than they did before PRWORA, indicating to Schneider that policymakers were motivated by a desire to encourage work rather than a wish to limit resources to the needy. Furthermore, although poverty reduction has not been a priority for national politicians since PRWORA, Mary Jo Bane (2009) finds that some state governments do appear to be interested in it. This suggests that, at least recently, a number of state governments are interested in poverty alleviation rather than reducing welfare rolls alone.

Ron Haskins (2001) believes that state actions failed to address technical implementation problems with Medicaid-welfare eligibility decoupling. He identifies a number of problems caseworkers face that he believes state legislators ought to address. These problems include flawed automated systems, long and complex application processes, burdensome office visit requirements, and confusing computer-generated notices to clients. Haskins also writes that, “TANF workers, logically enough, often see themselves as responsible primarily for TANF, with Medicaid an unwelcome secondary responsibility” (Haskins 2001, 282).

**Technical Explanations, Local Level**

This school of thought claims that despite a will to delink Medicaid and welfare eligibility, technical implementation problems kept this from being realized initially. Successful policy implementation depends on clear communications from those in charge. Diana DiNitto and Thomas Dye (1987) write that this becomes more difficult when
directives must flow through more layers of administration in decentralized settings. “Prompt, consistent, and uniform policy implementation” is especially unlikely when Congress, the President, and state legislatures delegate wide authority to program administrators as they did with PRWORA (DiNitto and Dye 1987, 266). Thus, according to DiNitto and Dye’s work, it should not be a surprise that decoupled eligibility implementation encountered many problems. In her case study of the Job Opportunities and basic skills program, Evelyn Brodkin (1997) argues that street level welfare policy cannot be entirely explained by formal policy and adds that caseworker ideology fails as an explanation. Instead, caseworkers “do what they can,” which is determined by their skills and available agency resources (Brodkin 1997, 24). Similarly, DiNitto and Dye (1987) assert that implementation can fail regardless of the strength and clarity of communications if local administrators lack adequate resources to fulfill policies. Caseworkers are more likely to offer valuable services like Medicaid to clients when it costs them little, but insufficient resources increase the costs significantly. In this case, resources that encourage Medicaid enrollment include time, training, information, and helpful information technology. Additionally, bureaucratic structure can hinder policy implementation because of bureaucratic inertia or because of conflicts among different governments or agencies that are each responsible for parts of a policy (DiNitto and Dye 1987).

According to this school of thought, caseworkers mostly adhere to organizational policies (Goodsell 1981, Scott 1997). Caseworkers interacting with clients believed in welfare reform’s emphasis on work but did not have the tools or resources to make work pay with Medicaid. Furthermore, the people with the ultimate responsibility of
implementing decoupled eligibility requirements, caseworkers, had no role in developing the change. This violates scholars' claim that those who will be affected by a policy must have a role in its formulation if it is to be effective (Hibbard 1981; Maynard-Moody, Musheno, and Palumbo 1990; Robinson, Bronson, and Blythe 1988). This argument differs subtly from Ron Haskins's that state policies ought to address problems of implementation. Whereas Haskins argues that state policymakers could fully address these problems, these scholars assert that involving caseworkers in policymaking initially would have limited the problems with implementation. The major technical implementation challenges contributing to decreases in Medicaid enrollment were (1) insufficient outreach, (2) out-of-date automated systems, and (3) conflicting program priorities that in practice emphasized work at the expense of Medicaid's goals.

Client Outreach

Irene Lurie's (2001) survey of changes in welfare offices cites studies showing haphazard information conveyance to welfare clients around the country. She cites a study by the Manpower Demonstration Research Corporation that found that caseworkers often did not explain Medicaid eligibility to clients, and when they did, they were not always accurate (Lurie 2001). Both the needy and TANF caseworkers did not always understand that Medicaid's work disincentive had been removed by delinking its eligibility from TANF's (Acs, Coe, Watson, and Lerman 1998; Alliance for Children and Families 1999). Others found that even though eligibility requirements for Medicaid and TANF were separated, they remained linked in the minds of caseworkers (Klein and Fish Parcham 1999). In addition, the practice of diverting potential applicants away from TANF in the first place created a group of people with the potential to be unaware of
their likely Medicaid eligibility. The Department of Health and Human Services’ Centers for Medicare and Medicaid Services alerted TANF administrators of the increased need for education and “aggressive outreach” to limit Medicaid enrollment declines caused by potential applicants being diverted from welfare (Golden and DeParle 1998).

Yeheskel Hasenfeld (1980) blames poorly-defined changes which raise the cost of implementation for resistance to change in human service organizations. Caseworker confusion about decoupling indicates that it was not clearly defined for them, which according to Hasenfeld’s claim, explains why decoupling implementation did not go smoothly.

Some researchers suggest that insufficient outreach does not satisfactorily explain Medicaid declines. Even in cases where welfare leavers are informed by caseworkers about their continuing Medicaid eligibility, they do not always take the necessary steps to continue receiving it. Marilyn Ellwood and Leighton Ku write that Medicaid’s confusing eligibility requirements and its past linkage to cash assistance have meant that former TANF recipients do not reply to notices about Medicaid redetermination (Ellwood and Ku 1998). Applicants confused by eligibility requirements have less incentive to complete a Medicaid application because they are not sure they will receive benefits. Additionally, the required documentation to continue receiving Medicaid places a large burden on parents with new jobs and may lead them to discontinue Medicaid receipt (Garrett and Holahan 2000; Alliance for Children and Families 1999).

**Automated Systems**

A number of studies fault automated systems for the decline in Medicaid enrollment. The Working Seminar on Social Program Information Systems predicted
that agencies that used modern information technology would be more successful in implementing the decoupled TANF and Medicaid eligibility requirements. The Working Seminar's summary states that a single case management plan for each client would be ideal, and that it could be assisted by helpful computer systems that reconcile different agencies' different and potentially conflicting eligibility requirements, goals, and cultures (Nathan and Ragan 2001). In local welfare offices, however, caseworkers were unable to access needed information from other service agencies about individual clients. Local officials also had limited access to information about their caseloads that would facilitate planning service strategies. On the other hand, ten of twelve localities studied by the GAO in 2000 reported that caseworkers had easy access to Medicaid eligibility determination on their desktop computers (U.S. GAO 2000, Fagnoni 2001). Problematic automated systems did cause tens of thousands of improper Medicaid denials and terminations in the years following welfare reform (Ragan 2003).

Conflicting Program Priorities

Because cash assistance ceased being an entitlement, welfare agencies are not required to give everyone the chance to apply for TANF. Agencies divert people from applying in the first place by offering a one-time payment and prohibiting the person from applying before a certain time or by encouraging potential applicants to find work instead of filing a long and complex application. By not applying for TANF, these diverted potential applicants also do not apply for Medicaid unless they are informed of their possible eligibility (Lurie 2001; Klein and Fish-Parcham 1999).

Section 1931 of PRWORA was drafted by Senators John Chafee (R – RI) and John Breaux (D-LA) and Representative Nancy Johnson (R – CT) with the intention of
preventing loss of Medicaid eligibility by giving states the option to expand Medicaid coverage. Regardless of state wishes and legislators’ intentions, however, PRWORA’s nature as a work program meant that the law made Medicaid a work support (Smith and Moore 2008).

Michael Lipsky emphasizes the role organizational evaluation plays in determining how caseworkers and other street level bureaucrats perform their jobs: “Behavior in organizations tends to drift toward compatibility with the ways the organization is evaluated” (Lipsky 1980, 51). Following welfare reform, “efforts to discipline the use of discretion by structuring incentives and routines and enhancing pressures to ‘perform’ in meeting program goals” have also grown (Soss, Fording, and Schram 2009). This tendency is harmful to organizations, Lipsky writes, because high-quality performance evaluations are practically impossible to achieve, leading to the reification of imperfect performance measures. A reliance on quantitative performance evaluation, in turn, “may not simply be ineffective but may also lead to an erosion of service quality” when workers behave in accordance with their evaluations (Lipsky 1980, 159). Ridzi found this to be the case in East County, NY where he observed welfare offices’ “emphasis on performance measures and de-emphasis on client rights” (Ridzi 2009, 67). Similarly in Florida, “case managers come to view ‘success’ through a smaller aperture and, accordingly, evaluate program tools more in terms of measured outputs than client outcomes” (Schram, Soss, Houser, and Fording, 2008). In Florida, one case manager stated that instead of counseling, he and his colleagues tracked clients’ work-activity hours to report to Quality Assurance managers (Soss, Fording, and Schram 2009). TANF caseworkers facing intense time restrictions and being discouraged from offering
holistic assistance could easily neglect information about continued Medicaid eligibility. Each of these examples of caseworkers de-prioritizing client rights and outcomes represents instances where Medicaid may not have been presented as a helpful option.

**Political Explanations, National Level**

Some scholars see welfare reform as essentially an effort to reduce government assistance to the needy. According to Peter Edelman (2009), PRWORA’s real message to states (inspired at least in part by general hostility towards the needy) was that they needed to shrink welfare rolls. While Edelman does not address Medicaid directly, the political attitude he describes could be understood as a reason that maintaining Medicaid enrollment was not a national priority. In their analysis of state TANF and Medicaid policies and the resulting effects on enrollment and unemployment, Wendy Chavkin, Diana Romero, and Paul H. Wise (2000) establish that state policies deterring TANF applicants caused declines in Medicaid enrollment and suggest that the cause of this problem was a widespread shift in attitudes about government assistance caused by PRWORA. They see the declines in all benefits as in part indicative of a new message to the poor that “in general, benefit programs are no longer available” (Chavkin, Romero, and Wise 2000, 906).

A number of scholars have argued that TANF and Medicaid have conflicting goals and that the focus on welfare after PRWORA favored TANF’s aims over Medicaid’s. PRWORA and the debate leading up to it framed dependency, not poverty, as the major problem (Schram 2001). This shift in perspective, according to Frank Ridzi, “embraces a neoliberal vision of globalization in which the government focuses less on
protecting its people than on encouraging them to ‘sink or swim’ in the global labor market” (Ridzi 2009, 23). Ridzi argues that this attitude (“work-first common sense”) was institutionalized and ultimately expressed by caseworkers guided by program administrators to prioritize employment and participation rates (Ridzi 2009, 32). Marilyn Ellwood (1999) also sees Medicaid enrollment declines as the result of conflicting objectives for the two programs. The Medicaid program’s goal of at least maintaining enrollment was lost in the shuffle when welfare’s goal was transformed to embrace caseload declines: “keeping families enrolled in Medicaid is not an explicit welfare reform objective” (Ellwood 1999, 12).

Several scholars perceived the national atmosphere leading up to PRWORA as hostile towards the poor. According to them, the Republicans’ Contract with America defined welfare reform as cuts in federal spending first, with increasing workforce participation as a secondary goal (Wexler and Copeland 2003; Axinn and Levin 1997). Ann Withorn writes that understanding welfare reform requires appreciating the “development of ideas” that led to PRWORA (Withorn 1996, 500). Withorn argues that liberals and conservatives both developed ideas that allowed for the “abandonment of poor women” and blacks (Withorn 1996, 501). These ideas were that welfare dependency is contradictory to American values, that AFDC could not achieve political support, and that help to the middle class would trickle down to the poor. Additionally, Withorn argues, right-wing politicians framed AFDC recipients as, “women without men who have too many rights, do not discipline their children, and fail to accept their suffering gracefully,” as the cause of ordinary Americans’ problems (Withorn 1996, 505). Joe Soss and Sanford F. Schram write that following “political and policy changes in the
1960s, public majorities came to resent ‘welfare’ in a way that far exceeded their opposition to helping the poor” (Soss and Schram 2007, 120). Soss and Schram used public opinion surveys to determine whether policy feedback affected Americans’ views of welfare recipients. They explained the lack of positive feedback effects by suggesting that as a highly visible policy without a direct impact on most Americans’ lives, welfare “symbolized a deeply felt sense that government was giving special favors to a group of undeserving others,” thereby contradicting American values (Soss and Schram 2007, 122). Welfare’s distance from the daily lives of the majority of the population allowed it to function as a symbol of violated national values because the public had such limited experience with the program. This view of government assistance as fundamentally contradictory to core American values created strong opposition to welfare. This overarching and unsympathetic belief in the inherent problems caused by an American underclass could be extended to claim that the aim in the mid-90s was to cut Medicaid rolls.

Others disagree with this characterization of welfare reform. Ron Haskins asserts that encouraging or requiring work was the central aim of PRWORA and eligibility decoupling, with the additional but secondary benefit that “aggressively conducted work programs clearly lessen both caseloads and spending” (Haskins 2001). Haskins also presents data showing that the federal government spent $52 billion on work support programs in 1999 but would have spent only $6 billion without expansions of these programs since the 1980s. This information, Haskins argues, “Represents a dramatic growth in the federal commitment to working families” (Haskins 2001, 271).
Among this literature, no scholar explicitly links negative attitudes held by politicians and the public about the poor and government assistance to the problem of Medicaid enrollment declines following PRWORA. Finding a clear connection between politicians' attitudes and the more specific problem of Medicaid declines is not as easy to achieve as the identification of an association between attitudes and welfare reform as a whole, which may explain why these arguments have not been applied to Medicaid. While there is not enough hard data to invalidate this school of thought, it suggests that feelings about the poor may not be the primary cause of the problem. A more substantial critique of this school is that the federal legislation included methods to retain or increase Medicaid enrollment. Decoupling cash and Medicaid eligibility meant that, legally and in terms of eligibility, there was no reason for Medicaid declines. Additionally, PRWORA gave states the option to expand Medicaid eligibility (Smith and Moore 2008). The welfare reform legislation does not indicate that political opposition to government assistance to the poor extended to Medicaid. Medicaid enrollment varied significantly among the states after 1996, though in most cases it did decline. Still, the fact that Medicaid enrollment grew substantially in several states indicates that the federal legislation did not have to cause falling Medicaid participation.

Political Explanations, State Level

PRWORA authorized $500,000,000, for states to cover necessary changes in administration to implement new eligibility requirements during the first three years of states’ welfare reform programs (Public Law 104-193). States, for the most part, did not take advantage of these funds: in October of 1998, only $17 million of the $500 million
had been requested (Ellwood 1999). The number increased to only $25.4 million the following year (U.S. GAO 1999). James Fossett, Thomas Gais, and Frank Thompson (2002) surveyed field researchers across the United States about Medicaid enrollment after welfare reform. They found that most states chose not to use the federal money for three reasons. First, Medicaid agencies were often not involved in initial welfare implementation, and as a result, Medicaid enrollment declines were not anticipated. Second, state IT resources were committed to preventing Y2K problems and were not used to update old eligibility technology. Finally, Fosset, Gais, and Thompson argue that states had never been interested in advertising Medicaid, "as many states did not think it prudent to undertake activities which, if successful, would result in increased Medicaid spending" (18). Leighton Ku and Bowen Garrett (2000) researched factors affecting state Medicaid enrollments from 1984 to 1996 and found evidence suggesting that on average, maintaining Medicaid enrollment was simply not a priority for states. However, they report that states' efforts to retain Medicaid enrollment varied substantially. These scholars explain Medicaid declines by states' political actions.

Mark Ragan (2003) studied eighteen states' varying efforts to adapt their automated eligibility systems to the new requirements of decoupled eligibility and found no correlation between the date when states completed information systems updates and changes in their Medicaid enrollment trends. Ragan argues that information system modifications were critical to implementation but that a variety of other crucial factors masked their effects: "Many states reverted to temporary manual processes, some sooner, some later, before information systems' modifications were completed. The date when manual processes were put in place, the level of automation, the accuracy of policy
implementation, the strength of outreach efforts, simplification of application processes, economic conditions, and other factors all played a role” (Ragan 2003, 8). Ragan’s finding suggests that technical explanations for Medicaid enrollment declines are insufficient. Furthermore, his research indicates that the ways states handled problems with automated systems and the ways they handled decoupled eligibility more broadly did indeed affect Medicaid enrollment.

Deborah Graefe, Gordon De Jong, Matthew Hall, Samuel Sturgeon, and Julie Van Eerden (2008) assert that PRWORA implementation drifted from federal guidelines because states applied their own policy goals. They found that states’ abilities to finance welfare benefits contributed to more generous policies. Jack Tweedie (1994) studied welfare policies in all fifty states and found that variation in states’ AFDC benefit levels were dependent primarily on state budgetary concerns. According to Tweedie, state political institutions are neither completely representative of their constituents nor informed primarily by the level of need in a state. Rather, “state’s decisions on benefit levels are influenced by the availability of state revenues and the size of the AFDC caseload” (Tweedie 1994, 668). The claim that variations in state welfare policies can be best explained by state budgetary concerns and not public opinion or need could be extended to explain the decline in Medicaid enrollment following PRWORA. States driven by budget concerns rather than poor peoples’ needs or voters’ preferences may thus have allowed or even encouraged declines in Medicaid coverage.

Paul Peterson, Barry Rabe, and Kenneth Wong (1986) argue that redistributive programs usually do not fare well when the federal government delegates implementation authority to the states, especially in localities where administration is politicized. In these
situations, “local administrators regarded federal regulations as subjects for bargaining rather than laws to be executed” (63). These scholars do believe redistributive problems can succeed despite devolved implementation when administrative professionals and bureaucrats take the leading role in implementation. Using this idea, Thompson and Gais (2000) evaluated federal and state actions regarding Medicaid and Food Stamps following welfare reform. Thompson and Gais do not believe that Medicaid could benefit from bureaucratic implementation: “The bureaucracy-dominated model seems less likely to apply to Medicaid, which is the elephant in the living room that cannot be ignored by political officials and key interest groups. Given Medicaid’s vast budget implications, state and federal administrators comprise a small subset of the players jostling with one another to shape the program” (137).

Alan Weil (2001) accounts for state variations as resulting from policies tailored to different circumstances (including budgetary circumstances) or from state policymakers pursuing different goals. According to Weil, while all states set out to promote personal responsibility and self-sufficiency among the poor, only some aimed to support the working poor and reduce poverty. Thus Medicaid was not encouraged as a work support or poverty alleviation program in states where policymakers did not have these goals. After examining states’ party systems and their effects on welfare benefits, Robert D. Brown (1995) also argues that state politicians play a crucial role in welfare policy, but he attributes variation across states to political parties. In particular, Brown found that party control matters for welfare policies when state partisan divisions fall along class lines.
James W. Fossett and Thomas L. Gais's (2002) study of fifteen states' Medicaid enrollment numbers and implementation procedures frames implementation in political terms which leads to a conclusion that initial enrollment declines have no long-term significance. Fossett and Gais found that most states did eventually take actions to advertise the availability of Medicaid and maintain enrollment. They note that states varied in the timing and extent of their efforts to support Medicaid enrollment and argue that these differences explain variations in states' initial Medicaid enrollment changes. Fossett and Gais eventually conclude that these political aspects of implementation are less important than the fact that there is no evidence to suggests that states deliberately participated in a "race to the bottom" to restrict Medicaid access.

Lawrence M. Mead also falls into the school of thought that interprets implementation politically. Mead (2004) studied welfare implementation in states with different political cultures: moralistic, public interest, individualistic, and traditionalist. Mead used Daniel Elazar's model of political culture and assigned states to categories where they fit best. Mead found that moralistic states' implementation met his criteria most closely. He argues that moralistic states' “problem-solving approach to legislation and especially their strong public administration” would best facilitate smooth welfare implementation. Kim Quaile Hill, Jan E. Leighley, and Angela Hinton-Andersson (1995) studied lower-class voting and welfare policies in all 50 states from 1978 to 1990 and argue that the generosity of welfare benefits is correlated with the state Democratic Party's liberalism and competitiveness as well as the level of mobilization of lower-class voters.
Other scholars frame implementation politically but do not focus on politicians. Norma M. Riccucci and Judith R. Saidel (1997) examined state bureaucracies in all fifty states to determine the extent to which they represented each state’s population. Riccucci and Saidel found that state bureaucracies were not representative of the larger population in terms of gender, race, and ethnicity which they suggest informs policy decisions.

**Political Explanations, Local Level**

Some scholars argue that local non-elected administrators, not federal or state politicians, were most critical in implementing TANF. Therefore, variations in TANF generosity cannot be explained by partisanship, voters, or politicians’ priorities. Instead, different state administrators account for policy variation as they “define and implement state priorities and policies” (Francis 1998, p. 159). Implementation scholars Elizabeth Robinson, Denise Bronson, and Betty Blythe (1988) emphasize the importance of organizational support when new practices are introduced in their analysis of the adoption of a new social work practice. Without organizational support, they argue, caseworkers are less likely to implement something new because the costs are too high. Workers are more likely to adopt a new practice if it is already in use by influential members of their organization. This logic suggests that caseworkers may have failed to successfully implement eligibility decoupling because local organizations and administrators did not provide the support or influence necessary to change front-line workers’ behavior.

Caseworkers’ attitudes and interpretations of the legislation may explain Medicaid enrollment declines if discretion allowed them to implement their own agendas. Schram (2001) found that welfare reform caused a cultural shift in welfare offices where
work was prioritized above all else and some case workers did not believe their clients were entitled to any benefits. In their study of street-level influence in two state's corrections programs, Steven Maynard-Moody, Michael Musheno, and Dennis Palumbo (1990) note that while street-level knowledge and discretion is crucial to good public service, caseworkers can influence policy implementation negatively. They may adapt policies to make their jobs easier or to limit the impact of a policy with which they disagree. Welfare caseworkers may well have been affected by the political discourse pushing work, but largely scholars suggest that they were not motivated by anti-poor sentiments. Attributing the problems with eligibility decline to local administrators’ and caseworkers’ wills requires accepting that these people use considerable discretion when performing their jobs. Most theories of implementation claim that discretion is inherent in street-level bureaucratic work (Lipsky 1980; Brodkin 1997).

Furthermore, the emphasis on employment has transformed some welfare offices into virtual employment centers. “Information about the availability of Medicaid benefits may be overlooked, as local welfare offices focus on increasing employment and reducing dependency” (Ellwood and Ku 1998, p. 143). In their analysis of Florida’s welfare program, Joe Soss, Richard C. Fording, and Sanford F. Schram argue that caseworkers are expected to promote overall well-being, but that “it is assimilated into (and equated with) the activities of job counseling and work promotion through the idea that ‘work first’ offers the best path toward achieving a self-sufficient, stable, and healthy family” (Soss, Fording, and Schram 2009).

Many states contract out welfare services to for-profit agencies. In his argument for public administration that appreciates the importance of networks, Laurence O’Toole
Jr. (1997) contends that reconciling various organizational needs is particularly challenging when governments, non-profits, and for-profits work together. Schram, Linda Houser, Soss, Fording, Paul Rosenstein, and Tatiana Winterbottom (2009) found that “a new business mentality permeates” welfare offices where caseworkers feel intense pressure to meet quotas with limited time. Hasenfeld argues in his examination of changing human service administration that individual for-profit service providers have stronger and narrower interests that can lead to competition with other service providers (Hasenfeld 1985). Acting in these interests usually prioritizes work placement rather than Medicaid enrollment. Some states used the flexibility PRWORA gave them to use performance contracts where a private agency receives funding based on its placement outcomes. According to Janice Johnson Dias and Steven Maynard-Moody who studied a for-profit welfare-to-work office, this incentive structure prioritizes “short-term deliverables,” gives caseworkers “little incentive to go beyond minimal services,” and can lead programs to “ignore clients’ needs” (Dias and Maynard-Moody 2006, 190, 198, 209). Ridzi observed that welfare staff members in East County, NY who were reluctant to embrace work-first came to promote it when their managers used quantitative performance monitoring. Given the impact performance measures can have on caseworker behaviors, it is crucial that “their job performance is not at all tied to whether qualifying families sign up for Medicaid once they no longer qualify for welfare benefits” (Ellwood 1999, 12). Even in government-run welfare offices, administrators clearly state, and researchers observe, that caseworkers’ goals are to focus on participation rates. The strong influence of performance measures on case managers’ behavior indicates that state policies were likely crucial in decoupled eligibility implementation. The focus on
reducing welfare participation did not originate in local offices, rather it stems from the chain of penalties that begins with the federal government (Ridzi 2009; Brodkin 1997). Soss, Fording, and Schram make a similar point, "By establishing outcome benchmarks focused on work participation and placement, higher-level officials define the goals of service provision and the terms of its evaluation" (Soss, Fording, and Schram 2009, 2). Each of these factors can keep caseworkers from informing clients of their potential Medicaid eligibility even as they are being diverted from TANF or are leaving it voluntarily.

Again, this school of thought lacks scholars who link it directly or forcefully to Medicaid enrollment. Claiming that local administrative or caseworker discretion was the primary cause of problems with eligibility decoupling requires accepting that federal and state policymakers took steps to make Medicaid an effective work support but that local workers possessed enough power to thwart these goals. Additionally, not all scholars agree that caseworker discretion makes policy implementation more difficult. One study found that higher levels of perceived power and discretion among caseworkers contributed to better PRWORA implementation. These researchers measured good PRWORA implementation by using county officials’ perceptions of their programs’ abilities to encourage work participation, reduce caseloads, reduce poverty, and improve child well-being. (Cho, Kelleher, Wright, and Yackee 2005).

Most but not all states experienced Medicaid declines after PRWORA. This indicates that the root of the problem was not in the national policy or politics since states were able to greatly increase Medicaid enrollment. Furthermore, the PRWORA was designed to encourage Medicaid enrollment by allowing for eligibility expansions and by
including $500 million for implementation costs. Because of this, an examination of state variations in Medicaid enrollment outcomes ought to best explain why some states were able to perform well while most did not.

At the local level of focus, researchers’ findings about the technical causes of Medicaid declines are certainly sound. However, these technical problems varied across the states and led to varying enrollment outcomes. The immediate causes of Medicaid enrollment declines did not originate in a vacuum, and an investigation into what factors led to them will provide more helpful information. The clear influence of local technical implementation problems on Medicaid enrollment rates, while not fully explaining the program, does suggest that street-level workers’ attitudes were not the primary cause. While cultural attitudes certainly vary, it is hard to explain the often extreme differences in state enrollment changes with case worker attitudes alone. PRWORA offered all states significant authority and discretion in designing their welfare reform policies which gave them the power to influence Medicaid enrollment rates. Most states’ abrupt changes in policy and enrollment trends following the adoption of CHIP without significant changes in their administrative capabilities suggests that they were able to mobilize in support of a more popular policy but for some reason, did not.

Given these flaws with the other possible explanations, a political explanation focused on states appears to fit best. States’ considerable power gave them the opportunity to affect Medicaid enrollment rates, and their diverse actions seem to be likely explanations for enrollment changes. The significant lack of state interest in the available implementation funds is most striking and certainly seems to suggest that many states chose not to comply fully with PRWORA’s decoupled eligibility provisions.
Hypothesis

I hypothesize PRWORA’s provisions to maintain or expand Medicaid enrollment were not fulfilled due to state policymakers’ lack of enthusiasm for or dislike of the Medicaid program. Many of the basic tenets of welfare reform (its goal to reduce caseloads, diversion, time limits) contradicted the goal of maintaining or increasing Medicaid enrollment, and the discretion granted to states by PRWORA allowed ambivalent state officials to neglect Medicaid enrollment.

Data Collection and Case Selection

I will conduct case studies of four states – two with higher Medicaid enrollment after PRWORA and two with lower. I selected states from a collection of eighteen studied by the Rockefeller Institute of Government’s Managing Medicaid Take-Up Series because it provided valuable data about state practices. I selected the four states based on their percentage change in Medicaid enrollment from 1996 (the year PRWORA was passed) to 1998 (the year when post-welfare Medicaid declines dipped lowest nationally). Colorado and Maryland were the two states with the biggest negative percent change in Medicaid enrollment – 45.1 percent and 50.9 percent respectively. Oregon and Utah were the two best performing states in this regard with 35.2 percent and 22.1 percent increases in Medicaid enrollment respectively.

To evaluate implementation of eligibility decoupling in these states, I will use R. Kent Weaver’s list of five causes of noncompliance which incorporates various sources of compliance problems. These sources of noncompliance are: (1) “incentive and sanction problems where positive and/or negative incentives are insufficient to ensure compliance;” (2) “monitoring problems where target compliance may be difficult or
costly to monitor;” (3) “resource problems where targets lack the resources to comply even if they want to;” (4) “information problems where targets lack information that would make compliance more likely;” and (5) “attitude and objectives problems where targets are hostile/mistrustful toward providers or programs” (Weaver 2009). Weaver writes that the positive versions of these five items are sources of compliance. The first four potential causes of noncompliance suggest technical reasons for poor implementation while the fifth, attitudes and objectives, is a political explanation.

I will evaluate each state’s implementation of eligibility decoupling through 1998 in terms of these five determiners of compliance. I will use newspaper articles and field research reports about the states’ Medicaid programs, welfare reform processes, and eligibility decoupling implementation.

The Cases

Colorado

According to Nancy Pindus, Randy Capps, Amy-Ellen Duke, and Karin Malm (1998), “Colorado is a fiscally conservative state, protective of individual rights and local government prerogatives” (1). Colorado citizens believe in self-responsibility and distrust big government (Goggin 2003). Moon et al. write, “The general philosophy of Colorado toward health care for the poor seems to be one of providing a floor while avoiding the establishment of new entitlements. Colorado’s minimalist approach stems less from a fear that it will become a welfare magnet…than from a desire to limit the role of government in the lives of citizens” (Moon et al. 1998, 19).

In 1992, the Colorado legislature briefly considered universal healthcare, but the required tax increases and proposed government-run purchasing cooperative proved
highly unpopular (Moon et al. 1998). Later, legislators voted to abolish Medicaid and its rising costs but were thwarted by a gubernatorial veto (Weissert 2002).

Colorado welfare reform involved a significant devolution of authority to counties which set their own eligibility criteria. This move reflects the widely held belief in community answers to local social problems in Colorado (Pindus, et al. 1998; Goggin 2003). Wallin et al. (1998) wrote that Colorado “values local solutions for local problems and private-sector initiatives” (1). Despite this, Colorado’s Democratic governor at the time of implementation, Roy Romer, worried that too much devolution would inspire a race to the bottom in Colorado counties (Goggin 2003). The Democratic Romer worked with a Republican-dominated legislature, and Moon et al. characterized their relationship as such: “Colorado’s general approach to policymaking appears to be one of making incremental changes, a strategy that seems to have resulted in areas of compromise between the governor and the legislature” (Moon et al. 1998, 7).

Colorado’s welfare reform program is called Colorado Works and was first implemented in July, 1997 (Pindus et al. 1998). The welfare program did not require job or alternative resource searches as conditions for application (Chavkin and Romero 2003). Colorado counties had the option to use a welfare diversion program in the form of lump sum payments worth up to three months of benefits in exchange for an applicant’s agreement not to apply for TANF for a set time (National Governors Association 1999). In 1996, 293,000 Coloradans or 7.5 percent of the state population received Medicaid. In 1997, enrollment declined to 235,000, and in 1998, it declined significantly to 161,000, or 4.0 percent of the state population (U.S. Census). This represented a 45.1 percent decline in Medicaid enrollment from 1996 to 1998. The
number of unemployed fell from 89,000 (unemployment rate: 4.2 percent) in 1996 to 86,000 (unemployment rate: 3.8 percent) in 1998 (Bureau of Labor Statistics 1998; 1999). The number of Coloradans without any health insurance also declined between 1996 and 1998, from 644,000 or 16.6 percent of the population to 599,000 or 15.1 percent of the population (U.S. Census). The falling unemployment and uninsured numbers do indicate that the Medicaid declines were likely caused in part by a good Colorado economy and were not as severe as they may first appear. Still, the number of people who lost Medicaid enrollment during the time period (132,000) is much larger than the number who gained insurance (45,000) and gained employment (3,000).

The $500 million fund established by PRWORA in 1996 was intended to match state spending on changes necessary to decouple eligibility requirements for Medicaid and TANF. The fund matched state spending on changes like redesigned Medicaid applications and outreach and education about delinked eligibility at rates of 75 percent or 90 percent of spending, depending on the types of changes. (Additionally, before PRWORA and in addition to this fund, state administrative spending on Medicaid is matched at least at a 50 percent rate by the federal government.) Colorado was given $5,166,316, but had not yet used any of this money in July 1999 despite time limits on the money’s availability (Ross and Guyer 1999). States were given three years after TANF implementation to use their money but could apply for funding to cover actions taken in these first three years retroactively until September, 2000 when the fund was scheduled to sunset. The three year time limit was scheduled to arrive on June 30, 2000 for Colorado. In November, 1999, all time limits were lifted by Congress, allowing states access to their allotted funds at any time (Darnell, Lee, and Murdock 1999).
Although Colorado had not yet drawn from the fund, state officials did report to researchers that they had taken actions that could be covered retroactively. Colorado made eligibility system changes and worked on creating new eligibility forms, both of which could be reimbursed at a 75 percent matching rate. Actions reimbursable at the 90 percent rate included worker training and hiring new outstationed Medicaid eligibility workers. Colorado officials did not report developing any outreach materials or conducting any outreach activities (Darnell, Lee, and Murdock 1999).

Colorado’s constitution includes state government spending limits. The state’s Taxpayer’s Bill of Rights (TABOR) put a 6 percent annual spending limit in Colorado’s constitution making the budget a zero sum game (Wallin et al. 1998; Moon et al. 1998; Pindus et al. 1998). TABOR included provisions to lift the spending limit, but Coloradans were unwilling to increase health care spending, “even as the state economy surges upward” (Wallin et al. 1998, 1). Colorado had a “substantial economic base from which the state could potentially draw revenues,” but the self-imposed spending limits took precedence (Moon et al. 1998, 7). As a result of TABOR, high increases in Medicaid spending were “viewed as a limit to flexibility in financing other state activities” (Wallin et al. 1998, 2).

The Colorado legislature’s desire for flexibility also contributed to a distaste for Medicaid. Legislators disliked Medicaid’s status as an entitlement benefit and its “mandatory benefits and eligibility rules” (Moon et al. 1998, 19). Because of this, legislators used “state-only programs where feasible to ensure flexibility and limit entitlement to new benefits” (Moon et al. 1998, 19). For example, in 1997, the state created a program to provide health insurance to welfare-leavers indefinitely, but required
that participants pay for the program (Wallin et al. 1998). State officials failed to request federal approval of the program for over a year, an oversight Republican state Representative Mike Coffman described as a “lack of compassion by bureaucrats,” though the bureaucrats defended it as a resource problem (Callahan 1998). Researchers noted that some legislators in Colorado believed that the availability of emergency care to anyone who needed it was a sufficient safety net, indicating a high degree of opposition to Medicaid from some (Moon et al. 1998).

State legislator Mike Coffman, an architect of Colorado’s welfare reform, demonstrated his contempt for federal limits on state flexibility and for money spent on welfare programs when he objected to a $9.8 million grant from the federal government to assist with the most challenging long-term welfare cases. Coffman described the grant as wasteful and “a way for Washington bureaucrats to meddle with Colorado’s successful, locally controlled welfare reform programs” (Callahan 1998). Coffman maintained that counties “couldn’t absorb all the money they [had]” and did not need additional funding (Callahan 1998). Governor Romer and labor officials held a different view of the federal funding. The governor’s spokesman said, “It’s irresponsible to suggest that we don’t need available federal money to invest in job training to make welfare reform work” (Callahan 1998).

Colorado, like all states, needed to develop new automated eligibility systems that could process different TANF and Medicaid eligibility requirements. Outdated technology caused tens of thousands of inappropriate Medicaid denials and terminations (Ragan 2003). More than 40,000 people had their Medicaid benefits inappropriately cut off between July, 1997 and August, 2000 when they stopped receiving TANF benefits
through Colorado Works. Colorado did not suffer for this until 2001 when a settlement was reached between the state and the former Medicaid recipients (Ragan 2003; Fossett, Gais, and Thompson 2002). State officials made no attempt to slow or counter declining caseloads until the lawsuit was filed in 2001 (Fosset, Gais, and Thompson 2002).

Technological challenges were especially severe because Colorado’s second-order devolution created more eligibility variety than in the other three states I studied. Pindus et al. write, “the current [1999] system is not designed to take into account county-specific policies... Counties are pessimistic about the state’s ability to solve the problems quickly” (Pindus et al. 1999, 68-9). The Colorado Department of Health Care Policy and Financing explained that its automated eligibility system was 20 years old in 1998 and contributed to lengthening eligibility determinations even beyond the maximum allowable time (Moon et al. 1998). Colorado did not delink Medicaid and cash welfare automated processing until 1999, but the continued improper Medicaid terminations through 2000 indicate that the changes did not fully address the system’s problems (Ragan 2003). With Colorado’s extensive devolution, smaller-scale agencies were responsible for locating effective strategies to maintain Medicaid enrollment.

In 1998, some welfare-leavers lost transitional Medicaid benefits because state health officials failed to request a waiver for Colorado’s longer transitional program, Transition-Plus, for thirteen months. State Representative Mike Coffman declared, “It shows a lack of compassion by bureaucrats that are running the system,” but the bureaucrats blamed insufficient resources. Deputy Director of the Colorado Department of Health Care Policy and Financing, Dean Woodward, responded, “We took longer than we normally would have done, but we’re a fairly small department, and administratively
are fairly thin” (Callahan 1998). Woodward explained the delay to one newspaper saying, “The department lost a lot of people in our research and development office at the time. We reassigned Transition-Plus to another unit and were slow” (McAvoy 1998).

Colorado had no organized Medicaid outreach effort. As a result, hospitals in Denver conducted their own outreach “to groups that qualify for subsidized health benefits but don’t know about them” (Austin 1999). Commenting on the nonexistent state effort, Dr. David Munch said, “there is a definite need to address this issue. We are talking about a significant number of people here that have a need” (Austin 1999). The Denver Health Medical Center applied for and received a five year $5 million grant from the W. K. Kellogg foundation and the Colorado Trust to “match poor Coloradans with health benefits from 14 available sources” (Austin 1999). The hospital planned to use the grant to hire its own eligibility workers to screen patients. The state government’s goal of reducing welfare rolls often overshadowed the issue of Medicaid enrollment. In Colorado, the Department of Health Care Policy and Financing warned that “The incentives counties face to reduce welfare rolls may take precedence over efforts to enroll or retain eligible persons in Medicaid” (Moon et al. 1998, 24).

Marilyn Ellwood (1999) spoke to Colorado welfare staff about a seven-county investigation done by the state on falling Medicaid enrollment. “They found that many welfare recipients were unwilling to provide the detailed income reporting required when they went to work to allow them to maintain their Medicaid enrollment. They also confirmed that some families stay away from Medicaid because they are nervous about the TANF recovery process. They fear that if the state gets details about their income, there may be an attempt to collect back TANF benefits for which they may have been
ineligible” (Ellwood 1999, 19). Colorado required monthly income reports from former welfare recipients in order to maintain transitional Medicaid, a burden which helps explain recipients’ reluctance to keep up with the paperwork.

Colorado conducted much more aggressive outreach for the Children’s Health Insurance Program (CHIP) than for Medicaid which was considered less politically popular (Bryner 2002b). The state used focus groups to develop a simplified and shortened CHIP application in 2001 (Burke 2003). Colorado also expanded its eligibility requirements to “parallel” changes in TANF that led to the Medicaid enrollment declines (Ellwood 1999, 13).

*Maryland*

Maryland began the process of welfare reform in the early 1990s with the Primary Prevention Initiative and the Disability Assistance and Loan Program, both enacted in 1992. The Primary Prevention Initiative required that AFDC participants’ children attend school regularly and receive preventive medical services or face reductions in their grants, but did not contain a work requirement (Norris and Bembry 1995). When working on welfare reform in 1992, state officials including Governor William Schaefer and the Department of Human Resources secretary demonstrated a belief in state control. The policymakers excluded “county-based welfare departments, the agencies in Maryland that are responsible for welfare delivery, from the policy-making process” (Norris and Bembry 1995, 148). Norris and Bembry’s account of Maryland’s welfare reform program’s creation in the early 1990s suggests an atmosphere not conducive to careful implementation. Governor William Schaefer and leaders of the state’s Department of Human Resources believed that promoting independence among the poor would bring
benefits both to the poor and to society in general. Furthermore, “because of the budget
deficit, the legislature was in a budget-cutting mood. In addition, a decidedly anti-
welfare mood had been present in the state since at least the 1990 election” (Norris and
Bembry 1995, 162). This mood kept implementation from receiving much attention. In
addition, the Department of Human Resources leaders were nervous about over-planning,
and the governor was pushing quick action to paint the state as a leader and innovator.
One Department of Human Resources official explained, “We could analyze forever and
never get anything done” (Norris and Bembry 1995, 163). Beginning the program in
July 1992 gave officials just seven months to “develop implementation procedures and
mechanisms, hire new staff, train staff in the new policies and procedures, create new
written procedures and forms, make changes in computerized systems, secure federal
approval of the reform, and inform welfare recipients of the new policies and their
requirements... When DHR finally made decisions about the details of the
implementations, it often did so with little or no information about their probable impacts
and without considering alternatives to them” (Norris and Bembry 1995, 171-2). Local
departments of social services were only involved in policy decisions following program
implementations if their directors pressured the Department of Human Resources (Norris
and Bembry 1995).

In 1995, Maryland received a waiver to create work requirements for AFDC
recipients which would begin in April 1996 (Abramowitz 1995). The program change
did not include time limits for welfare receipt and maintained welfare’s status as an
entitlement. In 1996, just before President Clinton signed PRWORA, Maryland received
a waiver to continue with this plan lacking time limits rather than implement the federal
legislation (Jeter 1996). While policymakers at first intended to continue with the state’s plan, they committed to the federal plan in September, 1996 because it offered considerably more money. Maryland would have received $218 million annually from the federal government under its original plan, but by accepting PRWORA, Maryland would receive $229 million (Scully 1996).

Maryland’s welfare reform was not characterized by devolution within the state. (Goggin 2003). The state required that applicants search for alternative resources and jobs before applying for TANF (Chavkin and Romero 2000). The Maryland welfare program also offered diversion payments of up to three-months-worth of benefits in exchange for assurances that potential applicants would not apply for TANF. Maryland offered the federal minimum twelve months of Transitional Medicaid Assistance for welfare leavers (National Governors Association 1999).

Thomas Oliver described Maryland healthcare policy as stable and slow to evolve: “Policies are typically formulated after a lengthy period of incubation...[Healthcare policy] is not reactionary, nor is it often progressive or visionary. A readiness and capacity to fix problems has prevented a full-blown health care crisis in the state, yet the power of entrenched interests and moderate leadership has kept Maryland from striking out with comprehensive health care reforms” (Oliver 2004). In 1987, Maryland showed at least some support for Medicaid when it relaxed its eligibility requirements significantly beyond federal minimums (Birnbaum 1999). Similarly, Oliver argues that Democratic Governor Parris Glendening’s HealthChoice – a mid-1990s plan to enroll most Medicaid recipients in managed care programs – was not
created primarily to cut costs. Rather, important aspects of the plan were designed to promote continuity of care and quality medical services (Oliver 2004).

Maryland Medicaid enrollment grew from 1991 to 1993 (the period surrounding the state's first efforts at welfare reform) from 368,000 enrollees to 492,000. From 1996 to 1998 (the period surrounding welfare reform including work requirements and time limits), Medicaid enrollment declined significantly from 452,000 enrollees to 222,000 (U.S. Census). This represents a 50.9 percent drop in Medicaid enrollment over two years. At the same time that Medicaid rates fell, the number of uninsured people in Maryland rose from 581,000 (11.4 percent of the population) to 837,000 (16.6 percent of the population). Unemployment fell slightly in Maryland between 1996 and 1998 from 136,000 (unemployment rate: 4.9 percent) to 125,000 (unemployment rate: 4.6 percent), and this was likely one cause of the falling Medicaid rates (Bureau of Labor Statistics 1998; 1999). Still, the large rise in the number of uninsured (larger than the number of people who stopped receiving Medicaid) and the small number of people who gained employment (11,000) indicate that a strong economy and increased work participation do not explain Maryland's significant Medicaid enrollment declines. One significant portion of this decline resulted from technological problems: 60,000 households incorrectly did not receive Medicaid as a result of leaving TANF or being denied for TANF coverage between January 1997 and April 1999 (Ragan 2003). Maryland did not fully delink TANF and Medicaid automated processing until April 2000 (Ragan 2003).

Maryland's deadline to use its share of the $500 million fund was scheduled for December 31, 1999. The time limit was never reached, however, because of Congress's removal of all time constraints on the money in November 1999 (Darnell, Lee, and
Murdock 1999). Maryland had still spent none of its share ($7,595,943) of the federal $500 million fund as of June 30, 1999 (Ross and Guyer 1999). However, in 1999 Maryland officials did report taking actions that the federal fund covered. The state placed eligibility workers in more locations, conducted local community activities, and developed educational brochures, all of which would be matched by the federal government at a rate of 90 percent. Maryland also reported making systems eligibility changes which would be reimbursed at the 75 percent rate (Darnell, Lee, and Murdock 1999).

Glendening exhibited a commitment to expanding health insurance in 1997 when he proposed expansion of the state insurance program Kids Count to cover pregnant women and children up to three years old in households with incomes below 250 percent of the federal poverty level. The bill died in the legislature despite a lack of opposition. Someone Oliver characterizes as a “participant in the legislative process” explained this legislative failure as the result of limited political or policymaking skill, rather than the result of opposition to health insurance for the poor: “It was poorly drafted from a legislative perspective, with a grant of authority to the health department to come up with a nice program. But none of the details were specified in the bill” (Oliver 2004, 216). Oliver, however, asserts that the bill’s failure was also due to legislators’ unwillingness to cover insurance for Maryland residents with such high incomes. Furthermore, he writes that Glendening was not committed to Medicaid itself and in fact was “no fan of Medicaid” (Oliver 2004, 218).

Outreach and enrollment promotion did not become a Medicaid priority in Maryland until the passage of CHIP. Maryland extended the Medicaid program to
include CHIP, and this program extension was approved in mid-1998. The state "invested sizeable resources in outreach and enrollment simplification" in Medicaid after CHIP was passed in 1997 (Burke and Abbey 2002, 13). Active outreach was both more expensive and more effective than little or no outreach (Fosset, Gais, and Thompson 2002), indicating the state's willingness to expend greater resources for children's health insurance.

CHIP provided states with a higher matching rate than Medicaid and also provided funds explicitly for outreach (Thompson and Gais 2000). Maryland responded strongly to this CHIP incentive. As a result, Medicaid enrollment increased significantly several years after welfare reform and the deep declines in Medicaid enrollment. The state hired a policy specialist to assist with Medicaid and CHIP simplification. Part of this effort included redesigning the application (Burke 2003). The Maryland state health secretary in 1998, Martin Wasserman, demonstrated a strong commitment to Medicaid outreach. He offered cash rewards to counties with the most successful outreach programs and in 2000 said, "I'm the cheerleader – I told my staff there is nothing I'd like more to do than go back to the General Assembly and ask for a budget deficiency" (Oliver 2004, 215).

Although Maryland's Medicaid rates were discouraging in 1998, they rebounded in subsequent years. More Maryland residents were enrolled in 2000 than in 1995, mostly due to spillover from extensive CHIP outreach which began in July 1998. "As a result of extensive outreach, Maryland exceeded their enrollment target by 50 percent during the first year of outreach efforts" (Burke and Abbey 2002).
Oregon

Oregon initiated a significant Medicaid restructuring before PRWORA with the Oregon Health Plan (OHP) in 1989. A budget shortfall in 1987 had inspired a Medicaid cost-containing bill which terminated coverage of bone marrow transplants. When a seven year old covered by Medicaid and in need of a transplant died, a backlash against the cut and calls for reforms of state health care ensued. The Oregon legislature responded and indicated a commitment to expanding Medicaid enrollment in 1989 with the OHP which passed nearly unanimously. The series of laws denied Medicaid coverage for “low-priority” services and used the money saved to expand Medicaid to cover all impoverished Oregonians (Sparer 1999; Jacobs, Marmor, and Oberlander 1999). Lawmakers intended that money saved by reducing benefits would finance the eligibility expansion, but federal intervention limited the number of service cuts allowed (Jacobs, Marmor, and Oberlander 1999; Sparer 1999). The Bush administration kept the state from implementing the most severe service cuts, arguing that they would negatively impact people with disabilities. Oregon politicians reacted strongly. Republican Senator Bob Packwood appeared to be personally hurt by the decision, telling reporters he was “outraged and disappointed” and felt the state had been “stabbed in the back” (Vernaci 1992). Oregon House Speaker, Republican Larry Campbell, indicated his will to implement the plan saying, “We’ve got 120,000 folks who are going to suffer as a result of this decision” (Cain 1992). Oregon officials negotiated with the federal government for three years before the Plan was finally authorized by the Clinton administration in 1993, and the state committed a number of resources to ensure approval. Oregon lobbied the White House and received support from other governors
on behalf of the National Governors Association. Oregon’s governor in 1993, Democrat Barbara Roberts also made personal appeals to the president and Health and Human Services Secretary Donna Shalala (Ota 1993). The OHP was implemented in 1994 but did not save the state much money or affect the services available to many Medicaid beneficiaries as a result of federal restrictions (Sparer 1999).

While the state received criticism for rationing medical benefits for the poor, the legislature’s effort to expand enrollment does indicate a relevant commitment to providing Medicaid to the poor. Jean Thorne, the Oregon Medicaid director in 1992, responded to the Congressional Office of Technology Assessment’s critical report on the OHP emphasizing the benefits to previously uninsured Oregonians: “I think that the people with Medicaid will do as well or better. And then there are 120,000 people who are living in poverty who will definitely do better” (Blackmun 1992). Based on their analysis of the OHP, Jacobs, Marmor, and Oberlander assert that “priority setting was never the ultimate objective of Oregon’s reformers; it was celebrated as the pragmatic means to widen access to health insurance” (Jacobs, Marmor, and Oberlander 1999, 171). Marsha Gold (1997) refers to official state publications that ranked expanded coverage and access higher than cutting costs in a list of the OHP’s goals, which suggests that state officials and politicians did not expect Oregonians to balk at these priorities. Gold writes, “Equity and access to care appear to be the main impetus for the development of the OHP” (Gold 1997, 642). The plan was widely popular in the state and received support from the public, the Oregon Medical Association, business organizations, the AFL-CIO, and legislators from both parties (Jacobs, Marmor, and Oberlander 1999; Cain 1992).
In 1994, when the program was finally implemented and it was clear that Medicaid benefit cuts alone were insufficient to fund expanded eligibility, legislators again demonstrated their commitment to expanded Medicaid enrollment. The legislature increased the amount of money from its general fund dedicated to Medicaid and raised the tax on tobacco (Jacobs, Marmor, and Oberlander 1999). In 1996, Oregonians voted to expand the Oregon Health Plan to cover children by supporting a further tobacco tax increase of 30 percent (Sparer 1999). Oregon’s governor from 1995 to 2003, Democrat John Kitzhaber, was a state senator in the late 1980s and a leader in Oregon’s health reform. Kitzhaber is a physician, and although his priorities shifted away from health policy as governor, “he remains knowledgeable about health care and interested in preserving the state’s reform activities. He would oppose any effort to significantly restrict the state’s health reform program” (Sparer 1999, 5).

Oregon lawmakers’ record is not perfect in terms of Medicaid eligibility expansion, however. In 1995, they limited Medicaid eligibility by creating a liquid asset test, requiring additional income information from applicants, and charging new recipients monthly premiums of $6 to $28 (Sparer 1999). In 1996, the OHP faced an $18.4 million budget shortfall. The state’s Legislative Emergency Board proposed a number of changes to save the program, including some which would reduce enrollment. One would change the date of an applicant’s eligibility for Medicaid to the date the state approved the application, rather than the date the person applied. Hospitals, doctors, and the Oregon Health Services Commission all criticized these money-saving moves, calling them violations of the OHP’s philosophy. These critics’ efforts proved effective and the two proposals were not considered by the Legislative Emergency Board. The board did
consider measures which would reduce Medicaid benefits, but enrollment and eligibility remained untouched (O’Neill 1996).

Jean Thorne, the Oregon Medicaid director during OHP’s implementation, and her staff conducted outreach about the extended Medicaid eligibility with pamphlets, a toll-free phone number, and hundreds of public meetings across the state. Advocacy groups, however, were skeptical that state officials were promoting enrollment as much as they could. Ellen Pinney, director of the Oregon Health Action Campaign, said, “My sense is that there’s a very real tension between how fast the state wants to bring on folks and how fast folks really could come on board if they knew more about the health plan” (O’Neill 1994).

Oregon began its work-oriented welfare program, Jobs Plus, in 1994, well before PRWORA. Jobs Plus provided government subsidized employment to welfare recipients in six pilot counties. The program consisted only of incentives to work, with no time limits work requirements (Suo 1994). Jobs Plus gave AFDC and food stamp recipients’ benefits in the form of cash to employers who in turn paid workers and contributed extra money to education accounts. In July, 1996, Jobs Plus was expanded and implemented across the state along with a requirement that all welfare recipients (with a few exceptions) search for employment or enter job-training programs (Heinz 1996). In addition to this mandatory job search, Oregon diverted potential applicants with available diversion payments worth up to one month of benefits (National Governors Association 1999). Holcomb et al. (1998) wrote of the program, “Oregon’s approach to reform is characterized by a nearly universal participation requirement, stringent penalties for noncompliance … [and] substantial emphasis on efforts to divert applicants from the
welfare system” (8). Oregon instituted a shorter time limit than the federal maximum, offering TANF for 24 months within an 84 month period (Holcomb et al. 1998). Oregon welfare workers conducted up-front interviews with all potential applicants. “Local staff in Oregon viewed the goal of its up-front ‘self-sufficiency interview’ as one of helping applicants realize that other options may be available to meet their needs, thereby rendering the need for ongoing cash assistance unnecessary” (Holcomb et al. 1998). This type of diversion and the staff’s willingness to encourage enrollment in Medicaid allowed new clients to learn about the two programs’ separated eligibility requirements.

Oregon devolved little welfare power within the state. Programmatic decisions were made at the state level and counties had very little discretion. Goggin (2003) describes Oregon as “one of the most extreme examples of state control” (5). Holcomb et al. (1998) paint a somewhat more flexible picture emphasizing counties’ discretion. “High-level managers maintained a consistent focus on goals while showing great flexibility in how to reach them...Local offices were given goals to achieve, but the details were for them to decide” (Holcomb et al. 1998, 117).

Oregon benefitted from both local and state efforts to promote service integration following welfare reform. In the 1980s and 1990s, the Oregon Department of Human Services had sought unsuccessfully to promote service integration at the state level. When this plan failed, state officials turned their focus to local promotions of the same practice. Local multi-service offices were made possible by “strong leadership at the state and local levels to create and implement a vision of integrated service delivery” (Ragan 2003, 3). At the county level, committed leaders were crucial in promoting service integration locally and at the state level. Ragan writes, “In Jackson County, managers
trace the beginnings of service integration to a county commissioner whose concern that families in the White City area were not receiving the needed services led her to press the state for changes. But rather than wait for the state to take action, local DHS and county program managers brought together local service providers to create a common vision" (Ragan 2003, 9). State consolidation of service offices further promoted integration. The governor, legislature, and director of the Department of Human Services all cooperated to combine the budgets of offices in DHS and to reduce the number of leadership positions to “send the message that all of the programs would work together toward a common goal – better outcomes for families” (Ragan 2003, 5). Ragan credits Oregon’s success in large part to state leadership:

“In the mid 1990s, the director of human services programs believed that it was possible to change the nature of service delivery to eliminate service gaps and avoid duplication of services and processes. Changes he initiated at the state level – combining funding streams for state programs, consolidating authority over programs, and initiating prototype service integration sites, have all contributed significantly to the progress that has been achieved in Oregon” (Ragan 2003, 9).

In 1993, 269,000 Oregonians received Medicaid. This number grew significantly through 1995 to 456,000, fell in 1996 to 347,00 and grew again through 1998 to its highest level, 469,000. Oregon Medicaid enrollment grew by 35.2 percent from 1996 to 1998. The number of unemployed Oregonians during the same time period dropped slightly from 102,000 (unemployment rate: 5.9 percent) to 98,000 (unemployment rate 5.6 percent) (Bureau of Labor Statistics 1998; 1999). At the same time, the number of Oregonians without health insurance also fell, from 497,000 (15.3 percent of the population) to 481,000 (14.3 percent of the state) (U.S. Census). These other figures
show that the large rise in Medicaid enrollment (122,000 more people in two years) was not caused by growing unemployment or health insurance losses.

As of June 30, 1999, Oregon had spent $1,497,655 (26 percent) of its $5,740,656 from the $500 million fund (Ross and Guyer 1999). The state's three year time limit on the money arrived on September 30, 1999, but the state regained access to the fund in November of that year when Congress removed all time limitations on the money. Oregon officials reported only one activity covered by the fund – training workers, an activity reimbursed at the 90 percent rate (Darnell, Lee, and Murdock 1999).

Successful eligibility decoupling Implementation in Oregon benefitted from staff trained extensively in specialized case management roles. Case managers were trained in one of four specialties: self-sufficiency interviews (including encouragement to apply for Medicaid) and intakes, job search and case management, harder to serve case management, and transitional benefits (Holcomb et al. 1998). Oregon case managers had the discretion to deter potential TANF applicants with diversion payments, and always included Medicaid and Food Stamp enrollment as part of this diversion process (Morgan, Acker, and Weigt 2010). TANF applicants in Oregon with incomes too high to qualify did usually receive other benefits as a result of the process. Morgan, Acker, and Weigt write, "Nearly all of the 'over-income' diverted applicants whom we interviewed did receive some other assistance, such as the Oregon Health Plan" (Morgan, Acker, and Weigt 2010, 78). This division of labor allowed the welfare caseworkers most crucial to Medicaid enrollment to be better trained in this role and to have a limited focus on work searches.
Utah

“Utah is characterized by conservative politics, Mormonism, a strong belief in self-sufficiency, and a communitarian spirit rooted in the pioneer experience” (Bryner 2002, 3). Bryner writes that this contributes to a state-wide willingness to help those in need, especially if they are trying to help themselves.

Welfare reform in Utah began in 1992 when the state received waivers for a pilot program called the Single Parent Employment Demonstration (SPED). SPED launched in 1993 in three Utah cities. The governor originally pushed for leadership consolidation and convinced skeptical Republicans in the legislature with assurances that the move would save money. On the other hand, moderate Republicans and Democrats in the legislature “took a neutral stance but were most swayed by arguments that consolidation would provide better service” (Bryner 2002, 10). The program spread around the state, and by 1996, half of Utah’s welfare caseloads operated under SPED. Utah politicians were so pleased with the program that in 1996 they renamed welfare the Family Employment Program and extended the pilot to cover the entire state. The Family Employment Program was revised slightly in 1997 to conform to PRWORA and became the state’s TANF program (Bryner 2002). Utah did not devolve much welfare authority within the state and programmatic decisions were all decided at the state level (Goggin 2003). In Utah welfare offices, Department of Workforce Services officials emphasized Medicaid and later CHIP availability to TANF recipients whose cash assistance ended (Bryner 2002).

In 1996, when the plan to expand Utah’s welfare-to-work program across the state was made, 122,000 people received Medicaid. Enrollment grew to 149,000 in 1998,
a 22.1 percent increase. Unemployment increased slightly in Utah over the same two years from 35,000 (unemployment rate: 3.5 percent) to 40,000 (unemployment rate: 3.8 percent) (Bureau of Labor Statistics 1998, 1999). This increase in unemployment helps to explain part, but not all, of the increase in Medicaid enrollment between 1996 and 1998.

Republicans dominate Utah politics, and the governor from 1993-2003, Michael Leavitt, was a Republican. Utah instituted a relatively generous TANF plan with “more generous earnings disregards than average...[Utah] places strong emphasis on education and training ...[and] provides funding for virtually anything required for recipients to be able to work” (Bryner 2002, 7). Since Medicaid allows poor people to accept low-wage jobs without benefits, this attitude is conducive to maintenance of Medicaid enrollment.

Financial limits kept the state from completing part of its 1994 plan, HealthPrint 2000, to expand Medicaid coverage. Expanding eligibility to cover Utahns with incomes between 75 and 100 percent of the federal poverty line comprised the final third of the plan, but in 1996 the state could not afford to cover all eligible state residents. Norma Wagner (1996) offered three explanations: “Legislators for the past three years have raided nearly $17 million in savings that resulted from shifting Medicaid patients into managed care and; the savings the state anticipated from shifting those patients into health-maintenance organizations is not going to be as much as thought. Additionally, the $11 million saved through fiscal 1997 already has been spent on...Phase II of the expansion” (Wagner 1996). Because Utah could only afford to cover half of this newly eligible group, the state began charging these new enrollees premiums ranging from $20 to $70 per month. The Director of the Utah Health Care Financing Division explained
that charging premiums helped pay for the eligibility expansion and also limited the number of Utahns were likely to apply (Wagner 1996). Michael Deily, director of the Utah health-care financing division was honest about the division's motivations—premiums would help cover the costs of expansion while also limiting the number of applicants. Deily explained, “We cannot generate enough savings to bring on everyone whose income is 75 percent to 100 percent of poverty...So we have to try to be sure to cover those who feel they really need the coverage” (Wagner 1996). Advocacy groups, understandably, were not convinced by Deily's logic. Bill Crim of Utah Issues said, “They're not going to make bundles of money on $20 premiums, and certainly that money is not going to pay for the expansion of the program. On the other hand, if you keep people out, that’s going to save hundreds of thousands of dollars” (Wagner 1996).

As of June 30, 1999, Utah had spent none of the available $4,006,172 from the $500 million fund (Ross and Guyer 1999). Utah officials did, however, report activities that would be covered by the fund. In October 1999, officials reported hiring outstationed eligibility workers and conducting local community activities, both of which would be reimbursed at the 90 percent rate. Utah also reported making eligibility systems changes which would be matched at the 75 percent rate. Officials did not report any outreach materials or programs. Utah originally had until September 30th to use its portion of the funds, but after reaching this time limit Congress gave states renewed, indefinite access to the money in November, 1999 (Darnell, Lee, and Murdock 1999).

Utah's history of promoting Medicaid enrollment gave state officials experience with Medicaid outreach. The Utah welfare program had had similar features to TANF since 1992, giving the state more time to adjust to work requirements' and time limits'
impacts on Medicaid enrollment. Therefore when Utah began a Medicaid outreach program in 1996, state officials were aware that it was needed and knew better how to reach eligible clients successfully (Bryner 2002; Burke 2003; Hobbs 1995). Bryner (2002) writes, "Welfare and Medicaid have always been seen as quite separate programs in Utah" (9). The program was conducted by the Utah Department of Health and only coincidentally began at the same time as TANF. The program was part of a campaign to increase Medicaid enrollment and entailed "more aggressively going to low income communities and registering those eligible for Medicaid" (Bryner 2002, 9). Burke and Abbey (2002) characterized the 1996 Medicaid outreach program as part of a "longstanding tradition of encouraging Medicaid enrollment" in the state (Burke and Abbey 2002, 13). Utah also already had procedures in place to automatically provide Transitional Medicaid Assistance to welfare leavers before welfare reform (Fosset, Gais, and Thompson 2002).

Fosset, Gais, and Thompson (2002) write that Utah took serious actions to limit the number of welfare leavers who lost Medicaid. The state facilitated this by having procedures in place before reform to increase enrollment and automatically extend Transitional Medicaid Assistance coverage to welfare leavers.

Discussion

Incentive and Sanction Problems

Weaver defines incentive and sanction problems as instances "where positive and/or negative incentives are insufficient to ensure compliance" (Weaver 2009, 10). Weaver emphasizes that creating an effective cost/benefit balance requires a full understanding of how program targets perceive the costs and benefits of compliance. He
notes that "this calculus may vary substantially" among targets, making a successful balance harder to achieve (Weaver 2009, 11). Weaver also cautions against too much faith in sanctions, writing "strengthening negative incentives also creates a stronger impetus to try to maneuver around those incentives, rather than complying" (Weaver 2009, 12).

The Clinton administration encouraged states to increase Medicaid enrollment. Fossett, Gais, and Thompson (2002) write that the president and Health and Human Services Secretary Donna Shalala "invested an unusually large amount of energy in encouraging states to expand enrollment. Improving access to health care was a high priority issue for the Clinton Administration and the President personally, and both the President and Secretary repeatedly and publicly promoted enrollment in Medicaid and CHIP by publicizing on-going enrollment problems and state success stories, [and] encouraging continuing media attention to take-up" (23). The Health Care Financing Administration contributed to the effort with "a steady stream of missives" to state Medicaid officials (23). Federal encouragement of Medicaid enrollment maintenance did not provide states with concrete incentives to implement decoupled eligibility, however. States did not receive financial or other rewards for avoiding or correcting Medicaid declines after PRWORA.

Criticisms and sanctions were also not an important part of federal policy. The Healthcare Financing Administration (HCFA) did publicly criticize New York for failing to monitor New York City, and this may have set an example for other states. Still, all of these federal actions occurred after welfare reform and Medicaid enrollment declines and therefore do not explain the initial variation among states.
The federal government applied pressure on states to correct Medicaid declines, but it did not punish them for slow action. Fossett, Gais, and Thompson (2002) write, “at least through 2000, federal pressures to make Medicaid and CHIP more accessible were strong” (21). Murphy (1971) found in his study of educational policy that executive branch administrators considered criticizing state implementation extreme. The executive branch’s dependence on states for information about the program also made it especially cautious about angering states. This dynamic may have been a part of the federal government’s treatment of states during TANF implementation, especially because of PRWORA’s strong emphasis on devolution. Fossett, Gais, and Thompson argue that this pressure was effective after the problems arose, and only because state interests agreed with the message. They write, “these pressures resonated with state-level political coalitions of health care providers, elected officials who saw decreased coverage as a problem and increased coverage as a political plus, and administrators who often saw expanded enrollments and higher take-up rates as good for their agencies and as good for their reputations among their professional peers” (21-22). This suggests that federal pressure to address Medicaid declines was effective only because it matched the attitudes of local groups, not because states were required to comply.

The national government did use its authority to preserve Medicaid services in Oregon when it rejected the original Oregon Health Plan in the late 1980s. Rejecting a state waiver is not the same as a sanction, however. Oregon policymakers had no reason to fear punishment after the fact if they failed to maintain Medicaid enrollment. Still, it is possible (though there is no supporting evidence) that implementation in Oregon was
successful in part because policymakers feared a negative federal reaction if they did not commit to Medicaid enrollment levels.

The federal government failed to enforce a type of promised sanction when Congress lifted time limits on money available to the states through PRWORA. The 1996 law made $500 million available in matching funds for programs and administrative changes to keep people from losing Medicaid as a result of decoupled eligibility. The money was to cover actions taken during the states’ first twelve quarters of their TANF programs or until October 1, 2000 and could be claimed retroactively. States, however, drew only 10 percent of the money from the fund by June 1999, and Congress lifted both time limits on the fund (Ross and Guyer, 1999). Thus states that were slow to use the available money were not punished.

Colorado and Maryland were both penalized for denying Medicaid improperly to thousands, but not by the federal government. Both states faced lawsuits and paid settlements to former Medicaid recipients. Maryland’s Medicaid enrollment had already rebounded when the case was settled, but in Colorado the lawsuit was what first inspired state officials to address the enrollment declines (Fossett, Gais, and Thompson 2002; Ragan 2003). This type of sanction therefore was an effective way of ensuring compliance, but it came too late for families in or near poverty that lost benefits improperly.

Fossett, Gais, and Thompson (2002) note that many states did not advertise Medicaid because successful outreach would cost the state money as more people enrolled in the program. This inherent disincentive to comply was overcome with CHIP when funds were made contingent on outreach. “[Federal] funds were explicitly
provided for outreach under CHIP, which marked the first occasion that many states had
to develop such activities” (18). The lack of an explicit, financial incentive to advertise
Medicaid seems to have been especially relevant in Maryland.

Sanctions and incentives cannot fully explain why Medicaid enrollment grew in
some states and fell in others because each state was subject to the same federal
restrictions and incentives. Still, the lack of substantive sanctions or threatened sanctions
for states with Medicaid declines offers a compelling explanation of why states
decoupled eligibility poorly. Colorado and Maryland faced no federal punishment for
their improper Medicaid denials and terminations.

*Monitoring Problems*

Monitoring problems occur when “target compliance may be difficult or costly to
monitor” (Weaver 2009, 10). Weaver observes that monitoring is especially difficult
when the activities being observed are illegal or private. Eligibility decoupling is neither.
Nonetheless, federal monitoring of state compliance was limited. Like sanctions and
incentives, monitoring was mostly uniform across the states and there is no evidence in
these four cases that monitoring or a lack thereof influenced how states implemented
eligibility decoupling. Although monitoring problems cannot explain why some states
performed better than others in decoupled eligibility implementation, they can help
explain why states that did poorly were able to. The improper Medicaid terminations and
denials in Colorado and Maryland demonstrate the lack of federal monitoring. These
problems were largely caught and dealt with by advocacy groups, not federal monitors.

In this case, state compliance was challenging to monitor because of the
significant devolution of authority to the states. Each state had a unique program, and
there was no standard benchmark of compliance to measure against. The General Accounting Office did study state implementation of welfare reform and reported problems with automated systems and enrollment declines (GAO 1998; GAO 2000). The 1998 report noted that Medicaid enrollment and outreach became especially crucial following welfare reform, but its accounts of state actions were vague and mostly positive: “To help ensure that Medicaid-eligible individuals enroll in the program, the states we visited are beginning to consider how to adapt or create new education and enrollment strategies” (19). Furthermore, this report did not attempt to monitor state outreach programs at all, suggesting that state actions to begin to consider outreach were sufficient. Other GAO reports demonstrated little concern with falling Medicaid enrollment and instead emphasized that Medicaid enrollment did not decline as much as welfare rolls (GAO 1999).

Resource Problems

Noncompliance results from resource problems when “targets lack the resources to comply even if they want to” (Weaver 2009, 10). Weaver writes that the provision of adequate resources for compliance is most challenging when: “(1) the resource needs of clients do not have a “one size fits all” character, (2) compliance is costly and complicated for targets, and (3) compliance is not a one-time action but stretches over time” (Weaver 2009, 14). The necessary resources for eligibility decoupling are diverse and include money, technology, and sufficient staff. In terms of decoupling implementation, the various states certainly did have different resource needs, compliance did cost states, and multiple actions were usually required over time to fully comply. However, states’ non-use of available resources and good performance despite
lacking resources suggest that resource levels do not explain the variation in implementation quality.

Money was a crucial resource for eligibility decoupling because both technology and outreach were needed to maintain Medicaid enrollment. The $500 million fund established by PRWORA in 1996 was intended to match state spending on changes necessary for decoupled eligibility implementation. The fund matched state spending on changes like redesigned Medicaid applications and outreach and education about delinked eligibility at rates of 75 percent or 90 percent. (Additionally, before PRWORA and in addition to this fund, state administrative spending on Medicaid is matched at least at a 50 percent rate by the federal government.) Colorado was given $5,166,316, Maryland $7,595,943, Oregon $5,740,656, and Utah $4,006,172. As noted in the case studies, Oregon was the only state studied which drew from the fund as of July 1999 (Ross and Guyer 1999). States were given three years after TANF implementation to use their money but could apply for funding to cover actions taken in these first three years retroactively until September, 2000 when the fund was scheduled to sunset. Thus each state had considerable federal matching funds available to finance eligibility decoupling specifically, and they were limited only by time. In November, 1999, all time limits were lifted, allowing states to access their allotted funds at any time (Darnell, Lee, and Murdock 1999). States’ apparent unwillingness to use federal money to cover most of the costs of decoupling implementation suggests that insufficient financial resources were not the problem.

Variations in states’ financial situations did affect the implementation of eligibility decoupling implementation, and also affected local attitudes towards Medicaid
enrollment. Colorado’s constitutionally mandated spending limits reduced the amount of money available to finance implementation and Medicaid while also fostering a negative attitude towards both, since money spent on them translated to less money for other programs. Furthermore, Colorado had a “substantial economic base from which the state could potentially draw revenues” (Moon et al. 1998, 7). Oregon had a more generous spending record with regards to Medicaid. Oregon lawmakers and residents demonstrated their willingness to finance Medicaid eligibility expansions through the Oregon Health Plan when they elected to raise tobacco taxes to cover unexpected program costs. Oregon also financed county service integration projects to encourage enrollment in multiple public benefit programs in the 1980s and 1990s (Ragan 2003b).

Technological resources were another crucial part of decoupled eligibility implementation. All states needed to update their automated systems to reflect Medicaid and TANF’s different eligibility requirements and to keep welfare termination from unintentionally causing Medicaid termination. Outdated technology was the immediate cause of Maryland and Colorado’s improper denials and terminations. Mark Ragan’s (2003) study of state automated systems indicates that most states took at least several years to complete automated eligibility determination decoupling. Maryland achieved this in April 2000. Colorado’s second order devolution made the process more challenging since counties with different eligibility requirements needed different systems. Colorado did separate automatic TANF and Medicaid eligibility systems in 1999, but improper Medicaid determinations continued into 2000. This suggests that as important as updated technology was to decoupled eligibility implementation, it was not the only or the most important component. Oregon and Utah – the two cases that
increased Medicaid enrollment—achieved decoupled eligibility system automation the latest. For Utah, this occurred in August, 2001. Ragan’s report noted that as of September, 2002 Oregon’s eligibility systems were not fully automated and required worker intervention. Given these four cases, technological resources appear surprisingly unimportant. Technological resource problems did contribute to Maryland and Colorado’s noncompliance, but fixing them in Colorado did not solve the problem. Furthermore, Oregon and Utah’s success despite technological resource problems suggests that other factors were more important in determining implementation success.

Sufficient numbers of competent staff represent another important technical resource relevant to successful implementation of decoupled eligibility. Adequate staffing is largely a function of a state’s commitment to a program, though, and therefore is better understood as a reflection of a state’s general political will than as a technical aspect of implementation. Medicaid enrollment in Oregon benefitted from staff members’ specialization. By training some caseworkers only to conduct initial self-sufficiency interviews, Oregon ensured that caseworkers responsible for encouraging clients to enroll in Medicaid had fewer other responsibilities. Staffing was also relevant to implementation in Colorado where the Department of Health Care Policy failed to request a crucial waiver for the state’s extended transitional Medicaid program. State politician Mike Coffman framed this as a political problem, telling reporters that the bureaucrats lacked compassion. The bureaucrats reinforced the framing of the problem as political but carefully and indirectly placed the blame on policymakers who left the department understaffed (Callahan 1998). Without more information about staff resources, it is impossible to draw broad conclusions. Still, the examples of Oregon and
Colorado indicate that the two different attitudes about welfare and Medicaid bureaucrats did affect implementation.

Information Problems

Information problems cause noncompliance when “targets lack information that would make compliance more likely” (Weaver 2009, 10). This can occur when it is unclear to targets what constitutes compliance or when targets do not know how to comply (Weaver 2009). In the case of Medicaid/TANF eligibility decoupling, information problems took the latter form. To implement decouple eligibility, states required information about outreach strategies, automated systems updates, and, to a lesser extent, organizational strategies.

After Medicaid enrollment declines became apparent, the Health Care Financing Administration made a concerted effort to provide all states with information on how to correct the problems. The HCFA sent letters to state Medicaid directors which “instructed states to review closed welfare cases for continued Medicaid eligibility [and] provided advice and examples of how to maximize coverage” (Fossett, Gais, and Thompson 2002, 23). One letter, sent in April 2000, emphasized states’ legal obligations to identify any improper Medicaid terminations, contact and reinstate recipients as necessary, and ensure that automated eligibility systems worked properly (Westmoreland 2000). These missives came after the problems with implementation had happened and been noticed by the federal government and therefore were not relevant to initial compliance. Still, the letters listed the types of information states were missing when they did a poor job of decoupling eligibility.
Colorado and Maryland both implemented welfare programs with work requirements because of PRWORA, while Oregon and Utah had begun work-oriented welfare earlier with AFDC waivers. Utah’s welfare program included similar features to TANF since 1992 which gave the state four years of experience to draw on when implementing PRWORA. Virtually all implementation scholars argue that implementation takes time, and Oregon’s and Utah’s head starts with welfare-to-work did give them advantages. Utah traditionally considered Medicaid and welfare “quite separate” programs which likely made decouple eligibility less of a disruption than in other states (Bryner 2002, 9). However, Oregon and Utah did not match Maryland and Colorado in Medicaid enrollment changes in the first years of welfare-to-work programs. Medicaid enrollment in both states fluctuated at first, and then rose steadily after 1996. This indicates that experience with welfare-to-work programs was not all that states needed to implement decouple eligibility. It is also important to note that taking time with decoupled eligibility implementation had much more serious consequences than in the cases often studied by implementation theorists. As Colorado and Maryland demonstrate, gradual state compliance cost families in fragile financial situations. Utah and Oregon did not have significant technological information advantages, suggesting again that access to information about how to comply was not a deciding factor.

Colorado’s second-order devolution compounded the state’s information challenges. Because implementation occurred at the county level and involved varying eligibility requirements, each county needed to seek out relevant information. Second-order devolution also increased the odds that some counties would not “find” adequate information to facilitate successful implementation. Colorado’s significant automated
systems problems and overall declines in Medicaid enrollment indicate that the state did not succeed in using the necessary information, but there is also no indication that Colorado officials made serious efforts to find crucial information.

**Attitude and Objectives Problems**

Finally, Weaver writes that problems with attitude and objectives interfere with compliance when “targets are hostile/mistrustful toward providers or programs” (Weaver 2009, 10). Weaver notes that attitudes and beliefs “constitute a very broad set of influences on target compliance” (Weaver 2009, 15), which is certainly true in the case of decoupled eligibility implementation. Weaver continues, “They include beliefs concerning the legitimacy of the policy itself, the government that imposes or enforces the policy, or a more general set of beliefs that simply have implications for compliance with a particular policy” (Weaver 2009, 15). The attitudes, beliefs, and priorities of implementers varied considerably across the states and had crucial impacts on implementation’s success.

In Colorado, fiscal conservatism was an important attitude affecting decoupled eligibility implementation. Moon et al. (1998) found that Coloradans’ desires to limit spending and avoid “big government” informed the state’s health care policies. They characterized Coloradans as avoiding the creation of entitlements for poor state residents. The Colorado legislature’s decision to abolish Medicaid as a cost-saving measure suggests that policymakers were certainly willing to sacrifice the program to limit state spending. The priority Colorado legislators put on saving money was not due to a lack of funds, as discussed above in the discussion of resources. Colorado’s economy was doing well in the mid-1990s and money could have been made available for decoupled
eligibility implementation. Instead, the state's constitutional spending limit (which included provisions for making exceptions) prevailed (Moon et al. 1998; Wallin et al. 1998). Influential state legislator Mike Coffman's call in 1998 for the state to refuse $9.8 million in federal funding to help cover long-term TANF cases indicates that his prioritization of spending limits was entirely due to principle rather than a lack of funds. The state did not use any of the available implementation money from the $500 million fund. This also indicates that financial shortages cannot explain the unsuccessful implementation, while suggesting that state choices can. Colorado's resistance to "big government" also led to the state's second-order devolution. As the discussions of resources and information above show, this structure only provided obstacles to successful decouple eligibility implementation.

Colorado's dislike of government spending was manifested in ways that harmed delinked eligibility implementation. The lack of a state outreach program led Denver-area hospitals to use grant money for their own program to match patients with health benefits for which they qualified (Austin 1999). Bryner (2002b) asserts that Colorado's aggressive outreach for CHIP occurred because the program for children was more politically popular than Medicaid. The state required monthly income reports from Transitional Medicaid Assistance recipients which, unsurprisingly, discouraged eligible people from receiving the benefit. This strict policy indicates that Colorado policymakers did not place a premium on "user-friendliness" for the program, which in turn suggests at best a lack of enthusiasm for Medicaid. The years of improper Medicaid denials when no effort was made to catch or prevent these mistakes also suggest that Colorado policymakers were not concerned by the drop in Medicaid enrollment.
Colorado was reluctant to commit state money to necessary implementation resources and procedures. Although there is no evidence in this case study to argue that state lawmakers were motivated by a desire to reduce spending on Medicaid by lowering enrollment, it is a possibility. The state’s history of opposition to Medicaid on financial grounds, however, make this explanation seem plausible.

Implementation in Maryland suffered because Medicaid and careful implementation were not high priorities. Maryland did not devolve welfare authority within the state, but policymakers also excluded county agencies from the policymaking process. This failure to focus on implementation early on by working with the people who would do the implementing contradicts the advice of virtually all implementation theorists. Maryland officials rushed the planning and implementation of the state’s 1992 welfare reform plan which did not contain work requirements. Norris and Bembry (1995) describe the process as practically opposed to planning for implementation. Policymakers warned against over planning and suggested that planning ahead of time would be counterproductive.

With thousands of improper Medicaid, and no attempt to identify or prevent them, even after decoupled eligibility systems were fully automated, it seems clear that falling Medicaid enrollment was not a prominent state concern. Maryland also chose not to use funds from the $500 million fund; again suggesting that implementation of decoupled eligibility was not a priority.

Maryland did not initially prioritize Medicaid outreach and education. The importance of these activities became apparent at the end of 1998 when the state’s considerable investment in outreach for CHIP resulted in huge enrollment increases.
Burke and Abbey (2002) write that the state “invested sizeable resources in outreach and enrollment simplification,” including cash rewards to counties with successful outreach programs, to facilitate CHIP enrollment (13). That Maryland was able to change its practices so dramatically and quickly indicates that the lack of outreach for Medicaid prior to CHIP resulted from policy decisions, not from a lack of resources or information. Maryland legislators’ largely positive history with Medicaid suggests that they did not neglect decoupled eligibility implementation intentionally to reduce Medicaid enrollment and spending. (As with Colorado, there is no concrete evidence about this potential motivation.) Instead, Maryland’s neglect of Medicaid appears to be the result of more benign but equally damaging motivations. Enough policymakers simply had other priorities which left Medicaid to be poorly implemented. Because CHIP focused primarily on a sympathetic group, children, and had enrollment as its primary purpose, it is easy to understand why outreach became a top priority for that program.

Oregon’s experience with the Oregon Health Plan both indicates and likely created interest in the state in Medicaid enrollment. The Plan, which expanded Medicaid eligibility to cover all Oregonians below the federal poverty level, was viewed as widely successful in the legislature and in the state at large. The Bush administration’s initial decision to block Oregon’s plan gave state politicians an opportunity to demonstrate their commitment to it. Politicians’ strong reactions to the federal government’s denial, followed by their strong efforts to negotiate a plan that would pass, indicate their devotion to the plan. The state legislature’s decision to fund the eligibility expansion when the OHP failed to finance it again demonstrates the state lawmakers’ attitudes.
This action also offers a stark contrast with the Colorado legislature, which resisted any additional spending.

Oregon officials also held a proven record of service integration promotion, an important component of successful delinked eligibility implementation. The state’s Department of Human Services first proposed service integration efforts in the 1980s and promoted them in counties in the 1990s. County officials credited this strong state leadership as essential to the service improvements.

State policymakers’ support for Medicaid enrollment and welfare enrollment diversion aligned to form policies that encouraged Medicaid’s use as a work support following passage of the PRWORA. Oregon relied heavily on diversion policies to deter welfare applicants. To assess applicants’ situations and encourage them, if possible, to seek alternative sources of support, welfare workers conducted “self-sufficiency” interviews before taking applications. During these interviews, the workers suggested Medicaid and food stamps as assistance options with less onerous requirements than TANF’s. In this way, Oregon’s welfare program made a concerted effort to increase Medicaid enrollment as a part of its welfare program which constituted a fundamental part of the state’s successful decoupled eligibility implementation. Oregon did take a portion of its share of the $500 million fund which indicates a distinct effort to implement decoupled eligibility. Oregon was the slowest case to automate its decoupled eligibility systems, but case workers maneuvered around this problem to avoid improper program denials and terminations.

Unlike Oregon, Utah has no extensive legislative history of attitudes in favor of Medicaid. Instead, the state’s emphasis on work supports and its attention to planning
and automated systems helped to make implementation successful. Bryner (2002) characterized the state’s welfare attitude as generous and with a focus on supporting “virtually anything required for recipients to be able to work” (7). This approach contributed to efforts to ensure that Utahns not receiving TANF did receive Medicaid if they were eligible. Importantly, Utah began this process even before PRWORA with outreach and attention to automated systems to ensure that welfare leavers did not incorrectly lose Medicaid too. Utah did have a history of Medicaid outreach and enrollment encouragement and gave the Department of Health the authority to conduct campaigns to increase enrollment. This led to the state’s aggressive outreach program at the same time as welfare reform implementation (Burke and Abbey 2002). Because welfare and Medicaid had always been considered “quite separate” programs (Bryner 2002, 9), it is unlikely that Utah policymakers and street-level workers interpreted welfare reform as a push to reduce all government assistance. Utah did not use its share of the $500 million promptly, but the state’s independent outreach program and other policy decisions compensated for this apparent lack of political will.

After 1998, national Medicaid enrollment rates began to rise. Understanding what caused this reversal can help explain why Medicaid enrollment fell in the first place. Schneider wrote in 2007 that nationally, Medicaid enrollment grew at a 5.9% rate on average since 1998 (Schneider 2007). Schneider found that the dramatic rise in Medicaid enrollment after 1998 was correlated with falling TANF caseloads. She writes, “Cutting the welfare rolls clearly leads to greater utilization of other social programs” (Schneider 2007, 14). Schneider finds that “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…Clearly, this ironic situation is an unintended consequence of the welfare reform legislation” (Schneider 2007, 18). While Schneider only mentions the initial enrollment drop in passing, her finance-centered argument leaves open the possibility that some states focused on saving money by not facilitating Medicaid enrollment. Schneider also writes that after nearly a decade of Medicaid enrollment increases since 1998, “many states have implemented a variety of measures designed specifically to stop (or at least slow) the growth of Medicaid enrollments and expenses” with eligibility restrictions and/or cuts in program expansions (Schneider 2007, 20).

Debra Ringold, Tricia Olson, and Laura Leete (2003) studied state Medicaid and CHIP outreach programs between 2000 and 2003. All eighteen states in their study began new outreach programs after CHIP was passed, and Medicaid enrollment dropped. They found that Colorado’s outreach was almost exclusively for CHIP, while Oregon and Utah focused primarily on Medicaid and Maryland publicized both programs. The federal CHIP legislation provided funding exclusively for outreach efforts, so one possible explanation of Colorado’s efforts is that the state’s policymakers remained opposed to spending on programs related to Medicaid but accepted and used the federal funding for the more popular CHIP. Maryland combined its CHIP and Medicaid programs, a move that helps explain its equal outreach for both. Oregon and Utah’s Medicaid-focused publicity may have simply been continuations of programs already in place. Oregon officials reported that they were reluctant to pursue CHIP outreach
because they knew it would increase Medicaid enrollment which "would put untenable budget pressure on their Medicaid programs" (Ringold, Olson, Leete 2003, 8). Contrasting Medicaid with CHIP suggests that stronger federal incentives and sanctions might have ensured uniform compliance. States had strong incentives to increase CHIP enrollment. "CHIP offered states a more generous federal match than they received under Medicaid if they agreed to provide insurance to more children. The statute imposed certain requirements on states concerning benefit packages...and maintenance of effort (participating states could not backslide on their Medicaid eligibility criteria for children)" (Thompson and Gais, 2000, 123).

Conclusion

Medicaid enrollment changes following welfare reform illustrate the complexity of policy change. PRWORA was primarily concerned with cash welfare but had a significant and widely unexpected effect on Medicaid by lowering and eventually raising enrollment. Welfare reform's impact on Medicaid also demonstrates the challenges posed by competing policy objectives. PRWORA aimed to reduce welfare rolls while simultaneously promoting work, a logically sound goal for the TANF program. However, these objectives left Medicaid, a work support, caught between roll reductions and work promotion. This positioning left Medicaid vulnerable to ambivalent political actors who in many cases chose the roll reducing path in the first years after welfare reform. Soon after welfare reform, CHIP affected Medicaid, though in this case positively. CHIP appears to have been the largest single solution to the problem of declining Medicaid enrollment, again highlighting the complexity of policy interaction.
Pressman and Wildavsky's work suggests that devolution of authority to states will necessarily create implementation challenges because it does not include implementation planning in the policymaking process. They write, "Implementation must not be conceived as a process that takes place after, and independent of, the design of policy" (Pressman and Wildavsky 1979, 143). While states did form their own welfare policies and had the opportunity to consider implementation in their planning, the federal government designed the basic policy structure and could not incorporate implementation in the design because of the authority given to states.

Pressman and Wildavsky (1979) studied a program that, unlike welfare reform, did not depend on state program designs. Still, they found that program administrators interpreted policy to promote their goals. These cases indicate that policymakers in Colorado, Maryland, Oregon, and Utah did the same. These cases also illustrate the complexity of successful decoupled eligibility implementation. Pressman and Wildavsky emphasized "the number of steps involved, the number of participants whose preferences have to be taken into account, [and] the number of separate decisions" (Pressman and Wildavsky 1979, 93). These factors seem to have aligned early in Oregon and Utah but caused delays in Colorado and Maryland where Medicaid enrollment was not a high priority for enough decision makers. Medicaid enrollment was a peripheral concern of work-centered welfare reform, and as Pressman and Wildavsky suggest, this certainly allowed it to be neglected by policymakers focused on implementing new welfare programs. Jerome T. Murphy's assessment of federalist implementation best sums up the opportunity for policy distortion during implementation: "The federalist system – with its dispersion of power and control – not only permits but encourages the evasion and
dilution of federal reform, making it nearly impossible for the federal administrator to impose program priorities; those not diluted by Congressional intervention can be ignored during state and local implementation” (Murphy 1971, 60).

Federalism depends on state compliance with federal laws and directives while also presenting significant compliance challenges. In the case of decoupled eligibility implementation, the federal government was unable to achieve widespread state compliance for several years. This problem is especially alarming because of its political nature. Technical problems can often be identified and resolved, but states’ political wills are complex and difficult to change. Anticipating the effects of a state’s unique politics is particularly challenging because, as these cases show, political actors can harm a program without being opposed to it. Few policymakers, especially in Maryland, were openly hostile to Medicaid. More often, they were focused on other issues and prioritized them over Medicaid enrollment.

This analysis indicates that variations in state policymakers’ attitudes can lead to significant differences in policy outcomes, and therefore argues for stronger federal action to account for diverse state politics. Federal incentives and sanctions may have prevented the problems with Medicaid enrollment decline. Achieving a successful incentive/sanction balance that does not just induce creative evasion is not a simple task. Further compounding the challenge is the inherent problem of monitoring state compliance when states are responsible for policy development. Without a standard to measure against, monitoring implementation is nearly impossible until after problems occur. Still, if states feared sanctions resulting from federal monitoring, their worry may have moved decoupled eligibility higher on policymakers’ priority lists. Compliance in
federalism is made more likely by a recognition that politics continue to influence policy during implementation.
REFERENCES


Birnbaum, Michael, “Health Policy for Low-Income People in Maryland,” The Urban Institute, April, 1999.


prepared for The Pedagogical State, September 24-25, 2008.

Schram, Sanford, Testimony, Hearing Before the Subcommittee on 21st Century Competitiveness of the Committee on Education and the Workforce, House of Representatives, Serial no. 107-30 (September, 2001).


Weaver, Kent, “If You Build It, Will They Come? Overcoming Unforeseen Obstacles to Program Effectiveness,” The Tansley Lecture, April 16, 2009.


Westmoreland, Timothy M., Letter from Health Care Financing Administration Director to State Medicaid Directors, April 7, 2000.
