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## What to Expect When You're Expecting. . .TANF-Style Medicaid Waivers

By Laura D. Hermer

### INTRODUCTION

Medicaid provides access to health care to nearly seventy million lower-income Americans.<sup>1</sup> Traditionally, Medicaid afforded coverage to poor children, parents, disabled individuals, and the elderly, but the Patient Protection and Affordable Care Act (“ACA”) allowed states to expand coverage to all low-income, working-age, non-disabled Americans.<sup>2</sup> Like cash welfare – Temporary Aid for Needy Families (“TANF”) or, before it, Aid to Families with Dependent Children (“AFDC”) – Medicaid is a means-tested program.<sup>3</sup> But Medicaid and its beneficiaries differ in many respects from cash welfare programs and those who receive them.<sup>4</sup> What might happen if Medicaid transformed into something resembling cash welfare: a time-limited welfare program with punitive trappings such as work requirements, compliance check-ins, and penalties for certain behaviors identified as “irresponsible”?

The struggle between these competing visions of Medicaid manifests at both the state and federal levels, and has been gestating for a number of years.<sup>5</sup> Since the early 2000s, proponents of the “welfare” model sought to allow states to reward Medicaid beneficiaries for following stipulated healthy behaviors or punish beneficiaries for failing to do so.<sup>6</sup> Extending this trend, welfare model proponents recently advocated requiring most adult Medicaid beneficiaries to work as a condition of program eligibility or maintenance, notwithstanding the fact that most non-elderly, non-disabled, adult Medicaid

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1. CTRS. FOR MEDICARE & MEDICAID SERVS. *July 2017 Medicaid and CHIP Enrollment Data Highlights*, (August 2017), <https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html>.

2. *See infra*, note 56 and associated text.

3. 42 U.S.C. § 1396a(a)(10)(A) (describing minimum eligibility requirements for Medicaid).

4. *See infra*, note 40 and associated text.

5. *See, e.g.*, Laura Hermer, *On the Expansion of “Welfare” and “Health” under Medicaid*, 9 ST. LOUIS. U. J. HEALTH L. & POL’Y 235, 238–42 (2016).

6. *Id.* at 238–40.

beneficiaries already do work.<sup>7</sup> The Obama administration temporarily arrested this trend through policy changes at the Center for Medicare and Medicaid Services (“CMS”) and the enactment of the ACA, which expanded Medicaid to all adults earning less than 133% of the federal poverty level in participating states without imposing any special requirements on beneficiaries and in the process treating Medicaid more as a social support for average, lower-income Americans such as the Earned Income Tax Credit (“EITC”) rather than as a welfare program such as TANF.<sup>8</sup>

Under the Trump administration, however, proponents of a welfare model of Medicaid are now in power, with ardent, active allies at the federal, state, and local levels.<sup>9</sup> The House of Representative’s version of the American Health Care Act, passed on May 4, 2017, contained a provision allowing states to impose work requirements on “able-bodied” adult Medicaid beneficiaries, and gave participating states a five percent increase in their Federal Medical Assistance Percentages (FMAP) to effectuate the provision.<sup>10</sup> The Senate’s version contained identical provisions.<sup>11</sup> Head administrators at the Department of Health and Human Services (HHS) and a number of states such as Indiana, Maine, and Wisconsin share this vision, proposing work requirements and/or time limits across this so-called “able-bodied” adult Medicaid population.<sup>12</sup> The former Secretary of HHS, Tom

7. See, e.g., INDIANA FAMILY & SOCIAL SERVS. ADMIN., HIP 2.0 Section 1115 Waiver Application (2014), [https://www.in.gov/fssa/hip/files/HIP\\_2\\_0\\_Waiver\\_\(Final\).pdf](https://www.in.gov/fssa/hip/files/HIP_2_0_Waiver_(Final).pdf); Rachel Garfield, Robin Rudowitz, & Anthony Damico, *Understanding the Intersection of Medicaid and Work*, KAISER FAM. FOUND. (Feb. 15, 2017), <https://www.kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-and-work/> (finding that “among the 24 million non-SSI adults (ages 19-64) enrolled in Medicaid in 2015, 6 in 10 (59%) are working themselves”).

8. See, CTRS. FOR MEDICARE & MEDICAID SERVS., *Affordable Care Act in Action at CMS*, <https://www.cms.gov/about-cms/aca/affordable-care-act-in-action-at-cms.html> (last visited Dec. 5, 2017); see also Patient Protection and Affordable Care Act, Pub. L. No. 111–148, § 2001, 124 Stat. 271 (2010).

9. Seema Verma, a proponent of ending Medicaid’s entitlement status and implementing “personal responsibility” requirements in the program, is now the Administrator for the Centers for Medicare and Medicaid Services. As such, she has substantial authority to set federal Medicaid policy. Ms. Verma helped develop the “Healthy Indiana” program under then-Governor of Indiana Mike Pence, who is now Vice President of the United States. See, e.g., CTRS. FOR MEDICARE & MEDICAID SERVS., *CMS Leadership*, <https://www.cms.gov/About-CMS/Leadership/index.html> (last visited Dec. 5, 2017); see also Seema Verma, MPH: President-elect Donald Trump’s Nominee for Administrator of the Centers for Medicare & Medicaid Services, SIDLEY AUSTIN, LLP (Jan. 2017), <https://www.sidley.com/~media/update-pdfs/2017/01/trump-hhs-seema-verma-profile—jan-2017.pdf>.

10. See generally, Cong. Budget Off. Cost Estimate, H.R. 1628: American Health Care Act of 2017 (2017).

11. See generally, Cong. Budget Off. Cost Estimate, H.R. 1628: Better Care Reconciliation Act of 2017 (2017).

12. See Alice Ollstein, *Republicans Have A New Plot To Gut Medicaid And They Don’t*

Price, and current CMS Administrator, Seema Verma, expressly welcomed state § 1115 Medicaid waiver proposals to impose work requirements,<sup>13</sup> and, to date, six states have either submitted such waiver requests, or are preparing to do so.<sup>14</sup> It is likely only a matter of time before work and/or other welfare reform-style requirements (“personal responsibility requirements”) are implemented, whether through an altered Medicaid statute at the federal level, or by granting state § 1115 waiver requests.

Many who believe Medicaid should remain in its traditional form as an open-ended health care program without welfare trappings argue that personal responsibility requirements are inappropriate and counterproductive.<sup>15</sup> These arguments typically are brief, and rest more on conceptual and policy arguments than on an evaluation of empirical evidence.<sup>16</sup> The question thus arises: what evidence, if any, suggests that imposing welfare reform-style requirements on certain Medicaid beneficiaries will yield harmful results to those beneficiaries, or harmful to Medicaid’s programmatic goal of ensuring health care access to low-income Americans? Given the high probability that personal responsibility requirements will, at least at some level, go into effect, it bears considering what to expect.

While one might expect the last two decades to have yielded clear and

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*Need Congress*, TALKING POINTS MEMO, DC (Aug. 17, 2017), <http://talkingpointsmemo.com/dc/medicaid-waivers-trump-hhs>.

13. Letter from Thomas E. Price, Sec’y, Dept. of Health & Human Servs., & Seema Verma, Admin., Ctrs. for Medicare & Medicaid Servs., to the U.S. Governors (Mar. 14, 2017) [hereinafter, Letter from Thomas E. Price and Seema Varna to Governors of the United States] (“Today, we reaffirm the agency’s commitment to support and complement the various federal, state, and local programs that have demonstrated success in assisting eligible low-income adult beneficiaries to improve their economic standing and materially advance in an effort to rise out of poverty. The best way to improve the long-term health of low-income Americans is to empower them with skills and employment. It is our intent to use existing Section 1115 demonstration authority to review and approve meritorious innovations that build on the human dignity that comes with training, employment and independence.”). For an introduction to § 1115 Medicaid waivers, *see, e.g.*, Hermer, *supra* note 5, at 237–38.

14. Elizabeth Hinton et al., *Section 1115 Medicaid Demonstration Waivers: A Look at the Current Landscape of Approved and Pending Waivers*, KAISER FAMILY FOUND. (Aug. 16, 2017), <https://www.kff.org/medicaid/issue-brief/section-1115-medicaid-demonstration-waivers-a-look-at-the-current-landscape-of-approved-and-pending-waivers/>.

15. *See, e.g.*, Nicole Huberfeld & Jessica L. Roberts, *Health Care and the Myth of Self-Reliance*, 57 B.C.L. REV. 1, 6, 15 (2015); Sidney D. Watson, *Out of the Black Box and Into the Light: Using Section 1115 Waivers to Implement the Affordable Care Act’s Medicaid Expansion*, 15 YALE J. HEALTH POL’Y L. ETHICS 213, 227 (2015).

16. Huberfeld & Roberts, *supra* note 15, at 6, 15 (observing that most families with Medicaid already have at least one worker and arguing that such requirements rely on a myth that receipt of means-tested government benefits breeds dependency); Watson, *supra* note 15, at 227 (noting that “work requirements and incentives are not “likely to assist in promoting the objectives’ of the Medicaid program,” and moreover contradict “the ACA’s new inclusive social insurance system”).

substantial evidence of the consequences of state-implemented work requirements in the TANF program, this is not the case.<sup>17</sup> Inadequate collection of data, large loopholes in work requirements, and some states' widely differing implementation policies at the county level makes it difficult to tell, with reliable certainty, what impact work requirements alone had on TANF take-up and retention, let alone any applicability such data might have to Medicaid.<sup>18</sup> That being said, existing data suggests that such requirements in TANF are associated with reduced cash welfare retention and reduced provision of cash benefits.<sup>19</sup> Existing data also suggests that time limits are associated, at least in some situations, with reduced uptake and retention.<sup>20</sup>

The data from TANF would be more useful if the program were implemented uniformly across each state, and if the effects of state policy choices on beneficiary take-up, retention, and outcomes were tracked through careful data collection and analysis. If personal responsibility requirements are imposed in Medicaid, we should similarly insist, to the extent it is feasible, on uniform program implementation and thorough, well-considered collection of data to better study their effects.

The first section of this article provides a brief overview and history of welfare reform-style requirements in Medicaid, and considers pending waiver requests to date, under the Trump administration. The second section evaluates issues with the legality of these pending waiver requests. The third section evaluates existing data on time limits and work requirements in the TANF program, and considers, based on this data, how such requirements might play out if implemented in state Medicaid programs. The article concludes that while time limits will likely have a negative effect on Medicaid uptake and retention, as well as on beneficiary health, the negative effects of work requirements, to the extent that evidence exists for them, may be more limited.

## I. OVERVIEW AND HISTORY OF WELFARE REFORM-STYLE REQUIREMENTS IN MEDICAID

Personal responsibility requirements in means-tested welfare programs are

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17. See *infra*, note 18 and associated text.

18. See Lynn A. Karoly, RAND, Estimating the Effect of Work Requirements on Welfare Recipients: A Synthesis of the National Literation (2001), <https://www.rand.org/content/dam/rand/pubs/testimonies/2005/CT185.pdf>; see also Jeffrey Grogger et al., RAND, Consequences of Welfare Reform: A Research Synthesis (2002), <https://www.acf.hhs.gov/sites/default/files/opre/consequencesofwelfarereform.pdf>.

19. LaDonna Pavetti, *Work Requirements Don't Cut Poverty, Evidence Shows*, CTR. ON BUDGET & POL'Y PRIORITIES (June 7, 2016), <https://www.cbpp.org/research/poverty-and-inequality/work-requirements-dont-cut-poverty-evidence-shows>; Hinton et al., *supra* note 14, at 1, 9.

20. Grogger et al., *supra* note 18, at xvi–xvii, 13.

nothing new.<sup>21</sup> The policies underlying public welfare programs in the United States – typically cash welfare, housing, and/or food – evidence a thoroughgoing skepticism about the deservingness and trustworthiness of those they serve.<sup>22</sup> Work requirements in particular have a long history, tracing their genesis to well before the Elizabethan Poor Law of 1601.<sup>23</sup> This section examines these requirements as implemented in cash welfare and in Medicaid over time, and as proposed to date under the Trump administration.

A. *Personal Responsibility Requirements in Cash Welfare and in Medicaid Prior to the Obama Administration*

Early American colonists continued the Elizabethan Poor Laws' tradition of local, decentralized responsibility for providing relief to the poor while requiring those who were not too sick, old, pregnant, or disabled to work.<sup>24</sup> While policies and rules varied widely by town, county, and state, the able-bodied were generally required to work, whether they lived on their own or, as was more common during the 19<sup>th</sup> century, in publicly funded poorhouses.<sup>25</sup> Many localities provided both "indoor" relief – welfare provided through residence in poorhouses – and "outdoor" relief – welfare provided to those who lived outside of poorhouses or other institutions.<sup>26</sup> However, the perception that outdoor relief engendered laziness and

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21. See generally William P. Quigley, *Five Hundred Years of English Poor Laws, 1349–1834: Regulating the Working and Nonworking Poor*, 30 AKRON L. REV. 73 (1996) [hereinafter, *Five Hundred Years of English Poor Laws*].

22. *Id.* at 92–93 (discussing the punishment of vagrants in a law enacted by Parliament in 1531).

23. For a detailed examination of these requirements over time, see *id.* (discussing the genesis and evolution of laws regulating work, begging, vagrancy, and poorhouses in England from the Statute of Laborers of 1349–1350 through the Reform of the Poor Laws of 1834).

24. William P. Quigley, *Work or Starve: Regulation of the Poor in Colonial America*, 31 U.S.F.L. REV. 35, 42–48 (1996) [hereinafter, *Work or Starve*] (tracing the origins of colonial approaches to poor relief to the English Poor Laws, modified by Puritanism and local conditions); see also James W. Fox, Jr., *Citizenship, Poverty, and Federalism: 1787–1882*, 60 U. PITT. L. REV. 421, 457 (1999) ("The laws governing the poor in colonial America were modeled after the English Poor Laws, which had been comprehensively codified by 1601. The main attributes of these early laws included: local control and responsibility, with some national (English) supervision; a mandate that those who were able-bodied had to work and could be sold into a form of enforced servitude; shaming as an appropriate punishment, including public branding and incarceration for non-work; a legal obligation for families of the poor to care for children and the elderly; use of forced apprenticeship for needy children; and public provision of food and medical care for the poor who were physically or mentally unable to work or obtain family support." (internal citations omitted)).

25. MICHAEL B. KATZ, *IN THE SHADOW OF THE POORHOUSE: A SOCIAL HISTORY OF WELFARE IN AMERICA* 38–40 (1986); but see also E. Munsterberg, *Poor Relief in the United States: View of a German Expert*, 7 AM. J. SOC. 501, 518–19, 522–23 (1902) (observing that, in many of the largest cities, outdoor relief had been entirely eliminated, even for those who are unable to work due to age or disability).

26. KATZ, *supra* note 25, at 41–43.

immorality among the poor led to reductions in the amount of outdoor relief as the 19<sup>th</sup> century progressed.<sup>27</sup>

Although most American poorhouses were eliminated by the 1930s, public sentiment about welfare recipients remained skeptical.<sup>28</sup> Aid to Dependent Children – a cooperative federal/state program enacted as part of the Social Security Act of 1935 and later broadened in the 1960s and renamed Aid to Families with Dependent Children (AFDC) – became a lightning rod for those who saw it as taxpayer funding for sloth, vice, and unwed motherhood.<sup>29</sup> This negative view not only persisted but grew during the 1980s, when some states sought and obtained waivers to implement work requirements in their cash welfare programs in the 1980s.<sup>30</sup> Building on this trend, in 1996 a Republican Congress, aided by President Bill Clinton, enacted the Personal Responsibility and Work Opportunity Act (“PRWORA”).<sup>31</sup> PRWORA ended cash welfare as an entitlement by block-granting federal funding to states, imposing a five-year, lifetime limit on benefits, and devolving most of the authority to develop rules for the new program, TANF to the states.<sup>32</sup> PRWORA requires states to ensure that fifty percent of its TANF recipients work or are involved in other qualifying activities, although there is substantial variability in the implementation of the requirement due to flexibility in law and associated regulations.<sup>33</sup> Under PRWORA, states also maintain considerable discretion to decide how to spend their block grants, whether on cash welfare to TANF recipients, work and training support, marriage promotion activities, child protective services,

27. *Id.* at 18–19, 41–43; *see also* Kenneth Hudson & Andrea Coukos, *The Dark Side of the Protestant Ethic: A Comparative Analysis of Welfare Reform*, 23 SOC. THEORY 1, 7–9, 12–13 (2005) (discussing, *inter alia*, widespread public belief that charity and welfare encourages the able-bodied poor to laziness and dependency, and the role that this belief has played in American welfare policy).

28. Peter L. Szanton, *The Remarkable “Quango”: Knowledge, Politics, and Welfare Reform*, 10 J. POL’Y ANALYSIS & MGMT 590, 592 (1991).

29. *Id.* (observing that, while “early recipients had been seen as victims of fate; many now seemed casually and voluntarily dependent”).

30. *See, e.g.*, JOEL F. HANDLER & YEHESEKEL HASENFELD, *BLAME WELFARE, IGNORE POVERTY AND INEQUALITY* 182 (2007) (“[b]y 1996, there were waivers in forty-three states. Some states cut benefits; others offered work incentives, including combining welfare with work, transitional child care and health care”); Szanton, *supra* note 28, at 592, 595–97 (noting that roughly half of all states developed demonstration programs in their Aid to Families with Dependent Children programs in the 1980s, and discussing the work of the Manpower Demonstration Research Corporation to evaluate the programs); *see also* Pamela Loprest et al., *Welfare Reform under PRWORA: Aid to Children with Working Families?*, 14 TAX POL’Y & THE ECON 157, 161–62 (2000).

31. Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. No. 104–193, 110 Stat. 2105 (codified as amended in scattered sections of 42, 8, & 7 U.S.C.).

32. 42 U.S.C. § 603(a) (2017); 42 U.S.C. § 608(a)(7) (2017).

33. 42 U.S.C. § 607(a)–(d) (2017); *see also* KATZ, *supra* note 25 and associated text.

or otherwise.<sup>34</sup>

Joel Handler and Yeheskel Hasenfeld characterize the negative attitudes toward the poor and the programs that help them, including PRWORA, as follows:

[u]nless welfare programs are harsh and stigmatizing, [single mothers on welfare] will be encouraged to have children, shun marriage, and perpetuate dependency. Who would choose welfare over a “normal” family life? Only those women who lack the proper values of majoritarian America.<sup>35</sup>

Scholars have identified the recurring nature of negative themes in U.S. welfare policy.<sup>36</sup> Among them: welfare should be a last resort, and should be a worse alternative than working in a low-wage job; poor people who can work should work; and welfare is harmful to the poor.<sup>37</sup> The underlying concern connecting these views is that the use of social welfare programs leads to dependence, to the detriment of both the beneficiary and society.<sup>38</sup> Welfare, according to this theory, encourages laziness, dependence, and immorality, all on the public fisc.<sup>39</sup>

Unlike cash welfare, Congress did not treat Medicaid as a handout

34. 42 U.S.C. § 604(a)–(h) (2017); *see also* GENERAL ACCOUNTING OFFICE, WELFARE REFORM: EARLY FISCAL EFFECTS OF THE TANF BLOCK GRANT 7–8 (1998) (“[S]tate MOE [maintenance of effort] funds may be used with more flexibility than TANF funds. TANF grant funds may be used for cash assistance, child care assistance, work placement programs, subsidized work programs and other efforts not specifically prohibited by PRWORA. MOE funds can be used not only for these purposes but also to provide benefits to some recipients excluded from TANF assistance. States make these budgetary decisions as part of their regular appropriations process.”).

35. HANDLER & HASENFELD, *supra* note 30, at 151.

36. *See, e.g., id.* at 151–85 (noting these features, particularly as applied to women of color and notwithstanding the rehabilitative interlude of the War on Poverty); *Five Hundred Years of English Poor Laws*, *supra* note 21, at 103–06 (detailing similarities between these ideas as instantiated in PRWORA and the English Poor Laws); Margaret R. Somers & Fred Block, *From Poverty to Perversity: Ideas, Markets, and Institutions over 200 Years of Welfare*, 70 AM. SOCIOLOGICAL REV., 260, 277–80 (2005) (detailing the Malthusian underpinnings of these ideas as expressed by conservative U.S. scholars); Hudson & Coukos, *supra* note 27, at 8–13 (showing connections between these ideas as expressed by conservative U.S. scholars and those embedded in Puritan theology).

37. HANDLER & HASENFELD, *supra* note 30, at 151–85; *Five Hundred Years of English Poor Laws*, *supra* note 21, at 103–06; Somers & Block, *supra* note 36, at 277–80; Hudson & Coukos, *supra* note 27, at 8–13.

38. *See generally*, HANDLER & HASENFELD, *supra* note 30; *Five Hundred Years of English Poor Laws*, *supra* note 21; Somers & Block, *supra* note 36; Hudson & Coukos, *supra* note 27.

39. HANDLER & HASENFELD, *supra* note 30, at 151–85; *Five Hundred Years of English Poor Laws*, *supra* note 21, at 103–06; Somers & Block, *supra* note 36, at 277–80; Hudson & Coukos, *supra* note 27, at 8–13.



begetting indolence, vice, and sloth when PRWORA was enacted.<sup>40</sup> Medicaid and cash welfare had been tightly linked for most of Medicaid's existence. When it enacted PRWORA, Congress separated Medicaid from the new TANF program and preserved Medicaid intact.<sup>41</sup>

The subsequent twenty years saw an increased push among many right-wing politicians and policy advocates, not merely to weaken provisions that protect many beneficiaries from meaningful out-of-pocket expenses and guarantee a rich panoply of benefits to all beneficiaries in all regions of each state, but also to label Medicaid as yet another expensive and dependence-creating government handout that discourages the poor from pulling themselves out of poverty.<sup>42</sup> Although subsequent Republican attempts failed to block-grant Medicaid, the Deficit Reduction Act of 2005 successfully raised cost-sharing amounts for Medicaid beneficiaries earning more than 100% of the federal poverty level ("FPL") and allowed states to offer "benchmark" benefits closely resembling the more limited benefits offered in private health insurance plans to certain categories of beneficiaries.<sup>43</sup>

At the same time, several states sought Medicaid § 1115 waivers that undercut Medicaid's status as a public entitlement program that offers a standard set of benefits to categorical and optional beneficiaries.<sup>44</sup> Utah, for example, successfully obtained a waiver that diminished benefits for certain categorically-eligible beneficiaries in order to pay for minimal primary care benefits for individuals who are not otherwise eligible for Medicaid.<sup>45</sup> Florida obtained permission from the Bush administration to require Medicaid beneficiaries in several counties to pick among different private managed care plans and use a health savings account, or else forego coverage until automatic enrollment, all in the name of "training" them how to use private

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40. Marilyn R. Ellwood & Leighton Ku, *Welfare and Immigration Reforms: Unintended Side-Effects for Medicaid*, 17 HEALTH AFFAIRS 137, 138 (1998).

41. *Id.* ("PRWORA tried to minimize the adverse effects of welfare reform on Medicaid by decoupling welfare and Medicaid"). Republicans in Congress wanted to block-grant Medicaid at the same time it enacted PRWORA. *See, e.g.*, Nancy E. Roman, *Welfare Bill Debate to Exclude Medicaid*, WASHINGTON TIMES (July 18, 1996) (discussing the negotiations that took place between House Republicans, who were moving forward with a bill that would both block-grant both Medicaid and AFDC, and President Clinton, who, as then-press specialist for the House Ways and Means Committee Ari Fleischer noted, "would veto a welfare-Medicaid bill"). President Clinton, however, insisted that the Medicaid provisions be removed from the welfare reform provisions as a condition of ultimately signing PRWORA into law, and the Republicans agreed. Roman, *supra*; *see also* Richard Wolf, *House Tries Again at Welfare Reform*, USA TODAY (July 18, 1996); Huberfeld & Roberts, *supra* note 15, at 7.

42. Huberfeld & Roberts, *supra* note 15, at 7.

43. Deficit Reduction Act of 2005, Pub. L. No. 109-171, 120 Stat. 4 (codified as amended in scattered sections of 7, 12, 19, 20, 26, 28, 29, 42, 47 U.S.C.).

44. *See infra* note 47, 53, 54, (showing various 1115 waiver requests by many states).

45. Utah Department of Health, Utah 1115 Demonstration Waiver (2016).

coverage.<sup>46</sup> Indiana, too, sought to “train” a subset of its otherwise uninsured, lower-income, adult population to be responsible and use private, high-deductible health plans funded in part by Medicaid dollars diverted, via a § 1115 waiver, from hospitals providing care to low-income Medicaid and uninsured patients.<sup>47</sup> West Virginia obtained permission to require Medicaid families with dependent children to opt for an “enhanced” benefit package by signing a “personal responsibility” pledge or else be automatically shunted into a “basic” benefit package lacking certain inpatient psychiatric services, certain rehabilitative and weight management services, and prescription drug benefits, among others.<sup>48</sup>

*B. Personal Responsibility Requirements in Medicaid Under the Obama Administration*

Under the Obama administration, these experiments briefly faded. However, they were given new life when the Supreme Court made the Affordable Care Act’s Medicaid expansion optional.<sup>49</sup> The Obama administration became willing to entertain proposals from majority-Republican states seeking §1115 waivers to experiment with certain features of their Medicaid programs, in exchange for expanding Medicaid.<sup>50</sup> As such,

46. Joan Alker & Lisa Portelli, *Understanding Florida’s Medicaid Reform Legislation*, 4 WINTER PARK HEALTH FOUND. 1, 7 (2005).

47. CTRS. FOR MEDICARE & MEDICAID SERVS., *Healthy Indiana Plan: Special Terms and Conditions*, 2 (2007) (discussing how the state allocated 40% of its disproportionate share hospital (DSH) funds to the program); see IND. FAMILY & SOC. SERVS. ADMIN., *The Healthy Indiana Plan: Section 1115 Affordable Choices Demonstration Proposal* 1, 41–42 (2007).

48. WEST VIRGINIA BUREAU FOR MEDICAL SERVS., MEDICAID PROVIDER MANUAL, §§ 527.1; 527.4; 527.4.1; 527.4.2; Appendix 2 & Appendix 4 (2009) (“The goal of Mountain Health Choices is to promote health and reward Medicaid members who choose to be personally responsible for their own healthcare and to adopt healthier lifestyles.”). Mountain Health Choices expired in 2013. See, e.g., *The Use of Healthy Behavior Incentives in Medicaid* MACPAC. 5, 1, 14 (2016), <https://www.macpac.gov/wp-content/uploads/2016/08/The-Use-of-Healthy-Behavior-Incentives-in-Medicaid.pdf>.

49. Nat’l Fed’n of Indep. Bus. v. Sebelius, 567 U.S. 519, 576 (2012) (requiring states to expand Medicaid to all non-elderly, non-disabled adults earning up to 133% of the federal poverty level). While the Court struck down the mandatory nature of the expansion, “[n]othing in our opinion precludes Congress from offering funds under the Affordable Care Act to expand the availability of health care, and requiring that all States accepting such funds comply with the conditions on their use. What Congress is not free to do is to penalize States that choose not to participate in that new program by taking away their existing Medicaid funding. Section 1396c gives the Secretary of Health and Human Services the authority to do just that. It allows her to withhold *all* ‘further [Medicaid] payments . . . to the State’ if she determines that the State is out of compliance with any Medicaid requirement, including those contained in the expansion. . . . In light of the Court’s holding, the Secretary cannot apply §1396 to withdraw existing Medicaid funds for failure to comply with the requirements set out in the expansion.” *Id.* at 585.

50. Elizabeth Mann & Molly E. Reynolds, *Republican-Controlled States Might be Trump’s Best Hope to Reform Health Care*, BROOKINGS (Aug. 17, 2017),

seven Republican-led states sought to impose even bolder changes to their Medicaid programs than previously made under the Bush Administration.<sup>51</sup> While the details of these expansions differed, some common themes emerged.<sup>52</sup> First, several states sought to accomplish the expansion using private coverage.<sup>53</sup> Second, several states wanted to eliminate certain traditionally generous features of Medicaid not typically found in private plans, such as coverage of non-emergency medical transportation costs and three-month retroactive eligibility.<sup>54</sup> Finally, several states sought to impose

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<https://www.brookings.edu/blog/fixgov/2017/08/17/republican-controlled-states-might-be-trumps-best-hope-to-reform-health-care/>.

51. See *infra*, note 56.

52. See *infra*, notes 53, 54, and 55.

53. ARKANSAS CENTER FOR HEALTH IMPROVEMENT, *Arkansas Health Care Independence Program ("Private Option"): Proposed Evaluation for § 1115 Demonstration Waiver* (2014), <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/1115/downloads/ar/health-care-independence-program-private-option/ar-private-option-demo-waiver-proposed-eval-02202014.pdf> ("Through a Section 1115 demonstration waiver, the State will utilize premium assistance to secure private health coverage offered on the newly formed individual health insurance marketplace (the Marketplace) to individuals who are ages 19–64 years with incomes at or below 138 percent of the federal poverty level (FPL)"); Letter from Andrew Slavitt, Acting Administrator, CMS, to Chris Priest, Director, Michigan Medical Services Administration (Dec. 17, 2015) ("...[B]eginning on April 1, 2018, which is 48 months after the initial implementation of the Healthy Michigan Plan, all beneficiaries in the demonstration with incomes above 100 percent of the FPL and who are not medically frail will have the opportunity to choose between coverage through a Healthy Michigan Plan or through a Qualified Health Plan offered on the Marketplace. . ."); Letter from Andrew Slavitt, Acting Administrator, Centers for Medicare & Medicaid Services, to Nicholas A. Toumpas, Commissioner, New Hampshire Department of Health and Human Services (March 4, 2015) ("The demonstration will affect non-medically frail individuals aged 19-64 in the new adult coverage group. The approved demonstration provides authority to New Hampshire to provide premium assistance to such individuals in the new adult group to enable them to enroll in qualified health plans (QHPs) offered in the Marketplace").

54. Letter from Marilyn Tavenner, Administrator, Centers for Medicare & Medicaid Services, to Jennifer Vermeer, Medicaid Director, State of Iowa (Dec. 10, 2013) ("Under the demonstration, the state is relieved of the responsibility to assure non-emergency medical transportation to and from the providers"); CTRS. MEDICARE & MEDICAID SERV., *Healthy Indiana Plan 2.0 Section 1115 Medicaid Demonstration Fact Sheet 2* (2015) ("The demonstration provides authority for the state to not offer non-emergency medical transportation (NEMT) for the new adult group during the first year of the demonstration; this authority may be extended subject to evaluation regarding the impact of this policy on access to care. Also reflecting the unique design of HIP 2.0, coverage will be effective: 1) the first day in the month in which an individual makes a POWER account contribution; or, for those with incomes at or below 100 percent of the FPL who do not make a POWER account contribution, coverage will start 2) the first of the month in which the 60 days payment period expires"); Letter from Andrew Slavitt, Acting Administrator, CMS, to Nicholas A. Toumpas, Commissioner, New Hampshire Department of Health and Human Services ("The demonstration includes a conditional waiver of retroactive coverage, with implementation of the waiver conditioned upon receipt of data demonstrating that the state's coverage system provides a seamless eligibility determination experience the beneficiary that ensures that the beneficiary will not have periods of uninsurance").

“personal responsibility” requirements on beneficiaries, ranging from incentives to utilize preventive health measures to imposing higher copayments or requiring beneficiaries to work in order to remain enrolled.<sup>55</sup>

Arizona, Arkansas, Indiana, Iowa, Michigan, Montana and New Hampshire obtained waivers from CMS allowing them to charge at least some expansion beneficiaries copayments, coinsurance, or contributions to be added to health savings accounts (termed by requesting states as “premiums”).<sup>56</sup> In the case of contributions to health savings accounts, beneficiaries making the required payments of these premiums can use them toward out-of-pocket costs for care.<sup>57</sup> In some cases, contributions to health savings accounts are made in lieu of cost-sharing.<sup>58</sup> Additionally, in some states, if beneficiaries obtain preventive services, they are allowed to pay no premiums, pay lower premiums, and/or roll premium contributions over from year to year.<sup>59</sup> Moreover, several of these states obtained permission to

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55. Jane B. Wishner et al., *Medicaid Expansion, the Private Option, and Personal Responsibility Requirements: The Use of Section 1115 Waivers to Implement Medicaid Expansion Under the ACA*, 4 URB. INST. (2015).

56. CTRS FOR MEDICARE & MEDICAID SERVS., *Special Terms and Conditions: Arizona Health Care Cost Containment System Medicaid Section 1115 Demonstration* 12–13 (2012) [https://www.azahcccs.gov/Members/Downloads/KidsCareII/AZ\\_SNCP\\_ProtocolApproval\\_STCs.pdf](https://www.azahcccs.gov/Members/Downloads/KidsCareII/AZ_SNCP_ProtocolApproval_STCs.pdf); CTRS FOR MEDICARE & MEDICAID SERVS., *Special Terms and Conditions, Arkansas Works* 18–19 (2016) <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ar/ar-works-ca.pdf>; CTRS. MEDICARE & MEDICAID SERV., *Special Terms and Conditions, Healthy Indiana Plan 2.0* 17–31 (2015) <https://www.medicaid.gov/MedicaidCHIPProgramInformation/ByTopics/Waivers/1115/downloads/in/in-healthy-indiana-plan-support-20-pa5.pdf>; CTRS. FOR MEDICARE & MEDICAID SERVS., *Special Terms and Conditions, Iowa Marketplace Choice Plan* 16–19 (2014) <https://dhs.iowa.gov/sites/default/files/Marketplace%20Choice%20STCs%20NEMT%20Amendment%202015%207.30.2015.pdf>; CTRS. FOR MEDICARE & MEDICAID SERVS., *Special Terms and Conditions, Healthy Michigan Section 1115 Demonstration* 12–17 (2017) <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/mi/mi-healthy-michigan-ca.pdf>; CTRS. FOR MEDICARE & MEDICAID SERVS., *Special Terms and Conditions, Montana Health and Economic Livelihood Partnership (HELP) Program Demonstration* 10–12 (2016) <http://dphhs.mt.gov/Portals/85/hrd/documents/1115/ApprovedMTHelpSection1115Waiver.pdf>; CTRS. FOR MEDICARE & MEDICAID SERVS., *Special Terms and Conditions, New Hampshire Health Protection Program Premium Assistance* 17, 32 (2017) <https://www.medicaid.gov/MedicaidCHIPProgramInformation/ByTopics/Waivers/1115/downloads/nh/nh-health-protection-program-premium-assistance-ca.pdf>.

57. See *Healthy Indiana Plan 2.0*, *supra* note 56, at 8; *Healthy Michigan Section 1115 Demonstration*, *supra* note 56, at 12–13; *Montana Health and Economic Livelihood Partnership*, *supra* note 56, at 2.

58. *Healthy Indiana Plan 2.0*, *supra* note 56, at 22; *Healthy Michigan Section 1115 Demonstration*, *supra* note 56, at 12–13; *Montana Health and Economic Livelihood Partnership* *Montana Health and Economic Livelihood Partnership*, *supra* note 56 at 2; *Iowa Marketplace Choice Plan*, *supra* note 56 at 17.

59. *Healthy Indiana Plan 2.0*, *supra* note 56, at 2, 23; *Iowa Marketplace Choice Plan*, *supra* note 56, at 48; *Healthy Michigan Section 1115 Demonstration*, *supra* note 56, at 2, 13–15.

disenroll beneficiaries earning more than the federal poverty level if they fail to pay the required premiums.<sup>60</sup> Some states additionally or alternatively provide noncompliant, higher-earning beneficiaries with only a limited benefit package.<sup>61</sup> In Arizona, Iowa, and Montana, a beneficiary can re-enroll by paying what they owe.<sup>62</sup> In Indiana, however, beneficiaries who are disenrolled for non-payment can be prohibited from resuming coverage for six months.<sup>63</sup> Arizona, Indiana, Michigan, and Montana justified their personal responsibility provisions as ostensibly helping beneficiaries become better consumers of health care services, often with an eye toward pushing them into private coverage.<sup>64</sup>

While the Obama administration allowed the waiver features discussed above, it disallowed others on the ground that they did not support the objectives of Medicaid and could hinder access to care.<sup>65</sup> For example, Arizona sought to impose non-nominal cost-sharing onto expansion beneficiaries earning less than the federal poverty level, exclude beneficiaries from coverage for six months if they fail to timely contribute to their health spending account, impose a work requirement, charge fees for missed

60. *Healthy Indiana Plan 2.0*, *supra* note 56; *Arizona Health Care Cost Containment System*, *supra* note 56, at 21; *Iowa Marketplace Choice Plan*, *supra* note 56, at 49; *Montana Health and Economic Livelihood Partnership (HELP)*, *supra* note 56, at 10. (explaining beneficiaries earning over the federal poverty level can be disenrolled; those earning 100% or less of the federal poverty level cannot be disenrolled, but their unpaid share is counted as a debt against them).

61. CTRS. FOR MEDICARE & MEDICAID SERVS., *Healthy Indiana Plan (HIP) 2.0*, 24 (2015) [https://www.in.gov/fssa/hip/files/HIP\\_CMS\\_Approved\\_STC\\_Technical\\_Corrections\\_5.14.15.pdf](https://www.in.gov/fssa/hip/files/HIP_CMS_Approved_STC_Technical_Corrections_5.14.15.pdf); CTRS. FOR MEDICARE & MEDICAID SERVS., *Healthy Michigan Section 1115 Demonstration*, *supra* note 56, at 11.

62. *Arizona Health Care Cost Containment System*, *supra* note 56, at 23; *Iowa Marketplace Choice Plan*, *supra* note 56, at 49; *Montana Health and Economic Livelihood Partnership (HELP)*, *supra* note 56, at 2 (explaining beneficiaries earning over the federal poverty level can be reenrolled upon payment of their liability or upon assessment of the debt against them by the state).

63. *See Healthy Indiana Plan 2.0 Fact Sheet*, *supra* note 53, at 2.

64. *See Arizona Health Care Cost Containment System*, *supra* note 56, at 39 (giving one goal as “transitioning eligible enrollees in the Demonstration to Medicaid, the Exchange or other coverage options”); *Healthy Indiana Plan 2.0* *supra* note 61, at 8 (“Robust participation in Gateway to Work will encourage member self-sufficiency and foster an eventual transition to the private market”); *Healthy Michigan 1115 Demonstration*, *supra* note 61, at 3 (stating that the goals of the plan include an examination of, “Whether the availability of affordable health insurance, which provides coverage for preventive and health and wellness activities, will increase healthy behaviors and improve health outcomes”); CTRS. FOR MEDICARE & MEDICAID SERVS., *Montana Health and Economic Livelihood Partnership (HELP) Program Demonstration* (2016) <http://dphhs.mt.gov/Portals/85/hrd/documents/1115/ApprovedMTHelpSection1115Waiver.pdf> (“Premiums and copayment liability will encourage HELP Program enrollees to be discerning health care purchasers, take personal responsibility for their health care decisions and develop health-conscious behaviors as consumers of health care services.”).

65. *See* Letter from Andrew Slavitt to Thomas Betlach, *infra* note 66.

appointments and impose both monthly income and work verification requirements and a five-year lifetime limit on coverage.<sup>66</sup> However, CMS did not approve these features.<sup>67</sup> Other states wanted to impose work requirements, but the Obama administration only permitted states to offer voluntary employment support activities and did not consider them to be part of any granted waiver.<sup>68</sup>

*C. Waiver Requests Involving Personal Responsibility Requirements  
Under the Trump Administration*

Under the Trump administration, the situation is different. One of now-former Secretary Price's and Administrator Verma's first acts following their confirmations was to issue a joint letter to state governors, "ushering in a new era for the federal and state Medicaid partnership where states have more freedom to design programs that meet the spectrum of diverse needs of their Medicaid population."<sup>69</sup> They promised to "fast-track" waiver approvals and demonstration extensions, and noted special interest in demonstrations seeking to impose work requirements and provisions that "align" Medicaid and private coverage for non-disabled adults.<sup>70</sup>

Some states accepted the offer, or are in the process of doing so.<sup>71</sup> For example, Arizona plans to resubmit its original waiver request, including the

66. Letter from Andrew Slavitt, Acting Administrator, Ctrs for Medicare & Medicaid Servs., to Thomas Betlach, Director, Arizona Health Care Cost Containment System (Sept. 30, 2016) at 3 [hereinafter, Letter from Andrew Slavitt to Thomas Betlach] <https://www.medicaid.gov/MedicaidCHIPProgramInformation/ByTopics/Waivers/1115/downloads/az/Health-Care-Cost-Containment-System/az-hccc-demo-ext-09302016.pdf>; *see also* Arizona Health Care Cost Containment System, *supra* note 56, at 16–18.

67. *See* Letter from Andrew Slavitt to Thomas Betlach, *supra* note 66, at 2–3.

68. One goal of Kentucky's pending application is to "[e]mpower people to seek employment and transition to commercial health insurance coverage." CABINET FOR HEALTH & FAM. SERVS., KENTUCKY HEALTH WAIVER APPLICATION 13 (2016) <http://chfs.ky.gov/NR/rdonlyres/A7F17FE37E2D40EFB4045D8D12DB9EAB/0/62216KentuckyHEALTHWaiverProposal.pdf> (describing how the now-terminated "Healthy Pennsylvania" waiver originally sought to impose a work requirement, but the state ultimately instead opted to provide optional job encouragement services that CMS did not consider to be part of the waiver); *see* Letter from Marilyn Tavenner, Administrator, Ctrs. Medicare & Medicaid Servs., to Beverly Mackereth, Secretary, Pennsylvania Department of Pub. Welfare 2 (August 18, 2014); Ind. Family & Social Servs. Admin., *Healthy Indiana Plan Draft Evaluation Design* 48 (2015) <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-draft-state-eval-design-06012015.pdf> (noting how Indiana attached a voluntary work referral program ("Gateway to Work") to its waiver. CMS did not include it as part of the waiver, but Indiana made it clear in its evaluation plan that it considers Gateway to Work to be part of the waiver plan and included it as an express waiver evaluation goal).

69. Letter from Thomas Price and Seema Verma to Governors of the United States, *supra* note 13.

70. *Id.* at 2.

71. *Id.*

previously-requested five-year lifetime limitation on coverage for the expansion population and work requirements.<sup>72</sup> Maine submitted a waiver request seeking permission to impose work requirements for “able-bodied” applicants who request more than three months of coverage every three years.<sup>73</sup> Maine also seeks, among other things, to eliminate both retroactive eligibility and hospital determinations of presumptive eligibility for most beneficiaries, ostensibly to encourage people to apply when healthy for coverage rather than waiting until they are sick.<sup>74</sup> Two of Maine’s three stated goals for its waiver request are “[t]o promote financial independence and transitions to employer sponsored or other commercial health insurance” and “[t]o encourage individual responsibility for one’s health and health care costs.”<sup>75</sup>

Wisconsin proposes to charge double the premium to beneficiaries who fail to control so-called “health risk behaviors” – use of alcohol, illicit drugs, or cigarettes, being overweight, or not using seatbelts.<sup>76</sup> It wants permission to impose a 48-month time limit on all expansion adults age 18-49 that can be tolled only if the beneficiary is engaged in eligible work activities.<sup>77</sup> Wisconsin also proposes to question all applicants about illicit drug use and test those whose responses indicate they may have a problem.<sup>78</sup> Those who test positive without a valid prescription must enter treatment, if available, or else lose eligibility for benefits.<sup>79</sup>

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72. *Id.*

73. MAINE DEP’T OF HEALTH & HUMAN SERV., *Section 1115 Waiver Application Draft* 5–7 (2017) [hereinafter, *Maine Waiver Application*], [http://www.maine.gov/dhhs/oms/documents/Draft\\_MaineCare\\_1115\\_application.pdf](http://www.maine.gov/dhhs/oms/documents/Draft_MaineCare_1115_application.pdf).

74. *Id.* at 11–12; MaineCare Services, *Section 1115 Demonstration Waiver-MaineCare Reform* (Sept. 9, 2017), <http://www.maine.gov/dhhs/oms/rules/demonstration-waivers.shtml> (Maine had additionally proposed charging beneficiaries for missed physician appointments, but removed this provision in the submitted waiver request); Letter from Ricker Hamilton, Acting Commissioner Dept. of Health and Human Servs., to Thomas E. Price, U.S. Sec. of Health & Human Servs. 58 (Aug. 1, 2017) [hereinafter, Letter from Ricker Hamilton to Thomas E. Price] [http://www.maine.gov/dhhs/oms/rules/MaineCare\\_1115\\_application\\_080217\\_to%20submit.pdf](http://www.maine.gov/dhhs/oms/rules/MaineCare_1115_application_080217_to%20submit.pdf).

75. *Maine Waiver Application*, *supra* note 73, at 4.

76. Letter from Michael Heifetz, Medicaid Dir., State of Wis., to, Brian Neale, Deputy Admin., Ctrs. For Medicare & Medicaid Servs. 8–9 (June 7, 2017), <https://www.dhs.wisconsin.gov/badgercareplus/clawaiver-finalapp.pdf>.

77. *Id.* at 10. (differing from Arizona’s proposed limit, Wisconsin does not have a lifetime limit. Rather, once a beneficiary has been covered for 48 months, excluding periods of tolling, then he will lose coverage and may reapply only after six months have passed).

78. *Id.* at 11–12.

79. *Id.* Programs of this sort have been shown to be administratively complex and costly, with little benefit. *See, e.g.,* Lizette Alvarez, *No Savings Are Found from Welfare Drug Tests*, N.Y. TIMES (Apr. 17, 2012), <http://www.nytimes.com/2012/04/18/us/no-savings-found-in-florida-welfare-drug-tests.html>.

These are not the only states that seek, or are likely to seek, restrictive waivers with personal responsibility requirements. However, they exemplify the direction that some states are moving with respect to their Medicaid programs.<sup>80</sup> These states are willing to accept a somewhat less restrictive view of Medicaid eligibility, but only if they are allowed to use Medicaid as a tool to reshape beneficiaries' lives.<sup>81</sup>

## II. CHALLENGES TO WAIVER REQUESTS

At the time of this writing, twenty-one waiver requests have been submitted to CMS during the Trump administration.<sup>82</sup> Requests for Medicaid waivers under § 1115 of the Social Security Act must meet a number of requirements to be lawfully granted.<sup>83</sup> Here, I examine the requirement that § 1115 waivers may only be granted if the Secretary finds they are, "likely to assist in promoting the objectives of title ... XIX."<sup>84</sup> Congress enacted Medicaid to provide "medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services."<sup>85</sup> Unlike the purpose of TANF or even the former AFDC statute, Medicaid's statement of purpose does not reflect an objective that beneficiaries should strive to become self-supporting by obtaining jobs.<sup>86</sup> Both waiver-seeking

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80. Indiana, Arkansas, Kentucky, and Utah are among additional states either seeking permission to impose personal responsibility requirements or considering doing so. For more information *see, e.g.*, Hinton et al., *supra* note 14.

81. This policy orientation is based on the writings of Lawrence Mead and others who seek to use welfare programs to "tell the poor what to do." *See* Mead, *infra* note 192 and associated text.

82. *See* Hinton et al., *supra* note 14.

83. *See generally*, 42 C.F.R. 431 (2016) (providing rules for requesting and obtaining a Medicaid or CHIP § 1115 waiver, including requirements for state and federal public notice, specific content in the application, and waiver monitoring, compliance, and evaluation); *see also* Beno v. Shalala, 30 F.3d 1057, 1069 (9th Cir. 1994) (providing that "[o]n its face, the statute allows waivers only (1) for experimental, demonstration or pilot projects, which (2) in the judgment of the Secretary are likely to assist in promoting the objectives of the Social Security Act and only (3) for the extent and period she finds necessary. Thus, while the Secretary has considerable discretion to decide which projects meet these criteria, she must, at a minimum, examine each of these issues").

84. 42 U.S.C. § 1315(a)(1) (2014); Title XIX is where Medicaid is codified.

85. *See* SOCIAL SECURITY ADMINISTRATION, COMPILATION OF SOCIAL SECURITY LAWS, [https://www.ssa.gov/OP\\_Home/ssact/title19/1901.htm](https://www.ssa.gov/OP_Home/ssact/title19/1901.htm); 42 U.S.C. § 1396-1 (2017). (appropriating financial assistance to families with dependent children and of aged, blind, or disable individuals); *see also* California Welfare Rights Org. v. Richardson, 348 F. Supp. 491 (1972) (holding that the "California co-payment experiment" was not in excess of the authority vested in the Secretary to approve experimental, pilot, or demonstration projects).

86. 42 U.S.C. § 601(a) (1997). TANF's purpose is to "(1) provide assistance to needy families so that children may be cared for in their own homes or in the homes of relatives; (2) end the dependence of needy parents on government benefits by promoting job preparation,



states and the Secretary of Health and Human Services must keep the objectives of Medicaid in mind when drafting and evaluating waiver requests, as failure to adhere to them may result in either denial of the waiver,<sup>87</sup> or a judicial finding that the grant was improper.<sup>88</sup> Notably, HHS

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work, and marriage; (3) prevent and reduce the incidence of out-of-wedlock pregnancies and establish annual numerical goals for preventing and reducing the incidence of these pregnancies; and (4) encourage the formation and maintenance of two-parent families.” TANF clearly contemplates moving recipients off of TANF and other programs and into the workforce. AFDC’s purpose, in contrast, was to “encourage[e] the care of dependent children in their own homes or in the homes of relatives by enabling each State to furnish financial assistance and rehabilitation and other services...to needy dependent children and the parents or relatives with whom they are living to help maintain and strengthen family life and to help such parents or relatives to attain or retain capability for the maximum self-support and personal independence consistent with the maintenance of continuing parental care and protection....” 42 U.S.C. § 601 (1995). While aspects of the language of AFDC’s purpose may appear analogous to Medicaid’s purpose, the fact that AFDC (and now TANF) provided cash benefits, whereas Medicaid provides health benefits, is salient. The primary – and often in the case of low-wage jobs, sole – form of compensation for employment is money. Only some jobs, however, additionally provide benefits such as health insurance. *See, e.g.,* KAISER FAMILY FOUND. EMP. HEALTH BENEFITS 2016 ANNUAL SURVEY (2016), <http://files.kff.org/attachment/Report-Employer-Health-Benefits-2016-Annual-Survey>. Low-wage jobs, in particular, rarely provide health insurance, yet these are precisely the jobs that Medicaid beneficiaries are likely to have or obtain. *Id.* The reason for this becomes clear when one considers that the annual wages for low-wage jobs are often little more, or even less, than the average cost of an employer-sponsored health insurance policy. *Id.* For further information about this subject, *see, e.g.,* Sara R. Collins et al., *On the Edge: Low Wage Workers and Their Health Insurance Coverage*, 38 INQUIRY 331, 332–33 (2013) (explaining why it is much less likely for low wage workers to have access to health insurance coverage).

87. *See, e.g.,* Letter from Andrew Slavitt to Thomas Betlach, *supra* note 66, at 2–3 (stating that, “[c]onsistent with Medicaid law, CMS reviews section 1115 demonstration applications to determine whether they further the objectives of the program, such as by strengthening coverage support for the objectives of the program. After reviewing Arizona’s application to determine whether it meets these standards, CMS is unable to approve the following requests, which could undermine access to care and do not support the objectives of the program: monthly contributions for beneficiaries in the new adult group with incomes up to and including 100 percent of FPL; exclusion from coverage for a period of six months for nonpayment of monthly premium contributions; a work requirement; fees for missed appointments; additional verification requirements; and a time limit on coverage or health outcomes for low-income individuals in the state or increasing access to providers”); Letter from Marilyn Tavenner, Administrator, Ctrs. for Medicare & Medicaid Servs., to Roderick Bremby, Commissioner, Connecticut Dep’t of Social Servs. 1 (Mar. 1, 2013) (denying Connecticut’s waiver request, finding that the proposal to impose an asset limit on very low-income beneficiaries would not likely to assist in promoting the objectives of title XIX).

88. *See, e.g.,* *Newton-Nations v. Betlach*, 660 F.3d 370, 381–82 (9th Cir. 2011) (finding that “[t]here is little, if any, evidence that the Secretary considered the factors § 1315 requires her to consider before granting Arizona’s waiver. Thus, the Secretary’s decision was arbitrary and capricious within the meaning of the APA insofar as it “entirely failed to consider an important aspect of the problem”); and *see* *Wood v. Betlach*, 922 F. Supp. 2d 836, 851 (D. Ariz. 2013) (finding that the Secretary’s grant of Arizona’s waiver request was arbitrary and capricious where the Secretary failed to consider evidence that imposition of higher copayments has resulted in beneficiaries relying on expensive emergency room care and having untreated conditions leading ultimately to more serious and expensive illnesses, rather

under the Obama administration refused to grant any waiver requesting mandatory work requirements, on the ground that they did not promote the purposes of Medicaid.<sup>89</sup>

Most of the States' current requests for waivers seeking to impose work requirements on certain Medicaid beneficiaries purport to be permissible based on a waiver of 42 USC § 1396a(a)(10)(A), which identifies mandatory eligibility for Medicaid for particular populations.<sup>90</sup> These waiver requests typically refer to the adult ACA expansion population, and in some cases also to parents of dependent children.<sup>91</sup> The requests suggest that states are conceptualizing work requirements as an additional condition of eligibility, and hence as a restriction. Courts have found it within the purview of the Secretary to grant waiver requests that impose requirements that may restrict eligibility or benefits.<sup>92</sup> However, either the restriction itself, or the overall demonstration project of which the restriction is a part, must further the purposes of the Medicaid statute by, for example, allowing a state to continue providing at least some coverage to an expansion population.<sup>93</sup>

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than saving money that the state could then use to further Medicaid's purpose of providing coverage to certain low-income populations).

89. See, e.g., Letter from Andrew Slavitt to Thomas Betlach, *supra* note 66, at 2–3 (stating that CMS would be unable to approve a work requirement).

90. See 42 USC § 1396a(a)(10)(A); see, e.g., IND. FAMILY & SOCIAL SERVS. ADMIN., *Healthy Indiana 2.0 Section 1115 Demonstration Amendment 25* (2017) [hereinafter, *Health Indiana Plan (HIP)*]; KY. CABINET FOR HEALTH & FAMILY SERVS., *Kentucky Health Section 1115 Demonstration Application 12* (2017) [hereinafter, *Kentucky Waiver Application*]; MAINE DEP'T OF HEALTH AND HUMAN SERV., *MaineCare 1115 Waiver Application 13* (2017).

91. See, e.g., *Maine Waiver Application*, *supra* note 73, at 13–14. (providing a table of eligibility groups impacted by the proposed work requirements and premiums).

92. See, e.g., *Aguayo v. Richardson*, 473 F.2d 1090, 1104–05 (1973) (holding that “only limitation imposed on the Secretary was that he must judge the project to be “likely to assist in promoting the objectives” of the designated parts of the Social Security Act,” and thus that granting a waiver may, in the process, result in the curtailment or denial of services); *Newton-Nations*, 660 F.3d at 380 (“...[F]or the Secretary to act within her § 1315 authority, the administrative record must demonstrate that she “examine[d] each of th[ree] issues.” First, whether the project is an “Experimental, Pilot or Demonstration Project.” Second, whether the project is “Likely To Assist in Promoting The Objectives Of The Act.” Third, “the extent and period” for which she finds the project is necessary”) (internal citations omitted).

93. See, e.g., *Newton-Nations*, 660 F.3d at 380 (“...[F]or the Secretary to act within her § 1315 authority, the administrative record must demonstrate that she “examine[d] each of th[ree] issues.” First, whether the project is an “Experimental, Pilot or Demonstration Project.” Second, whether the project is “Likely To Assist in Promoting The Objectives Of The Act.” Third, “the extent and period” for which she finds the project is necessary”) (internal citations omitted). Whether a demonstration project would fail this test because one portion of the project, such as work requirements, fails it, is uncertain. The district court in *Wood v. Betlach* held that it is the project as a whole that must pass the test, rather than each component of the project. *Wood v. Betlach*, 2013 WL 3871414, at ¶ 5 (D. Ariz. 2013) (“The imposition of copayments on the expansion population may be relevant or even central to the Secretary’s consideration of the experimental purpose of the demonstration project and of its overall effectiveness in furthering the objectives of the Medicaid Act, but nothing in *Newton-Nations*,

In the case of work requirement requests, states with waiver applications under consideration provide a variety of rationales for justification. None, however, appear likely to satisfy Medicaid's goals on their own if given more than a cursory examination. For example, Kentucky's waiver request references "achievement of maximum independence" as a ground for requiring certain individuals to work if they want to obtain or maintain benefits.<sup>94</sup> This "independence" rationale derives from language in 42 U.S.C. § 1396-1, stating that Medicaid is meant, in part, to provide medical care and rehabilitative services to help impoverished or disabled individuals attain or maintain the ability to take care of themselves, rather than, for example, becoming dependent on residential care.<sup>95</sup> However, there is no evidence that this provision relates to a beneficiary's employment or financial independence. Rather, it has to do with a beneficiary's ability to perform activities of daily living and other such tasks.

In a similar vein, Kentucky's waiver request also quotes from a CMS website, providing that "employment is a fundamental part of life for people with and without disabilities" and is "essential to an individual's economic self-sufficiency, self-esteem, and well-being."<sup>96</sup> However, this quote is taken out of context. Although the CMS webpage in question discusses employment in relation to Medicaid, it does so in the context of describing programs that help workers with disabilities who have earnings in excess of those allowed under traditional Medicaid rules to obtain Medicaid coverage.<sup>97</sup> In other words, CMS describes an expansive and positive approach to ensuring that disabled Medicaid beneficiaries can both remain

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*Beno*, or the language of Section 1115 persuades the Court that compliance with Section 1115 must be found in the copayments alone rather than the demonstration project as a whole."'). The issue, however, has not yet been adjudicated in a published case, or in any higher forum.

94. See *Kentucky Health Waiver Application*, *supra* note 68 (stating that "meaningful work and participating as a contributing member of society is . . . essential to individual's economic self-sufficiency").

95. See 42 U.S.C. § 1396-1(a).

96. See *Kentucky Waiver Application*, *supra* note 90, at 12 (indicating that Kentucky HEALTH's waiver requiring all able-bodied working age adult members without dependents participate in the community engagement and employment initiatives to maintain enrollment is based on the CMS's belief that "meaningful work and participating member of society is recognized as part of a healthy lifestyle and 'essential to individual's [sic] economic self-sufficiency, self-esteem and well-being"; see also Ctrs. for Medicare & Medicaid Servs., *Medicaid Employment Initiatives*, <https://www.medicaid.gov/medicaid/ltss/employment/index.html> (last visited Dec. 5, 2017) [hereinafter *Medicaid Employment Initiatives*] (describing Medicaid employment initiatives, and defining the importance of employment and meaningful work for disabled adult Medicaid beneficiaries).

97. See *Medicaid Employment Initiatives*, *supra* note 96 ("Medicaid Buy-In program is an optional State Medicaid benefit group for workers with disabilities who have earnings in excess of traditional Medicaid rules . . . Ideally, it means workers with disabilities do not need to choose between healthcare and work.").

employed and still receive the coverage they need,<sup>98</sup> rather than a restrictive and negative approach to limiting coverage by imposing work requirements on non-disabled Medicaid beneficiaries as proposed by Arizona, Kentucky, and other states.<sup>99</sup>

Like that of Kentucky, Indiana's waiver application also cites a connection between employment and superior health.<sup>100</sup> Indiana bases its assertion on two published articles, while at the same time admitting that at least some conflicting findings exist regarding the connection between work and health.<sup>101</sup> Kentucky, for its part, bases its own claim on only one published article.<sup>102</sup> The first article cited in Indiana's waiver application, *Psychological and Physical Well-Being During Unemployment: A Meta-Analytic Study*, found "a negative effect" on mental health" following involuntary job loss, notwithstanding the article's further finding that the effects of unemployment on the formerly employed are "not homogeneous."<sup>103</sup> The article arguably supports voluntary job training and placement efforts for interested individuals, such as those currently in place in Indiana and Montana.<sup>104</sup> However, factors such as financial worries and

98. *Id.* (indicating that the optional Medicaid Buy-In program "allows workers with disabilities to have higher earnings and maintain their Medicaid coverage," thus covering 142,000 individuals under this new eligibility group throughout 42 states).

99. *Kentucky Waiver Application*, *supra* note 90, at 12; AZ. HEALTH CARE COST CONTAINMENT SYSTEM, *Arizona Section 1115 Waiver Amendment Request: Senate Bill 1092 Arizona Legislative Directives*, at 2, <https://azahcccs.gov/Resources/Downloads/1115Waiver/SB1092WaiverRequest011017.pdf> (last visited Dec. 5, 2017).

100. *See Healthy Indiana Plan (HIP)*, *supra* note 90, at 4 ("In general, employed individuals are both physically and mentally healthier, as well as more financially stable, as compared to unemployed individuals.").

101. *Id.* at 4–5. Footnote 1 cites two articles: Frances M. McKee-Ryan et al., *Psychological and Physical Well-Being During Unemployment: A Meta-Analytic Study*, 90 J. APPLIED PSYCHOL. 53 (2005) and Karsten I. Paul et al., *Latent Deprivation Among People Who Are Employed, Unemployed, or Out of the Labor Force*, 143 J. PSYCHOL. 477 (2009).

102. *See Kentucky Waiver Application*, *supra* note 90, at 12 (citing Kenneth C. Hergenrather et al., *Employment as a Social Determinant of Health: A Systematic Review of Longitudinal Studies Exploring the Relationship Between Employment Status and Physical Health*, 29 REHABILITATION RES. POL'Y & EDUC. 2 (2015) in footnote 23).

103. *See* Frances M. McKee-Ryan et al., *Psychological and Physical Well-Being During Unemployment: A Meta-Analytic Study*, 90 J. APPLIED PSYCHOL. 53, 66–67 (2005) (finding that, while the results are suggestive of a negative causal impact of unemployment on mental health, limitations in the design of the studies used make it "unrealistic" to come to such a conclusion; moreover, while there is some evidence that re-employment is positively correlated with improved mental health, "the positive effects of becoming reemployed may be limited to those who regain satisfactory new jobs").

104. *See* In. Fam. Social Serv. Admin., *Healthy Indiana Plan: Gateway to Work*, <https://www.in.gov/fssa/hip/2466.htm> (describing Gateway to Work as a "free, voluntary program" that "that helps connect HIP members to Indiana's workforce training programs, work search resources and potential employers. HIP members who are unemployed or working less than 20 hours a week will be referred to available employment, work search and job

the centrality of work to an individual's identity appear to play a larger role in the effect of unemployment on a person's well-being than the mere fact of unemployment itself.<sup>105</sup> As such, the article provides questionable support for a requirement that non-disabled, non-pregnant adults age 19-64 must work at least 20 hours per week to obtain or retain Medicaid benefits.

The primary finding of the second article cited in Indiana's waiver application, *Latent Deprivation among People who Are Employed, Unemployed, or Out of the Labor Force*, is that deprivation of the "unintended by-products" of work – identified as "time structure, social contact, collective purpose, status, and activity" – was associated with depression in each group of German nationals studied: the employed, the unemployed, and those who are not in the workforce but are not seeking work, such as students and home-based caregivers.<sup>106</sup> Of these groups, the employed were least likely to experience latent deprivation, and the unemployed were the most likely to do so.<sup>107</sup> This article, although concerning Germans rather than Americans, suggests that employment may better provide certain non-economic mental health benefits than voluntary or involuntary unemployment.<sup>108</sup> As such, it could support a voluntary program providing training and job search support for individuals to obtain meaningful and satisfying employment.<sup>109</sup> However, it does not in itself support a mandatory program.

Kentucky's waiver application cites only a single research study, *Employment as a Social Determinant of Health: A Systematic Review of Longitudinal Studies Exploring the Relationship between Employment Status*

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training programs that will assist them in securing new or potentially better employment"); see also Eric Whitney, *Montana May Be Model for Future Medicaid Work Requirement*, NPR (Dec. 16, 2016), <http://www.npr.org/sections/health-shots/2016/12/23/506121944/montana-may-be-model-for-future-medicaid-work-requirement> (discussing Montana's voluntary job training program for the state's Medicaid expansion population).

105. McKee-Ryan et al., *supra* note 101, at 63, 64 (finding that "[u]nemployed individuals' work-role centrality had significant negative relationships with their mental health . . . and life satisfaction . . . , respectively," and that "perceived financial strain was associated with lower mental health and life satisfaction").

106. Karsten I. Paul et al., *Latent Deprivation Among People Who Are Employed, Unemployed, or Out of the Labor Force*, 143 J. PSYCHOL. 477, 487 (2009).

107. *Id.* at 483.

108. See *id.* at 486–87 (presenting results found using a sample of educated German population that correlate latent functions to mental health among all people in modern society and recognizing the limitations of results' generalizability).

109. See, e.g., Gayle Hamilton, *Improving Employment and Earnings for TANF Recipients*, URB. INST. 1, 3 (2012), <http://www.urban.org/sites/default/files/publication/25391/412566-Improving-Employment-and-Earnings-for-TANF-Recipients.pdf> (finding that a "mixed approach" program of job training and search support that encouraged individuals to find better-quality jobs with earnings above minimum wage, benefits, and opportunities for advancement worked better than either a pure training and education or job-search-first focus).

and *Physical Health*, in support of its work requirement request.<sup>110</sup> This article analyzed the results of studies across seven countries, and found a consistent association between employment and better health, as well as between unemployment and worse health.<sup>111</sup> These findings are relatively uncontroversial,<sup>112</sup> and appear, at first glance, to support Kentucky's request.

However, as the authors of the study themselves observe, the nature of the relationship between work, unemployment, and health is far from clear.<sup>113</sup> The studies that the authors analyzed all found associations between employment and better health.<sup>114</sup> However, they did not find that work, including menial or poorly paid work, causes better health – the finding that Kentucky's waiver application needs in order for the study to support its work request.<sup>115</sup> It may be just as likely that better health increases the chance that a person can be gainfully employed – a finding which would suggest Kentucky should continue making Medicaid available to all low-income, adult Kentuckians, including the unemployed.<sup>116</sup>

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110. See *Kentucky Waiver Application*, *supra* note 90, at 12 (citing Kenneth C. Hergenrather et al., *Employment as a Social Determinant of health: A Systematic Review of Longitudinal Studies Exploring the Relationship Between Employment Status and Physical Health*, 29 REHABILITATION RES. POL'Y & EDUC. 2 (2015)).

111. See generally Kenneth C. Hergenrather et al., *Employment as a Social Determinant of Health: A Systematic Review of Longitudinal Studies Exploring the Relationship between Employment Status and Physical Health*, 29 REHAB. RES., POL'Y, & EDUC. 2 (2015) (concluding from its study that “employed persons and reemployed persons present better physical health, whereas unemployed persons and persons who experience job loss present poorer physical health”).

112. See David Dooley, Jonathan Fielding, & Lennart Levi, *Health and Unemployment*, ANNUAL REV. PUB. HEALTH 449, 454 (1996) (“Most evidence supports the generally assumed negative effects of unemployment on physical and mental health and well-being.”).

113. See Hergenrather et al., *supra* note 111, at 13 (revealing variations of effects between full-time and part-time employment on specific sub-groups of people (e.g., women, men with HIV)).

114. *Id.*

115. Indeed, Hergenrather and colleagues note that “The association between employment and physical health was significant with status (e.g., overemployed, underemployed, part-time, temporary). Persons who were overemployed (i.e., working more than 45 hr per week) reported more chronic disease (i.e., number of chronic conditions reported during the past year) than persons employed full-time (e.g., working 35–45 hr per week). Underemployed (i.e., low-wage job, low-status job) persons reported poorer functional health (i.e., degree to which health or health-related problems interfered with daily activities) and more chronic disease than those adequately employed. Persons employed part-time, compared to persons employed full-time, reported decreased perceived health.” Hergenrather et al., *supra* note 111, at 13 (internal citations omitted).

116. Data suggest that this in fact may be correct. See, e.g., JACK HADLEY, SICKER AND POORER: THE CONSEQUENCES OF BEING UNINSURED, 83 (2002) (“Poor health appears to reduce work and income, as long as the effects of high income and wealth on the early retirement of the healthy do not dominate. . . . Controlling for prior health, poor current health is strongly associated with both labor force exit in general and application for disability insurance benefits.”).

Maine's application, unlike the others, makes little attempt to link employment and health.<sup>117</sup> Instead it claims that

[e]mployment provides not only monetary compensation, but also daily structure and a sense of pride that no government program can replicate. For these reasons, and in alignment with other social service programs in our state, DHHS intends to institute a community engagement and work requirement for able-bodied adults in MaineCare similar to the requirements DHHS implemented in the Supplemental Nutrition Assistance Program (SNAP) program in 2014.<sup>118</sup>

As such, the application makes essentially no attempt to contextualize the work requirement within any arguable objective of Medicaid. Instead, Maine's goal, in the waiver's own language, is "to increase employment and wage earnings of able-bodied adults, while subsequently focusing MaineCare funding on Maine's most needy individuals."<sup>119</sup> It is difficult to see how this rationale fits within Medicaid's objective to provide access to medical care for certain impoverished populations.<sup>120</sup> However, Maine's stated rationale for the work request is arguably more honest about the state's intent than that of Kentucky and Indiana. It clearly aligns requirements for Medicaid eligibility with those for welfare programs such as SNAP and TANF.<sup>121</sup> In so

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117. See *Maine Waiver Application*, *supra* note 73, at 5.

118. *Id.*

119. *Id.*; Maine's request also cites a state-produced 2016 study of Maine TANF recipients who left to program due to time limits in the second quarter of 2012. The study found that the 64% of TANF leavers with an employment record in at least one quarter between the second quarter of 2011 and the first quarter of 2016 experienced an increase in average wages, from \$1,884/quarter (\$628/month) in 2011–2012 to \$3,459/quarter (\$1,153/month) in 2015–2016. Governor's Office of Policy and Management, *Wage and Employment Outcomes for TANF Participants Closed for Time Limits* 6 (May 25, 2017), <http://www.maine.gov/economist/docs/TANF%20Report%20Final%205-25-17.pdf>. The average wage of the former TANF recipients with a wage history who were timed out of the program, in other words, was less than the federal poverty level for a family of two in 2016. Thirty-six percent of the timed-out former TANF recipients had no wage history at all during the relevant period. *Id.* The report speculated that these individuals may in fact have been employed, but not in positions that were included in the state Unemployment Insurance dataset used in performing the study. *Id.* at 12. If they were employed, they were self-employed, federally employed, working under the table, or had left the state. They may, of course, instead have been unemployed; see, e.g., JEFFREY GROGGER & LYNN A. KAROLY, *WELFARE REFORM: EFFECTS OF A DECADE OF CHANGE* 135 (2005) ("One problem with administrative data is that they miss people who move between states. Each state maintains its own earnings files, so when a worker moves out of state, her earnings record in the home state shows zero earnings. But earnings records also show zero earnings when a worker becomes jobless, and it is not possible to distinguish this status from those who have moved.").

120. See CMS, *MEDICAID & CHIP STRENGTHENING COVERAGE IMPROVING HEALTH* 4 (2017) (providing that Medicaid, along with CHIP, are the "cornerstone of health coverage for low-income children, parents and other adults, individuals with disabilities, and seniors").

121. See generally DEP'T OF HEALTH & HUMAN SERV., *TEMPORARY ASSISTANCE TO*

doing, Maine's application seeks to make Medicaid more closely resemble traditional welfare, including the stigma that can accompany such programs.<sup>122</sup>

### III. PERSONAL RESPONSIBILITY REQUIREMENTS: THE TANF EXPERIENCE

Setting aside the questionable legality of the applications, it nevertheless appears likely that HHS will grant one or more of the pending Medicaid waiver requests seeking welfare-style reforms.<sup>123</sup> The question then arises: what may be the effects of personal responsibility requirements, such as work requirements and time limits, on Medicaid beneficiaries? Some scholars of Medicaid policy have concluded, based on general outcomes from TANF and other welfare programs, that such requirements would disincentivize beneficiaries from applying for or maintaining coverage.<sup>124</sup> However, the impact of such requirements turns out to be a more complicated issue.

#### A. *Time Limits and Work Requirements: The Problems of Inconsistent Policy and Application*

Studies of TANF requirements have revealed some useful findings. First, cash welfare reform was associated with a significant caseload decline that persisted throughout two recessions, even while participation in other assistance programs, like unemployment and SNAP, increased.<sup>125</sup> Additionally, in many states, time limit restrictions have a negative impact on welfare use, at least in the case of families with very young children who may need to ration cash welfare use over time, given that in many cases they have, at most, five of the first eighteen years of their youngest child's life in which to use it.<sup>126</sup> Finally, the existence of alternative, supporting programs

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NEEDY FAMILIES PROGRAM, 11TH REPORT TO CONGRESS v (2016) (requiring individuals to participate in federally listed work activities to access TANF financial assistance); *See also* Letter from Adam Mejer, Deputy Chief of Staff for Policy, to Brian Neal, Director, Center for Medicaid and CHIP Services, *Kentucky HEALTH §1115 Demonstration Modification Request* 3 (July 3, 2017), <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ky/ky-health-pa2.pdf> (citing this as a reason for an amendment to its waiver application).

122. For a discussion of stigma associated with personal responsibility requirements, *see infra*, notes 191–192 and associated text.

123. Letter from Thomas E. Price and Seema Verma to Governors of the United States, *supra* note 13, at 1.

124. *See supra*, notes 15, 16 and associated text.

125. *See* Gregory Acs & Pamela Loprest, *TANF Caseload Composition and Leavers Synthesis Report* 21 (2007) (finding that “[t]he [TANF] caseload fell by half between 1996 and 2000 and has continued to fall at a slower rate since, from 2.3 million families in 2000 to 1.9 million in the first part of 2006”).

126. *See* Jeffrey Grogger, *The Effects of Time Limits, The EITC, and Other Policy Changes on Welfare Use, Work, and Income Among Female-Headed Families*, 85 REV. ECON. & STAT. 394, 404 (2003) [hereinafter *The Effects of Time Limits*] (concluding that time limits



such as the expanded EITC, Medicaid, and SNAP, in conjunction with periods of economic expansion, make work a viable alternative for many families who might otherwise seek cash welfare for support.<sup>127</sup>

Before moving on, the issue of time limits requires more attention. At least one study has found that the percentage of families actually timed out of TANF is very small, on average usually accounting for fewer than five percent of those leaving TANF every month.<sup>128</sup> There are several reasons for this. First, nearly half of TANF cases nationwide involve children only, and child-only cases are not subject to time limits.<sup>129</sup> Second, slightly less than half of states have a hard time limit, and most others permit access to some form of TANF-style benefits even after a time limit is reached.<sup>130</sup> Third, nearly all states allow exceptions to TANF time limits.<sup>131</sup> Finally, time limits, as mentioned above, are correlated with discrepancies between how families with younger children and families with older children use TANF.<sup>132</sup> Families with very young children appear to ration their use of TANF more carefully.<sup>133</sup> The rationing effect of time limits appears significantly less pronounced in families with only older dependent children, who are unlikely to exhaust their time limits before their children reach the age of majority.<sup>134</sup>

Projecting the likely effects of TANF-style reforms in Medicaid is difficult. Not only are data on the impacts of specific TANF interventions often difficult to compare, but also the differing purposes of TANF and

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have the greatest effects on families with the youngest children).

127. See NORMA B. COE ET AL., THE URBAN INST., NEW FEDERALISM ISSUES & OPTIONS FOR STATES, DOES WORK PAY? A SUMMARY OF THE WORK INCENTIVES UNDER TANF 4 (1998), <http://www.urban.org/sites/default/files/publication/66636/308019-Does-Work-Pay-A-Summary-of-the-Work-Incentives-under-TANF.pdf> (noting that TANF, food stamps, EITC, and other forms of assistance have the “potential to greatly affect the well-being of a family shifting from welfare to work”); see also *The Effects of Time Limits*, supra note 126, at 408 (concluding that EITC had substantial effects in behavior and may be the “single most important policy measure for explaining the decrease in welfare and the rise in work and earnings”).

128. Mary Farrell et al., *Welfare Time Limits: An Update on State Policies, Implementation, and Effects on Families*, DEP’T OF HEALTH & HUMAN SERVS. 1, 34, 43 (2008).

129. *Id.* at 50.

130. *Id.* at 7–10.

131. *Id.* at 10–12.

132. *The Effects of Time Limits*, supra note 126, at 394, 400 (“[E]ligibility for aid under TANF . . . ends when the youngest child in the family turns 18. Thus, families with younger youngest children have longer eligibility horizons than families with older youngest children”); Jeffrey Grogger & Charles Michalopoulos, *Welfare Dynamics Under Time Limits*, 111 J. POL. ECON. 530, 545, 550–51 (2003).

133. *The Effects of Time Limits*, supra note 126, at 400; Grogger & Michalopoulos, supra note 132, at 545, 550–51.

134. See Grogger & Michalopoulos, supra note 132, at 551 (“Whereas families with older youngest children have relatively little chance of prematurely exhausting their benefits . . . This prediction is largely borne out by our empirical results”).

Medicaid and the different needs of their clientele make comparisons problematic.<sup>135</sup> Take the issue of time limits on access to TANF versus Medicaid. TANF is only available to families with children under the age of eighteen, whereas Medicaid is available to people in all stages of life.<sup>136</sup> Unless a person is elderly, disabled, or has one or more chronic conditions, he is unlikely to know whether or when he will need Medicaid. This represents the central risk to the uninsured; the need for insurance is unpredictable, and when a pressing need arises, it may be too late or impossible to obtain it if there is a time limit to coverage and if one has exhausted it.<sup>137</sup> Imposing a five-year limit on Medicaid coverage of non-elderly, non-disabled adults will almost certainly encourage individuals to go bare rather than prudently obtaining coverage prior to needing it.<sup>138</sup> Time restrictions, combined with the unpredictability of needed care, thus encourage potential beneficiaries to refrain from obtaining necessary medical care until they have an emergency or are too sick to forgo treatment.<sup>139</sup> Time limits would accordingly threaten to undo recent gains in the health status of formerly uninsured Medicaid beneficiaries who obtained coverage courtesy of their state's expansion under the ACA.<sup>140</sup> They also arguably work at cross-purposes with states that are seeking to obtain, or have obtained, waivers of retroactive and presumptive eligibility on the theory that eliminating this standard feature of Medicaid encourages prudent and responsible enrollment on the part of Medicaid applicants.<sup>141</sup>

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135. See e.g., GROGGER & KAROLY, *supra* note 119, at 59–71 (detailing methodological problems with, and potential strategies for, estimating causal effects of specific welfare reform provisions).

136. See 42 U.S.C. § 1396(a)(10)(A) (2016) (enumerating a number of populations covered by Medicaid, ranging from children to the elderly).

137. See Steven D. Pizer et al., *Uninsured Adults with Chronic Conditions or Disabilities: Gaps in Public Insurance Programs*, 28 HEALTH AFF. W1141, W1145 (2009) (suggesting that lower uninsurance rates among people with disabilities or health conditions reflected the greater importance of health insurance to them relative to those who had neither a disability nor a health condition); see also Andrew P. Wilper et al., *Health Insurance and Mortality in US Adults*, 99 AM. J. PUB. HEALTH 2289, 2294 (2009) (showing an increased risk of death attributed to lack of insurance).

138. Pizer, *supra* note 137; see Wilper, *supra* note 137 (loss of government-sponsored insurance was associated with decreased use of physician services).

139. Wilper, *supra* note 137, at 2293.

140. See e.g. Sharon K. Long et al., *Sustained Gains in Coverage, Access, and Affordability under the ACA: A 2017 Update*, 36 HEALTH AFF. 1656, 1658–59 (2017) (finding increased access to Medicaid to be the “driving force” in insurance gains since 2013, a significant decline in self-reported unmet need for health services, and significant improvement in health care affordability).

141. See e.g. IOWA DEP'T OF HUMAN SERVS., *Section 1115 Demonstration Amendment: Iowa Wellness Plan* (June 27, 2017), [https://dhs.iowa.gov/sites/default/files/Iowa\\_Waiver\\_of\\_Retroactivity\\_Draft\\_6.22.17.pdf](https://dhs.iowa.gov/sites/default/files/Iowa_Waiver_of_Retroactivity_Draft_6.22.17.pdf) (“[T]he State seeks to more closely align Medicaid policy with that of the commercial market,

Once we get beyond time limits, variations in implementation of TANF policies complicate any projection of parallel policies on Medicaid.<sup>142</sup> To start, there have been wide discrepancies in TANF's role as a safety net from state to state.<sup>143</sup> For example, the effect of the Great Recession of 2007–2009 yielded substantially different effects on states' TANF caseloads.<sup>144</sup> In New Mexico, the TANF caseload increased roughly in tandem with the rise in the unemployment rate.<sup>145</sup> New Mexico had a sixty-month TANF time limit and high rates of other public benefits in conjunction with cash welfare.<sup>146</sup> By contrast, North Carolina's TANF caseload remained largely static while the unemployment rate rose sharply.<sup>147</sup> North Carolina imposed a twenty four-month time limit, after which participants became ineligible for the subsequent thirty six months.<sup>148</sup> Indeed, many states' TANF caseload trajectories differed markedly during the Great Recession.<sup>149</sup> A study by the Center for Budget and Policy Priorities found little overlap between states with the greatest rise in unemployment rates and states with the greatest increase in TANF caseloads.<sup>150</sup> Moreover, states facing similar increases in unemployment sometimes had widely disparate changes in their TANF caseloads.<sup>151</sup> For example, although Utah and Arizona saw similar increases in their unemployment rates, 188% and 174% respectively, Utah's TANF

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which does not allow for an individual to apply for retroactive health insurance coverage. Eliminating Medicaid retroactivity encourages individuals to obtain and maintain health insurance coverage, even when healthy").

142. See Haskins et al., *The Responsiveness of the Temporary Assistance for Needy Families Program During the Great Recession*, BROOKINGS INST. (2014), [https://www.brookings.edu/wpcontent/uploads/2016/06/responsiveness\\_tanf\\_great\\_recession\\_haskins.pdf](https://www.brookings.edu/wpcontent/uploads/2016/06/responsiveness_tanf_great_recession_haskins.pdf) (recognizing a complex interaction between social and political influences that cause the discrepancies between states).

143. See *id.* (examining the responsiveness of the TANF program to economic changes and its variations across states).

144. See *id.* (recognizing the difference in the extent TANF caseload rose and fell between states with regards to the recession).

145. *Id.* at 16.

146. See NEW MEXICO HUMAN SERVS. DEP'T, *New Mexico's Temporary Assistance for Needy Families (TANF) State Plan: Jan. 1, 2015 – Dec. 31, 2017*, 37 (2015) (proposing new plan for New Mexico, allowing for 60 months of TANF and \$200 monthly fixed bonus for eligible benefit groups); see also Haskins et al., *supra* note 142, at 43 (indicating that New Mexico was one of the states that implemented changes to attempt to reduce TANF caseload).

147. Haskins et al., *supra* note 142, at 16.

148. *Work First*, N.C. DEP'T OF HEALTH & HUMAN SERV. (last updated Apr. 19, 2017), <https://www2.ncdhhs.gov/DSS/workfirst/index.htm>.

149. Haskins et al., *supra* note 142, at 12.

150. LaDonna Pavetti et al., *TANF Emerging from the Downturn a Weaker Safety Net*, CTR. ON BUDGET & POL'Y PRIORITIES 7 (2013), <https://www.cbpp.org/sites/default/files/atoms/files/3-1-13tanf.pdf> [hereinafter, *TANF Emerging from the Downturn*].

151. *Id.*

population increased by 45%, while Arizona's increased by only 6%.<sup>152</sup>

These discrepancies reflect states' extensive latitude in shaping TANF programs and allocating TANF spending.<sup>153</sup> When TANF was enacted in 1996, Congress set federal funding at approximately \$16.6 billion per year, without any provision to increase the amount to take inflation or other matters into account.<sup>154</sup> States are required to expend, using state or local dollars, at least seventy-five percent of what they were spending on the program in fiscal year 1994 as a condition of receiving the federal block grant.<sup>155</sup> In exchange, the federal government gives states substantial flexibility to use their grant as they choose.<sup>156</sup> The law provides that states may use their grants "in any manner that is reasonably calculated to accomplish the purpose of [TANF], including to provide low income households with assistance in meeting home heating and cooling costs," or in any way it was permitted to use the funds under the old AFDC program.<sup>157</sup> Even where states must comply with federal requirements, those requirements are flexible.<sup>158</sup> For example, federal law requires states to certify, as a condition of receiving their TANF block grant, that at least fifty percent of their TANF families with at least one adult member are engaged in countable work activities.<sup>159</sup> However, there are a variety of ways that a state can meet or obtain exceptions from this participation requirement, and hence most states have TANF work participation rates that have been far less than fifty percent over the life of the program.<sup>160</sup>

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152. *Id.* These rates of unemployment growth reflect the period from the start of the Great Recession to the rates' respective peaks.

153. *Id.* at 9.

154. *See* 42 U.S.C. § 603(a)(1)(c) (2017) (lacking any provision regarding adjustment for inflation); *see also* DEP'T OF HEALTH & HUMAN SERVS., TEMPORARY ASSISTANCE TO NEEDY FAMILIES PROGRAM, 11TH REPORT TO CONGRESS 94-95 (2016) (calculating that the average grant value from 1996 to 2013, adjusted for inflation, declined by 26%).

155. DEP'T OF HEALTH & HUMAN SERVS., TEMPORARY AID TO NEEDY FAMILIES PROGRAM, 9TH REPORT TO CONGRESS 25 (2016); 42 U.S.C. § 603(a)(5)(iv)(I) (2017) (outlining the mandatory provisions, including the minimum spending, to continue to receive federal block grants for TANF).

156. *See* 42 U.S.C.A. § 601(a) (2017); *see also* Liz Schott et al., *How States Use Federal and State Funds Under the TANF Block Grant*, CTR. ON BUDGET & POL'Y PRIORITIES 1 (2015), [https://www.cbpp.org/sites/default/files/atoms/files/4-8-15tanf\\_0.pdf](https://www.cbpp.org/sites/default/files/atoms/files/4-8-15tanf_0.pdf) (presenting key argument for block granting was that states needed much greater flexibility over the use of the federal funds than AFDC's funding structure provided).

157. 42 U.S.C.A. § 604(a) (2017).

158. GENERAL ACCOUNTING OFFICE, *supra* note 34, at 3.

159. 42 U.S.C.S § 607 (2017) (exploring "block grants to states for temporary assistance for needy families").

160. *Id.*; *see also* Gene Falk, *Temporary Aid to Needy Families: The Work Participation Standard and Engagement in Welfare-to-Work Activities*, CONGRESSIONAL RES. SERV. 19-20 (2017), [http://www.aphsa.org/content/dam/NASTA/PDF/CRS-RPT\\_R44751\\_2017-02-01.pdf](http://www.aphsa.org/content/dam/NASTA/PDF/CRS-RPT_R44751_2017-02-01.pdf) (identifying multiple routes for states to meet the work participation standard and

As a consequence of this sort of flexibility, TANF policies differ widely from state to state.<sup>161</sup> Two such differences are TANF eligibility and access to cash benefits. In 2010, California families earning nearly eighty percent of the federal poverty level could qualify for TANF benefits and access the state's comparatively generous cash benefits.<sup>162</sup> Meanwhile, Texas families earning more than twenty-six percent of the federal poverty level no longer qualified for cash benefits.<sup>163</sup> Furthermore, Texas TANF benefits paled in comparison to California's; the average TANF benefit for a Texas family of three could not cover the state's average fair market rent for a one-bedroom apartment, and only ten percent of the state's TANF funds went to cover cash benefits for TANF recipients.<sup>164</sup>

*B. Disambiguating the Effects of TANF Policies from Other Factors*

State TANF policy choices are also affected by a variety of factors, including state and federal public benefit programs, economic policies, social policies, and tax policies.<sup>165</sup> State policies regarding the effects of federal work requirements and time limits have functioned in conjunction with a variety of federal and state policy choices, such as the EITC, availability of Supplemental Security Income ("SSI"), imposition of family caps, and state decisions on percentages of TANF funding to allocate to certain programs (e.g. cash assistance versus parenting training, child care, prekindergarten programs, and others).<sup>166</sup> This helps explain the disparate results discussed above regarding the experience of TANF populations in New Mexico versus North Carolina during the Great Recession.<sup>167</sup> Because North Carolina had a weaker TANF safety net than New Mexico, more low-income North Carolina residents turned to other means of public and private support than did New Mexicans.<sup>168</sup> North Carolina residents who could find a job and supplement their earnings through the EITC, or who could qualify for SSI benefits, pursued these alternatives.<sup>169</sup> Indeed, as TANF programs shrunk and otherwise became more difficult to access, more people obtained the EITC

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providing illustrations of state participation).

161. Heather Hahn et al., *State Approaches to the TANF Block Grant: Welfare is Not What You Think it is*, THE URB. INST. 9–22 (2012), <https://www.urban.org/sites/default/files/publication/25731/412635-State-Approaches-to-the-TANF-Block-Grant-Welfare-Is-Not-What-You-Think-It-Is.pdf>.

162. *Id.* at 11–13.

163. *Id.*

164. *Id.* at 12, 24.

165. *Id.* at 23–29.

166. *Id.*

167. Haskins et al., *supra* note 142, at 12–20.

168. *Id.*

169. *See id.* at 32–33; *Work First*, *supra* note 148 and associated text.

or SSI benefits.<sup>170</sup>

If we want to determine with any precision what effect work or another personal responsibility requirement had on TANF caseloads, it becomes difficult to disentangle the effects of these requirements from other requirements, state resource allocation decisions, and other relevant circumstances. This is the case, even years after implementation of PRWORA and alterations to it under the Deficit Reduction Act of 2005.<sup>171</sup> As one researcher noted,

[p]ost-1996, it is much more difficult to characterize the policy environment for each state. State welfare policies vary along multiple program dimensions, and the precise nature of the bundle matters since different program components may interact with each other. For instance, one may need to control for the interaction of [benefit reduction rates] and sanctions, rather than just controlling for each separately. Not all of the program elements described above are easily coded, and there is little guidance in the research to date showing the most effective way to measure and code some of the newer policies like time limits, sanctions or diversion activities. In some cases only a few states have adopted particular policies or combinations of policies. For data sets with state level observations, this can make it difficult to estimate precise policy effects.<sup>172</sup>

While the excerpt cited here is from a 2002 article, researchers working more recently still confront similar problems.<sup>173</sup>

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170. See, e.g., Jeffrey Grogger, *The Effect of Time Limits, the EITC, and Other Policy Changes on Welfare Use, Work, and Income Among Female-Headed Families*, 85 REV. ECON. & STATISTICS 394, 405-07 (2003) (finding that the EITC accounted for thirty-seven percent of the increase in employment of female heads of households between 1992 and 1996, and that most of the effect of the EITC on non-working welfare recipients was to move them off of welfare and into the workforce); Steve Wamhoff & Michael Wiseman, *The TANF/SSI Connection*, 66 SOC. SECURITY BULL. (2005/2006), <https://perma.cc/VZ96-Y8BT> (finding that “the incidence of SSI awards among TANF recipients has been much greater [in the early 2000s] than it was during the early 1990s . . . Award rates for children rose from an average of 0.92 per month per 1,000 child TANF recipients in 1991–1993 to 1.28 per 1,000 in 2001–2003. The change was even more dramatic for adults. On average in each month of 1991–1993, 1.55 TANF-linked SSI awards were made per 1,000 recipients. By 2001–2003, the average rate was slightly over 4 per 1,000 per month. Although the number of SSI awards associated with welfare went down between 1991–1993 and 2001–2003 by 42 percent for children and 25 percent for adults, the caseload fell substantially more, so incidence rose”).

171. Wamhoff & Wiseman, *supra* note 170.

172. Rebecca M. Blank, *Evaluating Welfare Reform in the United States*, 40 J. ECON. LIT. 1105, 1120 (2002).

173. See generally, GROGGER & KAROLY, *supra* note 119, at 248–52 (detailing gaps in our knowledge about welfare reform, emphasizing in particular deficiencies in long-term data, the relationship between the economy and welfare reform outcomes, and variability in researchers’ characterizations of state policy choices); Elizabeth Lower-Basch & Mark K. Greenberg, *Single Mothers in the Era of Welfare Reform*, in *THE GLOVES-OFF ECONOMY: WORKPLACE STANDARDS AT THE BOTTOM OF AMERICA’S LABOR MARKET* (A. Bernhardt, H.

While differentiating between the effects of work requirements, time limits, and other personal responsibility requirements on TANF utilization is difficult, extrapolating these effects to the Medicaid program can become speculative.<sup>174</sup> Consider work requirements. In a meta-analysis of experimental and observational studies in the first ten years of TANF, Jeffrey Grogger and Lynn A. Karoly found that work requirements in TANF were clearly associated with reduced cash welfare use and payments.<sup>175</sup> However, many of the studies Grogger and Karoly examined were performed during periods of economic expansion.<sup>176</sup> As such, it is left to speculation as to how many of these people would have started working and left welfare even without such requirements.<sup>177</sup> One is thus left to wonder: to what extent did the work requirement function simply as a “nudge” to encourage people to leave welfare or to work more and reduce their benefits? Did the work requirement actually help induce those who would have taken up or remained on welfare to become employed in a job that allowed them to become self-sufficient, or did something else happen to them?<sup>178</sup> Did those who took up work end up better off financially than they had been while on welfare, or were their financial circumstances relatively unchanged or even made worse?<sup>179</sup> Given especially that we know that TANF take-up became weaker

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Boushey, L. Dresser, and C. Tilly, eds. 2009) (discussing gaps in researchers’ knowledge of the effects of different state policies and conditions on work-related issues in welfare reform); Richard C. Fording et al., *Devolution, Discretion, and the Effect of Local Political Values on TANF Sanctioning*, 81 SOC. SERV. REV. 285, 285 (2007); LADONNA PAVETTI ET AL., REVIEW OF SANCTION POLICIES AND RESEARCH STUDIES 7 (2003) [hereinafter, *Review of Sanction Policies and Research Studies*], <https://perma.cc/7BM3-FRPE>.

174. Julia Paradise & Rachel Garfield, *What is Medicaid’s Impact on Access to Care, Health Outcomes, and Quality of Care? Setting the Record Straight on the Evidence*, KAISER FAM. FOUND. (Aug. 2, 2013), <https://www.kff.org/report-section/what-is-medicaids-impact-on-access-to-care-health-outcomes-and-quality-of-care-setting-the-record-straight-on-the-evidence-issue-brief/> (last visited Dec. 5, 2017) (noting that researchers commonly cite as a limitation of their studies the possibility that they did not fully control for underlying population differences that might help to explain their findings).

175. See, e.g., GROGGER & KAROLY, *supra* note 119, at 110–11 (finding that “all but one of the thirteen programs that imposed mandatory work or related activities significantly decreased welfare use,” with an average reduction in use of 5.1%).

176. *Id.* at 76–82, 98–101 (summarizing and citing the random assignment and observational studies used in tabular form, including the random assignment or sample period for each); U.S. *Business Cycle Expansions and Contractions*, NAT’L BUREAU OF ECON. RES. (2012) <https://perma.cc/3QDK-UC38>.

177. GROGGER & KAROLY, *supra* note 119; see, e.g., Gregory Acs & Pamela Loprest, *Final Report: TANF Caseload Composition and Leavers Synthesis Report*, 75–78 (2007) (demonstrating that, to date, the employment rate for TANF heads of families who leave the program has declined, and the earnings of TANF leavers appear to have leveled off).

178. See, e.g., Farrell et al., *supra* note 128.

179. GROGGER & KAROLY, *supra* note 119, at 235 (Grogger and Karoly found in a 2005 meta-analysis that the effect of mandatory work requirements on income was ambiguous: they noted that, of fourteen studies, six reported a negative effect on income and eight a positive

while poverty rates increased during the last recession, can we really conclude that work requirements have “succeeded,” merely because of their association with decreased take-up of cash welfare?<sup>180</sup>

### C. *The Indirect Effects of Hassle and Stigma*

Any such conclusion would be incomplete without also considering additional issues, such as “hassle factor” and the role of stigma on TANF utilization.<sup>181</sup> While the application of policies such as work requirements to any means-tested program involves hassle, some states take additional steps to make it more difficult to apply for and remain enrolled in these programs in an attempt to reduce their caseload.<sup>182</sup> Such strategies include requiring an in-person “workforce orientation,” requiring applicants to work a certain number of hours prior to receiving any assistance, requiring drug tests, or even simply advertising that the program carries such requirements and encouraging applicants to consider pursuing any other option before applying for the program in question.<sup>183</sup>

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effect. The magnitude of the changes was small, and many of the findings were statistically insignificant. They conclude that “on average, the gain in earnings just offsets the loss in welfare payments, leaving income roughly unchanged.”).

180. Falk, *supra* note 160, at 13.

181. The “hassle factor” is a well-recognized phenomenon in means-tested programs and is typically used to discourage individuals from seeking or obtaining assistance. *See, e.g.*, Marilyn Ellwood, *The Medicaid Eligibility Maze: Coverage Expands, but Enrollment Problems Persist Findings from a Five-State Study*, THE URB. INST., 1, 21 (1999) (“A senior Florida official suggested that once some families understand how Medicaid works and the hassle that is involved, they slip into pursuing coverage episodically, only bothering with all the paperwork if a child is sick or otherwise needs care”); David Ribar, Marilyn Edelhoch, & Qiduan Liu, *Watching the Clocks: The Role of Food Stamp Certification and TANF Time Limits in Caseload Dynamics*, THE J. OF HUMAN RESOURCES, 1, 6 (2005) (“The time required for face-to-face interviews and the paperwork hassles associated with even the mail-in procedure may have deterred participation, especially among working families who, in addition to facing frequent recertifications, also have less time because of their jobs”); Pamela Loprest, Stefanie, Schmidt, & Ann Dryden Witte, *Welfare Reform under PRWORA: Aid to Children with Working Families?* 14 TAX POL’Y & THE ECONOMY 157, 192 (James M. Poterba, ed. 2000) (“The second most common reason for leaving, reported by 10 percent of leavers, was administrative problems or hassles.”).

182. Richard C. Fording, Joe Soss, & Sanford F. Schram, *Devolution, Discretion, and the Effect of Local Political Values on TANF Sanctioning*, 81 SOCIAL SERV. REV. 285, 289–91 (2007); *Review of Sanction Policies and Research Studies*, *supra* note 173, at 7 (“To date, no systematic data has been collected on how sanctions are being implemented, probably because many of the key decisions are left to local offices, making it difficult to collect this information in a cost-effective manner. There may be considerable variation from office to office, and possibly from one worker to another within the same office. Factors that might influence the implementation of sanctions include the “culture” of the welfare office, especially the strategies used to communicate the importance of work and to encourage compliance, staff workloads and the complexity of the service delivery system.”).

183. *See, e.g.*, Texas Works Handbook, A-2200: Workforce Orientation, <https://perma.cc/KVA9-BTW8>; Maggie McCarty et al., *Drug Testing and Crime-Related*



This hassle factor unfolds at the local level and causes tracking problems of its own.<sup>184</sup> Devolution allows for far greater county-level or other local control, and this has certainly played out in TANF.<sup>185</sup> For example, one study by Richard Fording, Joe Soss, and Sanford Schram looked at the use of sanctions in TANF cases county by county in Florida.<sup>186</sup> Fording and his colleagues chose to study Florida because of the state's formal transfer of authority over its welfare programs and policies to local agencies, and because of the substantial policy variation between the different agencies.<sup>187</sup> The study found a relationship between local political conservatism and sanction use in TANF cases, with sanction use rising as the level of conservatism in the county increases.<sup>188</sup> Correspondingly, the study found that families were more likely to be able to stay on TANF longer in liberal Florida counties than in conservative ones.<sup>189</sup> As more control over Medicaid devolves onto states and possibly onto more local units of government, depending on what happens with ACA Marketplaces, one may see a similar pattern of this kind in some Medicaid programs.<sup>190</sup> It is not unreasonable to predict that these strategies may be used in at least some of the Medicaid waiver programs presently under consideration.

Another issue – one that, like the “hassle factor,” makes welfare enrollment and continuation less attractive – is stigma. The personal responsibility requirements discussed above assume that those who need benefits do so because they cannot take care of themselves, and that this inability, if not due to minority, age, or disability, is instead due to a failure to take proper responsibility for their lives.<sup>191</sup> Proponents of such requirements deliberately intend them to help teach the poor how to live.<sup>192</sup> It is one thing for a clerk at a grocery store to scoff at someone using an EBT card to buy her groceries, but it is arguably quite another if one's health care

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*Restrictions in TANF, SNAP, and Housing Assistance*, CONGRESSIONAL RES. SERV., 1, 7–10 (2016).

184. See Ellwood *supra*, note 181.

185. See, e.g., Fording et al., *supra* note 173, at 285–87.

186. *Id.* at 285.

187. *Id.* at 293–94.

188. *Id.* at 285–312.

189. *Id.* at 307–09.

190. *Id.*

191. See Lawrence M. Mead, *The Rise of Paternalism*, in *THE NEW PATERNALISM: SUPERVISORY APPROACHES TO POVERTY*, 19–20 (Lawrence M. Mead, ed. 1997); see also Casey Ross, *Trump Health Official Seema Verma Has a Plan to Slash Medicaid Rolls. Here's How*, STAT NEWS (Oct. 26, 2017), <https://www.statnews.com/2017/10/26/seema-verma-medicaid-plan/> (discussing the Trump administration's goal of moving “able-bodied” Medicaid beneficiaries off of public coverage).

192. See, e.g., LAWRENCE MEAD, *BEYOND ENTITLEMENT: THE SOCIAL OBLIGATIONS OF CITIZENSHIP* 10, 196–206, 246–48 (1986).

provider does so, due to increased stigmatization of Medicaid.

Stigmatization of Medicaid recipients within the health care community would be an especially bad result, given that Medicaid beneficiaries may already be disproportionately likely to experience discrimination by health care providers due to their race. First, physicians and other health care providers are just as likely to hold biases against particular groups as the population at large,<sup>193</sup> and substantial evidence exists that racial disparities in health outcomes may be caused, at least in part, by racial stereotyping and discrimination.<sup>194</sup> Medicaid beneficiaries are disproportionately likely to be a member of a racial minority.<sup>195</sup> Disparate treatment is an affront to patient dignity, can negatively impact outcomes for patients, and constitutes a poor use of public resources.<sup>196</sup>

Medicaid stigma does not derive from any explicit legislative intent, and no part of the Medicaid statute suggests that Congress intended the program to provide substandard care.<sup>197</sup> The statute does not have language suggesting that Congress intended Medicaid, like TANF, to “end the dependence of needy families on government benefits.”<sup>198</sup> On the contrary, the language in 42 U.S.C. § 1396a(a)(30)(A) suggests that Medicaid payments are supposed to be “consistent with efficiency, economy, and quality of care” and sufficient to make access and receipt of care analogous to that of the general population in that area.<sup>199</sup> Regardless of Medicaid’s long history of poor provider payment in most states,<sup>200</sup> Congress did not build substandard payments for poor-quality care into the statute.

Additionally, while Medicaid has historically been linked with and carried the stigma of cash welfare, Congress and federal agencies have endeavored over time to relieve Medicaid from its association to welfare.<sup>201</sup> This has not been a steady process, and there have been a number of significant retreats at

193. Dayna B. Matthew, *Health Care, Title VI, and Racism’s New Normal*, 6 GEO. J. L. & MOD. CRIT. RACE PERSP. 3, 20 (2014).

194. INSTITUTE OF MEDICINE, *UNEQUAL TREATMENT: CONFRONTING RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE*, 162–74 (Brian D. Smedley, Adrienne Y. Stith, & Alan R. Nelson, eds. 2003).

195. *Health Coverage by Race and Ethnicity: The Potential Impact of the Affordable Care Act*, THE HENRY J. KAISER FAM. FOUND. 1, 5 (Mar. 2013), <https://kaiserfamilyfoundation.files.wordpress.com/2014/07/8423-health-coverage-by-race-and-ethnicity.pdf>.

196. Matthew, *supra* note 193, at 4–5.

197. 42 U.S.C. § 1396–1 (1984); *see, e.g.*, Laura D. Hermer, *Medicaid, Low Income Pools, and the Goals of Privatization*, 17 GEO. J. ON POVERTY L. & POL’Y 405, 414 (2010) (demonstrating that at least some groups arguably intended quite the opposite).

198. 42 U.S.C. § 601(a)(2) (1997).

199. 42 U.S.C. § 1396a(a)(30)(A) (2016).

200. Julia Paradise, *Medicaid Moving Forward*, HENRY J. KAISER FAM. FOUND. (Mar. 09, 2015), <https://www.kff.org/health-reform/issue-brief/medicaid-moving-forward>.

201. *See* Huberfeld & Roberts, *supra* note 15, at 47.

varying times.<sup>202</sup> However, with the gradual delinking of Medicaid from cash welfare and the Affordable Care Act's expansion of Medicaid to all financially eligible, non-elderly adults in expansion states, it is arguably becoming increasingly difficult to cogently claim that Medicaid should be reserved only for the most impoverished and vulnerable groups and should be at most a temporary crutch for the poor, rather than a health care mainstay for populations that lack real and stable access to regular and necessary medical care.<sup>203</sup>

Nevertheless, the Trump administration's tone and messaging may threaten a growth in Medicaid stigmatization. Members of the administration's executive branch have communicated an unquestionably dismissive attitude toward welfare programs, welfare recipients, and poverty in general.<sup>204</sup> For example, in 2017, Ben Carson, the Secretary of the Department of Housing and Urban Development, opined that "poverty to a large extent is ... a state of mind. You take somebody that has the right mindset, you can take everything from them and put them on the street, and I guarantee in a little while they'll be right back up there."<sup>205</sup> Similarly, Mick Mulvaney, the head of the Office of Management and Budget, defended the Trump budget's massive cuts to a panoply of programs for low-income Americans by saying, "[w]e're no longer going to measure compassion by the number of programs or the number of people on those programs, but by the number of people we help get off of those programs," and that cutting programs "is how you can help people take charge of their own lives again..."<sup>206</sup>

Given this current political climate, the question remains as to whether

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202. Jeanne M. Lambrew, *Making Medicaid a Block Grant Program: An Analysis of the Implications of Past Proposals*, 83 MILBANK Q. 41, 52–55 (2005) (discussing problematic impacts of block grant proposals on Medicaid); *see also*, 42 U.S.C. § 1396u–7(a) (2017) (permitting states to provide certain groups of Medicaid beneficiaries with "benchmark benefits" that may differ from and be more limited than benefits provided to other groups of beneficiaries in the state, as enacted in the Deficit Reduction Act of 2005).

203. *See, e.g.*, Huberfeld & Roberts, *supra* note 15, at 37–38 (discussing the myth that working for pay eliminates dependence).

204. Julie Hirschfield Davis, *Trump's Budget Cuts Deeply into Medicaid and Anti-Poverty Efforts*, N.Y. TIMES (May 22, 2017), <https://www.nytimes.com/2017/05/22/us/politics/trump-budget-cuts.html> (noting that Mark Meadows, the chairman of the "conservative" House Freedom Caucus, remarked that Trump's proposed elimination of funding for "Meals on Wheels, even for some of us who are considered to be fiscal hawks, may be a bridge too far").

205. Jose A. DelReal, *Ben Carson Calls Poverty 'a State of Mind' During Interview*, WASH. POST (May 24, 2017), [https://www.washingtonpost.com/news/post-politics/wp/2017/05/24/ben-carson-calls-poverty-a-state-of-mind-during-interview/?utm\\_term=.e3f60be6e7e0](https://www.washingtonpost.com/news/post-politics/wp/2017/05/24/ben-carson-calls-poverty-a-state-of-mind-during-interview/?utm_term=.e3f60be6e7e0).

206. *Press Briefing on the FY2018 Budget*, WHITE HOUSE OFF. PRESS SEC. (May 23, 2017, 11:12 AM), <https://www.whitehouse.gov/the-press-office/2017/05/23/press-briefing-fy2018-budget>.

Medicaid personal responsibility requirements, directive and paternalistic by nature, will not only make it more difficult for individuals to qualify for and obtain Medicaid benefits, but also saddle them with a renewed stigma of alleged shiftlessness and dependence.<sup>207</sup> If so, to what extent might this additional stigma negatively affect the treatment they receive from health care professionals? Given that physicians hold biases that are similar to those in the general population, it would be reasonable to expect that if the general population increased bias toward welfare recipients after the enactment of PRWORA, physicians likely shared in that bias.<sup>208</sup> While the match between the programs and different factors at issue are imperfect at best, they provide some insight as to what we may expect by considering attitudes toward cash welfare prior to and following the enactment of PRWORA in 1996.<sup>209</sup>

One study by Jeffrey Will analyzed public opinion research regarding cash welfare recipients from the Depression to the early 1990s, before the inception of TANF.<sup>210</sup> The study found a longstanding dichotomy regarding public perception of welfare and those who receive it.<sup>211</sup> On the one hand, public opinion data consistently upheld the notion that no one should be hungry or otherwise in need of the basics of life.<sup>212</sup> On the other hand, a plurality or slight majority reported that they believe people on welfare are dishonest and lack integrity.<sup>213</sup> The same study found that study participants viewed hypothetical families seeking welfare as “more deserving” if they needed welfare for reasons beyond their control, or if the mother was actively seeking work.<sup>214</sup> Participants were less sympathetic toward hypothetical families where the mother was not seeking work, or was picky about job choices.<sup>215</sup>

A 2007 study found that public opinion of cash welfare recipients barely changed from the pre-TANF era to the post-TANF era.<sup>216</sup> The authors performed a meta-analysis of studies using different but roughly analogous

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207. *Id.*

208. Matthew, *supra* note 194, at 5.

209. *Id.*

210. See Jeffrey A. Will, *The Dimensions of Poverty: Public Perceptions of the Deserving Poor*, 22 SOC. SCI. RES. 312, 312–13 (1993).

211. *Id.* at 316.

212. *Id.* at 314–15.

213. *Id.* at 315.

214. *Id.* at 329.

215. *Id.*

216. Joe Soss & Sanford F. Schram, *A Public Transformed? Welfare Reform as Policy Feedback*, 101 AM. POL. SCI. REV. 111, 115–17 (2007) (“In sum, then, we find evidence of issue negation. . . but no transformation of views on welfare policy, welfare recipients, and the poor. . . . After 1996, welfare faded from the public agenda, but underlying images of welfare and policy-relevant groups shifted little.”).

questions from two time periods: 1989 and the early 2000s.<sup>217</sup> The study found that, during both time periods, anywhere between nearly half to over seventy percent of respondents agreed with statements that welfare recipients are dependent, lazy, or have little incentive to work.<sup>218</sup> The public appeared to be sympathetic to those in dire economic straits for reasons perceived beyond their control, but were less likely to be sympathetic towards individuals who made what appear to be poor life choices.<sup>219</sup> The intervening reforms putting time limits on cash welfare and requiring a substantial percentage of recipients to work appear to have made little change to the public's view of these populations.<sup>220</sup> The results suggest that, if similar reforms are imposed on certain Medicaid beneficiaries, the changes may only make it more difficult for beneficiaries to obtain or maintain benefits.<sup>221</sup> However, the proposed reforms may not alter the attitudes that physicians and others have toward beneficiaries, or make beneficiaries more likely to receive discriminatory or substandard care.<sup>222</sup>

#### IV. CONCLUSION

Medicaid and cash welfare are by no means analogous. But if public perception of Medicaid beneficiaries on whom time limits and work requirements are imposed follows a similar trend to that observed in TANF, then the impending waiver requirements may have little effect on public opinion, and thus, quite possibly also on providers' opinions of Medicaid beneficiaries.<sup>223</sup> Physicians have a history of problems with treating Medicaid patients, including bias against what they view as negative characteristics of Medicaid beneficiaries.<sup>224</sup> However, evidence suggests that impending personal responsibility requirements in some states' programs may not exacerbate those biases.<sup>225</sup>

Work requirements may, depending on implementation, have a negative effect on adult, non-disabled, non-elderly Medicaid beneficiaries, although the majority already work anyway.<sup>226</sup> Negative effects will depend greatly on how those requirements will be implemented and enforced, who will be

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217. *Id.* at 115.

218. *Id.* at 115–16.

219. Soss & Schram, *supra* note 216, at 116.

220. *Id.*

221. *Id.*

222. *Id.*

223. *Id.* at 107–09.

224. Will, *supra* note 210.

225. *Id.*

226. *See, e.g.*, Garfield, Rudowitz, & Damico, *supra* note 7 (finding that “among the 24 million non-SSI adults (ages 19-64) enrolled in Medicaid in 2015, 6 in 10 (59%) are working themselves”).

exempted from them, and how much flexibility states will use in imposing them in the event of a changing economic landscape, such as another recession. As for time limits, they are both counterintuitive and counterproductive in the context of Medicaid.<sup>227</sup> Given the well-documented ill effects of being uninsured, it would be imprudent to implement a policy that encourages eligible beneficiaries to go uninsured rather than risk running out of coverage when they really need it.

Non-disabled, non-elderly, non-pregnant Medicaid beneficiaries in states like Kentucky, Maine, and Indiana will likely experience negative effects from personal responsibility requirements, presuming the Secretary of HHS grants their respective waivers. Time limits would be particularly problematic. However, as long as funding remains open and states are required to carefully collect data, rigorously evaluate their waiver programs, and make changes when warranted, many of the TANF-style changes that some states seek may not have as dire an effect on beneficiaries and the care they receive as one might initially worry. Time may soon tell.

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227. *Id.* at 120.