ENDING THE CYCLE

REFORMING WELFARE IN PENNSYLVANIA

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Ending the Cycle: Reforming Welfare in Pennsylvania

Elizabeth Stelle[1]

Executive Summary

Government welfare, with its goal to provide a helping hand to those in need, has instead become a vast series of programs that fall far short of the good intentions behind them. Welfare spending in the Keystone State consumes a growing share of the state budget, and is projected to crowd out spending on other government programs in the near future. In addition to being costly, too many welfare programs frequently provide low-quality care to recipients. The result is that Pennsylvania's welfare system promotes greater dependence on government – instead of independence and personal responsibility – resulting in higher, rather than reduced poverty. This doesn't have to be the case.

Since fiscal year 2002-03, Pennsylvania total Public Welfare spending, including federal funds, rose 52% – when inflation was just 25%. Today, the Department of Public Welfare represents almost 40% of Pennsylvania's General Fund budget. This year, welfare exceeds education as the largest department in the state General Fund for the first time in the history of the Commonwealth. More importantly, increases in welfare spending outpace personal income and state tax revenue growth. In other words, welfare spending is growing faster than our economy. Medicaid alone consumes 31% of Pennsylvania's total operating budget, higher than every other state in the nation but one.

Such rates of spending – even on worthwhile poverty-reduction programs – are fiscally unsustainable. Worse, dramatic increases in welfare spending have failed to free Pennsylvanians from a poverty rate that has been climbing since 2000. Helping more Pennsylvanians escape poverty will require a complete restructuring of the current system, an overhaul that begins with the federal government but can be driven by the states demanding reform.

The majority of welfare programs, and subsequent funding, originate with the federal government, leaving states little room for innovation. The current federal funding system actually encourages states to spend more in order to draw down additional federal funds. Pennsylvania needs greater independence from the federal government to implement customized programs based on what works for Pennsylvanians.

Pennsylvania lawmakers must take on the task of overhauling the welfare system to ensure more efficient spending of tax dollars and to promote the economic independence of those now trapped in poverty. This will require systemic modifications, including:

- Utilizing performance-based budgeting to expand programs that work and end programs that don't.
- Aggressively identifying and cutting waste and abuse by enforcing eligibility standards.
- Restructuring Medicaid as a voucher system where patients are given more control over their healthcare.
- Closing the eligibility loopholes in long-term care to encourage the purchase of private long-term care insurance and prevent wealthy seniors from receiving government-paid nursing care.
- Establishing time limits on benefits and enhance work requirements to keep the safety net from becoming a permanent welfare hammock.

[1] The author wishes to thank Jason High, Nathan Benefield, Jay Ostrich, Dawn Meling, John Bouder, and Matthew Brouillette for their contributions to this report.

Gov. Tom Corbett and state lawmakers must rethink how the state provides for the truly needy. This entails difficult decisions about eligibility, benefits, and delivery. If no action is taken, welfare spending will continue to crowd out other departments like education and transportation, depriving the truly needy from proper care and leading to future tax increases.

Introduction

Pennsylvania's public welfare system is exploding, placing an ever-expanding cost burden on taxpayers and relegating its intended beneficiaries to a life of dependency on other taxpayers. For the first time in history, Public Welfare is the largest department in Pennsylvania's General Fund budget. For years, the Department of Education held this position. This change signifies a new era in Pennsylvania where the primary function of government has become redistribution of income with the intention of providing for those in need.

Much of the growth in Public Welfare is the result of specific decisions made by lawmakers in Pennsylvania and Washington, D.C. From abundant unearned benefits, to unenforced eligibility guidelines, to turning a blind eye on fraud, today's dysfunctional welfare system is a product of a host of irresponsible individual decisions. This should come as no surprise given former Gov. Ed Rendell counted it a success that his administration added Pennsylvanians to welfare programs.[2]

The course of Pennsylvania's welfare spending can still be reversed, while continuing to provide a safety net. Gov. Tom Corbett and state lawmakers must rethink how the state can sustain a beneficial yet temporary welfare system, thus providing a hand-up, rather than a perpetual handout. That entails difficult decisions about eligibility, benefits, and delivery of cash assistance, food stamps, and medical assistance. Those who have been defrauding Pennsylvanians for decades, essentially stealing from the truly needy, must be sought out, removed from the rolls, and penalized for their abuse of the system.

The welfare system in Pennsylvania is expensive, ineffective, and unaccountable. Ever-increasing spending has discouraged families from escaping the welfare trap, turning a government safety net into a hammock. Breaking the cycle of poverty at a time when the economy is stagnant will require greater flexibility and new accountability measures. This report seeks both to outline how costly and ineffective the welfare system has become, and to chart a course to restore public welfare's focus on breaking the cycle of dependency – the only way to truly serve Pennsylvania's most vulnerable citizens. Even if Pennsylvania cannot secure a federal waiver to enact sweeping reforms, the state can still pursue many policies to make the system more agile, harder to defraud and, above all, more successful at restoring Pennsylvanians' dignity and self-reliance.

Welfare Spending Is Skyrocketing

On June 30, 2011, Gov. Tom Corbett signed a $27.1 billion General Fund budget. The Department of Public Welfare represents 39% of this sum, an appropriation of $10.6 billion. Medicaid alone consumes 31% of the entire state operating budget, the second largest share of any state budget, according to National Association of State Budget Officers.[3] This fiscal year marks the first time in the history of the Commonwealth that Public Welfare exceeded Education as the largest department in the state General Fund.

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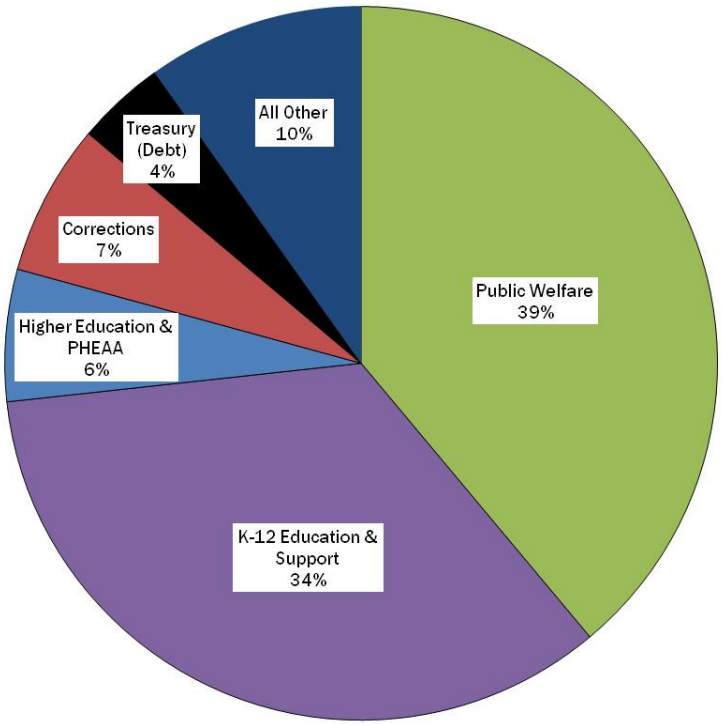
[2] Rendell, Edward G., Executive Budget Address Fiscal Year 2010-2011, February 9, 2010, www.commonwealthfoundation.org/docLib/20100209_BudgetAddress.pdf

[3] National Association of State Budget Officers, 2010 State Expenditure Report, Table 29, p.48, http://nasbo.org/LinkClick.aspx?fileticket=C3LJlSFxbdo%3d&tabid=79

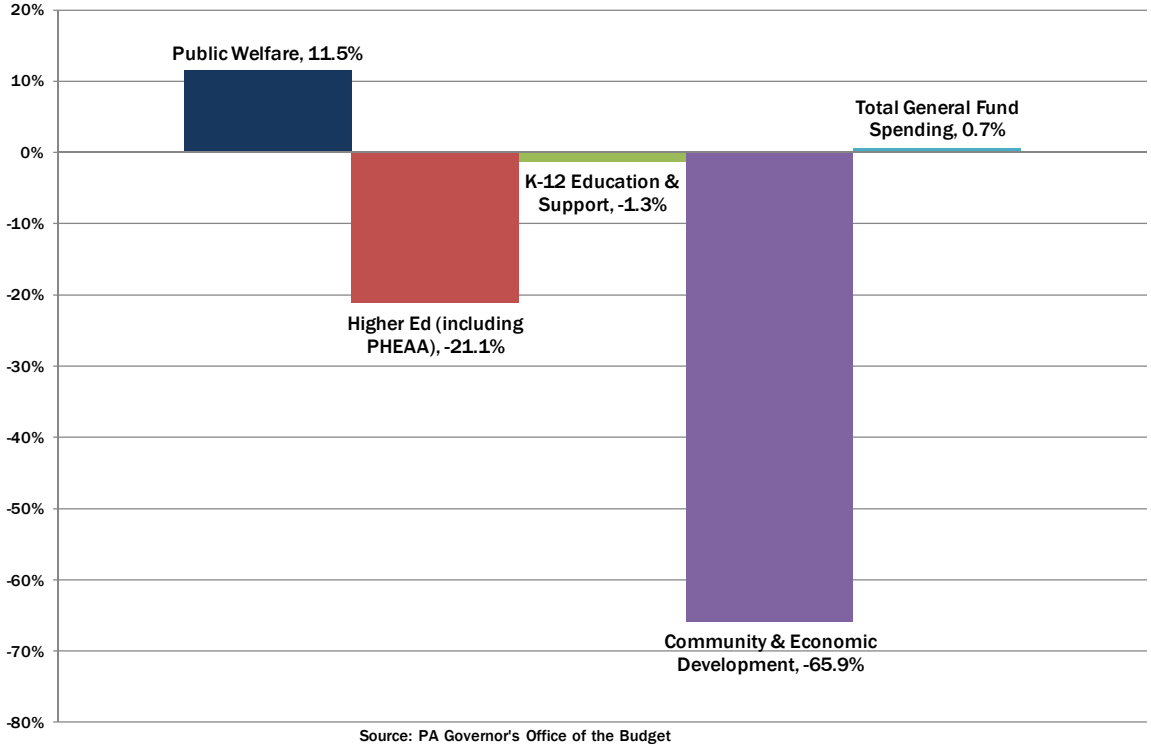
Chart 1: 2011-2012 Enacted General Fund Spending



Source: PA Governor's Office of the Budget

Public Welfare has largely escaped the budgetary cuts placed on other departments and programs. From FY 2007-08 to FY 2011-12, the Department of Public Welfare's budget steadily increased, outpacing total General Fund spending.

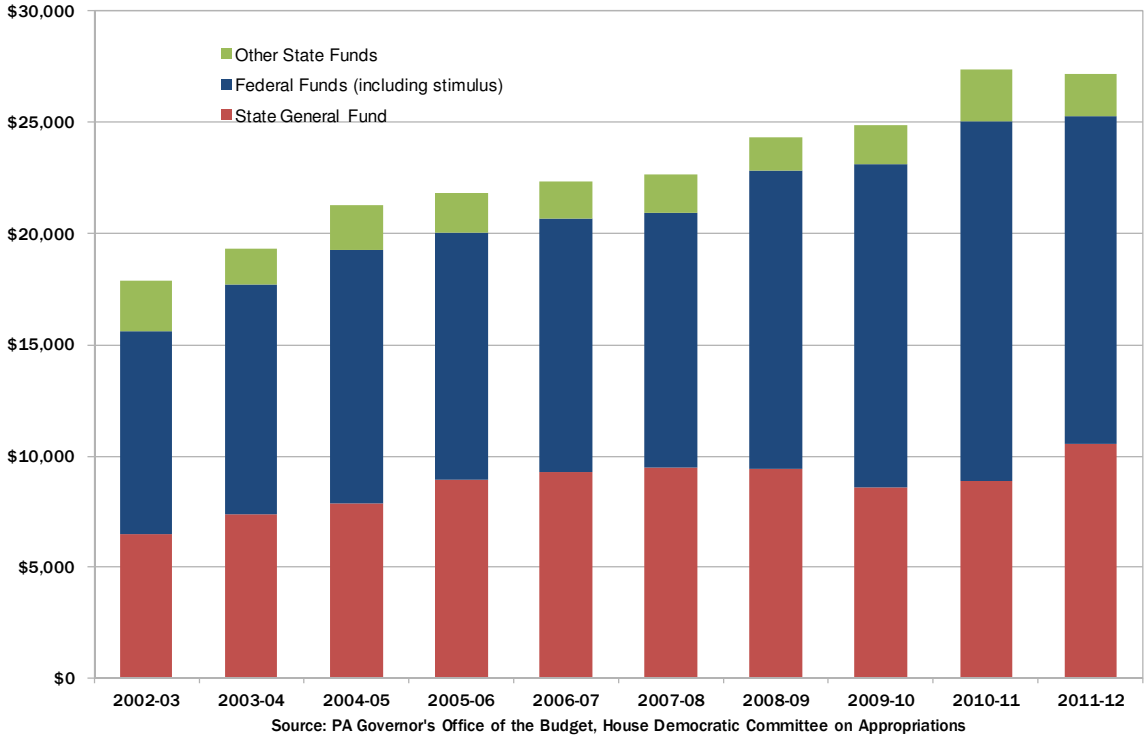
Chart 2: General Fund Spending Change, FY 2007-08 to FY 2011-12



Source: PA Governor's Office of the Budget

Since FY 2002-03, total Public Welfare spending, including federal funds to the state, rose from $17.9 billion to an estimated $27.2 billion for FY 2011-12, an increase of 52% – while inflation increased only 25%. The chart below details expenditures over this 10-year period.

Chart 3: Total Public Welfare Spending (amounts in millions)



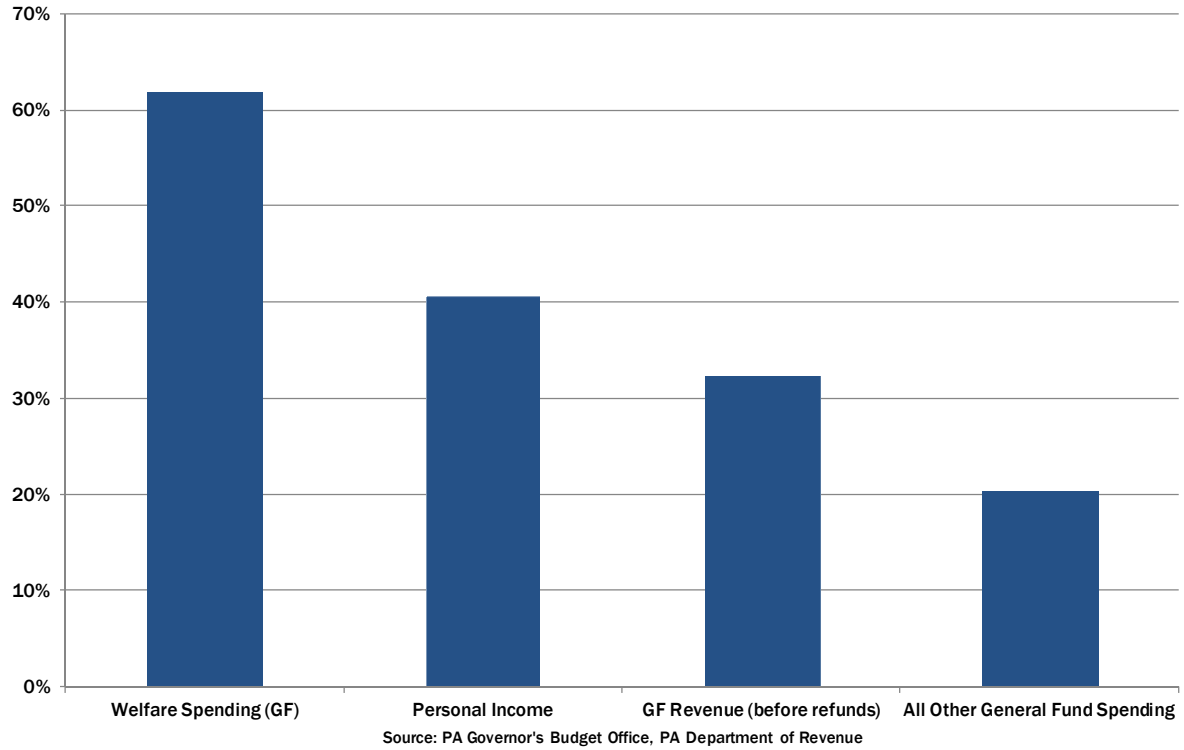
Source: PA Governor's Office of the Budget, House Democratic Committee on Appropriations

According to Census data, Pennsylvania is among the top-10 states in budget percentage spent on public welfare, surpassing neighboring states such as Maryland, New Jersey, and West Virginia.[4]

Increases in welfare spending outpace personal income and state tax revenue growth. In other words, welfare spending is growing faster than our economy and the taxpayers' ability to pay. Welfare has also grown three times as fast as the rest of the state budget since FY 2002-03. A growing welfare budget means fewer tax dollars for other priorities like education, transportation, and other core functions of government. Continued growth in welfare will either require cuts in other state programs, or significantly higher taxes.

[4] U.S. Census Bureau, State Government Finances, www.census.gov/govs

Chart 4: Welfare Spending vs. Personal Income, State Revenue, and All Other Spending, FY 2002-03 to FY 2011-12



Source: PA Governor's Budget Office, PA Department of Revenue

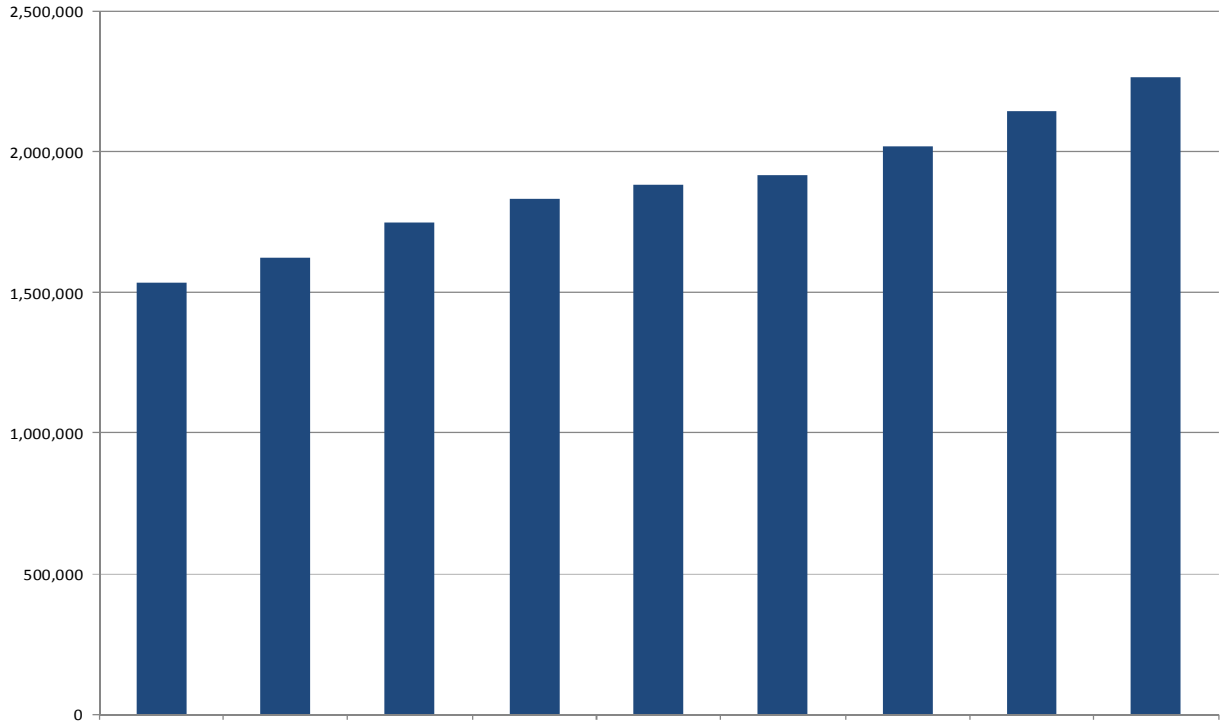
Dependency on Government is Growing

Growing enrollment in welfare programs is a large contributor to higher government spending and higher taxes. Medicaid, ("Medical Assistance" in the Pennsylvania state budget) has the broadest eligibility requirements of the welfare programs and participation has been on the rise every year since FY 2002-03. Almost 18% of the population was enrolled in Medicaid last year, though not everyone who qualifies for Medicaid enrolls.

Pennsylvania is quickly reaching a point where the tax base cannot support the services lawmakers are promising. Projections indicate that enrollment increases due to changes in federal eligibility laws will surpass the average growth of the last 10 years. Absent significant reforms, the Heritage Foundation expects Medicaid enrollment to increase 17.6% by 2014.[5]

[5] Blasé, Brian and Edmund Haislmaier, "Obamacare: Impact on States," Heritage Foundation, http://www.heritage.org

Chart 5: Medicaid Enrollment in Pennsylvania



Source: Department of Public Welfare Medical Assistance Statistics

Medicaid is just one program in the Department of Public Welfare. The wide array of state and federal programs allows many recipients to qualify automatically for numerous programs. Not surprisingly, many Pennsylvanians are highly dependent on welfare: more than 600,000 collect benefits from multiple programs. In FY 2009-10, about 30% of Pennsylvanians on Medicaid also received cash assistance benefits.

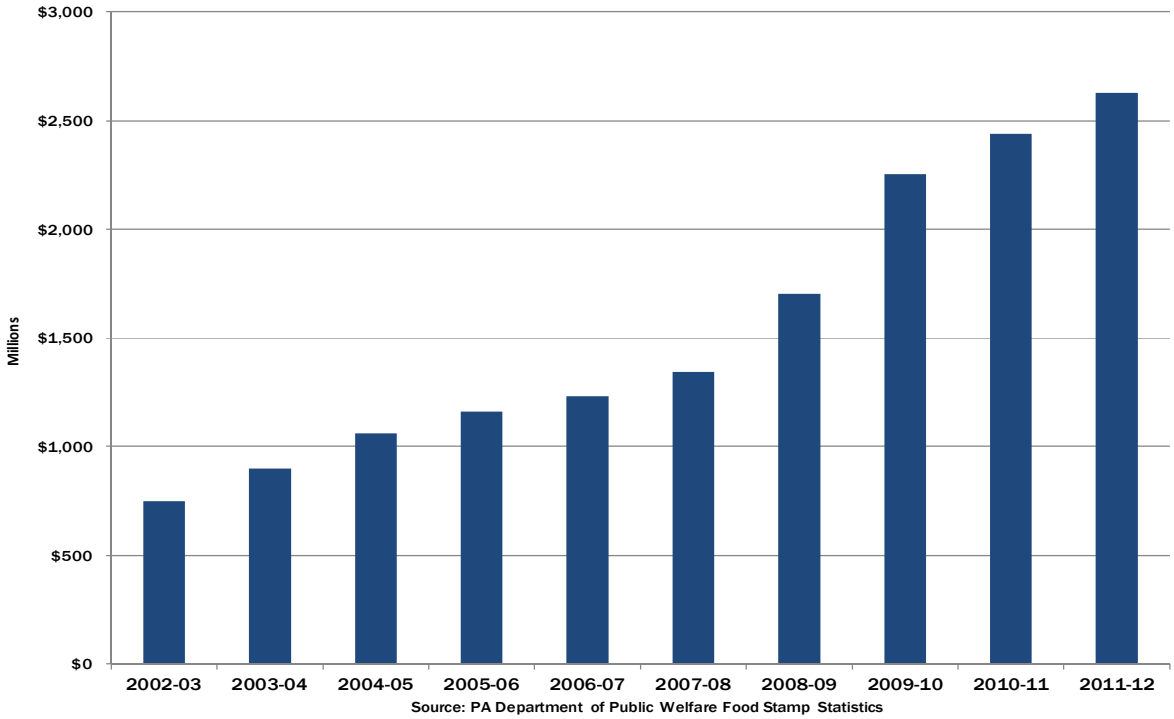
Pennsylvania ranks first in the nation in the percentage of children (67.7%, compared to the national average of 53%) approved for Supplemental Security Income benefits, a cash benefit targeting the disabled and children with behavioral, learning and mental disorders. Recent investigations show some low-income families seek out medical professionals to prescribe medication for their children, increasing the child's chances of being approved for SSI's generous benefits.[6] The benefit is primarily funded by the federal government but is administered by the Department of Public Welfare, and the state supplements the administration of federal benefits.

The Supplemental Nutrition Assistance Program (SNAP) is the new term for what is commonly called "food stamps." While SNAP is a federal program, the states administer it and shoulder a part of its administrative costs. The number of Pennsylvanians receiving SNAP benefits is at an all-time high, soaring 46% since December 2007.[7] As of the 2010-11 fiscal year, 1.7 million Pennsylvanians qualified for this type of assistance.

[6] Wren, Patricia, "A cruel dilemma for those on the cusp of adult life," Boston Globe, December 14, 2010, http://www.boston.com

[7] 2011-2012 Governor's Executive Budget, http://www.budget.state.pa.us/

Chart 6: SNAP (Food Stamp) Growth in PA



Source: PA Department of Public Welfare Food Stamp Statistics

In just eight fiscal years, total costs for SNAP have more than doubled. If these costs continue to grow at the average rate of the last eight years, they will exceed $4 billion per year by FY 2013-14.

Rampant Welfare Waste, Fraud and Abuse

Pennsylvania welfare enrollment has ballooned partly because of lax enforcement of eligibility requirements, deliberate fraud, and unnecessary errors. A series of reports from Auditor General Jack Wagner revealed error rates of more than 15 percent. Most eligibility errors were a result of the state's failure to verify the age, income eligibility, or disability status of the recipient. Enforcing existing guidelines would garner significant savings for state welfare programs. The Auditor General's office estimates that reducing the error rate by just one-tenth could save $436 million in fiscal year 2011-12, with savings of over $1.9 billion over four years.[8]

DPW's Office of Developmental Programs, which serves individuals with intellectual disabilities, conducted a series of audits that revealed numerous examples of waste and abuse. Providers billed the department for luxuries such as a chandelier, landscaping, and a six-person hot tub. Auditors also discovered the department paid for the construction of a bowling alley for the parents of a disabled individual and flea dipping for a therapeutic cat.[9]

The audits also revealed Supportive Concepts for Families Inc. billed the department for leases of luxury vehicles, including a 2006 Acura MDX for $689 a month and a 2005 Acura RL for two years at $835 a month. SCFF could have purchased four Chevy Impalas for the cost of leasing and

[8] Pennsylvania Office of the Auditor General, "Auditor General Jack Wagner Says Reducing Medicaid Error Rate Would Save Hundreds of Millions of Dollars"
http://www.auditorgen.state.pa.us/Department/Press/WagnerSaysReducingMedicaidErrRtWldSvMillions.html
[9] Pennsylvania Department of Public Welfare, Testimony before the Senate Public Health and Welfare Committee, September 28, 2011.

then purchasing one Acura RL.[10] The corporate structure of another provider, Lynch Homes, enabled it to charge rent to multiple counties on properties it already owned—costing DPW $1.6 million. None of these actions are illegal, but they demonstrate how providers can abuse the broken system.

ODP and Medicaid aren't the only programs combating waste fraud and abuse. The Special Allowance Program has been highlighted by the Auditor General as fraught with abuse, costing taxpayers tens of millions of dollars.[11] The nuanced rules and eligibility guideline lead to numerous overpayments and abuses. For example, Jewish Employment and Vocational Services (JEVS) exceeded allowable special allowance payments (SPAL) by $6,269 including ineligible expenses like $350 for TV and internet and $1,637 for court fees and fines. The Northern Tier Regional Planning and Development Commission made $11,000 in SPAL overpayments and Snyder County issued a mileage SPAL of $425.50 for transportation to school in December of 2009. The office later learned the client graduated in September of 2009. These are just a few examples of how the welfare budget is wasted little by little, leaving fewer resources for the truly needy.[12]

Harriet Garrett, the President of Creative Urban Educational Systems (C.U.E.S.), stole nearly $220,000 in taxpayer money to pay back taxes and purchase a $35,000 GMC Yukon Denali. In 2005, C.U.E.S. took over a DPW contract to provide training in medical assistance and medical billing to welfare recipients. Garrett employed two of her daughters and her husband at C.U.E.S., which was in violation of the contract. Students complained that instruction was severely lacking and that they were not provided with the proper books and materials for the program. Garrett was sentenced to 6 to 23 months in prison and ordered to pay $123,447 in restitution.[13]

Additional examples of fraud during the 2010-2011 fiscal year include the disqualification of 178 food stores from the SNAP program for trafficking (buying or selling benefits for money) and more than $305,000 in long-term care medical assistance overpayments.[14]

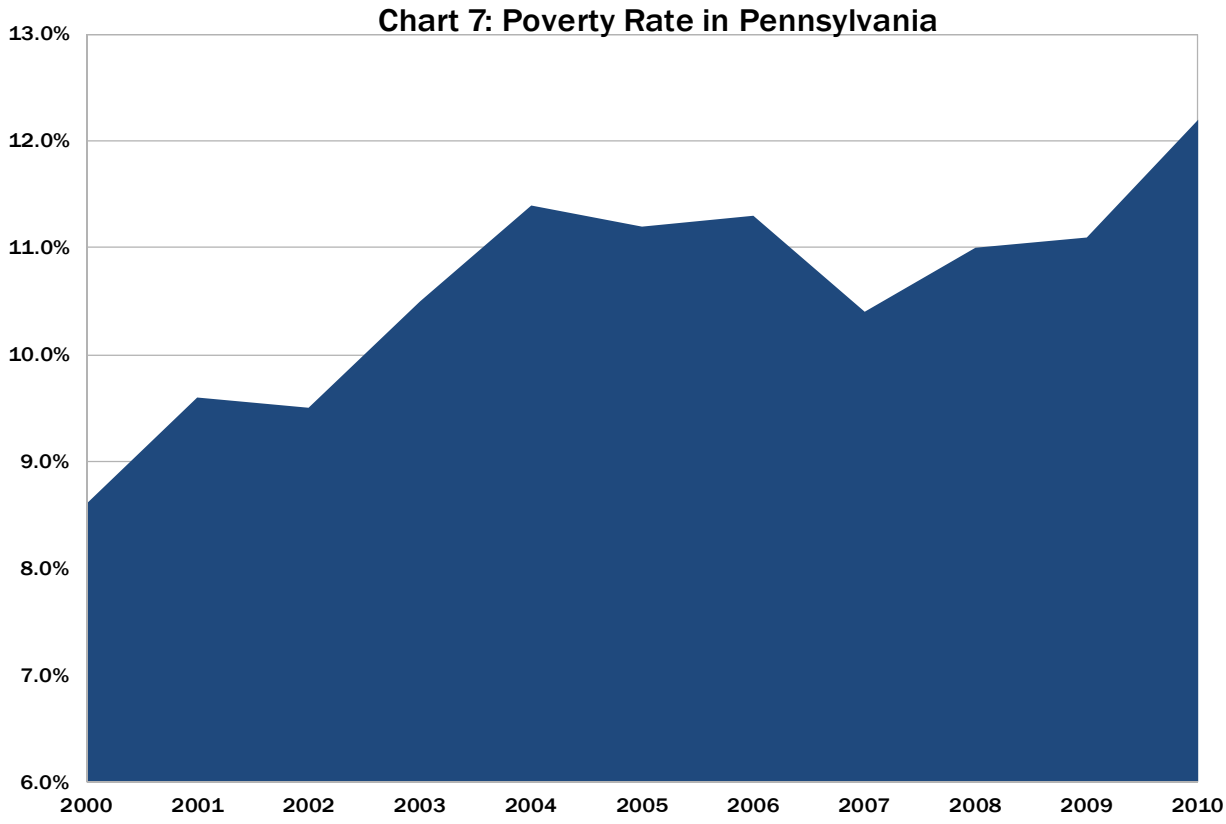
The amount of total fraud is unknown, since the Rendell administration *cut in half the number of fraud* referrals to the Office of Inspector General, the office responsible for litigating welfare fraud. In 2002, the Inspector General received approximately 47,000 cases referred for suspected welfare fraud. However, by 2010 the Inspector General the referrals declined only 27,645, even though caseloads had dramatically increased.[15] During FY 2010-2011, the Office of Inspector General (OIG) investigated 27,373 applications for benefits, saving more than $66.5 million by prosecuting fraud.[16]

Despite Welfare Spending, Poverty Continues to Rise

Over time, dramatic increases in welfare spending have consistently failed to reduce the poverty level. Pennsylvania's poverty rate has been climbing since 2000, regardless of the state's

[10] 2008 Performance Audit of Supportive Concepts for Families Inc., http://www.dpw.state.pa.us/publications/finalperformanceauditreports/index.htm
[11] "Auditor General Jack Wagner: DPW's Special Allowance Program Rife with Mismanagement, Potential for Fraud," Press Release, August 20, 2011.
[12] Final Performance Audit Reports, http://www.dpw.state.pa.us/publications/finalperformanceauditreports/index.htm
[13] "President of Philadelphia non-profit arrested for the theft of nearly $222,000 in taxpayer funds," Attorney General Press Release, May 21, 2010.
[14] Office of Inspector General 2010-2011 Annual Report, Office of the Inspector General, http://www.oig.state.pa.us/
[15] 2009-2010 Report on State Performance, http://www.performanceplan.state.pa.us/
[16] Office of Inspector General 2010-2011 Annual Report, Office of the Inspector General, http://www.oig.state.pa.us/

economic conditions. The poverty level has increased from 8.8% in 2000 to 12.2% in 2010.[17] The data indicate welfare spending is failing to bring independence to citizens.



Source: US Census, Current Population Survey

Medicaid Provides Low-Quality Care and Shifts Costs to Private Insurance

Advocates for more welfare spending highlight their concern for the poor, but recent research shows government-run health care programs, like Medicaid, offer surprisingly low-quality care.[18] Medicaid delivers episodic treatment, provides poor preventative care, offers sub-standard services to many beneficiaries and at times harms the poor.[19]

Studies find Medicaid patients receive worse care or have to wait longer to receive treatment than those with no insurance.[20] A study comparing cancer patients and different forms of health insurance found one-year cancer survival rates for prostate, breast, and lung cancers were higher among the uninsured than those with Medicaid.[21] A Columbia-Cornell study found that Medicaid

[17] Historical data from the U.S. Census, Current Population Survey. The American Community Survey, using a larger sample and the prior 12 months, rather than calendar year, reports a poverty rate of 13.4% for Pennsylvania in 2010. For more information see: http://www.census.gov/hhes/www/poverty/about/datasources/factsheet.html
[18] Koroukian, Siran M., Bakaki, Paul M., and Raghavan, Derek, "Survival Disparities by Medicaid Status," Cancer, Doi: 10.1002/cncr.27380, http://onlinelibrary.wiley.com/doi/10.1002/cncr.27380/abstract
[19] Bond, Michael, "Medicaid Reform: Mending the Holes in Pennsylvania's Health Care Safety Net," Commonwealth Foundation, www.commonwealthfoundation.org
[20] Gottlieb, Scott, "Medicaid Is Worse Than No Coverage at All," *Wall Street Journal*, March 10, 2011, http://online.wsj.com
[21] McDavid, Kathleen, et al., "Cancer Survival in Kentucky and Health Insurance Coverage," Archives of Internal Medicine, 163 (18): 2135. Table 4. http://archinte.ama-assn.org/cgi/reprint/163/18/2135.pdf

patients with clogged blood vessels in their legs or clogged carotid arteries (the arteries of the neck that feed the brain) fared worse than the uninsured.[22]

Medicaid pays doctors and hospitals far less for services than private insurance does. In fact, Medicaid payments represent only 73% of Medicare's already low reimbursement rates. Many medical professionals are increasingly unwilling to serve Medicaid patients because of these low reimbursement rates.[23] A survey of physicians in 2008 found 61% of internists and 56% of family and general practitioners accept none or only some Medicaid patients. More recently, a U.S. Government Accountability Office survey found more than three times as many participating physicians, 84%, experience difficulty referring Medicaid and CHIP children to specialty care, compared to only 26% for children with private insurance. [24]

Low reimbursements not only hurt the Medicaid patient by limiting access but harm all Pennsylvanians by driving up the cost of private coverage. A 2008 national study found Medicaid underpaid U.S. hospitals by $16.2 billion and physicians by $23.7 billion. The cost shifting from Medicaid and Medicare adds an estimated 10.6% to the average family of four's insurance premium. Of that increase $397 is passed on to the employee, along with an additional $276 in cost-sharing.[25]

Federal Government's Role

The majority of welfare programs and their funding originate with the federal government, leaving states with little room for innovation and flexibility in their administrative role. In order to qualify for federal matching funds states must contribute a certain level of financial support; these standards are known as Maintenance of Effort (MOE) requirements. MOE can also refer to maintaining policies or procedures. If a state violates the MOE for a program it can lose all matching funding. Pennsylvania currently receives about $14 billion in federal matching funds.

MOE has become especially burdensome to states in the past three years with the passage of the stimulus package and health care reform. To receive American Recovery and Reinvestment Act (ARRA) funding, states were required to freeze their Medicaid and CHIP eligibility levels, preventing states from touching the largest programs in the state budget to address deficits. The MOE requirement was extended by the Patient Protection and Affordable Care Act, despite the fact that the stimulus funds tied to MOE ended and will remain in place until the health care exchanges go into effect in 2014.

The current relationship between federal and state government relegates states to a largely administrative role with little discretion over funding or eligibility rules, despite each state's knowledge of its own local needs. A number of reforms are available to state lawmakers. But without federal reform or a waiver from Washington, states will be unable to experiment with welfare reforms.

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[22] Giacovelli, Jeannine K., et al., "Insurance Status Predicts Access to Care and Outcomes of Vascular Disease," Journal of Vascular Surgery 48(4): 905–911, http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2582051/?tool=pubmed

[23] Kaiser State Health Facts, Medicaid-to-Medicare Fee Index 2008, http://www.statehealthfacts.org

[24] Government Accountability Office, "Medicaid and CHIP: Most Physicians Serve Covered Children but Have Difficulty Referring Them for Specialty Care," http://www.gao.gov/new.items/d11624.pdf

[25] Fox, Will and John Pickering, "Hospital & Physician Cost Shift," Millian, http://www.ahip.org/content/default.aspx?docid=25216

Fixing Pennsylvania's Welfare System

Medicaid Vouchers

Despite federal mandates, meaningful reforms to reduce costs and restructure benefit provision can improve the current system. The most substantive state reform is the restructuring of Pennsylvania's Medicaid system into a voucher system.[26]

Before establishing a voucher program, the state must secure approval from the federal government in the form of a waiver. A federal waiver allowing the state to redraft Medicaid services, as states such as Rhode Island, Florida, South Carolina, and Louisiana have obtained, could save tax dollars and improve the quality of health care received by low-income families. Rhode Island secured a global waiver in 2008 saving the state hundreds of millions of dollars in the first 18 months. From 2007 to 2011, the Ocean State's Medicaid spending grew 6.2%, while Pennsylvania's grew 24%.[27] In Florida, a credit system providing Medicaid enrollees with the freedom to purchase insurance has increased competition among plans, reduced co-pays, and expanded patient benefits without increasing spending.[28] South Carolina and Louisiana have also used waivers to give Medicaid recipients the ability to choose a private plan.

In Pennsylvania, the state Department of Public Welfare essentially acts as the insurance company for everyone receiving Medical Assistance through Medicaid. Individuals that meet eligibility guidelines accept the state as their insurance company. Critical to reforming Medicaid is understanding that the Commonwealth of Pennsylvania does not provide health *care* to anyone. Rather, it provides health *insurance* to everyone.

Table 1: Medicaid versus Private Insurance

Private Insurance	Medicaid
Insured pays a monthly premium	Insured may be required to pay some premium, depending on their income
Insurance company pays for high-cost health incidents	Taxpayer pays for high-cost incidents
Adjusts premium based on risk	Premium is based on income, irrespective of risk
Risk is assumed by private company with profit motive	Risk is assumed by the taxpayer
Doctors paid for cost of services by insurance company	Doctors paid a portion of the cost of care
Insured covers set co-pays at each visit	Insured may cover small co-pays, but little skin in the game
Insured can exercise more control over funds by utilizing health savings accounts	Insured has no control over healthcare funds and reaps no benefit for using less expensive care

Why is this distinction so important? The entity providing insurance to the needy is a key cost factor when it comes to subsidizing health care. Government does not provide insurance like a private company. The table above illustrates the differences between private insurance and Pennsylvania's Medicaid system.

[26] Bond, Michael, "Medicaid Reform: Mending the Holes in Pennsylvania's Health Care Safety Net," Commonwealth Foundation, http://www.commonwealthfoundation.org
[27] Rhode Island Global Consumer Choice Compact Medicaid Waiver: A National Model for Medicaid Reform, http://www.nd.gov/dhs/info/testimony/2011-2012-interim/healthcare-reform/ri-waiver.pdf
[28] Bond, Michael, "Reforming Medicaid in Florida," James Madison Institute, www.jamesmadison.org

How a Voucher System Would Work

A voucher system for Medicaid recipients would not only benefit Pennsylvania's fiscal health, but it would also improve the level of care that Medicaid beneficiaries receive. As the insurance agent for Medicaid beneficiaries, state government dictates the reimbursement rate that providers receive which, in most cases, is far below what providers receive from private insurance companies. This causes many providers to either refuse Medicaid patients or to accept only a limited number, thus limiting access to care for Pennsylvanians receiving Medicaid benefits. In other words, health insurance does not guarantee health care access.

A voucher program allows the state government to subsidize a recipient's health insurance in the market. After a recipient's risk level and income are evaluated, an appropriate voucher would be issued for the recipient to purchase a private insurance plan. Any voucher would be treated as cash to avoid the need to mandate insurance companies to accept recipients. To avoid abuses, the voucher would only be accepted for health services.

This system provides the following benefits:

- Costs to the state become predictable because the state is no longer at risk for the health care incidents of recipients.
- Recipients have expanded access to care, as providers will no longer limit the number of recipients they accept due to low Medicaid reimbursement rates.
- Insurance companies have a large new pool of customers.

The current Medicaid system is in financial crisis and is unsustainable. Changing the philosophical approach of Medicaid, from an insurance provider to an insurance subsidy and rewarding personal responsibility, will have positive long-term effects for both the beneficiary and the taxpayer.

Addressing Waste and Fraud

Gov. Corbett signed a welfare code bill in June 2011 that gives the Secretary of Public Welfare the ability to bypass the legislature and the Independent Regulatory Review Commission (IRRC) the ability to revise regulations. The measures will strengthen income eligibility guidelines, reduce cash grants, and require beneficiaries to make larger co-pays to save hundreds of millions of dollars. Specifically these provisions will:

- Prohibit outside contracts unless their cost-effectiveness is proven.
- Allow for refusal of services to beneficiaries who do not make their co-payments.
- Alter pharmacy and dental benefits for adult Medicaid patients who are not disabled. (Some states do not provide dental benefits under Medicaid.)
- Freeze payments to state nursing homes for residents on Medicaid for two years.
- Establish childcare services co-pays based on a sliding income scale.
- Enforce rules that require middle class families (income in excess of 200% the Federal Poverty Level) to make co-payments for services to their disabled children on Medical Assistance.
- Extend the time to review Medicaid hospital re-admissions to determine payments.

The code also includes drug testing for felons, county or residence verification, a more robust verification system, and reducing limits for the special allowance program to ensure benefits go to the neediest Pennsylvanians.[29]

DPW is already realizing savings by conducting overdue Medicaid eligibility reviews for 154,000 cases. As of November 2011, the department removed more than 150,000 non-eligible individuals including 4,000 deceased Pennsylvanians. The department has already saved taxpayers $43 million with more than $100 million in additional estimated federal and state savings on the horizon.[30]

Long-Term Care Reform

The cost of Medicaid Long-Term Care (LTC), also referred to as long-term living, is a major driver of spending increases. With the baby-boomer wave about to crest, states with the biggest aging populations, such as Pennsylvania, must explore ways to encourage private LTC financing.

The first step is to seek authority through a waiver from the Centers for Medicare and Medicaid Services to reduce Medicaid LTC eligibility and to maximize private LTC alternatives. Without a federal waiver, savings from the following reforms will be somewhat limited.[31] Pennsylvania LTC reform should:

- **Discourage Artificial Poverty:** Reform should discourage transferring wealth to relatives to become Medicaid eligible by extending the "look-back period," during which assets transferred for less than fair-market value incur an eligibility penalty from five to 10 years (as in Germany).
    - Lawmakers should eliminate or radically reduce the home equity exemption for Medicaid LTC eligibility from $500,000.
    - Eligibility should preclude the use of trusts, annuities, promissory notes, and other techniques used to shelter assets from Medicaid LTC financial eligibility limits.

- **Enhance Estate Recovery**: The Department of Public Welfare should make greater effort to recover LTC costs from the estates of deceased beneficiaries. Pennsylvania reported estate recoveries of approximately $24 million for 2004. If estate recovery increased to the same rate as Oregon (5.8%) taxpayers would save an additional $213 million annually.[32] Pennsylvania should not automatically waive recovery of estates with small gross values but should pursue all estates for which recovery is cost effective.
    - DPW should consider hiring an outside contractor on contingency to pursue estate recoveries in exchange for a percentage of the amount recovered.

- **Encourage Private LTC Financing:** DPW should promote the purchase of private LTC insurance by educating Pennsylvanians about the importance of planning for LTC.
    - State lawmakers should consider tax incentives to encourage the purchase of private LTC insurance and reduce the number of those who become dependent on Medicaid.

[29] Pennsylvania House GOP Welfair Initiative, http://welfair.pahousegop.com/what.aspx
[30] Sapatkin, Don, "Pa.'s Drop in Medicaid Roles Stirs Controversy," *Philadelphia Inquirer*, December 15, 2011, www.phillyinquirer.com
[31] Moses, Stephen, "Long-Term Care Reform," Commonwealth Foundation, http://www.commonwealthfoundation.org
[32] Ibid.

- **Encourage Home Equity Conversions to Fund LTC:** DPW should encourage the use of reverse mortgages to fund LTC privately by publicizing and expanding Pennsylvania's Long-Term Care Partnership program.

These reforms would encourage those with greater wealth to partially fund their own long-term care, while protecting Medicaid LTC funds for those who truly need support.

Work Requirements and Time Limits on Benefits

Work requirements were a staple of the 1996 federal welfare reforms. To be eligible for the federal cash assistance program known as Temporary Assistance for Needy Families (TANF), states must have 50% of eligible recipients participating in work activities. The definition of work activities is fairly broad and includes education and training programs. The national success of these work requirements has been well documented. The poverty rate for African-American children from 1969 through 1996 never dropped below 39%, but from 1996 to 2001 it fell to 30%.[33] By 2009, TANF rolls had been cut in half.[34]

The best way to get out of poverty is through a job. Employment helps the poor build marketable skills and reduces the burden on taxpayers. Welfare benefits without limits only discourage job-hunting and diminish the value of work. In Pennsylvania, there is a 60-month limit on TANF, the same as the federal time limit. But there are no restrictions on how frequently benefits are accessed. For example, Ohio limits benefits by making recipients ineligible for 24 months after 36 months of benefits. Indiana limits lifetime benefits to 24 months.[35] Pennsylvania should restructure time limits to encourage welfare recipients to view these services as temporary assistance, not long-term support. Time limits should not be restricted only to cash assistance but should be applied to all welfare programs.

Performance-Based Budgeting

The budget and programs of any agency often begin by focusing almost entirely on "inputs" (i.e., how much money needs to be allotted to sustain current programs and expenses). Officials take existing programs, adjust costs for inflation, add caseload increases, and call this their baseline budget. In this model, the cost, effectiveness, and demand for existing programs is rarely considered.

In contrast, performance-based budgeting directs the department to ask what the core function of the program is, how much is available to spend, and what is the most efficient and effective way to deliver services within available funds. In performance-based budgeting, nothing is sacrosanct. Programs can be changed or eliminated and barriers can be moved.

Once those questions are answered, the agency is left to develop ways of measuring progress and success. Goals should be macro-level, issue-oriented statements of the outcomes the agency will achieve. Agencies should have at least one performance measure (defined outcome) for each major activity. Performance is the measure of how efficiently and effectively those priorities are delivered. Clear performance measures are essential to ensuring good intentions lead to good results.

[33] U.S. Census Bureau, Poverty Data, http://www.census.gov/hhes/www/poverty/
[34] U.S. Department of Health and Human Services, Administration for Children and Families, http://www.acf.hhs.gov
[35] Zeigler, Jennifer, "Implementing Welfare Reform: A State Report Card," Cato Institute. http://www.cato.org

DPW is already considering performance-based budgeting. Officials are looking at restructuring cash assistance to pay contractors for long-term performance, rewarding jobs retained instead of initial job placements. The department is also working to prioritize spending by establishing the Office of Program Integrity and consolidating financial management service contracts.

Conclusion

Absent reform, welfare spending will soon crowd out the other duties of state government and continue to trap Pennsylvanians in poverty. The first step is to recognize the magnitude of the problem. Pennsylvania's welfare crisis continues to compound with each fiscal year that passes. Welfare spending is skyrocketing, growing faster than our personal incomes and our economy, and threatening to overwhelm the state budget. At the same time, dependency on welfare benefits is becoming an epidemic, as many Pennsylvanians collect a variety of benefits from different state agencies and federal programs. Worst of all, the current system lures families into permanent poverty with overgenerous benefits that translate into sporadic and ineffective care.

To reduce poverty and aid the neediest, Pennsylvania must refocus the welfare system to reward self-reliance, rather than dependence on taxpayer support. More flexibility from the federal government would go a long way to ease the transformation of Pennsylvania's largest program, Medicaid. Absent approval from Washington to enact vouchers, Pennsylvania should give beneficiaries more control over their healthcare and continue to cut waste and abuse by enforcing eligibility standards. Opportunities to reduce abuse are especially plentiful in Long-Term Care, where wealthy seniors exploit loopholes to receive government-paid nursing care. Enhancing work requirements and time limits would also reduce the strain on the social safety net.

The enormous size of the modern welfare industrial complex is daunting, but policymakers must not delay reform. Deferring this task is a disservice to taxpayers who can no longer afford the department's sky-rocketing cost and an injustice to Pennsylvania's most vulnerable citizens.

About the Author & the Commonwealth Foundation

Elizabeth Stelle is a policy analyst with the Commonwealth Foundation.

The Commonwealth Foundation (CommonwealthFoundation.org) is Pennsylvania's free-market think tank. The Commonwealth Foundation crafts free-market policies, convinces Pennsylvanians of their benefits, and counters attacks on liberty.

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