SECTION 15. OTHER PROGRAMS

CONTENTS

OVERVIEW

A wide variety of Federal programs outside the jurisdiction of the Committee on Ways and Means provide benefits to individuals and families that also receive assistance from programs within the Committee's jurisdiction (see appendix K). This section describes several such programs: food stamps; Medicaid; the State Children's Health Insurance Program (SCHIP); housing assistance; School Lunch and Breakfast Programs; the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC); the Child and Adult Care Food Program (CACFP); the Workforce Investment Act (WIA); Head Start; the Low-Income Home Energy Assistance Program (LIHEAP); veterans benefits and services; and workers' compensation.

Most families receiving Temporary Assistance for Needy Families (TANF) or Supplemental Security Income (SSI) would have incomes low enough to qualify them for assistance under these programs. Unlike the principal assistance programs under the jurisdiction of the Committee on Ways and Means, participation in Head Start, LIHEAP, and other programs is limited by appropriations. Income received from TANF is counted in determining eligibility and benefit levels for these programs. However, because these programs provide in-kind rather than cash assistance, benefits are not counted in determining eligibility for TANF.

Tables 15–1 and 15–2 describe the overlap in recipients between programs within the jurisdiction of the Committee on Ways and Means and other major Federal assistance programs. Table 15–1 illustrates that 81.0 percent of TANF recipient households also received food stamps during the first quarter of 1998; 30.6 percent received WIC; 97.3 percent received Medicaid; 60.3 percent received free or reduced-price school meals; and 32.2 percent received housing assistance.

Table 15–2 presents the percentage of recipients of other means-tested programs who are participating in programs under Ways and Means jurisdiction. For example, 35.1 percent of food stamp households received TANF benefits at some time during the first quarter of 1998; 30.1 percent received SSI; 30.5 percent received Social Security; 1.6 percent received unemployment benefits; and 27.9 percent received Medicare.

Table 15–3 shows the percentage of households receiving Aid to Families with Dependent Children (AFDC)/TANF or SSI and also receiving assistance from other programs for selected time periods. The figures at the bottom of the AFDC/TANF portion of the table show that the number of households receiving AFDC/TANF increased rapidly between 1990 and 1994, declined somewhat in

TABLE 15–1.—PERCENT OF RECIPIENTS IN PROGRAMS WITHIN THE JURISDICTION OF THE COMMITTEE ON WAYS AND MEANS RECEIVING ASSISTANCE FROM OTHER MAJOR FEDERAL ASSISTANCE PROGRAMS, 1997–98

Other assistance program	Ways and Means assistance program				
	TANF	SSI	Social Security	Unemployment compensation	Medicare
Food stamps	81.0	43.7	7.3	7.0	7.3
WIC	30.6	5.5	1.3	7.9	0.9
Medicaid	97.3	95.0	16.9	16.9	17.2
Free or reduced-price school meals	60.3	18.4	4.0	18.0	2.9
Public or subsidized rental housing	32.2	23.4	5.7	4.0	5.8
VA compensation or pensions	1.1	2.8	4.9	1.2	4.9
Number of households receiving benefits (in thousands)	3,008	4,772	28,833	1,546	26,525

Note.—Table shows number of households for December 1997–March 1998. Table reads that 81.0 percent of TANF households also receive food stamps. SSI recipients living in California receive a higher SSI payment in lieu of food stamps, and thus are not included in the food stamp percentages.

Source: U.S. Census Bureau, Survey of Income and Program Participation.

TABLE 15–2.—PERCENT OF RECIPIENTS IN OTHER MAJOR FEDERAL ASSISTANCE PROGRAMS RECEIVING ASSISTANCE UNDER PROGRAMS WITHIN THE JURISDICTION OF THE COMMITTEE ON WAYS AND MEANS, 1997–98

Ways and Means assistance program	Other assistance program					
	Food stamps	WIC	Free or reduced-price school meals	Public or subsidized rental housing	Medicaid	VA compensation or pensions
TANF	35.1	25.6	21.5	21.6	22.5	1.4
SSI	30.1	7.4	10.4	24.9	34.8	5.7
Social Security	30.5	10.2	13.6	36.3	37.4	59.3
Unemployment compensation	1.6	3.4	3.3	1.4	2.0	0.8
Medicare	27.9	6.3	9.0	34.3	35.2	55.2
Number of households receiving benefits (in thousands)	6,932	3,585	8,444	4,487	13,014	2,369

Note.—Table shows households for December 1997–March 1998. Table reads that 35.1 percent of food stamp recipient households receive TANF. SSI recipients living in California receive a higher SSI payment in lieu of food stamps, and thus are not included in the food stamp percentages.

Source: U.S. Census Bureau, Survey of Income and Program Participation.

TABLE 15–3.—PERCENT OF HOUSEHOLDS RECEIVING AFDC/TANF OR SSI AND ALSO RECEIVING ASSISTANCE FROM OTHER PROGRAMS FOR SELECTED TIME PERIODS

Assistance program	Year							
	1984	1987	1990	1992	1993	1994	1995	1997–98
AFDC/TANF:								
Food stamps	81.4	81.7	82.7	86.2	88.9	88.3	87.2	81.0
WIC	15.3	18.6	18.7	21.5	18.5	21.4	24.7	30.6
Free or reduced-price school meals	49.2	55.6	52.7	55.5	56.9	57.5	63.1	60.3
Public or subsidized rental housing	23.0	19.4	34.7	29.5	33.1	30.3	31.1	32.2
Medicaid	93.2	95.5	97.6	96.2	97.6	96.4	97.2	97.3
VA compensation or pensions	2.8	1.9	1.3	1.9	1.1	1.1	0.8	1.1
Number of households receiving benefits (in thousands)	3,585	3,527	3,434	4,057	4,831	4,906	4,652	3,008
SSI:								
Food stamps	46.5	39.7	41.3	46.2	48.0	50.1	50.0	43.7
WIC	2.5	2.5	3.0	4.3	3.7	5.4	5.6	5.5
Free or reduced-price school meals	12.7	11.9	15.3	18.2	21.3	23.8	25.2	18.4
Public or subsidized rental housing	21.6	20.0	21.4	23.8	23.9	24.9	24.1	23.4
Medicaid	100.0	99.6	99.7	99.8	99.5	100.0	100.0	95.0
VA compensation or pensions	4.7	7.7	5.7	4.0	4.5	3.9	3.6	2.8
Number of households receiving benefits (in thousands)	3,008	3,341	3,037	3,957	3,861	4,223	4,580	4,772

Note.—Data on households interviewed between December 1997 and March 1998. SSI recipients living in California receive a higher SSI payment in lieu of food stamps, and thus are not included in the food stamp percentages; in 1997, the TANF Program replaced the Aid to Families with Dependent Children (AFDC) Program.

Source: U.S. Census Bureau, Survey of Income and Program Participation.

1995, and then fell rapidly between 1995 and 1997/1998. Due to the rapid decline after 1994, the AFDC/TANF rolls declined by 16 percent over the entire period. The number of households receiving SSI declined slightly in 1990 and 1993, but otherwise increased throughout the period between 1984 and 1998. The rolls increased by nearly 60 percent over this period.

The percentage of AFDC/TANF households receiving other benefits fluctuated over the 1984–98 period, but the biggest programs—food stamps, school meals, housing assistance, and Medicaid—increased and then declined. Food stamps experienced increased coverage until 1993, after which it fell off by nearly 9 percent between 1994 and 1998. School lunches also fell off somewhat between 1995 and 1998. Medicaid coverage increased between 1984 and 1990, but the pattern was erratic after that and 1990 proved to be the high-water mark of coverage. The high-water mark for housing was 1990. The pattern of receiving other benefits for SSI households is broadly similar; namely, initial increases and then declines. For every program, except Medicaid which was received by 100 percent of SSI households, and veterans benefits, coverage increased between 1984 and 1994 but then declined either between 1994 and 1995 or between 1995 and 1998. Medicaid too declined from its 100 percent coverage in 1995 to 95 percent in 1998. The explanation for declining coverage probably varies from program to program, but the pattern of general decline after 1994 or 1995 deserves careful study, especially if it continues to occur over the next several years.

FOOD STAMP PROGRAM

Food stamps are designed primarily to increase the food purchasing power of eligible low-income households to a point where they can buy a nutritionally adequate low-cost diet. Participating households are expected to devote 30 percent of their counted monthly cash income to food purchases.[1] Food stamp benefits then make up the difference between the household's expected contribution to its food costs and an amount judged to be sufficient to buy an adequate low-cost diet. This amount, the maximum food stamp benefit, is set at the level of the U.S. Department of Agriculture's lowest cost food plan (the Thrifty Food Plan or TFP), varied by household size, and adjusted annually for inflation. Thus, a participating household with no counted cash income receives the maximum monthly allotment for its household size while a household with some counted income receives a lesser allotment, normally reduced from the maximum at the rate of 30 cents for each dollar of counted income.

Benefits are available to most households that meet Federal eligibility tests for limited monthly income and liquid assets. But household members must fulfill requirements related to work effort and, in general, must be U.S. citizens. Recipients in the two primary cash welfare programs (TANF and SSI) generally are automatically eligible for food stamps, as are recipients of State general

[1] Because not all of a household's income is actually counted when determining its food stamp benefits, the program, in effect, assumes that most participants are able to spend about 20–25 percent of their total cash monthly income on food.

assistance (GA) payments, if their household is composed entirely of TANF, SSI, or GA beneficiaries.[2]

ADMINISTRATION, PROGRAM VARIATIONS, AND FUNDING

The regular Food Stamp Program operates in all 50 States, the District of Columbia, Guam, and the Virgin Islands. The Federal Government is responsible for most of the rules that govern the program, and, with limited variations for Alaska, Hawaii, and the territories, these rules are nationally uniform. However, by law and regulation, States have a number of significant options to vary from Federal administrative, benefit calculation, and eligibility rules, especially for those who also are recipients of their State's cash welfare programs, and a number of waivers from regular rules and procedures have been (and continue to be) granted. Sales taxes on food stamp purchases may not be charged, and food stamp benefits do not directly affect other assistance available to low-income households, nor are they taxed as income.

Alternative programs are offered in Puerto Rico, the Northern Mariana Islands, and American Samoa, and program variations occur in a number of demonstration projects and in those jurisdictions that have elected to exercise the limited number of program options allowed.

Funding is overwhelmingly Federal, although the States and other jurisdictions have financial responsibility for significant administrative costs, as well as liability for erroneous benefit determinations (as assessed under the food stamp "quality control" system, discussed below).

Federal administrative responsibilities

At the Federal level, the program is administered by the Agriculture Department's Food and Nutrition Service (FNS). The FNS gives direction to welfare agencies through Federal regulations that define eligibility requirements, benefit levels, and administrative rules. It is also responsible for arranging for printing food stamp coupons and distributing them to welfare agencies, for overseeing State programs for the electronic issuance of food stamp benefits, and for approving and overseeing participation by retail food stores and other outlets that may accept food stamps. Other Federal agencies that have administrative roles to play include: the Federal Reserve System (through which food stamp benefits are redeemed for cash, and which has some jurisdiction over "electronic benefit transfer (EBT)" methods for issuing food stamp benefits), the Social Security Administration (responsible for providing the Social Security numbers recipients must have, for providing limited application "intake" services, and for providing information to verify recipients' income), the Internal Revenue Service (providing assistance in verifying recipients' income and assets), the Immigration and Naturalization Service (helping welfare offices confirm alien applicants' status), and the Secret Service and the Agriculture De-

[2] Except for (1) SSI recipients in California, where a State-financed adjustment to SSI benefits has replaced food stamp assistance; and (2) General Assistance Programs that do not meet minimum Federal standards for determining need.

partment's Inspector General (responsible for counterfeiting and trafficking investigations).

State and local administrative responsibilities

States, the District of Columbia, Guam, and the Virgin Islands, through their local welfare offices, have primary responsibility for the day-to-day administration of the Food Stamp Program. They determine eligibility, calculate benefits, and issue food stamp allotments (using coupons or electronic benefit transfers) following Federal rules. They also have a significant voice in carrying out employment and training programs and in determining some administrative features of the program (e.g., the extent to which verification of household circumstances is pursued, the length of eligibility certification periods, the structure of EBT systems). Most often, the Food Stamp Program is operated through the same welfare agency and staff that runs the State's TANF Program.

Puerto Rico, the Northern Mariana Islands, and American Samoa

In addition to the regular Food Stamp Program, the Food Stamp Act directs funding for a Nutrition Assistance Program in the Commonwealth of Puerto Rico and another in American Samoa. Separate legislation authorizes a variant of the Food Stamp Program in the Commonwealth of the Northern Mariana Islands.

Since July 1982, Puerto Rico has operated a Nutrition Assistance Program of its own design, funded by an annual Federal "block grant."[3] The Commonwealth's Nutrition Assistance Program differs from the regular Food Stamp Program primarily in that: (1) funding is limited to an annual amount specified by law[4]; (2) the Food Stamp Act allows the Commonwealth a great deal of flexibility in program design, as opposed to the regular program's extensive Federal rules (e.g., benefits are paid in cash (checks) rather than food stamp coupons); (3) income eligibility limits are about one-third those used in the regular Food Stamp Program; (4) maximum benefit levels are about 40 percent less than in the 48 contiguous States and the District of Columbia; and (5) different rules are used in counting income for eligibility and benefit purposes. In fiscal year 1999, Puerto Rico's Nutrition Assistance Program aided approximately 1.1 million persons each month with monthly benefits averaging $74.50 a person ($193 a household).

Under the terms of the 1976 Covenant with the Commonwealth of the Northern Mariana Islands and implementing legislation (Public Law 96–597), a variant of the Food Stamp Program was negotiated with the Commonwealth and began operations in July 1982. The program in the Northern Marianas differs primarily in that: (1) it is funded entirely by Federal money, up to a maximum grant of $5.1 million a year (increased to $6.1 million for fiscal year 2000); (2) a portion of each household's food stamp benefit must be used to purchase locally produced food; (3) maximum allotments are about 5 percent higher than in the 48 contiguous States and the District of Columbia; and (4) income eligibility limits are about

[3] Prior to July 1982, the regular Food Stamp Program operated in Puerto Rico, although with slightly different eligibility and benefit rules.

[4] For fiscal years 2000 and 2001, $1.268 billion and $1.301 billion are earmarked. The block grant funds the full cost of benefits and half the cost of administration.

half those in the regular program. As of the end of fiscal year 1999, the Northern Marianas' program assisted 5,100 people each month with monthly benefits averaging about $75 a person (see section 12).

As with the Northern Marianas, American Samoa operates a variant of the regular Food Stamp Program. Under the Secretary of Agriculture's authority to extend Agriculture Department programs to American Samoa (Public Law 96–597) and a 1996 amendment to the Food Stamp Act made by the Federal Agriculture Improvement and Reform Act (Public Law 104–127), American Samoa receives an annual grant of up to $5.3 million to operate a Food Stamp Program limited to low-income elderly and disabled persons. While maximum monthly allotments are similar to those in the regular Food Stamp Program ($125 a person), income eligibility limits are about 25 percent lower. In fiscal year 1999, the program aided about 3,200 persons a month with average monthly benefits of just over $100 a person (see section 12).

Program options

The Food Stamp Act authorizes demonstration projects to test program variations that might improve operations. However, because of the law's substantial limits on how much any demonstration can reduce benefits or restrict eligibility, an administration policy that effectively bars demonstrations that have a significant cost to the Food Stamp Program, and implementation of the 1996 welfare reform law's provisions for State flexibility, no major demonstration projects are operational. Instead: (1) a few small demonstrations are operating in some States (these deal with joint application processing and standardized food stamp benefits for SSI recipients, cash benefits for the elderly and SSI recipients, and evaluation of earlier welfare reform demonstrations); and (2) extensive waivers of administrative rules are routinely granted.

In addition to demonstration projects, States are allowed to implement some options. States may change administrative requirements such as those pertaining to application processing and reporting of household circumstances. They may issue benefits (at their own cost) to ineligible noncitizens and those ineligible under the new work rule for able-bodied adults without children (discussed below). With 50-percent Federal cost sharing, they can operate "outreach" programs to inform low-income persons about food stamps and support nutrition education efforts. They may choose to issue food stamp benefits through EBT systems. They may choose to operate a "simplified" program under which they can use many of their TANF rules and procedures when determining food stamp benefits for TANF recipients. They largely determine the length of eligibility certification periods. They may sanction food stamp recipients failing to meet other public assistance program rules or failing to cooperate in child support enforcement. They may, to a certain extent, waive the application of the new work rule for able-bodied adults without dependents (ABAWDs) (discussed below); and they may choose to disqualify an entire household if the head of household fails to fulfill work-related requirements. They may include the cash value of food stamp benefits when using welfare to subsidize some recipients' wages and can

pay food stamp benefits in cash to other working households getting off cash welfare. Finally, States and localities may opt to run "workfare" programs, and States determine the type(s) of employment or training programs in which recipients must participate.

Funding

The Food Stamp Act provides 100 percent Federal funding of food stamp benefits, except where States choose to "buy into" the program and pay for issuing food stamp benefits to ineligible noncitizens or those made ineligible by the new work rule for ABAWDs (discussed below). The Federal Government also is responsible for its own administrative costs: overseeing program operations (including oversight of participating food establishments), printing and distributing food stamp coupons to welfare agencies, redeeming food stamp benefits through the Federal Reserve, and paying the Social Security Administration for certain intake services.

In most instances, the Federal Government provides half the cost of State welfare agency administration.[5] However, the 50-percent Federal share can be increased to as much as 60 percent if the State has a very low rate of erroneous benefit determinations. In addition, the Federal Government shares the cost of carrying out employment and training programs for food stamp recipients: (1) each State receives a Federal grant for basic operating costs (a formula share of $172 million in fiscal year 2000 and $219 million in fiscal year 2001); and (2) additional operating costs, as well as expenses for support services to participants (e.g., transportation, child care) are eligible for a 50-percent Federal match.[6] Finally, States are allowed to retain a portion of improperly issued benefits they recover (other than those caused by welfare agency error): 35 percent of recoveries in fraud cases and 20 percent in other circumstances. Federal and State Food Stamp Act spending since 1979 is shown in table 15–4.

ELIGIBILITY

The Food Stamp Program has financial, employment/training-related, and "categorical" tests for eligibility. Its financial tests require that most of those eligible have monthly income and liquid assets below limits set by law. Under the employment/training-related tests, certain household members must register for work, accept suitable job offers, and fulfill work or training requirements (such as looking or training for a job) established by State welfare agencies. And, under a new work requirement established in 1996, food stamp eligibility for ABAWDs is limited to 3–6 months in any 36-month period unless they are working at least half time or in a work or training activity. Categorical eligibility rules make some automatically eligible for food stamps (many TANF, SSI, and GA recipients), and categorically deny eligibility to others (e.g., strikers and most noncitizens, postsecondary students, and people living in institutional settings). Applications cannot be denied because of the length of a household's residence in a welfare agency's jurisdiction

[5] Under the terms of Public Law 105–185, most States are subject to an annual reduction in their normal Federal share totaling about $200 million nationwide.

[6] The overwhelming majority (80 percent) of the formula grant funds must be spent on services to those covered by a new work requirement for able-bodied adults without dependents.

or because the household has no fixed mailing address or does not reside in a permanent dwelling.

TABLE 15–4.—RECENT FOOD STAMP ACT EXPENDITURES, 1979–99

[Obligations in millions of dollars]

Fiscal year	Benefits [1] (Federal)	Administration [2]		Total
		Federal	State and local	
1979	$6,480	$515	$388	$7,383
1980	8,685	503	375	9,563
1981	10,630	678	504	11,812
1982	10,408	709	557	11,674
1983	11,955	778	612	13,345
1984	11,499	971	805	13,275
1985	11,556	1,043	871	13,470
1986	11,415	1,113	935	13,463
1987	11,344	1,195	996	13,535
1988	11,999	1,290	1,080	14,369
1989	12,483	1,332	1,101	14,916
1990	15,090	1,422	1,174	17,686
1991	18,249	1,516	1,247	21,012
1992	21,883	1,656	1,375	24,914
1993	23,033	1,716	1,572	26,321
1994	23,736	1,789	1,643	27,168
1995	23,759	1,917	1,748	27,424
1996	23,510	1,984	1,842	27,336
1997	20,810	2,058	1,904	24,772
1998	18,228	2,169	1,988	22,385
1999	17,217	2,100	1,874	21,191

[1] All benefit costs associated with the Food Stamp Program, Puerto Rico's block grant, and grants to American Samoa and the Northern Marianas are included. Fiscal year 1998 and 1999 amounts shown in the table also cover the cost of State-financed benefits for noncitizens (approximately $100 million a year). For certain years, small downward adjustments have been made for overpayments collected from recipients and issued but unredeemed benefits. Over time, the figures reflect both changes in benefit levels and numbers of recipients.

[2] All Federal administrative costs associated with the Food Stamp Program appropriation and grants to Puerto Rico, American Samoa, and the Northern Marianas are included: Federal matching spending for the various administrative and employment and training program expenses of States and other jurisdictions, and direct Federal administrative costs. Figures for Federal administrative costs beginning with fiscal year 1993 are for those paid out of food stamp appropriations; for earlier years, these figures include estimates of food-stamp-related Federal administrative expenses paid out of other Agriculture Department appropriations accounts ($40–$60 million a year). Fiscal year 1998 and 1999 Federal amounts shown in the table also cover the administrative cost of State-financed benefits for noncitizens. State and local costs are estimated based on the known Federal shares of administrative and employment and training program expenses and represent an estimate of these costs to States and other jurisdictions; however, the State/local figures shown in the table do not include administrative expenses for State-financed benefits to noncitizens.

Source: U.S Department of Agriculture budget justification materials for fiscal years 1981–2000. Compiled by the Congressional Research Service.

The food stamp household

The basic food stamp beneficiary unit is the "household." A food stamp household can be either a person living alone or a group of individuals living together; there is no requirement for cooking fa-

cilities. The food stamp household is unrelated to recipient units in other welfare programs (e.g., TANF families with dependent children, elderly or disabled individuals or couples in the SSI Program).

Generally speaking, individuals living together constitute a single food stamp household if they customarily purchase food and prepare meals in common. Members of the same household must apply together, and their income, expenses, and assets normally are aggregated in determining food stamp eligibility and benefits. However, persons who live together can sometimes be considered separate "households" for food stamp purposes, related coresidents generally are required to apply together, and special rules apply to those living in institutional settings. Most often, persons living together receive larger aggregate benefits if they are treated as more than one food stamp household.

Persons who live together, but purchase food and prepare meals separately, may apply for food stamps separately, except for: (1) spouses; (2) parents and their children (21 years or younger), and (3) minors 18 years or younger (excluding foster children, who may be treated separately) who live under the parental control of a caretaker. In addition, persons 60 years or older who live with others and cannot purchase food and prepare meals separately because of a substantial disability may apply separately from their coresidents as long as their coresidents' income is below prescribed limits (165 percent of the Federal poverty guidelines).

Although those living in institutional settings generally are barred from food stamps, individuals in certain types of group living arrangements may be eligible and are automatically treated as separate households, regardless of how food is purchased and meals are prepared. These arrangements must be approved by State or local agencies and include: residential drug addict or alcoholic treatment programs, small group homes for the disabled, shelters for battered women and children, and shelters for the homeless.

Thus, different food stamp households can live together, food stamp recipients can reside with nonrecipients, and food stamp households themselves may be "mixed" (include recipients and nonrecipients of other welfare benefits).

Income eligibility

Except for households composed entirely of TANF, SSI, or GA recipients (who generally are automatically eligible for food stamps), monthly cash income is the primary food stamp eligibility determinant.[7] In establishing eligibility for households without an elderly or disabled member,[8] the Food Stamp Program uses both the household's basic (or "gross") monthly income and its counted (or "net") monthly income. When judging eligibility for households with elderly or disabled members, only the household's counted monthly

[7] Although they do not have to meet food stamp financial eligibility tests, TANF, SSI, and general assistance households must still have their income calculated under food stamp rules to determine their food stamp benefits.

[8] In the Food Stamp Program, "elderly" persons are those 60 years or older. The "disabled" generally are beneficiaries of governmental disability-based payments (e.g., Social Security or SSI disability recipients, disabled veterans, certain disability retirement annuitants, and recipients of disability-based Medicaid or general assistance).

income is considered; in effect, this procedure applies a more liberal income test to elderly and disabled households.

Basic (or gross) monthly income includes all of a household's cash income except the following "exclusions" (disregards): (1) most payments made to third parties (rather than directly to the household); (2) unanticipated, irregular, or infrequent income, up to $30 a quarter; (3) loans (deferred repayment student loans are treated as student aid, see below); (4) income received for the care of someone outside the household; (5) nonrecurring lump-sum payments such as income tax refunds and retroactive lump-sum Social Security payments (these are instead counted as liquid assets); (6) Federal energy assistance; (7) expense reimbursements that are not a "gain or benefit" to the household; (8) income earned by schoolchildren 17 or younger; (9) the cost of producing self-employment income; (10) Federal postsecondary student aid (e.g., Pell grants, student loans); (11) advance payments of Federal earned income credits; (12) "on-the-job" training earnings of dependent children under 19 in the Workforce Investment Act (WIA), formerly the Job Training Partnership Act (JTPA), Programs, as well as monthly "allowances"; (13) income set aside by disabled SSI recipients under an approved "plan for achieving self-support"; and (14) payments required to be disregarded by provisions of Federal law outside the Food Stamp Act (e.g., various payments under laws relating to Indians, payments under the Older Americans Act Employment Program for the Elderly).

Counted (or net) monthly income is computed by subtracting certain "deductions" from a household's basic (or gross) monthly income. This procedure is based on the recognition that not all of a household's income is equally available for food purchases. Thus, a standard portion of income, plus amounts representing work expenses or excessively high nonfood living expenses, are disregarded.

For households without an elderly or disabled member, counted monthly income equals gross monthly income less the following deductions:

—A standard deduction set at $134 a month, regardless of household size; different standard deductions are used for Alaska ($229), Hawaii ($189), Guam ($269), and the Virgin Islands ($118).

—Any amounts paid as legally obligated child support;

—Twenty percent of any earned income, in recognition of taxes and work expenses;

—Out-of-pocket dependent care expenses, when related to work or training, up to $175 a month per dependent, $200 a month for children under age 2;

—Shelter expenses that exceed 50 percent of counted income after all other deductions, up to a periodically adjusted ceiling now standing at $275 a month. Different ceilings prevail in Alaska, Hawaii, Guam, and the Virgin Islands: $478, $393, $334, and $203, respectively.

For households with an elderly or disabled member, counted monthly income equals gross monthly income less:

—The same standard, child support, earned income, and dependent care deductions noted above;

—Any shelter expenses, to the extent they exceed 50 percent of counted income after all other deductions, with no limit; and
—Any out-of-pocket medical expenses (other than those for special diets) that are incurred by an elderly or disabled household member, to the extent they exceed a threshold of $35 a month.

Except for those households comprised entirely of TANF, SSI, or GA recipients, in which case food stamp eligibility generally is automatic, all households must have net monthly income that does not exceed the Federal poverty guidelines. Households without an elderly or disabled member also must have gross monthly income that does not exceed 130 percent of the inflation-adjusted Federal poverty guidelines. Both these income eligibility limits are uniform for the 48 contiguous States, the District of Columbia, Guam, and the Virgin Islands; somewhat higher limits (based on higher poverty guidelines) are applied in Alaska and Hawaii. The net and gross eligibility limits on income are summarized in table 15–5.

TABLE 15–5.—COUNTED (NET) AND BASIC (GROSS) MONTHLY INCOME ELIGIBILITY LIMITS FOR THE FOOD STAMP PROGRAM, FISCAL YEAR 2000

Household size	48 States, the District of Columbia, and the territories	Alaska	Hawaii
Counted (net) monthly income eligibility limits [1]:			
1 person	$687	$860	$791
2 persons	922	1,154	1,061
3 persons	1,157	1,447	1,331
4 persons	1,392	1,740	1,601
5 persons	1,627	2,034	1,871
6 persons	1,862	2,327	2,141
7 persons	2,097	2,620	2,411
8 persons	2,332	2,914	2,681
Each additional person	+235	+294	+270
Basic (gross) monthly income eligibility limits [2]:			
1 person	893	1,118	1,029
2 persons	1,199	1,500	1,380
3 persons	1,504	1,881	1,731
4 persons	1,810	2,262	2,082
5 persons	2,115	2,644	2,433
6 persons	2,421	3,025	2,784
7 persons	2,726	3,406	3,135
8 persons	3,032	3,788	3,486
Each additional person	+306	+382	+351

[1] Set at the applicable Federal poverty guidelines, updated for inflation through calendar 1998.
[2] Set at 130 percent of the applicable Federal poverty guidelines, updated for inflation through calendar 1998.

Source: U.S. Department of Agriculture, Food and Nutrition Service.

Allowable assets

Except for households automatically eligible for food stamps because they are composed entirely of Temporary Assistance for Needy Families (TANF), Supplemental Security Income (SSI), or GA recipients, eligible households must have counted liquid assets that do not exceed federally prescribed limits. Households without an elderly member cannot have counted liquid assets above $2,000. Households with an elderly member cannot have counted liquid assets above $3,000.

Counted liquid assets include cash on hand, checking and savings accounts, savings certificates, stocks and bonds, individual retirement accounts (IRAs) and Keogh plans (less any early withdrawal penalties), and nonrecurring lump-sum payments such as insurance settlements. Certain less liquid assets are also counted: a portion of the value of vehicles (generally, the fair market value in excess of $4,650) and the equity value of property not producing income consistent with its value (e.g., recreational property).

Counted assets do not include the value of the household's residence (home and surrounding property), business assets, personal property (household goods and personal effects), lump-sum earned income tax credit payments, burial plots, the cash value of life insurance policies and pension plans (other than Keogh plans and IRAs), and certain other resources whose value is not accessible to the household, would not yield more than $1,000 if sold (e.g., a car with a small equity value), or are required to be disregarded by other Federal laws.

Work-related requirements

To gain or retain eligibility, most able-bodied adults must: (1) register for work (typically with the welfare agency or a State employment service office); (2) accept a suitable job if offered one; (3) fulfill any work, job search, or training requirements established by administering welfare agencies; (4) provide the administering welfare agency with sufficient information to allow a determination with respect to their job availability; and (5) not voluntarily quit a job without good cause or reduce work effort below 30 hours a week. If the household head fails to fulfill any of these requirements, the entire household may, at State option, be disqualified for up to 180 days. Individual disqualification periods differ according to whether the violation is the first, second, or third; minimum periods, which may be increased by the State welfare agency, range from 1 to 6 months.

Those who are exempt by law from these basic work requirements include: persons physically or mentally unfit for work; those under age 16 or over age 59; and individuals between 16 and 18 if they are not head of household or are attending school or a training program; persons working at least 30 hours a week or earning the minimum wage equivalent; persons caring for dependents who are disabled or under age 6; those caring for children between ages 6 and 12 if adequate child care is not available (this second exemption is limited to allowing these persons to refuse a job offer if care is not available); individuals already subject to and complying with another assistance program's work, training, or job search require-

ments; otherwise eligible postsecondary students; and residents of drug addiction and alcoholic treatment programs.

Those not exempted by one of the above-listed rules must, at least, register for work and accept suitable job offers. However, their State welfare agency may require them to fulfill some type of work, job search, or training obligation. Welfare agencies must operate an employment and training program of their own design for work registrants whom they designate. Welfare agencies may require all work registrants to participate in one or more components of their program, or limit participation by further exempting additional categories and individuals for whom participation is judged impracticable or not cost effective. Program components can include any or all of the following activities: supervised job search or training for job search, workfare, work experience or training programs, education programs to improve basic skills, or any other employment or training activity approved by the Agriculture Department. However, at least 80 percent of unmatched Federal money provided for States' employment and training programs must be spent on services to those covered by the new work rule for ABAWDs (see below).

Recipients who take part in an employment or training activity beyond work registration cannot be required to work more than the minimum wage equivalent of their household's benefit. Total hours of participation (including both work and any other required activity) cannot exceed 120 hours a month. Welfare agencies also must provide support for costs directly related to participation (e.g., transportation and child care). Agencies may limit this support to $25 per participant per month for all support costs other than dependent care, and to local market rates for necessary dependent care.

In addition to these work-related requirements, the 1996 welfare reform law (Public Law 104–193) added a new work requirement for most able-bodied adults between 18 and 50 without dependents. They are ineligible for food stamps if, during the prior 36 months, they received food stamps for 3 months while not working at least 20 hours a week or participating in an approved work/training activity. Those disqualified under this rule are able to reenter the Food Stamp Program if, during a 30-day period, they work 80 hours or more or participate in a work/training activity. If they then become unemployed or leave work/training, they are eligible for an additional 3-month period on food stamps without working at least 20 hours a week or participating in a work/training activity. But they are allowed only one of these added 3-month eligibility periods in any 36 months for a potential total of 6 months on food stamps in any 36 months without half-time work or enrollment in a work/training program.

At State request, this rule can be waived for areas with very high unemployment (over 10 percent) or lack of available jobs. Moreover, States may, on their own initiative, exempt up to 15 percent of those covered under the new work rule.

In fiscal year 1999, States reported 2 million new work registrants. Of these, approximately 1.4 million—including an estimated 700,000 ABAWDs—were subject to employment and training program placement. Just over 600,000 of the 1.4 million poten-

tially subject to employment and training participation requirements were reported actually placed in a work/training component. Work/training slots were not found for many of the remainder, or they left the Food Stamp Program or were sanctioned for failure to fulfill their obligation.

Categorical eligibility rules and other limitations

Food stamp eligibility is sometimes denied for reasons other than financial need or compliance with work-related requirements. Many noncitizens are barred—eligibility is extended only to children, the elderly, and disabled who were legally resident before August 1996, refugees and asylees for a limited period of time, veterans, those with a substantial history of work covered under the Social Security system, and certain other limited groups of aliens. Households with members on strike are denied benefits unless eligible prior to the strike. With some exceptions, postsecondary students (in school half time or more) who are fit for work and between ages 18 and 50 are ineligible. Persons living in institutional settings are denied eligibility, except those in special SSI-approved small group homes for the disabled, persons living in drug addiction or alcohol treatment programs, and persons in shelters for battered women and children or shelters for the homeless. Boarders cannot receive food stamps unless they apply together with the household in which they are boarding. Those who transfer assets for the purpose of qualifying for food stamps are barred. Persons who fail to provide Social Security numbers or cooperate in providing information needed to verify eligibility or benefit determinations are ineligible. Food stamps are denied those who intentionally violate program rules, for specific time periods ranging from 1 year (on a first violation) to permanently (on a third violation or other serious infraction); and States may impose food stamp disqualification when an individual is disqualified from another public assistance program. Automatic disqualification is required for those applying in multiple jurisdictions, fleeing arrest, or convicted of a drug-related felony. And States may disqualify individuals not cooperating with child support enforcement authorities or in arrears on their child support obligations.

BENEFITS

Food stamp benefits are a function of a household's size, its net monthly income, and maximum monthly benefit levels (in some cases, adjusted for geographic location). An eligible household's net income is determined (i.e., the deductions noted earlier are subtracted from gross income), its maximum benefit level is established, and a benefit is calculated by subtracting its expected contribution (30 percent of its counted net income) from its maximum allotment. Thus, a 3-person household with $400 in counted net income (after deductions) would receive a monthly allotment of $215 (the maximum 3-person benefit in the 48 States, $335, less 30 percent of net income, $120).

Allotments are not taxable and food stamp purchases may not be charged sales taxes. Receipt of food stamps does not affect eligibility for or benefits provided by other welfare programs, although some programs use food stamp participation as a "trigger" for eligi-

bility and others take into account the general availability of food stamps in deciding what level of benefits to provide. In fiscal year 1999, monthly benefits averaged $72 a person and about $170 a household.

Maximum monthly allotments

Maximum monthly food stamp allotments are tied to the cost of purchasing a nutritionally adequate low-cost diet, as measured by the Agriculture Department's Thrifty Food Plan (TFP). Maximum allotments are set at: the monthly cost of the TFP for a four-person family consisting of a couple between ages 20 and 50 and two school-age children, adjusted for family size (using a formula reflecting economies of scale developed by the Human Nutrition Information Service), and rounded down to the nearest whole dollar. Allotments are adjusted for food price inflation annually, each October, to reflect the cost of the TFP in the immediately previous June.

Maximum allotments are standard in the 48 contiguous States and the District of Columbia; they are higher, reflecting substantially different food costs, in Alaska, Hawaii, Guam, and the Virgin Islands (table 15–6).

Minimum and prorated benefits

Eligible one-and two-person households are guaranteed a minimum monthly food stamp allotment of $10. Minimum monthly benefits for other household sizes vary from year to year, depending on the relationship between changes in the income eligibility limits and the adjustments to the cost of the TFP. In a few cases, benefits can be reduced to zero before income eligibility limits are exceeded. At present, minimum monthly allotments for households of three or more persons range from $2 to over $80.

In addition, a household's calculated monthly allotment can be prorated (reduced) for 1 month. On application, a household's first month's benefit is reduced to reflect the date of application. If a previously participating household does not meet eligibility recertification requirements in a timely fashion, but does become certified for eligibility subsequently, benefits for the first month of its new certification period normally are prorated to reflect the date when recertification requirements were met.

Application, processing, and issuing food stamps

Food stamp benefits normally are issued monthly. The local welfare agency must either deny eligibility or make food stamps available within 30 days of initial application and must provide food stamps without interruption if an eligible household reapplies and fulfills recertification requirements in a timely manner. Households in immediate need because of little or no income and very limited cash assets, as well as the homeless and those with extraordinarily high shelter expenses, must be given expedited service (provision of benefits within 7 days of initial application).

TABLE 15–6.—MAXIMUM MONTHLY FOOD STAMP ALLOTMENTS, FISCAL YEAR 2000

Household size	48 States and the District of Columbia	Alaska [1]	Hawaii	Guam	Virgin Islands
1 person	$127	$158	$199	$188	$164
2 persons	234	290	365	345	301
3 persons	335	415	523	495	431
4 persons	426	528	664	628	548
5 persons	506	627	789	746	651
6 persons	607	752	947	896	781
7 persons	671	831	1,047	990	863
8 persons	767	950	1,196	1,131	987
Each additional person	+96	+119	+150	+141	+123

[1] Maximum monthly allotments for designated urban areas of Alaska. Two separate higher allotment levels are applied in remote rural areas of Alaska. They are 28 and 55 percent higher than the urban allotments shown here.

Source: U.S. Department of Agriculture.

Food stamp issuance is a welfare agency responsibility, and issuance practices differ among welfare agencies. Food stamp coupons have traditionally been issued by: (1) providing (usually mailing) recipients an authorization-to-participate card that is then turned in at a local issuance point (e.g., a bank or post office) when picking up their monthly allotment; or (2) mailing food stamp coupon allotments directly to recipients. However, in a growing number of States, electronic benefit transfer (EBT) systems are used. EBT systems replace coupons with an ATM-like card used to make food purchases at the point of sale by deducting the purchase amount from the recipient's food stamp benefit account. EBT issuance is used (either statewide or in part of the State) in the majority of States (reaching more than half of food stamp recipients). All remaining States are well along in the process of converting to EBT issuance, which is expected to be the national norm by 2002.

Using food stamps

"Paper" food stamp benefits are usually issued in the form of booklets of coupons. The smallest coupon denomination is $1; if change of less than $1 is due on a food stamp purchase, it is returned in cash. Typically, participating households use their food stamps in approved grocery stores to buy food items for home preparation and consumption; food stamp purchases are not taxable. However, the actual list of approved uses for food stamps is more extensive, and includes: (1) food for home preparation and consumption, not including alcohol, tobacco, or hot foods intended for immediate consumption; (2) seeds and plants for use in gardens to produce food for personal consumption; (3) food purchased at approved farmers' markets; (4) in the case of the elderly and SSI recipients and their spouses, meals prepared and served through approved communal dining programs; (5) in the case of the elderly

and those who are disabled to an extent that they cannot prepare all of their meals, home-delivered meals provided by programs for the homebound; (6) meals prepared and served to residents of drug addiction and alcoholic treatment programs, small group homes for the disabled, shelters for battered women and children, and shelters or other establishments serving the homeless; and (7) where the household lives in certain remote areas of Alaska, equipment for procuring food by hunting and fishing (e.g., nets, hooks, fishing rods, and knives). As noted earlier, food stamp benefits also can be used through EBT cards. In this case, the card is swiped through an approved retailer's point-of-sale device, automatically debiting the recipient's food stamp account and crediting the retailer's bank account; unlike coupon transactions, recipients receive no cash change, and special arrangements must be made for nontraditional sites like farmers' markets.

QUALITY CONTROL (QC)

Since the early 1970s, the Food Stamp Program has had a QC system to monitor the degree to which erroneous eligibility and benefit determinations are made by State welfare agencies. The system was established by regulation in the 1970s as an administrative tool to enable welfare officials to identify problems and take corrective actions. Today, by legislative directive, the QC system also is used to calculate and impose fiscal sanctions on States that have very high rates of erroneous benefit and eligibility decisions. It also provides outside evaluators with a general picture of the integrity of the eligibility and benefit determination process in each State.

Under the QC system, welfare agencies, with Federal oversight, continuously sample their active food stamp caseloads, as well as their decisions to deny or end benefits. The agencies perform in-depth investigations of the eligibility and benefit status of the randomly chosen cases looking for errors in applying Federal rules and otherwise erroneous benefit and eligibility outcomes. Over 90,000 cases are reviewed each year, and each State's sample is designed to provide a statistically valid picture of erroneous decisions and, in most instances, their dollar value in benefits. The resulting error rate information is used by program managers to chart needed changes in administrative practices, and by the Federal Government to assess fiscal sanctions on States with error rates above certain tolerance levels. This information also is used to reward States with error rates below a separate lower tolerance level, and to review administering agency plans for action to correct procedures to control errors. Both error rate findings and any assessed sanctions are subject to appeal through administrative law judges and the Federal courts. Sanctions may be reduced or waived if the State shows good cause or if it is determined that the sanction amounts should be invested in improved State administration. Interest may be charged on outstanding sanction liabilities if the administrative appeals process takes more than 1 year.

QC reviews generate annual estimates of the proportion of cases in which administrators or recipients make an "error" and the dollar value of those errors. Caseload and dollar error rates are calculated for overpayments (including incorrect payments to eligible

and ineligible households) and underpayments. The accuracy of welfare agency decisions denying or terminating assistance also is measured, with an error rate reflecting the proportion of denials and terminations that were improper; no dollar value is calculated. The national weighted average for the dollar value of overpayments was estimated at 7.6 percent in fiscal year 1998 (table 15–7). This was noticeably above the all-time low of 7 percent in 1991. Error rates for underpayments have been relatively unchanged historically (running about 2 percent), but have risen recently. In fiscal year 1998, the national weighted average underpayment dollar error rate was estimated at 3.1 percent. Finally, the rate of denials and terminations found improper in the most recent estimate (1994) was 3.8 percent.

TABLE 15–7.—FOOD STAMP QUALITY CONTROL ERROR RATES, FISCAL YEAR 1998

[Percent of benefits paid or not paid in error]

State	Overpayment error rate	Underpayment error rate	Combined error rate
Alabama	6.55	1.12	7.67
Alaska	11.82	2.37	14.19
Arizona	4.32	1.58	5.90
Arkansas	4.96	1.01	5.96
California	8.17	4.35	12.52
Colorado	7.67	3.02	10.69
Connecticut	10.34	2.79	13.13
Delaware	9.71	2.74	12.45
District of Columbia	7.41	3.25	10.66
Florida	8.47	4.47	12.94
Georgia	9.90	3.75	13.65
Guam	8.15	2.17	10.32
Hawaii	3.23	1.58	4.82
Idaho	6.12	4.33	10.45
Illinois	11.04	3.00	14.04
Indiana	4.98	1.81	6.79
Iowa	10.02	3.35	13.37
Kansas	8.03	3.08	11.10
Kentucky	4.53	2.87	7.40
Louisiana	5.52	2.16	7.67
Maine	7.43	2.72	10.15
Maryland	11.56	3.84	15.40
Massachusetts	4.96	2.51	7.46
Michigan	13.13	4.55	17.67
Minnesota	3.35	1.83	5.18
Mississippi	3.70	2.31	6.01
Missouri	6.73	1.57	8.31
Montana	5.29	2.04	7.33
Nebraska	12.51	4.18	16.69
Nevada	6.25	2.62	8.88
New Hampshire	5.74	4.46	10.19
New Jersey	8.70	3.21	11.91
New Mexico	7.80	2.85	10.64
New York	8.61	4.33	12.93

TABLE 15–7.—FOOD STAMP QUALITY CONTROL ERROR RATES, FISCAL YEAR 1998—Continued

[Percent of benefits paid or not paid in error]

State	Overpayment error rate	Underpayment error rate	Combined error rate
North Carolina	7.92	2.86	10.78
North Dakota	6.32	3.03	9.36
Ohio	6.19	3.10	9.29
Oklahoma	7.65	3.22	10.87
Oregon	11.47	1.98	13.45
Pennsylvania	7.42	2.43	9.85
Rhode Island	4.66	2.37	7.03
South Carolina	6.60	1.46	8.07
South Dakota	1.59	0.52	2.11
Tennessee	6.58	2.16	8.74
Texas	3.82	1.45	5.27
Utah	7.69	2.01	9.70
Vermont	10.56	2.69	13.25
Virginia	6.83	4.30	11.13
Virgin Islands	4.41	2.15	6.56
Washington	12.04	3.16	15.21
West Virginia	8.51	2.88	11.39
Wisconsin	9.28	5.30	14.58
Wyoming	3.48	1.33	4.81
U.S. average	7.63	3.07	10.69

Note.—Underpayment and overpayment rates may not add to combined rates due to rounding.

Source: Food and Nutrition Service.

The dollar error rates reported through the food stamp QC system are used as the basis for assessing the financial liability of States for overpaid and underpaid benefits. Although well over $1 billion in sanctions have been assessed since the early 1980s, less than $10 million has been collected. The appeals process has delayed collection, and sanctions have been forgiven or waived both by Congress and the administration. In amending the rules governing sanctions in 1988 and 1990, Congress forgave accumulated sanctions, and, in late 1992, the administration waived sanctions by allowing States to invest the amounts in improved administration. Permission for States to invest sanction amounts in improved program administration has now become the rule, and States regularly apply and agree to invest sanction amounts under Federal guidelines rather than pay the Federal Government. Moreover, the administration chose to reduce sanction assessments for fiscal year 1998 from $78 million (22 States) to $27 million (16 States) by removing small errors from the assessment calculations and because of the presumed error-rate effects of high and increased proportions of households with earnings and immigrant applicants.

Legislated rules governing fiscal sanctions have changed a number of times. Under the most recent revision (1993), sanctions are assessed against States with combined (overpayment and underpayment) dollar error rates above the national weighted average

combined error rate for the year in question (10.7 percent in 1998). Each State's sanction amount is determined by using a "sliding scale" so that its penalty assessment equals an amount reflecting the degree to which the State's combined error rate exceeds the national average (the "tolerance level"). For example, if the tolerance level is 10 percent and a State's error rate is 12 percent, the State would be assessed a sanction of 0.4 percent of benefits paid in the State that year (the State's error rate is 2 percentage points, or 20 percent, above the tolerance level, and it is assessed a sanction representing 20 percent of the amount by which it exceeds the tolerance level; 2 percentage points $\times$ 0.2 = 0.4). A State with a combined error rate of 14 percent would owe a penalty of 1.6 percent of benefits, or 40 percent of the amount by which it exceeds the 10-percent tolerance level (4 percentage points $\times$ 0.4 = 1.6). Thus, the degree to which a State is assessed sanctions increases as its error rate rises, rather than having sanctions assessed equally on each dollar above the tolerance level. In fiscal year 1998, 22 States had combined error rates above the 10.7 percent tolerance level and were assessed some $78 million in sanctions (later lowered to $27 million, see above).

States also can receive increased Federal funding for administration if their error rates are below a second, much lower threshold. States with a combined error rate below 6 percent are entitled to a larger-than-normal Federal share of their administrative costs. The regular 50-percent Federal match is, depending on the degree to which the State's error rate is below 6 percent, raised to a maximum of 60 percent, as long as the State's rate of improper denials and terminations is below the national average. This "enhanced" administrative funding has typically totaled $10–$20 million a year; in fiscal year 1998, five States had combined error rates below 6 percent (and the requisite low rate of improper denials) and received $27 million in enhanced funding.

Finally, the QC system identifies the various sources of error and requires that States develop and carry out corrective action plans to improve payment accuracy. These reviews generally show that the primary responsibility for overpayment errors is almost evenly split between welfare agencies and clients. The most common errors are related to establishing food stamp expense deductions and households' income.

Intentional program violations (e.g., fraud) can occur in a number of ways; the most common are intentionally misrepresenting household circumstances in order to obtain food stamps or increase benefits and trafficking in food stamp coupons. About one-quarter of the dollar value of erroneous benefit and eligibility determinations identified through QC reviews are fraudulent—just under 2 percent of all benefits issued in 1998. The most recent Agriculture Department study on the extent of food stamp coupon trafficking estimated it at some $800 million in 1993—3.7 percent of all benefits issued that year.

INTERACTION WITH TANF, SSI, AND GA PROGRAMS

The Food Stamp Program is intertwined with Temporary Assistance for Needy Families (TANF), SSI, and State/local General Assistance (GA) Programs in three ways: it is administratively linked

with TANF and GA Programs, most TANF, SSI, and GA recipients are automatically (categorically) eligible for food stamps, and the food stamp recipient population is made up largely of TANF, SSI, and GA participants.

State and local offices and personnel administering TANF and GA Programs are typically the same offices that enroll people for food stamps and issue food stamp benefits. Joint food stamp-TANF/GA application and interview procedures are common. And information about applicants and recipients is shared. This coadministration does not apply in the case of the SSI Program, which is administered separately through Social Security Administration offices—although these offices do provide limited intake and referral services for the Food Stamp Program and one small pilot project provides standardized food stamp benefits through SSI offices.

Food stamp rules generally make households in which all members are TANF, SSI, or GA recipients categorically eligible for food stamps, without reference to regular food stamp eligibility requirements. TANF recipients are broadly defined as anyone receiving benefits or services through a State's TANF Programs. SSI recipients' eligibility for food stamps is barred in California (see earlier eligibility discussion), and GA Programs must meet minimal Federal standards to qualify their recipients for food stamps. Categorical eligibility for food stamps is particularly important in cases where States have chosen TANF rules that are more liberal than food stamps (e.g., disregarding the value of vehicles for working households) in order to encourage work effort. However, it is important to keep in mind that food stamp rules often qualify a household for food stamps even after loss of TANF, SSI, or GA benefits.

For most persons participating in the Food Stamp Program, food stamp aid represents a second or third form of government assistance. Fewer than 20 percent of food stamp households rely solely on nongovernmental sources for their cash income, although over one-quarter have some income from these sources (e.g., earnings, private retirement income). According to 1997 data from QC surveys, TANF (or Aid to Families with Dependent Children (AFDC)) contributed to the income of some 35 percent of food stamps households, and for the large majority of them TANF/AFDC was their only cash income. Supplemental Security Income (SSI) benefits went to about 26 percent of food stamp households; GA payments were received by around 6 percent.

RECIPIENCY RATES

Table 15–8 shows overall food stamp participation rates from 1975 to 1998 using two measures: as a proportion of the total U.S. population and as a percentage of the population with income below the Federal poverty thresholds. Food stamp enrollment has fluctuated widely over the last 25 years, reaching its peak in fiscal year 1994; in that year, it averaged 27.5 million persons a month, with an all-time high of 28 million in the spring of 1994 (not including 1.4 million persons receiving aid under Puerto Rico's nutrition assistance grant in lieu of food stamps).

TABLE 15–8.—FOOD STAMP PARTICIPATION RATES IN THE UNITED STATES, 1975–98

Year	Number of food stamp participants (in millions)	Food stamp participation as a percent of——	
		Total population [1]	Poor population
1975	16.3	7.6	63.0
1976	17.0	7.9	68.1
1977	15.6	7.2	63.1
1978	14.4	6.5	58.8
1979	15.9	7.1	61.0
1980	19.2	8.4	65.6
1981	20.6	9.0	64.7
1982	20.4	8.8	59.3
1983	21.6	9.2	61.2
1984	20.9	8.8	62.0
1985	19.9	8.3	60.2
1986	19.4	8.0	59.9
1987	19.1	7.8	59.1
1988	18.7	7.6	58.9
1989	18.8	7.6	59.6
1990	20.0	8.0	59.6
1991	22.6	9.0	63.3
1992	25.4	10.0	68.9
1993	27.0	10.4	68.7
1994	27.5	10.5	72.1
1995	26.6	10.1	73.0
1996	25.5	9.6	69.8
1997	22.9	8.5	64.3
1998	19.8	8.2	57.4

[1] Calculated as a percent of total U.S. resident population at the end of the fiscal year through 1996. For later fiscal years, calculated as a percent of total U.S. resident population reported in the March Current Population Survey (271 million for 1998).

Note.—Participants in Puerto Rico are not included in this table. Data are monthly average for each year.

Source: U.S. Census Bureau.

Food stamp enrollment is responsive to changes in the economy (i.e., recipients' employment status and earnings), food stamp eligibility rules (and potential applicants' perception of their eligibility status), and administrative practices, as well as recipients getting or losing public assistance eligibility. With few changes in eligibility rules, the caseload expanded from a monthly average of 22.6 million persons in fiscal year 1991 to the 1994 peak. Since 1994, enrollment has declined continuously, dropping to 19.8 million persons in 8.2 million households during fiscal year 1998 because of the effects of an improved economy, Federal and State welfare reform initiatives, and a lower participation rate among those eligible. In fiscal year 1999, participation continued to decline, to a monthly average of 18.2 million people in 7.7 million households, reaching the lowest level since the 1970s.

Until recently, Agriculture Department studies (e.g., for January 1994) have indicated that just over 70 percent of those individuals

eligible for food stamps actually participate.[9] The improved state of the economy and a number of more restrictive food stamp eligibility rules implemented in recent years are acknowledged to be primary factors affecting reduced food stamp participation. But the relatively dramatic recent decline in enrollment has led many observers to conclude that other factors are at work and that the 70+ percent participation rate noted above (as opposed to the number of persons eligible) has dropped significantly, to 63 percent in fiscal year 1997 by one estimate. Reasons cited for this decline range from changing welfare office administrative practices to recipients' lack of understanding that being dropped from (or discouraged from applying for) one public assistance program does not mean automatic ineligibility for food stamps. Based on preliminary Department studies, less-than-optimum participation appears to be concentrated among needy families with children and the "working poor," but a full understanding of the dynamics of declining participation has not emerged.

Table 15–9 shows the average monthly number of people (in thousands) who received food stamp benefits in each State, the District of Columbia, and the participating Commonwealths and territories for selected years between 1975 (when the Food Stamp Program became nationally available) and 1999. There has been a general increase in food stamp participants since 1975, with enrollment peaking in 1994.

RECENT LEGISLATIVE HISTORY

(For legislative history prior to 1996, see previous editions of the *Green Book*.)

The 1996 Omnibus "farm bill" (the Federal Agriculture Improvement and Reform Act; Public Law 104–127) extended the Food Stamp Act's overall authorization for appropriations through fiscal year 1997, with no specific dollar limits. It also: (1) continued the requirement for nutrition assistance grants to Puerto Rico and American Samoa, and for employment and training programs, through fiscal year 2002; (2) revised rules for penalizing food stores in trafficking cases involving management; and (3) extended authority for several pilot projects.

Later in 1996, the omnibus welfare reform law (the Personal Responsibility and Work Opportunity Act; Public Law 104–193) made the most extensive changes to the Food Stamp Program since the Food Stamp Act was rewritten in 1977. Under this law, spending

[9] Participation rates were and are not uniformly as high as 70+ percent among all segments of the food-stamp-eligible population: e.g., participation is very low among the elderly (below one-third) and the "working poor" (less than half those eligible) and relatively high among those enrolled in other public assistance programs. While overall participation among eligible individuals was estimated at some 70 percent, the proportion of benefits issued as a proportion of potential benefits to all those eligible was projected to be higher (approximately 80 percent). Participation rates also varied by State—from an estimated 40 percent to virtually all those thought to be eligible in a few States according to one Department study. Participation also differed by presence of children (higher participation rates) and income (declining participation rates with increased income).

TABLE 15–9.—FOOD STAMP RECIPIENTS BY JURISDICTION, SELECTED FISCAL YEARS 1975–99

[In thousands]

State	1975 [1]	1979 [2]	1985 [3]	1990 [3]	1994 [3]	1995 [3]	1996 [3]	1997 [3]	1998 [3]	1999 [3]
Alabama	393	525	588	449	551	525	509	486	427	405
Alaska	12	25	22	25	46	45	46	45	42	41
American Samoa	NA	NA	NA	NA	2	3	3	3	3	3
Arizona	166	129	206	317	512	480	427	364	296	257
Arkansas	268	277	253	235	283	272	274	266	256	253
California	1,517	1,334	1,615	1,936	3,155	3,175	3,143	2,815	2,259	2,027
Colorado	162	145	170	221	268	252	244	217	191	173
Connecticut	189	155	145	133	223	227	223	210	196	178
Delaware	39	45	40	33	59	57	58	54	46	39
District of Columbia	112	100	72	62	91	94	93	90	85	84
Florida	767	828	630	781	1,474	1,395	1,371	1,192	991	933
Georgia	569	559	567	536	830	816	793	698	632	617
Guam	21	18	20	12	15	16	18	18	25	20
Hawaii	84	96	99	77	115	125	130	127	122	125
Idaho	39	47	59	59	82	80	80	70	62	57
Illinois	948	837	1,110	1,013	1,189	1,151	1,105	1,020	923	820
Indiana	255	275	406	311	521	470	390	348	313	298
Iowa	118	117	203	170	196	184	177	161	141	129
Kansas	63	73	119	142	192	184	172	149	119	115
Kentucky	449	405	560	458	522	520	478	444	412	396
Louisiana	502	523	644	727	756	711	670	575	537	516
Maine	151	121	114	94	136	132	131	124	115	109
Maryland	273	299	291	254	387	399	375	354	323	264
Massachusetts	560	429	337	347	442	410	374	340	293	261

Michigan	685	706	985	917	1,031	971	935	839	772	683
Minnesota	191	143	228	263	316	308	295	260	220	208
Mississippi	390	452	495	499	511	480	457	399	329	288
Missouri	299	280	362	431	593	576	554	478	411	408
Montana	38	33	58	57	71	71	71	67	62	61
Nebraska	50	55	94	95	111	105	102	97	95	92
Nevada	34	27	32	50	97	99	97	82	72	62
New Hampshire	66	44	28	31	62	58	53	46	40	37
New Jersey	565	524	464	381	545	540	541	490	425	385
New Mexico	154	159	157	157	244	239	235	205	175	178
New York	1,398	1,704	1,834	1,546	2,154	2,183	2,099	1,919	1,627	1,545
North Carolina	537	517	474	419	630	614	631	586	528	505
North Dakota	19	20	33	39	45	41	40	38	34	33
Northern Mariana Islands	NA	NA	4	4	4	4	4	4	4	4
Ohio	924	760	1,133	1,078	1,245	1,155	1,045	874	734	640
Oklahoma	184	184	263	267	376	375	354	309	288	271
Oregon	208	160	228	216	286	289	288	259	238	224
Pennsylvania	893	923	1,032	954	1,208	1,173	1,124	1,009	907	835
Puerto Rico	1,800	1,822	1,480	1,480	1,410	1,370	1,330	1,240	1,180	1,140
Rhode Island	104	80	69	64	93	100	91	85	73	76
South Carolina	421	369	373	299	385	364	358	349	333	309
South Dakota	31	37	48	50	53	50	49	47	45	44
Tennessee	435	531	518	527	735	662	638	586	538	511
Texas	1,085	1,027	1,263	1,880	2,730	2,564	2,372	2,034	1,636	1,401
Utah	50	44	75	99	128	119	110	98	92	88
Vermont	46	40	44	38	65	59	56	53	46	44
Virginia	293	320	360	346	547	546	538	476	397	362
Virgin Islands	25	34	32	18	20	23	31	20	17	17
Washington	239	205	281	337	468	476	476	442	362	307

TABLE 15–9.—FOOD STAMP RECIPIENTS BY JURISDICTION, SELECTED FISCAL YEARS 1975–99—Continued

[In thousands]

State	1975 [1]	1979 [2]	1985 [3]	1990 [3]	1994 [3]	1995 [3]	1996 [3]	1997 [3]	1998 [3]	1999 [3]
West Virginia	204	182	278	262	321	329	300	287	269	247
Wisconsin	163	171	363	286	330	320	283	232	193	182
Wyoming	11	11	27	28	34	34	33	29	25	23
Total	19,199	18,926	21,385	21,510	28,888	27,995	26,871	24,106	20,974	19,334

[1] Year end participation, July 1975. Total does not match totals in other tables, which are annual average participation.

[2] Year end participation, September 1979. Total does not match totals in other tables, which are annual average participation. During fiscal year 1979, and into 1980, participation increases were largely due to the elimination of the food stamp purchase requirement. Figures for Alabama and Mississippi are estimates.

[3] Annual average monthly participation.

NA—Not available.

Note.—Data are average monthly number of recipients for each year.

Source: U.S. Department of Agriculture, Food and Nutrition Service. Compiled by the Congressional Research Service.

on food stamps was projected for a net reduction of $23.3 billion through fiscal year 2002 (or 13 percent less than under then-current law over fiscal years 1997–2002). The food-stamp-related provisions of the welfare reform act: (1) gave States significantly more control over program operations and expanded their administrative options (e.g., allowed States to more closely conform their TANF and food stamp rules and sanction food stamp recipients for failure to meet other public assistance program requirements), (2) established a new work rule limiting participation by able-bodied adults without dependents (ABAWDs) who are not working or in training for work to 3 months in any 3-year period, (3) added other new work rules (e.g., disqualification for significantly reduced work effort), (4) instituted an across-the-board benefit reduction, (5) barred eligibility for most legally resident noncitizens, (6) increased penalties for violating Food Stamp Program rules, and (7) encouraged implementation of electronic benefit transfer (EBT) systems for issuing food stamp benefits (requiring systems be in place nationwide by 2002).

In 1997, the Balanced Budget Act's (BBA) food stamp component followed up on the 1996 welfare reform law with amendments that allowed States to exempt significant numbers of ABAWDs from new work requirements and more than doubled Federal funding for employment and training programs for food stamp recipients (targeted on adults without dependents). It also required States to establish systems to ensure that prisoners are not counted as part of any food stamp household. Separately, the 1997 emergency supplemental appropriations law (Public Law 105–18) permitted States to "buy into" the Food Stamp Program and pay for benefits to noncitizens ineligible for federally financed food stamps and adults without dependents made ineligible by work requirements.

Most recently, the 1998 Agricultural Research, Extension, and Education Reform Act (Public Law 105–185) significantly reduced spending for the Federal share of State food stamp administrative costs—some $200 million a year—by imposing a flat annual dollar reduction on most States' entitlements to correct for a perceived "windfall" extra payment States can potentially receive through the interaction between food stamp and TANF funding rules. It also lowered Federal payments to States for employment and training programs for food stamp recipients. A portion of the money saved by these reductions was then used to restore food stamp eligibility to some of the noncitizens made ineligible by the 1996 welfare reform law (e.g., elderly and disabled persons legally resident at the time the 1996 law was enacted).

Table 15–10 provides an overview of the characteristics of food stamp households for selected years since 1980; table 15–11 summarizes annual vital statistics about the program since 1972.

MEDICAID

Medicaid, authorized under title XIX of the Social Security Act, is a Federal-State matching entitlement program providing medical assistance to low-income persons who are aged, blind, disabled, members of families with dependent children, or in certain other

TABLE 15–10.—CHARACTERISTICS OF FOOD STAMP HOUSEHOLDS, SELECTED YEARS 1980–97

[In percent]

Food stamp recipient households	1980 (August)	1985 (Summer)	1989 (Summer)	1990 (Summer)	1991 (Summer)	1992 (Summer)	1993 (Summer)	1994 (Summer)	1995 (Annual)	1996 (Annual)	1997 (Annual)
With gross monthly income:											
Below the Federal poverty levels	87	94	92	92	91	92	91	90	92	91	92
Between the poverty levels and 130 percent of the poverty levels	10	6	8	8	9	8	8	9	8	8	8
Above 130 percent of the poverty levels	2	(1)	(1)	(1)	(1)	(1)	1	1	(1)	1	(1)
With earnings	19	20	20	19	20	21	21	21	21	23	24
With public assistance income [2]	65	68	73	73	70	66	68	69	68	67	67
With AFDC/TANF income	NA	39	42	43	41	40	40	38	38	37	35
With SSI income	18	19	21	19	19	19	20	23	23	24	26
With children	60	59	60	61	61	62	60	61	60	59	58
And female heads of household	NA	46	50	51	51	51	52	51	50	50	49
With elderly members [3]	23	21	20	18	17	15	16	16	16	16	18
With elderly female heads of household [3]	NA	16	14	11	10	9	NA	11	NA	NA	[4] 12
Average household size	2.8	2.7	2.6	2.6	2.6	2.5	2.6	2.5	2.5	2.5	2.4

[1] Percentage equals 0.5 or less.
[2] Public assistance income includes Aid to Families with Dependent Children, TANF, SSI, and general assistance.
[3] Elderly members and heads of household include those age 60 or older.
[4] Estimate.

NA—Not available.

Note.—The proportion of households with public assistance income shown in this table is an estimate that generally overcounts them because it is not corrected for households with multiple sources of public assistance income. The proportion of households with elderly female heads shown in this table for years prior to 1994 is an estimate that generally undercounts them because it counts only single-person female households. The 1995–97 figures represent characteristics over the full course of each fiscal year.

Source: U.S. Department of Agriculture, Food and Nutrition Service surveys of the characteristics of food stamp households. Compiled by the Congressional Research Service.

TABLE 15–11.—HISTORICAL FOOD STAMP STATISTICS, SELECTED YEARS, 1972–99

Fiscal year	Total Federal spending (in millions) [1]		Average monthly participation (in millions of persons)	Average monthly benefits (per person)		Four-person maximum monthly allotment [3]
	Current dollars	Constant (1999) dollars [2]		Current dollars	Constant (1999) dollars [2]	
1972 [4]	$1,871	$7,516	11.1	$13.50	$52.90	$108
1974	2,843	10,097	12.9	17.60	53.30	116
1975 [5]	4,624	14,774	17.1	21.40	59.00	150
1976	5,692	16,973	18.5	23.90	62.00	162
Transition quarter [6]	1,367	3,941	17.3	24.40	62.90	166
1977	5,469	15,161	17.1	24.70	61.60	166
1978	5,573	14,434	16.0	26.80	61.00	170
1979 [7]	6,995	16,444	17.7	30.60	62.50	182
1980	9,188	19,008	21.1	34.40	65.30	204
1981	11,308	21,051	22.4	39.50	68.70	209
1982 [8]	11,117	19,286	22.0	39.20	65.70	233
1983 [8]	12,733	21,329	23.2	43.00	71.20	253
1984 [8]	12,470	20,056	22.4	42.70	68.50	253
1985 [8]	12,599	19,560	21.4	45.00	70.80	264
1986 [8]	12,528	18,970	20.9	45.50	70.10	268
1987 [8]	12,539	18,463	20.6	45.80	67.50	271
1988 [8]	13,289	18,798	20.1	49.80	70.90	290
1989 [8]	13,815	18,649	20.2	51.90	69.30	300
1990 [8]	16,512	21,233	21.5	59.00	74.00	331
1991 [8]	19,765	24,195	24.1	63.90	77.10	352
1992 [8]	23,539	27,966	26.9	68.50	82.20	370
1993 [8]	24,749	28,543	28.4	68.00	80.00	375
1994 [8]	25,525	28,679	28.9	69.00	78.90	375
1995 [8]	25,676	28,067	28.0	71.30	78.90	386
1996 [8]	25,494	27,116	26.9	73.30	78.60	397
1997	22,868	23,684	24.1	71.30	73.90	400
1998	20,397	20,786	21.0	71.10	72.50	408
1999	19,317	19,317	19.3	72.30	72.30	419

[1] Spending for benefits and administration, including Puerto Rico.

[2] Constant dollar adjustments were made using the overall Consumer Price Index for All Urban Consumers (CPI–U) for spending and the CPI–U ''food at home'' component for benefits.

[3] For the 48 contiguous States and the District of Columbia, as in effect at the beginning of the fiscal year in current dollars.

[4] The first fiscal year in which benefit and eligibility rules were, by law, nationally uniform and indexed for inflation.

[5] The first fiscal year in which food stamps were available nationwide.

[6] July through September 1976.

[7] The fiscal year in which the food stamp purchase requirement was eliminated, on a phased in basis.

[8] Includes funding for Puerto Rico's nutrition assistance grant; earlier years include funding for Puerto Rico under the regular Food Stamp Program. Participation figures include enrollment in Puerto Rico (averaging 1.1 to 1.5 million persons a month under the nutrition assistance grant and higher figures in earlier years). Average benefit figures do not reflect benefits in Puerto Rico under its nutrition assistance grant. For fiscal years 1998 and 1999, State-financed costs for benefits to some noncitizens are included (approximately $100 million a year).

Note.—Figures in this table have been revised from similar tables presented in earlier versions of the Green Book to reflect more recent spending information and more precise inflation adjustments for constant dollar amounts.

Source: Compiled by the Congressional Research Service.

categories of pregnant women and children. Within Federal guidelines, each State designs and administers its own program. Thus, there is substantial variation among States in coverage, types and scope of benefits offered, and amount of payment for services.

Legislation passed in the 105th Congress changed the rules governing Medicaid reimbursement to hospitals and community health centers, increased States' flexibility to enroll Medicaid recipients into managed care programs, and gave States additional options for conducting outreach and eligibility determinations. Recent legislation in the 106th Congress made further changes to Medicaid law. In addition to technical amendments to the Balanced Budget Act of 1997, Public Law 106–113 included provisions allowing for increased disproportionate share allotments to certain States and the District of Columbia. The legislation also extended access to a special $500 million fund to pay for Medicaid eligibility determinations resulting from welfare reform and modified the phase-out schedule of cost-based reimbursement for federally qualified health centers and rural health clinics. The Foster Care Independence Act of 1999 (Public Law 106–169) allowed States to extend health insurance coverage under Medicaid for former foster care youth under age 21. Finally, the Ticket to Work and Work Incentives Improvement Act of 1999 (Public Law 106–170) gave States the option to eliminate upper income and assets eligibility limits for workers with disabilities.

ELIGIBILITY

The requirements of Federal law, coupled with the decisions of individual States in structuring their Medicaid Programs, determine who is actually eligible for Medicaid in a given State. In general, Federal law places limitations on the categories of individuals that can be covered and establishes specific eligibility rules for groups within those broad categories. Traditionally, Medicaid eligibility was limited to the following categories of individuals: low-income families with dependent children (in which one parent was absent, incapacitated or unemployed), low-income persons with disabilities, and low-income elderly. In addition, certain individuals with higher income, especially those facing large costs for medical care, were eligible as "medically needy." Beginning in the 1980s, additional coverage categories were added to Medicaid for higher income children and pregnant women. Other coverage groups are identified in the statute as needing special protection against the high cost of medical care. Over 50 distinct population groups are identified in the Federal law. Some are mandatory groups that all States must cover; some are optional eligibility groups.

Contributing to the complexity of the Medicaid Program are financial criteria. Medicaid is a means-tested entitlement program. To qualify, applicants' income and resources must be within certain limits, most of which are determined by States, again within Federal statutory parameters. Further complicating this picture is the flexibility States have in defining countable income and assets. Consequently, income and resource standards vary considerably among States, and different standards apply to different population groups within a State. In general, individuals in similar circumstances may be automatically eligible for coverage in one State,

but required to assume a certain portion of their medical expenses before they can obtain coverage in a second State, and not eligible at all in a third State.

FAMILIES, PREGNANT WOMEN, AND CHILDREN

Prior to the enactment of the 1996 welfare reform law (Public Law 104–193), there were two major routes to Medicaid for low-income families and children. The first was through cash welfare: individuals who qualified for Aid to Families with Dependent Children (AFDC), cash assistance, or Supplemental Security Income (SSI) were automatically eligible for Medicaid. The second was through legislation enacted during the last two decades that extended coverage to low-income pregnant women and children with no ties to the welfare system. The 1996 reforms replaced the AFDC Program with a block grant to States for Temporary Assistance for Needy Families (TANF), severing the automatic connection between cash assistance received by low-income families with children and Medicaid. The following categories describe eligibility pathways for families, pregnant women, and low-income children since welfare reform.[10]

Persons who would be eligible for cash assistance under the old AFDC Program

Unlike AFDC, TANF eligibility does not confer automatic Medicaid eligibility. Nonetheless, current law (section 1931) preserves Medicaid entitlement for individuals who meet the requirements for the former AFDC Programs that were in effect in their States on July 16, 1996, even if they do not qualify for assistance under TANF. This categorical group was created to ensure that low-income families do not lose their Medicaid eligibility as a result of welfare reform. States are required to use the eligibility determination processes that were already in place for AFDC and Medicaid, including the same income and resource standards and other rules formerly used to determine if a family's income and composition made it eligible for AFDC and Medicaid. The 1996 welfare reform law allows States to modify their "prereform" AFDC income and resource standards as follows: (1) States may lower their income eligibility standards, but not below those used on May 1, 1988; (2) States may increase their income and resource standards up to the percentage increase in the Consumer Price Index (CPI); and (3) States may use less restrictive income and resource methodologies than those in effect on July 16, 1996.

The 1996 income standards for AFDC Programs are well below the current Federal poverty level (FPL). For example, the maximum AFDC payment levels on July 16, 1996, range from about 14 percent of the current poverty level in Alabama to about 86 percent in Connecticut. The median level nationwide is 45 percent. In addition, for most eligibility categories in most States, individuals must have resources valued at less than a specified amount (typically $1,000 for an adult with one or more dependent children) to be eligible for Medicaid. States determine what items constitute count-

[10] Children can also qualify for Medicaid as a result of disability. For a detailed description of eligibility for persons with disabilities, see the subsequent section on SSI-related groups.

able resources and the dollar value assigned to those countable items. Assets may include, for example, cars, savings accounts, real estate, trust funds, and tax credits.

A number of States have established more generous standards for determining Medicaid eligibility than those in place in 1996 and some States have taken advantage of the flexibility offered under section 1931 to realign Medicaid eligibility with eligibility for the new TANF Programs. By using less restrictive methods for calculating income and/or resources, those States effectively raised the income and resource standards in determining Medicaid eligibility for persons living in families with dependent children.

In the near term, the flexibility afforded by section 1931 is not likely to become a major pathway for children into the Medicaid Program. Children with income too high to qualify for cash assistance have a number of other pathways to Medicaid. On the other hand, this provision may hold important promise for extending coverage to the parents of children who have fewer alternative pathways to Medicaid, or for simplifying Medicaid eligibility while at the same time qualifying entire families for coverage—an option that could help to raise participation in a program that has become increasingly complex for States to administer and for qualifying family members to navigate.

Poverty level pregnant women and children

Between 1986 and 1991, Congress gradually extended Medicaid to groups of pregnant women and children defined in terms of family income, rather than in terms of their ties to the AFDC Program. These are groups who, prior to the 1996 welfare reforms, did not qualify for cash assistance.

States are required to cover pregnant women and children under age 6 with family incomes below 133 percent of the Federal poverty income guidelines. In 2000, the poverty guideline in the 48 contiguous States and the District of Columbia is $14,150 for a family of three. Coverage for pregnant women is limited to services related to the pregnancy or complications of the pregnancy. Eligibility extends to 60 days after termination of the pregnancy. Children receive full Medicaid coverage.

Since July 1, 1991, States have been required to cover all children who are under age 19, who were born after September 30, 1983, and whose family income is below 100 percent of the FPL. The 1983 start date means that the mandatory coverage is extended to children by one age cohort each year until reaching all those under age 19 in fiscal year 2002.

States are permitted, but not required, to cover pregnant women and infants under 1 year of age whose family income is between 133 and 185 percent of the FPL. In 1999, 41 States and the District of Columbia extended coverage to some or all pregnant women and infants in this category. States wishing to further expand eligibility have several options under Medicaid law, including waivers of Federal rules. The Balanced Budget Act of 1997 (Public Law 105–33), gives States the option of providing 12 months of continuous Medicaid coverage for children regardless of whether they continue to meet income eligibility tests, and to presume that certain low-income children are eligible in advance of completing the application

process, allowing the States to provide services during the time that eligibility is being determined. States have been able to use "presumptive eligibility" for providing coverage to pregnant women before enrollment is finalized since 1986.

Transitional medical assistance

An increasingly important eligibility group for families with children is called "transitional medical assistance" or TMA. TMA was created to address the concern that the loss of Medicaid for individuals who could successfully obtain employment would provide a disincentive to seek and to keep jobs. States are required to continue Medicaid for 6 months for families that were covered by Medicaid under section 1931 in at least 3 of the last 6 months preceding the month in which the family lost such assistance due to increased hours of employment, increased earnings of the caretaker relative, or the family member's loss of one of the time limited earned income disregards. States must extend Medicaid coverage for an additional 6 months for families that were covered during the entire first 6-month period, and are earning below 185 percent of the Federal poverty line. The eligibility pathway for these groups will sunset at the end of fiscal year 2001.

A small additional group of TMA-eligible persons are those who lose Medicaid coverage under section 1931 because of increased child or spousal support. Families eligible for this 4 month extension must have been receiving Medicaid under section 1931 in at least 3 of the preceding 6 months.

Other AFDC-related groups

While the AFDC Program no longer exists, a number of Medicaid eligibility groups that are tied to States' former AFDC rules remain. These rules continue to apply today because of the 1996 welfare reform law's provision requiring Medicaid coverage for people who would have qualified for the former AFDC Program. Other AFDC-related groups include persons who did not receive cash assistance because the payment would be less than $10; persons whose payments were reduced to zero because of recovery of previous overpayments; certain work supplementation participants; and persons who were ineligible for AFDC because of a requirement that could not be imposed under Medicaid. For example, States are permitted to deny Medicaid benefits to nonpregnant adults and heads of households who lose TANF benefits because of refusal to work, but must continue to provide Medicaid coverage to their children.

States must continue Medicaid for recipients of adoption assistance and foster care under title IV–E of the Social Security Act. The Foster Care Independence Act of 1999 (Public Law 106–169) amends Medicaid law by giving States the option to extend Medicaid coverage to former foster care recipients ages 18, 19, and 20, and further allows States to limit coverage to those who were eligible for assistance under title IV–E before turning 18 years of age.

Ribicoff children

"Ribicoff children," named for the former Senator that sponsored legislation authorizing coverage for this group, is a coverage path-

way that is gradually diminishing in importance as more children are included under the poverty-related coverage categories. Ribicoff children are children under age 21 who meet income and resource requirements for the former AFDC Program but who do not meet other categorical requirements for AFDC. Included in this category are often children who are in State-sponsored foster care, are institutionalized, or are inpatients in psychiatric facilities.

Targeted low-income children authorized under the State Children's Health Insurance Program (SCHIP)

SCHIP was established by the Balanced Budget Act of 1997 under a new title XXI of the Social Security Act. The program, while completely separate from Medicaid, allows States to access funds to cover targeted low-income children through group health or other insurance that meets specific standards for benefits and cost sharing, or through their Medicaid Programs, or through a combination of both.[11] SCHIP is discussed here because many States have extended Medicaid coverage to targeted low-income children, although they pay for that coverage with title XXI funds.

Title XXI defines SCHIP-eligible children as those who are not eligible for Medicaid or are covered under a group health plan or other insurance, and are living in families with incomes that are either: (1) above the State's Medicaid financial eligibility standard in effect in March 1997 but less than 200 percent of the FPL; or (2) in States with Medicaid income levels for children already at or above 200 percent of the poverty level as of March 1997, within 50 percentage points over this income standard. Within those broad statutory requirements, each State can define the group of targeted low-income children who may enroll in SCHIP. As of January 1, 2000, the Health Care Financing Administration (HCFA) had approved SCHIP plans for all 50 States, the District of Columbia, and 5 territories. Twenty-four States use Medicaid expansions, 15 have separate State programs, and 17 combine a Medicaid expansion and a separate State program. (For a more detailed description of the SCHIP Program, see below).

Section 1902(r)(2) and demonstration waivers

Medicaid statute includes other provisions that provide States with options to extend coverage to individuals who would not otherwise qualify. One of these provides States with flexibility in defining methods for counting income and assets (authorized under section 1902(r)(2) of the Social Security Act), and another allows States to create demonstration projects (authorized under section 1115 of the Social Security Act) to test new approaches for providing health care coverage.

Section 1902(r)(2) of the Social Security Act allows State Medicaid Programs to submit a State plan amendment to use more liberal methods for calculating income and resources for some categories of Medicaid eligibles. Most States that have chosen to implement section 1902(r)(2) have done so only for children. In addition, most States using the flexibility created by section 1902(r)(2)

[11] Under limited circumstances, States have the option to purchase a health benefits plan that is provided by a community-based health delivery system, or to purchase family coverage under a group health plan as long as it is cost effective to do so.

do so by disregarding certain types or amounts of income to extend Medicaid to children in families with earnings that are too high to qualify for one of the other eligibility groups, or have assets that exceed the allowable levels.

Demonstration waivers, authorized in section 1115 of the Social Security Act, enable States to waive some Medicaid requirements to create demonstration projects that promote the objectives of the Medicaid statute. Through a fairly cumbersome application process, a number of States have used such waivers to enact broad-based and sometimes statewide health reforms although demonstrations under this provision need not be statewide. A number of the demonstrations extend comprehensive health insurance coverage to low-income children (and families) who would otherwise not be eligible for Medicaid. Section 1115 waivers are also often used by the States to enroll their Medicaid beneficiaries in managed care plans.[12] (See "Medicaid Managed Care" section below.)

AGED AND DISABLED PERSONS

SSI-related groups

With one important exception, States are required to provide Medicaid coverage to recipients of SSI, the cash assistance program for aged, blind and disabled persons. For 2000, persons qualifying for SSI cannot have income in excess of $572 per month or resources of more than $2,000.

The major exception to automatic Medicaid coverage for SSI recipients is in so-called "209(b)" States. States may elect the option, described in section 209(b) of the Social Security Amendments of 1972 (Public Law 92–603), allowing them to use income and resource standards that are no more restrictive than those in effect on January 1, 1972 (before the implementation of SSI) that established the option. These standards may vary in the definition of disability used, or in income or resource standards or definitions. There are 11 section 209(b) States:

Connecticut	Minnesota	Ohio
Hawaii	Missouri	Oklahoma
Illinois	New Hampshire	Virginia
Indiana	North Dakota	

States that use more restrictive eligibility rules under section 209(b) must also allow applicants to deduct medical expenses from their income (not including SSI or State supplemental payments) in determining eligibility. This process is known as "spend down." For example, if an applicant has a monthly income of $600 (not including SSI or State supplemental payments) and the State's maximum allowable income is $300, the applicant would qualify for Medicaid after incurring $300 in medical expenses. As discussed below, the spend down process is also used in establishing eligibility for the medically needy.

Many States, recognizing that the SSI benefit standard may provide too little income to meet the individual's living expenses, supplement SSI with additional cash assistance payments known as State supplemental payments. States use a variety of different poli-

[12] Section 1115 waivers have been used to create managed care delivery systems to provide acute and long-term care services to the aged and disabled.

cies for providing these payments. Some States provide State supplemental payments to certain groups of elderly or disabled individuals whose income is too high to qualify for SSI. In those States, Medicaid coverage may be extended to persons receiving State supplemental payments on the same basis as persons receiving SSI. Some examples of specified groups of elderly or disabled State supplemental payment recipients include those living independently in the community but with special needs for in-home personal care assistance or home-delivered meals; or those residing in protected living arrangements, such as adult foster care or domiciliary care provided in large congregate care facilities. In 1999, all but seven States provided some amount of supplemental payments.

When States provide Medicaid coverage to persons receiving State supplemental payments, the combined Federal SSI and State supplemental benefit payments become the effective income eligibility standard. Because specified amounts of income are disregarded in determining eligibility for SSI and most State supplemental payment programs, a person with income which exceeds the maximum benefit may still be eligible for cash assistance and Medicaid. For 209(b) States, however, the effective Medicaid income eligibility standards may be below the SSI/State supplemental payment standard, because some of those States use more restrictive income standards or definitions of countable income.

States must continue Medicaid coverage for several defined groups of individuals who have lost SSI or State supplemental payment eligibility. The qualified severely impaired are disabled persons who have returned to work and have lost eligibility as a result of employment earnings, but still have the condition that originally rendered them disabled and meet all nondisability criteria for SSI except income (the current law threshold for earnings is $1,109 per month). States must continue Medicaid coverage to a qualified severely impaired individual if the person needs Medicaid to continue employment and the individual's earnings are insufficient to provide the equivalent of SSI, Medicaid, and attendant care benefits the individual would qualify for in the absence of earnings.

Effective in August 1997, as a part of BBA 1997, States can opt to expand eligibility for employed, disabled individuals with incomes up to 250 percent of poverty. Those beneficiaries can buy into Medicaid by paying a sliding scale premium based on the individual's income as determined by the State. The 1999 ticket to work legislation further allows States to cover employed, disabled individuals at higher income and resource levels (i.e., income over 250 percent of the FPL and resources over $2,000 for an individual or $3,000 for a couple). States may also cover financially eligible working individuals whose medical condition has improved such that they no longer meet the Social Security definition of disability. States can require these individuals to "buy in" to Medicaid coverage by paying premiums or other cost-sharing charges on a sliding fee scale based on income, as established by the State.

States must also continue Medicaid coverage for persons who were once eligible for both SSI and Social Security payments and who lose SSI because of a cost-of-living adjustment in their Social Security benefits. Similarly, Medicaid continuations have been provided for certain other persons who lose SSI as a result of eligi-

bility for or an increase in Social Security or veterans benefits. Finally, States must continue Medicaid for certain SSI-related groups who received benefits in 1973, including "essential persons" (persons who care for a disabled individual).

States have the option of extending coverage to certain additional elderly or disabled persons. These include individuals eligible for SSI but not receiving it; and elderly and disabled persons whose income does not exceed 100 percent of the FPL and whose resources do not exceed the SSI standard.[13]

Qualified Medicare beneficiaries and related groups

Certain low-income individuals are entitled to assistance in paying their Medicare part B premiums and other Medicare cost-sharing through the Medicaid Program. Such persons fall into one of the following four coverage groups:

1. *Qualified Medicare beneficiaries (QMBs).*—QMBs are aged or disabled persons with incomes at or below the Federal poverty line ($8,350 for an individual and $11,250 for a couple in 2000[14]) and assets below $4,000 for an individual and $6,000 for a couple. QMBs are entitled to have their Medicare cost-sharing charges, including the part B premium, paid by Medicaid. Medicaid protection is limited to payment of Medicare cost-sharing and premium charges (i.e., the Medicare beneficiary is not entitled to coverage of Medicaid plan services) unless the individual is otherwise entitled to Medicaid.
2. *Specified low-income Medicare beneficiaries.*—These are persons who meet the QMB criteria, except that their income is slightly over the QMB limit. The specified low-income Medicare beneficiary limit is 120 percent of the FPL. Medicaid protection is limited to payment of the Medicare part B premium (i.e., the Medicare beneficiary is not entitled to coverage of Medicaid plan services) unless the individual is otherwise entitled to Medicaid.
3. *Qualifying individuals (QI–1).*—These are persons who meet the QMB criteria, except that their income is between 120 and 135 percent of poverty. Further, they are not otherwise eligible for Medicaid. Medicaid protection is limited to payment of the Medicare part B premium.[15]
4. *Qualifying individuals (QI–2).*—These are persons who meet the QMB criteria, except that their income is between 135 and 175 percent of poverty. Further, they are not otherwise eligible for Medicaid. Medicaid protection is limited to payment of that portion of the part B premium attributable to the transfer of

[13] Certain States providing Medicaid coverage to persons receiving State supplemental payments may end up covering persons with incomes at 100 percent of the Federal poverty level or higher, when State supplemental payments provide income at those levels.

[14] The levels are actually higher since $20 per month of unearned income is disregarded in the calculation.

[15] In general, Medicaid payments are shared between the Federal Government and the States according to a matching formula. However, expenditures under the QI–1 and QI–2 programs are paid for 100 percent by the Federal Government (from the Medicare Part B Trust Fund) up to the State's allocation level. A State is only required to cover the number of persons which would bring its spending on these population groups in a year up to its allocation level. Any expenditures beyond that level are paid by the State. Total allocations are $200 million in fiscal year 1998, $250 million for fiscal year 1999, $300 million for fiscal year 2000, $350 million for fiscal year 2001, and $450 million for fiscal year 2002. Assistance under the QI–1 and QI–2 programs is available for the period January 1, 1998–December 31, 2002.

home health visits ($1.07 in 1998; $2.23 in 1999 and $2.87 in 2000).[16]

Institutionalized persons and related groups (all optional)

States may provide Medicaid to certain otherwise ineligible persons because their incomes are too high to qualify for SSI or State supplemental payments but who are in nursing facilities (NFs) or other institutions. States have the option to establish a special income standard, known as "the 300 percent rule," to allow these persons to qualify for Medicaid coverage. Individuals qualifying for coverage through this pathway may have income that is not higher than 300 percent of the maximum SSI benefit applicable to a person living at home with no other resources. For 2000, this limit is $1,536 per month.

States can also apply this higher income standard to persons qualifying under the waiver authority of section 1915(c) of the Social Security Act. Section 1915(c) waivers allow States to waive Medicaid statewideness and comparability rules to provide home- and community-based services to defined groups of individuals who would otherwise require institutional care. States are required to make a special application to HCFA to implement such waivers. With approval, they can provide a wide variety of nonmedical, social, and supportive services that have been shown to be critical in allowing chronically ill and disabled persons to remain in their homes. States are using waiver programs to provide services to a diverse long-term care population, including children, the elderly, and others who are disabled or who have chronic mental illness, mental retardation and developmental disabilities, and AIDS. In addition, under this waiver authority States are permitted to disregard income of other relatives living in the home of the disabled beneficiary. (This is especially important for disabled persons who are able to live at home with their spouse or parents and who need Medicaid assistance to do so.)

States are also able to provide Medicaid to several other classes of persons who need the level of care provided by an institution and who would be eligible if they were in an institution but can also be cared for at home. These include children being cared for at home under the "Katie Beckett" option,[17] persons of any age who are ventilator-dependent, and persons receiving hospice benefits in lieu of institutional services.

Finally, in 1997, Congress created a Medicaid requirement that States continue Medicaid coverage for those disabled children who were receiving SSI on the date of enactment of the 1996 welfare reform law but who would lose such coverage based on the new definition of childhood disability created in that legislation.

Aliens

Legal immigrants arriving in the United States after August 22, 1996 are ineligible for Medicaid benefits for 5 years. Coverage of

[16] See footnote number 6.

[17] Named for a ventilator-dependent child who was unable to leave an institutionalized setting to receive care at home because, if discharged, she would no longer have been eligible for Medicaid. This option requires States to serve all such children in the State and is distinguished from 1915(c) waivers that allow States to extend coverage to individuals in limited geographic areas.

such persons after the 5 year ban is a State option. States are required to provide Medicaid coverage to legal immigrants who resided in the country and were receiving benefits on August 22,1996, and for those residing in the country as of that date who become disabled in the future. States are also required to provide coverage to: refugees for the first 7 years after entry into the United States; asylees for the first 7 years after asylum is granted; individuals whose deportation is being withheld by the Immigration and Naturalization Service for the first 7 years after grant of deportation withholding; lawful permanent aliens after they have been credited with 40 quarters of coverage under Social Security; and honorably discharged U.S. military veterans, active duty military personnel, and their spouses and unmarried dependent children. Qualified aliens and nonqualified aliens who meet the financial and categorical eligibility requirements for Medicaid may receive emergency Medicaid services.

THE MEDICALLY NEEDY

As of January 2000, 39 States and other jurisdictions covered at least some groups of the medically needy. These are persons who meet the nonfinancial standards for inclusion in one of the groups covered under Medicaid, but who do not meet the applicable income or resource requirements for categorically needy eligibility. The State may establish higher income or resource standards for the medically needy. In addition, individuals may spend down to the medically needy standard by incurring medical expenses, in the same way that SSI recipients in section 209(b) States may spend down to Medicaid eligibility. For the medically needy, spend down may involve the reduction of assets and income.

The State may set its separate medically needy income standard for a family of a given size at any level up to 133⅓ percent of the maximum payment for a similar family under the State's AFDC Program (in effect on July 16, 1996, as modified). States may limit the groups of individuals who may receive medically needy coverage. If the State provides any medically needy program, however, it must include all children under 18 who would qualify under one of the mandatory categorically needy groups, and all pregnant women who would qualify under either a mandatory or optional group, if their income or resources were lower.

At the close of fiscal year 1998, the following 35 States, the District of Columbia, and 3 territories covered some groups of the medically needy:

American Samoa
Arkansas
California
Connecticut
District of Columbia
Florida
Georgia
Hawaii
Illinois
Iowa
Kansas
Kentucky
Louisiana
Maine
Maryland
Massachusetts
Michigan
Minnesota
Montana
Nebraska
New Hampshire
New Jersey
New York
North Carolina
North Dakota
Oklahoma
Oregon
Pennsylvania
Puerto Rico
Rhode Island
Tennessee
Texas
Utah
Vermont
Virginia
Virgin Islands
Washington
West Virginia
Wisconsin

MEDICAID AND THE POOR

In 1998, Medicaid covered 10.2 percent of the total U.S. population (excluding institutionalized persons) and 40.3 percent of those with incomes below the FPL. Because categorical eligibility requirements for children are less restrictive than those for adults, poor children are much more likely to receive coverage. Table 15–12 shows Medicaid coverage by age and income status in 1998, as reported in the March 1999 Current Population Survey (CPS) conducted by the U.S. Census Bureau. Note that persons shown as receiving Medicaid may have had other health coverage as well. Nearly all the elderly, for example, have Medicare and/or private coverage.

TABLE 15–12.—MEDICAID COVERAGE BY AGE AND FAMILY INCOME, 1998

[In thousands]

Age	Covered by Medicaid	Persons in age group	Percent with Medicaid
In poverty:			
0–5	3,112	5,087	61.2
6–10	2,385	4,148	57.5
11–18	2,521	5,253	48.0
19–44	3,632	12,320	29.5
45–64	1,373	4,647	29.5
65 or older	1,004	3,386	29.6
Total	16,920	36,650	40.3
Family income between 100 and 132 percent of poverty:			
0–5	762	1,668	45.7
6–10	509	1,457	34.9
11–18	550	1,801	30.5
19–44	819	5,289	15.5
45–64	358	2,066	17.3
65 or older	458	2,702	16.9
Total	3,456	14,980	23.1
Family income between 133 and 185 percent of poverty:			
0–5	771	2,799	27.5
6–10	537	2,349	22.8
11–18	683	3,334	20.5
19–44	951	9,700	9.8
45–64	450	3,648	12.3
65 or older	438	4,589	9.5
Total	3,829	26,420	14.5
Family income greater than 185 percent of poverty:			
0–5	964	14,010	6.9
6–10	712	12,450	5.7

TABLE 15–12.—MEDICAID COVERAGE BY AGE AND FAMILY INCOME, 1998—Continued

[In thousands]

Age	Covered by Medicaid	Persons in age group	Percent with Medicaid
11–18	1,058	21,350	5.0
19–44	1,719	77,850	2.2
45–64	844	47,780	1.8
65 or older	1,063	21,720	4.9
Total	6,359	195,200	3.3
All persons:			
0–5	5,609	23,560	23.8
6–10	4,142	20,410	20.3
11–18	4,812	31,740	15.2
19–44	7,121	105,200	6.8
45–64	3,025	58,140	5.2
65 or older	2,962	32,390	9.1
Total	27,670	271,400	10.2

Source: Congressional Research Service tabulations from the March 1999 Current Population Survey (CPS). Number of recipients on the CPS is lower than the number on administrative records due to underreporting by CPS respondents due in part to welfare reform and the transition to managed care (see more detailed discussion in the section text). Counts exclude approximately 800,000 children in foster care for whom income data are not available on the CPS.

Children under age 6 with family incomes below poverty are most likely to be covered. Coverage rates drop steadily with age and income until age 65. Estimates of the number of people with Medicaid coverage based on the CPS and other national surveys have always differed from official numbers published by HCFA based on data reported by States on form HCFA–2082. While estimates of Medicaid coverage based on the CPS show a substantial decline over the period from 1994 to 1998, administrative data reported by the States to HCFA show little or no decline nationally over the same period. While not all of the reasons for this divergence are understood, some plausible explanations for at least part of the growing disparity may be: (1) double counting and classification errors on the HCFA–2082; (2) imprecise imputation or underreporting of Medicaid status based on receipt of cash assistance on the CPS; and (3) respondents reporting their current insurance coverage rather than coverage last year when responding to the questions on the CPS. Moreover, with the widespread transition of Medicaid from fee-for-service reimbursement to capitated managed care, some beneficiaries may report the source of their health insurance coverage incorrectly. They may now carry health insurance cards that identify them as members of a health maintenance organization such as Kaiser or Blue Cross/Blue Shield rather than as Medicaid beneficiaries or they may be classified as uninsured if the plan in which they are enrolled is not included among those listed on the CPS questionnaire. Changes have been made to the March 2000 CPS that should improve the reporting of Medicaid coverage by respondents.

SERVICES

States are required to offer the following services to categorically needy recipients under their Medicaid Programs: inpatient and outpatient hospital services; laboratory and x-ray services; NF services for those over age 21; home health services for those entitled to NF care; early and periodic screening, diagnosis, and treatment for those under age 21; family planning services and supplies; physicians' services; and nurse-midwife services. The Omnibus Budget Reconciliation Act (OBRA) of 1989 required States to provide ambulatory services offered by federally qualified health centers, effective April 1, 1990, and services furnished by certified family or pediatric nurse practitioners, effective July 1, 1990. States may also provide additional medical services such as drugs, eyeglasses, and inpatient psychiatric care for individuals under age 21 or over 65 (see table 15–24).

Federal law establishes the following requirements for coverage of the medically needy: (1) if a State provides medically needy coverage to any group, it must provide ambulatory services to children and prenatal and delivery services for pregnant women; (2) if a State provides institutional services for any medically needy group, it must also provide ambulatory services for this population group; and (3) if the State provides medically needy coverage for persons in intermediate care facilities for the mentally retarded or in institutions for mental disease, it must offer to all groups covered in its medically needy program either all of the mandatory services or alternatively the care and services listed in 7 of the 25 paragraphs in the law defining covered services.

FINANCING

The Federal Government helps States pay the cost of Medicaid services by means of a variable matching formula which is adjusted annually. The Federal matching rate, which is inversely related to a State's per capita income, can range from 50 to 83 percent. In 2000 the highest rate is 76.80 percent, with 15 States and other jurisdictions receiving the minimum match of 50 percent. Beginning in fiscal year 1998 the Federal matching rate for the District of Columbia increased permanently to 70 percent; Alaska's matching percentage increased to 59.8 percent for fiscal years 1998, 1999, and 2000. Federal matching for the territories is set at 50 percent with a maximum dollar limit placed on the amount each territory can receive. The Federal share of administrative costs is 50 percent for all States except for certain items for which the authorized rate is higher.

REIMBURSEMENT POLICY

States establish their own service reimbursement policies within general Federal guidelines. OBRA 1989 codified the regulatory requirement that payments must be sufficient to enlist enough providers so that covered services will be available to Medicaid beneficiaries at least to the extent they are available to the general population in a geographic area. Beginning April 1, 1990, States were required to submit to the Secretary their payment rates for pediatric and obstetrical services along with additional data that would

assist the Secretary in evaluating the State's compliance with this requirement. Effective October 1, 1997, States no longer must assure adequate payment levels to obstetricians and pediatricians nor provide annual reports on their payment levels for these services.

Until 1980, States were required to follow Medicare rules in paying for institutional services. The Boren amendment, enacted with respect to nursing homes in 1980 and extended to hospitals in 1981, authorized States to establish their own payment systems, as long as rates were reasonable and adequate to meet the costs of efficiently and economically operated facilities. Rates for hospitals had to also be sufficient to assure reasonable access to inpatient services of adequate quality. The Balanced Budget Act (BBA) of 1997 repealed the Boren amendment. Effective October 1, 1997, States must instead provide public notice of the proposed rates for hospitals, NFs, and intermediate care facilities for the mentally retarded and the methods used to establish those rates.

State hospital reimbursement systems must provide for additional payments to facilities serving a disproportionate share of low-income patients. Unlike comparable Medicare payments, Medicaid disproportionate share hospital (DSH) payments must follow a formula that considers a hospital's charity patients as well as its Medicaid caseload. Beginning in fiscal year 1992, DSH payments in the national aggregate, as well as in each State, are permitted to equal up to 12 percent of total Medicaid spending applicable to a fiscal year, excluding administrative costs. The 12 percent limit was phased in through the use of State-specific DSH allotments (limits on Federal matching payments) for each Federal fiscal year. BBA 1997 (Public Law 105–33) lowered the DSH allotments by imposing a freeze and making graduated proportional reductions. It established additional caps on the State DSH allotments for fiscal years beginning in 1998 and specifies those caps for 1998–2002. Thereafter, annual DSH allotments for a State equal the allotment for the preceding fiscal year increased by the percentage change in the medical care component of the Consumer Price Index for All Urban Consumers, subject to a ceiling of 12 percent of the total amount of expenditures under the State plan for medical assistance during the fiscal year. Public Law 105–33 also imposed a new cap on DSH payments to institutions for mental disease and other mental health facilities. Finally, the law required States to pay disproportionate share adjustments on behalf of individuals in managed care entities directly to the hospitals rather than to the managed care entities and not to include such payments in the capitation rate. Public Law 106–113 made further changes to DSH by increasing the disproportionate share allotments for certain States and the District of Columbia. This law also removed the July 1, 1999, end date for increased hospital-specific limits for disproportionate share payments in California, extending the transition period indefinitely.

OBRA 1990 established new rules for Medicaid reimbursement of prescription drugs. The law denies Federal matching funds for drugs manufactured by a firm that has not agreed to provide rebates. Under amendments made by the Veterans Health Care Act of 1992, a manufacturer is not deemed to have a rebate agreement unless the manufacturer has entered into a master agreement with

the Secretary of Veterans Affairs. Rebate amounts vary depending on the nature of the drug. The minimum rebate is 11 percent of the average price.

Practitioners and providers are required to accept payments under the program as payment in full for covered services except where nominal cost-sharing charges may be required. States may generally impose such charges with certain exceptions. They are precluded from imposing cost sharing on services for children under 18, services related to pregnancy, family planning or emergency services, and services provided to NF inpatients who are required to spend all of their income for medical care except for a personal needs allowance. Effective August 5, 1997 States are permitted to pay Medicaid rates to providers for services to "dual eligibles" (those Medicare beneficiaries who are also eligible for full Medicaid benefits) and QMBs).

ADMINISTRATION

Medicaid is a State-administered program. At the Federal level, the Health Care Financing Administration (HCFA) of the U.S. Department of Health and Human Services (DHHS) is responsible for overseeing State operations.

Federal law requires that a single State agency be charged with administration of the Medicaid Program. Generally, that agency is either the State welfare agency, the State health agency, or an umbrella human resources agency. The single State agency may contract with other State entities to conduct some program functions. Further, States may process claims for reimbursement themselves or contract with fiscal agents or health insuring agencies to process these claims.

MEDICAID AND MANAGED CARE

To contain escalating health care costs and improve access to the Medicaid Program, States are increasingly adopting managed care delivery systems. Enrollment in Medicaid managed care has increased steadily during the 1990s. According to HCFA, by 1998, 20.2 million Medicaid recipients were enrolled in some form of managed care, representing 49.7 percent of all Medicaid recipients that year. Medicaid managed care refers to a system of health care delivery in which the provision of an agreed upon set of Medicaid-covered health care services is coordinated by a health plan or a primary care case manager. These plans, or case managers, are obligated by contract or agreement to be responsible for the care provided (or not provided) to enrollees. The goal of managed care systems is to provide access to quality health care while containing costs by ensuring that all necessary services are provided to individuals.

The Balanced Budget Act of 1997 included several provisions that significantly affect the operation of State Medicaid managed care programs. Effective October 1, 1997, States no longer need a waiver of Federal law to require the majority of Medicaid beneficiaries to enroll in managed care. Prior to BBA 1997, States wishing to require Medicaid beneficiaries to enroll in managed care had to obtain one of two types of waivers from HCFA. The first type

of waiver, known as a "freedom-of-choice" waiver, is permitted by section 1915(b) of the Social Security Act. Section 1915(b) waivers allow States to waive specific requirements for a specific population or geographical area, and have been used to require Medicaid beneficiaries to enroll in managed care plans and to restrict the providers from whom enrollees receive Medicaid-covered services. There are currently 270 freedom-of-choice programs operating in 34 States. The second, a section 1115(a) waiver, offers States greater flexibility, allowing HCFA to waive a broad range of Medicaid requirements. As of March 2000, statewide section 1115(a) waivers were approved in 21 States, implemented in 19, and pending in 3 States. In addition to permitting States to require Medicaid beneficiaries to enroll in managed care and to restrict their choice of providers, these waivers allow States to expand coverage to those not traditionally eligible for Medicaid, to impose premiums and copayments on those new eligibles, and to modify the Medicaid benefit package. Section 1115(a) waivers are approved on condition that they are budget neutral to the Federal Government—that Federal costs over the life of the waiver (typically 5 years) are no more than if the State had continued operating its prewaiver Medicaid Program. To enforce budget neutrality, some waivers employ aggregate caps on Federal matching and others use per capita expenditure caps. Some States exempt aged, blind, and disabled Medicaid eligibles, who often incur high medical expenses, from mandatory managed care participation. Most Medicaid managed care programs have operated under waiver authorities allowed by Medicaid statute.

Medicaid managed care programs generally fall into two categories: those in which the health plan assumes full financial risk for services it provides to enrollees, referred to as "risk-based" programs; and those in which an individual health care provider (a physician or other licensed health professional) is paid a small monthly amount by the State in return for managing health care services for a defined population, referred to as "primary care case management (PCCM)" programs. In the latter case, the provider acts as a gatekeeper for services needed by an individual, but does not assume financial risk for health care services provided. There are other hybrid models of Medicaid managed care in which entities assume either full or partial risk for selected services and may also function as PCCMs for enrolled beneficiaries. For analytic purposes, such hybrid models are also typically classified as "risk-based" programs. According to a survey conducted by the National Academy for State Health Policy (1999), 48 States (all except Alaska and Wyoming) and the District of Columbia reported using some form of Medicaid managed care in 1998. Forty-five States had risk-based programs, and 29 States had nonrisk PCCM programs.

The Medicaid population covered by State managed care programs is composed primarily of low-income women and children. As of 1998, all States operating risk-based programs enrolled the Aid to Families with Dependent Children (AFDC) related population and poverty-level children; and 43 enrolled poverty-level pregnant women. Some States enroll populations with more complex medical needs, such as the noninstitutionalized elderly, and persons with mental and physical disabilities. As of 1998, 26 States covered the

noninstitutional elderly in their risk-based programs; 32 covered Supplemental Security Income (SSI) eligible children; and 30 covered SSI eligible adults living in the community. In general, States tend to require risk-based managed care plans to provide a comprehensive range of Medicaid-covered services. The exceptions to this are long-term care services needed by the elderly and disabled, which generally are not included under managed care, and behavioral health services, which are sometimes provided under a separate contract. This is in contrast to States that operate PCCM programs; most States limit the PCCM providers to gatekeeper functions for a smaller range of services.

Despite changes to Medicaid law made by BBA 1997, waivers are still required to mandate the enrollment of children with special health care needs, Native Americans/Alaska Natives, and dual-eligible Medicaid-Medicare beneficiaries into managed care. BBA 1997 also permits States to contract with managed care organizations serving only Medicaid beneficiaries and to "lock" beneficiaries into the same plan for up to 12 months. Prior to BBA 1997, States required a section 1115 waiver to implement these requirements. BBA 1997 establishes rules intended to safeguard the quality of care provided under managed care arrangements. These include provisions related to enrollment and disenrollment; information that States must provide enrollees and potential enrollees; assurances of adequate capacity and access to care; balance billing protections; solvency standards; marketing materials; grievance procedures; and other quality assurance standards the Secretary of the DHHS is charged with developing. The law adopts the "prudent layperson" standard to whether a Medicaid managed care organization would have to pay for services provided to an enrollee in an emergency room and includes a ban on so-called "gag rules," prohibiting interference with physician advice to enrollees.

LEGISLATIVE HISTORY

(For legislative history prior to 1996, see previous editions of the *Green Book*.)

The following is a summary of major Medicaid changes enacted in the Contract with America Advancement Act of 1996, Public Law 104–121:

1. *Alcoholics and drug addicts.*—SSI benefits are terminated for individuals receiving disability cash assistance based on a finding of alcoholism and drug addiction. Persons who lose SSI eligibility, which gives them automatic Medicaid coverage, may still be eligible for Medicaid if they meet other Medicaid eligibility criteria. States are required to perform a redetermination of Medicaid eligibility in any case in which an individual loses SSI and that determination affects her Medicaid eligibility.

The following is a summary of major Medicaid changes enacted in the Personal Responsibility and Work Opportunity Act of 1996, Public Law 104–193:

1. *Eligibility.*—A new cash welfare block grant to States, Temporary Assistance for Needy Families (TANF), is established. The automatic link between AFDC and Medicaid is severed. Families who meets AFDC eligibility criteria as of July 16, 1996 are eligible for Medicaid, even if they do not qualify for

TANF. States must use the same income and resource standards and other rules previously used to determine eligibility, and the prereform AFDC family composition requirement still must be met. A State may lower its income standard, but not below the standard it applied on May 1, 1988. A State may increase its income and resource standards up to the percentage increase in the Consumer Price Index (CPI) subsequent to July 16, 1996. States may use less restrictive methods for counting income and resources than were required by law as in effect on July 16, 1996. States are permitted to deny Medicaid benefits to adults and heads of households who lose TANF benefits because of refusal to work; States may not apply this requirement to poverty-related pregnant women and children.

2. *Disabled children.*—The definition of disability used to establish the eligibility of children for SSI is narrowed. Children who lose SSI eligibility, which gives them automatic Medicaid coverage, may still be eligible for Medicaid if they meet other Medicaid eligibility criteria. States are required to perform a redetermination of Medicaid eligibility in any case in which an individual loses SSI and that determination affects his or her Medicaid eligibility.
3. *Aliens.*—For legal resident aliens and other qualified aliens who entered the United States on or after August 22, 1996 whose coverage is not mandatory (e.g., they have been credited with 40 quarters of Social Security coverage), Medicaid is barred for 5 years. Except for emergency services, Medicaid coverage for such aliens entering before August 22, 1996 and coverage after the 5 year ban are State options.
4. *Administration.*—A State may use the same application form for Medicaid as they use for TANF. A State may choose to administer the Medicaid Program through the same agency that administers TANF or through a separate Medicaid agency. A special fund of $500 million is provided for enhanced Federal matching for States' expenditures attributable to the administrative costs of Medicaid eligibility determinations due to the law.

The following is a summary of major Medicaid changes enacted in the Balanced Budget Act of 1997, Public Law 105–33:

1. *Eligibility.*—The Balanced Budget Act restores Medicaid eligibility and SSI coverage for legal immigrants who entered the country prior to August 22, 1996 and later become disabled; guarantees continued Medicaid eligibility for children with disabilities who are expected to lose their SSI eligibility as the result of restrictions enacted in 1996; and extends the exemption from the ban on Medicaid and other forms of public assistance for refugees and individuals seeking asylum from 5 to 7 years. States are permitted to provide continuous Medicaid coverage for 12 months to all children, regardless of whether they continue to meet income eligibility tests. States are permitted to create a new Medicaid eligibility category for individuals with incomes up to 250 percent of poverty and who would, but for income, be eligible for SSI. Such individuals can "buy into" Medicaid by paying a sliding scale premium based on the individuals' income as determined by the State.

2. *Payment methodology.*—The law repeals the Boren amendment, which directed that payment rates to institutional providers be "reasonable and adequate" to cover the cost of "efficiently and economically operated" facilities, and repeals the law requiring States to assure adequate payment levels for services provided by obstetricians and pediatricians. The requirement to pay federally qualified health centers and rural health clinics 100 percent of reasonable costs will be phased out over 6 fiscal years, with special payment rules in place during fiscal years 1998–2002 to ease the transition.
3. *Payments for disproportionate share hospitals.*—The law reduces State DSH allotments by imposing freezes and making graduated proportionate reductions. Limitations are placed on payments to institutions for mental disease. The act establishes additional caps on the State DSH allotments for fiscal years beginning in 1998 and specifies those caps for 1998–2002. States are required to report annually on the method used to target DSH funds and to describe the payments made to each hospital.
4. *Managed care.*—The law eliminates the need for 1915(b) waivers for most Medicaid populations. Under the new law, States can require the majority of Medicaid recipients to enroll in managed care simply by amending their State plan. Waivers are still required to mandate that children with special health care needs and certain dual eligible Medicaid-Medicare beneficiaries enroll with managed care entities. The law establishes a statutory definition of PCCM, adds it as a covered service, and sets contractual requirements for both PCCM and Medicaid managed care organizations. The act also includes managed care provisions that establish standards for quality and solvency, and provide protections for beneficiaries. The law repeals the provision that requires managed care organizations to have no more than 75 percent of their enrollment be Medicaid and Medicare beneficiaries and the prohibition on cost sharing for services furnished by health maintenance organizations.

The following is a summary of the major Medicaid changes included in the Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP) Balanced Budget Refinement Act of 1999, incorporated by reference in the Consolidated Appropriations Act for fiscal year 2000, Public Law 106–113:

1. *Increase in DSH allotments for selected States.*—The law increases the Federal share of DSH payments to Minnesota, New Mexico, Wyoming, and the District of Columbia for each of fiscal years 2000–2002.
2. *Administration.*—The law extends beyond fiscal year 2000 the availability of a $500 million fund created to assist with the transitional costs of new Medicaid eligibility activities resulting from welfare reform, and allows these funds to be used for costs incurred beyond the first 3 years following welfare reform.
3. *Federally qualified health centers services and rural health clinics.*—The law slows the phase-out of the cost-based system of reimbursement for services provided by federally qualified

health centers and rural health clinics and authorizes a study of the impact of reducing or modifying payments to such providers.

4. *Payments for monitoring services and external review requirements.*—The law provides that States will receive enhanced matching payments for medical and utilization reviews for Medicaid fee-for-service, and quality reviews for Medicaid managed care, when conducted by certain entities similar to peer review organizations. It also eliminates duplicative requirements for external review and requires the DHHS Secretary to certify to Congress that the external review requirements for Medicaid managed care are fully implemented.
5. *Federal matching for disproportionate share hospital payments.*—The law clarifies that Medicaid disproportionate share hospital payments are matched at the Medicaid Federal medical assistance percentage and not at the enhanced Federal medical assistance percentage authorized under title XXI.
6. *Outpatient drugs.*—The law allows rebate agreements entered into after the date of enactment of this act to become effective on the date on which the agreement is entered into, or at State option, any date before or after the date on which the agreement is entered into.
7. *Disproportionate share hospital transition rule.*—The law extends a provision included in the Balanced Budget Act of 1997 related to allocation of DSH funds among California's hospitals.

The following is a summary of the major Medicaid changes enacted in the Foster Care Independence Act of 1999, Public Law 106–169:

1. *Foster care children.*—States are given the option to extend Medicaid coverage to former foster care recipients ages 18, 19, and 20, and States may limit coverage to those who were eligible for assistance under title IV–E before turning 18 years of age. The law also includes a "sense of Congress" statement indicating that States should provide health insurance coverage to all former foster care recipients ages 18, 19, and 20.

The following is a summary of the major Medicaid changes enacted in the Ticket to Work and Work Incentives Improvement Act of 1999, Public Law 106–170:

1. *Employed, disabled individuals.*—States can opt to cover working persons with disabilities at higher income and resource levels than otherwise permitted (i.e., income over 250 percent of the Federal poverty level (FPL) and resources over $2,000 for an individual or $3,000 for a couple). States may also cover financially eligible working individuals whose medical condition has improved such that they no longer meet the Social Security definition of disability. States can require these individuals to "buy in" to Medicaid coverage. These individuals pay premiums or other cost-sharing charges on a sliding fee scale based on income, as established by the State.

PROGRAM DATA

Under current law, Federal Medicaid outlays are projected to reach $116.1 billion in fiscal year 2000, a 7.5 percent increase over

the $108 billion projected for fiscal year 1999. This and other Medicaid Program data are presented in tables 15–13 to 15–26.

TABLE 15–13.—HISTORY OF MEDICAID PROGRAM COSTS, 1966–2001

[In millions of dollars]

Fiscal year	Total		Federal		State	
	Program costs	Percentage change	Program costs	Percentage change	Program costs	Percentage change
1966 [1]	$1,658	.....	$789	.....	$869	.....
1967 [1]	2,368	42.8	1,209	53.2	1,159	33.4
1968 [1]	3,686	55.7	1,837	51.9	1,849	59.5
1969 [1]	4,166	13.0	2,276	23.9	1,890	2.2
1970 [1]	4,852	16.5	2,617	15.0	2,235	18.3
1971	6,176	27.3	3,374	28.9	2,802	25.4
1972 [2]	8,434	36.6	4,361	29.3	4,074	45.4
1973	9,111	8.0	4,998	14.6	4,113	1.0
1974	10,229	12.3	5,833	16.7	4,396	6.9
1975	12,637	23.5	7,060	21.0	5,578	26.9
1976	14,644	15.9	8,312	17.7	6,332	13.5
TQ [3]	4,106	NA	2,354	NA	1,752	NA
1977	17,103	[4] 16.8	9,713	[4] 16.9	7,389	[4] 16.7
1978	18,949	10.8	10,680	10.0	8,269	11.9
1979	21,755	14.8	12,267	14.9	9,489	14.8
1980	25,781	18.5	14,550	18.6	11,231	18.4
1981	30,377	17.8	17,074	17.3	13,303	18.4
1982	32,446	6.8	17,514	2.6	14,931	12.2
1983	34,956	7.7	18,985	8.4	15,971	7.0
1984	37,569	7.5	20,061	5.7	17,508	9.6
1985 [5]	40,917	8.9	[6] 22,655	12.9	[6] 18,262	4.3
1986	44,851	9.6	24,995	10.3	19,856	8.7
1987	49,344	10.0	27,435	9.8	21,909	10.3
1988	54,116	9.7	30,462	11.0	23,654	8.0
1989	61,246	13.2	34,604	13.6	26,642	12.6
1990	72,492	18.4	41,103	18.8	31,389	17.8
1991	91,519	26.2	52,532	27.8	38,987	24.2
1992	118,166	29.1	67,827	29.1	50,339	29.1
1993	131,775	11.5	75,774	11.7	56,001	11.2
1994	143,204	8.7	82,034	8.3	61,170	9.2
1995	156,395	9.2	89,070	8.6	67,325	10.1
1996	161,963	3.6	91,990	3.3	69,973	3.9
1997	167,635	3.5	95,552	3.8	72,083	3.1
1998	177,364	5.8	100,177	4.8	77,187	7.1
1999 [7]	189,547	6.9	108,042	7.9	81,505	5.6
2000 [7]	203,714	7.5	116,117	7.5	87,597	7.5

TABLE 15–13.—HISTORY OF MEDICAID PROGRAM COSTS, 1966–2001—Continued

[In millions of dollars]

Fiscal year	Total		Federal		State	
	Program costs	Percentage change	Program costs	Percentage change	Program costs	Percentage change
2001 [7]	219,014	7.5	124,838	7.5	94,176	7.6

[1] Includes related programs which are not separately identified, though for each successive year a larger portion of the total represents Medicaid expenditures. As of January 1, 1970, Federal matching was only available under Medicaid.

[2] Intermediate care facilities transferred from the cash assistance programs to Medicaid effective January 1, 1972. Data for prior periods do not include these costs.

[3] Transitional quarter (beginning of Federal fiscal year moved from July 1 to October 1).

[4] Represents increase over fiscal year 1976, i.e., 5 calendar quarters.

[5] Includes transfer of function of State fraud control units to Medicaid from Office of Inspector General.

[6] Temporary reductions in Federal payments authorized for fiscal years 1982–84 were discontinued in fiscal year 1985.

[7] Current law estimate.

NA—Not available.

Note.—Totals may not add due to rounding. Except for fiscal years 1999–2001, program costs are taken from the HCFA 64 report. These payments are primarily for direct payment for medical benefits but include all other Medicaid expenditures claimed by the State. Total State expenditures include lump sum adjustments, disproportionate share hospital payments, and administrative costs. These data do not match payments reported on the HCFA–2082 reports, which typically exclude lump-sum payments not attributable to individual claims, such as institutional cost settlements, disproportionate share hospital payments, and administrative costs.

Source: Budget of the U.S. Government, fiscal years 1969–2001 and Health Care Financing Administration.

TABLE 15–14.—UNDUPLICATED NUMBER OF MEDICAID RECIPIENTS BY ELIGIBILITY CATEGORY, FISCAL YEARS 1972–98

[In thousands]

Fiscal year	Total recipients	Age 65 or older	Blind/ disabled	Children	Adults	Other [1]
1972	17,606	3,318	1,733	7,841	3,137	1,576
1973	19,622	3,496	1,905	8,659	4,066	1,495
1974	21,462	3,732	2,357	9,478	4,392	1,502
1975	22,007	3,615	2,464	9,598	4,529	1,800
1976	22,815	3,612	2,669	9,924	4,774	1,836
1977 [2]	22,832	3,636	2,802	9,651	4,785	1,959
1978	21,965	3,376	2,718	9,376	4,643	1,852
1979	21,520	3,364	2,753	9,106	4,570	1,727
1980 [3]	21,605	3,440	2,911	9,333	4,877	1,499
1981 [3]	21,980	3,367	3,079	9,581	5,187	1,364
1982 [3]	21,603	3,240	2,890	9,563	5,356	1,434
1983 [3]	21,554	3,371	2,921	9,535	5,592	1,129
1984 [3]	21,607	3,238	2,913	9,684	5,600	1,187
1985 [3]	21,814	3,061	3,017	9,757	5,518	1,214
1986 [3]	22,515	3,140	3,182	10,029	5,647	1,362
1987 [3]	23,109	3,224	3,381	10,168	5,599	1,418
1988 [3]	22,907	3,159	3,487	10,037	5,503	1,343
1989 [3]	23,511	3,132	3,591	10,318	5,717	1,175
1990	25,255	3,202	3,718	11,220	6,010	1,105
1991	28,280	3,359	4,068	13,415	6,778	658
1992	30,926	3,742	4,462	15,104	6,954	664
1993	33,432	3,863	5,016	16,285	7,505	763
1994	35,053	4,035	5,459	17,194	7,586	779
1995	36,282	4,119	5,859	17,164	7,604	1,537
1996	36,118	4,285	6,221	16,739	7,127	652
1997	34,872	3,955	[4] 6,129	15,266	6,803	524
1998	40,649	3,964	[4] 6,638	18,309	7,908	655

[1] This category includes other title XIX, such as Ribicoff children and foster care children.

[2] Fiscal year 1977 began in October 1976 and was the first year of the new Federal fiscal cycle. Before 1977, the fiscal year began in July.

[3] Beginning in fiscal year 1980, recipients' categories do not add to the unduplicated total due to the small number of recipients that are in more than one category during the year.

[4] In fiscal year 1997 HCFA combined the blind and disabled categories.

Note.—For 1972–97, a recipient is an individual for whom a fee-for-service claim was paid during the year. For fiscal year 1998 only, a recipient is an individual for whom a fee-for-service claim was paid during the year, or for whom a capitation payment was made during the year. Capitated service delivery systems became more prominent under Medicaid starting in 1995, and primarily include non-disabled children and adults. See tables 15–25 and 15–26 for detailed data on capitated beneficiaries and expenditures.

Source: Health Care Financing Administration, U.S. Department of Health and Human Services. Form HCFA–2082.

TABLE 15–15.—MEDICAID RECIPIENTS BY SERVICE CATEGORY, FISCAL YEAR 1998

[In thousands of people]

Service category	Number of recipients
Inpatient hospital	4,273
Mental health facility	135
Nursing facility	1,646
Intermediate care facility for the mentally retarded	126
Physician	18,555
Dental	4,965
Other practitioner	4,342
Outpatient hospital	12,158
Clinic	5,285
Laboratory and x ray	9,381
Home health	1,225
Prescribed drugs	19,338
Family planning	2,011
Early and periodic screening	6,175
Personal care support	3,108
Home- and community-based	467
Primary care case management	4,066
Prepaid health care	20,203
Other care	6,975
Unduplicated total	40,649

Note.—A recipient is an individual for whom a fee-for-service claim was paid during the year or for whom a capitation payment was made during the year. See tables 15–25 and 15–26 for detailed data on capitated beneficiaries and expenditures.

Source: Health Care Financing Administration, U.S. Department of Health and Human Services. Form HCFA–2082 Report.

TABLE 15–16.—MEDICAID RECIPIENTS AND PAYMENTS BY BASIS OF ELIGIBILITY, FISCAL YEAR 1998

Basis of eligibility	Payments (in millions of dollars)	Percentage	Recipients (in thousands)	Percentage	Per capita payments
Age 65 and older	$40,602	28.5	3,964	9.8	$10,243
Blind/disabled	60,375	42.4	6,637	16.3	9,097
Children	20,459	14.4	18,309	45.0	1,117
Adults	14,833	10.4	7,908	19.5	1,876
Foster care children	2,347	1.6	655	1.6	3,583
Unknown	3,702	2.6	3,176	7.8	1,166
Total	142,318	100	40,649	100	3,501

Note.—A recipient is an individual for whom a fee-for-service claim was paid during the year, or for whom a capitation payment was made during the year. The data in this table includes payments for capitated delivery systems and fee-for-service delivery systems. See tables 15–25 and 15–26 for detailed data on capitated beneficiaries and expenditures. Medicaid payments reported on the HCFA–2082 for fiscal year 1998 include payments made for Medicaid claims processed during the year.

Source: Health Care Financing Administration, U.S. Department of Health and Human Services. Form HCFA–2082 Report.

TABLE 15–17.—MEDICAID RECIPIENTS BY BASIS OF ELIGIBILITY BY JURISDICTION, FISCAL YEAR 1998

State	Total recipients	Age 65 and older	Blind/disabled	Children	Adults	Foster care/children	Unknown
Alabama	527,078	64,651	145,892	262,547	48,049	4,038	1,901
Alaska	74,508	50306	8,912	37,429	19,990	1,055	1,816
Arizona	507,668	27,473	78,121	282,256	114,360	5,458	NA
Arkansas	424,727	50,746	96,507	179,405	85,023	4,994	8,052
California	7,082,175	587,326	926,252	3,345,491	1,646,576	138,609	437,921
Colorado	344,916	43,264	62,492	154,206	66,485	14,354	4,115
Connecticut	381,208	51,741	51,586	189,083	81,613	7,185	NA
Delaware	101,436	6,652	13,726	49,425	28,831	461	2,341
District of Columbia	166,146	7,979	22,551	58,488	25,682	1,664	49,782
Florida	1,904,591	186,566	383,978	944,280	354,337	20,311	15,119
Georgia	1,221,978	89,197	226,263	666,385	202,223	6,508	31,402
Hawaii	184,614	17,022	16,913	75,329	64,575	3,022	7,753
Idaho	123,176	12,210	17,395	57,056	17,147	1,351	18,017
Illinois	1,363,856	108,132	262,773	620,251	293,879	78,821	NA
Indiana	607,293	72,880	91,514	313,972	101,228	5,802	21,897
Iowa	314,936	39,847	51,219	138,633	78,021	4,836	2,380
Kansas	241,933	27,388	43,388	120,383	40,811	4,029	5,934
Kentucky	644,482	65,739	178,672	273,114	111,161	6,369	9,427
Louisiana	720,615	93,838	160,544	345,723	120,369	141	NA
Maine	170,456	22,669	37,064	74,213	30,487	2,160	3,863
Maryland	561,085	44,502	104,461	264,965	106,312	15,219	25,626
Massachusetts	908,238	113,876	197,426	409,962	186,362	612	NA
Michigan	1,362,890	91,663	259,243	616,825	287,617	28,346	79,196
Minnesota	538,413	58,701	73,913	293,632	96,443	6,476	9,248
Mississippi	485,767	60,567	131,439	218,491	61,217	2,894	11,159
Missouri	734,015	88,776	113,652	384,773	115,773	14,859	16,182
Montana	100,760	9,130	16,378	45,686	20,665	3,186	5,715
Nebraska	211,188	25,162	27,724	106,023	42,199	10,080	NA
Nevada	128,144	12,320	19,320	65,349	21,460	3,155	6,540
New Hampshire	93,970	12,291	12,124	51,166	14,838	2,434	1,117

New Jersey	813,251	94,244	151,050	372,807	172,122	15,605	7,423
New Mexico	329,418	19,601	44,824	209,014	52,197	1,558	2,224
New York	3,073,241	393,567	592,598	1,315,777	689,543	81,756	NA
North Carolina	1,167,988	158,676	198,254	609,190	189,692	12,176	NA
North Dakota	62,280	10,376	8,953	27,779	11,398	1,481	2,293
Ohio	1,290,776	168,246	232,986	586,546	276,603	24,395	NA
Oklahoma	342,475	NA	NA	NA	NA	NA	342,475
Oregon	511,171	39,401	97,889	129,409	210,350	13,701	20,421
Pennsylvania	1,523,120	222,458	272,083	745,977	257,602	23,026	1,974
Puerto Rico	964,015	NA	NA	NA	NA	NA	964,015
Rhode Island	153,130	17,540	28,524	64,882	30,866	3,583	7,735
South Carolina	594,962	72,074	102,904	269,751	121,013	6,412	22,808
South Dakota	89,537	9,496	15,767	48,794	14,154	1,326	NA
Tennessee	1,843,661	88,948	302,470	554,235	479,727	12,130	406,151
Texas	2,324,810	301,368	288,293	1,327,276	391,786	16,087	NA
Utah	215,801	9,716	20,093	106,259	44,966	3,783	30,984
Vermont	123,992	14,101	15,258	53,842	36,814	1,952	2,025
Virginia	653,236	86,550	121,112	333,370	107,944	4,260	NA
Virgin Islands	19,764	1,516	1,208	11,424	5,616	NA	NA
Washington	1,413,208	61,996	112,306	489,005	181,319	14,342	554,240
West Virginia	342,668	29,157	73,037	153,021	56,682	5,065	25,706
Wisconsin	518,595	63,432	120,136	231,607	82,360	13,094	7,966
Wyoming	46,121	4,146	6,793	24,639	9,448	523	572
All jurisdictions	40,649,482	3,964,223	6,637,980	18,309,145	7,907,935	654,684	3,175,515

NA—Not available.

Note.—A recipient is an individual for whom a fee-for-service claim was paid during the year or for whom a capitation payment was made during the year. Capitated service delivery systems became more prominent under Medicaid starting in 1995, and primarily include nondisabled children and adults. See tables 15–25 and 15–26 for detailed data on capitated beneficiaries and expenditures.

Source: Health Care Financing Administration, U.S. Department of Health and Human Services. HCFA–2082 Report.

TABLE 15–18.—MEDICAID PAYMENTS BY BASIS OF ELIGIBILITY OF RECIPIENT BY STATE, FISCAL YEAR 1998

[In millions of dollars]

State	Total expenditures	Age 65 and older	Blind/ disabled	Children	Adults	Foster care children
Alabama	$1,902	$550	$598	$187	$34	$18
Alaska	330	57	115	86	61	10
Arizona	1,644	324	610	405	297	8
Arkansas	1,376	430	791	262	99	29
California	14,237	2,878	6,143	2,665	2,149	250
Colorado	1,439	438	582	150	125	101
Connecticut	2,421	1,048	890	289	176	17
Delaware	420	95	197	68	55	2
District of Columbia	731	151	346	78	53	16
Florida	5,687	1,555	2,659	846	549	51
Georgia	3,012	493	1,403	583	458	24
Hawaii	507	157	128	117	89	5
Idaho	425	124	168	52	38	2
Illinois	6,173	1,105	3,262	786	686	333
Indiana	2,564	864	1,084	400	175	23
Iowa	1,289	464	489	179	134	19
Kansas	916	253	450	132	60	7
Kentucky	2,425	583	1,162	387	240	43
Louisiana	2,384	672	1,101	372	238	0
Maine	747	239	329	96	44	26
Maryland	2,489	604	1,184	387	239	40
Massachusetts	4,609	1,475	2,174	561	398	1
Michigan	4,345	940	1,945	516	515	52
Minnesota	2,924	993	1,223	455	197	37
Mississippi	1,442	415	665	226	120	12
Missouri	2,570	927	1,016	410	157	47
Montana	361	115	139	57	38	6
Nebraska	753	264	278	108	67	36
Nevada	462	92	174	79	52	41
New Hampshire	606	227	221	99	34	24
New Jersey	4,219	1,325	1,978	434	370	97
New Mexico	862	146	310	270	105	26
New York	24,299	7,871	11,645	2,324	2,091	367
North Carolina	4,014	1,193	1,663	716	397	44
North Dakota	341	131	140	34	23	10
Ohio	6,121	2,245	2,545	705	554	71
Oklahoma	1,178	0	0	0	0	0
Oregon	1,378	113	268	367	576	37
Pennsylvania	6,080	2,510	1,988	1,025	457	98
Puerto Rico	250	0	0	0	0	0
Rhode Island	919	298	455	81	59	13
South Carolina	2,019	478	762	305	162	51
South Dakota	356	107	161	57	27	4
Tennessee	3,167	675	991	411	633	58
Texas	7,140	2,342	2,485	1,397	872	44
Utah	619	90	227	120	79	30

TABLE 15–18.—MEDICAID PAYMENTS BY BASIS OF ELIGIBILITY OF RECIPIENT BY STATE, FISCAL YEAR 1998—Continued

[In millions of dollars]

State	Total expenditures	Age 65 and older	Blind/ disabled	Children	Adults	Foster care children
Vermont	351	97	136	55	47	15
Virginia	2,118	639	933	336	201	9
Virgin Islands	10	2	2	3	3	0
Washington	2,044	573	623	341	354	22
West Virginia	1,243	359	474	154	102	32
Wisconsin	2,206	817	978	256	123	35
Wyoming	192	54	84	30	22	1
All jurisdictions ..	142,318	40,602	60,375	20,459	14,833	2,347

Note.—The data in this table include payments for capitated service delivery systems and fee-for-service delivery systems. Capitated service delivery systems became more prominent under Medicaid starting in 1995, and primarily include nondisabled children and adults. See tables 15–25 and 15–26 for detailed data on capitated beneficiaries and expenditures. Medicaid payments reported on the HCFA–2082 for fiscal year 1998 include payments made for Medicaid claims processed during the year. These payments typically exclude lump sum payments not attributable to individual claims, such as disproportionate share hospital payments, and other institutional cost settlements, or administrative costs.

Source: Health Care Financing Administration, U.S. Department of Health and Human Services. Form HCFA–2082 Report.

TABLE 15–19.—AMOUNTS OF MEDICAID PAYMENTS BY BASIS OF ELIGIBILITY AND TYPE OF SERVICE, FISCAL YEAR 1998

Service category	Aged	Blind/disabled	Children	Adults	Foster care/ children	Total
	In millions of dollars					
Inpatient hospital	$1,871.1	$9,643.4	$4,825.5	$4,211.0	$307.5	$21,498.7
Mental health facility	854.7	1,142.4	361.6	125.7	288.8	2,800.5
Nursing facility	25,529.8	5,952.3	90.8	104.8	11.2	31,892.1
Intermediate care facility for the mentally retarded	691.7	8,763.3	41.8	37.4	16.4	9,481.7
Physician	695.0	2,102.0	1,524.6	1,533.2	119.4	6,070.0
Outpatient hospital	585.2	2,682.7	1,149.6	1,182.6	90.6	5,759.0
Early and periodic screening, diagnosis, and treatment	13.9	364.1	822.3	28.7	97.0	1,334.8
Prescribed drugs	3,805.9	7,618.5	1,011.8	916.1	119.7	13,521.7
Dental	58.6	200.8	460.2	156.4	21.4	901.4
Other practitioner	92.8	218.2	166.4	72.5	34.5	587.1
Clinic	223.0	2,240.7	750.0	514.8	138.8	3,921.2
Laboratory and x ray	55.0	367.6	166.4	311.5	16.2	938.7
Family planning	2.6	51.4	65.0	316.5	3.7	449.1
Home health	797.5	1,691.8	101.5	61.2	43.7	2,701.5
Personal care support	2,367.1	4,376.5	856.2	205.2	346.5	8,222.0
Home- and community-based waiver	950.1	5,478.7	72.0	70.2	117.4	6,708.7
Other care	719.0	2,382.0	621.3	252.1	361.7	4,386.2
Prepaid health care	1,281.7	5,061.1	7,258.2	4,716.6	210.2	19,296.2
Primary care case management	4.8	26.0	66.5	18.4	1.7	134.4
Unknown/error	2.5	11.4	47.4	−1.6	0.2	1,712.8
Total	40,602.1	60,375.1	20,459.1	14,833.1	2,346.8	142,317.9

	Percentage					
Inpatient hospital	4.6	16.0	23.6	28.4	13.1	15.1
Mental health facility	2.1	1.9	1.8	0.8	12.3	2.0
Nursing facility	62.9	9.9	0.4	0.7	0.5	22.4
Intermediate care facility for the mentally retarded	1.7	14.5	0.2	0.3	0.7	6.7
Physician	1.7	3.5	7.5	10.3	5.1	4.3
Outpatient hospital	1.4	4.4	5.6	8.0	3.9	4.0
Early and periodic screening, diagnosis, and treatment	0.0	0.6	4.0	0.2	4.1	0.9
Prescribed drugs	9.4	12.6	4.9	6.2	5.1	9.5
Dental	0.1	0.3	2.2	1.1	0.9	0.6
Other practitioner	0.2	0.4	0.8	0.5	1.5	0.4
Clinic	0.5	3.7	3.7	3.5	5.9	2.8
Laboratory and x ray	0.1	0.6	0.8	2.1	0.7	0.7
Family planning	0.0	0.1	0.3	2.1	0.2	0.3
Home health	2.0	2.8	0.5	0.4	1.9	1.9
Personal care support	5.8	7.2	4.2	1.4	14.8	5.8
Home- and community-based waiver	2.3	9.1	0.4	0.5	5.0	4.7
Other care	1.8	3.9	3.0	1.7	15.4	3.1
Prepaid health care	3.2	8.4	35.5	31.8	9.0	13.6
Primary care case management	0.0	0.0	0.3	0.1	0.1	0.1
Unknown/error	0.0	0.0	0.2	–0.0	0.0	1.2
Total	100	100	100	100	100	100

Note.—Parentheses are used to indicate negative values. Negative values typically result from large negative claims payment adjustments. The data in this table include payments for capitated service delivery systems and fee-for-service delivery systems. See tables 15–25 and 15–26 for detailed data on capitated beneficiaries and expenditures. Medicaid payments reported on the form HCFA–2082 for fiscal year 1998 include payments made for Medicaid claims processed during the year.

Source: Health Care Financing Administration, Data and Data Systems Group, Division of Information Analysis and Technical Assistance.

TABLE 15–20.—MEDICAID PAYMENTS AND PER CAPITA PAYMENTS BY BASIS OF ELIGIBILITY, SELECTED FISCAL YEARS 1975–98

Basis of eligibility	Fiscal year						Percent change 1975–98
	1975	1980	1985	1990	1995	1998	
	Nominal payments, in millions of dollars						
Payments:							
Age 65 and older	$4,358	$8,739	$14,096	$21,508	$36,527	$40,602	831.7
Blind/disabled	3,145	7,621	13,452	24,403	49,418	60,375	1819.7
Children	2,186	3,123	4,414	9,100	17,976	20,459	835.9
Adults	2,062	3,231	4,746	8,590	13,511	14,833	619.4
Other	492	596	798	1,051	1,499	6,048	1129.3
Total	12,242	23,311	37,508	64,859	120,140	142,318	1062.5
Per capita payment:							
Age 65 and older	1,205	2,540	4,605	6,717	8,868	10,242	750.0
Blind/disabled	2,146	2,619	7,600	11,807	17,678	9,095	323.8
Children	228	335	452	811	1,047	1,117	389.9
Adults	455	663	860	1,429	1,777	1,876	312.3
Other	273	NR	658	1,062	2,380	1,579	478.4
Total	556	1,079	1,719	2,568	3,311	3,501	529.7

	Constant 1998 dollars in millions						
Payments:							
Age 65 and older	13,684	17,740	21,426	27,100	39,084	40,602	196.7
Blind/disabled	9,875	15,471	20,447	30,748	52,877	60,375	511.4
Children	6,864	6,340	6,709	11,466	19,234	20,459	198.1
Adults	6,475	6,559	7,214	10,823	14,457	14,833	129.1
Other	1,545	1,210	1,213	1,324	1,604	6,048	291.5
Total	38,440	47,321	57,012	81,722	128,550	142,318	270.2
Per capita payment:							
Age 65 and older	3,784	5,156	7,000	8,463	9,489	10,242	170.7
Blind/disabled	6,738	5,317	31,080	14,877	18,915	9,095	35.0
Children	716	680	687	1,022	1,120	1,117	56.0
Adults	1,429	1,346	1,307	1,801	1,901	1,876	31.3
Other	857	NR	1,000	1,338	2,547	1,579	84.2
Total	1,746	2,190	2,613	3,236	3,543	3,501	100.5

Note.—Totals may not add due to rounding and include other coverage groups and individuals for whom basis of eligibility is unknown. Fiscal year 1975 ended in June; all other fiscal years end in September. Nominal dollars were converted to constant dollars by inflating each year's spending for the cumulative growth in the Consumer Price Index for All Urban Consumers (CPI–U) (inflation) between that fiscal year and fiscal year 1998. The 1998 data reflect changes in HCFA–2082 reporting forms that affected coverage categories. For fiscal years 1975–97, a recipient is an individual for whom a fee-for-service claim was paid during the year. For fiscal year 1998 only, a recipient is an individual for whom a fee-for-service claim was paid during the year, or for whom a capitation payment was paid during the year. The fiscal year 1998 dollar figures include payments for capitated delivery systems and fee-for-service delivery systems. See tables 15–25 and 15–26 for detailed data on capitated beneficiaries and expenditures. Medicaid payments reported on the HCFA–2082 for fiscal year 1998 include payments made for Medicaid claims processed during the year.

Source: Health Care Financing Administration, U.S. Department of Health and Human Services. Form HCFA–2082 Report.

TABLE 15–21.—MEDICAID PAYMENTS BY SERVICE CATEGORY, FISCAL YEAR 1998

Service category	Payments (in millions of dollars)	Percentage
Inpatient hospital	$21,499	15.1
Mental health facility	2,801	2.0
Nursing facility	31,892	22.4
Intermediate care facility for the mentally retarded	9,482	6.7
Physician	6,070	4.3
Dental	901	0.6
Other practitioner	587	0.4
Outpatient hospital	5,759	4.0
Clinic	3,921	2.8
Laboratory and x ray	939	0.7
Home health	2,702	1.9
Prescribed drugs	13,522	9.5
Family planning	449	0.3
Early and periodic screening	1,335	0.9
Personal care support	8,222	5.8
Home- and community-based	6,709	4.7
Primary care case management	134	0.1
Prepaid health care	19,296	13.6
Other care	4,386	3.1
Total	142,318	100

Note.—The data in this table include payments for capitated service delivery systems and fee-for-service delivery systems. See tables 15–25 and 15–26 for detailed data on capitated beneficiaries and expenditures. Medicaid payments reported on the HCFA–2082 for fiscal year 1998 include payments made for Medicaid claims processed during the year.

Source: Health Care Financing Administration, U.S. Department of Health and Human Services. Form HCFA–2082 Report.

TABLE 15–22.—AVERAGE PAYMENTS BY BASIS OF ELIGIBILITY BY JURISDICTION, FISCAL YEAR 1998

State	Total payments	Age 65 and older	Blind/disabled	Children	Adults	Foster care/children
Alabama	$3,609	$8,513	$4,098	$711	$701	$4,414
Alaska	4,434	10,765	12,919	2,297	3,072	9,150
Arizona	3,238	11,801	7,804	1,436	2,595	1,438
Arkansas	3,239	8,474	8,198	1,462	1,168	5,779
California	2,010	4,900	6,632	797	1,305	1,800
Colorado	4,173	10,117	9,312	970	1,879	7,051
Connecticut	6,350	20,258	17,259	1,529	2,156	2,396
Delaware	4,138	14,325	14,317	1,372	1,906	3,500
District of Columbia	4,402	18,901	15,354	1,340	2,076	9,498
Florida	2,986	8,336	6,926	896	1,550	2,533
Georgia	2,465	5,531	6,200	874	2,265	3,681
Hawaii	2,749	9,238	7,588	1,554	1,376	1,785
Idaho	3,446	10,195	9,640	906	2,205	1,845
Illinois	4,526	10,217	12,415	1,268	2,335	4,224

TABLE 15–22.—AVERAGE PAYMENTS BY BASIS OF ELIGIBILITY BY JURISDICTION, FISCAL YEAR 1998—Continued

State	Total payments	Age 65 and older	Blind/disabled	Children	Adults	Foster care/children
Indiana	4,222	11,853	11,845	1,273	1,732	3,918
Iowa	4,092	11,641	9,555	1,293	1,718	3,842
Kansas	3,788	9,239	10,377	1,096	1,460	1,836
Kentucky	3,763	8,870	6,506	1,417	2,158	6,788
Louisiana	3,308	7,165	6,860	1,075	1,980	1,095
Maine	4,383	10,556	8,879	1,300	1,435	12,222
Maryland	4,437	13,571	11,331	1,459	2,246	2,628
Massachusetts	5,075	12,954	11,013	1,369	2,133	1,604
Michigan	3,188	10,258	7,501	836	1,789	1,821
Minnesota	5,432	16,923	16,552	1,550	2,041	5,667
Mississippi	2,969	6,857	5,062	1,034	1,958	4,284
Missouri	3,501	10,445	8,940	1,067	1,353	3,137
Montana	3,585	12,593	8,478	1,239	1,862	1,888
Nebraska	3,566	10,511	10,031	1,015	1,581	3,594
Nevada	3,606	7,439	9,013	1,209	2,442	13,016
New Hampshire	6,449	18,451	18,246	1,928	2,282	9,912
New Jersey	5,188	14,063	13,094	1,164	2,152	6,245
New Mexico	2,617	7,440	6,918	1,290	2,006	16,800
New York	7,907	20,000	19,651	1,766	3,032	4,492
North Carolina	3,437	7,520	8,389	1,176	2,093	3,653
North Dakota	5,476	12,660	15,656	1,212	2,009	6,829
Ohio	4,742	13,345	10,923	1,202	1,990	2,927
Oklahoma	3,439	0	0	0	0	0
Oregon	2,695	2,867	2,736	2,832	2,740	2,673
Pennsylvania	3,992	11,283	7,307	1,374	1,775	4,249
Puerto Rico	259	0	0	0	0	0
Rhode Island	6,004	16,996	15,936	1,254	1,916	3,731
South Carolina	3,393	6,631	7,408	1,132	1,340	7,990
South Dakota	3,974	11,315	10,193	1,169	1,895	2,855
Tennessee	1,718	7,588	3,276	741	1,319	4,767
Texas	3,071	7,771	8,620	1,053	2,224	2,746
Utah	2,867	9,276	11,290	1,134	1,768	7,887
Vermont	2,834	6,893	8,897	1,020	1,271	7,921
Virginia	3,243	7,377	7,706	1,009	1,859	2,204
Virgin Islands	511	1,643	1,463	274	484	0
Washington	1,447	9,236	5,546	697	1,952	1,527
West Virginia	3,628	12,322	6,483	1,004	1,794	6,374
Wisconsin	4,255	12,880	8,144	1,106	1,497	2,651
Wyoming	4,163	13,037	12,308	1,236	2,310	2,802
All jurisdictions	3,501	10,243	9,097	1,117	1,876	3,583

Note.—A recipient is an individual for whom a fee-for-service claim was paid during the year, or for whom a capitation payment was made during the year. The data in this table include payments for capitated service delivery systems and fee-for-service delivery systems. See tables 15–25 and 15–26 for detailed data on capitated beneficiaries and expenditures.

Source: Health Care Financing Administration, U.S. Department of Health and Human Services. Form HCFA–2082 Report.

TABLE 15–23.—TOTAL AND PER CAPITA MEDICAID PAYMENTS FOR RECIPIENTS BY MAINTENANCE ASSISTANCE STATUS AND BASIS OF ELIGIBILITY, FISCAL YEAR 1998

Maintenance assistance status and basis of eligibility	Total payments (in millions of dollars)	Percentage of total	Payments per capita
Receiving cash payments	$63,035	44.3	$3,590
Aged	9,176	6.4	5,516
Blind/disabled	39,128	27.5	7,924
Children	8,427	5.9	1,121
Adults	6,304	4.4	1,834
Poverty related	19,758	13.9	2,147
Aged	4,566	3.2	7,608
Blind/disabled	4,432	3.1	7,760
Children	6,296	4.4	1,029
Adults	4,464	3.1	2,332
Other coverage groups	30,686	21.6	4,834
Aged	14,499	10.2	15,954
Blind/disabled	8,174	5.7	14,211
Children	3,405	2.4	1,264
Adults	2,261	1.6	1,493
Foster care children	2,347	1.6	3,585
Medically needy	25,139	17.7	5,754
Aged	12,361	8.7	15,610
Blind/disabled	8,641	6.1	15,611
Children	2,331	1.6	1,177
Adults	1,805	1.3	1,731
Unknown	3,700	2.6	1,166
Total	142,318	100.0	3,501

Note.—A recipient is an individual for whom a fee-for-service claim was paid during the year, or for whom a capitation payment was made during the year. Totals may not add due to rounding. Totals include other coverage groups and unknowns. The data in this table includes payments for capitated delivery systems and fee-for-service delivery systems. See tables 15–25 and 15–26 for detailed data on capitated beneficiaries and expenditures. Medicaid payments reported on the HCFA–2082 for fiscal year 1998 include payments made for Medicaid claims processed during the year.

Source: Health Care Financing Administration, U.S. Department of Health and Human Services. Form HCFA–2082 Report.

TABLE 15–24.—OPTIONAL MEDICAID SERVICES AND NUMBER OF STATES [1] OFFERING EACH SERVICE, OCTOBER 1996

Service	States offering services to categorically needy only	States offering services to both categorically and medically needy	Access to include Medicaid services to the uninsured
Podiatrist	9	27	10
Optometrist	11	28	10
Chiropractor	4	20	4
Psychologist	6	20	6
Medical social worker	1	6	3
Nurse anesthetist	8	16	5
Private duty nursing	4	16	6
Clinic	13	33	9
Dental	11	26	9
Physical therapy	10	29	6
Occupational therapy	6	24	6
Speech, hearing and language disorder	11	26	5
Prescribed drugs	14	32	10
Dentures	7	25	6
Prosthetic devices	14	31	10
Eyeglasses	12	27	9
Diagnostic	5	22	7
Screening	5	20	7
Preventive	6	20	6
Rehabilitative	13	31	9
Services for age 65 and older in mental institutions:			
Inpatient hospital	12	21	9
Skilled nursing facility	9	17	6
Intermediate care facility for the mentally retarded	18	22	10
Inpatient psychiatric	12	21	9
Christian science nurses	1	2	1
Christian science sanitoria	3	7	4
Skilled nursing facility for under age 21	16	26	10
Emergency hospital	11	25	8
Personal care	7	18	6
Transportation	13	32	10
Case management	11	27	8
Hospice	8	22	8
Respiratory care	2	9	3
Tuberculosis related	1	5	3

[1] Includes the territories.

Source: Health Care Financing Administration, U.S. Department of Health and Human Services.

TABLE 15–25.—PREPAID HEALTH CARE MEDICAID RECIPIENTS BY BASIS OF ELIGIBILITY, FISCAL YEAR 1998

[In thousands]

State	Total recipients	Age 65 and older	Blind/ disabled	Child	Adult	Unknown
Alabama	344.9	0.0	0.0	0.0	0.0	344.9
Alaska	0.0	0.0	0.0	0.0	0.0	0.0
Arizona	368.3	0.0	0.0	0.0	0.0	368.3
Arkansas	244.8	22.6	70.7	110.7	35.8	5.0
California	6,022.5	548.1	894.7	3,053.2	1,390.1	136.4
Colorado	316.1	37.3	58.6	148.3	56.5	15.3
Connecticut	271.4	0.0	0.9	185.6	77.9	7.0
Delaware	85.2	0.3	8.1	47.2	27.6	2.0
District of Columbia	100.9	0.0	1.9	43.3	15.3	40.4
Florida	791.8	17.3	110.2	507.5	149.4	7.4
Georgia	78.5	0.7	8.3	53.6	15.7	0.2
Hawaii	144.7	0.0	0.0	75.3	64.6	4.8
Idaho	0.0	0.0	0.0	0.0	0.0	0.0
Illinois	142.4	0.1	1.3	101.1	38.7	1.2
Indiana	271.0	59.3	42.2	127.8	38.8	2.9
Iowa	246.6	0.8	41.6	130.6	68.5	5.0
Kansas	44.0	0.0	0.1	34.1	9.6	0.2
Kentucky	194.2	9.3	50.9	97.8	35.1	1.0
Louisiana	0.0	0.0	0.0	0.0	0.0	0.0
Maine	9.3	0.0	0.0	6.7	2.5	0.1
Maryland	449.8	6.3	75.2	258.3	91.2	18.9
Massachusetts	768.8	1.7	111.7	451.1	203.7	0.6
Michigan	758.2	8.7	130.5	422.7	181.0	15.3
Minnesota	318.9	27.6	2.6	222.3	64.3	2.1
Mississippi	17.6	0.8	4.7	9.7	2.4	0.0
Missouri	336.1	0.0	0.5	248.2	69.8	17.6
Montana	96.7	8.6	15.8	44.5	19.8	8.0
Nebraska	159.6	1.2	14.6	98.0	37.5	8.3
Nevada	55.9	0.6	0.1	40.7	12.6	1.9
New Hampshire	11.2	0.0	0.0	9.1	1.9	0.1
New Jersey	545.4	35.5	16.5	353.3	138.8	1.4
New Mexico	263.3	1.0	26.7	192.2	41.7	1.6
New York	884.4	6.2	51.0	565.6	258.0	3.6
North Carolina	220.7	0.0	12.3	194.3	9.8	4.3
North Dakota	1.5	0.0	0.0	1.1	0.4	0.0
Ohio	453.3	0.1	1.9	315.0	135.8	0.5
Oklahoma	0.0	0.0	0.0	0.0	0.0	0.0
Oregon	481.5	37.7	93.8	123.8	201.5	24.8
Pennsylvania	902.9	63.0	144.5	505.6	178.6	11.2
Rhode Island	96.2	0.0	0.6	63.5	29.7	2.4
South Carolina	17.2	0.4	1.6	13.6	1.5	0.1
South Dakota	84.0	8.1	14.7	47.0	12.9	1.3
Tennessee	1,764.3	84.2	293.6	552.7	472.5	361.4
Texas	0.0	0.0	0.0	0.0	0.0	0.0
Utah	170.3	6.6	11.3	92.5	29.4	30.6
Vermont	69.7	0.0	1.1	36.7	31.5	0.4

TABLE 15–25.—PREPAID HEALTH CARE MEDICAID RECIPIENTS BY BASIS OF ELIGIBILITY, FISCAL YEAR 1998—Continued

[In thousands]

State	Total recipients	Age 65 and older	Blind/ disabled	Child	Adult	Unknown
Virginia	159.4	1.2	20.5	105.7	32.0	0.0
Washington	1,146.2	1.6	10.7	455.4	141.9	536.7
West Virginia	0.1	0.0	0.0	0.0	0.0	0.1
Wisconsin	293.2	0.3	6.1	211.4	67.6	7.9
Wyoming	0.0	0.0	0.0	0.0	0.0	0.0
All jurisdictions	20,202.9	997.3	2,352.0	10,356.9	4,493.6	2,003.2

Note.—Recipients are those for whom a capitation payment was made during the year. Prepaid health care includes all managed care plans except primary care case management (PCCM) programs. Totals may not match those reported on other sources and should be used with caution due to errors in State reporting.

Source: Health Care Financing Administration, U.S. Department of Health and Human Services. Form HCFA–2082 Report.

TABLE 15–26.—MEDICAID PAYMENTS FOR PREPAID HEALTH CARE BY BASIS OF ELIGIBILITY, FISCAL YEAR 1998

[In millions of dollars]

State	Total payments	Age 65 and older	Blind/ disabled	Child	Adult	Maintenance assistance status unknown
Alabama	$289.0	0.0	0.0	0.0	0.0	$289.0
Alaska	0.0	0.0	0.0	0.0	0.0	0.0
Arizona	1,431.4	$305.9	$538.3	$348.6	$231.0	7.6
Arkansas	4.4	0.4	1.8	1.7	0.4	0.1
California	2,867.7	243.4	502.1	1,461.2	627.0	34.0
Colorado	238.6	18.3	92.0	62.9	26.2	39.2
Connecticut	377.2	0.0	0.9	230.0	138.9	7.4
Delaware	122.0	1.7	50.0	31.8	36.9	1.6
District of Columbia	98.2	0.0	10.6	25.5	9.1	53.1
Florida	701.3	71.5	279.2	223.8	121.8	5.1
Georgia	57.9	0.8	18.2	22.4	16.4	0.1
Hawaii	213.6	0.0	0.0	117.1	88.9	7.6
Idaho	0.0	0.0	0.0	0.0	0.0	0.0
Illinois	241.3	1.4	1.3	135.3	102.5	0.7
Indiana	168.0	33.3	22.1	75.1	36.4	1.1
Iowa	107.2	0.2	26.6	41.5	37.9	0.9
Kansas	17.2	0.0	0.0	11.3	5.8	0.1
Kentucky	311.5	9.9	140.9	122.1	37.5	1.0
Louisiana	0.0	0.0	0.0	0.0	0.0	0.0
Maine	4.2	0.0	0.0	2.9	1.3	0.0
Maryland	852.0	29.4	429.6	217.3	157.7	17.9
Massachusetts	477.9	17.8	168.9	191.7	99.5	0.1
Michigan	823.7	7.7	370.0	206.7	223.3	16.1

TABLE 15–26.—MEDICAID PAYMENTS FOR PREPAID HEALTH CARE BY BASIS OF ELIGIBILITY, FISCAL YEAR 1998—Continued

[In millions of dollars]

State	Total payments	Age 65 and older	Blind/ disabled	Child	Adult	Maintenance assistance status unknown
Minnesota	483.2	99.2	3.7	273.5	105.5	1.3
Mississippi	22.2	1.1	8.7	10.1	2.2	0.1
Missouri	277.7	0.0	0.2	207.0	60.1	10.3
Montana	53.6	4.1	21.7	18.2	5.9	3.7
Nebraska	73.0	1.8	17.9	20.9	12.9	19.5
Nevada	32.3	0.5	0.0	15.1	15.5	1.1
New Hampshire	12.1	0.0	0.0	10.0	2.0	0.1
New Jersey	617.6	8.0	37.3	338.9	232.5	0.8
New Mexico	372.6	1.8	134.6	163.8	66.3	6.1
New York	1,638.4	107.9	645.8	490.8	391.2	2.7
North Carolina	85.7	0.0	8.9	65.5	9.3	2.0
North Dakota	1.3	0.0	0.0	0.8	0.5	0.0
Ohio	494.8	0.7	3.4	282.7	207.8	0.4
Oklahoma	0.0	0.0	0.0	0.0	0.0	0.0
Oregon	665.9	53.0	131.2	174.5	281.4	25.7
Pennsylvania	1,801.1	177.8	663.2	652.0	290.8	17.2
Rhode Island	114.9	0.0	0.3	58.1	51.1	5.4
South Carolina	17.2	10.3	2.6	3.2	1.1	0.0
South Dakota	3.8	0.3	0.7	2.3	0.4	0.1
Tennessee	1,859.1	61.2	571.1	396.5	630.3	199.9
Texas	0.0	0.0	0.0	0.0	0.0	0.0
Utah	147.7	4.5	35.9	45.5	19.2	42.7
Vermont	53.9	0.0	2.3	21.4	29.9	0.2
Virginia	186.3	2.0	68.8	73.8	41.7	0.0
Washington	529.0	0.9	7.0	211.1	188.2	121.9
West Virginia	26.6	0.0	0.0	0.0	0.0	26.6
Wisconsin	321.9	4.8	43.3	193.3	72.3	8.1
Wyoming	0.0	0.0	0.0	0.0	0.0	0.0
All jurisdictions	19,296.2	1,281.7	5,061.1	7,258.2	4,716.6	978.7

Note.—Totals may not match those reported on other sources and should be used with caution due to errors in State reporting. Payments include only capitation payments made on behalf of individuals enrolled in prepaid health care. Prepaid health care includes all managed care plans except PCCM programs.

Source: Health Care Financing Administration, U.S. Department of Health and Human Services. Form HCFA–2082 Report.

STATE CHILDREN'S HEALTH INSURANCE PROGRAM

The Balanced Budget Act of 1997 (BBA 1997, Public Law 105–33) established the State Children's Health Insurance Program (SCHIP) under a new title XXI of the Social Security Act. In general, the program offers Federal matching funds to States and territories to provide health insurance to certain low-income children.

ELIGIBILITY

Under SCHIP, States may cover children in families with incomes above the State's Medicaid eligibility standard but less than 200 percent of the Federal poverty level (FPL).[18] However, States in which the maximum Medicaid income level for children was at or above 200 percent FPL prior to the enactment of SCHIP may increase this income level by an additional 50 percentage points above the level used under the State's Medicaid Program.

Not all targeted low-income children will necessarily receive medical assistance under SCHIP for two reasons. First, unlike Medicaid, Federal law does not establish an individual entitlement[19] to benefits under SCHIP. Instead, it entitles States with approved SCHIP plans to predetermined Federal allotments based on a distribution formula set in the law. Second, each State can define the group of targeted low-income children who may enroll in SCHIP. Title XXI allows States to use the following factors in determining eligibility: geography, age, income and resources, residency, disability status (so long as any standard relating to that status does not restrict eligibility), access to other health insurance, and duration of eligibility for coverage. Title XXI funds cannot be used for children who would have been eligible for the State's Medicaid plan under the eligibility standards that were in effect prior to the enactment of the law establishing SCHIP or for children covered by a group health plan or other insurance.

To date, the upper income eligibility limit under SCHIP has reached 350 percent of the FPL in one State (table 15–27).[20] Eleven States have asset tests for some groups of SCHIP beneficiaries, typically those in Medicaid rather than separate State programs (see Benefits subsection).[21] While increases in coverage have been achieved for all age groups under SCHIP, the most significant increases in eligibility to date have benefited older adolescents. States are taking advantage of the opportunity to use enhanced matching funds under SCHIP to bring in older teens in families with incomes up to 100 percent FPL sooner than required under current Medicaid law, and in many cases, cover such children at income levels well above poverty.

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[18] In 2000 the poverty guideline in the 48 contiguous States and the District of Columbia is $17,050 for a family of four (*Federal Register*, 2000).

[19] The one exception to this rule is when a State chooses to implement a Medicaid expansion under SCHIP. Children who qualify for SCHIP through a Medicaid expansion are entitled to Medicaid benefits as long as they continue to meet these specific eligibility criteria (even if SCHIP itself terminates) or until the State is granted approval to eliminate the eligibility category created by the Medicaid expansion through SCHIP.

[20] For determining income eligibility for SCHIP and Medicaid, some States apply "income disregards." These are specified dollar amounts subtracted from gross income to compute net income, which is then compared to the applicable income criterion. Such disregards increase the effective income level above the stated standard. State SCHIP plans do not consistently report the use of income disregards, nor whether the stated income standards include or exclude such disregards.

[21] States may apply resource or asset tests in determining financial eligibility. Individuals must have resources for which the dollar value is less than a specified standard amount in order to qualify for coverage. States determine what items constitute countable resources and the dollar value assigned to those countable resources. Assets may include, for example, cars, savings accounts, real estate, trust funds, tax credits, etc. See the Kaiser Commission on Medicaid and the Uninsured: Medicaid for Children and CHIP-Funded Separate State Programs (Fact Sheet), revised December 1, 1999.

BENEFITS

States may choose from three options when designing their SCHIP Programs. They may expand their current Medicaid Program, create a new "separate State" insurance program, or devise a combination of both approaches. Under limited circumstances, States have the option to purchase a health benefits plan that is provided by a community-based health delivery system or to purchase family coverage under a group health plan as long as it is cost effective to do so.[22]

States that choose to expand Medicaid to new eligibles under SCHIP must provide the full range of mandatory Medicaid benefits, as well as all optional services specified in their State Medicaid plans. Alternately, States may choose any of three other benefit options: (1) a benchmark benefit package, (2) benchmark equivalent coverage, or (3) any other health benefits plan that the Secretary determines will provide appropriate coverage to the targeted population of uninsured children.[23]

A benchmark benefit package is one of the following three plans: (1) the standard Blue Cross/Blue Shield preferred provider option plan offered under the Federal Employees Health Benefit Plan, (2) the health coverage offered and generally available to State employees in the State involved, and (3) the health coverage offered by a health maintenance organization with the largest commercial (non-Medicaid) enrollment in the State involved.

TABLE 15–27.—STATE CHILDREN'S HEALTH INSURANCE PROGRAM AGGREGATE ENROLLMENT STATISTICS FOR FISCAL YEAR 1999

State	Type of SCHIP Program	Date implemented [1]	Upper eligibility [2] (in percent)	State reported fiscal year 1999 SCHIP enrollment [3] (total children ever served in fiscal year 1999)		Fiscal year 1999 total SCHIP enrollment
				Separate program	Medicaid expansion	
Alabama [4]	COMBO	02/01/98	200	25,738	13,242	38,980
Alaska	ME	03/01/99	200	NA	8,033	8,033
American Samoa [5]	ME	04/01/99	NA	NA	NA	0
Arizona	SSP	11/01/98	200	26,807	NA	26,807
Arkansas	ME	10/01/98	100	NA	913	913
California	COMBO	03/01/98	250	187,854	34,497	222,351
Colorado	SSP	04/22/98	185	24,116	NA	24,116
Connecticut	COMBO	07/01/98	300	5,277	4,635	9,912
Delaware	SSP	02/01/99	200	2,433	NA	2,433
District of Columbia.	ME	10/01/98	200	NA	3,029	3,029
Florida [6]	COMBO	04/01/98	200	116,123	38,471	154,594

[22] In the case of community-based health delivery systems, the cost of coverage cannot exceed, on an average per child basis, the cost of coverage that would otherwise be provided. In the case of family coverage, the alternative must be cost effective relative to the amount paid to obtain comparable coverage only of the targeted low-income children, and it must not substitute for health insurance coverage that would otherwise be provided to the children.

[23] When the law establishing SCHIP was enacted, existing State programs in Florida, New York, and Pennsylvania were designated as meeting the minimum benefit requirements under this program.

TABLE 15–27.—STATE CHILDREN'S HEALTH INSURANCE PROGRAM AGGREGATE ENROLLMENT STATISTICS FOR FISCAL YEAR 1999—Continued

State	Type of SCHIP Program	Date implemented [1]	Upper eligibility [2] (in percent)	State reported fiscal year 1999 SCHIP enrollment [3] (total children ever served in fiscal year 1999)		Fiscal year 1999 total SCHIP enrollment
				Separate program	Medicaid expansion	
Georgia	SSP	11/01/98	200	47,581	NA	47,581
Guam [5 7]	ME	10/01/97	NA ...	NA	NA	0
Hawaii [8]	ME	07/01/00	185	NA	NI	NI
Idaho	ME	10/01/97	150	NA	8,482	8,482
Illinois [9]	ME	01/05/98	133	7,567	35,132	42,699
Indiana [8]	COMBO	10/01/97	200	NI	31,246	31,246
Iowa	COMBO	07/01/98	185	2,694	7,101	9,795
Kansas	SSP	01/01/99	200	14,443	NA	14,443
Kentucky [8 10]	COMBO	07/01/98	200	NI	18,579	18,579
Louisiana	ME	11/01/98	150	NA	21,580	21,580
Maine	COMBO	07/01/98	185	3,786	9,871	13,657
Maryland	ME	07/01/98	200	NA	18,072	18,072
Massachusetts	COMBO	10/01/97	200	24,408	43,444	67,852
Michigan	COMBO	05/01/98	200	14,825	11,827	26,652
Minnesota [10]	ME	10/01/98	280	NA	21	21
Mississippi [8]	COMBO	07/01/98	200	NI	13,218	13,218
Missouri	ME	09/01/98	300	NA	49,529	49,529
Montana	SSP	01/01/99	150	1,019	NA	1,019
Nebraska	ME	05/01/98	185	NA	9,713	9,713
Nevada	SSP	10/01/98	200	7,802	NA	7,802
New Hampshire	COMBO	05/01/98	300	3,700	854	4,554
New Jersey	COMBO	03/01/98	350	43,824	31,828	75,652
New Mexico [10]	ME	03/31/99	235	NA	4,500	4,500
New York [6 11]	COMBO	04/15/98	192	519,401	1,900	521,301
North Carolina [10]	SSP	10/01/98	200	57,300	NA	57,300
North Dakota [8]	COMBO	10/01/98	140	NI	266	266
Northern Mariana Islands [5 7]	ME	10/01/97	NA ...	NA	NA	0
Ohio	ME	01/01/98	150	NA	83,688	83,688
Oklahoma [10]	ME	12/01/97	185	NA	40,196	40,196
Oregon	SSP	07/01/98	170	27,285	NA	27,285
Pennsylvania [6]	SSP	05/28/98	200	81,758	NA	81,758
Puerto Rico [12]	ME	01/01/98	200	NA	20,000	20,000
Rhode Island [13]	ME	10/01/97	300	NA	7,288	7,288
South Carolina [14]	ME	10/01/97	150	NA	45,737	45,737
South Dakota	ME	07/01/98	140	NA	3,191	3,191
Tennessee [10]	ME	10/01/97	100	NA	9,732	9,732
Texas [8]	COMBO	07/01/98	200	NI	50,878	50,878
Utah [15]	SSP	08/03/98	200	13,040	NA	13,040
Vermont [10]	SSP	10/01/98	300	2,055	2,055	NA
Virginia	SSP	10/22/98	185	16,895	NA	16,895
Virgin Islands [5 16]	ME	04/01/98	NA ...	NA	120	120
Washington [8]	SSP	02/01/00	250	NI	NA	NI
West Virginia	COMBO	07/01/98	150	6,656	1,301	7,957

TABLE 15–27.—STATE CHILDREN'S HEALTH INSURANCE PROGRAM AGGREGATE ENROLLMENT STATISTICS FOR FISCAL YEAR 1999—Continued

State	Type of SCHIP Program	Date implemented [1]	Upper eligibility [2] (in percent)	State reported fiscal year 1999 SCHIP enrollment [3] (total children ever served in fiscal year 1999)		Fiscal year 1999 total SCHIP enrollment
				Separate program	Medicaid expansion	
Wisconsin	ME	04/01/99	185	NA	12,949	12,949
Wyoming [8]	SSP	12/01/99	133	NI	NA	NI
Total, 56 plans.	.....	.....	.....	1,284,387	695,063	1,979,450

[1] Implementation date of the initial SCHIP plan as reported by States. In some States the initial SCHIP plan involved a modest expansion of coverage and was followed by a plan amendment to further expand coverage. As of January 1, 2000, there are 37 States with approved amendments, and another 13 States have pending State plan amendments.

[2] Reflects upper eligibility level of SCHIP plans and amendments approved as of January 1, 2000. Upper eligibility is defined as a percent of the Federal poverty level (FPL). In 1999, the FPL was $16,700 for a family of four. In general, States with Medicaid expansion SCHIP Programs must establish their upper eligibility levels net of income disregards. States with separate SCHIP Programs can establish their upper eligibility levels on a gross income basis or net of income disregards. Puerto Rico defines the upper eligibility limit as 200 percent of Puerto Rico's poverty level.

[3] State reported enrollment in fiscal year 1999 reflects formal State quarterly electronic statistical data submissions and estimates by States in cases where electronic State quarterly data submissions were not available.

[4] Alabama's enrollment for Medicaid expansion SCHIP is estimated.

[5] Due to the unique nature of their SCHIP plans, these U.S. territories and jurisdictions may cover existing Medicaid populations with SCHIP funds, but only after their Medicaid funding caps are reached.

[6] Florida, New York and Pennsylvania had State-funded programs prior to SCHIP. Title XXI permitted children previously in the State-funded program to be covered under SCHIP and requires these States to maintain at least the previous levels of spending.

[7] Guam and the Commonwealth of the Northern Mariana Islands did not exceed their Medicaid funding caps, and therefore could not claim any SCHIP funding in fiscal year 1999.

[8] These States have plans or amendments approved, but these programs were not implemented as of September 30, 1999. Therefore, the enrollment counts do not correspond fully to the upper eligibility levels reported in this table since these eligibility levels reflect plans and plan amendments approved as of January 1, 2000.

[9] Illinois is covering children under its proposed separate SCHIP Program; although the amendment is pending.

[10] State reported SCHIP enrollment is estimated.

[11] New York's enrollment for Medicaid expansion SCHIP is estimated.

[12] Puerto Rico's SCHIP allotment funded 20,000 children; another 44,324 children were funded with territorial funds.

[13] Rhode Island has implemented their program to 250 percent FPL. In addition, Rhode Island has an approved amendment (February 5, 1999) to further expand the program to 300 percent FPL.

[14] South Carolina's enrollment for SCHIP reflects estimated enrollment from October 1998–July 1999.

[15] Utah SCHIP enrollment for fiscal year 1999 reflects the total number of children ever enrolled in the fourth quarter.

[16] Virgin Island's SCHIP enrollment reflects the number of children for which health care claims were paid during the period from July 1998 through April 1999.

COMBO—Combination approach. ME—Medicaid expansion. NA—Not applicable. NI—"Not implemented" denotes States with approved SCHIP plans or amendments with implementation dates after fiscal year 1999. SSP—Separate State programs.

Note.—Fiscal year 1999 enrollment statistics reflect unedited, unduplicated data as submitted by States to HCFA.

Source: Health Care Financing Administration (undated).

Benchmark equivalent coverage is defined as a package of benefits that has the same actuarial value as one of the benchmark benefit packages. A State choosing to provide benchmark equivalent coverage must cover each of the benefits in the "basic benefits category." The benefits in the basic benefits category are inpatient and outpatient hospital services, physicians' surgical and medical services, laboratory and x-ray services, and well-baby and well-child care, including age-appropriate immunizations. Benchmark equivalent coverage must also include at least 75 percent of the actuarial value of coverage under the benchmark plan for each of the benefits in the "additional service category." These additional services include prescription drugs, mental health services, vision services, and hearing services. States are encouraged to cover other categories of service not listed above. Abortions may not be covered, except in the case of a pregnancy resulting from rape or incest, or when an abortion is necessary to save the mother's life.

COST SHARING

Federal law permits States to impose cost sharing for some beneficiaries and some services under SCHIP. States that choose to implement SCHIP as a Medicaid expansion must follow the cost-sharing rules of the Medicaid Program. If the State implements SCHIP through a separate State program, premiums or enrollment fees for program participation may be imposed, but the maximum allowable amount is dependent on family income. For families with incomes under 150 percent FPL, premiums may not exceed the amounts set forth in Federal Medicaid regulations. Additionally, these families may be charged service-related cost sharing, but such cost sharing is limited to nominal amounts defined in Federal Medicaid regulations.

For a family with income above 150 percent FPL, service-related cost sharing may be imposed in any amount, provided cost sharing for higher income children is not less than cost sharing for lower income children. However, the total annual aggregate cost sharing (including premiums, deductibles, copayments and any other charges) for all targeted low-income children in a family may not exceed 5 percent of total family income for the year. In addition, States must inform families of these limits and provide a mechanism for families to stop paying once the cost-sharing limits have been reached.

Preventive services are exempt from cost sharing for all families regardless of income. In the proposed SCHIP regulations published in November 1999, the Health Care Financing Administration (HCFA) defines preventive services to include the following: all healthy newborn inpatient physician visits, including routine screening (inpatient and outpatient); routine physical examinations; laboratory tests; immunizations and related office visits as recommended by the American Academy of Pediatrics; and routine preventive and diagnostic dental services (for example, oral examinations, prophylaxis and topical fluoride applications, sealants, and x rays).

FINANCING

The Balanced Budget Act of 1997 appropriated a total of $39.7 billion for SCHIP for fiscal year 1998 through fiscal year 2007.[24] A total of $4.295 billion was appropriated for fiscal year 1998, $4.307 billion for fiscal year 1999, and $4.309 billion for fiscal year 2000. Allotment of funds among the States is determined by a formula set in law. This formula is based on a combination of the number of low-income children and low-income uninsured children in the State, and includes a cost factor that represents average wages in the State compared to the national average. A State with an approved plan has 3 fiscal years in which to draw down a given year's funding.

Like Medicaid, SCHIP is a Federal-State matching program. For each dollar of State spending, the Federal Government makes a matching payment. A State's share of program spending is equal to 100 percent minus the enhanced Federal medical assistance percentage (FMAP). The enhanced SCHIP FMAP is equal to a State's Medicaid FMAP increased by the number of percentage points that is equal to 30 percent multiplied by the number of percentage points by which the FMAP is less than 100 percent. For example, among States with a Medicaid FMAP of 60 percent, under Medicaid such States must spend 40 cents for every 60 cents that the Federal Government contributes. The enhanced FMAP for such States equals the Medicaid FMAP increased by 12 percentage points (60 percent + [30 percent $\times$ 40 percent] = 72 percent.) In this example, the State share equals 100 percent $-$ 72 percent = 28 percent.

Compared with the Medicaid FMAP, which ranges from 50 to 76.8 percent in fiscal year 2000, the enhanced FMAP for SCHIP ranges from 65 to 83.76 percent. All SCHIP assistance for targeted low-income children, including child health coverage provided through a Medicaid expansion, is eligible for the enhanced FMAP. The Medicaid FMAP and the enhanced SCHIP FMAP are subject to a ceiling of 83 and 85 percent, respectively.

There is a limit on Federal spending for SCHIP administrative expenses, which include activities such as data collection and reporting, as well as outreach and education. For Federal matching purposes, a 10 percent cap applies to State administrative expenses. This cap is tied to the dollar amount that a State draws down from its annual allotment to cover benefits under SCHIP, as opposed to 10 percent of a State's total annual allotment.

LEGISLATIVE HISTORY

Under the Balanced Budget Act of 1997, SCHIP was established, effective August 5, 1997. The legislation specified eligibility criteria; coverage requirements for health insurance; Federal allotments and the State allocation formula; payments to States and the enhanced FMAP formula; the process for submission, approval and amendment of State SCHIP plans; strategic objectives and per-

[24] The law sets aside 0.25 percent of SCHIP funds for the five territories and commonwealths (Puerto Rico, Guam, Virgin Islands, American Samoa, and the Northern Mariana Islands). It also sets aside $60 million annually for special diabetes grants for fiscal year 1998 through fiscal year 2002 only.

formance goals, and plan administration; annual reports and evaluations; options for expanding coverage of children under Medicaid; and diabetes grant programs.

During late 1997 through 1999, changes to SCHIP have been included in four laws passed subsequent to BBA 1997. Major provisions affecting SCHIP in these laws are summarized below.

The District of Columbia Appropriations Act of 1998 (Public Law 105–100) and the 1998 Supplemental Appropriations and Rescissions Act (Public Law 105–174) made technical corrections to SCHIP. In addition, Public Law 105–100 increased the fiscal year 1998 SCHIP appropriation from $4.275 billion to $4.295 billion.

Two changes to SCHIP were made in the Omnibus Consolidated and Emergency Supplemental Appropriations Act, fiscal year 1999 (Public Law 105–277). For fiscal year 1999, an additional appropriation of $32 million for the territories was provided, bringing the fiscal year 1999 total appropriation to $4.295 billion. In addition, for fiscal year 1998 and fiscal year 1999, this law changed the annual State allotment formula by stipulating that children with access to health care funded by the Indian Health Service and no other health insurance would be counted as uninsured (rather than as insured as required under the previously existing law).

Finally, the recently enacted Medicare, Medicaid and SCHIP Balanced Budget Refinement Act of 1999 (incorporated by reference in Public Law 106–113) made a number of mostly technical corrections to the program, of which the major changes are enumerated below:

1. Stabilizing the SCHIP allotment formula

Annual Federal allotments to each State are determined in part by States' success in covering previously uninsured low-income children under SCHIP. Under prior law, the more successful a State is in enrolling children in SCHIP, especially early in the program, the greater the potential reduction in subsequent annual allotments. To limit the amount a State's allocation can fluctuate from one year to the next, the Balanced Budget Refinement Act of 1999 modifies the allotment distribution formula and establishes new floors and ceilings.

2. Targeted, increased allotments

Additional allotments for the commonwealths and territories are provided for fiscal years 2000–2007.

3. Improved data collection and evaluation

First, the law provides new funding for the collection of data to produce reliable, annual State-level estimates of the number of uninsured children. These data changes will improve research and evaluation efforts. They will also affect State-specific counts of the number of low-income children and the number of such children who are uninsured that feed into the formula that determines annual State-specific allotments from Federal SCHIP appropriations. Second, new funding is also provided for a Federal evaluation to identify effective outreach and enrollment practices for both SCHIP and Medicaid, barriers to enrollment, and factors influencing beneficiary dropout. Finally, the law also requires: (a) an Inspector Gen-

eral audit and GAO report on enrollment of Medicaid-eligible children in SCHIP, (b) States to report annually the number of deliveries to pregnant women and the number of infants who receive services under the Maternal and Child Health Services Block Grant or who are entitled to SCHIP benefits, and (c) the Secretary of Health and Human Services to establish a clearinghouse for the consolidation and coordination of all Federal databases and reports regarding children's health.

PROGRAM DATA

As of December 1, 1999, the Health Care Financing Administration had approved SCHIP plans for all 50 States, the District of Columbia and all 5 territories. Twenty-five are Medicaid expansions (ME), 16 are separate State programs (SSP), and 15 provide health insurance coverage through a combination approach (COMBO).

As of December 1, 1999, 44 amendments to original State plans were submitted; 32 amendments had been approved and 12 were still in review. Several States have multiple amendments. The content of the plan amendments varies among States. Some States use the amendments to extend coverage beyond income levels defined in their original State plan (e.g., Michigan, New Mexico, and Nebraska). Others define new copayment standards for program participants (e.g., Missouri and Pennsylvania). Still others modify benefit packages (e.g., Alabama, Indiana, New Hampshire, and North Carolina).

Officials at HCFA anticipate that amendments will be submitted throughout the life of the program and that the nature of the amendments will change as the program evolves. The proposed program regulations issued in November 1999 indicate that HCFA will consider section 1115 research and demonstration waivers of title XXI provisions only after a State has had at least 1 year of SCHIP experience and has conducted an evaluation of that experience.

Early HCFA enrollment estimates indicate that nearly 1 million children (982,000) were enrolled in SCHIP under 43 operational State programs as of December 1998. More recently, HCFA reported that nearly 2 million children (1,979,450) were enrolled in SCHIP during fiscal year 1999 under 53 operational State programs. Over 1.2 million of these children were served by separate programs and almost 700,000 were enrolled in Medicaid expansions (see table 15–27). Subsequent to enactment of the Balanced Budget Act (BBA) of 1997, the Congressional Budget Office (CBO) estimated that SCHIP would cover an average of 2.3 million children per year after 1999 (CBO, 1998). The administration's goal is to enroll 5 million children in SCHIP by fiscal year 2002.

Because annual SCHIP allotments remain available for a period of 3 years, nearly all States continue to draw down on their fiscal year 1998 allotments, and have until the end of fiscal year 2000 to spend these funds.[25] Table 15–28 provides information on SCHIP allotments and reported expenditures by State for fiscal year 1998. These expenditures are based on unaudited State claims submitted to HCFA and do not represent actual outlays. As of January 4, 2000, States have claimed $986.8 million, or 23.3 percent of the

[25] Unspent funds will be redistributed to States that have fully expended their allotments.

TABLE 15–28.—ESTIMATED SCHIP FEDERAL ALLOTMENTS AND EXPENDITURES—FISCAL YEAR 1998

State	Fiscal year 1998 allotment	Expenditures [1]			S–SCHIP [2]
		Total dollars	Percent of allotment	M–SCHIP	
Alabama	85,975,213	25,421,675	29.6	10,840,371	14,581,304
Alaska	6,889,296	3,806,310	55.2	3,425,679	380,631
American Samoa [3]	128,850	(4)	0.0	(4)	(4)
Arizona	116,797,799	8,836,776	7.6	(4)	8,836,776
Arkansas	47,907,958	680,106	1.4	612,096	68,010
California	854,644,807	68,780,451	8.0	7,012,804	61,767,647
Colorado	41,790,546	10,024,469	24.0	(4)	10,024,469
Connecticut	34,959,075	12,301,470	35.2	9,567,126	2,734,344
Delaware	8,053,463	883,874	11.0	(4)	883,874
District of Columbia	12,076,002	498,585	4.1	498,585	(4)
Florida	270,214,724	57,362,492	21.2	27,317,491	30,045,001
Georgia	124,660,136	7,428,825	6.0	(4)	7,428,825
Guam [5]	375,812	(4)	0.0	(4)	(4)
Hawaii [6]	8,945,304	(4)	0.0	(4)	(4)
Idaho	15,879,707	5,280,101	33.3	4,752,091	528,010
Illinois	122,528,573	20,812,534	17.0	20,812,534	(4)
Indiana	70,512,432	61,716,155	87.5	59,547,425	2,168,730
Iowa	32,460,463	10,839,004	33.4	8,901,735	1,937,269
Kansas	30,656,520	8,790,887	28.7	(4)	8,790,887
Kentucky	49,932,527	17,825,116	35.7	17,352,499	472,617
Louisiana	101,736,840	10,361,817	10.2	9,325,635	1,036,182
Maine	12,486,977	5,617,064	45.0	4,060,701	1,556,363
Maryland	61,627,358	14,251,164	23.1	13,527,138	724,026

TABLE 15–28.—ESTIMATED SCHIP FEDERAL ALLOTMENTS AND EXPENDITURES—FISCAL YEAR 1998—Continued

State	Fiscal year 1998 allotment	Expenditures [1]			S–SCHIP [2]
		Total dollars	Percent of allotment	M–SCHIP	
Massachusetts	42,836,231	35,385,895	82.6	29,961,560	5,424,335
Michigan	91,585,508	15,576,561	17.0	9,076,713	6,499,848
Minnesota	28,395,980	7,189	0.0	7,189	(4)
Mississippi	56,017,103	8,092,064	14.4	8,092,064	(4)
Missouri	51,673,123	19,708,219	38.1	19,166,928	541,291
Montana	11,740,395	599,352	5.1	(4)	599,352
Nebraska	14,862,926	3,773,847	25.4	3,773,847	(4)
Nevada	30,407,067	4,110,173	13.5	(4)	4,110,173
New Hampshire	11,458,404	965,340	8.4	395,135	570,205
New Jersey	88,417,899	23,156,897	26.2	16,266,802	6,890,095
New Mexico	62,972,705	767,955	1.2	767,955	(4)
New York	255,626,409	255,626,409	100.0	477,118	255,149,291
North Carolina	79,508,462	34,921,019	43.9	(4)	34,921,019
North Dakota	5,040,741	75,874	1.5	74,324	1,550
Northern Mariana Islands [7]	118,113	(4)	0.0	(4)	(4)
Ohio	115,734,364	44,510,120	38.5	44,510,120	(4)
Oklahoma [8]	85,699,060	(4)	0.0	(4)	(4)
Oregon	39,121,663	7,638,628	19.5	(4)	7,638,628
Pennsylvania	117,456,520	48,751,058	41.5	(4)	48,751,058
Puerto Rico	9,835,550	9,835,550	100.0	9,835,550	(4)
Rhode Island	10,684,422	2,321,095	21.7	2,321,095	(4)
South Carolina	63,557,819	63,557,819	100.0	61,250,170	2,307,649
South Dakota	8,541,224	1,546,059	18.1	1,391,453	154,606

Tennesseee[8]	66,153,082	(4)	0.0	(4)	(4)
Texas	561,331,521	39,799,551	7.1	35,917,987	3,881,564
Utah	24,241,159	7,994,253	33.0	(4)	7,994,253
Vermont	3,535,445	524,624	14.8	(4)	524,624
Virginia	68,314,914	4,992,151	7.3	(4)	4,992,151
Virgin Islands[3]	279,175	(4)	0.0	(4)	(4)
Washington[6]	46,661,213	(4)	0.0	(4)	(4)
West Virginia	23,606,744	1,078,823	4.6	247,648	831,175
Wisconsin[3]	40,633,039	(4)	0.0	(4)	(4)
Wyoming[9]	7,711,638	(4)	0.0	(4)	(4)
Total	4,235,000,000	986,835,400	23.3	441,087,568	545,747,832

[1] Federal expenditures as reported by the States (Form HCFA–21C through September 30, 1999 as tabulated on January 4, 2000).

[2] Amounts may include Medicaid SCHIP administrative expenditures at enhanced Medicaid matching rates at State option.

[3] As of January 4, 2000, American Samoa, the Virgin Islands and Wisconsin had not submitted any expenditure reports.

[4] Not applicable or missing data. See footnotes for individual States for further explanation.

[5] Guam will be revising its expenditure reports through the fourth quarter of fiscal year 1999 to show that all the fiscal year 1998 allotment was spent.

[6] Hawaii and Washington show no expenditures because the implementation date for their programs is July 1, and February 1, 2000, respectively.

[7] Under its current SCHIP plan, the Northern Mariana Islands must exhaust their regular Medicaid funds (which has not been done for fiscal year 1998) before SCHIP funds become available.

[8] As of early January 2000, Oklahoma and Tennessee could not get their Medicaid computer systems altered to adequately identify SCHIP expenditures, so costs have been claimed under regular Medicaid. Beginning with the first quarter of fiscal year 2000, these States plan to report SCHIP expenditures and begin the process of adjusting regular Medicaid claims for prior periods.

[9] Wyoming shows no expenditures because it did not begin enrolling children into SCHIP until October 1, 1999 (beyond fiscal year 1998).

M–SCHIP—Medicaid expansion CHIP.

S–SCHIP—Separate State CHIP.

Source: Health Care Financing Administration.

total fiscal year 1998 appropriation of $4.235 billion available to States and territories. Just over half of these claims (55.3 percent) cover administrative and benefit costs for separate State programs; the remainder are for costs incurred under Medicaid expansions. Actual Federal spending in fiscal year 1998 totaled less than $500 million. CBO estimates that Federal State Children's Health Insurance Program (SCHIP) spending will total approximately $1 billion for fiscal year 1999 and $2 billion for fiscal year 2000 (CBO, 2000). The discrepancies between dollar figures reported by HCFA versus CBO are due primarily to differences in reporting periods and the time lag between claim submission and subsequent adjudication, and actual disbursement of Federal funds.

The proportion of State SCHIP allotments claimed by early January 2000, varies considerably across States. Ten States and territories reported no expenditures (see table 15–28 footnotes for explanations). An additional 27 States submitted expenditure reports claiming 25 percent or less of their allotments. Another 13 States claimed between 26 and 50 percent of available funds. Finally, six jurisdictions submitted expenditure reports totaling over 50 percent of allotments. Three of these six jurisdictions—New York, Puerto Rico and South Carolina—had claimed their full fiscal year 1998 allotments as of early January 2000, and have also submitted expenditure reports to access their fiscal year 1999 SCHIP funding.

FEDERAL HOUSING ASSISTANCE [26]

A number of Federal programs administered by the U.S. Department of Housing and Urban Development (HUD) and the Rural Housing Service (RHS) address the housing needs of low-income households. Housing assistance has never been provided as an entitlement to all households that qualify for aid. Instead, Congress has traditionally appropriated funds for a number of new commitments each year. Until the 1990s, those commitments generally ran up to 40 years, with the result that the appropriations were actually spent gradually over many years. More recently, funding has been provided 1 year at a time. Those additional commitments have expanded the pool of available aid, thus increasing the total number of households that can be served. They have also contributed to growth in Federal outlays in the past and have committed the government to continuing expenditures for many more years to come. The traditional housing programs have been augmented over the years with additional programs funded through block grants to State and local governments. This section describes recent trends in the number and mix of new commitments, as well as trends in expenditures for both the traditional assistance programs and the more recent block grant programs. The section focuses primarily on programs administered by HUD.

[26] This discussion draws directly from the Congressional Budget Office (1988). For this report, CBO has updated all figures with 12 additional years of data. For a more recent study on these topics, see Congressional Budget Office (1994). Assistance provided through various aspects of the Tax Code is excluded from the discussion.

TYPES OF ASSISTANCE

The Federal Government has traditionally provided housing aid directly to low-income households in the form of rental subsidies and mortgage interest subsidies. For the most part, both the number of households receiving aid and total Federal expenditures have steadily increased, but the growth of households assisted through the traditional programs has slowed since the 1980s and, in recent years, the number of such assisted households may have declined.[27] Starting in the mid-1980s, a number of statutes were enacted—including the Stewart B. McKinney Homeless Assistance Act of 1987 (hereafter referred to as the McKinney Act) and the 1990 Cranston-Gonzalez National Affordable Housing Act (hereafter referred to as the 1990 Housing Act) that authorized new, indirect approaches in the form of housing block grants to State and local governments. Those governments may use the grants for various housing assistance activities specified in the laws. Data on the number of households assisted through those types of programs are not readily available, however.

A number of different housing assistance programs evolved over time in response to changing housing policy objectives. The primary purpose of housing assistance has always been to reduce housing costs and improve housing quality for low-income households. Other goals have included promoting residential construction, expanding housing opportunities for disadvantaged groups and groups with special housing needs such as the elderly, the disabled, and the homeless, promoting neighborhood preservation and revitalization, increasing home ownership, and empowering the poor to become self-sufficient.

New housing programs have been developed because of shifting priorities among these objectives as housing-related problems changed and because of the relatively high Federal costs associated with some approaches. Other programs have become inactive as Congress stopped appropriating funds for new assistance commitments through them. Because housing programs traditionally have involved multiyear contractual obligations, however, these so-called inactive programs continue to play an important role by serving a large number of households through commitments for which funds were appropriated some time ago.

Direct rental assistance

Most Federal housing aid is now targeted to very-low-income renters through the rental assistance programs administered by HUD and the RHS (Schussheim, 2000). Rental assistance is provided through two basic approaches: (1) project-based aid, which is typically tied to projects specifically produced for low-income households through new construction or substantial rehabilitation; and (2) household-based subsidies, which permit renters to choose standard housing units in the existing private housing stock. Some funding is also provided each year to modernize units built with Federal aid. Rental assistance programs generally reduce tenants'

[27] Because of changes in the way in which HUD reports the number of households assisted through the traditional programs, it is not entirely clear whether the number has just leveled off or has actually declined during the past 3 years.

rent payments to a fixed percentage—currently 30 percent—of their income after certain deductions, with the government paying the remaining portion of the rent.

Almost all project-based aid is provided through production-oriented programs, which include the Public and Indian Housing Program, the section 8 New Construction and Substantial Rehabilitation Program, and the section 236 Mortgage Interest Subsidy Program—all administered by HUD—and the section 515 Mortgage Interest Subsidy Program administered by the RHS.[28] Today new commitments are being funded through only two of these four programs—a modified version of the section 8 New Construction Program for elderly and disabled families only and the section 515 program. In addition, some new housing for Native Americans continues to be developed through the Indian Housing Block Grant Program.

Some project-based aid is also provided through several components of HUD's section 8 Existing Housing Program, which tie subsidies to specific units in the existing housing stock, many of which have received other forms of aid or mortgage insurance through HUD. Traditionally, those components have included the section 8 loan management set-aside (LMSA) and property disposition (PD) components, which are designed to improve cash flows in selected financially troubled projects that are or were insured by the Federal Housing Administration or to provide deeper subsidies to the occupants; the section 8 conversion assistance component, which subsidizes units that were previously aided through other programs; and the section 8 Moderate Rehabilitation Program, which provides subsidies to units that have been brought up to standard by the owner.[29] In recent years, few, if any, new commitments have been funded through these programs. Today, new funding is predominantly used for tenant protection to enable tenants to remain in or move out of projects where rents are being raised after the owners opt out of the Federal assistance programs. Tenant protection assistance is also used to replace aid to households that are being displaced from assisted projects because the projects are being demolished.

Household-based subsidies have traditionally been provided through two other components of the section 8 Existing Housing Program—section 8 rental certificates and vouchers. These programs tie aid to households that choose units meeting certain housing standards in the private housing stock. Certificate holders generally must occupy units with rents that are within guidelines—the so-called fair market rents—established by HUD. Voucher recipients, however, are allowed to occupy units with rents above the HUD guidelines provided they pay the difference. Starting in 2000, the certificate and voucher program are being combined into one program that pays the difference between 30 percent of a tenant's income and the lesser of the tenant's actual housing cost or a payment standard determined by local rent levels. Commitments to aid additional households are being made under this program. In addi-

[28] A small number of renters continue to receive project-based subsidies through the now inactive section 221(d)(3) Below-Market Interest Rate and Rent Supplement Programs.

[29] The 1990 Housing Act repealed the section 8 Moderate Rehabilitation Program at the end of fiscal year 1991, except for single-room occupancy units for the homeless.

tion, because of the tenant protection programs discussed above, aid is gradually being shifted from project-based to household-based assistance.

Direct home ownership assistance

Each year, the Federal Government also assists some low- and moderate-income households in becoming homeowners by making long-term commitments to reduce their mortgage interest. Most of this aid has been provided through the section 502 program administered by the RHS. This program supplies direct mortgage loans at low interest rates roughly equal to the long-term government borrowing rates or provides guarantees for private loans with interest rates that may not exceed those set by the Department of Veterans Affairs (VA). Many home buyers, however, receive much deeper subsidies through the interest-credit component of this program, which reduces their effective interest rate to as low as 1 percent.

A number of home buyers have received aid through the section 235 program administered by HUD. That program provides interest subsidies for mortgages financed by private lenders. New commitments are now being made only through the section 502 program but a small number of homeowners continue to receive aid from prior commitments made under the section 235 program.[30] Both programs generally reduce mortgage payments, property taxes, and insurance costs to a fixed percentage of income, ranging from 20 percent for the RHS program to 28 percent for the latest commitments made under the HUD program.

Homeless programs

Since the mid-1980s, a number of programs specifically designed to address the issue of homelessness have been authorized. The still active programs, most of which were authorized by the McKinney Act, include the Emergency Shelter Grants Program, the Supportive Housing Program, the Shelter Plus Care Program, and the Moderate Rehabilitation for Single Room Occupancy Dwellings Program. Another program, which is designed to prevent rather than deal with homelessness, is the Housing Opportunities for Persons with AIDS (HOPWA) Program, authorized by the 1990 Housing Act.

Under these programs, HUD funds housing assistance indirectly in the form of block grants to State and local governments. They in turn are required to contribute matching funds under all programs except under the Single Room Occupancy Dwellings and HOPWA Programs. Funds are distributed by formula or by competition, depending on the type of program. Funds may be used for a variety of housing activities that may be supported on a short-term, emergency basis or on a more permanent basis. Those activities include acquisition, rehabilitation, and new construction of facilities, tenant rental assistance (including section 8), supportive services, and administration costs.

[30] The Housing and Community Development Act of 1997 terminated the section 235 program at the end of fiscal year 1989.

Other housing block grant programs

Several programs funded through block grants that are not specifically designed to deal with homelessness have been authorized since the early 1980s. Most of these programs have been terminated or are no longer being funded today.

Some assistance for the construction or rehabilitation of rental housing was funded under two small HUD programs authorized in 1983, the Rental Housing Development Grants (HoDAG) and the Rental Rehabilitation Block Grant Programs.[31] These programs distributed funds through a national competition and by formula, respectively, to units of local government that met certain eligibility criteria.

The 1990 Housing Act authorized several new housing assistance approaches, including the Home Ownership and Opportunity for People Everywhere (HOPE) Program and the HOME Investment Partnerships Block Grant Program. Since 1996, funds have been appropriated only for the HOME Program. The HOME Program provides Federal grants to State and local governments on a formula basis. Currently, participating jurisdictions generally must provide matching contributions of at least 25 percent of HOME funds spent in each fiscal year. Some or all of the matching requirement may be waived for jurisdictions that can show they are financially distressed. Funds may be used for tenant-based rental assistance or assistance to new home buyers.[32] They may also be used for acquisition, rehabilitation, or in limited circumstances, construction of both rental and owner-occupied housing.

Trends in Levels and Budgetary Impact of Housing Aid

This section examines trends in the levels and the budgetary impact of housing aid. Figures are presented only for programs administered by HUD. Because of data limitations, figures for the number of assisted households are presented only for those subsidized through the traditional programs that provide direct rental and home ownership assistance. Figures for the budgetary impact are shown for all housing programs discussed above.

Trends in net new commitments

Although HUD has been subsidizing the shelter costs of low-income households since 1937, more than half of all currently outstanding commitments under the traditional assistance programs were funded over the past 24 years. Between 1977 and 2000, funds were appropriated for about 2.6 million net new commitments to aid low-income renters (table 15–29). Another 108,000 new commitments were funded in the form of mortgage assistance to low- and moderate-income home buyers. Between 1977 and 1983, the number of net new rental commitments funded each year declined steadily, however, from 354,000 to 54,000. Trends have been somewhat erratic since that time. During the late 1990s relatively few

[31] The Housing and Community Development Act of 1987 terminated the HoDAG Program at the end of fiscal year 1989; the 1990 Housing Act repealed the Rental Rehabilitation Block Grant Program at the end of fiscal year 1991.

[32] Prior to the enactment of the HOME Program, some of the activities for home buyers were supported under the Nehemiah Housing Opportunity Grant Program, which was authorized by the Housing and Community Development Act of 1987.

TABLE 15–29.—NET NEW COMMITMENTS FOR RENTERS AND HOME BUYERS RECEIVING DIRECT HOUSING ASSISTANCE ADMINISTERED BY HUD, BY TYPE OF SUBSIDY, SELECTED YEARS 1977–2000

Fiscal year	Net new commitments for renters			Net new commitments for home buyers [3]
	Existing housing [1]	New construction [2]	Total	
1977	12,7581	226,832	354,413	4,719
1980	58,402	129,490	187,892	58,907
1981	83,520	75,365	158,885	5,102
1982	37,818	18,018	55,836	4,754
1983	54,071	−339	53,732	2,630
1984	78,648	9,619	88,267	930
1985	85,741	16,980	102,721	4,586
1986	85,476	13,109	98,585	5
1987	72,788	20,192	92,980	60
1988	64,270	19,991	84,261	0
1989	67,653	14,053	81,706	0
1990	61,309	7,428	68,737	0
1991 [4]	55,900	13,082	68,982	0
1992 [4]	62,008	23,537	85,545	0
1993 [4]	50,162	18,715	68,877	0
1994 [4]	47,807	17,652	65,459	0
1995 [4]	16,904	16,587	33,491	0
1996 [4]	7,055	1,438	8,493	0
1997 [4]	9,229	12,449	21,678	0
1998 [4]	18,376	17,675	36,051	0
1999 [4]	16,225	11,060	27,285	0
2000 est. [4]	126,000	9,556	135,556	0

[1] Includes units assisted through section 8 certificates and vouchers, loan management set-aside (LMSA), PD, and Moderate Rehabilitation Programs.

[2] Includes units assisted through the section 8 New Construction and Substantial Rehabilitation Program, section 202/811 Housing for the Elderly and the Disabled, section 236, and Public and Indian Housing Programs. Excludes units constructed under the Indian Housing Block Grant Program.

[3] Includes units assisted through the various section 235 programs.

[4] Figures are no longer adjusted for units for which funds were deobligated because data were unavailable.

Note.—Because reliable data are not readily available, this table excludes substantial numbers of commitments made through the various programs for the homeless (including HOPWA) and other block grant programs such as the HOME Investment Partnerships Program.

Net new commitments for renters represent net additions to the available pool of rental aid and are defined as the total number of commitments for which new funds are appropriated in any year.

To avoid double counting, numbers are adjusted for commitments for which such funds are deobligated or canceled that year (except where noted otherwise); the commitments for units converted from one type of assistance to another; starting in 1985, the commitments replacing those lost because private owners of assisted housing opt out of the programs or because public housing units are demolished; and, starting in 1989, the commitments for units whose section 8 contracts expire.

New commitments for home buyers are defined as the total number of new loans that HUD subsidizes each year. This measure of program activity is meant to indicate how many new home buyers can be helped each year. It is not adjusted to account for homeowners who leave the program in any year because of mortgage repayments, prepayment, or foreclosures. Thus, it does not represent net additions to the total number of assisted homeowners and therefore cannot be added to net new commitments for renters.

Source: Congressional Budget Office based on data from the U.S. Department of Housing and Urban Development.

new commitments were funded, ranging from less than 8,500 in 1996 to 36,000 in 1998. For fiscal year 2000, however, funds were appropriated for more than 135,000 new commitments.

The production-oriented approach in rental programs was sharply curtailed in 1982 in favor of the less costly section 8 Existing Housing Programs. Between 1977 and 1981, commitments through programs for new construction and substantial rehabilitation ranged annually from 47 to 69 percent of the total. After 1981, the proportion never exceeded 32 percent until 1995, when it rose to roughly one-half of the total. Because in recent years the number of commitments funded for existing housing has been so low, the new construction commitments (primarily for the elderly and disabled) have been a relatively high proportion of the total.

Trends in number of assisted households

The total number of households receiving housing assistance from HUD has increased substantially, almost 113 percent, from 2.4 million at the beginning of fiscal year 1977 to 5.1 million at the beginning of fiscal year 2000 (table 15–30). That increase results largely from net new commitments, but also from commitments made before 1977 that have been processed during this period. The number of households receiving rental subsidies increased from 2.1 million to 5.1 million. The number of assisted homeowners dropped steadily from 331,000 to 43,000, however, reflecting commitments for newly assisted home buyers, if any, being more than offset by loan repayments, prepayments, and foreclosures.

Among rental assistance programs, the shift away from production-oriented programs toward existing housing is reflected in the increasing proportion of renters receiving aid through the latter approach, from 13 percent at the beginning of fiscal year 1977 to about 42 percent at the beginning of fiscal year 2000. During that period, the proportion of renters receiving household-based subsidies increased from 8 percent to 32 percent.

Trends in budget authority

Under the direct housing assistance programs, funding for additional commitments used to be provided each year through appropriations of long-term (up to 40 years) budget authority for subsidies to households and through appropriations of budget authority for grants to public housing agencies and developers of rental housing. Today, most rental subsidies, both for new commitments and for the renewal of expiring contracts, are funded for 1 year at a time. Only new commitments that subsidize the operating costs of projects being built for the elderly and disabled are funded for 5-year periods. For the homeless and other housing block grant programs, funds are appropriated on an annual basis but spend out over periods as long as 10 years.

Annual appropriations of new budget authority for all housing assistance programs combined were cut dramatically during the 1980s. They dropped (in 2000 dollars) from a high of $82.5 billion in 1978 to a low of $12.5 billion in 1989 (table 15–31). Those cuts reflect four underlying factors affecting budget authority for the direct housing assistance programs: the previously mentioned reduction in the number of newly assisted households; the shift toward

TABLE 15–30.—TOTAL HOUSEHOLDS RECEIVING DIRECT HOUSING ASSISTANCE ADMINISTERED BY HUD, BY TYPE OF SUBSIDY, 1977–2000

[In thousands of households]

Start of fiscal year	Assisted renters					Total assisted homeowners [5]	Total assisted renters and homeowners [4]
	Existing housing			New construction [3]	Total assisted renters [4]		
	Household-based [1]	Project-based [2]	Subtotal existing housing				
1977	162	105	268	1,799	2,067	331	2,398
1978	297	126	423	1,928	2,350	293	2,643
1979	427	175	602	1,978	2,580	262	2,842
1980	521	185	707	2,090	2,797	235	3,032
1981	599	221	820	2,228	3,212	219	3,431
1982	651	194	844	2,373	3,379	241	3,619
1983	691	265	955	2,485	3,615	242	3,857
1984	728	357	1,086	2,589	3,851	230	4,081
1985	749	431	1,180	2,657	4,015	210	4,225
1986	797	456	1,253	2,686	4,135	200	4,336
1987	893	473	1,366	2,721	4,279	182	4,461
1988	956	490	1,446	2,736	4,371	159	4,530
1989	1,025	509	1,534	2,748	4,485	148	4,632
1990	1,090	527	1,616	2,755	4,569	141	4,710
1991	1,137	540	1,678	2,778	4,656	130	4,786
1992	1,166	554	1,721	2,786	4,705	125	4,830
1993	1,326	574	1,900	2,762	4,861	98	4,959
1994	1,392	593	1,985	2,764	4,939	95	5,035
1995	1,474	607	2,081	2,778	5,049	80	5,130
1996	1,413	608	2,021	2,817	5,028	76	5,104
1997	1,465	586	2,051	2,822	5,063	68	5,132

TABLE 15–30.—TOTAL HOUSEHOLDS RECEIVING DIRECT HOUSING ASSISTANCE ADMINISTERED BY HUD, BY TYPE OF SUBSIDY, 1977–2000—Continued

[In thousands of households]

Start of fiscal year	Assisted renters					Total assisted homeowners [5]	Total assisted renters and homeowners [4]
	Existing housing			New construction [3]	Total assisted renters [4]		
	Household-based [1]	Project-based [2]	Subtotal existing housing				
1998	1,481	564	2,045	2,786	5,021	60	5,082
1999	1,613	542	2,154	2,757	5,101	53	5,154
2000	1,621	522	2,143	2,728	5,061	43	5,104

[1] Includes units assisted through section 8 certificates and vouchers.

[2] Includes units assisted through the section 8 loan management set-aside (LMSA), PD, conversion (from rent supplement and section 236 Rental Assistance Program), and Moderate Rehabilitation Programs.

[3] Includes units assisted through the section 8 New Construction and Substantial Rehabilitation Program, section 236, Rent Supplement, and Public Housing Programs, including Indian units originally constructed under the Public Housing Program but currently assisted through the section 8 loan management set-aside (LMSA), PD, conversion (from rent supplement and section 236 Rental Assistance Program), and Moderate Rehabilitation Programs.

[4] Figures for total assisted renters have been adjusted since 1980 to avoid double-counting households receiving more than one subsidy. Therefore, the total is less than the sum of the components.

[5] Includes units assisted through the various section 235 programs.

Note.—Because reliable data are not readily available, this table excludes substantial numbers of households receiving aid through the various programs for the homeless (including the Housing Opportunities for Persons with AIDS Program) and other block grant programs such as the HOME Investment Partnerships Program).

Source: Congressional Budget Office based on data from the U.S. Department of Housing and Urban Development.

TABLE 15–31.—NET BUDGET AUTHORITY APPROPRIATED FOR HOUSING ASSISTANCE ADMINISTERED BY HUD, BY BROAD PROGRAM CATEGORIES, 1977–2000

[In millions of current and 2000 dollars]

Fiscal year	Direct housing assistance [1] in current dollars	Homeless programs [2] in current dollars	Other housing block grants [3] in current dollars	Total net budget authority	
				Current dollars	2000 dollars
1977	$28,579	0	0	$28,579	$77,944
1978	32,193	0	0	32,193	82,470
1979	25,123	0	0	25,123	59,100
1980	27,435	0	0	27,435	58,075
1981	26,021	0	0	26,021	50,057
1982	14,766	0	0	14,766	26,544
1983	10,001	0	0	10,001	17,214
1984	10,810	0	$615	11,425	18,867
1985	11,071	0	0	11,071	17,633
1986	9,888	0	144	10,032	15,591
1987	8,645	$195	300	9,140	13,806
1988	8,353	107	204	8,664	12,570
1989	8,664	172	170	9,006	12,476
1990	10,331	284	152	10,767	14,206
1991	19,029	339	105	19,473	24,457
1992	16,730	498	1,861	19,089	23,277
1993	18,280	672	1,485	20,437	24,181
1994	18,107	979	1,173	20,259	23,358
1995	11,676	1,291	1,462	14,429	16,182
1996	13,218	994	1,400	15,612	17,036
1997	8,672	1,019	1,370	11,061	11,753
1998	14,175	1,027	1,500	16,702	17,463
1999	16,544	1,200	1,600	19,344	19,846
2000	17,459	1,252	1,600	20,311	20,311

[1] Includes the following programs: section 8 Low-Income Housing Assistance, section 202/811 Housing for the Elderly and the Disabled, section 236 Rental Housing Assistance, Rent Supplement, section 235 Homeownership Assistance, Public Housing Capital, Public Housing Operating Subsidies, Public Housing Drug Elimination Grants, Revitalization of Severely Distressed Public Housing, Low-Rent Public Housing Loan Fund, Indian Housing Block Grants.

[2] Includes the following programs: Housing Opportunities for Persons with AIDS (HOPWA), Homeless Assistance Grants, Supplemental Assistance for Facilities to Assist the Homeless, Emergency Shelter Grants, Supportive Housing, Shelter Plus Care Program, section 8 Moderate Rehabilitation for Single Room Occupancy Dwellings, Innovative Homeless Initiatives Demonstration Program.

[3] Includes the following programs: HOME Investment Partnerships Program, Nehemiah Housing Opportunity Grant Program, Rental Housing Development Grants (HoDAG), Rental Rehabilitation Block Grant Program.

Note.—All figures are net of funding rescissions, exclude reappropriations of funds, and include supplemental appropriations. Figures exclude budget authority for HUD's section 202 loan fund.

Source: Congressional Budget Office based on data from the U.S. Department of Housing and Urban Development.

cheaper existing housing assistance; a systematic reduction in the average term of new commitments from more than 24 years in 1977 to less than 5 years today; and changes in the method for financing the construction and modernization of public housing and the construction of housing for the elderly and the disabled.[33]

Between 1991 and 1994, budget authority levels (in 2000 dollars) rose sharply to between $23 and $25 billion. Those trends reflect primarily the cost of renewing section 8 contracts that expired, with contracts being extended for 5-year terms. In addition, appropriations for homeless programs and other housing block grant programs rose significantly during that period.

After 1994, budget authority levels dropped again to as low as $11.8 billion in 1997. That decrease is explained by decreases in net budget authority appropriated for direct housing assistance, which were only partially offset by increases in appropriations for homeless and other housing block grant programs. The decreases in net budget authority for direct assistance reflect several factors: a gradual reduction in the terms of renewed contracts from 5 years to 1 year; further reductions in funding for new activity; and substantial rescissions of budget authority that had been appropriated in earlier years.

Trends in outlays

Total outlays for all housing programs administered by the U.S. Department of Housing and Urban Development (HUD) increased (in 2000 dollars) steadily from 1977 through 1996, from $16 billion to $57 billion (table 15–32). The lion's share of that increase is explained by increases in outlays for direct housing assistance, reflecting both the continuing increase in the number of assisted households and increases in the average subsidy in real terms.

Several factors have contributed to the growth of average subsidies over the 1977–96 period. First, rents in assisted housing have probably risen faster than the income of assisted households, causing subsidies to rise faster than the inflation index used here—the Consumer Price Index for All Urban Consumers (CPI–U–X1).[34] Second, the number of households that occupy units completed under the section 8 New Construction Program rose during the 1980s. Those units require larger subsidies compared with the older units that were built prior to the 1980s under the Mortgage Interest Subsidy and Public Housing Programs. Third, the share of households receiving less costly home ownership assistance has de-

[33] Before 1987, new commitments for the construction and modernization of public housing were financed over periods ranging from 20 to 40 years, with the appropriations for budget authority reflecting both the principal and interest payments for this debt. Starting in 1987, these activities have been financed with up front grants, which reduced their budget authority requirements by between 51 and 67 percent. Similarly, prior to 1991, housing for the elderly and the disabled was financed by direct Federal loans for construction, coupled with 20 years of section 8 rental assistance, which helped repay the direct loan. Starting in 1991, the loans have been replaced by grants, which reduced the amount of budget authority required for annual rental assistance. Moreover, starting in 1995, the term of the rental assistance was decreased from 20 years to 5 years, thereby reducing the budget authority even more.

[34] For example, between 1980 and 1990, the CPI–U–X1 increased 59 percent. Over the same period, the Consumer Price Index (CPI) for residential rents and median household income of renters increased by 71 and 70 percent, respectively, while the maximum rents allowed for section 8 existing housing rental certificates—the so-called fair market rents—rose even faster, by 85 percent.

TABLE 15–32.—OUTLAYS FOR HOUSING ASSISTANCE ADMINISTERED BY HUD, BY BROAD PROGRAM CATEGORIES, 1977–2000

[In millions of current and 2000 dollars]

Fiscal year	Direct housing assistance (in current dollars)			Homeless programs [3] (in current dollars)	Other housing block grants [4] (in current dollars)	Total outlays	
	Section 8 and other assisted housing [1]	Public housing [2]	Subtotal assisted housing			Current dollars	2000 dollars
1977	$1,331	$1,564	$2,895	0	0	$5,790	$15,791
1978	1,824	1,779	3,603	0	0	7,206	18,460
1979	2,374	1,815	4,189	0	0	8,378	19,709
1980	3,146	2,218	5,364	0	0	10,728	22,709
1981	4,254	2,478	6,732	0	0	13,464	25,901
1982	5,293	2,553	7,846	0	0	15,692	28,208
1983	6,102	3,318	9,420	0	0	18,840	32,428
1984	7,068	3,932	11,000	0	0	22,000	36,331
1985	7,771	17,261	25,032	0	$15	50,079	79,760
1986	8,320	3,859	12,179	0	142	24,500	38,075
1987	8,993	3,517	12,510	$2	165	25,187	38,046
1988	9,985	3,699	13,684	37	180	27,585	40,020
1989	10,689	3,774	14,463	72	275	29,273	40,553
1990	11,357	4,331	15,688	85	276	31,737	41,875
1991	12,107	4,786	16,893	125	168	34,079	42,802
1992	13,052	5,182	18,234	150	35	36,653	44,694
1993	14,032	6,447	20,479	180	276	41,414	49,002
1994	15,289	6,857	22,146	225	862	45,379	52,321
1995 [5]	16,448	7,505	23,953	359	1,259	49,524	55,542
1996 [5]	17,496	7,668	25,164	616	1,273	52,217	56,979
1997	17,131	7,809	24,940	718	1,263	51,861	55,104

TABLE 15–32.—OUTLAYS FOR HOUSING ASSISTANCE ADMINISTERED BY HUD, BY BROAD PROGRAM CATEGORIES, 1977–2000—Continued

[In millions of current and 2000 dollars]

Fiscal year	Direct housing assistance (in current dollars)			Homeless programs [3] (in current dollars)	Other housing block grants [4] (in current dollars)	Total outlays	
	Section 8 and other assisted housing [1]	Public housing [2]	Subtotal assisted housing			Current dollars	2000 dollars
1998 [5]	16,975	8,028	25,003	916	1,316	52,238	54,617
1999 [5]	17,171	7,805	24,976	1,032	1,367	52,351	53,710
2000 est. [5]	17,443	8,094	25,537	1,174	1,456	53,704	53,704

[1] Includes the following programs: section 8 Low-Income Housing Assistance, section 202/811 Housing for the Elderly and the Disabled, section 236 Rental Housing Assistance, Rent Supplement, section 235 Homeownership Assistance.

[2] Includes the following programs: Public Housing Capital, Public Housing Operating Subsidies, Public Housing Drug Elimination Grants, Revitalization of Severely Distressed Public Housing, Low-Rent Public Housing Loan Fund, Indian Housing Block Grants.

[3] Includes the following programs: Housing Opportunities for Persons with AIDS (HOPWA), Homeless Assistance Grants, Supplemental Assistance for Facilities to Assist the Homeless, Emergency Shelter Grants, Supportive Housing, Shelter Plus Care Program, section 8 Moderate Rehabilitation for Single Room Occupancy Dwellings Program, Innovative Homeless Initiatives Demonstration Program.

[4] Includes the following programs: HOME Investment Partnerships Program, Nehemiah Housing Opportunity Grant Program, Rental Housing Development Grants (HoDAG), Rental Rehabilitation Block Grant Program.

[5] In order to reflect trends more accurately, figures have been adjusted to account for advance spending in certain years. In 1995, $1.2 billion of spending occurred that should have occurred in 1996. In 1998, $680 million of spending occurred that should have occurred in 1999. The Congressional Budget Office also expects that $680 million of spending will occur in 2000 that should occur in 2001.

Note.—The bulge in outlays for public housing in 1985 is caused by a change in the method of financing public housing, which generated close to $14 billion in one-time expenditures. That amount paid off—all at once—the capital cost of public housing construction and modernization activities undertaken between 1974 and 1985, which otherwise would have been paid off over periods of up to 40 years. Because of that expenditure, however, outlays for public housing since that time have been lower than they would have been otherwise.

Source: Congressional Budget Office based on data from the U.S. Department of Housing and Urban Development.

TABLE 15–33.—PER UNIT OUTLAYS FOR HOUSING AID ADMINISTERED BY HUD, 1977–97

[In current and 1997 dollars]

Fiscal year	Per unit outlays	
	Current dollars	1997 dollars
1977	$1,160	$2,980
1978	1,310	3,160
1979	1,430	3,160
1980	1,750	3,480
1981	2,100	3,810
1982	2,310	3,900
1983	2,600	4,220
1984	2,900	4,500
1985	6,420	9,620
1986	3,040	4,440
1987	3,040	4,320
1988	3,270	4,460
1989	3,390	4,420
1990	3,610	4,480
1991	3,830	4,530
1992	4,060	4,670
1993	4,450	4,960
1994	4,720	5,120
1995	5,080	5,360
1996	5,350	5,490
1997 (estimate)	5,490	5,490

Note.—The peak in outlays per unit in 1985 of $6,420 is attributable to the bulge in 1985 expenditures associated with the change in the method for financing public housing. Without this change, outlays per unit would have amounted to around $2,860.

Source: Congressional Budget Office based on data provided by the U.S. Department of Housing and Urban Development.

creased. Fourth, housing assistance has been targeted increasingly toward poorer segments of the population, requiring larger subsidies per assisted household (table 15–33).

Since 1996, outlays for all housing assistance programs have decreased from $57 billion to around $54 billion in 1999 and 2000 (in 2000 dollars). That drop is explained by a decrease in constant outlays for direct housing assistance from $54.9 billion in 1996 to an estimated $51.1 billion in 2000, offset only partially by an increase in real outlays for homeless and other housing block grant programs from $2.1 billion to an estimated $2.6 billion.

The decrease in constant dollar outlays for direct housing assistance, which is also evident in the leveling off of outlays in current dollars, is not easily explained because of a lack of reliable data on the underlying factors that may have contributed.

Given that the number of assisted households has more or less leveled off at around 5 million, the factor likely to be responsible for the decrease in real outlays is a decrease in real average sub-

sidies.[35] Indeed, several cost containment measures have been enacted in recent legislation that have slowed down the growth in average subsidies in current dollars, thereby helping to reduce average subsidies in 2000 dollars. First, rents in assisted housing are increasing at a slower rate or are even declining in many cases. Because the Federal Government pays part of those rents, subsidies have been lower than they would have been otherwise. In particular, the maximum allowable rent in the section 8 voucher and certificate program has been lowered from the 45th percentile to the 40th percentile of the local rent distribution. That decrease is being phased in gradually, as households move from their current units or turn over their certificate or voucher to a new recipient. Also, rents in certain assisted housing projects are no longer increased annually, while rent adjustments in other cases are being reduced. Second, many assisted households who had been contributing little or nothing to their rent are now charged a minimum rent of up to $50 per month. Third, preference rules for admitting new tenants have been relaxed, thereby allowing a gradual shift to a population with somewhat higher incomes. Fourth, in several of the years during the period, the reissuing of section 8 certificates and vouchers upon turnover has been delayed for 3 months.

In addition to the legislative changes, some nonlegislative factors may have contributed to the drop in real subsidies. First, the booming economy of the late 1990s likely has increased the incomes of many assisted households, thereby resulting in larger shares of the rent being paid by them and lower shares by HUD. Second, anecdotal evidence suggests that new recipients of section 8 certificates and vouchers in some parts of the country have trouble finding units in which to use their housing assistance because of very tight housing markets or a lack of landlords willing to participate in the programs. As a result, the utilization rate of certificates and vouchers has been decreasing.

Future trends in outlays for housing assistance will be affected by further changes made by recent legislation. On the one hand, the so-called mark-to-market initiative, enacted by the Multifamily Assisted Housing Reform and Affordability Act of 1997, will reduce rents in certain section 8 projects with federally insured mortgages, thereby reducing outlays for the section 8 program. Under this initiative, project rents will be reduced to market levels as the section 8 contracts expire. To avoid defaults on the federally insured mortgages, HUD will write down, if needed, those mortgages to levels that are supportable by the new lower rents. On the other hand, a second initiative, enacted in 1999 by the Preserving Affordable Housing for Senior Citizens and Families into the 21st Century Act, will allow rents to increase in certain section 8 projects, thereby increasing outlays for section 8. To prevent owners from opting out of the Federal assistance programs, rents will be raised to market levels. In cases where owners opt out anyway, tenants will be enabled to stay in the project through the use of vouchers that will be issued at market rent levels even if the latter exceed the section 8 fair market rent in the area.

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[35] The apparent fluctuations in total number of assisted households between 5.021 and 5.101 million is most likely due to inaccuracies in the data.

SCHOOL LUNCH AND BREAKFAST PROGRAMS[36]

The School Lunch and School Breakfast Programs provide Federal cash and commodity support for meals. The meals are served by public and private nonprofit elementary and secondary schools and residential child care institutions (RCCIs) that opt to enroll and guarantee to offer free or reduced-price meals meeting Federal nutrition standards to eligible low-income children. The programs are "entitlement" programs, and both subsidize participating schools and RCCIs for all meals served that meet Federal nutrition standards at specific, inflation-indexed rates for each meal. Each program has a three-tiered system for per-meal Federal reimbursements to schools and RCCIs that: (1) allows children to receive free meals if they have family income below 130 percent of the Federal poverty guidelines (about $21,700 for a four-person family in the 1999–2000 school year); (2) permits children to receive reduced-price meals (no more than 40 cents for a lunch or 30 cents for a breakfast) if their family income is between 130 and 185 percent of the poverty guidelines (between about $21,700 and $30,900 for a four-person family in the 1999–2000 school year); and (3) provides a small per-meal subsidy for "full-price" meals (the price is set by the school or RCCI) served to children whose families do not apply, or whose family income does not qualify them for free or reduced-price meals. Children in Temporary Assistance for Needy Families (TANF) and food stamp households may automatically qualify for free school meals without an income application, and the majority actually receive them.

The School Lunch Program subsidizes lunches (4.5 billion in fiscal year 1999) to children in 6,000 RCCIs and almost all schools (91,000). During fiscal year 1999, average daily participation was 27 million students (57 percent of the children enrolled in participating schools and RCCIs); of these, 48 percent received free lunches, and 9 percent ate reduced-price lunches (table 15–34). More than 90 percent of Federal funding is used to subsidize free and reduced-price lunches served to low-income children. For the 1999–2000 school year, per-lunch Federal subsidies (cash and commodity support) range from about 34 cents for full-price lunches to $2.13 and $1.73 for free and reduced-price lunches.[37] Fiscal year 1999 Federal school lunch costs (including commodity assistance) totaled over $6 billion (table 15–34).

The School Breakfast Program serves far fewer students than does the School Lunch Program; about 1.3 billion breakfasts in 66,000 schools (and 6,000 RCCIs) were subsidized in fiscal year 1999. Average daily participation was 7.4 million children (21 percent of the 36 million students enrolled in participating schools and RCCIs). Unlike the School Lunch Program, the great majority received free or reduced-price meals: 77 percent received free meals, and 8 percent purchased reduced-price meals (table 15–35). In the

[36] Other major Federal child nutrition programs include: the Child and Adult Care Food Program (discussed in section 9) and the Summer Food Service Program (which provides subsidies for meals served during the summer months to some 2 million children participating in recreational and other programs in low-income areas).

[37] Schools and RCCIs with very high proportions of low-income children receive an extra 2 cents a meal. Federally donated commodity assistance make up about 15 cents of each cited subsidy rate.

1999–2000 school year, per-breakfast Federal subsidies (cash only) range from about 21 cents for full-price meals to $1.09 and 79 cents for free and reduced-price breakfasts, respectively.[38] Fiscal year 1999 Federal school breakfast funding totaled about $1.4 billion (table 15–35).

TABLE 15–34.—NATIONAL SCHOOL LUNCH PROGRAM PARTICIPATION AND FEDERAL COSTS, FISCAL YEARS 1977–99

[In millions]

Fiscal year	Participation 9 month average [1]				Federal costs	
	Free meals	Reduced-price meals	Full-price meals [2]	Total [3]	Current dollars [4]	Constant 1999 dollars
1977	10.5	1.3	14.5	26.3	$2,111.1	$5,857.3
1978	10.3	1.5	14.9	26.7	2,293.6	5,945.0
1979	10.0	1.7	15.3	27.0	2,659.0	6,247.2
1980	10.0	1.9	14.7	26.6	3,044.9	6,298.5
1981	10.6	1.9	13.3	25.8	2,959.5	5,510.6
1982	9.8	1.6	11.5	22.9	2,611.5	4,528.5
1983	10.3	1.5	11.2	23.0	2,828.6	4,738.6
1984	10.3	1.5	11.5	23.3	2,948.2	4,744.1
1985	9.9	1.6	12.1	23.6	3,034.4	4,709.2
1986	10.0	1.6	12.2	23.8	3,160.2	4,786.9
1987	10.0	1.6	12.4	24.0	3,245.6	4,779.6
1988	9.8	1.6	12.8	24.2	3,383.7	4,785.7
1989	9.7	1.6	12.7	24.2	3,479.4	4,697.5
1990	9.9	1.6	12.8	24.1	3,676.4	4,727.6
1991	10.3	1.8	12.1	24.2	4,072.9	4,986.0
1992	11.1	1.7	11.7	24.5	4,474.5	5,317.4
1993	11.8	1.7	11.3	24.8	4,663.8	5,379.1
1994	12.2	1.8	11.3	25.3	4,994.5	5,613.2
1995	12.4	1.9	11.3	25.6	5,254.0	5,743.6
1996	12.6	2.0	11.3	25.9	5,441.0	5,786.3
1997	13.0	2.0	11.3	26.3	5,729.8	5,935.1
1998	13.0	2.2	11.3	26.5	5,872.1	5,984.8
1999	13.0	2.4	11.6	27.0	6,249.8	6,249.8

[1] In order to reflect participation for the actual school year (September through May), these estimates are based on 9 month averages of October through May, plus September, rather than averages of the 12 months of the fiscal year (October through September).

[2] The Federal Government provides a small subsidy for these meals.

[3] Details may not sum to total because of rounding.

[4] Includes cash payments and the value of ''entitlement'' commodities; does not include the value of ''bonus'' commodities. Overstates actual support for school lunches because a portion (less than $75 million a year) of commodity support included in the figures is used for other child nutrition programs.

Note.—Constant dollars were calculated using the fiscal year CPI–U.

Source: U.S. Department of Agriculture, Food and Consumer Service (FCS): (1) budget justification materials prepared by the FCS for appropriations requests for fiscal years 1980–2001; and (2) monthly ''Program Information Report'' summaries prepared by the FCS.

[38] Subsidies are substantially higher (about 20 cents more) for schools in which breakfast service is required by State law or at least 40 percent of lunches are served free or at reduced price.

TABLE 15–35.—SCHOOL BREAKFAST PROGRAM PARTICIPATION AND FEDERAL COSTS, SELECTED FISCAL YEARS 1977–99

[In millions]

Fiscal year	Participation 9 month average [1]				Federal costs	
	Free meals	Reduced-price meals	Full-price meals [2]	Total [3]	Current dollars [4]	Constant 1999 dollars
1977 ...	2.0	0.1	0.4	2.5	$148.6	$412.3
1980 ...	2.8	0.2	0.6	3.6	287.8	595.3
1981 ...	3.0	0.2	0.5	3.8	331.7	617.6
1982 ...	2.8	0.2	0.4	3.3	317.3	550.2
1983 ...	2.9	0.1	0.3	3.4	343.8	576.0
1984 ...	2.9	0.1	0.4	3.4	364.0	585.7
1985 ...	2.9	0.2	0.4	3.4	379.3	588.7
1986 ...	2.9	0.2	0.4	3.5	406.3	615.5
1987 ...	3.0	0.2	0.4	3.7	446.8	658.0
1988 ...	3.0	0.2	0.5	3.7	482.0	681.7
1989 ...	3.1	0.2	0.5	3.8	507.0	684.5
1990 ...	3.3	0.2	0.5	4.0	589.1	757.6
1991 ...	3.6	0.2	0.6	4.4	677.2	829.0
1992 ...	4.0	0.3	0.6	4.9	782.6	930.0
1993 ...	4.4	0.3	0.7	5.4	868.4	1,001.6
1994 ...	4.8	0.3	0.7	5.8	958.7	1,077.5
1995 ...	5.1	0.4	0.8	6.3	1,181.8	1,291.9
1996 ...	5.3	0.4	0.9	6.6	1,124.2	1,195.5
1997 ...	5.5	0.9	6.9	6.6	1,212.7	1,256.2
1998 ...	5.6	1.0	7.1	6.6	1,299.6	1,324.5
1999 ...	5.7	1.1	7.4	6.6	1,354.8	1,354.8

[1] In order to reflect participation for the actual school year (September through May), these estimates are based on 9 month averages of October through May, plus September, rather than averages of the 12 months of the fiscal year (October through September).

[2] The Federal Government provides a small subsidy for these meals.

[3] Details may not sum to totals due to rounding.

[4] Does not include the value of any federally donated commodities. Fiscal year 1995 figure for Federal costs is not reduced for a ''write-down'' of approximately $50–$80 million for unclaimed obligations.

Note.—Constant dollars were calculated using the fiscal year CPI–U.

Source: U.S. Department of Agriculture, Food and Consumer Service (FCS): (1) budget justification materials prepared by the FCS for appropriations requests for fiscal years 1980–2001; and (2) monthly ''Program Information Report'' summaries prepared by the FCS.

SPECIAL SUPPLEMENTAL NUTRITION PROGRAM FOR WOMEN, INFANTS, AND CHILDREN (WIC)

The Special Supplemental Nutrition Program for Women, Infants, and Children (the WIC Program) provides food assistance, nutrition risk screening, and related services (e.g., nutrition education and breastfeeding support) to low-income pregnant and postpartum women and their infants, as well as to low-income children up to age 5. Participants in the program must have family income at or below 185 percent of poverty, and must be judged to be nutritionally at risk. Nutrition risk is defined as detectable abnormal nutritional conditions; documented nutritionally-related medical conditions; health-impairing dietary deficiencies; or conditions

that predispose people to inadequate nutrition or nutritionally related medical problems.

Beneficiaries of the WIC Program receive supplemental foods each month in the form of actual food items or, more commonly, vouchers for purchases of specific items in retail stores. The law requires that the WIC Program provide foods containing protein, iron, calcium, vitamin A, and vitamin C, and allows Federal limits on the foods that may be provided by the WIC Program. Among the items that may be included in a food package are milk, cheese, eggs, infant formula, cereals, and fruit or vegetable juices. U.S. Department of Agriculture regulations require tailored food packages that provide specified types and amounts of food appropriate for six categories of participants: (1) infants from birth to 3 months; (2) infants from 4 to 12 months; (3) women and children with special dietary needs; (4) children from 1 to 5 years of age; (5) pregnant and nursing mothers; and (6) postpartum nonnursing mothers. In addition to food benefits, recipients also must receive nutrition education and breast feeding support (where called for).

The Federal cost of providing WIC benefits varies widely depending on the recipient and the foods included in the food package, as well as differences in retail prices (where vouchers are used), food costs (where the WIC agency buys and distributes food), and administrative costs (including the significant costs of nutrition risk screening, breastfeeding support, and nutrition education). Moreover, the program's food costs are significantly influenced by the degree to which States gain rebates from infant formula manufacturers under a requirement to pursue "cost containment" strategies; these rebates total over $1 billion a year nationwide. In fiscal year 1999, the national average Federal cost of a WIC food package (after rebates) was $32.50 a month, and, for each participant, the average monthly "administrative" cost (including nutrition risk assessments and nutrition education) was about $12.

The WIC Program has categorical, income, and nutrition risk requirements for eligibility. Only pregnant and postpartum women, infants, and children under age 5 may participate. As noted above, WIC applicants must show evidence of health or nutrition risk, medically verified by a health professional, in order to qualify. They must also have family income below 185 percent of the most recent Federal poverty guidelines (about $25,700 a year for a three-person family in 1999). State WIC agencies may (but seldom do) set lower income eligibility cutoff points. Receipt of TANF, food stamps, or Medicaid assistance also can satisfy the WIC Program's income test, and States may consider pregnant women meeting the income test "presumptively" eligible until a nutritional risk evaluation is made. Drawing on a 1996 study, over 60 percent of WIC enrollees had family income below the Federal poverty guidelines, 25 percent of WIC enrollees were cash welfare recipients, 36 percent received food stamps, and 55 percent were covered by Medicaid.

WIC participants receive benefits for a specified period of time, and in some cases must be recertified during this period to show continuing need. Pregnant women may continue to receive benefits throughout their pregnancy and for up to 6 months after childbirth, without recertification. Nursing mothers are certified at 6-month intervals, ending with their infant's first birthday.

The WIC Program, which is federally funded but administered by State and local health agencies, does not serve all who are eligible. It is not an "entitlement" program, and participation is limited by the amount of Federal funding appropriated, whatever State supplementary funding is provided, and the extent of manufacturers' infant formula rebates. In fiscal year 1999, Federal spending was $3.956 billion, and the program served a monthly average of 7.3 million women, infants, and children: 23 percent women, 26 percent infants, and 51 percent children. The administration's most recent estimate of the total number of persons eligible and likely to apply for WIC benefits is 7.5 million persons, although other sources suggest the number exceeds 8 million people. Table 15–36 summarizes WIC participation and Federal costs.

TABLE 15–36.—SPECIAL SUPPLEMENTAL NUTRITION PROGRAM FOR WOMEN, INFANTS, AND CHILDREN (WIC) PARTICIPATION AND FEDERAL SPENDING, SELECTED FISCAL YEARS 1977–99

[Dollars in millions]

Fiscal year	Participation (in thousands)				Federal spending	
	Women	Infants	Children	Total [1]	Current dollars [2]	Constant 1999 dollars
1977	165.0	213.0	471.0	848.0	$255.9	$710.0
1980	411.0	507.0	995.0	1,913.0	724.7	1,499.1
1981	446.0	585.0	1,088.0	2,119.0	874.4	1,628.1
1982	478.0	623.0	1,088.0	2,189.0	948.2	1,644.2
1983	542.0	730.0	1,265.0	2,537.0	1,123.1	1,881.5
1984	657.0	825.0	1,563.0	3,045.0	1,386.3	2,230.8
1985	665.0	874.0	1,600.0	3,138.0	1,488.9	2,310.7
1986	712.0	945.0	1,655.0	3,312.0	1,580.5	2,394.1
1987	751.0	1,019.0	1,660.0	3,429.0	1,663.6	2,449.9
1988	815.0	1,095.0	1,683.0	3,593.0	1,802.4	2,549.2
1989	951.8	1,259.6	1,907.0	4,118.4	1,929.4	2,604.9
1990	1,035.0	1,412.5	2,069.4	4,516.9	2,125.9	2,733.8
1991	1,120.1	1,558.8	2,213.8	4,892.6	2,301.1	2,817.0
1992	1,221.5	1,684.1	2,505.2	5,410.8	2,566.5	3,050.0
1993	1,364.9	1,741.9	2,813.4	5,920.3	2,819.5	3,252.0
1994	1,499.2	1,786.3	3,191.7	6,477.2	3,159.8	3,551.2
1995	1,576.8	1,817.3	3,500.1	6,894.2	3,451.0	3,772.6
1996	1,648.2	1,827.3	3,712.3	7,187.8	3,688.2	3,922.2
1997	1,710.5	1,863.0	3,835.4	7,408.9	3,845.7	3,983.5
1998	1,733.3	1,882.8	3,749.2	7,365.3	3,895.8	3,970.6
1999	1,742.5	1,897.6	3,671.4	7,311.5	3,955.6	3,955.6

[1] Details may not sum to totals due to rounding.

[2] Includes funding for studies, surveys, pilots, and farmers' market programs. Spending figures include adjustments for significant interyear carryovers and reflect spending by State WIC agencies derived both from current-year appropriations and prior-year amounts, adjusted for amounts carried forward into the next year.

Note.—Constant dollars were calculated using the fiscal year CPI–U.

Source: U.S. Department of Agriculture, Food and Consumer Service (FCS): (1) budget justification materials prepared by the FCS for appropriations requests for fiscal years 1980–2001; and (2) monthly ''Program Information Report'' summaries prepared by the FCS.

CHILD AND ADULT CARE FOOD PROGRAM

The Child and Adult Care Food Program (CACFP) is a permanently authorized entitlement under section 17 of the Richard B. Russell National School Lunch Act. It provides Federal subsidies for breakfasts, lunches, suppers, and snacks served in participating nonresidential child care centers (including homeless shelters, Head Start centers, and afterschool care centers) and family or group day care homes, as well as for snacks offered in outside-of-school programs.[39] Sponsors giving administrative support for providers also are paid limited amounts for their costs. Subsidized meals and snacks must meet Federal nutrition standards, and providers must fulfill any State or local licensing/approval requirements or minimum alternative Federal requirements (or otherwise demonstrate that they comply with government-established standards for other child-care programs). Federal assistance is made up overwhelmingly of cash subsidies based on the number of meals/snacks served or paid for administration; about 3 percent is in the form of federally donated food commodities. CACFP subsidies to participating centers, homes, and outside-of-school programs are available for meals and snacks served to children age 12 or under (through age 18 in outside-of-school settings), migrant children age 15 or under, and handicapped children of any age, but preschool children form the majority.

At the Federal level, the program is administered by the Agriculture Department's Food and Nutrition Service (FNS). At the State level, a variety of agencies have been designated as responsible by the individual States, and, in one State (Virginia), the FNS is the designated State agency. Federal CACFP payments flow to individual providers either directly from the State agency (this is the case with many child care centers able to handle their own administrative responsibilities) or through "sponsors" who oversee and provide support for a number of local providers (this is the case with some child care centers and all day care homes). The CACFP dates back to 1968, when Federal assistance for programs serving children outside of school ("special food service" programs) was first authorized. In 1975, the summer food service and child care components of this assistance were first formally separated as individual programs.

In fiscal year 1999, the cost of CACFP cash and commodity subsidies for meals/snacks, sponsors' administrative costs, and a separate payment to State agencies for audit and oversight was $1.599 billion, approximately the same as it was in fiscal years 1996–98. Total average daily attendance in participating centers, homes, and outside-of-school programs was 2.6 million children, up from 2.4 million in fiscal year 1996.

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[39] CACFP subsidies also are available for meal services to chronically impaired adults and the elderly in adult day care centers under the same general terms and conditions as child care centers. However, few adult care centers participate (about 1,900 sites serving some 63,000 persons daily in fiscal year 1999), and Federal spending for them is a minor fraction of the total cost of the CACFP ($36 million in fiscal year 1999, or about 2 percent of overall CACFP spending). In limited cases, residential child care facilities may receive CACFP subsidies for snacks served in afterschool programs.

CENTERS AND OUTSIDE-OF-SCHOOL PROGRAMS

Child care centers in the CACFP serve an average of 40–60 children and are of 5 types: (1) public or private nonprofit centers (including afterschool care centers), (2) Head Start centers, (3) for-profit proprietary centers (see restrictions noted below), (4) outside-of-school programs (often operated by schools), and (5) shelters for homeless families. In fiscal year 1999, some 37,000 centers/sites (15,000 sponsors) with an average daily attendance of 1.66 million children participated in the CACFP. Over 60 percent of children in the CACFP are reached through centers or outside-of-school programs. Of these, about half are in public or private nonprofit centers/programs, and some 30 percent are in Head Start centers; just under 20 percent are in for-profit centers.[40] On the other hand, CACFP funding for centers/programs represents half of total CACFP spending, primarily because their subsidies are, for the most part, differentiated by individual children's family income and larger administrative cost payments generally are provided for sponsors of day care homes (see below). Proprietary centers are eligible for CACFP subsidies only if they receive title XX funding for at least 25 percent of their enrollment or licensed capacity, regardless of the income status of the children they serve.[41]

Day care centers may receive daily subsidies for up to two meals and one snack or one meal and two snacks for each child. All meals and snacks served in centers are federally subsidized to at least some degree; different subsidies are provided for breakfasts, lunches/suppers, and snacks, and subsidy rates are set in law and indexed for inflation annually. However, cash subsidies vary according to the family income of each child, and applications for free or reduced-price meals and snacks normally must be taken. The largest subsidies are paid for meals and snacks served to children with family income below 130 percent of the Federal poverty income guidelines: for July 1999–June 2000, these subsidies are 54 cents for each snack, $1.09 for each breakfast, and $1.98 for each lunch/supper. Smaller subsidies are available for meals and snacks served at a reduced price (no more than 15 cents for snacks, 30 cents for breakfasts, and 40 cents for lunches/suppers) to children with family income between 130 and 185 percent of the poverty guidelines: for July 1999–June 2000, these are 27 cents for snacks, 79 cents for breakfasts, and $1.58 for lunches/suppers. The smallest subsidies are paid for meals and snacks served to children who do not qualify or apply for free or reduced-price meals and snacks: for July 1999–June 2000, these are 5 cents for snacks, 21 cents for breakfasts, and 19 cents for lunches and suppers. "Independent" centers (those without sponsors handling administrative responsibilities) must pay for administrative costs associated with the CACFP out of non-Federal funds or a portion of their meal subsidy

[40] Children in participating homeless shelters represent a very minor fraction of those served under the CACFP; only about 100 shelter sites participate.

[41] FNS guidelines, however, allow proprietary centers to participate where Child Care and Development Block Grant and title XX funds are "pooled" in such a way as to meet the 25-percent requirement, thus requiring relatively minimal contributions under title XX itself if this arrangement is used. In two States (Iowa and Kentucky), a demonstration project allows proprietary centers to participate in the CACFP if children representing at least 25 percent of their enrollment or licensed capacity have family income below 185 percent of the Federal poverty income guidelines (i.e., would be eligible for free or reduced-price meals and snacks).

payments. In other cases, center sponsors may retain a proportion of the meal subsidy payments they receive on behalf of their centers to cover their costs. Finally, Federal commodity assistance is available to centers, generally valued at about 15 cents a meal.

In addition to the regular CACFP for centers described above, the 1998 child nutrition reauthorization law allows public and private nonprofit organizations (including schools and child care centers) operating outside-of-school programs to get Federal CACFP subsidies for snacks served free in their programs to children (through age 18) in low-income areas—at the free snack rate noted above.

FAMILY AND GROUP DAY CARE HOMES

CACFP-subsidized day care homes serve an average of 4–6 children; just under 40 percent of children in the CACFP are in day care homes, and about half the money spent under the CACFP supports meals and snacks served in homes. In fiscal year 1999, 175,000 home sites (with almost 1,200 sponsors) received subsidies for an average daily attendance of some 970,000 children. As with centers, payments are provided for no more than two meals and one snack (or one meal and two snacks) a day for each child. Unlike centers, day care homes must participate under the auspices of a public or (most often) private nonprofit sponsor that typically has 100 or more homes under its supervision; CACFP day care home sponsors receive monthly administrative payments (separate from meal subsidies) based on the number of homes for which they are responsible. Also unlike centers, day care homes receive cash subsidies (but not commodities) that generally do not differ by individual children's family income. Instead, there are two distinct subsidy rates. "Tier I" homes (those located in low-income areas or operated by low-income providers) receive higher subsidies for each meal/snack they serve: for July 1999–June 2000, all lunches and suppers are subsidized at $1.69 each, all breakfasts at 92 cents, and all snacks at 50 cents. "Tier II" homes (those not located in low-income areas or without low-income providers) receive smaller subsidies: for July 1999–June 2000, these are $1.02 for lunches/suppers, 34 cents for breakfasts, and 13 cents for snacks. However, tier II providers may seek the higher tier I subsidy rates for individual low-income children for whom financial information is collected and verified.

WORKFORCE INVESTMENT ACT

Title II of the Job Training Partnership Act of 1982 (JTPA) provided block grants to States to fund training and related services for economically disadvantaged youths and adults. Title II consisted of three programs: the II–A Adult Training Program, the II–B Summer Youth Employment and Training Program, and the II–C (year-round) Youth Training Program. Prior to the 1992 amendments to JTPA, which became effective July 1, 1993, title II–A provided services to both adults and youth.

In 1998, Congress passed the Workforce Investment Act (WIA, Public Law 105–220), which repealed and replaced JTPA on July 1, 2000. Program information in this edition of the *Green Book* is

taken from data available under JTPA. The 2002 edition will contain program data for WIA. A brief description of the major differences between WIA and JTPA concludes this section of the *Green Book*. Table 15–37 cross references the authorization for the JTPA Programs discussed in this section with their authorization under WIA.

TABLE 15–37.—CROSS REFERENCE OF PROGRAMS AUTHORIZED UNDER JTPA WITH THEIR AUTHORIZATION UNDER WIA

Job Training Partnership Act (JTPA)	Workforce Investment Act (WIA)
Adult Training Program—Title II–A	Adult Activities—Title I, Subtitle B, Chapter 5
Youth Training Program—Title II–C	Youth Activities—Title I, Subtitle B, Chapter 4
Summer Youth Employment and Training Programs—Title II–B.	no separate summer youth program; summer youth activities are included in Youth Activities above
Job Corps—Title IV–B	Job Corps—Title I, Subtitle C

As shown in table 15–38a, of title II–A participants who terminated during program year 1997, 45 percent were white, 34 percent were black, and 17 percent were Hispanic. Of participants who terminated benefits, 71 percent entered employment. The average hourly wage for adult terminees who entered employment was $7.94.

Among the 36 percent of title II–A terminees who were cash welfare recipients at the time of enrollment in program year 1997, 86 percent received Temporary Assistance for Needy Families (TANF) payments. Women comprised 86 percent of terminees receiving cash welfare payments, as compared with 58 percent of terminees who were not recipients. Among title II–A participants receiving cash welfare payments, 25 percent did not complete high school, compared with 19 percent of those participants who were not recipients. Sixty-eight percent of cash welfare recipients entered employment in program year 1997, compared with 73 percent for those II–A terminees who did not receive cash welfare payments. The average hourly starting wage for cash welfare recipients entering employment was $7.88, compared with $8.46 for nonrecipients.

As shown in table 15–38b, of the youth participants in year-round services who terminated during program year 1997, 38 percent were white, 33 percent were black, and 24 percent were Hispanic. Of the title II–C participants who terminated, 48 percent entered employment, and the average hourly wage for terminees who entered employment was $6.52.

Among the 26 percent of title II–C (youth) participants receiving cash welfare payments in program year 1997, 48 percent entered employment, compared with 48 percent of II–C participants who did not receive cash welfare payments. The average hourly starting wage for cash welfare recipients was $6.55, compared with $6.51 for nonrecipients. Among the 53 percent of II–C terminees who had

TABLE 15–38a.—CHARACTERISTICS OF JTPA TITLE II–A ADULT TERMINEES, PROGRAM YEARS 1992–97 [1] [2]

[In percent]

Selected characteristics	1992	1993	1994	1995	1996	1997
Sex:						
Male	41	36	33	33	31	32
Female	59	64	67	67	69	68
Ethnic status:						
White (excluding Hispanic)	52	53	52	48	46	45
Black (excluding Hispanic)	30	31	31	32	33	34
Hispanic	15	13	14	17	17	17
Other D4	3	3	4	5	5	
Age at enrollment:						
22–29	42	42	42	42	42	41
30–54	56	56	56	56	56	57
55 and older	3	2	2	2	2	2
Economically disadvantaged	NA	97	98	98	98	98
Receiving TANF/AFDC	28	32	35	35	33	31
Receiving cash welfare (including TANF/AFDC)	33	40	42	41	39	36
Unemployment compensation claimant	13	14	10	8	9	8
Education status:						
Less than high school graduate	25	24	23	22	22	21
High school graduate	51	55	56	56	56	57
Post high school	25	21	21	21	22	21
Average weeks participated	26	31	37	39	39	37
Entered employment	62	62	63	63	66	71
Average hourly wage at placement	$6.40	$6.86	$7.09	$7.25	$7.58	$7.94
Total terminees	257,561	180,178	175,647	162,120	151,155	147,717

[1] Prior to 1993, title II–A served both adults and youth. Data in this table is for adults only.

[2] Numbers (except total terminees, average weeks participated, and average hourly wage at placement) represent percentages.

Source: U.S. Department of Labor.

TABLE 15–38b.—CHARACTERISTICS OF JTPA YEAR-ROUND YOUTH PROGRAM TERMINEES, PROGRAM YEARS 1992–97 [1] [2]

[In percent]

Selected characteristics	1992	1993	1994	1995	1996	1997
Sex:						
Male	47	45	44	42	41	41
Female	53	55	56	58	59	59
Ethnic status:						
White (excluding Hispanic)	40	41	41	38	38	38
Black (excluding Hispanic)	36	35	35	34	33	33
Hispanic	21	20	20	24	25	24
Other	4	4	5	4	4	5
Age at enrollment:						
14–15	18	16	14	12	9	9
16–17	33	34	36	35	33	34
18–21	48	49	50	53	58	57
Economically disadvantaged	NA	95	95	95	96	96
Receiving TANF/AFDC	25	27	27	26	25	22
Receiving cash welfare (including TANF/AFDC)	27	35	31	30	29	26
Unemployment compensation claimant	1	1	1	1	1	1
Education status:						
Less than high school graduate	78	79	77	75	71	71
High school graduate	18	19	20	22	26	26
Post high school	4	3	3	3	3	3
Average weeks participated	29	35	36	40	39	37
Entered employment	34	34	37	38	45	48
Average hourly wage at placement	$5.19	$5.45	$5.61	$5.81	$6.17	$6.52
Total terminees	255,268	167,444	158,083	113,563	76,700	74,816

[1] Prior to 1993, youth were served under title II–A. Since that time, year-round services for youth are provided under title II–C.

[2] Numbers (except total terminees, average weeks participated, and average hourly wage at placement) represent percentages.

Source: U.S. Department of Labor.

either dropped out of school or were behind in grade level, the average entered employment rate in program year 1997 was 40 percent as compared with 57 percent for those not in this legislatively defined hard-to-serve category. The average hourly starting wage for youths who had dropped out of school or were behind in their

grade level was $6.13 compared with $6.83 for those not in this category.

In fiscal year 1999, an estimated $1.1 billion is expected to be spent for JTPA II–A and II–C grants, providing training and other services to over 513,000 participants. Data on participation and budget authority for recent years are provided in table 15–39 below.

For the Summer Youth Employment and Training Program (title II–B), $871 million was appropriated for the summer of 1998, with 495,100 participants served. For the summer of 1999, $871 million was appropriated to serve an estimated 495,000 individuals. Table 15–40 presents a funding and participation history of the summer program.

Job Corps, authorized by title IV–B of JTPA, serves economically disadvantaged youth, ages 16–24, who demonstrate both the need for, and the ability to benefit from, an intensive and wide range of services provided in a residential setting. The program is administered directly by the Federal Government through contractors and currently operates at 114 centers around the country. Services include basic education, vocational skill training, work experience, counseling, health care, and other supportive services.

In program year 1997 (July 1, 1997–June 30, 1998), nearly 66,000 new students enrolled in Job Corps Centers, 60 percent of whom were male. In that same year, 50 percent of new students were African-American, 28 percent were white, 16 percent were Hispanic, 4 percent were Native Americans, and 2 percent were Asian or Pacific Islanders. Seventy-eight percent of new students had dropped out of high school and 63 percent had never worked full time. Thirty-three percent of new students in program year 1997 came from families on public assistance.

The average length of stay in Job Corps in program year 1997 was 7.3 months. The Labor Department estimates that 70 percent of terminees entered employment after leaving the program, while another 10 percent either continued their education or entered another training program, for a total positive termination rate in 1997 of 80 percent.

Table 15–41 provides a funding and participation history of the Job Corps since 1982. The program was first authorized in the mid-60s by the Economic Opportunity Act and has been authorized under JTPA since 1982.

DESCRIPTION OF MAJOR DIFFERENCES BETWEEN WIA AND JTPA

One of the major differences between WIA and JTPA is that WIA creates a coordinated service delivery system called the one-stop system as the basic delivery system for providing services to adults. (One criticism of JTPA was that programs authorized by it were not coordinated with each other or with other training programs.) Under WIA, each local area in a State must have a one-stop delivery system to provide "core services," such as job search assistance, "intensive services," such as comprehensive assessments, and job training. The one-stop system is created by the local workforce investment board with the agreement of the chief elected official, e.g., the mayor. The workforce investment board is certified by the Governor and is responsible for setting local workforce investment pol-

TABLE 15–39.—JOB TRAINING PROGRAMS [1] FOR THE DISADVANTAGED: NEW ENROLLEES, FEDERAL APPROPRIATIONS AND OUTLAYS, FISCAL YEARS 1975–98

Fiscal year	New enrollees/ total participants [2]	Appropriations (millions)	Outlays (millions)	Budget authority in constant 1990 dollars	Outlays in constant 1990 dollars
1975	1,126,000	$1,580	$1,304	$3,755	$3,099
1976	1,250,000	1,580	1,697	3,515	3,775
1977	1,119,000	2,880	1,756	5,964	3,636
1978	965,000	1,880	2,378	3,658	4,627
1979	1,253,000	2,703	2,547	4,829	4,550
1980	1,208,000	3,205	3,236	5,154	5,203
1981	1,011,000	3,077	3,395	4,493	4,958
1982	NA	1,594	2,277	2,175	3,107
1983	NA	2,181	2,291	2,846	2,990
1984	716,200	1,886	1,333	2,361	1,669
1985	803,900	1,886	1,710	2,279	2,066
1986	1,003,900	1,783	1,911	2,101	2,252
1987	960,700	1,840	1,880	2,108	2,154
1988	873,600	1,810	1,902	1,991	2,092
1989	823,200	1,788	1,868	1,877	1,961
1990	630,000	1,745	1,803	1,745	1,803
1991	603,900	1,779	1,746	1,694	1,676
1992	602,300	1,774	1,767	1,637	1,632
1993	641,700	1,692	1,747	1,530	1,580
Adult	371,700	1,015	1,048	918	948
Youth	270,000	677	699	612	632
1994	635,300	1,597	1,693	1,415	1,500
Adult	370,400	988	1,016	875	900
Youth	264,900	609	677	540	600
1995	536,200	1,124	1,534	971	1,325
Adult	353,500	997	934	861	807
Youth	[3] 182,700	127	600	110	518
1996	480,600	977	1,023	825	865
Adult	338,600	850	866	718	732
Youth	142,000	127	157	107	133
1997	483,100	1,022	949	845	784
Adult	367,300	895	799	740	660
Youth	115,800	127	150	105	124
1998	452,400	1,085	1,162	886	949
Adult	333,600	955	900	780	735
Youth	118,800	130	262	106	214

[1] Figures shown in years 1975–83 are for training activities under the Comprehensive Employment and Training Act (CETA); public service employment under CETA is not included. Figures shown in years 1984–92 are for activities under title II–A of the Job Training Partnership Act (JTPA). For 1993–96 figures are for titles II–A (adult) and II–C (youth) of the JTPA, as amended in 1992.

[2] Figures for 1975–94 are new enrollees. Total participants are shown from 1995 forward.

[3] Reduced budget authority in fiscal year 1995 was insufficient to serve those already enrolled and to enroll a comparable number of new participants. In fiscal year 1996, transfers from II–B (summer youth) enabled more participants to be enrolled. This transfer authority continues to be used by States to serve more year-round youth.

NA—Not available.

Source: U.S. Department of Labor.

TABLE 15–40.—SUMMER YOUTH EMPLOYMENT AND TRAINING PROGRAM: FEDERAL APPROPRIATIONS, OUTLAYS, AND PARTICIPANTS, FISCAL YEARS 1984–98 [1]

[In millions of dollars]

	Appropriations [2]	Outlays		Participants [3]
		Current dollars	Constant 1990 dollars	
1984	$824	$584	$731	672,000
1985	724	776	938	767,600
1986	636	746	879	785,000
1987	750	723	828	634,400
1988	718	707	778	722,900
1989	709	697	732	607,900
1990	700	699	699	585,100
1991	683	698	663	555,200
1992	[3] 995	958	912	782,100
1993	[4] 1,025	915	827	647,400
1994	[5] 888	834	739	574,400
1995	[6] 185	883	763	495,300
1996	[7] 625	1,030	870	410,700
1997	[8] 871	913	754	492,900
1998	[9] 871	787	643	495,100

[1] Appropriations and outlays are for fiscal years; participants are for calendar years.

[2] Because JTPA is an advance-funded program, appropriations for the Summer Youth Employment and Training Program in a particular fiscal year are generally spent the following summer. For example, fiscal year 1991 appropriations were spent during the summer of calendar year 1992. The pattern has varied somewhat in recent years. These variations are noted.

[3] Fiscal year 1992 funding includes a $500 million supplemental appropriation for summer 1992 and $495 million for summer 1993.

[4] Fiscal year 1993 funding includes $354 million for summer 1993 and $671 million for summer 1994.

[5] Fiscal year 1994 funding includes $206 million for summer 1994 and $682 million for summer 1995.

[6] Public Law 104–19 rescinded $682 million in fiscal year 1995 funds which were to be available for the summer of 1996. The remaining $185 million was for the summer of 1995.

[7] Fiscal year 1996 funds are for the summer of 1996.

[8] Fiscal year 1997 funds are for the summer of 1997.

[9] Fiscal year 1998 funds are for the summer of 1998.

Source: Employment and Training Administration, U.S. Department of Labor.

icy. The board is similar to the private industry council under JTPA. Each local one-stop system must include at least one physical center, which may be supplemented by affiliated sites. The law mandates 19 "partners," which must provide "applicable" services through the one-stop system. Mandated partners include the Employment Service, welfare-to-work, Trade Adjustment Assistance, and NAFTA Transitional Adjustment Assistance. Partners must enter into written agreements with the local boards regarding services to be provided, the funding of the services and operating costs of the system, and methods of referring individuals among partners. A one-stop operator, which could be a single entity or a consortium of entities (e.g., a postsecondary education institution, an employment service agency, a private nonprofit organization, and a government agency) must be designated by the board through a competitive process or through an agreement between the board and a consortium of at least three partners.

TABLE 15–41.—JOB CORPS: FEDERAL APPROPRIATIONS, OUTLAYS, AND NEW ENROLLEES, FISCAL YEARS 1982–98 [1]

[In millions of dollars]

	Appropriations	Outlays		New enrollees
		Current dollars	Constant 1990 dollars	
1982	$590	$595	$812	53,581
1983	618	563	735	60,465
1984	599	581	727	57,386
1985	617	593	716	63,020
1986	612	594	701	64,964
1987	656	631	723	65,150
1988	716	688	757	68,068
1989	742	689	724	62,550
1990	803	740	740	61,453
1991	867	769	769	62,205
1992	919	834	789	61,762
1993	966	936	846	62,749
1994	1,040	981	869	58,460
1995	1,089	1,011	873	68,540
1996	1,094	994	840	67,774
1997	1,154	1,165	963	65,705
1998	1,246	1,197	977	67,425

[1] Appropriations and outlays are for fiscal years; enrollees are for program years.

Source: Employment and Training Administration, U.S. Department of Labor.

A second difference between WIA and JTPA is that there is no income eligibility requirement for adults in order to receive services. Any adult (defined under WIA as age 18 and older rather than as age 22 and older under JTPA) is eligible to receive job search assistance and other core services. To be eligible to receive comprehensive assessments and other intensive services, an individual has to be unemployed, and unable to obtain employment through core services or employed but in need of intensive services to obtain or retain employment that allows for self-sufficiency. To be eligible to receive job training, an individual has to have met the eligibility for intensive service and been unable to obtain employment through those services. A local area is required to give priority for receiving intensive services and training to recipients of public assistance and other low-income individuals if WIA funds allocated to the local area under the adult funding stream are limited.

A third difference is that under WIA, training for adults is to be provided primarily through "individual training accounts." The purpose of individual training accounts is to provide individuals the opportunity to choose training courses and providers. Typically, under JTPA, services were procured for groups of individuals. Under WIA, the one-stop operator is responsible for arranging payment to the training provider, who must be identified by the Governor as an eligible provider in accordance with statutory provisions. Local boards retain a list of eligible providers along with performance and cost information. Individuals who have individual

training accounts may choose providers from this list in consultation with a case manager.

A fourth difference is that under WIA, the Summer Youth Employment and Training Program is eliminated as a separately funded program. Local areas are required, however, to provide summer employment opportunities under youth activities, which continue to be for low-income youth.

Regarding Job Corps, WIA includes new provisions to help assure that youth are placed in centers closest to their homes; to strengthen linkages between centers and local communities; and to establish performance measures and expected performance levels.

HEAD START

Head Start began operating in 1965 under the general authority of the Economic Opportunity Act of 1964. Head Start provides a wide range of services to primarily low-income children, ages 0 to 5, and their families. Its goals are to improve the social competence, learning skills, and health and nutrition status of low-income children so that they can begin school on an equal basis with their more advantaged peers. The services provided include cognitive and language development; medical, dental, and mental health services (including screening and immunizations); and nutritional and social services. Parental involvement is extensive, through both volunteer participation and employment of parents as Head Start staff. Formal training and certification as child care workers is provided to some parents through the Child Development Associate Program.

Head Start's eligibility guidelines require that at least 90 percent of the children served come from families with incomes at or below the poverty line. At least 10 percent of the enrollment slots in each local program must be available for children with disabilities. In fiscal year 1999, 835,635 children were served in Head Start Programs, at a total Federal cost of $4.658 billion. In June 1999, 30 percent of Head Start children came from families receiving TANF benefits. Table 15–42 provides historical data on participation in and funding of the Head Start Program, while table 15–43 provides characteristics of children enrolled in the program.

LOW-INCOME HOME ENERGY ASSISTANCE PROGRAM (LIHEAP)

BACKGROUND

The Federal Government has been involved in providing energy assistance for the poor since 1973. But in 1980, in response to the 1973–74 Organization of Petroleum Exporting Countries (OPEC) oil embargo and the accompanying shortages and increased petroleum prices, Congress passed the Crude Oil Windfall Profit Tax Act (Public Law 96–223), title III of which was officially named the Home Energy Assistance Act of 1980. The 1980 program generally is considered the predecessor to the present Low-Income Home Energy Assistance Program.

TABLE 15–42.—HEAD START ENROLLMENT AND FEDERAL FUNDING, FISCAL YEARS 1965–99

Fiscal year	Enrollment	Appropriations (in millions of dollars)
1965 (summer only)	561,000	$96.4
1966	733,000	198.9
1967	681,400	349.2
1968	693,900	316.2
1969	663,600	333.9
1970	477,400	325.7
1971	397,500	360.0
1972	379,000	376.3
1973	379,000	400.7
1974	352,800	403.9
1975	349,000	403.9
1976	349,000	441.0
1977	333,000	475.0
1978	391,400	625.0
1979	387,500	680.0
1980	376,300	735.0
1981	387,300	818.7
1982	395,800	911.7
1983	414,950	912.0
1984	442,140	995.8
1985	452,080	1,075.0
1986	451,732	1,040.0
1987	446,523	1,130.5
1988	448,464	1,206.3
1989	450,970	1,235.0
1990	548,470	[1] 1,552.0
1991	583,471	1,951.8
1992	621,078	2,201.8
1993	713,903	2,776.3
1994	740,493	3,325.7
1995	750,696	3,534.1
1996	752,077	3,569.3
1997	793,809	3,980.5
1998	822,316	4,347.4
1999	835,365	4,658.2

[1] After sequestration.

Source: Head Start Bureau, U.S. Department of Health and Human Services.

TABLE 15–43.—CHARACTERISTICS OF CHILDREN ENROLLED IN HEAD START, SELECTED FISCAL YEARS 1980–99

[In percent]

Fiscal year	Disabled	Age of children enrolled				Enrollment by race				
		5 and older	4	3	Under 3	Native American	Hispanic	Black	White	Asian
1980	12	21	55	24	0	4	19	42	34	1
1982	12	17	55	26	2	4	20	42	33	1
1984	12	16	56	26	2	4	20	42	33	1
1986	12	15	58	25	2	4	21	40	32	3
1988	13	11	63	23	3	4	22	39	32	3
1990	14	8	64	25	3	4	22	38	33	3
1991	13	7	63	27	3	4	22	38	33	3
1992	13	7	63	27	3	4	23	37	33	3
1993	13	6	64	27	3	4	24	36	33	3
1994	13	7	62	28	3	4	24	36	33	3
1995	13	7	62	27	4	4	25	35	33	3
1996	13	6	62	29	4	4	25	36	32	3
1997	13	5	60	30	4	4	26	36	31	3
1998	13	6	59	31	4	3	26	36	32	3
1999	13	5	58	33	4	3	27	35	31	3

Source: Head Start Bureau, U.S. Department of Health and Human Services.

In 1981, title XXVI of the Omnibus Budget Reconciliation Act (OBRA, Public Law 97–35), the Low-Income Home Energy Assistance Act of 1981, authorized the Secretary of Health and Human Services to make LIHEAP allotments to States for fiscal years 1982–84. The act permitted States to provide three types of energy assistance. States can: (1) help eligible households pay their home heating or cooling bills; (2) use up to 15 percent of their LIHEAP allotment for low-cost weatherization; and (3) provide assistance to households during energy-related emergencies.

LIHEAP is a block grant program under which the Federal Government gives States, the District of Columbia, U.S. territories and Commonwealths (American Samoa, Commonwealth of Puerto Rico, Commonwealth of the Northern Mariana Islands, Guam, Palau, and the U.S. Virgin Islands), and Indian tribal organizations annual grants to operate multicomponent home energy assistance programs for needy households. Public Law 103–252, the Human Services Reauthorization Act of 1994, reauthorized LIHEAP through fiscal year 1999. In 1998, Public Law 105–285 reauthorized LIHEAP at "such sums as may be necessary" for fiscal years 2000 and 2001, and $2 billion annually for fiscal years 2002–4. In fiscal year 1981, more than $1.8 billion was appropriated for the program. Over the years, LIHEAP funding has reached a high of $2.1 billion in 1985 and a low of about $1.06 billion in 1996 (see bottom of table 15–44). As noted in the table's footnotes, the funding allotments include LIHEAP contingency funds released in a given fiscal year. In fiscal year 2000, $1.1 billion was appropriated for LIHEAP, with an additional $300 million for emergencies. Due

TABLE 15–44.—LOW-INCOME HOME ENERGY ASSISTANCE PROGRAM STATE ALLOTMENTS, SELECTED FISCAL YEARS 1985–99

[In thousands of dollars]

State	1985	1991	1992	1993	1994	1995 [1]	1996 [2]	1997 [3]	1998 [4]	1999 [5]
Alabama	$18,234	$15,856	$12,664	$11,344	$12,127	$11,063	$9,077	$9,937	$16,612	$9,225
Alaska	7,247	9,594	8,034	7,241	7,741	7,062	5,794	6,343	15,344	5,888
Arizona	8,150	6,200	6,125	5,486	5,865	5,350	4,390	4,806	4,049	4,461
Arkansas	13,973	11,069	9,663	8,656	9,253	8,442	6,926	7,582	12,334	7,039
California	97,894	68,764	67,940	60,855	65,056	59,352	48,693	53,308	44,917	49,489
Colorado	33,299	23,419	23,688	21,218	22,683	20,694	16,978	18,587	15,661	17,255
Connecticut	43,440	35,541	30,902	27,680	34,986	28,011	22,148	24,247	20,430	25,633
Delaware	5,931	5,471	4,102	3,674	4,214	3,583	2,940	3,218	2,712	3,682
District of Columbia	6,940	5,269	4,799	4,299	4,595	4,193	3,440	3,766	3,173	4,581
Florida	28,970	21,731	20,039	17,950	19,188	17,506	14,362	15,722	39,195	14,596
Georgia	22,910	17,439	15,844	14,191	15,171	13,841	11,355	12,431	23,142	11,541
Hawaii	2,243	1,531	1,596	1,429	1,528	1,394	1,144	1,252	1,055	1,162
Idaho	12,877	9,493	9,240	8,277	8,848	8,072	6,622	7,250	6,109	6,731
Illinois	123,679	85,711	85,533	76,614	93,921	90,445	61,302	76,588	56,548	78,262
Indiana	55,371	41,069	38,727	34,689	39,408	39,568	27,756	30,386	25,603	35,353
Iowa	38,581	28,719	27,466	24,584	34,335	28,584	19,671	24,576	18,145	23,491
Kansas	18,211	12,901	12,605	11,290	12,069	11,011	9,034	9,890	8,333	12,488
Kentucky	29,141	22,537	20,153	18,052	24,639	22,996	14,444	15,813	13,324	22,430
Louisiana	18,867	13,203	12,947	11,597	12,398	11,311	9,279	10,159	18,193	9,431
Maine	27,914	23,550	20,020	17,932	27,275	17,489	14,349	15,708	13,236	15,365
Maryland	34,214	29,361	23,662	21,194	29,288	20,671	16,959	18,566	15,643	20,812
Massachusetts	86,878	69,364	61,815	55,369	73,071	56,312	44,304	48,502	40,868	52,790
Michigan	113,951	86,099	81,206	72,738	126,605	81,746	58,201	63,717	53,687	63,103
Minnesota	82,239	62,063	58,504	52,404	93,421	56,152	41,931	52,386	38,679	45,696
Mississippi	15,683	12,391	10,858	9,725	10,397	9,485	7,782	8,519	11,547	7,909
Missouri	48,026	35,779	34,165	30,603	32,715	37,030	24,487	30,592	22,587	32,524
Montana	12,298	10,938	10,838	9,708	10,378	9,468	7,768	9,705	7,165	7,895
Nebraska	19,032	13,851	13,573	12,158	12,997	14,572	9,728	12,154	8,974	12,022
Nevada	4,151	3,214	2,877	2,577	2,754	2,513	2,062	2,257	1,902	2,095
New Hampshire	16,447	13,648	11,700	10,480	14,352	10,535	8,386	9,180	7,735	9,297

TABLE 15–44.—LOW-INCOME HOME ENERGY ASSISTANCE PROGRAM STATE ALLOTMENTS, SELECTED FISCAL YEARS 1985–99—Continued

[In thousands of dollars]

State	1985	1991	1992	1993	1994	1995 [1]	1996 [2]	1997 [3]	1998 [4]	1999 [5]
New Jersey	82,849	66,929	57,386	51,402	61,894	50,132	41,129	45,027	37,939	50,855
New Mexico	9,973	8,123	7,668	6,868	7,342	6,698	5,495	6,016	5,069	5,585
New York	263,291	214,983	187,373	167,835	240,880	175,232	134,293	147,019	123,877	164,971
North Carolina	40,378	35,612	27,924	25,013	26,739	24,394	20,014	21,910	28,253	47,176
North Dakota	14,612	12,503	11,773	10,546	19,376	10,868	8,438	13,302	7,784	8,576
Ohio	109,413	78,365	75,666	67,776	96,381	76,346	54,231	59,370	50,025	63,606
Oklahoma	16,004	12,250	11,641	10,427	11,147	10,169	8,343	9,134	14,606	8,480
Oregon	25,808	19,298	18,360	16,445	17,580	16,039	13,159	14,405	12,138	13,373
Pennsylvania	141,479	107,475	100,647	90,152	116,857	95,330	72,135	78,971	66,540	86,271
Rhode Island	14,220	11,572	10,175	9,114	11,471	9,341	7,293	7,984	6,727	9,133
South Carolina	14,544	12,451	10,058	9,009	9,631	8,787	7,209	7,892	13,753	7,326
South Dakota	11,434	10,691	9,562	8,565	11,150	9,319	6,853	10,802	6,322	6,965
Tennessee	29,520	21,652	20,415	18,286	19,548	17,834	14,632	16,018	21,842	14,871
Texas	48,206	36,455	33,337	29,861	31,922	29,123	23,893	26,158	73,089	24,284
Utah	14,827	11,062	11,008	9,860	10,541	9,617	7,890	8,637	7,278	8,018
Vermont	12,328	9,813	8,770	7,855	13,197	7,908	6,285	6,881	5,798	6,863
Virginia	41,677	36,051	28,822	25,817	28,277	25,179	20,657	22,615	19,055	28,635
Washington	40,896	31,495	30,199	27,050	28,917	26,382	21,644	23,695	19,965	21,997
West Virginia	19,285	13,676	13,337	11,946	16,503	11,651	9,559	10,465	8,817	12,607
Wisconsin	74,027	56,987	52,662	47,171	65,147	53,718	37,744	41,320	34,816	42,851
Wyoming	6,195	4,605	4,407	3,948	4,220	3,850	3,159	3,458	2,914	3,210
U.S. total	2,077,577	1,607,819	1,472,503	1,318,961	1,709,998	1,386,368	1,055,364	1,188,225	1,133,512	1,247,899

[1] Includes $100 million in LIHEAP emergency contingency funds. [2] Includes $180 million in LIHEAP emergency contingency funds. [3] Includes $215 million in LIHEAP emergency contingency funds. [4] Includes reallotment of $81,913 in fiscal year 1997 block grant funds and $160 million in emergency contingency funds. [5] Includes reallotment of $2,204,442 in fiscal year 1998 block grant funds and $175,298,765 in emergency contingency funds.

Note.—Columns may not add due to rounding. The table includes payments to Indian tribal organizations and excludes payments to the insular areas.

Source: U.S. Department of Health and Human Services.

to cold weather emergencies and an increase in the price of home heating oil, all $300 million in the LIHEAP contingency fund had been released by President Clinton by midway through the fiscal year.

PROGRAM COMPONENTS

Federal LIHEAP funds may be used by grantees for the following activities:

—Home heating and cooling assistance;
—Energy crisis intervention (with a reasonable amount reserved, based on prior years' data, until March 15 of each program year);
—Low-cost weatherization or other energy-related home repairs (not to exceed 15 percent of the funds allotted to or available to a grantee, although a grantee may request a waiver that increases the amount of LIHEAP funds for weatherization from 15 to 25 percent);
—Administrative and planning costs (not to exceed 10 percent of funds net of set-asides for Indian tribal grants);
—Carryover of funds to the next fiscal year (not to exceed 10 percent of funds net of set-asides for Indian tribal grants); and
—Development or implementation of a leveraging incentive program that may be used by States to attract funds from non-Federal sources.

ALLOTMENTS TO STATES

Several sources of Federal and non-Federal funds generally are available to LIHEAP grantees:

—Federal LIHEAP block grant allotments;
—LIHEAP emergency contingency allotment for weather emergencies (these funds can only be released at the President's directive);
—LIHEAP leveraging incentive awards;
—LIHEAP carryover (grantees can request that up to 10 percent of their Federal LIHEAP funds be held available for the next fiscal year);
—Oil overcharge funds (disbursed by the Department of Energy from settlements of cases of oil price overcharges pursuant to the Emergency Petroleum Act of 1973. States determine how to allocate these funds among several eligible activities, including LIHEAP); and
—State and other funds (States use their own funds to supplement LIHEAP benefits or administrative costs. Other funds include reimbursements to LIHEAP agencies for taking application for low-income weatherization programs or winter heating protection programs.).

Table 15–44 shows State allotments for selected fiscal years.

ELIGIBILITY AND TYPES OF ASSISTANCE

States have considerable discretion to determine eligibility criteria for LIHEAP and the types of energy assistance to be provided. At State option, LIHEAP payments can be made to households, based on categorical eligibility, where one or more persons are re-

ceiving Supplemental Security Income (SSI), Temporary Assistance for Needy Families (TANF), food stamps, or needs-tested veterans benefits. States can also elect to make payments to households with incomes of up to 150 percent of the Federal poverty income guidelines or 60 percent of the State's median income, whichever is greater.

Individuals who are denied benefits are entitled to an administrative hearing. The term "household" is defined as any individual or group of individuals who are living together as one economic unit and for whom residential energy is customarily purchased in common, or who make undesignated payments for energy in the form of rent. States cannot establish an income eligibility ceiling that is below 110 percent of the poverty level, but may give priority to those households with the highest energy costs in relation to household income, taking into consideration the presence of very young children, frail elderly, or persons with disabilities. States also are prohibited from treating categorically eligible and income eligible households differently with respect to LIHEAP. However, Public Law 103–185 permits States to reduce benefits to tenants of federally assisted housing if it is determined that such a reduction is reasonably related to any utility allowance they may receive. LIHEAP benefits cannot be used to calculate income or resources, or affect other benefits, under Federal or State law, including public assistance programs.

Section 607(a) of Public Law 98–558 directs the U.S. Department of Health and Human Services to collect annual data, including information on the number of LIHEAP households in which at least one household member is 60 years old or handicapped. In addition, Public Law 103–252 authorized the establishment of the Residential Energy Assistance Challenge Program, an incentive grant program designed to increase efficient energy use, minimize health and safety risks, and prevent hopelessness among low-income families with high energy burdens. Up to 25 percent of leveraging incentive moneys may be used to fund Residential Energy Assistance Challenge Programs.

States have considerable discretion in the methods they may use to provide assistance to eligible households, including cash payments, vendor payments, two-party checks, vouchers/coupons, and payments directly to landlords. When paying home energy suppliers directly, States are required to give assurances that suppliers will charge the eligible households the difference between the amount of the assistance and the actual cost of home energy. Also, States may use Federal funds to provide tax credits to energy suppliers that supply home energy to low-income households at reduced rates. Table 15–45 presents estimates by State for 1996 of total dollars spent on heating assistance, the number of households receiving benefits from the single largest program component (heating assistance), and average heating benefits.

TABLE 15–45.—LOW-INCOME HOME ENERGY ASSISTANCE PROGRAM ESTIMATED HEATING ASSISTANCE BENEFITS, NUMBER OF HOUSEHOLDS, AND ESTIMATED AVERAGE BENEFITS, FISCAL YEAR 1996

State	Estimated heating assistance benefits	Number of households assisted	Estimated average benefits
Alabama	$5,621,197	39,706	$142
Alaska	3,651,347	11,501	313
Arizona	3,074,995	21,083	146
Arkansas	3,035,652	36,353	82
California	35,666,584	156,168	61
Colorado	14,409,351	44,361	325
Connecticut	22,051,236	66,111	334
Delaware	2,270,577	11,594	185
District of Columbia	2,356,837	11,551	178
Florida	7,285,632	66,117	83
Georgia	8,670,527	70,577	123
Hawaii	853,616	5,087	165
Idaho	3,389,067	15,302	252
Illinois	46,182,974	178,895	250
Indiana	17,196,420	94,582	182
Iowa	14,425,722	70,248	205
Kansas	6,076,885	23,732	208
Kentucky	5,909,767	88,811	87
Louisiana	2,957,469	251	156
Maine	9,996,455	38,670	220
Maryland	16,278,609	79,615	187
Massachusetts	41,083,489	125,205	325
Michigan	30,226,450	276,731	109
Minnesota	30,569,495	87,080	345
Mississippi	4,209,335	30,019	121
Missouri	19,221,339	105,010	183
Montana	4,327,949	18,558	235
Nebraska	4,286,609	25,990	167
Nevada	1,414,462	8,752	162
New Hampshire	6,109,284	18,664	341
New Jersey	30,975,527	141,931	229
New Mexico	3,717,176	68,467	54
New York	80,268,491	600,834	135
North Carolina	10,457,970	187,016	43
North Dakota	4,728,402	13,573	343
Ohio	22,685,929	237,614	96
Oklahoma	5,660,502	72,396	78
Oregon	9,004,376	43,659	187
Pennsylvania	44,064,583	239,378	166
Rhode Island	4,969,966	17,834	278
South Carolina	4,685,600	51,735	89
South Dakota	4,221,823	13,608	310
Tennessee	9,394,892	64,444	145
Texas	5,084,520	30,809	165
Utah	5,013,975	25,313	198
Vermont	4,173,735	21,393	196
Virginia	17,529,360	106,960	164

TABLE 15–45.—LOW-INCOME HOME ENERGY ASSISTANCE PROGRAM ESTIMATED HEATING ASSISTANCE BENEFITS, NUMBER OF HOUSEHOLDS, AND ESTIMATED AVERAGE BENEFITS, FISCAL YEAR 1996—Continued

State	Estimated heating assistance benefits	Number of households assisted	Estimated average benefits
Washington	15,900,645	48,823	325
West Virginia	5,278,394	45,508	116
Wisconsin	33,895,611	109,876	273
Wyoming	2,280,336	6,657	321
Total	[1] $696,801,144	3,974,152	[2] $175

[1] Includes leveraging incentive funds.

[2] Computed based on dividing the total estimates of obligated heating assistance funds by total number of households receiving heating assistance.

Source: Administration for Children and Families, U.S. Department of Health and Human Services.

Planning and Administration

LIHEAP is administered within the U.S. Department of Health and Human Services (DHHS) by the Administration for Children and Families. Grantees are required to submit an application for funds to the Secretary of DHHS. As part of the annual application, the chief executive officer of the State (Indian tribe, or territory), or her designee, is required to make several assurances related to eligibility requirements, anticipated use of funds, as well as to satisfy planning and administrative requirements. States are prohibited from using more than 10 percent of their total LIHEAP allotment for planning and administrative costs.

States must provide for public participation and public hearings in the development of the State plan, including making it, and any substantial revisions, available for public inspection and allowing public comment on the plan. Public Law 98–558 requires States to engage an independent person or organization to prepare an audit at least once every 2 years. However, the Single Audit Act of 1984 (Public Law 98–502) supersedes this requirement in most instances, and requires grantees to conduct an annual audit of all Federal financial assistance received.

VETERANS BENEFITS AND SERVICES

The Department of Veterans Affairs (VA) offers a wide range of benefits and services to eligible veterans, members of their families, and survivors of deceased veterans. VA programs include veterans compensation and pensions, readjustment benefits, medical care, and housing and loan guaranty programs. The VA also provides life insurance, burial benefits, and special counseling and outreach programs. In fiscal year 1999, Federal appropriations for veterans benefits and services were over $44 billion (table 15–46).

TABLE 15–46.—BUDGET AUTHORITY FOR VETERANS BENEFITS AND SERVICES, DEPARTMENT OF VETERANS AFFAIRS, FISCAL YEARS 1980–99

[In thousands of dollars]

Fiscal year	Service-connected compensation and survivor payments; means-tested pensions	Education, training, readjustment	Medical care	Housing loans [1]	Other benefits and services	Total: veterans benefits and services
1980	$11,770	$2,374	$6,409	NA	$641	$21,194
1981	13,210	2,351	6,919	NA	671	23,150
1982	14,510	1,964	7,802	NA	687	24,963
1983	14,216	1,667	8,816	−$78	721	25,341
1984	14,884	1,582	9,078	201	751	26,496
1985	15,089	1,066	10,005	306	789	27,256
1986	15,363	605	9,964	200	757	26,888
1987	15,392	393	10,481	100	824	27,190
1988	15,848	395	10,836	1,484	817	29,380
1989	16,384	335	11,523	778	871	29,891
1990	16,660	251	12,168	548	897	30,524
1991	17,790	824	13,194	730	1,013	33,251
1992	17,412	600	14,256	815	1,020	34,103
1993	18,123	675	15,235	1,181	993	36,208
1994	18,597	1,031	16,187	188	1,006	37,009
1995	18,824	1,090	16,555	612	1,078	38,159
1996	19,703	1,013	16,812	612	1,023	38,763
1997	20,660	1,178	17,375	−291	1,014	39,936
1998	21,517	1,168	17,959	1,145	1,003	42,792
1999	22,934	989	18,032	1,087	1,115	44,157

[1] Housing loans are net income and expenditures from VA housing program revolving funds. Figures for the VA housing funds are unavailable in this format before fiscal year 1983.

NA—Not available.

Source: Office of the President (2000).

Service-connected compensation is paid to veterans who have disabilities from injuries and illnesses traceable to a period of active-duty military service. The amounts of monthly payments are determined by disability ratings that are based on presumed average reductions in earning capacities caused by the disabilities. Disability ratings generally range from 10 percent to 100 percent in 10-percent intervals; however, some disabilities are determined to be service-connected, but are given a zero-percent rating. Death compensation, or dependency and indemnity compensation, is paid to surviving dependents of veterans who died as a result of service-connected causes. In fiscal year 1999, about 2.3 million disabled veterans and 324,000 survivors received about $18 billion in compensation payments.

Veterans pensions are means-tested cash benefits paid to war veterans who have become permanently and totally disabled from non-service-connected causes, and to survivors of such disabled and

impoverished war veterans. Under the current or "improved law" program, benefits are based on family size, and the pensions provide a floor of income. For 2000, the basic benefit before subtracting other income sources is $11,773 for a veteran with one dependent, $8,989 for a veteran living alone). Somewhat less generous benefits are available to survivors; a surviving spouse with no children could receive two-thirds ($6,026) of the basic benefit amount given a single veteran. About 604,000 persons received about $3.1 billion in veterans pension payments in fiscal year 1999.

Several VA programs support readjustment, education, and job training for veterans and military personnel who meet certain eligibility criteria. The largest of these programs was the Montgomery GI bill (MGIB). The MGIB provides educational assistance to persons, who as members of the Armed Forces or the Selected Reserve, elect to participate in the program after June 30, 1985. The purposes of the MGIB are to assist service members leaving the Armed Forces in their readjustment into civilian life, to provide an incentive for the recruitment and retention of qualified personnel in the Armed Forces, and to develop a more educated and productive work force. To participate in the MGIB, active duty military personnel contribute $100 per month, for the first 12 months of enlistment. Benefit levels are contingent upon length of service. To receive the maximum benefit of $536 per month for 36 months, service members must generally serve continuously for 3 years.

The VA also provides vocational rehabilitation to disabled veterans. In fiscal year 1999, spending for VA readjustment programs was nearly $1 billion (table 15–46). In addition, the Department of Labor also provides employment counseling and job training for veterans.

The VA provides a comprehensive array of inpatient and outpatient medical services through 172 medical centers, 134 nursing homes, 40 domiciliaries, 527 ambulatory clinics, and 206 readjustment counseling centers (Vet centers). Public Law 104–262 reformed eligibility rules for VA medical services. These reforms not only simplified the rules, but give the VA greater flexibility in how it provides medical care to veterans. Past eligibility rules were seen as emphasizing inpatient over outpatient care and, thus, impeded the efficient use of VA medical resources. Under the new eligibility rules, the VA provides free medical care, both inpatient and outpatient, to veterans for service-connected conditions and to low-income veterans for nonservice-connected conditions. For 2000, veterans with an income of $27,468 or less, and married or with one dependent; plus $1,532 for each additional dependent; or $22,887 or less if single; would meet the low-income criterion for free medical care. As facilities and other resources permit, the VA provides care to veterans for nonservice-connected conditions with incomes that exceed these limits; however, copayments are required. Again, as facilities and other resources permit, the VA provides nursing home care to veterans, with priority going to those with service-connected disabilities. The VA also contracts with private facilities and/or medical providers when it is determined to be in the interests of the veteran and cost effective for the VA. VA-operated nursing home care is augmented by VA-supported care through con-

tracts with private community nursing homes and with per diem payments for veterans in State-run homes for veterans.

In fiscal year 1999, VA medical treatment programs cost $18 billion (table 15–46). VA medical services were provided to about 3.6 million separate applicants, resulting in about 752,000 inpatient episodes and 38 million outpatient visits (table 15–47).

TABLE 15–47.—NUMBER OF RECIPIENTS OF VETERANS BENEFITS AND SERVICES, SELECTED FISCAL YEARS 1975–99

[In thousands]

Fiscal year	Compensation and pensions	Readjustment, education, job training	Medical care		Housing loans
			Inpatient [1]	Outpatient [2]	
1975	4,855	2,692	1,220	14,630	290
1980	4,646	1,233	1,359	17,930	297
1981	4,535	1,081	1,360	17,809	188
1982	4,407	906	1,358	18,510	103
1983	4,286	755	1,401	18,616	245
1984	4,123	629	1,412	19,601	252
1985	4,005	492	1,435	20,188	179
1986	3,900	419	1,462	21,635	314
1987	3,850	365	1,466	21,635	479
1988	3,762	352	1,224	23,233	235
1989	3,686	349	1,153	22,629	190
1990	3,614	360	1,113	22,600	196
1991	3,546	322	1,072	23,007	181
1992	3,462	388	988	23,902	266
1993	3,397	438	974	24,236	383
1994	3,351	472	963	25,443	602
1995	3,332	476	930	27,565	263
1996	3,315	475	850	30,055	292
1997	3,290	480	700	32,648	239
1998	3,270	479	632	35,777	369
1999	3,254	458	752	37,799	396

[1] Patients treated: the sum of discharges and deaths during the period plus patients remaining as bed occupants or absent bed occupants at the end of the report period.

[2] Visits for outpatient care.

Source: Department of Veterans Affairs.

WORKERS' COMPENSATION

OVERVIEW THROUGH 1996 [42]

Workers' compensation laws provide for cash and medical benefits to persons with job-related disabilities and survivors' benefits to dependents of those whose death resulted from a work-related accident or illness. In 1996, workers' compensation laws protected approximately 115 million workers in 51 jurisdictions, including the District of Columbia. Although the laws vary from State to State, and among the Federal programs, the underlying principle is that employers should assume the costs of occupational disabil-

[42] Largely drawn from Mont et al. (1999).

ities without regard to fault. Prior to the enactment of workers' compensation laws (the first of which was enacted in 1908), a worker was only protected in cases in which employer negligence could be proven as the cause of injury or death. By 1949, all States and the Federal Government had enacted laws to cover workers and their dependents in any case of occupational disability or death.

Most workers' compensation benefits are paid by insurance companies through policies purchased by private employers that are keyed to the benefits required by the State or Federal workers' compensation law covering the employer. In addition, benefits may be paid by special State or Federal insurance funds, by employers themselves acting as self-insurers, and by the Federal Government (for Federal employees and some black lung beneficiaries). State laws generally are administered by entities such as industrial commissions or special units within State labor departments. Federal laws are administered by the U.S. Department of Labor, although the Social Security Administration has responsibility for paying some black lung claims.

Federal involvement in the workers' compensation system is minimal. Federal laws cover work-related disability and death benefits for Federal employees, certain maritime and railroad employees, and benefits for black-lung-related disability or death.[43] In general, Federal funding extends only to benefits for Federal employees and some black lung beneficiaries and administrative costs at the Labor Department and Social Security Administration.[44] There are no Federal standards for or controls over the State laws that cover most of the work force, although they are structured similarly, and a 1972 Federal commission issued a still-current set of recommended goals for State laws. Workers' compensation benefits are not taxed at any level of government; if taxed as income by the Federal Government, the Joint Committee on Taxation estimates revenues would be about $4 billion (for tax year 1995).

Cash compensation for lost earnings made up 61 percent of total workers' compensation benefits in 1996. Some 70 percent of cash payments are for permanent partial disabilities of either major or minor severity. These payments cover loss (or loss of use) of body parts and partial, but permanent, loss of earning capacity due to work-related injuries. About 5–8 percent of cash benefits are awarded to survivors because of work-related deaths. The remainder is paid for temporary disabilities in which an employee is un-

[43] The Federal Employees' Compensation Account covers Federal employees and certain others (e.g., some law enforcement officers and volunteers, postal service employees). The Longshore and Harbor Workers' Compensation Act (LHWCA) and the Jones Act cover certain workers in maritime endeavors (including, for example, workers on the outer continental shelf). The Federal Employers' Liability Act covers interstate railroad employees. The Black Lung Benefits Act provides for benefits to coal mine employees and survivors for disability or death related to black lung disease.

[44] Under the Federal Employees' Compensation Account, the Federal Government pays all administrative and benefit costs from annual appropriations to the employing agencies and the Labor Department. Under the LHWCA, private employers are responsible for virtually all benefits; the Federal Government pays for a very small and declining payment to pre-72 claimants and, standing in the place of a State, the administrative costs of the system. Under the Jones Act and the Federal Employers' Liability Act, there are few Federal costs, limited to some Federal court costs and potential effects on the Federal appropriation for Amtrak. Under the Black Lung Benefits Act, Federal appropriations pay for benefits and administrative costs for claims filed before 1974 (through the Social Security Administration) and Department of Labor administrative expenses (for claims filed later). Black lung benefits for claims filed after 1973 are paid directly by responsible coal mine operators or the Black Lung Disability Trust Fund (which is financed through an excise tax on coal and borrowing from the Federal Treasury).

able to work, or must work at a reduced level, but is expected to recover fully.

Permanently disabled workers receiving workers' compensation also may be eligible for benefits under the Social Security Disability Insurance (DI) Program if they meet generally more stringent DI tests. However, the Social Security Act stipulates that total benefits under workers' compensation and DI cannot exceed 80 percent of a worker's former earnings (or, if higher, 80 percent of the total family Social Security benefit). If there is an excess, the Social Security benefit is reduced by the amount of the excess, or, in 13 States, the workers' compensation benefit is reduced.

Workers' compensation laws require that all injury-related medical and hospital care be paid for. As a result, medical expenses made up 39 percent of total workers' compensation benefits in 1996. Medical benefits are typically paid on an "as-charged" basis; the majority of States and the Federal Government allow relatively unfettered employee choice of physician/care provider. However, the medical benefit component of workers' compensation has grown substantially in recent years, and a growing number of States (now over half) have instituted at least some form of "managed care" or "fee schedules" to control these costs.

Workers' compensation laws make coverage compulsory for most private employers, except in Texas and Wyoming.[45] If employers reject coverage in these States, they lose the use of common-law negligence defenses if sued. However, many State laws exempt from coverage employees of nonprofit, charitable, or religious institutions, as well as very small employers, domestic and agricultural employment, and casual labor. Coverage of State and local government employees differs widely from State to State.

In 1996, 114.6 million employees were covered by State or Federal workers' compensation laws, which represented 90 percent of employed persons, and was up from 88 percent in 1991 (National Academy, 1999).

The total of workers' compensation benefit costs (including those for black lung recipients) is driven by the level of benefits provided under workers' compensation laws, the cost of medical benefits, and injury rates, as well as "administrative" factors such as the degree of litigation involved. Of the 1996 total of $42.4 billion of benefits, some $25.8 billion, or 61 percent, was in the form of cash compensation for lost wages, and the rest was in the form of medical treatment and rehabilitation (table 15–48).

Cash compensation levels are established by formulas set in State and Federal workers' compensation laws and are typically a percentage of weekly earnings at the time of injury or death. Most laws provide benefits equal to two-thirds of gross (pretax) lost earnings (or earning capacity); but several States calculate benefits as a percentage of lost "spendable" (aftertax) earnings, usually replacing 75 or 80 percent. Workers' compensation laws also set maximum weekly benefit amounts. While maximum benefits are most often set at between two-thirds and 100 percent of the State's average weekly wage, they vary widely. For example, as of January 1996, maximum weekly compensation for permanent total disabil-

[45] Coverage in Wyoming is mandatory for extra-hazardous occupations.

ity ranged from $1,402 for Federal employees ($872 for those covered by the Federal LHWCA) to $947 for Iowa (the highest State figure) and $293 for Mississippi (the lowest State figure).

The Bureau of Labor Statistics reported a 1999 workplace injury and illness incidence rate of 7.1 cases per 100 full-time equivalent private industry workers. The incidence rate for lost workday cases was 2.1. These were down almost 20 to 40 percent, respectively, since 1990. According to the Survey of Occupational Injuries and Illnesses, the total number of private sector workplace injuries/illnesses in 1997 was 6.1 million, of which 1.8 million resulted in days away from work. In addition, the Bureau of Labor Statistics Census of Fatal Occupational Injuries reported 6,026 fatalities resulting from on-the-job injuries in 1998, down 3 percent from 1997 (Bureau of Labor, 1999).

Generally, employers insure against their workers' compensation liability through commercial insurance companies. However, they also may self-insure by providing proof of financial ability to carry their own risk (normally, large employers), purchase their insurance through a State "fund" (essentially, a State-run insurance company), or buy insurance commercially through a State-established "high-risk" insurance pool. In two States (North Dakota and Wyoming), employers must purchase insurance from their State fund, and, in four other States (Nevada, Ohio, Washington, West Virginia), they must either self-insure or buy insurance from the State fund. And nearly half of the remaining States have fully "competitive" State funds that allow employers to buy private insurance, self insure, or buy from a State fund.

In 1996, 48 percent ($20.5 billion) of the total of $42.4 billion in workers' compensation benefits (including all cash and medical costs under Federal and State laws) was paid by private insurers; 26 percent ($10.9 billion) was provided through self-insurance; 19 percent ($7.9 billion) came from State funds; and 7 percent ($3.1 billion) was paid under Federal programs.[46]

Total workers' compensation costs to employers in a given year are greater than annual benefits paid out because of the built-in cost of long-term benefits. In 1996, employer costs totaled $55.2 billion. These costs included benefits paid, administration of insurance operations, insurer profits and taxes, and reserves for future benefit payments. Benefits to workers represent about 77 cents of each dollar of employers' costs. Where insurance is purchased, the premium paid by employers varies with the risk involved in the covered employment and the industrial classification of the employer's particular industry, although it may be modified by "experience rating" for some moderate to large employers and other factors judged relevant by the insurer.

By type of insurer, the total 1996 cost to employers was: 55 percent paid to private insurers, 18 percent paid to State funds, 22 percent financed by self-insured employers, and 5 percent from the Federal Government for Federal employees and black lung beneficiaries.

[46] Federal program disbursements were for black lung benefits and payments for Federal employees. Some of the payments financed through private insurers, self-insurance, and State funds were mandated by Federal laws covering private-sector employers (e.g., the LHWCA).

In 1996, average employer costs per covered employee were $483; as a proportion of employers' payrolls, this represented $1.67 per $100 of payroll. Although substantial increases in employers' workers' compensation costs were recorded in the 1980s, these costs actually decreased in real terms in the early 1990s, dropping from a high of $2.16 per $100 of payroll in 1991.

Table 15–48 illustrates benefit payments under workers' compensation laws by type of benefit for the period 1987–96. In 1996, total benefits paid equaled $42.4 billion, of which $41.2 billion was paid out under regular State and Federal workers' compensation laws and nearly $1.2 billion was provided through the Federal Black Lung Benefit Programs.

TABLE 15–48.—ESTIMATED WORKERS' COMPENSATION BENEFIT PAYMENT AMOUNTS BY TYPE OF BENEFIT, SELECTED YEARS 1987–96

[In millions of dollars]

Type of benefit	1987	1990	1993	1996
Regular program:				
Medical and hospitalization	$9,794	$15,067	$17,409	$16,514
Compensation	15,979	21,737	24,160	24,694
Disability	15,046	20,635	22,930	NA
Survivor	933	1,102	1,229	NA
Total	25,773	36,804	41,569	41,208
Black Lung Program:				
Medical and hospitalization	118	120	112	95
Compensation	1,426	1,314	1,243	1,059
Disability	698	577	520	NA
Survivor	729	737	723	NA
Total	1,545	1,434	1,355	1,154
Regular and Black Lung:				
Medical and hospitalization	9,912	15,187	17,521	16,609
Compensation	17,406	23,051	25,403	25,753
Disability	15,775	21,212	23,450	NA
Survivor	1,631	1,839	1,952	NA
Total	27,318	38,238	42,925	42,362

NA—Not available.

Source: Mont (1999); Nelson (1991, 1993); Schmulowitz (1995).

Recent Developments in Statistical Compilation

The historical data series providing national information on the costs, benefits, and coverage of the workers' compensation system (used in the above overview through 1993) was discontinued by the

Social Security Administration (SSA) after publication of data for 1993. However, while not directly comparable to the historical SSA series, estimates from other sources, including the now-retired author of the SSA series (Jack Schmulowitz) and John F. Burton (editor of John Burton's Workers' Compensation Monitor) are available to portray recent cost trends.[47]

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[47] Further updated information is also available from the National Academy of Social Insurance and in Burton et al. (1997) and National Foundation (1997).

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