SECTION 16. 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 sev-

* The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 changed several of these programs; see appendix L for details.

eral such programs: food stamps; Medicaid; housing assistance; school lunch and breakfast programs; the Special Supplemental Food Program for Women, Infants, and Children (WIC); the Job Training Partnership Act; Head Start; the Low-Income Home Energy Assistance Program (LIHEAP); Veterans' benefits and services; and workers' compensation.

Most families receiving Aid to Families with Dependent Children (AFDC) or Supplemental Security Income (SSI) would have incomes low enough to qualify them—or particular members of their families—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 AFDC 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 AFDC.

Tables 16–1 and 16–2 describe the overlap in recipients between programs within the jurisdiction of the Committee on Ways and Means and other major Federal assistance programs. Table 16–1 illustrates that 87.2 percent of AFDC recipient households received food stamps during the first quarter of 1995; 24.7 percent received WIC; 97.2 percent received Medicaid; 63.1 percent received free or reduced-price school meals; and 31.1 percent received housing assistance.

TABLE 16–1.—PERCENT OF RECIPIENTS IN PROGRAMS WITHIN THE JURISDICTION OF THE COMMITTEE ON WAYS AND MEANS RECEIVING ASSISTANCE FROM OTHER MAJOR FEDERAL ASSISTANCE PROGRAMS, 1995

Other assistance program	Ways and Means assistance program				
	AFDC	SSI	Social Security	Unemployment compensation	Medicare
Food stamps	87.2	50.0	7.7	9.1	7.4
WIC	24.7	5.6	1.0	4.4	0.6
Medicaid	97.2	100.0	14.0	16.2	14.3
Free or reduced-price school meals	63.1	25.2	4.0	16.5	2.6
Public or subsidized rental housing	31.1	24.1	6.8	4.1	7.2
VA compensation or pensions	0.8	3.6	5.3	1.7	5.6
Number of households receiving benefits (in thousands)	4,652	4,580	27,654	2,246	25,271

Note.—Table shows number of households in the first quarter of 1995. Table reads that 87.2 percent of AFDC 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. Bureau of the Census.

Table 16–2 presents the percentage of recipients of other means-tested programs who are participating in programs under Ways and Means jurisdiction. For example, 48.9 percent of food stamp households received AFDC benefits at some time during the first quarter of 1995; 27.6 percent received SSI; 25.6 percent received Social Security; 2.5 percent received unemployment benefits; and 22.5 percent received Medicare.

TABLE 16–2.—PERCENT OF RECIPIENTS IN OTHER MAJOR FEDERAL ASSISTANCE PROGRAMS RECEIVING ASSISTANCE UNDER PROGRAMS WITHIN THE JURISDICTION OF THE COMMITTEE ON WAYS AND MEANS, 1995

Ways and Means assistance program	Other assistance program					
	Food stamps	WIC	Free or reduced school meals	Public or subsidized rental housing	Medicaid	VA compensation or pensions
AFDC	48.9	41.7	30.3	28.7	35.6	1.6
SSI	27.6	9.3	11.9	22.0	36.1	6.7
Social Security	25.6	9.9	11.4	37.6	30.6	59.3
Unemployment compensation	2.5	3.6	3.8	1.8	2.9	1.6
Medicare	22.5	5.8	6.8	36.2	28.4	57.7
Number of households receiving benefits (in thousands)	8,298	2,757	9,681	5,031	12,685	2,465

Note.—Table shows households in the first quarter of 1995. Table reads that 48.9 percent of food stamp recipient households receive AFDC. 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. Bureau of the Census.

Table 16–3 shows the percentage of households receiving AFDC or SSI and also receiving assistance from other programs for selected time periods. The figures at the bottom of the AFDC and SSI portions of the table show that the number of households receiving AFDC increased rapidly between 1990 and 1994 and then declined somewhat in 1995. The AFDC rolls increased by nearly one-third 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 1995. The rolls increased by more than 50 percent over this period.

The percentage of AFDC and SSI households receiving other benefits fluctuated somewhat over the period, but the general trend was toward increased coverage for all benefits except VA compensation or pensions. The percentage of AFDC households receiving food stamps, for example, increased from 81 percent in 1984 to 87 percent in 1995; receipt of Medicaid over the same period increased from 93 to 97 percent of households. Similarly, the percentage of SSI households receiving food stamps increased from 46 to 50 percent while Medicaid coverage held at or very near 100 percent over the period. The percentage of AFDC and SSI households receiving WIC, school meals, and housing also increased over the period 1984–95.

TABLE 16–3.—PERCENT OF HOUSEHOLDS RECEIVING AFDC OR SSI AND ALSO RECEIVING ASSISTANCE FROM OTHER PROGRAMS FOR SELECTED TIME PERIODS

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

Note.—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. Bureau of the Census.

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 be able 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 level, is derived from the U.S. Department of Agriculture's lowest cost food plan (the Thrifty Food Plan), 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 nearly all households that meet Federal eligibility tests for limited monthly income and liquid assets, as long as certain household members fulfill work registration and, when imposed, employment and training program requirements. In addition, recipients in the two primary Federal/State cash welfare programs, the AFDC and SSI Programs, generally are automatically eligible for food stamps, as are recipients of State general assistance payments, if the household is composed entirely of AFDC, SSI, or general assistance 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 virtually all of the rules that govern the program and, with limited variations for Alaska, Hawaii, and the territories, these rules are nationally uniform. States, the District of Columbia, and the territories may choose to offer the program or not. However, if they do offer food stamp assistance, it must be made available throughout the jurisdiction and comply with Federal rules. Sales taxes on food stamp purchases may not be charged, and food stamp benefits do not 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).

Federal administrative responsibilities

At the Federal level, the program is administered by the Agriculture Department's Food and Consumer Service (FCS). The FCS

[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 percent of their total cash monthly income on food.

[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.

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 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 stamps are redeemed for cash, and which has some jurisdiction over "electronic benefit transfer" 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 Department'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 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). Most often, the Food Stamp Program is operated through the same welfare agency and staff that runs the Federal/State AFDC and Medicaid Programs.

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; (3) benefits are paid in cash (checks) rather than food stamp coupons; (4) income and liquid assets eligibility limits are about half those used in the regular Food Stamp Program; (5) maximum benefit levels are about one-quarter less than in the 48 contiguous States and the District of Columbia; and (6) different rules

[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 year 1995, $1.143 billion was earmarked. The block grant funds the full cost of benefits and half the cost of administration.

are used in counting income for eligibility and benefit purposes. In fiscal year 1995, Puerto Rico's nutrition assistance program aided approximately 1.37 million persons each month with monthly benefits averaging $66 a person.

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; (2) a portion of each household's food stamp benefit must be used to purchase locally produced food; (3) maximum allotments are about 20 percent higher than in the 48 contiguous States and the District of Columbia; and (4) income eligibility limits are about half those in the regular program. In fiscal year 1995, the Northern Marianas' program assisted some 4,200 people each month with monthly benefits averaging $77 a person.

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. In fiscal year 1995 (the first full fiscal year of operations), the program aided about 2,700 persons a month with average monthly benefits of about $100 a person.

Program options

The Food Stamp Act authorizes demonstration projects to test program variations that might improve operations, so long as benefits are not reduced and the projects are cost neutral. At present, five types of demonstration projects are underway: (1) a limited number of projects that "cash out" food stamp benefits (these projects cash out food stamps for the elderly and SSI recipients, very poor households that are eligible for expedited service, and households that are part of State welfare reform efforts); (2) some 20 welfare reform demonstrations in which food stamp rules are changed to support AFDC reform efforts (e.g., food stamps are used as a wage supplement or cashed out; food stamps are consolidated with AFDC benefits; food stamp income and asset rules are changed to encourage employment); (3) demonstrations conforming the operations of the AFDC JOBS Program and the Food Stamp Program's employment and training activities; (4) a project granting quarterly (instead of monthly) benefit payments to SSI recipients eligible for very small benefits; and (5) awards to nonprofit organizations to test ways to improve program responsiveness to specific low-income groups.

In addition to demonstration projects, States are allowed to implement a few optional aspects of the Food Stamp Program. States may require "monthly reporting" and "retrospective budgeting" for parts of their food stamp caseload. They may disregard the first $50 a month in child support payments if they pay the benefit cost of doing so. 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 electronic benefit transfer systems. Finally, States or localities may opt to run "workfare" programs, and States determine which 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. The Federal Government is also 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 cost of carrying out employment and training programs for food stamp recipients is shared in two ways: (1) each State receives a Federal grant for basic operating costs (a formula share of $75 million a year); 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. Finally, States are allowed to retain a portion of improperly issued benefits they recover (other than those caused by welfare agency error): 25 percent of recoveries in fraud cases and 10 percent in other circumstances. As shown in table 16–4, food stamp spending has grown from $7.4 billion in 1979 to $27.4 billion in 1995.

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 food stamp 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. The limited number of categorical eligibility rules make some automatically eligible for food stamps (most AFDC, SSI, and general assistance recipients), and categorically deny eligibility to others (e.g., strikers, illegal and temporarily resident aliens, most postsecondary students, people living in institutional settings). Applications cannot be denied because of the length of a household's residence in a welfare agency's jurisdiction or because the household has no fixed mailing address or does not reside in a permanent dwelling.

[5] Until April 1994, the cost of certain activities was matched at more than the 50-percent rate: costs associated with the development of computer capability and fraud control activities were eligible for 63 and 75 percent Federal sharing, respectively; costs for implementing the Systematic Alien Verification for Entitlements (SAVE) Program were fully reimbursed by the Federal Government.

TABLE 16–4.—RECENT FOOD STAMP ACT EXPENDITURES

[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	23,761	1,917	1,748	27,426

[1] All benefit costs associated with the Food Stamp Program and Puerto Rico's block grant are included. The benefit amounts shown in the table reflect small downward adjustments for overpayments collected from recipients and, beginning in 1989, 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 and Puerto Rico's block grant are included: Federal matching for the various administrative and employment and training expenses of States and other jurisdictions, and direct Federal administrative costs. Figures for Federal administrative costs beginning with fiscal year 1989 include only those paid out of food stamp appropriation and the food stamp portion of the general appropriation for food program administration. Figures for earlier years include estimates of food stamp related Federal administrative expenses paid out of other Agriculture Department accounts. State and local costs are estimated based on the known Federal shares and represent an estimate of all administrative expenses of participating States and other jurisdictions (including Puerto Rico).

Source: U.S Department of Agriculture budget justification materials for fiscal years 1981–97. 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 facilities. The food stamp household is unrelated to recipient units in other welfare programs (e.g., AFDC 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, some related coresidents 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), other than children who themselves have a spouse or children; 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.

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 AFDC, SSI, or general assistance recipients (who generally are automatically eligible for food stamps), monthly cash income is the primary food stamp eligibility determinant.[6] In establishing eligibility for households without an elderly or disabled member,[7] 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 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) energy

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

[7] 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).

assistance; (7) expense reimbursements that are not a “gain or benefit” to the household; (8) income earned by schoolchildren; (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 Job Training Partnership Act (JTPA) Programs, as well as JTPA monthly “allowances”; (13) income set aside by disabled SSI recipients under an approved “plan to achieve self-sufficiency” (PASS); 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 their gross monthly income less the following deductions:

—An inflation-indexed (each October) standard deduction set at $134 a month in fiscal year 1996, regardless of household size; different standard deductions are used for Alaska ($229), Hawaii ($189), Guam ($269), and the Virgin Islands ($118). The normal October 1995 adjustment was suspended under terms of the fiscal year 1996 appropriation for food stamps;

—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 $247 a month. Different ceilings prevail in Alaska, Hawaii, Guam, and the Virgin Islands: $429, $353, $300, and $182, respectively. Under current law, ceilings on shelter expense deductions will be completely lifted as of January 1997.

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

—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 AFDC, SSI, or general assistance 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, as adjusted for inflation each October. 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 16–5.

TABLE 16–5.—COUNTED (NET) AND BASIC (GROSS) MONTHLY INCOME ELIGIBILITY LIMITS FOR THE FOOD STAMP PROGRAM, FISCAL YEAR 1996

Household size	48 States, the District of Columbia, and the territories	Alaska	Hawaii
COUNTED (NET) MONTHLY INCOME ELIGIBILITY LIMITS [1]			
1 person	$623	$779	$718
2 persons	836	1,045	963
3 persons	1,050	1,312	1,208
4 persons	1,263	1,579	1,453
5 persons	1,426	1,845	1,698
6 persons	1,690	2,112	1,943
7 persons	1,903	2,379	2,188
8 persons	2,116	2,645	2,433
Each additional person	+214	+267	+245
BASIC (GROSS) MONTHLY INCOME ELIGIBILITY LIMITS [2]			
1 person	$810	$1,012	$933
2 persons	1,087	1,359	1,252
3 persons	1,364	1,706	1,570
4 persons	1,642	2,052	1,889
5 persons	1,919	2,399	2,207
6 persons	2,196	2,746	2,526
7 persons	2,474	3,092	2,844
8 persons	2,751	3,439	3,163
Each additional person	+278	+347	+319

[1] Set at the applicable Federal poverty guidelines, updated for inflation through calendar 1994.
[2] Set at 130 percent of the applicable Federal poverty guidelines, updated for inflation through calendar 1994.

Source: U.S. Department of Agriculture.

Allowable assets

Except for households automatically eligible for food stamps because they are composed entirely of AFDC, SSI, or general assistance recipients, eligible households must have counted or 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 $4,600) 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 or are required to be disregarded by other Federal laws.

Work registration, employment, and training requirements

Unless exempt, adult applicants for food stamps must register for work, typically with the welfare agency or a State employment service office. To maintain eligibility, they must accept a suitable job if offered one and fulfill any work, job search, or training requirements established by administering welfare agencies. If the household head fails to fulfill any of these requirements, the entire household is disqualified, typically for 2 months; in other cases, failure to comply disqualifies the noncomplying household member only.

Those who are exempt by law from these 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, and 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 requirements; 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, the main thrust of the food stamp employment and training program is to ensure that nonexempt recipients also fulfill some type of work, job search, or training obligation. To carry this out, welfare agencies are required to 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 (with the Agriculture Department's approval) by further exempting additional categories and individuals for whom participation is judged impracticable or not cost-effective. But the agency must allow otherwise exempt recipients to participate as volunteers and may set up special programs for them.

Once the pool of work registrants who will be required to participate in an employment or training program is identified, welfare agencies must place a minimum proportion (10 percent) in one or more program components. 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.

In fiscal year 1995, there were some 5.6 million work registrants, of whom 37 percent were exempted from employment and training program requirements. Of the remainder, 1.5 million persons participated in some employment activity and over 500,000 received "notices of adverse action" because they failed to meet participation requirements. The overwhelming majority of those fulfilling an employment activity requirement participated in work or job search or job search training (as opposed to education or other training).

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, and total hours of participation (including both work and any other required activity) cannot exceed 120 hours a month. Welfare agencies also must provide participants 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.

Categorical eligibility rules and other limitations

Some rules deny food stamp eligibility for reasons other than financial need or compliance with employment and training requirements. Households in which the head has voluntarily quit a job without good cause are barred for 90 days. 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. Illegal and temporarily resident aliens are barred, and legal aliens may be barred based on their sponsor's income. 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 they are boarding with. 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. And food stamps are denied those who intentionally violate program rules, for specific time periods ranging from 6 months (on a first violation) to permanently (on a third violation or other serious infraction).

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., deductions 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 income) from its maximum allotment. 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 eligibility and others take into account the general availability of food stamps in deciding what level of benefits to provide. In fiscal year 1995, monthly benefits averaged $71 a person and about $175 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), increased by 3 percent, 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 16–6).

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.

TABLE 16–6.—MAXIMUM MONTHLY FOOD STAMP ALLOTMENTS, FISCAL YEAR 1996

Household size	48 States and the District of Columbia	Alaska [1]	Hawaii	Guam	Virgin Islands
1 person	$119	$153	$198	$175	$153
2 persons	218	280	364	322	281
3 persons	313	401	522	461	402
4 persons	397	510	663	586	511
5 persons	472	605	787	696	607
6 persons	566	726	945	835	728
7 persons	626	803	1,044	923	805
8 persons	716	918	1,193	1,055	920
Each additional person	+90	+115	+149	+132	+115

[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 29 and 56 percent higher than the urban allotments shown here.

Source: U.S. Department of Agriculture.

Application, processing, and issuing food stamps

Food stamp benefits are normally 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 5 days of initial application).

Food stamp issuance is a welfare agency responsibility and issuance practices differ among welfare agencies. Most food stamp coupons are issued by: (1) providing (usually mailing) recipients an authorization-to-participate (ATP) 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, several pilot projects issue cash benefits, and in a small but growing number of State or substate areas, 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 statewide in five States; in eight States benefits are issued through an EBT system in at least part of the State. More than twenty additional States are well along in the process of converting to EBT issuance.

Using food stamps

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. 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) in the case of the elderly and SSI recipients and their spouses, meals prepared and served through approved communal dining programs; (4) 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; (5) 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 (6) 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.

QUALITY CONTROL (QC)

Since the early 1970s, the Food Stamp Program, like other welfare programs, has had a quality control 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.

Under the quality control 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 welfare 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.

Quality control reviews generate annual estimates of the proportion of cases in which an error is made and the dollar value of the errors as a proportion of total benefit dollars. 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 7.3 percent in fiscal year 1995. This was slightly higher than the all-time low of 7 percent in 1991. Error rates for underpayments have been relatively unchanged over time. In fiscal year 1995, the national weighted average underpayment dollar error rate was estimated at 2.4 percent. Finally, the rate of denials and terminations found improper in the most recent estimate (1994) was 3.8 percent (table 16–7).

TABLE 16–7.—FOOD STAMP QUALITY CONTROL ERROR RATES, FISCAL YEAR 1995

[Percent of benefits paid or not paid in error]

State	Underpayment error rate	Overpayment error rate	Combined error rate
Alabama	1.05	5.98	7.02
Alaska	1.20	3.93	5.12
Arizona	2.88	10.60	13.48
Arkansas	1.50	4.01	5.51
California	3.40	6.08	9.48
Colorado	1.52	4.87	6.39
Connecticut	1.09	7.45	8.54
Delaware	1.45	7.96	9.41
District of Columbia	2.89	6.42	9.31
Florida	2.60	8.47	11.07
Georgia	3.38	7.61	10.99
Guam	2.16	5.36	7.53
Hawaii	1.17	2.61	3.78
Idaho	1.61	5.08	6.69
Illinois	2.20	9.49	11.70
Indiana	3.26	13.09	16.35
Iowa	3.20	8.42	11.63
Kansas	1.44	6.67	8.11
Kentucky	1.45	3.25	4.70
Louisiana	2.05	5.12	7.17
Maine	2.03	4.44	6.46
Maryland	2.43	9.66	12.09
Massachusetts	1.73	3.24	4.97
Michigan	1.88	7.67	9.55
Minnesota	1.92	4.65	6.58
Mississippi	1.55	8.44	9.99
Missouri	3.40	9.56	12.96
Montana	3.00	5.18	8.18
Nebraska	2.41	6.30	8.71

TABLE 16–7.—FOOD STAMP QUALITY CONTROL ERROR RATES, FISCAL YEAR 1995—Continued

[Percent of benefits paid or not paid in error]

State	Underpayment error rate	Overpayment error rate	Combined error rate
Nevada	2.50	6.91	9.41
New Hampshire	3.94	6.31	10.25
New Jersey	1.99	6.71	8.70
New Mexico	1.43	6.14	7.57
New York	3.41	6.06	9.46
North Carolina	2.66	5.48	8.14
North Dakota	0.98	5.00	5.98
Ohio	3.39	11.18	14.57
Oklahoma	2.32	8.81	11.13
Oregon	2.08	6.96	9.04
Pennsylvania	2.41	6.55	8.96
Rhode Island	1.30	3.94	5.24
South Carolina	1.81	4.43	6.24
South Dakota	0.62	2.94	3.56
Tennessee	1.50	9.10	10.60
Texas	1.34	7.37	8.71
Utah	1.80	6.16	7.96
Vermont	1.55	7.58	9.13
Virginia	3.17	10.20	13.37
Virgin Islands	1.36	3.98	5.35
Washington	1.41	7.12	8.53
West Virginia	2.51	8.61	11.13
Wisconsin	2.62	9.57	12.19
Wyoming	2.70	4.88	7.58
U.S. average	2.42	7.30	9.72

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

Source: Food and Consumer Service (1995).

The dollar error rates reported through the food stamp quality control system are used as the basis for assessing the financial liability of States for overpaid and underpaid benefits. Although about $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.

Rules governing fiscal sanctions have changed a number of times. Under the most recent revision (1993), sanctions are assessed States with combined (overpayment and underpayment) dollar error rates above the national weighted average combined error rate for the year in question (9.7 percent in 1995). 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 1995, 16 States had combined error rates above the 9.7 percent tolerance level and were assessed some $73 million.

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 1995, eight States had combined error rates below 6 percent and received $16 million in enhanced funding.

Finally, the quality control 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 quality control reviews are fraudulent—under 2 percent of all benefits issued in 1995. 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 CASH ASSISTANCE PROGRAMS

The Food Stamp Program is intertwined with cash assistance in two ways: it is administratively linked to cash welfare aid at the State and local levels, and its recipient population is made up largely of recipients of other government benefits.

At the State and local levels, the Food Stamp Program is administered by the same welfare offices and personnel that administer cash assistance such as AFDC and general assistance. Joint food stamp and cash welfare application and interview procedures are the general rule. This coadministration does not apply for most elderly or disabled persons, whose cash assistance from the Supplemental Security Income Program (SSI) is administered through Social Security Administration offices, although these offices do provide limited intake services for the Food Stamp Program.

For most persons participating in the Food Stamp Program, food stamp aid represents a second or third form of government payment. Fewer than 20 percent of food stamp households rely solely on nongovernmental sources for their cash income, although over 25 percent have some income from these sources (e.g., earnings, private retirement income). According to quality control data, the AFDC Program contributes to the income of about 41 percent of food stamp households, and for almost all of them AFDC is their only cash income. SSI benefits go to some 19 percent of food stamp households, and almost one-third of these have no other income. About 20 percent of food stamp households receive Social Security or veterans benefits; nearly 15 percent are paid general assistance, unemployment insurance, or workers' compensation benefits.

RECIPIENCY RATES

Table 16–8 shows food stamp participation rates from 1975 to 1995 using three different measures. Food stamp enrollment has fluctuated widely over the last 20 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 in Puerto Rico).

A recent (October 1994) report from the U.S. Department of Agriculture provides a more refined analysis of participation rates and the extent to which the program is serving its target population. The report estimates that 74 percent of persons eligible participated (69 percent of eligible households). These participants received 82 percent of benefits payable if all eligibles had been enrolled. However, subgroups of the food-stamp-eligible population participated at very diferent rates: (1) most eligible children were enrolled (86 percent); (2) only one-third of eligible elderly persons participated, and the majority of those not participating lived alone; (3) virtually all eligible single-parent households were enrolled, while only 78 percent of eligible households with children and two or more adults participated; (4) eligible households headed by African-Americans participated at a greater rate (92 percent) than households headed by Hispanics (61 percent) or white non-Hispanics (59 percent); and (5) virtually all eligible households with income below half the Federal poverty guidelines were enrolled, but the participation rate fell for eligible households with larger incomes (e.g., the participation rate for those with income between half the poverty guidelines and the guidelines themselves was 76 percent). Finally, another (December 1995) report from the Agriculture Department notes that about half of the major increase in food stamp enrollment from 1988 to 1993 (a rise of over 40 percent) was a result of a higher participation rate among eligibles—as opposed to an increased number of eligible persons.

TABLE 16–8.—FOOD STAMP PARTICIPATION RATES IN THE UNITED STATES, 1975–95

Year	Number of food stamp participants (in millions)	Food stamp participation as a percent of—		
		Total population [1]	Poor population	Pre-transfer poor population
1975	16.3	7.6	63.0	NA
1976	17.0	7.9	68.1	NA
1977	15.6	7.2	63.1	NA
1978	14.4	6.5	58.8	NA
1979	15.9	7.1	61.0	57.1
1980	19.2	8.4	65.6	60.7
1981	20.6	9.0	64.7	60.8
1982	20.4	8.8	59.3	56.3
1983	21.6	9.2	61.2	58.5
1984	20.9	8.8	62.0	58.5
1985	19.9	8.3	60.2	56.6
1986	19.4	8.0	59.9	56.2
1987	19.1	7.8	59.1	55.6
1988	18.7	7.6	58.9	55.2
1989	18.8	7.6	59.6	55.6
1990	20.0	8.0	59.6	55.7
1991	22.6	9.0	63.3	59.3
1992	25.4	10.0	68.9	64.0
1993	27.0	10.4	68.7	NA
1994	27.5	10.5	72.1	NA
1995	26.6	10.1	NA	NA

[1] Calculated as a percent of total U.S. resident population at the end of the fiscal year. Total U.S. resident population was 263.2 million persons at the end of fiscal year 1995.

NA—Not available.

Note.—Participants in Puerto Rico are not included in this table.

Source: U.S. Bureau of the Census.

Table 16–9 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 1995. There has been a general increase in food stamp participants since 1975, with enrollment peaking in 1994. The number of recipients has declined significantly since its height in the spring of 1994.

TABLE 16–9.—FOOD STAMP RECIPIENTS BY STATE, SELECTED FISCAL YEARS 1975–95

[Thousands of persons]

State	1975 [1]	1979 [2]	1985 [3]	1990 [3]	1991 [3]	1992 [3]	1993 [3]	1994 [3]	1995 [3]
Alabama	393	525	588	449	504	550	560	551	525
Alaska	12	25	22	25	30	38	43	46	45
Arizona	166	129	206	317	388	457	489	512	480
Arkansas	268	277	253	235	258	277	285	283	272
California	1,517	1,334	1,615	1,936	2,212	2,558	2,866	3,155	3,175
Colorado	162	145	170	221	241	260	273	268	252
Connecticut	189	155	145	133	171	202	215	223	227
Delaware	39	45	40	33	41	51	58	59	57
District of Columbia	112	100	72	62	72	82	87	91	94
Florida	767	828	630	781	1,021	1,404	1,500	1,474	1,395
Georgia	569	559	567	536	648	751	807	830	816
Hawaii	84	96	99	77	83	94	103	115	125
Idaho	39	47	59	59	65	72	79	82	80
Illinois	948	837	1,110	1,013	1,096	1,156	1,178	1,189	1,151
Indiana	255	275	406	311	375	448	497	521	470
Iowa	118	117	203	170	180	192	196	196	184
Kansas	63	73	119	142	156	175	188	192	184
Kentucky	449	405	560	458	496	529	530	522	520
Louisiana	502	523	644	727	742	779	779	756	711
Maine	151	121	114	94	116	133	138	136	132
Maryland	273	299	291	254	304	343	375	387	399
Massachusetts	560	429	337	347	397	429	443	442	410
Michigan	685	706	985	917	978	994	1,022	1,031	971
Minnesota	191	143	228	263	286	309	317	316	308
Mississippi	390	452	495	499	520	536	537	511	480
Missouri	299	280	362	431	490	549	591	593	576
Montana	38	33	58	57	61	66	70	71	71
Nebraska	50	55	94	95	99	107	113	111	105
Nevada	34	27	32	50	63	80	93	97	99
New Hampshire	66	44	28	31	47	58	60	62	58
New Jersey	565	524	464	381	441	495	531	545	540
New Mexico	154	159	157	157	188	221	244	244	239
New York	1,398	1,704	1,834	1,546	1,717	1,885	2,045	2,154	2,183
North Carolina	537	517	474	419	517	597	627	630	614

TABLE 16–9.—FOOD STAMP RECIPIENTS BY STATE, SELECTED FISCAL YEARS 1975–95—Continued

[Thousands of persons]

State	1975 [1]	1979 [2]	1985 [3]	1990 [3]	1991 [3]	1992 [3]	1993 [3]	1994 [3]	1995 [3]
North Dakota	19	20	33	39	41	46	48	45	41
Ohio	924	760	1,133	1,078	1,171	1,251	1,269	1,245	1,155
Oklahoma	184	184	263	267	296	346	370	376	375
Oregon	208	160	228	216	240	265	283	286	289
Pennsylvania	893	923	1,032	954	1,052	1,137	1,186	1,208	1,173
Rhode Island	104	80	69	64	78	87	92	93	100
South Carolina	421	369	373	299	329	369	394	385	364
South Dakota	31	37	48	50	52	55	56	53	50
Tennessee	435	531	518	527	608	702	774	735	662
Texas	1,085	1,027	1,263	1,880	2,155	2,454	2,659	2,730	2,564
Utah	50	44	75	99	110	123	133	128	119
Vermont	46	40	44	38	47	54	58	65	59
Virginia	293	320	360	346	414	495	535	547	546
Washington	239	205	281	337	385	432	462	468	476
West Virginia	204	182	278	262	281	310	322	321	329
Wisconsin	163	171	363	286	294	334	337	330	320
Wyoming	11	11	27	28	31	33	34	34	34
American Samoa	NA	NA	NA	NA	NA	NA	NA	2	3
Guam	21	18	20	12	11	20	13	15	16
Northern Marianas	NA	NA	4	4	2	2	3	4	4
Puerto Rico	1,800	1,822	1,480	1,480	1,490	1,480	1,440	1,410	1,370
Virgin Islands	25	34	32	18	15	16	18	20	23
Total	19,199	18,926	21,385	21,510	24,105	26,888	28,426	28,888	27,995

[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.

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

Legislative History

In the early 1980s, Congress enacted major revisions to the Food Stamp Program to hold down costs and tighten administrative rules. The Omnibus Budget Reconciliation Act of 1981, the Agriculture and Food Act of 1981, and the Omnibus Budget Reconciliation Act of 1982 all contained amendments that the Congressional Budget Office has estimated held food stamp spending for fiscal years 1982 through 1985 nearly $7 billion (13 percent) below what would have been spent under pre-1981 law. These laws delayed various inflation indexing adjustments, reduced the maximum benefit guarantee by 1 percent (restored in 1984), established income eligibility ceilings at 130 percent of the Federal poverty levels, initiated prorating of first-month benefits, replaced the Food Stamp Program in Puerto Rico with a nutrition assistance block grant, reduced benefits for those with earnings and high shelter expenses, ended eligibility for most postsecondary students and strikers, and raised fiscal penalties for States with high rates of erroneous benefit and eligibility determinations.

In 1985, the Food Security Act (Public Law 99–198) reauthorized food stamp appropriations through fiscal year 1990 and reversed the earlier trend, significantly liberalizing food stamp rules. Major new initiatives included: a requirement for States to implement employment and training programs for food stamp recipients, automatic food stamp eligibility for AFDC and SSI recipients, and a prohibition on collection of sales taxes on food stamp purchases. Benefits were raised for some disabled and those with earnings, high shelter costs, and dependent care costs. Puerto Rico's nutrition assistance block grant was increased. Eligibility standards were liberalized, primarily by increasing and easing limits on assets. This was followed by several laws in 1986 and 1987 that opened up access to and increased benefits for the homeless, liberalized treatment of student aid, energy assistance, and income received from employment programs for the elderly and charitable organizations, further added to benefits for those with high shelter costs, and allowed Washington State to operate a special AFDC/food stamp demonstration project (followed by similar authorization for Minnesota in 1989).

Legislation expanding eligibility and benefits continued into 1988 and 1989. The Hunger Prevention Act of 1988 (Public Law 100–435) increased food stamp benefits across the board, liberalized several eligibility and benefit rules, eased program access and administrative rules, and restructured the employment and training program and quality control system. The across-the-board benefit increase in maximum benefits (above normal inflation adjustments) called for by the act was 0.65 percent in fiscal year 1989, 2.05 percent in fiscal year 1990, and 3 percent in later years. Eligibility and benefit liberalizations included higher benefits for those with dependent care expenses, extension of liberal treatment for disabled applicants and recipients to new categories of disability, addition of a new income disregard for earned income tax credits, and liberalized treatment for farm households. Major provisions pertaining to program access and administration authorized 50-percent Federal cost sharing for State-option outreach activities, required coordination with cash welfare program application procedures, loosened rules governing monthly reporting and retrospective budgeting, allowed training of community volunteers to help screen applicants, and required, in some instances, issuance of the first 2 months' worth of benefits in a single allotment. Employment and training rules were revised by allowing some expansion in the types of activities supported (e.g., basic skills education), requiring increased support for participants' dependent care expenses, and mandating new performance standards for States. Finally, the food stamp quality control system was completely revamped to substantially reduce fiscal sanctions on States for erroneous benefit determinations, retroactive to fiscal year 1986.

The 1990 Food, Agriculture, Conservation, and Trade Act (Public Law 101–624) reauthorized food stamp appropriations through fiscal year 1995. Although early versions of this act would have significantly liberalized food stamp eligibility and benefit rules, budget constraints dictated minimal expansions. The changes included: limited revisions for postsecondary students, forgiveness of most pre-1986 quality control sanctions on States, a few changes in administrative rules to open up program access and strengthen penalties for trafficking, and new pilot projects and study commissions for welfare program coordination. In addition, other laws eliminated a special requirement for single food stamp/SSI applications for those about to be discharged from institutions and barred the Food Stamp Program from counting (as a liquid asset) lump-sum earned income tax credit payments.

The Mickey Leland Childhood Hunger Relief Act (incorporated in the 1993 Omnibus Budget Reconciliation Act, Public Law 103–66) increased food stamp benefits and eased eligibility rules by: increasing and then removing the limit on special benefit adjustments (deductions) for households with very high shelter expenses, ending a practice of reducing benefits when there are short "procedural" breaks in enrollment, disregarding child support payments as income to the payor, increasing the degree to which vehicles are disregarded as assets in judging eligibility, revising the definition of a food stamp household to allow more persons who live together to apply separately, increasing the degree to which dependent care expense deductions can be claimed, expanding the degree to which earned income credits are disregarded as assets and State/local general assistance is disregarded as income, and boosting Puerto Rico's block grant. The Act also lowered the Federal share of some State administrative expenses (to 50 percent), reduced quality control fiscal penalties on States with high rates of erroneous benefit and eligibility determinations, and liberalized the appeals process for those penalties. Finally, it expanded support for employment and training programs for food stamp recipients, added a new method for collecting claims against recipients, and increased penalties for trafficking in food stamps. The net cost of the 1993 amendments was estimated at $2.5 billion over fiscal years 1994–98.

Most recently, 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.

Table 16–10 provides an overview of the characteristics of food stamp households for selected years since 1980; table 16–11 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 for low-income persons who are aged, blind, disabled, members of families with dependent children, and certain other 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 amounts of payments for services (for additional information, see Committee on Energy and Commerce, 1993).

ELIGIBILITY

Although Medicaid eligibility has traditionally been linked to actual or potential receipt of cash assistance under AFDC or SSI, both of which are under jurisdiction of the Committee on Ways and Means, legislation in the last decade has gradually extended coverage to low-income pregnant women and children who have no ties to the welfare system, and has provided partial coverage for new groups of low-income Medicare beneficiaries.

Medicaid is available to two broad classes of eligible persons: the "categorically needy" and the "medically needy." The two terms once distinguished between welfare-related beneficiaries and those qualifying only under special Medicaid rules. However, nonwelfare groups have been added to the "categorically needy" list over the years. As a result, the terms are no longer especially helpful in sorting out the various populations for whom mandatory or optional Medicaid coverage has been made available, and some analysts believe they should be abandoned. However, the distinction between the categorically and medically needy is still an important one because the scope of covered services that States must provide to the categorically needy is much broader than the minimum scope of services for the medically needy.

All States must cover certain mandatory groups of categorically needy individuals.[8] Coverage of additional categorically needy groups is optional, as is coverage of the medically needy. The following discussion describes the mandatory and optional categorically eligible groups; the medically needy are discussed separately at the end of this section.

[8] Arizona does not operate a traditional Medicaid Program. Since 1982 it has operated a federally assisted medical assistance program for low-income persons under a demonstration waiver.

TABLE 16–10.—CHARACTERISTICS OF FOOD STAMP HOUSEHOLDS, SELECTED YEARS 1980–94

[In percent]

Food stamp recipient households	Year and month survey was conducted										
	1980 (Aug.)	1985 (Summer)	1986 (Summer)	1987 (Summer)	1988 (Summer)	1989 (Summer)	1990 (Summer)	1991 (Summer)	1992 (Summer)	1993 (Summer)	1994 (Summer)
With gross monthly income:											
Below the Federal poverty levels	87	94	93	94	92	92	92	91	92	91	90
Between the poverty levels and 130 percent of the poverty levels	10	6	6	6	8	8	8	9	8	8	9
Above 130 percent of the poverty levels	2	([3])	([3])	([3])	([3])	([3])	([3])	([3])	([3])	1	1
With earnings	19	20	21	21	20	20	19	20	21	21	21
With public assistance income [1]	65	68	69	74	72	73	73	70	66	68	69
With AFDC income	NA	39	38	41	42	42	43	41	40	40	38
With SSI income	18	19	18	21	20	21	19	19	19	20	23
With children	60	59	61	61	61	60	61	61	62	60	61
And female heads of household	NA	46	48	50	50	50	51	51	51	52	51
With elderly members [2]	23	21	20	21	19	20	18	17	15	16	16
With elderly female heads of household [2]	NA	16	15	15	14	14	11	10	9	NA	11
Average household size	2.8	2.7	2.7	2.7	2.6	2.6	2.6	2.6	2.5	2.6	2.5

[1] Public assistance income includes Aid to Families with Dependent Children, Supplemental Security Income, and general assistance.
[2] Elderly members and heads of household include those age 60 or older.
[3] Less than 0.5 percent.

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.

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

TABLE 16–11.—HISTORICAL FOOD STAMP STATISTICS, 1972–95

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[2]
	Current dollars	Constant (1995) dollars[3]		Current dollars	Constant (1995) dollars[3]	
1972[4]	$1,871	$6,879	11.1	$13.50	$47.90	$108
1973	2,211	7,813	12.2	14.60	47.70	112
1974	2,843	9,230	12.9	17.60	48.10	116
1975[5]	4,624	13,520	17.1	21.40	53.40	150
1976	5,692	15,552	18.5	23.90	56.10	162
Transition quarter[6]	1,367	3,597	17.3	24.40	56.10	166
1977	5,469	13,881	17.1	24.70	55.60	166
1978	5,573	13,206	16.0	26.80	55.10	170
1979[7]	6,995	15,043	17.7	30.60	56.40	182
1980	9,188	17,401	21.1	34.40	59.00	204
1981	11,308	19,264	22.4	39.50	62.10	209
1982[8]	11,117	17,646	22.0	39.20	59.40	233
1983[8]	12,733	19,529	23.2	43.00	64.30	253
1984[8]	12,470	18,365	22.4	42.70	62.00	253
1985[8]	12,599	17,896	21.4	45.00	64.00	264
1986[8]	12,528	17,352	20.9	45.50	63.40	268
1987[8]	12,539	16,899	20.6	45.80	61.00	271
1988[8]	13,289	17,191	20.1	49.80	64.00	290
1989[8]	13,815	17,055	20.2	51.90	62.60	300
1990[8]	16,512	19,426	21.5	59.00	66.90	331
1991[8]	19,765	22,133	24.1	63.90	69.70	352
1992[8]	23,539	25,585	26.9	68.50	74.30	370
1993[8]	24,749	26,106	28.4	68.00	72.30	375
1994	25,525	26,233	28.9	69.00	71.30	375
1995	25,678	25,678	28.0	71.30	71.30	386

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

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

[3] 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.

[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 1.4 to 1.5 million persons a month under the nutrition assistance grant and higher figures in earlier years). Average benefit figures do not reflect somewhat lower benefits in Puerto Rico under its nutrition assistance grant.

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.

AFDC-related groups

States must provide Medicaid to all persons receiving cash assistance under AFDC, as well as to additional AFDC-related groups that are not actually receiving cash payments. These groups include: persons who do not receive a payment because the amount would be less than $10; persons whose payments are reduced to zero because of recovery of previous overpayments; certain work supplementation participants; certain children for whom adoption assistance agreements are in effect or for whom foster care payments are being made under title IV–E of the Social Security Act; and persons ineligible for AFDC because of a requirement that may not be imposed under Medicaid.

States are required to continue Medicaid for specified periods for certain families losing AFDC benefits after receiving them in at least 3 of the preceding 6 months. If the family loses AFDC benefits because of increased income from earnings or hours of employment, Medicaid coverage must be extended for 12 months. (During the second 6 months a premium may be imposed, the scope of benefits may be limited, or alternate delivery systems may be used.) If the family loses AFDC because of increased child or spousal support, coverage must be extended for 4 months. States are also required to furnish Medicaid to certain two-parent families whose principal earner is unemployed and who are not receiving cash assistance because the State is one of those permitted (under the Family Support Act of 1988) to set a time limit on AFDC coverage for such families.

States are permitted, but not required, to provide coverage to additional AFDC-related groups. The most important of these are the "Ribicoff children," whose income and resources are within AFDC standards but who do not meet the definition of "dependent child." States may cover these children up to a maximum age of 18, 19, 20, or 21, at the State's option, and may limit coverage to reasonable subgroups, such as children in privately subsidized foster care, or those who live in certain institutional settings. States may also furnish Medicaid to persons who would receive AFDC if the State's AFDC Program were as broad as permitted under Federal law.

Non-AFDC 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 and resources, rather than in terms of their ties to the AFDC Program.

States are required to cover pregnant women and children under age 6 with family incomes below 133 percent of the Federal poverty income guidelines. (The State may impose a resource standard that is no more restrictive than that for SSI, in the case of pregnant women, or AFDC, in the case of children.) Coverage for pregnant women is limited to services related to the pregnancy or complications 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 Federal poverty level. (Coverage of such children through age 7 has been optional since OBRA 1987.) The 1983 start date means that the age of mandatory coverage will increase each year until reaching age 18 in fiscal year 2002.

States are permitted, but not required, to cover pregnant women and infants under 1 year old with incomes below a State-established maximum that is above 133 percent of the poverty level. As of July 1995, 35 States and the District of Columbia had made use of this option; 25 had set their income limits at the maximum of 185 percent.

SSI-related groups

States are generally required to cover recipients of SSI. However, States may use more restrictive eligibility standards for Medicaid than those for SSI if they were using those standards on January 1, 1972 (before the implementation of SSI). States that have chosen to apply at least one more restrictive standard are known as "section 209(b)" States, after the section of the Social Security amendments of 1972 (Public Law 92–603) that established the option. These States may vary in their definition of disability, or in their standards related to income or resources. There are 12 section 209(b) States:

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

States using more restrictive income standards must allow applicants to deduct medical expenses from income (not including SSI or State supplemental payments, SSP) in determining eligibility. This process is known as "spenddown." For example, if an applicant has a monthly income of $400 (not including any SSI or SSP) and the State's maximum allowable income is $350, the applicant would be required to incur $50 in medical expenses before qualifying for Medicaid. As will be discussed below, the spenddown process is also used in establishing eligibility for the medically needy.

States must continue Medicaid coverage for several defined groups of individuals who have lost SSI or SSP 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. Medicaid must be continued if such an individual needs continued medical assistance 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. 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 (COLA) in their Social Security benefits. Similar Medicaid continuations have been provided for certain other persons who lose SSI as a result of eligibility for or increases 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 are permitted to provide Medicaid to individuals who are not receiving SSI but are receiving State-only supplementary cash payments.

Qualified Medicare beneficiaries and related groups

Effective January 1, 1991, States must provide limited Medicaid coverage for "qualified Medicare beneficiaries" (QMBs). These are aged and disabled persons who are receiving Medicare, whose income is below 100 percent of the Federal poverty level, and whose resources do not exceed twice the allowable amount under SSI. States must pay Medicare part B premiums (and, if applicable, part A premiums) for QMBs, along with required Medicare coinsurance and deductible amounts.

In addition, all States must pay part B premiums (but not part A premiums or part A or B coinsurance and deductibles) for beneficiaries who would be QMBs except that their incomes are between 100 and 120 percent of the poverty level.

States are also required to pay part A premiums, but no other expenses, for "qualified disabled and working individuals." These are persons who formerly received Social Security disability benefits and hence Medicare, have lost eligibility for both programs, but are permitted under Medicare law to continue to receive Medicare in return for payment of the part A premium. Medicaid must pay this premium on behalf of such individuals who have incomes below 200 percent of poverty and resources no greater than twice the SSI standard.

States are permitted to provide full Medicaid benefits, rather than just Medicare premiums and cost sharing, to QMBs who meet a State-established income standard that is no higher than 100 percent of the Federal poverty level.

Institutionalized persons and related groups (all optional)

States may provide Medicaid to certain otherwise ineligible groups of persons who are in nursing facilities or other institutions, or who would require institutional care if they were not receiving alternative services at home or in the community.

States may establish a special income standard for institutionalized persons, not to exceed 300 percent of the maximum SSI benefits payable to a person who is living at home and has no other resources. States may also provide Medicaid to persons who would qualify for SSI but for the fact that they are in an institution.

A State may obtain a waiver under section 2176 of OBRA 1981 to provide home and community-based services to a defined group of individuals who would otherwise require institutional care. Persons served under such a waiver may receive Medicaid coverage if they would be eligible if they lived in an institution. Such individuals may also be covered in a State that terminates its waiver program in order to take advantage of a new, no-waiver home and community-based services option created by OBRA 1990.

A State may also 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. These include children being cared for at home, persons of any age who are ventilator-dependent, and persons receiving hospice benefits in lieu of institutional services.

OPTIONAL COVERAGE: THE MEDICALLY NEEDY

Forty States and other jurisdictions provide Medicaid to at least some groups of "medically needy" persons. 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, spenddown 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 133 percent of the maximum payment for a similar family under the State's AFDC Program. 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.

As of October 1, 1995, the following 40 States and territories covered some groups of the medically needy:

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

MEDICAID AND THE POOR

In 1994, Medicaid covered 12 percent of the total U.S. population (excluding institutionalized persons) and 46.2 percent of those with incomes below the Federal poverty level. Because categorical eligibility requirements for children are less restrictive than those for adults, poor children are much more likely to receive coverage. Table 16–12 shows Medicaid coverage by age and income status in 1994, as reported in the March 1995 Current Population Survey (CPS) conducted by the 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.

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.

TABLE 16–12.—MEDICAID COVERAGE BY AGE AND FAMILY INCOME, 1994

[In thousands]

Age	Covered by Medicaid	Persons in age group	Percent with Medicaid
In poverty:			
0–5	4,358	6,093	71.5
6–10	2,762	4,228	65.3
11–18	2,940	5,611	52.4
19–44	5,101	13,823	36.9
45–64	1,366	4,639	29.4
65 or older	1,050	3,663	28.7
Total	17,577	38,057	46.2
Family income between 100 and 133 percent of poverty:			
0–5	875	1,967	44.5
6–10	548	1,472	37.2
11–18	575	1,987	28.9
19–44	1,151	6,258	18.4
45–64	346	1,997	17.3
65 or older	552	2,907	19.0
Total	4,047	16,589	24.4
Family income between 133 and 185 percent of poverty:			
0–5	825	2,822	29.2
6–10	391	2,166	18.0
11–18	496	3,257	15.2
19–44	1,072	10,175	10.5
45–64	374	3,625	10.3
65 or older	430	4,915	8.8
Total	3,588	26,960	13.3
Family income greater than 185 percent of poverty:			
0–5	1,109	13,379	8.3
6–10	621	11,401	5.4
11–18	874	19,094	4.6
19–44	2,034	75,164	2.7
45–64	707	41,187	1.7
65 or older	843	19,783	4.3
Total	6,189	180,009	3.4

TABLE 16–12.—MEDICAID COVERAGE BY AGE AND FAMILY INCOME, 1994—Continued

[In thousands]

Age	Covered by Medicaid	Persons in age group	Percent with Medicaid
All persons:			
0–5	7,167	24,261	29.5
6–10	4,321	19,267	22.4
11–18	4,885	29,949	16.3
19–44	9,358	105,420	8.9
45–64	2,794	51,449	5.4
65 or older	2,876	31,269	9.2
Total	31,400	261,614	12.0

Source: CRS tabulations from the March 1995 Current Population Survey (CPS). Table excludes persons in institutions and approximately 250,000 children under age 15 living with nonfamily caretakers. Number of recipients is lower than the number on administrative records due to underreporting by CPS 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; nursing facility (NF) services for those over age 21; home health services for those entitled to NF care; early and periodic screening, diagnosis, and treatment (EPSDT) for those under age 21; family planning services and supplies; physicians' services; and nurse-midwife services. OBRA 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 16–24). OBRA 1990 added two new optional services: home and community-based services for the functionally disabled elderly and community supported living arrangement services for the developmentally disabled. Total expenditures under these services are capped. States are permitted to establish limitations on the amount of care provided under a service category (such as limiting the number of days of covered hospital care or number of physicians' visits). Certain services to children may not be limited.

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 (ICF/MRs) or in institutions for mental diseases, it must offer to all groups covered in its medically needy program the same mix of institutional and noninstitutional services as required under prior law (that is, 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 though currently the highest rate is 78.07 percent, with 11 States and the District of Columbia receiving the minimum match of 50 percent. 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 where 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 are required to submit to the Secretary their payment rates for pediatric and obstetrical services along with additional data that will assist the Secretary in evaluating the State's compliance with this requirement.

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 must also be sufficient to assure reasonable access to inpatient services of adequate quality. A Supreme Court ruling in 1990, *Wilder* v. *Virginia Hospital Association*, affirmed that hospitals have the right under this rule to seek Federal court review of State reimbursement levels. Suits alleging inadequate hospital and nursing home payment have been filed in a number of States.

In addition to meeting general adequacy tests, State hospital reimbursement systems must provide for additional payments to facilities serving a disproportionate share of low-income patients. Unlike the comparable Medicare payments, Medicaid payments must follow a formula that considers a hospital's charity patients as well as its Medicaid caseload.

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. OBRA 1990 established a 4-year moratorium on reductions in most payment rates for pharmacists.

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, HMO services for the categorically needy, and services provided to nursing facility inpatients who are required to spend all of their income for medical care except for a personal needs allowance.

ADMINISTRATION

Medicaid is a State-administered program. At the Federal level, the Health Care Financing Administration (HCFA) of the Department of Health and Human Services 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. Managed care refers to an array of health plans which attempt to control the cost and quality of care by coordinating medical and other health-related services. States wishing to require Medicaid beneficiaries to enroll in managed care plans must obtain one of two types of waivers from the HCFA. Section 1115(a) of the Social Security Act offers States the greatest flexibility, allowing HCFA to waive a broad range of Medicaid requirements. Statewide section 1115(a) waivers have been approved in 13 States, implemented in 9, and are pending in 11 States. These waivers allow States to expand coverage to those not traditionally eligible, to impose premiums and copayments on those new eliginles, and to modify the Medicaid benefit package. A second kind 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 91 freedom-of-choice programs operating in 42 States.

Managed care includes a wide array of approaches to organizing the delivery of health care. In contrast to traditional "fee-for-service" plans, most managed care plans are "capitated," meaning they receive a fixed amount of money per person to provide a set of services for any patient enrolled. However, some plans are a synthesis of partially capitated and fee-for-service care. Arrangements include primary care case managers (PCCMs), preferred provider organizations (PPOs), health maintenance organizations (HMOs), and point-of-service plans (POSs). Medicaid managed care enrollment has increased 140 percent since 1993. Currently there are approximately 11.6 million Medicaid recipients enrolled in some type of managed care: 5.1 million in HMOs, 3.6 million in PCCM, and 2.9 million in other variations. Of these, approximately 7.5 million recipients are in fully capitated plans.

Arizona received the first comprehensive statewide section 1115(a) waiver in 1982. Since 1993, Delaware, Hawaii, Minnesota, Oklahoma, Oregon, Rhode Island, Tennessee, and Vermont have received and implemented statewide section 1115(a) waivers. Statewide waivers have been approved but not implemented in Florida, Kentucky, Massachusetts and Ohio. Most of these waivers are designed to move Medicaid beneficiaries into managed care and to expand Medicaid eligibility to low-income and uninsured persons not statutorily entitled to coverage. However, there is significant variability in the degree of expanded coverage offered under each. Many waivers require newly-covered enrollees to contribute to the cost of their medical care by paying premiums and copayments based on income, some limit eligibility to certain populations, and most impose upper income eligibility limits.

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. Many States exempt Medicaid eligibles who are SSI recipients (aged, blind, and disabled), who often incur high medical expenses, from mandatory managed care participation. Research by the Government Accounting Office (GAO) has shown that Arizona's waiver program has succeeded in containing health care costs by developing a competitive Medicaid health care market. GAO questions whether approved section 1115(a) waivers in other States, notably Oregon, Hawaii, and Florida, will be cost neutral, and suggests that statewide section 1115(a) waivers instead could increase Federal Medicaid expenditures significantly by expanding coverage to those ineligible under traditional plans.

Until 1982, Arizona was the only State that did not have a Medicaid Program. The State became the first to mandate managed care enrollment for its Medicaid-eligibles when it received a section 1115(a) waiver to implement the Arizona Health Care Cost Containment System. The Arizona system, with an estimated 450,000 enrollees, is fully capitated and includes both acute care and long-term care programs. The waiver has been extended through 1997. Oregon's Health Plan Demonstration, implemented February 1994, is part of the State's health care reform goal of universal coverage. The plan expands Medicaid eligibility to an estimated 120,000 people with incomes below 100 percent of the Federal poverty level. The benefit package, developed by the State in conjunction with health care providers and consumers, consists of a prioritized list of 581 conditions and treatments, in addition to certain preventive services. Most care is delivered through fully capitated managed care health plans. Similarly, Tennessee's TennCare Program is designed to provide benefits to traditional Medicaid beneficiaries, uninsured State residents, and those who are otherwise uninsurable. There is no upper income eligibility limit, expanding eligibility to an estimated additional 500,000 persons. The plan requires new eligibles to share the cost of medical care by paying premiums, deductibles, and copayments based on income. Plan enrollment, capped by the State at 1.4 million, is currently about 1.3 million.

LEGISLATIVE HISTORY

The following is a summary of the major Medicaid changes enacted as part of the Omnibus Budget Reconciliation Act of 1990 (OBRA 1990), Public Law 101–508:

1. *Reimbursement for prescribed drugs*.—The law requires manufacturers of prescription drugs to provide rebates to State Medicaid Programs. States are required to cover all the drugs manufactured by a firm entering into a rebate agreement. The minimum rebate is 10 percent of the average manufacturer price for the product. Beginning in 1993, States are required to have prospective (i.e., point-of-sale) and retrospective drug utilization review (DUR) programs, to assure that prescriptions are appropriate and medically necessary. Until the end of 1993, enhanced Federal matching payments were provided for State administrative costs related to the rebate and DUR programs. The law establishes a 4-year moratorium on reductions in most payment rates for pharmacists.
2. *Required payment of premiums and cost sharing for enrollment under group health plans where cost effective*.—Effective January 1, 1991, the law requires States to pay premiums for group health plans for which Medicaid beneficiaries are eligible, when it is cost effective to do so. Guidelines for determining cost effectiveness were to be issued by the Secretary. States pay any cost sharing required by a plan and continue to furnish any Medicaid benefits not covered under the plan. Providers under group health plans are required to accept plan payment as payment in full for Medicaid enrollees.
3. *Protection of low-income Medicare beneficiaries*.—The law accelerates phase in of the requirement that States pay Medicare premiums and cost sharing for QMBs, Medicare beneficiaries with incomes below 100 percent of the Federal poverty level. For all but five States, the requirement was effective January 1, 1991. All States must pay part B premiums (but not part A premiums or cost sharing) for beneficiaries with incomes below 120 percent of the poverty level beginning in 1995.
4. *Child health provisions*.—Effective July 1, 1991, all States are required to cover children under age 19 who were born after September 30, 1983, and whose family income is below 100 percent of the Federal poverty level. States are required to accept Medicaid applications for mothers and children at locations other than welfare offices, and are required to continue benefits for pregnant women until 2 months after the end of

the pregnancy, and for infants through the first year of life. States are required to make additional payments for outlier cases and are prohibited from imposing durational limits on coverage for patients who are under age 1 in any hospital or under age 6 in a disproportionate share hospital.

5. *Home and community-based care as optional service*.—The law permits States to provide home and community-based services to functionally disabled Medicaid beneficiaries age 65 or over, effective the later of July 1, 1991, or 30 days after the publication of interim rules. States are permitted to limit eligibility for the services without waivers and thus to provide the services without meeting cost-effectiveness tests. Federal matching payments cannot exceed 50 percent of what it would have cost to provide Medicare nursing facility care to the same group of beneficiaries. Total Federal expenditures were limited to $580 million over the period fiscal years 1991 to 1995.
6. *Community supported living arrangements*.—The law permits between two and eight States to provide community supported living arrangement services to developmentally disabled individuals who live with their families or in small community residential settings, effective the later of July 1, 1991, or 30 days after the publication of interim rules. Services include personal assistance, training and habilitation, and other services needed to help with activities of daily living. Total Federal expenditures were limited to $100 million over the period fiscal years 1991 to 1995.
7. *Payments for COBRA continuation coverage*.—The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA, Public Law 99–272) provides that employees or dependents leaving an employee health insurance group in a firm with 20 or more employees must be offered an opportunity to continue buying insurance through the group for 18 to 36 months (depending on the reason for leaving the group). OBRA 1990 permits State Medicaid Programs to pay for COBRA continuation coverage, when it is cost effective to do so, effective January 1, 1991. States may pay premiums for individuals with incomes below 100 percent of poverty and resources less than twice the SSI limit who are eligible for continuation coverage under a group health plan offered by an employer with 75 or more employees.
8. *Miscellaneous*.—The law establishes demonstration projects in three to four States to test the effect of providing Medicaid to families with incomes below 150 percent of the Federal poverty level that do not meet categorical eligibility requirements, and projects in two States to provide Medicaid coverage for early intervention services for HIV-infected individuals who do not meet disability criteria. The law also includes new measures to ensure the quality of physician services under Medicaid, technical corrections in nursing home reform provisions, and numerous other technical and miscellaneous amendments.

The following is a summary of the major changes enacted in the Medicaid Voluntary Contribution and Provider-Specific Tax amendments of 1991, Public Law 102–234.

1. *Voluntary contributions and provider-specific taxes.*—The law caps Federal matching payments for State Medicaid spending that is financed with revenues from provider donations or taxes. Generally effective January 1, 1992, before the Federal share is computed, a State's expenditures for Medicaid are reduced by revenues received by a State or local government from provider-related donations, and health care-related taxes that are not broad based. Broad based taxes are those that are uniformly imposed on all providers in a class, or all businesses in a class furnished by the providers. States with non-broad-based taxes in effect or approved as of November 22, 1991, are permitted to continue them temporarily, but the taxes may not be increased. States with voluntary contribution programs in effect or reported as of September 30, 1991, for States' fiscal year 1992, may continue them temporarily but may not increase them. During fiscal years 1993–95, Federal matching funds for revenue from voluntary contributions, provider specific taxes, and broad-based taxes were limited to the greater of 25 percent of the State share of Medicaid expenditures or the amount of donations and taxes collected in the State in fiscal year 1992. Federal matching funds are allowable for certain donations. These are bona fide provider donations that are not related to Medicaid payments to the provider, and donations in the form of payment for outstationing Medicaid eligibility workers. Beginning in fiscal year 1993, the latter type of donations are limited to 10 percent of a State's Medicaid administrative costs.
2. *Payments for disproportionate share hospitals.*—The law places an aggregate national cap of 12 percent of Medicaid expenditures on payment adjustments for disproportionate share hospitals (DSH). Beginning with fiscal year 1993, States with DSH payments of 12 percent or more of total Medicaid expenditures in fiscal year 1992 cannot exceed this dollar level in the future; States with DSH payments of less than 12 percent may increase them at the same rate as their overall Medicaid expenditure growth.

Two 1991 acts concern enrollment in two health maintenance organizations. The law specifies that no more than 75 percent of the enrollees of an HMO may be Medicaid or Medicare beneficiaries. Public Law 102–276 authorized a waiver of this requirement for the Dayton Area Health Plan; Public Law 102–317 authorized a similar waiver for the Tennessee Primary Care Network.

The following is a summary of major Medicaid changes enacted in the Veterans Health Care Act of 1992, Public Law 102–585, pertaining to Medicaid reimbursement policies for prescription drugs.

1. *Calculation of best price.*—The law excludes certain prices from calculation of best price (the lowest price available from a manufacturer) for Medicaid drug rebates. The law excludes the prices charged to the Indian Health Service, the Department of Veterans Affairs, veterans' State homes, the Department of Defense, the Public Health Service and certain private and nonprofit hospitals, as well as any prices charged under the Federal Supply Schedule of the General Services Administration or under State pharmaceutical assistance programs.

2. *Rebate amounts*.—The law changes the minimum basic rebates for brand name drugs to 15.7 percent of the average manufacturer price (AMP) in calendar year 1993, 15.4 percent of the AMP in 1994, 15.2 percent of the AMP in 1995, and 15.1 percent of the AMP thereafter. In each calendar year, the basic rebate is the greater of the percentage stated, or the difference between the AMP and the best price.

The following is a summary of major Medicaid changes enacted in the Omnibus Budget Reconciliation Act of 1993 (OBRA 1993), Public Law 103–66.

1. *Medicaid fraud control units*.—The law changed the State option to a requirement that each State operate a Medicaid fraud and abuse control unit unless the State demonstrates that effective operation of a unit would not be cost effective and that, in the absence of a unit, beneficiaries would be protected from abuse and neglect.
2. *Prescription drug formularies*.—States have been prohibited from using drug formularies (lists of covered and excluded drug products) and from imposing restrictions on new drug products for 6 months after a drug is approved by the Food and Drug Administration. States are allowed to use formularies to cover only the State's designated drug(s) in a class of therapeutic alternatives and impose certain requirements on prescriptions for new drugs.
3. *Asset and trust provisions*.—Some individuals must spend their assets down to a State-established level before Medicaid pays for nursing facility and other medical care. To try to ensure that these persons apply their assets to the cost of their care and do not give them away in order to gain Medicaid eligibility sooner than they otherwise would, Medicaid prohibits persons from transferring assets for less than fair market value. OBRA 1993 amends Medicaid law to close loopholes that allow individuals to shelter or divest assets in order to become eligible for Medicaid-covered long-term care. States are required to provide for a delay in Medicaid eligibility for institutionalized persons or their spouses who dispose of assets for less than fair market value. A transfer that occurred during the 36-month period prior to an application for coverage would trigger a period of ineligibility beginning with the month the assets were transferred. Under the OBRA 1993 amendments, the period of ineligibility is determined by comparing the cost of care and the fair market value of the assets transferred. States are required to seek recovery of Medicaid expenditures from the estate of a deceased beneficiary who received certain Medicaid benefits. Amounts paid by Medicaid for nursing facility services, home and community-based care, and related hospital and prescription drug services must be recovered from the estates of individuals who were over age 55 when such services were received. OBRA 1993 provides for exemptions to these asset transfer and recovery provisions if application of the law would result in "undue hardship" according to criteria established by the Secretary.
4. *Child support enforcement*.—A child who is covered by Medicaid may also be covered by private health insurance that is

carried by a noncustodial parent. To improve medical support for children, Medicaid law is amended to mandate that States have laws in effect to require the cooperation of employers and insurers in obtaining parental coverage.

5. *Disproportionate share hospitals (DSH).*—States are prohibited from designating a hospital as a DSH unless Medicaid beneficiaries account for at least 1 percent of the hospital's impatient days. In addition, the law requires that DSH payments to a State or locally owned or operated facility cannot exceed the costs the facility incurs in furnishing inpatient or outpatient service to Medicaid beneficiaries or uninsured patients. For this purpose, a facility's cost is net of payments received from Medicaid (other than DSH payments) and from uninsured individuals.
6. *Physician referral.*—Medicaid payments for designated health services (including clinical laboratory, physical and occupational therapy, radiology, or other diagnostic services, home health and other services) are limited if such services are furnished upon referral from a physician who has a specified financial relationship with the provider furnishing the service.
7. *Childhood immunization.*—A new entitlement program is established under which States are entitled to receive vaccines purchased by the Federal Government for federally eligible children up to age 18. Providers registered in a State's immunization program are entitled to receive free vaccines for children covered under the new law. Children eligible to receive federally purchased vaccines are Medicaid-eligible, American Indian or Alaska Native, children whose health insurance does not cover the cost of vaccines, and children who receive immunization at federally qualified health centers or rural health clinics.
8. *Tuberculosis-related services.*—States are permitted to provide Medicaid coverage for outpatient tuberculosis-related services to tuberculosis-infected individuals who meet the income and resource limits that apply to disabled persons.

PROGRAM DATA

Under current law, Federal Medicaid outlays are projected to reach $105.8 billion in fiscal year 1997, an 11-percent increase over the $94.9 billion projected for fiscal year 1996. This and other Medicaid Program data are presented in tables 16–13 to 16–24.

TABLE 16–13.—HISTORY OF MEDICAID PROGRAM COSTS, 1966–97

Fiscal year	Total: Dollars (in millions)	Total: Percent increase	Federal: Dollars (in millions)	Federal: Percent increase	State: Dollars (in millions)	State: Percent increase
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	132,010	11.7	75,774	11.7	56,236	11.7
1994	143,919	9.0	82,034	8.3	61,885	10.0
1995	156,263	8.6	89,070	8.6	67,193	8.6
1996 [7]	166,477	6.5	94,892	6.5	71,585	6.5
1997 [7]	185,212	11.2	105,571	11.2	79,641	11.2

[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 (ICFs) 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., five 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.

Source: Budget of the U.S. Government, fiscal years 1969–97 (see Office of the President, 1996, in reference list), and Health Care Financing Administration, Division of Budget.

TABLE 16–14.—UNDUPLICATED NUMBER OF MEDICAID RECIPIENTS BY ELIGIBILITY CATEGORY, FISCAL YEARS 1972–94

[Numbers in thousands]

Fiscal year	Total recipients	Age 65 or over	Blindness	Permanent and total disabled	Dependent children under age 21	Adults in family with dependent children	Other
1972	17,606	3,318	108	1,625	7,841	3,137	1,576
1973	19,622	3,496	101	1,804	8,659	4,066	1,495
1974	21,462	3,732	135	2,222	9,478	4,392	1,502
1975	22,007	3,615	109	2,355	9,598	4,529	1,800
1976	22,815	3,612	97	2,572	9,924	4,774	1,836
1977 [1]	22,832	3,636	92	2,710	9,651	4,785	1,959
1978	21,965	3,376	82	2,636	9,376	4,643	1,852
1979	21,520	3,364	79	2,674	9,106	4,570	1,727
1980 [2]	21,605	3,440	92	2,819	9,333	4,877	1,499
1981 [2]	21,980	3,367	86	2,993	9,581	5,187	1,364
1982 [2]	21,603	3,240	84	2,806	9,563	5,356	1,434
1983 [2]	21,554	3,371	77	2,844	9,535	5,592	1,129
1984 [2]	21,607	3,238	79	2,834	9,684	5,600	1,187
1985 [2]	21,814	3,061	80	2,937	9,757	5,518	1,214
1986 [2]	22,515	3,140	82	3,100	10,029	5,647	1,362
1987 [2]	23,109	3,224	85	3,296	10,168	5,599	1,418
1988 [2]	22,907	3,159	86	3,401	10,037	5,503	1,343
1989 [2]	23,511	3,132	95	3,496	10,318	5,717	1,175
1990 [3]	25,255	3,202	83	3,635	11,220	6,010	1,105
1991 [3]	28,280	3,359	85	3,983	13,415	6,778	658
1992 [3]	30,926	3,742	84	4,378	15,104	6,954	664
1993 [3]	33,432	3,863	84	4,932	16,285	7,505	642

TABLE 16–14.—UNDUPLICATED NUMBER OF MEDICAID RECIPIENTS BY ELIGIBILITY CATEGORY, FISCAL YEARS 1972–94—Continued

[Numbers in thousands]

Fiscal year	Total recipients	Age 65 or over	Blindness	Permanent and total disabled	Dependent children under age 21	Adults in family with dependent children	Other
1994 [3]	35,053	4,035	87	5,372	17,194	7,586	573

[1] Fiscal year 1997 began in October 1976 and was the first year of the new Federal fiscal cycle. Before 1977, the fiscal year began in July.

[2] 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.

[3] Recipient categories do not add to the unduplicated total due to "unknown."

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

TABLE 16–15.—MEDICAID RECIPIENTS BY BASIS OF ELIGIBILITY BY STATE, FISCAL YEAR 1994

State	Total recipients	Aged	Blind	Disabled	AFDC children	AFDC adults	Other
Alabama	543,537	71,473	1,580	123,669	244,281	98,852	2,597
Alaska	68,854	4,456	95	5,921	38,836	19,546	0
Arizona	509,663	26,700	804	58,379	309,537	114,243	0
Arkansas	339,920	51,953	1,260	82,221	112,370	58,547	30,669
California	5,007,635	510,470	24,655	678,923	2,259,597	1,422,414	81,900
Colorado	289,423	36,840	154	41,059	142,193	66,733	2,444
Connecticut	354,473	63,321	289	44,434	165,726	80,701	2
Delaware	74,800	5,819	117	10,907	40,397	15,594	1,614
District of Columbia	127,208	9,365	168	21,509	67,278	28,774	114
Florida	1,727,034	204,302	3,189	247,881	990,980	229,455	51,227
Georgia	1,084,929	104,296	10,415	168,190	542,580	246,953	163
Hawaii	120,793	16,468	14	12,757	59,680	27,840	0
Idaho	110,043	9,022	48	16,737	59,333	24,407	496
Illinois	1,441,034	116,261	1,322	258,471	719,431	313,273	32,276
Indiana	604,770	69,545	1,037	66,109	319,276	144,423	0
Iowa	302,535	38,425	584	46,690	135,634	74,821	5,595
Kansas	251,742	25,523	115	35,748	125,396	58,409	136
Kentucky	637,558	63,112	1,853	143,295	272,754	134,178	0
Louisiana	778,223	100,878	1,795	147,520	375,960	152,070	0
Maine	176,998	23,245	254	33,229	76,758	37,922	4,801
Maryland	415,101	46,492	288	80,868	198,228	80,217	9,008
Massachusetts	710,490	102,417	6,842	140,879	304,265	156,087	0
Michigan	1,186,621	83,543	2,113	211,069	571,418	316,712	1,766
Minnesota	425,563	59,503	564	68,241	196,612	97,779	2,864
Mississippi	536,916	65,009	1,580	115,720	258,293	83,153	1,782
Missouri	668,765	89,812	1,113	90,881	328,035	157,499	0
Montana	96,206	9,119	80	15,155	34,379	23,587	11,917
Nebraska	164,440	21,031	239	22,053	73,565	25,153	22,399
Nevada	95,411	10,642	425	13,848	46,086	21,868	1,644
New Hampshire	85,555	12,837	411	10,496	42,247	19,136	150

TABLE 16–15.—MEDICAID RECIPIENTS BY BASIS OF ELIGIBILITY BY STATE, FISCAL YEAR 1994—Continued

State	Total recipients	Aged	Blind	Disabled	AFDC children	AFDC adults	Other
New Jersey	789,692	88,479	1,229	135,452	363,967	190,084	153
New Mexico	268,204	17,922	641	37,049	151,993	60,599	0
New York	2,907,963	367,833	3,764	467,563	1,300,163	596,873	171,767
North Carolina	985,273	137,899	934	112,432	491,043	242,965	0
North Dakota	62,769	10,943	23	8,383	26,556	13,312	2,496
Ohio	1,523,296	185,106	998	209,919	784,774	339,301	3,198
Oklahoma	390,628	53,181	696	52,150	197,674	86,329	600
Oregon	411,311	33,656	1,269	42,973	172,182	79,421	0
Pennsylvania	1,255,358	142,712	822	262,758	580,848	236,787	29,980
Rhode Island	114,850	18,949	219	24,437	43,896	26,895	454
South Carolina	486,110	77,542	1,852	86,068	231,724	87,582	1,342
South Dakota	72,151	9,360	163	12,389	36,598	13,542	0
Tennessee	938,711	105,085	2,992	199,627	451,584	166,889	12,534
Texas	2,513,959	308,543	4,155	246,866	1,407,134	547,261	0
Utah	157,099	9,415	155	16,967	86,489	43,511	0
Vermont	94,150	10,291	80	13,481	46,907	20,660	12
Virginia	642,947	85,077	1,112	95,751	334,420	126,587	0
Washington	668,363	53,495	393	100,605	328,483	176,968	6,642
West Virginia	366,638	34,612	305	67,243	160,734	99,890	3,854
Wisconsin	473,740	67,960	1,206	103,049	141,358	84,776	73,162
Wyoming	50,544	4,627	11	5,458	26,152	10,731	525
Puerto Rico	926,518	159,533	415	57,105	709,465	0	0
Virgin Islands	16,499	1,280	9	967	9,156	4,463	624
United States	34,109,996	3,874,566	86,422	5,313,479	16,475,804	7,581,309	572,283
All jurisdictions	35,053,013	4,035,379	86,846	5,371,551	17,194,425	7,585,772	572,907

Note.—Total recipients include unknowns which are not reflected in this table.

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

TABLE 16–16.—MEDICAID EXPENDITURES BY BASIS OF ELIGIBILITY BY STATE, FISCAL YEAR 1994

State	Total expenditures	Aged	Blind	Disabled	AFDC children	AFDC adults	Other	Aged, blind and disabled [2]	AFDC children [2]
Alabama	1,312	411	5	524	191	175	5	71.7	14.6
Alaska	243	42	1	67	76	57	0	45.2	31.5
Arizona	199	13	1	63	73	50	0	38.2	36.8
Arkansas	1,253	350	7	591	122	77	98	75.7	9.7
California	9,988	2,577	107	3,538	1,468	2,067	179	62.3	14.7
Colorado	952	302	4	358	138	138	12	69.7	14.5
Connecticut	1,943	902	4	664	213	160	([1])	80.8	11.0
Delaware	277	72	1	126	41	30	5	71.9	14.7
District of Columbia	550	146	1	257	94	52	([1])	73.4	17.1
Florida	4,266	1,324	14	1,486	1,052	323	67	66.2	24.7
Georgia	2,845	577	97	971	576	602	([1])	57.8	20.2
Hawaii	338	147	([1])	87	50	52	0	69.3	14.8
Idaho	331	83	([1])	149	52	45	1	70.3	15.7
Illinois	4,826	934	10	2,368	807	586	121	68.6	16.7
Indiana	2,250	769	7	801	381	283	0	70.1	16.9
Iowa	982	271	2	418	160	123	7	70.5	16.3
Kansas	782	230	1	314	129	98	([1])	69.7	16.5
Kentucky	1,779	435	8	776	279	265	0	68.5	15.7
Louisiana	2,684	661	12	1,132	519	361	0	67.2	19.3
Maine	807	286	1	318	101	81	20	75.0	12.5
Maryland	1,875	474	2	843	300	185	71	70.4	16.0
Massachusetts	3,052	1,308	72	1,073	351	248	0	80.4	11.5
Michigan	3,274	724	11	1,558	502	473	5	70.1	15.3
Minnesota	1,982	836	7	826	178	133	2	84.2	9.0
Mississippi	1,090	297	5	445	205	132	5	68.6	18.8
Missouri	1,809	593	5	649	332	229	0	68.9	18.3
Montana	303	98	([1])	115	35	38	14	70.7	11.7
Nebraska	593	199	2	205	85	45	56	68.5	14.4
Nevada	307	71	3	119	51	43	14	62.9	16.7
New Hampshire	389	181	8	129	43	28	([1])	81.6	11.1

TABLE 16–16.—MEDICAID EXPENDITURES BY BASIS OF ELIGIBILITY BY STATE, FISCAL YEAR 1994—Continued

State	Total expenditures	Aged	Blind	Disabled	AFDC children	AFDC adults	Other	Aged, blind and disabled [2]	AFDC children [2]
New Jersey	3,612	1,132	10	1,601	367	486	1	75.9	10.2
New Mexico	638	118	5	252	163	100	0	58.8	25.5
New York	18,731	6,906	97	7,439	2,377	1,604	308	77.1	12.7
North Carolina	2,685	832	10	851	557	434	0	63.1	20.8
North Dakota	284	112	(1)	115	30	22	3	80.0	10.7
Ohio	4,995	1,816	5	1,792	803	578	1	72.3	16.1
Oklahoma	974	307	2	333	220	111	(1)	65.9	22.6
Oregon	1,036	237	24	367	234	117	0	60.6	22.6
Pennsylvania	4,224	1,665	3	1,630	534	348	42	78.1	12.6
Rhode Island	685	208	30	294	87	63	4	77.7	12.6
South Carolina	1,396	387	7	569	257	175	1	69.0	18.4
South Dakota	284	96	1	124	42	22	0	77.6	14.7
Tennessee	1,965	535	9	770	368	233	52	66.8	18.7
Texas	6,141	1,637	22	1,810	1,527	1,145	0	56.5	24.9
Utah	451	83	1	165	95	97	0	55.3	21.1
Vermont	259	80	1	110	40	28	(1)	73.6	15.3
Virginia	1,723	549	6	643	299	226	0	69.6	17.3
Washington	1,574	496	2	558	232	282	2	67.1	14.7
West Virginia	1,107	268	1	432	158	197	50	63.4	14.3
Wisconsin	1,830	756	8	753	102	114	95	82.9	5.6
Wyoming	157	43	(1)	60	27	24	1	65.5	17.1
Puerto Rico	233	39	(1)	14	180	0	0	22.8	77.2
Virgin Islands	8	2	(1)	1	2	2	(1)	45.0	26.1
United States	108,029	33,576	644	41,639	17,121	13,583	1,242	70.2	15.8
All jurisdictions	108,270	33,618	644	41,654	17,302	13,585	1,243	70.1	10.0

[1] Denotes expenditures of less than $500,000. [2] As percentage of total spending.

Note.—In millions; total expenditures include unknowns which are not reflected in this table.

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

TABLE 16–17.—TOTAL AND PER CAPITA MEDICAID PAYMENTS FOR CATEGORICALLY NEEDY AND MEDICALLY NEEDY, FISCAL YEARS 1975, 1981, 1992, AND 1994

Category of needy	1975			1981			1992			1994			Percent change 1975–94	
	Total amount (millions)	Percent of total	Per capita	Total amount (millions)	Percent of total	Per capita	Total amount (millions)	Percent of total	Per capita	Total amount (millions)	Percent of total	Per capita	Total spending	Per capita
Categorically needy:														
Receiving cash payments	$7,188	58.7	$431	$14,534	53.4	$861	$41,742	46.0	$2,238	$49,682	45.9	$2,519	591.2	484.5
Aged	1,341	11.0	555	2,480	9.1	1,270	5,795	6.4	3,778	6,485	6.0	4,273	383.6	669.9
Blind	61	0.5	717	109	0.4	1,527	334	0.4	4,669	373	0.3	5,464	511.5	662.1
Disabled	2,042	16.7	1,094	5,616	20.6	2,490	19,863	21.9	6,097	25,683	23.7	6,549	1,157.7	498.6
AFDC children	1,850	15.1	222	3,002	11.0	361	8,376	9.2	891	9,259	8.6	963	400.5	333.8
Adults in AFDC families	1,895	15.5	478	3,328	12.2	769	7,374	8.1	1,682	7,882	7.3	1,712	315.9	258.2
Not receiving cash payments	1,753	14.3	1,261	4,736	17.4	2,641	16,064	17.7	4,243	18,173	16.8	4,057	936.7	221.7
Aged	1,275	10.4	2,331	3,143	11.6	5,273	7,085	7.8	11,658	8,068	7.5	12,977	532.8	456.7
Blind	12	0.1	1,094	19	0.1	2,785	80	0.1	15,310	87	0.1	18,377	625.0	1,579.8
Disabled	353	2.9	1,854	1,214	4.5	5,146	5,065	5.6	11,913	5,236	4.8	11,044	1,383.3	495.7
AFDC children	61	0.5	152	153	0.6	302	1,764	1.9	1,156	2,440	2.3	1,177	3,900.0	674.3
Adults in AFDC families	27	0.2	144	87	0.3	298	1,428	1.6	1,606	1,566	1.4	1,637	5,700.0	1,036.8
Other	25	0.2	463	120	0.4	734	643	0.7	1,927	778	0.7	2,232	3,012.0	382.1
Total	8,941	73.0	495	19,270	70.8	1,032	57,807	63.7	2,577	67,855	62.7	2,803	658.9	466.3
Medically needy:														
Aged	1,742	14.2	2,672	4,303	15.8	5,260	8,927	9.8	11,724	9,383	8.7	11,833	438.6	342.9
Blind	20	0.2	1,472	27	0.1	3,132	71	0.1	21,865	69	0.1	18,463	245.0	1,154.3
Disabled	657	5.4	2,202	2,471	9.1	4,924	5,243	5.8	13,876	5,838	5.4	13,064	788.6	493.3
AFDC children	274	2.2	324	353	1.3	460	1,592	1.8	943	1,839	1.7	1,004	571.2	209.9

TABLE 16–17.—TOTAL AND PER CAPITA MEDICAID PAYMENTS FOR CATEGORICALLY NEEDY AND MEDICALLY NEEDY, FISCAL YEARS 1975, 1981, 1992, AND 1994—Continued

Category of needy	1975			1981			1992			1994			Percent change 1975–94	
	Total amount (millions)	Percent of total	Per capita	Total amount (millions)	Percent of total	Per capita	Total amount (millions)	Percent of total	Per capita	Total amount (millions)	Percent of total	Per capita	Total spending	Per capita
Adults in AFDC families	140	1.1	368	348	1.3	613	1,265	1.4	1,930	1,497	1.4	1,980	969.3	438.0
Other	467	3.8	267	433	1.6	360	268	0.3	1,844	277	0.3	2,135	−40.7	699.6
Total	3,301	27.0	838	7,935	29.2	2,145	17,367	19.1	4,782	18,903	17.5	4,771	472.6	469.3
Grand total	12,242	100.0	556	27,205	100.0	1,216	90,814	100.0	2,936	108,270	100.0	3,089	784.4	455.6

Note.—Totals may not addd due to rounding. Fiscal year 1975 ends in June; fiscal years 1981 and 1988 end in September. Total includes other coverage groups and unknowns. Other categories not shown in the total for 1994 are: Other coverage pre-1988, $13,582; coverage from 1988, $7,705; and medical assistance status unknown, $225.

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

TABLE 16–18.—MEDICAID RECIPIENTS AND PAYMENTS BY BASIS OF ELIGIBILITY, FISCAL YEAR 1994

Basis of eligibility	Amount (in millions)	Percent of total	Recipients (in thousands)	Percent of total	Per capita payments
Aged	$33,618	31.0	4,035	11.5	$8,330.8
Blind	644	0.6	87	0.2	7,412.0
Disabled	41,654	38.5	5,372	15.3	7,754.6
AFDC child	17,302	16.0	17,194	49.1	1,006.3
AFDC adult	13,585	12.5	7,586	21.6	1,790.8
Other	1,243	1.1	573	1.6	2,168.8
Total	108,270	100.0	35,053	100.0	3,088.8

Note.—Recipients and payments total include unknowns which are not shown in this table.

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

TABLE 16–19.—MEDICAID PAYMENTS AND PER CAPITA PAYMENTS BY BASIS OF ELIGIBILITY, SELECTED FISCAL YEARS 1975–94

[In millions of dollars]

Basis of eligibility	Fiscal year 1975	1981	1984	1985	1986	1987	1988	1989	1990	1991	1992	1994	Percent change 1975–94
	[In nominal dollars]												
Payments:													
Age 65 and over	4,358	9,926	12,815	14,096	15,097	16,037	17,135	18,558	21,508	25,453	29,078	33,618	671.4
Blind	93	154	219	249	277	309	344	409	434	475	530	644	593.0
Disabled	3,052	9,301	11,758	13,203	14,635	16,507	18,250	20,476	23,969	27,798	33,326	41,654	1,264.7
Dependent children under age 21	2,186	3,508	3,979	4,414	5,135	5,508	5,848	6,892	9,100	11,690	14,491	17,302	691.5
Adults in families with dependent children	2,062	3,763	4,420	4,746	4,880	5,592	5,883	6,897	8,590	10,439	12,185	13,585	558.9
Other	492	552	700	798	980	1,078	1,198	1,137	1,051	973	1,032	1,243	152.7
Total [1]	12,242	27,204	33,891	37,508	41,005	45,050	48,710	54,500	64,859	77,048	90,814	108,270	784.4
Per capita payment:													
Age 65 and over	1,205	2,948	3,957	4,605	4,808	4,975	5,425	5,926	6,717	7,577	7,770	8,331	591.1
Blind	850	1,784	2,766	3,104	3,401	3,644	4,005	4,319	5,212	5,572	6,298	7,412	772.1
Disabled	1,296	3,108	4,149	4,496	4,721	5,008	5,366	5,858	6,595	6,979	7,612	7,755	498.3
Dependent children under age 21	228	366	411	452	512	542	583	668	811	871	959	1,006	341.8
Adults in families with dependent children	455	725	789	860	864	999	1,069	1,206	1,429	1,540	1,752	1,791	293.4
Other	273	405	590	658	719	761	891	967	1,062	1,732	1,814	2,169	694.0
Total, per capita payment	556	1,238	1,569	1,719	1,821	1,949	2,126	2,318	2,568	2,725	2,936	3,089	455.2
	[In constant 1994 dollars]												
Payments:													
Age 65 and over	12,135	16,445	18,348	....	20,348	....	21,563	22,294	24,609	27,725	30,747	33,618	177.0

Blind	259	255	314	....	373	....	433	491	497	517	560	644	148.7
Disabled	8,499	15,410	16,835	....	19,725	....	22,967	24,598	27,425	30,279	35,238	41,654	390.1
Dependent children under age 21	6,087	5,812	5,697	....	6,921	....	7,359	8,279	10,412	12,733	15,323	17,302	184.2
Adults in families with dependent children	5,742	6,234	6,323	....	6,577	....	7,403	8,285	9,829	11,371	12,884	13,585	136.6
Other	1,370	915	1,002	....	1,321	....	1,508	1,366	1,203	1,360	1,091	1,243	9.3
Total [1]	34,089	45,070	48,524	....	55,267	....	61,299	65,470	74,212	83,325	96,025	108,270	217.6
Per capita payment:													
Age 65 and over	3,355	4,884	5,666	....	5,480	....	6,827	7,119	7,686	8,253	8,216	8,331	138.3
Blind	2,367	2,956	3,960	....	4,584	....	5,040	5,183	5,964	6,069	6,659	7,412	213.2
Disabled	3,609	5,249	5,940	....	6,363	....	6,753	7,037	7,546	7,602	8,049	7,755	114.9
Dependent children under age 21	635	606	588	....	690	....	734	802	928	949	1,014	1,006	58.5
Adults in families with dependent children	1,267	1,201	1,130	....	1,164	....	1,345	1,449	1,635	1,677	1,853	1,791	41.4
Other	760	671	845	....	969	....	1,021	1,162	1,215	1,887	1,918	2,169	185.3
Total, per capita payment	1,548	2,051	2,246	....	2,454	....	2,675	2,785	2,938	2,968	3,104	3,089	99.5

[1] Data includes unknowns.

Note.—Total may not add due to rounding. Fiscal year 1975 ends in June; all other fiscal years end in September. Nominal dollars converted of constant dollars using CPI–U price index. Total expenditures includes other coverage groups and unknowns for fiscal year 1994.

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

TABLE 16–20.—MEDICAID PAYMENTS BY SERVICE CATEGORY, FISCAL YEARS 1975, 1981, 1990, AND 1994

[In millions of constant 1994 dollars]

Service category	1975		1981		1990		1994		Average annual percent change 1975–92
	Amount	Percent	Amount	Percent	Amount	Percent	Amount	Percent of total	
Inpatient hospital	$9,396	30.9	$11,693	29.7	$18,388	28.4	$28,237	26.1	5.6
General	8,389	27.6	10,423	26.4	16,674	25.7	26,180	24.2	5.8
Mental	1,007	3.3	1,271	3.2	1,714	2.6	2,057	1.9	4.2
Skilled nursing facilities	[1] 6,052	19.9	5,846	14.8	8,026	12.4	27,095	25.0	7.8
Intermediate care facilities	5,632	18.5	10,870	27.6	17,021	26.2	8,347	7.7	([1])
Intermediate care facilities for the mentally retarded	945	3.1	4,341	11.0	7,354	11.3			2.0
Other	4,687	15.4	6,530	16.6	9,667	14.9	7,189	6.6	3.7
Physician	3,046	10.0	3,044	7.7	4,018	6.2	969	0.9	−0.4
Dental	843	2.8	787	2.0	593	0.9	1,040	1.0	2.7
Other practitioner	316	1.0	330	0.8	372	0.6	6,342	5.9	10.3
Outpatient hospital	927	3.0	2,041	5.2	3,324	5.1	3,747	3.5	6.0
Clinic	967	3.2	540	1.4	1,688	2.6	1,176	1.1	6.8
Lab and x ray	313	1.0	213	0.5	721	1.1	7,042	6.5	21.1
Home health	174	0.6	620	1.6	3,404	5.2	8,875	8.2	6.9
Prescribed drugs	2,026	6.7	2,224	5.6	4,420	6.8	516	0.5	6.2
Family planning	167	0.5	201	0.5	265	0.4	980	0.9	([1])
Early and periodic screening	([2])	([2])	97	0.2	198	0.3	188	0.2	([1])
Rural health clinic	([2])	([2])	6	0.0	34	0.1			
Other	579	1.9	897	2.3	2,385	3.7	6,522	6.0	10.8
Total	30,440	100.0	39,414	100.0	64,859	100	108,270	100.0	6.1

[1] Prior to fiscal year 1991, there were two categories of Medicaid nursing home care: skilled nursing facilities and intermediate nursing facilities.
[2] 1975 data not available.

Note.—Totals may not add due to rounding. Fiscal year 1975 ends in June; all other fiscal years end in September. Spending amounts converted to constant dollars using the Consumer Price Index (CPI–U). Data exclude unknowns.

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

TABLE 16–21.—MEDICAID RECIPIENTS BY SERVICE CATEGORY, SELECTED FISCAL YEARS 1975–94

[In thousands]

Service category	Fiscal year						
	1975	1981	1989	1990	1991	1992	1994
Inpatient hospital:							
General	3,432	3,703	4,171	4,593	5,137	5,768	5,866
Mental	67	90	90	92	5,072	77	85
Nursing facilities [1]	1,312	1,385	1,452	1,461	1,499	1,573	1,639
Intermediate care facilities for the mentally retarded	69	151	148	147	146	151	159
Physician	15,198	14,403	15,686	17,078	19,321	21,627	24,267
Dental	3,944	5,173	4,214	4,552	5,209	5,700	6,352
Other practitioner	2,673	3,582	3,555	3,873	4,282	4,711	5,409
Outpatient hospital	7,437	10,018	11,344	12,370	14,137	15,120	16,567
Clinic	1,086	1,755	2,391	2,804	3,511	4,115	5,258
Laboratory & x ray	4,738	3,822	7,759	8,959	10,505	11,804	13,412
Home health	343	402	609	719	813	925	1,293
Prescribed drugs	14,155	14,256	15,916	17,294	19,602	22,030	24,471
Family planning	1,217	1,473	1,564	1,752	2,185	2,550	2,566
Early and periodic screening	(2)	1,969	2,524	2,952	3,957	4,982	6,456
Rural health clinics	(2)	81	166	224	405	743	945
Other	2,911	2,344	4,583	5,126	5,957	6,702	9,908
Unduplicated total	22,007	21,980	23,511	25,255	28,280	30,926	35,053

[1] Prior to fiscal year 1991, there were two categories of Medicaid nursing home care: skilled nursing facilities and intermediate nursing facilities.
[2] 1975 data not available.

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

TABLE 16–22.—MEDICAL VENDOR PAYMENTS BY BASIS OF ELIGIBILITY AND TYPE OF SERVICE, FISCAL YEAR 1994

Type of service	Aged	Blind	Disabled	AFDC		Other	Total
				Children	Adults		
			[In millions of dollars]				
Inpatient hospital services	1,963.7	88.0	10,862.6	6,902.5	5,768.0	494.3	26,079.1
Mental hospital services for the aged	782.1	0.5	41.0	6.8	2.3	9.3	842.0
SNF/ICF mental health services for the aged	54.9	0.0	4.2	0.0	0.0	0.0	59.1
Inpatient psychiatric services, aged under 21	0.5	0.3	428.8	544.5	12.2	165.4	1,151.7
ICF services for the mentally retarded	584.9	103.0	7,598.1	45.5	1.9	3.8	8,337.2
Nursing facilities services	22,660.3	190.5	4,172.0	24.1	24.3	8.1	27,079.3
Physicians services	543.9	27.2	1,911.7	2,270.7	2,290.2	124.0	7,167.7
Dental services	55.8	1.5	158.2	516.9	212.3	22.6	967.2
Other practitioners services	84.9	2.9	437.8	311.7	153.1	48.7	1,039.1
Outpatient hospital services	454.0	22.9	2,165.2	1,925.1	1,673.8	89.7	6,330.6
Clinic services	218.0	24.5	2,075.8	811.6	545.3	65.4	3,740.6
Home health services	2,663.0	69.2	4,005.9	203.5	73.6	24.4	7,039.7
Family planning services	1.2	0.5	34.7	53.0	417.9	7.3	514.6
Lab and x-ray services	66.0	4.0	364.7	249.6	475.3	13.5	1,173.1
Prescribed drugs	2,650.6	62.5	4,084.1	1,063.1	960.9	46.7	8,867.9
Early and periodic screening	0.2	1.7	148.8	768.0	28.2	25.7	972.6
Rural health clinic services	6.9	0.3	32.0	100.2	46.3	2.4	188.1
Other care	823.0	44.3	3,129.4	1,505.1	898.8	91.2	6,491.8
Unknown/error	0.6	0.0	2.6	0.6	0.1	0.0	3.8
Total	33,617.8	643.7	41,654.1	17,302.5	13,584.7	1,242.5	108,045.2

[In percent]

Inpatient hospital services	5.8	13.7	26.1	39.9	42.5	39.8	24.1
Mental hospital services for the aged	2.3	0.1	0.1	0.0	0.0	0.7	0.8
SNF/ICF mental health services for the aged	0.2	0.0	0.0	0.0	0.0	0.0	0.1
Inpatient psychiatric services, aged under 21	0.0	0.0	1.0	3.1	0.1	13.3	1.1
ICF services for the mentally retarded	1.7	16.0	18.2	0.3	0.0	0.3	7.7
Nursing facilities services	67.4	29.6	10.0	0.1	0.2	0.7	25.1
Physicians services	1.6	4.2	4.6	13.1	16.9	10.0	6.6
Dental services	0.2	0.2	0.4	3.0	1.6	1.8	0.9
Other practitioners services	0.3	0.5	1.1	1.8	1.1	3.9	1.0
Outpatient hospital services	1.4	3.6	5.2	11.1	12.3	7.2	5.9
Clinic services	0.6	3.8	5.0	4.7	4.0	5.3	3.5
Home health services	7.9	10.8	9.6	1.2	0.5	2.0	6.5
Family planning services	0.0	0.1	0.1	0.3	3.1	0.6	0.5
Lab and x-ray services	0.2	0.6	0.9	1.4	3.5	1.1	1.1
Prescribed drugs	7.9	9.7	9.8	6.1	7.1	3.8	8.2
Early and periodic screening	0.0	0.3	0.4	4.4	0.2	2.1	0.9
Rural health clinic services	0.0	0.1	0.1	0.6	0.3	0.2	0.2
Other care	2.4	6.9	7.5	8.7	6.6	7.3	6.0
Unknown/error	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0

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

TABLE 16–23.—AVERAGE EXPENDITURE PER RECIPIENT BY BASIS OF ELIGIBILITY BY STATE, FISCAL YEAR 1994

State	Total	Aged	Blind	Disabled	AFDC		Other
					Children	Adults	
Alabama	$2,414	$5,747	$3,331	$4,241	$783	$1,766	$1,854
Alaska	3,531	9,443	6,161	11,360	1,970	2,902	0
Arizona	390	469	877	1,076	236	436	0
Arkansas	3,687	6,737	5,918	7,192	1,083	1,314	3,198
California	1,995	5,048	4,343	5,211	650	1,453	2,180
Colorado	3,288	8,186	26,386	8,713	973	2,072	4,819
Connecticut	5,482	14,250	13,983	14,936	1,285	1,985	783
Delaware	3,699	12,330	7,157	11,591	1,008	1,950	2,972
District of Columbia	4,326	15,573	8,337	11,940	1,398	1,805	1,893
Florida	2,470	6,481	4,491	5,995	1,061	1,407	1,313
Georgia	2,623	5,534	9,315	5,771	1,062	2,436	2,229
Hawaii	2,798	8,920	10,458	6,834	836	1,854	0
Idaho	3,010	9,216	8,021	8,924	878	1,860	1,785
Illinois	3,349	8,034	7,454	9,162	1,121	1,869	3,764
Indiana	3,721	11,061	6,820	12,118	1,193	1,957	0
Iowa	3,244	7,059	4,248	8,959	1,177	1,640	1,274
Kansas	3,105	9,023	4,736	8,776	1,028	1,684	1,577
Kentucky	2,790	6,894	4,228	5,414	1,021	1,974	0
Louisiana	3,449	6,553	6,438	7,674	1,380	2,371	0
Maine	4,558	12,287	5,472	9,562	1,313	2,126	4,127
Maryland	4,517	10,198	7,549	10,426	1,513	2,307	7,835
Massachusetts	4,296	12,776	10,470	7,620	1,152	1,590	0
Michigan	2,759	8,670	5,396	7,382	879	1,494	2,752
Minnesota	4,657	14,047	11,873	12,111	906	1,358	682
Mississippi	2,030	4,575	3,335	3,844	793	1,583	2,952
Missouri	2,705	6,603	4,488	7,138	1,011	1,457	0

Montana	3,148	10,793	4,917	7,614	1,031	1,591	1,174
Nebraska	3,604	9,462	7,993	9,288	1,162	1,788	2,521
Nevada	3,213	6,685	6,387	8,592	1,113	1,984	8,330
New Hampshire	4,545	14,074	18,831	12,285	1,019	1,466	462
New Jersey	4,573	12,791	7,879	11,820	1,009	2,555	3,285
New Mexico	2,380	6,574	7,872	6,815	1,071	1,655	0
New York	6,441	18,774	25,838	15,910	1,828	2,687	1,794
North Carolina	2,725	6,036	11,191	7,569	1,134	1,785	0
North Dakota	4,522	10,222	7,535	13,709	1,144	1,673	1,317
Ohio	3,279	9,813	4,595	8,538	1,023	1,704	311
Oklahoma	2,494	5,770	3,065	6,384	1,114	1,291	799
Oregon	2,519	7,035	18,731	8,536	1,358	1,474	0
Pennsylvania	3,365	11,670	3,582	6,204	919	1,469	1,407
Rhode Island	5,968	10,987	138,766	12,030	1,972	2,325	8,180
South Carolina	2,871	4,990	4,025	6,609	1,108	1,993	867
South Dakota	3,936	10,243	5,747	9,972	1,141	1,615	0
Tennessee	2,093	5,087	2,887	3,855	814	1,395	4,116
Texas	2,443	5,305	5,364	7,332	1,085	2,092	0
Utah	2,871	8,819	4,857	9,752	1,101	2,228	0
Vermont	2,756	7,786	7,442	8,172	845	1,377	2,383
Virginia	2,680	6,454	5,518	6,720	893	1,783	0
Washington	2,355	9,280	4,564	5,544	705	1,595	332
West Virginia	3,018	7,742	4,633	6,424	982	1,973	13,037
Wisconsin	3,863	11,120	6,810	7,304	724	1,351	1,293
Wyoming	3,111	9,308	1,104	10,976	1,030	2,231	2,021
Puerto Rico	251	244	211	247	254	0	0
Virgin Islands	478	1,938	135	1,105	225	475	263
United States	$3,167	$8,666	$7,447	$7,836	$1,039	$1,792	$2,171
All jurisdictions	3,089	8,331	7,412	7,755	1,006	1,791	2,169

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

TABLE 16–24.—OPTIONAL MEDICAID SERVICES AND NUMBER OF STATES [1] OFFERING EACH SERVICE, OCTOBER 1995

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
Podiatrists' services	11	29	6
Optometrists' services	14	30	6
Chiropractors' services	5	21	2
Psychologists' services	6	18	3
Medical social workers' services	1	5	1
Nurse anesthetists' services	8	13	2
Private duty nursing	7	18	3
Clinic services	15	35	5
Dental services	12	31	6
Physical therapy	11	29	4
Occupational therapy	7	24	4
Speech, hearing and language disorder	11	26	4
Prescribed drugs	16	34	6
Dentures	8	26	5
Prosthetic devices	15	32	6
Eyeglasses	13	30	....
Diagnostic services	8	23	4
Screening services	7	23	3
Preventive services	7	21	4
Rehabilitative services	15	31	6
Services for age 65 and older in mental institutions:			
A. Inpatient hospital services	13	22	5
B. SNF services	10	17	4
C. ICF/MR services	22	23	6
Inpatient psychiatric services	11	24	6
Christian science nurses	1	2	1
Christian science sanitoria	2	8	3
SNF for under age 21	14	27	6
Emergency hospital services	13	24	5
Personal care services	9	19	3
Transportation services	14	34	6
Case management services	16	26	5
Hospice services	11	23	4
Respiratory care services	2	10	4
TB related services	2	6	2

[1] Includes the territories.

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

FEDERAL HOUSING ASSISTANCE [9]

A number of Federal programs administered by the Department of Housing and Urban Development (HUD) and the Farmers Home Administration (FmHA) address the housing needs of lower income households. Housing assistance has never been provided as an entitlement to all households that qualify for aid. Instead, each year the Congress has appropriated funds for a number of new commitments. Because these commitments generally run from 2 to 50 years, the appropriation is actually spent gradually over many years. These 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 years to come. This section describes recent trends in the number and mix of new commitments, as well as trends in expenditures.

TYPES OF ASSISTANCE

The Federal Government has traditionally provided housing aid directly to lower income households in the form of rental subsidies and mortgage-interest subsidies. The 1990 Cranston-Gonzalez National Affordable Housing Act (hereafter referred to as the 1990 Housing Act), authorized a new, indirect approach in the form of housing block grants to State and local governments, which may use these funds for various housing assistance activities specified in the law. Both the number of households receiving aid and total Federal expenditures have steadily increased each year, but the growth in assisted households has slowed since the 1980s.

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 improve housing quality and to reduce housing costs for lower income households. Other goals have included promoting residential construction, expanding housing opportunities for disadvantaged groups and groups with special housing needs, promoting neighborhood preservation and revitalization, increasing home ownership, and, most recently, 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.

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[9] This discussion draws directly from Congressional Budget Office (1988). For this report, CBO has updated all figures with 7 additional years of data. For a more recent study on these topics, see Congressional Budget Office (1994).

Traditional rental assistance

Most Federal housing aid is now targeted to very-low-income renters through the rental assistance programs administered by HUD and the FmHA (Congressional Research Service, 1991; 1993). Rental assistance is provided through two basic approaches: (1) project-based aid, which is typically tied to projects specifically produced for lower 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' 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 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 FmHA.[10] New commitments are being funded through three of the four—the Public Housing Program, a modified version of the section 8 New Construction Program for elderly and disabled families only, and the section 515 program. Some assistance has also been funded annually under two small HUD programs authorized in 1983—the rental housing development grants (HoDAG) and the Rental Rehabilitation Block Grant Programs.[11] These programs distributed funds through a national competition and by formula, respectively, to units of local government that meet eligibility criteria established by statute.

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. These components, all of which are currently active, include 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 (FHA); 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 tied to units that are brought up to standard by the owner.[12]

Household-based subsidies are provided through two other components of the section 8 Existing-Housing Program—section 8 rental certificates and vouchers. These programs, both of which are currently active, tie aid to households that choose standard units in the private housing stock. Certificate holders generally must oc-

[10] 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.

[11] 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.

[12] 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.

cupy 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.

Traditional homeowners' 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.[13] Most of this aid has been provided through the section 502 program administered by the FmHA. 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. Many homebuyers, 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. This 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.[14] Both programs generally reduce mortgage payments, property taxes, and insurance costs to a fixed percentage of income, ranging from 20 percent for the FmHA Program to 28 percent for the latest commitments made under the HUD Program. Households with relatively low incomes generally would have to pay larger shares, however, since mortgage payments must cover a minimum interest rate—currently 1 percent and 4 percent for the FmHA and HUD Programs, respectively. Starting in 1991, however, the FmHA has allowed some very-low-income households to defer up to 25 percent of their monthly payments, subject to later repayment.

New directions in housing assistance

The 1990 Housing Act authorized several new housing assistance approaches. The major initiatives of the 1990 act are: the HOME Investment Partnerships Block Grant Program, the Home Ownership and Opportunity for People Everywhere (HOPE) Program, and the National Home Ownership Trust Demonstration. For 1996, funds were appropriated only for the HOME Program.

The HOME Program is designed to increase the supply of housing affordable to low-income families through the provision of Federal grants to State and local governments. Funds may be used for tenant-based rental assistance or for acquisition, rehabilitation or, in limited circumstances, construction of both rental and ownership housing. Currently, participating jurisdictions must provide matching contributions of at least 25 percent of HOME funds spent in each fiscal year.

[13] In addition, a small number of very-low-income homeowners receive grants or loans each year from the FmHA for housing repairs.

[14] The Housing and Community Development Act of 1987 terminated the section 235 program at the end of fiscal year 1989.

Trends in Commitments and Payments

Trends in commitments

Although the Federal Government has been subsidizing the shelter costs of low-income households since 1937, more than half of all currently outstanding commitments were funded over the past 20 years. Between 1977 and 1996, about 2.8 million net new commitments were funded to aid low-income renters. Another 1.1 million new commitments were provided in the form of mortgage assistance to low- and moderate-income homebuyers. Between 1977 and 1983, the number of net new rental commitments funded each year declined steadily, however, from 375,000 to 78,000. Trends have been somewhat erratic since 1983. Over the 20-year period, commitments for new homebuyers generally decreased, ranging from a high of 140,000 in 1980 to a low of less than 24,000 in 1991 (see table 16–25).

The production-oriented approach in rental programs has been sharply curtailed since 1982 in favor of the less costly section 8 Existing-Housing and Voucher Programs. Between 1977 and 1982, commitments through programs for new construction and substantial rehabilitation ranged annually from 53 to 73 percent of the total; since then, however, they have ranged between 28 percent and 40 percent of all additional rental commitments.

The total number of households receiving assistance has increased substantially, from 3.2 million at the beginning of fiscal year 1977 to over 5.7 million at the beginning of fiscal year 1996—an increase of more than 80 percent (see table 16–26). This increase results largely from net new commitments over the past 20 years, 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 to 5.1 million. The number of homeowners receiving assistance in a given year rose from less than 1.1 million in 1977 to over 1.2 million in 1983, but then declined steadily to less than 0.7 million by 1996. The latter pattern reflects commitments for newly assisted households being more than offset by loan repayments, prepayments, and foreclosures among previously assisted households, and by sales of 141,000 loans by the FmHA to investors. (Although these 141,000 families continued to benefit from these loans, even after the transfer to the private sector, data are not readily available on the attrition of these loans between 1988 and 1994). Thus, the proportion of all assisted households that receives homeownership assistance has declined from 34 percent at the beginning of 1977 to less than 12 percent at the beginning of 1996. 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 40 percent at the beginning of 1996, with the proportion of renters receiving household-based subsidies increasing from 8 to 28 percent.

TABLE 16–25.—NET NEW COMMITMENTS FOR RENTERS AND NEW COMMITMENTS FOR HOMEBUYERS, 1977–96

Fiscal year	Net new commitments for renters			New commitments for homebuyers
	Existing housing	New construction	Total	
1977	127,581	247,667	375,248	112,234
1978	126,472	214,503	340,975	112,214
1979	102,669	231,156	333,825	107,871
1980	58,402	155,001	213,403	140,564
1981	83,520	94,914	178,434	74,636
1982	37,818	48,157	85,975	66,711
1983	54,071	23,861	77,932	54,550
1984	78,648	36,719	115,367	44,409
1985	85,741	42,667	128,408	45,387
1986	85,476	34,375	119,851	25,479
1987	72,788	37,247	110,035	24,132
1988	65,295	36,456	101,751	26,200
1989	68,858	30,049	98,907	25,264
1990	61,309	23,491	84,800	24,968
1991	55,900	28,478	84,378	23,879
1992 [1]	62,595	38,324	100,919	25,690
1993 [1]	50,593	34,065	84,658	30,982
1994 [1]	66,907	29,194	96,101	38,588
1995 [1]	25,822	19,440	45,262	31,985
1996 (estimate) [1]	8,172	17,731	25,903	42,350

[1] Figures are not adjusted for units for which funds were deobligated because data were unavailable.

Note.—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, these numbers are adjusted for the number of commitments for which such funds are deobligated or canceled that year (except where noted otherwise); the number of commitments for units converted from one type of assistance to another; in the FmHA section 515 program, the number of units that receive more than one subsidy; starting in 1985, the number of commitments specifically designed to replace 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 number of commitments for units whose section 8 contracts expire.

New commitments for homebuyers are defined as the total number of new loans that the FmHA or HUD makes or subsidizes each year. This measure of program activity is meant to indicate how many new homebuyers can be helped each year and is therefore not adjusted to account for homeowners who leave the programs in any year because of mortgage repayments, prepayments, 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 provided by the U.S. Department of Housing and Urban Development and the Farmers Home Administration.

Trends in commitments, budget authority, and outlays

Funding for most additional commitments for housing assistance is provided each year through appropriations of long-term budget authority for subsidies to households and through appropriations of budget authority for grants, direct loans, and loan guarantees to public housing agencies, homebuyers, and developers of rental housing.

TABLE 16–26.—TOTAL HOUSEHOLDS RECEIVING ASSISTANCE BY TYPE OF SUBSIDY, 1977–96

[In thousands]

Fiscal year	Assisted renters					Total assisted homeowners [1]	Total assisted homeowners and renters [1]
	Existing housing			New construction	Total assisted renters		
	Household based	Project based	Subtotal				
1977	162	105	268	1,825	2,092	1,071	3,164
1978	297	126	423	1,977	2,400	1,082	3,482
1979	427	175	602	2,052	2,654	1,095	3,749
1980	521	185	707	2,189	2,895	1,112	4,007
1981	599	221	820	2,379	3,012	1,127	4,139
1982	651	194	844	2,559	3,210	1,201	4,411
1983	691	265	955	2,702	3,443	1,226	4,668
1984	728	357	1,086	2,836	3,700	1,219	4,920
1985	749	431	1,180	2,931	3,887	1,193	5,080
1986	797	456	1,253	2,986	3,998	1,176	5,174
1987	893	473	1,366	3,047	4,175	1,126	5,301
1988	956	490	1,446	3,085	4,296	918	5,213
1989	1,025	509	1,534	3,117	4,402	892	5,295
1990	1,090	527	1,616	3,141	4,515	875	5,390
1991	1,137	540	1,678	3,180	4,613	853	5,465
1992	1,166	554	1,721	3,204	4,680	826	5,506
1993	1,326	574	1,900	3,196	4,851	774	5,625
1994	1,392	593	1,985	3,213	4,962	751	5,714
1995	1,487	595	2,081	3,242	5,087	705	5,792
1996	1,413	608	2,021	3,293	5,079	670	5,748

[1] Starting 1988, figures reflect a one-time decrease of 141,000 in the number of assisted homeowners because of asset sales by the FmHA to private investors.

Note.—Figures for total assisted renters have been adjusted since 1980 to avoid double-counting households receiving more than one subsidy. Data are for beginning of fiscal year.

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

Annual appropriations of new budget authority for housing assistance were cut dramatically during the 1980s. These cuts reflect four underlying factors: the previously mentioned reduction in the number of newly assisted households; the shift toward cheaper existing-housing assistance; a systematic reduction in the average term of new commitments from more than 24 years in 1977 to about 8 years in 1994; 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.[15] For HUD's pro-

[15] 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 were financed with up front grants, which reduce their budget authority requirements by between 51 percent 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 year section 8 rental assistance, which helped repay the direct loan. Starting in 1991, the loans have been replaced by grants, which has reduced the amount of budget authority required for annual rental assistance.

grams alone, appropriations of budget authority declined (in 1996 dollars) from a high of $75.5 billion in 1978 to a low of $11.3 billion in 1989 (see table 16–27). The increased levels of budget authority since 1990 reflect primarily the cost of renewing section 8 contracts that expire.

TABLE 16–27.—NET BUDGET AUTHORITY APPROPRIATED FOR HOUSING AID ADMINISTERED BY HUD, 1977–96

[In millions of current and 1996 dollars]

Fiscal year	Net budget authority	
	Current dollars	1996 dollars
1977	28,579	71,377
1978	32,169	75,466
1979	25,123	54,121
1980	27,435	53,183
1981	26,022	45,841
1982	14,766	24,307
1983	10,001	15,764
1984	11,425	17,278
1985	11,071	16,147
1986	10,032	14,277
1987	8,979	12,421
1988	8,592	11,415
1989	[1] 8,879	11,264
1990	[1] 10,557	12,755
1991	[1] 19,239	22,128
1992	[1] 18,855	21,054
1993	[1] 20,236	21,927
1994	[1] 19,710	20,811
1995	[1] 13,240	13,598
1996 (estimate)	[1] 14,926	14,926

[1] Includes $99 million, $1,164 million, $8,814 million, $7,585 million, $6,926 million, $5,202, $2,197 million, and $4,351 million for renewing expiring section 8 contracts in 1989, 1990, 1991, 1992, 1993, 1994, 1995, and 1996 respectively.

Note.—All figures are net of funding rescissions, exclude reappropriations of funds, but include supplemental appropriations. Totals include funds appropriated for public housing operating subsidies, and, starting in 1992, for HOME and HOPE grants. Excludes budget authority for HUD's section 202 loan fund and for programs administered by the Farmers Home Administration.

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

On the other hand, with the continuing increase in the number of households served, total outlays (expenditures on behalf of all households actually receiving aid in a given year) for all of HUD's housing assistance programs combined have risen steadily (in 1996 dollars), from $7.3 billion in fiscal year 1977 to an estimated $26 billion in fiscal year 1996, an increase of 256 percent (see table 16–28). Moreover, despite measures to contain costs, and the increase in household contributions from 25 to 30 percent of adjusted income, average Federal outlays per unit for all programs combined have generally continued to rise in real terms, from around $2,900 in 1977 to an estimated $5,480 in 1996—an increase of 89 percent (see table 16–29).[16]

TABLE 16–28.—OUTLAYS FOR HOUSING AID ADMINISTERED BY HUD, 1977–96

[In millions of current and 1996 dollars]

Fiscal year	Outlays	
	Current dollars	1996 dollars
1977	2,928	7,312
1978	3,592	8,427
1979	4,189	9,025
1980	5,364	10,399
1981	6,733	11,861
1982	7,846	12,915
1983	9,419	14,846
1984	11,000	16,635
1985	25,064	36,555
1986	12,179	17,332
1987	12,509	17,304
1988	13,684	18,180
1989	14,466	18,352
1990	15,690	18,958
1991	16,897	19,435
1992	18,242	20,370
1993	20,487	22,198
1994	22,183	23,422
1995	[1] 24,002	24,651
1996 (estimate)	[1] 25,954	25,954

[1] Figures have been adjusted to account for $1.2 billion of advance spending that occurred in 1995 but that should have occurred in 1996.

Note.—The bulge in outlays in 1985 is caused by a change in the method of financing public housing, which generated close to $14 billion in one-time expenditures. This 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 this one-time 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 provided by the U.S. Department of Housing and Urban Development.

Several factors have contributed to this growth. 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 revised Consumer Price Index, for all urban consumers (CPI–U–X1).[17] Second, the number of households that occupy units completed under the section 8 New Construction Program rose during the 1980s. These units require larger subsidies

[16] The change in the method for financing the construction and modernization of public housing caused a large one-time expenditure in 1985, when most of the outstanding debt incurred since 1974 for construction and modernization was paid off (see table 16–29). Without that bulge in expenditures, average outlays per unit in 1985 would have been about $3,950 in 1994 dollars.

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

compared with the older units that were built prior to the 1980s under the Mortgage-Interest Subsidy Programs and the Public Housing Program. Third, the share of households receiving less costly home ownership assistance has decreased. Fourth, housing aid is being targeted toward a poorer segment of the population, requiring larger subsidies per assisted household.

TABLE 16–29.—PER UNIT OUTLAYS FOR HOUSING AID ADMINISTERED BY HUD, 1977–96

[In current and 1996 dollars]

Fiscal year	Per unit outlays	
	Current dollars	1996 dollars
1977	1,160	2,900
1978	1,310	3,070
1979	1,430	3,070
1980	1,750	3,390
1981	2,100	3,710
1982	2,310	3,800
1983	2,600	4,100
1984	2,900	4,380
1985	6,420	9,360
1986	3,040	4,320
1987	3,040	4,210
1988	3,270	4,340
1989	3,390	4,300
1990	3,610	4,360
1991	3,830	4,410
1992	4,060	4,540
1993	4,450	4,830
1994	4,720	4,980
1995	5,070	5,200
1996 (estimate)	5,480	5,480

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.

SCHOOL LUNCH AND BREAKFAST PROGRAMS [18]

The School Lunch and School Breakfast Programs provide Federal cash and commodity support for meals 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 to eligible low-income children. The programs are "entitlement" programs, and both subsidize participating schools and RCCIs for all meals served that meet Federal

[18] Other major Federal child nutrition programs include: the Child and Adult Care Food Program (discussed in section 10) 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).

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 $16,400 for a three-person family in the 1995–96 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 $16,400 and $23,300 for a three-person family in the 1995–96 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 AFDC 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 (nearly 4.3 billion in fiscal year 1995) to children in over 5,000 RCCIs and almost all schools (90,000 in 1995). During fiscal year 1995, average daily participation was 25.7 million students (57 percent of all 45.1 million enrolled students); of these, 48 percent received free lunches, and 7 percent ate reduced-price lunches (see table 16–30). However, although just over half the meals served go to children from low-income families, more than 90 percent of Federal funding is used to subsidize their lunches, as opposed to full-price lunches, because subsidies for free and reduced-price lunches are much higher. In the 1995–96 school year, per-lunch Federal subsidies (cash and commodity support) ranged from about 32 cents for full-price lunches to $1.94 and $1.54 for free and reduced-price lunches.[19] Fiscal year 1995 Federal school lunch costs (including commodity assistance) totaled nearly $5.3 billion (see table 16–30).

The School Breakfast Program serves far fewer students than does the School Lunch Program; about 1.1 billion breakfasts in 60,000 schools (and 5,000 RCCIs) were subsidized in fiscal year 1995. Average daily participation was 6.3 million children (20 percent of all 31.8 million enrolled students). Unlike the School Lunch Program, the great majority received free or reduced-price meals: 81 percent received free meals, and 6 percent purchased reduced-price meals (see table 16–31). In the 1995–96 school year, per-breakfast Federal subsidies (cash only) ranged from about 20 cents for full-price meals to $1 and 70 cents for free and reduced-price breakfasts, respectively.[20] Fiscal year 1995 Federal school breakfast funding totaled about $1.1 billion (see table 16–31).

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[19] Schools and RCCIs with very high proportions of low-income children receive an extra 2 cents a meal. Federally donated commodity assistance made up about 14 cents of each cited subsidy rate.

[20] Subsidies are substantially higher (about 19 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 16–30.—THE NATIONAL SCHOOL LUNCH PROGRAM PARTICIPATION AND FEDERAL COSTS, FISCAL YEARS 1977–95

[Dollars in millions]

Fiscal year	Participation 9 month average (in millions) [1]				Federal costs	
	Free meals	Reduced-price meals	Full-price meals [2]	Total [3]	Current dollars [4]	Constant 1995 dollars
1977	10.5	1.3	14.5	26.3	$2,111.1	$5,358.1
1978	10.3	1.5	14.9	26.7	2,293.6	5,435.1
1979	10.0	1.7	15.3	27.0	2,659.0	5,718.3
1980	10.0	1.9	14.7	26.6	3,044.9	5,766.8
1981	10.6	1.9	13.3	25.8	2,959.5	5,041.7
1982	9.8	1.6	11.5	22.9	2,611.5	4,145.2
1983	10.3	1.5	11.2	23.0	2,828.6	4,338.3
1984	10.3	1.5	11.5	23.3	2,948.2	4,342.0
1985	9.9	1.6	12.1	23.6	3,034.4	4,334.9
1986	10.0	1.6	12.2	23.8	3,160.2	4,377.0
1987	10.0	1.6	12.4	24.0	3,245.6	4,374.1
1988	9.8	1.6	12.8	24.2	3,383.7	4,377.4
1989	9.7	1.6	12.7	24.2	3,479.4	4,295.6
1990	9.9	1.6	12.8	24.1	3,676.4	4,325.2
1991	10.3	1.8	12.1	24.2	4,072.9	4,560.9
1992	11.1	1.7	11.7	24.5	4,474.5	4,863.6
1993	11.8	1.7	11.3	24.8	4,663.8	4,919.6
1994	12.2	1.8	11.3	25.3	4,994.5	5,133.1
1995	12.4	1.9	11.3	25.6	5,254.0	5,254.0

[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 only because a small 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. For fiscal years 1994 and 1995: (1) budget justification materials prepared by the U.S. Department of Agriculture for fiscal year 1996 and 1997 appropriations requests; and (2) monthly ''Program Information Report'' summaries prepared by the U.S. Department of Agriculture's Food and Consumer Service, Program Information Division.

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 and nutritional screening 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 incomes at or below 185 percent of poverty, and must be nutritionally at risk. Nutritional risk is defined as detectable abnormal nutritional conditions; documented nutritionally-related medical conditions; healthimpairing dietary deficiencies; or conditions that predispose people to inadequate nutrition or nutritionally related medical problems.

TABLE 16–31.—THE SCHOOL BREAKFAST PROGRAM PARTICIPATION AND FEDERAL COSTS, FISCAL YEARS 1977–95

[Dollars in millions]

Fiscal year	Participation 9 month average (in millions) [1]				Federal costs	
	Free meals	Reduced-price meals	Full-price meals [2]	Total [3]	Current dollars [4]	Constant 1995 dollars
1977	2.0	0.1	0.4	2.5	$148.6	$377.2
1978	2.2	0.2	0.4	2.8	181.2	429.4
1979	2.6	0.2	0.5	3.3	231.0	496.8
1980	2.8	0.2	0.6	3.6	287.8	545.1
1981	3.0	0.2	0.5	3.8	331.7	565.1
1982	2.8	0.2	0.4	3.3	317.3	503.6
1983	2.9	0.1	0.3	3.4	343.8	527.3
1984	2.9	0.1	0.4	3.4	364.0	536.1
1985	2.9	0.2	0.4	3.4	379.3	538.8
1986	2.9	0.2	0.4	3.5	406.3	562.7
1987	3.0	0.2	0.4	3.7	446.8	602.2
1988	3.0	0.2	0.5	3.7	482.0	623.5
1989	3.1	0.2	0.5	3.8	507.0	625.9
1990	3.3	0.2	0.5	4.0	589.1	693.1
1991	3.6	0.2	0.6	4.4	677.2	758.3
1992	4.0	0.3	0.6	4.9	782.6	850.6
1993	4.4	0.3	0.7	5.4	868.4	916.0
1994	4.8	0.3	0.7	5.8	958.7	985.3
1995	5.1	0.4	0.8	6.3	1,181.8	1,181.8

[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 obligations not expected to be paid.

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

Source: U.S. Department of Agriculture, Food and Consumer Service. For fiscal years 1994 and 1995: (1) budget justification materials prepared by the U.S. Department of Agriculture for fiscal year 1996 and 1997 appropriations requests; and (2) monthly ''Program Information Report'' summaries prepared by the U.S. Department of Agriculture's Food and Consumer Service, Program Information Division.

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 (USDA) 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 nutritional risk screening, breast feeding 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 1995, the national average Federal cost of a WIC food package (after rebates) was just over $30 a month, and, for each participant, the average monthly administrative cost (including nutritional risk assessments) was about $11.

The WIC Program has categorical, income, and nutritional risk requirements for eligibility. Only pregnant and postpartum women, infants, and children under age 5 may participate. WIC applicants must show evidence of health or nutritional 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 (currently, about $24,000 a year for a three-person family). But State WIC agencies may, and in some cases do, set lower income eligibility cutoff points; they can set them as low as poverty guidelines themselves (about $12,500 for three persons in 1996). Receipt of AFDC, 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 1994 study, over 60 percent of WIC enrollees had family income below the Federal poverty guidelines, 27 percent of WIC enrollees were AFDC recipients, 36 percent received food stamps, and 53 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 1995, $3.45 billion in Federal funds were spent, and the program served a monthly average of 6.9 million women, infants, and children: 23 percent women, 26 percent infants, and 51 percent children. With an increased appropriation for fiscal year 1996, participation is likely to surpass 7.2 million persons a month. The most recent estimate of the total number of persons eligible and likely to apply for WIC benefits (incorporated in the Administration's fiscal year 1997 budget request) is 7.5 million persons, although earlier estimates by the Administration and the Congressional Budget Office have placed the figure somewhat higher (perhaps as high as 8 million). Table 16–32 summarizes WIC participation and Federal costs.

TABLE 16–32.—THE SUPPLEMENTAL NUTRITION PROGRAM FOR WOMEN, INFANTS, AND CHILDREN (WIC) PARTICIPATION AND FEDERAL SPENDING, FISCAL YEARS 1977–95

[Dollars in millions]

Fiscal year	Participation (in thousands)				Federal spending	
	Women	Infants	Children	Total [1]	Current dollars [2]	Constant 1995 dollars
1977	165.0	213.0	471.0	848.0	$255.9	$649.5
1978	240.0	308.0	633.0	1,181.0	379.6	899.5
1979	312.0	389.0	782.0	1,483.0	525.4	1,129.9
1980	411.0	507.0	995.0	1,913.0	724.7	1,372.5
1981	446.0	585.0	1,088.0	2,119.0	874.4	1,489.6
1982	478.0	623.0	1,088.0	2,189.0	948.2	1,505.1
1983	542.0	730.0	1,265.0	2,537.0	1,123.1	1,719.9
1984	657.0	825.0	1,563.0	3,045.0	1,386.3	2,041.7
1985	665.0	874.0	1,600.0	3,138.0	1,488.9	2,114.9
1986	712.0	945.0	1,655.0	3,312.0	1,580.5	2,189.1
1987	751.0	1,019.0	1,660.0	3,429.0	1,663.6	2,242.2
1988	815.0	1,095.0	1,683.0	3,593.0	1,802.4	2,331.7
1989	951.8	1,259.6	1,907.0	4,118.4	1,929.4	2,382.0
1990	1,035.0	1,412.5	2,069.4	4,516.9	2,125.9	2,501.1
1991	1,120.1	1,558.8	2,213.8	4,892.6	2,301.1	2,576.8
1992	1,221.5	1,684.1	2,505.2	5,410.8	2,566.5	2,789.7
1993	1,364.9	1,741.9	2,813.4	5,920.3	2,819.5	2,974.2
1994	1,499.2	1,786.3	3,191.7	6,477.2	3,159.8	3,247.5
1995	1,576.8	1,817.3	3,500.1	6,894.2	3,451.0	3,451.0

[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. For fiscal years 1994 and 1995: (1) budget justification materials prepared by the U.S. Department of Agriculture for fiscal year 1996 and 1997 appropriations requests; and (2) monthly "Program Information Report" summaries prepared by the U.S. Department of Agriculture's Food and Consumer Service, Program Information Division.

JOB TRAINING PARTNERSHIP ACT

Title II of the Job Training Partnership Act of 1982 (JTPA) provides block grants to States to fund training and related services for economically disadvantaged youths and adults. Title II consists 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—the beginning of program year 1993—title II–A provided services to both adults and youth.

JTPA's title II programs are administered by States and localities, which select participants and design projects within Federal guidelines. The programs are intended to increase participants' future employment and earnings and reduce their dependence on welfare. Services authorized under title II–A include institutional and on-the-job training, work experience, job search assistance, counseling, and other work-related assistance. In general, participants must be economically disadvantaged, which is defined as being a member of a family whose total income for the 6-month period prior to application (exclusive of unemployment compensation, child support payments, and welfare payments) does not exceed the higher of the poverty line or 70 percent of the Bureau of Labor Statistics' lower living standard. Members of families receiving Aid to Families With Dependent Children (AFDC) or other cash welfare payments and those eligible for food stamps are also defined as economically disadvantaged.

As shown in table 16–33a, of title II–A participants who terminated during program year 1994, 52 percent were white, 31 percent were black, and 14 percent were Hispanic. Of participants who terminated benefits, 63 percent entered employment. The average hourly wage for adult terminees who entered employment was $7.09.

Among the 40 percent of title II–A terminees who were cash welfare recipients at the time of enrollment in program year 1993, 80 percent received AFDC payments. Women comprised 80 percent of terminees receiving cash welfare payments, as compared with 52 percent of terminees who were not recipients. Among title II–A participants receiving cash welfare payments, 27 percent did not complete high school, compared with 21 percent of those participants who were not recipients. Fifty-six percent of cash welfare recipients entered employment in program year 1993, compared with 67 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 $6.62, compared with $6.99 for nonrecipients.

As shown in table 16–33b, of the youth participants in year-round services who terminated during program year 1994, 41 percent were white, 35 percent were black, and 20 percent were Hispanic. Of the title II–C participants who terminated, 37 percent entered employment, and the average hourly wage for terminees who entered employment was $5.61.

Among the 35 percent of title II–C (youth) participants receiving cash welfare payments in program year 1993, 29 percent entered employment, compared with 36 percent of II–C participants who did not receive cash welfare payments. The average hourly starting wage for cash welfare recipients and nonrecipients was nearly identical. Among the almost 55 percent of II–C terminees who had either dropped out of school or were behind in grade level, the average entered employment rate in program year 1993 was 30 percent as compared with 41 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 $5.20 compared with $5.70 for those not in this category.

TABLE 16–33a.—CHARACTERISTICS OF JTPA TITLE II–A ADULT TERMINEES, PROGRAM YEARS 1990–94 [1]

Selected characteristics	Program years				
	1990	1991	1992	1993	1994
Total terminees	307,935	276,227	257,561	180,178	175,647
Sex:					
Male	42	42	41	36	33
Female	58	58	59	64	67
Ethnic status:					
White (excluding Hispanic)	52	54	52	53	52
Black (excluding Hispanic)	31	29	30	31	31
Hispanic	14	13	15	13	14
Other	4	4	4	3	3
Age at enrollment:					
22–29	43	42	42	42	42
30–54	54	55	56	56	56
55 and older	3	3	3	2	2
Economically disadvantaged	[2] 93	[2] 93	NA	97	98
Receiving AFDC	26	27	28	32	35
Receiving public assistance (including AFDC)	31	35	33	40	42
U.C. claimant	8	10	13	14	10
Education status:					
High school graduate	49	50	51	55	56
Post high school	24	24	25	21	21
Average weeks participated	23	25	26	31	37
Entered employment	63	63	62	62	63
Average hourly wage at placement	$5.85	$6.08	$6.40	$6.86	$7.09

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

Source: U.S. Department of Labor.

In fiscal year 1996, an estimated $1 billion is expected to be spent for JTPA II–A and II–C grants, providing training and other services to about 329,000 new enrollees. Data on participation (new enrollees) and budget authority for recent years are provided in table 16–34 below. Figures for 1996 are estimates based on assumptions of continued spending.

For the summer youth program (title II–B), approximately $867 million was appropriated for the summer of 1995, with an estimated 489,200 participants served. The funding included $682 million appropriated in fiscal year 1994 plus $185 million added in fiscal year 1995. For the summer of 1996, $625 million was appropriated to serve an estimated 521,000 individuals. Funds originally appropriated in fiscal year 1995 were rescinded by Public Law 104–

19; funds currently available for the summer of 1996 were appropriated in fiscal year 1996.

TABLE 16–33b.—CHARACTERISTICS OF JTPA YEAR-ROUND YOUTH PROGRAM TERMINEES, PROGRAM YEARS 1990–94 [1]

Selected characteristics	Program years				
	1990	1991	1992	1993	1994
Total terminees	266,623	257,503	255,268	167,444	158,083
Sex:					
Male	48	47	47	45	44
Female	52	53	53	55	56
Ethnic status:					
White (excluding Hispanic)	42	43	40	41	41
Black (excluding Hispanic)	36	35	36	35	35
Hispanic	18	19	21	20	20
Other	4	4	4	4	5
Age at enrollment:					
14–15	15	16	18	16	14
16–17	32	32	33	34	36
18–21	53	51	48	49	50
Economically disadvantaged	[2] 93	[2] 92	NA	95	95
Receiving AFDC	21	23	25	27	27
Receiving public assistance (including AFDC)	23	25	27	35	31
U.C. claimant	1	2	1	1	1
Education status:					
Less than high school graduate	74	76	78	79	77
High school graduate	21	20	18	19	20
Post high school	5	4	4	3	3
Average weeks participated	26	28	29	35	36
Entered employment	39	36	34	34	37
Average hourly wage at placement	$4.93	$5.07	$5.19	$5.45	$5.61

[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] The Job Training Quarterly Surveys issued by Employment and Training Administration, U.S. Department of Labor.

Source: U.S. Department of Labor.

In the summer of 1994, 45 percent of title II–B enrollees were ages 14 and 15, 37 percent were either 16 or 17 years old, and 18 percent were between the ages of 18 and 21. During that summer, 84 percent of summer enrollees were students and 8 percent were high school graduates. Black youth comprised 41 percent of enrollees, while 27 percent were white, 27 percent were Hispanic, 3 percent were Asian or Pacific Islanders, and 1 percent were Native American. Eight percent had limited English-speaking ability, and 15 percent had disabilities.

TABLE 16–34.—JOB TRAINING PROGRAMS [1] FOR THE DISADVANTAGED: NEW ENROLLEES, FEDERAL APPROPRIATIONS AND OUTLAYS, FISCAL YEARS 1975–96

Fiscal year	New enrollees	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	[2] 603,900	1,779	1,746	1,694	1,676
1992	[2] 602,300	1,774	1,767	1,637	1,632
1993	[2] 584,547	1,692	1,747	1,530	1,580
Adult	316,687	1,015	1,048	918	948
Youth	267,860	677	699	612	632
1994	[2] 541,463	1,597	1,693	1,415	1,500
Adult	312,297	988	1,016	875	900
Youth	229,166	609	677	540	600
1995	[2] 340,354	1,124	1,534	971	1,325
Adult	310,123	997	934	861	807
Youth	[3] 30,231	127	600	110	518
1996	[2] 329,178	977	1,023	824	862
Adult	254,318	850	866	717	730
Youth	74,860	127	157	107	132

[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] Estimate.

[3] According to the Department of Labor, 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.

NA—Not available.

Source: U.S. Department of Labor.

Table 16–35 presents a funding and participation history of the summer program.

TABLE 16–35.—SUMMER YOUTH EMPLOYMENT PROGRAM: FEDERAL APPROPRIATIONS, OUTLAYS, AND PARTICIPANTS, FISCAL YEARS 1984–96

[Dollars in millions]

Fiscal or calendar year	Appropriations	Outlays: Current dollars	Outlays: Constant 1990 dollars	Participants [1]
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	[2] 995	958	[3] 912	782,100
1993	[4] 1,025	915	827	[3] 647,400
1994	[5] 888	834	739	[3] 574,400
1995	[6] 185	883	763	[3] 489,200
1996	[7] 625	NA	NA	[3] 521,000

[1] Because JTPA is an advance-funded program, appropriations for the summer youth 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.
[2] Fiscal year 1992 funding includes a $500 million supplemental appropriation for summer 1992 and $495 million for summer 1993.
[3] Estimate.
[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.

NA—Not available.

Note.—Appropriations and outlays are for fiscal years; participants are for calendar years.

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

Job Corps, authorized by title IV–B of JTPA, serves economically disadvantaged youth, ages 14–24, 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 110 centers around the country. Services include basic education, vocational skill training, work experience, counseling, health care, and other supportive services.

In program year 1994 (July 1, 1994–June 30, 1995), 61 percent of Job Corps enrollees were male. In that same year, 51 percent of enrollees were black, 28 percent were white, 15 percent were Hispanic, 4 percent were Native Americans, and 3 percent were Asian or Pacific Islanders. Seventy-nine percent of the enrollees had dropped out of high school and 69 percent had never worked full time. Forty-three percent of Job Corps enrollees in program year 1994 came from families on public assistance.

The average length of stay for Job Corps enrollees in program year 1994 was 7.5 months. The Labor Department estimates that

63 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 1994 of 73 percent.

Table 16–36 provides a funding and participation history of the Job Corps since 1982. The program was first authorized in the mid-1960s by the Economic Opportunity Act and has been authorized under JTPA since 1982.

TABLE 16–36.—JOB CORPS: FEDERAL APPROPRIATIONS, OUTLAYS, AND NEW ENROLLEES, FISCAL YEARS 1982–96

[Dollars in millions]

	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	59,422
1996	1,094	[1] 1,049	[1] 885	[1] 63,955

[1] Estimate.

Note.—Appropriations and outlays are for fiscal years; enrollees are for calendar years.

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

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 1995, 750,696 children were served in Head Start programs, at a total Federal cost of $3.534 billion. In June 1995, 51 percent of Head Start children came from families receiving AFDC benefits. Table 16–37 provides historical data on participation in and funding of the Head Start Program, while table 16–38 provides characteristics of children enrolled in the program.

TABLE 16–37.—HEAD START ENROLLMENT AND FEDERAL FUNDING, FISCAL YEARS 1965–95

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

[1] After sequestration.

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

TABLE 16–38.—CHARACTERISTICS OF CHILDREN ENROLLED IN HEAD START, SELECTED FISCAL YEARS 1980–95

[In percent]

Fiscal year	Age of children enrolled					Enrollment by race				
	Disabled	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

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

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 (LIHEAP).

In 1981, title XXVI of the Omnibus Budget Reconciliation Act (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 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 current low of about $0.87 billion (see bottom of table 16–39).

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 16–39 shows State allotments for selected fiscal years.

TABLE 16–39.—LOW-INCOME HOME ENERGY ASSISTANCE PROGRAM STATE ALLOTMENTS, SELECTED FISCAL YEARS 1981–96

States	Fiscal year								
	[1] 1981	1985	1990	1991	1992	1993	1994	1995	1996
Alabama	15,674	18,234	11,961	15,856	12,664	11,344	12,127	11,604	7,445
Alaska	7,505	7,247	7,635	9,594	8,034	7,241	7,741	7,062	4,752
Arizona	6,426	8,150	5,785	6,200	6,125	5,486	5,865	5,350	3,600
Arkansas	11,960	13,973	9,127	11,069	9,663	8,656	9,253	8,442	5,681
California	84,088	97,894	64,168	68,764	67,940	60,855	65,056	59,352	39,939
Colorado	29,319	33,299	22,373	23,419	23,688	21,218	22,683	20,694	13,925
Connecticut [2]	38,247	43,440	29,187	35,541	30,902	27,680	34,986	26,996	18,166
Delaware [2]	5,077	5,931	3,874	5,471	4,102	3,674	4,214	3,583	2,411
District of Columbia	5,940	6,940	4,533	5,269	4,799	4,299	4,595	4,193	2,821
Florida	25,921	28,970	18,926	21,731	20,039	17,950	19,188	17,506	11,780
Georgia	19,609	22,910	14,964	17,439	15,844	14,191	15,171	13,841	9,314
Hawaii	1,975	2,243	1,507	1,531	1,596	1,429	1,528	1,394	938
Idaho	11,181	12,877	8,727	9,493	9,240	8,277	8,848	8,072	5,432
Illinois [2]	105,862	123,679	80,784	85,711	85,533	76,614	93,921	74,721	50,281
Indiana [2]	47,431	55,371	36,577	41,069	38,727	34,689	39,408	33,831	22,766
Iowa [2]	29,470	38,581	25,922	28,719	27,466	24,584	34,335	23,977	16,134
Kansas	15,515	18,211	11,905	12,901	12,605	11,290	12,069	11,011	7,410
Kentucky [2]	24,943	29,141	19,034	22,537	20,153	18,052	24,639	17,606	11,847
Louisiana	16,024	18,867	12,228	13,203	12,947	11,597	12,398	11,311	7,611
Maine [2]	27,513	27,914	18,908	23,550	20,020	17,932	27,275	17,489	11,769
Maryland [2]	29,285	34,214	22,348	29,361	23,662	21,194	29,288	20,671	13,910
Massachusetts [2]	82,707	86,878	58,383	69,364	61,815	55,369	73,071	54,001	36,338
Michigan [2]	111,598	113,951	76,697	86,099	81,206	72,738	126,605	70,941	47,737
Minnesota [2]	72,409	82,239	55,256	62,063	58,504	52,404	93,421	51,109	34,392
Mississippi	13,930	15,683	10,255	12,391	10,858	9,725	10,397	9,485	6,383
Missouri	37,885	48,026	32,268	35,779	34,165	30,603	32,715	29,846	20,084
Montana	11,350	12,298	10,236	10,938	10,838	9,708	10,378	9,468	6,371
Nebraska	13,799	19,032	12,820	13,851	13,573	12,158	12,997	11,857	7,979
Nevada	3,560	4,151	2,717	3,214	2,877	2,577	2,754	2,513	1,691

New Hampshire [2]	14,481	16,447	11,051	13,648	11,700	10,480	14,352	10,221	6,878
New Jersey [2]	71,025	82,849	54,200	66,929	57,386	51,402	61,894	50,132	33,735
New Mexico	8,867	9,973	7,242	8,123	7,668	6,868	7,342	6,698	4,507
New York [2]	231,907	263,291	176,970	214,983	187,373	167,835	240,880	163,688	110,149
North Carolina	34,561	40,378	26,374	35,612	27,924	25,013	26,739	24,394	16,415
North Dakota [2]	7,995	14,612	11,120	12,503	11,773	10,546	19,376	10,285	6,921
Ohio [2]	93,651	109,413	71,465	78,365	75,666	67,776	96,381	66,102	44,481
Oklahoma	15,998	16,004	10,995	12,250	11,641	10,427	11,147	10,169	6,843
Oregon	22,723	25,808	17,340	19,298	18,360	16,445	17,580	16,039	10,793
Pennsylvania [2]	124,568	141,479	95,059	107,475	100,647	90,152	116,857	87,924	59,166
Rhode Island [2]	12,594	14,220	9,610	11,572	10,175	9,114	11,471	8,889	5,981
South Carolina	13,822	14,544	9,500	12,451	10,058	9,009	9,631	8,787	5,913
South Dakota [2]	10,241	11,434	9,031	10,691	9,562	8,565	11,150	8,353	5,621
Tennessee	25,267	29,520	19,281	21,652	20,415	18,286	19,548	17,834	12,001
Texas	41,261	48,206	31,487	36,455	33,337	29,861	31,922	29,123	19,598
Utah	13,289	14,827	10,397	11,062	11,008	9,860	10,541	9,617	6,471
Vermont [2]	10,854	12,328	8,283	9,813	8,770	7,855	13,197	7,661	5,155
Virginia [2]	39,019	41,677	27,222	36,051	28,822	25,817	28,277	25,179	16,943
Washington	33,104	40,896	28,522	31,495	30,199	27,050	28,917	26,382	17,753
West Virginia [2]	16,507	19,285	12,596	13,676	13,337	11,946	16,503	11,651	7,840
Wisconsin [2]	61,679	74,027	49,738	56,987	52,662	47,171	65,147	46,005	30,958
Wyoming	3,561	6,195	4,163	4,605	4,407	3,948	4,220	3,850	2,591
U.S. total	1,813,177	2,077,577	1,390,749	1,607,819	1,472,503	1,318,961	1,709,998	1,286,368	865,626

[1] Includes reallocation of funds and crisis intervention funds.
[2] Includes $300 million in LIHEAP contingency funds released in February 1994 to States hit by unusually harsh winter weather.

Note.—Columns may not add due to rounding. The table includes payments to Indian tribal organizations and excludes minor costs.

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

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 receiving Supplemental Security Income (SSI), Aid to Families with Dependent Children (AFDC), 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 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 (REACH) 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 REACH 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 16–40 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 16–40.—HEATING ASSISTANCE BENEFITS, NUMBER OF HOUSEHOLDS ASSISTED, AND AVERAGE BENEFIT BY STATE, FISCAL YEAR 1996

State	Total heating assistance [1] benefits	Estimated number of households assisted	Estimated average benefit (in dollars)
Alabama	$6,763,061	55,435	$122
Alaska	4,220,958	12,229	345
Arizona	3,421,066	21,019	163
Arkansas	4,848,231	51,877	87
California	32,768,699	350,000	93
Colorado	18,117,579	61,237	303
Connecticut	28,915,128	75,636	411
Delaware	2,636,007	13,623	194
District of Columbia	3,068,303	14,607	210
Florida	11,292,706	122,747	92
Georgia	10,325,887	65,689	157
Hawaii	1,033,936	6,519	159
Idaho	4,883,453	27,005	181
Illinois	57,164,769	217,693	267
Indiana	28,440,973	108,210	254
Iowa	14,458,451	73,558	197
Kansas	4,436,830	27,093	164
Kentucky	9,242,136	144,087	64
Louisiana	3,398,538	24,071	141
Maine	10,650,000	53,000	201
Maryland	19,272,857	85,722	225
Massachusetts	48,846,902	140,176	348
Michigan	68,200,000	375,500	182
Minnesota	39,829,936	103,760	383
Mississippi	5,317,082	35,447	150
Missouri	21,549,728	115,248	187
Montana	6,187,090	21,787	284
Nebraska	5,350,000	31,000	173
Nevada	2,331,140	9,534	245
New Hampshire	8,191,877	22,349	366
New Jersey	44,016,381	164,956	283
New Mexico	5,645,250	68,358	89
New York	103,025,580	957,442	108
North Carolina	14,926,921	186,152	80
North Dakota	6,026,140	14,650	411
Ohio	27,788,359	287,629	97
Oklahoma	7,010,932	75,205	95
Oregon	11,089,195	54,709	215
Pennsylvania	49,307,783	287,993	171
Rhode Island	7,956,629	22,787	349
South Carolina	5,772,063	74,134	78
South Dakota	6,758,611	17,138	394
Tennessee	13,894,707	69,494	200
Texas	5,096,583	35,149	145
Utah	7,291,447	33,225	219
Vermont	6,772,740	22,745	281
Virginia	20,657,059	118,709	174
Washington	17,224,663	63,727	209

TABLE 16–40.—HEATING ASSISTANCE BENEFITS, NUMBER OF HOUSEHOLDS ASSISTED, AND AVERAGE BENEFIT BY STATE, FISCAL YEAR 1996—Continued

State	Total heating assistance [1] benefits	Estimated number of households assisted	Estimated average benefit (in dollars)
West Virginia	6,601,747	56,913	116
Wisconsin	32,625,604	120,000	300
Wyoming	3,278,725	11,303	232
Total	$887,930,442	5,208,276	

[1] Includes leveraging awards.

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

PLANNING AND ADMINISTRATION

LIHEAP is administered within the Department of Health and Human Services by the Administration for Children and Families. Grantees are required to submit an application for funds to the Secretary of Health and Human Services. 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 1995, Federal outlays for veterans' benefits and services were $37.9 billion.

Service-connected compensation is paid to veterans who have disabilities from injuries and illnesses sustained while in 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 to 100 percent in 10-percent intervals; multiple injuries may result in combined-degree ratings, however, and some injuries are compensable at a zero-percent rating. Death compensation, or dependency and indemnity compensation, is paid to survivors of veterans who died as a result of service-connected causes. In fiscal year 1995, about 2.2 million disabled veterans and 307,443 survivors received about $14.8 billion in compensation payments.

Veterans pensions are means-tested cash benefits paid to war veterans who have become permanently and totally disabled from nonservice-connected causes, and to survivors of war veterans. Under the current or "improved law" program, benefits are based on family size and the pensions provide a floor of income. For 1996, the basic benefit before subtracting other income sources is $10,801 for a veteran with one dependent ($8,246 for a veteran living alone). Somewhat less generous benefits are available to survivors; a surviving spouse with no children could receive two-thirds of the basic benefit amount given a single veteran. About 798,721 persons received $3.0 billion in veterans pension payments in fiscal year 1995.

Several VA programs support readjustment, education, and job training for veterans and military personnel who meet certain eligibility criteria. In 1992, 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 $416.62 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 1995, the net outlay for VA readjustment programs was $1.124 billion. In addition, the Department of Labor provides employment counseling and job training for veterans.

The VA provides a comprehensive array of inpatient and outpatient medical services through 173 medical centers, 131 nursing homes, 39 domiciliaries, and 391 ambulatory clinics. Eligibility rules for VA medical services are complex and vary by types of care and groups of veterans. The VA is required to provide free priority medical care, both inpatient and outpatient, to veterans for service-connected conditions. In addition, the VA is required to provide free inpatient medical care, and may provide outpatient care, to low-income veterans for nonservice-connected conditions if they meet certain income criteria. For 1996, the low-income criterion for free medical care is $21,001 or less for single veterans and $25,204 or less for married veterans and veterans with one dependent; each additional dependent adds another $1,404 to the family total. As facilities and other resources permit, the VA provides care to veterans for nonservice-connected conditions with incomes that exceed the limits enumerated above; 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 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 contracts with private community nursing homes and with per diem payments for veterans in state-run homes for veterans.

In fiscal year 1995, VA medical programs cost $16.4 billion, and medical services were provided to about 2.9 million separate applicants, resulting in 1 million inpatient episodes and 29 million outpatient visits.

Table 16–41 summarizes annual expenditures on the various veterans programs and services for selected years between 1975 and 1995; table 16–42 summarizes the annual number of recipients of the various benefits over the period.

TABLE 16–41.—EXPENDITURES FOR VETERANS BENEFITS AND SERVICES, SELECTED FISCAL YEARS 1975–95

[In millions of dollars]

Fiscal year	Compensation and pensions [1]	Readjustment, education, job training	Medical programs [2]	Housing loans [3]	Other veterans benefits and services	Total
1975	7,860	4,593	3,665	24	458	16,599
1980	11,688	2,342	6,515	−23	665	21,185
1981	12,909	2,254	6,965	201	662	22,991
1982	13,710	1,947	7,517	102	682	23,958
1983	14,250	1,625	8,272	3	696	24,846
1984	14,400	1,359	8,861	244	751	25,614
1985	14,714	1,059	9,547	214	758	26,292
1986	15,031	526	9,872	114	813	26,356
1987	14,962	454	10,266	330	769	26,782
1988	15,963	454	10,842	1,292	877	29,428
1989	16,544	459	11,343	878	843	30,066
1990	15,241	278	12,134	517	943	29,112
1991	16,961	427	12,889	85	987	31,349
1992	17,296	783	14,091	901	1,067	34,138
1993	17,758	826	14,812	1,299	1,025	35,720
1994	19,613	1,115	15,678	197	1,039	37,642
1995	18,966	1,124	16,428	329	1,091	37,938

[1] Primarily compensation and pension benefits; includes amounts for insurance and burial benefits.

[2] Medical program expenditure data include outlays for direct medical services, medical research and training, and construction programs.

[3] Numbers provided for expenditures under housing loans are not comparable to program expenditures in the other columns because they are revolving funds with loan outlays and repayments.

Source: Office of the President (1996).

TABLE 16–42.—NUMBER OF RECIPIENTS OF VETERANS BENEFITS AND SERVICES, SELECTED FISCAL YEARS 1975–95

[In thousands]

Fiscal year	Compensation and pensions	Readjustment, education, job training	Medical programs [1]	Housing loans
1975	4,855	2,692	1,985	290
1980	4,646	1,233	2,671	297
1981	4,535	1,081	2,765	188
1982	4,407	906	2,720	103
1983	4,286	755	2,933	245
1984	4,123	629	3,026	252
1985	4,005	492	2,963	179
1986	3,900	419	2,942	314
1987	3,850	365	2,900	479
1988	3,762	352	2,922	235
1989	3,686	349	3,344	190
1990	3,614	360	3,018	196
1991	3,546	322	2,963	181
1992	3,462	388	2,927	266
1993	3,397	438	2,800	383
1994	3,351	472	2,965	602
1995	3,332	476	2,696	263

[1] Recipients are the number of applicants during the year.

Source: U.S. Department of Veterans Affairs.

WORKERS' COMPENSATION [21]

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 1993, workers' compensation laws protected approximately 96.1 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 disabilities 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 com-

[21] Largely drawn from Schmulowitz (1995).

missions 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.[22] 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.[23] 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 59 percent of total workers' compensation benefits in 1993. 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 unable 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 41 percent of total workers' compensation benefits in

[22] The Federal Employees' Compensation Act (FECA) 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 (FELA) covers interstate railroad employees. The Black Lung Benefits Act (BLBA) provides for benefits to coal mine employees and survivors for disability or death related to black lung disease.

[23] Under the FECA, 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-1972 claimants and, standing in the place of a State, the administrative costs of the system. Under the Jones Act and the FELA, there are few Federal costs, limited to some Federal court costs and potential effects on the Federal appropriation for Amtrak. Under the BLBA, 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).

1993. 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 South Carolina and Texas.[24] 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 1993, 96.1 million employees were covered by State or Federal workers' compensation laws, and wages and salaries of covered workers totaled $2.5 trillion, about 82 percent of all civilian wages and salaries. However, while the number of covered employees grew from 1991, when 93.6 million workers were covered, the proportion of the civilian payroll covered by workers' compensation laws declined from 84 percent.

The total of $42.9 billion in 1993 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.

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 disability ranged from $1,299 for Federal employees ($782 for those covered by the Federal LHWCA) to $846 for Iowa (the highest State figure) and $264 for Mississippi (the lowest State figure).

In 1993, compensation under regular Federal and State Workers' Compensation Programs totaled $24.2 billion, of which $1.2 billion was paid to survivors. In addition, $1.2 billion in black lung cash benefits were provided, almost 60 percent of which went to survivors.

In 1993, medical and hospitalization payments under regular Federal and State workers' compensation laws totaled $17.4 billion, and an additional $100 million was paid out for black lung beneficiaries.

[24] While coverage in New Jersey is technically elective, no employer has chosen an exemption from the workers' compensation statute, which requires that the election be made in writing prior to an accident.

The Bureau of Labor Statistics (BLS) reported a 1993 workplace injury and illness incidence rate of 8.5 cases per 100 full-time equivalent private industry workers. The incidence rate for lost workday cases was 3.8. Since 1989, the overall incidence rate has ranged between 8.9 and 8.4, and the lost-workday rate has varied between 3.8 and 4.1. According to the Survey of Occupational Injuries and Illnesses, the total number of private sector workplace injuries/illnesses in 1993 was 6.7 million, of which nearly 3 million involved lost workdays. In addition, the BLS Census of Fatal Occupational Injuries reported some 6,300 fatalities resulting from on-the-job injuries (see Schmulowitz, 1995).

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 1993, 51 percent ($21.8 billion) of the total of $42.9 billion in workers' compensation benefits (including all cash and medical costs under Federal and State laws) was paid by private insurers; 23 percent ($9.9 billion) was provided through self-insurance; 19 percent ($8.1 billion) came from State funds; and 7 percent ($3.1 billion) was paid under Federal programs. [25]

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 1993, employer costs totaled $57.3 billion. These costs included benefits paid, administration of insurance operations, insurer profits and taxes, and reserves for future benefit payments. 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 1993 cost to employers was: $33.6 billion (59 percent) paid to private insurers, $10.9 billion (19 percent) paid to State funds, $10.6 billion (18 percent) financed by self-insured employers, and $2.3 billion (4 percent) from Federal appropriations for Federal employees and from that portion of black lung benefits financed by coal mine employers (as opposed to Federal appropriations).

In 1993, average employer costs per covered employee were $597; as a proportion of employers' payrolls, this represented $2.30 per $100 of payroll. Although substantial increases in employers' work-

[25] 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).

ers' compensation costs were recorded in the 1980s, these costs actually decreased in real terms in the early 1990s, dropping from a high of $2.40 per $100 of payroll in 1991.

Table 16–43 shows the estimated number of workers covered and the total annual payroll in covered employment for selected years between 1948 and 1993. Over that time, the number of workers covered in an average month increased from 36 to 96.1 million, and covered payroll rose from $105 billion to $2.5 trillion.

TABLE 16–43.—ESTIMATED NUMBER OF WORKERS COVERED BY WORKERS' COMPENSATION IN AVERAGE MONTH AND TOTAL ANNUAL PAYROLL IN COVERED EMPLOYMENT, SELECTED YEARS 1948–93 [1]

Year	Workers covered in average month		Total payroll in covered employment	
	Number (in millions)	Percent of employed wage and salary workers [2]	Amount (in billions)	Percent of civilian wage and salary disbursements
1948	36.0	77.0	$105	79.9
1953	40.7	80.0	154	81.5
1958	42.5	80.2	192	83.1
1963	47.3	80.5	254	83.7
1968	56.8	83.8	376	83.0
1973	66.3	86.3	578	84.2
1978	75.6	86.7	922	84.3
1983	78.0	85.6	1,382	84.6
1988	91.3	87.0	2,000	84.2
1990	95.1	87.0	2,250	84.0
1991	93.6	87.0	2,300	84.0
1993	96.1	NA	2,500	82.0

[1] Before 1963, excludes Alaska and Hawaii.
[2] Beginning in 1968, excludes those under age 16 and includes certain workers previously classified as self-employed.

NA—Not available.

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

Table 16–44 illustrates benefit payments under workers' compensation laws by type of benefit for the years 1987–93 (except 1992). In 1993, total benefits paid equaled $42.9 billion, of which $41.6 billion was paid out under regular State and Federal workers' compensation laws and nearly $1.4 billion was provided through the Federal Black Lung Benefit Programs.

TABLE 16–44.—ESTIMATED WORKERS' COMPENSATION BENEFIT PAYMENT AMOUNTS BY TYPE OF BENEFIT 1987–93

[In millions]

Type of benefit	1987	1988	1989	1990	1991	1993
Regular program	$25,773	$29,234	$32,837	$36,804	$40,778	$41,569
Medical and hospitalization	9,794	11,401	13,299	15,067	16,715	17,409
Compensation	15,979	17,833	19,538	21,737	24,063	24,160
Disability	15,046	16,956	18,553	20,635	22,840	22,930
Survivor	933	877	985	1,102	1,223	1,229
Black Lung Program	1,545	1,499	1,479	1,434	1,391	1,355
Medical and hospitalization	118	117	125	120	117	112
Compensation	1,426	1,381	1,354	1,314	1,274	1,243
Disability	698	657	618	577	533	520
Survivor	729	725	736	737	741	723
Total (Regular and Black Lung) ...	27,318	30,733	34,316	38,238	42,169	42,925
Medical and hospitalization	9,912	11,518	13,424	15,187	16,832	17,521
Compensation	17,406	19,215	20,892	23,051	25,337	25,403
Disability	15,775	17,613	19,171	21,212	23,373	23,450
Survivor	1,631	1,602	1,721	1,839	1,964	1,952

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

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