SECTION 15 - OTHER PROGRAMS

CONTENTS

OVERVIEW

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

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

Tables 15-1 and 15-2 describe the overlap in recipients between programs within the jurisdiction of the Committee on Ways and Means and other major Federal assistance programs. Table 15-1 illustrates that 80.8 percent of TANF recipient households also received food stamps during the first half of 2002; 35.1 percent received WIC; 99.6 percent received Medicaid; 62.3 percent received free or reduced-price school meals; and 37.6 percent received housing assistance.

Table 15-2 presents the percentage of recipients of other means-tested programs who are participating in programs under Ways and Means jurisdiction. For example, 16.2 percent of food stamp households received TANF benefits at

some time during the first half of 2002; 30.2 percent received SSI; 30.5 percent received Social Security; 4.9 percent received unemployment benefits; and 26.0 percent received Medicare.

TABLE 15-1-- PERCENT OF RECIPIENTS IN PROGRAMS WITHIN THE JURISDICTION OF THE COMMITTEE ON WAYS AND MEANS RECEIVING ASSISTANCE FROM OTHER MAJOR FEDERAL ASSISTANCE PROGRAMS, 2002

Other Assistance Programs	Ways and Means Assistance Programs				
	TANF	SSI	Social Security	Unemployment Compensation	Medicare
Food Stamps	80.8	40.2	6.7	10.6	6.3
WIC	35.1	5.2	1.2	8.4	0.8
Medicaid	99.6	96.4	18.2	23.5	17.8
Free or reduced-price school meals	62.3	17.7	4.3	16.1	3.0
Public or subsidized rental housing	37.6	22.9	5.6	3.0	5.6
VA compensation or pensions	1.0	3.6	4.6	1.4	4.8
Number of recipients in households receiving benefits (in thousands)	1,393	5,207	31,358	3,209	28,452

Note-Table shows number of recipient households for February-May 2002. Tables read that 80.8 percent of households with TANF recipients also received food stamp benefits.

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

TABLE 15-2 -- PERCENT OF RECIPIENTS IN OTHER MAJOR FEDERAL ASSISTANCE PROGRAMS RECEIVING ASSISTANCE UNDER PROGRAMS WITHIN THE JURISDICTION OF THE COMMITTEE ON WAYS AND MEANS, 2002

Ways and Means Assistance Programs	Other Assistance Programs					
	Food Stamps	WIC	Free or reduced-price school meals	Public or subsidized rental housing	Medicaid	VA compensation or pensions
TANF	16.2	10.8	9.0	10.9	8.0	0.6
SSI	30.2	6.0	9.6	24.8	29.0	7.0
Social Security	30.5	8.1	13.9	36.9	32.9	54.4
Unemployment Compensation	4.9	6.0	5.4	2.0	4.4	1.7
Medicare	26.0	5.1	9.0	33.5	29.2	52.3
Number of recipients in households receiving benefits (in thousands)	6,924	4,517	9,620	4,795	17,322	2,639

Note-Table shows number of recipient households for February-May 2002. Tables read that 16.2 percent of households with food stamp recipients also received TANF.

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

Table 15-3 shows the percentage of households receiving Aid to Families with Dependent Children (AFDC)/TANF or SSI and also receiving assistance from other programs for selected time periods. The figures at the bottom of the AFDC/TANF portion of the table show that the number of households receiving AFDC/TANF increased rapidly between 1990 and 1994, declined somewhat in 1995, and then fell rapidly between 1995 and 2002. Due to the rapid decline after 1994, the AFDC/TANF rolls declined by 61 percent over the entire period. The number of households receiving SSI declined slightly in 1990 and 1993, but otherwise increased throughout the period between 1984 and 2002. The rolls increased by 73 percent over this period.

TABLE 15-3--PERCENT OF HOUSEHOLDS RECIEVING TANF OR SSI AND ALSO RECEIVING ASSISTANCE FROM OTHER PROGRAMS, SELECTED YEARS 1984-2002

Assistance program	1984	1987	1990	1992	1993	1994	1995	1997-98	2002
AFDC/TANF:									
Food stamps	81.4	81.7	82.7	86.2	88.9	88.3	87.2	81.0	80.8
WIC	15.3	18.6	18.7	21.5	18.5	21.4	24.7	30.6	35.1
Free or reduced-price school meals	49.2	55.6	52.7	55.5	56.9	57.5	63.1	60.3	62.3
Public or subsidized rental housing	23.0	19.4	34.7	29.5	33.1	30.3	31.1	21.2	37.6
Medicaid	93.2	95.5	97.6	96.2	97.6	96.4	97.2	97.3	99.6
VA compensation or pensions	2.8	1.9	1.3	1.9	1.1	1.1	0.8	1.1	1.0
Number of households receiving benefits (in thousands)	3,585	3,527	3,434	4,057	4,831	4,906	4,652	3,008	1,391
SSI:									
Food stamps	46.5	39.7	41.3	46.2	48.0	50.1	50.0	43.7	40.2
WIC	2.5	2.5	3.0	4.3	3.7	5.4	5.6	5.5	5.2
Free or reduced-price school meals	12.7	11.9	15.3	18.2	21.3	23.8	25.2	18.4	17.7
Public or subsidized rental housing	21.6	20.0	21.4	23.8	23.9	24.9	24.1	23.4	22.9
Medicaid	100.0	99.6	99.7	99.8	99.5	100.0	100.0	95.0	96.4
VA compensation or pensions	4.7	7.7	5.7	4.0	4.5	3.9	3.6	2.8	3.6
Number of households receiving benefits (in thousands)	3,008	3,341	3,037	3,957	3,861	4,223	4,580	4,772	5,207

Note-Data on households interviewed between February and May 2002.
Source: U.S. Census Bureau, Survey of Income and Program Participation.

The percentage of AFDC/TANF households receiving other benefits fluctuated over the 1984-2002 period, but several the biggest programs--school meals, housing assistance, and Medicaid--increased then declined, and then

increased again in 2002. Food Stamps experienced increased coverage until 1993, after which it fell off by 9 percent through 2002. School lunches also fell off somewhat between 1995 and 1998 before increasing in 2002. Medicaid coverage increased between 1984 and 1990, but the pattern was erratic after that prior to 2002 establishing a new high-water mark of coverage. Similarly, the high-water mark for housing was 2002. The pattern of receiving other benefits for SSI households is broadly similar; namely, initial increases and then declines prior to selected increases again in 2002. For every program, except Medicaid which was received by 100 percent of SSI households, and veterans benefits, coverage increased between 1984 and 1994 but then declined either between 1994 and 1995 or between 1995 and 1998. Medicaid too declined from its 100 percent coverage in 1995 to 95 percent in 1998. Declines continued through 2002 in food stamps, WIC, school meals, and housing. However, coverage under Medicaid and VA Compensation Programs turned upward again.

FOOD STAMP PROGRAM

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

Benefits are available to most households that meet Federal eligibility tests for limited monthly income and liquid assets. But household members must fulfill requirements related to work effort and must meet citizenship and legal permanent residence tests. Recipients in the two primary cash welfare programs (TANF and SSI) generally are automatically eligible for food stamps, as are recipients of State general assistance (GA) payments, if their household is composed entirely of TANF, SSI, or GA beneficiaries.[2]

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[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 20-25 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 for deeming need.

ADMINISTRATION, PROGRAM VARIATIONS, AND FUNDING

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

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

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

Federal Administrative Responsibilities

At the Federal level, the program is administered by the Agriculture Department's Food and Nutrition Service (FNS). The FNS gives direction to welfare agencies through Federal regulations that define eligibility requirements, benefit levels, and administrative rules. It also is responsible for overseeing State programs for the electronic issuance of food stamp benefits, and for approving and overseeing participation by retail food stores and other outlets that may accept food stamps. Other Federal agencies that have administrative roles to play include: the Federal Reserve System (through which food stamp benefits are redeemed for cash, and which has some jurisdiction over "electronic benefit transfer (EBT)" methods for issuing food stamp benefits), the Social Security Administration (responsible for 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 Bureau of Citizenship and Immigration Services of the Department of Homeland Security (helping welfare offices confirm alien applicants' status), and the Agriculture Department's Inspector General (responsible for trafficking investigations).

State and Local Administrative Responsibilities

States, the District of Columbia, Guam, and the Virgin Islands, through their local welfare offices, have primary responsibility for the day-to-day administration of the Food Stamp Program. They determine eligibility, calculate benefits, and issue food stamp allotments (using coupons or, in most cases, electronic benefit

transfer cards) following Federal rules. They also have a significant voice in carrying out employment and training programs and in determining some administrative features of the program (e.g., the extent to which verification of household circumstances is pursued, the length of eligibility certification periods, the structure of EBT systems). Most often, the Food Stamp Program is operated through the same welfare agency and staff that runs the State's TANF Program.

Puerto Rico, the Northern Mariana Islands, and American Samoa

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

Since July 1982, Puerto Rico has operated a Nutrition Assistance Program of its own design, funded by an annual Federal "block grant."[3] The Commonwealth's Nutrition Assistance Program differs from the regular Food Stamp Program primarily in that: (1) funding is limited to an annually indexed amount specified by law[4]; (2) the Food Stamp Act allows the Commonwealth a great deal of flexibility in program design, as opposed to the regular program's extensive Federal rules (e.g., 75 percent of benefits, paid through electronic benefit transfers, are earmarked for food purchases, the remainder may be claimed as cash, and rules barring certain not citizens do not apply); (3) income eligibility limits are about one-third those used in the regular Food Stamp Program; (4) maximum benefit levels are about 40 percent less than in the 48 contiguous States and the District of Columbia; and (5) different rules are used in counting income for eligibility and benefit purposes. In fiscal year 2002, Puerto Rico's Nutrition Assistance Program aided approximately 1 million persons each month with monthly benefits averaging $98 dollars a person ($244 a household).

Under the terms of the 1976 Covenant with the Commonwealth of the Northern Mariana Islands and implementing legislation (Public Law 96-597), a variant of the Food Stamp Program was negotiated with the Commonwealth and began operations in July 1982. The program in the Northern Marianas differs primarily in that: (1) it is funded entirely by Federal money, up to a maximum grant negotiated periodically ($7.1 million per year for fiscal years 2003 and 2004); (2) a portion of each household's food stamp benefit must be used to purchase locally produced food; (3) maximum allotments are about 5 percent higher than in the 48 contiguous States and the District of Columbia; and (4) income eligibility limits are about half those in the regular program. In September 2003, the Northern Marianas' program assisted 6,800 persons with a monthly benefit averaging $80 per 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 2002 amendment to the Food Stamp Act made by the Farm Security and

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

[4] For fiscal years 2003 and 2004, $1.395 billion and $1.397 billion are earmarked. The block grant funds the full cost of benefits and half the cost of administration.

Rural Investment Act (Public Law 107-171), American Samoa receives an annually indexed grant ($5.6 million per year in fiscal years 2003 and 2004) to operate a Food Stamp Program limited to low-income elderly and disabled persons. While maximum monthly allotments are similar to those in the regular Food Stamp Program ($132 per person), income eligibility limits are about 25 percent lower. In September 2003, the program aided about 2,900 persons per month.

Program Options

The Food Stamp Act authorizes demonstration projects to test program variations that might improve operations. However, because of (1) the law's substantial limits on how much any demonstration can reduce benefits or restrict eligibility, (2) an administration policy that effectively bars demonstrations that have a significant cost to the Food Stamp Program, and (3) implementation of provisions for State flexibility included in the 1996 Welfare Reform Law (Public Law 104-193) and the 2002 Farm Security and Rural Investment Act (Public Law 107-171), no major demonstration projects are operational. Instead, a few small demonstrations are operating in some States (these deal with joint application processing and standardized food stamp benefits for SSI recipients, cash benefits for the elderly and SSI recipients, and "privatizing" program administration), and extensive waivers of administrative rules are routinely granted.

States also are allowed a number of significant options in how they implement the Food Stamp Program. States may establish their own administrative standards in areas such as application processing, ongoing recertification of recipient households, reporting of changes in household circumstances (and adjusting benefits to take these changes into account), counting child support payments, and standardizing the treatment of utility expenses in benefit calculations. In addition, States can use most of the rules they have established for TANF and Medicaid programs when deciding what income and resources (assets) to exclude in food stamp eligibility and benefit determinations, and may grant 5-month "transitional" food stamp benefits to those leaving the TANF program (without requiring them to reapply for food stamps). The states may issue benefits (at their own cost) to ineligible noncitizens and those ineligible under the work rule for able-bodied adults without dependents (ABAWDs; discussed below). With 50 percent Federal cost-sharing, they can operate "outreach" programs to inform low-income persons about food stamps and support nutrition education efforts. They may choose to operate a "simplified" program under which they can use many of their TANF rules and procedures when determining food stamp benefits for TANF recipients. States may sanction food stamp recipients failing to meet other public assistance program rules or failing to cooperate in child support enforcement efforts. They may, to a certain extent, waive the application of the work rule for ABAWDs; and they may choose to disqualify an entire household if the head of the household fails to fulfill work-related requirements. In some instances, they may include the cash value of food stamp benefits when using welfare to subsidize recipients' wages. States and localities may opt to run "workfare" programs for food stamp recipients. Finally, States determine the content of employment and training programs for food stamp recipients (and, in

many cases, who must participate).

Funding

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

TABLE 15-4 -- RECENT FOOD STAMP ACT EXPENDITURES, SELECTED YEARS, 1980-2002

[In millions of dollars]

Fiscal Year	Benefits[1] (Federal)	Administration[2]		Total
		Federal	State and local	
1980	$8,685	$503	$375	$9,563
1985	11,556	1,043	871	13,470
1990	15,090	1,422	1,174	17,686
1991	18,249	1,516	1,247	21,012
1992	21,883	1,656	1,375	24,914
1993	23,033	1,716	1,572	26,321
1994	23,736	1,789	1,643	27,168
1995	23,759	1,917	1,748	27,424
1996	23,510	1,984	1,842	27,336
1997	20,810	2,058	1,904	24,772
1998	18,228	2,169	1,988	22,385
1999	17,217	2,100	1,874	21,191
2000	16,320	1,935	2,086	20,341
2001	16,711	2,102	2,233	21,045
2002	19,393	2,264	2,397	24,054

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

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

Source: U.S. Department of Agriculture budget justification for fiscal years 1981-2004. Complied by the Congressional Research Service.

In most instances, the Federal Government provides half the cost of State

welfare agency administration.[5] In addition, the Federal Government shares the cost of carrying out employment and training programs for food stamp recipients: (1) each State receives a Federal grant for basic operating costs (a formula share of $90 million per year, plus a share of $20 million a year for those States pledging to serve all ABAWDs; and (2) additional operating costs, as well as expenses for support services to participants (e.g. transportation and 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): 35 percent of recoveries in fraud cases and 20 percent in other circumstances. Federal and State Food Stamp Act spending in selected years since 1980 is shown in 15-4.

The Food Stamp Program has financial, employment/training-related, and "categorical" tests for eligibility. Its financial tests require that most of those eligible have monthly income and liquid assets below limits set by law (income limits are inflation indexed). 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. Under a work requirement established in 1996, food stamp eligibility for ABAWDs is limited to 3-6 months in any 36-month period unless they are working at least half time or in a work or training activity. Categorical eligibility rules make some automatically eligible for food stamps (many TANF, SSI, and GA recipients), and categorically deny eligibility to others (e.g., strikers and many noncitizens, postsecondary students, and people living in institutional settings). Applications cannot be denied because of the length of a household's residence in a welfare agency's jurisdiction or because the household has no fixed mailing address or does not reside in a permanent dwelling.

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., TANF families with dependent children, elderly or disabled individuals or couples in the SSI Program).

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

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

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

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

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

Income Eligibility

Except for households composed entirely of TANF, SSI, or GA recipients (who generally are automatically eligible for food stamps), monthly cash income is the primary food stamp eligibility determinant.[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 it's 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) Federal energy assistance; (7) expense reimbursements that are not a "gain or benefit" to the household; (8) income earned

[6] Although they do not have to meet food stamp financial eligibility tests, TANF, SSI, and general assistance households must still have their income calculated under food stamp rules to determine their food stamp benefits. Thus food stamp benefits are reduced by 30 cents for ever dollar of cash benefits under TANF or SSI.

[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 the recipients of disability-based Medicaid or general assistance.

by schoolchildren 17 or younger; (9) the cost of producing self-employment income; (10) Federal postsecondary student aid (e.g., Pell grants, student loans); (11) advance payments of Federal earned income credits; (12) "on-the-job" training earnings of dependent children under 19 in the Workforce Investment Act (WIA), formerly the Job Training Partnership Act (JTPA), Programs, as well as monthly "allowances"; (13) income set aside by disabled SSI recipients under an approved "plan for achieving self-support"; and (14) payments required to be disregarded by provisions of Federal law outside the Food Stamp Act (e.g., various payments under laws relating to Indians, payments under the Older Americans Act Employment Program for the Elderly). In addition, States may, within certain limits, choose to exclude other types of income they disregard in their TANF or Medicaid programs.

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

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

- A "standard" monthly deduction that varies by household size and is indexed for inflation (for fiscal year 2004, this deduction in the 48 States and the District of Columbia is $134 for households of 1-4 persons, $149 for 5-person households, and $171 for households of 6 or more persons). Different standard deductions are used for Alaska, Hawaii, Guam, and the Virgin Islands (e.g., the fiscal year 2004 deduction for 4-person households is $229 in Alaska, $189 in Hawaii, $269 in Guam, and $127 in the Virgin Islands).
- 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 per month per dependent, $200 per month for children under age 2; and
- Shelter expenses (including utility costs) that exceed 50 percent of counted income after all other deductions, up to a periodically adjusted ceiling that is $378 per month for fiscal year 2004. Different ceilings prevail in Alaska ($604), Hawaii ($509), Guam ($444), and the Virgin Islands ($298).

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

- The same standard, child support, earned income, and dependent care deductions noted above;
- Any shelter expenses, to the extent they exceed 50 percent of counted income after all other deductions, with no limit; and
- Any out-of-pocket medical expenses (other than those for special diets)

that are incurred by an elderly or disabled household member, to the extent they exceed a threshold of $35 a month.

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

TABLE 15-5 -- COUNTED (NET) AND BASIC (GROSS) MONTHLY INCOME ELIGIBILITY LIMITS FOR THE FOOD STAMP PROGRAM, FISCAL YEAR 2004

Household size	48 States, D.C., and the territories	Alaska	Hawaii
Counted (net) monthly income eligibility limits[1]:			
1 person	749	935	861
2 persons	1,010	1,262	1,162
3 persons	1,272	1,590	1,463
4 persons	1,534	1,917	1,764
5 persons	1,795	2,245	2,065
6 persons	2,057	2,572	2,365
7 persons	2,319	2,900	2,666
8 persons	2,580	3,227	2,967
Each additional person	+262	+328	+301
Basic (gross) monthly income eligibility limits[2]:			
1 person	973	1,215	1,120
2 persons	1,313	1,641	1,511
3 persons	1,654	2,066	1,902
4 persons	1,994	2,492	2,293
5 persons	2,334	2,918	2,684
6 persons	2,674	3,344	3,075
7 persons	3,014	3,769	3,466
8 persons	3,354	4,195	3,857
Each additional person	+341	+426	+392

[1] Set at the applicable Federal poverty guidelines, updated for inflation through calendar 2002.

[2] Set at 130 percent of the applicable Federal poverty guidelines, updated for inflation through calendar 2002.

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

Allowable Assets

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

assets above $2,000. Households with an elderly or disabled 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 also are counted: a portion of the value of vehicles and the equity value of property not producing income consistent with its value (e.g., recreational property).

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

Some special rules apply when counting allowable assets. Although the general rule is that the fair market value of a vehicle in excess of $4,650 is to be counted as an asset, States may (and often do) count vehicles as assets only to the extent they do under their TANF programs. Moreover, States generally may exclude additional assets to the extent they do so under their TANF or Medicaid programs.

Work-Related Requirements

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

Those who are exempt by law from these basic work requirements include: persons physically or mentally unfit for work; those under age 16 or over age 59; individuals between 16 and 18 if they are not head of household or are attending school or a training program; persons working at least 30 hours a week or earning the minimum wage equivalent; persons caring for dependents who are disabled or under age 6; those caring for children between ages 6 and 12 if adequate child care is not available (this second exemption is limited to allowing these persons to refuse a job offer if care is not available); individuals already subject to and complying with another assistance program's work, training, or job search 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, their State welfare agency may require them to fulfill some type of work, job search, or training obligation. Welfare agencies must operate an employment and training program of their own design for work registrants whom they designate. Welfare agencies may require all work registrants to participate in one or more components of their program, or limit participation by further exempting additional categories and individuals for whom participation is judged impracticable or not cost effective. Program components can include any or all of the following activities: supervised job search or training for job search, workfare, work experience or training programs, education programs to improve basic skills, or any other employment or training activity approved by the Agriculture Department.

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

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

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

In fiscal year 2002, States reported 2.3 million new work registrants. Of these, approximately 1.2 million -- including an estimated 450,000 ABAWDs-- were subject to employment and training program placement.

Categorical Eligibility Rules and Other Limitations

Food stamp eligibility is sometimes denied for reasons other than financial need or compliance with work-related requirements. Many noncitizens are barred--eligibility is extended only to permanent residents legally present in the U.S. for at least 5 years, legal immigrant children (under 18), the elderly and

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

BENEFITS

Food stamp benefits are a function of a household's size, its net monthly income, and inflation-indexed maximum monthly benefit levels (in some cases, adjusted for geographic location). An eligible household's net income is determined (i.e., the deductions noted earlier are subtracted from gross income), its maximum benefit level is established, and a benefit is calculated by subtracting its expected contribution (30 percent of its counted net income) from its maximum allotment. Thus, a 3-person household with $400 in counted net income (after deductions) would receive a monthly allotment of $251 (the fiscal year 2004 maximum 3-person benefit in the 48 States, $371, less 30 percent of net income, $120).

Allotments are not taxable and food stamp purchases may not be charged sales taxes. Receipt of food stamps does not affect eligibility for or benefits provided by other welfare programs, although some programs use food stamp participation as a "trigger" for eligibility and others take into account the general availability of food stamps in deciding what level of benefits to provide. In fiscal year 2002, monthly benefits averaged $80 per person (see Table 15-11).

Maximum Monthly Allotments

Maximum monthly food stamp allotments are tied to the cost of purchasing a nutritionally adequate low-cost diet, as measured by the Agriculture Department's Thrifty Food Plan (TFP). Maximum allotments are set at: the monthly cost of the

TFP for a four-person family consisting of a couple between ages 20 and 50 and two school-age children, adjusted for family size (using a formula reflecting economies of scale developed by the Human Nutrition Information Service), and rounded down to the nearest whole dollar. Allotments are adjusted for food price inflation annually, each October, to reflect the cost of the TFP in the immediately previous June.

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

TABLE 15-6-- MAXIMUM FOOD STAMP ALLOTMENTS, FISCAL YEAR 2004

Household size	48 States and D.C.	Alaska[1]	Hawaii[2]	Guam	Virgin Islands
1 person	$141	$167	$210	$182	$208
2 person	259	307	386	333	382
3 person	371	439	553	477	547
4 person	471	558	702	606	695
5 person	560	663	834	720	826
6 person	672	795	1,001	864	991
7 person	743	879	1,106	955	1,095
8 person	849	1,005	1,264	1,092	1,252
Each additional person	+106	+126	+158	+137	+157

[1] Maximum allotment levels in rural Alaska are 27 percent to 55 percent higher than the urban Alaska allotments noted here. The allotment levels noted here are those in effect as of October 1, 2003. However, under legislation pending as of December 1, 2003, they are scheduled to increase slightly: to $169, $309, $443, $563, $669, $803, $887, $1,014 and + $127.

[2] The allotment levels noted here are those in effect as of October 1, 2003. However, under legislation pending as of December 1, 2003, they are scheduled to increase slightly to $212, $389, $557, $707, $840, $1,008, $1,114, $1273, and +159.

Source: U.S. Department of Agriculture.

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.

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

Application, Processing, and Issuing Food Stamps

Food stamp benefits normally are issued monthly. The local welfare agency must either deny eligibility or make food stamps available within 30 days of initial

application and must provide food stamps without interruption if an eligible household reapplies and fulfills recertification requirements in a timely manner. Households in immediate need because of little or no income and very limited cash assets, as well as the homeless and those with extraordinarily high shelter expenses, must be given expedited service (provision of benefits within 7 days of initial application).

Food stamp issuance is a welfare agency responsibility, and issuance practices differ among welfare agencies. Food stamp coupons have traditionally been issued by: (1) providing (usually mailing) recipients an authorization-to-participate card that is then turned in at a local issuance point (e.g., a bank or post office) when picking up their monthly allotment; or (2) mailing food stamp coupon allotments directly to recipients. However, in most States electronic benefit transfer (EBT) systems now 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 all States except California (which is scheduled for statewide issuance by the end of 2004); it also is used in Puerto Rico and the Virgin Islands (Guam is scheduled to convert to EBT in mid-2004).

Items That May Be Purchased With Food Stamp Benefits

Typically, participating households use their food stamp benefits in approved grocery stores to buy food items for home preparation and consumption; food stamp purchases are not taxable. However, the actual list of approved uses for food stamps is more extensive, and includes: (1) food for home preparation and consumption, not including alcohol, tobacco, or hot foods intended for immediate consumption; (2) seeds and plants for use in gardens to produce food for personal consumption; (3) food purchased at approved farmers' markets; (4) in the case of the elderly and SSI recipients and their spouses, meals prepared and served through approved communal dining programs; (5) in the case of the elderly and those who are disabled to an extent that they cannot prepare all of their meals, home-delivered meals provided by programs for the homebound; (6) meals prepared and served to residents of drug addiction and alcoholic treatment programs, small group homes for the disabled, shelters for battered women and children, and shelters or other establishments serving the homeless; and (7) where the household lives in certain remote areas of Alaska, equipment for procuring food by hunting and fishing (e.g., nets, hooks, fishing rods, and knives). Food stamp benefits now normally are accessed through EBT cards. The card is swiped through an approved retailer's point-of-sale device, automatically debiting the recipient's food stamp account and crediting the retailer's bank account; unlike coupon transactions, recipients receive no cash change, and special arrangements must be made for nontraditional sites like farmers' markets.

QUALITY CONTROL (QC)

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

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

QC reviews generate annual estimates of the proportion of cases in which administrators or recipients make an "error" and the dollar value of those errors. Caseload and dollar error rates are calculated for overpayments (including incorrect payments to eligible and ineligible households) and underpayments. The accuracy of welfare agency decisions denying or terminating assistance also is measured periodically, 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 6.2 percent for fiscal year 2002 (Table 15-7). This is the lowest on the record. Error rates for underpayments have been relatively unchanged historically (running about 2 or 3 percent. Finally, the rate of improper denials/terminations in the most recent estimate (fiscal year 2002) was 7.9 percent (as a rate of improper decisions, not unissued dollars).

The dollar error rates reported through the food stamp QC system are used as the basis for assessing the financial liability of States for overpaid and underpaid benefits. Although about $2 billion in sanctions have been assessed since the early 1980s, less than $20 million has been collected. The appeals process has delayed collection, sanctions have been forgiven or waived both by Congress and the

administration, permission has been given for States to invest sanction amounts in improved program administration, small errors have been removed from assessment calculations, and States' reported error rates have been reduced because of the presumed error-rate effects of high and increased proportions of "error-prone" households with earnings and immigrant applicants.

Legislated rules governing fiscal sanctions also have changed a number of times. Under the most recent revision (enacted in 2002 and effective for error rates reported for fiscal year 2003 and beyond), sanctions are assessed against States with persistently high rates of error. Sanctions are calculated in cases in which a State has a combined (overpayment and underpayment) dollar error rate above 105 percent of the weighted national average – after a statistical adjustment to ensure there is a 95 percent statistical probability that the State's "true" error rate exceeds the sanction threshold. However, they are not "assessed" until a State has exceeded the 105 percent threshold for two consecutive years. In that case, the Agriculture Department may (1) require the State to invest up to 50 percent of the amount in administrative improvements, (2) place up to 50 percent of the amount "at risk" for collection in the next year, and (3) waive any amount. If a State then fails to reduce its combined error rate below the 105 percent threshold for a third consecutive year, the "at risk" amount is collected.

TABLE 15-7-- FOOD STAMP QUALITY CONTROL ERROR RATES, FISCAL YEAR 2002

[Percent of benefits paid or not paid in error]

State	Overpayment error rate	Underpayment error rate	Combined error rate
Alabama	7.57	1.16	8.74
Alaska	8.23	2.76	10.99
Arizona	3.86	1.41	5.27
Arkansas	3.53	0.75	4.29
California	10.15	4.69	14.84
Colorado	7.23	2.43	9.66
Connecticut	8.74	2.96	11.70
Delaware	5.23	3.24	8.46
District of Columbia	6.62	2.14	8.75
Florida	7.42	2.19	9.61
Georgia	5.59	1.14	6.73
Guam	4.14	1.91	6.05
Hawaii	3.67	1.36	5.03
Idaho	5.66	3.39	9.04
Illinois	7.32	1.42	8.75
Indiana	5.90	2.40	8.31
Iowa	4.79	1.65	6.44
Kansas	8.95	2.75	11.70
Kentucky	6.27	1.44	7.71
Louisiana	3.88	1.90	5.78
Maine	4.19	2.07	6.26
Maryland	6.05	2.75	8.80
Massachusetts	6.28	2.11	8.40
Michigan	9.54	4.56	14.10

TABLE 15-7-- FOOD STAMP QUALITY CONTROL ERROR RATES, FISCAL YEAR 2002 -continued

[Percent of benefits paid or not paid in error]

State	Overpayment error rate	Underpayment error rate	Combined error rate
Minnesota	4.51	1.22	5.73
Mississippi	3.50	0.89	4.39
Missouri	7.88	1.89	9.77
Montana	6.53	1.64	8.18
Nebraska	5.20	1.82	7.02
Nevada	6.43	1.15	7.59
New Hampshire	10.56	1.46	12.03
New Jersey	3.20	0.87	4.08
New Mexico	5.54	1.17	6.71
New York	5.33	2.41	7.75
North Carolina	3.59	1.11	4.70
North Dakota	3.99	2.14	6.14
Ohio	4.51	1.99	6.50
Oklahoma	6.10	1.84	7.94
Oregon	8.40	2.66	11.07
Pennsylvania	7.54	1.95	9.49
Rhode Island	7.58	2.63	10.21
South Carolina	4.18	0.23	4.40
South Dakota	1.73	0.39	2.12
Tennessee	6.06	0.97	7.02
Texas	3.47	1.38	4.85
Utah	4.88	1.72	6.60
Vermont	6.83	0.85	7.68
Virginia	4.82	1.92	6.74
Virgin Islands	4.16	1.55	5.72
Washington	5.96	2.20	8.16
West Virginia	5.47	1.66	7.13
Wisconsin	9.19	3.49	12.69
Wyoming	2.84	0.45	3.29
U.S. Average	6.16	2.10	8.26

Note- Underpayment and overpayment rates may not add to combined rates due to rounding.
Source: Food and Nutrition Service.

Under this new system, States are liable for amounts equal to the value of food stamps issued in the State (in the second consecutive year they exceed the 105 percent threshold) multiplied by 10 percent of the amount by which the State's combined error rate exceeds 6 percent. For example, in a State that issued $100 million in food stamp benefits and had a 12 percent combined error rate (in its second consecutive year above the threshold for sanctions), the amount of the sanction would be $100 million x 6 percent (i.e., the 6 percent by which the State exceeded the 6-percent base) x 10 percent, or $600,000. In addition (and separate from the QC system), States are required to attempt to collect identified overpayments. In fiscal year 2001, over $200 million in overpayments were collected.

Under the revised QC system, States also can receive performance bonus payments, if they meet the standard set by the Agriculture Department. To carry this out, the Department is required to measure States' performance as to actions taken to correct errors, reduce error rates, improve eligibility determinations, and other indicators of effective administration. The law sets aside $48 million a year for bonus payments.

Finally, the QC system identifies the various sources of error and requires States with combined error rates above 6 percent to develop and carry out corrective action plans to improve administration and payment accuracy. These reviews generally show that the primary responsibility for overpayment errors is almost evenly divided between welfare agencies and clients, and that most errors are mistakes (and not intentional violations). The most common errors are related to establishing food stamp expense deductions and households' income correctly.

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 benefits to obtain cash or non-food items. Roughly one-quarter of the dollar value of erroneous benefit and eligibility determinations identified through QC reviews are fraudulent – about 1.5 percent of all benefits issued in fiscal year 2002. Among cases in which States establish actual claims against households for overpayment, fewer than 10 percent were classified as fraud in fiscal year 2001. The most recent Agriculture Department study on the extent of food stamp trafficking estimated that about $395 million per year was diverted from food stamp benefits by trafficking between 1999 and 2002.

INTERACTION WITH TANF, SSI, AND GA PROGRAMS

The Food Stamp Program is intertwined with Temporary Assistance for Needy Families (TANF), Supplemental Security Income (SSI), and State/local General Assistance (GA) programs in several ways: it is administratively linked with TANF and GA programs, TANF recipients can receive "transitional" food stamp benefits when leaving TANF, most TANF, SSI, and GA recipients are automatically (categorically) eligible for food stamps, and the food stamp recipient population is, to a large extent, made up of TANF, SSI, and GA participants.

State and local offices and personnel administering TANF and GA programs are typically the same offices that enroll people for food stamps and issue food stamp benefits. States may choose to use many TANF rules on how to count income and assets when determining food stamp benefits. Joint food stamp-TANF/GA application and interview procedures are common. Information about applicants and recipients is shared. TANF/GA cash benefits sometimes are included as part of the food stamp electronic benefit transfer (EBT) system (i.e., both TANF cash and food stamp benefits can be accessed with the same EBT debit card). This coadministration does not apply in the case of the SSI Program, which is administered separately through Social Security Administration offices – although these offices do provide limited intake and referral services for the Food Stamp Program and some pilot projects provide standardized food stamp benefits through

SSI offices.

States have the option to give up to 5 months' transitional food stamp benefits to those leaving TANF (for reasons other than a sanction) – without requiring that the household apply for food stamps. The transitional benefit is the amount received prior to leaving TANF, adjusted to account for the loss of TANF income. Transitional benefit households may reapply during the 5-month period to have their benefits adjusted based on changed circumstances, and States may opt to adjust benefits based on information received from another program (like Medicaid) in which the household participates. At the end of the transitional period, households may reapply for continued food stamps under regular food stamp rules.

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

For most persons participating in the Food Stamp Program, food stamp aid represents a second or third form of government assistance. Only about 20 percent of food stamp households rely solely on nongovernmental sources for their cash income, although about 30 percent have some income from these sources (e.g., earnings, private retirement income). According to 2001 data from QC surveys, TANF contributed to the income of some 23 percent of food stamp households. SSI benefits went to 32 percent of food stamp households, and GA payments were received by just under 6 percent.

Table 15-8 shows overall food stamp participation rates in selected years from 1975 to 2002 using two measures: as a proportion of the total U.S. population and as a percentage of the population with income below the Federal poverty thresholds. Food stamp enrollment has fluctuated widely over the last 25 years, reaching its peak in fiscal year 1994; in that year, it averaged 27.5 million persons a month, with an all-time high of 28 million in the spring of 1994 (not including 1.4 million persons receiving aid under Puerto Rico's nutrition assistance grant in lieu of food stamps).

RECIPIENCY RATES

Food stamp enrollment is responsive to changes in the economy (i.e., recipients' employment status and earnings), food stamp eligibility rules (and potential applicants' perception of their eligibility status), and administrative practices, as well as the number of recipients getting or losing public assistance

eligibility. With few changes in eligibility rules, the caseload expanded from a monthly average of 22.6 million persons in fiscal year 1991 to the 1994 peak. From 1994 through 2000, enrollment declined dramatically to a low of 17.2 million persons in 2000 – the lowest level since the 1970s – due to Federal and State welfare reform initiatives, a lower participation rate among those eligible, and the effects of a strong economy. Since 2000, participation has risen to more than 19 million in 2002 due to outreach changes, an increasing rate of participation among eligible individuals, and weakened economic conditions.[8]

TABLE 15-8 -- FOOD STAMP PARTICIPATION RATES IN THE UNITED STATES, SELECTED YEARS 1975-2002

Year	Number of food stamp participants (in millions)	Food stamp participation as a percent of:	
		Total population[1]	Poor population
1975	16.3	7.6	63.0
1980	19.2	8.4	65.6
1985	19.9	8.3	60.2
1990	20.0	8.0	59.6
1991	22.6	9.0	63.3
1992	25.4	10.0	68.9
1993	27.0	10.4	68.7
1994	27.5	10.5	72.1
1995	26.6	10.1	73.0
1996	25.5	9.6	69.8
1997	22.9	8.5	64.3
1998	19.8	8.2	57.4
1999	18.2	6.6	55.5
2000	17.2	6.2	54.4
2001	17.3	6.1	52.6
2002	19.1	6.7	55.2

[1] Calculated as a percent of total U.S. resident population at the end of the fiscal year through 1996. For later fiscal years, calculated as a percent of total U.S. resident population reported in the March Current Population Survey (285 million for 2002).

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

Source: U.S. Census Bureau and Food and Nutrition Service.

Table 15-9 shows the average monthly number of people (in thousands) who received food stamp benefits in each State, the District of Columbia, and the participating Commonwealths and territories for selected years between 1975 (when the Food Stamp Program became nationally available) and 2002. There was a general increase in food stamp participants between 1975 and 1995, followed by sharp declines through 2000 and modest increases in recent years.

[8] According to a July 2003 Agriculture Department study based on participation in September of each year, the participation rate among eligible individuals rose three percentage points between September 1999 and September 2001 – from 59 percent to 62 percent – after five consecutive years of falling participation rates. This same study indicated that participation rates varied widely among segments of the food stamp population – e.g., 80 percent for households with children, 28 percent for the elderly, and 52 percent for those living in households with earnings.

RECENT LEGISLATIVE HISTORY

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

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

Later in 1996, the omnibus welfare reform law (the Personal Responsibility and Work Opportunity Reconciliation Act; Public Law 104-193) made the most extensive changes to the Food Stamp Program since the Food Stamp Act was rewritten in 1977. Under this law, spending on food stamps was projected for a net reduction of $23.3 billion through fiscal year 2002 (or 13 percent less than under then-current law over fiscal years 1997-2002). The food-stamp-related provisions of the welfare reform act: (1) gave States significantly more control over program operations and expanded their administrative options (e.g., allowed States to more closely conform their TANF and food stamp rules and sanction food stamp recipients for failure to meet other public assistance program requirements); (2) established a new work rule limiting participation by able-bodied adults without dependents (ABAWDs) who are not working or in training for work to 3 months in any 3-year period; (3) added other new work rules (e.g., disqualification for significantly reduced work effort); (4) instituted an across-the-board benefit reduction; (5) barred eligibility for most legally resident noncitizens; (6) increased penalties for violating Food Stamp Program rules; and (7) encouraged implementation of electronic benefit transfer (EBT) systems for issuing food stamp benefits (requiring systems be in place nationwide by 2002).

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

The 1998 Agricultural Research, Extension, and Education Reform Act (Public Law 105-185) significantly reduced spending for the Federal share of State food stamp administrative costs--some $200 million per year--by imposing a flat annual dollar reduction on most States' entitlements to correct for a perceived "windfall" extra payment States can potentially receive through the interaction

between food stamp and TANF funding rules. It also lowered Federal payments to States for employment and training programs for food stamp recipients. A portion of the money saved by these reductions was then used to restore food stamp eligibility to some of the noncitizens made ineligible by the 1996 welfare reform law (e.g., elderly and disabled persons legally resident at the time the 1996 law was enacted).

Most recently, the Farm Security and Rural Investment Act of 2002 (Public Law 107-171) reauthorized appropriations for the Food Stamp Program and made the most extensive changes since the 1996 welfare reform law. It expanded eligibility for noncitizens children and other noncitizens who meet a 5-year legal residence test. It raised benefits, primarily for larger households, by increasing the amount of income that is disregarded when setting benefits (i.e., indexing the "standard deduction" and varying it by household size). It allowed States to guarantee 5-months of "transitional" food stamp benefits to those leaving TANF. A number of other State options were established to ease access to the program and administrative burdens on applicants/recipients and program operators. These let States reduce recipient reporting requirements, simplify benefit calculations, and conform income and asset definitions to those used in TANF and Medicaid. It ended Federal restrictions on the spending of work/training funds and changed and generally reduced the Federal share of this spending. Finally, the new law revamped the Food Stamp Program's quality control system to (1) dramatically reduce the number of States likely to be sanctioned for high rates of erroneous benefit decisions (only those with persistently high error rates would be penalized), and (2) grant bonus payments to States with exemplary administrative performance.

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

MEDICAID

OVERVIEW

Medicaid was enacted in 1965, in the same legislation that created the Medicare program, the Social Security Amendments of 1965 (P.L. 89-97). It grew out of and replaced two earlier programs of Federal grants to States that provided medical care to welfare recipients and the aged.

Medicaid is a means-tested entitlement program. It is jointly financed by Federal and State funds. Federal contributions to each State are based on a State's willingness to finance covered medical services and a matching formula. Each State designs and administers its own program under broad Federal rules. The Centers for Medicare and Medicaid Services (CMS), within the U.S. Department of Health and Human Services (HHS), is responsible for Federal oversight of the program. In FY2002, total (preliminary) Federal and State spending on Medicaid reached $258.2 billion, slightly exceeding total outlays for Medicare. No other means-tested cash or noncash program comes close to approaching this spending

TABLE 15-9 -- FOOD STAMP RECIPIENTS BY JURISDICTION, SELECTED FISCAL YEARS 1975-2002

[In thousands]

State	1975[1]	1979[2]	1985[3]	1990[3]	1995[3]	1997[3]	1999[3]	2000[3]	2001[3]	2002[3]
Alabama	393	525	588	449	525	486	405	396	411	444
Alaska	12	25	22	25	45	45	41	38	38	46
American Samoa	NA	NA	NA	NA	3	3	3	3	NA	3
Arizona	166	129	206	317	480	364	257	259	291	379
Arkansas	268	277	253	235	272	266	253	247	256	284
California	1,517	1,334	1,615	1,936	3,175	2,815	2,027	1,832	1,668	1,709
Colorado	162	145	170	221	252	217	173	156	154	178
Connecticut	189	155	145	133	227	210	178	165	157	169
Delaware	39	45	40	33	57	54	39	32	32	40
District of Columbia	112	100	72	62	94	90	84	81	73	74
Florida	767	828	630	781	1,395	1,192	933	882	887	990
Georgia	569	559	567	536	816	698	617	559	574	646
Guam	21	18	20	12	16	18	20	22	23	24
Hawaii	84	96	99	77	125	127	125	118	108	106
Idaho	39	47	59	59	80	70	57	58	60	70
Illinois	948	837	1,110	1,013	1,151	1,020	820	779	825	886
Indiana	255	275	406	311	470	348	298	300	347	411
Iowa	118	117	203	170	184	161	129	123	126	141
Kansas	63	73	119	142	184	149	115	117	124	140
Kentucky	449	405	560	458	520	444	396	103	413	450
Louisiana	502	523	644	727	711	575	516	500	518	588
Maine	151	121	114	94	132	124	109	403	104	111
Maryland	273	299	291	254	399	354	264	219	208	228
Massachusetts	560	429	337	347	410	340	261	232	219	243
Michigan	685	706	985	917	971	839	683	611	641	750
Minnesota	191	143	228	263	308	260	208	196	198	217
Mississippi	390	452	945	499	480	399	288	276	298	325

TABLE 15-9 -- FOOD STAMP RECIPIENTS BY JURISDICTION, SELECTED FISCAL YEARS 1975-2002-continued

[In thousands]

State	1975[1]	1979[2]	1985[3]	1990[3]	1995[3]	1997[3]	1999[3]	2000[3]	2001[3]	2002[3]
Missouri	299	280	362	431	576	478	408	420	454	515
Montana	38	33	58	57	713	67	61	59	62	63
Nebraska	50	55	94	95	105	97	92	82	81	88
Nevada	34	27	32	50	99	82	62	61	69	97
New Hampshire	66	44	28	31	28	46	37	36	36	41
New Jersey	565	524	464	381	540	490	385	345	318	320
New Mexico	154	159	157	157	239	205	178	169	163	170
New York	1,398	1,704	1,834	1,546	2,183	1,919	1,545	1,439	1,354	1,357
North Carolina	537	517	474	419	614	586	505	488	494	574
North Dakota	19	20	33	39	41	38	33	32	38	37
Northern Mariana Islands	NA	NA	4	4	4	4	4	5	NA	6
Ohio	924	760	1,133	1,078	1,155	874	640	610	641	735
Oklahoma	184	184	263	267	375	309	271	253	271	317
Oregon	208	160	228	216	289	259	224	234	281	359
Pennsylvania	893	923	32	954	1,173	1,009	835	777	748	767
Puerto Rico	1,800	1,822	1,480	1,480	1,370	1,240	1,140	1,080	1,070	1,040
Rhode Island	104	80	69	64	100	85	76	74	71	72
South Carolina	421	369	373	299	364	349	309	295	316	379
South Dakota	31	37	48	50	50	47	44	43	45	48
Tennessee	435	531	518	527	662	586	511	496	522	598
Texas	1,085	1,027	1,263	1,880	2,564	2,034	1,401	1,333	1,366	1,554
Utah	50	44	75	99	119	98	88	82	80	90
Vermont	46	40	44	38	59	53	44	41	39	40
Virginia	193	320	360	346	546	476	362	336	331	354
Virgin Islands	25	34	32	18	23	20	17	16	13	12

Washington	239	205	281	337	476	442	307	295	309	350
West Virginia	204	182	278	262	329	287	247	227	221	236
Wisconsin	163	171	363	286	320	232	182	193	216	262
Wyoming	11	11	27	28	34	29	23	22	23	24
Total	19,199	18,926	21,385	21,510	27,995	24,106	19,334	18,251	18,385	20,159

[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, participations increases were largely due to the elimination of food stamp purchase requirement. Figures for Alabama and Mississippi are estimates.

[3] Annual average monthly participation.

NA -Not available.

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

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

TABLE 15-10 -- CHARACTERISTICS OF FOOD STAMP HOUSEHOLDS, SELECTED YEARS 1980-2001[1]

Food stamp recipient households	1980	1985	1990	1995	1996	1997	1998	1999	2000	2001
With gross monthly income:										
Below the Federal poverty level	87	94	92	92	91	92	90	89	89	89
Between the poverty level and 130 percent of the poverty level	10	6	8	8	8	8	9	10	10	10
Above 130 percent of the poverty level	2	[2]	[2]	[2]	1	[2]	1	1	1	1
With earnings	19	20	19	21	23	24	26	27	27	27
With public assistance income[3]	65	68	73	68	61	61	59	57	57	55
With AFDC/TANF income	NA	39	43	38	37	35	31	27	26	23
With SSI income	18	19	19	23	24	26	28	30	32	32
With children	60	59	61	60	59	58	58	56	54	54
With female heads of household	NA	46	51	50	50	49	NA	NA	NA	34
With elderly members[4]	23	21	18	16	16	18	18	20	21	20
Average household size	2.8	2.7	2.6	2.5	2.5	2.4	2.4	2.4	2.3	2.3

[1] Data for 1995 through 2001 represent characteristics over the full course of each Fiscal Year; 1985 and 1990 are during summer; and 1980 is from August.

[2] Percentage equals 0.5 or less.

[3] Public assistance income includes Aid to Families with Dependent Children, TANF, SSI, and general assistance.

[4] Elderly members and heads of household include those age 60 or older.

NA- Not available.

Note- For years prior to 1996, the proportion of households with public assistance income shown in this table is an estimate that generally over counts them because it is not corrected for households with multiple sources of public assistance income.

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

TABLE 15-11-- HISTORICAL FOOD STAMP STATISTICS, SELECTED YEARS, 1972-2002

Fiscal year	Total Federal spending (in millions)[1]		Average monthly participation (in millions of persons)	Average monthly benefits (per person)		Four-person maximum monthly allotment[3]
	Current dollars	Constant 2002 dollars[2]		Current dollars	Constant 2002 dollars[2]	
1972[4]	$1,871	$7,954	11.1	$13.50	$57.40	$108
1975[5]	4,624	15,413	17.1	21.40	71.30	150
1980	9,188	20,545	21.1	34.40	76.90	204
1985	12,599	21,136	21.4	45.00	75.50	264
1990	16,512	22,952	21.5	59.00	82.00	331
1991	19,765	26,155	24.1	63.90	84.50	352
1992	23,539	30,238	26.9	68.50	88.00	370
1993	24,749	30,856	28.4	68.00	84.80	375
1994	25,525	31,010	28.9	69.00	83.80	375
1995	25,676	30,341	28.0	71.30	84.20	386
1996	25,494	29,307	26.9	73.30	84.30	397
1997	22,868	25,605	24.1	71.30	79.80	400
1998	20,397	22,472	21.0	71.10	78.30	408
1999	19,317	20,881	19.3	72.30	78.10	419
2000	18,255	19,125	18.3	72.80	76.30	426
2001	18,813	19,095	18.4	74.80	75.90	434
2002	21,657	21,657	20.2	79.60	79.60	452

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

[2] Constant dollar adjustments were made using the overall Consumer Price Index for All Urban Consumers (CPI-U).

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

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

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

Note- Data for 1982 and subsequent years include funding for Puerto Rico's nutrition assistance grant; earlier years include funding for Puerto Rico under the regular Food Stamp Program; participation figures include enrollment in Puerto Rico (averaging 1.1 to 1.5 million persons a month under the nutrition assistance grant and higher figures in earlier years); average benefit figures do not reflect benefits in Puerto Rico under its nutrition assistance grant.

Source: Compiled by the Congressional Research Service.

level. In fact, of all federally supported social programs, only Social Security costs more.

To many, Medicaid is an enigma. The program's complexity surrounding who is eligible, what services are paid for, and how those services are reimbursed and delivered is one source of this confusion. Variability across State Medicaid programs is the rule, not the exception. In recent years, more and more States have implemented a variety of major program changes using special waiver authority. Income eligibility levels, services covered, and the method for and amount of reimbursement for services differ from State to State. Furthermore, Medicaid is a program that is targeted at individuals with low-income, but not all of the poor are eligible, and not all those covered are poor. For populations like children and families, primary and acute care often are delivered through managed care, while

the elderly and disabled typically obtain such care on a fee-for-service basis. Nationwide, Medicaid finances the majority of long-term care services. Such services include, for example, nursing home care and community-based services designed to support the elderly and disabled in their homes. Recently, some States have begun to integrate Medicare and Medicaid financing and/or coordinate acute and long-term care services for these populations.

The complexity of Medicaid presents an enormous challenge for anyone attempting to make generalizations about the program. This subsection describes Federal Medicaid rules that govern: (1) who is eligible, (2) what services are covered and how they are delivered, (3) how the program is financed and administered, (4) key provider reimbursement issues, and (5) the significant role of waivers in expanding eligibility and modifying services. It concludes with a brief legislative history beginning with major laws affecting Medicaid since 1996.

ELIGIBILITY

The Federal Medicaid statute defines over 50 distinct population groups as being potentially eligible for States' programs. Some groups are mandatory, meaning that all States that participate in the Medicaid program must cover them; others are optional. Prior to the 1980s, Medicaid eligibility was limited to very low-income families with dependent children, poor elderly and disabled individuals, and the "medically needy."

Beginning in the 1980s, additional eligibility pathways were added to the Medicaid statute to allow for the coverage of higher income children and pregnant women as well as other elderly and disabled individuals. Most recently, States were given the option to provide Medicaid to other groups with specific characteristics including certain women with breast or cervical cancer, to uninsured individuals with tuberculosis, and to working individuals with disabilities. Not all groups of Medicaid beneficiaries receive the same set of benefits. To understand the different benefits offered to each group, see "Benefits" below.

Medicaid is a means-tested program. To qualify, applicants' income and resources must be within certain limits. The specific income and resource limitations that apply to each eligibility group are set through a combination of Federal parameters and State definitions. Consequently, those standards vary considerably among States, and different standards apply to different population groups within a State. For many of those groups, moreover, States have permission under a special provision, Section 1902(r)(2), to use more liberal standards for computing income and resources than are specified within each of the groups' definitions. Most States use Section 1902(r)(2) to ignore or disregard certain types or amounts of income or assets, thereby extending Medicaid to individuals with earnings or assets too high to otherwise qualify under the specified rules for that eligibility pathway.

The two primary pathways to Medicaid for low-income family members, pregnant women, and children are through (1) Section 1931 of Medicaid statute, for those families who would have been eligible for cash welfare payments under former Aid to Families with Dependent Children (AFDC) program rules, and (2) a series of targeted Medicaid expansions for poor pregnant women and children begun in the 1980s. Other important pathways for low-income family members, including transitional medical assistance, other AFDC-related groups, and children qualifying for the State Children's Health Insurance Program (SCHIP) who are receiving their health coverage under the Medicaid program, are explained below.

Section 1931: Persons qualifying under the former AFDC program rules

Families who are eligible for Temporary Assistance for Needy Families (TANF) are not automatically eligible for Medicaid. Medicaid's Section 1931, however, preserves Medicaid entitlement for individuals who meet the requirements of the former AFDC programs in effect in their States on July 16, 1996. This categorical group was created when TANF replaced AFDC in 1996 to ensure that low-income families do not lose Medicaid as a result of welfare reform. States have significant flexibility in defining the income and resource standards for those families qualifying for Medicaid under Section 1931: (1) income standards may be reduced below those in effect in 1996, but they cannot be lower than those used on May 1, 1988; (2) income and resource standards may be increased for any period after 1996, but by no more than the percentage increase in the Consumer Price Index (CPI) for the same period; and (3) States may use less restrictive methods for counting income and resources than those in effect on July 16, 1996.

Certain individuals qualifying under the Section 1931 pathway may be denied Medicaid coverage if they refuse to cooperate with States' TANF work requirements. States are permitted to deny Medicaid benefits to nonpregnant adults and heads of households who lose TANF benefits because of refusal to work, but must continue to provide Medicaid coverage to their children.

In 2002, 39 States had taken advantage of the flexibility of Section 1931 to expand eligibility for working families by disregarding some earned income, thereby allowing families with higher total income to qualify for the program. Other States eliminated various income and assets rules, thus expanding low-income working families' access to Medicaid.[9]

Poverty-related pregnant women and children

Between 1986 and 1991, Congress gradually extended Medicaid to new groups of pregnant women and children. Under these provisions, States are required to cover pregnant women and children under age 6 with family incomes below 133 percent of the Federal poverty income guidelines.[10] Coverage for pregnant women

[9] Maloy, K.A., Kenney, K.A., Darnell, J., Cyprien, S., *Can Medicaid Work for Low-Income Working Families?*, Kaiser Commission on the Future of Medicaid and the Uninsured, April 2002.

[10] 100 percent of FPL is equal to $15,260 and 133 percent of FPL is equal to $20,256 for a family of three in 2003.

qualifying through this pathway is limited to services related to the pregnancy or complications of the pregnancy and extends to 60 days after termination of the pregnancy. Children receive full Medicaid coverage.

States are required to cover all children over the age of five and under 19 who are in families with income below 100 percent of the Federal poverty level (FPL). This requirement has been phased-in since July 1, 1991 and was fully implemented in 2002.

States have the option to go beyond the above mandatory groups to include pregnant women and infants under 1 year of age whose family income is over 133 and up to 185 percent of the FPL. In 2002, 36 States and the District of Columbia extended coverage to some or all pregnant women and infants in this category.

Transitional medical assistance

Transitional medical assistance (TMA) was established prior to the 1996 welfare reform to address the concern that individuals receiving AFDC payments would not seek work or would turn down work opportunities for fear of losing Medicaid. TMA requires States to continue providing Medicaid for 6 months to families that were receiving Medicaid under Section 1931 in at least 3 of the last 6 months. The extended Medicaid coverage is available to individuals (and their families) who would otherwise have lost such assistance due to increased work hours, increased earnings of the caretaker relative, or the loss of one of the time-limited earned income disregards. In addition, States are required to extend Medicaid coverage for a second 6 months to families that were covered during the entire first 6-month TMA period, and whose earnings are below 185 percent of poverty. The provisions authorizing TMA are due to sunset at the end of March 2004, although this date has been repeatedly extended. A small additional group of mandatory TMA-eligible persons are those who would otherwise lose Medicaid coverage under Section 1931 because of increased child or spousal support. Families eligible for this 4-month extension must have been receiving Medicaid under Section 1931 in at least 3 of the preceding 6 months.

Other AFDC-related groups

While the AFDC program no longer exists, a number of Medicaid eligibility groups tied to States' former AFDC rules remain. States must provide Medicaid to recipients of adoption assistance and foster care (who are under age 18) under Title IV–E of the Social Security Act. In 1999 States were given the option to extend Medicaid to former foster care recipients who are aged 18, 19, or 20.

Ribicoff children, a pathway named for the former Senator who sponsored legislation authorizing this group, are those under age 21 who meet income and resource requirements for the former AFDC Program but who do not meet other categorical requirements for AFDC. States have the option to cover Ribicoff children and have a great deal of flexibility in defining the specific group of children to be covered under this category. Often States use this authority to cover children in State-sponsored foster care, children who are institutionalized, or who are inpatients in psychiatric facilities. Although many of the children who have traditionally been covered under Ribicoff are now eligible under other poverty-

related groups, Ribicoff remains an important pathway to eligibility for some small groups of older adolescents in foster care and children in two-parent families.

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

Section 4911 of the Balanced Budget Act of 1997 (BBA 1997, P.L. 105-33) established an additional coverage group for low-income children.[11] Targeted low-income children are those who are not otherwise eligible for Medicaid, are not covered under a group health plan or other insurance, and are living with families with income that is either: (1) above the State's Medicaid financial eligibility standard in effect in June 1997 but less than 200 percent of the FPL; or (2) in States with Medicaid income levels for children already at or above 200 percent of the poverty level as of June 1997, within 50 percentage points over this income standard. States either can establish a specific coverage group for targeted low-income children or they can build upon other existing Medicaid coverage groups for children. As of February 2003, 37 States cover targeted low-income children under Medicaid.

THE AGED AND PERSONS WITH DISABILITIES

Persons who qualify for Supplemental Security Income (SSI)

With one important exception, States are required to provide Medicaid coverage to recipients of SSI. SSI, authorized under Title XVI of the Social Security Act, is a means-tested cash assistance program for aged, blind, and disabled individuals whose income falls below the Federal maximum monthly SSI benefit and whose resources are limited. To qualify for SSI, a person must satisfy the program criteria for age or disability and meet certain citizenship or United States residency requirements. Eligibility for SSI is restricted to otherwise qualified individuals whose resources do not exceed $2,000 for an individual and $3,000 for a couple; certain resources, such as a person's home, are exempt. Income cannot exceed the maximum Federal SSI benefit of $552 per month in 2003 for an individual living independently, and $829 for a couple living independently. The SSI benefit level of $552 per month for an individual is 74 percent of FPL.

The major exception to Medicaid coverage of SSI recipients is in States that exercise the so-called "209(b)" option described in Section 209(b) of the Social Security Amendments of 1972 (P.L. 92-603). Such States may use income, resource, and disability standards that are no more restrictive than those in place on January 1, 1972. As of 2001, there were 11 Section 209(b) States, including Connecticut, Illinois, Hawaii, Indiana, Minnesota, Missouri, New Hampshire, North Dakota, Ohio, Oklahoma, and Virginia. Each of these has at least one

[11] This provision establishes a Medicaid coverage group that is parallel to the group of children eligible for health coverage under another provision of BBA 97, the State Children's Health Insurance Program (Section 4901). The two provisions allowed States to choose, after the passage of BBA 97, to either extend Medicaid for targeted low-income children, to create a new SCHIP program for those children, or coordinate both programs to cover the target population.

eligibility standard that is more restrictive than current SSI standards and some have certain standards that are more liberal. States that use more restrictive eligibility rules under Section 209(b) must also allow applicants to deduct medical expenses from their income when determining financial eligibility for Medicaid. This process is sometimes referred to as "spend-down."[12]

Recipients of State Supplemental Payment (SSP) benefits

Many States provide SSP benefits with State-only dollars on a monthly basis. These payments are intended to cover such items as food, shelter, clothing, utilities, and other daily necessities. The amount of the benefit is determined by the individual States. States may provide supplemental payments to all persons who receive SSI, and/or to individuals who meet all SSI criteria, other than income. States also may choose to provide SSP benefits only to particular groups, such as elderly persons living independently in the community without special needs, or elderly individuals who require in-home personal care assistance or home-delivered meals. In all of these cases, States decide whether to extend Medicaid coverage to all SSP recipients, to only some of these recipients, or to none at all. When a State provides Medicaid eligibility to persons receiving only SSP-and not SSI-then the maximum income eligibility standard for Medicaid is an amount equivalent to the combined Federal SSI payment and the SSP benefit. For 209(b) States, however, the effective maximum financial eligibility standard for these individuals is the 209(b) categorical eligibility standard plus the SSP payment.

Poverty-related group for the aged and disabled

The enactment of the Omnibus Budget Reconciliation Act of 1986 (OBRA 86) offered States an option for covering persons whose income exceeds SSI or 209(b) levels. This option allows States to cover aged and disabled individuals with incomes up to 100 percent of FPL. In 2001, there were 21 States using this option.[13]

Coverage for institutionalized individuals and related groups under the special income rule

States may extend Medicaid to certain individuals with incomes too high to qualify for SSI, and who are eligible for nursing facility or other institutional care. Under the special income rule, also referred to as "the 300 percent rule," such

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[12] An example of spend-down is as follows: if an applicant has a monthly income of $700 (not including any SSI or State Supplemental Payments (SSP)) and the State's maximum allowable income standard for spend-down eligibility is $600, the applicant would qualify for Medicaid after incurring $100 in medical expenses in that month.

[13] A survey by the American Public Human Services Association reported the District of Columbia (up to 100 percent) and the following States had implemented this option as of October 2001: California (up to 100 percent), Florida (90 percent), Georgia (100 percent), Illinois (85 percent), Maine (100 percent), Massachusetts (100 percent), Michigan (100 percent), Minnesota (95 percent), Mississippi (100 percent), Nebraska (100 percent), New Jersey (100 percent), North Carolina (100 percent), Pennsylvania (100 percent), Rhode Island (100 percent), South Carolina (100 percent), Utah (100 percent), Vermont (100 percent), Virginia (80 percent). In a separate survey, CRS determined that Oklahoma (100 percent) and Hawaii (100 percent) also used this option in 2001.

persons must (1) require care provided by a nursing home or other medical institution for no fewer than 30 consecutive days, (2) meet the resource standard determined by the State, and (3) have income that does not exceed a specified level - no greater than 300 percent of the maximum SSI payment applicable to a person living at home. For 2003, this limit is $1,656 per month, three times the monthly SSI payment of $552. States may use a level that is lower than the maximum of 300 percent of SSI.

Since 1993 (OBRA 93), States that use only the special income rule for institutional eligibility, and do not use the medically needy option (described below), must allow applicants to place income in excess of the special income level in a special trust, often called a Miller Trust, and receive Medicaid coverage for their care.[14] Following the individual's death, the State becomes the beneficiary of amounts in the trust.

Working individuals with disabilities

Concern that many workers with disabilities would lose eligibility for Medicaid as a result of increased earnings and yet not have access to affordable or adequate health insurance through their jobs, prompted Congress to establish a variety of special rules that would protect working individuals with disabilities from losing their Medicaid benefits. One rule does so by changing SSI program rules for working persons with disabilities. In order for disabled persons to qualify for SSI and, thus become eligible for Medicaid, applicants must establish disability status under the criteria determined by the Secretary of the Department of Health and Human Services (HHS). These criteria are linked to an individual's ability to work or earn income from work, commonly referred to as an individual's ability to "engage in substantial gainful activity" (SGA). Current regulations provide that an individual is able to engage in SGA if his or her earnings exceed $800 per month, as of January 2003. For persons who are blind, SGA is $1,330 per month for 2003. SGA is defined in Federal regulations as paid work involving significant and productive physical or mental duties.[15] Section 1619(a) of SSI law permits those States that extend Medicaid to SSI recipients to allow certain persons with a disability who had been eligible for an SSI payment for at least one month and who meet all other eligibility rules, to continue receiving Medicaid even when they are working at the SGA level. The amount of their SSI special cash benefits is gradually reduced as their earnings increase under an income disregard formula[16]

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[14] OBRA 1993 codified a 1990 ruling from the United States District Court for the District of Colorado which first coined the term "Miller Trust." See *Miller v. Ybarra*, 746 F.Supp. 79 (E. Colo 1990).

[15] The inability to engage in SGA must be a result of a medically determined physical or mental impairment expected to result in death or that has lasted, or can be expected to last, for a continuous period of at least 12 months. A child under age 18 may qualify as disabled if he or she has an impairment that results in "marked and severe" functional limitations.

[16] Not all income is counted for SSI purposes. Different exemptions, or disregards, apply for the different types of income. Earned income that is exempt from being counted includes the first $65 per month in wages; one-half of all wages over $65; impairment-related expenses necessary for blind and disabled workers; and income used for a plan for achieving self support (PASS). Unearned income exclusions include the first $20 per month of non-needs tested benefits and all of the following: Food Stamps; housing and energy assistance; state and local needs-based assistance; in-

until their countable earnings reach the SSI benefit standard or what is known as the *breakeven point* ($552 per month in 2003).

In addition, individuals who are blind or have a disability can continue to be eligible for Medicaid even if their earnings exceed the SSI income disregard breakeven point under a special group referred to as "qualified severely impaired individuals." Special eligibility status granted by Section 1619(b)(1) and 1905(q), under which the individual is considered an SSI recipient for purposes of Medicaid eligibility (although he or she is not actually receiving a SSI cash benefit) applies as long as the individual: (1) continues to be blind or have a disabling impairment; (2) continues to meet all the other requirements, except for earnings, for SSI eligibility; (3) would be seriously inhibited from continuing to work by the termination of eligibility for Medicaid services; and (4) has earnings that are not sufficient to provide a reasonable equivalent to the benefits that would have been available if he or she did not have SSI, state supplementary payments, Medicaid and publicly funded personal care.

Other provisions give States even more flexibility to cover working persons with disabilities. The Balanced Budget Act of 1997 (BBA 97, P.L. 105-33) allows States to provide Medicaid coverage to working individuals with disabilities whose family's net income does not exceed 250 percent of the FPL. Two other provisions were added under the Ticket to Work and Work Incentives Improvement Act of 1999 (TWWIIA, P.L. 106-170). The first allows States to further expand Medicaid coverage to working individuals with disabilities, between the ages of 16 and 64, with incomes and resources as defined by the State and allows States to impose premiums and other cost-sharing on individuals who qualify. The second allows States, under certain circumstances, to provide coverage to persons whose medical condition has improved and who has therefore become ineligible for SSI on the basis of disability.

Qualified Medicare beneficiaries and related groups

Certain low-income individuals who are aged or have disabilities as defined under SSI and who are eligible for Medicare are also eligible to have some of their Medicare cost-sharing expenses paid for by Medicaid. There are four categories of such persons[17]:

- *Qualified Medicare Beneficiaries (QMB)*-- Qualified Medicare beneficiaries are aged or disabled Medicare beneficiaries with incomes no greater than 100 percent of the Federal poverty level and assets no greater than $4,000 for an individual and $6,000 for a couple. States are required to cover, under their Medicaid programs, the costs of Medicare premiums, deductibles, and coinsurance for Medicare covered benefits for such persons. Other Medicaid covered services, such as nursing facility care, prescription drugs, and primary and acute care services, are not covered for these individuals unless they qualify for Medicaid through other

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kind support and maintenance payments from non-profit organizations; and student grants and scholarships.

[17] The program known as Qualifying Individuals-2 (QI-2) terminated on September 30, 2002.

eligibility pathways (e.g. via SSI, medically needy, or the special income rule).

- *Specified Low-Income Medicare Beneficiaries (SLMB)* -- Specified low-income Medicare beneficiaries meet QMB criteria, except that their income is greater than 100 percent of FPL but does not exceed 120 percent FPL. Under this Medicaid pathway, States are required to cover only the monthly Medicare Part B premium. Other Medicaid covered services are not covered for these individuals unless they qualify for Medicaid through other eligibility pathways.
- *Qualifying Individuals (QI-1)* -- The QI-1 eligibility pathway applies to aged and disabled Medicare beneficiaries whose income is between 120 and 135 percent of FPL. For these individuals, States are required to pay the monthly Medicare Part B premium, only until the Federal allotment for this purpose is depleted.[18] These individuals are not otherwise eligible for Medicaid.
- *Qualified Disabled and Working Individuals* (QDWIs) -- States are required to pay the Medicare Part A premiums for persons who were previously entitled to Medicare on the basis of a disability, who lost their entitlement based on earnings from work, but who continue to have a disabling condition. Such persons may qualify only if their incomes are below 200 percent of FPL, their resources are below 200 percent of the SSI limit ($4,000), and they are not otherwise eligible for Medicaid.

MEDICALLY NEEDY

States may extend Medicaid coverage to persons who are members of one of the broad categories of Medicaid covered groups (i.e., are aged, have a disability or are in families with children), but do not meet the applicable income requirements and, in some instances, resources requirements for other eligibility pathways. Under this option, States may set their medically needy monthly income limits for a family of a given size at any level up to 133 1/3 percent of the maximum payment for a similar family under the state's AFDC program in place on July 16, 1996. For families of one, the statute gives certain states some flexibility to set these limits to amounts that are reasonably related to the AFDC payment amounts for two or more persons.

While 133 1/3 percent of the former AFDC program standard is generally higher than the income standard for other Medicaid pathways for families, it is generally lower than the income standard for elderly or disabled SSI recipients. For all groups, States are required to allow individuals to spend down to the medically needy income standard by incurring medical expenses, in the same way that SSI

[18] In general, Medicaid payments are shared between the Federal government and the States according to a matching formula (see the Medicaid section on financing). However, expenditures under the QI-1 program are paid 100 percent by the Federal government (from the Part B trust fund) up to the State's allocation level. A State is required to cover only the number of persons which would bring its spending on these population groups in a year up to its allocation level. This temporary program, originally slated to end September 30, 2002, has been extended through September 30, 2004, most recently by P.L. 108-173.

recipients in Section 209(b) States may spend down to Medicaid eligibility.

Under the statute, States may limit the categories of individuals who can qualify as medically needy. If a State provides any medically needy program, however, it must include all children under 18 who would qualify under one of the welfare-related groups, and all pregnant women who would qualify under either a mandatory or optional group, if their income or resources were lower. In 2002, 35 States[19] and the District of Columbia covered the medically needy.

OTHER INDIVIDUALS COVERED

In recent years, new groups have been added to Medicaid that move the program further away from its traditional links to cash assistance programs. Demonstration waivers have allowed States the flexibility to target enrollment and benefits to various groups, and two new pathways were added to Medicaid for individuals with specific medical diagnoses. With specific restrictions, Medicaid is also available to certain immigrants.

Individuals qualifying under demonstration waivers

Demonstration waivers available under the authority of Section 1115 of the Social Security Act enable States to experiment with new approaches for providing health care coverage that promote the objectives of the Medicaid program. Section 1115 allows the Secretary of HHS to waive a number of Medicaid rules - including many of the Federal rules relating to Medicaid eligibility.[20] The Health Insurance Flexibility and Accountability (HIFA) Initiative is an explicit effort of HHS to encourage States to seek Section 1115 waivers to extend Medicaid and SCHIP to the uninsured, with a particular emphasis on Statewide approaches that maximize private health insurance coverage options and target populations with incomes below 200 percent of FPL. A number of States have used such waivers to enact broad-based and sometimes statewide health reforms, although demonstrations under Section 1115 need not be statewide. A number of the demonstrations extend comprehensive health insurance coverage to low-income children and families who would not otherwise be eligible for Medicaid.

Women with breast and cervical cancer

Women who are eligible for Medicaid under this optional coverage group are those who have been screened for and found to have breast or cervical cancer (including precancerous conditions) through the National Breast and Cervical Cancer Early Detection Program (NBCCEDP). Women who qualify must be under age 65, uninsured, and otherwise not eligible for Medicaid. Benefits are limited to

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[19] These include Arkansas, California, Connecticut, Florida, Georgia, Hawaii, Illinois, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Montana, Nebraska, New Hampshire, New Jersey, New York, North Carolina, North Dakota, Oklahoma, Oregon, Pennsylvania, Rhode Island, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, and Wisconsin. All States except Texas cover aged and disabled medically needy groups.

[20] See also the discussion of Section 1115 waivers in this subsection.

the period in which the beneficiary requires breast or cervical cancer treatment. In 2002, 42 States[21] chose to cover women who meet these requirements.

Persons with tuberculosis

States may choose to offer Medicaid to people with tuberculosis (TB) who are uninsured. Individuals qualifying under this pathway are entitled only to those services related to the treatment of tuberculosis. In 2002, 8 States[22] and the District of Columbia covered such persons with TB.

Immigrants

Legal immigrants arriving in the United States after August 22, 1996 are ineligible for Medicaid benefits for their first 5 years here. Coverage of such persons after the 5-year ban is a State option.[23] States may provide Medicaid coverage to legal immigrants who resided in the country and were receiving benefits on August 22, 1996, and for those residing in the country as of that date who become disabled in the future. States are also required to provide coverage to:

- refugees for the first 7 years after entry into the United States;
- asylees for the first 7 years after asylum is granted;
- certain individuals whose deportation is being withheld by the Immigration and Naturalization Service for seven years after the deportation is first withheld;
- lawful permanent aliens after they have been credited with 40 quarters of coverage under Social Security; and
- immigrants who are honorably discharged U.S. military veterans, active duty military personnel, and their spouses and unmarried dependent children who otherwise meet the State's financial eligibility criteria.

In addition, States are required to provide emergency Medicaid services to all legal and undocumented noncitizens who meet the financial and categorical eligibility requirements for Medicaid.

ENROLLMENT

In 2000, there were 44.3 million people enrolled in Medicaid. Over one-half (51 percent) of those enrolled were under age 19[24], about 37 percent were ages 19

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[21] These include Alabama, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Michigan, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, North Carolina, North Dakota, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, and Wyoming.

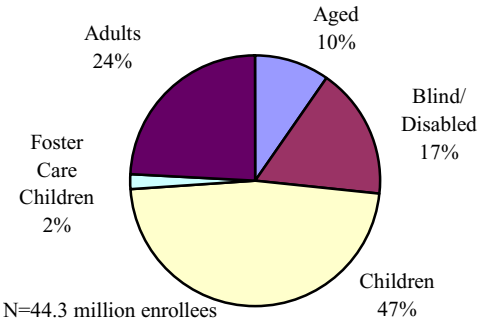
[22] These include California, Florida, Louisiana, Minnesota, New York, Oklahoma, Utah, and Wyoming.

[23] All States except for Colorado and Utah have opted to cover such persons. Colorado's coverage for this group was repealed in May 2003, and was later upheld after a legal challenge by the American Civil Liberties Union of Colorado.

[24] Chart 15-1 shows 49 percent of Medicaid enrollment in 2000 were children (47 percent children plus 2 percent foster care children). Additional children who are blind or disabled are included in the blind/disabled category.

through 64, and almost 10 percent were 65 or over. Charts 15-1 and 15-2 show 2000 Medicaid enrollment by basis of eligibility (BOE) and by major enrollment group, respectively. State reported data are not available in a format that allows for examining enrollment by the pathways as described above.

CHART 15-1--ENROLLEES BY BASIS OF ELIGIBILITY, FISCAL YEAR 2000



Note-Medicaid enrollees include all persons enrolled in Medicaid during the year whether or not any payments for services have been made on their behalf. Total enrollees include those in the 50 States and the District of Columbia.
Source: Congressional Research Services tabulation of data from the Medicaid Statistical Information System (MSIS) for FY2000 for all States except Hawaii. Hawaii did not report MSIS data from FY2000. CRS approximated FY2000 data for Hawaii using data reported for FY1999.

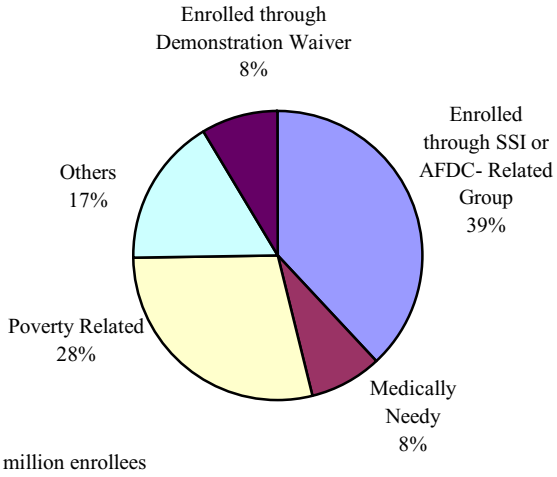
Chart 15-1 shows that Medicaid enrollment is predominantly non-disabled adults (e.g., parents) under age 65 and children (about 73 percent). Chart 15-2 shows that almost half of Medicaid enrollment in 2000 is through traditional pathways: 39 percent of enrollees are SSI recipients, SSI-related enrollees, and members of families that would have been eligible for former AFDC programs and now qualify through Section 1931, and an additional 8 percent are the medically needy. Over one-third of 2000 enrollment is through relatively new pathways: 28 percent of individuals on the program are enrolled through the poverty-level pathways added to Medicaid since the mid-1980s and 8 percent through demonstration waivers. Finally, about 17 percent of Medicaid enrollees are in the "other" group, including foster care children, elderly individuals in institutions, families receiving transitional medical assistance, and persons receiving State supplementary SSI payments. This "other" grouping includes over 60 specific eligibility pathways.

Table 15-12 presents Medicaid recipients[25] by basis of eligibility for selected years from 1975 through 2000. Since the mid-1970s, the number of individuals receiving at least one Medicaid service during the year has more than doubled, and during the 1990s, Medicaid enrollment growth quickened. Prior to 1998, Medicaid

[25] Recipients are those enrollees for whom either a service payment or a capitated payment is made during the year.

recipients, as reported by States using HCFA-2082 reporting forms, excluded individuals for whom only capitated[26] payments were made. HMO enrollment, however, also grew rapidly, especially among non-disabled children and adults, after 1995. Individuals in HMOs, totaling over 5 million in 1995, are not reflected in the figures in Table 15-12, prior to 2000.

CHART 15-2 --MEDICAID ENROLLEES BY MAJOR ENROLLMENT GROUP, FISCAL YEAR 2000



Note-Medicaid enrollees include all persons enrolled in Medicaid during the year whether or not any payments for services have been made on their behalf. Total enrollees include those in the 50 States and the District of Columbia.
Source: Congressional Research Services tabulation of data from the Medicaid Statistical Information System (MSIS) for FY2000 for all states except Hawaii. Hawaii did not report MSIS data from FY2000. CRS approximated FY2000 data for Hawaii using data reported for FY1999.

Table 15-13 shows all Medicaid enrollees in fiscal year 2000 by State. Individuals counted in this table include all recipients plus all other individuals enrolled in the program in any month whether or not services were paid on their behalf. States are ranked by the total number of enrollees. California, the State with the highest Medicaid enrollment, had 8.1 million individuals in the program in 2000. The second highest enrollment was in New York with 3.4 million enrollees. The top ten States, in terms of enrollment, accounted for over one-half of the program's total enrollment.

[26] Capitation payments are fixed payment amounts made to providers or managed care organizations, usually monthly, for each person enrolled. The amounts are pre-paid and do not vary by the frequency or type of services provided during the period over which the payments apply.

TABLE 15-12--UNDUPLICATED NUMBER OF MEDICAID RECIPIENTS BY ELIGIBILITY CATEGORY FOR SELECTED YEARS 1975-2000

[In Thousands]

Year	Total Recipients	Aged	Blind/Disabled	Children	Adults	Foster Care Children	Average Annual Growth
1975	20,320	3,577	2,442	9,121	4,271	NA	--
1980	20,660	3,439	2,874	8,921	4,585	NA	0.0%
1985	20,973	3,060	2,947	9,214	5,034	NA	0.0%
1990	23,964	3,201	3,661	10,783	5,618	NA	3.7%
1995	35,210	3,938	5,768	16,572	7,376	NA	9.4%
2000	42,763	3,731	6,889	18,962	8,750	761	4.3%

Notes- For 1975-1995, recipients are those individuals for whom a fee-for-services claim was paid during the year. For 2000, recipients include both those individuals for whom a fee-for-service claim was paid during the year and those for whom a capitation payment was made during the year. Capitated service delivery systems became more prominent under Medicaid starting in 1995, primarily enrolling non-disabled adults and children. As a result, about 5.3 million people enrolled in such capitated arrangements are not included in this table before 2000. See subsection on Medicaid managed care for more detailed information on capitated beneficiaries and expenditures. Totals do not sum because table does not include recipients of services for whom basis of eligibility is unknown. Total recipients in this table include recipients in 50 States and the District of Columbia.

NA - Not available.

Source: CRS Tabulations of HCFA 2082 data (for 1975-1995) and MSIS person-level summary records (for 1999 and 2000). Hawaii did not report MSIS data for 2000. CRS estimated Hawaii's enrollment for FY2000 using data from 1999.

MEDICAID AND THE POOR

In CY 2002, Medicaid covered 11.6 percent of the total U.S. population (excluding institutionalized persons) and 40.5 percent of those with incomes below the federal poverty level (FPL), according to data from the March 2003 Current Population Survey (CPS) conducted by the U.S. Census Bureau. Because categorical eligibility requirements for children are less restrictive than those for adults, poor children are much more likely to receive coverage. Table 15–14 shows Medicaid coverage by age and income status in CY 2002. The estimates of those with Medicaid coverage include those covered by the State Children's Health Insurance Program (SCHIP). Note that persons shown as receiving Medicaid may have had other health coverage as well. Nearly all the elderly, for example, had Medicare. Of persons with family incomes below poverty, more than two-thirds of children under age 6 are covered by Medicaid, compared to less than a third of those 19 and older.

Many individuals, even below the poverty level, are not eligible for Medicaid due to categorical restrictions. Nondisabled, childless, nonaged adults are never eligible for Medicaid, regardless of their income, unless their State obtains a special waiver to cover such individuals. In addition, even those who are eligible may not enroll. For example, all children under 6 years old in families with incomes below 133 percent of FPL are a mandatory coverage group. However, more than 2 million of these children are not enrolled in Medicaid. This may be for several reasons, including that these children have another source of health insurance, their families are unaware that Medicaid is available, or they do not perceive that coverage is needed.

Estimates of the number of people with Medicaid based on the CPS and other national surveys always have differed from official numbers published by the Centers for Medicare and Medicaid Services (CMS), based on data provided by States. The most recent administrative data for Medicaid are from fiscal year 2000, which list more than 44 million Americans as enrolled in Medicaid, including those in institutions. The CPS estimates that, in calendar year 2000, enrollment in Medicaid was approximately 30 million. While not all of the reasons for this difference are understood, the following may be plausible explanations for at least part of the disparity: (1) double counting and classification errors in the administrative data; (2) imprecise imputation of Medicaid status on the CPS based on receipt of cash assistance; and (3) inaccurate survey response by those respondents who did not want to report being covered by a public assistance program or who reported their current insurance coverage rather than their coverage for the entire previous year, as is requested for the CPS. Also, the CPS is a survey of only the noninstitutionalized population. According to the Medicaid administrative data, approximately 2 million of the 44 million counted as enrolled in Medicaid in fiscal year 2000 were institutionalized.

TABLE 15-13--MEDICAID ELIGIBLES BY BASIS OF ELIGIBILITY BY STATE, FISCAL YEAR 2000

[In Thousands of People]

State	Total Eligibles	Rank	Aged	Blind/ Disabled	Children	Foster Care Children	Adults	Others
Alabama	665.8	23	86.2	177.1	346.6	5.4	50.4	0.0
Alaska	109.5	47	6.2	10.7	65.5	1.6	25.5	0.0
Arizona	683.2	21	33.1	94.8	391.0	--	164.3	0.0
Arkansas	504.3	29	54.1	100.9	233.8	5.6	109.9	13.0
California	8,063.6	1	592.1	925.3	3,042.2	145.1	3,358.9	5.0
Colorado	377.7	32	45.9	65.5	181.0	17.1	68.2	80.0
Connecticut	417.7	30	55.5	56.9	225.2	9.3	70.8	0.0
Delaware	124.3	45	9.1	15.9	56.1	2.0	41.2	0.0
District of Columbia	150.8	43	10.0	30.5	71.4	4.3	34.6	35.0
Florida	2,237.6	4	226.1	460.2	1,071.8	39.1	440.4	0.0
Georgia	1,238.8	10	110.4	224.3	679.6	18.7	205.8	0.0
Hawaii	202.9	39	18.8	21.6	85.1	4.1	73.3	0.0
Idaho	150.8	42	11.6	23.9	90.4	2.0	23.0	0.0
Illinois	1,736.2	6	118.1	290.2	880.8	83.7	363.3	0.0
Indiana	756.2	18	76.5	106.6	439.3	11.2	122.6	0.0
Iowa	316.4	34	41.0	55.5	147.7	9.3	63.0	0.0
Kansas	267.8	35	32.8	51.1	135.9	11.0	37.0	0.0
Kentucky	724.5	19	71.4	199.5	347.3	8.4	97.9	0.0
Louisiana	827.4	16	99.1	173.0	444.6	9.9	100.8	0.0
Maine	214.1	37	24.5	48.8	93.5	3.3	44.0	0.0
Maryland	721.8	20	54.9	114.8	382.7	16.0	153.3	0.0
Massachusetts	1,103.7	12	111.4	226.6	452.2	0.7	312.8	0.0
Michigan	1,360.7	9	100.0	282.1	697.2	41.1	240.2	113.0
Minnesota	596.7	25	64.0	83.5	298.4	9.4	141.4	0.0
Mississippi	595.8	26	69.6	152.1	306.8	3.4	63.9	1.0
Missouri	991.4	13	100.6	136.5	519.2	21.6	213.5	0.0
Montana	97.1	49	9.9	17.3	46.5	4.0	19.3	2.0
Nebraska	238.1	36	23.1	29.0	131.1	9.5	44.7	721.0
Nevada	158.5	41	17.1	28.6	77.2	5.2	30.4	0.0

New Hampshire	110.2	46	13.0	13.8	64.6	2.6	16.1	0.0
New Jersey	855.7	15	107.3	163.6	430.7	18.7	135.4	0.0
New Mexico	398.5	31	22.1	49.0	252.4	3.4	71.5	0.0
New York	3,401.4	2	386.9	674.0	1,416.4	84.2	840.0	0.0
North Carolina	1,228.1	11	176.5	219.1	609.0	15.0	208.6	0.0
North Dakota	62.2	50	9.7	9.3	29.4	1.7	12.1	0.0
Ohio	1,420.4	8	146.4	262.4	730.6	39.1	241.6	156.0
Oklahoma	584.6	27	63.1	73.8	354.6	7.6	85.5	0.0
Oregon	560.7	28	41.7	61.6	224.2	14.0	219.2	35.0
Pennsylvania	1,767.8	5	204.9	391.4	739.9	45.6	386.1	0.0
Rhode Island	182.1	40	18.7	34.0	78.8	5.3	45.4	0.0
South Carolina	775.4	17	78.0	117.3	391.6	7.1	181.3	32.0
South Dakota	98.7	48	10.0	15.8	55.8	1.7	15.4	0.0
Tennessee	1,535.1	7	89.1	318.9	653.5	12.7	461.0	0.0
Texas	2,707.0	3	361.0	346.5	1,520.1	28.6	450.8	0.0
Utah	203.8	38	11.7	25.3	113.6	6.5	46.7	0.0
Vermont	147.8	44	18.6	18.2	63.5	2.3	45.2	49.0
Virginia	681.3	22	95.4	131.5	348.7	13.7	92.0	1.0
Washington	916.8	14	69.1	121.7	520.3	13.9	191.9	1.0
West Virginia	354.3	33	31.9	84.5	171.1	6.2	60.6	0.0
Wisconsin	619.1	24	61.8	132.0	267.6	18.8	138.8	1.0
Wyoming	52.5	51	4.9	8.2	27.8	1.5	10.0	0.0
Total	44,297.3	--	4,295.0	7,474.8	21,004.3	852.1	10,669.8	1,245.0

Notes- Medicaid eligibles include all persons enrolled in Medicaid during the year whether or not any payments for services were made on their behalf. Hawaii did not report MSIS data for FY2000. CRS approximated FY2000 data for Hawaii using data reported for FY1999. Totals do not sum because table excludes individuals whose basis of eligibility was unknown.

Source: Congressional Research Service (CRS) tabulation of data from the Medicaid Statistical Information System (MSIS) for FY2000 for all States except Hawaii.

TABLE 15-14--MEDICAID COVERAGE BY AGE AND FAMILY INCOME, CALENDAR YEAR 2002

[In Thousands of People]

Age	Covered by Medicaid	Persons in age group	Percent with Medicaid
In poverty:			
0-5	3,040	4,395	69.2
6-10	2,173	3,512	61.9
11-18	2,599	4,798	54.2
19-44	3,452	12,727	27.1
45-64	1,720	5,565	30.9
65 and older	1,028	3,586	28.7
Total	14,013	34,582	40.5
Family income between 100 and 132 percent of poverty:			
0-5	980	1,866	52.5
6-10	654	1,469	44.5
11-18	1,005	2,318	43.4
19-44	1,018	5,849	17.4
45-64	547	2,675	20.5
65 and older	553	3,047	18.1
Total	4,757	17,224	27.6
Family income between 133 and 184 percent of poverty:			
0-5	1,089	2,716	40.1
6-10	790	2,272	34.8
11-18	1,051	3,413	30.8
19-44	1,067	9,809	10.9
45-64	523	4,166	12.6
65 and older	508	5,245	9.7
Total	5,028	27,621	18.2
Family income of 185 percent of poverty and greater:			
0-5	1,670	14,452	11.6
6-10	1,108	12,596	8.8
11-18	1,711	22,855	7.5
19-44	2,295	78,406	2.9
45-64	1,209	55,227	2.2
65 and older	1,194	22,355	5.3
Total	9,187	205,891	4.5
All persons:			
0-5	6,779	23,429	28.9
6-10	4,726	19,848	23.8
11-18	6,366	33,384	19.1
19-44	7,832	106,790	7.3
45-64	3,999	67,633	5.9
65 and older	3,283	34,234	9.6
Total	32,985	285,317	11.6

Note- Number of Medicaid enrollees on the CPS is lower than the number on Medicaid administrative records. Counts exclude approximately 600,000 children who did not live with a family member (generally children in foster care) for whom income data are not available on the CPS. In 2002, the poverty threshold for a family with two adults and two children was $18,244.
Source: Congressional Research Service tabulations from the March 2003 Current Population Survey (CPS).

BENEFITS

Medicaid's basic benefits rules require all States to provide certain "mandatory" services as listed in Medicaid statute. The statute lists additional services that are considered optional - that is, Federal matching payments are available for optional services if States choose to include them in their Medicaid plans. States define the specific features of each mandatory and optional service to be provided under that plan within broad Federal guidelines. Those four basic guidelines include:

- *Amount, duration, and scope* --Each covered service must be sufficient in amount, duration, and scope to reasonably achieve its purpose. The State may not arbitrarily deny or reduce the amount, duration, or scope of services solely because of the type of illness or condition. The State may place appropriate limits on a service based on such criteria as medical necessity.
- *Comparability*--With certain exceptions defined in regulations, services available to any categorically needy beneficiary in a State must be equal in amount, duration, and scope to those available to any other categorically needy beneficiary in the State. Similarly, services available to any medically needy beneficiary in a State must be equal in amount, duration, and scope to those available to any other medically needy beneficiary in the State.
- *Statewideness*--Generally, a State plan must be in effect throughout an entire State; that is, the amount, duration, and scope of coverage must be the same statewide.
- *Freedom-of-Choice*--With certain exceptions, a State's Medicaid plan must allow recipients freedom of choice among health care providers participating in Medicaid. States may provide and pay for Medicaid services through various prepayment arrangements, such as a health maintenance organization (HMO).

The Secretary may waive applicability of these requirements under certain circumstances (see the following discussion of waivers). The following services are mandatory for most groups of Medicaid recipients:

- inpatient hospital services (excluding inpatient hospital services for mental disease);
- outpatient hospital care including Federally Qualified Health Center (FQHC) services and, if permitted under State law, rural health clinic (RHC) services;
- laboratory and x-ray services;
- certified pediatric and family nurse practitioners;
- nursing facility services for those age 21 and over;
- early and periodic screening, diagnosis, and treatment for children under the age 21 (EPSDT, defined below);
- physicians' services;

- family planning services and supplies;
- medical supplies and surgical services of a dentist;
- home health services for those entitled to nursing facility care;
- nurse-midwife services;
- pregnancy-related services (including treatment for conditions that may complicate pregnancy); and
- 60 days of postpartum-related services

The statute lists a wide variety of optional benefits that can be covered. Some of the optional benefits are specific items, such as eyeglasses and prosthetic devices, that States may include as a Medicaid benefit. Others are types of medical providers, such as chiropractors and podiatrists, whose services can be considered Medicaid covered benefits. States have a great deal of flexibility in choosing among the listed items, in defining the scope of selected optional benefits, and in developing programs that meet the needs of their Medicaid populations. Other optional services include such items as prescription drugs, and inpatient psychiatric care for individuals under age 21 or over 65, dental care, physical therapy, case management, and many other services. Table 15-15 identifies the major optional benefits provided under State Medicaid plans in 2002.

In addition to the above general rules regarding mandatory and optional benefits, the Medicaid statute specifies special benefits or special rules regarding certain benefits for targeted groups of individuals. These special categories of benefits include:

- *EPSDT*--Children under the age of 21 are entitled to the program of preventive child-care referred to as EPSDT. EPSDT is comprised of screening services including a comprehensive health and developmental history, comprehensive physical exams, appropriate immunizations according to the schedule established by the Advisory Committee on Immunization Practices, laboratory tests and lead toxicity screening, health education, vision services including eyeglasses, dental services, hearing services, and other necessary health care to correct or ameliorate defects, physical and mental illnesses, and conditions identified through the screening services. Under EPSDT, if an optional service is determined to be a necessary treatment to correct or ameliorate a condition identified through screening, States are required to provide that service, even if they have not chosen to cover that optional service under the general benefits rules described above.
- *Pregnancy-related services*--While all women who qualify for Medicaid are eligible for pregnancy-related services, women who qualify under one of the pregnancy-related eligibility groups are eligible for only pregnancy-related services (including treatment of conditions that may complicate pregnancy). Eligibility for these individuals extends through the pregnancy and for a period of 60 days postpartum.
- *Benefits for the medically needy*--Special benefits rules apply if States choose to cover medically needy populations. States may offer a more restricted benefit package for those enrollees but are required, at a

minimum, to offer the following: prenatal and delivery services for pregnant women; ambulatory services for individuals under 18 and those entitled to institutional services; and home health services for individuals entitled to nursing facility services. Broader requirements apply if a State has chosen to provide coverage for medically needy persons in institutions for mental disease and intermediate care facilities for the mentally retarded. If so, the State is required to cover either all of the mandatory services, or alternatively, the optional services listed in any 7 of the categories of care and services in Medicaid law defining covered benefits.

– *Tuberculosis (TB)-related services*--States are given the option of providing TB-related services to individuals infected with tuberculosis who meet certain income and resource requirements but are not otherwise eligible for Medicaid. TB-related services include prescription drugs, physicians' services, outpatient hospital services, clinic services, FQHC services, RHC services, laboratory and x-ray services, case management, and services designed to encourage completion of regimens of prescribed drugs.

In addition, States are able to waive many of the basic benefits rules to provide special home and community-based services for persons who are in need of long-term care and to conduct demonstration projects that test alternative methods of meeting the overall purpose of the Medicaid statute. These waivers include:

- *Home and Community-Based Long-Term Care Services (HCBS)*--Under the HCBS waiver authority, States can provide special benefits tailored to meet the long-term care needs of targeted populations. Among the benefits offered under these programs are case management; homemaker; home health aide; personal care; adult day health; habilitation; respite care; day treatment or other partial hospitalization services; and psychosocial rehabilitation and clinic services for individuals with chronic mental illness. States also can cover a wide range of other medical, non-medical, social and supportive services that allow persons who need long-term care to remain in the community. (For more information on HCBS waivers, see the "Medicaid Waiver Programs" subsection below).
- *Section 1115 Research and Demonstration Waivers*--States have a great deal of flexibility to define benefits under Section 1115 waivers. Many of the rules outlined above regarding benefits may be waived. Under comprehensive 1115 demonstrations, States generally provide a broad range of services statewide. The Bush Administration has encouraged States to pursue targeted policies under three waiver initiatives, all using Section 1115 authority. Under Pharmacy Plus waivers, States are encouraged to provide only pharmacy benefits to low-income seniors and individuals with disabilities. Under Family Planning waivers, States are encouraged to provide only family planning services to certain individuals

TABLE 15-15--OPTIONAL MEDICAID SERVICES AND NUMBER OF STATES[1] OFFERING EACH SERVICE, NOVEMBER 2002

Services	Number of States offering services to:			
	Categorically needy only	Medically needy only	Both categorically and medically needy	Populations added through 1115 waivers
Chiropractors	2	--	30	--
Dental	4	--	45	--
Dentures	4	--	34	--
Diagnostic services	4	--	31	--
Emergency hospital services in non-Medicare participating hospital	3	--	34	--
Eyeglasses	4	--	44	--
Home health therapies:				
Physical	6	--	44	--
Speech and Language	6	--	43	--
Occupational	5	--	44	--
Audiology Services	5	--	40	--
Hospice	7	--	35	1
Inpatient hospital & nursing facility services for 65 and older in IMD[2]	10	--	33	--
Intermediate care services for the mentally disabled	10	--	41	1
Inpatient psychiatric under age 21	10	--	34	1
Mental health rehabilitation and stabilization	4	--	40	--
Nurse anesthetists	2	--	26	--
Occupational therapy	2	--	37	1
Optometrists	5	--	48	--
Other rehabilitative services	2	--	20	--
Personal care	8	--	28	--
Physical therapy	3	--	42	1
Physician directed clinic services	5	--	45	--
Podiatrists	5	--	43	--
Prescribed drugs	6	--	47	--

Preventive services	3	1	31	--
Private duty nursing	3	1	25	1
Prosthetic devices	6	--	45	1
Psychologists	2	--	30	--
Religious (non-medical) health care institution	2	--	11	--
Respiratory care services for ventilator dependent	3	--	13	--
Screening services	3	--	29	--
Skilled nursing facility for under age 21	9	--	41	--
Targeted case management	10	--	40	--
Therapies for speech, hearing and language disorders	4	--	40	1
Transportation	4	--	46	--

Note- Row totals do not sum because a State may appear more than once.
[1] Includes all States, the District of Columbia, Puerto Rico and Virgin Islands.
[2] In Delaware, Indiana, New York, North Dakota, and Wyoming, only inpatient hospital services are provided to inpatients in institutions for mental disease (IMDs). In South Dakota and Idaho, only skilled nursing facility services are provided to inpatients in IMDs.
Source: Medicaid At-a-Glance 2002, Publication No. CMS-11024-02. Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services.

of childbearing age. Under Specialty Services and Populations Demonstrations, States provide pharmacy benefits to those with HIV/AIDS and conduct cash and counseling projects that provide cash to enrollees who may then arrange and purchase certain services on their own. (For more information on research and demonstration waivers, see the "Medicaid Waiver Programs" subsection below).

Tables 15-16 and 15-17 show recipients and expenditures by type of service for fiscal year 2000. The single benefit used by the largest number of Medicaid recipients was prescription drugs, for 20.5 million recipients, followed by physician services, used by 19.1 million recipients.[27] Nursing facility services accounted for the largest share of Medicaid spending (23.9 percent), followed closely by inpatient hospital services (16.9 percent). Prescription drugs and physician services, while accounting for the largest number of users, accounted for 13.9 percent and 4.7 percent of all spending on services, respectively.

Chart 15-3 shows average per recipient Medicaid spending by basis of eligibility-the aged, blind and disabled, adults, children, and others for fiscal year 2000. The figure points out the relatively low cost of non-disabled children and adults to the Medicaid program. While these groups comprise the majority of Medicaid enrollment, their costs are relatively small ($2,030 per adult and $1,237 per child) when compared with the per recipient cost of the elderly ($11,928), and blind and disabled ($10,559) recipients. This chart, on the other hand, underestimates the average cost of long-term care services for the comparatively few users of those services (see Table 15-16). Because these averages were calculated for all program recipients (of any service), they are below the average cost of services for only those individuals actually using the specific service. This difference is especially pronounced for long-term care services because relatively few users of those services account for a small number of very expensive claims.

FINANCING

The Federal government helps States pay for Medicaid services by means of a variable matching formula, called the Federal medical assistance percentage (FMAP), which is adjusted annually.[28] With specific exceptions (described below), the Federal matching rate, which is inversely related to a State's per capita income, can range from 50 to 83 percent. Beginning in fiscal year 1998, the Federal matching rate for the District of Columbia increased to 70 percent and Alaska's matching percentage is calculated using the 3-year average per capita income for

[27] Capitated payment systems accounted for a larger number of recipients than prescription drugs (almost 21.3 million recipients). Capitated payment services, however, despite being included alongside such services as prescription drugs and inpatient hospital services, are not considered a single benefit. The term refers to a managed care delivery system that provides a specified set of Medicaid benefits to a specified group of enrollees. (For more information on Medicaid managed care, see "Delivery Systems" subsection.)

[28] FMAP is a measure of the average per capita income in each State, squared, compared to that of the nation as a whole.

the State divided by 1.05. Federal matching for five territories is 50 percent, with a maximum dollar limit placed on the amount each territory can receive.

TABLE 15-16--MEDICAID RECIPIENTS BY SERVICE CATEGORY, FISCAL YEAR 2000

[In millions of people]

Service Category	Recipients
Acute Care	
Capitated Payment Services	21.261
Prescribed Drugs	20.517
Physician Services	19.104
Outpatient Hospital Services	13.226
Lab & X-ray Services	11.396
Other Care and Services	9.037
Clinic Services	7.667
Dental Services	5.892
PCCM Services	5.560
Inpatient Hospital Services	4.933
Other Practitioner Services	4.735
Sterilization Services	0.137
Mental Health Facility Services	0.102
Long-Term Care	
Personal Support Services	4.549
Nursing Facility Services	1.703
Home Health Services	0.995
ICF/MR Services	0.118
Unknown	0.176
Unduplicated total	42.763

Notes - PCCM denotes primary care case management, under which primary care providers are provided with a small fee, usually paid on a monthly basis, for each enrollee for whom they coordinate primary care services. Recipients in this table include all individuals for whom a fee-for-service claim was paid during the year and those for whom a capitation payment was made during the year.

Source: Congressional Research Service (CRS) tabulation of data from the Medicaid Statistical Information System (MSIS) for FY2000 for all States except Hawaii. Hawaii did not report MSIS data for FY2000. CRS approximated FY2000 data for Hawaii using data reported for FY1999.

To provide fiscal relief to States, Federal matching rates were changed temporarily by the Jobs and Growth Tax Relief Reconciliation Act (JGTRRA, P.L. 108-27), which altered the rates for certain expenditures[29] for the last 2 quarters of fiscal year 2003 and the first 3 quarters of fiscal year 2004. For these quarters, the Federal matching percentage for each State is held harmless for declines from the prior fiscal year, and then is increased by 2.95 percentage points. The Federal matching percentages for all States and jurisdictions for fiscal years 2003 and 2004 are shown in Table-15-18.

[29] See the Legislative history subsection for further information.

TABLE 15-17--TOTAL MEDICAID PAYMENTS BY BASIS OF ELIGIBILITY (BOE), TYPE OF SERVICE, AND AS A PERCENTAGE OF TOTAL PAYMENTS BY BOE, FISCAL YEAR 2000

[In order of descending total service payments]

Service Type	Total Service Payments	Aged	Blind/ disabled	Children	Adults	Foster care	Unknown
			[In millions of dollars]				
Acute Care							
Capitated Payment Services	$24,413	$1,721	$6,878	$9,459	$5,777	$323	$255
Inpatient Hospital Services	24,266	1,630	10,409	4,537	4,767	360	2,562
Prescribed Drugs	20,014	5,355	11,591	1,338	1,444	224	62
Other Care and Services	14,680	2,448	9,874	848	593	554	363
Outpatient Hospital Services	7,053	667	3,174	1,310	1,443	123	336
Physician Services	6,806	633	2,316	1,765	1,697	166	229
Clinic Services	6,174	267	2,638	1,063	823	272	1,112
Mental Health Facility Services	1,768	312	515	402	24	339	175
Dental Services	1,404	80	286	764	208	40	28
Lab & X-ray Services	1,288	90	538	180	423	17	39
Other Practitioner Services	658	79	257	192	75	49	6
PCCM Services	165	3	32	108	18	2	2
Sterilization Services	128	0	9	2	109	0	9
Subtotal	108,817	13,285	48,517	21,968	17,401	2,469	5,178
Long Term Care							
Nursing Facility Services	34,432	27,058	6,967	34	33	22	318
Personal Support Services	11,567	2,688	6,415	1,340	232	740	152
ICF/MR Services	9,375	708	8,611	15	5	18	17
Home Health Services	3,119	718	2,175	90	65	60	12
Subtotal	58,493	31,172	24,168	1,479	335	840	499
Unknown	997	45	57	18	27	1	850
Total Payments by BOE	168,307	44,503	72,742	23,466	17,763	3,309	6,525
			[Percentage of total payments by BOE]				
Acute Care							
Capitated Payment Services	14.5	3.9	9.5	40.3	32.5	9.8	3.9
Inpatient Hospital Services	14.4	3.7	14.3	19.3	26.8	10.9	39.3
Prescribed Drugs	11.9	12.0	15.9	5.7	8.1	6.8	1.0
Other Care and Services	8.7	5.5	13.6	3.6	3.3	16.7	5.6

TABLE 15-17--TOTAL MEDICAID PAYMENTS BY BASIS OF ELIGIBILITY (BOE), TYPE OF SERVICE, AND AS A PERCENTAGE OF TOTAL PAYMENTS BY BOE, FISCAL YEAR 2000-continued

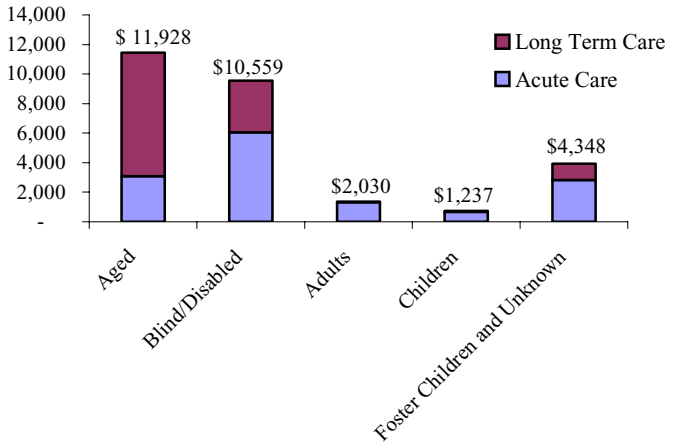
[In order of descending total service payments]

Service Type	Total Service Payments	Aged	Blind/ disabled	Children	Adults	Foster care	Unknown
Outpatient Hospital Services	4.2	1.5	4.4	5.6	8.1	3.7	5.1
Physician Services	4.0	1.4	3.2	7.5	9.6	5.0	3.5
Clinic Services	3.7	0.6	3.6	4.5	4.6	8.2	17.0
Mental Health Facility Services	1.1	0.7	0.7	1.7	0.1	10.2	2.7
Dental Services	0.8	0.2	0.4	3.3	1.2	1.2	0.4
Lab & Xray Services	0.8	0.2	0.7	0.8	2.4	0.5	0.6
Other Practitioner Services	0.4	0.2	0.4	0.8	0.4	1.5	0.1
PCCM Services	0.1	0.0	0.0	0.5	0.1	0.1	0.0
Sterilization Services	0.1	0.0	0.0	0.0	0.6	0.0	0.1
Subtotal	64.7	29.9	66.7	93.6	98.0	74.6	79.4
Long Term Care							
Nursing Facility Services	20.5	60.8	9.6	0.1	0.2	0.7	4.9
Personal Support Services	6.9	6.0	8.8	5.7	1.3	22.4	2.3
ICF/MR Services	5.6	1.6	11.8	0.1	0.0	0.5	0.3
Home Health Services	1.9	1.6	3.0	0.4	0.4	1.8	0.2
Subtotal	34.8	70.0	33.2	6.3	1.9	25.4	7.6
Unknown	0.6	0.1	0.1	0.1	0.2	0.0	13.0

Notes-Totals may not sum due to rounding. Comparing the payments information presented above with data from the other primary source of State-reported Medicaid payment data, the CMS-64, results in apparent inconsistencies that relate to differences in the information captured. MSIS total reported payments are lower than CMS-64 total reported payments primarily because MSIS totals do not include payments made to disproportionate share hospitals. Other less significant differences between MSIS and the CMS-64 occur because adjudicated claims data are used in MSIS versus the reporting of actual payments reflected in the CMS-64. Differences may also occur because of internal State practices for capturing and reporting these data through two separate systems.

Source: Congressional Research Service (CRS) tabulation of data from the Medicaid Statistical Information System (MSIS) for FY2000 for all States except Hawaii. Hawaii did not report MSIS data for FY2000. CRS approximated FY2000 data for Hawaii using data reported for FY1999.

CHART 15-3--MEDICAID EXPENDITURES PER RECIPIENT BY ACUTE AND LONG-TERM CARE AND BASIS OF ELIGIBILITY, FISCAL YEAR 2000



Notes- Medicaid recipients include all individuals for whom any claim was paid during the year and for whom a capitation payment was made during the year. In these calculations, total expenditures for long term care and acute care services were divided by the total number of program recipients of any service in each eligibility group, whether or not all of those individuals were users of long-term care services and acute care services. This results in averages for all recipients that can diverge from the averages among only those individuals who used that particular type of service. This is especially true for long-term care where relatively few users account for a small number of large and costly claims. For a list of which services were classified as long term care and acute care, see Table 15-16. Source: Congressional Research Service (CRS) tabulation of data from the Medicaid Statistical Information System (MSIS) for FY2000 for all States except Hawaii. Hawaii did not report MSIS data for FY2000. CRS approximated FY2000 data for Hawaii using data reported for FY1999

REIMBURSEMENT POLICY

For the most part, States establish their own rates to pay Medicaid providers for services. By regulation these rates 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. The Balanced Budget Act of 1997 (BBA 97, P.L. 105-33) required that beginning October 1, 1997, States must provide public notice of the proposed rates for hospitals, nursing facilities, and intermediate care facilities for the mentally retarded and the methods used to establish those rates.

All providers are required to accept payments under the program as payment in full for covered services except where States require nominal cost-sharing by beneficiaries. States generally may impose such charges with certain exceptions. They are precluded from imposing cost sharing on services for children under 18, services related to pregnancy, family planning or emergency services, and services provided to nursing facility residents who are required to spend all of their income

for medical care except for a personal needs allowance. Effective August 5, 1997, States are permitted to pay Medicaid rates, instead of Medicare rates, to providers for services to dual eligibles (those Medicare beneficiaries who also are eligible for full Medicaid benefits) and qualified Medicare beneficiaries (QMBs; see "Eligibility" subsection).

Certain types of providers are subject to special rules. Three such circumstances are discussed in detail below.

TABLE 15-18--FEDERAL MEDICAL ASSISTANCE PERCENTAGES BY STATE FOR FISCAL YEARS 2003 AND 2004

State	Fiscal Year 2003		Fiscal Year 2004	
	First 2 Quarters	Last 2 Quarters	First 3 Quarters	Last Quarter
Alabama	70.60	73.55	73.70	70.75
Alaska	58.27	61.22	61.34	58.39
Arizona	67.25	70.20	70.21	67.26
Arkansas	74.28	77.23	77.62	74.67
California	50.00	54.35	52.95	50.00
Colorado	50.00	52.95	52.95	50.00
Connecticut	50.00	52.95	52.95	50.00
Delaware	50.00	52.95	52.95	50.00
District of Columbia	70.00	72.95	72.95	70.00
Florida	58.83	61.78	61.88	58.93
Georgia	59.60	62.55	62.55	59.58
Hawaii	58.77	61.72	61.85	58.90
Idaho	70.96	73.97	73.91	70.46
Illinois	50.00	52.95	52.95	50.00
Indiana	61.97	64.99	65.27	62.32
Iowa	63.50	66.45	66.88	63.93
Kansas	60.15	63.15	63.77	60.82
Kentucky	69.89	72.89	73.04	70.09
Louisiana	71.28	74.23	74.58	71.63
Maine	66.22	69.53	69.17	66.01
Maryland	50.00	52.95	52.95	50.00
Massachusetts	50.00	52.95	52.95	50.00
Michigan	55.42	59.31	58.84	55.89
Minnesota	50.00	52.95	52.95	50.00
Mississippi	76.62	79.57	80.03	77.08
Missouri	61.23	64.18	64.42	61.47
Montana	72.96	75.91	75.91	72.85
Nebraska	59.52	62.50	62.84	59.89
Nevada	52.39	55.34	57.88	54.93
New Hampshire	50.00	52.95	52.95	50.00
New Jersey	50.00	52.95	52.95	50.00
New Mexico	74.56	77.51	77.80	74.85
New York	50.00	52.95	52.95	50.00
North Carolina	62.56	65.51	65.80	62.85
North Dakota	68.36	72.82	71.31	68.31
Ohio	58.83	61.78	62.18	59.23
Oklahoma	70.56	73.51	73.51	70.24
Oregon	60.16	63.11	63.76	60.81
Pennsylvania	54.69	57.64	57.71	54.76

TABLE 15-18--FEDERAL MEDICAL ASSISTANCE PERCENTAGES BY STATE FOR FISCAL YEARS 2003 AND 2004- continued

State	Fiscal Year 2003		Fiscal Year 2004	
	First 2 Quarters	Last 2 Quarters	First 3 Quarters	Last Quarter
Rhode Island	55.40	58.35	58.98	56.03
South Carolina	69.81	72.76	72.81	69.86
South Dakota	65.29	68.88	68.62	65.67
Tennessee	64.59	67.54	67.54	64.40
Texas	59.99	63.12	63.17	60.22
Utah	71.24	74.19	74.67	71.72
Vermont	62.41	66.01	65.36	61.34
Virginia	50.53	54.40	53.48	50.00
Washington	50.00	53.32	52.95	50.00
West Virginia	75.04	78.22	78.14	75.19
Wisconsin	58.43	61.52	61.38	58.41
Wyoming	61.32	64.92	64.27	59.77
America Samoa	50.00	52.95	52.95	50.00
Guam	50.00	52.95	52.95	50.00
Northern Marina Islands	50.00	52.95	52.95	50.00
Puerto Rico	50.00	52.95	52.95	50.00
Virgin Islands	50.00	52.95	52.95	50.00

Sources: The FMAPs displayed for the first 2 quarters of fiscal year 2003 and the last quarter of fiscal year 2004 were published in the Federal Register (November 30, 2001, Volume 66, No. 231, and November 15, 2002, Volume 67, No. 221, respectively). The FMAPs displayed for the last 2 quarters of fiscal year 2003 were taken from the Centers for Medicare and Medicaid Services Memorandum of June 13, 2003 (MDL #03-005) to State Medicaid Directors on the impact of P.L. 108-27. Finally, the FMAPs displayed for the first 3 quarters of fiscal year 2004 were estimated by the Congressional Research Service.

Reimbursement for prescription drugs

The Omnibus Budget Reconciliation Act of 1990 (OBRA 90, P.L. 101-508) established rules for Medicaid reimbursement of prescription drugs. Medicaid payments for drugs are subject to upper payment limits. For drugs with generic versions available from three or more manufacturers, the upper payment limit is 150 percent of the average wholesale price. For other drugs, the upper payment limit is either the estimated price paid by the provider for the drug plus a dispensing fee or the provider's usual charge for the drug to the general public. The law denies Federal matching funds for drugs manufactured by a firm that has not agreed to provide rebates to States. Under amendments made by the Veterans Health Care Act of 1992 (P.L. 102-585), 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 upon whether the drug is available from multiple sources (a generic version of the drug is available) or available from a single source (a generic version of the drug is not available). The rebate for drugs ranges from 11 percent to 15.1 percent of the average manufacturer price.

Disproportionate share hospital payments

States must provide for additional payments to hospitals serving a disproportionate share of low-income patients. Unlike comparable Medicare payments, Medicaid disproportionate share hospital (DSH) payments must follow a formula that considers a hospital's charity patients as well as its Medicaid caseload. Beginning in fiscal year 1992, State DSH payments were limited as part of an effort to rein in fast growth. DSH payments were limited to 12 percent of total Medicaid spending. The 12 percent figure was phased in through the use of State-specific DSH allotments (caps on Federal matching payments) for each Federal fiscal year. BBA 97 lowered the DSH allotments by imposing a freeze and making graduated proportional reductions for 1998 - 2002. Thereafter, annual DSH allotments for a State equal the allotment for the preceding fiscal year increased by the percentage change in the medical care component of the Consumer Price Index for All Urban Consumers. BBA 97 also imposed a new cap on DSH payments to institutions for mental disease and other mental health facilities. The Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA 2000, P.L. 106-554) established a 175 percent (of uncompensated care costs) cap for all public hospitals in the nation for a two-year period beginning in State fiscal year 2003.

*Upper payment limits for certain institutional provider*s

In 1987, the Secretary of HHS issued regulations establishing separate upper payment limits for inpatient and outpatient services provided by different types of facilities. An aggregate upper payment limit was established for each type of institutional provider of Medicaid services by ownership (State versus other) that would not exceed what would have been paid for those services under Medicare payment principles. In 2000, the Secretary determined that some States made arrangements with city or county facilities to pay these facilities at inflated rates. The city or county facilities then transferred some or all of the enhanced payments back to the State. BIPA 2000 addressed these funding methods by requiring regulations to provide separate upper payment limits for private and public facilities up to 100 percent of the Medicare rate for such services. Later, through regulation, the Clinton Administration allowed payments to city and county public hospitals up to 150 percent of the Medicare rate for their services. In January 2002, the Bush Administration changed the special rule for city and county hospitals to 100 percent of the Medicare rate.

ADMINISTRATION

Medicaid is a State-administered program. At the Federal level, the Centers for Medicare and Medicaid Services (CMS) of the U.S. Department of Health and Human Services (HHS) 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. The Federal share of administrative costs is 50 percent for all States, except for certain items for which the authorized rate is higher.

DELIVERY SYSTEMS

There are two systems for delivering services under Medicaid: fee-for-service and managed care. These systems differ in how the State pays for the services and how the individual accesses service providers. Most States use a combination of both of these systems to deliver Medicaid services. The primary elements of these systems and initiatives to deliver long-term care services are discussed below.

Fee-For-Service

The fee-for-service (FFS) system has been the primary method of paying for and delivering Medicaid services since the program's enactment in 1965. Under fee-for-service, a Medicaid beneficiary determines, in consultation with a physician, the type of services needed and can receive those services from any Medicaid-certified provider. States may limit the amount of services or require prior approval of services, but the individual retains significant flexibility. The provider receives payment from the State Medicaid agency for that particular service based on rates established by the State. States have significant flexibility in developing how payment rates are calculated and there is significant variation by State and by service. For example, the rate may be related to the actual cost of the service for an individual provider or could be a fixed, pre-determined amount for a particular procedure.

Although enrollment in managed care has increased over the last decade, the fee-for-service system continues to be a widespread and important service delivery mechanism. The fee-for-service system is used for individuals whose Medicaid eligibility group or geographic location is not served through managed care, or for persons who opt out when managed care is voluntary. The fee-for-service system also is used for those Medicaid services not covered by a managed care contract.

For individuals who live in rural areas and individuals who are elderly or have a disability, fee-for-service continues to be the dominant delivery system. States have tended to exclude these groups from managed care programs. Individuals in rural areas often have limited choice of managed care plans and service providers. Individuals who are elderly or who have a disability often have complex medical conditions which can be costly and require specialty care, and their health status can be unpredictable. Though individuals who are elderly or who have a disability tend to be excluded, States have started to develop managed care approaches for these groups to contain costs and test alternative delivery systems as discussed below.

Under a primarily fee-for-service system, State Medicaid expenditures and the number of enrollees have increased significantly. Over the 10-year period between 1985 and 1995, State Medicaid expenditures increased from $18.2 billion

to $67.3 billion, an average growth rate of 14 percent annually. This increase reflected both increases in medical costs and increases in the number of Medicaid enrollees. Between 1985 and 1995, the number of Medicaid enrollees increased 66 percent from 21.8 million to 36.2 million. During that period, States also lacked a coordinated system for delivering services. No one was designated to assist the individual in sorting through his or her health care options or ensuring timely access to appropriate services. In an effort to slow the growth of expenditures and improve service delivery, many States turned to managed care for many of their enrollees.

Managed Care

The number of Medicaid beneficiaries enrolled in a managed care plan of any type increased from 9.5 percent of the Medicaid population in 1991 to 57.6 percent in 2002. As of June 30, 2002, 21.3 million individuals receiving Medicaid were enrolled in some form of managed care. Alaska, Mississippi, and Wyoming were the only States that did not use managed care to deliver services to Medicaid beneficiaries.

Under managed care, the State contracts with one or more plans to provide an agreed upon set of benefits. The contract could include a comprehensive set of services or include only one service, such as, case management. For each managed care contract, the State establishes fixed, prospective, monthly, per person payment rates referred to as a "capitation" payment for the covered services. The capitation rate is based on the average cost of services for a defined group. After determining the average cost, States may use a variety of actuarial methods to adjust the average cost for specific individuals by age, geographic location, and/or diagnosis. For example, a State may establish different rates for men and women in different age brackets. The plan would receive the rate associated with the individual enrolled based on that person's gender and age. The capitation payment does not vary on a monthly basis if the volume of services actually used by the individual differs from that assumed in the capitation payment. The plan also negotiates payment rates with participating providers. In contrast, under fee-for-service, the State establishes the provider payment rates as described earlier. The goal of managed care is to reduce unnecessary service use, improve access to quality health care by having a central point of contact, and increase care coordination thereby reducing expenditures.

Types of managed care--Managed care plans vary in the financial responsibility or "risk" the plan assumes and the services they provide. In a risk-based managed care contract, the plan is fiscally responsible for the provision of all services agreed upon in the contract regardless of actual use by beneficiaries. Under a non-risk based contract, States either implement processes to share the financial burden with the plan or the State assumes full financial responsibility for the services provided. For example, in a non-risk based contract, at the end of the fiscal period, a State may modify the payments to a managed care plan if actual

service use differs from projected use (upon which the original capitation payment was based).

There is also significant variation in the amount and types of services that each State includes in its Medicaid managed care contracts. Some States contract with a plan for a limited benefit package such as case management, dental, or mental health services. Other States have included a comprehensive[30] set of services.

The primary types of Medicaid managed care arrangements are described below:

- *Managed care organization (MCO)* --Under a managed care organization (such as an HMO), the entity has a comprehensive, risk-based contract with the State. The State pays the organization a fixed, prospective, per person per month rate for providing medical care for all plan enrollees.
- *Pre-paid health plan (PHP)*--Pre-paid health plans refer to risk-based contracts that include less than a comprehensive set of services (such as only behavioral health services), or non-risk based contracts for any package of services. Essentially, such plans do not have a risk-based contract with the State for a comprehensive set of services.
- *Primary care case management (PCCM)*--Under a PCCM model, providers receive a per person, monthly fee for coordinating each enrollee's care. The provider is not fiscally responsible for the services used by the individual. All services are provided through the fee-for-service delivery system. The PCCM must be a physician or licensed health care professional; this provider acts as a care coordinator and/or gatekeeper to the services specified under the PCCM contract.

There are also several hybrids of the MCO, PHP and PCCM models. Most States have implemented multiple models. For example, a State may have an MCO for children and families enrolled in Medicaid and a PHP for mental health services for individuals with a relevant disability. As of June 30, 2002, 47 States and the District of Columbia were using some form of Medicaid managed care, 44 States had risk-based plans[31] and 30 States had non-risk PCCM plans.[32]

As discussed earlier, managed care has primarily included low-income adults and children, as shown in Table 15-19. Of the 21.3 million Medicaid recipients enrolled in a managed care organization or pre-paid health plan in fiscal year 2000, 78 percent were low-income adults and children, 18 percent were individuals with disabilities and the elderly, and 5 percent had an unknown basis of eligibility.[33]

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[30] The law considers a service package to be "comprehensive" if it includes inpatient hospital services and any of the following services, or any three or more of the following services: (1) outpatient hospital services; (2) rural health clinic services; (3) Federally qualified health center (FQHC) services; (4) other laboratory and x-ray services; (5) nursing facility services; (6) early and periodic screening, diagnostic, and treatment (EPSDT) services; (7) family planning services; (8) physician services; or (9) home health services.

[31] Includes PHPs and hybrid managed care models.

[32] CMS, 2002 *Medicaid Managed Care Enrollment Report, Plan Type Breakout Enrollment by State.* See www.cms.hhs.gov/medicaid/managedcare/mctype02.pdf.

[33] Does not total to 100 percent due to rounding. This does not include individuals receiving only PCCM services.

Medicaid expenditures in fiscal year 2000 for services provided in managed care or a pre-paid health plan followed a similar pattern, as shown in Table 15-20. Of the $24.4 billion in Medicaid expenditures for individuals in a managed care organization (MCO) or pre-paid health plan (PHP), 64 percent were for low-income adults and children, 35 percent were for individuals with disabilities and the elderly, and 1 percent were for individuals whose basis of eligibility was unknown.

TABLE 15-19--MEDICAID RECIPIENTS SERVED THROUGH MCO AND/OR PHP PLANS BY BASIS OF ELIGIBILITY, FISCAL YEAR 2000

[In thousands of people]

State	Total	Aged	Blind and Disabled	Children	Adults	Foster care	Unknown
Alabama	--	--	--	--	--	--	--
Alaska	--	--	--	--	--	--	--
Arizona	650	29	90	379	137	8	6
Arkansas	--	--	--	--	--	--	--
California	5,778	501	863	2,409	1,152	125	728
Colorado	343	39	58	162	50	16	17
Connecticut	291	--	1	213	64	7	5
Delaware	100	--	10	51	36	2	--
Dist. of Columbia	101	--	3	66	30	--	1
Florida	769	19	116	480	126	9	19
Georgia	22	--	4	15	4	--	--
Hawaii	167	--	5	84	71	4	3
Idaho	--	--	--	--	--	--	--
Illinois	237	--	1	173	55	1	7
Indiana	178	--	6	131	36	1	4
Iowa	252	2	46	133	56	9	6
Kansas	57	--	--	43	11	--	2
Kentucky	700	49	184	346	97	8	16
Louisiana	--	--	--	--	--	--	--
Maine	3	--	--	2	1	--	--
Maryland	507	7	71	335	77	15	2
Massachusetts	779	2	117	385	255	1	19
Michigan	1,055	10	185	596	181	24	59
Minnesota	375	35	4	229	105	1	1
Mississippi	9	--	3	5	1	--	1
Missouri	395	--	1	277	99	13	4
Montana	3	--	--	--	2	--	--
Nebraska	172	1	13	116	35	8	-
Nevada	71	--	--	47	17	--	7
New Hampshire	7	--	--	6	1	--	--
New Jersey	560	33	19	403	95	1	8
New Mexico	297	1	28	217	44	3	4
New York	1,082	9	90	570	304	4	104
North Carolina	62	--	6	39	11	1	4
North Dakota	1	--	--	1	--	--	--
Ohio	362	--	6	273	82	--	1
Oklahoma	382	--	37	274	69	1	1
Oregon	508	35	53	207	198	12	3
Pennsylvania	1,015	66	215	510	180	26	18

TABLE 15-19--MEDICAID RECIPIENTS SERVED THROUGH MCO AND/OR PHP PLANS BY BASIS OF ELIGIBILITY, FISCAL YEAR 2000-continued

State	Total	Aged	Blind and Disabled	Children	Adults	Foster care	Unknown
Rhode Island	123	--	1	76	44	1	1
South Carolina	43	--	3	36	3	--	--
South Dakota	99	10	16	56	15	2	--
Tennessee	1,552	87	315	637	452	12	49
Texas	727	40	64	504	114	3	1
Utah	195	9	21	103	35	6	21
Vermont	66	--	1	35	29	2	--
Virginia	213	2	30	144	37	--	--
Washington	613	3	3	466	126	1	14
West Virginia	--	--	--	--	--	--	--
Wisconsin	342	1	10	221	106	3	1
Wyoming	--	--	--	--	--	--	--
Total	21,263	992	2,700	11,456	4,647	330	1,137
% of Total	100	5	13	54	22	2	5

Notes - Does not include individuals who received only primary care case management services (PCCM). Dashes denote no managed care program, except in some cases States reported capitation payments as part of other services and did not report these payments in the MCO or PHP categories. This was most likely to occur when there was only one service provided under that managed care program (e.g., transportation). Alternate data sources from the Centers for Medicare and Medicaid Services website (cms.hhs.gov/medicaid/managedcare/mmcns600.asp) show that Alabama, Arkansas, and West Virginia had capitated MCO or PHP programs during FY2000.

Source: Congressional Research Service (CRS) tabulation of data from the Medicaid Statistical Information System (MSIS) for FY2000 for all States except Hawaii. Hawaii did not report MSIS data for FY2000. CRS approximated FY2000 data for Hawaii using data reported for FY1999.

Trends in Managed Care -- In the early and mid-1990s, States significantly expanded enrollment in Medicaid managed care programs, but the programs growth is slowing. In fiscal years 2001 and 2002, the number of individuals enrolled in a managed care plan as a percentage of all Medicaid eligible individuals increased 1.9 percent and 1.3 percent, respectively. This is a significant decrease over the 61.1 percent and 38.4 percent annual growth rates of fiscal years 1994 and 1995, respectively. The expansion of Medicaid managed care in the early and mid-1990s should be viewed in the context of a general trend toward managed care across many sectors of the U.S. health care system. Despite the significant growth of managed care both in Medicaid and the overall health care system, the extent to which it has accomplished the goal of controlling health care expenditures and increasing quality has been inconclusive.

Finally, in both Medicaid and the U.S. health care system in general, managed care continues to evolve. Some of these changes include plans entering and exiting certain geographic locations, and company consolidations and bankruptcies. There has been a significant number of risk-based managed care plans that have entered and left the Medicaid program. In a survey of all States that had risk-based programs in 1998 conducted by the National Academy for State Health Policy (May 2001), 82 percent of these States had turnover in plans between

1998 and 2000. State agencies most commonly cited financial reasons (e.g., insufficient capitation payments, inadequate risk-sharing methodology) for managed care plans leaving the Medicaid program. Five States reported that this turnover in plans resulted in moving solely to a PCCM model of service delivery. The turnover is not necessarily negative if it strengthens the overall delivery system, but it may result in decreased continuity of services and additional administrative costs if beneficiaries must switch providers or re-enroll in a different plan.

Long-Term Care Delivery System

Long-term care refers to a wide range of supportive and health services for persons who have lost the capacity for self-care due to illness, frailty, or a disabling condition. It differs from acute care in that the goal of long-term care is not to cure an illness that is generally of short duration, but to allow an individual to attain and maintain an optimal level of functioning over the long-term.

TABLE 15-20--TOTAL MEDICAID PAYMENTS FOR MCO AND PHP RECIPIENTS BY BASIS OF ELIGIBILITY, FISCAL YEAR 2000

[In millions of dollars]

State	Total	Aged	Blind and Disabled	Children	Adults	Foster Care	Unknown
Alabama	--	--	--	--	--	--	--
Alaska	--	--	--	--	--	--	--
Arizona	$1,709	$330	$690	$395	$257	$9	$29
Arkansas	--	--	--	--	--	--	--
California	3,846	347	650	1,828	837	41	142
Colorado	372	49	156	82	32	52	--
Connecticut	411	--	1	284	116	8	1
Delaware	169	2	51	45	70	1	--
Dist. of Columbia	136	--	27	63	46	--	--
Florida	743	78	297	247	104	6	10
Georgia	7	--	3	2	1	--	--
Hawaii	235	--	5	120	101	7	1
Idaho	--	--	--	--	--	--	--
Illinois	213	1	1	133	76	--	1
Indiana	143	--	5	96	41	1	1
Iowa	139	1	36	60	40	2	--
Kansas	43	--	--	23	14	--	5
Kentucky	467	21	214	190	38	4	--
Louisiana	--	--	--	--	--	--	--
Maine	2	--	--	1	1	--	--
Maryland	911	30	395	301	174	15	-3
Massachusetts	525	25	178	178	142	--	2
Michigan	1,274	15	658	347	235	10	8
Minnesota	660	135	8	329	190	1	-2
Mississippi	-3	--	--	-2	--	--	-1
Missouri	383	--	1	277	91	13	--
Montana	3	--	--	--	2	--	--
Nebraska	110	2	24	40	15	29	--

TABLE 15-20--TOTAL MEDICAID PAYMENTS FOR MCO AND PHP RECIPIENTS BY BASIS OF ELIGIBILITY, FISCAL YEAR 2000-continued

State	Total	Aged	Blind and Disabled	Children	Adults	Foster Care	Unknown
Nevada	72	--	--	33	32	--	7
New Hampshire	4	--	--	4	1	--	--
New Jersey	648	8	49	422	168	1	--
New Mexico	526	2	173	243	84	18	5
New York	1,469	142	263	558	492	3	11
North Carolina	55	--	17	23	14	1	--
North Dakota	1	--	--	1	--	--	--
Ohio	385	--	4	248	132	--	--
Oklahoma	221	1	63	130	26	--	--
Oregon	763	74	212	164	288	24	1
Pennsylvania	2,523	253	1,144	734	349	42	1
Rhode Island	140	--	1	64	74	--	--
South Carolina	28	9	5	11	2	--	--
South Dakota	6	1	1	4	1	--	--
Tennessee	2,948	105	1,106	733	974	20	9
Texas	634	68	188	297	81	1	--
Utah	131	5	52	39	16	2	16
Vermont	25	--	--	11	13	1	--
Virginia	322	5	139	124	54	--	--
Washington	658	2	1	387	261	--	7
West Virginia	--	--	--	--	--	--	--
Wisconsin	358	11	59	190	91	7	--
Wyoming	--	--	--	--	--	--	--
Total	24,413	1,721	6,878	9,459	5,777	323	255
% of Total	100	7	28	39	24	1	1

Notes - Does not include individuals receiving only primary care case management services (PCCM). Dashes denote no managed care program, except in some cases States reported capitation payments as part of other services and did not report these payments in the MCO or PHP categories. This was most likely to occur when there was only one service provided under that managed care program (e.g., transportation). Alternate data sources from the Centers for Medicare and Medicaid Services website (cms.hhs.gov/medicaid/managedcare/mmcns600.asp) show that Alabama, Arkansas, and West Virginia had capitated MCO or PHP programs during FY2000.

Source: Congressional Research Service (CRS) tabulation of data from the Medicaid Statistical Information System (MSIS) for FY2000 for all States except Hawaii. Hawaii did not report MSIS data for FY2000. CRS approximated FY2000 data for Hawaii using data reported for FY1999.

Since the establishment of the Medicaid program in 1965, long-term care services (i.e. nursing home and home care) have been delivered largely through the fee-for-service delivery system. A 1981 amendment to the Medicaid statute established Section 1915(c) waivers, giving States the option of providing home and community-based services to individuals who otherwise would be eligible for institutional care. Many States arrange for these services to be delivered on a fee-for-service basis, often using case managers to determine service needs and authorize delivery. Concerns about uncoordinated long-term and acute care, inefficiencies in disease management for persons with multiple chronic conditions,

and growing costs, however, have encouraged Federal and some State governments to develop alternative systems to pay for and deliver long-term care services.

In recent years, many of the alternative delivery systems that States and the Federal government have developed coordinate long-term care services for dual eligibles–persons who are eligible for both Medicaid and Medicare–through managed care programs. One example is the Program for All-Inclusive Care for the Elderly (PACE), originally modeled after the On Lok Senior Health Services pilot project in San Francisco. PACE makes available all services covered under both programs without amount, duration or scope limitations, and without application of any deductibles, copayments or other cost sharing. Under the program, certain low-income individuals age 55 and older, who would otherwise require nursing home care, receive all health, medical, and social services they need. An interdisciplinary team of physicians, nurses, physical therapists, social workers, and other professionals develop and monitor care plans for enrollees. Monthly capitated payments are made to providers from both the Medicare and Medicaid programs. As specified in Medicare and Medicaid statutes, the amount of these payments from both programs must be less than what would have otherwise been paid for a comparable frail population not enrolled in the PACE program. Payments are also adjusted to account for the comparative frailty of PACE enrollees. PACE providers assume the risk for expenditures that exceed the revenue from the capitation payments. The Balanced Budget Act of 1997 made PACE a permanent benefit category under Medicare and a State plan optional benefit under Medicaid. As of February 2003, there were 28 PACE sites across the country.

Other examples of State initiatives to provide coordinated long-term care services include the Minnesota Senior Health Options (MSHO), the Wisconsin Partnership Program, and the Continuing Care Network (CCN) demonstration of Monroe County, New York. The MSHO program combines Medicare and Medicaid financing to integrate acute and long-term care services for dually eligible seniors residing in seven counties in Minnesota. The program consolidates all Medicare and Medicaid managed care requirements into a single contract overseen by the State, allowing MSHO to reduce duplication and resolve important differences across Medicare and Medicaid delivery systems. Like PACE, the Wisconsin Partnership Program pays capitated payments to providers to coordinate acute and long-term care services for persons who would otherwise qualify for nursing home care. It also places a strong emphasis on services provided in home and community settings. This program, however, was designed specifically to serve rural areas. New York's CCN project enrolls at least 10,000 elderly beneficiaries, including 1,500 who had been certified for care in a nursing facility. To participate, enrollees must be age 65 or over, eligible for Medicare and/or Medicaid, and reside in the program's service area. Capitation payments made to CCN are intended to cover all of Medicare's acute care services for this population and most of Medicaid's long-term care services. Medicaid prescription drug coverage, for example, is paid separately on a fee-for-service basis.

States have also experimented with other initiatives that capitate payments for acute and long-term care services under the Medicaid program only. Examples of

these demonstrations include the nation's only statewide mandatory Medicaid managed care program–the Arizona Long-Term Care System (ALTCS)–and small, voluntary programs such as Florida's Community-Based Diversion Pilot Project. Florida's Diversion program serves selected metropolitan areas and counties. Case managers employed through both of these programs arrange Medicaid long-term care services and coordinate with Medicare providers to deliver acute care services.

All of these programs were designed with the expectation that they would control costs and reduce administrative complexity. They also intend to delay institutionalization, and thus incur savings for Medicaid through the provision of expanded home and community-based care options and, in some cases, greater beneficiary control over services. Those programs that also capitate Medicare are intended to reduce hospitalization and skilled nursing facility expenditures as well as other acute care costs associated with institutional care. While these initiatives exist in a number of States, they account for a relatively small share of total Medicaid spending for long-term care.

MEDICAID WAIVER PROGRAMS

Under current law, States have the flexibility to waive certain Medicaid program requirements to provide services to individuals not traditionally eligible for Medicaid, limit benefit packages for certain groups, and provide home and community-based services to people with long-term care needs, among other purposes. States must submit proposals outlining terms and conditions for proposed waivers to CMS for approval before implementing these programs. The two primary provisions of the Social Security Act used today that authorize States to implement waiver programs are Section 1115 and Section 1915(c).

In recent years, there has been increased interest among States in demonstration programs as a means to restructure Medicaid coverage, control costs, and increase flexibility. Whether large or small reforms, the waiver programs have resulted in significant changes for Medicaid beneficiaries nationwide.

Section 1115 Waiver Demonstration Programs

Section 1115 of the Social Security Act provides the Secretary of Health and Human Services (HHS) with broad authority to waive certain statutory requirements in the Medicaid program allowing States to conduct research and demonstration programs to further the goals of Title XIX.[34] Under Section 1115, the Secretary may waive Medicaid requirements contained in Section 1902, known as freedom of choice of provider, comparability, and statewideness (see "Benefits" subsection for a discussion of these requirements).

States often use Section 1115 waivers to offer different service packages or a combination of services in different parts of the State, test new reimbursement methods, change eligibility criteria in order to offer coverage to new or expanded

[34] Section 1115 also authorizes the Secretary to conduct research and demonstration projects under several other programs authorized in the Social Security Act, including TANF, SSI, and SCHIP.

groups, cover non-Medicaid services (e.g., cash and counseling demonstrations[35]), or contract with a greater variety of managed care plans. Demonstration programs generally are approved for a five-year period, however CMS has granted program extensions for many of the comprehensive waiver programs (i.e., programs that generally offer a statewide comprehensive service package to populations traditionally eligible for Medicaid as well as expansion populations). Some of these extensions have allowed Section 1115 waiver programs to remain in operation for 10 or more years. For example, Arizona's entire Medicaid program operates under Section 1115 waiver authority, and this program is in its 20th year.

While Section 1115 is explicit about provisions in Medicaid law that may be waived in conducting research and demonstration projects, a number of other provisions in Medicaid law and regulations specify limitations or restrictions on how a State may operate a waiver program. For example, one provision restricts States from establishing waivers that fail to provide all mandatory services to the mandatory poverty-related groups of pregnant women and children; another provision specifies restrictions on cost-sharing imposed under demonstration waivers.

Financing -- Approved Section 1115 waivers are deemed to be part of a Medicaid State plan and are financed through Federal and State matching funds at the regular FMAP rate. However, unlike regular Medicaid, costs associated with waiver programs must be budget neutral to the Federal government over the life of the waiver program. To meet the budget neutrality test, estimated spending under the waiver cannot exceed the estimated cost of the State's existing Medicaid program. For example, costs associated with an expanded population (e.g., those not already covered under the State' Medicaid program), must be offset by reductions elsewhere within the Medicaid program. Several methods used by States to generate cost savings for the waiver component include: (1) moving part of the Medicaid population into managed care; (2) limiting benefit packages for certain eligibility groups; (3) providing targeted services to certain individuals so as to divert them from full Medicaid coverage; and (4) using enrollment caps and cost-sharing to reduce the amounts States must pay.

Program Types -- CMS classifies Section 1115 waiver programs into five distinct categories:

- *Comprehensive demonstrations*--These demonstrations provide a broad range of services that generally are offered statewide to populations

[35] Cash and counseling demonstrations are designed to test a consumer-directed approach to the financing and delivery of personal attendant services (e.g., assistance with activities of daily living such as eating, bathing, toileting, transport from bed to chair, etc.) for elderly and disabled individuals. These demonstrations provide cash payments to enrollees so that they may directly arrange and purchase services that best meet their needs. States must submit a Section 1115 waiver for a Cash and Counseling demonstration if: cash is provided directly to an individual; cash is used to pay a legally responsible relative (e.g., spouses or parents); the State intends to change Medicaid eligibility requirements; and/or the State intends to waive the requirement to pay only those agencies that have provider agreements with the State.

traditionally eligible for Medicaid as well as expansion populations. In fiscal year 2002, there were 20 approved Medicaid comprehensive State reform waivers,[36] with two pending implementation. Fiscal year 2002 State-reported enrollment estimates for the comprehensive demonstration waivers totaled approximately 7.2 million,[37] and Federal expenditures for these programs were approximately $15.8 billion.[38]

- *Family planning demonstrations*--These demonstrations provide family planning services for certain individuals of childbearing age in 16 States.[39] For the family planning demonstrations, fiscal year 2002 enrollment counts totaled 1.8 million, and Federal expenditures were approximately $327 million.[40]
- *Specialty services and population demonstration*--These demonstrations generally include programs that provide cash to enrollees so that they may directly arrange and purchase services that best meet their needs. In addition, they also include waivers to provide pharmacy benefits to persons with specific conditions, such as HIV/AIDS. In fiscal year 2002, there were 10 such programs in 8 States.[41] These demonstrations covered just under 7,000 individuals at a Federal cost of approximately $41.6 million.[42]
- *The Health Insurance Accountability and Flexibility Initiative (HIFA)*- These demonstrations are designed to encourage States to extend Medicaid and SCHIP to the uninsured, with a particular emphasis on statewide approaches that maximize private health insurance coverage options and target populations with incomes below 200 percent of FPL. As of January 2003, there were six Medicaid Section 1115 waivers approved under the HIFA initiative in 5 States.[43] Four of the six HIFA

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[36] States with comprehensive demonstration waivers include Arizona, Arkansas, California (Los Angeles county), Delaware, District of Columbia, Hawaii, Kentucky, Maryland, Massachusetts, Minnesota, Missouri, New Jersey, New York, Oklahoma, Oregon, Rhode Island, Tennessee, Utah, Vermont, and Wisconsin.

[37] The fiscal year 2002 State-reported enrollment estimate for California (Los Angeles county) is not available. Several States cover SCHIP Medicaid expansion children in their Medicaid Section 1115 waiver programs. Because expenditures associated with these children are not captured in the Medicaid 1115 expenditure data, where possible, counts of SCHIP children have been removed from the State-reported enrollment totals.

[38] The fiscal year 2002 State-reported expenditure estimate for Utah is not available. New York's fiscal year 2002 State-reported estimate was based on historical spending.

[39] States with family planning demonstration waivers include Alabama, Arizona, Arkansas, California, Delaware, Florida, Maryland, Missouri, New Mexico, New York, Oregon, Rhode Island, South Carolina, and Washington.

[40] Arizona, Delaware, Missouri, New York, and Rhode Island report their family planning demonstration expenditures as a part of their comprehensive demonstration waivers. Fiscal year 2002 State-reported expenditures for Maryland were not available.

[41] States with specialty service and population demonstration waivers include Arkansas (2 waivers), Colorado (2 waivers), District of Columbia, Florida, Maine, New Jersey, New Hampshire, and Oregon.

[42] Fiscal year 2002 State-reported enrollment and expenditure data were not available for Arkansas and New Hampshire.

[43] States with approved Medicaid or Medicaid/SCHIP combined waivers include Illinois, Maine,

programs (Illinois, New Jersey, New Mexico, and Oregon) are Medicaid/SCHIP combined waivers. A combined HIFA waiver generally means that the State will finance changes to its Medicaid program using unspent SCHIP funds. No enrollment or expenditure data were available for fiscal year 2002 as these programs were new at that time.

– *Pharmacy plus demonstrations*--These demonstrations provide comprehensive pharmacy benefits for low-income seniors and individuals with disabilities with income at or below 200 percent of FPL. The demonstrations may provide pharmaceutical products, assist individuals who have private pharmacy coverage with high premiums and cost sharing, or provide wraparound pharmaceutical coverage to bring private sources of pharmacy coverage up to the level of desired demonstration benefit coverage. Enrollees are not eligible for the comprehensive Medicaid benefits available under the State's Medicaid plan. In fiscal year 2002, there were four approved Pharmacy Plus waivers in four States.[44] Two States reported waiver data in fiscal year 2002. In these States, enrollment counts totaled 193,574 at a Federal cost of approximately $169 million.

Section 1915(c) Home and Community-Based Waiver Programs

In 1981, Congress added Section 1915(c) to the Medicaid statute. Section 1915(c) authorizes the Secretary of HHS to waive certain requirements[45] of Medicaid law allowing States to cover a range of home and community-based services for persons who otherwise would be eligible for Medicaid-funded institutional care. The 1915(c) waivers, often referred to as home and community-based services (HCBS) waivers, were designed to reduce the institutional bias in the Medicaid program that favors institutional care over care in the home or in the community.

The waivers allow States to cover a broad range of medical and non-medical social services to enable people with chronic long-term care needs to remain in the community. Unlike the budget neutrality test required for Section 1115 waivers (under which estimated spending under the waiver cannot exceed the estimated costs of the State's existing Medicaid program), the cost-effectiveness test under 1915(c) prohibits expenditures from exceeding the cost of institutional care that would have been provided to waiver recipients absent the waiver.[46] To assist States in containing costs, Section 1915(c) allows States to place caps on the total number of individuals that may be covered under each waiver and/or set expenditure restrictions on a per capita basis (e.g., not to exceed $20,000 per year per waiver

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New Jersey, New Mexico (2 waivers), and Oregon. HIFA waivers authorized solely under the SCHIP program are not included.

[44] States with approved Pharmacy Plus waivers include Florida, Illinois, Wisconsin, and South Carolina.

[45] States can waive statewideness and comparability, and may apply certain institutional eligibility rules to persons in home and community-based waivers.

[46] Section 1915(c) waivers are prohibited from covering expenses for room and board, while such costs would be covered by Medicaid in an institutional setting.

recipient) or on an aggregate basis (e.g., a cost cap applied to all persons under a waiver in the State).

Medicaid regulations require that waiver participants fall into one of the following target groups: the aged, persons with physical disabilities, persons with mental retardation or developmental disabilities (MR/DD), and persons with mental illness. Generally, States must apply for separate waivers to serve these different groups. Section 1915(c) also gives States the flexibility to define the categories of individuals within these broader target groups who may be eligible for certain waivers and the services they will receive. For example, States may cover only the elderly for case management services, or only individuals with physical disabilities for personal attendant care. States also may limit eligibility for services to individuals who have certain conditions, such as HIV/AIDS.

Further, eligibility is limited to individuals who otherwise would be eligible for institutional care provided in a hospital, nursing facility or intermediate care facility for the mentally retarded (ICF/MR). There are no Federal requirements that describe the level and/or severity of functional limitations that individuals must have to be admitted to an institutional setting and thus would be eligible for a 1915(c) waiver, although States generally determine eligibility for long-term care services based on a test of applicants' functional limitations for most waiver programs. The design of these tests varies across States, but often includes tests to determine an applicant's limitations in ability to carry out activities of daily living (ADLs) and instrumental activities of daily living (IADLs).[47]

Although these programs are optional, all States provide some HCBS waiver services to certain Medicaid enrollees with long-term care needs. As of June 2003, CMS reported that 246 programs were in operation across the country. In 1999, the most recent year for which data are available, 1915(c) waivers served 707,132 individuals. CMS estimates that about 875,000 people were served in 2000.[48] The most recent expenditure data from fiscal year 2002 showed that total Medicaid spending on 1915(c) waivers reached $16.3 billion versus $11.2 billion in 1999.

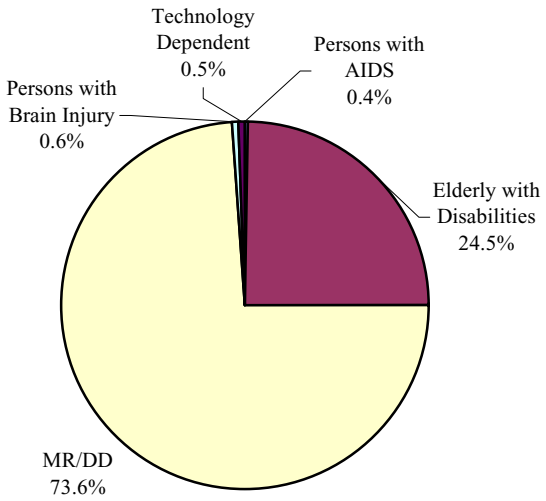
The cost of providing waiver services to recipients varies across target populations (Chart 15-4). Spending on waivers for persons with MR/DD, for example, totaled $12 billion in fiscal year 2002, accounting for 73.6 percent of total HCBS waiver spending. Waiver spending on elderly individuals and persons with physical disabilities totaled $4 billion in fiscal year 2002, accounting for 24.5 percent of total spending on HCBS waivers. Waivers for AIDS or AIDS-related conditions (ARC) totaled $66.2 million (0.4 percent), for technology dependent individuals totaled $88.8 million (0.5 percent), and for persons with brain injuries $104.7 million (0.6 percent). In addition, three small waiver programs serving individuals with a primary diagnosis of mental illness

[47] ADLs refer to activities necessary to carry out basic human functions, and include the following: bathing, dressing, eating, mobility inside the home, toileting, and transferring from a bed to a chair. IADLs refer to tasks necessary for independent community living, and include the following: shopping, light housework, telephoning, money management, and meal preparation.

[48] States are required to report enrollment data for 1915(c) waivers to CMS through the submission of Forms 372. The most recent year for which all States have submitted these forms is 1999.

totaled $32.4 million and accounted for about 0.2 percent of all HCBS waiver expenditures.

CHART 15-4--MEDICAID HCBS WAIVER EXPENDITURES BY TARGET POPULATION, 2002



Notes – "Technology Dependent" are persons who are technology dependent or medically fragile. "MR/DD" are persons with mental retardation and/or developmental disabilities. Data are provided to CMS through Form 64 reports by States. Eiken and Burwell report that FY 2002 waiver expenditures may be understated by about $400 million (2-3 percent) since they do not include all prior period adjustments or corrections submitted by States to CMS. CMS Form 64 data are by date of payment, not by date of service. CMS 64 data on HCBS waiver spending represent only Medicaid fee-for-service spending, not spending through capitated managed care programs. Arizona, Florida, Wisconsin, Texas, and Minnesota are examples of States that pay for at least some HCBS waiver services through capitated long-term care programs. Totals may not sum to 100 due to rounding. Source: Eiken, S. and Burwell, B. Medicaid HCBS Waiver Expenditures, FY 1997 through FY 2002, The MEDSTAT Group, May 15, 2003.

LEGISLATIVE HISTORY

Below is a summary of major Medicaid changes enacted in public laws passed during 1996 forward. (For legislative history prior to 1996, see previous editions of the *Green Book.*)

Contract with America Advancement Act of 1996, Public Law 104-121:

Alcoholics and drug addicts--SSI benefits are terminated for individuals receiving disability cash assistance based on a finding of alcoholism and drug addiction. Persons who lose SSI eligibility still may be eligible for Medicaid if they meet other Medicaid eligibility criteria. States are required to perform a

redetermination of Medicaid eligibility in any case in which an individual loses SSI.

Personal Responsibility and Work Opportunity Act of 1996, Public Law 104-193:

Eligibility--A new cash welfare block grant to States, Temporary Assistance for Needy Families (TANF), is established. The automatic link between AFDC and Medicaid is severed. Families who meet AFDC eligibility criteria as of July 16, 1996 are eligible for Medicaid, even if they do not qualify for TANF. States must use the same income and resource standards and other rules previously used to determine eligibility, including the pre-reform AFDC family composition requirement. A State may lower its income standard, but not below the standard it applied on May 1, 1988. A State may increase its income and resource standards up to the percentage increase in the Consumer Price Index (CPI) subsequent to July 16, 1996. States may use less restrictive methods for counting income and resources than were required by law as in effect on July 16, 1996. States are permitted to deny Medicaid benefits to adults and heads of households who lose TANF benefits because of refusal to work; States may not apply this requirement to poverty-related pregnant women and children.

Disabled children--The definition of disability used to establish the eligibility of children for SSI is narrowed. Children who lose SSI eligibility still may be eligible for Medicaid if they meet other Medicaid eligibility criteria. States are required to perform a redetermination of Medicaid eligibility in any case in which an individual loses SSI and that determination affects his or her Medicaid eligibility.

Aliens--Legal resident aliens and other qualified aliens who entered the United States on or after August 22, 1996 are barred from Medicaid for 5 years. Significant exceptions are made for such aliens with a substantial U.S. work history or a military connection. Except for emergency services, Medicaid coverage for such aliens entering before August 22, 1996 and coverage after the 5-year ban are State options.

Administration--A State may use the same application form for Medicaid as they use for TANF. A State may choose to administer the Medicaid Program through the same agency that administers TANF or through a separate Medicaid agency. A special fund of $500 million is provided for enhanced Federal matching for States' expenditures attributable to the administrative costs of Medicaid eligibility determinations due to the law.

Balanced Budget Act of 1997, Public Law 105-33:

Eligibility--The Balanced Budget Act restores Medicaid eligibility and SSI coverage for legal immigrants who entered the country prior to August 22, 1996 and later become disabled; guarantees continued Medicaid eligibility for children with disabilities who are expected to lose their SSI eligibility as the result of restrictions enacted in 1996; and extends the period that States must provide coverage to refugees, asylees, and individuals whose deportation has been withheld from 5 to 7 years. States are permitted to provide continuous Medicaid coverage

for 12 months to all children, regardless of whether they continue to meet income eligibility tests. States are permitted to create a new Medicaid eligibility category for working persons with disabilities with income up to 250 percent of poverty and who would, but for income, be eligible for SSI. Such individuals can "buy into" Medicaid by paying a sliding scale premium based on the individual's income as determined by the State.

Payment methodology--The law repeals the Boren amendment, which directed that payment rates to institutional providers be "reasonable and adequate" to cover the cost of "efficiently and economically operated" facilities, and repeals the law requiring States to assure adequate payment levels for services provided by obstetricians and pediatricians. The requirement to pay Federally qualified health centers and rural health clinics 100 percent of reasonable costs is phased out over 6 fiscal years, with special payment rules in place during fiscal years 1998-2002 to ease the transition.

Payments for disproportionate share hospitals--This law includes several provisions affecting disproportionate share hospital (DSH) payments provided to hospitals that treat a disproportionate share of the uninsured and Medicaid beneficiaries. It reduces State DSH allotments by imposing freezes and making graduated proportionate reductions. Limitations are placed on payments to institutions for mental disease. The Act establishes additional caps on the State DSH allotments for fiscal years beginning in 1998 and specifies those caps for 1998-2002. States are required to report annually on the method used to target DSH funds and to describe the payments made to each hospital.

Managed care--The law eliminates the need for 1915(b) waivers to enroll most Medicaid populations in managed care. States can require the majority of Medicaid recipients to enroll in managed care simply by amending their State plan. Waivers still are required to mandate that children with special health care needs and certain dually eligible Medicaid-Medicare beneficiaries enroll with managed care entities. The law establishes a statutory definition of primary care case management (PCCM), adds it as a covered service, and sets contractual requirements for both PCCM and Medicaid managed care organizations. The Act also includes managed care provisions that establish standards for quality and solvency, and provide protections for beneficiaries. The law repeals the provision that requires managed care organizations to have no more than 75 percent of their enrollment be Medicaid and Medicare beneficiaries, and the prohibition on cost sharing for services furnished by health maintenance organizations.

Nursing Home Resident Protection Amendments of 1999, Public Law 106-004:

Transfer or discharge of nursing facility residents--This law prohibits the transfer or discharge of nursing facility residents, both those covered and not covered by Medicaid, as a sole result of a nursing home's voluntary withdrawal from participation in the Medicaid program, except under certain circumstances.

Information for new residents-- For new residents, meaning those entering a facility subsequent to the effective date of the facility's withdrawal from Medicaid, the following information must be provided orally and in writing: (a) notice that the

facility does not participate in Medicaid; and (b) the facility may transfer or discharge such a new resident when that resident is no longer able to pay for his/her care, even if such a new resident is covered by Medicaid.

Facility requirements--Facilities that voluntarily withdraw from Medicaid are still subject to all applicable requirements of Title XIX, including the nursing facility survey, certification and enforcement authority, as long as patients covered under Medicaid prior to the facility's withdrawal continue to reside in the facility.

1999 Emergency Supplemental Appropriations Act, Public Law 106-31:

Tobacco settlement payments to States--Amounts recovered or paid to States by manufacturers of tobacco products as part of the comprehensive tobacco settlement of November 1998 or to any individual State based on a separate settlement or litigation shall be retained in full by such States. That is, such States do not have to pay the Federal government a portion of these amounts equal to the applicable (State-specific) Federal medical assistance percentage.

Restriction on use of tobacco settlement funds--States receiving these sums are not permitted to use these funds to pay for administrative expenses incurred in pursuing such tobacco litigation.

Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP) Balanced Budget Refinement Act of 1999, incorporated by reference in the Consolidated Appropriations Act for Fiscal Year 2000, Public Law 106-113:

Increase in DSH allotments for selected States--The law increases the Federal share of DSH payments to Minnesota, New Mexico, Wyoming, and the District of Columbia for each of fiscal years 2000-2002.

Administration--The law extends beyond fiscal year 2000 the availability of a $500 million fund created to assist with the transitional costs of new Medicaid eligibility activities resulting from welfare reform, and allows these funds to be used for costs incurred beyond the first 3 years following welfare reform.

Federally qualified health center (FQHC) services and rural health clinics (RHCs)--The law slows the phase-out of the cost-based system of reimbursement for services provided by FQHCs and RHCs, and authorizes a study of the impact of reducing or modifying payments to such providers.

Payments for monitoring services and external review requirements--The law provides that States will receive enhanced matching payments for medical and utilization reviews for Medicaid fee-for-service, and quality reviews for Medicaid managed care, when conducted by certain entities similar to peer review organizations. It also eliminates duplicative requirements for external review, and requires the HHS Secretary to certify to Congress that the external review requirements for Medicaid managed care are fully implemented.

Federal matching for disproportionate share hospital payments--The law clarifies that Medicaid disproportionate share hospital payments are matched at the Medicaid Federal medical assistance percentage and not at the enhanced Federal medical assistance percentage authorized under title XXI (SCHIP).

Outpatient drugs--The law allows rebate agreements entered into after the date of enactment of this Act to become effective on the date on which the agreement is entered into, or at State option, any date before or after the date on which the agreement is entered into.

Disproportionate share hospital transition rule--The law extends a provision included in the Balanced Budget Act of 1997 related to allocation of DSH funds among California's hospitals.

Foster Care Independence Act of 1999, Public Law 106-169:

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

Ticket to Work and Work Incentives Improvement Act of 1999, Public Law 106-170:

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

Agriculture Risk Protection Act of 2000, Public Law 106-224:

Information sharing--This law allows schools operating Federally subsidized school meal programs to take a more active role in identifying children eligible for, and enrolling such children in, the Medicaid and SCHIP programs. It permits schools to share income and other relevant information collected when determining eligibility for free and reduced-price school meals with State Medicaid and SCHIP agencies, as long as there is a written agreement that limits use of the information and parents are notified and given a chance to "opt out."

Demonstration project--The law also establishes a demonstration project in one State in which administrative funds under the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) may be used to help identify children eligible for, and enroll such children in, the Medicaid and SCHIP programs.

Children's Health Act of 2000, Public Law 106-310:

Rights of institutionalized children--The law requires that general hospitals, nursing facilities, intermediate care facilities and other health care facilities

receiving Federal funds, including Medicaid, protect the rights of each resident, including the right to be free from physical or mental abuse, corporal punishment, and any restraints or involuntary seclusions imposed for the purposes of discipline or convenience. Restraints and seclusion may be imposed in such facilities only to ensure the physical safety of the resident, a staff member, or others. Additional requirements govern reporting of resident deaths, promulgation of regulations regarding staff training, and enforcement. (Other Medicaid requirements regarding restraints and seclusion for inpatient psychiatric services for persons under age 21 are specified in Federal regulations.)

Children's rights in community-based settings--The law also includes requirements for protecting the rights of residents of certain non-medical, community-based facilities for children and adolescents, when that facility receives funding under this Act or under Medicaid. For such individuals and facilities, restraints and seclusion may be imposed only in emergency circumstances and only to ensure the physical safety of the resident, a staff member or others, and less restrictive interventions have been determined to be ineffective. Use of a drug or medication that is not a standard treatment for a resident's medical or psychiatric condition is prohibited. Likewise, use of mechanical restraints is prohibited. Seclusion may be used only when a staff member is providing continuous face-to-face monitoring and when strong licensing/accreditation and internal controls are in place. (Time out is not considered to be seclusion.) Additional requirements govern reporting of resident deaths, promulgation of regulations regarding staff training, and enforcement.

Breast and Cervical Cancer Prevention and Treatment (BCCPT) Act of 2000, Public Law 106-354:

Eligibility--The law establishes a new optional coverage group under Medicaid for uninsured women who are under age 65, have been screened under the Centers for Disease Control and Prevention's Breast and Cervical Cancer Early Detection Program and need treatment for breast or cervical cancer, and who are not otherwise eligible for Medicaid under a mandatory coverage group. States have the option of extending presumptive eligibility to these women; presumptive eligibility allows individuals whose family income appears to meet applicable financial standards to enroll temporarily in Medicaid, until a final formal determination of eligibility is made. Medicaid providers are the only entities qualified to determine presumptive eligibility for these women.

Benefits--Medical coverage is limited to medical assistance provided during the period in which the individual requires breast or cervical cancer treatment.

Financing--The Federal share of Medicaid payments for this group uses the enhanced matching rate structure under the State Children's Health Insurance Program, which ranges from 65 to 85 percent.

Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, incorporated by reference in Public Law 106-554:

Disproportionate share hospitals – State disproportionate share hospitals (DSH) allotments for 2001 and 2002 are increased. It also extends a special DSH payment rule for hospitals in California to qualifying facilities in all States, and provides additional funds to certain public hospitals not receiving DSH payments.

Federally qualified health centers (FQHCs) and rural health clinics (RHCs)--The law replaces cost-based reimbursement with a prospective payment system for FQHCs and RHCs.

Upper payment limit rules--It also modifies proposed rules governing upper payment limits on inpatient and outpatient services provided by certain types of facilities, and requires that the final regulations be issued by the end of 2000.

Other provisions--Additional changes affect extensions of Section 1115 Medicaid waivers, Medicaid county-organized health systems, the Federal medical assistance percentage for Alaska, transitional medical assistance for welfare-to-work families, determination of presumptive eligibility for children, outreach to and enrollment of certain Medicare beneficiaries eligible for Medicaid cost-sharing assistance, PACE waivers, and posting of information on nursing facility services.

Native American Breast and Cervical Cancer Treatment Technical Amendment Act of 2001, Public Law 107-121:

Eligibility--This law allows States to include in the optional Medicaid eligibility category created by the Breast and Cervical Cancer Prevention and Treatment (BCCPT) Act of 2000, American Indian and Alaskan Native women with breast or cervical cancer who are eligible for health services provided under a medical program of the Indian Health Service or a tribal organization. All provisions under the BCCPT Act of 2000 apply to such women.

Public Health Security and Bioterrorism Preparedness and Response Act of 2002, Public Law 107-188:

Waiver of provider requirements and Medicare+Choice payment limits--The law authorizes the Secretary to temporarily waive conditions of participation and other certification requirements for any entity that furnishes health care items or services to Medicare, Medicaid, or SCHIP beneficiaries in an emergency area during a declared disaster or public health emergency. During such an emergency, the Secretary may waive: (a) participation, State licensing (as long as an equivalent license from another State is held and there is no exclusion from practicing in that State or any State in the emergency area), and pre-approval requirements for physicians and other practitioners; (b) sanctions for failing to meet requirements for emergency transfers between hospitals; (c) sanctions for physician self-referral; and (d) limitations on payments for health care and services furnished to individuals enrolled in Medicare+Choice (M+C) plans when services are provided outside the plan. To the extent possible, the Secretary must ensure that M+C enrollees do not pay more than would have been required had they received care within their plan network.

Notification to Congress--The law also requires the Secretary to provide Congress with certification and written notice at least 2 days prior to exercising this waiver authority. It also provides for this waiver authority to continue for 60 days, and permits the Secretary to extend the waiver period.

Evaluation--The Secretary is further required, within 1 year after the end of the emergency, to provide Congress with an evaluation of this approach and recommendations for improvements under this waiver authority.

Health Care Safety Net Amendments of 2002, Public Law 107-251:

Study of migrant farm workers--This law requires the Secretary to conduct a study of the problems experienced by farm workers and their families under Medicaid and SCHIP, specifically barriers to enrollment, and lack of portability of Medicaid and SCHIP coverage for farm workers eligible in one State who move to other States on a periodic basis. The Secretary also must identify possible strategies to increase enrollment and access to benefits for these families. Strategies to be examined must include: (a) use of interstate compacts to establish portability and reciprocity, (b) multi-State demonstration projects, (c) use of current law flexibility for coverage of residents and out-of-State coverage, (d) development of programs of national migrant family coverage, (e) use of incentives to private coverage alternatives, and (f) other solutions as deemed appropriate. In conducting the study, the Secretary must consult with several groups. The Secretary must submit a report on this study to the President and Congress in October 2003. This report shall address findings and conclusions and provide recommendations for appropriate legislative and administrative action.

Jobs and Growth Tax Relief Reconciliation Act of 2003, Public Law 108-27:

Temporary increase in the Federal medical assistance percentage (FMAP)--With respect to certain expenditures for Medicaid benefits, this law increases FMAP for all 50 States, the District of Columbia and 5 commonwealths and territories for a period of 5 calendar quarters, including the last 2 quarters of fiscal year 2003 and the first 3 quarters of fiscal year 2004. There is a two-step process for determining the increase. First, each State's fiscal year 2003 FMAP, as would otherwise be calculated, must be at least equal to the State's fiscal year 2002 FMAP, and second, the FMAP determined under this step is increased by 2.95 percentage points. For the fiscal year 2004 FMAP change, the same calculations (substituting fiscal year 2003 for fiscal year 2002) are applied to determine the temporary increase. The law also increases the limitation on payments for the commonwealths and territories.

State eligibility for increased FMAP-- To qualify for the increased FMAP payments, a State cannot have a Medicaid plan with more restrictive eligibility rules than the plan in effect on September 2, 2003. If a State restores the program eligibility to the levels in effect on September 2, 2003, then the State would qualify for increased matching payments for the entire quarter in which eligibility is reinstated. If a State expands eligibility rules after the beginning of the higher payments (April 1, 2003) and before September 2, 2003, the State is not eligible

for the higher payments for the period beginning on April 1, 2003 to the date that eligibility was expanded.

State Children's Health Insurance Program Allotments Extension Act of 2003, Public Law 108-74:

State eligibility for increased FMAP—This law modifies the requirements regarding State eligibility for the temporary increase in FMAP payments authorized under Public Law 108-27 (see above). Specifically, P.L. 108-74 provides that if a State reduces eligibility after September 2, 2003, and later restores eligibility to the September 2, 2003 levels, the State would qualify for the higher payments from the date of the eligibility restoration rather than for the entire calendar quarter. In addition, if a State expands eligibility rules after the beginning of the higher payments (April 1, 2003) and before September 2, 2003, the State is eligible for the higher payments for the period beginning on April 1, 2003 to the date that eligibility was expanded.

STATE CHILDREN'S HEALTH INSURANCE PROGRAM

The Balanced Budget Act of 1997 (BBA 97; Public Law 105-33) established the State Children's Health Insurance Program (SCHIP) under a new Title XXI of the Social Security Act. In general, the program offers Federal matching funds to States and territories to provide health insurance to certain low-income children.

ELIGIBILITY

Under SCHIP, States may cover children under 19 years of age in families with incomes that are above the State's Medicaid eligibility standard but less than 200 percent of the Federal poverty level (FPL).[49] However, States in which the maximum Medicaid income level for children was at or above 200 percent FPL prior to the enactment of SCHIP may increase the SCHIP income level by an additional 50 percentage points above the prior level used under the State's Medicaid program.

Not all targeted low-income children necessarily will receive medical assistance under SCHIP for two reasons. First, unlike Medicaid, Federal law does not establish an individual entitlement[50] to benefits under SCHIP. Instead, it entitles States with approved SCHIP plans to pre-determined Federal allotments based on a distribution formula set in the law. Second, each State can define the group of targeted low-income children who may enroll in SCHIP. Title XXI allows States to use the following factors in determining eligibility: geography (e.g., sub-

[49] For example, in 2002, the poverty guideline in the 48 contiguous States and the District of Columbia was $18,100 for a family of four (*Federal Register*, v. 67, no. 31, February 14, 2002. p. 6931-6933.) In 2003, the comparable poverty guideline for a family of four is $18,400 (*Federal Register*, v. 68, no. 26, February 7, 2003, p. 6456-6458).

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

State areas or statewide), age (e.g., subgroups under 19), income and resources, residency, disability status (so long as any standard relating to that status does not restrict eligibility), access to other health insurance, and duration of SCHIP enrollment. Title XXI funds cannot be used for children who would have been eligible for the State's Medicaid plan under the eligibility standards that were in effect prior to March 31, 1997 or for children covered by a group health plan or other insurance.

As of fiscal year 2002, the upper income eligibility limit under SCHIP had reached 350 percent FPL (in one State; see Table 15-21).[51] Twenty-four States and the District of Columbia had established upper income limits at 200 percent FPL. Another 13 States exceeded 200 percent FPL. The remaining 13 States set maximum income levels below 200 percent FPL.[52]

BENEFITS

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

States that choose to expand Medicaid to new eligibles under SCHIP must provide the full range of mandatory Medicaid benefits, as well as all optional services specified in their State Medicaid plans. States that choose to create separate SCHIP programs may elect any of three benefit options: (1) a benchmark benefit package, (2) benchmark equivalent coverage, or (3) any other health benefits plan that the Secretary determines will provide appropriate coverage to the targeted population of uninsured children.[53]

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

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[51] For determining income eligibility for SCHIP and Medicaid, some States apply "income disregards." These are specified dollar amounts subtracted from gross income to compute net income, which is then compared to the applicable income criterion. Such disregards may increase the effective income level above the stated standard.

[52] States may apply resource or asset tests in determining financial eligibility, but are not required to do so. Individuals must have resources for which the dollar value is less than a specified standard amount in order to qualify for coverage. States determine what items constitute countable resources and the dollar value assigned to those countable resources. Assets may include, for example, cars, savings accounts, real estate, trust funds, and tax credits.

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

TABLE 15-21--PRELIMINARY SCHIP ENROLLMENT DATA FOR THE 50 STATES AND THE DISTRICT OF COLUMBIA FOR FISCAL YEAR 2002

State and Program Type	Date enrollment began	SCHIP upper income eligibility standard (% FPL)	FFY2002 enrollment (number of children ever enrolled during year)			Adults Ever Enrolled in SCHIP Demonstrations
			Medicaid expansion	Separate Child Health Program	Total	
Alabama (C)	2/1/1998	200%	17,332	66,027	83,359	NA
Alaska (M)	3/1/1999	200%	22,291	NA	22,291	NA
Arizona (S)	11/1/1998	200%	NA	92,705	92,705	30,382
Arkansas (M)	10/1/1998	100%	1,912	NA	1,912	NA
California (C)	3/1/1998	250%	81,089	775,905	856,994	NA
Colorado (S)	4/22/1998	185%	NA	51,826	51,826	NA
Connecticut (C)	7/1/1998	300%	3,216	18,130	21,346	NA
Delaware (S)	2/1/1999	200%	NA	9,691	9,691	NA
District of Columbia (M)	10/1/1998	200%	5,060	NA	5,060	NA
Florida (C)	4/1/1998	200%	4,706	363,474	368,180	NA
Georgia (S)	11/1/1998	235%	NA	221,005	221,005	NA
Hawaii (M)	7/1/2000	200%	8,474	NA	8,474	NA
Idaho (M)	10/1/1997	150%	16,895	NA	16,895	NA
Illinois (C)	1/5/1998	185%	42,992	25,040	68,032	NA
Indiana (C)	10/1/1997	200%	50,423	15,802	66,225	NA
Iowa (C)	7/1/1998	200%	13,373	21,133	34,506	NA
Kansas (S)	1/1/1999	200%	NA	40,783	40,783	NA
Kentucky (C)	7/1/1998	200%	59,642	34,299	93,941	NA
Louisiana (M)	11/1/1998	200%	87,675	NA	87,675	NA
Maine (C)	7/1/1998	200%	15,033	7,553	22,586	NA
Maryland (C)	7/1/1998	300%	121,305	3,875	125,180	NA
Massachusetts (C)	10/1/1997	200%	77,788	38,911	116,699	NA
Michigan (C)	5/1/1998	200%	26,777	45,105	71,882	NA
Minnesota (M)	10/1/1998	280%	NR	NA	NR	40,008
Mississippi (C)	7/1/1998	200%	1,180	63,625	64,805	NA
Missouri (M)	9/1/1998	300%	112,004	NA	112,004	NA
Montana (S)	1/1/1999	150%	NA	13,875	13,875	NA
Nebraska (M)	5/1/1998	185%	16,227	NA	16,227	NA
Nevada (S)	10/1/1998	200%	NA	37,878	37,878	NA
New Hampshire (C)	5/1/1998	300%	438	7,700	8,138	NA
New Jersey (C)	3/1/1998	350%	42,017	75,036	117,053	142,427
New Mexico (M)	3/31/1999	235%	19,940	NA	19,940	NA

TABLE 15-21--PRELIMINARY SCHIP ENROLLMENT DATA FOR THE 50 STATES AND THE DISTRICT OF COLUMBIA FOR FISCAL YEAR 2002 -continued

State and Program Type	Date enrollment began	SCHIP upper income eligibility standard (% FPL)	FFY2002 enrollment (number of children ever enrolled during year)			Adults Ever Enrolled in SCHIP Demonstrations
			Medicaid expansion	Separate Child Health Program	Total	
New York (C)	4/15/1998	250%	NR	807,145	807,145	NA
North Carolina (S)	10/1/1998	200%	NA	120,090	120,090	NA
North Dakota (C)	10/1/1998	140%	892	3,571	4,463	NA
Ohio (M)	1/1/1998	200%	183,034	NA	183,034	NA
Oklahoma (M)	12/1/1997	185%	84,490	NA	84,490	NA
Oregon (S)	7/1/1998	170%	NA	42,976	42,976	NA
Pennsylvania (S)	5/28/1998	200%	NA	148,689	148,689	NA
Rhode Island (M)	10/1/1997	250%	19,515	NA	19,515	22,459
South Carolina (M)	10/1/1997	150%	68,928	NA	68,928	NA
South Dakota (C)	7/1/1998	200%	8,893	2,290	11,183	NA
Tennessee (M)	10/1/1997	100%	NR	NA	NR	NA
Texas (C)	7/1/1998	200%	10,491	716,961	727,452	NA
Utah (S)	8/3/1998	200%	NA	33,808	33,808	NA
Vermont (S)	10/1/1998	300%	NA	6,162	6,162	NA
Virginia (C)	10/22/1998	200%	11,484	56,490	67,974	NA
Washington (S)	2/1/2000	250%	NA	8,754	8,754	NA
West Virginia (S)	7/1/1998	200%	NA	35,949	35,949	NA
Wisconsin (M)	4/1/1999	185%	62,391	NA	62,391	113,842
Wyoming (S)	12/1/1999	133%	NA	5,059	5,059	NA
Total	–	–	1,297,907	4,017,322	5,315,229	349,118

S – Separate child health programs

M – Medicaid expansion program

C – Combination programs

NR – Indicates that State has not reported data via the Statistical Enrollment Data System (SEDS)

FPL - Poverty level

NA - Not applicable

Note- For States with combination programs, the "total" column shows the sum of the unduplicated number of children ever enrolled in the SCHIP Medicaid expansion program during the year and the unduplicated number of children ever enrolled in the separate SCHIP program during the year. Because a child may be enrolled in both programs during the year, there may be some double counting of children enrolled in these States.

Source: Data on date enrollment began and the SCHIP upper income eligibility standard are taken from the Centers for Medicare and Medicaid Services, The State Children's Health Insurance Program, Annual Enrollment Report Federal Fiscal Year 2001: October 1, 2000 – September 30, 2001, February 6, 2002. When applicable, these FY2001 upper income limit data were updated by CRS to reflect effective thresholds during FY2002. The State-reported SCHIP enrollment figures are taken from Centers for Medicare and Medicaid Services, Fiscal Year 2002 Number of Children Ever Enrolled in SCHIP – Preliminary Data Summary, January 31, 2003.

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

COST SHARING

Cost-sharing refers to the out-of-pocket payments made by beneficiaries of a health insurance plan. Cost-sharing may include, for example, monthly premiums, enrollment fees, deductibles, copayments, coinsurance and other similar charges.

Federal law permits States to impose cost-sharing for some beneficiaries and some services under SCHIP. States that choose to implement SCHIP as a Medicaid expansion must follow the nominal cost-sharing rules of the Medicaid program.

If a State implements SCHIP through a separate State program, premiums or enrollment fees for program participation may be imposed, but the maximum allowable amount is dependent on family income. For all families with incomes under 150 percent FPL and enrolled in separate State programs, premiums may not exceed the amounts set forth in Federal Medicaid regulations.

Additionally, these families may be charged service-related cost-sharing, but such cost-sharing is limited to (1) nominal amounts defined in Federal Medicaid regulations for the subgroup with income below 100 percent FPL, and (2) slightly higher amounts defined in SCHIP regulations for families with income between 101-150 percent FPL. For families with income above 150 percent FPL, cost-sharing may be imposed in any amount, provided that cost-sharing for higher income children is not less than cost-sharing for lower income children.

Most importantly, the total annual aggregate cost-sharing (including premiums, deductibles, copayments and any other charges) for all children in any SCHIP family may not exceed 5 percent of total family income for the year. In addition, States must inform families of these limits and provide a mechanism for families to stop paying once the cost-sharing limits have been reached.

Preventive services are exempt from cost-sharing for all families regardless of income. The Centers for Medicare and Medicaid Services (CMS) defines preventive services to include the following: all healthy newborn inpatient physician visits, including routine screening (inpatient and outpatient); routine physical examinations; laboratory tests; immunizations and related office visits;

and routine preventive and diagnostic dental services (for example, oral examinations, prophylaxis and topical fluoride applications, sealants, and x-rays).

FINANCING

The Balanced Budget Act of 1997 appropriated a total of $39.7 billion for SCHIP for fiscal years 1998 through 2007.[54] The funding level by fiscal year varies across time. The total annual appropriation for each of fiscal years 1998 through 2001 is about $4.3 billion. This annual total drops to about $3.2 billion for fiscal years 2002 through 2004, then rises to $4.1 billion for fiscal years 2005 and 2006, with a further increase to $5.0 billion in fiscal year 2007. The drop in funding for fiscal years 2002 through 2004, sometimes referred to as the "SCHIP dip," was written into SCHIP's authorizing legislation due to budgetary constraints applicable at the time the legislation was drafted.

Allotment of funds among the States is determined by a formula set in law. This formula is based on a combination of the number of low-income children and low-income, uninsured children in the State, and includes a cost factor that represents average health service industry wages in the State compared to the national average. A State must draw down its entire allotment for a given fiscal year before it can access the next year's funding.

States have three fiscal years in which to draw down a given year's allotment. For example, fiscal year 2002 allotments are available until the end of fiscal year 2004. At the end of the applicable three-year period, unspent allotments are subject to redistribution among only those States that fully expend their allotments, by a method to be determined by the Secretary.

In 2000, the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) established special redistribution rules for unspent fiscal years 1998 and 1999 allotments. The reallocation process is the same for each of these two fiscal years and is applied to each year separately. From those States that did not fully expend their original allotments for a given year within the applicable three-year time frame, a pool of unused funds was formed. From this pool, 1.05% was set aside for redistribution among the 5 territories that exceeded their original allotments for that year based on each territory's designated proportion of the original total appropriation established for the territories. Then the States that fully expended (exceeded) their original allotments for that year received redistributed funds equal to their excess spending–12 States for fiscal year 1998 redistributions and 13 States for fiscal year 1999 redistributions. Finally, the remaining States that did not use all their original allotments for these years retained a portion of the remaining unused funds in the pool, equal to the ratio of such a State's unspent original allotment to the total amount of unspent funds for that fiscal year. The deadline for spending all fiscal year 1998 and 1999 reallocated funds was September 30, 2002.

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

In August 2003, the State Children's Health Insurance Program Allotments Extension Act (Public Law 108-74) extended the availability of fiscal year 1998 and 1999 reallocated funds through the end of fiscal year 2004. This law also created a special redistribution rule for unspent fiscal year 2000 and 2001 SCHIP allotments that differs from the approach used for the fiscal year 1998 and 1999 reallocation process. The fiscal year 2000 and 2001 methodology is identical for each of these two years and is applied to each year separately. For example, for fiscal year 2000, each State that did not spend its full original allotment by the 3-year deadline will retain 50 percent of its unspent funds. The remaining unspent funds across such States will form a pool for redistribution among the territories and remaining States that did fully expend (and exceeded) their original fiscal year 2000 allotments by the 3-year deadline. Of the total redistribution pool, 1.05 percent is earmarked for the territories, each of which will receive an amount from this earmark that is equal to its designated proportion of the total fiscal year 2000 funds originally allotted to the territories. The remaining redistribution pool is divided among those States that exceeded their original fiscal year 2000 allotments. Each such State will receive an amount that is based on the proportion of its excess spending relative to the total amount of excess spending for all such States. Reallocated fiscal year 2000 and 2001 funds are available until the end of fiscal years 2004 and 2005, respectively. Finally, this new law also permits certain States to use up to 20 percent of their reallocated fiscal year 1998 through 2001 SCHIP funds for Medicaid expenditures for services delivered to Medicaid beneficiaries under age 19 who are not otherwise eligible for SCHIP and have family income that exceeds 150 percent of the FPL. (See the Legislative History section for more details.)

Like Medicaid, SCHIP is a Federal-State matching program. For each dollar of State spending, the Federal government makes a matching payment drawn from SCHIP allotments. A State's share of program spending for Medicaid is equal to 100 percent minus the Federal medical assistance percentage (FMAP). The enhanced SCHIP FMAP is equal to a State's Medicaid FMAP increased by the number of percentage points that is equal to 30 percent multiplied by the number of percentage points by which the FMAP is less than 100 percent.[55] For example, in States with a Medicaid FMAP of 60 percent, the enhanced FMAP equals the Medicaid FMAP increased by 12 percentage points (60 percent + [30 percent multiplied by 40 percentage points] = 72 percent). In this example, the State share is 100 percent - 72 percent = 28 percent.

Compared with the Medicaid FMAP, which ranges from 50 percent to 76.62 percent in fiscal year 2003, the enhanced FMAP for SCHIP ranges from 65 percent to 83.63 percent. All SCHIP assistance for targeted low-income children, including child health coverage provided through a Medicaid expansion, is eligible for the enhanced FMAP. The Medicaid FMAP and the enhanced SCHIP

[55] The Federal medical assistance percentage (FMAP) and the enhanced Federal medical assistance percentage (enhanced FMAP) are calculated and published annually by the Secretary of HHS. FMAP is a measure of the average income per person in each State, squared, compared to that of the nation as a whole. This formula is designed to provide a higher FMAP to States with lower per capita income.

FMAP are subject to a ceiling of 83 percent and 85 percent, respectively.

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

GENERAL PROGRAM CHARACTERISTICS

The 50 States, the District of Columbia and 5 territories operate 56 SCHIP programs. As of May 2002, 21 had Medicaid expansions, 16 had separate State programs, and 19 provided health insurance coverage through a combination approach. Because some States had multiple plans for different SCHIP subgroups, in total the 35 States with separate SCHIP programs (SSPs) actually had 42 distinct programs identified by CRS. For example, some States have created more than one SSP for children at different income levels with different benefit packages. As of May 2002, among these 42 SSPs, 15 were benchmark plans (10 based on the State employees' health plan, 4 based on the largest commercial HMO and 1 based on FEHBP). Another 14 SSPs were Secretary-approved programs (11 modeled after Medicaid, 2 modeled after the State employees' health plan and 1 that built upon a comprehensive Medicaid waiver demonstration financed through SCHIP). Ten SSPs were classified as benchmark-equivalent (six equivalent to the State employees' health plan, two equivalent to FEHBP, one equivalent to the largest commercial HMO, and one exceeding the actuarial value of all three types of benchmark plan options). Finally, three SSPs were unique comprehensive State-based plans that were deemed to meet SCHIP requirements under the Balanced Budget Act of 1997.

SCHIP programs across States are evolving rapidly as evidenced by the numerous changes States have made to their original State plans over time. As of February 2003, 150 amendments to original State plans had been approved and 17 more were in review. Several States have multiple amendments. The content of the plan amendments varies among States. For example, some States use amendments to extend coverage beyond income levels defined in their original State plans. Others define new copayment standards for program participants. Still others modify benefit packages.

In addition to the amendment process, States that want to make changes to their SCHIP programs that go beyond what the law will allow may do so through what is called an 1115 waiver (named for the section of the Social Security Act that defines the circumstances under which such waivers may be granted). The Secretary may waive certain statutory requirements for conducting research and demonstration projects under SCHIP that allow States to adapt their programs to specific needs. On August 4, 2001, the Bush Administration announced the Health Insurance Flexibility and Accountability (HIFA) Demonstration Initiative. Using 1115 waiver authority, this initiative is designed to encourage States to

extend Medicaid and SCHIP to the uninsured, with a particular emphasis on Statewide approaches that maximize private health insurance coverage options and target populations with income below 200 percent FPL.

As of March 2003, CMS had approved 12 SCHIP 1115 waivers in 10 States.[56] Four additional 1115 waiver proposals were under review at that time. Five of the twelve approved waivers are HIFA demonstrations in Arizona, California, Colorado, New Jersey, and New Mexico. In eight of the ten States with approved 1115 waivers (excluding Maryland and Ohio), SCHIP coverage is expanded to include one or more categories of adults[57] with children, typically parents of Medicaid/SCHIP children, caretaker relatives, legal guardians, and/or pregnant women. Two States (Arizona and New Mexico) also cover childless adults under their HIFA demonstrations. In addition to expanding coverage to new populations under waivers, some States have used this authority for other purposes. Rhode Island will use redistributed SCHIP funds to finance coverage of adults with children in its waiver program. Through HIFA, New Jersey will offer the same (SCHIP) benefit package to adults covered under its SCHIP and Medicaid waiver demonstrations. Using 1115 waiver authority, both Maryland and New Mexico require a 6-month period of no insurance prior to enrollment under their waivers.[58] New Mexico also has modified its cost-sharing rules for SCHIP Medicaid expansion participants. Finally, Ohio received approval to implement an annual enrollment fee and to give 12 months of continuous eligibility for certain beneficiaries in its Medicaid expansion.[59]

TRENDS IN ENROLLMENT AND EXPENDITURES

Nearly 1 million children (982,000) were enrolled in SCHIP under 43 operational State programs as of December 1998.[60] Nearly 2 million children (1,979,450) were enrolled in SCHIP during fiscal year 1999 under 53 operational State programs.[61] The latest official numbers show that SCHIP enrollment reached a total of 5.3 million children in fiscal year 2002 (see Table 15-21). Of this total,

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[56] The 10 States are Arizona, California, Colorado, Maryland, Minnesota, New Jersey, New Mexico, Ohio, Rhode Island, and Wisconsin. New Jersey and New Mexico each have two approved 1115 waivers. The remaining States have one waiver each.

[57] As noted above, States have the option to purchase family coverage under a group health plan that may cover adults as long as it is cost-effective to do so (relative to the amount paid for comparable coverage
for the children only), and it must not substitute for health insurance that otherwise would be provided to the children. For States seeking greater flexibility both in selecting which adults to cover and in the benefit package offered to those adults, a waiver is required.

[58] In general, for Medicaid expansions under SCHIP, all Medicaid rules apply. Thus, when States with SCHIP Medicaid expansions want to implement other rules (e.g., establish waiting periods before enrollment, implement enrollment fees, etc.), a waiver is required.

[59] Due to a variety of budget and resource constraints, in May 2002, Ohio decided not to pursue implementation of its waiver.

[60] U.S. Health Care Financing Administration. *A Preliminary Estimate of the Children's Health Insurance Program Aggregate Enrollment Numbers Through December 31, 1998* (background only). April 20, 1999.

[61] U.S. Health Care Financing Administration. *The State Children's Health Insurance Program Annual Enrollment Report, October 1, 1998 – September 30, 1999* (no date).

4.0 million were covered in separate State programs, and 1.3 million participated in SCHIP Medicaid expansions. In addition, five States also reported enrollment of nearly 350,000 adults in fiscal year 2002. Two of these States (New Jersey and Wisconsin) accounted for nearly three-fourths of adult enrollment in SCHIP. Adult enrollment exceeded child enrollment in three of these States (New Jersey, Rhode Island, and Wisconsin).

To date, SCHIP spending has fallen well below allotment levels for a variety of reasons. Despite the fact that 42 States began enrolling children in their SCHIP programs in late 1997 or 1998 (see Table 15-21), new programs take time to get off the ground and participation rates rose more slowly than expected. Table 15-22 shows total available funds and cumulative spending by State for fiscal year 1998 through fiscal year 2002, as of the end of fiscal year 2002. During this period, States had access to fiscal years 1998 and 1999 redistributed funds as well as their original allotments for fiscal years 2000, 2001 and 2002. By the end of fiscal year 2002, eight States had spent less than 25 percent of their available allotments. Of these eight States, two had spent less than 10 percent of these funds. Another 21 States had used between one-fourth and one-half of their allotments. The remaining 22 States had expended more than 50 percent of available funds. Of these 22 States, 2 had spent more than 75 percent of their allotments. As SCHIP enrollment across States grows over time, expenditures under the program are likely to account for an ever increasing share of available allotments.

Nationally, through September 2002, $9.4 billion or 47 percent of available funds had been expended, leaving an unspent balance of approximately $10.7 billion from the fiscal years 1998 through 2002 allotments. As of October 2003, several SCHIP allotment accounts are available to the States and territories. (Accessing each account is subject to specific rules.) These "open accounts" include fiscal years 1998 and 1999 reallocated funds (available through the end of fiscal year 2004), unspent fiscal years 2000 and 2001 allotments to be reallocated among all of the States and territories based on a special redistribution formula (available through the end of fiscal years 2004 and 2005, respectively), and the three original allotment accounts for fiscal years 2002, 2003, and 2004, not yet subject to redistribution (available through the end of fiscal years 2004, 2005, and 2006 respectively).

LEGISLATIVE HISTORY

Below is a summary of major SCHIP changes enacted in public laws beginning with the legislation authorizing the program in 1997:

Balanced Budget Act of 1997 (BBA 1997), Public Law 105-33:

Creation of SCHIP-Under BBA 1997, the State Children's Health Insurance Program was established, effective August 5, 1997. A number of provisions specified eligibility criteria; coverage requirements for health insurance; Federal allotments and the State allocation formula; payments to States

and the enhanced FMAP formula; the process for submission, approval and amendment of State SCHIP plans; strategic objectives and performance goals, and plan administration; annual reports and evaluations; options for expanding coverage of children under Medicaid; and diabetes grant programs.

TABLE 15-22--SCHIP PROGRAM ALLOTMENTS AND EXPENDITURES BY STATE, FISCAL YEARS 1998-2002

[In Thousands of Dollars]

	Total available (Adjusted)[1] allotments for fiscal years 1998-2002	Total expenditures applied against allotments	Percent of available (adjusted)[1] allotments spent	Allotment balance at end of fiscal year 2002[2]
Alabama	$320,043	$153,953	48.1	$166,090
Alaska	$91,051	$66,482	73.0	$24,569
Arizona	$479,610	$213,005	44.4	$266,605
Arkansas	$195,714	$6,213	3.2	$189,501
California	$2,998,522	$1,022,659	34.1	$1,975,864
Colorado	$184,182	$76,067	41.3	$108,115
Connecticut	$154,601	$54,410	35.2	$100,191
Delaware	$37,435	$7,190	19.2	$30,245
District of Columbia	$46,358	$17,008	36.7	$29,349
Florida	$1,059,194	$648,261	61.2	$410,933
Georgia	$543,921	$239,137	44.0	$304,784
Hawaii	$40,828	$7,363	18.0	$33,465
Idaho	$83,117	$40,113	48.3	$43,005
Illinois	$573,738	$128,896	22.5	$444,842
Indiana	$461,019	$235,787	51.1	$225,232
Iowa	$143,700	$79,904	55.6	$63,797
Kansas	$132,745	$82,104	61.9	$50,641
Kentucky	$374,247	$217,915	58.2	$156,333
Louisiana	$351,625	$140,437	39.9	$211,188
Maine	$85,592	$48,956	57.2	$36,636
Maryland	$446,975	$318,362	71.2	$128,613
Massachusetts	$358,621	$189,717	52.9	$168,904
Michigan	$441,650	$128,810	29.2	$312,840
Minnesota	$129,139	$65,423	50.7	$63,716
Mississippi	$240,217	$147,912	61.6	$92,305
Missouri	$343,483	$175,404	51.1	$168,080
Montana	$58,964	$30,839	52.3	$28,125
Nebraska	$72,741	$31,138	42.8	$41,603
Nevada	$128,342	$47,977	37.4	$80,365
New Hampshire	$44,369	$9,413	21.2	$34,956
New Jersey	$542,408	$451,398	83.2	$91,009
New Mexico	$209,107	$26,128	12.5	$182,979
New York	$2,517,549	$1,405,833	55.8	$1,111,716
North Carolina	$545,750	$257,313	47.1	$288,437
North Dakota	$23,829	$8,164	34.3	$15,664
New Hampshire	$44,369	$9,413	21.2	$34,956
New Jersey	$542,408	$451,398	83.2	$91,009
Ohio	$589,150	$326,767	55.5	$262,383

TABLE 15-22--SCHIP PROGRAM ALLOTMENTS AND EXPENDITURES BY STATE, FISCAL YEARS 1998-2002-continued

[In Thousands of Dollars]

	Total available (adjusted)[1] allotments for fiscal years 1998-2002	Total expenditures applied against allotments	Percent of available (adjusted)[1] allotments spent	Allotment balance at end of fiscal year 2002[2]
Oklahoma	$302,822	$107,317	35.4	$195,505
Oregon	$181,828	$51,227	28.2	$130,601
Pennsylvania	$588,656	$317,709	54.0	$270,947
Rhode Island	$70,031	$65,522	93.6	$4,510
South Carolina	$437,593	$206,138	47.1	$231,455
South Dakota	$34,379	$18,542	53.9	$15,836
Tennessee	$307,585	$60,139	19.6	$247,446
Texas	$1,882,714	$881,015	46.8	$1,001,700
Utah	$125,376	$69,232	55.2	$56,143
Vermont	$17,536	$6,848	39.0	$10,688
Virginia	$284,710	$92,210	32.4	$192,500
Washington	$205,491	$14,180	6.9	$191,310
West Virginia	$95,929	$59,860	62.4	$36,069
Wisconsin	$248,170	$159,327	64.2	$88,843
Wyoming	$28,126	$7,160	25.5	$20,966
MOE[3]	$7,894	NA	NA	$7,894
Puerto Rico	$208,136	$178,424	85.7	$29,711
Guam	$7,953	$5,550	69.8	$2,403
Virgin Islands	$5,908	$4,079	69.1	$1,828
American Samoa	$2,598	$4,128	158.9	-$1,530
Northern Mariana Islands	$2,499	$5,203	208.2	-$2,704
Total	$20,095,471	$9,420,272	46.9	$10,675,199

[1] "Adjusted" refers to increases or decreases to the amounts provided through the redistribution of unspent FYs 1998 and 1999 funds. For States that received redistributions of other States' unspent funds, this amount is greater than what was provided by original allotments. For States that contributed unspent funds to the pool for redistribution to other States, this amount is less than what was provided by original allotments.

[2] Figures in this column do not show the exact amount of funds available to States in FY2003. Some States lost access to unspent reallocated money from FYs 1998 and 1999, and unspent FY2000 original allotments, all of which expired on September 30, 2002. In addition, some States will gain additional funds through the redistribution of unspent FY2000 allotments that CMS will make available in the spring of 2003. Also new FY2003 allotments became available on October 1, 2002.

[3] MOE refers to one of the maintenance of effort provisions in SCHIP statute. When SCHIP was created, three States – Florida, New York and Pennsylvania – had existing comprehensive State-based health benefit programs for children that were deemed to meet SCHIP requirements. These States are required to maintain their prior level of spending under SCHIP. Specifically, beginning in FY1999, the allotment for a given fiscal year will be reduced by the difference between the States' spending in the prior fiscal year versus fiscal year 1996 (before SCHIP began). The $7.9 million shown for MOE in this table reflects spending patterns in Pennsylvania for FY1999, in which Pennsylvania's share of SCHIP costs was $7.9 million less than FY1996 spending, so its allotment for FY2000 has been reduced by $7.9 million. This amount will be included in the redistribution process for FY2000. (Pennsylvania's share of FY1998 SCHIP costs was $2.2 million less than FY1996 spending, and its SCHIP allotment for FY1999 was reduced by $2.2 million. This amount is not shown in the MOE cell because it has already been redistributed to other States in the FY1999 redistribution process.)

NA-Not applicable

Source: Centers for Medicare and Medicaid Services, last updated November 20, 2002.

District of Columbia Appropriations Act of 1998, Public Law 105-100:

Increased appropriation-This law increased the fiscal year 1998 SCHIP appropriation from $4.275 billion to $4.295 billion.

Omnibus Consolidated and Emergency Supplemental Appropriation Act, fiscal year 1999, Public Law 105-277:

Increased appropriation for territories-For fiscal year 1999, an additional appropriation of $32 million for the territories was provided, bringing the fiscal year 1999 total appropriation to $4.307 billion.

Change in allotment formula affecting some Native American children-For fiscal year 1998 and fiscal year 1999, the law changed the annual State allotment formula by stipulating that children with access to health care funded by the Indian Health Service and no other health insurance would be counted as uninsured (rather than as insured as required under the previously existing law).

The Medicare, Medicaid and SCHIP Balanced Budget Refinement Act of 1999 (BBRA 1999), incorporated by reference in the Consolidated Appropriations Act for Fiscal Year 2000, Public Law 106-113:

Stabilizing the SCHIP allotment formula-Annual Federal allotments to each State are determined in part by States' success in covering previously uninsured low-income children under SCHIP. Under prior law, the more successful a State was in enrolling children in SCHIP, especially early in the program, the greater the potential reduction in subsequent annual allotments. To limit the amount a State's allocation can fluctuate from one year to the next, BBRA 99 modified the allotment distribution formula and established new floors and ceilings.

Targeted, increased allotments-Additional allotments for the commonwealths and territories were provided for fiscal years 2000 through 2007.

Improved data collection-The law provided new funding for the collection of data to produce reliable, annual State-level estimates of the number of uninsured children. These data changes will improve research and evaluation efforts. They also will affect State-specific counts of the number of low-income children and the number of such children who are uninsured that feed into the formula that determines annual State-specific allotments from Federal SCHIP appropriations.

Federal evaluation-New funding also was provided for a Federal evaluation[62] to identify effective outreach and enrollment practices for both SCHIP and Medicaid, barriers to enrollment, and factors influencing beneficiary dropout.

Additional reports and a clearinghouse-The law also required: (a) an inspector general audit[63] and GAO report on enrollment of Medicaid-eligible

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[62] *Implementation of the State Children's Health Insurance Program: Momentum is Increasing After a Modest Start*, First Annual Report, Cambridge, MA: Mathematica Policy Research, Inc., January 2001. Additional reports describing results from other components of the national evaluation of SCHIP are available from the U.S. Department of Health and Human Services.

[63] The OIG has issued two audit reports: Department of Health and Human Services, Office of Inspector General: *State Children's Health Insurance Program: Assessment of State Evaluations Reports*, OEI-05-00-00240, February 2001, and Department of Health and Human Services, Office of Inspector

children in SCHIP,[64] (b) States to report annually the number of deliveries to pregnant women and the number of infants who receive services under the Maternal and Child Health Services Block Grant or who are entitled to SCHIP benefits, and (c) the Secretary of Health and Human Services to establish a clearinghouse for the consolidation and coordination of all Federal databases and reports regarding children's health.

Agriculture Risk Protection Act of 2000, Public Law 106-224: See the description of this law in the *Medicaid* subsection.

Children's Health Act of 2000, Public Law 106-310:

Rights of institutionalized children-The law requires that general hospitals, nursing facilities, intermediate care facilities and other health care facilities receiving Federal funds, including SCHIP, protect the rights of each resident, including the right to be free from physical or mental abuse, corporal punishment, and any restraints or involuntary seclusions imposed for the purposes of discipline or convenience. Restraints and seclusion may be imposed in such facilities only to ensure the physical safety of the resident, a staff member or others. Additional requirements govern reporting of resident deaths, promulgation of regulations regarding staff training, and enforcement.

Children's rights in community-based settings-The law also includes requirements for protecting the rights of residents of certain non-medical, community-based facilities for children and adolescents, when that facility receives funding under this Act or under Medicaid. (Forthcoming regulations are expected to clarify if and how these rights apply to such facilities funded by SCHIP.) For such individuals and facilities, restraints and seclusion may be imposed only in emergency circumstances and only to ensure the physical safety of the resident, a staff member, or others, and only when less restrictive interventions have been determined to be ineffective. Additional requirements govern reporting of resident deaths, promulgation of regulations regarding staff training, and enforcement.

Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), incorporated by reference into the Consolidated Appropriations Act 2001, Public Law 106-554:

Special redistribution rules for unspent fiscal year 1998 and 1999 allotments-For each of these years separately, a pool of unspent funds is created from the unused allotment amounts of those States that did not fully expend their original allotments within the applicable 3-year time frame. From this pool, 1.05 percent is set aside for the territories that exceeded their original allotments for that year, based on each territory's designated proportion of the original total

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General: *State Children's Health Insurance Program: Ensuring Medicaid Eligibles are not Enrolled in SCHIP*, OEI-05-00-00241, February 2001.

[64] U.S. General Accounting Office: *Children's Health Insurance: Inspector General Reviews Should Be Expanded to Further Inform the Congress*, GAO-02-512, March 2002.

appropriation allotted to the territories. Then the States that fully expended (exceeded) their original allotments for that year receive redistributed funds from the remaining pool equal to their excess spending. The remaining States that did not use all their original allotments for the year retain a portion of the remaining funds in the pool, equal to the ratio of such a State's unspent original allotment to the total amount of unspent funds for that fiscal year. These latter States are permitted to use up to 10 percent of their retained fiscal year 1998 funds for outreach activities. This allowance is over and above spending for such activities under the general administrative cap described above. The deadline for spending all redistributed and retained funds from fiscal years 1998 and 1999 is September 30, 2002. (See the text for additional information on redistribution of unspent SCHIP funds.)

Presumptive eligibility-Under Medicaid presumptive eligibility rules States are allowed to temporarily enroll children whose family income appears to be below Medicaid income standards, until a final formal determination of eligibility is made. BIPA clarified States' authority to conduct presumptive eligibility determinations, as defined in Medicaid law, under separate (non-Medicaid) SCHIP programs.

Authority to pay SCHIP Medicaid expansion costs from Title XXI appropriation-Under prior law, States' allotments under SCHIP paid only the Federal share of costs associated with separate (non-Medicaid) SCHIP programs. The Federal share of costs associated with SCHIP Medicaid expansions was paid for under Medicaid. State SCHIP allotments were reduced by the amounts paid under Medicaid for SCHIP Medicaid expansion costs. BIPA authorized the payment of the costs of SCHIP Medicaid expansions and the costs of benefits provided during periods of presumptive eligibility from the SCHIP appropriation rather than the Medicaid appropriation, and as a conforming amendment, eliminated the requirement that State SCHIP allotments be reduced by these (former) Medicaid payments. Also, for fiscal years 1998 through 2000 only, BIPA authorized the transfer of unexpended SCHIP appropriations to the Medicaid appropriation account for the purpose of reimbursing payments associated with SCHIP Medicaid expansion programs.

Public Health Security and Bioterrorism Preparedness and Response Act of 2002, Public Law 107-188:

See the description of this law in the *Medicaid* subsection.

Health Care Safety Net Amendments of 2002, Public Law 107-251:

See the description of this law in the *Medicaid* subsection.

State Children's Health Insurance Program Allotments Extension Act, Public Law 108-74:

Extension of available SCHIP reallocated funds from fiscal years 1998 and 1999-This law extends the availability of fiscal year 1998 and 1999 reallocated funds through the end of fiscal year 2004 (rather than the end of fiscal year 2002).

Revision of methods for reallocation of unspent fiscal years 2000 and FY2001, and extension of the availability of such funds-The law also establishes a new method for reallocating unspent funds from fiscal years 2000 and 2001 allotments. For fiscal year 2000, each State (and territory) that did *not* spend its full original allotment by the 3-year deadline retains 50% of its unspent funds. The remaining 50 percent from each such State forms a pool of unspent funds for redistribution among the territories and other States that did fully expend (and exceeded) their fiscal year 2000 allotments by the 3-year deadline. First, 1.05 percent of the total redistribution pool is set aside for allocation among the territories, from which each of the territories receives an amount equal to its designated proportion of the total fiscal year 2000 funds originally allotted to the territories. Then the remaining redistribution pool is allocated to each State that fully expended (exceeded) its fiscal year 2000 original allotment by the 3-year deadline. The redistribution amount for each such State is based on the proportion of its excess spending relative to the total amount of excess spending for all such States. The same methodology is applied to reallocation of unspent fiscal year 2001 original allotments. Reallocated funds for fiscal years 2000 and 2001 are available until the end of fiscal years 2004 and FY2005, respectively.

Authority for qualifying States to use certain funds for Medicaid expenditures-The law permits certain States to use not more than 20 percent of reallocated fiscal year 1998 through 2001 SCHIP funds for Medicaid expenditures for services delivered to Medicaid beneficiaries under age 19 whose family income exceeds 150 percent of the federal poverty level (FPL) and who otherwise are not eligible for SCHIP. For such services, the additional payments due are based on the SCHIP enhanced federal matching rate (up to the 20 percent cap on the use of reallocated funds for this purpose). Qualifying States include those that on or after April 15, 1997 had an income eligibility standard of at least 185 percent of the FPL for at least one category of children, other than infants. (Other qualifications apply to States with Statewide waivers under Section 1115 of the Social Security Act.)

FEDERAL HOUSING ASSISTANCE[65]

A number of Federal programs administered by the U.S. Department of Housing and Urban Development (HUD) and the Rural Housing Service (RHS) address the housing needs of low-income households. Housing assistance has never been provided as an entitlement to all households that qualify for aid. Instead, Congress has traditionally appropriated funds for a number of new commitments each year. Until the 1990s, those commitments generally ran up to 40 years, with the result that the appropriations were actually spent gradually over many years. More recently, funding has been provided 1 year at a time. Those additional commitments have expanded the pool of available aid, thus increasing the total

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

number of households that can be served. They have also contributed to growth in Federal outlays in the past and have committed the government to continuing expenditures for many more years to come. The traditional housing programs have been augmented over the years with additional programs funded through block grants to State and local governments. This section describes recent trends in the number and mix of new commitments, as well as trends in expenditures for both the traditional assistance programs and the more recent block grant programs. The section focuses primarily on programs administered by HUD.

TYPES OF ASSISTANCE

The Federal Government has traditionally provided housing aid directly to low-income households in the form of rental subsidies and mortgage interest subsidies. For the most part, both the number of households receiving aid and total Federal expenditures have steadily increased, but the growth of households assisted through the traditional programs has slowed since the 1980s and, in recent years, the number of such assisted households may have declined.[66] Starting in the mid-1980s, a number of statutes were enacted-including the Stewart B. McKinney Homeless Assistance Act of 1987 (hereafter referred to as the McKinney Act) and the 1990 Cranston-Gonzalez National Affordable Housing Act (hereafter referred to as the 1990 Housing Act) that authorized new, indirect approaches in the form of housing block grants to State and local governments. Those governments may use the grants for various housing assistance activities specified in the laws. Data on the number of households assisted through those types of programs are not readily available, however.

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

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

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

Direct Rental Assistance

Most Federal housing aid is now targeted to very-low-income renters through the rental assistance programs administered by HUD and the RHS (Schussheim, 2000). Rental assistance is provided through two basic approaches: (1) project-based aid, which is typically tied to projects specifically produced for low-income households through new construction or substantial rehabilitation; and (2) household-based subsidies, which permit renters to choose standard housing units in the existing private housing stock. Some funding is also provided each year to modernize units built with Federal aid. Rental assistance programs generally reduce tenants' 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 also is provided through production-oriented programs, which include the Public and Indian Housing Program, the section 8 New Construction and Substantial Rehabilitation Program, and the section 236 Mortgage Interest Subsidy Program-all administered by HUD-and the section 515 Mortgage Interest Subsidy Program administered by the RHS.[67] Today new commitments are being funded through only two of these four programs-a modified version of the section 8 New Construction Program for elderly and disabled families only and the section 515 program. In addition, some new housing for Native Americans continues to be developed through the Indian Housing Block Grant Program.

Some project-based aid is also provided through several components of HUD's section 8 Existing Housing Program, which tie subsidies to specific units in the existing housing stock, many of which have received other forms of aid or mortgage insurance through HUD. Traditionally, those components have included the section 8 loan management set-aside (LMSA) and property disposition (PD) components, which are designed to improve cash flows in selected financially troubled projects that are or were insured by the Federal Housing Administration or to provide deeper subsidies to the occupants; the section 8 conversion assistance component, which subsidizes units that previously were aided through other programs; and the section 8 Moderate Rehabilitation Program, which provides subsidies to units that have been brought up to standard by the owner.[68] In recent years, few, if any, new commitments have been funded through these programs. Today, new funding is predominantly used for tenant protection to enable tenants to remain in or move out of projects where rents are being raised after the owners opt out of the Federal assistance programs. Tenant protection assistance is also used to replace aid to households that are being displaced from assisted projects because the projects are being demolished.

Household-based subsidies traditionally have been provided through two other components of the section 8 Existing Housing Program-section 8 rental

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[67] 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.

[68] 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.

certificates and vouchers. These programs tie aid to households that choose units meeting certain housing standards in the private housing stock. Certificate holders generally must occupy units with rents that are within guidelines-the so-called fair market rents-established by HUD. Voucher recipients, however, are allowed to occupy units with rents above the HUD guidelines provided they pay the difference. Starting in 2000, the certificate and voucher program are being combined into one program that pays the difference between 30 percent of a tenant's income and the lesser of the tenant's actual housing cost or a payment standard determined by local rent levels. Commitments to aid additional households are being made under this program. In addition, because of the tenant protection programs discussed above, aid gradually is being shifted from project-based to household-based assistance.

Direct Home Ownership Assistance

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

A number of home buyers have received aid through the section 235 program administered by HUD. That program provides interest subsidies for mortgages financed by private lenders. New commitments now are 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.[69] Both programs generally reduce mortgage payments, property taxes, and insurance costs to a fixed percentage of income, ranging from 20 percent for the RHS program to 28 percent for the latest commitments made under the HUD program.

Homeless Programs

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

Under these programs, HUD funds housing assistance indirectly in the form

[69] The Housing and Community Development Act of 1997 terminated the section 235 program at the end of fiscal year 1999.

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

Other Housing Block Grant Programs

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

Some assistance for the construction or rehabilitation of rental housing was funded under two small HUD programs authorized in 1983, the Rental Housing Development Grants (HoDAG) and the Rental Rehabilitation Block Grant Programs.[70] These programs distributed funds through a national competition and by formula, respectively, to units of local government that met certain eligibility criteria.

The 1990 Housing Act authorized several new housing assistance approaches, including the Home Ownership and Opportunity for People Everywhere (HOPE) Program and the HOME Investment Partnerships Block Grant Program. Since 1996, funds have been appropriated only for the HOME Program. The HOME Program provides Federal grants to State and local governments on a formula basis. Currently, participating jurisdictions generally must provide matching contributions of at least 25 percent of HOME funds spent in each fiscal year. Some or all of the matching requirement may be waived for jurisdictions that can show they are financially distressed. Funds may be used for tenant-based rental assistance or assistance to new home buyers.[71] They may also be used for acquisition, rehabilitation, or in limited circumstances, construction of both rental and owner-occupied housing.

TRENDS IN LEVELS AND BUDGETARY IMPACT OF HOUSING AID

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

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[70] 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.

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

Trends in Net New Commitments

Although HUD has been subsidizing the shelter costs of low-income households since 1937, more than half of all currently outstanding commitments under the traditional assistance programs were funded over the past 26 years. Between 1977 and 2002, funds were appropriated for about 2.7 million net new commitments to aid low-income renters (Table 15-23). Another 108,000 new commitments were funded in the form of mortgage assistance to low- and moderate-income home buyers. Between 1977 and 1983, the number of net new rental commitments funded each year declined steadily, however, from 354,000 to 54,000. Trends have been somewhat erratic since that time. During the late 1990s relatively few new commitments were funded, ranging from less than 8,500 in 1996 to 36,000 in 1998. For fiscal year 2000, however, funds were appropriated for nearly 130,000 new commitments before declining again to about 34,000 in 2002.

The production-oriented approach in rental programs was sharply curtailed in 1982 in favor of the less costly section 8 Existing Housing Programs. Between 1977 and 1981, commitments through programs for new construction and substantial rehabilitation ranged annually from 47 to 69 percent of the total. After1981, the proportion never exceeded 32 percent until 1995, when it rose to roughly one-half of the total. Because in the late 1990s the number of commitments funded for existing housing has been so low, the new construction commitments (primarily for the elderly and disabled) have been a relatively high proportion of the total.

Trends in Budget Authority

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

Annual appropriations of new budget authority for all housing assistance programs combined were cut dramatically during the 1980s. They dropped (in 2002 dollars) from a high of $75 billion in 1978 to a low of $12 billion in 1988 and 1989 (Table 15-24). Those cuts reflect four underlying factors affecting budget authority for the direct housing assistance programs: the previously mentioned reduction in the number of newly assisted households; the shift toward cheaper existing housing assistance; a systematic reduction in the average term of new commitments from more than 24 years in 1977 to less than 5 years recently; 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.[72]

TABLE 15-23--NET NEW COMMITMENTS FOR RENTERS AND HOME BUYERS RECEIVING DIRECT HOUSING ASSISTANCE ADMINISTERED BY HUD, BY TYPE OF SUBSIDY, 1980-2002

Fiscal Year	Net new commitments for renters			Net commitments for home buyers[3]
	Existing housing[1]	New construction[2]	Total	
1980	58,402	129,490	187,892	58,907
1981	83,520	75,365	158,885	5,102
1982	37,818	18,018	55,836	4,754
1983	54,071	-339	53,732	2,630
1984	78,648	9,619	88,267	930
1985	85,741	16,980	102,721	4,586
1986	85,476	13,109	98,585	5
1987	72,788	20,192	92,980	60
1988	64,270	19,991	84,261	0
1989	67,653	14,053	81,706	0
1990	61,309	7,428	68,737	0
1991	55,900	13,082	68,982	0
1992	62,008	23,537	85,545	0
1993	50,162	18,715	68,877	0
1994	47,807	17,652	65,459	0
1995	16,904	16,587	33,491	0
1996	7,055	1,438	8,493	0
1997	9,229	12,449	21,678	0
1998	18,376	17,675	36,051	0
1999	16,225	11,060	27,285	0
2000	121,951	8,001	129,952	0
2001	85,720	7,611	93,331	0
2002	25,900	7,635	33,535	0

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

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

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

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

[72] 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 interested payments for this debt. Starting in 1987, these activities have been financed with up front grants, which reduced their budget authority requirements by between 51 and 67 percent. Similarly, prior to 1991, housing for the elderly and the disabled was financed by direct Federal loans for construction, coupled with 20 years of section 8 rental assistance. Moreover, starting in 1995, the term of the rental assistance was decreased from 20 years to 5 years, thereby reducing the budget authority even more.

TABLE 15-23--NET NEW COMMITMENTS FOR RENTERS AND HOME BUYERS RECEIVING DIRECT HOUSING ASSISTANCE ADMINISTERED BY HUD, BY TYPE OF SUBSIDY, 1980-2002-continued

Note-Because reliable data are not readily available, this table excludes substantial numbers of commitments made through the various programs for the homeless (including HOPWA) and other block grant programs such as the HOME Investment Partnerships Program. Net new commitments for renters represent net additions to the available pool of rental aid and are defined as the total number of commitments for which new funds are appropriated in any year. To avoid double counting, numbers are adjusted for commitments for which such funds are deobligated or canceled that year (except where noted otherwise); the commitments for units converted from one type of assistance to another; starting in 1985, the commitments replacing those lost because private owners of assisted housing opt out of the programs or because public housing units are demolished; and starting in 1989, the commitments for units whose section 8 contracts expire. New commitments for home buyers are defined as the total number of new loans that HUD subsidizes each year. This measure of program activity is meant to indicate how many new home buyers can be helped each year. It is not adjusted to account for homeowners who leave the program in any year because of mortgage repayments, prepayment, or foreclosures. Thus, it does not represent net additions to the total number of assisted homeowners and therefore cannot be added to net new commitments for renters.

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

Between 1991 and 1994, budget authority levels (in 2002 dollars) rose sharply to between $23 and $24 billion. Those trends reflect primarily the cost of renewing section 8 contracts that expired, with contracts being extended for 5-year terms. In addition, appropriations for homeless programs and other housing block grant programs rose significantly during that period.

After 1994, budget authority levels dropped again to as low as $12 billion in 1997. That decrease is explained by decreases in net budget authority appropriated for direct housing assistance, which were only partially offset by increases in appropriations for homeless and other housing block grant programs. The decreases in net budget authority for direct assistance reflect several factors: a gradual reduction in the terms of renewed contracts from 5 years to 1 year; further reductions in funding for new activity; and substantial rescissions of budget authority that had been appropriated in earlier years.

The years since 1997 have seen consistent increases in budget authority, with the 2002 level of nearly $26 billion more than double the 1997 level.

Trends in Outlays

Total outlays for all housing programs administered by the U.S. Department of Housing and Urban Development (HUD) increased (in 2002 dollars) steadily from 1977 through 1996, from $7 billion to nearly $30 billion (Table 15-25). The lion's share of that increase is explained by increases in outlays for direct housing assistance, reflecting both the continuing increase in the number of assisted households and increases in the average subsidy in real terms.

TABLE 15-24--NET BUDGET AUTHORITY APPROPRIATED FOR HOUSING ASSISTANCE ADMINISTERED BY HUD, BY BROAD PROGRAM CATEGORIES, 1977-2002

[In millions of dollars]

Fiscal Year	Direct housing assistance[1] in current dollars	Homeless programs[2] in current dollars	Other housing block grants[3] in current dollars	Total net budget authority	
				Current dollars	2002 dollars
1977	$28,579	0	0	$28,579	$71,166
1978	32,193	0	0	32,193	74,987
1979	25,123	0	0	25,123	54,155
1980	27,435	0	0	27,435	54,288
1981	26,021	0	0	26,021	46,951
1982	14,766	0	0	14,766	24,895
1983	10,001	0	0	10,001	16,154
1984	10,810	0	$615	11,425	17,794
1985	11,071	0	0	11,071	16,692
1986	9,888	0	144	10,032	14,771
1987	8,645	$195	300	9,140	13,099
1988	8,353	107	204	8,664	12,021
1989	8,664	172	170	9,006	12,034
1990	10,331	284	152	10,767	13,866
1991	19,029	339	105	19,473	24,137
1992	16,730	498	1,861	19,089	23,054
1993	18,280	672	1,485	20,437	24,111
1994	18,107	979	1,173	20,259	23,393
1995	11,676	1,291	1,462	14,429	16,307
1996	13,218	994	1,400	15,612	17,299
1997	8,672	1,019	1,370	11,061	12,021
1998	14,175	1,027	1,500	16,702	17,900
1999	16,544	1,200	1,600	19,354	20,469
2000	17,474	1,252	1,617	20,343	21,110
2001	20,724	1,380	1,796	23,900	24,207
2002	22,522	1,400	1,796	25,718	25,718

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

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

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

TABLE 15-24--NET BUDGET AUTHORITY APPROPRIATED FOR HOUSING ASSISTANCE ADMINISTERED BY HUD, BY BROAD PROGRAM CATEGORIES, 1977-2002-continued

Note-All figures are net of funding rescissions, exclude reappropriations of funds, and include supplemental appropriation. Figures exclude budget authority for HUD's section 202 loan funds. Dollar conversion calculated using GDP deflator.

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

Several factors have contributed to the growth of average subsidies over the 1977-96 period. First, rents in assisted housing probably have risen faster than the income of assisted households, causing subsidies to rise faster than the inflation index used here-the Consumer Price Index for All Urban Consumers (CPI-U-X1).[73] Second, the number of households that occupy units completed under the section 8 New Construction Program rose during the 1980s. Those units require larger subsidies compared with the older units that were built prior to the 1980s under the Mortgage Interest Subsidy and Public Housing Programs.

Third, the share of households receiving less costly home ownership assistance has decreased.

Since 1996, outlays for all housing assistance programs stabilized at around $29 billion through 2001 before rising again to nearly $32 billion in 2002.

The leveling off in constant dollar outlays for direct housing assistance in the late 1990s is not easily explained because of a lack of reliable data on the underlying factors that may have contributed. Nevertheless, several factors may have played a role.

The number of assisted households has more or less leveled off at around 5 million. Further, several cost containment measures have been enacted in recent legislation that have slowed down the growth in average subsidies in current dollars, thereby helping to reduce average subsidies in 2002 dollars. First, rents in assisted housing are increasing at a slower rate or are even declining in many cases. Because the Federal Government pays part of those rents, subsidies have been lower than they would have been otherwise. In particular, the maximum allowable rent in the section 8 voucher and certificate program has been lowered from the 45th percentile to the 40th percentile of the local rent distribution. That decrease is being phased in gradually, as households move from their current units or turn over their certificate or voucher to a new recipient. Also, rents in certain assisted housing projects no longer are increased annually, while rent adjustments in other cases are being reduced. Second, many assisted households who had been contributing little or nothing to their rent are now charged a minimum rent of up to $50 per month. Third, preference rules for admitting new tenants have been relaxed, thereby allowing a gradual shift to a population with somewhat higher incomes. Fourth, in

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

several of the years during the period, the reissuing of section 8 certificates and vouchers upon turnover has been delayed for 3 months.

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

Future trends in outlays for housing assistance will be affected by further changes made by recent legislation. On the one hand, the so-called mark-to-market initiative, enacted by the Multifamily Assisted Housing Reform and Affordability Act of 1997, will reduce rents in certain section 8 projects with federally insured mortgages, thereby reducing outlays for the section 8 program. Under this initiative, project rents will be reduced to market levels as the section 8 contracts expire. To avoid defaults on the federally insured mortgages, HUD will write down, if needed, those mortgages to levels that are supportable by the new lower rents. On the other hand, a second initiative, enacted in 1999 by the Preserving Affordable Housing for Senior Citizens and Families into the 21st Century Act, will allow rents to increase in certain section 8 projects, thereby increasing outlays for section 8. To prevent owners from opting out of the Federal assistance programs, rents will be raised to market levels. In cases where owners opt out anyway, tenants will be enabled to stay in the project through the use of vouchers that will be issued at market rent levels even if the latter exceed the section 8 fair market rent in the area. The extent to which these factors, as well as the slowing economy, combined to effect the rise in outlays in 2002 remains unclear.

SCHOOL LUNCH AND BREAKFAST PROGRAMS[74]

The School Lunch and School Breakfast Programs provide Federal cash and commodity support for meals. The meals are served by public and private nonprofit elementary and secondary schools and residential child care institutions (RCCIs) that opt to enroll and guarantee to offer free or reduced-price meals meeting Federal nutrition standards to eligible low-income children. Both programs are "entitlement" programs, and both subsidize participating schools and RCCIs for all meals served that meet Federal nutrition standards at specific, inflation-indexed rates for each meal. Each program has a three-tiered system for per-meal Federal reimbursements to schools and RCCIs that: (1) allows children to receive free meals if they have family income below 130 percent of the Federal poverty

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

guidelines (about $23,900 for a four-person family in the 2003-2004 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 $23,900 and $34,000 for a four-person family in the 2003-2004 school year); and (3) provides a small per-meal subsidy for "full-price meals (the price is set by the school or RCCI) served to children whose families do not apply, or whose family income does not qualify them for free or reduced-price meals. Children in Temporary Assistance for Needy Families (TANF) and food stamp households may automatically qualify for free school meals without an income application, and the majority actually receive them.

In addition to the regular School Lunch program, schools and RCCIs may expand their program to cover children through age 18 in after-school programs (or other programs operating outside regular school schedules). Federal subsidies are paid to schools operating these programs at the free snack rate (discussed in a following section on the Child and Adult Care Food program) when they are served free to children in lower-income areas. In other cases, subsidies vary by the child's family income (as in the regular program).

The School Lunch Program subsidizes lunches (4.7 billion in fiscal year 2002) to children in about 6,000 RCCIs and almost all schools (93,000). During fiscal year 2002, average daily participation was 28 million students (57 percent of the children enrolled in participating schools and RCCIs); of these, 48 percent received free lunches, and 9 percent ate reduced-price lunches (Table 15-26). The remainder were served full-price (but still subsidized) meals. More than 90 percent of Federal funding is used to subsidize free and reduced-price lunches served to low-income children. For the 2003-2004 school year, per-lunch Federal subsidies (cash and commodity support) range from about 36 cents for full-price lunches to $2.34 and $1.94 for free and reduced-price lunches.[75] Fiscal year 2002 Federal school lunch costs (including commodity assistance) totaled nearly $6.9 billion (Table 15-26).

The School Breakfast Program serves far fewer students than does the School Lunch Program; about 1.4 billion breakfasts in 71,000 schools (and 6,000 RCCIs) were subsidized in fiscal year 2002. Average daily participation was 8.1 million children (21 percent of the 38 million students enrolled in participating schools and RCCIs). Unlike the School Lunch Program, the great majority received free or reduced-price meals: 74 percent received free meals, and 9 percent purchased reduced-price meals (Table 15-27). In the 2003-2004 school year, per-breakfast Federal subsidies (cash

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

TABLE 15-25--OUTLAYS FOR HOUSING ASSISTANCE ADMINISTERED BY HUD, BY BROAD PROGRAM CATEGORIES, 1977-2002

Fiscal year	Direct housing assistance (in current dollars)			Homeless programs[3] (in current dollars)	Other housing block grants[4] (in current dollars)	Total outlays	
	Section 8 and other assisted housing[1]	Public housing[2]	Subtotal assisted housing			Current dollars	2002 dollars
1977	$1,331	$1,564	$2,895	0	0	$2,895	$7,209
1978	1,824	1,779	3,603	0	0	3,603	8,392
1979	2,374	1,815	4,189	0	0	4,189	9,030
1980	3,146	2,218	5,364	0	0	5,364	10,614
1981	4,254	2,478	6,732	0	0	6,732	12,147
1982	5,293	2,553	7,846	0	0	7,846	13,228
1983	6,102	3,318	9,420	0	0	9,420	15,216
1984	7,068	3,932	11,000	0	0	11,000	17,132
1985	7,771	17,261	25,032	0	$15	25,047	37,764
1986	8,320	3,859	12,179	0	142	12,321	18,141
1987	8,993	3,517	12,510	$2	165	12,677	18,168
1988	9,985	3,699	13,684	37	180	13,901	19,287
1989	10,689	3,774	14,463	72	275	14,810	19,789
1990	11,357	4,331	15,688	85	276	16,049	20,668
1991	12,107	4,786	16,893	125	168	17,186	21,303
1992	13,052	5,182	18,234	150	35	18,419	22,245
1993	14,032	6,447	20,479	180	276	20,935	24,699
1994	15,289	6,857	22,146	225	862	23,233	26,827
1995	16,448	7,505	23,953	359	1,259	25,571	28,900
1996	17,496	7,668	25,164	616	1,273	27,053	29,976
1997	17,131	7,809	24,940	718	1,263	26,921	29,258

1998	16,975	8,028	25,003	916	1,316	27,235	29,188
1999	17,171	7,805	24,976	1,032	1,367	27,375	28,952
2000	17,359	7,860	25,219	1,110	1,510	27,829	28,878
2001	18,153	8,188	26,341	1,208	1,448	28,997	29,369
2002	20,037	8,926	28,963	1,358	1,545	31,866	31,866

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

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

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

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

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

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

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

only) range from 22 cents for full-price meals to $1.20 and 90 cents for free and reduced-price breakfasts, respectively.[76] Fiscal year 2002 Federal school breakfast funding totaled about $1.5 billion (Table 15-27).

TABLE 15-26-- SCHOOL LUNCH PROGRAM PARTICIPATION AND FEDERAL COSTS, SELECTED FISCAL YEARS 1980-2002

[In millions]

Fiscal year	Participation[1]				Federal costs	
	Free meals	Reduced-price meals	Full-price meals[2]	Total[3]	Current dollars[4]	Constant 2002 dollars
1980	10.0	1.9	14.0	26.6	$287.8	6,808.5
1985	9.9	1.6	12.1	23.6	379.3	5,090.4
1990	9.9	1.7	12.6	24.2	589.1	5,110.4
1991	10.3	1.8	12.1	24.2	677.2	5,389.7
1992	11.2	1.7	11.7	24.6	782.6	5,747.9
1993	11.8	1.7	11.3	24.8	868.4	5,814.6
1994	12.2	1.8	11.3	25.3	958.7	6,067.7
1995	12.5	1.9	11.3	25.7	1,181.8	6,028.6
1996	12.7	2.0	11.3	26.0	1,124.2	6,254.7
1997	13.0	2.2	11.3	26.4	1,212.7	6,415.6
1998	13.1	2.2	11.3	26.6	1,299.6	6,469.4
1999	13.0	2.4	11.6	27.0	1,354.8	6,755.8
2000	13.0	2.5	11.8	27.3	6,332.1	6,634.0
2001	12.9	2.6	12.0	27.5	6,582.2	6,680.9
2002	13.4	2.6	12.0	28.0	6,892.1	6,892.1

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

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

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

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

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

Source: U.S. Department of Agriculture, Food and Nutrition Service (FNS): (1) budget justification materials prepared by the FNS for appropriations requests for fiscal years 1980-2004; and (2) monthly "Program Information Report" summaries prepared by the FNS.

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

The Special Supplemental Nutrition Program for Women, Infants, and Children (the WIC Program) provides food assistance, nutrition risk screening, and related services (e.g., nutrition education and breastfeeding support) to low-income pregnant and postpartum women and their infants, as well as to low-income

[76] Subsidies are substantially higher (about 23 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. Most schools receive these extra subsidies for free and reduced-price breakfasts.

children up to age 5. Participants in the program must have family income at or below 185 percent of poverty, and must be judged to be nutritionally at risk. Nutrition risk is defined as detectable abnormal nutritional conditions; documented nutritionally-related medical conditions; health-impairing dietary deficiencies; or conditions that predispose people to inadequate nutrition or nutritionally related medical problems.

TABLE 15-27--SCHOOL BREAKFAST PROGRAM PARTICIPATION AND FEDERAL COSTS, SELECTED FISCAL YEARS 1980-2002

[In millions]

Fiscal Year	Participation[1]				Federal costs	
	Free meals	Reduced-price meals	Full-price meals[2]	Total[3]	Current dollars[4]	Constant 2002 dollars
1980	2.8	0.2	0.6	3.6	287.8	643.5
1985	2.9	0.2	0.4	3.4	379.3	636.3
1990	3.3	0.2	0.5	4.0	589.1	818.9
1991	3.6	0.2	0.6	4.4	677.2	896.1
1992	4.0	0.3	0.6	4.9	782.6	1,005.3
1993	4.4	0.3	0.7	5.4	868.4	1,082.7
1994	4.8	0.3	0.7	5.8	958.7	1,164.7
1995	5.1	0.4	0.8	6.3	1,181.8	1,396.5
1996	5.3	0.4	0.9	6.6	1,124.2	1,292.3
1997	5.5	0.5	1.0	7.0	1,212.7	1,357.9
1998	5.6	0.5	1.0	7.2	1,299.6	1,431.8
1999	5.7	0.6	1.1	7.4	1,354.8	1,464.5
2000	5.7	0.6	1.2	7.5	1,422.9	1,490.7
2001	5.8	0.7	1.3	7.8	1,468.3	1,490.2
2002	6.0	0.7	1.4	8.1	1,541.0	1,541.0

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

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

Source: U.S. Department of Agriculture, Food and Nutrition Service (FNS): (1) budget justification materials prepared by the FNS for appropriations requests for fiscal years 1980-2004; and (2) monthly "Program Information Report" summaries prepared by the FNS.

Beneficiaries of the WIC Program receive supplemental foods each month in the form of actual food items or, more commonly, vouchers for purchases of specific items in retail stores. The law requires that the WIC Program provide foods containing protein, iron, calcium, vitamin A, and vitamin C, and allows Federal limits on the foods that may be provided by the WIC Program. Among the items that may be included in a food package are milk, cheese, eggs, infant formula, cereals, and fruit or vegetable juices. U.S. Department of Agriculture regulations require tailored food packages that provide specified types and amounts of food appropriate for six categories of participants: (1) infants from birth to 3 months;

(2) infants from 4 to 12 months; (3) women and children with special dietary needs; (4) children from 1 to 5 years of age; (5) pregnant and nursing mothers; and (6) postpartum nonnursing mothers. In addition to food benefits, recipients also must receive nutrition education and breast-feeding support (where called for).

The Federal cost of providing WIC benefits varies widely depending on the recipient and the foods included in the food package, as well as differences in retail prices (where vouchers are used), food costs (where the WIC agency buys and distributes food), and administrative costs (including the significant costs of nutrition risk screening, breastfeeding support, and nutrition education). Moreover, the program's food costs are significantly influenced by the degree to which States gain rebates from infant formula manufacturers under a requirement to pursue "cost containment" strategies; these rebates total over $1.5 billion a year nationwide and pay for the cost of serving a significant portion of the WIC population. In fiscal year 2002, the national average Federal cost of a WIC food package (after rebates) was $35 a month, and, for each participant, the average monthly "administrative" cost (including nutrition risk assessments and nutrition education) was about $13.

The WIC Program has categorical, income, and nutrition risk requirements for eligibility. Only pregnant and postpartum women, infants, and children under age 5 may participate. As noted above, WIC applicants must show evidence of health or nutrition risk, medically verified by a health professional, in order to qualify. They also must have family income below 185 percent of the most recent Federal poverty guidelines (about $28,200 a year for a three-person family in fiscal year 2004). State WIC agencies may (but seldom do) set lower income eligibility cutoff points. Receipt of TANF, food stamps, or Medicaid assistance also can satisfy the WIC Program's income test, and States may consider pregnant women meeting the income test "presumptively" eligible until a nutritional risk evaluation is made. Drawing on a 2002 study, almost two-thirds of WIC enrollees had family income below the Federal poverty guidelines, 10 percent of WIC enrollees were cash welfare (TANF) recipients, 18 percent received food stamps, and 54 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 2002, Federal spending was $4.37 billion, and the program served a monthly average of 7.5 million women, infants, and children: 24 percent women, 25 percent infants, and 51 percent children. The administration's most recent estimate of the total number of persons eligible and likely to apply for WIC benefits is 7.5 million persons, although other

sources suggest the number exceeds 8 million people. Table 15-28 summarizes WIC participation and Federal costs.

TABLE 15-28--SPECIAL SUPPLEMENTAL NUTRITION PROGRAM FOR WOMAN, INFANTS, AND CHILDREN (WIC) PARTICIPATION AND FEDERAL SPENDING, SELECTED FISCAL YEARS 1977-2002

[Numbers in thousands, Dollars in millions]

Fiscal Year	Participation (9 month average)				Federal spending	
	Women	Infants	Children	Total[1]	Current dollars[2]	Constant 2002 dollars
1977	165.0	213.0	471.0	848.0	$255.9	$767.5
1980	411.0	507.0	995.0	1,913.0	724.7	1,620.5
1985	665.0	874.0	1,600.0	3,138.0	1,488.9	2,497.7
1990	1,035.0	1,412.5	2,069.4	4,516.9	2,125.9	2,955.1
1991	1,120.1	1,558.8	2,213.8	4,892.6	2,301.1	3,045.1
1992	1,221.5	1,684.1	2,505.2	5,410.8	2,566.5	3,296.9
1993	1,364.9	1,741.9	2,813.4	5,920.3	2,819.5	3,515.2
1994	1,499.2	1,786.3	3,191.7	6,477.2	3,159.8	3,838.8
1995	1,576.8	1,817.3	3,500.1	6,894.2	3,451.0	4,078.0
1996	1,648.2	1,827.3	3,712.3	7,187.8	3,688.3	4,239.8
1997	1,710.5	1,863.0	3,835.4	7,408.9	3,845.7	4,306.0
1998	1,733.3	1,882.8	3,749.2	7,365.3	3,895.8	4,292.0
1999	1,742.5	1,897.6	3,671.4	7,311.5	3,955.6	4,275.9
2000	1,750.0	1,894.2	3,554.0	7,198.1	3,976.4	4,166.0
2001	1,779.7	1,921.2	3,604.6	7,305.6	4,147.3	4,209.5
2002	1,812.2	1,928.2	3,748.2	7,488.6	4,372.3	4,372.3

[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 Nutrition Service (FNS): (1) budget justification materials prepared by the FNS for appropriations requests for fiscal years 1980-2004; and (2) monthly "Program Information Report" summaries prepared by the FNS.

CHILD AND ADULT CARE FOOD PROGRAM

The Child and Adult Care Food Program (CACFP) is a permanently authorized entitlement under section 17 of the Richard B. Russell National School Lunch Act. It provides Federal subsidies for breakfasts, lunches, suppers, and snacks served in participating nonresidential child care centers (including homeless shelters, Head Start centers, and after school care centers) and family or group day care homes, as well as for snacks offered in outside-of-school programs.[77] Sponsors

[77] CACFP subsidies also are available for meal services to chronically impaired adults and the elderly in adult day care centers under the same general terms and conditions as child care centers. However, few adult care centers participate (about 2,200 sites serving some 80,000 persons daily in fiscal year 2002),

giving administrative support for providers also are paid limited amounts for their costs. Subsidized meals and snacks must meet Federal nutrition standards, and providers must fulfill any State or local licensing/approval requirements or minimum alternative Federal requirements (or otherwise demonstrate that they comply with government-established standards for other child-care programs). Federal assistance is made up overwhelmingly of cash subsidies based on the number of meals/snacks served or paid for administration; about 3 percent is in the form of federally donated food commodities. CACFP subsidies to participating centers, homes, and outside-of-school programs are available for meals and snacks served to children age 12 or under (through age 18 in outside-of-school settings), migrant children age 15 or under, and handicapped children of any age, but preschool children form the majority.

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

In fiscal year 2002, the cost of CACFP cash and commodity subsidies for meals/snacks, sponsors' administrative costs, and a separate payment to State agencies for audit and oversight was $1.8 billion, up $100 million from 2001. Total average daily attendance in participating centers, homes, and outside-of-school programs was 2.7 million children, slightly higher than 2001 (2.6 million).

CENTERS AND OUTSIDE-OF-SCHOOL PROGRAMS

Child care centers in the CACFP serve an average of 40-60 children and are of 5 types: (1) public or private nonprofit centers (including after school care centers), (2) Head Start centers, (3) for-profit proprietary centers (see restrictions noted below), (4) outside-of-school programs (often operated by schools), and (5) shelters for homeless families. In fiscal year 2002, some 42,000 centers/sites (17,000 sponsors) with an average daily attendance of 1.8 million children participated in the CACFP. Two-thirds of children in the CACFP were reached through centers or outside-of-school programs. Of these, 37 percent were in public or private nonprofit centers, 28 percent were in Head Start centers, 28 percent were

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and Federal spending for them is a minor fraction of the total cost of the CACFP ($57 million in fiscal year 2002, or about 3 percent of overall CACFP spending). In limited cases, residential child care facilities may receive CACFP subsidies for snacks served in afterschool programs.

in for-profit center, and 7 percent were in outside-of-school programs. On the other hand, CACFP funding for centers/programs represented half of total CACFP spending, primarily because their subsidies are, for the most part, differentiated by individual children's family income and larger administrative cost payments generally are provided for sponsors of day care homes (see below). Proprietary centers can be eligible in one of two ways: (1) if they receive Title XX funding for at least 25 percent of their enrollment, regardless of the income status of the children they serve (this includes cases in which Child Care and Development Block Grant and Title XX funds are "pooled" in such a way as to meet the 25 percent requirement, even when Title XX money represents a minority of the pooled funding); or (2) if children representing at least 25 percent of their enrollment or licensed capacity have family income below 185 percent of the Federal poverty income guidelines (i.e., would be eligible for free or reduced price meals or snacks). However, authority to participate under the second rule is renewed annually under current law and may expire, except in three States (Delaware, Iowa, and Kentucky) where it is permanently in place.

Day care centers may receive daily subsidies for up to two meals and one snack or one meal and two snacks for each child, so long as they meet Federal nutrition standards. All meals and snacks served in centers are federally subsidized to at least some degree; different subsidies are provided for breakfasts, lunches/suppers, and snacks, and subsidy rates are set in law and indexed for inflation annually. However, cash subsidies vary according to the family income of each child, and applications for free or reduced-price meals and snacks normally must be taken. The largest subsidies are paid for meals and snacks served to children with family income below 130 percent of the Federal poverty income guidelines: for July 2003-June 2004, these subsidies are 60 cents for each snack, $1.20 for each breakfast, and $2.19 for each lunch/supper. Smaller subsidies are available for meals and snacks served at a reduced price (no more than 15 cents for snacks, 30 cents for breakfasts, and 40 cents for lunches/suppers) to children with family income between 130 and 185 percent of the poverty guidelines: for July 2003-June 2004, these are 30 cents for snacks, 90 cents for breakfasts, and $1.79 for lunches/suppers. The smallest subsidies are paid for meals and snacks served to children who do not qualify or apply for free or reduced-price meals and snacks: for July 2003-June 2004, these are 5 cents for snacks, 22 cents for breakfasts, and 21 cents for lunches and suppers. "Independent" centers (those without sponsors handling administrative responsibilities) must pay for administrative costs associated with the CACFP out of non-Federal funds or a portion of their meal subsidy payments. In other cases, center sponsors may retain a proportion of the meal subsidy payments they receive on behalf of their centers to cover their costs. Finally, Federal commodity assistance is available to centers, generally valued at about 15 cents a meal.

While Federal subsidies for centers differ by the income of the child served the meal/snack, there is no requirement that "free" or "reduced-price" meals/snacks be served. Centers may adjust their fees to account for Federal subsidies or charge

separately for meals to account for the subsidies; the CACFP itself does not regulate the fees they charge.

In addition to the regular CACFP, public and private nonprofit organizations (including child care centers and schools) operating after-school programs any receive CACFP subsidies for snacks served free in their programs to children (through age 18) in lower-income areas, at the free snack rate noted above. In Delaware, Illinois, Michigan, Missouri, Pennsylvania, New York, and Oregon, Federal subsidies also are offered for free suppers, at the free lunch/supper rate noted above.

FAMILY AND GROUP DAY CARE HOMES

CACFP-subsidized day care homes serve an average of 4-6 children; just under 40 percent of children in the CACFP are in day care homes, and about half the money spent under the CACFP supports meals and snacks served in homes. In fiscal year 2002, 165,000 home sites (with some 1,000 sponsors) received subsidies for an average daily attendance of some 900,000 children. As with centers, payments are provided for no more than two meals and one snack (or one meal and two snacks) a day for each child. Unlike centers, day care homes must participate under the auspices of a public or (most often) private nonprofit sponsor that typically has 100 or more homes under its supervision; CACFP day care home sponsors receive monthly administrative payments (separate from meal subsidies) based on the number of homes for which they are responsible. Also unlike centers, day care homes receive cash subsidies (but not commodities) that generally do not differ by individual children's family income. Instead, there are two distinct subsidy rates. "Tier I" homes (those located in low-income areas or operated by low-income providers) receive higher subsidies for each meal/snack they serve: for July 2003-June 2004, all lunches and suppers are subsidized at $1.83 each, all breakfasts at 99 cents, and all snacks at 54 cents. "Tier II" homes (those not located in low-income areas or without low-income providers) receive smaller subsidies: for July 2003-June 2004, these are $1.10 for lunches/suppers, 37 cents for breakfasts, and 15 cents for snacks. However, Tier II providers may seek the higher Tier I subsidy rates for individual low-income children for whom financial information is collected and verified.

WORKFORCE INVESTMENT ACT (WIA)

WIA, enacted in August 1998, repealed the Job Training Partnership Act (JTPA) on July 1, 2000, and replaced it with Title I of WIA, Workforce Investment Systems. The purpose of WIA is to provide workforce investment activities that increase the employment, retention, and earnings of participants. WIA programs are intended to increase occupational skills attainment by participants, and, as a result, improve the quality of the workforce, reduce welfare dependency, and enhance the productivity and competitiveness of the Nation. WIA authorizes several job training programs including Adult Employment and Training Activities,

Youth Activities, and Job Corps.

Under WIA's adult program, adults receive services through a coordinated service delivery system overseen by local workforce investment boards.[78] This system, called the "One-Stop" system, is intended to provide a "seamless" system of services to improve employment opportunities for individuals. Through one-stop centers individuals receive core services, such as outreach, initial assessment of skills and needs, and job search and placement assistance. Through one-stop centers, eligible individuals also receive access to intensive services such as comprehensive assessments and development of individual employment plans, and to training services such as occupational skills training and on-the job training.

Anyone age 18 and older is eligible to receive core services. To be eligible to receive intensive services, an individual has to have received at least one core service, have been unable to obtain or retain employment through core services and need intensive services to obtain or retain employment. To be eligible to receive training services, an individual has to have received at least one intensive service, have been unable to obtain or retain employment through such services, have the skills and qualifications to successfully participate in select training programs that are directly linked to employment opportunities in the local area, and be unable to obtain other grant assistance, including Pell grants, or need assistance above the levels provided by such other grants.

As shown in Table 15-29 of WIA adult participants who received intensive or training services and exited the program during program year 2001,[79] 43 percent were white, 29 percent were black, and 22 percent were Hispanic. Seventy-three percent were low-income and 80 percent were unemployed at the time of entry in the program.

Among the 73 percent of low-income "exiters" who received intensive or training services, 44 percent received intensive services only and 56 percent received training services. Of the low-income exiters who received intensive or training services and were unemployed at entry, 72 percent entered employment in the first quarter after exit. Of all low-income exiters who received intensive or training services, the average earnings of those with earnings in the first quarter after exit was $3,649.[80]

Under WIA's youth program, youth, who are generally required to be low-income, receive services such as tutoring and study skills training, alternative high school services, and summer youth opportunities. Services to youth are provided through grants to providers made on a competitive basis. At least

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[78] Under WIA's adult and youth programs, funds are allocated to states by a statutory formula. States, in turn, allocate at least 85 percent of the funds to local workforce investment boards.

[79] Program year 2001 for WIA programs is July 1, 2001 through June 30, 2002.

[80] The information on entered employment and average earnings is for persons who exited the program from October 1, 2000 to September 30, 2001. Individuals who were reported as institutionalized or deceased at exit and those who had medical conditions that precluded continued participation in WIA or entry into employment are excluded from the percentages.

30 percent of the funds allocated to local areas have to be spent on activities for out-of-school youth.

TABLE 15-29--CHARACTERISTICS OF WIA ADULT EXITERS WHO RECEIVED INTENSIVE OR TRAINING SERVICES, PROGRAM YEAR 2001[1]

Selected Characteristics	Percent
Sex:	
Male	42
Female	58
Race/Ethnicity:	
Hispanic	22
Non-Hispanic white (only)	43
Black or African American (only)	29
Other	6
Age at enrollment:	
18-21	11
22-29	28
30-54	55
55 and older	6
Low income	73
Receiving TANF	11
Receiving public assistance (including TANF)	16
Unemployment Compensation claimant	14
Employed at registration:	
Employed	20
Not employed	80
Highest Grade Completed:	
Less than High School Graduate	20
High School Graduate/Equivalent	56
Post High School	24

[1] The number of exiters for fiscal year 2001 who received intensive or training services is 135,448.
Source: Program Year 2001 WIASRD Data Book, September 3, 2003. Social Policy Research Associates, prepared for U.S. Department of Labor.

As shown in Table 15-30, of WIA youth participants who exited the program during program year 2001, 28 percent were white, 33 percent were black, and 34 percent were Hispanic. Ninety-four percent were low-income.

In FY2003, an estimated $899 million is expected to be spent to serve 545,600 adults under WIA Adult Activities, and an estimated $994 million is expected to be spent to serve 445,800 youth under Youth Activities. Data on participation and budget authority for recent years are provided in Table 15-31.

Job Corps, authorized by Title I-C of WIA, serves low-income youth ages 16-24 who demonstrate both the need for and the ability to benefit from an intensive and wide array of training, career development, job placement, and support services in a residential setting. The program is administered by DOL through contracts with large and small corporations and nonprofit organizations for

the operation of 90 centers, and through interagency agreements with the U.S. Departments of Agriculture and the Interior for the operation of 28 additional centers on public lands.

TABLE 15-30--CHARACTERISTICS OF WIA YOUTH EXITERS, PROGRAM YEAR 2001

Selected Characteristics	Percent[1]
Sex:	
Male	47
Female	53
Race/Ethnicity:	
Hispanic	34
Non-Hispanic white (only)	28
Black or African American (only)	33
Other	5
Age at enrollment:	
14-15	33
16-17	37
18	13
19-21	18
Low income	94
Receiving TANF	13
Receiving public assistance (including TANF)	18
Unemployment Compensation claimant	1
Highest Grade Completed:	
Less than High School Graduate	86
High School Graduate/Equivalent	13
Post High School	1
Education Status at Registration:	
Attending High School or Below	69
Attending Post-Secondary School	2
High School Drop-out	17
High School Graduate/Equivalent	11
Average Weeks Participated	40
Total exiters	126,348

[1] Percent except average weeks participated, and total exiters. Percentages under headings may not add to one hundred due to round.

Source: Program Year 2001 WIASRD Data Book, September 3, 2003. Social Policy Research Associates, prepared for U.S. Department of Labor.

In program year 2001 (July 1, 2001-June 30, 2002), nearly 68,000 new students enrolled in Job Corps Centers, 60 percent of whom were male. In that same year, 47 percent of new students were African-American, 29 percent were white, 18 percent were Hispanic, 4 percent were American Indian, and 2 percent were Asian or Pacific Islanders. Seventy-seven percent of new students had dropped out of high school; the average grade level for reading at enrollment was

7.5. Twenty percent of new students in program year 2001 came from families on public assistance.

TABLE 15-31--WIA JOB TRAINING PROGRAMS FOR ADULTS AND YOUTH: NEW ENROLLEES, FEDERAL APPROPRIATIONS, AND OUTLAYS, FISCAL YEARS 1999-2003

[Appropriations and Outlays in millions of dollars]

Fiscal Year	Program	Participants	Appropriations	Outlays
1999	Adult	324,800	955	884
	Youth	120,000	130	181
2000	Adult	268,700	950	797
	Youth	307,200	1,001	431
2001	Adult	398,500	950	759
	Youth	375,500	1,128	723
2002	Adult	475,200	945	1,078
	Youth	396,500	1,128	1,072
2003 (est.)	Adult	545,600	899	968
	Youth	445,800	994	1,140

Source: Department of Labor, Employment and Training Administration, Office of Financial and Administrative Services.

Of all Job Corps members who left the program in program year 2001, 76 percent were placed in jobs, full-time advanced education or training, or the military. The average length of stay in Job Corps in program year 2001 was 7.6 months.

In FY2003, an estimated $1.5 billion is expected to be spent to serve 68,454 youth under the Job Corps. Data on participation and budget authority for recent years are provided in Table 15-32.

TABLE 15-32--JOB CORPS FEDERAL APPROPRIATIONS, OUTLAYS, AND NEW ENROLLEES, FISCAL YEARS, 1999-2003

[Appropriations and Outlays in millions of dollars]

Year	Appropriations	Outlays	New enrollees
1999	1,308	1,154	70,565
2000	1,358	1,253	71,487
2001	1,399	1,291	67,833
2002	1,454	1,467	64,043
2003 est.	1,513	1,550	68,454

Source: Department of Labor, Employment and Training Administration, Office of Job Corps.

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 peers from higher-income households. 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 2002, 912,345 children were served in Head Start Programs, at a total Federal cost of $6.5 billion. In May 2002, 21 percent of Head Start families received TANF benefits. Table 15-33 provides historical data on participation in and funding of the Head Start Program, while Table 15-34 provides characteristics of children enrolled in the program.

TABLE 15-33--HEAD START ENROLLMENT AND FEDERAL FUNDING, FISCAL YEARS 1965-2002

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

TABLE 15-33--HEAD START ENROLLMENT AND FEDERAL FUNDING, FISCAL YEARS 1965-2002-continued

Fiscal year	Enrollment	Appropriations (in millions of dollars)
1990	548,470	1,552.0[1]
1991	583,471	1,951.8
1992	621,078	2,201.8
1993	713,903	2,776.3
1994	740,493	3,325.7
1995	750,696	3,534.1
1996	752,077	3,569.3
1997	793,809	3,980.5
1998	822,316	4,347.4
1999	835,365	4,658.2
2000	857,664	5,266.2
2001	905,235	6,199.1
2002	912,345	6,536.6

[1] After sequestration.

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

LOW-INCOME HOME ENERGY ASSISTANCE PROGRAM (LIHEAP)

BACKGROUND

The Low-Income Home Energy Assistance program (LIHEAP) is a block grant program under which the Federal government gives annual grants to States, the District of Columbia, U.S. territories and Commonwealths, and Indian tribal organizations in order to operate home energy assistance programs for low-income households. Originally established in 1981 by Title XXVI of Public Law 97-35, the program has been reauthorized and amended several times, most recently in 1998, when Public Law 105-185 reauthorized LIHEAP through FY2004. The statute authorizes appropriations for both regular LIHEAP grants and for contingency funds. This program is operated out of the Division of Energy Assistance in the Office of Community Services, Administration for Children and Families, within the Department of Health and Human Services (HHS).

Regular funds are allocated to States according to a three-tier formula prescribed in the LIHEAP statute as amended by the Human Services Reauthorization Act (HSRA) of 1984 (Public Law 98-558). The particular tier used for the allocations is determined by the size of the appropriation for that fiscal year. For funding levels below $1.975 billion a Tier I rate, determined in 1981, is applied. For allocations from $1.975 up to $2.25 billion a new Tier II rate is applied. At the Tier II rate, States are subject to a hold-harmless level where their new Tier II allocation must be at least as great as the allocation the State received in 1984. Those States with the greatest percentage increase in their allocations and which are not at a hold-harmless level must have their allocations ratably reduced

TABLE 15-34--CHARACTERISTICS OF CHILDREN ENROLLED IN HEAD START, SELECTED FISCAL YEARS 1980-2002

Fiscal Year	Disabled	Age of Children Enrolled				Enrollment by Race				
		5 and older	4	3	Under 3	Native American	Hispanic	Black	White	Asian
1980	12	21	55	24	0	4	19	42	34	1
1982	12	17	55	26	2	4	20	42	33	1
1984	12	16	56	26	2	4	20	42	33	1
1986	12	15	58	25	2	4	21	40	32	3
1988	13	11	63	23	3	4	22	39	32	3
1990	14	8	64	25	3	4	22	38	33	3
1991	13	7	63	27	3	4	22	38	33	3
1992	13	7	63	27	3	4	23	37	33	3
1993	13	6	64	27	3	4	24	36	33	3
1994	13	7	62	28	3	4	24	36	33	3
1995	13	7	62	27	4	4	25	35	33	3
1996	13	6	62	29	4	4	25	36	32	3
1997	13	5	60	30	4	4	26	36	31	3
1998	13	6	59	31	4	3	26	36	32	3
1999	13	5	58	33	4	3	27	35	31	3
2000	13	5	56	33	6	3	29	35	30	3
2001	13	4	54	35	7	4	30	34	30	2
2002	13	5	52	36	7	3	30	33	28	3

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

until the hold-harmless provision for States below that level is met. The Tier II formula is required by law to account for variations in heating and cooling needs of the States, variations in types of energy used, variations in energy prices, and variations in the low-income population and their heating and cooling methods, while using the most current data available.

For funding levels at or above $2.25 billion a Tier III rate is applied. The Tier III rate uses the Tier II methodology but there are additional requirements for distributing funds. States that would have received less than 1 percent of a total $2.25 billion allocation must be allocated funds using the rate they would have experienced at a hypothetical $2.14 billion allocation (if this rate is greater than the calculated rate at $2.25 billion). In both the Tier II and Tier III rates, a State will not be allocated fewer funds than the State received in 1984. However, the proportion of total regular funds each State receives may differ substantially from the proportion received in 1984.

For FY2003 the LIHEAP appropriation was $1.7 billion with an additional $100 million transferred from the FY2001 Supplemental Appropriations. The total of $1.8 billion was then subject to a 0.65 percent rescission, resulting in an allocation for regular LIHEAP funds in FY2003 of $1,788,300,000.

Contingency funds are released and allocated at the discretion of the President and the Secretary of HHS and can be done at any point in the fiscal year. In FY2003, $200 million in supplemental contingency funds were released to States in January. All States in FY2003 received a proportion of these contingency funds, which were primarily allocated in the same manner as regular LIHEAP funds.

Table 15-35 displays LIHEAP allocations by State (including tribal organizations but excluding U.S. territories). As noted in the table's footnotes, the funding allotments include LIHEAP contingency funds released in a given fiscal year.

FEDERAL REQUIREMENTS FOR THE ALLOTMENTS

Decisions regarding LIHEAP are made by the States under broad Federal rules. Federal rules allow States to use LIHEAP funds for the following activities: aid in paying heating or cooling bills; low-cost weatherization projects (limited to 15 percent of allotment unless the grantee has a waiver for up to 25 percent); services to reduce the need for energy assistance (limited to 5 percent of allotment); assistance with energy-related emergencies (with a reasonable amount reserved, based on prior years' data, until March 15 of each program year); and development or implementation of a leveraging incentive program that may be used by grantees to attract funds from non-Federal sources. Up to 10 percent of LIHEAP funds may be used for administrative and planning costs. Federal rules also allow carryover of up to 10 percent funds into the next fiscal year.

States decide the mix and dollar range of benefits, choose how benefits are provided, and decide which agencies will administer the program. When paying home energy suppliers directly, States are required to give HHS 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 LIHEAP funds to provide tax credits to energy suppliers that supply home energy to low-income households at reduced rates. Tables 15-36 and 15-37 present estimates by State for FY2001 of total dollars spent on heating, cooling, emergency, and weatherization assistance as well as the number of households receiving benefits and average benefits (as of Fall 2003, these are the latest data available).

TABLE 15-35--LOW-INCOME HOME ENERGY ASSISTANCE PROGRAM STATE ALLOTMENTS, FISCAL YEARS 1999-2003

[In thousands of dollars]

State	1999[1]	2000[2]	2001[3]	2002[4]	2003[5]
Alabama	$9,225	$11,040	$15,475	$14,362	$16,214
Alaska	5,888	9,177	9,912	9,168	11,168
Arizona	4,461	4,807	7,291	8,768	7,816
Arkansas	7,039	7,681	11,829	10,959	12,333
California	49,489	53,320	84,164	77,049	86,715
Colorado	17,255	18,591	29,545	28,861	30,240
Connecticut	25,633	34,424	38,737	36,651	43,809
Delaware	3,682	5,388	5,098	5,006	5,766
District of Columbia	4,581	3,883	5,935	5,742	6,269
Florida	14,596	16,892	22,841	22,725	25,871
Georgia	11,541	13,698	19,494	17,968	20,315
Hawaii	1,162	1,252	1,755	1,809	2,036
Idaho	6,731	7,264	10,785	11,372	12,035
Illinois	78,262	67,127	107,759	105,174	109,621
Indiana	35,353	30,393	48,219	47,632	50,205
Iowa	23,491	22,033	34,463	32,245	35,516
Kansas	12,488	9,892	15,880	15,304	16,090
Kentucky	22,430	16,345	24,160	26,052	26,076
Louisiana	9,431	10,161	15,794	14,683	16,531
Maine	15,365	32,377	24,716	22,704	29,684
Maryland	20,812	23,359	29,262	28,414	32,063
Massachusetts	52,790	71,712	77,358	74,300	86,090
Michigan	63,103	63,731	102,991	99,822	105,368
Minnesota	45,696	47,461	72,968	68,606	77,485
Mississippi	7,909	9,649	13,313	12,313	13,868
Missouri	32,524	27,196	42,252	41,055	43,753
Montana	7,895	8,506	13,198	12,879	13,967
Nebraska	12,022	10,711	17,072	16,794	17,439
Nevada	2,095	2,258	3,418	4,575	3,698
New Hampshire	9,297	17,629	14,544	13,269	16,923
New Jersey	50,855	67,290	72,660	69,879	78,880
New Mexico	5,585	6,018	9,563	8,696	9,787
New York	164,971	209,880	236,852	228,349	260,507
North Carolina	47,176	29,038	33,535	35,753	38,071
North Dakota	8,576	9,715	14,411	13,823	15,633
Ohio	63,606	59,384	94,532	94,545	98,149
Oklahoma	8,480	9,136	14,445	13,202	14,852
Oregon	13,373	14,409	21,082	22,458	23,960
Pennsylvania	86,271	106,313	126,165	121,386	136,651

TABLE 15-35--LOW-INCOME HOME ENERGY ASSISTANCE PROGRAM STATE ALLOTMENTS, FISCAL YEARS 1999-2003-continued

[In thousands of dollars]

State	1999[1]	2000[2]	2001[3]	2002[4]	2003[5]
Rhode Island	9,133	13,420	12,883	12,328	14,202
South Carolina	7,326	10,182	12,100	13,347	13,378
South Dakota	6,965	8,291	11,805	11,404	12,622
Tennessee	14,871	16,022	23,786	23,152	26,385
Texas	24,284	26,163	40,597	37,807	42,543
Utah	8,018	8,639	13,822	13,438	14,105
Vermont	6,863	10,228	10,809	9,946	12,601
Virginia	28,635	28,742	34,492	35,827	39,070
Washington	21,997	23,700	34,423	34,248	39,250
West Virginia	12,607	10,496	16,129	16,336	17,355
Wisconsin	42,851	42,153	65,903	62,426	69,545
Wyoming	3,210	3,459	5,460	5,326	5,629
U.S. total	1,247,899	1,370,633	1,825,683	1,769,935	1,958,134

[1] Includes reallotment of $2,204,442 in fiscal year 1998 block grant funds and $175,298,765 in emergency contingency funds.

[2] Includes $744,350,000 in emergency contingency funds, including $400 million in FY2000 contingency funds released in late September 2000, making it effectively available to States in FY2001.

[3] Includes $455,650,000 in emergency contingency funds.

[4] Includes $100,000,000 in emergency contingency funds.

[5] Includes $200,000,000 in emergency contingency funds. The final FY2003 appropriations included $1.688 billion in new regular funds and converted $100 million of the contingency funds originally appropriated in FY2001 into regular funds.

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

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

TABLE 15-36--LOW-INCOME HOME ENERGY ASSISTANCE PROGRAM ESTIMATED HEATING AND COOLING ASSISTANCE AND AVERAGE BENEFITS, FISCAL YEAR 2001[1]

State	Heating assistance			Cooling assistance		
	Assisted Households	Amount of Assistance	Average Household Benefit	Assisted Households	Amount of Assistance	Average Household Benefit
Alabama	53,209	$6,952,037	$130	20,375	$2,380,428	$116
Alaska	7,549	8,704,243	1,149	0	0	0
Arizona	17,222	4,982,615	289	0	0	0
Arkansas	53,288	6,164,464	116	0	0	0
California	134,236	31,063,739	266	0	0	0
Colorado	76,470	43,836,549	573	0	0	0
Connecticut	78,976	37,545,257	475	0	0	0
Delaware	10,985	3,194,550	239	4,266	1,050,000	224
District of Columbia	18,879	6,918,699	366	0	0	0
Florida	20,215	2,117,897	105	38,755	3,960,450	102
Georgia	130,120	17,313,858	132	12,568	2,515,840	200
Hawaii	5,937	1,509,047	257	0	0	0
Idaho	30,997	6,394,427	229	0	0	0
Illinois	181,201	119,427,603	501	0	0	0

TABLE 15-36--LOW-INCOME HOME ENERGY ASSISTANCE PROGRAM ESTIMATED HEATING AND COOLING ASSISTANCE AND AVERAGE BENEFITS, FISCAL YEAR 2001[1]-continued

State	Heating assistance			Cooling assistance		
	Assisted Households	Amount of Assistance	Average Household Benefit	Assisted Households	Amount of Assistance	Average Household Benefit
Indiana	128,608	37,812,921	294	24,799	954,013	38
Iowa	83,728	43,775,132	523	0	0	0
Kansas	28,027	10,140,405	467	0	0	0
Kentucky	154,147	14,489,026	108	0	0	0
Louisiana	1,738	2,351,796	210	26,649	7,055,390	140
Maine	52,421	20,580,155	438	0	0	0
Maryland	76,424	34,559,038	471	0	0	0
Massachusetts	133,355	78,755,827	652	0	0	0
Michigan	302,582	75,869,231	251	0	0	0
Minnesota	110,341	58,851,989	562	0	0	0
Mississippi	57,617	8,523,334	150	22,186	2,272,889	152
Missouri	110,133	26,390,001	240	0	0	0
Montana	16,769	7,994,730	475	0	0	0
Nebraska	29,646	5,421,890	183	5,482	592,096	91
Nevada	9,025	2,797,917	296	4,884	1,106,759	296
New Hampshire	27,276	15,047,793	594	0	0	0
New Jersey	121,419	64,413,570	339	27,447	2,747,000	100
New Mexico	44,502	10,219,960	250	0	0	0
New York	697,465	107,401,024	154	0	0	0
North Carolina	150,445	11,843,457	70	0	0	0
North Dakota	15,442	8,121,985	653	337	0	--
Ohio	245,305	46,510,148	196	0	0	0
Oklahoma	60,383	19,189,305	318	14,025	2,088,735	149
Oregon	73,043	16,135,232	220	0	0	0
Pennsylvania	300,462	76,639,340	255	0	0	0
Rhode Island	24,606	9,353,098	380	0	0	0
South Carolina	50,589	4,997,258	110	0	0	0
South Dakota	15,159	9,030,294	640	0	0	0
Tennessee	60,206	13,760,997	246	6,107	1,189,292	203
Texas	8,734	5,069,161	459	14,443	21,767,574	1,428
Utah	31,233	12,329,322	391	0	0	0
Vermont	18,483	13,189,281	805	0	0	0
Virginia	84,237	25,624,956	288	15,763	3,244,192	213
Washington	66,741	26,997,172	385	0	0	0
West Virginia	45,332	9,061,501	200	11,762	1,810,692	150
Wisconsin	115,881	68,479,467	470	0	0	0
Wyoming	9,587	4,600,308	422	0	0	0
Total[2]	4,380,375	1,302,453,006	297	249,848	54,735,350	219

[1] States provide all estimates in all categories. As a result the average household benefit is not the calculated average but rather the State estimated rate.

[2] Includes leveraging incentive funds.

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

ELIGIBILITY STANDARDS

Federal law limits eligibility to households with incomes up to 150 percent of the Federal poverty income guidelines (or, if higher, 60 percent of the State median income). States may adopt lower income limits, but these limits may not be less than 110 percent of the poverty guidelines. 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 may choose to make eligible for LIHEAP assistance any household where at least one member is a recipient of Temporary Assistance for Needy Families (TANF), Supplemental Security Income (SSI), Food Stamps, or certain needs-tested veterans' programs.

Within these limits, States decide which, if any, types of assistance to provide, what income limits to use, and whether to impose other eligibility tests. However, Federal law gives priority for aid to households with the greatest energy needs or cost burdens, especially those households that include disabled or elderly individuals or young children. Federal rules require States to treat owners and renters "equitably," to adjust benefits for household income and home energy costs, and to have a system of "crisis intervention" assistance for those in immediate need. LIHEAP assistance does not reduce eligibility or benefits under other Federal aid programs targeted to low-income individuals and families. Federal rules also require outreach activities, coordination with the Department of Energy's weatherization program, annual audits and appropriate fiscal controls, and fair hearings for those aggrieved.

PLANNING AND ADMINISTRATION

States are required to submit an application for funds to the Secretary of HHS. As part of the application, the chief executive officer of the State (Indian tribe, or territory), or a designee, is required to make several assurances related to eligibility requirements, anticipated use of funds, as well as satisfy planning and administrative requirements.

States must provide for public participation and public hearings in the development of the State plan, including making the plan, and any substantial revisions, available for public inspection and allowing public comments. 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 cases, requiring States to conduct an annual audit for all Federal financial assistance received.

TABLE 15-37--LOW-INCOME HOME ENERGY ASSISTANCE PROGRAM ESTIMATED CRISIS AND WEATHERIZATION ASSISTANCE AND ESTIMATED AVERAGE BENEFITS, FISCAL YEAR 2001[1]

State	Winter year round crisis assistance			Summer crisis assistance			Weatherization Assistance[2]	
	Assisted Households	Amount of Assistance	Average Household Benefit	Assisted Households	Amount of Assistance	Average Household Benefit	Assisted Households	Amount of Assistance
Alabama	16,577	$3,335,856	$195	18,776	$2,647,770	$145	611	$930,649
Alaska	417	284,208	682	0	0	0	617	4,030,139
Arizona	4,750	1,405,352	296	0	0	0	556	1,514,440
Arkansas	24,302	3,999,583	165	0	0	0	647	2,147,702
California	57,727	22,205,019	302	0	0	0	18,781	19,684,960
Colorado	2,119	920,826	612	0	0	0	1,826	3,346,308
Connecticut	21,465	6,814,489	175	0	0	0	0	0
Delaware	3,080	616,000	200	0	0	0	343	630,000
District of Columbia	5,798	1,000,000	172	0	0	0	298	873,469
Florida	44,614	11,554,923	259	23,212	4,442,521	191	1,041	3,337,938
Georgia	0	0	0	0	0	0	924	2,000,737
Hawaii	0	0	0	704	66,046	94	0	0
Idaho	2,688	1,039,661	257	0	0	0	1,370	2,642,951
Illinois	10,067	9,103,020	449	0	0	0	1,368	16,089,906
Indiana	29,000	3,406,949	117	0	0	0	1,406	8,215,392
Iowa	1,949	1,232,826	276	0	0	0	1,391	2,693,869
Kansas	6,823	2,535,101	467	0	0	0	785	1,851,953
Kentucky	70,642	7,583,593	100	0	0	0	822	4,023,650
Louisiana	20,769	3,044,242	340	0	0	0	319	1,920,157
Maine	3,587	1,249,816	250	0	0	0	1,822	4,710,451
Maryland	1,695	0	0	0	0	0	0	0
Massachusetts	12,743	8,557,446	681	0	0	0	10,530	4,000,000

TABLE 15-37--LOW-INCOME HOME ENERGY ASSISTANCE PROGRAM ESTIMATED CRISIS AND WEATHERIZATION ASSISTANCE AND ESTIMATED AVERAGE BENEFITS, FISCAL YEAR 2001[1]-continued

State	Winter year round crisis assistance			Summer crisis assistance			Weatherization Assistance[2]	
	Assisted Households	Amount of Assistance	Average Household Benefit	Assisted Households	Amount of Assistance	Average Household Benefit	Assisted Households	Amount of Assistance
Michigan	60,867	22,431,839	369	0	0	0	2,808	12,152,377
Minnesota	33,504	17,238,371	352	0	0	0	564	2,373,319
Mississippi	2,712	454,578	172	1,717	113,643	80	0	0
Missouri	67,959	22,931,225	338	0	0	0	0	0
Montana	1,137	269,277	250	0	0	0	752	3,239,773
Nebraska	36,358	10,654,121	160	0	0	0	509	2,276,657
Nevada	0	0	0	6	987	165	0	0
New Hampshire	3,841	0	0	0	0	0	409	850,000
New Jersey	10,915	11,831,000	311	0	0	0	1,038	3,246,000
New Mexico	2,454	1,545,320	250	0	0	0	402	0
New York	159,390	113,242,106	352	0	0	0	9,320	42,582,158
North Carolina	115,338	14,840,753	300	0	0	0	1,729	3,936,704
North Dakota	1,766	1,598,719	735	0	0	0	1,123	2,090,888
Ohio	122,491	41,112,591	192	42,380	9,061,289	170	5,363	9,453,229
Oklahoma	22,928	5,942,372	259	0	0	0	316	896,953
Oregon	7,222	1,473,758	204	0	0	0	2,438	4,244,195
Pennsylvania	124,991	62,900,000	507	0	0	0	6,251	16,851,279
Rhode Island	22,585	2,825,114	125	0	0	0	624	1,927,041
South Carolina	13,194	6,990,066	320	0	0	0	736	1,674,599
South Dakota	487	600,000	200	0	0	0	569	1,770,630
Tennessee	20,867	5,033,750	250	0	0	0	2,179	1,903,012
Texas	98,941	2,981,859	30	0	0	0	3,460	10,463,872

Utah	1,378	603,850	276	0	0	0	502	2,489,028
Vermont	5,225	1,540,167	159	0	0	0	1,078	0
Virginia	9,920	2,708,018	317	0	0	0	2,376	5,644,346
Washington	27,627	1,206,754	438	0	0	0	3,094	5,717,502
West Virginia	14,102	3,458,788	245	0	0	0	1,069	2,618,526
Wisconsin	24,737	11,203,318	319	0	0	0	3,074	9,785,486
Wyoming	1,812	442,230	260	0	0	0	207	1,364,975
Total[3]	1,355,560	457,948,854	338	86,795	16,332,256	188	97,447	234,197,220

[1] States provide all estimates in all categories. As a result the average household benefit is not the calculated average but rather the State estimated rate.

[2] States are not required to estimate average benefits for weatherization assistance.

[3] Includes leveraging incentive funds.

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

Section 607(a) of Public Law 98-558 directs HHS 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.

AVAILABLE SOURCES OF FUNDS

Several sources of Federal and non-Federal funds are available for State LIHEAP programs:

- 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 (established by Public Law 101-501 to reward States that have acquired non-Federal home energy resources for low-income households);
- Residential Energy Assistance Challenge (REACH) grants which award funds to demonstration projects to increase energy efficiency and reduce the vulnerability of low-income households (REACH grants receive 25 percent of the LIHEAP leveraging incentive allocation);
- LIHEAP carryover (States can request that up to 10 percent of their Federal LIHEAP funds be carried over for use in the next fiscal year);
- Oil overcharge funds (disbursed by the Department of Energy from settlements related to 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 may use their own funds to supplement LIHEAP benefits or administrative costs. Other funds include reimbursements to LIHEAP agencies for taking applications for low-income weatherization programs or winter heating protection programs.)

PERFORMANCE MEASUREMENT

The LIHEAP statute provides that Federal LIHEAP funds should serve low-income households that pay high home energy costs relative to income and that have very young, disabled, or elderly individuals. HHS has developed performance goals and measures to enable it to quantify State performance. The performance goals are to increase the percentage of LIHEAP recipient households having: a household member 5 years old or younger; a household member at least 60 years old; and the lowest income households with the highest energy costs. Achievement of these goals will be measured using specially developed benefit-targeting and burden-targeting indexes. The agency intends to measure performance using a FY2001 baseline. The data collected are intended to help States improve program outreach and management, and to assist HHS in determining how best to offer technical assistance to States.

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 2002, Federal appropriations for veterans benefits and services were nearly $53 billion (Table 15-38).

Service-connected compensation is paid to veterans who have disabilities from injuries and illnesses traceable to a period of active-duty military service. The amounts of monthly payments are determined by disability ratings that are based on presumed average reductions in earning capacities caused by the disabilities. Disability ratings generally range from 10 percent to 100 percent in 10-percent intervals; however, some disabilities are determined to be service-connected, but are given a zero-percent rating. Death compensation, or dependency and indemnity compensation, is paid to surviving dependents of veterans who died as a result of service-connected causes. In fiscal year 2002, about 2.4 million disabled veterans and 308,000 survivors received about $22 billion in compensation payments.

Veterans pensions are means-tested cash benefits paid to war veterans who have become permanently and totally disabled from non-service-connected causes, and to survivors of such disabled and impoverished war veterans. Under the current or "improved law" program, benefits are based on family size, and the pensions provide a floor of income. For 2002, the basic benefit before subtracting other income sources is $12,516 for a veteran with one dependent, $9,556 for a veteran living alone. Somewhat less generous benefits are available to survivors; a surviving spouse with no children could receive two-thirds ($6,497) of the basic benefit amount given a single veteran. About 581,000 persons received about $3.1 billion in veterans pension payments in fiscal year 2002.

Several VA programs support readjustment, education, and job training for veterans and military personnel who meet certain eligibility criteria. The largest of these programs was the Montgomery GI bill (MGIB). The MGIB provides educational assistance to persons, who as members of the Armed Forces or the Selected Reserve, elect to participate in the program after June 30, 1985. The purposes of the MGIB are to assist service members leaving the Armed Forces in their readjustment into civilian life, to provide an incentive for the recruitment and retention of qualified personnel in the Armed Forces, and to develop a more educated and productive work force. To participate in the MGIB, active duty military personnel contribute $100 per month, for the first 12 months of enlistment. Benefit levels are contingent upon length of service. To receive the maximum benefit of $800 per month for 36 months, service members must generally serve continuously for 3 years. Those who enlist and serve for less than three years will receive $650 a month.

TABLE 15-38--BUDGET AUTHORITY FOR VETERANS BENEFITS AND SERVICES, DEPARTMENT OF VETERANS AFFAIRS, FISCAL YEARS 1980-2002

[In Millions of Dollars]

Fiscal Year	Service connected compensation and survivor payments; means tested options	Education, training, readjustment	Medical care	Housing loans[1]	Other benefits and services	Total veterans benefits and services
1980	$11,770	$2,374	$6,409	NA	$641	$21,194
1981	13,210	2,351	6,919	NA	671	23,150
1982	14,510	1,964	7,802	NA	687	24,963
1983	14,216	1,667	8,816	-$78	721	25,341
1984	14,884	1,582	9,078	201	751	26,496
1985	15,089	1,066	10,005	306	789	27,256
1986	15,363	605	9,964	200	757	26,888
1987	15,392	393	10,481	100	824	27,190
1988	15,848	395	10,836	1,484	817	29,380
1989	16,384	335	11,523	778	871	29,891
1990	16,660	251	12,168	548	897	30,524
1991	17,790	824	13,194	730	1,013	33,251
1992	17,412	600	14,256	815	1,020	34,103
1993	18,123	675	15,235	1,181	993	36,208
1994	18,597	1,031	16,187	188	1,006	37,009
1995	18,824	1,090	16,555	612	1,078	38,159
1996	19,703	1,013	16,812	612	1,023	38,763
1997	20,660	1,178	17,375	-291	1,014	39,936
1998	21,517	1,168	17,959	1,145	1,003	42,792
1999	22,934	989	18,032	1,087	1,115	44,157
2000	21,568	1,469	19,871	1,791	1,625	46,324
2001	23,356	1,981	21,362	498	1,801	48,998
2002	24,944	2,135	22,799	921	2,087	52,886

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

NA-Not available.

Source: Office of the President (2003).

The VA also provides vocational rehabilitation to disabled veterans. In fiscal year 2002, spending for VA readjustment programs was more than $2 billion (Table 15-38). In addition, the Department of Labor also provides employment counseling and job training for veterans.

The VA provides a comprehensive array of inpatient and outpatient medical services through 172 medical centers, 137 nursing homes, 43 domiciliaries, 684 outpatient clinics, and 206 readjustment counseling centers (Vet centers). Public Law 104-262 reformed eligibility rules for VA medical services. These reforms not only simplified the rules, but give the VA greater flexibility in how it provides medical care to veterans. Past eligibility rules were seen as emphasizing inpatient over outpatient care and, thus, impeded the efficient use of VA medical resources. Under the new eligibility rules, the VA provides free medical care, both inpatient and outpatient, to veterans for service-connected conditions and to low-income veterans for nonservice-connected conditions. For

2002, veterans with an income of $29,168 or less and married or with one dependent (plus $1,630 for each additional dependent) or $24,304 or less if single would meet the low-income criterion for free medical care. As facilities and other resources permit, the VA provides care to veterans for nonservice-connected conditions with incomes that exceed these limits; however, copayments are required. Again, as facilities and other resources permit, the VA provides nursing home care to veterans, with priority going to those with service-connected disabilities. The VA also contracts with private facilities and/or medical providers when it is determined to be in the interests of the veteran and cost effective for the VA. VA-operated nursing home care is augmented by VA-supported care through contracts with private community nursing homes and with per diem payments for veterans in State-run homes for veterans.

In fiscal year 2002, VA medical treatment programs cost $23 billion (Table 15-38). VA medical services were provided to about 4.8 million separate applicants, resulting in about 732,000 inpatient episodes and 47 million outpatient visits (Table 15-39).

WORKERS' COMPENSATION

OVERVIEW

Since 1911, every State has adopted a workers' compensation law, but there are no national standards for this system. Before the passage of these laws, compensation for work-related injury or death was the exception rather than the rule, as employees had to sue their employers for negligence, and this could be difficult to prove. The goal of workers' compensation programs is to provide prompt, adequate benefits to injured workers' while at the same time limiting employers' liabilities. Workers' compensation has become a substantial component of the U.S. social insurance system and a significant element of the overall cost of employment (See Table 15-40.) With this system employers can expect more predictable costs than under the law of negligence, while employees are spared lengthy and uncertain litigation. (While the elimination of lawsuits was fairly well achieved at first, significant amounts of litigation have re-emerged in recent years.) Another purported benefit is that employers have a tangible incentive to improve workplace safety.

Although workers' compensation laws differ from State to State, they tend to have common features based on the same overall principles:

- Victims of work-related injuries are entitled to receive prompt reasonable compensation for injury, and in case of death dependents receive income and burial benefits. However, employees and survivors are barred from suing the employers except under unusual circumstances or if the employer does not pay compensation. Negligence and fault are largely immaterial and do not affect the worker's right of recovery.
- Employers pay all costs, either directly or through insurance. A variety of public and private sector insurance mechanisms are used

(see Table 15-41), with larger employers tending to "self-insure," which means to bear the financial risks themselves.

TABLE 15-39--NUMBER OF RECIPIENTS OF VETERANS BENEFITS AND SERVICES, FISCAL YEARS 1980-2002

[In Thousands]

Fiscal Year	Compensation and pensions	Readjustment, education, job training	Medical Care		Housing Loans
			Inpatient[1]	Outpatient[2]	
1980	4,646	1,233	1,359	17,930	297
1981	4,535	1,081	1,360	17,809	188
1982	4,407	906	1,358	18,510	103
1983	4,286	755	1,401	18,616	245
1984	4,123	629	1,412	19,601	252
1985	4,005	492	1,435	20,188	179
1986	3,900	419	1,462	21,635	314
1987	3,850	365	1,466	21,635	479
1988	3,762	352	1,224	23,233	235
1989	3,686	349	1,153	22,629	190
1990	3,614	360	1,113	22,600	196
1991	3,546	322	1,072	23,007	181
1992	3,462	388	988	23,902	266
1993	3,397	438	974	24,236	383
1994	3,351	472	963	25,443	602
1995	3,332	476	930	27,565	263
1996	3,315	475	850	30,055	292
1997	3,290	480	700	32,648	239
1998	3,270	479	632	35,777	369
1999	3,254	458	752	37,799	396
2000	3,260	448	718	39,266	176
2001	3,220	471	729	43,808	253
2002	3,253	520	732	46,970	295

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

[2] Visits for outpatient care.

Source: Department of Veterans Affairs.

TABLE 15-40--FINANCIAL DIMENSIONS OF WORKERS' COMPENSATION

Benefits paid (in billions of dollars)	1990	1995	2000
Wage replacement	21.7	25.7	25.0
Medical	15.1	16.6	19.9
Employer cost per worker ($)	503	506	442
Employer cost as a % of total wages	2.13	1.83	1.25

Source: Mont et al. (2002)

TABLE 15-41--BENEFIT PAYMENTS BY INSURANCE ARRANGEMENT
[As Percent of Total Payments]

	1990	1995	2000
By insurance companies[1]			
Private Sector	58.1	41.7	48.3
State-run	15.4	17.5	15.0
Federal Programs[2]	7.6	7.2	6.6
Self-insured (including insurance deductibles)	19.0	33.7	30.1

[1] Excluding deductibles.
[2] Federal employees, longshore and harbor workers, black lung program.
Source: Mont et al. (2002).

- Cases are handled in the first instance by the employing firm or its insurer. A State government appeals mechanism is available to resolve disputed claims with relatively little complexity or delay. Fees to lawyers and witnesses are minimized and costs of litigation are reduced or reimbursable to workers' regardless of the outcome.
- There is no provision for "pain and suffering" or other non-economic damages, or for punitive damages. The purpose of the system is to make the worker economically whole (or nearly so), not to implement a wider conception of justice.
- Cash compensation is based on lost earnings or earning capacity. Typically, the benefit for total disability is two-thirds of lost earnings, paid for the term of the disability or a maximum allowable period. Benefits are not subject to Federal income tax. Injury-related medical costs are to be fully covered, although the majority of States have established some cost controls (e.g., fee schedules, utilization reviews), and a number of States limit employees' choice of physician.
- The States also have put into place mechanisms to facilitate and encourage the worker's return to the labor market through vocational rehabilitation, in order to minimize losses to both workers and employers. Moreover, the payment of less than 100 percent of normal earnings could be interpreted as a return-to-work incentive.
- State compensation laws also have established special funds and provisions to compensate special situations, such as aggravation of injuries from previous jobs.

BENEFITS

Workers' compensation provides two kinds of benefits, income replacement and medical care. The income benefit for total disability is set at a specified fraction of the worker's usual earnings for as long as he or she is unable to return to work. Partial disability is compensated proportionately to total disability

according to the estimated fraction of earning capacity that has been lost.[81] The replacement rate even for total disability is less than 100 percent for two reasons. First, the benefit is not subject to Federal (and usually not to State) income tax, and second, the decrease in income discourages fraudulent claims and gives an incentive to claimants to return to work as soon as possible. Table 15-42 indicates the variations in benefit formulas by State for permanent total disability.[82] In order to provide a "basic" level of income support and to limit program costs, benefits are subject to various maximums and minimums, which are defined in State law in terms of the State average weekly wage (SAWW). As shown in the table, maximums range from $1069 (Iowa) to $323 (Mississippi). The variations result both from differences in the SAWW and from differences in the percentage limitation - with maximums varying from 200 percent of SAWW (Iowa) to nearly 67 percent (California, Delaware and Mississippi).

There are no direct cost-of-living increases in benefits. However, for those whose benefit is determined by the maximum or minimum, their benefit would change as those benchmarks change in step with the SAWW. Benefits may be reduced ("offset") to reflect income support from other sources, such as Social Security or private pension plans, under provisions varying greatly from State to State. (The table notes only those States that end benefits completely at a presumed retirement age.)

In cases of death, benefits are paid in similar fashion - as a percentage of previous earnings - but with various time limits. The limit can be a specific time period, such as 10 years, but more often the benefit continues until the spouse remarries (or reaches a specified age) and the youngest child reaches age 18. No payment is due if there are no immediate "dependents" as defined by State law. These provisions are in keeping with the philosophy of workers' compensation as a practical method of maintaining the worker's role as breadwinner, rather than a liability-based system of distributive justice.

The medical benefit in principle is straightforward: whatever care is necessary to heal the work-related injury. In practice many disputes arise. The principal points of contention include such questions as: Was the injury work-related? Did it aggravate a previously existing condition? What treatments are medically necessary? How much should providers be reimbursed? Who chooses the providers? Such questions have been extensively litigated, and the answer in each case will depend on the particulars of the situation and the development of case law in each State. By statute, the States have established procedures for physician selection and for resolving disputes, and mandated various programs of vocational rehabilitation. Cost containment mechanisms also have been adapted from innovations in the health insurance arena. However, the workers'

[81] Certain particular injuries, such as loss of a limb, are compensated according to a special formula rather than by estimating lost earning capacity.

[82] This information is simplified. Reference should be made to State law and regulation for precise terms.

compensation medical system remains separate from health insurance, even from the insurance plan of the same employer, and is governed by its own body of law. Cases of occupationally caused disease, as opposed to traumatic injury, present special problems because causation may be difficult to prove. Symptoms may not develop until long after exposure, exposure that may itself have occurred over a long period of low doses of a harmful substance or stress. Moreover, the resulting illness may be indistinguishable from illness that could have other, non-work causes, e.g., lung cancer or on-the-job heart attack. Early workers' compensation laws dealt with these ambiguities restrictively, some by disqualifying all illnesses (as opposed to injury), some by excluding "diseases of ordinary life," some by enumerating specific diseases as "occupational." Since 1970 the States have made all illnesses compensable, at least in principle, though some distinctions still are made, such as a lower level of payments for illness.

TABLE 15-42--MAXIMUM BENEFITS FOR PERMANENT TOTAL DISABILITY, JANUARY 2002

State	Cap Based on Percent of Worker's Earnings	Cap Based on Percent of SAWW	
		Percent	Amount[1]
Alabama	66.67	100	$549
Alaska	80% of spendable earnings	120	762
Arizona	66.67	NA	374
Arkansas	66.67	85	425
California	66.67	66.67	490
Colorado	66.67	91	646
Connecticut	75% of spendable earnings	100	887
Delaware	66.67	66.67	469
District of Columbia	66.67	100	993
Florida	66.67	100	594
Georgia	66.67	NA	400
Hawaii	66.67	100	564
Idaho	67	90	473
Illinois	66.67	133.33	972
Indiana	66.67	NA	508
Iowa	80% spendable earnings	200	1,069
Kansas	66.67	75	417
Kentucky	66.67	100	551
Louisiana	66.67	75	398
Maine	80% spendable earnings	90	472
Maryland	66.67	100	668
Massachusetts	66.67	100	891
Michigan	80% spendable earnings	90	644
Minnesota	66.67	NA	750
Mississippi	66.67	66.67	323
Missouri	66.67	105	629
Montana	66.67	100	454
Nebraska	66.67	100	528
Nevada	66.67	100	581
New Hampshire	60	150	998
New Jersey	70	75	629

TABLE 15-42--MAXIMUM BENEFITS FOR PERMANENT TOTAL DISABLIITY, JANUARY 2002-continued

State	Cap Based on Percent of Worker's Earnings	Cap Based on Percent of SAWW	
		Percent	Amount[1]
New Mexico	66.67	100	517
New York	66.67	NA	400
North Carolina	66.67	110	654
North Dakota	66.67	110	516
Ohio	66.67	100	628
Oklahoma	70	100	473
Oregon	66.67	100	645
Pennsylvania	66.67	100	662
Rhode Island	75% of spendable earnings	110	682
South Carolina	66.67	100	549
South Dakota	66.67	100	468
Tennessee	66.67	100	581
Texas	75	100	533
Utah	66.67	85	471
Vermont	66.67	150	827
Virginia	66.67	100	645
Washington	60 to 75	120	851
West Virginia	66.67	100	506
Wisconsin	66.67	110	647
Wyoming	66.67	66.67	527
Federal Employees (FECA)	66.67 to 75	No max	no max
Longshore workers	66.67	200% of national average	966

[1] As the "percent" column reflects, these amounts are usually determined in State law as a percentage of the Statewide average wage. The benefit for permanent total disability is normally payable for life, with the following qualifications: until the worker qualifies for Social Security (KY, WV); until age 65 (TN); until age 67 (MN); up to 450 weeks except for certain injuries (TX); up to 450 weeks or 145,305 (MS); up to 450 weeks except in continuing rehabilitation cases; up to 500 weeks (SC); up to 80 months, with an extra 150 per month per child to age of majority (WY); up to 125,000 (KS); maximum 316 per week after first year (ID). In WA the percent cap based on the worker's earnings depends on marital status and dependents.

NA-Maximum is a dollar figure set by law or regulation rather than percentage.

Source: U.S. Department of Labor (2002).

FEDERAL ROLE

With few exceptions (to be described presently), the rights and obligations of workers' compensation are defined and overseen pursuant to State law. Some coordination on the national level is afforded by organizations such as the International Association of Industrial Accident Boards and Commissions [www.iaiabc.org], the National Association of Insurance Commissioners [www.naic.org], and the National Council on Compensation Insurance [www.ncci.com] (which develops research and statistics used in setting insurance rates and terms).

Calls have been made from time to time for the Federal government to set minimum national standards for workers' compensation. When the Occupational

Safety and Health Act (P.L. 91-596) was passed in 1971, the subject was broached via a provision in that act establishing a commission to study workers' compensation. The commission made many recommendations, 19 of which it deemed essential, in areas including worker eligibility, disease coverage, rehabilitation services, and size and duration of cash benefits (National Commission, 1972). In the next decade or so, Congressional investigation of these matters aided in inducing some reforms, but did not result in the passage of Federal mandates for the States. As of 1998, the States were, on average, in compliance with 12.8 of the commission's 19 "essential" recommendations (LRP Publications 1998, Table III-B). Expenditure on cash benefits, however, has been estimated at less than half of what would be required by adoption of the subsequent model act of the Council of State Governments.[83]

Federal Employees Compensation Act (FECA)-The Federal government directly provides or oversees workers' compensation or similar benefits for certain groups of workers. The largest of these is the Federal workforce, which is covered by the Federal Employees Compensation Act (FECA, 5 U.S.C., Chapter 81) rather than by State law. FECA is administered by the Office of Workers' Compensation Programs (OWCP), in the U.S. Department of Labor, through 12 district offices located across the United States. Eligible workers include (along with the regular executive, legislative, and judicial branch employees) civilian defense workers, medical workers in veterans' hospitals, and the 800,000 employees of the Postal Service. Additionally, special legislation extends coverage to Peace Corps and VISTA (Volunteers In Service To America) volunteers; Federal petit or grand jurors; volunteer members of the Civil Air Patrol; Reserve Officer Training Corps Cadets; Job Corps, Neighborhood Youth Corps, and Youth Conservation Corps enrollees; and non-Federal law enforcement officers under certain circumstances involving crimes against the United States.

During FY2001, the program provided workers' compensation coverage for approximately 2.7 million workers. In that year the program paid approximately 2.2 billion in benefits to nearly 280,000 workers, including 165,915 new cases. Of the benefits paid, almost $1.5 billion was for wage-loss compensation, $617 million for medical and rehabilitation services, and $128 million for death benefits.

While FECA greatly resembles most State workers' compensation programs, it also has a number of distinctive features, among which the most important are:

- A benefit formula that, at 75 percent of pay, is somewhat more generous than the usual level of State benefits, 66-2/3 percent (although FECA recipients without any dependents receive 66- 2/3 percent);
- Full salary continuation for up to 45 days before switching to FECA benefits;
- No maximum cap for workers throughout the General Schedule of positions up to and including GS-15;

[83] This ratio rose from 37 percent in 1972 to a peak of 48 percent in 1985, and has since come down to 46 percent as of 1998 (Burton 2001).

- An appeals process, putatively non-adversarial and contained within the Department of Labor, whose appeals board's decision is final.

Longshore and Harbor Workers' Compensation Act (LHWCA)--The Longshore and Harbor Workers' Compensation Act (33 U.S.C. 901-950) covers injuries that occur during maritime employment on navigable waters of the United States. Benefits are paid by the employers, with oversight by the Office of Workers' Compensation Programs (OWCP) in the U.S. Department of Labor rather than State governments. The program was originally established in response to a Supreme Court decision (*Southern Pacific Co. v. Jensen*, 244 U.S. 205) holding that State workers' compensation laws did not apply on the nation's navigable waters. The exact extent of coverage under LHWCA has been changed from time to time, but essentially, maritime employment includes the building, repairing, loading or unloading of vessels. The term navigable waters includes places beyond those where a boat could float, such as land that adjoins water at a pier, wharf, dry dock, or terminal. Areas not just on a pier or wharf, but also nearby, can be included if they are used for loading, unloading, repairing, or building vessels. The law exempts shipyards dealing with recreational boats under 65 feet in length and certain land operations of yards dealing exclusively with smaller commercial vessels, e.g., work boats under 1,600 tons gross.

LHWCA also covers several miscellaneous classes of employees through extensions to the law:

- The Defense Base Act (August 16, 1941) covers employees on overseas military, air, or naval bases or other areas under public works contracts performed by contractors with U.S. government agencies;
- The Nonappropriated Fund Instrumentalities Act (June 19, 1952) covers civilian employees in post exchanges or service clubs of the armed forces; and
- The Outer Continental Shelf Lands Act (August 7, 1953) covers mineral exploration and production workers such as those on offshore drilling platforms.

The law is more generous than most State workers' compensation laws in some respects, notably: (a) payments for permanent total disability and for death receive annual cost-of-living increases, and (b) compensation is available for occupationally-caused disease that manifests itself after retirement has begun. This provision was added in 1984 due to concern over diseases caused by asbestos.

The law also allows an injured worker to sue third parties (rather than the employer or a co-worker) who may be at fault for his or her injuries. For example, when an individual working for a repair firm is injured on a vessel, there may be a claim of negligence against the vessel and its owner. However, under the 1972 amendments (P.L. 92-576) the worker cannot bring claims under the doctrine of "seaworthiness," which would entail absolute liability on the part of the owner.

In FY2001, 23,480 lost-time injuries were reported under the Act by 330 self-insured employers and 410 insurance carriers. At the end of FY2001, 14,830 workers were continuing to receive compensation payments. Benefits paid in Calendar 2000 totaled $675 million, of which $511 million was for wage-loss

and survivor benefits and $164 million in medical costs. Federal administrative costs were $25 million.

Black Lung Program--As part of the Coal Mine Health and Safety Act of 1969 (P.L. 91-173, now codified at 30 U.S.C. 901 et seq.), which mandated reductions in miners' exposure to coal dust, income and medical support was offered to those who contract black lung disease. While dust control has yielded some success in a reduction of new cases, nearly 5,000 new claims are still being received each year and more than 60,000 primary beneficiaries remain on the rolls, at a total cost of $400 million per year.

Former miners who suffer total disability or death due to coal workers pneumoconiosis or related diseases are eligible for medical and income benefits. The medical benefit consists of diagnostic testing (available for all claimants) and services needed due to the disease, including drugs, durable medical equipment, home nursing visits, and hospitalization. The base rate of the income benefit is set at three-eighths of the Federal salary for an employee in grade GS-2, Step 1, i.e., a base rate of $535 per month in calendar year 2003. The benefit is augmented if the miner (or his survivor) has dependents, up to as much as double the base rate when there are three or more dependents. Black lung benefits are not subject to Federal income tax but may be taxed by the States. The benefits may be subject to offsets, depending on when the initial claim was made, against various other income support systems such as workers' compensation, disability insurance, and Social Security.

The program is administered by the Division of Coal Mine Workers' Compensation, (a component of the Office of Workers' Compensation Programs in the Department of Labor), and is funded primarily by a tax on coal production. In its fiscal year 2003 and 2004 budgets, the Administration proposed a refinancing to eliminate a debt of $7.7 billion that the black lung fund owes to the Treasury. Much of this would be achieved through intra-governmental transfers with no external effect, but the plan also would entail extending the life of the coal tax, which currently is scheduled to end in 2014.

Radiation Exposure Compensation Act (RECA)--RECA (42 USC 2210, note) was passed in 1990 as a form of government compensation to three groups of people who suffered injury due to atmospheric testing of nuclear weapons in the Western States, namely, (a) civilian government[84] and contractor workers who participated in the tests, (b) civilians who may have been injured by the fallout thereof ("downwinders"), and (c) mining and milling workers who produced uranium for weapons. Proof of causation is not necessary; rather, the claimant need show only that he/she was potentially exposed to radiation in a manner specified in the Act and has contracted one of the specified types of cancer.

More specifically:

- Atomic test participants qualify if they were employed and present on site. They receive $75,000.

[84] Military personnel are covered by the Radiation-Exposed Veterans' Compensation Act, P.L. 100-321, as amended.

- Downwinders qualify if they were in the "affected area" (certain counties in the Mountain States) for two years during 1951 to 1958 (or throughout the month of July 1962). They receive $50,000.
- Uranium miners and millers qualify if they worked in the mines at any time from 1947 to 1971 and received specified cumulative doses of radiation. They receive $150,000 and necessary medical treatment.

The program is administered by the Department of Justice, Civil Division, and payment is in the form of a lump sum. Declining amounts have been authorized to be appropriated for each year through 2011, with 143 million being the amount for fiscal year 2003.

Energy Employees Compensation--The Energy Employees Occupational Illness Compensation Program Act (42 USC 7384 et seq.) was passed in recognition of the vital role played and the special hazards encountered by those who worked in the production of nuclear weapons and components. The Act provides lump sum compensation of 150,000 (and necessary medical expenses) to those who contract certain illnesses such as cancer and berylliosis after having worked in plants making atomic weapons and related facilities (the "nuclear weapons complex"). There also are provisions to help former workers obtain regular workers' compensation (in addition to the lump sum benefit) and to obtain needed records from government contractors. The lead agency is the Department of Labor, with additional roles played by the Department of Energy and the National Institute for Occupational Safety and Health.

The program was initiated in July 2001, and by January 30, 2003 some 30,000 applications had been received. Of those, 6,423 had been approved and $460 million in benefits had been paid out. About 12,000 cases were pending.

Railroad Workers and Seamen--Rather than looking to workers' compensation coverage, workers in these industries obtain redress for injuries by filing suit under specialized Federal statutes. For railroad workers, the Federal Employers' Liability Act (45 U.S.C. 51-60) mandates the common law principle of comparative negligence, but with various modifications generally more favorable to the worker than traditional common law. For seamen, the Merchant Marine Act of 1920, commonly known as the Jones Act (46 U.S.C. 688 et seq.), provides similar standards.

MAJOR DEVELOPMENTS SINCE 1980

The influence of the National Study Commission and subsequent Congressional interest prompted liberalization of benefits in many States in the 1980s, especially in the matter of "benefit adequacy," i.e. amounts under the basic wage replacement formula. From 1972, when benefits averaged 0.68 percent of overall payroll, payments grew continuously, peaking at 1.66 percent in 1992 (Thomason et al., 2001). In addition to benefits formula liberalization, medical cost inflation played a role. By the 1990s, employer and insurance groups were campaigning for relief from their State legislatures, arguing, among other things,

that workers' compensation costs figure prominently as an indicator of "business climate" that influences business location decisions.

TABLE 15-43--BENEFITS AS A PERCENTAGE OF COVERED WAGES BY STATE, 1997 VERSUS 2000

[In Percent]

State	1997	2000	Change from 1997 to 2000
Alabama	1.25	1.08	-0.17
Alaska	1.64	1.76	0.12
Arizona	0.81	0.68	-0.13
Arkansas	0.68	0.68	0.00
California	1.60	1.49	-0.11
Colorado	1.20	0.98	-0.22
Connecticut	1.20	0.89	-0.31
Delaware	1.02	0.69	-0.33
District of Columbia	0.47	0.34	-0.13
Florida	1.48	1.11	-0.37
Georgia	0.74	0.71	-0.03
Hawaii	1.83	1.49	-0.34
Idaho	1.18	1.11	-0.07
Illinois	0.87	0.82	-0.05
Indiana	0.59	0.63	0.04
Iowa	0.82	0.84	0.02
Kansas	1.02	0.92	-0.10
Kentucky	1.02	1.06	0.04
Louisiana	0.93	0.90	-0.03
Maine	2.09	1.61	-0.48
Maryland	1.72	1.48	-0.24
Massachusetts	0.62	0.47	-0.15
Minnesota	1.02	0.88	-0.14
Mississippi	1.04	1.05	0.01
Missouri	0.82	0.69	-0.13
Montana	2.16	1.74	-0.42
Nebraska	0.95	0.77	-0.18
Nevada	1.41	0.90	-0.51
New Hampshire	0.97	0.81	-0.16
New Jersey	0.70	0.64	-0.06
New Mexico	0.81	0.79	-0.02
New York	0.88	0.76	-0.12
North Carolina	0.67	0.69	0.02
North Dakota	1.24	1.19	-0.05
Ohio	1.35	1.19	-0.16
Oklahoma	1.75	1.13	-0.63
Oregon	1.00	0.81	-0.19
Pennsylvania	1.60	1.29	-0.31
Rhode Island	0.96	0.99	0.03

TABLE 15-43--BENEFITS AS A PERCENTAGE OF COVERED WAGES BY STATE, 1997 VERSUS 2000-continued

[In Percent]

State	1997	2000	Change from 1997 to 2000
South Carolina	1.17	1.26	0.09
South Dakota	1.07	0.90	-0.17
Tennessee	0.68	0.79	0.11
Texas	0.71	0.75	0.04
Utah	0.54	0.55	0.01
Vermont	1.29	1.37	0.08
Virginia	0.64	0.49	-0.15
Washington	1.66	1.54	-0.12
West Virginia	3.93	4.24	0.31
Wisconsin	0.88	0.87	-0.01
Wyoming	1.41	0.80	-0.61
Total[1]	1.15	1.03	-0.12

[1] Including Federal programs.

Source: Mont et al. (2002).

Thus, starting in 1992, economic and political reaction to the previous expansion in benefits led to an opposite kind of "reform," one which emphasized cost control. The types of measures adopted include: promotion of prompt return to work (with incentives for both employer and employee); some reduction of benefit levels, streamlining of dispute settlement procedures; medical cost control; efforts against fraud; higher deductibles in employers' insurance policies; and mandates for workplace safety programs (Burton, 2001; Conway & Svenson, 1998). As a result of such measures, expenditures on benefits declined significantly, from 1.66 percent of payroll in 1992 to 1.03 percent by 2000.

Table 15-43 provides a State-by-State breakdown of the benefit/wage ratio, comparing 2000 with 1997. Much of the variation among States at any point in time is determined by the mix of industries that are prevalent in each. The States with the highest payout rates in 2000 (West Virginia, Alaska, and Montana) have substantial activity in extractive industries (mining, forestry and fisheries) with inherently high injury rates. The jurisdictions with the lowest rates (District of Columbia, Massachusetts, and Virginia) are largely involved with technology, finance and service industries.[85] Nevertheless, standards established in State legislation and administration have some effect on benefit costs and, more clearly, in the relatively sudden increases and decreases seen in recent years. (Changes in statistical methods between the years also may have played a role.)

[85] The rate paid by each employer is not affected by the State mix of industries. Rather, it is a function of the employer's own industry and the employer's size, occupational mix and, in most cases, own accident experience.

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