
APPENDIX C. BACKGROUND INFORMATION ON INCOME SECURITY AND HEALTH PROGRAMS

This appendix provides detail on federal income security and health programs. Like Chapter VI, it concentrates on public assistance programs, most of which are funded jointly by the states and the federal government. The first section of the appendix describes income security programs while the second discusses health care programs. 1/

INCOME SECURITY PROGRAMS

Over one-third of the federal budget in 1982 was devoted to income security programs. The largest of these are Social Security and other retirement programs, but since those programs are generally accepted as federal responsibilities they are not examined here. The income security programs discussed are means-tested and are jointly operated by the federal government and state or local governments (see Table C-1).

Aid to Families with Dependent Children (AFDC)

The AFDC program provides grants to states for income assistance to low-income families with children. AFDC is an entitlement, which means that all applicants who are eligible and who apply receive benefits. Eligibility is jointly determined by the federal government and each state. The federal government stipulates the category of people eligible--generally single-parent families with children--and states determine the income level at which such households may receive assistance and the amount of assistance they receive. 2/ The federal government pays a share of program

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1. The budget numbers shown in this appendix are generally outlays, rather than budget authority as was shown in previous appendixes. Many of the programs discussed here are entitlements for which funds are usually appropriated as needed. Outlay estimates for the non-entitlement programs considered here have also been given, where possible, to allow consistent comparisons across programs.
 2. The federal government allows, but does not require, two-parent families with an unemployed parent to be covered, at state option.

TABLE C-1. FEDERAL OUTLAYS FOR INCOME SECURITY PROGRAMS, 1982 AND 1983 (In millions of dollars)

| Program | 1982 Actual | 1983 Estimated |
|--|----------------|-------------------|
| Aid to Families with Dependent Children <u>a/</u> | 7,990 | 8,153 |
| Supplemental Security Income | 7,677 | 8,870 |
| Food Stamps | 11,014 | 12,539 |
| Housing Assistance <u>b/</u> | 7,888 | 9,356 |
| Child Nutrition <u>c/</u> | 3,950 | 4,421 |
| Others <u>d/</u> | 3,899 | 3,797 |

SOURCE: Congressional Budget Office.

- a. Includes Child Support Enforcement.
- b. Includes the public housing program and the lower income housing assistance program (Section 8 of the Housing Act of 1937, as amended).
- c. Includes National School Lunch Program, Special Supplemental Food Program for Women, Infants, and Children (WIC), National School Breakfast Program, Childcare Feeding Program, Summer Feeding Program, Special Milk Program, and other small programs.
- d. Includes Low Income Home Energy Assistance (LIHEA), Earned Income Tax Credit, and Refugee Assistance.

costs in each state, based on the state's per capita income. The federal share varies from 50 to 78 percent and currently averages about 55 percent. Estimated federal outlays in 1983 are \$8.2 billion.

Since states determine benefit levels for the AFDC program, families with similar characteristics and similar incomes may receive widely varying amounts of assistance in different states. Each state sets payment standards, which are the maximum benefits paid to families of varying sizes that have no other source of income. Payment standards (in the continental United States) vary from a low of \$96 per month for a family of three in Mississippi to a high of \$513 per month for a similar family in Connecticut. Benefits are calculated as the difference between the family's adjusted income and the state's payment standard.

Program History. AFDC was established in 1935 under the Social Security Act to assist families with an absent or disabled parent. Since then, several important changes in eligibility and work rules have been made.

The major change in program eligibility came in 1961, when states were given the option of providing benefits to two-parent families whose primary wage earner is unemployed or partially employed. To date, 20 states and the District of Columbia have exercised this option. Other eligibility changes, made as part of the Omnibus Budget Reconciliation Act of 1981, include ending benefits for children beyond high school age and for pregnant women without children until the third trimester of their pregnancies.

Several changes designed to increase recipients' work incentives have also been enacted. In 1967, a rule was established allowing the first \$30 per month in earnings to be disregarded in computing AFDC payments, as well as one-third of each recipient's earnings above that threshold. Also beginning in 1967, the Congress required states to deny AFDC payments to adults who refused to accept employment or training opportunities and authorized federal grants to provide such opportunities through the work incentive (WIN) program. In 1971, registration for WIN was made mandatory for all able-bodied AFDC recipients when their youngest child reached the age of six. In 1981, however, the Omnibus Budget Reconciliation Act reversed the trend toward stronger work incentives by limiting to four months the period during which earnings are disregarded, and by reducing benefit levels for working parents through changes in the treatment of work expense deductions. At the same time, an attempt was made to tighten work requirements by authorizing states to establish community work programs ("workfare") in which recipients would be required to work on public projects in exchange for their benefits.

Reciency and Benefits. The number of AFDC recipients grew from 3 million in 1960 to over 11 million in the late 1970s and then--largely as a result of changes implemented in the 1981 budget reconciliation

act--declined to 10.4 million in 1982. Since 1961, the fraction of all families receiving aid that are two-parent families with an unemployed primary wage earner has ranged from about 4 percent to its current level of about 7 percent.

Benefit increases under AFDC have varied widely over time and among states. Average benefits per person increased by about 36 percent in real terms between 1960 and 1970. From 1970 to 1980, benefits on average rose by 5 percent in real terms, but most of this increase occurred in just a few states, while benefits in most states failed to keep pace with inflation. Between 1980 and 1982, average benefits fell 11 percent in real terms.

The costs of the AFDC program have risen in response to both increases in program participation and increases in benefits. Federal spending for AFDC totaled \$667 million in 1960 and increased to \$2.3 billion in 1970. Federal outlays rose in real terms through the 1970s by an average annual rate of under 4 percent. Between 1980 and 1982, real outlays grew by under 1 percent, to \$8.0 billion in 1982.

Supplemental Security Income (SSI)

SSI is an entitlement program that provides income support for elderly and disabled persons. Unlike in AFDC, the federal government determines SSI eligibility standards, sets the basic program benefits, and pays the full costs of providing basic assistance. States may then supplement these benefits. Persons are categorically eligible for SSI if they are either 65 years of age or older or are disabled, with benefit levels determined by income. Federal payment standards for recipients with no other income are currently set at \$304 for individuals and at \$456 a month for couples. The benefits provided are the difference between the payment standard and a recipient's adjusted income. Estimated federal outlays in 1983 are \$8.9 billion.

Although federal SSI benefits are uniform among states, variations in states' supplemental benefits mean that similar households may receive different benefit levels from state to state, although the variation is not as great as in the AFDC program. In establishing the SSI program in 1972, the Congress required states that had previously provided higher benefits to any group than would be provided under SSI to maintain the previous level of support. In 1981, 7 states provided only required supplemental benefits; 24 provided supplementation to selected categories of recipients; and 17 states and the District of Columbia supplemented federal SSI payments to all or nearly all recipients. State supplements range up to \$167 a month for individuals and up to \$412 for couples, though most are below these levels.

Program History. SSI was created under the 1972 amendments to the Social Security Act and took effect in January 1974. It replaced federal grants to states under the earlier Old Age Assistance (OAA), Aid to the Blind (AB), and Aid to the Permanently and Totally Disabled (APTD) programs.

Few major changes have been made in the SSI program since its enactment. In 1976, states were required to pass on the cost-of-living adjustments made in federal SSI benefit levels each year, thus preventing them from reducing their required hold-harmless payments by the amount of the federal increase. The Social Security Disability Amendments of 1980 modified eligibility requirements and the benefit structure to provide greater work incentives for the disabled. In 1981 and 1982, minor modifications were made in the benefit calculation rules, lowering average benefit levels slightly. Additional changes in 1983 that increased program benefits for most recipients, however, more than offset these reductions.

Reciency and Benefits. The number of SSI beneficiaries in December 1974 was 4 million, up from the 3.1 million receiving aid under the programs that preceded SSI. The program peaked at 4.3 million recipients in 1976 and since then has slowly declined to 4.0 million in 1982. The number may rise in the near term, however, because in 1983 the Congress passed legislation requiring that the Social Security Administration notify certain Social Security recipients that they may be eligible for SSI. The composition of SSI beneficiaries has shifted over time, with the number who are disabled rising from 39 percent in 1974 to 57 percent in 1982, the share who are elderly declining from 58 percent in 1974 to 41 percent in 1982, and the proportion who are blind remaining nearly constant at 2 percent. ^{3/}

Benefits under the federal portion of the SSI program are increased each year by the same cost-of-living adjustments used in Social Security retirement and disability programs. Thus, the delay in the annual cost-of-living increase authorized by the Social Security Amendments of 1983 will reduce benefits by \$400 million over the next three years. The amendments also increased SSI benefits by up to \$20 a month for single recipients and by up to \$30 a month for married recipients. These increases will more than offset the average reduction caused by delay in the cost-of-living adjustment, resulting in a net increase in SSI outlays of about \$1.4 billion over the 1982-1985 period.

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3. These percentages probably understate somewhat the share of SSI recipients who are elderly, because disabled recipients are classified as such even after they reach the age of 65.

The federal government currently provides about 75 percent of SSI benefits, at a cost of \$7.7 billion in 1982. The states' contributions to SSI vary widely. For states that provide only the required hold-harmless benefits, costs have fallen dramatically, particularly when compared with the costs of the pre-SSI programs. States providing limited supplementation have also experienced declining costs, at least in real terms, as caseloads have fallen. For states providing nearly universal supplementation, costs have generally risen as a result of growth in both caseloads and payment standards.

Food Stamps

The Food Stamp program--an entitlement that is federally funded but administered by states and localities--provides coupons to low-income persons and families with which they may purchase food. It is the only federal income security program with no categorical limitations; eligibility is based on income. The federal government pays all of the benefit costs and about half of state and local administrative expenses.

Both benefit levels and eligibility criteria are federally determined and are uniform among states.^{4/} Benefits are based on the Thrifty Food Plan, a low-cost but nutritionally adequate diet. For a family with no income, benefits equal 99 percent of the Thrifty Food Plan amount--\$199 per month for a family of three, for example. Since families are assumed to spend about 30 percent of their income on food, benefits are reduced by 30 cents for each dollar of adjusted income. Cash transfer payments like AFDC and SSI benefits are counted as income in determining a family's food stamp benefits, and, since benefit levels in those programs vary among states, federal spending on food stamps also varies considerably among states. In states with high payment levels for AFDC and SSI, average food stamp benefits tend to be fairly low, while in low cash-benefit states, food stamp benefits are relatively high. Estimated federal outlays in 1983 are \$12.5 billion.

Program History. In the early years of the Food Stamp program, states played an important role in determining who benefited. Following a set of pilot programs initiated by an executive order in 1961, the Food Stamp Act of 1964 established a state-oriented, but nationwide, program in which states could participate. The federal government, which financed the entire program save a share of administrative costs, set the benefit levels. States decided the geographic coverage of the program--with the option of

4. Benefit levels are higher in Alaska and Hawaii.

providing benefits only in some areas--and the criteria for determining eligibility. Eligible households were required to pay a portion of their incomes in order to obtain their allotment of stamps, a provision commonly referred to as the "purchase requirement."

Over time, the federal government assumed a larger role in determining eligibility and benefit levels. The 1971 Food Stamp Amendments replaced varying state eligibility standards with uniform federal standards, and indexed allotments to the rate of food price inflation. Another set of amendments, enacted in 1973, provided for nationwide operation of the program in all states and localities, expanded eligibility, and introduced semiannual indexing of allotments. The Food Stamp Act of 1977 eliminated the purchase requirement and replaced it with the reduction of benefits by 30 cents for each dollar of income. The new act also simplified the deductions from income and restricted eligibility and benefits somewhat, though some benefits lost to elderly and disabled recipients by these changes were restored by amendments in 1979. Further, small changes were made by amendments in 1980, including provisions intended to reduce error and fraud.

In 1981 and 1982, Congress made several changes that further reduced eligibility and benefits. For example, the Omnibus Budget Reconciliation Act and the Agriculture and Food Act of 1981 eliminated inflation indexing of benefits for 1982, postponed certain other inflation-related adjustments in later years, and replaced the Food Stamp program in Puerto Rico with a block grant. In addition, the incentives for states to lower their rates of erroneous payments were replaced by stronger sanctions that reduce federal funding for administrative costs in states that fail to achieve specified annual reductions in error rates.

Reciency and Benefits. Participation in the Food Stamp program in 1962 averaged 143,000 recipients per month and steadily climbed to 4.3 million in 1970 as the number of participating localities increased. Continuing geographic expansion, adoption of uniform federal eligibility standards, the recession in 1974-1975, and--most important--the transfer of participants in the Food Distribution Program to food stamps caused the number of recipients to quadruple between 1970 and 1975, to about 17 million. Average monthly participation declined steadily from the recession peak of 19.3 million in May 1975 to a low of 15.2 million in September 1978 as unemployment dropped. With the elimination of the purchase requirement and other changes in 1979 and with the economic downturn of 1980, participation again increased to a peak of about 23 million in March 1981 and declined slowly afterward. The legislative changes in 1981 and 1982 eliminated the eligibility of about 4 percent of program recipients, while the

recent recession increased participation. With the decline in unemployment, monthly participation is currently averaging roughly 23 million people.

Monthly food stamp benefits--currently averaging about \$43 per person--are a function of the level of the Thrifty Food Plan, price inflation, household size and composition, and the cash incomes of participants from earnings and government transfers. Average monthly benefits increased in real terms about 50 percent from 1970 through 1975 and have increased another 80 percent since 1975, although the rate of increase has been much lower in recent years.

Federal outlays for food stamps totaled almost \$37 million in 1965. With growing levels of participation and benefits, outlays increased to \$577 million in 1970 and to \$4.6 billion in 1975. Outlays increased more slowly after 1975, reaching \$9.1 billion in 1980. Legislative changes in 1981 and 1982 are expected to reduce outlays for the 1982-1985 period by about 13 percent relative to what they would have been under previous law, mostly by delaying benefit increases. Program funding totaled \$11.0 billion in 1982.

Housing Assistance

The federal government provides direct housing assistance to lower-income households through a variety of programs, the largest being the public housing program and the housing assistance payments program (commonly called the Section 8 program, after the section of the Housing Act of 1937, as amended, that authorized it).^{5/} Unlike other income security programs in this section, housing programs are not entitlements, and therefore not all eligible households who apply receive assistance.

Through the public housing program, the federal government finances the construction costs of rental housing projects owned and operated by local public housing authorities (PHAs) and also pays a portion of the operating expenses associated with these projects. The units are then rented to low-income households who pay a fixed share of their income toward their shelter costs. Through the Section 8 program, the federal government enables eligible households to live in privately-owned housing in either existing, recently rehabilitated, or newly built structures of their own

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5. The federal government also provides housing assistance to middle- and upper-income households through the tax system by allowing the deduction of interest payments on mortgages and of property taxes paid to state and local governments. The cost of this aid was nearly four times the cost of direct housing assistance programs in 1982.

choosing. The federal government pays the difference between a fixed portion of a household's adjusted income and the unit's rent, not to exceed a federally established maximum level.

The federal role in these housing programs includes determining the amount of assistance to be made available each year, the programs through which it is to be made available, and the eligibility criteria to be used in identifying recipients. Local PHAs then allocate available assistance among eligible households and, in the case of the public housing program, operate housing projects. The costs of housing assistance not covered by tenant rents are generally borne by the federal government, though localities contribute by accepting payments in lieu of taxes on public housing projects. Estimated federal outlays in 1983 are \$9.4 billion (see Table C-2).

TABLE C-2. FEDERAL OUTLAYS FOR HOUSING ASSISTANCE PROGRAMS, 1982 AND 1983 (In millions of dollars)

| Program | 1982 Actual | 1983 Estimated |
|---------------------------------------|----------------|-------------------|
| Public Housing | 2,574 | 3,312 |
| Housing Assistance Payments <u>a/</u> | 4,085 | 4,880 |
| Other <u>b/</u> | <u>1,229</u> | <u>1,164</u> |
| Total | 7,888 | 9,356 |

SOURCE: Congressional Budget Office.

- a. Section 8 of the Housing Act of 1937, as amended.
- b. Includes rental housing assistance, rent supplements, homeownership assistance, and college housing grants.

Program History. Federal housing assistance has served several goals that have received varying emphasis over time, including stimulating economic activity through new construction, revitalizing low-income neighborhoods, and assisting low-income households. Federal policy has generally

shifted from public to private ownership of housing, from improving the quality of housing to lowering the costs paid by low-income households, and from serving households of modest means to aiding very poor households.

The public housing program is the oldest federal housing assistance program, established in 1937 as a means of stimulating economic activity following the Depression. ^{6/} Through it, local PHAs were able to construct new rental housing, often as part of efforts to restore declining neighborhoods, thus increasing the supply of decent-quality housing. Tenants of public housing were generally experiencing temporary hardship, and the program was not designed to serve very poor households who could not pay the required rent levels. Federal subsidies covered only debt service on initial construction costs.

In the postwar period, public housing tenants grew relatively poorer because of shifting federal policies and widening opportunities for middle-income households. As the rents paid by tenants fell increasingly short of the levels required to pay operating costs, in 1969 the federal government limited tenant rents to 25 percent of adjusted household income and instituted subsidies for operating expenses on behalf of all tenants. These subsidies have grown to nearly half of public housing operating costs in 1982.

From 1937 until 1961, the public housing program was the sole mechanism for federal housing assistance, and during that period over 460,000 units were made available. Beginning in the 1960s, additional forms of federal assistance relying on the private market were developed, including rent supplements to cover the difference between the share of household income designated for rent and actual rents in privately owned projects, and reduced-interest mortgages for multifamily projects that resulted in lower rents charged to low-income households. By 1973, total public housing units available numbered just over one million, while 721,000 units were provided through other federal programs.

In response to growing concern about the costs and effectiveness of these programs, the Congress in 1974 instituted the Section 8 program, which provides supplementary rental payments to private landlords on behalf of low-income households. Although program emphasis was initially placed on improving the housing stock through new construction and substantial rehabilitation--in response to the priorities of local PHAs--the rising costs of this approach have recently dictated a shift toward reliance on the existing stock of private housing. Of Section 8 assistance commitments

6. For further detail on the public housing program, see Congressional Budget Office, Federal Subsidies for Public Housing: Issues and Options (1983).

made through 1981, 45 percent were for newly constructed or substantially rehabilitated units; in 1982, only 20 percent of commitments were for such units.

The major recent change in housing assistance programs was made under the Omnibus Budget Reconciliation Act of 1981, which increased the rents paid by assisted households from 25 to 30 percent of adjusted income, to be phased in over a five-year period. Further, the act required that 95 percent of new housing commitments be directed to households with incomes below 50 percent of area median income, with no more than 5 percent provided to households with adjusted incomes between 50 and 80 percent of the area median.

Reciency and Benefits. In 1982, 4.0 million federal rental housing assistance commitments were outstanding, while 18.6 million renter households were eligible for such aid on the basis of their incomes.^{7/} Of the total, 1.2 million commitments were for the public housing program, while 1.6 million were through the Section 8 program. Outlays for housing assistance programs have climbed from \$2.1 billion in 1975 to \$7.9 billion in 1982. Of the 1982 total, \$2.6 billion was for the public housing program and \$4.1 billion for the Section 8 program.

Child Nutrition Programs

Child nutrition programs include the National School Lunch Program, the Special Supplemental Food Program for Women, Infants, and Children (WIC), the National School Breakfast program, the Child Care Feeding program, the Summer Feeding program, the Special Milk program, and several others. They provide cash and commodities to states for distribution to individuals, schools, and child care programs. The WIC program provides food supplements to low-income women and young children, while other programs subsidize meals for children in schools, child care facilities, and other institutions.

Federal aid amounts to about half of total spending on child nutrition programs, with the remainder coming from states and local institutions and from families. Typically, the programs are locally operated and administered. The federal government assists participating institutions by providing a mix of commodities and cash reimbursements based on the number of meals served, using nationwide formulas to determine the amount of

7. See Congressional Budget Office, Federal Housing Assistance: Alternative Approaches (May 1982), p. 28.

subsidy. Total estimated obligations in 1983 are \$4.4 billion (see Table C-3). In addition, roughly \$0.4 billion in commodities will be provided.

In most programs, all meals served receive some federal subsidy, regardless of the family income of the participant, as long as federal nutritional criteria are met. Substantially higher subsidies, however, are provided for meals served free or at a reduced price to children from low-income families. Income eligibility for free meals is 130 percent of OMB's income poverty guidelines and 185 percent of these guidelines for reduced-price meals. ^{8/}

Program History. Federal aid for child nutrition began during the Depression with the purchase and distribution of surplus agricultural commodities to school lunch programs, and has expanded since then to encompass a wide range of programs. Cash subsidies to school lunch programs began in 1943 and were permanently authorized by the Child Nutrition Act of 1946. The school lunch program remained the only federal child nutrition effort until enactment of the Special Milk Program in 1957. A period of expansion in federal child nutrition programs began with the Child Nutrition Act of 1966, which established the National School Breakfast Program. The National School Lunch Amendments of 1968--which authorized the Child Care Food Program--extended federal nutrition assistance from schools to other institutions serving children by authorizing a summer meal program and a year-round food service program for children in day-care facilities. In 1969, the Department of Agriculture began what was eventually called the Commodity Supplemental Food Program, which provided free commodities to low-income, nutritionally at-risk, pregnant women, new mothers, and young children. The Special Supplemental Food Program for Women, Infants, and Children (WIC), was created in 1972 to serve the same groups through federal grants to state agencies.

The Omnibus Budget Reconciliation Acts of 1980 and 1981 lowered federal subsidy rates in the school lunch and related programs and restricted income eligibility for free and reduced-price meals. In addition, eligibility limits were lowered for WIC, and the Special Milk Program was substantially reduced.

Reciprocity and Benefits. Increased participation in child nutrition programs during the 1970s was largely the result of new programs and new

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8. For a family of three in the continental United States and the District of Columbia between July 1983 and June 1984 the limit for free meals is \$10,686 per year and \$15,207 for reduced-price meals. The limits are higher in Alaska and Hawaii.

TABLE C-3. FEDERAL OBLIGATIONS FOR CHILD NUTRITION PROGRAMS, 1982 AND 1983 (In millions of dollars)

| Program | 1982 Actual | 1983 Estimated |
|---|----------------|-------------------|
| National School Lunch Program | 2,134 | 2,350 |
| Supplemental Food Program for Women, Infants and Children (WIC) <u>a/</u> | 929 | 1,194 |
| National School Breakfast Program | 319 | 335 |
| Childcare Feeding Program | 290 | 344 |
| Summer Feeding Program | 89 | 94 |
| State Administration | 45 | 47 |
| Special Milk Program | 20 | 20 |
| Other <u>b/</u> | <u>8</u> | <u>8</u> |
| Total | 3,834 | 4,392 |

SOURCE: Congressional Budget Office.

NOTE: Because of limited data, this table reports obligations and is not, therefore, consistent with funding reported for child nutrition programs in Table C-1.

- a. Includes Commodity Supplemental Feeding Program.
- b. Includes funding for nutrition education and training, as well as special studies.

national eligibility standards that included higher income eligibility limits for free and reduced-price meals. Overall, the number of meals served in the school meal and child care programs increased by half to 5.4 billion in 1980 with most of the increase occurring in programs other than the school

lunch program. The school lunch program--the largest of the child nutrition programs--served 4.4 billion meals to 27 million children in 1980, an increase of one-fifth from 1970. Most of the increase in the school lunch program occurred in the free and reduced-price categories where participation increased 150 percent during the decade. The creation of the WIC program in 1974 also increased participation in nutrition programs, adding about 88,000 in 1974 and nearly 2 million in 1980. The budget reconciliation acts of 1980 and 1981 reversed the trend of growing participation in school and child care nutrition programs; in the school lunch program, for example, participation declined from 27 million to 23 million between 1980 and 1982, although these acts had little effect on WIC participation.

Because of these increases in participation, higher federal reimbursement rates, and the creation of WIC, federal expenditures increased from \$0.7 billion in 1970 to \$4.6 billion in 1980. Much of the growth occurred in the meal categories with highest federal subsidies and in the entirely federally funded WIC program. As a result, the federal share of total child nutrition spending increased from less than a third in 1970 to a half in 1980. Because of cutbacks enacted in 1980 and 1981, outlays for child nutrition fell from \$4.3 billion in 1980 to \$4.0 billion in 1982. Expenditures for programs other than WIC declined from \$3.5 billion to \$3.0 billion, while WIC increased from \$0.7 billion to \$0.9 billion.

Other Income Security Programs

In addition to the major public assistance programs discussed above, a number of smaller programs provide assistance to low-income families and individuals for specific purposes (see Table C-4). The largest of these is the Low Income Energy Assistance program (LIEA), which provides funds to states to aid individuals with high fuel bills, energy related emergencies, or weatherization projects. The assistance may be any combination of direct payments to individuals, vendor payments, vouchers, tax credits, or other forms of aid, and state programs vary widely in types of aid, eligibility criteria, and participation rates. In 1982, about two-thirds of energy assistance funds were used for heating assistance, and the average benefit provided for this purpose was \$182. In all, between 8 and 9 million assistance grants were made. The program is entirely federally funded, but is operated by the states, which have considerable discretion in the allocation of funds.

Other income security programs that provide some aid to low-income households include the earned income tax credit and the Refugee Assistance program. The first of these is a refundable credit available to those with earnings below \$10,000 and little other income, and the second provides grants to states to aid needy refugees and immigrants.

TABLE C-4. FEDERAL OUTLAYS FOR OTHER INCOME SECURITY PROGRAMS, 1982 AND 1983 (In millions of dollars)

| Programs | 1982 Actual | 1983 Estimated |
|--------------------------------|----------------|-------------------|
| Refugee and Entrant Assistance | 1,011 | 632 |
| Low Income Energy Assistance | 1,687 | 1,960 |
| Earned Income Tax Credit | <u>1,201</u> | <u>1,205</u> |
| Total | 3,899 | 3,797 |

SOURCE: Congressional Budget Office.

HEALTH PROGRAMS

The major federal health care programs are Medicare--for elderly and disabled persons who are eligible for Social Security--and Medicaid, which makes payments to providers of medical services on behalf of public assistance recipients and other medically needy persons. In addition, the federal government funds a number of much smaller grant programs for health care that support community health centers, family planning services, migrant health services, and black lung clinics, among other things (see Table C-5). As in Chapter VI, Medicare is not discussed here, since it is not an intergovernmental program.

Medicaid

Medicaid is an entitlement program, jointly operated and financed by the federal and state governments, that provides payments for medical services to low-income persons. The federal government designates eligibility for all recipients of AFDC and SSI, who account for about three-quarters of all Medicaid recipients, and states may at their option include other

TABLE C-5. FEDERAL OUTLAYS FOR SELECTED HEALTH CARE PROGRAMS, 1982 AND 1983 (In millions of dollars)

| Program | 1982 Actual | 1983 Estimated |
|------------------------------|----------------|-------------------|
| Medicaid | 17,391 | 19,472 |
| Health Care Grants <u>a/</u> | 1,334 | 1,558 |

SOURCE: Congressional Budget Office

- a. Appropriations, not outlays. Includes Preventive Health Care Block Grant, Substance Abuse and Mental Health Block Grant, Maternal and Child Health Block Grant, Primary Care Block Grant, Family Planning Services, Migrant Health Services, and Black Lung Clinics.

groups. 9/ Since the income cutoffs for SSI and AFDC eligibility differ across states, eligibility for Medicaid also varies.

The major supplemental coverage that states have elected to provide is for the "medically needy," who account for about 13 percent of current Medicaid recipients. Thirty states now have programs for the medically needy, and eligibility requirements under them vary considerably. In general, however, recipients under these programs have medical expenditures that are high relative to their incomes and meet the categorical eligibility requirements, except for income level, for either AFDC or SSI. States may also choose to cover people who meet some, but not all, of the categorical eligibility criteria for AFDC or SSI.

States pay a fixed share of total Medicaid expenditures, with the percentage in each state depending on the state's per capita income. The formula used to determine a state's share of costs is generally the same for Medicaid as for AFDC. The federal share of Medicaid expenditures varies among states from 50 to 78 percent, and averages about 55 percent. States

9. States have the option of limiting Medicaid coverage for SSI recipients by requiring them to meet any more restrictive eligibility criteria in effect before the implementation of SSI.

are required to provide certain services, and may provide additional services at their option. Somewhat more than half of total federal expenditures go for required services, although much of the remainder is spent on services that may provide lower-cost substitutes for some mandatory services, such as intermediate care facilities. Estimated federal outlays in 1983 are \$19.5 billion.

Program History. Federal matching payments for medical services to recipients of federally supported public assistance programs were first authorized in 1950 by amendments to the Social Security Act. In the early 1960s, the federal government began to provide matching grants to states to pay the costs of medical services to aged, blind, or disabled persons who were medically needy but who were not eligible for public assistance. About four-fifths of states participated in these optional programs.

The current Medicaid program--authorized in 1965 under Title XI of the Social Security Act--replaced earlier matching grant programs. By the end of calendar year 1966, Medicaid's first year, 26 states had begun operation of Medicaid programs. Another 11 began their programs in 1967, and all remaining states but Arizona soon followed. 10/

The services covered through Medicaid have changed little over the program's history, but increases in the number of participants and in usage have prompted efforts to reduce program outlays. Both the Omnibus Budget Reconciliation Act of 1981 (OBRA) and the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) contained provisions directed toward limiting the increase in Medicaid outlays. The 1981 act provided that the amount that a state was otherwise entitled to receive in Medicaid matching funds would be reduced by 3 percent in fiscal year 1982, 4 percent in 1983, and 4.5 percent in 1984, although these reductions could be avoided if states successfully reduced error and growth rates. States were given additional flexibility in designing and modifying their Medicaid programs to adjust to the reductions, such as the adoption of alternative hospital reimbursement methods and the provision of home- and community-based services for persons who would otherwise require institutional care. TEFRA allowed states to require small copayments by patients in most cases, and expanded the states' authority to impose property liens to pay for nursing home care. It also added home health care services for disabled children as an optional covered service.

In response to severe fiscal pressure, however, some states cut back their Medicaid programs even before implementation of the federal changes enacted in 1981 and 1982. More than 30 states reduced benefits, eligibility,

10. In 1982, Arizona established a demonstration Medicaid program.

or provider reimbursement in 1981, and approximately the same number made such cutbacks in 1982 after OBRA took effect. Common changes included limiting the number of annual hospital days, limiting payments for emergency room and outpatient care, and dropping eligibility for certain categories of recipients. States also took advantage of the flexibility provided under recent federal acts by, for example, substituting home health care for nursing home care. On the other hand, some states acted in 1982 to reinstate benefits previously cut, to lift access restrictions, or to increase payments to providers. State activity in 1983 has also been mixed, with some states adding or reinstating services and others reducing them.

Reciency and Benefits. Starting from 11.5 million recipients in 1968, when most state programs had been established, Medicaid participation grew rapidly in the early and mid-1970s as a result of increases in the number of AFDC recipients and in the number of aged, blind, and disabled people qualifying for Medicaid after implementation of national eligibility standards for SSI. The number of recipients has declined from a peak of 22.9 million in 1977 and has fluctuated around 22 million in recent years. In 1982, 44 percent of Medicaid recipients were dependent children, 25 percent were adults in families with dependent children, 15 percent were aged, and 13 percent were disabled.

The federal government requires basic services to be provided under state Medicaid programs, and also pays for selected supplementary services. States must provide inpatient and outpatient hospital care, physicians' services, diagnostic services, nursing home care, family planning consultation, and screening services for children. Required services account for about 55 percent of program outlays. In addition to the required services, each state has chosen to provide some of the optional services, including intermediate (non-hospital) care, prescription drugs, dental services, and prosthetic devices, for example.

Federal outlays for Medicaid increased from \$2.7 billion in 1970 to \$14 billion in 1980. This large increase was due to a number of factors, notably growing numbers of eligible individuals and increased usage of some medical services. The recent cutbacks in Medicaid, both at states' initiative and in response to federal cutbacks, have reduced the annual rate of increase in Medicaid outlays from an average of over 15 percent annually between 1975 and 1980 to less than 10 percent between 1981 and 1982. Outlays in 1982 were \$17.4 billion.

Health Care Grant Programs

In addition to Medicaid, the federal government funds a number of nonentitlement health care programs. These include four block grants--for

preventive health care; substance abuse and mental health; maternal and child health; and primary care--and three narrower-purpose grant programs for family planning services, migrant health services, and black lung clinics (see Table C-6). The Administration has proposed that the latter narrow-purpose programs be folded into the Primary Care Block Grant, which supports community health centers.

The four block grants were created by the Omnibus Budget Reconciliation Act of 1981, which consolidated 21 small categorical health programs. For each of these block grants, funding was set at or below the total that had been appropriated for the individual programs before consolidation. As a result, funding for all the programs consolidated was about 25 percent lower in 1982 than it would have been had current policy in 1981 been continued. Real spending for the three narrower-purpose health grant programs also declined--by more than 30 percent--from 1981 to 1982.

Preventive Health Care. The Congress created this block grant by combining small grant programs for rodent control, fluoridation, hypertension, health education, home health care, and emergency medical services with a previously existing broad-based program for public health services authorized under Section 314(d) of the Public Health Services (PHS) Act. Federal funds are distributed by formula to states and may be used for a wide variety of preventive health services, most of which are also supported by state and local governments. Benefits are community-wide.

Substance Abuse and Mental Health. This block grant combined separate programs for alcohol abuse, drug abuse, and mental health that had been enacted in the 1960s in order to increase the availability of community-based treatment centers. In 1982, states were required to divide spending under the block grant between mental health and substance abuse programs in the same proportions as had existed in the predecessor programs in 1980, although this restriction was to be relaxed and then eliminated in later years (by 1985). Funds are distributed by formula to states. State and local governments provide substantial funding for mental health and substance abuse programs as well, but much of this is for institutional care rather than community-based services.

Maternal and Child Health Care. The 1981 budget reconciliation act combined a number of small grant programs--for services to disabled children, the prevention of lead poisoning, genetic screening, sudden infant death programs, hemophilia treatment, and adolescent pregnancy prevention--with programs for promoting the health of mothers and children in rural or economically depressed regions authorized under Title V of the Social Security Act. Funds are distributed to states by a formula based on the number of low-income children. States are required to provide matching

TABLE C-6. FEDERAL APPROPRIATIONS FOR HEALTH CARE GRANT PROGRAMS, 1982 AND 1983 (In millions of dollars)

| Program | 1982 Actual | 1983 Estimate |
|--|----------------|------------------|
| Preventive Health Care Block Grant | 82 | 86 |
| Substance Abuse and Mental Health Block Grant | 432 | 469 |
| Maternal and Child Health Block Grant | 374 | 478 |
| Primary Care Block Grant | 281 | 360 |
| Family Planning Services | 124 | 124 |
| Migrant Health Services | 38 | 38 |
| Black Lung Clinics | 3 | 3 |
| Total | 1,334 | 1,558 |

SOURCE: Congressional Budget Office.

funds--three state dollars for every four federal dollars received. Under the new block grant, states provide services to mothers and children in high risk groups, but they are permitted to establish income-based charges for beneficiaries with incomes above the federal poverty guidelines.

Primary Care. This block grant continued the grants for community health centers established in 1966 under Section 314(e) of the PHS Act. Under this grant, the federal government provides formula grants to states for distribution to local agencies for the development and operation of health centers in communities that are medically underserved. States are required to provide a matching share of funds, which will increase from a fifth in 1983 to a third in 1984.

Family Planning Services. Funding for this grant is authorized under Title X of the PHS Act and is used by state, local, and nonprofit agencies to operate family planning clinics, offering services primarily--but not exclusively--to low-income women and teenagers. In 1981, about 4 million women were served. Funds are distributed among the states by formula based on the number of low-income women and the number of women under 20. Additional federal funding for family planning services is available through the Maternal and Child Health Block Grant, Medicaid, and the Social Services Block Grant. Although state and local governments also fund family planning services from their own sources, it is estimated that 86 percent of all public funding is federal, with 40 percent channeled through Title X.

Migrant Health Services. Grants for migrant health centers are authorized by the PHS Act and are awarded competitively to public and nonprofit agencies in areas with seasonal influxes of migrant workers. Funds are used to provide access to primary health care and environmental health services for about 2.7 million migratory and seasonal farmworkers and their families. In 1981, about half a million persons were served. Although state and local governments provide some funding for these services, federal dollars provide about 95 percent of all public spending for migrant health services.

Black Lung Clinics. The black lung clinics program is authorized under the Black Lung Benefits Act of 1972, and provides support for respiratory and pulmonary health care in areas where there are significant numbers of active and retired coalminers. Services are provided through existing community health centers, other outpatient health care facilities, or free-standing black lung clinics. Funds are distributed among the states by formula, based on the number of active and retired miners. In 1981, the program supported about 70 clinics in 14 states serving between 50,000 and 60,000 persons.

