

DOM-45 CONSOLIDATE SOCIAL SERVICE PROGRAMS AND REDUCE THEIR BUDGETS

		Annual Savings (Millions of dollars)					Cumulative Five-Year Savings
		1996	1997	1998	1999	2000	
Discretionary Spending							
From the 1995 Funding Level							
Budget Authority	a	595	595	595	595	595	2,380
Outlays	a	375	595	595	595	595	2,160
From the 1995 Funding Level Adjusted for Inflation							
Budget Authority	a	755	850	940	1,035	1,035	3,580
Outlays	a	480	815	905	1,000	1,000	3,200
Direct Spending							
Budget Authority	a	835	835	840	845	845	3,355
Outlays	a	785	835	840	840	840	3,300

a. The option would not take effect until 1997.

Social services are provided to many individuals and families through an array of programs, each with its own rules and regulations. Those programs may be administered at either the federal or state level by separate agencies, even though they serve the same or a very similar clientele. In recent years, the number of separate programs has grown, particularly in child care, which has seen five new ones enacted since 1988.

This option would consolidate a number of social service programs into one or more block grants. A large array of programs could be consolidated. For the purposes of this illustrative estimate, the consolidation would bring together the Social Services Block Grant (SSBG), the Community Services Block Grant, Title IV-A "At-Risk" Child Care and Transitional Child Care programs, the Child Care and Development Block Grant, Dependent Care Planning and Development Grants, and grants to states for services and meals from the Administration on Aging. Two block grants--one for families with young children and one for the elderly--might be appropriate since the programs being considered in this option provide services primarily to those groups.

Consolidating these programs and holding spending in their new budget at 25 percent below the 1995 funding level would reduce federal government outlays over the 1997-2000 period by \$5.5 billion (\$2.2 billion in discretionary spending and \$3.3 billion in direct spending) measured from the 1995 funding level. The savings from the 1995 funding level adjusted for inflation would be \$6.5 billion (\$3.2 billion in discretionary spending and \$3.3 billion in direct spending) over the same period. (The specific year-to-year savings would, however, depend on the particular features of the new block grant.) Three of the programs that would be consolidated--SSBG and the two Title IV-A child care programs--are entitlements that would affect direct spending. The remaining programs are discretionary and require annual appropriations. To allow time for designing and coordinating consolidation options, particularly the exact set of programs to include, implementation would be delayed until 1997.

With consolidation, localities could provide social services more efficiently. Duplicate services could be eliminated, and administrative costs would decline because of simpler rules and regulations that

would facilitate a reduction in administrative personnel. States and localities would have more freedom to tailor programs to local needs. Moreover, different services provided to the same individual or family could be coordinated more easily, improving service delivery from the client's perspective.

There would, however, be some risks. States would be unlikely to replace all or most of the lost federal funding, although individuals and families who were most in need could be protected, either by directing the consolidated grants toward states and

areas with the lowest incomes or fiscal capacities or by federally mandating income limits for eligibility. In addition, because much of the affected spending is for child care subsidies, low-income mothers might find it more difficult to work outside the home, which could increase spending for welfare programs. Also, Transitional Child Care is an open-ended entitlement program, and converting it to a capped grant might reduce future funding. Finally, consolidation would diminish federal control over the specific uses of funds.

DOM-46 ELIMINATE OR REDUCE FUNDING FOR THE ARTS AND HUMANITIES

	Annual Savings (Millions of dollars)					Cumulative Five-Year Savings
	1996	1997	1998	1999	2000	
Eliminate Funding						
From the 1995 Funding Level						
Budget Authority	1,114	1,117	1,117	1,117	1,117	5,582
Outlays	803	1,037	1,091	1,117	1,117	5,165
From the 1995 Funding Level Adjusted for Inflation						
Budget Authority	1,145	1,179	1,223	1,268	1,315	6,130
Outlays	823	1,085	1,181	1,251	1,297	5,637
Reduce Funding by 50 Percent						
From the 1995 Funding Level						
Budget Authority	557	559	559	559	559	2,793
Outlays	402	519	545	559	559	2,584
From the 1995 Funding Level Adjusted for Inflation						
Budget Authority	573	590	611	634	657	3,065
Outlays	412	543	590	626	649	2,820

NOTE: The savings shown in 1996 and 1997 would require a rescission of all or part of the advance appropriations for the Corporation for Public Broadcasting of \$312 million in 1996 and \$315 million in 1997.

The federal government subsidizes various arts and humanities activities. In 1994, federal outlays for the Corporation for Public Broadcasting, the Smithsonian Institution, the National Gallery of Art, the National Endowment for the Arts, the National Endowment for the Humanities, and the John F. Kennedy Center for the Performing Arts totaled about \$1 billion.

Eliminating funding for these programs over the 1996-2000 period would reduce federal outlays by about \$5.2 billion measured from the 1995 funding level and about \$5.6 billion measured from the 1995 level adjusted for inflation. Holding funding at half of the 1995 level would save almost \$2.6 billion measured from the 1995 funding level and about \$2.8 billion measured from the 1995 level adjusted for

inflation during that period. This option would reduce the appropriation by nearly 60 percent, in real terms, in the fifth year. The final effect of either option on arts and humanities activities would depend on the extent to which other funding sources--states, private individuals, firms, and foundations--increased their contributions and on whether higher admission fees to these activities were used to make up for reduced federal funding.

Proponents of this option argue that federal funding for the arts and humanities is not affordable in a time of fiscal stringency, especially when programs addressing central federal concerns are not fully funded. Moreover, because many arts and humanities programs benefit predominantly higher-income people, instituting or raising admission fees or ticket

prices could substitute for federal aid in many cases. In a number of cities here and abroad, for example, museums charge fees.

Reducing or eliminating federal appropriations for the arts and humanities would probably result in

fewer of those activities, however, because other funding sources would not be likely to offset fully the loss in federal subsidies. As a result, activities that preserve and advance the nation's cultural heritage would be likely to decline.

DOM-47 REDUCE THE MATERNAL AND CHILD HEALTH CARE BLOCK GRANT
AND THE PREVENTIVE HEALTH SERVICES BLOCK GRANT

	Annual Savings (Millions of dollars)					Cumulative Five-Year Savings
	1996	1997	1998	1999	2000	
From the 1995 Funding Level						
Budget Authority	421	421	421	421	421	2,105
Outlays	193	363	415	421	421	1,812
From the 1995 Funding Level Adjusted for Inflation						
Budget Authority	449	480	512	544	579	2,565
Outlays	206	401	484	522	555	2,168

In its appropriations for 1995, the Congress provided about \$842 million in block grants for programs in maternal and child health and preventive health services. Almost all of those funds are distributed to the states, with a small amount being used for federal initiatives. The block grants, which are funded through the Public Health Service, allow states considerable flexibility in choosing the programs to fund within the specified areas. These grants do not generally restrict benefits to categories of recipients, such as low-income families.

Each block grant supports a wide range of programs. The Maternal and Child Health Care Block Grant subsidizes programs that provide such services as preventive care, prenatal care, health assessments for children, rehabilitation services for blind and disabled children, and community-based services for children with special health care needs. The 1995 funding for that block grant was \$684 million. The Preventive Health Services Block Grant supports programs in such areas as immunization, hypertension control, dental health, environmental health, and injury protection. Funding for 1995 was \$158 million.

If funding for each of these block grants was held at half of the 1995 funding level, the savings in outlays for the 1996-2000 period would be about \$1.8 billion measured from the 1995 funding level and about \$2.2 billion measured from the 1995 level ad-

justed for inflation. In 2000, spending would equal 43 percent of the 1995 spending level adjusted for inflation.

The principal justification for these reductions is that the federal commitment to other programs directed toward maternal and child health and preventive health services has increased substantially in recent years. For example, Medicaid's coverage of low-income women and young children has expanded in several ways. States are now required to provide Medicaid coverage to pregnant women and to children under age six in families with income below 133 percent of the federal poverty level. States are also now required to provide Medicaid coverage to children under the age of 19 who were born after September 30, 1983, and whose family income is below the poverty line. The phase-in will continue until all children under the age of 19 with family income below the poverty line are covered by Medicaid in 2002. Thus, the block grants are not essential for ensuring access to health services for those individuals.

In addition, states have the option of providing Medicaid coverage for pregnant women and infants in families with income of up to 185 percent of the poverty line. As of July 1994, 34 states and the District of Columbia had set income thresholds above 133 percent of the poverty line for that population. Similarly, between 1991 and 1994, funding for pro-

grams of the Centers for Disease Control and Prevention for immunization, tuberculosis control, prevention of human immunodeficiency virus infection, and breast cancer screening increased by \$508 million.

The major disadvantage of cutting the block grants is that in the current fiscal environment, many

states might be unable to assume a greater share of the financial responsibility for the affected programs. Cuts in the block grants could adversely affect the health of people--especially those in low-income families not eligible for Medicaid--who would receive less assistance from those programs.

DOM-48 ELIMINATE SUBSIDIES FOR HEALTH PROFESSIONS EDUCATION

	Annual Savings (Millions of dollars)					Cumulative Five-Year Savings
	1996	1997	1998	1999	2000	
From the 1995 Funding Level						
Budget Authority	288	288	288	288	288	1,440
Outlays	138	256	288	288	288	1,259
From the 1995 Funding Level Adjusted for Inflation						
Budget Authority	298	308	319	330	342	1,596
Outlays	143	270	312	323	334	1,382

The Congress provided \$288 million to the Public Health Service in 1995 to subsidize education for physicians, nurses, and public health professionals. Those funds primarily furnish institutional support through grants and contracts to schools for designated training programs in the health professions. A limited amount of the assistance is provided through loans, loan guarantees, and scholarships for students. The programs promote physician training in primary care, advanced nursing education, and increased enrollment of minority and economically disadvantaged students:

- o *Primary care training.* Several programs provide federal grants to medical schools and teaching hospitals to develop, expand, or improve graduate medical education in primary care specialties and to encourage practice in rural and low-income urban areas. Funding for 1995 is \$131 million.
- o *Nursing education.* The subsidies to nursing schools are meant to increase graduate training for nurse administrators, educators, supervisors, researchers, and nursing specialists, including nurse-midwives and nurse-practitioners. Funding for 1995 is \$61 million.
- o *Support for minority and economically disadvantaged students.* Over half of these funds go to professional schools for recruiting, training, and

counseling minority and economically disadvantaged students. The remaining funds are for student loans and scholarships. Funding for 1995 is \$95 million.

Eliminating all of these subsidies would save, over the 1996-2000 period, about \$1.3 billion measured from the 1995 funding level and about \$1.4 billion measured from the 1995 level adjusted for inflation. The principal justification for this option is that market forces provide strong incentives for individuals to seek training and jobs in the health professions. Over the past several decades, physicians--the principal health profession targeted by the subsidies--have rapidly increased in number, from 142 physicians in all fields for every 100,000 people in 1950, to 161 in 1970 and 244 in 1990. Projections by the American Medical Association indicate that the total number of physicians per capita will continue to rise through 2000. In the case of nurses, if a shortage indeed existed, higher wages and better working conditions would attract more people to the profession and more trained nurses to nursing jobs, and would encourage more of them to seek advanced training.

Moreover, because the subsidies go mainly to institutions, they may have little effect on the numbers or characteristics of people studying to be health professionals. For example, most of the subsidies for nurses' training are directed toward increasing skills through baccalaureate degree programs and advanced

education in nursing, rather than raising the number of new entrants into the profession. Similarly, over half of the funds for increasing enrollment of minority and economically disadvantaged students are used to support schools' recruitment, training, and counseling efforts. Many critics of the subsidies contend that schools in the health professions have a strong commitment to recruiting students from diverse backgrounds. Given that commitment, schools would probably continue much of their recruiting and training efforts even if the subsidies were eliminated.

The major disadvantage of eliminating the subsidies is that the incentives supplied by market forces may not be sufficient to meet entirely the goals of these health professions programs. For example,

third-party reimbursement schedules for primary care may not encourage enough physicians to enter those specialties and may not include financial inducements sufficient to increase access to care in rural and inner-city areas. In addition, fewer people might choose advanced training in nursing, which could limit the opportunities for the use of relatively inexpensive physician substitutes. Another drawback relates to the goal of increasing enrollment of minority and economically disadvantaged students. To the extent that schools did not fully offset the cut in federal funds for scholarships, fewer such students might enter the health professions, possibly exacerbating the problem of access to care in medically underserved areas.

**DOM-49 REDUCE FUNDING FOR RESEARCH SUPPORTED BY
THE NATIONAL INSTITUTES OF HEALTH**

	Annual Savings (Millions of dollars)					Cumulative Five-Year Savings
	1996	1997	1998	1999	2000	
From the 1995 Funding Level						
Budget Authority	1,133	1,133	1,133	1,133	1,133	5,665
Outlays	487	1,043	1,133	1,133	1,133	4,929
From the 1995 Funding Level Adjusted for Inflation						
Budget Authority	1,507	1,905	2,329	2,755	3,209	11,705
Outlays	648	1,558	2,056	2,478	2,916	9,656

The federal government is providing \$11.3 billion in 1995 for research funded through the National Institutes of Health (NIH). About 60 percent of the NIH research budget is awarded to universities and other nonprofit institutions through research grants and contracts. The rest is spent for research within the institutes, research contracts with industrial firms, research by state and local governments, foreign research, and administration.

A reduction in funding for NIH research could be justified by its rapid growth in recent years. Between 1984 and 1994, NIH expenditures more than doubled. If funds for NIH research were reduced to 90 percent of the 1995 funding level and held there, the 1996-2000 savings in outlays would be \$4.9 billion. Measured against the 1995 funding level adjusted for inflation, the savings would be about \$9.7 billion. The NIH could respond to such reductions by limiting its overhead reimbursements for research grants and by funding research projects at a reduced proportion of their costs, thereby encouraging researchers to find additional sources of support. (See DOM-63 for a related option.)

In 1995, NIH allocated \$6.2 billion--over half of its total funding--to competitively awarded research grants. Reducing NIH funding might mean that fewer research grants could be awarded. Because funding for those projects is based on a rating system, the least promising projects would be dropped

first. In 1992, NIH funded 30 percent of the grant applications it received. Reducing the number of grants that NIH awards could cause some biomedical researchers to leave the field or seek employment in the private sector.

The federal government is the mainstay of support for basic biomedical research on which advances in medical technology depend, and many people argue that the government should spend more, not less, on such research. Basic research is aimed at discovering fundamental properties of nature--it can result in new knowledge that has applications for many treatments. But the results of basic research usually cannot be appropriated by a single firm; rather, they increase a knowledge base that many firms use in their search for cures to specific diseases. Because a firm cannot fully appropriate the benefits of this kind of research, it may spend less on it than is socially optimal. Hence, many people argue that there is an important role for government in funding basic biomedical research.

Advocates of such funding point to the benefits of past federal support of basic research, which has played a role in the recent explosion of knowledge about molecular biology and human genetics. Such knowledge could help in the search for new diagnostic tests and cures for serious health conditions that threaten the lives or well-being of millions of people--for example, birth defects, arthritis, diabetes, multi-

ple sclerosis, immune system diseases, heart disease, and cancer. The reduction in NIH expenditures set out in this option could slow progress in those important areas.

Proponents of a reduction in NIH spending for health research and development maintain that the

effects of less government funding could be softened by increases in private-sector expenditures. To support their claim, they point to the recent increase in such funding: between 1982 and 1992, private-sector spending for health research and development more than doubled, even exceeding the increase in NIH spending.

**DOM-50 LIMIT THE GOVERNMENT'S SHARE OF THE COST FOR THE FEHB PROGRAM
TO A FIXED AMOUNT PER EMPLOYEE**

	Annual Savings (Millions of dollars)					Cumulative Five-Year Savings
	1996	1997	1998	1999	2000	
Discretionary Spending						
Budget Authority	100	200	400	700	900	2,300
Outlay	100	200	400	700	900	2,300
Direct Spending						
Budget Authority	100	200	400	600	900	2,200
Outlays	100	200	400	600	900	2,200

NOTES: Estimates do not include any savings realized by the U.S. Postal Service.

In order to show the effect of the specific programmatic changes in this option, savings are calculated relative to spending that has been projected under the assumption that current laws and policies affecting this activity remain unchanged. Those current-law estimates differ from projections that are not based on any programmatic assumptions and simply assume that the 1995 level of spending for this activity (or that amount adjusted for inflation) is provided in every year.

The Federal Employees Health Benefits (FEHB) program provides health insurance coverage for over 4 million active federal employees and annuitants, as well as their 4.6 million dependents and survivors, at an annual cost to the government of about \$13 billion. Two important differences exist between the FEHB program and the health insurance coverage provided by private employers. First, participants in the FEHB program choose from among many health insurance plans offering varying levels of benefits and premiums; they can also switch plans during an annual open-enrollment period. In contrast, many private-sector employees are offered no choice among plans, although larger firms tend to provide several alternatives. Second, in the FEHB program, the government and participants jointly finance the coverage through insurance premiums. In 1995, the government is expected to pay, on average, about 72 percent of the premiums for active employees and 73 percent for annuitants. Many large private employers pick up the entire cost of covering an individual employee and roughly 75 percent of the additional cost of family coverage.

Although health insurance costs have risen sharply over the past decade, premiums for FEHB

plans have, on average, risen more slowly than those for private-sector employers. Over the past five years, FEHB plan premiums have increased an average of 6.8 percent a year, whereas the premiums paid by medium and large firms surveyed by Hay/Huggins Company, a benefits consulting firm, increased by 10.8 percent a year. Furthermore, FEHB premiums are expected to decline by 3.3 percent in 1995; the Congressional Budget Office (CBO) projects, however, that aggregate private health premiums are likely to rise by about 5 percent. Much more so than private-sector employees, federal employees have been able to switch from high-cost to lower-cost plans to blunt the effects of rising premiums. The dollar cap in the cost-sharing structure of FEHB (see below) encourages that efficient behavior and intensifies competitive pressures on all participating plans to hold down premiums.

Here is how that cost sharing works. For both employees and retirees, the government contributes 75 percent of the premium for the particular option selected by the enrollee, up to a cap of \$1,600 per year for individuals (\$3,490 for families). The dollar cap is set at 60 percent of the average high-option premiums for individuals and families in the "Big

Six" plans--five large plans and a phantom plan that acts as a placeholder for a former participating insurer. (Employer costs are higher under the U.S. Postal Service collective bargaining agreement.) Employees have an incentive not to choose plans with premiums above \$2,133 (\$4,653 for family coverage) because they pay 100 percent of the added cost of the premium. Thus, the dollar cap helps to control program costs.

By contrast, the requirement that enrollees pay 25 percent of the premium in plans with costs below \$2,133 gives employees only a weak incentive for price-conscious selection among those health plans and also blunts price competition among plans to attract participants. Under the current arrangement, if an employee switched from a plan costing \$2,100 to one costing only \$1,800, his or her annual cost would be reduced by only \$75. The provision requiring employees to pay at least 25 percent of premiums potentially affects an increasing proportion of enrollees. Between 1987 and 1992, the number of enrollees paying 25 percent of the premium while the government contributes less than the maximum dollar amount rose from 28 percent of total enrollment to 69 percent.

Budgetary savings and better cost-reducing incentives would be gained by revising the FEHB program so that the government simply paid the first \$1,535 of an employee's premium (\$3,430 for family coverage). Those amounts are based on the average government contributions in 1995 and would increase annually by the rate of inflation rather than by the rate of change in the Big Six premiums. Because those premiums are expected to rise faster than inflation, the government's savings would be considerable. In addition, the government would have more control over its premium contributions because they would be more predictable. Federal employees and retirees would also have the opportunity--by choosing low-cost plans--to reduce their share of the total premium below the 25 percent minimum under current law.

Compared with current law, savings in discretionary spending from reduced payments for *current employees* and their dependents would total \$2.3 billion over five years. Yet despite those savings, government spending for FEHB premiums for current

employees would still be growing each year. If the goal was to hold government payments constant over time, additional policy actions would be required. Savings in direct spending, relative to current-law spending, from reduced benefits for *retirees* would reach \$2.2 billion over five years. CBO's estimate does not include any savings from potential reductions in premiums as a result of increased competition among insurance plans.

This option would require the roughly two-thirds of all enrollees who currently choose a plan with a premium in the range of \$1,535 (\$3,430 for family coverage) to \$2,133 (\$4,653 for family coverage) to pay all of the premium above the new cap--not just one-quarter of it, as at present. The 31 percent of participants enrolled in the Blue Cross-Blue Shield high-option plan and other plans with premiums above \$2,133 (\$4,653) would also continue to pay all of that extra cost. With all consumers subject to paying all of those incremental costs, the incentive to select a lower-cost plan would be strengthened. Because purchasers would be more price-conscious, many plans would have a greater incentive to economize and offer lower premiums to retain their participants. Almost all plans currently have premiums above \$1,535 (\$3,430 for family coverage), and there would be no incentive to offer a premium below that amount. In the lowest-cost plans, which include the standard options under the Mail Handlers and the George Washington University Hospital plans, enrollees could look forward to having the government pay the entire premium, with no cost to them.

The health care sector is currently undergoing dramatic changes. After several years of extremely rapid growth, spending slowed in the early 1990s. Employers and employees, in sorting out some new health insurance options, have stirred up a nascent price competition among health plans--historically, a weak force. A variety of new plans, commonly grouped under the managed care category, are attempting to capitalize on the new price consciousness of consumers and are rapidly claiming a share of the market from traditional fee-for-service plans. In 1994, about 40 percent of federal employees were enrolled in managed care plans.

This proposal would accelerate the changes currently under way in the health care market by intensi-

fyng competition among FEHB plans. The FEHB program is often held up as a model of managed competition. If that approach works as theorists have predicted, the program changes in this option could reduce the growth of health premium costs. Many FEHB plans, especially the managed care plans, have a significant ability to control their premium costs. Further, enrollees would receive the full benefit if their premiums rose more slowly than inflation.

On the downside, this option would result in enrollees' paying an increasing share of their premiums when premium rates rose faster than inflation. Currently, the government bears most of that risk; large private-sector employers bear essentially all of it. The added cost to workers would amount to about \$500 per worker in 2000 and more in later years. Asking employees and retirees to pay more would have a number of consequences. Although it could encourage participants to select more cost-efficient plans, it could also place more participants in plans

with inferior benefits. Because the added costs to employees amount to a reduction in compensation, the government might find it harder to attract and retain high-quality employees. Finally, for current retirees and long-time federal workers, cuts in promised benefits amount to a retroactive change in the terms of their employment that lowers their standard of living. (For further discussion of the pros and cons of such cuts, see DOM-60 and ENT-50.)

The option has an additional drawback in that it would strengthen the existing incentives for FEHB plans to seek out healthy people and for healthy people to select cheap plans. Those patterns isolate sick people in selected plans that then experience increases in costs and risk financial instability. The Office of Personnel Management, which administers the FEHB program, can review plans to try to limit that form of adverse selection. However, its effectiveness in limiting all adverse selection is doubtful.

DOM-51 REDUCE FEDERAL RENT SUBSIDIES BY SHIFTING SOME COSTS TO TENANTS OR THE STATES

	Annual Savings (Millions of dollars)					Cumulative Five-Year Savings
	1996	1997	1998	1999	2000	
Reduce Section 8 Subsidies						
Budget Authority	140	306	724	820	1,344	3,334
Outlays	218	454	708	983	1,281	3,644
Reduce Public Housing Operating Subsidies						
Budget Authority	108	222	346	478	620	1,774
Outlays	49	158	277	404	541	1,429

NOTE: Savings from the 1995 funding level and from the 1995 funding level adjusted for inflation would be essentially equal because they would depend on tenants' incomes and on the number of assisted households, both of which would be virtually the same for the two funding levels.

Most lower-income renters who receive federal rental assistance are aided through the Section 8 programs or the public housing program, which are administered by the Department of Housing and Urban Development (HUD). Those federal programs usually pay the difference between 30 percent of a household's adjusted income and either the actual cost of the dwelling or, under the Section 8 voucher program, a payment standard. In 1994, average federal expenditures per assisted household for all of HUD's rental housing programs combined were roughly \$4,800. That amount includes both housing subsidies and fees paid to administering agencies.

Savings in outlays could be achieved by reducing federal payments on behalf of recipients. To diminish or eliminate the impact of that change on assisted tenants, state governments--which currently contribute no funds toward these federal rental assistance programs--could be allowed to make up some or all of the decrease. This option would increase combined tenant and state rent contributions over a five-year period from 30 percent to 35 percent of a tenant's adjusted income. For the Section 8 programs, it would save a total of \$3.6 billion in outlays over the 1996-2000 period. For public housing, total savings would be \$1.4 billion over the five-year period. (The savings from the 1995 funding level and from the 1995 funding level adjusted for inflation would be essentially equal over that period. That outcome oc-

curs because savings would depend on tenants' incomes and on the number of assisted households, both of which would be virtually the same for the two funding levels.) Realizing those savings, however, would require changing the authorizing legislation for those programs as well as cutting annual appropriations.

One rationale for involving states in housing assistance is that those programs generate substantial local benefits, such as improved quality of the housing stock. If all states paid 5 percent of the adjusted incomes of those receiving assistance, housing costs for assisted families would not rise. Moreover, since eligibility for housing assistance is determined by each area's median income, tying states' contributions to renters' incomes would ensure that lower-income states would pay less per assisted family than would higher-income states. Finally, if a state chose not to participate and consequently rent payments by its households increased to 35 percent of their adjusted incomes, those out-of-pocket costs would still be well below the nearly 50 percent of income that the typical unassisted renter who is eligible for assistance pays.

Absorbing part of the costs of rental housing assistance, however, would be difficult for states that are experiencing fiscal distress. Unless all states made up the reduction in federal assistance, this strat-

egy would increase housing costs for some current recipients of aid, who are generally poor. Moreover, raising rent payments could prompt some stable, slightly higher-income households to leave assisted housing projects in areas of the country where unas-

sisted housing of the same quality would now be cheaper. That outcome would change the economic mix of households in those projects, possibly reduce the projects' viability, and increase the average cost of subsidizing them.