

Discussion Papers

Assessing Federalism:
ANF and the Recent
Evolution of American
Social Policy Federalism

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Assessing
the New
Federalism

*An Urban Institute
Program to Assess
Changing Social
Policies*

Assessing the New Federalism is a multiyear effort to monitor and assess the devolution of social programs from the federal government to the state and local levels. In collaboration with Child Trends, the project studies changes in family well-being.

Key components of the project include a household survey and studies of policies in 13 states, available at the Urban Institute's web site, <http://www.urban.org>. This paper is one in a series of discussion papers analyzing information from these and other sources.

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Assessing Federalism

American social welfare programs have long been funded, regulated, and provided by a mix of federal, state, and local government entities. The allocation of specific responsibilities among governmental levels has periodically shifted in significant ways. Primary responsibility has also varied widely by program area over time. How different program responsibilities are allocated matters because it can affect the ability of government to effectively support low-income families and individuals in need of assistance.

Decisions about federalism often seem abstract, involving debates about the relative advantages of uniform national standards and benefit levels versus encouragement of state ingenuity and tailoring to local conditions. Arguments are also often framed in broad philosophic or ideological terms. At the end of the day, however, how critical social programs are structured between the federal and state governments may significantly influence their strengths and limitations and how well they can help poor and low-income people.

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) was widely seen as representing a key moment of renegotiation in the uneasy American system of social policy federalism. It followed a period of widespread state experimentation with welfare and other programs through federal S. 1115 waivers, and the nation seemed poised to pursue devolution on a sweeping scale. The intense and extended debate around welfare reform also saw multiple legislative attempts to block-grant Food Stamps and child nutrition programs, Medicaid, and federal child-welfare funding programs. Although ultimately most of these efforts would be unsuccessful, the mid-1990s was marked by a broad sense that the nation was on the cusp of a radical shift in American social policy federalism.

The Urban Institute's *Assessing the New Federalism* (ANF) project was established to explore and understand better what was unfolding in the aftermath of PRWORA, focusing on a set of key social programs. ANF analyzed trends and policies that affect low-income families and explored the respective roles of state and federal governments in financing, regulating, and administering essential social programs from early 1997 on. It looked in particular at income and work supports, family supports, and health programs for low-income families. Much of ANF's work was rooted in the National Survey of America's Families (NSAF), which assessed the circumstances of more than 40,000 families (more than 100,000 children and nonelderly adults) in 1997, 1999, and 2002. ANF also entailed a set of in-depth case studies of 13 states and 17 localities in 1997 and 1999 that focused on human services and health systems and programs.

The 13 ANF states represented over half the low-income population nationwide receiving these services.¹ More than 450 publications, including policy briefs, discussion papers, book chapters, and reports, resulted from ANF's work between 1997 and 2005. This paper builds on a series of ANF publications that explored various aspects of social policy federalism since 1996. They included a series of child-welfare financing publications that addressed the funding decisions of the 50 states at five points in time, a series of publications examining states' health care budget decisions, a book exploring federalism and health care, and a study of four intergovernmental social programs' ability to address the extreme stress created by Hurricane Katrina.

This paper explores what ANF's work can tell us about the evolution of federalism within five major social programs during the nine years between 1997 and 2006. It is one of several papers distilling ANF's lessons, including "Assessing the New Federalism: Eight Years Later"

¹ The states were Alabama, California, Colorado, Florida, Massachusetts, Michigan, Minnesota, Mississippi, New Jersey, New York, Texas, Washington, and Wisconsin.

(Golden 2005). That paper focused on lessons about policy and its impact on families; this paper focuses on lessons about federal-state relationships. It addresses Temporary Assistance for Needy Families (TANF), Food Stamps, Medicaid, the State Children’s Health Insurance Program (SCHIP), and child welfare.² One strength of the body of ANF research is that it covers a period of both strong and constrained state budgets and national economic conditions, allowing some examination of changing federal-state arrangements within these program areas as they evolved within a shifting economic context.

The paper is the result of a review and synthesis of more than 60 publications addressing state and federal financing and/or programmatic arrangements in the major program areas, informed by interviews with experts who participated in ANF research.³ The next section, “A Constrained Devolution of Social Policy,” broadly explores the extent of devolution in these programs. After that, “The Federal Government’s Ambivalent Approach to Establishing Program Standards and Accountability Requirements” looks at the unsettled nature of the relative federal-state roles in establishing program standards and accountability requirements, and “The Federal Role in Program Financing” examines the shifts in federal and state financing within a changing economic context. “A Widening of State Variation in Standards and Funding?” explores the apparent widening of program variation at the state level since the mid-1990s. The final section draws out a number of conclusions.

A Constrained Devolution of Social Policy

Passionate debate accompanied the enactment of PRWORA and consideration of the other proposals to block-grant and otherwise fundamentally alter essential social programs in the

² While child care and child support enforcement were important parts of PRWORA and welfare reform, this analysis does not explore these policy areas.

³ While most were ANF publications, at times we consulted other Urban Institute research or research by other organizations if it addressed key questions related to federalism that ANF did not cover.

1990s. Ultimately, however, the extent of devolution in the five key programs this paper addresses has been much more limited than many had foreseen a decade ago. Not only were efforts to block-grant the full range of programs unsuccessful, where block-granting did occur, it was not the “halfway house” to full divestiture of federal accountability and financing responsibility that some had envisioned. This section reviews the broad developments in state-federal arrangements across the five program areas between 1997 and 2006.

Temporary Assistance to Needy Families

Federal cash assistance was the most clearly devolved program of the five this paper explores. PRWORA abolished the Aid to Families with Dependent Children (AFDC) program and with it the individual entitlement to assistance. PRWORA converted AFDC’s uncapped federal entitlement funding system, in which every dollar of state money was matched by a dollar or more of federal funds to the fixed-sum TANF block grant, initially authorized for six years. It gave states broad new discretion to determine eligibility standards and program design within certain federal requirements. It is probably the program where the concern was greatest that devolution and block grants would lead to a federal and state abandonment of low-income families—a “race to the bottom” in which states would move swiftly to cut their benefits and alter their policies in order to avoid being more generous than their neighbors and thus attract an influx of needy people (Peterson 1995).

But this worst-case scenario did not, by and large, come to pass. The overall federal block grant—\$16.6 billion a year—equaled the amount of money states had received under AFDC in the mid-1990s, despite the fact that the vibrant economy of the time and already-changing welfare policies would spur caseload declines. The federal legislation included a “maintenance of effort” (MOE) requirement that states keep up 75 to 80 percent of their mid-1990s AFDC

spending, preventing them from pulling out large amounts of funding.⁴ And although states were taking increasingly varied and sometimes strict approaches to supporting low-income and poor families, they also were not, on the whole, racing their neighbors downward on such key policies as benefit levels, time limits, and income disregards (Rowe 2005; Holcomb and Martinson 2002). The new federal welfare legislation allowed states to use TANF for a broad range of purposes to support low-income families. Over time, the states used the block grant to fund a wider array of programs and activities supporting a wider range of families than AFDC would have allowed. These programs included employment and training, child care, child welfare, family formation and marriage education, out-of-wedlock pregnancy prevention, and state earned income tax credits. With declining caseloads, more parents working, and a greater number of acceptable uses for TANF funds, cash assistance became a smaller part of the program, and services became larger (Zedlewski, Merriman et al. 2002).

While state policy variation increased markedly, states did not abandon their policy and financial commitments to low-income families in a race to the bottom, and many states adopted such policies as expanded earned income disregards, increased asset limits, and other approaches intended to support work. Part of this commitment to low-income families was clearly the result of the initially strong economy, which contributed to large state reserves of TANF funds until the early 2000s, and a strong job market. But it also appeared to be the result of a strong federal, state, and local convergence around PRWORA's work emphasis and, at least initially, the funding to support it (Zedlewski, Merriman et al. 2002).

⁴ The MOE requirement is lowered to 75 percent if the state meets its work requirements, as most states did between 1997 and 2006. Both the federal grant and the MOE requirements have been eroded by inflation over time. Their value decreased between initial passage of PRWORA and the delayed reauthorization, and they will decrease further since reauthorization has not increased either type of funding.

Food Stamps

Several efforts in the mid-1990s to block-grant the Food Stamp program failed, and instead it has remained an individual entitlement program to all low-income people that meet national eligibility criteria, with full federal funding of benefits. It is the only fully federally funded program of the five this paper explores and had a budget of \$31 billion in 2005. Nevertheless, the program has experienced changes in federal and state standards and practices over the nine years.

States saw sharp declines in Food Stamp participation from 1996 to 2000 (from 25.5 to 17.2 million). These decreases were linked to the end of AFDC, dropping welfare caseloads, and strict state administrative practices to meet federally monitored quality control standards. PRWORA also disqualified many legal immigrants and able-bodied childless adults who did not work from receiving food stamps, contributing to the declines. In an effort to reverse them, the federal government initiated food stamp modernization and simplification efforts to improve access for eligible people. The new federal rules provided states with greater flexibility to experiment with strategies to increase enrollments. The period would also see efforts to restore benefits to some of the groups disqualified by PRWORA.

After a period in which federal actions had contributed to sharp declines in coverage, federal and state agencies worked together in an effort to expand participation. By 2005, enrollments had again reached more than 25 million, about the same as in 1996. There appeared to a broad consensus around providing food assistance to groups deemed most “deserving” in the wake of welfare reform, in particular low-income non-immigrant working families. Food stamps’ fully federal and uncapped financing system also provided states with an incentive to expand outreach and enrollment assertively since they bore limited financial risk and food assistance could serve as an important support for low-income families, including those leaving TANF.

Medicaid

The Medicaid program also saw energetic, though ultimately unsuccessful, efforts during the welfare reform debate toward block-granting and capping this health insurance program for poor and low-income children, pregnant women, some parents, and the elderly. Established in 1965, Medicaid has instead remained an open-ended federal entitlement both to states and—within federal and state income eligibility limits—to individuals. Fiscal responsibility is shared between the federal government and the states, and the federal match rate (or federal medical assistance percentage, FMAP) is based on state per capita income (it was 50 to 76 percent in 2006; Mississippi received the highest match and 12 wealthier states, the lowest).

The federal government gives states significant discretion in deciding who to cover and what services to provide: it prescribes coverage of certain groups and a basic package of services, but beyond these mandatory groups and services states determine eligibility and services. The federal government has also increasingly granted states waivers to design program and financing systems outside the required scope of the law. By 2005, the program was marked by a high level of state variation in the groups covered and services provided, the use of such programmatic approaches as managed care and participant cost-sharing, and specific funding amounts and mechanisms used. By 2004, Medicaid covered 42 million adults and children in an average month at a total cost to the state and federal governments of \$288 billion, \$173 billion from the federal and \$115 billion from the states (Ellis, Smith, and Rousseau 2005; Kaiser Family Foundation [KFF] 2006a).

By and large, Medicaid's entitlement status for both individuals and states, its guaranteed federal match, and the relative political strength of its providers appeared to mitigate for some time state incentives to cut services in the face of growing demand, revenue shortfalls, and health care inflation (Zuckerman interview).

State Children's Insurance Program

SCHIP is a joint federal-state program enacted as part of the 1997 Balanced Budget Act and was designed from the start to combine significant federal funding with a high level of state control in program design and standards.⁵ SCHIP's structure—pairing relatively loose federal standards and accountability requirements with a more generous federal match rate than Medicaid's—was intended to increase insurance of low-income children in families between 100 and 200 percent of FPL and higher, and overall it has succeeded. SCHIP is a capped block grant, authorized at a total of about \$40 billion for 10 years. Although it builds in key ways on the Medicaid program, it is much smaller (about 2 percent the budget) and different in critical provisions. States may create separate SCHIP programs, expand their Medicaid program to cover children at a higher income level than the Medicaid program would otherwise allow, or do both (though they may not cover Medicaid-eligible kids with SCHIP funds).

Although the program is optional, all states and the District of Columbia have adopted it, and they did so quickly. By fiscal year (FY) 2003, 18 states had separate programs, 13 had Medicaid expansion programs,⁵ and 18 had combination programs (Dubay, Hill, and Kenney 2002). During FY 2004, 6.1 million children were enrolled during at least part of the year (and about 4 million in the last month of 2004) at a total cost of about \$6.6 billion (Wooldridge et al. 2005; KFF 2006b; Kaiser Commission on Medicaid and the Uninsured [KCMU] 2005b).

While children's enrollment was slower than anticipated, states responded with assertive outreach and streamlined enrollment procedures to cover more children relatively quickly.

Between December 1998 and 2004, enrollment grew from 897,000 to 4 million with little

⁵ ANF followed the implementation of SCHIP in 13 states, and tracked state and national developments through the NSAF. The 13 ANF states, however, were not entirely representative of SCHIP nationally. A higher proportion had separate SCHIP programs rather than Medicaid expansions and provided greater coverage of parents, as well as higher income eligibility. Two states, New Jersey and Florida, had state children's insurance programs before SCHIP (Hill, Courtot, and Sullivan 2005).

evidence that the program displaced employer-sponsored private insurance (Weil and Hill 2003; KCMU 2005b). The effect of the recession was variable among the states, but by and large, state financial support for SCHIP was relatively resilient. At the beginning of 2004, however, the program had its first decline in enrollment, a 1 percent drop that reflected the cumulative effect of state program changes in response to the economic downturn (Hill et al. 2005).

Child Welfare

Federal child-welfare funding was also the subject of intense pressure to block-grant, again ultimately unsuccessful. Child welfare has long been a largely decentralized program area with a high level of state discretion, though about half its funding comes from federal sources (Geen, Waters Boots, and Tumlin 1999; Scarcella et al. 2006). In some ways, it represents a story of greater rather than less federal involvement, with congressional legislation providing both new federal accountability requirements of the states and new funding. The 1997 Adoption and Safe Families Act (ASFA) aimed to enable and compel the states to accomplish the goals of earlier federal legislation, particularly emphasizing increased permanency, safety, monitoring, and accountability. ASFA authorized tracking and monitoring of outcomes and additional funds for adoption incentives, and it represented a significant change in the federal government's approach to child-welfare services provided by the states (Malm et al. 2001, Bess interview). From state fiscal year (SFY) 1996 to 2004, child-welfare spending from all sources increased about 40 percent.⁶ By SFY 2004, 49 percent of all child-welfare spending came from federal sources, 39 percent from state revenues, and 12 percent from local sources. Federal funding had increased by about 49 percent since 1996 (Scarcella et al. 2006).

⁶ ANF tracked changes in child welfare arrangements through five periodic child welfare financing surveys (in 1997, 1999, 2001, 2003, and 2005), as well as case studies, interviews, and surveys addressing policy changes and state and local implementation. The financing studies provided a SFY 1996 baseline and tracked spending sources and levels within and across a vast majority of states up to SFY 2004. The number of states responding in each round of the financing surveys ranged from 48 to 51 (including the District of Columbia).

Over the same period, many states and localities also made significant efforts to improve their service standards and increase accountability and oversight, under court order or by their own volition. In the area of child welfare, in particular, lawsuits and court settlements often compel policy change, and the judiciary has played a particularly critical role in defining which children the states must serve and what services they must fund and provide. Mirroring this, state and local funding for child welfare increased on average by 21 percent and 55 percent, respectively, between SFY 1996 and 2004 (Scarcella et al. 2006).

The Federal Government's Ambivalent Approach to Establishing Program Standards and Accountability Requirements

The federal government has taken an unsettled and somewhat inconsistent approach over the past nine years to its role in establishing program standards and accountability requirements. In many cases, it has actively facilitated greater state policy authority through statutes, regulations, and waivers. In other cases, however, it has asserted new federal authority to require certain state program outcomes or practices. It has also established in some programs new prohibitions on states' use of federal funds.

Temporary Assistance to Needy Families

PRWORA was approved amidst expectations of a broad federal divestiture of service and accountability requirements. Certainly, the new legislation initiated major shifts from the federal government to the states in policymaking authority in critical areas (and the states in some cases devolved it further to the localities). But at the same time, several key provisions placed significant new requirements on the states and limited their discretion in using federal TANF funds in important ways.⁷

⁷ The TANF reauthorization provisions of the 2005 Deficit Reduction Act would enact further requirements.

PRWORA outlined several broad federal policy goals for TANF, emphasizing support for needy families, increasing work, decreasing nonmarital births, and supporting married families.⁸ Within the parameters of these broad goals, the states were granted wide discretion in determining how to design, fund, and operate their TANF programs. However, Congress also prescribed certain new program standards and accountability mandates, as well as prohibitions, for states using federal TANF block-grant funds.⁹ These included

1. a 60-month time limit on federally funded TANF cash benefits, with exemption of 20 percent of a state's caseload;
2. beefed-up work participation requirements that were expected to affect far more recipients of cash benefits than did AFDC's work requirements under the now-defunct JOBS program;
3. strengthened requirements for state work participation rates, reaching 50 percent of the adult caseload by 2002; and
4. sharp restrictions on the eligibility of most legal immigrants, precluding states from using federal TANF funds to provide them with benefits.

The federal law certainly allowed states much greater authority in deciding a wider range of program standards than did AFDC, without having to request and receive waivers. After PRWORA, states had discretion for determining their benefit levels and income eligibility thresholds (as they had under AFDC), whether to provide a state entitlement to assistance in the absence of a federal one, what time limits to impose, how to define—within prescribed parameters—“countable” work activities, how to count income and assets in determining benefits, what sanctions to impose on recipients who didn't comply with program rules, and

⁸ The specific goals in the legislation were (1) to provide assistance to needy families so the children may be cared for in their homes or in the homes of relatives; (2) to end the dependency of needy parents on government benefits by promoting job preparation, work, and marriage; (3) to prevent and reduce the incidence of out-of-wedlock pregnancies and establish annual numerical goals for preventing and reducing the incidence of these pregnancies; and (4) to encourage the formation and maintenance of two-parent families.

⁹ PRWORA included a range of child support enforcement provisions, but this paper does not explore this program area.

other key provisions (Rowe 2005). States could also decide what other activities related to TANF's four broad goals they would fund.

But states also had to grapple with meeting the new federal requirements and addressing federal prohibitions. The work requirement, in particular, was predicted to be difficult. It proved easier than anticipated, however, because of the sharp caseload declines and the caseload reduction credit—PRWORA included a credit system that made it far easier than initially expected for states to reach the required rate because of their falling caseloads. The strong economy also drew recipients into work. States also expressed anxiety about the federal five-year “hard” time limit, anticipating possible crises as participants approached their “cliffs.”

Food Stamps

In the years following PRWORA, the federal government maintained its nationally uniform income eligibility thresholds and benefit levels for the Food Stamp program. The new law had initially imposed strict eligibility restrictions on many legal immigrants and childless adults, but over time the federal government provided new flexibility to the states in program administration and Congress eased some immigrant restrictions.

Food stamps are generally limited to families with gross income below 130 percent of FPL and net income (gross income minus 20 percent of earnings and some other deductions) below 100 percent of FPL.¹⁰ The formula counts a household's gross or net income (130 percent or 100 percent, respectively) minus 20 percent of wages, as well as household composition. Low asset limits for vehicles were almost universal before 1999, when the federal government began allowing states to raise these limits (Zedlewski et al. 2006).

¹⁰ Households in which everyone receives cash assistance from TANF, SSI, or (in some states) General Assistance are categorically eligible, even if their income or assets would otherwise exceed program limits. Households with at least one person who is elderly or disabled are subject to the net income test but not the gross income test.

PRWORA dramatically tightened restrictions on the eligibility of legal noncitizen immigrants for food stamps, with limited exemptions for some refugees, legal residents with substantial work histories, and veterans. Subsequent legislation gave states the decision of providing legal noncitizen immigrants with food stamps but required states that did so to fully fund the cost. PRWORA also imposed a three-month time limit on the eligibility of able-bodied adults without dependent children (ABAWDs). The law required states to coordinate their TANF program requirements more closely with Food Stamps benefits so food stamps no longer increased to compensate for the loss in income when families were sanctioned off TANF. The federal government also allowed states the flexibility to develop their own “Simplified Food Stamp programs” for welfare recipients and to coordinate eligibility for their TANF and Food Stamp programs (Zedlewski 1999).¹¹

Congress and the Clinton and Bush administrations enacted a number of policies in PRWORA’s wake to soften the law’s food stamps provisions and increase state flexibility in program administration. These modifications reduced administrative burdens on states and simplified client application and reporting requirements, restored eligibility for some immigrants, and liberalized asset restrictions affecting car ownership. The Balanced Budget Act of 1997 included modest food stamp restorations for legal elderly, disabled, and child immigrants living in the United States before August 1996. The 2001 Agriculture Appropriations Act allowed states to apply the vehicle asset tests used in their TANF programs (typically considerably more generous than the Food Stamp program’s vehicle asset threshold). The 2002 Farm Security and Rural Investment Act (the “Farm Bill”) further restored benefits to immigrant children eligible

¹¹ Soon after the passage of PRWORA, 40 states took advantage of the option to link program eligibility for TANF and food stamps, which subject food stamp recipients to sanctions for reasons related to their TANF participation and appeared to contribute to the precipitous decline in food stamp participation in the late 1990s (Zedlewski et al. 2006; Dean 2005).

before PRWORA and to most legal adult immigrants who had been in the country for five years (Zedlewski and Rader 2004). Even with these changes, however, most noncitizen immigrants remained ineligible until five years after they legally entered the country.

Several new policy changes simplified the administrative requirements of participants and extended benefits through household transition periods, thus making benefit receipt less sensitive to changes in work and other circumstances. In 1999, the Clinton administration offered states new options for substantially reducing the reporting and certification requirements for working families.¹² The following year, it issued regulations further easing reporting requirements and adding a transitional benefit alternative, giving states the option to extend food stamp benefits (for up to three months) for families leaving welfare without regard to their continuing income eligibility. The 2002 Farm Bill further broadened these initiatives, allowing states to require only semiannual reports for most families (with or without earnings) and extending the transitional benefit alternative to five months (Zedlewski and Rader 2004).

Finally, several changes, both explicit and implicit, signaled to the states that federal oversight of and penalties for payment errors would be eased. For many years the federal government had attempted to exercise tight control over state practices through the quality control (QC) system. It measured under- or overpayments and awarded financial bonuses to states with exemplary performance and penalized those with error rates above the national average through fiscal sanctions. Almost half the states received sanctions every year. Beginning in 1999, the federal government reduced the number of sanctions on states and eased sanction

¹² States could require families with earnings to file reports either every three months or only when a change occurred, such as a new job, a change in pay, or a change in hours. The new regulations also specified that states had to require families to complete face-to-face interviews only once a year.

collections, allowing states to reinvest them in a broader range of permissible activities, including activities designed to increase participation (Zedlewski and Rader 2004).¹³

Medicaid

Basic federal benefit and eligibility standards for the Medicaid program did not change significantly between 1996 and 2005, but during this time the federal Department of Health and Human Services (HHS) accommodated and even encouraged major state experimentation and variation, largely through the use of waivers (Long and Coughlin 2006).

As table 1 indicates, the federal government mandates that states provide minimum coverage for certain children and adults up to prescribed income thresholds with a mandatory benefits package, though states may also expand their Medicaid coverage beyond these thresholds to specified maxima. All states have relatively high proportions of low-income parents whose incomes fall above eligibility thresholds and are therefore ineligible for Medicaid and childless adults also are typically not covered by Medicaid.¹⁴

Table 1. Mandatory and Optional Medicaid Coverage

Covered group	Income eligibility thresholds	Benefits package^a
Required:		
Parents	State AFDC level as of 1996	Mandatory services include most acute care services, and nursing facility services. Major optional services include drugs, most personal care services, and institutional psychiatric services.
Pregnant women	≤133% FPL	
Children under age 6	≤133% FPL	
Children age 6–18	≤100% FPL	

Source: Winston et al. (2006).

a. The 2005 Deficit Reduction Act gave states new flexibility as of 2006 to provide certain beneficiaries with more limited benefits.

At the same time, however, HHS has eased the waiver approval process, allowing for much greater variability in coverage and benefit levels. Since 1997, waivers have been granted

¹³ The 2002 Farm Bill was critical to this change. It altered the rules that had previously guaranteed that half the states would always be subject to penalties for “above average” error rates. It also allowed states that were subject to penalties to invest these amounts in improving their systems rather than returning the money to the federal treasury (Finegold interview).

¹⁴ Except if states have waivers explicitly allowing them to do this.

for a wide range of purposes. HHS issued federal regulations in 2001 to establish the Health Insurance Flexibility and Accountability (HIFA) waiver initiative with the main purpose of encouraging premium assistance programs to reduce the number of uninsured. It gave states broader authority over Medicaid and SCHIP design and financing, streamlining the waiver application and review process and encouraging states to maximize their use of employer-sponsored coverage. As of the end of 2006, the federal government had granted 13 states HIFA waivers (Sachs, Walls, and Friedenzohn 2006; Coughlin and Holahan 2005). The use of other Section 1115 waivers has also grown sharply, with 10 states receiving comprehensive waivers between 2001 and 2005; within four years, almost half of all states received federal approval to substantially change their Medicaid programs, and seven more were developing waiver proposals. Finally, HHS initiated waivers in September 2005 for “host” states that received evacuees from the Gulf Coast states hit by Hurricane Katrina to offset the associated costs; by December 2005, 17 states had received these waivers (Winston et al. 2006).

State Children’s Health Insurance Program

SCHIP’s design has, from the outset, given states great flexibility in setting standards and few specific federal outcome or performance requirements. Those states with separate SCHIP programs could adopt more limited benefit packages than for Medicaid, as long as they met certain minimum standards. If they chose to expand Medicaid, however, they were required to meet the federally mandated service standards for children in that program.

Under federal law, states could impose cost-sharing, such as up-front enrollment fees, monthly premiums, deductibles, and co-payments on enrollee families (federal law limited cost sharing to 5 percent of family income). States could also establish waiting periods to discourage

families from dropping their employer coverage in order to enroll their children in SCHIP.¹⁵

Because SCHIP is not an individual entitlement, states with separate SCHIP programs could cap enrollment when budget shortfalls dictated. The law allowed states to publicize the program and simplify enrollment as they chose (Dubay et al. 2002). SCHIP funds could not be used to cover undocumented immigrants or children who were already covered by Medicaid.

Since 1997, federal actions have affected SCHIP program standards, including 2000 HHS guidelines that gave states the option of expanding SCHIP coverage to parents through S. 1115 waivers; Minnesota, New Jersey, Rhode Island, and Wisconsin were the first to do so (Howell et al. 2002). Coverage of adults with SCHIP funds has been controversial, however, and in 2006 the Deficit Reduction Act explicitly prohibited states from covering nonparents (Congressional Budget Office 2006).

Child Welfare

In contrast to its approach in the other four programs, the federal government has been more assertive in establishing standards and accountability requirements for child welfare over the past nine years. Responsibility for program standard-setting and funding have for some time been shared between the federal and state (and, in some cases, local) governments. During the period under review, several major federal legislative and regulatory changes significantly affected child-welfare standard-setting and accountability requirements (Malm et al. 2001).

The 1997 ASFA aimed to enable and compel the states to accomplish the goals of the 1980 Adoption Assistance and Child Welfare Act—safety, permanency, and child and family well-being—emphasizing in particular increased permanency and safety. Among other things, ASFA instituted the federally mandated Child and Family Services Reviews (CFSRs) to provide

¹⁵ Under SCHIP, states are required to show that in some way they are addressing the problem of “crowding out” of employer coverage, although low-wage jobs often do not provide employer coverage (Wooldridge et al. 2005; Hill interview).

greater accountability for child and family outcomes and implementation of more standardized data reporting among the states. It mandated that states develop new permanency planning procedures and reduce time for permanency decisions, among other things. The CFSR process allowed states to develop program improvement plans to address system weaknesses before facing significant federal penalties. ASFA also authorized additional funds for an adoption incentive program, which provided monetary incentives to states for increased adoptions. The legislation represented a major change in the federal government's approach to child-welfare services provided by the states, marking a shift toward a more outcomes-oriented system (Scarcella et al. 2006; Malm et al. 2001; Bess interview).¹⁶

The Foster Care Independence Act and amendments (1999 and 2001) replaced the prior IV-E Independent Living program for youth aging out of foster care and established the Chafee Foster Care Independence Program, doubling mandatory funding from \$70 to \$140 million. It also required states to extend services to young people who have aged out of foster care, allowed states to provide Medicaid coverage to former foster children until they are 21, permitted funds to be used for education and training vouchers for eligible youth, and added federal funding for education and training vouchers.

The Federal Role in Program Financing: Complex Relationships and Divergent Trends

The federal government's financing role in social policy is complex, and it varied widely among the five programs. Even within individual programs it shifted significantly over the nine years of the study. Overall, the scale of federal funding was largely maintained in most program areas, though TANF and SCHIP began to feel the constraints of their fixed funding allocations. The

¹⁶ In addition, 1993 federal legislation required states to establish foster care and adoption data collection systems, resulting in the Statewide Automated Child Welfare Information Systems (SACWIS) and the Adoption and Foster Care Analysis and Reporting System (AFCARS), which has now been largely implemented (Malm et al. 2001).

economic boom of the late 1990s followed by the recession of the early 2000s, however, led to unanticipated changes in program context—such as the initial decline in welfare caseloads, the subsequent tightening and weakening of the job market, and eventual losses of employer sponsored-health insurance—that put pressure on federal funding. At times, and for complex reasons, individual federal funding streams—in particular TANF and Medicaid—were used in apparently unanticipated ways.

Temporary Assistance to Needy Families

The new TANF block grant maintained, at least for a time, prior levels of federal funding, though how it ultimately was employed varied in certain ways from AFDC's purposes. PRWORA resulted in the consolidation of several categorical funding streams, including emergency assistance (EA) and the Job Opportunity and Basic Skills (JOBS) work-support program, into one \$16.6 billion annual block grant for cash assistance allocated among the states. The funding level was based on total state AFDC spending in the mid-1990s and was fixed until program reauthorization, which was initially slated for 2002. After repeated delays, reauthorization finally occurred as part of the Deficit Reduction Act in 2006. The DRA provided no additional funding to address inflation.

Allocations among the states were based on their (widely divergent) patterns of historic AFDC spending, with some upward adjustments in the form of supplemental grants for high-growth and high-poverty states. With the states' MOE funding requirements (which provided about \$10 billion a year), TANF essentially set a funding floor for the program's first six years, though without an inflation adjustment the floor gradually declined over time. TANF also initially represented a relative shift in the share of funding responsibility from the states toward the federal government, since the federal government maintained its prior AFDC spending level

while the states' required MOE was only 75 to 80 percent of their past spending (Zedlewski, Merriman et al. 2002).

Some policymakers, advocates, and others were concerned that the block-grant structure would create incentives for states to cut programs or access in times of economic stress since they would have to cover the full marginal cost of each additional recipient. For the first few years of the program, however, there was actually far more money available than would otherwise have been the case. The strong economy of the late 1990s and the steep decline in caseloads—dropping nationwide from about 4 million families in 1996 to about 2 million in 2000—decreased the demand for cash assistance, leaving most states with significant TANF surpluses (Golden 2005).

The decline in cash assistance caseloads also made a greater proportion of funds available for allowable expenditures other than cash benefits. Expenditures for cash assistance fell nationally from 76 percent of total TANF spending in 1996 to 41 percent in 2000. The biggest redirection in the early years was to child care. By 2000, 20 percent of TANF funds went for this purpose, while another 20 percent was dedicated to work activities and other work supports. States also found other uses for their surpluses, including child-welfare functions (in part, at least, replacing lost EA funds), transfers to the Social Service Block Grant for a wide range of social programs, and tax cuts (Golden 2005; Scarcella et al. 2006; Geen et al. 1999).

As the economy turned downward, however, the block grant began to feel the effects of inflation and competition from among the wide range of services and benefits that had come to rely on TANF funding. The fixed appropriation, unresponsive to inflationary pressure, meant that the real value of the block grant dropped over 20 percent between 1996 and 2005. Caseloads nationwide did not by and large rise after 2000, and state TANF surpluses and MOE

requirements helped alleviate the recession's effects for a time. But state TANF surpluses were largely depleted by 2003, and states faced increasingly difficult trade-offs in funding decisions (Finegold, Schardin, and Steinbach 2003).

Food Stamps

The Food Stamp program saw no major changes in federal-state funding arrangements over the nine years. Despite attempts to block-grant the program in the mid-1990s, it remained a federally funded entitlement program for individuals, which protected it from state budget pressures during the recession.¹⁷ Federal expenditures on the program actually decreased between 1996 and 2000, from \$24.3 billion to \$17 billion, as a result of dramatic caseload declines. After federal and state efforts to facilitate participation, expenditures increased, reaching \$31 billion in 2005.

Medicaid

By the early 2000s, Medicaid expenditures and the demand for Medicaid services were growing sharply at exactly the same time state fiscal conditions deteriorated. Medicaid enrollments actually decreased between 1997 and 1999 (in part because of welfare reform and the link between AFDC and Medicaid eligibility).¹⁸ Between June 2000 and June 2004, however, monthly enrollments grew from 31.6 million people to 41.3 million as eligible adults and children lost coverage previously provided by employers, either because adults lost jobs or because employers raised premiums or ceased coverage. This further strained the system (Ellis et al. 2005; Zuckerman and Cook 2006). Correspondingly, federal and state Medicaid spending grew from \$205 billion in 2000 to \$288 billion in 2004 (Bruen 2002; KFF 2006a). The economic

¹⁷ States are responsible for about half the administrative costs; their portion of total spending on the Food Stamp program ranged from 7 to 11 percent during this period.

¹⁸ AFDC recipients had been categorically eligible for Medicaid. Under PRWORA, states were to continue to provide Medicaid coverage for people who would have been eligible for AFDC under that obsolete system. This confusing eligibility mechanism appeared to contribute to dropping rolls.

downturn, along with the associated increase in Medicaid enrollment, was the main cause of the increase in Medicaid spending (Coughlin and Zuckerman 2005).

In the context of increased demand and budget pressures, states had a fiscal incentive—because Medicaid is a federally matched open-ended entitlement—to try to maximize the amount of spending they could claim that otherwise would require funding by state general revenues or less highly subsidized sources. This led to one of the key federalism stories around Medicaid: the creative and often aggressive tactics many states used to claim federal reimbursement and the federal-state tension these tactics exacerbated. To a significant extent the states can decide how to pay for their program costs. States can claim for federal reimbursement for a range of approved purposes and populations, and the program includes an array of complex state-federal funding mechanisms (Coughlin and Zuckerman 2003). Over time, states appeared to claim for a wider range of services, such as certain child welfare– and juvenile justice–related expenses, and to use the existing financing mechanisms more aggressively. The two most common approaches to Medicaid maximization were disproportionate share hospital (DSH) payments, intended to provide federal reimbursement to states for hospitals that served high proportions of uninsured patients, and upper payment limits (UPL).¹⁹ The trend toward maximization has altered the effective federal match rates among the states, with more aggressive states enjoying higher de facto FMAPs, one study indicating as much as 3 percent higher on average (Coughlin and Zuckerman 2003).

Congress and the administration took steps to contain maximization with limited effect, and, to some extent, to assist states with their budget crises. Federal regulations issued in 2001 aimed to limit states’ use of Medicaid maximization, allowing for a “phase out” period that gave

¹⁹ A 2001 CMS survey indicated that almost half the states had used these mechanisms inappropriately to draw down more federal funds than allowed by law (Coughlin and Zuckerman 2003).

the most aggressive states time to transition to other funding sources. The 2003 Jobs and Growth Tax Relief Reconciliation Act provided \$20 billion in additional federal funds to states between April 2003 and September 2004 with states receiving about half the money through a temporary “bump-up” in their FMAPs and the remainder through a temporary general revenue sharing program. The 2003 Medicare Modernization Act (MMA) attempted to address Medicaid maximization with provisions allowing increased DSH payments in some states, while at the same time cutting back on these states’ UPL funding. Other aspects of the MMA had Medicare taking over the Medicaid drug benefit for joint Medicare-Medicaid enrollees (“dual eligibles”) but required states to send to the federal government the amount they would have spent on drugs for this population (Coughlin and Zuckerman 2005; HHS 2003; Zuckerman interview).

State Children’s Health Insurance Program

SCHIP’s initial capped grant entailed allocations across program years and allocations across states, and both proved problematic over time. In 1997, Congress authorized an annual average of \$4 billion for SCHIP for each of 10 years, but the per-year funding allocations were frontloaded, even though states were just beginning program implementation. The law gave states three years to spend a given year’s allocation, and although some states established small programs relatively quickly that allowed them to start drawing federal money, the overall number of enrollees and the pace of spending was still very low. Initially, the states’ low enrollment rates led to a large portion of the SCHIP appropriation remaining unspent as states established and implemented their programs. While almost \$17.2 billion was allocated for the first four program years, only about \$5.8 billion was spent during this time (Weil and Hill 2003).

The 1997 BBA included an allocation formula for each state’s annual federal appropriation based on the number of low-income uninsured children in the state (present need),

and the total number of low-income children in the state (underlying need). Directing funds to states with the greatest present need without in effect penalizing states that had already taken steps on their own to cover uninsured children was challenging.²⁰ Some states that moved more quickly or had more developed existing infrastructures to build on were able to spend their funds more quickly, while others risked losing some of their funds because of slow implementation. Funds that remained unspent after three years were to be returned to a reallocation pool and redistributed to the treasury and to other states that had drawn down all their federal allotments. Ultimately, Congress passed a compromise measure in 2000 that gave the slow-spending states two additional years to spend their money, while still allowing a portion of the unspent funds to go to states that had spent more than their allocation. In 2004, 36 states spent over 100 percent of their yearly SCHIP allocations; at the same time, \$1.3 billion in unspent federal SCHIP money went back to the treasury (Dubay et al. 2002; Hill et al. 2005).

Child Welfare

The federal government's role in child-welfare funding has remained relatively steady in proportionate terms, with the federal share hovering around half of total spending over the study period. Both total federal spending on child welfare and state spending have increased since 1996. Child-welfare spending from all sources increased nationwide by 40 percent between SFY 1996 and 2004 to at least \$23.3 billion; federal funding for child welfare in SFY 2004 amounted to at least \$11.7 billion, or about half the total. In SFY 1996, it was at least \$7.8 billion in 2004 dollars (Scarcella et al. 2006).

Federal financing of child welfare is complex and appears to have become more so over the past nine years. It is complicated in the sense that states draw on many different funding

²⁰ Some states, including Washington and Minnesota, were penalized.

sources to pay for their child-welfare programs, rather than relying on one or two dedicated federal funding streams. It is also complicated because the 50 states differ from each other in the federal funding programs upon which they draw. This makes child welfare even harder to generalize about than the other programs described here.

States have drawn on numerous major federal sources, two dedicated to child welfare and several others nondedicated. The nondedicated sources have allowed states to fund social workers and services that are not allowable expenses in the narrower, dedicated funding streams such as Title IV-E of the Social Security Act, as well as to gain greater flexibility—including the ability to draw on block grant or fully federal funds without a required state match—or higher federal match rates. Their relative use, however, has changed notably over time.

Title IV-E is an uncapped individual entitlement (with a required state match) dedicated to child-welfare services. It has multiple components, including foster care, adoption assistance, and the Chafee program (which has capped funding). In SFY 2004, IV-E expenditures made up about half of federal child-welfare funding, similar to the share of total federal funding in the prior years of the ANF financing studies. IV-E adoption assistance funding increased, but growth in the program overall was limited by a “lookback” provision of PRWORA that based individuals’ eligibility for IV-E on what their eligibility for federal cash assistance would have been under 1996 AFDC standards. Because these income eligibility standards have not been adjusted for inflation since 1996, fewer families have been eligible for IV-E over time. In addition, the provision makes eligibility determination particularly cumbersome. Reflecting these problems, states’ IV-E “penetration rates” decreased from 58 percent of children in the states’ foster care systems in SFY 2000 to 54 percent in SFY 2004. Title IV-B, the other major

dedicated funding source, is a capped grant that made up only 5 percent of federal child-welfare spending by states in SFY 2004.

States also relied increasingly on TANF funds, at least for a time, although there are great variations by state in whether and how much TANF they use for child welfare. Until PRWORA's passage, states had used AFDC's emergency assistance funds to support a range of child-welfare services. In 1996, 13 percent of federal expenditures for child-welfare activities came from EA funds (Geen et al. 1999). Following welfare reform, this decreased to 8 percent of federal expenditures from TANF funds in SFY 1998. After TANF regulations were issued in 1999, however, clarifying that the block grant could be used for child-welfare services, TANF played a growing role in federal child-welfare funding. States spent a total of about \$3 billion in TANF funds in SFY 2004, an increase of 216 percent since SFY 1996.²¹ As noted below, states varied widely in their reliance on TANF. The use of TANF funds shifted considerably over the eight years of ANF's financing study, however, with TANF child-welfare spending subsequently decreasing by 3 percent between SFY 2002 and 2004, reflecting at least in part the decline of state TANF surpluses (Scarcella et al. 2006).

Medicaid, the other major nondedicated federal funding source, supported a number of child welfare-related services (in addition to providing routine health coverage to children and youth in foster care).²² These included transportation, rehabilitative services, targeted case management (assistance with access to medical, educational, social, and related services), and therapeutic and psychiatric residential treatment. The ANF study found that in SFY 2004 states spent at least \$1.0 billion in Medicaid funding for these child welfare-related nonroutine

²¹ Based on data from 39 states.

²² Youth who are IV-E eligible are categorically eligible for Medicaid. At state option non-IV-E eligible youth can be made eligible for Medicaid while in foster care. All states have chosen this option.

services.²³ Between SFY 1996 and SFY 2004, overall Medicaid spending for child-welfare services increased by 41 percent, \$286 million (Scarcella et al. 2006).²⁴

A Widening of State Variation in Standards and Funding?

The recent shifts in federal-state arrangements across both standard setting and financing functions appear to have contributed to a widening of state variation in standards for, and financing of, three of these programs: TANF, Food Stamps, and Medicaid (with state variation a hallmark of SCHIP since its inception). There were some shared patterns among the states: many states moved toward increased income disregards for TANF assistance, for instance, many expanded food stamp outreach efforts, and many used waivers to implement Medicaid managed care. But overall, the range of types of policy choices and the variation in specific policy responses within these programs has widened over the nine-year period. To a great degree this variation reflects divergent historic decisions about how to support poor and low-income people, often at least partially based on disparate state fiscal capacities (Yilmaz et al. 2006). It also seems to have reinforced the relative strengths and weaknesses of states' circumstances and capacities.

Temporary Assistance to Needy Families

Before PRWORA, states varied significantly in their decisions about welfare benefit levels and income eligibility thresholds. For example, in 1995, the maximum monthly benefit for a family of three ranged from \$923 in Alaska to \$120 in Mississippi. The growing use of Section 1115 waivers in the early 1990s also contributed to a significant level of variation (37 states had waivers by 1996). But PRWORA has increased the number of program dimensions by which states' and even localities' welfare policies and practices may differ without requiring waivers, and many jurisdictions have taken full advantage of this flexibility.

²³ Based on data from 41 states, though not all reported that they used Medicaid funds.

²⁴ Based on data from 38 states.

States still set widely differing maximum cash benefit levels (though they had compressed slightly by 2004), from \$170 for a family of three in Mississippi to \$923 in Alaska.²⁵ Many states (over half) increased the income levels at which families could receive benefits to help recipients combine low-wage work with assistance, though others did not.²⁶ About two-thirds of states modified program rules to allow more two-parent families to qualify, while one-third did not. The vast majority of states (all but three) increased their income disregards so more recipients could retain TANF benefits while working. But states varied in their approaches to time limits: as of 2003, 35 states allowed recipients to receive benefits up to the federal maximum of 60 months, 5 had no time limit for at least a part of their caseload, and 3 had time limits as low as 24 months (Rowe and Giannarelli 2006). States also made significantly differing decisions about what to use their TANF funds for: as of 2000, nine states spent less than a quarter of their TANF funding on cash assistance, while three states still spent over 55 percent on cash aid (Zedlewski, Merriman et al. 2002).

States' financing decisions have also varied widely after PRWORA, in part because of the relative flexibility the block-grant structure provided, the amount of money available to states, and their fiscal, demographic, and political contexts. The TANF allocation formula for grants contributed to significant cross-state differences in funding levels and locked in preexisting differences, since allocations were based on states' historic spending decisions. This meant the average federal contribution per poor family in traditionally low-benefit states (typically those with low fiscal capacity and Southern states) has been lower than in higher-benefit states (typically those with stronger fiscal capacity). As of 2002, 18 states received

²⁵ The maximum monthly income at which a family of three was eligible for cash assistance in FY 2003 ranged from \$205 in Alabama to \$1,641 in Hawaii.

²⁶ These thresholds failed to keep up with inflation, however, resulting in real income threshold declines in two-thirds of the states.

federal TANF funding of less than \$2,000 per poor family, 19 states received \$2,000 to \$4,000 per poor family, and 14 states received more than \$4,000 per poor family. For example, Connecticut received about \$7,000 in TANF funds per poor family, seven times the \$1,000 allotment for Alabama (Merriman 2002). These discrepancies both reflected states' varying decisions about their cash assistance programs and perpetuated them, limiting into the future the ability of low-fiscal capacity states to serve more expansively their poor and low-income families.

Food Stamps

States have exercised significant discretion over certain food stamp practices through changes in outreach, enrollment, reporting, and recertification; these expansions were supported by the program's full federal funding and softened oversight. Before the federal changes in food stamp policy and easing of QC monitoring, many states had imposed complex enrollment and certification requirements (including three-month certification periods and frequent in-person contact with benefit offices). After the implementation of the new federal options for reducing the reporting and certification requirements for some beneficiaries, food stamp offices engaged in a range of new activities.

Though specific state responses varied by type of policy, in most cases they used their new discretion to expand access to food stamps and make it easier for working families to enroll and maintain benefits. Outreach to previously unenrolled households became prevalent. After PRWORA, however, states differed substantially from each other in their policies toward immigrants who had lost eligibility because of changes in federal standards. Some states with the highest percentages of immigrants in their populations, notably California, Rhode Island, and New Jersey, provided food stamps to immigrants denied them under federal rules (Zimmerman

and Tumlin 1999). Some states with very small immigrant populations, such as Maine and Nebraska, did as well. Other high-immigrant states, such as Texas, New York, and Florida, replaced federal food stamps for only small numbers of immigrants; still others, such as Oregon, Michigan, and Pennsylvania, did nothing at all. Over 40 states sought waivers to provide assistance to ABAWDs living in their areas of highest unemployment (Super 2006).²⁷

Medicaid

By 2006, the Medicaid program was marked by a high level of variation in the groups states chose to cover and services they provided, the use of such programmatic approaches as managed care and participant cost-sharing, and specific financing mechanisms. While program eligibility, benefit packages, and participation among poor and low-income people have varied widely by state for many years, given the significant discretion federal law allows through state options, the level of variation appears to have increased in recent years, particularly with the growing use of waivers. Eligibility for poor adults, in particular, has been uneven, based on the 13 ANF states. For example, while 84 percent of adults with incomes below the FPL were eligible for Medicaid in Washington in 2002, 15 percent were eligible in Colorado (Golden 2005). This was the result at least in part of differing state decisions about which groups to cover beyond those federally mandated. Participation rates among those who were eligible in the 13 ANF states also varied, from 81 percent in Massachusetts to 36 percent in Mississippi (Golden 2005).

States have increasingly used waivers to modify which groups covered and the services they are offered, and waivers have been granted for a wide range of purposes. For example, the Oregon Health Plan (OHP) established a priority list of benefits for people covered by Medicaid. Utah's waiver allowed the state to implement a limited package of benefits with only primary

²⁷ States have shown more willingness to request ABAWD area waivers than in the early post-PRWORA years. Still, only a minority of the states use the full extent of these area waivers and other options to protect all their ABAWDs from the time limits (Finegold interview).

and preventative care services to adults up to 150 percent of FPL, a higher income level than required. Waiver plans have also allowed states to shift to defined contribution approaches (Sachs et al. 2006). The use of Medicaid managed care, typically through waivers, has added to the level of state variation. This broad approach to Medicaid financing and service delivery gained favor through the 1990s as a potential way to cut costs and cover more participants. Although managed care approaches may no longer be seen as cheaper, states have continued to pursue them for other reasons, such as the ability to provide participants with a consistent “medical home” (Zuckerman interview).

States have taken differing approaches to financing their Medicaid systems, and their use of particular types of financing mechanisms has varied for reasons including the structures of their health care systems (such as greater or lesser reliance on charity hospitals to provide care for low-income people), their ability and willingness to pursue Medicaid maximization, and the characteristics of their eligible populations. The impact of declines in employer-sponsored insurance has also been uneven across states, contributing to differing budget pressures and responses (Coughlin and Zuckerman 2005; Zuckerman and Cook 2006).

One 2005 study of Medicaid financing in 8 of the 13 ANF states (Alabama, California, Colorado, Massachusetts, Michigan, New York, Texas, and Washington), found a range of state approaches to addressing revenue shortfalls and increased Medicaid demand in the face of the recession. Some states made program cuts, fairly modest in 2003, with more states focusing on reducing or freezing provider reimbursement rates. The following year saw more substantial cuts, though their depth varied widely, with few reductions in New York and California and

sizeable ones in Texas, Colorado, Massachusetts, and Washington (Coughlin and Zuckerman 2005).²⁸

While few states enacted broad-based tax increases, many states pushed further on Medicaid maximization and pursued temporary revenue measures, such as borrowing from other dedicated sources, including TANF reserves (in New York), education funds (Alabama), and transportation projects (California). In FY 2004, states relied much less on reserve funds but continued to seek one-time strategies.²⁹ Finally, in 2005, one state that had generally resisted earlier cuts—New York—significantly cut its enrollment (reducing eligibility for low-income children, imposing an asset test and co-payment on some enrollees, and reducing enrollment assistance), though others pursued more limited tactics (Coughlin and Zuckerman 2005).

State Children's Health Insurance Program

Significant state variation in program standards and funding was embedded in the design of SCHIP from its inception, and the period from 1997 to 2005 saw diverse approaches. But the level of variation also reflected preexisting state decisions about health coverage for children and the effects of federal decisions about allocating the infusion of new federal funding for the specific goal of insuring low-income children.

Before SCHIP, states had addressed the problem of uninsured children in very different ways through Medicaid and other programs; when SCHIP was enacted, child uninsurance rates varied widely, from about 6 percent in Vermont to about 26 percent in Arizona. The federal allocation formula for SCHIP funding initially appeared to achieve the goal of narrowing the

²⁸ State officials noted that these cuts would have been significantly greater without the additional federal assistance provided by the 2003 tax relief act and its requirement that states maintain their eligibility standards (Coughlin and Zuckerman 2005).

²⁹ Three states (California, Colorado, and Texas) went so far as to move from accrual to cost-based accounting systems for Medicaid and some other programs, in essence shifting some of their 2004 financial obligations to FY 2005.

differences among the states in the eligibility of low-income children for health insurance coverage (Ullman, Hill, and Almeida 1999). But over time the effects of the reallocation of unspent federal SCHIP funds offset this relative flattening of interstate differences. While in the end federal funds covered more children overall, the way they were allocated also exacerbated preexisting cross-state differences in coverage rates (Weil and Hill 2003).³⁰

Policymakers indicated they were drawn to the program because of the common goal of insuring low-income children, as well as the flexibility it provided: SCHIP was not an entitlement program, families could be required to share costs, and benefits could be limited. These program characteristics made SCHIP “more like private insurance” and less like traditional Medicaid, and they gave states flexibility to deal with future uncertainty (Hill 2000; Dubay et al. 2002; Hill interview). States initially responded to the policy flexibility by taking a generally expansive approach to eligibility and other standards.

Over three-quarters set the upper income limits at twice the FPL or higher: 25 set them at 200 percent of FPL and 14 set them above 200 percent, while 11 states set their income limits below 200 percent of FPL (Dubay et al. 2002; Weil and Hill 2003). Before SCHIP, the average health coverage income threshold for children in the states was 121 percent of FPL; after SCHIP, it increased to 206 percent (Ullman et al. 1999). Some states also provided significantly broader service packages than required by law. One-third of all states with separate SCHIP programs chose to offer their full Medicaid package to SCHIP enrollees, and some others (at least six) provided Medicaid-equivalent packages for children with special needs. Many states (27 of 33 with separate SCHIP programs) used waiting lists of six months or less when a child was leaving private insurance. Initial cost-sharing arrangements were generally viewed as affordable (Dubay

³⁰ The SCHIP allocation formula was also controversial because of its reliance on estimates of uninsurance from the Current Population Survey (CPS), which was considered inaccurate for some states, leading to undercounting and therefore underfunding (Weil and Hill 2003; Hill interview).

et al. 2002). States conducted extensive outreach and streamlined their enrollment procedures, with spillover into many state Medicaid programs where outreach and simplified enrollment also became important program goals.

However, when budget crises hit, a number of states took advantage of the policy flexibility to somewhat curtail their programs. For example, in addition to the enrollment caps that 3 of the 13 ANF states (Alabama, Colorado, and Florida) imposed in 2003, 4 states instituted more restrictive enrollment procedures, 6 increased cost-sharing, 2 reduced benefits, and 5 decreased provider payments (Hill, Stockdale, and Courtot 2004). All the ANF states cut outreach (most virtually eliminating it) and enrollment assistance, though cuts came at different paces, with New York last to make them in 2004. State SCHIP directors noted that the program fared better than other state programs, however, and even in 2003 several ANF states continued improving enrollment procedures and benefits (Hill et al. 2005).

Actual benefits were the best-protected element of SCHIP. As states began to feel budget constraints in 2002, 4 of the 13 ANF states (Colorado, Florida, Mississippi, and New York) actually expanded their packages; in 2003, while 2 states (Florida and Texas) cut them, 2 others (Alabama and Minnesota) increased them. By 2004, some states began to reverse cuts, with all three states that had imposed enrollment caps lifting them under considerable political pressure. Other prior cuts remained, however, and some states made new ones in a set of trade-offs. Eligibility criteria generally remained consistent; Texas was the only ANF state in 2005 that had a lower income limit than it had had in 2002 (Hill et al. 2005).

Since the establishment of SCHIP, states as a rule have strongly supported program funding, even in the face of significant budget pressures during the recession. Efforts to freeze enrollment in the states typically faced strong public opposition, resulting in restorations the

following legislative session. SCHIP directors said that the program's effectiveness in reducing the number of uninsured children, relatively small size, high federal match rate, and popularity among policymakers, providers, the public, and consumers all contributed to its durability. But SCHIP was not completely immune from budget cuts in all states. At the beginning of 2004, the program had its first decline in enrollment, a 1 percent drop that reflected the cumulative effect of state program changes in response to the economic downturn (Hill et al. 2005).

Child Welfare

Child welfare is distinctive among the five programs in that the past nine years have been characterized by *increased* federal oversight and accountability requirements—contrary in many ways to the other program areas where federal facilitation of increased state experimentation and variability has been more prevalent.³¹ State and local child-welfare program standards and accountability requirements and financing arrangements have tended to be highly decentralized, arising from a mix of federal and state statutes, regulations, and judicial decrees. Child-welfare policy has been particularly driven by state or local crises, such as high-profile child deaths, leading to periodic efforts to improve the quality and capacity of child-welfare services and to provide funding to support it. In recent years, the major federal initiatives reflected in ASFA and, to a lesser extent, the Chafee Act have brought somewhat greater consistency in standards and reporting requirements to state child-welfare systems (Scarcella et al. 2006; Malm et al. 2001; Bess interview).

ANF found wide state variation in child-welfare financing patterns and decisions, including decisions about what federal funding streams to use. Spending on child welfare over the ANF period ultimately did not respond to federal and state budget pressures by decreasing;

³¹ However, states were able to apply for a limited number of time-limited IV-E waivers to experiment with new means of using these funds.

funding from all sources increased. But funding patterns and decisions varied by state and by specific funding stream for complex reasons. Illustrating the extent of this variation, while overall spending increased 40 percent between SFY 1996 and SFY 2004, in 13 states it actually decreased.

Nondedicated federal funds made up 41 percent of all federal funds that states used in SFY 2004, though this ranged from 3 percent in Arkansas to 77 percent in Alabama. Reliance on Medicaid as a percentage of all federal funds in SFY 2004 ranged from 0 in eight states to 62 percent in Rhode Island. The reasons for this cross-state range included a lack of rehabilitative services or TCM in the state's Medicaid plan (making reimbursement impossible for these services), and variations in caseload. States' use of TANF funds similarly varied widely, with 8 of the 46 states reporting no use at all and 5 reporting over \$200 million in TANF expenditures in SFY 2004 (Scarcella et al. 2006).

While individual states differed widely, ANF researchers did not find that regional differences or differences in state agency structures explained this variation. Instead, it appears to be heavily influenced by the context of individual states. These included differences in caseload size and characteristics, the role of key political actors, specific court decisions and decrees, competing political and policy priorities, and the ability and willingness to maximize the different federal funding sources.

Conclusion

By 2006, the devolution of social policy (as represented by the five programs this paper discusses) was significantly more limited than many had predicted nine years earlier.³² In the mid-1990s, Congress considered block-granting each of the five programs; ultimately only the

³² This section largely represents the authors' observations and does not necessarily reflect the conclusions of the ANF researchers.

cash assistance program was transformed from an open-ended federal entitlement to a capped block grant. The SCHIP program—established in 1997—was also designed from the start to entail capped funding. The other programs either maintained their prior federal entitlement status (food stamps were fully federally funded and Medicaid partially so) or had a limited federal entitlement component to start with that remained largely unchanged (as in the case of child welfare’s IV-E program).

Federal standards and accountability. The federal government’s approach to standard setting and accountability requirements was inconsistent both within programs and across programs. In TANF, the federal government expanded the array of policy dimensions over which states had control without seeking federal approval through waivers. At the same time, it imposed new outcome requirements on states, most notably the work participation rates, and prohibited states from using federal funds for particular purposes, such as covering certain legal immigrants or supporting nonexempt families beyond five years of cash aid. In Food Stamps, the federal government eased its enforcement of QC rules, allowing states greater leeway to expand coverage with less fear of federal error penalties, and provided states with new programmatic options to increase enrollments. Overall, national eligibility rules did not change, but the federal government prohibited states from using federal funds to cover many legal immigrants and adults without children.

Medicaid by and large maintained its coverage requirements and benefit standards (at least until the Deficit Reduction Act in early 2006), but the federal government facilitated greater state experimentation and variation through waivers. SCHIP’s design allowed for significant state policy authority, and the nine-year period saw states take advantage of this flexibility.

In child welfare, however, the federal approach differed in a basic way. While child welfare began as a fundamentally decentralized program with a high level of state discretion, over the nine years of ANF the federal government took a fairly consistent and more assertive role in setting standards and establishing accountability requirements.

Across the programs, then, the federal government encouraged greater state flexibility, mandated new federal accountability requirements, and prohibited certain state policy actions. These activities indicate an ambivalent and unsettled approach toward program standard setting that seems unlikely to resolve substantially in the coming years, given its complex roots.³³

Federal financing. By and large, federal funding continued and even increased in certain program areas, though in others the structural constraints of block grants and their funding caps were being felt by the mid-2000s. Initially, states benefited from TANF's block-grant funding in the years of declining caseloads, since funding amounts were based on what AFDC funding would have been under the high caseload levels of the mid-1990s. But over time, the effects of the recession and decreasing state revenues, competition for TANF funds, and the cumulative effects of inflation on the fixed funding stream dried up TANF surpluses and started to constrain state options. The full federal funding of Food Stamp benefits remained unchanged, and expenditures increased overall from \$24 billion in 1996 to \$31 billion in 2005.³⁴ To a great extent, the federal entitlement and full funding inoculated the Food Stamp program from the effects of the recession and state budget crises.

Medicaid expenditures increased markedly, to a significant extent because of its entitlement status and increased enrollments as the economy and employer-sponsored insurance

³³ Political, ideological, financial, and pragmatic factors all contributed to this at-times contradictory approach to federal social policy standard setting; a more complete analysis of the relative roles of these factors would be useful but is beyond the scope of this paper.

³⁴ Caseloads dropped sharply between 1996 and 2000, then increased.

declined. SCHIP's fixed grant structure remained unchanged, but states drew down far more in funding by 2004 than they had in 1998, exceeding their annual allotment level and pushing against its capped funding. Reflecting this strain, the program saw its first enrollment dip in 2004. Federal funding for child welfare increased markedly (as did state and local funding), though the particular federal funding sources shifted over time.

Over the nine years, the differing federal financing structures and incentives embedded within them interacted with the national and state budget cycles in ways that appeared to either put pressure on the programs and their ability to meet demand (TANF and SCHIP) or protect them from downward pressures, though to varying degrees (Food Stamps and Medicaid).

State variation. Ultimately, changes in federal-state standard setting and financing arrangements contributed to significant state policy variation in most of these programs, and the extent of variation appears to have increased over time.³⁵ These were complicated programs to begin with, with an array of federal and state and sometimes local rules, and they have generally become more complicated over the nine years. Certainly, the federal government's expansive granting of state TANF waivers before PRWORA contributed to growing program diversity in that program even then. But by 2006, a fundamental characteristic of the TANF program was state diversity in program approaches across a wide range of dimensions. These included time limits, sanction policies, family caps, the treatment of assets, and specific work requirements, as well as benefit levels and income eligibility.³⁶

The Food Stamp program, while still uniform nationally in eligibility and benefits, has seen a variety of new state practices for enrolling recipients and maintaining their participation.

³⁵ There are at least two key aspects to this variation: the number of dimensions over which states have policy control and along which state policies can vary, and the extent of variation within each dimension.

³⁶ The amount of TANF funding also varied widely by state, with the initial federal block-grant allocations made according to states' historic welfare spending (often linked to their fiscal capacities) and few changes in these allocations since 1996. How states have met their MOE requirements has also differed.

Increased use of Medicaid waivers has contributed to that program's already substantial cross-state variation, and states have taken differing approaches to financing their share of program costs. SCHIP has been marked from the start by marked differences in state policies. While state child-welfare program standards have always been highly diverse, state financing decisions appear to be increasingly varied (or at least no less varied) over time.

There is undoubtedly some benefit to the growing level of state variation that appears to have arisen in the past nine years. In the area of health, ANF researchers find evidence of policy innovation, though this tends to be associated with state wealth (Holahan and Pohl 2003). There also appears to be some, if limited, policy learning and diffusion across program and/or states. For example, some Medicaid programs learned from SCHIP's energetic outreach and enrollment practices in the early days of that program. But overall, the evidence of successful systematic and widespread policy learning and diffusion appears fairly limited (Weil, Holahan, and Weiner 2003).

The growing variation has made these already complex programs even more complicated. Simply cataloging the rules of each state and/or local system for each main program, and tracking the changes in them over time, is no small feat. Understanding how they have been implemented "on the ground" and how they interact with each other also appears to have grown more difficult. Certainly there are commonalities among the states and localities in how they have designed and implemented these programs. But there are also simply more decisionmaking units within which variation can occur, and more dimensions along which state and local policymakers can choose to deviate from their prior approaches and from other jurisdictions. These five essential safety-net programs from the outset differed markedly in their funding

structures and allocations of federal-state authority. The past nine years have seen an intensification of this complexity.

There may also be indications that the growing variation across the states (and localities) in standards and financing is making their policy approaches toward poor and low-income people more unequal over time. The period from 1997 to 2006 saw a range of interacting trends that affected the demand for programs for low-income people and state responses to this demand. It is exceedingly difficult to tease out the specific effects of changes in federal-state arrangements, shifts in economic conditions, and other aspects of state systems change that occurred for reasons aside from devolution. But the general trend appears to be one of greater state policy difference, with policies in certain states—especially low-fiscal-capacity states—particularly limited, and those in other states—especially wealthier states—markedly more expansive. Given the wide variety of state circumstances and capacities, there is reason for concern about a growing trend toward systems of social assistance that are structured to be heavily reliant on these unequal capacities.³⁷ If we in fact believe there should be certain national priorities—health care for all children, for example—the evidence so far indicates that this is likely to require basic national financing and standards. This paper only begins to address these issues, but these essential questions warrant further examination.

³⁷ ANF's assessment of the ability of several of these programs to address the types of challenges Hurricane Katrina created focuses on some issues of unequal fiscal capacity and program structure (Winston et al. 2006).

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