

**A New Puzzle for Federalism:  
Different state responses to Medicaid and Food Stamps**

James W. Fossett  
University at Albany  
and  
Rockefeller Institute of Government

Thomas L. Gais  
Rockefeller Institute of Government

Presented at American Political Science Association Annual Meetings, August 2002

## **A New Puzzle for Federalism: Different State Responses to Medicaid and Food Stamps**

James Fossett and Thomas Gais<sup>1</sup>

Although devolution in human services in recent years is typically identified with the federal and state welfare reforms and the new block grant, Temporary Assistance for Needy Families, in fact states have acquired greater discretion and flexibility across a number of programs, even including large entitlements such as Medicaid and the Food Stamp Program. Some of the options available to states in implementing these very large programs predate federal welfare reform. Yet some options have also grown out of complex interactions between the state, local, and federal governments in the aftermath of welfare reforms and assessments of the reform's consequences. For example, in both Medicaid and Food Stamps, sharp declines in entitlement caseloads led to heightened concern at both the state and the national levels about the effects of welfare reforms on program access and participation. In both program areas, federal agencies made at least some effort to address problems of access through a number of measures, including new options for program policies and administration, policy clarifications and enforcement, entreaties to states to address access issues, sharing practices, and analyses of the scope of the problems and the effects of potential solutions.

From a federalism perspective, what is interesting about these developments is the opportunity to see how states responded to this growth in flexibility. For the most part, the dominant theoretical traditions would suggest a fairly clear pattern of response by states to increased discretion in these two program areas. The "race to the bottom" hypothesis argues that state flexibility in programs serving low-income families generally leads to a reduction in benefits and services. States and localities, unlike the federal government, have open boundaries and, as a consequence, some low-income families may be influenced by benefit levels in deciding where they will live. Assuming that state policymakers—for several possible reasons—want to minimize the number of poor families who move into their states, they are viewed as likely to compete with other jurisdictions, especially neighboring states, to keep benefits for poor families down. In contrast, "fiscal federalism" arguments call attention not to the potential recipients of programs and their behavior but instead to the effective costs of providing benefits to families. This is clearly a viewpoint that the Congress has taken seriously as it establishes different funding formulae, depending on the federal government's priorities and its estimates of what fiscal inducements are needed to get states to implement and contribute to a program. Under these assumptions, states are probably more likely to contribute to a program when they do not have to share a large part of the costs. By contrast, if states do have to absorb a large part of the costs, they are less likely to support the program, and they are especially likely to avoid significant expansion of benefits.

Although we are not claiming that we are fully testing these theories of policy choices in this paper, we do present them because we think recent experiences in health care policies and the Food Stamp Program raise important questions about the adequacy of these lines of argument. Devolution has given states greater decision-making authority in both of these program areas in recent years, both of which serve similar low-income clienteles. We might therefore expect some reduction in benefits or administrative access to benefits in both programs. However, we would also expect different responses to the new flexibility. Both the race to the bottom and the fiscal federalism hypotheses would suggest that Medicaid would be particularly likely to undergo a reduction in benefits and availability. Medicaid is a costly program to states—typically the largest single human service program in their budgets—and states have a lot of discretion in setting policies and structuring the administration of the program. By contrast, the Food Stamp Program offers states less flexibility and a very attractive fiscal formula: indeed, states pay none of the benefits and are only responsible for half of the program's administrative costs. Given this pattern, we would expect—if our two hypotheses are correct—that states would show little interest in expanding Medicaid programs if given a chance, considerable readiness to cut back on such programs if resources become scarce, and much more likely to support program expansions (to the extent possible) in their administration of the Food Stamp Program. But, as President Nixon might have put it, that would be wrong.

### **Medicaid—A Race to Where?**

Medicaid presents perhaps the most obvious program to examine for evidence of a "race to the bottom."

---

<sup>1</sup>

• James W. Fossett is associate professor of public administration and health policy and management at the University at Albany of the State University of New York. He is also a senior fellow at the Nelson A. Rockefeller Institute of Government. Thomas L. Gais is director of the Federalism Research Group at the Rockefeller Institute of Government, which is the public policy research institute of the State University of New York.

Unlike Food Stamps, Medicaid costs states a lot of money—states spending from their own sources on Medicaid in 1997, the year after welfare reform was passed, amounted to roughly \$65 billion<sup>1</sup>. While federal spending for Medicaid is larger than that for states—federal Medicaid spending in 1997 was almost \$95 billion—Medicaid remains a sizeable item in most state budgets and one which is more difficult to forecast and control than such programs as education or public safety. States cannot refuse to pay for any covered services provided by an eligible provider to a Medicaid patient even if this payment exceeds the funds appropriated through the state budget process. The cost of Food Stamp benefits, by contrast, is born totally by the federal government—states are only responsible for paying some share of the costs of administering the program.

Second, unlike Food Stamps, states have considerable discretion in what they spend on Medicaid. Food Stamp standards for eligibility and payments are uniform and set by federal regulations. By contrast, states have discretion over who is eligible for Medicaid, the services covered by the program, and the fees paid to providers<sup>i</sup>. While states are required to cover some “categorically needy” groups which receive income assistance from welfare or Supplemental Security Income and meet minimum federal income standards for coverage of pregnant women and children, states exercise much control over who is and is not covered beyond these federal minimums. States vary widely, for example, in the extent to which they cover the so-called “medically needy” with incomes too high for categorical coverage, but with large medical bills that would bring them below the categorical income standard. In similar fashion, while there is a mandatory package of services that all states must cover in their Medicaid program, states can decide whether or not to cover a range of optional services, including such potentially expensive services as prescription drugs, personal care services, and a variety of institutional care options for the elderly. States also exercise more control over the fees paid to physicians, hospitals, and other providers than over the benefits provided to Food Stamp recipients. While overall state Medicaid spending is limited to what the same package would cost under Medicare (the so-called “upper payment limit”) federal control over the fees paid for particular services was quite limited during the period after the implementation of welfare reform. The Balanced Budget Act of 1997 abolished the Boren Amendment, which provided hospitals and nursing homes with grounds for suing states for “reasonable and adequate payment” and eliminated requirements that states pay federally qualified health care centers at 100 percent of the cost of providing care. The elimination of these requirements significantly expanded state flexibility over the rates paid for Medicaid services.

Medicaid, in short, would appear to present large opportunities for states to realize significant budgetary savings by restricting coverage, services, or rates. In the aftermath of welfare reform, arguments were made that states could also realize Medicaid savings by simply not making much effort to keep former welfare recipients who moved into the labor force enrolled in Medicaid. Concern was expressed by advocates in the aftermath of welfare reform that the strong focus in many states on “diversion” programs which encouraged or forced clients into the work force would cause many who remained eligible for Medicaid to lose coverage<sup>ii</sup>. States had historically done much better at covering “categorically needy” clients than those not receiving cash assistance, and there was concern that the rapid decline in cash assistance caseloads expected from welfare reform would produce an equally sizeable decline in Medicaid coverage as well. The Personal Responsibility Act contained several provisions intended to allow states to preserve and even expand access to Medicaid for low income women and children and authorized \$500 million that states could use in a variety of ways to maintain Medicaid coverage for families no longer receiving welfare payments. Many states were initially slow to make use of these additional powers and resources, leading to concerns that many former Medicaid clients were having difficulty maintaining coverage even though many remained eligible. Early state response to welfare reform in some highly visible cases, particularly New York City, appeared to validate these concerns, as some public rhetoric stressed the need to remove clients from all forms of public support rather than just welfare. These concerns were given further credibility by declines in aggregate Medicaid caseloads over the two years following welfare reform, which several observers connected to efforts to reduce welfare caseloads<sup>v</sup>. These arguments could be taken as evidence

---

<sup>i</sup> ..Katharine Levit, Cynthia Smith, Cathy Cowan, Helen Lazenby, and Ann Martin, “Inflation Spurs Health Spending in 2000” Health Affairs 21(January/February 2002): 172-181.

<sup>i</sup> i..For a useful summary of coverage and service requirements and options, see U.S. House of Representatives, Committee on Ways and Means, 2000 Green Book: Background Material and Data on Programs within the Jurisdiction of the Committee on Ways and Means

<sup>i</sup> ii..See, for example, K. Maloy et al, A Description of State Approaches to Diversion Programs and Activities (Washington, D.C., George Washington University, 1998)

<sup>v</sup> v..See, among others, Leighton Ku and Brian Bruen, “The Continuing Decline in Medicaid Coverage” (Washington, DC; Urban Institute, 1999) and John Holahan and J Kim “Why Does the Number of Uninsured Americans Continue to Grow?” Health Affairs 19 (July/August 2000):188-196.

that states were, if not racing to the bottom, at least slowly sliding in that direction by making little effort to insure that former welfare recipients remained enrolled in Medicaid or to identify and enroll Medicaid-eligible clients.

More recent data suggests a more complex picture. Field research conducted by the Rockefeller Institute of Government in 2001 in sixteen states indicates that Medicaid enrollment trends among low income adults and children have reversed themselves in many states. Table 1 reports annual average monthly Medicaid enrollment for this group for the period 1995-2000<sup>v</sup>. These data indicate that Medicaid enrollment declined in almost all states between the adoption of welfare reform in 1996 until 1998. Beginning in 1998, however, these enrollment trends reversed themselves in many states and grew, in some cases substantially, through 2000. While Medicaid enrollment in 2000 was lower in six states than before the implementation of welfare reform in 1996, enrollment was higher in ten of the sixteen states. In six states, enrollment gains were in excess of 10 percent. In addition to the expansions of eligibility for children for subsidized health care provided through the CHIP program, five of these states— Arizona, Missouri, Ohio, Oregon, and New Jersey—have also adopted substantial expansions of Medicaid eligibility for adults since the adoption of welfare reform.

While there are several causes of this disparity in enrollment growth, perhaps the most significant are differences in the scale and timing of state administrative actions to publicize the availability of coverage and make Medicaid more accessible. Medicaid agencies varied widely in the speed with which they responded to the implementation of welfare reform and its effects on their clients. Medicaid clients and even some eligibility workers were initially confused about the Medicaid status of former welfare recipients, and eligibility processes did not routinely check for continued Medicaid eligibility when welfare cases were closed. States varied widely in the speed with which they educated clients and workers and made the necessary changes in computer systems and other administrative processes to re-establish contact with a clientele that was less reliant on welfare. Particularly after the passage of the Children’s Health Insurance Program (CHIP) in 1997, many states simplified their Medicaid application processes by eliminating or scaling back requirements for face-to-face eligibility determination and extensive documentation and verification of income and other items required to determine eligibility. States varied considerably in the scale and timing of these efforts and the energy with which they pursued contacts with recipients and tried to connect Medicaid and CHIP eligibility. Some states “integrated” the eligibility processes for the two programs so that any application was evaluated for eligibility for both programs, while others kept eligibility determination separate.

**TABLE 1: TOTAL AVERAGE MONTHLY MEDICAID ENROLLMENT 1995-2000**

	1995	1996	1997	1998	1999	2000	95-'00 Change	%
*Missouri	417,177	411,126	391,492	420,938	524,247	610,357		46.31%
*Maryland	371,065	376,977	371,804	384,585	413,096	457,899		23.40%
Washington	502,439	533,992	557,890	543,282	537,747	603,225		20.06%
*Florida	1,093,648	1,042,612	948,987	923,885	1,042,800	1,243,289		13.68%
*Michigan	692,665	624,491	587,240	756,921	742,716	783,192		13.07%
^Utah	n.a.	157,100	146,700	158,200	164,500	167,300		6.49%
Georgia	840,286	871,996	921,741	905,547	897,496	880,020		4.73%
Arizona	368,863	381,312	361,328	301,664	324,483	379,823		2.97%
^Colorado	n.a.	176,150	168,422	160,234	165,353	180,314		2.36%
*New Jersey	478,015	472,864	450,072	427,085	422,748	484,107		1.27%

<sup>v</sup> ..The numbers in the table represent average monthly enrollment in the calendar year in question for nondisabled children and adults under 65, including those enrollees in the Children’s Health Insurance Program (CHIP) who were added as part of a Medicaid expansion, the medically needy, and any other separately recognized group, such as foster children, whose members are not elderly or disabled. See Courtney E. Burke and Craig W. Abbey, “Medicaid Enrollment Trends, 1995-2000” (Albany, Rockefeller Institute of Government, 2002).

*Wisconsin	312,653	289,861	250,430	228,454	240,461	307,177	-1.75%
*West Virginia	188,224	188,741	198,863	177,612	174,774	167,245	-11.15%
Kansas	136,388	127,871	117,086	103,361	110,515	119,866	-12.11%
*Ohio	1,294,496	1,199,832	1,120,088	1,080,691	1,079,189	1,112,211	-14.08%
Oregon	340,675	316,784	293,995	286,321	288,350	282,909	-16.96%
*Texas	1,430,655	1,387,073	1,299,534	1,166,107	1,113,195	1,125,280	-21.35%

^Calculations are based on 1996 enrollment \*Totals Include CHIP programs that were Medicaid expansions.

At least among the states in Table 1, there is a rough correlation between the timing and scale of these efforts and enrollment growth. Those states with large enrollment growth invested considerable effort in outreach and enrollment simplification, while those states where enrollment declined typically made less of an investment. Of the six states which lost enrollment, for example, four—Texas, Ohio, Oregon and Wisconsin— did not adopt any major enrollment simplification initiatives over this period, and Kansas and West Virginia made only modest changes.

National evidence suggests that these enrollment simplification efforts were rather broadly diffused across the states rather than being limited to a small number of outliers. Table 2 reports on current usage of a variety of such measures for both children and parents. While some measures such as presumptive eligibility and twelve month continuous eligibility are only used by a minority of states, almost all states have taken at least some measures to make Medicaid more accessible. All but a few states, for example, eliminated requirements for face to face eligibility interviews and asset tests for children, and have eliminated verification of residency and children’s ages.

**Table 2: Summary of Selected Simplified Enrollment and Renewal Procedures for Children in Medicaid and CHIP Programs**

	Medicaid	SCHIP	* Aligned Medicaid and Separate SCHIP
No Face-to-Face Interview for Enrollment	^47	34	^47
Eliminated Asset Test for Enrollment	45	34	44
Joint Application	N/A	N/A	33
12 Month Continuous Eligibility for Renewal	18	23	17
Presumptive Eligibility for Enrollment	9	5	6

\* Aligned Medicaid and SCHIP – indicates the number of states that have adopted a particular enrollment simplification strategy and have applied the procedure to both their children’s Medicaid program and their SCHIP-funded separate program. States that have used SCHIP funds to expand Medicaid exclusively are considered “aligned” if the simplified procedure applies to children in the “regular” Medicaid program and the SCHIP-funded Medicaid expansion program.

^ 48 States eliminated face-to-face interviews upon renewal for Medicaid and aligned programs for both children and adults

Taken together, these findings do not provide evidence that states have made any significant attempts to limit Medicaid eligibility or restrict access to coverage. To the contrary, most evidence suggests that almost all states have made at least perfunctory efforts to make Medicaid *more* accessible, and significant numbers—perhaps even a majority—have invested considerable administrative energy and resources both to increase the proportion of their population that is eligible for public insurance programs and to increase enrollment among those who are eligible. While state investment in such efforts obviously varies widely, there is no evidence to support charges of a generalized “race to the bottom”, or even an inertial slide.

Available evidence also suggests that efforts to enhance Medicaid and CHIP enrollment have proven sustainable even in the face of increasing state financial problems. One of the “enabling” factors for enrollment enhancement efforts in many states through the late 1990’s was the strong financial position of most states. Strong local economies and the boom in the stock market which prevailed over most of this period both reduced Medicaid caseloads and produced strong growth in state revenues, particularly income taxes. This combination of strong budgets and reduced caseloads, together with the enhanced match available under the CHIP program and the low cost of covering low income women and children compared to other Medicaid populations<sup>i</sup>, made expanding coverage of the demographic groups affected by welfare reform relatively inexpensive.

More recently, state economies and budgets have deteriorated significantly. The recession of 2001 and particularly the sharp decline in the stock market which began in mid-2001 have substantially reduced state revenues, particularly income tax collections. While mild by historical standards, the recession of 2001 likely increased the number of adults and children eligible for both Medicaid and CHIP and may have led to increases in caseloads in many states. State tax revenue began to decline in mid-2001, with the rate of decline accelerating through mid-2002<sup>i</sup> This sharp decline in resources has made deliberations over state budgets for FY 2002 and FY 2003 extremely difficult, particularly in states which rely heavily on the income tax as a revenue source and have relatively large wealthy populations. These states have been adversely affected by the decline in the stock market, which has dramatically reduced income from capital gains, as well as income from bonuses, the exercise of stock options, and other market-related compensation.

In spite of this sharp deterioration in state financial situations, there has been little attempt to date to rollback any of the eligibility expansions enacted in the late 1990’s or to undo the enrollment simplification efforts intended to make Medicaid and CHIP more accessible. A Rockefeller Institute of Government study of decisions in sixteen states affecting Medicaid and other health programs in 2003 budgets suggests that Medicaid has been unaffected by recent state budget difficulties<sup>ii</sup>. Table 3 lists these states and the division of state actions to fill 2003 budget gaps between revenue enhancements and expenditure cuts, and the percentage of enacted expenditure reductions that affect Medicaid. These data suggest that even in states which relied heavily on spending cuts rather than revenue enhancements as budget balancing devices, Medicaid spending was only marginally affected. Only in Tennessee and Utah did Medicaid account for more than a small fraction of enacted expenditure reductions. At least in this set of states, other state functions—particularly education and corrections—have absorbed the bulk of expenditure reductions.

Table 3: Budget Balancing Methods in FY ‘03

State	% Revenue	% Spending	MA as % of Cut
UT	58%	42%	20%
OH	33%	66%	<5%
WI	91%	9%	1%
OR	55%	45%	1.40%
NJ	40%	60%	1%
AR	20%	80%	increase
TN	75%	25%	100%
MI	80%	20%	25% increase
CO	18%	82%	5.40%
KS	50%	50%	<1%

?West Virginia, Georgia, Florida Texas did no unusual gap filling in FY '03 budget as enacted – mid year corrections are either enacted or likely in most of these states.

<sup>i</sup> i. Per capita Medicaid payments for children and adults in 1998, for example, totaled \$1,117 and \$1,876 respectively, while comparable payments for the elderly and disabled averaged \$10,243 and \$9,097 respectively. U.S. House of Representatives, Committee on Ways and Means, 2000 Green Book: Background Material and Data on Programs within the Jurisdiction of the Committee on Ways and Means, Table 15-16, p. 915.

<sup>i</sup> iNicolas W. Jenny “Large Decline in April-June Quarter Caps Terrible Fiscal Year for States” State Fiscal News (Rockefeller Institute of Government, Albany, 2002).

<sup>i</sup> ii..James W. Fossett, “Health Spending and State Budgets, FY 2003” (Presentation at the National Academy of State Health Policy Annual Meetings, August 6, 2002)

Rather than a “race” or even a “slide” to the bottom, in short, state actions affecting Medicaid in the aftermath of welfare reform have been largely oriented towards expanding public coverage and enrollment. In addition to the expansion of public coverage for children provided by the CHIP program, some states have expanded coverage for adults as well. While efforts to make public programs more accessible have varied widely across states, almost all states have made at least some effort to simplify their Medicaid enrollment processes and many have undertaken aggressive outreach programs to identify and enroll eligible clients. These initiatives have been largely unaffected by recent state budget difficulties, suggesting at least a modicum of political sustainability.

### **Food Stamps—No Race, But Little Change**

From a fiscal incentives perspective, states ought to want to maximize use of the Food Stamp Program. The federal government pays 100 percent of the benefits and half of the program’s administrative costs. Administrative costs constituted 19 percent of total program spending in 1999. State spending therefore made up about 9 percent of the all FSP expenditures, with the federal government absorbing the remaining 91 percent. Although states may have to pay additional amounts as a result of excessive error rates in awarding benefits, these penalties, though sometimes considerable, are often paid by the states to themselves as investments in administrative improvements or are forgiven by the Congress every few years or so.

There are other reasons why states might want to maximize take-up rates in the Food Stamp Program. The program has features of a work support, a function which may be quite attractive to states that want to increase incentives for low-income families to get and keep jobs. Benefits may be available to families whose gross monthly income is as high as 130 percent of the federal poverty level, and benefit amounts are reduced by only 30 percent for dollar increase in net income, a more generous formula than most earnings disregards under state TANF programs. Indeed, the effective disregard is even more generous, since only 80 percent of earned income is counted in net income; thus, an additional dollar of earned income may reduce a household’s FSP benefit by only 24 cents. This function as a work support may be particularly critical in states that offer small cash benefits under their TANF programs—traditionally conservative southern and mountain states. Because the Food Stamp Program counts TANF cash assistance as income in determining the size of benefits to households, larger payments are made to low-income households with children in such states.

Although the Food Stamp Program is a federal program that operates under federal rules, states have options in carrying out the program, and some of these options can be used to enhance program access. States can affect the costs to households associated with getting and keeping Food Stamp benefits by determining the length and complexity of applications, the extent to which verification of household circumstances is pursued, and the length of eligibility certification periods. States may also choose to issue Food Stamp benefits through Electronic Benefit Transfer systems, which may reduce the stigma and inconvenience often experienced by program recipients.

Program access may also be shaped by a number of other state decisions. With 50 percent federal cost sharing, states may operate outreach programs that inform low-income households of the eligibility requirements, application procedures, and benefits of the Food Stamp Program. Under the Clinton Administration, new rules were promulgated that allowed states to substitute more lenient TANF vehicle disregards for the relatively restrictive vehicle disregards offered under the Food Stamp Program. In fact, the 1996 Personal Responsibility Act offered states the option of operating a “simplified” program under which they can use TANF rules and procedures in determining FSP benefits for TANF recipients. States also have flexibility in determining the harshness with which TANF work-related sanctions carry over into FS benefits, and states may, using their own money, provide benefits to noncitizens who lost their eligibility for federal FS payments under the 1996 Act.

#### *State responses*

Despite the options available to states and the fiscal and other incentives they have to expand access to the Food Stamp Program, few states have moved very far in this direction—and certainly few states have shown an interest in expanding access to Food Stamp benefits comparable to their efforts under Medicaid and CHIP. Our conclusions must be tentative. The Rockefeller Institute is only now—i.e., mid-August, 2002—completing field research on state and local changes in Food Stamp Program policies and administrative structures and processes in 16 localities

across the country, a study conducted under a cooperative agreement with the Economic Research Service of the U.S. Department of Agriculture. When these field research reports are submitted, compared, and analyzed, we can present a fuller and more nuanced picture of how states have changed the implementation of the Food Stamp Program in the last several years, especially since the enactment of federal and state welfare reforms. However, for the purposes of this paper, some points seem clear enough to state, based on our discussions with the field researchers and on their reports on the implementation of TANF in the same local sites.

First, with few exceptions, the Food Stamp Program and its implementation has shown comparatively little change in recent years. In a context of extensive and widespread changes in programs and institutions under TANF and health care, the staticity of the FSP has stood out. The most widespread changes typically occurred several years ago when state welfare reforms were first put into effect: many states consolidated the “front doors” for TANF, Food Stamps, and Medicaid by creating common initial application forms. Although Medicaid is often operated by a state health agency separate from the agency responsible for Food Stamps and TANF, several states—for example, Missouri, Georgia, and New York—wrapped together the street-level administration of these programs around that time. In these as well as several other states, this tendency toward consolidation has had the effect of streamlining the intake process. Families are often given short initial application forms that were used to guide families to the programs for which they may be eligible and to begin the application process. This streamlining may enhance access for families to the Food Stamp Program, though the changes seemed to have been largely motivated by states’ interests in reducing and simplifying the workloads of their local offices and employees.

Second, Food Stamp outreach activities have been generally limited efforts and restricted to a small number of states. Federally funded outreach programs have only been established by a minority of states—only 11 in federal fiscal year 2000—and these efforts are usually much less intensive than the outreach efforts for Medicaid or CHIP. More typical have been incremental changes in procedures to deal with specific take-up problems among families already involved with human service agencies. For example, several state report new procedures such that families who lose their TANF eligibility (perhaps after getting a job) are reviewed for and informed of their eligibility regarding Food Stamps and other benefits (such as child care subsidies and Medicaid). Also, in counties where institutional delinquency due to privatization has occurred, states and localities have attempted to minimize the transaction costs of obtaining FSP (as well as Medicaid) benefits after visiting or enrolling in the TANF program. For example, in Florida’s District 21, the private firm (Lockheed Martin) responsible for case management and eligibility determination under TANF may conduct initial (though not final) eligibility reviews for Food Stamps and Medicaid; a second face-to-face interview must be conducted by the state’s Department of Children and Families before such authorization occurs. However, broader efforts to inform low-income families not currently or recently participating in welfare programs are not widespread, nor is there any trend toward expansion.

Third, concerns about eligibility errors under the Food Stamp Quality Control program remain salient in several sites in early 2002. This continued emphasis on minimizing eligibility errors may have limited states’ attention to and interest in problems of accessibility and convenience. In Michigan, for example, some local administrators reported that, around March 2002, priorities in Lansing and their own primary interest shifted away from the goals of WorkFirst/Project Zero—which emphasized employment of all nonexempt adult clients—to concentrate on the FSP error rate. The QC emphasis comes through in enhanced training activities for workers (e.g., Georgia), inclusion of FS error rates in county performance measures (Ohio), and stricter recertification requirements for the FSP in comparison to TANF and Medicaid. Michigan, for example, requires more frequent recertifications for FS than for Medicaid and TANF, and it requires in-person rather than phone interviews for recertification.

This picture of relatively little change or interest in expanding access to the Food Stamp Program is not, to be sure, universal. Texas is a surprising exception. When the Rockefeller Institute field research team in Texas examined welfare reform implementation in 1997-98, access to the Food Stamp Program appeared to be diminished by a number of factors, such as diversion under the state program “Texas Works,” statewide adoption of a three-month recertification process, statewide implementation of “biometric imaging” (which required electronic fingerprinting for all adults on the caseload), as well as federal policy curtailments of benefits for legal immigrants. However, recent policies have been much more user friendly. In 2000, the state contracted with a nonprofit agency, the Texas Association of Community Action Agencies, to conduct a statewide Food Stamp education campaign. State legislation in 2001 eliminated face-to-face interviews and permitted phone or mail transactions for applications and recertifications; reduced coverage of the biometric imaging requirement; and raised resource limits for families on Food Stamps.

These changes appeared in Texas to have had an impact on perceptions state employees had of their missions. Our field researchers report that managers and employees now often state their jobs as making sure that all applicants receive the services they need and for which they are qualified—a very different emphasis than what they heard in the first years of welfare reform. Perhaps as a result of this shift in orientation, Food Stamp caseloads in the state have

begun to track differently from welfare caseloads. Although Texas Food Stamp and TANF/AFDC caseloads both dropped 31 percent between 1996 and 1998, Food Stamp caseloads declined by only 19 percent between 1998 and 2000, while welfare caseloads fell 28 percent. Texas's experience suggests that states can do a lot to enhance access to the Food Stamp Program—and that such efforts are not incompatible with even some of the most stringent efforts at welfare reform. But that only makes less understandable the absence of similarly vigorous efforts in other states.

#### **Explanations:**

### **Or Why Didn't the Race to the Bottom Happen, and Why Was Support for Expansion Greater Under Medicaid and CHIP than for Food Stamps?**

These counterintuitive findings suggest the need for more complex political explanations of state behavior than that provided by current theories of fiscal federalism or tax and welfare minimization as compared with other states. In spite of the fact that Medicaid costs states sizeable amounts of money and enhanced eligibility could be argued to make states more attractive destinations for the low income families that “race to the bottom” arguments assume they are anxious to avoid, many states have actively invested in efforts to expand enrollment and have protected these investments under difficult budget circumstances. And despite the fact that the Food Stamp Program costs states so little to provide relatively fungible and work-supporting benefits to low income families, we have found comparatively limited efforts to expand FSP enrollments—an outcome that seems to contradict expectations based on fiscal federalism models.

The absence of a race, or even a slide, to the bottom under Medicaid can be traced to three interconnected features of the program's political environment; one particular to the late 1990's and two common to Medicaid politics in many states. One of the reasons for state actions to expand eligibility and access were unusually strong incentives from federal and other external actors encouraging them to do so. Second, the increasing scope and scale of Medicaid programs in many states has created a sizeable “Medicaid industrial complex” of providers and public bureaucracies that are dependent on Medicaid funds as a major revenue source which requires high levels of Medicaid enrollment to continue. Third, the presence of widely cited, readily understood measures of population health status which might be adversely affected by Medicaid cuts may have led politicians to avoid taking actions that might be construed as making conditions worse.

#### *Federal Encouragement to Increase Enrollment*

Perhaps the most distinctive political feature around Medicaid in the late 1990's was an almost unprecedented effort by federal officials and other external actors to encourage states to expand health coverage among low income populations, particularly children. Legislatively, the passage of the CHIP program in 1997 provided states with substantial funds, at a more favorable match rate than Medicaid, to further expand public insurance coverage beyond the traditional Medicaid population. CHIP also provided funding explicitly for outreach activities and other efforts to locate and enroll program eligibles, support which had previously been lacking under Medicaid.

In addition to enhanced funding, federal actors, beginning with President Clinton and HHS Secretary Donna Shalala, invested an unusually large amount of energy in encouraging states to expand enrollment. Improving access to health care was a high priority issue for the Clinton Administration and the President personally, and both the President and Secretary repeatedly and publicly promoted enrollment in Medicaid and CHIP by publicizing on-going enrollment problems and state success stories, encouraging continuing media attention to take-up<sup>iii</sup>. The president also required eight federal departments to develop plans for helping to enroll children in these programs, which produced over 150 proposed action steps<sup>x</sup>. Both the White House and the Health Care Financing Administration (HCFA) encouraged state interest groups such as the National Governors Association and the American Public Human Service Association to address the enrollment issue and solicited media support for public service ads. Several health-related foundations also initiated research and service programs intended to publicize, analyze and address the enrollment problem. The largest such initiative was sponsored by the Robert Wood Johnson Foundation, which allocated approximately \$50 million to fund community coalitions in all fifty states to develop outreach initiatives and encourage states to to simplify and improve eligibility processes and computer systems.

These public initiatives were further reinforced by a steady stream of missives from HCFA to state Medicaid

---

<sup>i</sup> iii..Frank Thompson and Thomas Gais “Federalism and the Safety Net: Delinkage and Participation Rates” Publius 30(Winter/Spring 2000): 199-142.

<sup>x</sup> x..U.S. Department of Health and Human Services. Report to the President:InterAgency Task Force on Childrens Health Insurance Outreach. Washington, DC, 1998.

and CHIP officials. These communications variously instructed states to review closed welfare cases for continued Medicaid eligibility, provided advice and examples of how to maximize coverage, and promised lenient treatment in the quality control process for mistakes. In early 1999, for example, HCFA and the Administration for Children and Families issued an extensive "Guide to Expanding Coverage in the Post-Welfare Reform World" <sup>x</sup> which had the avowed intent of instructing states how to expand coverage to the maximum limits of the law. More recently, HCFA issued a "Dear Medicaid Director" letter requiring states to identify and reinstate individuals and families who had been improperly terminated from Medicaid as part of their separation from TANF<sup>i</sup>.

Finally, HCFA officials have occasionally relied on admonition and the threat of sanctions to encourage states to pursue expanded enrollment. When, for example, New York City officials pursued an aggressive TANF diversion strategy that also discouraged enrollment in Medicaid and Food Stamps, HCFA administrators complained loudly and publicly to New York State officials in Albany that they were not doing enough to monitor practices in New York City. In May 1999, HCFA officials in the New York regional office announced that they would require New York State officials to document their efforts to comply with federal enrollment requirements. In August, President Clinton announced that he was instructing HCFA to "conduct comprehensive on-site reviews of Medicaid enrollment and eligibility processes in all states to determine levels of compliance with federal laws and offer recommendations for improvement"<sup>ii</sup>

This combination of attention, exhortation, encouragement, and financial support from both federal and private sources is unlikely to have been decisive either in compelling action by unwilling states or in increasing enrollments, but it has unquestionably given considerable support and resources to politicians, state agencies and advocacy groups who wish to boost enrollment in Medicaid and CHIP. The availability of both federal and foundation funding to support outreach and administrative improvements lessens the need to seek funds from state sources, and the favorable publicity given to well-performing states allows elected officials in these states to claim credit for these achievements. Children are a popular political constituency even in conservative states, and the availability of financial support and favorable publicity may have limited potential opposition to these efforts.

The change in administrations after the 2002 presidential election has not produced a dramatic shift in federal policy, but rather a diversion of the attention of upper-level policy makers in the White House, HHS and HCFA (now CMS, or the Center for Medicare and Medicaid Services) to prescription drugs, Medicare reform, and other issues. Medicaid caseloads have been increasing in the last year as a result of declines in the national economy, and the recent deterioration in state finances has led to demands from the National Governors Association and other state interest groups for an enhanced federal match and more flexibility in waivers to alter the service package and increase co-pays and premium sharing for any further expansions of eligibility. Bush Administration officials have been sympathetic to requests for more flexibility, but have so far resisted calls for an enhanced federal match. There have been decidedly fewer public calls for states to take aggressive action to enhance enrollments, particularly given recent increases in caseloads and states financial problems, but no clear set of signals that rolling back enrollment has become acceptable.

### *Is there a Medicaid Constituency?*

A second set of factors which may limit a race to the bottom around Medicaid is the presence in many states of a significant constituency for continued or enhanced Medicaid enrollment and spending. While this constituency varies widely in size, scope, and political effectiveness across states, the presence of significant numbers of geographically dispersed public and private agencies which derive considerable economic benefit from Medicaid may make it more difficult for those parties interested in reducing state taxes or the generosity of Medicaid eligibility and service coverage to make a convincing political case for significant reductions in Medicaid spending. The limited political appeal of cutting Medicaid is reduced further by the federal match associated with state expenditures. Reducing spending in

---

<sup>x</sup> ..U.S. Department of Health and Human Services. Supporting Families in Transition: A Guide to Expanding Health Coverage in the Post-Welfare Reform World. (Washington, DC, 1999).

<sup>i</sup> i..U.S. Health Care Financing Administration, Letter to State Medicaid Directors, April 7, 2000. <http://www.hcfa.gov/medicaid/smd40700.htm>

<sup>ii</sup> ii.. Robert Pear "Clinton to Chide States for Failing to Cover Children" New York Times (August 8, 1999):1:27 and Raymond Hernandez "Inquiry Grows as Rolls Fall for Medicaid" New York Times (June 8, 1999):B1.

program areas which are largely or exclusively financed with state funds only reduces spending by the amount of the reduction in state funds; reducing state spending in Medicaid reduces total spending by between two and four times the amount of the cut in state funds. Skilled advocates may be able to exploit this disparity as a means of protecting Medicaid programs from significant reductions.

Perhaps the central actors in the Medicaid constituency in most states are Medicaid agencies themselves, who appear to have played a central role in shaping state enrollment initiatives in the late 1990's in most states. The professional "policy community" within which Medicaid managers and executives move has long stressed universal coverage as a central professional value, and the agendas of conferences over this period sponsored by the major professional associations to which these managers belong were replete with presentations on eligibility and enrollment enhancement issues. States which had achieved high rates of enrollment growth were widely lauded in these venues for having done so, and their managers were invited to make presentations describing their programs. Managers wishing to enhance their professional standing in these circles thus had some incentive to focus on this set of issues. While there are some states in which governors took the lead in pushing state efforts to increase Medicaid and CHIP enrollment, the Rockefeller Institute study of take-up implementation indicates that differences in the size and scope of state efforts to expand access to Medicaid and CHIP were largely the result of differences in the level of effort and resources invested in outreach and enrollment simplification by mid- and upper-level managers in Medicaid and related agencies. While some of these differences in scope and scale certainly reflect differences in the receptivity of governors and legislatures to these initiatives, Medicaid and CHIP managers unquestionably had a considerable amount of discretion in shaping how aggressively their states solicited enrollment and had some professional incentive to promote these efforts.

A second internal political reason apart from professional values and prestige for states to avoid "racing to the bottom" is that Medicaid in many states is a significant revenue source rather than an expenditure. Over the last fifteen years, states have developed and exploited a variety of creative "Medicaid maximization strategies" which have the effects of shifting state-funded programs onto Medicaid or generating federal Medicaid matching funds, which states frequently use for general budget purposes, without any significant state expenditure. In the aggregate, these devices generate sizeable federal revenue for many states—federal payments for the purpose of aiding so-called "disproportionate share hospitals" amounted to some \$15 billion in 1998, and so-called "UPL" payments in 2000 amounted to some \$10 billion<sup>iii</sup>. State "Medicaiding" of human service programs is harder to measure precisely, but many states, particularly the large industrialized states in the Northeast and Midwest, have shifted significant amounts of program spending in public health, mental health, mental retardation and developmental disabilities, and even special education onto Medicaid<sup>i</sup>. While states vary widely in their use of these devices, states which rely on them heavily have incentives to maintain a high level of Medicaid enrollments to increase the amount of revenue they can collect through these devices. This reliance on Medicaid as a revenue source may have lessened the incentive for at least some states to look to Medicaid as a source of significant budget savings.

A second constituency in many states which is also dependent on continued high levels of Medicaid enrollment are the providers of medical and other covered services to Medicaid clients. While Medicaid is normally conceived as a health care program, much of its political appeal lies in its standing as an economic development program which supports large numbers of jobs, both directly and indirectly, and provides significant income to a sizeable number of health care workers.

The importance of Medicaid as a revenue source for health care providers varies widely by state and by type of provider. Medicaid accounted for 15.7 percent of personal health care spending nationally in 1998, ranging from just under 10 percent in Virginia to over 30 percent in New York. In some health care sectors, Medicaid's prominence as a payer is significantly larger. Medicaid is obviously a major payer for the large public hospitals and other providers which provide substantial amounts of care to populations in low income urban areas, but there are other, less obvious, groups of providers for which Medicaid is a major revenue source. Medicaid is the largest maternal and child health program in the country, covering roughly 25 percent of the nation's children and over 40 percent of the births. Medicaid accounts

---

<sup>i</sup> iii..For an excellent recent description of these devices, see Teresa Coughlin and Stephen Zuckerman "States Use of Medicaid Maximization Strategies to Tap Federal Revenues" (Urban Institute, Washington, 2002), available at <http://www.urban.org/Template.cfm?NavMenuID../ViewPublication.cfm.&PublicationID=779>.

<sup>i</sup> iFor rough estimates of the size of this shifting in one state, see James W. Fossett, Carol Ebdon, and Norman Brier, "When is Growth not Growth: The Curious Case of Mental Health Budgeting in New York" Public Budgeting and Finance (Winter, 1997), and James W. Fossett. "Medicaid and Health Reform: The Case of New York." Health Affairs (Fall, 1993).

for roughly half of the nation's expenditures on nursing home care, and accounts for a very large proportion of public spending on programs for the mentally retarded and developmentally disabled, as well as a significant share of spending on public mental health programs. Agencies which provide long term care and services to the mentally retarded and disabled are broadly dispersed geographically, creating large blocs of state legislators whose districts have a significant economic stake in continued Medicaid spending.

These data suggest that in many states, there are significant numbers of physicians, hospitals, nursing homes, and public or non-profit agencies providing services of various kinds who are dependent on Medicaid for a significant portion of their revenue. Rather than being concentrated in low income inner city areas, these organizations are broadly scattered across suburban and rural areas as well, creating a potentially broad political base for continued support of their activities. States in many cases have shifted payments to these agencies from general funds to Medicaid and expanded eligibility in order to increase the flow of Medicaid funds to these agencies, further enhancing this dependence. While states vary widely in the extent in the size, scope and political effectiveness of this group of providers, the potential adverse economic consequences of significant reductions in Medicaid may make state policy makers less willing to contemplate sizeable reductions in Medicaid eligibility or spending.

There is, in short, a significant internal constituency within most states that is dependent on Medicaid for professional prestige and revenue for both states and providers. The size and political effectiveness of this constituency varies across states, but is probably largest and most effective in the large, liberal, urbanized states of the Northeast and Midwest who have the most generous Medicaid programs and the highest Medicaid spending levels. Even in the poorer, more conservative states in the South and West, however, significant sectors of the health care industry are dependent on Medicaid for support and might be expected to resist efforts to curtail Medicaid eligibility.

#### *Health Performance Measures: A Counterweight to Taxes?*

A third factor which may have lessened the appeal of a race to the bottom in Medicaid coverage and spending are the visibility of alternative "performance measures" of health conditions within states that may serve as a counterweight to the indicators of state tax burdens and overly generous welfare programs to which "race to the bottom" arguments contend states are most responsive. Such widely reported and easily understood measures of population health as the rates of infant mortality and low weight births and comparable measures of the status of children also provide a means of comparing states to each other. Particularly among states which rank poorly on these indicators, the desire to improve "performance" relative to one's neighbors may make policy makers more willing to spend money on health programs and less willing to roll back Medicaid coverage and spending if it can be made to appear that such roll backs will worsen their state's standing on such measures.

Evidence that policy makers are responsive to measures of state "standing" other than taxes or welfare generosity is anecdotal, but abundant. While a variety of research indicates there is no simple connection between Medicaid coverage and birth outcomes, the political connection has proven persuasive. Particularly in states which rank towards the bottom on such measures, concern over poor state "performance" on these measures has been the subject of newspaper articles and editorials, creating pressure on politicians to respond in some fashion. It has frequently proven politically possible to cast this low standing as an obstacle to economic improvement and represent efforts to overcome low standing as important to improving a state's reputation as a desirable location for families and companies. Southern governors, whose states had among the highest rates of infant mortality and low weight births in the country, were among the strongest supporters of Medicaid eligibility expansions to pregnant women and infants during the late 1980's and early 1990's. In similar fashion, individual Southern governors have made efforts to reduce infant mortality, improve child health, or other nominally "liberal" policies central elements of campaign platforms or legislative initiatives. Since these states also have high Medicaid match rates compared to wealthier, better "performing" states, such initiatives are less expensive in poorer states than they might be elsewhere.

#### *Why have state efforts to increase access to Food Stamps been less common or muted?*

Although it is no simple task to explain why something has not happened—why, in particular, there has not been a more widespread and intense effort to increase take-up rates for the Food Stamp Program among the states—some factors seem to be important based on our preliminary reviews of the field research on TANF and Food Stamps. Clearly, the continued (and in some cases, increasing) salience of quality control problems in the Food Stamp Program seems to limit interest in expansionary measures. The Food Stamp caseload has been increasingly composed of households with earned income (from 21 percent in 1995, to 27 percent in 2001) and with no cash assistance from TANF or AFDC (households with cash assistance declined from 38 percent of the caseload in 1995 to 23 percent in 2001). Thus, especially among families with children, income is increasingly derived from sources outside of and not

directly monitored by the public assistance system—and thus contribute disproportionately to eligibility errors. Although some states, such as Texas, are attempting to address both goals simultaneously—by, for example, using information systems and outside data sources to check and monitor eligibility data. However, most states continue to place the burden of verification on families and rely on frequent recertifications to ensure accuracy.

Yet our preliminary research also suggests other reasons for the comparative lack of strong and sustained efforts to expand access to the Food Stamp Program—reasons that help distinguish state treatments of the FSP from their handling of Medicaid and CHIP. First, the Food Stamp Program differs markedly from the health programs in their bureaucratic and professional presence at the state and local level. Food Stamps are often managed by relatively small bureaucracies within large social service agencies at the state and local level. In most states, these large and complex social service agencies encompass cash assistance, child care, child welfare, SSI, and a wide variety of programs. Food Stamps is itself a large program in budgetary terms, but because it is a federal program and states are not required to develop extensive rules and make complex policy decisions, program implementation does not, unlike the health care entitlements, demand a large and specialized bureaucracy. The result is that not many state and local bureaucrats view Food Stamps as their major responsibility. Thus, not many are likely to argue vigorously to top administrators and the executive officials that expansion of the FSP is critical.

In addition to the small size of Food Stamp bureaucracies, the Food Stamp Program does not seem to have a strong and focused policy community to support it at the state and local levels. Nutritionists might theoretically serve such a role, but since Food Stamp implementation largely involves issues of administering an income maintenance program, nutritionists are unlikely to dominate state and local FS offices. Also, it is hardly clear that nutritionists are interested in expansion of the Food Stamp Program by itself (rather than concerned about how the benefits are actually used). As a result, there is no policy community that is responsible for the program and that perceives that their professional reputations can be greatly enhanced by expanding participation in the FSP.

Although the program enjoys the support of a broad coalition at the national level—encompassing urban moderates and liberals as well as members of Congress from farm and food-processing states—constituencies at the state and local levels for a more accessible program are harder to find. In preliminary conversations with our field researchers, most report relatively little public attention to or political mobilization around declines in Food Stamp caseloads or problems of access. Some of the larger states have hunger action networks or other organizations with a sustained interest in the Food Stamp Program. Private food charities might have some direct interest in FS implementation issues, but the resources of such organizations are rarely sufficient to allow them to carry out extensive political lobbying efforts. But unlike the case in health care, the providers of benefits—for example, retail food stores—have rarely shown active interest in the issue at the state and local levels. Thus, unlike the case with Medicaid, Food Stamps is rarely viewed as a means of supporting critical local institutions, much less providing jobs.

The lower level of federal activism—at least when compared to efforts in the health care area—may also account for some of the weakness of efforts at Food Stamp outreach. Before this year's reauthorization of the Food Stamp Program and a number of major changes that could lead to higher levels of access and participation, efforts by the federal government to address low Food Stamp take-up rates tended to focus on specific problems posed by welfare reform. The Food and Nutrition Service (FNS) of the U.S. Department of Agriculture expended some effort to detect inappropriate practices, such as closing doors to Food Stamp enrollment early in the morning. Under the Clinton Administration, the USDA used letters to governors, regional federal administrators, and public education campaigns and hotlines to clarify notification requirements (especially in the context of TANF diversion efforts), disseminate best practices, and explain the program's access requirements. Federal regulations promulgated near the end of the Clinton Administration gave states more discretion to extend certification periods. Also in 2000, the Administration for Children and Families of the Department of Health and Human Services included in its high performance measures for states the take-up rates of low-income families in Food Stamps (as well as Medicaid and CHIP). However, despite these clarifications, entreaties, investigations, and rule changes, the strong emphasis on minimizing error rates was left fundamentally intact, and state administrators generally did not perceive a major shift by the federal government away from error minimization and towards maximum access.

## **Conclusions**

The two program analyses contained in this paper present evidence of state actions that might be deemed “irrational” or “counterintuitive” under major prevailing theories of state policy behavior. Rather than respond “rationally” to financial incentives to increase spending on food stamps, which is almost completely financed by the federal government, and limit spending on Medicaid, where states have significant financial responsibilities, most states

appear to have made little effort to increase spending on food stamps and spent appreciable amounts of their own money on Medicaid outreach and enrollment simplification efforts whose avowed purpose is to increase Medicaid enrollment and expenditures even further. In similar fashion, states have not availed themselves of the discretion available to them under Medicaid to make themselves less attractive to potential low income residents and lower state taxes, thereby making themselves more attractive to wealthy residents and companies. Rather, they have rather broadly, though not universally, undertaken efforts to expand Medicaid enrollment that can be interpreted as a “race to the top” rather than in the other direction. In most cases, they have chosen to maintain these efforts under conditions of considerable budgetary stress.

These counterintuitive findings suggest the need for further research attention to two issues that appear to be significant determinants of states response to recent federal policy changes. One is the set of external cues and incentives to which states respond. “Race to the bottom” arguments presume that states are responsive primarily to comparisons of their tax rates and social program spending with those of their neighbors. High taxes and levels of social spending are presumed to attract low income residents and repel higher income taxpayers and corporations, motivating states to lower both in order to attract more desirable residents. The findings here suggest that states are responsive to a more complex set of external cues, some of which encourage increased, rather than reduced, social program spending. Positive reinforcement for enrollment enhancement efforts from Presidents, cabinet secretaries, foundations, and professional associations appear to have been important political resources for agencies, elected officials and advocates seeking to enhance Medicaid enrollment, and the presence of politically, if not substantively, convincing measures of state health “problems” that can be addressed by improving access to Medicaid may have provided political leaders in poorly performing states with motivation to expand and maintain Medicaid coverage. By contrast, the lack of external reinforcement, recognition and resources for state agencies to address the much larger decline in food stamp caseloads after welfare reform, and the limited financial and program resources provided to states to enhance enrollment may have lowered the salience of access to food stamps on the agendas of state policy makers. The further lack of a simple, readily understood measure of nutritional “performance” that can be reported in the media may have made it difficult for politicians, bureaucrats, and advocates to construct a convincing public case that declining food stamp caseloads was evidence of a “problem” that needed to be addressed.

Perhaps more significantly, these findings suggest the importance of internal state program constituencies as an explanation for state response to external incentives. The differences between food stamps and Medicaid is particularly telling in this regard. Medicaid is a major payer in the health care system in most states, is a dominant payer in important sectors of the health care system such as maternal and child health and long term care, and has become a significant revenue source for many states independent of its role as a supporter of revenue and jobs in the private and non-profit sectors. Medicaid has thus attracted a significant bureaucratic and provider constituency which draws significant revenue from the program and might be expected to both support efforts to expand coverage and oppose efforts to restrict either enrollment or spending. Improving access to health care for the poor is also an important professional value in the policy community within which Medicaid managers participate, providing a further reason for state agencies to press for improved enrollment and spending. By contrast, food stamps is a much smaller portion of nutrition spending and has developed no clear “provider” constituency which derives significant income from the program which it is willing to invest political resources to protect. The Food Stamp program has a much smaller bureaucratic presence inside most state agencies than Medicaid, and the “policy community” around the program is smaller, less cohesive, and appears not to have developed the clear commitment to enhanced access that characterizes the health policy community. This lack of a well-developed bureaucratic and provider constituency appears to have made it more difficult for program advocates to press an effective case that states should make use of available discretion and resources to maintain or enhance access to the program in the aftermath of welfare reform.