



**THE NELSON A.
ROCKEFELLER INSTITUTE OF GOVERNMENT**
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**THE DECLINE OF STATES IN FINANCING THE U.S. SAFETY NET:
RETRENCHMENT IN STATE AND LOCAL SOCIAL WELFARE SPENDING, 1977-2007**

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**RETRENCHMENT CONTINUED:
STATE AND LOCAL SOCIAL WELFARE SPENDING, 1977-2007¹**

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This paper examines social welfare spending on the eve of the recession to understand the likely trajectory of funding for different elements of state and local social welfare systems. It finds that state and local spending outside of medical assistance lost much of its real fiscal value since the last recession of 2001-02, especially when inflation-adjusted expenditures are compared to measures of need. Other trends include a growing concentration of state social welfare budgets around medical assistance, declines in federal assistance to states, and growing differences in social service spending across states of different fiscal capacities. The recession may exacerbate most of these developments and, along with the federal stimulus package, reduce the role of state governments in funding the national social welfare system.

State and local social welfare programs will no doubt be strained by the current recession and its effects on low-income families and individuals. The nation's unemployment rate grew from 4.9 to 10.2 percent between January 2008 and October 2009, and it is expected to grow well into 2010 (U.S. Department of Labor 2009). The federal poverty rate also rose in 2008, and as it typically rises in the wake of unemployment, it too will probably climb in subsequent years (DeNavas-Walt et al. 2009). While these and other indicators of need rise, state and local governments face strong pressures to cut spending in social programs as such governments experience sharp slowdowns or reductions in tax revenues (Dadayan and Boyd 2009).

What is less well understood is the fact that these short-run changes are operating on a state and local social welfare system that has been losing fiscal value for several years. Major elements of state and local social welfare expenditures stopped growing after the last recession of 2001-02, and some types of expenditures have remained low relative to economic needs since then. In sharp contrast to the 1990s — when resources for low-income families grew, services diversified, and states experienced remarkably similar changes in social welfare systems — recent years have seen contraction, a narrowing of services around medical assistance, and highly varied changes from one state to another.

These developments do not necessarily mean that states have engaged in a “race to the bottom,” the scenario in which states would slash all benefits to low-income households after getting greater flexibility over social welfare policies and budgets in the 1990s

¹ This paper revises and expands on “Stretched Net: The Retrenchment of State and Local Social Welfare Spending Before the Recession,” by Thomas Gais, in *Publius* 39 (Summer 2009): 557-579.

(Rom, Peterson, and Scheve 1998). It is true that cash assistance caseloads fell precipitously in the 1990s and declined during most of the current decade and even in the first half of 2008. Yet states increased their spending on social welfare programs in the first years of welfare reform and devolution, though the mix of programs changed from cash to social services, while means-tested medical assistance skyrocketed. The recent decline in state and local social programs began years later, in 2002, when state resources became scarce after the first post-reform economic downturn.

By 2007, on the eve of the Great Recession, state and local social welfare spending was still lower than its level *before* the economic downturn of 2001–02 – after adjusting for inflation and the number of poor people in the U.S. State and local spending on social welfare programs is likely to fall further relative to need during the current state fiscal crisis, apart from the temporary effects of the American Reinvestment and Recovery Act or future actions. Expansions in some social programs that are more or less exclusively funded by the federal government, such as Food Stamps and various federal refundable tax credits, will compensate somewhat for these declines. But that shift within the national safety net implies a diminished fiscal role for state and local governments in the overall U.S. social welfare system, a change with important implications for who is helped or not helped by social programs as well as for American federalism.

DATA

These findings are based largely on data from the U.S. Census Bureau’s Survey of State and Local Government Finances, which collects annual expenditure, revenue, and other fiscal data (U.S. Bureau of the Census 2006). Its expenditure data are organized into functional categories, one of which is “public welfare.” (For a description of the “public welfare” category of spending, including definitions of subcategories, see Appendix A.) Public welfare expenditures – which we call “social welfare expenditures” in this article – generally include spending on programs that support lower-income households, such as programs with means tests. To trace broad changes in the public welfare spending, this analysis organized several of the subcategories under the “public welfare” function into three types of expenditures:

- *Cash assistance*, including AFDC payments and TANF cash assistance – which together comprise most of these expenditures – as well as general assistance, home relief, refugee assistance, emergency relief, and state supplements to Supplemental Security Income (SSI);²
- *Medical assistance*, that is, payments to private health care providers for medical assistance or health care on behalf of low-income or medically needy persons [these payments approximate expenditures under Medicaid and the State Child Health Insurance Program (SCHIP)];

²AFDC refers to Aid to Families with Dependent Children, a program that provided cash benefits to low-income families with children, funded by both the federal and state governments. In 1996, AFDC was replaced by TANF, or Temporary Assistance for Needy Families, a program that gave states greater flexibility in the types of benefits and services provided to families, but that imposed new restrictions (such as time limits and work requirements) on cash assistance.

- *Social services*, which encompass a wide variety of services and benefits, including childcare subsidies, child welfare (programs to prevent abuse, neglect, and foster care placement), foster care and adoption assistance, social services for disabled persons, temporary shelters and other services for the homeless, welfare benefits other than cash assistance, administrative expenses to operate programs for low-income persons, and other payments to private vendors “for services and commodities other than medical, hospital, and health care.” The “social services” category also includes cash or quasi-cash benefits for specific needs, such as low-income energy assistance and benefits provided through mechanisms outside traditional welfare payments, such as refundable earned income tax credits, individual development accounts, and “diversion” or one-time payments to help needy families avoid regular “welfare” reciprocity.

These three types of expenditures totaled \$375.3 billion across all U.S. state and local governments in fiscal year 2007.³ The largest category was medical assistance, which comprised 73.4 percent of total social welfare expenditures. Social services constituted the second largest type, making up 21.3 percent. Cash assistance was only 5.2 percent of all social welfare spending.

Most of the dollars spent by state and local governments on social welfare functions came from revenues raised by the federal government, which typically passed the money down to state and local public agencies through intergovernmental grants, such as Medicaid, Temporary Assistance for Needy Families (TANF), or the Child Care and Development Block Grant (CCDBG). Of total social welfare spending in 2007, 62.8 percent (\$235.8 billion) came from federal sources. State and local governments funded the remaining 37.2 percent (\$139.5 billion) out of their own revenue sources.

Based on the Census data, social welfare spending was only a small part of total state and local spending: 16.8 percent of direct general expenditures in 2007. Spending on medical assistance constituted 12.3 percent of direct general expenditures by state and local governments. Spending on social services made up 3.6 percent, while cash assistance expenditures were 0.9 percent of total direct general expenditures.

The Survey of State and Local Government Finances has several strengths as a data source. It offers a long and nearly uninterrupted annual time series of state and local expenditures on important public functions.⁴ The categories it uses to classify public expenditures are stable, permitting comparisons over time even while federal and state programs come and go. The survey also collects data on programs wholly funded and operated by state governments, unlike federal administrative data for specific programs

³ The 2007 state and local spending data are the most recent information available from the Census Bureau. By fiscal year 2007, the Census Bureau means the state or local government’s own fiscal year ending anytime between July 1, 2006, and June 30, 2007.

⁴ Fiscal data were not collected from all local governments for 2001 and 2003. The Census Bureau surveyed only a sample of local governments in those years, enough to estimate total finances across all local governments in each of those years but not enough to estimate state-level totals for local governments. We therefore include these two years when calculating national trends but exclude them from analyses of differences among states.

(such as Medicaid), which only includes state expenditures that match federal spending or that are in some other way linked to the federal program.

However, the survey also has limits. It does not show all U.S. social welfare expenditures but only those that run through state or local government budgets. It does not, for instance, include the refundable portion of the federal Earned Income Tax Credit and most of the Supplemental Security Income program. It includes Food Stamp (now, Supplemental Nutrition Assistance Program, or SNAP) administrative costs, since those are paid out of the states' own budgets. However, it does not encompass the costs of SNAP benefits, which are paid by the federal government.

Another weakness of the survey is the flip side of its strength. It asks state officials to assign expenditures to the Census Bureau's functional categories. Yet many analysts are interested in particular programs. Although there is a rough correspondence between "cash assistance" and TANF assistance, and between "medical assistance" and Medicaid/SCHIP, these relations are hardly exact. Still, although the categories do not map precisely onto specific programs, the data remain the best source for understanding broad shifts over time in the allocation of state and local expenditures.

TRENDS IN SOCIAL WELFARE SPENDING

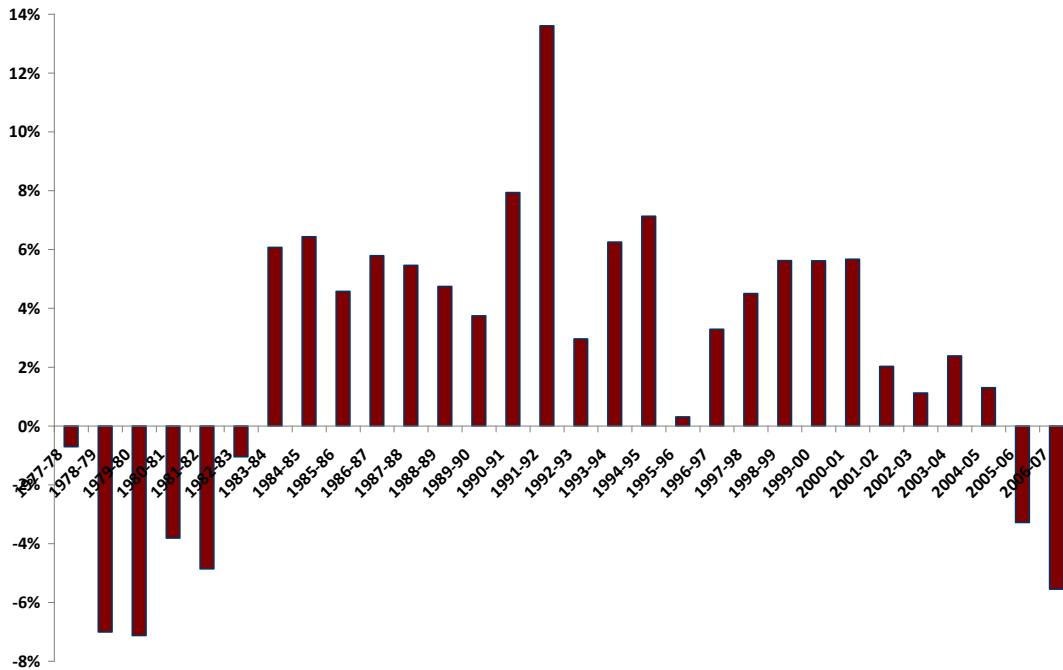
In this analysis, we describe social welfare expenditures in real, inflation-adjusted terms.⁵ We also compare spending levels to estimates of need by calculating expenditures per poor person, that is, by dividing social welfare spending in a state by the number of persons living under the federal poverty level.⁶ This method of comparing spending to need is not a perfect way of adjusting for the low-income populations targeted by these programs. For instance, many state Medicaid and SCHIP programs cover people with low incomes but who are not poor, while AFDC/TANF programs typically offer cash benefits only to families well below the federal poverty level. Also, most programs provide benefits or services to only some people living in poverty, such as families with children, homeless individuals, or those requiring childcare. Nonetheless, the measure is a good approximation of differences in spending on needy persons across states and programs and over time.

When we examine social welfare spending in this way, one of the most striking findings is the most recent: in 2007, for the first time since 1982-1983, total social welfare spending by state and local governments dropped for the second year in a row after adjusting for inflation and need. Real spending per poor person fell 5.6 percent between 2006 and 2007, as shown in Figure 1, which displays annual real changes in social welfare spending per poor person between 1977 and 2007. This decline came on the heels of a 3.1 percent drop in total social welfare spending between 2005 and 2006.

⁵ Unless otherwise stated in this article, all expenditures are expressed in terms of 2006 dollars per person living under the federal poverty level. Inflation adjustments are based on the Bureau of Economic Analysis's State and Local Government Consumption Expenditures and Gross Investment Price Index for Gross Domestic Product.

⁶ We divide by the three-year average of the number of poor persons in a particular year in order to reduce measurement error and volatility in calculations in each year.

Figure 1. Percent Annual Change in State and Local Spending on Social Welfare, Per Poor Person, 2006 Dollars, 1977–2007 (Adjusted to State-Local Government GDP Index).



This two-year decline came after several years of slow growth in social welfare spending. After social welfare spending accelerated in the late 1990s and grew strongly through 2001, annual growth rates fell. This slowdown after 2002 marked the end of a long period of expansion in social welfare spending from 1984 through 2001.

The drop in social welfare spending between 2006 and 2007 was largely the result of a 4.5 percent drop in medical assistance spending. Figure 2 reveals this and other components of change in social welfare spending by showing medical assistance, cash assistance, and social service expenditures after adjusting for inflation and the number of poor persons. Cash assistance also fell between 2006 and 2007, by 16.8 percent. Social services also declined in 2007, by 5.9 percent.

As Figure 2A shows, the two-year drop in medical assistance spending came after a stretch of 22 years of uninterrupted growth. To the extent that the “medical assistance” category approximates Medicaid, this long period of growth encompasses several distinct stages, with different forces driving costs in each period (Smith et al. 2008, 24; Gruber 2003). Yet the basic story over these two decades was the expansion of Medicaid from a program that primarily served families on welfare well into the 1980s, to one that served many poor elderly and disabled persons as well as a wider range of low-income families with children, including families not on welfare and often with incomes over the federal poverty level (U.S. House of Representatives 2004, 15–48; Howard 2007, 95–98). Spending growth was also driven by the general costs of health care; by expansions

in the range of services covered under Medicaid; and by arrangements crafted by states with health care providers to generate additional matching dollars to draw down federal dollars (Coughlin et al. 2004).

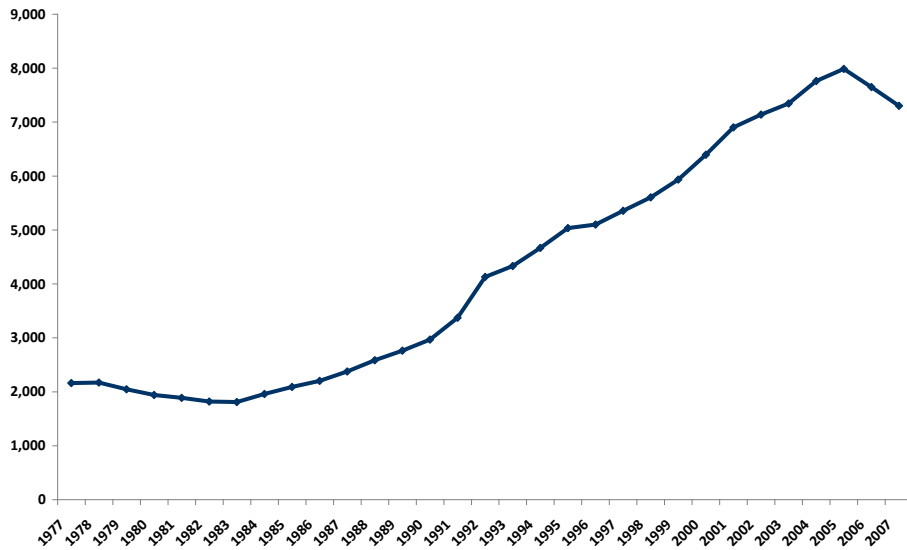
The sharp downturn between 2005 and 2007 in medical assistance was attributable in part to a one-time shift in responsibility from the states to the federal government for the costs of prescription drugs used by “dual eligibles,” persons eligible for both Medicaid and Medicare. But though states got some long-run relief by shedding responsibility for the costs of pharmaceuticals for some Medicaid clients, there is little reason to expect Medicaid costs to grow at a slower rate in the future (Smith et al. 2008, 8).

Figure 2B shows the trends for cash assistance and social services in real spending per poor person. After showing similar trends from the late 1970s through the early 1990s, cash assistance and social service expenditures moved in different directions after 1994. Cash assistance expenditures declined persistently over 12 straight years, from 1995 to 2007, when it lost 56.5 percent of its real value per poor person. Social service spending, by contrast, grew between 1994 and 2002. After 2002, however, social service spending also fell; it lost 15.8 percent of its real value per poor person between 2002 and 2007. Thus, the slowdown after 2002 in total social welfare spending was the result of a long-run decline in cash assistance, a more recent yet persistent drop in social services, and a very recent and probably short-run decline in medical assistance.

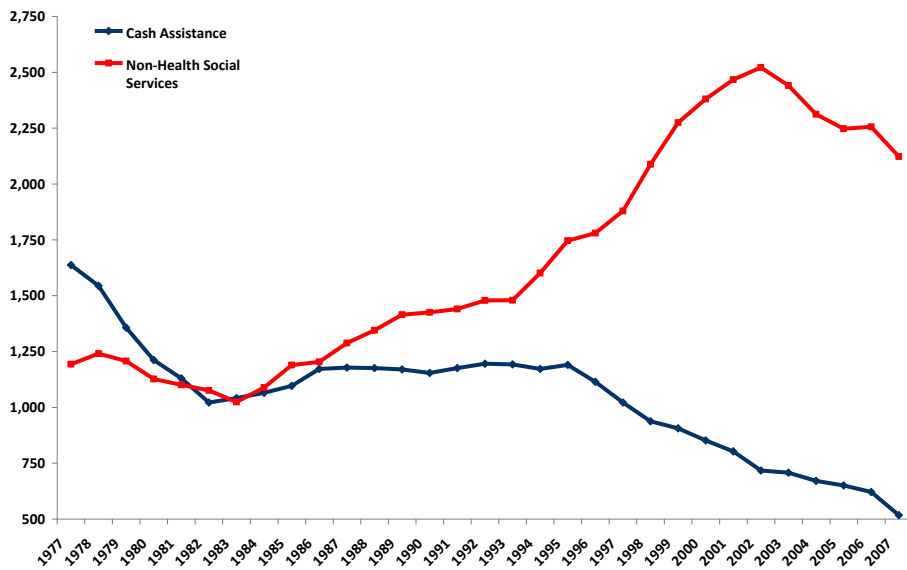
The inflection point in social service spending in 2002 marked the end of an expansionist, transformational period for social welfare spending, a period that began in the middle 1990s. Although real expenditures on cash assistance per poor person declined by \$478 between 1993 and 2002 (a drop of 40.0 percent), that decline in spending was small compared to simultaneous increases in spending on social services (which grew by \$1,043, an increase of 70.6 percent, between 1993 and 2002) and medical assistance (which swelled by \$3,011, an increase of 73.0 percent, over the same period). These changes combined to expand total social welfare spending as well as shift the balance between different types of expenditures, away from cash assistance and toward health and social services. In 1993, for every dollar spent on cash assistance, \$1.24 was spent on social services and \$3.63 on medical assistance. By 2002, for every dollar of cash assistance, \$3.52 was spent on social services and \$9.96 on medical assistance.

Figure 2. Total State and Local Spending on Medical Assistance, Cash Assistance, and Social Services, Per Poor Person, 2006 Dollars, 1977–2007.

A. Medical Assistance



B. Cash Assistance and Social Services



What accounted for the decline in cash assistance and the expansion of social services in the 1990s? One factor was the economic growth of the 1990s. Cash assistance enrollments typically decline when unemployment falls (Blank 2001). Expanded access to the Earned Income Tax Credit and its increased value in the 1990s also dampened participation in welfare programs (Grogger 2004). In turn, the caseload changes affect state expenditures on cash assistance, which declines when employment rates rise

(McGuire and Merriman 2005, Table 4; Lewin Group and Rockefeller Institute 2004). By contrast, social services tend to grow when unemployment is low, perhaps because most services are discretionary programs, and their funding may go up with the availability of greater revenues from state and federal governments.

Federal and state welfare reforms also contributed to the shift toward social services and away from cash assistance. In addition to substantial federal increases in childcare grants to the states, the 1996 Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) replaced Aid to Families with Dependent Children, largely a cash assistance program, with a block grant, Temporary Assistance for Needy Families (TANF). The grant ended the entitlement to cash assistance and imposed restrictions on the receipt of cash assistance, such as work requirements and time limits – changes that contributed to declines in cash assistance rolls (Blank 2001; Grogger 2004; Lurie 2006).

TANF also gave states flexibility to apply their federal dollars and required state expenditures to services and other “nonassistance” programs for low-income families, largely to encourage and support work. “Nonassistance” are services or benefits for needy families that do not meet TANF’s definition of “assistance,” which encompasses “cash, payments, vouchers, and other forms of benefits designed to meet a family’s ongoing basic needs,” such as food, clothing, shelter, and utilities (U.S. House of Representatives 2004, 7-5). Nonassistance may include short-term diversion payments (nonrecurrent payments to needy families who agree not to apply for assistance), childcare subsidies for working families, refundable earned income tax credits, case management and employment services, transportation assistance, and other services and work supports. Many states found it easy to invest more funds in services under TANF because of fiscal savings reaped from the large declines in welfare rolls. In 1997, the year after TANF was enacted, only 22.7 percent of state spending under TANF went to nonassistance services and benefits; by 2002, that percentage rose to 55.8 percent (U.S. Department of Health and Human Services 2009b). In fact, even this change underestimates the shift to services, since it does not include the block grant money states transferred to their Social Service Block Grant programs or their Child Care Development Funds.

Beginning in 2002, however, these circumstances changed. The economic downturn starting in late 2001 sharply cut state revenues at least through 2003 and made discretionary spending like social services vulnerable to state cutbacks (Boyd et al. 2008, 2). Also, after several years of rapid increases in services, TANF spending leveled off after 2001, as states spent down the surpluses they had built up in the 1990s from the block grant, and as inflation eroded the value of federal assistance (Lewin Group and Rockefeller Institute 2004, 63–64). And even though welfare rolls fell during and after the 2001–02 recession, the declines in enrollments were much smaller than in the 1990s – and thus fewer TANF dollars were available for work supports and services.

TRENDS BY STATE FISCAL CAPACITY

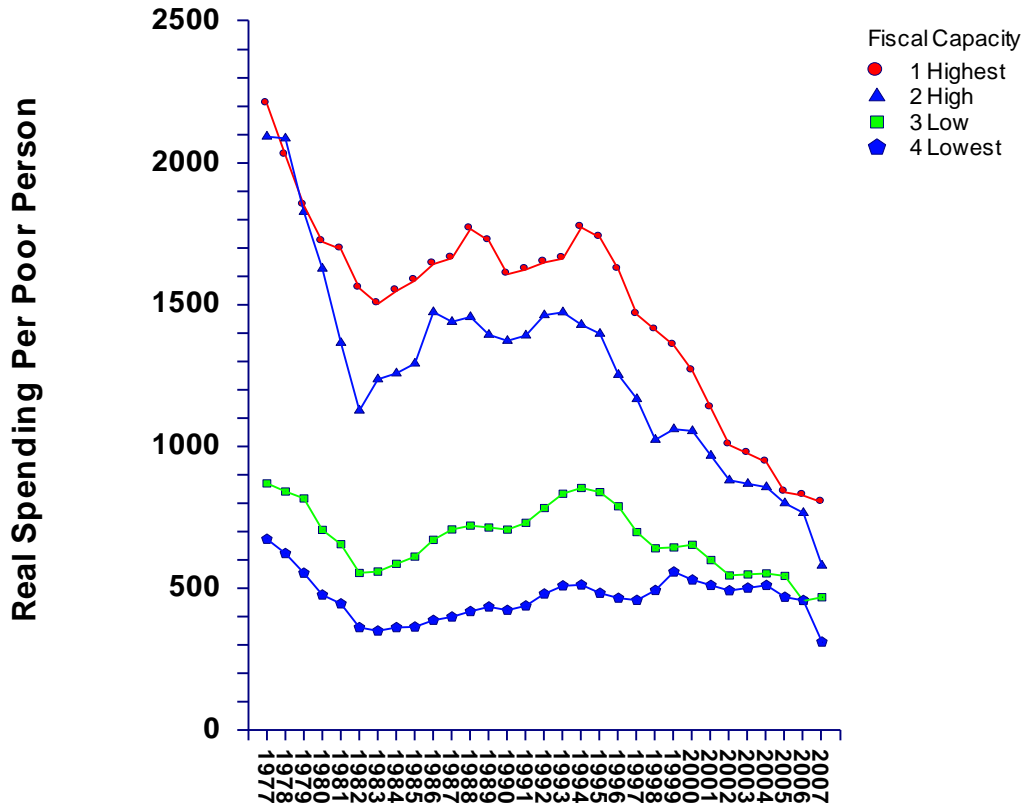
Changes in social welfare spending have varied considerably among states. Spending fell in many states since 2002 but increased in others, and one of the most important

contrasts was between states of different fiscal capacities. State fiscal capacity — the resources available to a state for taxation and other own-source revenues — has long been correlated with state welfare benefits and expenditures on social welfare programs (Gais and Weaver 2002; Grogan 1994; Plotnick and Winters 1985). It is difficult to determine the extent to which these correlations reflect causal relationships, as state fiscal capacity is correlated with other economic and social factors as well as federal grant formulas. Nonetheless, the association between state fiscal capacity and social welfare spending and benefits is itself significant for normative assessments of public policy and federalism. For instance, to the extent that social welfare assistance is strongly associated with state fiscal capacity, public programs reinforce rather than counter economic inequalities across states.

We measure state fiscal capacity using states' real per capita personal income. Some other measures of fiscal capacity take into account a wider range of taxable resources, including business income, nonresident earnings and sales, and natural resources (Mikesell 2007). However, for the purpose of creating categories of states according to their average fiscal capacities over a long period of time, as done in this paper, real personal income has the virtue of being available on an annual basis for this entire period. Personal income is also a good indicator of residents' ability to pay income, property, and sales taxes, which are the largest sources of tax revenue for state and local governments. Finally, real per capita personal income is strongly correlated with other indicators of state fiscal capacity (Lewin Group and Rockefeller Institute 2004, 5).

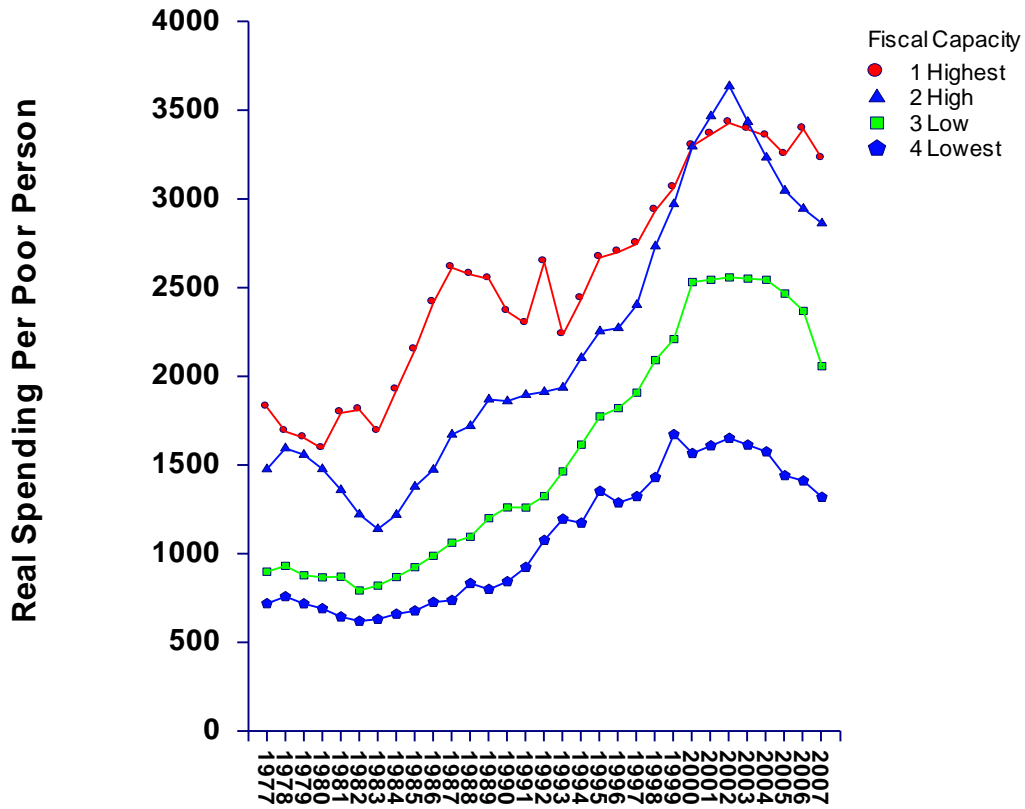
When we examine the relationship between state fiscal capacity and state expenditures for social welfare programs, we find substantial changes in recent years. Since the mid-1990s, for instance, cash assistance spending declined much more among high fiscal capacity states, producing a downward convergence in state spending. Figure 3 shows this trend by displaying changes in the mean level of cash assistance spending for four groups of states sorted according to their fiscal capacities: from Quartile 1, the 12 states with the highest levels of per capita personal income, down to Quartile 4, the 12 states with the lowest levels of per capita personal income. (For a listing of states by fiscal capacity quartiles see Appendix B.) In 1994, the four groups of states were far from one another in their average spending levels, with the wealthiest states showing the highest level of spending on cash assistance, and the poorest states showing the lowest. However, starting around 1995, wealthy states cut their cash assistance spending dramatically, while less-wealthy states did not. By 2007, the wealthiest quartile of states spent 2.6 times the amount that the poorest quartile of states spent on cash assistance — down from a 3.5 ratio in 1994.

Figure 3. Average (Mean) State Spending on Cash Assistance, Per Poor Person, 2006 Dollars (Q1 Highest Fiscal Capacity; Q4 Lowest Fiscal Capacity), 1977-2007.



As states became more alike in their spending on cash assistance, their spending on social services diverged. Many states saw increases in social service spending beginning in the mid-1990s, but wealthy states experienced larger and more extended increases in spending than did the poor states. Figure 4 shows these trends. Quartile 4, the poorest quartile of states, increased social service spending from 1996 through 1999, after which expenditures declined. Spending by the next poorest quartile of states (Quartile 3) peaked a year later, in 2000, leveled off until 2004, and then fell. Quartile 2 states reached their peak in 2002 and then dropped sharply. Finally, the wealthiest quartile (Quartile 1) was the only one whose spending remained at roughly the same level since the end of the 1990s. As a result, in 2007, the wealthiest quartile spent 2.4 times the amount that the poorest quartile of states spent on social services, up from a 1.8 ratio in 1999.

Figure 4. Average (Mean) State Spending on (Nonhealth) Social Services, Per Poor Person, 2006 Dollars, 1977-2007. Stratified by State Fiscal Capacity Quartiles (Q1 Highest Fiscal Capacity; Q4 Lowest Fiscal Capacity).



Differences in medical assistance spending between the wealthiest and poorest states have typically been smaller when compared to differences in expenditures for cash assistance and social services (Figure 5). These differences declined after 1990, as low fiscal-capacity states increased their spending on Medicaid rapidly (probably due to expanded federal mandates). After 2002, state differences in medical assistance spending remained fairly stable. In 2002, wealthy states in Quartile 1 spent about 1.4 times what states in Quartile 4 spent. In 2007, that ratio was about the same, at 1.5.

Figure 5. Average (Mean) State Spending on Medical Assistance, Per Poor Person, 2006 Dollars, 1977-2007. Stratified by State Fiscal Capacity Quartiles (Q1 Highest Fiscal Capacity; Q4 Lowest Fiscal Capacity).

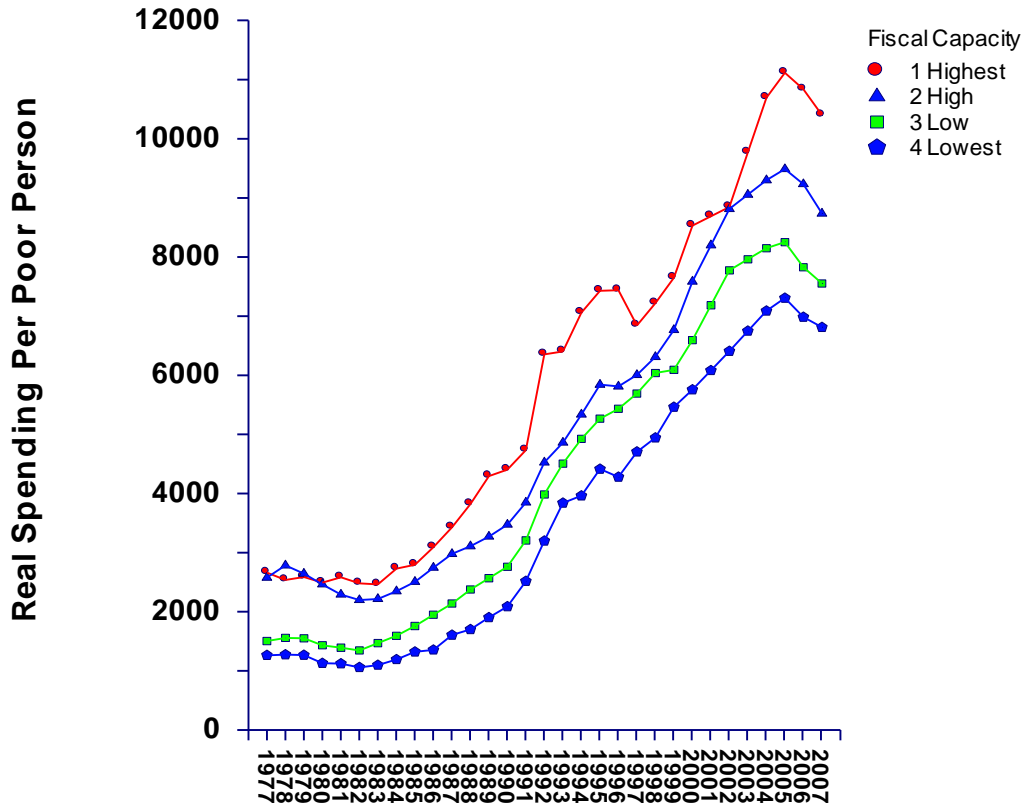


Table 1 summarizes these numerous shifts in expenditures by showing changes in real spending per poor person in the decade from 1997 to 2007. It compares spending changes for different types of social welfare programs and for states of different fiscal capacities. Table 1A shows changes in terms of real dollars per poor person. Table 1B expresses these changes in percentage terms.

The changes in Table 1 show, as we would expect, large and widespread increases in state and local spending on medical assistance between 1997 and 2007 – both in absolute and percentage terms. Table 1 also shows large and widespread declines in spending on cash assistance, although the absolute dollar declines are much greater among the high fiscal capacity states. It also reveals the highly varied changes in social service spending, with much larger increases in expenditures among the two wealthiest quartiles of states. Finally, Table 1A shows that the declines in cash assistance spending are greater in absolute value than the increases in social service expenditures in each of the four state quartiles; thus, social welfare spending *outside of medical assistance* has dropped in real dollars per poor person since 1997.

Table 1. Changes in Real Spending Per Poor Person on Medical Assistance, Cash Assistance, and Social Services, by State Fiscal Capacity, 1997-2007

State fiscal capacity quartiles	Category of social welfare expenditures				Number of states
	Medical assistance	Cash assistance	Social services	Total	
<u>A. Changes expressed in real dollars per poor person</u>					
1 Highest income states	3,557	-662	480	3,375	12
2	2,730	-587	460	2,603	13
3	1,861	-229	149	1,781	13
4 Lowest income states	2,107	-147	-4	1,956	12
<u>B. Percentage change in real dollars per poor person</u>					
1 Highest income states	52%	-45%	17%	31%	12
2	45%	-50%	19%	27%	13
3	33%	-33%	8%	21%	13
4 Lowest income states	45%	-32%	0%	30%	12

As Figure 6 shows, all of these changes combined to produce major shifts in the spending profiles of states with different fiscal capacities. The figure shows the percentages of total spending for cash assistance, medical assistance, and social services for states of different fiscal capacities in 1987, 1997, and 2007. Four changes are notable. First, medical assistance increased from around half of states' total social welfare budgets in 1987 to about three-fourths of their budgets in 2007. Second, cash assistance declined from about one-fifth of states' social welfare budgets in 1987 to less than one-twentieth in 2007. Third, social services did not drop greatly over these years for states as a whole. Such spending declined from slightly more than one-fourth of states' social welfare expenditures in 1987 to a little more than one-fifth in 2007. However, the drop was largest among the lowest fiscal capacity states in Quartile 4. These states saw a decline in social service spending from 27 percent of the total social welfare budget in 1987 to only 15 percent in 2007.

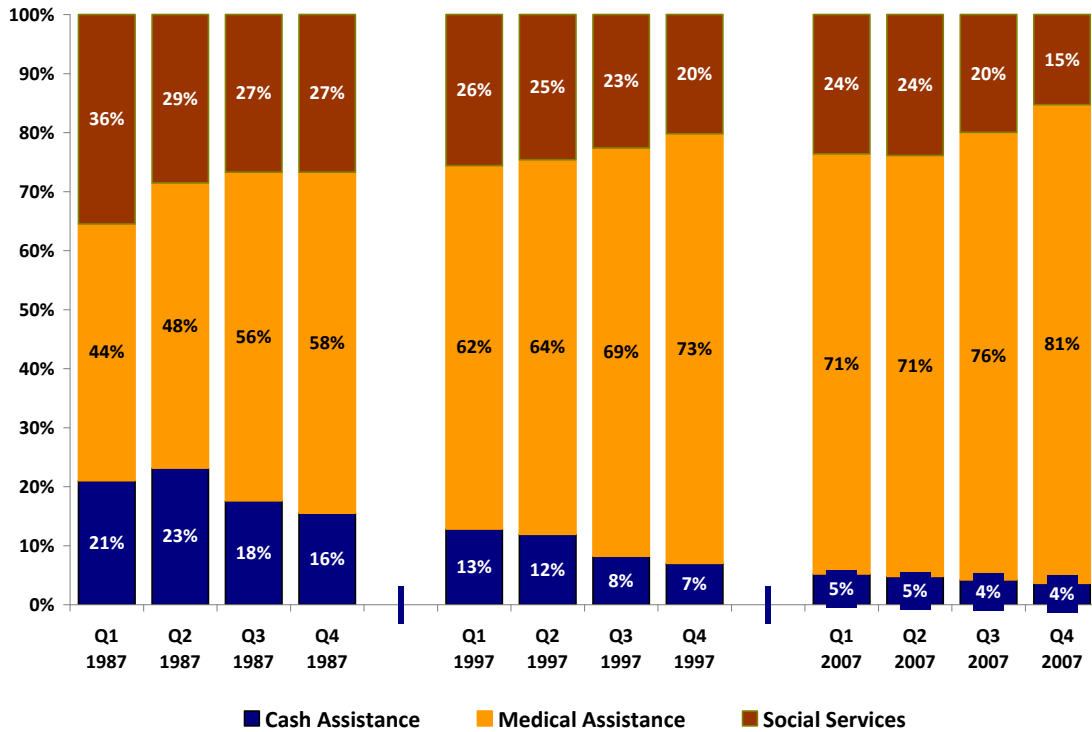
State and local social welfare spending has thus changed enormously, particularly in the last decade. Cash assistance went from a significant to a negligible part of social welfare expenditures. Medical assistance has grown vigorously among all states. Social service spending has increased moderately among the high fiscal capacity states but hardly at all among low fiscal capacity states. Finally, although the 1990s showed a roughly equivalent shift of spending from cash assistance to social services, since 2002 state and local spending declined for social services as well as cash assistance. Nonhealth social welfare spending is thus now lower than it was in 1997. As a result, medical assistance is now absorbing a larger and larger share of total social welfare spending, particularly among the lowest fiscal capacity states.

PROCESSES

Many factors contribute to these changes, and we do not pretend to have identified all the relevant forces. However, at least three distinct yet intertwined processes are likely to be important in understanding the complex changes in state and local social welfare expenditures: changes in intergovernmental relations, differences in the responses of

social welfare programs to political and economic conditions; and interactions between different social welfare expenditures. Future analyses will attempt to join these processes into a single model. Here, we only sketch these processes and how they may affect the changes we have described.

Figure 6. Percentage Distribution of State and Local Spending on Different Types of Social Welfare Programs, by State Fiscal Capacity, 1987, 1997, and 2007.



First, trends in federal transfer payments to states and in state spending out of their own revenue sources may help account for some of the observed dynamics in state spending on social welfare programs. Unfortunately, the Census Bureau’s state and local fiscal data only distinguish between i) expenditures supported by federal transfers and ii) expenditures supported by state and local own-source revenues for *total* social welfare expenditures. In other words, the data do not indicate the split between federal and state/local sources for spending on cash assistance, medical assistance, or social services. Because medical assistance is a large part of total social welfare spending, changes and variations in federal transfers are thus strongly affected by Medicaid and SCHIP.

Even at this high level of aggregation, the trends are suggestive. As Figure 7 shows, states with all levels of fiscal capacity saw increases in federal transfers through the 1980s, 1990s, and 2000s – until 2003-04, when states saw sharp declines in federal transfer payments (for a discussion of changes in federal policies during this period, see Allard 2007). Although the declines in federal transfers since 2005 no doubt reflect the

drop in medical assistance expenditures (Figure 5), note that the overall decline in federal assistance began before 2005. This timing suggests that federal transfers in support of nonhealth programs may have also contributed to the recent declines.

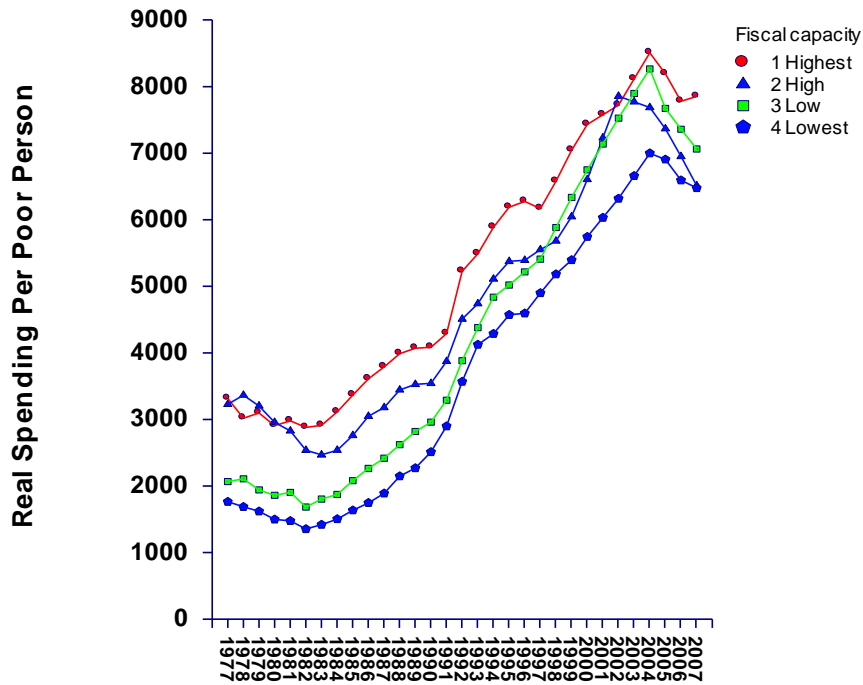
While federal transfers fell at similar rates for wealthy as well as poor states, states of different fiscal capacities showed different trends in social welfare expenditures from their own taxes and other revenue sources (Figure 7B). The two wealthiest quartiles increased their own-source expenditures for social welfare programs more or less consistently since 1997, until 2006-2007. By contrast, the two poorer state quartiles saw little growth in spending since the late 1990s. That is, as the federal government cut back its support for social welfare programs for all states, wealthy states made up some of the loss by increasing their spending, while low fiscal capacity states barely maintained their own-source expenditures. This combination of federal and state actions may help account for some of the growing divide in spending between high and low fiscal capacity states.

A second process contributing to the patterns we've observed involves *the diverse ways in which different types of social welfare programs respond to political, economic, and demographic factors*. These variations may reflect not only differences in program structures (e.g., entitlements vs. block grants) and client needs (e.g., medical assistance dollars go largely to an older population whose eligibility is largely unaffected by business cycles, while childcare and TANF assistance to a much younger population are more affected by economic cycles) but also different political processes and influences.

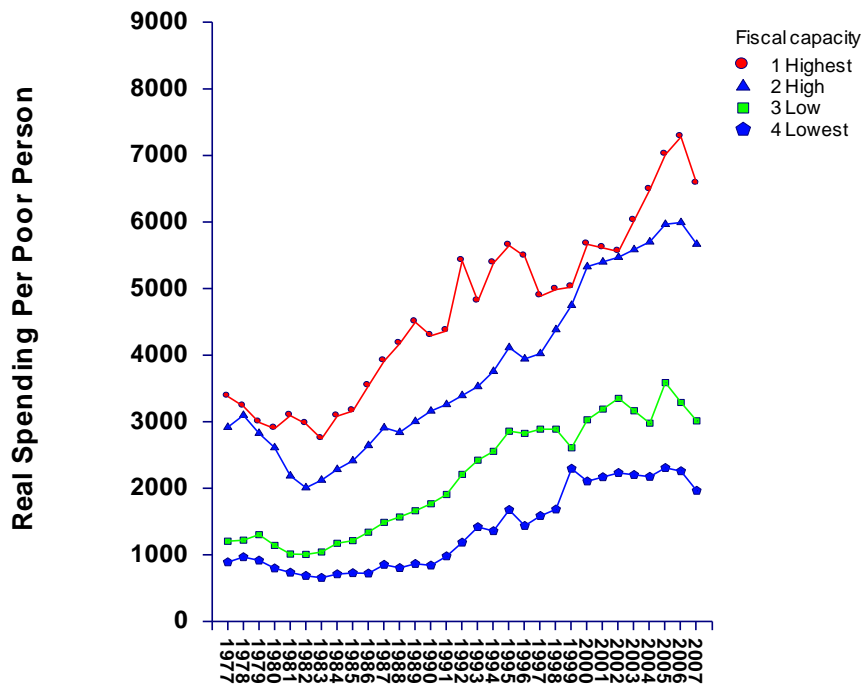
For instance, cash assistance spending may be strongly affected by legislative decisions about benefit levels, eligibility, and other conditions (such as time limits), all of which may reflect fairly abstract, ideological, and often divisive views about the poor. By contrast, social service programs are often less controversial in terms of goals and benefits – such as adoption assistance and childcare subsidies – but may be constrained simply by the availability of resources, especially since providers and other organized advocates tend not to be strong in many states. Finally, medical assistance expenditures probably reflect a combination of entitlement dynamics – in which spending is driven in large part by changes in the number of eligible people, especially high-cost eligibles such as elderly and disabled individuals – as well as the availability of resources and political support within the state to devote greater resources to medical assistance. That is, Medicaid and SCHIP are in part entitlements with certain mandatory and minimum eligibility and coverage requirements. But states can also increase or decrease eligibility for optional populations, expand or contract coverage for optional services, or raise or lower payments to medical vendors – in response to political shifts and changes affecting access to state fiscal resources.

Figure 7. State and Local Social Welfare Expenditures Supported by Federal Transfers vs. State and Local Own-Source Revenues, by State Fiscal Capacity, 1977-2007.

A. Spending From Federal Transfers



B. Spending from State and Local Own-Source Revenues



To determine whether different types of social welfare expenditures respond to different state-level variables, we estimated the linear effects of the same set of explanatory variables on state and local spending on cash assistance, social services, and medical assistance. The estimates came from regressions using time-series cross-sectional data (TSCS). The time series runs from 1978 to 2007. The cross-sectional data refer to the states. The dependent variables are state and local spending (using the same Census Bureau data employed above), expressed in terms of real, per poor person expenditures. Explanatory variables include:

- 1) *Measures of resources and access to resources*, namely, state fiscal capacity, measured by per capita personal income; and institutional constraints on state resources, including state tax and spending limitations and supermajority requirements for tax or spending decisions; state unemployment rates also indicate changes in resources (as an indicator of economic cycles) as well as in social needs;
- 2) *Measures of political control and preferences*, such as the party of the governor, the percent of Democratic votes in the two-party vote in recent presidential elections (an indirect measure of a state's political ideology), the percent of Democrats among the state's legislators, and the percent of the state's population that is unionized;
- 3) *Characteristics of the population that may affect demand for services or benefits*, including the percentages of the states' residents who are African-American, young (under 25), and elderly (over 65); and the population density of the state as a rough indicator of its urbanization.

Descriptions of the variables may be found in Appendix C. Coefficients were estimated using ordinary least squares regression, along with the Prais-Winsten procedure and panel-corrected standard errors.⁷ The equations included year effects (to control for policy, economic, or other changes affecting all states in a particular year) as well as state effects (to control for long-run differences in states that affect spending).

Table 2 shows the estimated coefficients from the three different equations. The equations examined the linear effects of the independent variables on annual spending

⁷ An advantage in using TSCS data, compared to using time-series or cross-sectional data alone, is that it accounts not only for why individual states behave differently, but also why an individual state behaves differently at different times. But TSCS data makes empirical analysis more difficult because of complicated error terms, which may not be independent of each other. Error terms may be serially correlated within a state and be spatially correlated in one year across states. Thus, this paper employs the OLS estimation, along with the Prais-Winsten procedure and panel-corrected standard errors. In this procedure, the common first-order autocorrelation (AR(1)) coefficient is employed, and the first observations in the dependent and independent variables are transformed using the Prais-Winsten transformation.

per poor person for each of the three types of social welfare spending: cash assistance, social services, and medical assistance.⁸

The estimated coefficients in Table 2 suggest some similarities in how different types of social welfare functions respond to different factors, but they also reveal important differences:

1. *Cash assistance* is related to long-run political tendencies and demographic characteristics. It is positively associated with a state's population density (and thus perhaps the political strength of its cities). It is negatively related to the proportion of a state's population that is African-American. It is also negatively related to the proportion of a state's legislators who are Democratic (which may reflect a regional (Southern) effect for most of this period). Unionization approaches significance and shows a weak, positive correlation with greater spending on cash assistance. Cash assistance is not significantly associated with fiscal resource variables.
2. *Social service* spending is, by contrast, strongly related to variables indicating a state's fiscal resources to support such programs. It is significantly and positively correlated with a state's per capita personal income. It is negatively related to the presence of state tax and expenditure limits (which impose restrictions on the growth of taxes or expenditures). It is negatively associated to unemployment, a correlation that suggests such programs are cut during fiscal downturns. Interestingly, it is also negatively associated with the proportion of elderly and young persons in a state's population, the target populations for many social services. These relationships mean that social service spending is highest in states with high proportions of nonelderly adults — typically taxpayers — and comparatively few service recipients.
3. *Medical assistance* is correlated with both the political and demographic factors associated with cash assistance and the resource-related variables associated with social service spending. Per capita personal income is related to medical assistance spending. Supermajority and state tax and expenditure limits are both negatively related to such expenditures. Medical assistance spending is also lower, other things being equal, during periods of high unemployment.

Medical assistance spending, like cash assistance, is also lower in states with higher proportions of African-Americans. It is lower in states with many young people and is (though not quite significantly) higher in states with more elderly people — perhaps reflecting the greater costs of providing health care to older individuals, or perhaps reflecting differences in political demands.

⁸ Arizona, Hawaii, and Alaska were not included in the analysis due to extreme values that would have exerted a disproportionate effect on the estimates. Hawaii and Alaska's expenditures are typically much higher than other states, partly because of very different price levels. Arizona had a very low level of spending on medical assistance for several years, reflecting its very late adoption of Medicaid.

Table 2. Estimated Regression Coefficients for State and Local Expenditures on Cash Assistance, Medical Assistance, and Social Services, Expressed in Constant Dollars Per Poor Person, 1977-2007.

Underlined coefficients are significant with probability 0.05 (two tailed test). Double underlined coefficients are significant with probability 0.01. State and year effect coefficients not reported but available on request.

	Per poor person spending		
	Cash assistance	Medical assistance	Social services
<u>Measures of resources, resource constraints, and demands</u>			
Per capita personal income (ln; 2 year lag)	.697	<u>.447</u>	<u>.506</u>
State tax and spending limits	-.015	<u>-.068</u>	<u>-.072</u>
Supermajority requirements	-.116	<u>-.092</u>	-.026
Unemployment (lagged, 2 years)	.016	<u>-.017</u>	<u>-.036</u>
<u>Political measures</u>			
Governor's party (Democrat)	.032	.025	.012
Last presidential election percent (Dem)	-.001	-.001	.001
Democrats in state legislature (percent)	<u>-.005</u>	-.001	-.001
Unionization (percent)	.008	.003	.002
<u>Characteristics of the population</u>			
Youth (percent of population under 25)	-.017	<u>-.042</u>	<u>-.029</u>
Elderly (percent of population over 65)	-.051	.007	<u>-.064</u>
African-American (percent of population)	<u>-.031</u>	<u>-.020</u>	-.015
Population density (ln)	<u>.900</u>	.246	-.102
(Note: "ln" refers to natural logarithm.)			
Number of observations	1,316	1,316	1,316

These estimates provide some clues in interpreting recent trends in social welfare spending. The growth of social service spending, for instance, may have been dampened or reversed in many states in the 2000s, not only by the shifting age distribution but also by the spread of tax and expenditure limitations among states in the 1990s and then later by the higher rates of unemployment following the 2001-02 recession. More generally, these findings also suggest that, *as cash assistance declines and social and medical assistance come to take up a larger share of total social welfare spending by state and local governments, state fiscal resources may become increasingly important factors in accounting for variation in spending across states and over time.*

This last finding may help us understand the third process possibly shaping these trends and variations: *interactions between different types of social welfare expenditures.* One possible interpretation of the patterns we have seen is that the recent decline of social services was in part a consequence of a squeeze in resources stemming in part from the widespread growth of health spending, even in low fiscal capacity states, and the comparatively small fiscal surpluses generated among poor states in the 1990s and early 2000s from falling cash assistance caseloads. Thus, while wealthier states may have applied surpluses generated by the drop in cash assistance spending to expansions in social services through the early 2000s, low fiscal capacity states typically had little or no such surpluses — while all states' nonhealth expenditures are pressed by the growth in

medical assistance. Estimating these interactions between different expenditures is challenging, but we are working on that task now.

IMPLICATIONS

While cash assistance fell rapidly in the late 1990s and early 2000s, state and local service spending expanded not only in level but also in diversity, as many states reduced their spending on cash assistance and shifted resources to childcare subsidies, employment services, case management, refundable earned income tax credits, child welfare programs, and other nonhealth services and benefits.

But that broad expansion did not last. It ended abruptly after 2002, when social service spending joined cash assistance in its downward trend, while medical assistance spending continued to grow until 2006 and 2007. By 2007, state spending patterns had shifted markedly, as cash assistance dropped to a miniscule share of total social welfare spending, medical assistance swelled as a proportion of total expenditures, and social services became more unequally distributed across states of different fiscal capacities.

One implication of these findings concerns the probable effects of the recession. The recession will act on spending levels already low in terms of nonhealth spending when compared to levels at the beginning of this decade. Table 2 also suggests that as the social welfare system shifts to one in which expenditures on social services and medical assistance dominate, state and local social welfare spending becomes increasingly vulnerable to rises in unemployment and perhaps other aspects of economic stress. Absent new interventions, expenditures for social services and medical assistance might drop to real levels we have not seen since the early 1990s.

However, there has, of course, been a major intervention: the American Recovery and Reinvestment Act of 2009 (ARRA). Based on Congressional Budget Office estimates, the two-year outlays may be as high as \$204 billion for the additional funds provided by the ARRA through the income support, social service, and medical assistance programs listed in Table 3. Despite this large sum, however, the ARRA may not greatly affect the trends and patterns described in this paper. Most of the additional cash assistance and income support funds go to programs that do not run through state budgets: for instance, federal refundable tax credits, SNAP/Food Stamps, and SSI. Also, not all of these programs target low-income families: Unemployment Insurance includes incentives for states to expand eligibility for benefits among low-income workers, but most UI benefits will still go to persons well above the poverty line.

The largest potential source of support for state spending on low-income families is the TANF “emergency contingency fund,” which offers states support for 80 percent of the costs of increased spending on cash assistance in 2009 and 2010, if a state’s caseload grows and the state increases its spending on such assistance (Parrott and Schott 2009). However, most states will still be required to engage large shares of their recipients in a recently narrowed range of work-related activities, a challenging task even in better economic times (Gardiner et al. 2007), and one reason why many states are reluctant to increase TANF caseloads significantly.

Medical assistance spending will probably resume its long-run growth. ARRA provides states a large though temporary increase in the share of Medicaid paid by the federal government. By lowering Medicaid's "price," the stimulus may lead states to devote an even greater share of their social welfare budgets to medical assistance – or at least discourage them from making large cuts in Medicaid if they are avoidable.

The area most vulnerable to cuts is, as already noted, social services. ARRA provides some support for services, including childcare subsidies, training and employment services, and homelessness prevention.

Also, the temporary increase in the percentage of federal funding that applies to Medicaid also applies to Title IV-E foster care and adoption assistance. These amounts are significant, even large, within these particular service areas, but they may be stalled by lengthy contracting processes, federal efforts to reform the Workforce Investment Act, and even states' reluctance to hire staff to administer such short-term grants (Vestal 2009). Of course, once most of the ARRA funding is gone by 2011, services may well see deep and persistent cuts.

Some of the largest provisions in the stimulus package create or augment cash or cash-like benefits offered by the federal government. ARRA creates a "Making Work Pay" refundable tax credit of up to \$400 per person, which offsets payroll taxes paid by low-income workers. It expands eligibility for the Child Tax Credit (which provides up to \$1,000 per child) by lowering the minimum earnings a taxpayer must make to qualify for the refundable portion. The package also funds a 14 percent increase in maximum Food Stamp benefits (the program is now called the Supplemental Nutrition Assistance Program or SNAP).

These changes, juxtaposed against our finding of a decline in nonhealth spending by state and local governments, point to another implication of our findings: the declining role of state and local governments in funding nonhealth social welfare programs. For instance, in 2002, total state and local spending on cash assistance and social services (estimated from the Census data) was 11 percent greater than total spending in the three

Table 3. Projected Outlays for Selected Programs Affected by the American Recovery and Reinvestment Act of 2009.

Program	Two year outlays, ARRA
<u>Cash assistance/income support</u>	
Refundable tax credits (CTC, Making Work Pay)	\$62.1
Unemployment Insurance	\$37.4
Supplemental Nutritional Assistance Program	\$10.9
Supplemental Security Income	\$4.5
TANF Assistance	\$2.6
Women, Infants, & Children (WIC)	\$0.5
<u>Medical assistance</u>	
Medicaid	\$77.3
<u>Social services</u>	
Child Care and Development Block Grant	\$2.0
Child support enforcement	\$2.0
Homelessness Prevention Fund	\$1.5
Workforce Investment Act (youth programs only)	\$1.3
Community Services Block Grant	\$1.0
Foster care and adoption assistance	\$0.8

largest nonhealth programs whose benefits were paid (more or less) exclusively by the federal government: Supplemental Security Income (for aged, blind, and disabled persons), the Earned Income Tax Credit (now the largest nonhealth program for low-income people), and the Food Stamp Program. Just four years later, in 2006, state and local spending on cash assistance and social services was 5 percent less than federal expenditures for these three programs.

By far the fastest growth among these federal programs occurred in SNAP/Food Stamps, which is administered by the states but whose benefits are paid by the federal government. Although Food Stamps was considered a rule-bound, restrictive program just a few years ago, its coverage is now vastly greater than TANF's, even among low-income families with children, TANF's target population. In 2000, Food Stamp cases with children numbered 30 percent fewer than all TANF cases (all of which, of course, included children). Yet by 2006, Food Stamp cases with children outnumbered TANF cases by 44 percent. In several states – such as Texas, Georgia, and Oklahoma – Food Stamp cases with children exceeded TANF cases by ratios of four or more (U.S. Department of Agriculture 2009). Much of this growth was due to increases in Food Stamp take-up rates, which rose from 54 percent of eligible people in 2002 to 67 percent in 2006 (Cunyngham et al. 2008; Castner and Schirm 2005).

There are reasonable arguments for shifting responsibility for income support programs to the federal level (Nathan 1973). The federal government can handle countercyclical demands more easily than state governments (McGuire and Merriman 2005). Also, state choices regarding welfare benefits and conditions on TANF/AFDC cash assistance have long been influenced by race (as noted in Table 2; also see associations between cash assistance policies and race in other studies, such as Plotnick and Winters 1985; Howard 2007, 187; Soss et al. 2001; and Gais and Weaver 2002).

However, the role of the states remains critical in the nation's safety net. Even though TANF cash assistance has shrunk rapidly in recent years, it remains one of the few sources of income support for families with children who face significant barriers to work but who fail to qualify for SSI. The federal government has greatly expanded its support for low-income families in recent years – through the expanded Earned Income Tax Credit, the refundable Child Tax Credit, and the new refundable portion of Making Work Pay – but those programs only help working families, not the poorest families. Also, without effective state and local human service bureaucracies to connect low-income households with federal as well as state benefits, many parts of the U.S. safety net are distant and inaccessible. The federal government has very little capacity to directly help low-income households find the benefits for which they are eligible.

Thus, a growing challenge for U.S. social welfare system to create a durable framework for financing the benefits and administration of the nation's fragmented, complex system of programs spread across all levels of American government – a framework that would ensure greater balance of funding between different social welfare programs, across states of different fiscal capacities, and between the federal and state governments.

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APPENDIX A

STATE AND LOCAL GOVERNMENT SPENDING CATEGORIES

<i>Social Welfare Spending Category</i>	<i>Detailed Item in Census Data</i>	<i>Definition</i>
Cash Assistance	67 Federal Categorical Assistance Programs	Includes direct cash payments by states to beneficiaries under AFDC/TANF program. Also included is, to the extent it passes through state accounts, federal SSI, plus any state supplements. (The only federal SSI included in 67 is retroactive federal payments to reimburse the state for payments made to individuals under state supplement programs.)
	68 Other Cash Assistance Programs	Includes cash assistance programs not under federal categorical programs (e.g., general assistance, refugee assistance, home relief, and emergency relief).
Medical Assistance	74 Vendor Payments for Medical Care	Includes payments made directly to private vendors for medical assistance and hospital and health care (payments consist mostly of Medicaid and SCHIP).
Nonhealth Social Services	75 Vendor Payments for Other Purposes	Includes payments made directly to private vendors for services and commodities other than medical, hospital, and health care.
	77 Welfare Institutions	Includes payments for provision, construction, and maintenance of nursing homes and welfare institutions owned and operated by a government.
	79 Other Public Welfare	Includes operational payments for public employees in the sphere of public welfare, and payments for welfare programs including child welfare, adoption assistance, foster care, low-income energy assistance and weatherization, social services to the physically disabled, programs funded by the Social Services Block Grant, welfare-related community action programs, and temporary shelters and other services for the homeless.

Source: U.S. Bureau of the Census. *Government Finance and Employment Classification Manual*. (Washington, D.C.: Census Bureau, 2006).

http://ftp2.census.gov/govs/class06/2006_classification_manual.pdf

APPENDIX B

LISTING OF STATES BY FISCAL CAPACITY

Highest fiscal capacity (Quartile 1)

Alaska
California
Colorado
Connecticut
Delaware
Illinois
Maryland
Massachusetts
Nevada
New Hampshire
New Jersey
New York

High fiscal capacity (Quartile 2)

Florida
Hawaii
Kansas
Michigan
Minnesota
Ohio
Oregon
Pennsylvania
Rhode Island
Virginia
Washington
Wisconsin
Wyoming

Low fiscal capacity (Quartile 3)

Arizona
Georgia
Indiana
Iowa
Maine
Missouri
Nebraska
North Carolina
Oklahoma
South Dakota
Tennessee
Texas
Vermont

Lowest fiscal capacity (Quartile 4)

Alabama
Arkansas
Idaho
Kentucky
Louisiana
Mississippi
Montana
New Mexico
North Dakota
South Carolina
Utah
West Virginia

APPENDIX C

DESCRIPTIONS OF VARIABLES IN REGRESSION EQUATIONS

Each variable is measured as state and local spending divided by the average number of poor people in a state. The number of poor people is estimated by averaging annual Census estimates of the number of persons living under the Federal Poverty Level in the state across three years to reduce sample and measurement error.

Personal income per capita (PCPI) is used here to measure a state's fiscal capacity. Here we use the natural logarithm of PCPI. Two-year lagged values are used to reduce the potential problem of endogeneity (e.g., changes in public spending may also influence state residents' income).

The state-level tax and expenditure limitation (TEL) variable is measured as 1 if a state has a state-level TEL in effect during a particular year, 0 otherwise.

A variable on supermajority legislation requirements for tax increases is measured as 1 if a state requires supermajority rules (e.g., greater than 50 percent majority in one or both legislative chambers) for tax increases, 0 otherwise.

The popular vote for the Democratic Party in presidential elections is a measure of the state's ideological tendencies; it is measured as the average percentage of the total popular presidential vote for the Democratic Party in the state's previous three presidential elections.

The Democrats variable is measured as the percentage of state legislators affiliated with Democratic Party out of all legislators in both houses.

The party affiliation of the governor is measured as 1 if a governor is Democrat, 0 otherwise.

Unemployment rates are the average monthly rates across the year, expressed in the two-year lagged values to avoid endogeneity (e.g., public spending may affect employment levels).

The union variable is measured as the percentage of union members among all nonagricultural wage and salary employees in a state, including employees in the public sector.

The size of the youth population is measured as the share of individuals 24 years of age or younger in a state's total population.

The elderly population is measured as the share of individuals 65 years of age or older in a state's total population.

The African-American population is measured as the percentage of people identifying themselves as African-American in a state's total population.

Population density is expressed as the number of residents per square mile, and in the natural logarithm form.