The New Retrenchment: Social Welfare Spending, 1977-2006

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Summary

In 2006, for the first time since 1983, social welfare spending by state and local governments dropped after adjusting for inflation and the number of people living in poverty — a rough estimate of the real value of such programs for their target populations.[1] By social welfare spending, we mean expenditures under programs primarily serving low-income persons and families. The three categories of social welfare spending are expenditures for cash assistance, medical assistance, and (nonhealth) social services.

Medical assistance, the largest component of social welfare spending, accounted for much of the decline in total social welfare spending. It fell 4.1 percent between 2005 and 2006 (again, after adjustments for inflation and poverty).[2] Cash assistance spending declined by 4.3 percent. Social services — including child care, protective services, energy assistance, and many other nonhealth social services programs — was essentially unchanged, rising only 0.5 percent in 2006.

The decline in social welfare spending in 2006 was largely due to a drop in federal grants to state and local governments. Federal grants fund most state and local social welfare spending, typically about six out of every ten dollars. The remaining social welfare expenditures (about four out of ten dollars) are supported by state and local "own source" revenues — that is, taxes, fees, and other revenues directly collected by state and local governments. In 2006, state and local social welfare spending from "own source" revenues was essentially unchanged from 2005.

The decline in medical assistance expenditures was for the most part the result of national-level changes in the Medicaid program. In 2006, the federal Medicare program took over the costs of prescription drugs for "dual eligibles," persons eligible for both Medicare and Medicaid.

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1 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. There are many ways to adjust for inflation, but our choice of method does not significantly change our basic conclusions. See, for example, Appendix C, which shows that adjustments based on the Services Price Index for Personal Consumption Expenditures — another plausible method for our purposes — produces very similar trends.

2 Unless otherwise stated in this report, all expenditures are expressed in terms of 2006 dollars per person living under the federal poverty level.

That shift produced a one-time cut in Medicaid's responsibilities, though it may not reduce the rate of growth in the program's spending in subsequent years. Before 2006, medical assistance spending increased 22 years in a row, and that growth probably resumed by 2008 and is likely to continue thereafter.

However, other recent changes suggest that the United States recently entered a new phase of declining fiscal resources for state and local social welfare programs outside of medical assistance. The 2006 drop in cash assistance spending was the *eleventh* consecutive annual decline in real terms per poor person.[3] The negligible growth in social services in 2006 followed three years of spending reductions between 2002 and 2005. Thus, since 2002, cash assistance and social services declined, while medical assistance absorbed a growing share of total state and local social welfare spending. These trends were particularly acute in states with low fiscal capacities, that is, states with lower per capita personal incomes and thus fewer resources to compensate for declines in federal grants.

These recent contractions contrasted sharply with the expansion and diversification of social welfare spending in the mid-1990s and early 2000s. In this earlier period, total social welfare spending not only increased but also was transformed, as cash assistance spending fell while social service and medical assistance spending grew. Many states used federal grants, increasing state revenues, and savings from falling welfare caseloads to expand childcare, employment services, refundable earned income tax credits, child welfare services, and other programs for low-income families and individuals.

But those trends ended in most states by 2002 — and among relatively poor states, even earlier. In this new, post-2002 period, social welfare spending outside of medical assistance no longer grew to meet expanding needs during periods of economic stress. Instead, nonhealth spending appeared to be increasingly dependent on state and local resources, across states and over time. Given the downturn or slow growth of state revenues in most states in late 2007 and early 2008, states are thus likely to see further contractions, and these reductions will probably be applied to nonhealth spending levels already lower than those seen before the last economic downturn (in real, per poor person terms).

This report is the first in a series by the Rockefeller Institute on changes in social welfare spending and implications for American federalism. Future reports will include analyses of changes in Temporary Assistance for Needy Families, a comparison of spending trends at both the federal and state levels, and changes in state spending on children.

Data

The findings in this report come from data collected by the U.S. Census Bureau's Survey of State and Local Government Finances, which collects annual expenditure, revenue, and other fiscal data.[4]

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3 Studies found the decline in cash assistance to be partly explained by economic growth in the 1990s, and partly by policy changes under AFDC waivers and state implementation of TANF, after its enactment in 1996. TANF added work requirements and time limits to cash assistance, incorporated caseload reductions in state performance requirements, and eliminated the federal matching of state spending on assistance to all eligible families.

4 Data may be found at U.S. Census Bureau, "Federal, State, and Local Governments: State and Local Government Finances," available at http://www.census.gov/govs/www/estimate.html.

Its expenditure data are organized into a variety of functional categories, including "public welfare."[5] Public welfare expenditures — which we call "social welfare expenditures" in this report — 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 study organized several of the subcategories under the "public welfare" function into three types of expenditures:

- *Cash assistance*, which includes AFDC payments to low-income families and TANF cash assistance — which appear to comprise most of these expenditures — as well as general assistance, home relief, refugee assistance, emergency relief, and state supplements to SSI;[6]
- *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));
- *Social services*, which encompass a variety of services and benefits, including childcare subsidies, child welfare (programs to prevent abuse, neglect, and foster care placement), foster care and adoption assistance, low-income energy 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."

These three types of expenditures totaled $368.5 billion across all U.S. state and local governments in fiscal year 2006.[7] The largest category was medical assistance, which comprised 73 percent of total social welfare expenditures. Social services constituted the second largest type, making up 21 percent. Cash assistance was only 6 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 2006, 61 percent ($224.2 billion) came from federal sources. State and local governments funded the remaining 39 percent ($144.3 billion) out of their own revenue sources.

Social welfare spending was only a small part of total state and local spending, about 17 percent of direct general expenditures in 2006. Spending on medical assistance constituted 13 percent of di-

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5 For a description of the "public welfare" category of spending, including definitions of subcategories, see Appendix A.

6 AFDC 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.

7 The 2006 state and local spending data are the most recent information available from the Census Bureau. By fiscal year 2006, the Census Bureau means the state or local government's own fiscal year ending anytime between July 1, 2005 and June 30, 2006. See U.S. Bureau of the Census, *Government Finance and Employment: Classification Manual* (Washington, D.C.: U.S. Bureau of the Census, 2006), p. 3-1.

rect general expenditures by state and local governments. Spending on social services made up 3 percent, while cash assistance expenditures were only 1 percent of total direct general expenditures.

Trends in Social Welfare Spending

In this report, we describe social welfare expenditures in real, inflation-adjusted terms.[8] 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.[9] This method of comparing spending to need is not perfect. Many state Medicaid and SCHIP programs covered people who had low incomes but were not under the federal poverty level, while many AFDC/TANF programs offered cash benefits only to families well under the federal poverty level.[10] Also, for some programs, such as SCHIP and AFDC/TANF, which only provide benefits to children or households with children, people living in poverty but not caring for children are not eligible for the program. 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 also the most recent: In 2006, for the first time since 1983, social welfare spending by state and local governments in the United States dropped after adjusting for inflation and need. Real spending per poor person fell 3.1 percent between 2005 and 2006 (Figure 1).[11]

Although the decline is new, it comes after several years of slow — and slowing — growth in social welfare spending. After social welfare spending accelerated in the late 1990s and continued to be strong through 2001, annual changes in spending fell dramatically. This period of slow growth or decline after 2002 did not approach the large reductions in social welfare spending per poor person between 1979 and 1983. Yet it marked the end of a long period of expansion in social welfare spending from 1984 through 2001.

The 2005-06 decline in social welfare spending was largely the result of a 4.1 percent drop in medical assistance spending (Figure 2). Cash assistance also fell between 2005 and 2006, by 4.3 percent. However, as Figure 2 makes clear, cash assistance was so low by the end of the 1990s, its effects on total social welfare spending were small. The third category of social welfare spending — nonhealth social services — grew between 2005 and 2006 but nearly imperceptibly, by only 0.5 percent.

The 2005-06 drop in real medical assistance spending per poor person was the first decline since 1982-83 — a stretch of 22 years of uninterrupted growth — and it was the largest decline since 1978-79, when medical assistance spending fell 5.9 percent. By itself, this one-year decline in medical assistance spending did not suggest any long-run trend. It was largely the result of a

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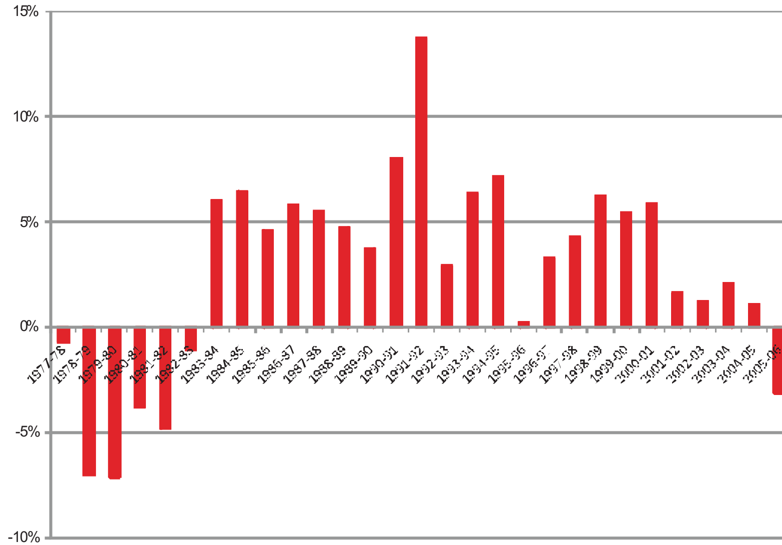
8 Please see Appendix B for more information on alternative inflation adjustment techniques and results.

9 More specifically, 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; for a time series of these three-year averages, by state fiscal capacity, see Appendix E.

10 U.S. House of Representatives, Committee on Ways and Means, *2004 Green Book,* 108th Congress, 2nd Session (Washington, DC: Committee on Ways and Means, 2004), pp. 7-45–7-51.

11 As Appendix B show, the overall trends in per poor social welfare spending are very similar regardless of the type of inflation adjustment.

Figure 1
Percent Annual Change in State and Local Spending on Social Welfare, Per Poor Person, 2006 Dollars, 1977-2006
Adjusted to State-Local Government Consumption Expenditures Price Index



one-time shift in responsibility from the states to the federal governments for paying the costs of prescription drugs used by "dual eligibles," persons eligible for both Medicaid and Medicare. Although states got some long-run relief by shedding responsibility for the costs of pharmaceuticals for some Medicaid clients, there is little reason to expect the costs of the Medicaid program as a whole to grow at a slower rate in the future, and other data sources indicate a resumption of growth in Medicaid spending in 2007 and 2008.[12]

The 2006 decline in cash assistance expenditures occurred in a context very different from the drop in medical assistance spending. It came after eleven consecutive years of decreases, from 1995 to 2006. During this time, cash assistance lost 47.9 percent of its real value per poor person. The weak growth of nonhealth social services in 2006 also followed an extended downward trend, albeit a shorter one, between 2002 and 2005. The slowdown since 2002 in total social welfare spending was therefore the result of a long-run decline in cash assistance, a more recent drop in nonhealth social services, and sharp yet probably isolated decrease in medical assistance spending in 2006.

The year 2002 also marked the end of an expansionist, transforming period for social welfare spending, a period which roughly began in the middle 1990s. As Figure 2 shows, medical assis-

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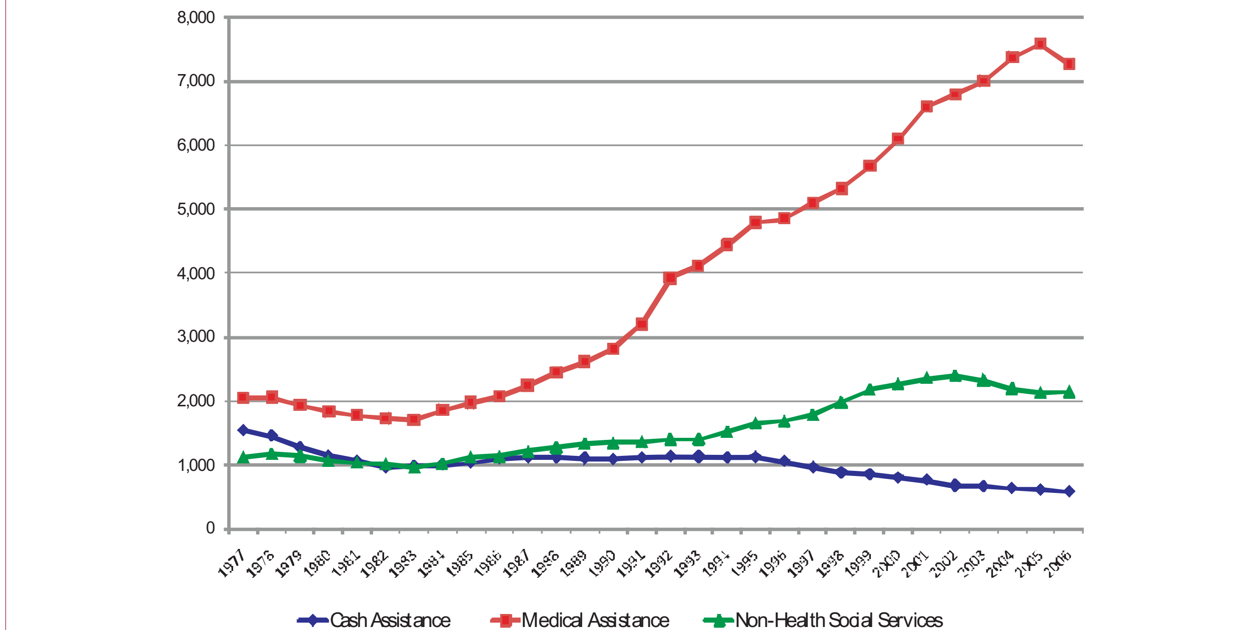
12 Data obtained from the Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services, show total Medicaid spending increasing between federal fiscal years 2006 and 2007, even after adjusting for inflation. In nominal terms (not adjusted for inflation), total Medicaid spending rose from $312.7 billion in federal fiscal year (FFY) 2006 to $329.7 in FFY 2006. After adjusting for inflation, total Medicaid spending increased from $328.7 billion in FFY 2006 to $329.7 billion in FFY 2007 (in 2007 dollars), a very small increase but a resumption of real growth nonetheless. (Spending data obtained from Center for Medicaid and State Operations, August, 2008.) For an earlier analysis suggesting a resumption of health spending growth by 2008, see Robin Rudowitz and Vernon Smith, "As Tough Times Wane, States Act to Improve Medicaid Coverage and Quality: A 50 State Medicaid Budget Survey for State Fiscal Years, 2006 and 2007," *Kaiser Commission on Medicaid and the Uninsured*, October, 2007, pp. 4-6, at http://www.kff.org/medicaid/upload/kcmu101007slides.pdf (accessed July 5, 2008).

Figure 2
Total State and Local Spending on Cash Assistance, Medical Assistance, and (Nonhealth) Social Services, Per Poor Person, 2006 Dollars, 1977-2006



tance spending grew vigorously between the late 1980s and at least through 2005. Social service spending also grew rapidly, though for a shorter span, between 1993 and 2002. Cash assistance never showed much growth in real terms per poor person, and it consistently declined after 1995.

However, if we add cash assistance and social services together to make a category of *total nonhealth spending*, that spending grew, since the growth of service spending exceeded the decline in cash assistance expenditures. Between 1993 and 2002, state and local real expenditures on cash assistance per poor person declined by $452 (a drop of 39.8 percent). Spending on social services increased by $996 (an increase of 70.7 percent), and medical assistance spending grew by $2,683 (an increase of 65.1 percent). The result of all these changes was an expansion in total social welfare spending as well as a change in the balance between different types of social welfare expenditures. In 1993, for every dollar spent on cash assistance, 1.2 dollars were spent on social services and 3.6 dollars on medical assistance. In 2002, for every dollar of cash assistance, 3.5 dollars were spent on social services and 10.0 dollars on medical assistance.

What accounted for this expansion of social services and the decline in cash assistance in the 1990s? One factor was the rapid economic growth of the 1990s. In previous econometric analyses, we found that social services typically grew during periods of low unemployment, such as the period between 1993 and 2001, probably because state revenues expanded during such times. During these periods of economic expansion, cash assistance spending usually declined or held steady — thus sometimes providing additional resources for social services.[13]

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13 The Lewin Group and the Nelson A. Rockefeller Institute of Government, *Spending on Social Welfare Programs in Rich and Poor States*, Final Report, Prepared for the Department of Health and Human Services, Assistant Secretary for Planning and Evaluation (June 30, 2004), at http://aspe.hhs.gov/hsp/social-welfare-spending04/index.htm.

Federal and state welfare reforms also contributed to the shift toward social services and away from cash assistance. The 1996 enactment and subsequent interpretations of TANF gave states flexibility to apply their block grants to services and other "nonassistance" programs for low-income families, largely to encourage and support work — and TANF spending shifted rapidly.[14] In 1997, only 22.7 percent of state spending under TANF (which included federal grant dollars and state "maintenance of effort" expenditures) went to "nonassistance" services and other benefits not counted as cash assistance; by 2002, that percentage rose to 55.8 percent.[15] Many states found it easy to invest more funds in social services under TANF because of fiscal savings reaped from the large declines in cash assistance enrollments under welfare reform.

Beginning in 2002, however, these circumstances changed. The economic downturn starting in late 2001 depressed state revenues at least through 2003 and made discretionary spending like social services vulnerable to state cutbacks.[16] Also, after several years of rapid increases in services, total TANF spending leveled off after 2001, as states spent down some of the surpluses they had built up in the 1990s from the block grant, and as inflation eroded the value of federal assistance.[17] 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 fewer TANF dollars were made available for work supports and other social services.[18]

Trends by State Fiscal Capacity

Changes in social welfare spending 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.[19] State fiscal capacity — the resources available to a state for taxation and other revenues — has long been found to be related to state spending on social welfare programs.[20] Yet the relationships between fiscal capacity and state expenditures for social welfare programs have changed substantially in recent years.

Since the middle 1990s, for instance, cash assistance spending declined much more among high fiscal capacity states, producing a downward convergence of 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 per-

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14 Donald J. Boyd, Patricia L. Billen, Richard P. Nathan, Phil Dearborn, Carol Meyers, and Jane McNeil, *The Fiscal Effects of Welfare Reform: State Social Service Spending Before and After Welfare Reform*, Final Report, Prepared for the Department of Health and Human Services (May 2003), at http://www.rockinst.org/WorkArea/showcontent.aspx?id=7156.

15 For data on TANF spending, including assistance and nonassistance, see Administration for Children and Families, "TANF Financial Data," at http://www.acf.hhs.gov/programs/ofs/data/index.html.

16 On changes in state and local revenues in 2001-02 (and subsequent years), see Donald Boyd, Lucy Dadayan, and Nino Giguashvili, "State Taxes Slow Yet Again, and Further Weakening Appears Likely," *State Revenue Report* (July 2008), p. 2. At http://www.rockinst.org/WorkArea/showcontent.aspx?id=15052.

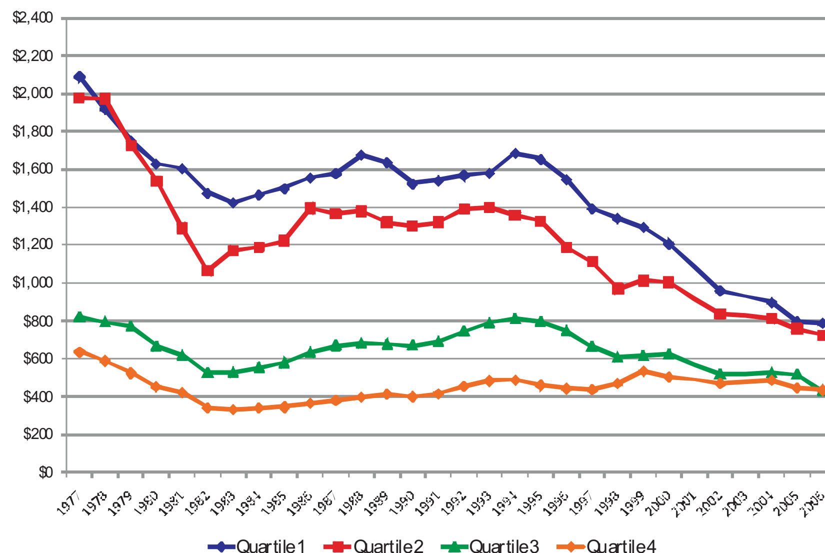
17 Lewin Group and Rockefeller Institute, *Spending*, pp. 63-64.

18 For data on the number of families or individuals receiving assistance under the TANF program, see http://www.acf.hhs.gov/programs/ofa/data-reports/caseload/caseload_current.htm.

19 In this paper, we measure state fiscal capacity using states' real per capita personal income. See Appendix E for stratification of states into four different capacity groups.

20 Lewin Group and Rockefeller Institute, *Spending*, p. 5.

Figure 3
Average (Mean) State Spending on Cash Assistance, Per Poor Person, 2006 Dollars
Stratified by state fiscal capacity quartiles
(Q1 = highest fiscal capacity; Q4 = lowest fiscal capacity)



sonal income, down to Quartile 4, the 12 states with the lowest levels of per capita personal income.[21] 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, those differences began to diminish in the 1990s. Starting around 1995, wealthy states cut their cash assistance spending dramatically, while less-wealthy states did not (Figure 3). By 2006, the wealthiest quartile of states spent 1.8 times the amount that the poorest quartile of states spent on cash assistance — down from a 3.5 ratio in 1996.[22]

While 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

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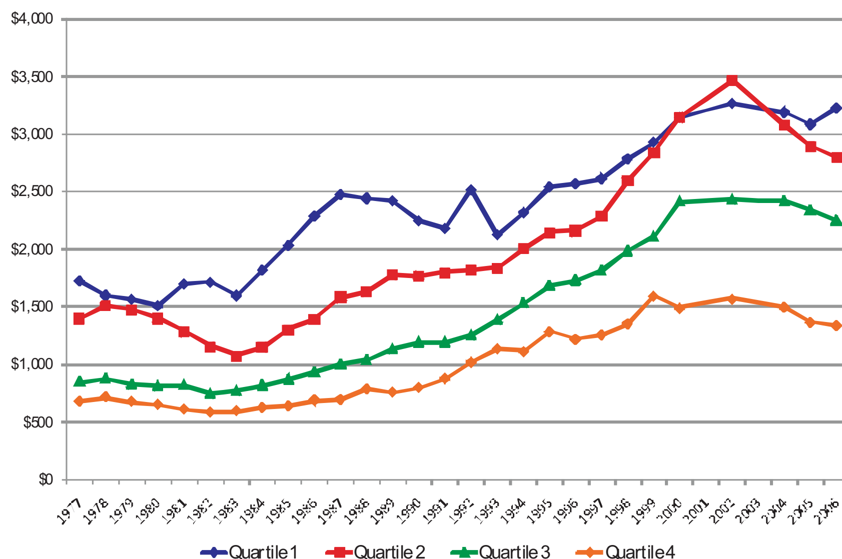
21 See Appendix C for a listing of states by fiscal capacity quartiles.

22 *Why* the decline in spending on cash assistance is greater among wealthier states is not clear. TANF caseloads have not dropped faster among wealthier states. Between 2000 and 2007, Quartile 1 (wealthiest) states saw a decline in average monthly TANF recipients of 31.3 percent, while Quartile 4 (poorest) states actually reported a larger drop of 36.9 percent over the same period. (Quartile 2 and 3 states reported 27.8 and 34.5 percent declines, respectively). For sources of data on TANF caseloads, see note 15. One possible explanation of the difference is grounded in the fact that wealthy states typically have higher "break-even points" (earning levels at which a family loses welfare eligibility) when compared to low fiscal capacity states. By having high break-even points — and thus retaining people with earnings on welfare rolls — wealthy states can reduce cash assistance spending in two ways: by cutting caseloads, and by reducing the size of welfare checks as a result of increased earnings among recipients. By contrast, in low fiscal capacity states, break-even points are often so low, nearly anyone who gets a job loses eligibility, so such states only reduce spending through caseload reductions. A second explanation may involve the elimination or reduction of general assistance programs (cash assistance programs that aided indigent persons in general, not just families with children). In the 1990s, many states cut back on such programs, which before the cuts had been larger and more common among the wealthy states. A third explanation may involve changes in reporting. Under AFDC, some services (such as child care subsidies) were sometimes counted as cash assistance. If those services were more extensive among wealthy states, the shift towards reporting them as services (as, for instance, TANF nonassistance) would also produce a more rapid decline in cash assistance spending among the wealthier states.

Figure 4
Average (Mean) State Spending on (Nonhealth) Social Services, Per Poor Person, 2006 Dollars
Stratified by state fiscal capacity quartiles
(Q1 = highest fiscal capacity; Q4 = lowest fiscal capacity)



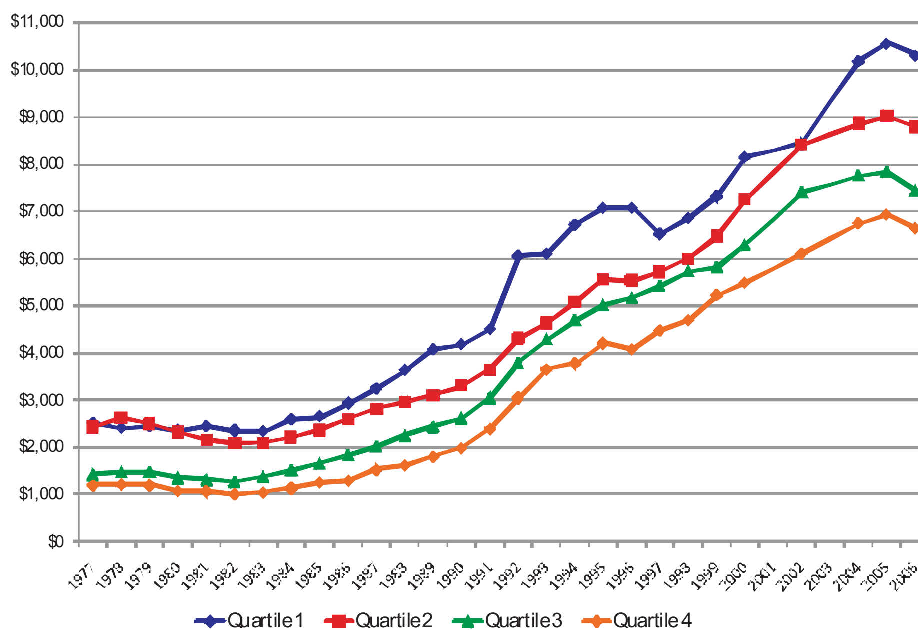
mid-1990s, but the wealthy states experienced larger and more extended increases in spending than did the poorer states. Figure 4 shows these trends. Quartile 4, the poorest quartile of states, increased social service spending from 1996 through 1999, when such expenditures peaked and subsequently declined. The next poorest quartile of states (Quartile 3) peaked a year later, in 2000, but also leveled off for a few years until such spending fell after 2004. Quartile 2 states reached their peak in 2002 and then fell. Finally, the wealthiest quartile (Quartile 1) was the only one whose spending remained at roughly the same level since the end of the 1990s, and that increased spending on social services between 2005 and 2006. As a result, in 2006, 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.

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 considerably after 1990, as low fiscal-capacity states began to increase their spending on Medicaid rapidly, probably as a result of the federal government's efforts to expand mandatory eligibility groups and services during this period.[23] However, since 2002, state differences in medical assistance spending began to creep up again. In 2002, wealthy states in Quartile 1 spent about 1.4 times what states in Quartile 4 spent; but by 2006, that ratio increased to 1.6, as states in the wealthiest quartile increased their spending more than others did (Figure 4).

Tables 1 and 2 summarize the two recent periods of change in social welfare spending and compare the states according to their fiscal capacities. The cells show the changes in 2006 dollars

23 After 1987 and especially by 1992, the income cut-off for Medicaid eligibility was raised considerably, decoupled from AFDC participation, and expanded to include a wider range of families (not just single parent families). See Jonathan Gruber, "Medicaid," in *Means Tested Transfer Programs in the United States* (Chicago: University of Chicago Press, 2003), p. 20.

Figure 5
Average (Mean) State Spending on Medical Assistance, Per Poor Person, 2006 Dollars
Stratified by state fiscal capacity quartiles
(Q1 = highest fiscal capacity; Q4 = lowest fiscal capacity)



per poor person between 1996 and 2002 (Table 1) and between 2002 and 2006 (Table 2).[24] Between 1996 and 2002, medical assistance grew in all four quartiles of states, though the growth was stronger among the three poorer quartiles. For instance, medical assistance spending grew by only 19 percent between 1996 and 2002 among the wealthiest states (Quartile 1), but it swelled by nearly 50 percent among the states in the other three (and poorer) quartiles during this period.[25] Thus, medical assistance spending became more equal across states of different fiscal capacities.

As already noted, cash assistance spending also showed decreasing differences among states of different income levels between 1996 and 2002 (Table 1). However, unlike medical assistance, cash assistance converged *downward*. Cash assistance dropped by about one-third among the wealthier states — Quartiles 1, 2, and 3 — while it grew slightly among the low-fiscal-capacity states in Quartile 4. Social service spending increased in all quartiles between 1996 and 2002, and the increases in social services were greater than declines in cash assistance. However, social service spending grew the least among the lowest income states. As a result, the period between 1996

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24 We selected 1996 as a base year for comparisons, even though the drop in cash assistance spending and the growth of medical assistance and social services began earlier. Some of the earlier changes in cash assistance and social services were permitted by AFDC waivers granted to selected states by the federal government before 1996. After 1996, the Personal Responsibility and Work Opportunity Reconciliation Act gave all states flexibility in re-shaping the benefits and services offered by state welfare programs. To minimize the selection effects of waivers on comparisons across state quartiles, we thus used 1996 as a base year rather than, say, 1993, when social services at the national level began to grow. However, our conclusions are not affected by whether we use 1993, 1994, or 1996 as base years for observing changes in spending between the 1990s and 2002.

25 Between 1996 and 2002, medical assistance spending increased by 52 percent in Quartile 2, 43 percent in Quartile 3, and 50 percent in Quartile 4, the poorest quartile. In Quartile 1, the wealthiest states, medical assistance spending increased by only 19 percent.

and 2002 produced a major shift in the composition of nonhealth spending, though the shift was stronger among the wealthier three quartiles, which saw declines in cash assistance as well as major increases in social services.

Table 1
Changes in Spending Per Poor Person, Averaged Across States Within Fiscal Capacity Quartiles, 1996-2002

State Fiscal Capacity Quartile	*Dollar Changes, 1996 – 2002 (2006 Dollars)*			
	Medical Assistance	*Cash Assistance*	*Social Services*	*Total*
1 (highest income states)	1,347	(588)	697	1,455
2	2,864	(353)	1,302	3,813
3	2,236	(231)	704	2,709
4 (lowest income states)	2,031	26	348	2,405

Table 2 shows very different spending changes in 2002-2006. Medical assistance still grew, though weakly (and that would be true even if the changes were expressed as average annual changes, taking into account the fact that this period is two years shorter than the earlier period, 1996-2002). In contrast to the previous period, medical assistance grew more vigorously among the wealthiest states. Cash assistance continued its decline, though even the states in the poorest quartile saw drops in cash assistance spending since 2002. However, the decline in cash assistance spending was still greater among the wealthier states. Finally, social services declined in all quartiles. The smallest decline in social services occurred among the wealthiest states (Quartile 1); much larger drops in social service spending were found among states in Quartiles 2 and 4.

The different trends with respect to states of different fiscal capacities are also evident in the most recent data. Out of 12 states in Quartile 1, the wealthiest, eight states saw increases in social service spending between 2005 and 2006, and only four saw declines. Of the 12 relatively poor states in Quartile 4, seven states experienced decreases in their social service spending between 2005 and 2006.[26]

Table 2
Changes in Spending Per Poor Person, Averaged Across States Within Fiscal Capacity Quartiles, 2002-2006

State Fiscal Capacity Quartile	*Dollar Changes, 2002 – 2006 (2006 Dollars)*			
	Medical Assistance	*Cash Assistance*	*Social Services*	*Total*
1 (highest income states)	1,880	(171)	(39)	1,669
2	385	(111)	(664)	(390)
3	35	(87)	(184)	(235)
4 (lowest income states)	537	(34)	(232)	271

26 This information may be obtained from the table in Appendix D, "Changes in Spending Per Poor Person, Dollar Changes, FY 2005–FY 2006 (2006 Dollars).

What accounts for these differences in spending trends across fiscal capacity? Recent declines in federal spending (Figure 6) do not directly explain the growing differences in social welfare spending between rich and poor states. As Figure 6 shows, after many years of growth, federal grants to states in support of social welfare declined in all state quartiles after 2004 — and the size of the declines in federal assistance was similar across the state quartiles.[27]

However, states' own spending — that is, spending money raised from their own-source revenues, not from federal grants — varied widely. As Figure 7 indicates, the wealthiest two quartiles of states increased their spending after 2004 — indeed, consistently since 2002 — while the two poorest quartiles showed little or no growth in spending since 2002. Thus, declines in federal grants may have exerted indirect effects on differences in state spending for social welfare. Wealthy states compensated with their own resources for losses in federal grants, while low fiscal capacity states did not, a difference that led to a growing divide between high and low fiscal capacity states in their contributions to social welfare programs.

As Figure 8 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 1986, 1996, and 2006. Four changes are notable: First, medical assistance increased from around half of states' total social welfare budgets in 1986 to about three-fourths of their budgets in 2006. Second, cash assistance declined from about one-fifth of states' social welfare budgets in 1986 to about one-twentieth in 2006. 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 1986 to slightly less than that in 2006. However, the drop was largest among the lowest fiscal capacity states in Quartile 4. These states saw a decline in social service spending from 29 percent of the total social welfare budget in 1986 to only 16 percent in 2006.

Conclusions and Implications

State and local social welfare spending in the U.S. — including cash assistance, social services, and medical assistance — has undergone enormous shifts since the early 1990s. Sharp and persistent declines in cash assistance caseloads in the 1990s raised concerns that states were engaged in a "race to the bottom," a competition among states to cut enrollments regardless of economic need. However, such concerns were alleviated in the 1990s and early 2000s by large and widespread increases in spending on medical assistance and social services. These changes — driven in part by welfare reforms and facilitated by growing state revenues and savings from caseload declines — revealed that investments in low-income families were not cut but replaced by services aimed at promoting health and especially work, such as childcare subsidies, refundable state earned income tax credits, employment services, and transportation assistance.[28]

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27 Census data only include information on the sources of funding for the general category, "public welfare." Data are not available on the split between federal grants and state and local own-source revenues in support of cash assistance, medical assistance, or social services.

28 Thomas L. Gais, Richard P. Nathan, Irene Lurie, and Thomas Kaplan, "Implementation of the Personal Responsibility Act of 1996," in *The New World of Welfare*, edited by Rebecca Blank and Ron Haskins (Washington, DC: Brookings Institution Press, 2001), pp. 48-52.

Figure 6
Average (Mean) State Spending on Social Welfare from Federal Transfers, Per Poor Person, 2006 Dollars
Stratified by state fiscal capacity quartiles
(Q1 = highest fiscal capacity; Q4 = lowest fiscal capacity)

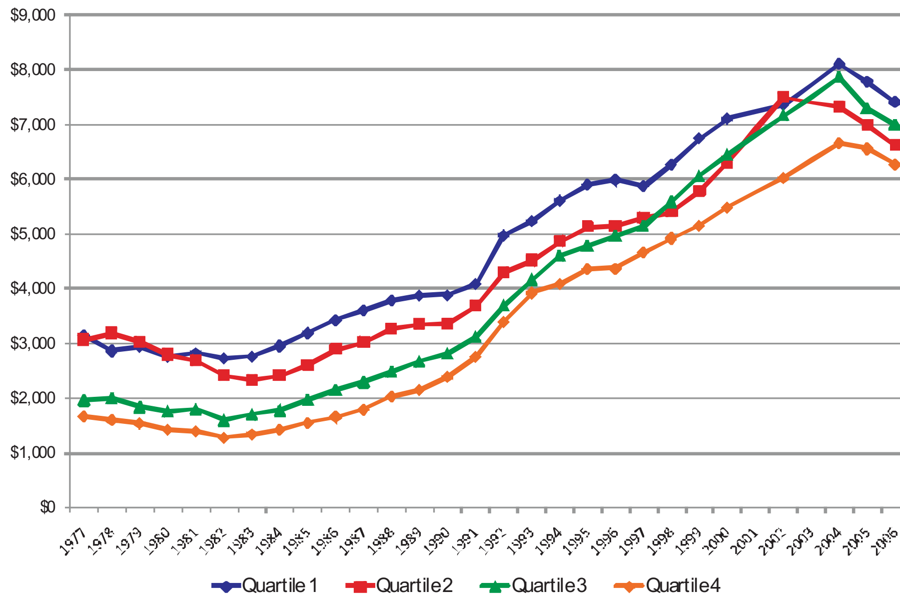


Figure 7
Average (Mean) State Spending on Social Welfare from State and Local Sources, Per Poor Person, 2006 Dollars
Stratified by state fiscal capacity quartiles
(Q1 = highest fiscal capacity; Q4 = lowest fiscal capacity)

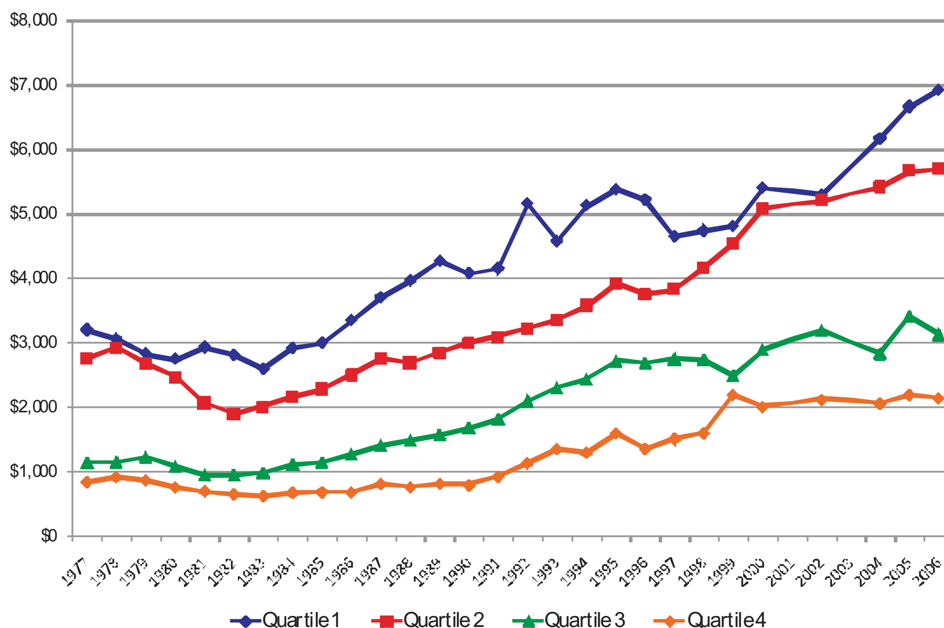
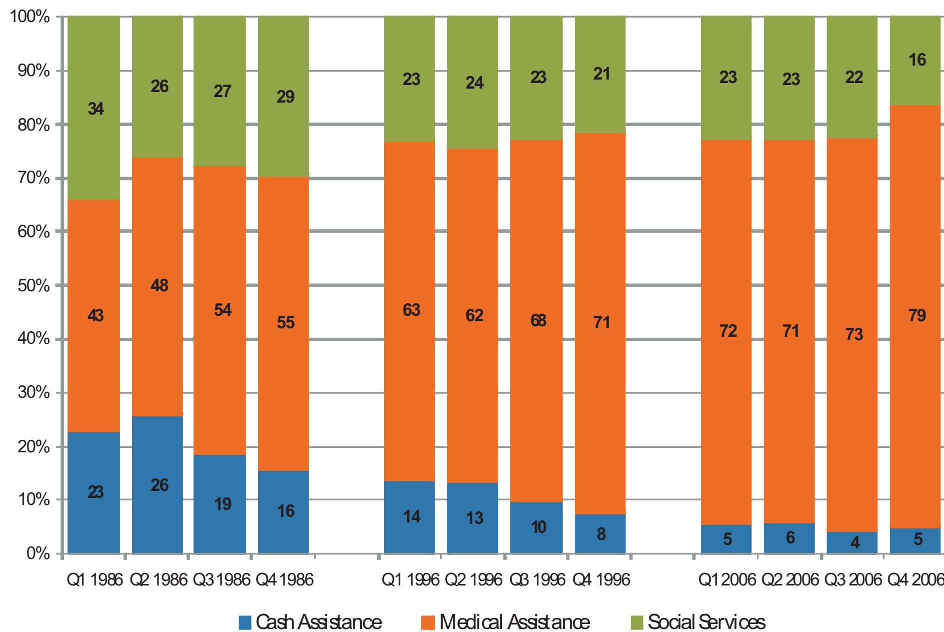


Figure 8
Average Percentage Distribution of Social Welfare Spending Across Three Functions (Cash Assistance, Medical Assistance, and Social Services), 1986, 1996, and 2006
Stratified by state fiscal capacity quartiles
(Q1 = highest fiscal capacity; Q4 = lowest fiscal capacity)



However, this report found that, though medical assistance spending has generally grown in recent years, *both* cash assistance and social services have been falling in most states since at least 2002 — after adjusting for inflation and need — and that the decline in social service expenditures has been particularly acute in low fiscal capacity states. *State and local government spending on social welfare has thus shifted from a period of expanding resources, growing diversity of services, and widespread change across many states in the 1990s, to a new period characterized by contraction, increased concentration of services around medical assistance, and highly varied changes from one state to another.*

What do these findings mean for the years after 2006? Although Census Bureau data on state and local expenditures are unavailable for 2007 or 2008, other data suggest that the decline in nonhealth spending probably continued into these years. For instance, the number of families receiving TANF assistance fell 4.4 percent between December 2006 and December 2007.[29] States may also push down caseloads in 2008 and in the near future as they continue to respond to the stricter performance requirements of the reauthorized TANF law.[30] Spending data from other sources indicate that 2007 TANF spending — including social services supported with TANF funds as well as the program's

29 For data on the number of families or individuals receiving assistance under the TANF program, see http://www.acf.hhs.gov/programs/ofa/data-reports/caseload/caseload_current.htm.

30 For research on the five states' early responses to the reauthorized TANF program and its administrative interpretations, see Karen Gardiner, Mike Fishman, Mark Ragan, and Tom Gais, *Local Implementation of TANF in Five Sites: Changes Related to the Deficit Reduction Act*, Final Report, Prepared for the Administration for Children and Families, Office of Planning, Research, and Evaluation (March 31, 2008), at http://www.acf.hhs.gov/programs/opre/welfare_employ/local_impl/reports/five_sites_reduction/five_sites_reduction.pdf.

cash assistance benefits — was lower than it had been in 2006 after adjustments for inflation.[31] By contrast, as already noted, medical assistance spending appeared to resume its long-term pattern of growth in 2007, even after adjusting for inflation and the number of poor persons.[32] Finally, federal assistance for major social service programs hardly grew even in nominal terms between 2006 and 2007 — thus putting more of the burden on states to meet the needs of low-income families.[33]

The future, of course, is hard to predict. However, in the near term — say, within the next three or four years — it is reasonable to expect that social welfare spending outside of medical assistance will fall to levels (after adjusting for inflation and need) not seen since the middle or perhaps even early 1990s. A main reason for this expectation is the current slowdown in state and local taxes and other own-source revenues, which slowed considerably in the last quarter of 2007 and the first quarter of 2008, and which will probably continue to decline or grow slowly for several more quarters.[34] In past recessions, state spending cuts are typically most severe between two and four years after the downturn in revenues.[35] Given our findings — which indicate that states have increasingly had to rely on their own fiscal resources to support social welfare programs in recent years — an extended drop in state revenues may have a large impact on social welfare spending, especially on nonhealth social services. Thus, although such services (as well as cash assistance) represent only a small part of states' overall budgets, the recent trends we identified suggest that they are vulnerable to budget cuts in the fiscal crises now afflicting many states. *Because these cuts would be imposed on programs that already lost a large part of their value relative to their target populations since the last economic downturn, the final result may be a substantial shrinkage in state and local resources to meet the nonhealth needs of low-income people.*[36]

Understanding the long-term outlook is even more difficult. It is impossible, for instance, to predict with any precision what will happen to federal assistance to state and local governments in the coming years. Nor is it feasible to forecast state and local revenues over the next several years. We also do not know future changes in economic need, such as changes in the number of poor individuals or households.

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31 Estimates of 2007 state expenditures from the National Association of State Budget Officers (NASBO) indicate that TANF and "other cash assistance" both fell after adjustments for inflation between 2006 and 2007 — by 3 percent and 2 percent, respectively. Data obtained from staff at NASBO by the Rockefeller Institute.

32 See note 12.

33 Federal budget documents show that grants to state and local governments under "Children and Families Service Programs" were $8.490 billion in FY 2005, $8.492 in FY 2006, and $8.496 in FY 2007. The lack of any significant growth in nominal terms implies real declines in inflation-adjusted terms.

34 Boyd, Dadayan, and Giguashvili, "State Taxes Slow Yet Again," p. 1.

35 Donald Boyd, "Recessions and State-Local Finances," Presentation to the CSG/WEST Annual Meeting, Anchorage, Alaska, July 18, 2008, at http://www.rockinst.org/WorkArea/showcontent.aspx?id=15240, p. 51.

36 Cash assistance spending, for instance, is already at very low levels relative to indicators of economic need. Fewer people receive cash assistance now. In 2005, only 1.7 percent of the U.S. population obtained TANF assistance (by far, the largest of the cash assistance programs state and local governments administer), down from a peak of 5.4 percent in 1993. Much of the decline was not due to fewer people in economic need but to fewer cash recipients among eligible persons. The federal government estimated, for instance, that only 42.0 percent of the people eligible for TANF assistance actually received it in 2004 (the most recent data available), about half of the percentage of eligible persons receiving assistance in 1995 (when 84.3 percent of economically eligible persons received it). See U.S. Department of Health and Human Services, *Indicators of Welfare Dependence*, Annual Report to Congress, 2007 (Washington, D.C.: Department of Health and Human Services, 2007), Table IND 3a, p. II-13.

However, some factors suggested by our analysis could have long-term consequences. One such factor is the relationship between medical assistance spending and other social welfare expenditures. The rapid growth of medical assistance in the 1990s and early 2000s relative to other social service expenditures suggests that such spending might *crowd out* state spending on other services, especially in low-fiscal capacity states where own-source revenues are scarce. Although we have not yet tested the crowd-out hypothesis in a multivariate analysis, our field research study conducted several years ago in six low fiscal capacity states found many government officials who believed that such effects occurred.[37] Also, though annual changes in medical assistance and social service spending sometimes paralleled each other, they often ran in different directions. For example, when medical assistance spending grew slowly between 1992 and 1998, social service spending began to increase; and while medical assistance grew vigorously through 2005, social service spending dropped after 2002.

It is not unreasonable to expect medical assistance, and Medicaid in particular, to have many advantages over other social programs in competing for state resources. Medicaid is an open-ended entitlement with a generous match rate from the federal government, especially for low fiscal capacity states. Many voters view health benefits more as rights than as privileges — and as important to provide to people unable to afford coverage on their own. Medicaid also has stronger political allies. It serves many middle class families, and it gets active political support from powerful health care institutions, such as hospitals, medical schools, pharmaceutical firms, some doctors, and nursing homes and other long-term care facilities. Especially in low fiscal capacity states, Medicaid is often a central funding source for many of these institutions and health professionals.[38]

Nonhealth services and certainly cash assistance have fewer of these political advantages. Thus, if and when fiscal pressures are strong from education, corrections, and infrastructure programs, states may at least implicitly hold down nonhealth service spending — much of which is discretionary — to deal with the incessant growth of health-related expenditures. Especially if states play a major fiscal role in the next several years in efforts to expand health coverage among uninsured and under-insured individuals, the possibility of crowd-out effects poses a danger that other social welfare programs will be squeezed, perhaps severely, and perhaps for many years.

However, Medicaid in some instances may also *absorb* the costs of traditional social services. As Steven R. Smith observed, the Medicaid program has become a major source of funding for an increasingly diverse array of home and community services.[39] Much of this growth has been the result of the movement, especially strong since the early 1990s, to shift persons with developmental disabilities or mental illnesses as well as elderly people out of institutions and nursing homes and into less restrictive settings, such as home care, supported living in apartments, and group homes. To promote and support this shift, Medicaid was increasingly used to fund the many services people needed to live safely and comfortably in these noninstitutional settings — services such as home health, supported living, case management and mental health counseling.[40]

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37 Lewin Group and Rockefeller Institute, *Spending*. This point was not discussed in the published report but came up in several interviews.

38 Lewin Group and Rockefeller Institute, *Spending*, p. 69.

39 Steven Rathgeb Smith, "Medicaid and the Changing Politics of State and Federal Social Policy," Presented at the Annual Meeting of the American Political Science Association, August 28-31, 2008, Boston, p. 1.

40 Smith, "Medicaid," pp. 4-7.

This development probably does not undermine our conclusions about the relative growth rates of health and nonhealth spending. We measure "medical assistance" not in terms of spending under the Medicaid program but in functional terms — that is, by using the Census Bureau's subcategory, "vendor payments for medical care," which includes payments to hospitals, doctors, and others health care providers for "medical assistance." However, the shift probably does mean that Medicaid is funding a growing share of such Census categories as "vendor payments for other purposes" and "other public welfare," both of which are part of what we call "social services" in this report — and that non-Medicaid program spending in support of social services has probably declined faster than social service expenditures as a whole.

The increasingly central role of Medicaid in supporting social services may mean, in the long run, that such expenditures are less likely to fall in the aggregate, as some of Medicaid's political strengths are increasingly carried over in support of such services. Yet it may also mean that eligibility for social services is more and more contingent on Medicaid eligibility, while other clients may be less well served or not served at all.[41] Thus, it is possible that both the crowd-out and absorption effects operate at the same time. Perhaps total funding for social services will grow in the future, yet the services and clients will increasingly be those covered by Medicaid, especially those that need extensive services to remain in home and community-based care, while funding for other services and clients may decline.

A second long-term issue is the apparent fraying of welfare reform. It briefly seemed possible that the sometimes bipartisan excitement over welfare reform in many states in the 1990s augured a new commitment to social programs, grounded largely in pro-employment values. Although cash assistance remained politically unpopular in many states, a wide variety of services — notably, child care subsidies, child support enforcement, employment services, and state EITCs — gained political legitimacy and fiscal support as work supports or other means of achieving welfare reform's goal of "self-sufficiency." Fueled by growing state revenues and falling cash assistance rolls in the 1990s, state social welfare budgets, especially service expenditures, grew rapidly — and in some states, such services and benefits were administratively integrated to promote work and personal responsibility.

However, 12 years after the enactment of federal welfare reform, not much political excitement remains. Although program changes continue to occur — and probably accelerated after TANF's reauthorization in early 2006 — the recent changes have been less dramatic and innovative, and they typically involved administrative rather than major policy changes.[42] Cash benefits have dwindled in real value, as some states have not increased their nominal levels in many years.[43] Caseloads fell so much in some states, earlier efforts to integrate services for TANF recipients seemed less worthwhile and were ended, while other programs, such as Food Stamps, became more

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41 Smith, "Medicaid," p. 9.

42 For recent changes in five urban sites in the implementation of welfare reform, see Gardiner, Fishman, Ragan, and Gais, *Local Implementation of TANF in Five Sites*. A follow-up to this study found that states made a variety of changes in their TANF programs to comply with the federal laws after TANF reauthorization; see Gardiner, et al., *Local Implementation: Changes*.

43 In nominal terms, the average (mean) of states' maximum cash benefit for a family of three was $777 in 2006, an increase of only 0.9 percent from 2003 before adjusting for inflation. In prior years, cash benefits increased more substantially. States' mean maximum benefits increased 7.1 percent between 1999 and 2003, and 7.5 percent between 1996 and 1999 (before adjusting for inflation). Gretchen Rowe and Mary Murphy, *The Welfare Rules Databook: State Policies as of July 2006* (Washington, DC: Urban Institute, 2008), pp. 176-177.

central to state human service systems.[44] Especially in the wake of the 2001-02 state revenue crises, the TANF block grant was used to support an increasingly diverse set of programs, including prekindergarten and child welfare programs — perhaps making the TANF block grant more of a general source of funding for social programs rather than a coherent and focused program.[45]

Evidence of the depletion of welfare reform's political force is still circumstantial, and there are states where it remains a vigorous program. But where the fraying has been real, and interest in welfare reform and its broad goals has eroded, social service expenditures may have lost one of their strongest political buttresses — a loss that may lead to future declines in spending unless or until the reform goals regain their strength or some other broadly popular initiative takes its place. Some states are launching antipoverty efforts, though it is not yet clear whether the numerous recommendations from states' blue-ribbon panels will produce actual programs with significant funding, much less serve as a political stimulus for social welfare programs.[46] However, the attempts underline the persistence of the central problem: Under what conditions can social welfare programs sustain enough political support to generate the resources needed to respond to the needs of low-income families? Medicaid may succeed due to the nature of its benefits, the breadth of the population it covers, and its alliance with politically active service providers. Some federal programs — such as the refundable child tax credit and EITC — succeed in part by virtue of their political near-invisibility, as they use the tax system to provide support and side-step state and local grants or bureaucracies. But these types of measures probably cannot work with many social welfare services and benefits, which are not delivered by major industries, cannot easily be administered through the tax system, and will surely be implemented by state and local governments for the foreseeable future. Creating an enduring common purpose across the diverse efforts to help low-income people, backed by financial commitments and shared by the many governments involved in the U.S. social welfare system, thus remains a major challenge for American federalism and governance.

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44 Gardiner, et al., *Local*, pp. 26-27.

45 See Lewin Group and Rockefeller Institute, *Spending*, pp. 65-66 One indicator of the growing diversity of programs funded by the TANF block grant is the percentage of block grant dollars assigned to the residual, "Other" category of expenditures in the federal financial report; that percentage increased from 8 percent to 13 percent of all spending of federal block grant dollars between fiscal years 2000 and 2006. See Administration for Children and Families, U.S. Department of Health and Human Services, "TANF Financial Data," at http://www.acf.hhs.gov/programs/ofs/data/index.html, especially, for each fiscal year, Table A, Combined Federal Funds, Breakdown of Other Expenditures on Non-Assistance, columns for Line 6m, "Other."

46 Christine Vestal, "States Adopt Bold Anti-Poverty Measures," *Stateline.org* (August 7, 2008), at http://www.stateline.org/live/details/story?contentId=331776.

Appendix A
State and Local Government Spending by Detailed Item, FY 2006 (in billions)

Social Welfare Spending Category	*Detailed Item in Census Data*	*FY2006 (billions)*	*Definition*
Cash Assistance	67 Federal Categorical Assistance Programs	$17.2	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	$4.6	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	$267.8	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	$5.8	Includes payments made directly to private vendors for services and commodities other than medical, hospital, and health care.
	77 Welfare Institutions	$5.0	Includes payments for provision, construction, and maintenance of nursing homes and welfare institutions owned and operated by a government.
	79 Other Public Welfare	$68.2	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.

Appendix B
Adjustments for Inflation and Need

In this paper, social welfare spending data are adjusted to account for inflation using Bureau of Economic Analysis's State and Local Government Consumption Expenditures and Gross Investment Price Index for Gross Domestic Product (NIPA Table 1.1.4, Line 24). All figures are expressed in 2006 dollars. To check on the robustness of our findings, we also adjusted social welfare spending data using the overall Services Price Index for Personal Consumption Expenditures (NIPA Table 2.3.4, Line 13), which is a plausible alternative method of adjusting for inflation in this context. This appendix compares social welfare spending and its components to show how different ways adjusting for inflation affect spending trends. It also shows the effects of adjusting spending figures for the number of poor persons in each state.

Figure Appendix B-1 compares annual changes in total social welfare spending in (1) nominal terms (not adjusted for inflation), (2) adjusted for inflation using the State and Local Government Consumption Expenditures and Gross Investment Price Index (hereafter called State and Local Consumption Expenditures Index), and (3) adjusted for inflation using the overall Services Price Index for Personal Consumption Expenditures (hereafter called Services Price Index). The graph shows that, though are occasional discrepancies, the two different methods of adjusting for inflation do not produce very different results. In both cases, growth in social welfare spending slowed after 1999 and was especially slow after 2002. The one major difference is an upturn in spending in 2005 using the Services Price index, when the State and Local Government Consumption index showed a decline. As expected, the nominal data show higher rates of growth throughout the time series, though the pattern over time tends to parallel fairly closely the adjusted rates — suggesting that the changes over time are due more to spending changes than to shifts in inflation rates.

Figure Appendix B-2 compares state and local expenditure levels — not annual changes — across the three types of social welfare spending: cash assistance, medical assistance, and social services. The spending levels are also compared across three types of adjustments: spending is expressed in nominal terms (no adjustment for inflation), adjusted using the State and Local Government Consumption Expenditures Index, and the Services Price Index. The graphs show that, although nominal spending levels show much more growth than inflation-adjusted levels, the two types of inflation adjustments generally show very similar trends. This is also true for Figure Appendix B-3, which shows the same spending levels in Figure Appendix B-2 but after those expenditures are expressed in terms of the number of poor persons in the nation.

Figure Appendix B-1. Annual Percentage Changes in Social Welfare Spending, 1977-2006

Changes Calculated in Dollars Expressed in Three Ways:
Nominal Dollars, Adjusted to State-Local Government Consumption,
Expenditures Price Index, and Adjusted to Overall Services Price Index

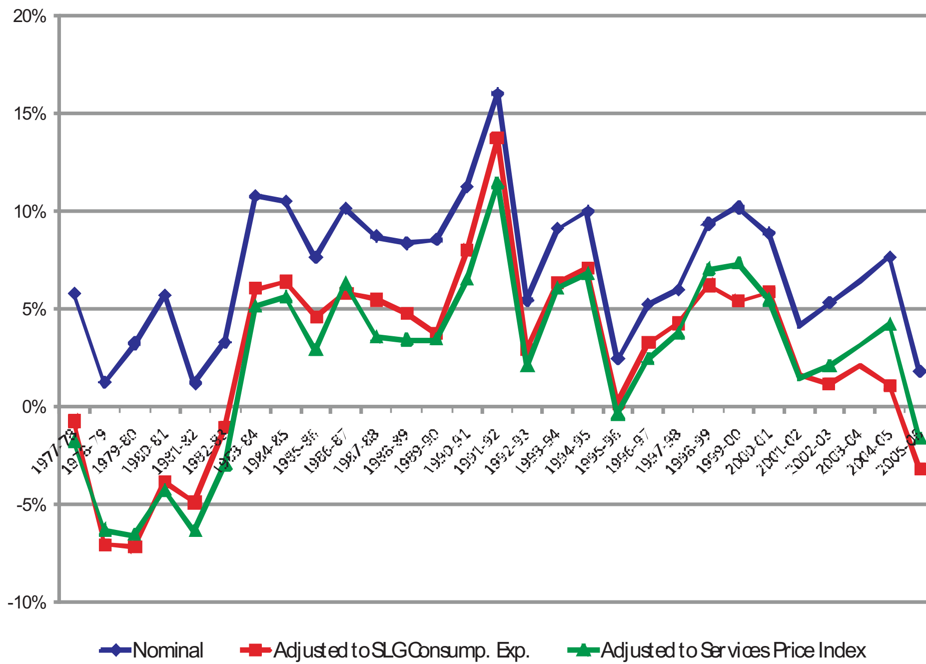
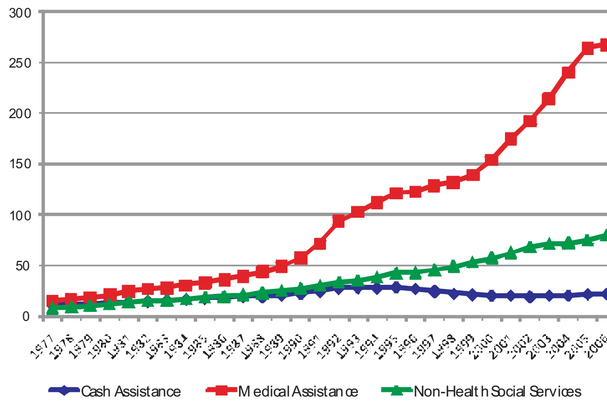
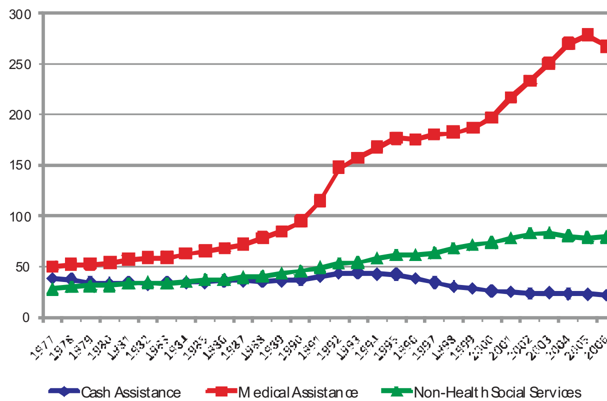


Figure Appendix B-2. Total State and Local Spending on Cash Assistance, Medicaid, and (Nonhealth) Social Services, 1977-2006 (In $ Millions)

Nominal Spending



Adjusted to State-Local Government Consumption Expenditures Price Index (NIPA Table 1.1.4, Line 24)



Adjusted to Overall Services Price Index (NIPA Table 2.3.4, Line 13)

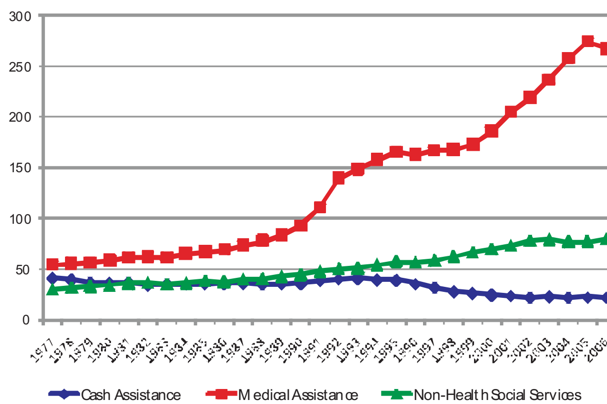
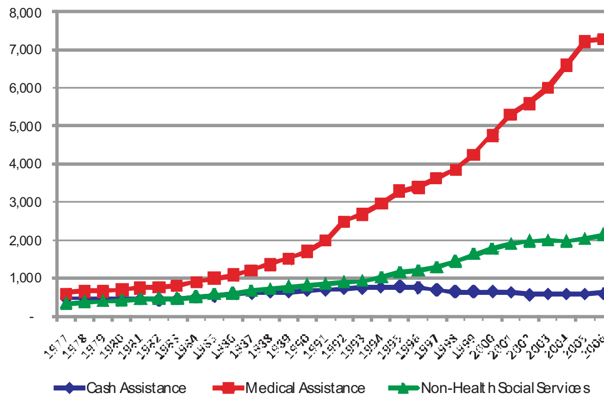
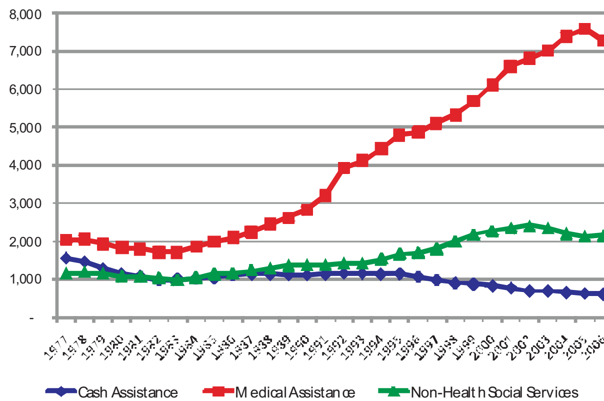


Figure Appendix B-3. Total State and Local Spending on Cash Assistance, Medicaid, and (Nonhealth) Social Services, Per Poor Person, 1977-2006

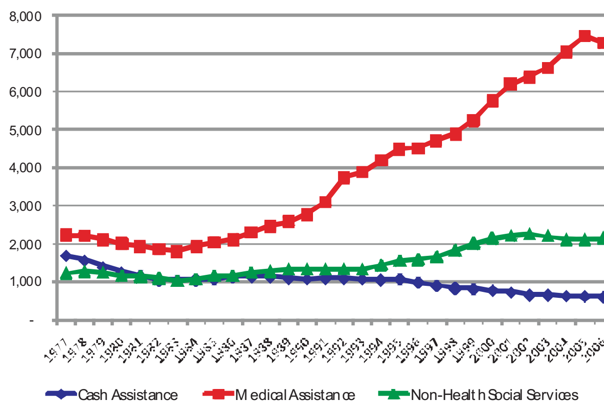
Nominal Spending



Adjusted to State-Local Government Consumption Expenditures Price Index (NIPA Table 1.1.4, Line 24)



Adjusted to Overall Services Price Index (NIPA Table 2.3.4, Line 13)



Appendix C
State Fiscal Capacity Quartiles, Based on Per Capita Personal Income, Averaged, 2006 Dollars, 1977-2006

Appendix C shows states' stratification into four fiscal capacity quartiles, where Quartile 1 represents states with the highest fiscal capacities, while Quartile 4 represents states with the lowest fiscal capacities. In this report, we measure state fiscal capacity based on states' real per capita personal income (PCPI), averaged across the years examined in this study (1977-2006). Data for PCPI may be found at U.S. Bureau of Economic Analysis, available at http://www.bea.gov/regional/spi/.

PCPI is a relatively good indicator for measuring residents' ability to pay taxes and subsequently fund services. Even though there are other methods for measuring state fiscal capacity such as Representative Tax System (RTS) or Total Taxable Resources (TTR), PCPI is more widely used, particularly due to readily and timely available data.

Quartile	*State*	1977-2006 Average, PCPI
Quartile 1	Alaska	38,486
	California	35,569
	Colorado	34,125
	Connecticut	42,970
	Delaware	34,533
	Illinois	34,830
	Maryland	37,325
	Massachusetts	38,239
	Nevada	34,416
	New Hampshire	34,434
	New Jersey	40,020
	New York	37,516
Mean PCPI of Quartile 1		***36,872***
Quartile 2	Florida	31,733
	Hawaii	34,045
	Kansas	30,836
	Michigan	32,050
	Minnesota	33,750
	Ohio	31,082
	Oregon	30,491
	Pennsylvania	32,385
	Rhode Island	32,340
	Virginia	33,800
	Washington	33,648
	Wisconsin	31,005
	Wyoming	31,986
Mean PCPI of Quartile 2		***32,242***
Quartile 3	Arizona	28,611
	Georgia	29,168
	Indiana	29,469
	Iowa	29,663
	Maine	28,195
	Missouri	29,927
	Nebraska	30,394
	North Carolina	28,487
	Oklahoma	27,737
	South Dakota	27,723
	Tennessee	28,062
	Texas	30,263
	Vermont	29,415
Mean PCPI of Quartile 3		***29,009***
Quartile 4	Alabama	26,199
	Arkansas	24,670
	Idaho	26,462
	Kentucky	26,203
	Louisiana	26,262
	Mississippi	22,825
	Montana	26,641
	New Mexico	25,661
	North Dakota	27,713
	South Carolina	26,053
	Utah	26,002
	West Virginia	24,660
Mean PCPI of Quartile 4		***25,779***

Appendix D

Appendix D provides three sets of tables on changes in real social welfare spending per poor person for three different time periods: FY 2005-06, FY 1996-02, and FY 2002-06. The social welfare spending data are adjusted to account for inflation using Bureau of Economic Analysis's State and Local Government Consumption Expenditures and Gross Investment Price Index for Gross Domestic Product (NIPA Table 1.1.4, Line 24 available at http://www.bea.gov/national/nipaweb). States are ranked according to their changes in total social welfare spending, from low (or declines in spending, indicated by figures in parentheses) to high.

Changes in Spending Per Poor Person, Dollar Changes, FY 2005 – FY 2006 (2006 Dollars)						
State	Total Social Welfare	Medical Assistance	Cash Assistance	Non-Health Social Services	Social Welfare Spending from Federal Transfers	Fiscal Capacity Quartile
New Hampshire	(3,750)	(3,572)	(45)	(133)	(1,508)	1
Vermont	(3,330)	(2,627)	(205)	(497)	(562)	3
Minnesota	(3,219)	(2,502)	(162)	(555)	(1,783)	2
Tennessee	(1,580)	(1,616)	11	25	(1,034)	3
Mississippi	(1,363)	(1,345)	2	(20)	(1,014)	4
Missouri	(1,256)	(952)	(523)	218	(755)	3
South Carolina	(1,224)	(1,185)	(16)	(24)	(1,084)	4
New Mexico	(977)	(872)	(43)	(63)	(604)	4
Nebraska	(974)	(572)	(34)	(368)	(678)	3
Georgia	(956)	(1,208)	17	235	(680)	3
Massachusetts	(762)	(581)	(79)	(101)	(517)	1
North Carolina	(690)	(529)	(118)	(43)	(672)	3
Oregon	(685)	(438)	6	(253)	(1,102)	2
Florida	(603)	(533)	(27)	(43)	(285)	2
West Virginia	(535)	(444)	(33)	(58)	(461)	4
Pennsylvania	(480)	(462)	65	(83)	(1,541)	2
New York	(427)	(285)	(83)	(59)	(591)	1
Washington	(413)	(303)	0	(111)	149	2
Idaho	(398)	(322)	97	(173)	(223)	4
Arizona	(382)	(353)	(43)	14	151	3
Wyoming	(364)	142	(25)	(481)	(474)	2
Oklahoma	(329)	(226)	18	(121)	(345)	3
Kansas	(309)	(354)	63	(18)	(236)	2
California	(305)	(388)	4	80	(312)	1
Hawaii	(134)	10	(97)	(48)	146	2
Utah	(127)	39	(61)	(105)	(33)	4
Texas	(119)	(164)	(19)	65	(104)	3
North Dakota	(108)	(67)	(81)	39	(404)	4
Michigan	(17)	(235)	15	203	(188)	2
Louisiana	(12)	(33)	5	15	(239)	4
Ohio	(2)	323	(34)	(292)	(221)	2
Colorado	88	216	3	(131)	146	1
Arkansas	90	83	(4)	11	(11)	4
Indiana	98	(24)	(59)	182	151	3
Alabama	137	58	14	65	121	4
Alaska	177	(37)	(135)	350	(2,711)	1
Montana	240	262	3	(25)	169	4
Wisconsin	265	84	(23)	204	(8)	2
Kentucky	281	268	(10)	24	320	4
Nevada	373	333	(14)	54	(74)	1
Delaware	392	46	(20)	365	(124)	1
Illinois	393	318	(84)	158	314	1
Virginia	443	409	(19)	52	166	2
New Jersey	535	(357)	392	499	525	1
South Dakota	554	373	(174)	355	339	3
Maine	554	1,770	65	(1,281)	(244)	3
Connecticut	900	624	(55)	331	121	1
Rhode Island	928	886	(172)	214	342	2
Maryland	963	681	(6)	288	157	1
Iowa	1,060	1,018	(15)	56	709	3

Changes in Spending Per Poor Person, Dollar Changes, FY 1996 – FY 2002 (2006 Dollars)						
State	Total Social Welfare	Medical Assistance	Cash Assistance	Non-Health Social Services	Social Welfare Spending from Federal Transfers	Fiscal Capacity Quartile
New Jersey	(3,171)	(2,288)	(712)	(171)	1,180	1
New Hampshire	(1,697)	(1,968)	(386)	657	838	1
Massachusetts	(1,038)	(484)	(756)	203	(1,952)	1
Illinois	(824)	(764)	(586)	526	324	1
Colorado	(408)	(81)	(640)	313	(523)	1
Louisiana	(332)	(59)	49	(323)	1,316	4
Utah	431	1,192	57	(818)	(821)	4
North Carolina	500	549	(372)	324	1,168	3
Maine	722	453	(405)	674	863	3
Texas	826	1,023	(247)	50	730	3
Nevada	961	785	(165)	340	808	1
Montana	1,168	740	(223)	651	973	4
West Virginia	1,235	832	(82)	484	1,089	4
Arkansas	1,321	1,102	(100)	319	406	4
Hawaii	1,431	855	(928)	1,504	(370)	2
Wisconsin	1,649	1,282	(34)	402	2,512	2
Arizona	1,660	2,191	(292)	(239)	2,073	3
Indiana	2,244	1,228	(660)	1,676	1,835	3
Michigan	2,265	1,308	(513)	1,470	2,279	2
Washington	2,288	1,936	(257)	610	1,528	2
Florida	2,321	2,212	(276)	386	1,077	2
Virginia	2,372	2,152	(633)	854	1,506	2
Georgia	2,481	2,662	(314)	132	1,871	3
New York	2,850	2,775	(918)	992	2,700	1
Alabama	2,856	1,776	990	91	2,305	4
Kansas	2,869	2,395	(326)	800	2,210	2
South Carolina	3,097	2,758	(89)	428	2,465	4
Tennessee	3,108	2,985	(37)	160	1,975	3
California	3,213	2,349	(385)	1,249	2,176	1
South Dakota	3,304	2,527	152	626	3,457	3
Nebraska	3,358	2,399	(117)	1,076	2,162	3
Connecticut	3,535	3,239	(528)	824	2,788	1
Oklahoma	3,628	3,371	(214)	470	1,691	3
Mississippi	3,676	3,144	(60)	592	2,687	4
North Dakota	3,704	2,658	(287)	1,334	2,273	4
Idaho	3,753	3,249	247	257	1,994	4
Oregon	3,840	2,843	(146)	1,143	4,056	2
New Mexico	3,844	3,400	67	378	2,458	4
Missouri	4,064	3,378	(61)	747	3,127	3
Kentucky	4,109	3,581	(261)	789	2,610	4
Ohio	4,197	3,452	(431)	1,176	2,714	2
Delaware	4,264	3,329	(344)	1,279	3,271	1
Wyoming	4,375	3,507	(203)	1,071	3,141	2
Pennsylvania	4,594	3,192	(550)	1,951	2,808	2
Vermont	4,595	2,740	(213)	2,068	4,138	3
Alaska	4,711	5,716	(1,514)	509	2,535	1
Iowa	4,723	3,565	(228)	1,386	3,583	3
Maryland	5,065	3,552	(126)	1,640	2,444	1
Rhode Island	6,627	5,698	(34)	964	2,906	2
Minnesota	10,743	6,408	(259)	4,594	4,231	2

Changes in Spending Per Poor Person, Dollar Changes, FY 2002 – FY 2006 (2006 Dollars)						
State	Total Social Welfare	Medical Assistance	Cash Assistance	Non-Health Social Services	Social Welfare Spending from Federal Transfers	Fiscal Capacity Quartile
Minnesota	(4,736)	(1,014)	(300)	(3,422)	(1,308)	2
Oregon	(3,372)	(2,840)	(15)	(517)	(5,820)	2
Missouri	(3,171)	(2,240)	(588)	(343)	(2,438)	3
Michigan	(2,938)	(1,611)	(157)	(1,170)	(1,410)	2
Indiana	(2,717)	(1,443)	(43)	(1,230)	(2,026)	3
Georgia	(2,228)	(2,241)	(114)	127	(2,602)	3
Kentucky	(1,781)	(1,202)	(83)	(496)	(1,160)	4
Wisconsin	(1,648)	(481)	(648)	(519)	(2,372)	2
Mississippi	(1,646)	(1,100)	(17)	(529)	(924)	4
Iowa	(1,359)	257	(171)	(1,444)	208	3
South Carolina	(1,107)	(627)	75	(555)	(383)	4
Colorado	(1,062)	121	(21)	(1,162)	(360)	1
Tennessee	(958)	(792)	(70)	(95)	(1,537)	3
Ohio	(926)	35	(320)	(641)	(1,007)	2
Maryland	(735)	50	(339)	(446)	(807)	1
Nebraska	(712)	(556)	(40)	(116)	2,492	3
Connecticut	(417)	(678)	(524)	785	(1,930)	1
Kansas	(363)	142	60	(565)	(749)	2
Oklahoma	(219)	(182)	0	(38)	(270)	3
North Carolina	(208)	(263)	406	(350)	21	3
West Virginia	(113)	841	(192)	(762)	292	4
Alabama	(96)	(128)	(15)	46	(215)	4
South Dakota	18	(202)	(324)	544	(1,346)	3
Texas	29	141	(80)	(32)	(195)	3
North Dakota	103	657	(60)	(495)	67	4
Nevada	166	94	(79)	151	(438)	1
Washington	198	425	(33)	(193)	(293)	2
California	199	441	(231)	(11)	(602)	1
Pennsylvania	318	2,015	32	(1,730)	(1,508)	2
Montana	446	958	(32)	(480)	691	4
Arizona	456	117	(74)	414	835	3
Wyoming	541	894	92	(445)	(626)	2
New York	1,127	1,566	(108)	(331)	186	1
Rhode Island	1,169	2,816	(619)	(1,028)	(477)	2
Utah	1,224	959	93	172	1,341	4
Florida	1,305	965	94	246	1,043	2
New Mexico	1,433	1,090	101	242	1,535	4
Louisiana	1,462	1,556	(63)	(30)	(176)	4
Idaho	1,501	1,763	(117)	(145)	842	4
Arkansas	1,830	1,672	(94)	252	1,096	4
Illinois	1,876	2,118	(251)	8	445	1
Delaware	1,889	2,457	(126)	(441)	(873)	1
Alaska	2,014	2,764	(620)	(130)	561	1
Virginia	2,418	1,474	886	58	599	2
Maine	2,464	2,852	36	(424)	2,073	3
Hawaii	2,956	2,183	(514)	1,287	2,531	2
New Hampshire	3,529	3,484	(68)	114	146	1
Massachusetts	5,084	4,711	(70)	443	3,616	1
Vermont	5,548	5,013	(62)	597	2,556	3
New Jersey	6,360	5,430	379	552	545	1

Appendix E

Appendix E shows the trends in average number of people living in poverty across the states within each state fiscal capacity quartile. We used three-year average for calculating the number of poor people to smooth out year-to-year fluctuations, which are normal and inevitable occurrences. Poverty data may be found at U.S. Census Bureau, Current Population Survey, available at http://www.census.gov/hhes/www/poverty/histpov/hstpov21.html.

Figure Appendix E-1
Number of Persons Living in Poverty, Averaged Across States
In Thousands of Persons
Stratified by State Fiscal Capacity Quartiles
(Q1 = highest fiscal capacity; Q4 = lowest fiscal capacity)