Passage from “Welfare: Not Even Treating the Symptoms.”

“Living in poverty and on public assistance is a harsh, ongoing economic struggle that becomes more acute by the end of the month. There is very little slack in the rope. When an unanticipated event leads to economic stress, entire lives suffer, domino fashion. Everyday life is complicated by a variety of negative physical consequences, including the difficulty of carrying out the most basic tasks.”

What are some of difficulties faced by people living on public assistance?

- Having to shop at smaller more expensive food stores due to a lack of transportation.
- Having to go to the laundromat (via bus) and care for children at the same time.
- Suffering through tooth pain due to the inability to afford a dentist.
- Having no credit.
- Not being able to eat at a restaurant or to see a movie.
- Forgoing seeing family and/or friends or participating in public activities (e.g., going to church) due to inadequate transportation or other situational factors.

For many persons on public assistance, the end of the month is a time for careful reflection. Money doesn’t often last throughout the month, and so families on welfare must make some accommodations for this fact. Living on public assistance is indeed living on the edge.


- Under Roosevelt, the New Deal embodied two concepts that were drastically different from earlier policy.
  - Federal government would assume a large responsibility for social insurance.
  - The government was seen as having a permanent role in public welfare.
  - The culmination of these two factors was the Social Security Act of 1935. Programs created under this act include Aid to Dependent Children, Aid to the Blind, and Old Age Assistance programs.
- Other programs created under the Roosevelt administration include the Federal Emergency Relief Act, the Civilian Conservation Corps, the Civil Works Administration, and the Works
Progress Administration.

- In the Kennedy administration, the AFDC program was expanded (to include married couples whose head of household was unemployed) and the Food Stamp program was created.

- The Johnson administration launched the War on Poverty. Under this administration, programs such as Medicare, Medicaid, Head Start, and the Elementary and Secondary Act were created.

- Under the Reagan administration, the Family Support Act was created. This act provided funds for job training for welfare recipients; required welfare recipients with children over three to participate in job training; made it mandatory for states to provide AFDC to two-parent families; and required states to increase child support collections.

- On August 22, 1996, Bill Clinton signed into legislation the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, thus “ending welfare as we know it.”

“Current” welfare system

- There are two types of welfare: cash assistance programs and in-kind programs. Both types are means-tested. That is, for an individual or family to qualify, their income must fall below a certain level.

- Cash assistance programs (benefits will vary by state)
  - Aid to Families with Dependent Children (AFDC). Eligibility requirements in all states include: family income must fall below a certain level, there must be at least one child under the age of eighteen, and must have one parent absent due to death, desertion, divorce, incapacitation, or incarceration. Grants depend upon the size of the family income and the number of children in the household.
  - Supplemental Security Income (SSI). Provides cash payments to older adults and those who are disabled or blind, all of whom must meet certain income requirements.
  - General Assistance. The types of programs and benefits vary from state to state. Benefits are usually given on a short-term basis.

- In-kind programs
  - Food Stamp Program. It is administered by the Department of Agriculture, and as such, benefits do not vary across states. To qualify, family income must fall below 130% of the poverty line. A family of four with no income would receive about $300 per month.
• Special Supplemental Food Program for Women, Infants and Children (WIC). Program is designed to upgrade the nutrition of these groups.

• Free or Reduced-Price School Lunch Program. Provides free lunches for children whose family income falls below 125% of the poverty line and reduced-price lunches for children whose family income falls in between 125% and 195% of the poverty line.

• Medicaid. This program is designed to provide for the health insurance needs of the poor. All persons qualifying for AFDC also qualify for Medicaid, as do most people on SSI.

• Housing Assistance. Designed to provide subsidized housing for the poor.
  - Public Housing. These are rental units owned by public housing authorities, which are public or quasi-public entities. There are approximately 1.2 million public housing units, 550,000 of which are occupied by families with children. Rents paid by the tenants go directly to the PHA for operating and maintenance costs.
  - Section 8 Tenant-based Vouchers and Certificates. Individuals and families use these to rent private housing. Recipients can rent housing of their choice, but it must be approved by the PHA. There are about 1.5 million vouchers, of which 980,000 are used by families with children. Generally speaking, tenants will pay 30% of their income in rent, and the remainder of the rent will be paid by the PHA.
  - Project-based section 8 assistance. These are rental units in buildings owned and operated by private owners (either for-profit or non-profit) who have received subsidies from the federal government. There are about 1.4 million such units, with about 500,000 occupied by families with children.
  - Approximately 25% of those receiving AFDC/TANF (see below) benefits also receive public housing benefits.

What did the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 do to change the current welfare system?

- It is estimated that the changes will produce a savings of $54.5 billion over 6 years, most of which will come due to changes in the Food Stamp program and in reductions to benefits for legal immigrants.

- The bill eliminated AFDC and replaced it with Temporary Assistance for Needy Families (TANF).
This bill provides block grants for states to offer time-limited cash assistance. Under the block grant scheme, children who live in very poor circumstances are not guaranteed support even if their family meets all of the requirements (including work requirements).

Families are limited to receiving only five years of support over their lifetimes. States can employ a shorter deadline should they desire to do so. With the 5-year time limit, the Congressional Budget Office (CBO) estimates that 2.5 to 3.5 million children will be affected by the time limit. Were the state to use a two-year time limit, this number would increase to 5.5 million (even taking into account the exemption below).

Each state is able to exempt 20% of their caseload from the five year support deadline.

Medicaid. Because Medicaid eligibility is tied to AFDC eligibility, problems could have resulted from eliminating AFDC. However, it was decided that eligibility for Medicaid would be determined based on each state's AFDC requirements as of July 1996. The bill also maintains a transitional period for Medicaid, wherein recipients can continue to receive Medicaid for a defined period of time (usually 4 months) after finding a job (and losing AFDC eligibility).

One of the biggest changes wrought by the bill was the cuts in the Food Stamp program. It is estimated that food stamp cuts will save a total of $27 billion over six years.

Essentially, food stamp benefits are cut by almost 20%, the equivalent of reducing the average food stamp benefit from its current level of 80 cents per person per meal to 66 cents.

The very poor and families with children will be the most affected. It is estimated that in the first full year that the new program is in effect, about seven million families with children will lose $435 in food stamp benefits. For the very poor (incomes less than half of the poverty line; below $6,250 for a family of three), the cuts will hit the hardest. In the first year, they will lose about $655 and by 2002, the loss will be $790 per year.

The new program also limits persons between the ages of 18 and 50 who are not raising minor children to three months while unemployed out of a 36 month period, with no exemptions given for hardship cases. After three months, these individuals can continue receiving food stamps only if they are working at least half-time or are in a workfare or training slot.

“This provision will cause hardship among individuals who have worked and paid their taxes but then lose a job due to a recession, a plant closing, or a company downsizing and cannot find a new job in three months. This provision is likely to hit particularly hard at unemployed workers in small towns or rural areas who lose their jobs when a plant closes, relocates, or downsizes, since there may be only a limited number of new employment opportunities in their area.”

What effect has the new welfare law had on Michigan?

- AFDC was changed to the Family Independence Program (FIP).
- Attendance at an orientation to the Work First program is a condition of eligibility for cash welfare benefits.
- Minor parents must live in approved adult-supervised settings and attend school as conditions of eligibility.
- Recipients working for three consecutive months receive “cashed out” food stamp benefits.
- The time limit (3 months) for food stamp eligibility for able-bodied adults was implemented.
- The state will not impose the 5 year time limit on cash benefits. For those going past the five year limit, benefits will be taken from state funds.
- A typical family of three on the FIP program receives about $459 per month. Food stamp benefits average about $72 per month per person.

Rank goes into various explanations for poverty and being on public assistance. Most of the explanations he covers were also covered in the earlier lecture on poverty. One major exception is the Dual Labor Market theory. What is this theory and how does it overlap with our previous discussion of the explanations for poverty?

The Dual Labor Market Theory argues that there are two labor markets.

- In the primary market, jobs are characterized by stability, high wages, good working conditions, a greater degree of internal job structure (i.e., less work stress), and unionization.
- In the secondary market, jobs are characterized as being menial, having poor working conditions, and low pay (with no benefits).
- Poverty results from persons being employed in the secondary labor market due to both low wages and unstable employment. During times of joblessness, workers will turn to the welfare system to get by.
- The discussion of the dual labor market overlaps to a certain degree with our earlier discussions of deindustrialization, unemployment/underemployment, and discrimination (with more women and minorities filling jobs in the secondary market).
• This chapter provides some insight into the predictors of seeking assistance and of the process itself.

• Table 3.1 and Figure 3.2 provide different breakdowns of the welfare recipiency.


• The major goals of Medicaid were twofold: to ensure that those persons eligible for services received adequate care and that the burden of medical costs for limited resources was reduced. Targeted goals include:

  • Reducing access differentials. Before the passage of Medicaid, the poor were ill more often than persons with higher incomes yet they received less medical care. Medicaid helped to reverse some of these differentials in access to care. However, when utilization (e.g., doctor visits, hospital stays) is adjusted for health status, poor persons still receive less medical care than their better-off counterparts. Why?

  • More than half of the people living in poverty do not meet the income requirement to qualify for Medicaid and so are often not covered by health insurance. More recent research also reveals that persons on Medicaid may not receive as good quality of care as those using private insurance.

  • Bringing the poor into mainstream medical care. Because of Medicaid, the poor no longer have to rely on free care or care from charity hospitals. Rather, they can gain access to private and public hospitals and to a lesser extent, physician’s offices. Some physicians are reluctant to take Medicaid patients due to low payment rates, high administrative burden, and to high liability risk. Clearly then, more progress is needed to bring the poor into mainstream medical care.

  • A major goal of Medicare was to prevent major financial outlays due to medical problems among the elderly. However, because Medicare relies on cost-sharing, the medical costs can still weigh heavily upon low-income elderly persons. Many elderly with sufficient income can rely on private insurance to cover the gaps in Medicare coverage; however, others must rely on Medicaid to fill in these gaps. What is the problem with the system?

  • Many elderly do not have the funds for private insurance to supplement Medicare but earn too much income to qualify for Medicaid. In addition, many older adults who qualify for Medicaid coverage either do not seek it due to lack of knowledge or are
unwilling to seek it due to the stigma of receiving welfare.

What is the current state of insurance coverage in the U.S.?

- About 41 million Americans, or 18% of the non-elderly population are uninsured (as of 1996).
- About 80% of the uninsured are full-time workers or are dependents of full-time workers.
- Over 50% of the insured make less than 200% of the poverty line. The near-poor run the highest risk of not having insurance; over 25% of them are uninsured. (see Figures 2 & 3)
- As discussed by Rowland, uninsured individuals are much less likely to seek out medical care than are their insured counterparts.

What are the current trends of Medicaid?

- In 1995, about 35.2 million persons were covered by Medicaid at a cost of $152.4 billion.
- The Medicaid population consists of:
  - 17.5 million children
  - 8.0 million adults in families
  - 3.9 million elderly persons
  - 5.8 million blind and disabled persons
- Although adults and children in low-income families make up nearly 75% of recipients, they only account for 28% of Medicaid spending. About 60% covers care for the elderly and disabled, whereas 12% goes to Disproportionate share hospital (DSH) payments. The latter are payments to hospitals with disproportionately large populations of indigent patients.
- Federally mandated services provided by Medicaid include:
  - Inpatient and outpatient hospital visits
  - Physician, midwife, and certified nurse practitioner visits
  - Laboratory tests and x-rays
  - Nursing homes and home health care
  - Early and periodic screening, diagnosis, and treatment for children under 21
  - Family planning
❖ Rural health clinics/federally qualified health centers

❖ Medical expenditures by service (Figure)

What about the EITC?

❖ The Earned Income Tax Credit (EITC) was established in 1975 to offset the adverse effects of Social Security and Medicare payroll taxes on working poor families and to strengthen work incentives by increasing the renumeration from low-paid work. The tax credit is paid by the IRS. If the credit exceeds the tax liability for the family, they receive a refund check from the IRS for the difference.

❖ In 1997, about 16 million working families with children benefited from the credit. The maximum credit amounts in 1997 are $2,210 for families with one child and $3,656 for families with 2 or more children. The benefit decreases as earnings increase.

❖ There is some evidence to indicate that the EITC is associated with increases in employment among single mothers. Other evidence indicates that the EITC reduces poverty, especially among children.
Figure 2
Health Insurance Coverage by Poverty Level, 1995

- U.S. Total: 72% Uninsured, 22% Medicaid, 11% Private/Other
- Poor (<100% FPL): 16% Uninsured, 23% Medicaid, 55% Private/Other
- Near-Poor (100-199% FPL): 17% Uninsured, 55% Medicaid, 27% Private/Other
- Non-Poor (200% FPL): 11% Uninsured, 88% Medicaid, 1% Private/Other


Figure 3
Percent of Low-Income Population Uninsured or with Medicaid, 1995

- Children (0-17): 49% Medicaid, 13% Uninsured, 62% Total
- Women (18-44): 32% Medicaid, 27% Uninsured, 59% Total
- Men (18-44): 12% Medicaid, 46% Uninsured, 58% Total
- Women (45-64): 17% Medicaid, 30% Uninsured, 47% Total
- Men (45-64): 13% Medicaid, 31% Uninsured, 44% Total

Low-income defined as <200% of FPL.
Medicaid Beneficiaries and Expenditures by Enrollment Group, 1995

- Elderly: 11.0%
- Blind & Disabled: 16.6%
- Adults: 22.6%
- Children: 49.7%

Beneficiaries: Total = 35.2 million people

- Elderly: 26.3%
- Blind & Disabled: 33.7%
- Adults: 10.9%
- Children: 16.7%

Expenditures*: Total = $152.4 billion

* Disproportionate share hospital payments.

Note: Total expenditures exclude administrative expenses, adjustments and the territories.


Medicaid Expenditures by Service, 1995

- Inpatient Hospital: 17.7%
- Drug: 5.5%
- Physician/Outpatient: 12.6%
- Other Acute: 7.3%
- Payments to MCOs: 6.5%
- Payments to Medicare: 25%
- DSH Payments: 12.5%
- Home Health: 6.8%
- Mental Health: 2.0%
- ICF/MR: 6.6%
- Nursing Facility Care: 20.0%

Total = $152.4 billion