Affordable Housing and Child Health

A Child Health Impact Assessment of the Massachusetts Rental Voucher Program

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Draft Report

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Executive Summary

Introduction

Thousands of families, most of them working poor, struggle to meet their housing needs or can only afford substandard, crowded housing. Many cannot afford any housing at all and are homeless.[1] Children in these families suffer long-term physical and developmental health effects that harm them and result in substantial economic costs to the Commonwealth.

A growing body of medical and public health evidence indicates that non-medical factors, such as housing, profoundly influence child health and well-being. Concerned about the health effects of these non-medical factors, a multidisciplinary working group of pediatricians, public health researchers, health economists and attorneys from several universities and hospitals in the Boston area developed a **Child Health Impact Assessment (CHIA)**. The emerging process of Child Health Impact Assessment offers an objective, evidence- and experience-based method through which to evaluate the implications of policy, regulations, and legislation for children's health and well-being.[i] The evaluations undertaken through CHIA are particularly focused on policy arenas outside the traditional realm of medicine, public health and health policy. Child health impacts are usually not considered in policy debates in these domains, making the effects on children invisible to policy makers. However, policies in the area of education, housing, immigration and naturalization, criminal justice, employment and income supports all will affect child health and well-being.

A child's physical living environment, comprised of the housing and neighborhood in which she resides, has a crucial impact on health and well-being. Stability, affordability and quality of housing as well as neighborhood quality determine the nature and direction of this child health impact. Sound housing policy should reflect not only economic and environmental factors; it should consider desirable child health outcomes as well.

This paper reports the findings of a CHIA conducted of the **Massachusetts Rental Voucher Program (MRVP)** and proposed changes to the program for FY2006. MRVP is a housing assistance/homelessness prevention program for Massachusetts residents that received new attention from affordable housing stakeholders during the FY2006 budget process. This report provides a voice to potentially vulnerable children so that housing policy decisions, seemingly disconnected from children's health issues, will include an understanding of its health impacts on the Commonwealth's children.

Influence of Housing on Child Health

There is extensive research in the medical and social science literature exploring the connection between many aspects of housing and child health dating back for almost a century. Child health can be influenced by physical housing conditions, homelessness, affordability of adequate housing and neighborhood environmental conditions. This report will look at specific research on housing and its influence on such childhood conditions as asthma, injuries, inadequate immunizations, anxiety and depression as well as behavior,

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[i] See more detailed description of the Child Health Impact Assessment concept and methodology in Appendix I.

development and educational attainment. The report will summarize the evidence that forms the basis for this child health impact assessment.

Housing conditions have a substantial impact on child health

- Children exposed to substandard housing conditions suffer an increased asthma burden, higher rates of infectious diseases and more childhood injuries, such as falls, death or injury due to fires or burns.

Homelessness and housing instability have an adverse impact on the physical, mental and developmental well-being of children. These children:

- Often lack primary pediatric care, including immunizations, lead and tuberculosis screening and are more likely to have increased emergency department visits or hospitalizations;
- Are more likely to experience hunger and food insecurity;
- Have higher rates of mental health problems and educational problems, including special education use and grade repetition, at an increased cost of $6700 and $6800 per child.

Unaffordable housing requires families to make trade-offs between rent and food or medical care, leading to food insecurity, malnutrition and missed preventative medical care, all of which have lasting effects on children's health and development.

Affordable Housing and the Massachusetts Rental Voucher Program

Massachusetts is one of the least affordable states for housing in the United States.[2] Housing is deemed affordable if a family spends less than 30% of its income on rent. The gap between income and rent means that many families pay more than 50% of their income on rent, making them "shelter poor." The cost for housing in the Boston metropolitan area remains extremely high with a standard modest apartment in Greater Boston currently estimated to rent for $1266.[3] Ninety percent of low income renter households with children are considered to be "shelter poor", which means that they can not meet other basic needs after paying for their housing costs.[4] In Massachusetts, data from 1998 indicates that 39% of all renter households were shelter-poor, with a median income of $11,000.[5]

Affordable housing assistance for low income families in Massachusetts is provided through several programs, including the state funded **Massachusetts Rental Voucher Program (MRVP**). MRVP provides rental assistance to eligible families that otherwise would be homeless or have to live in substandard, unsafe, unhealthy dwellings.

Implications of MRVP for child health and well-being

The Governor, the House and the Senate made several proposals that would change the current Massachusetts Rental Voucher Program. The potential health impact on children of each proposed component is summarized in the following chart.

Summary of Potential Impact of Proposed MRVP Program Changes on Child Health

Program Component	Program Component or Proposal	Direction, Type, Extent of Impact *
Time Limits	Impose time limits on assistance: 36-month limit on continuous use of benefits 60-month limit on lifetime use of benefits *(Governor's Budget)*	Direction – Negative for disenrolled families Extent -- Significant Proposal will: 1. Create difficulty finding safe, affordable housing. 2. Increase proportion of income spent on rent. *Impact:* *⇑ Food insecurity for those who reach limit by 50%* *⇑ Environmental exposures to known hazards*
Work Requirements	Require non-elderly, non-disabled household members to work or participate in approved alternative activities: 20 hours/week if youngest child is age 1-6 years 24 hours/week if youngest child is age 6-8 30 hours/week if youngest child is age 9 or older *(Governor's Budget)*	Direction – Negative for disenrolled families Extent -Unclear. Depends on proportion not already working or subject to TAFDC work requirements. Proposal will: 1. Require families new to work force to find child care 2. Not provide increase in affordable child care *Impact:* *Families disenrolled for noncompliance will be at risk of housing instability and food insecurity will increase 50%* *Children may be placed in substandard child care.*
Increased Frequency of Eligibility Redetermination	Re-determine eligibility semiannually rather than annually. *(Governor's Budget)*	Direction – Negative for disenrolled families Extent – Moderate Proposal will: Result in disenrollments of families Increase proportion of income spent on rent for disenrolled families *Impact:* *Families disenrolled will be at risk of housing instability and food insecurity, with associated adverse child health effects.*
Tenant Rent Contribution Cap	Subsidize households with mobile vouchers so that they pay no more than 40% of income on rent *(Senate Budget)*	Direction – Positive Extent -Significant. Proposal will: 1. Decrease the proportion of income spent on rent 2. Increase ability to meet other basic needs *Impact:* *⇓ Food insecurity and ⇓ Housing instability with associated positive child health effects*
Tenant Mobility	Gradually increase the number of mobile vouchers actually in use:[+] Require DHCD to re-issue mobile vouchers (within 90 days) that are ceded when households exit the program *(Senate and House Budgets)* No language regarding reissuing mobile vouchers *(Governor's Budget)*	Direction – Unclear. Depends on whether families with mobile vouchers are able to move out of high poverty areas. Extent – Unclear Proposal may: 1. Increase tenant mobility out of high poverty areas *Impact:* *Girls: ⇓ Risky behaviors, ⇑ School performance* *Boys: ? effect on behavior problems*

* See Section 1 for discussion of evidence on which these conclusions are based.

[+] Currently, due to budget constraints, mobile vouchers are not reissued when households exit the program.

Conclusions

Housing has a substantial influence on child health and well-being. Based on a review of the available evidence, we offer the following summary of the likely impact of proposed executive and legislative changes to the Massachusetts Rental Voucher Program:

1) Instituting time limits for housing subsidies in a region that lacks affordable housing puts children's health at risk due to budget trade-offs between housing expenses and other basic needs, such as food, and to exposure to substandard housing. These budget trade-offs could result in a 50% increase in food insecurity, which is related to malnutrition, poor growth and increased risk of illness. Living in substandard housing increases the risk of injuries, lead poisoning and asthma, among other effects.

2) Instituting work requirements will likely result in MRVP disenrollments for some families not currently subject to other work requirements, leading to housing instability and its adverse health and developmental effects. Without a supply of adequate, affordable child care, children will be at risk of poor health and development outcomes from exposure to substandard child care.

3) Increasing the frequency of eligibility redeterminations may increase the number of families who disenroll from the program, despite ongoing eligibility, leading to housing instability and increased household budget trade-offs between rent and other basic needs.

4) Proposals that decrease tenant rent share will decrease the need for trade-offs between housing and other basic needs, such as food or medical care.

5) Proposals that lead to increased homelessness or housing instability will result in increased education costs of $6700 for each child needing special education and $6800 for each child who must repeat a grade.

6) Insufficient data is available to predict direction and extent of effects of proposed changes to increase tenant mobility. Ability to move out of high poverty areas seems to have positive effect, particularly on girls. Actual impact of the proposed changes will depend to a substantial extent on whether families with mobile vouchers are able to move out of high poverty areas.

7) Children in families who are not able to use their mobile vouchers to move out of high poverty areas may still experience the health benefits of increased household resources available for other basic needs, especially if there is limit on the maximum family contribution to rent.

The Child Health Impact Assessment Working Group has identified important gaps in data available to analyze the impact of MRVP on families in the Commonwealth. The Department of Community and Housing Development should support the collection and tracking of data on MRVP enrollees so that the influence and impact of the program could be more directly monitored.

Introduction

A growing body of medical and public health evidence indicates that non-medical factors, such as housing, profoundly influence child health and well-being. Concerned about the health effects of these non-medical factors, a multidisciplinary working group of pediatricians, public health researchers, health economists and attorneys from several universities and hospitals in the Boston area developed a **Child Health Impact Assessment (CHIA)**. The emerging process of Child Health Impact Assessment offers an objective, evidence- and experience-based method through which to evaluate the implications of policy, regulations, and legislation for children's health and well-being. (See a more detailed description of the Child Health Impact Assessment concept and methodology in Appendix I)

The evaluations undertaken through CHIA are particularly focused on policy arenas outside the traditional realm of medicine, public health and health policy. Child health impacts are usually not considered in policy debates in these domains, making the effects on children invisible to policy makers. However, policies in the area of education, housing, immigration and naturalization, criminal justice, employment and income supports all will affect child health and well-being.

A child's physical living environment, comprised of the housing and neighborhood in which he resides, has a crucial impact on health and well-being. Stability, affordability and quality of housing as well as neighborhood quality determine the nature and direction of this child health impact. Sound housing policy should reflect not only economic and environmental factors; it should consider desirable child health outcomes as well. This paper reports the findings of a child health impact assessment conducted of proposed changes to the Massachusetts Rental Voucher Program (MRVP) for FY 2006. MRVP is a housing assistance/homelessness prevention program for Massachusetts residents that received new attention from affordable housing stakeholders during the FY2006 budget process. The report is comprised of 4 sections:

Section 1 summarizes the evidence on the numerous mechanisms through which housing and neighborhoods impact child health.

Section 2 outlines the components of the current MRVP program and proposed changes in the context of the broader issue of affordable housing and homelessness prevention in Massachusetts.

Section 3 presents an analysis of the likely health impact of individual program and proposal components, based on available data.

Section 4 provides a summary and recommendations that can be used to inform public discussion of MRVP policy.

1 The Influence of Housing on Child Health

There is extensive medical and social science research documenting the connection between housing and child health and well-being. The mechanisms through which housing can affect health can be separated into four categories:

- **Physical housing conditions**, such as lead paint exposure, rodent infestations or mold conditions, overcrowding and fall and burn hazards
- **Homelessness**, or **housing instability**
- **Affordability** of adequate housing
- **Mobility and Neighborhood** environment

The research has also looked at a number of child health and well-being outcomes, including:

- **Physical health**, such as asthma, injuries, immunization status
- **Mental health**, such as anxiety and depression
- **Behavior, development** and **educational attainment**

It is beyond the scope of this report to describe this vast literature. Rather, we will summarize the overarching themes of evidence that form the basis for child health impact assessment of the Massachusetts Rental Voucher Program.

Housing conditions have a substantial impact on child health

Physical housing conditions have been associated with many common chronic diseases of childhood. The most common of these are *asthma, lead poisoning* and *unintentional injuries*. Examples of substandard housing conditions that affect child health identified in the American Housing Survey conducted by the Department of Housing and Urban Development include:

- Rodent and cockroach infestation
- Lack of heat during the winter
- Leaks and related mold
- Uncovered radiators
- Peeling paint and lead paint
- Exposed wires
- Holes in walls
- Lack of running water in past 3 months

A 1999 survey of Boston families waiting for Section 8 vouchers indicates that they were significantly more likely to experience these substandard housing conditions than families living in voucher assisted apartments.[6] Children in families reporting two or more housing hazards were 2.5 times more likely to be in fair or poor health compared to children in families reporting fewer hazards. Almost half of parents in the study reported that their children had suffered health consequences due to these housing conditions. [6]

Children exposed to substandard housing conditions suffer an increased asthma burden

Asthma is a major cause of child morbidity in Massachusetts, particularly among low income children and is a leading cause of lost school and work days.[7,8] Homeless children and those living in poor housing conditions experience significantly higher rates of asthma, and require more frequent emergency room visits and hospital admissions due to asthma.[9,10]

There is substantial evidence linking childhood asthma to conditions such as infestations of cockroaches, rats and mice, poor ventilation and excess moisture and mold, which are associated with inadequate housing and overcrowding.[11-15] Both homeless families and those in unsanitary conditions have higher exposure to these hazards that cause or exacerbate asthma.[8,16-18] Studies linking asthma to residential exposures found that over 40% of asthma cases could be attributed to residential exposures such as cockroaches, dust mites, environmental tobacco smoke or pets in the home.[13] There is mounting evidence that cockroach exposure causes worsening of children's asthma. Children allergic to cockroaches who were exposed to them at home suffered: [12]

- 3.4 times more hospitalizations than other asthma patients
- 78 percent more unscheduled visits to health care clinicians
- More days of wheezing
- More nights awake struggling to breathe
- More missed school

If these conditions were eliminated, an estimated 800,000 cases of childhood asthma and an estimated $800 million could be saved in asthma health care costs of children under 16 years of age.[13,14]

Overcrowding and unsanitary conditions contribute to higher rates of infectious diseases.

Overcrowding and unsanitary conditions of the homeless and those at risk for homelessness propagate the spread of infectious diseases. Significantly higher rates of upper respiratory infections, gastrointestinal problems including diarrhea, ear infections

and skin infestations, such as lice and scabies, have been noted in homeless children when compared to their low income housed counterparts.[9,18-22] Rafferty[23] found:

- 42% of homeless children versus 22% low income housed children had upper respiratory infections
- 20% versus 5% had skin ailments
- 18% versus 12% had ear disorders
- 15% versus 4% had gastrointestinal problems.

These differences were attributed to crowding, use of bathrooms by many people, inadequate facilities to change and bathe infants, unsanitary conditions and chronic sleep disruption.[23]

Elevated lead levels in children have cognitive and behavioral effects

Lead contaminated house dust is a major source of lead exposure for children.[24-26] Older and rental housing remain the most common types of housing with lead hazards. In addition to having lead paint, rental housing built before 1978 often exhibits poor conditions, such as dampness and extremes of temperature, which precipitate paint degradation.[27,28] A national survey of young children indicated that children under the age of 6 were more likely to have an elevated lead level if they lived in housing built before 1960, in a rental home, in the Northeast, or with low household income.[27,29] Homeless children are twice as likely to have elevated lead levels as children in stable housing.[23,30]

Even low-level elevation in blood lead concentration has been associated with cognitive deficits, aggressive behavior, hearing dysfunction, tooth decay, delinquency, attentional problems, and low birth weight.[31] On average, studies show persistent effects of lead exposure, with an estimated 2.5 point drop in IQ for an increase from 10 μg/dl in blood lead to 20 μg/dl in blood lead.[32] This resulted in a loss of an estimated 2.5 million IQ points in children between the ages of 1 and 5 in the United States.[18] Lead exposure has also been associated with delinquent behaviors in adolescents.[33]

Injuries

The leading cause of morbidity and mortality for US children less than 20 years is unintentional injuries.[34,35] Injuries accounted for 37 percent of all childhood mortality in 2002 and 4,995 deaths in US children ages 1 to 15 years.[36] The majority of injuries among US children occur in and around the home.[37,38] Leading residential mechanisms of injury in children are falls, poisonings, burns, drowning and suffocations.[39] Examples of how injuries or even death could be related to substandard housing conditions are below:

- Falls from windows without appropriate window guards
- Death or injury from fires related to improper wiring, lack of smoke detectors, or use of space heaters due to difficulty affording heating fuel
- Burns from uncovered radiators, inappropriately high hot water heater temperatures or from using ovens as heating source

Reports of home heating burns are extremely common, either from wood stoves, kerosene heaters, floor furnaces or exposed home radiators, and these burns can cause serious life-long injury. In 1993, approximately 1800 children visited emergency rooms for burns related to non-vehicle radiators alone.[40,41] In 2002, 2670 people died in house fires.[42] Prior data indicates that 20% of deaths are of children less than 10 years of age.[43] Those who are poor, living in substandard homes and children younger than 4 years of age are at higher risk. [44,45]

Homelessness adversely affects the physical, mental and developmental well-being of children.

Homelessness is a multifactorial problem related to economic issues, such as high housing costs and low household income, individual issues, such as mental illness or substance abuse, and social policies, such as the availability and accessibility of housing assistance programs, and mental health programs. However, housing affordability is also a critical factor. A nationwide survey of 27 cities conducted by the U.S. Conference of Mayors found that lack of affordable housing is the primary cause of homelessness.[46] Thus, any discussion of the impact of housing on child health, must include a consideration of homelessness, which housing assistance programs are designed to prevent.

Homelessness among children and youth is defined by the McKinney-Vento Homeless Assistance Act, as those "who lack a fixed, regular, and adequate nighttime residence" (See Appendix II).[47] Homeless families may live in shelters, doubled up with family or friends, in cars or vacant buildings. Homeless families experience overcrowding, often with entire families living in one room, inadequate food preparation and storage facilities, unsanitary conditions, sleep deprivation, lack of transportation to get children to school and to health care appointments, and social and geographic isolation.

There are approximately 10,500 homeless families in Massachusetts.[5] The evidence indicates that the children in these families experience substantial adverse health outcomes in all three domains – physical health, mental health and behavioral development and education.

Homelessness puts children's physical health at risk

Homeless parents rate the overall health of their children worse than families with secure housing.[9,18] Karr found that homeless families rated the health of children as fair to poor 13% of the time, compared with 4% of housed families.[20] Both homeless families and those in unsanitary conditions have higher exposure to allergens that cause or exacerbate asthma, such as cockroach and rodent infestations, dust mites, inadequate heat, excess moisture, poor ventilation and mold.[8,17,18,48] Medical management of asthma or other health conditions may be more difficult for homeless than housed parents due to inability to purchase and/or store medications as well as limited access to electricity and refrigeration.[20,49] Furthermore, the effects of homelessness may be long lasting. Those who experienced multiple housing deprivations in childhood have 25% greater risk to have poor health and/or disabilities as adults, as well as increased mortality.[50,51]

The majority of the evidence from numerous studies indicates that homeless children are more likely to:

- Lack primary care, including the necessary immunizations and tuberculosis and lead screening [9,20,30,52]
- Experience hunger or food insecurity [22,53]
- Experience respiratory and other infections related to crowding in shelters or "doubled up" living situations[22]
- Have untreated or undertreated asthma[9,49]
- Have diarrhea[22,23]
- Experience growth delay[54]
- Experience more illness symptoms, including fever, ear infections, and asthma[9]

Many of these health affects can be attributed to altered patterns of health care related to housing disruptions. Homeless children are much less likely to have a regular source of pediatric care that would provide preventive primary care.[9,19] Studies indicate that about half of homeless children do not have adequate access to appropriate medical care, using the emergency rooms or hospitals as their only care.[55,56] Lack of transportation or telephone service also makes it difficult for homeless parents to make and keep medical appointments.[20] Furthermore, homeless children are more likely to wait until a health problem becomes urgent before seeking care, and therefore have significantly higher hospital admission rates than low income housed children.[20] Dental care is also often overlooked. Homeless children have significantly fewer dental visits and 10 times more dental caries than housed children.[20,57]

A recent study from Worcester, Massachusetts compared 293 homeless children with 223 low income, housed children (who had never been homeless). The researchers found the homeless children suffered:[9]

- Double the risk of having two or more emergency room visits in a year
- Twice as many hospitalizations
- Significantly worse overall health status

These health outcomes can affect the children in other ways. For example, multiple respiratory and ear infections can lead to hearing problems, language delays and even poor school performance. Malnutrition impairs cognitive and behavioral development. Emergency room visits and hospitalizations result in missed school, adversely affecting school performance.

Homeless children suffer mental health consequences

The evidence demonstrates adverse effects among homeless children, compared to their low income housed counterparts, in several mental health domains. Homelessness is predictive of increased anxiety and depression, as well as additional internalizing

behavioral problems.[20,23,58-60] Findings regarding externalized behavioral problems are mixed, with some researchers finding no significant differences between homeless and housed youths and others finding clinically significant differences.[57-60] Controlling for factors in addition to homelessness, behavior problems may also be associated with greater parental stress and family disruption, as well as harmful effects of poverty.[57,60,61]

Exposure to violence is substantial among homeless children. Although such exposure is detrimental to all children, homeless children are particularly vulnerable because they have few supports for recovery from such trauma. Children are further traumatized by exposure to substance abuse problems, family disintegration, lack of social supports and disruption of friendships, all of which are associated with frequent moves and unstable housing.[20,57,61] The data for homeless children is striking:

- Homeless children are more likely to experience anxiety, depression or other internalized behavioral disorders [23,57,58,60,62]
- Half of all children in shelters show signs of anxiety and depression [58]
- Homeless children are more likely to have alcohol dependency [63]
- 57% of homeless school-aged children have witnessed or been victims of violence in their neighborhoods or communities[64]
- Homeless children are more likely to have a mother who is a victim of domestic violence or sexual abuse [22]

Homeless children suffer behavioral, development and educational consequences

Although some studies suggest that low income homeless children do not have different developmental outcomes than low income housed children, the majority of the evidence suggests that homeless children experience adverse developmental and behavioral effects.[65] This research indicates that compared to other low income children, homeless children are:

- More likely to be developmentally delayed[58,66]
- More likely to have significant behavioral disturbances, like tantrums and aggressive behavior.[23]

Housing instability adversely affects child health and well-being

Housing instability refers to *involuntary* moves that result from inability to pay rent or other circumstances, such as domestic violence. Homelessness is the extreme end of housing instability, since those in unstable housing situations are never far away from being homeless. Because Massachusetts rents are so high, and low income family resources are often insufficient to cover increasing housing costs along with other living expenses, many families live on the brink of homelessness, where an unanticipated expense may result in the loss of housing. This lack of housing stability among the poor can cause or exacerbate stress and anxiety for both parents and children, whereas actual loss of housing has significant consequences for physical and mental health of children. Those

who are able to maintain an apartment may live in severe substandard conditions, give up food, medical or dental and still fear homelessness.[5,19]

For many Massachusetts families with children, housing subsidies may be the difference between having a home and homelessness, or between living in a substandard apartment with unhealthy housing conditions versus a permanent living space that meets health and safety regulations. Housing vouchers are one of several tools to decrease the negative consequences of housing instability and are positively correlated with increased employment and self-sufficiency.[67] In a five year study of families living in shelters, housing subsidies were an extremely strong predictor of housing stability for formerly homeless families. Independent of individual and family factors, formerly homeless families receiving subsidized housing are 20 times more likely to have stable housing than similar families without subsidies.[68]

A study of Worcester homeless children indicated that they moved 3.4 times in a year, compared to less than once among low income housed children.[59] Housing instability resulting from homelessness or housing disruptions is significantly correlated with a number of adverse educational outcomes:

- Missed school -- 40-50% missed 1 week in 3 months and about one-fifth missed more than 3 weeks in that period [18,19,22,23]
- Poor academic performance[19,20,23,58,69]
- Need to repeat a grade[22,23,58,69-71]
- Increased need for special education[22,58,72]

The high cost of educational failure

Homelessness and housing instability lead to adverse educational outcomes that result in substantial increased costs to the Commonwealth:

- **Special education**: The cost of special education was $13,542 per pupil, $6763 more than the cost of regular education.
- **Grade repetition:** The additional cost of repeating a grade is $6,800 per pupil.

Source: Massachusetts Department of Education data, 2003.

These adverse educational outcomes are likely related to frequent moves during periods of housing instability and the subsequent disruptions in schooling, as well as the cognitive and behavioral effects described above. These measures may also be affected by lack of transportation or parental fear of an abusive partner following children home from school.[22,57] Students who change schools frequently fall behind their stably housed classmates by up to one year of learning over 6 years.[73] The current climate of promoting high stakes educational testing, such as the MCAS, increases the importance of such poor school performance.

Unaffordable housing forces health harming family budget trade-offs

Increased economic demands on low income households with limited budgets result in trade-offs between fixed housing costs and other basic needs. Housing costs are usually the largest portion of household budgets and are usually paid first, limiting income available for other expenses such as food, clothing, health care, utilities or transportation. Although housing is considered affordable if a family spends less than 30% of their income on it, half of low income working families with children spent more than half of their income on rent. [74]

Families facing high housing cost combined with limited income experience a situation of "shelter poverty", which means they can not adequately meet their other needs after paying for housing.[5] Up to 90% of low income renter households with children are "shelter poor".[4]

Making ends meet?

Using a shelter poverty scale of housing affordability that takes into account other basic needs, such as food, clothing, transportation, and child care and varies with household size, type and income, University of Massachusetts researchers found that:

- A married couple with two children would need an income of $36,500 a year to afford the fair market rent of $560 for a 2 bedroom apartment in Pittsfield.[5]
- A similar family in the metropolitan Boston area would need $43,000 to afford the fair market rent of $940. If they both worked full time at minimum wage jobs, they would not be able to afford any housing after paying for all of their other household needs.

Confronted with unaffordable housing, families make these budget trade-offs between housing and important basic needs. A 2005 national study of housing costs indicates that compared to low income families who pay less than 30% of their income for housing, low income families who pay more than 50% of their income for housing spend:[1]

- 30% less on food
- 70% less on health care
- 70% less on transportation

Massachusetts families are not immune from these trade-offs. Data from the Boston metropolitan area in 2001 showed that 41% of food bank clients had to choose between rent and food and 26 % had to choose between food and medical care. [75]

Trade-offs resulting in food insecurity are particularly important for children's health and well-being.

- **"Heat or eat"**

  A study of Boston children between 6 months and 2 years of age presenting to Boston Medical Center found that growth decreased during winter months. Families without heat or threatened with utility disconnections were twice as likely to have children experiencing hunger or be at risk for hunger.[76]

- **"Rent or eat"**

  Children eligible for, but not receiving rent subsidies are up to 8 times more likely to demonstrate malnutrition and stunted growth.[21,77]

  A recent study of 11,700 families in six cities, including Boston, indicates that children in families receiving rent subsidies were significantly less likely to show growth impairment related to undernutrition compared to similar children who were not receiving such subsidies.[77]

Food insecurity resulting from housing cost trade-offs adversely affects child health

Poor children are five times more likely to experience food insecurity and hunger and have significantly lower intake of calories, iron, folate and other nutrients, compared with non-poor children. [78,79] Food insecurity is defined as not having access at all times to enough food for an active healthy life. Among food insecure families with children, half reported that they were sometimes not able to feed their children balanced meals and 25% reported that their children did not have enough to eat because the family could not afford adequate food. [80] A quarter of Eastern Massachusetts families using food banks reported that their children had skipped meals because there was not enough money for food.[75]

There is substantial evidence indicating that food insecurity poses a substantial threat to child health and well-being. Food insecurity is especially harmful for young children because they are in a period of rapid growth and brain development and are sensitive to even brief periods of nutritional deprivation.[81] A nutritionally inadequate diet makes children susceptible to an "infection-malnutrition cycle" by impairing children's immune function, making them more prone to infection and illness. [82] An inadequate food supply prevents children from fully recovering from weight loss or interrupted growth during illness episodes, leading to poor nutritional status that puts them at risk for a subsequent illness, creating a cycle of poor growth and increased risk of illness. Not surprisingly, homeless children are more vulnerable to food insecurity and hunger.[20,21]

Food insecure children:

- Are 2-3 times more likely to be in fair or poor health or chronically ill[82-84]
- Are 30% more likely to be hospitalized by age 3 years[82]
- Are more likely to show poor growth [54,81,85,86]
- Score lower on measures of physical and psychosocial functioning[87]
- Have deficits in cognitive and behavioral development that affect school performance[83,88-94]

Housing mobility and the neighborhood environment

Neighborhoods affect families and children through a number of mechanisms, including: concentration of poverty, neighborhood socioeconomic composition, physical condition of buildings and streets, residential stability, unemployment, family composition as well as social relationships and norms.[95-97] Social experiments designed to test the impact of housing mobility and the neighborhood environment have yielded interesting and somewhat mixed results over the past decade.[98-101] The basic tenet of this research is to test empirically the outcomes of housing mobility, specifically, whether mobile vouchers increase the number of people that move from neighborhoods with a high concentration of poverty and social disorganization to neighborhoods where both material and social resources are more accessible, and how such moves affect family health and well-being.

The most well known of these mobility studies is the "Moving to Opportunity" (MTO) project.[102] This demonstration project, involving 5 large metropolitan areas (Baltimore, Boston, Chicago, Los Angeles and New York), utilized a random experimental design to test whether mobile vouchers combined with housing search and counseling services to help people move to higher socioeconomic neighborhoods would improve life chances over project-based housing or regular Section 8 assistance.[98]

These research studies are especially pertinent for this analysis since several were focused on Boston. The evidence suggests mobile vouchers have not been shown to make significant improvements for all families. This is thought to be due in part to the fact that many families are not able to use mobile vouchers to move out of high poverty areas. There is also some difficulty distinguishing between the specific, direct effects of mobility and the impact of housing assistance generally.[103] Overall, the research suggests that when families move from neighborhoods with high concentrations of poverty (e.g., more than 40%) to areas of lower poverty or mixed income, their children experience a number of positive outcomes, but some data suggest differences by gender.

- Less exposure to violence and victimization from crime,[19,98,99,104] resulting in reduced stress and stress-related disorders[105]
- Improved asthma[98,106]
- Decreased accidents and injuries[98,99,104,106]
- Decreased behavioral problems – some data indicate particular effects among boys[106,107], while other indicate particular effects among girls[108]
- Decreased anxiety and depression, some data indicate particular effects among boys [107,108]; while other data indicate particular effects among girls [108]
- Improved school performance, including increased IQ, math and reading test scores and decreased drop out rates[98,101,109,110]
- Decreased risk behaviors, such as cigarette smoking and dependency, potentially more so among girls[103,107,108,111]

There is also some indication that the short term positive impacts may give way to longer term impacts that are more mixed, showing different direction of effects for boys and girls.[103,112] This data suggests better outcomes for girls than for boys.

An important caveat to this research is that families with mobile vouchers are not universally successful in finding appropriate housing where a landlord will accept the voucher, particularly in rural areas.[4] HUD data suggests that a family's ability to locate housing that will accept their voucher varies from 37-100% nationally and is 51-60% in Boston.[113,113]

2 Massachusetts Rental Voucher Program and Affordable Housing in Massachusetts

The importance of affordable, safe housing for child health and well-being outlined in the previous section highlights the need for a consideration of the health effects of policies made outside the medical and public health realms. Because key policy decision makers do not always understand or consider the impact of such policies on children, they miss the opportunity to enhance the positive effects on children and minimize the negative ones. The new approach of a Child Health Impact Assessment provides a framework for such a consideration.

The current public debate about the Massachusetts Rental Voucher Program offered an opportunity to evaluate these impacts using this new approach. MRVP is one of several federal and state funded programs that were designed to provide affordable housing for low income Massachusetts residents. (See Appendix III) These include the federally funded Housing Choice Voucher Program, commonly known as Section 8, and the state-funded Residential Assistance for Families in Transition (RAFT) and public housing. This analysis focuses on the MRVP, but the other affordable housing programs will be briefly reviewed in order to place MRVP within the overall context of such programs.

The Massachusetts Context: Affordable Housing Demand and Supply

Massachusetts is one of the least affordable states for housing in the United States.[2] Housing is deemed affordable if a family spends less than 30% of its income on rent. The cost for housing in the Boston metropolitan area remains extremely high with a standard modest apartment in Greater Boston currently estimated to rent for $1266.[3] Latest census figures show that 36.6% of Massachusetts households pay more than 35% of their income for housing. Families with children have the highest incidence of housing cost burdens.[1] Over 236,000 households with income at or below 50% of state median, paid over half their income for housing.[114] After paying rent, these families have little disposable income available to meet other basic needs such as food, health care, or child care.

In order to afford the average 2 bedroom rental unit, an hourly wage of $20.93 is required.[2] That wage is out of reach for low income families. The gap between rents and incomes remains wide. (See Table 1 below.) At a minimum wage of $6.75 per hour, a renter in Massachusetts must work 124 hours per week to afford a 2 bedroom unit. This gap in affordability is highlighted in a recent US Conference of Mayors survey that shows that Boston has less than half the number of affordable housing units as there are families that need them.[46]

According to the Commonwealth Housing Task Force, one of the critical barriers to economic development in Massachusetts is lack of affordable housing, which is especially difficult for households struggling on low and moderate incomes.[115] Many working families

cannot afford to pay for housing. The recent 2004 City of Boston Homeless Census found a total of 3,069 men, women and children in families in need of emergency shelter including 1,412 living in congregate and scattered site shelters. This reflects a 91.7% increase in the number of homeless families from eleven years ago.[116] An estimated 10,000 families will be homeless during 2005, but Massachusetts family shelters will not be able to accommodate even half of these.[114]

Table 1: Fair Market Rents and Average Median Income in Massachusetts by Metropolitan Area

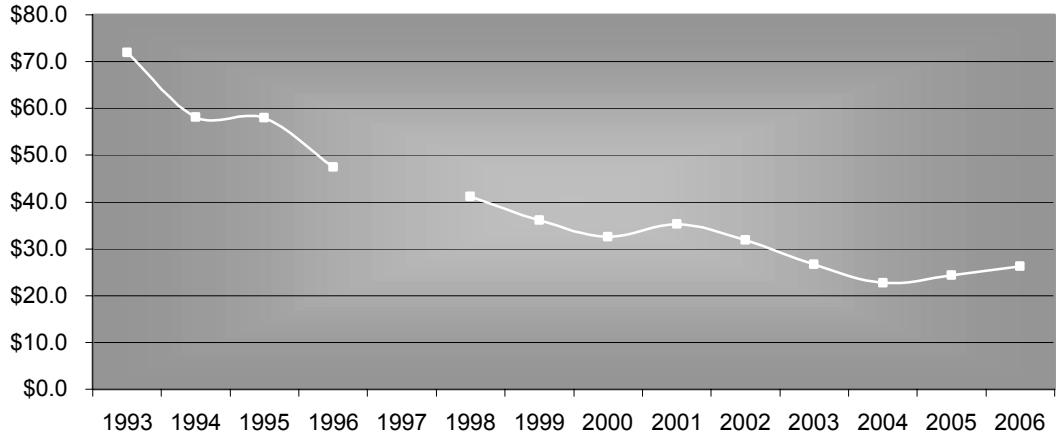
Metropolitan Statistical Area	Fair Market Rent, 2005 (40^{th} percentile of rents) for 2 bedroom rental	Area Median Monthly Income, 2004
Massachusetts	**$1,088**	$ 6267
Barnstable-Yarmouth	$ 919	$ 5150
Boston	$ 1266	$ 6883
Brockton	$ 1086	$ 6075
Fitchburg-Leominster	$ 784	$ 5183
Lawrence	$ 1009	$ 6292
Lowell	$ 1102	$ 6667
New Bedford	$ 677	$ 4583
Pittsfield	$ 654	$ 4742
Fall River-Providence-Warwick, RI	$ 845	$ 5000
Springfield	$ 772	$ 4950
Worcester	$ 840	$ 5775

Sources: U.S Department of Housing and Urban Development,[3] National Low Income Housing Coalition[2]

Massachusetts Rental Voucher Program

The Massachusetts Rental Voucher Program (MRVP) was established in 1992 to merge the Chapter 707 Program and the State Housing Voucher Program, two longstanding housing assistance programs for low income state residents. Through MRVP, the legislature aimed to "provide a permanent improvement in the lives of individuals and families by offering both tenant-based and project-based rental subsidies" while simultaneously limiting expenditure on rental assistance.[117] Since 1992, the legislature has decreased funding for MRVP (see Figure 1). In fiscal year 2005, the state budget appropriation for MRVP was approximately $24.3 million, down from approximately $88.5 million in 1992. Funding decreases correspond with reductions in the number of households assisted, from a high of 14, 886 in 1993 to the current low of 4,715 households assisted in 2005.[118] MRVP is authorized to serve approximately 7,500 households, but only serves 4,715 due to budget constraints. Recent, severe cuts in the Housing Choice Voucher Program (formerly known as the Section 8 program) combined with steady increases in state rents have caused MRVP to regain the attention of stakeholders in the program: low income tenants, housing advocates, government bodies administering the program, and state policymakers.

Figure 1: Annual Funding for the Massachusetts Rental Voucher Program, 1993 – 2006 (in millions)



*1997 data missing; 2006 data based on Massachusetts FY2006 Conference Report, pending approval.

Sources: McCormack Institute Center for Social Policy Research,[118] The General Court of the Commonwealth of Massachusetts[119]

Current MRVP Program Description

MRVP, administered through the Department of Housing and Community Development and local housing authorities, is authorized to provide service to almost 7,500 households but is unable to do so because of budget limitations. Long waiting lists for MRVP vouchers have been closed for some time. MRVP participants receive rental assistance either through a *project-based voucher,* or a *tenant-based voucher* (also known as a mobile voucher). Both forms of assistance subsidize tenants to live in rental housing throughout Massachusetts, provided that the housing meets habitability criteria set forth in local sanitary laws. To be eligible for MRVP, tenants must have incomes that do not exceed 200% of the federal poverty level. Homeless families are given priority for participation. Using a project-based voucher, a household pays a maximum of 30-35% of its income to rent a unit in a housing development whose owner has contracted with the governing local housing authority (LHA) to participate in MRVP. Project-based vouchers are not portable; if the household vacates the unit, it effectively exits the program. Currently, there are 3,171 project-based vouchers in use.

A household receiving tenant-based assistance can use its voucher in any private apartment in Massachusetts where the landlord will accept it. Families using tenant-based vouchers must pay at least 30% of their income toward rent, but there is no upper limit on the percent of income they must contribute. It is unknown what percent of renters using tenant-based vouchers pay more than 35% of their income toward rent. If the household relocates or has a change in income or composition, the LHA may re-determine the value of the voucher. Currently, there are 1,544 tenant-based vouchers in use. Due to budget constraints, mobile vouchers ceded when households exit the program are not reissued.

Currently, eligibility for the program is reviewed annually. If the local housing authority (LHA) finds the household ineligible at the time of review because of an increase in net income, or failure to comply with the terms of its lease, the LHA can terminate the household from MRVP. The owner of the rental unit can also decide to exit MRVP at the time of the annual review. There are no immigration-based restrictions on eligibility.

Table 2: Massachusetts Rental Voucher Program Highlights

Program Component	Program Details
Funding and Costs	$24,283,345 in FY2005
	Funds 4,715 vouchers (~60% of the 7,483 authorized vouchers)
	3,172 project-based
	1,543 mobile/tenant-based
	Starting in 2002, due to budget shortfalls, DHCD has not reissued mobile vouchers that have been ceded by households exiting the program.
Administration	Administered at state level by Massachusetts Department of Housing and Community Development (DHCD)
	Administered at local level by Local Housing Authorities (LHAs), which comprise:
	Public Housing Authorities
	Regional Non-Profit Agencies
	Administrative fee: $25/voucher/month paid to LHA
Requirements for Initial Eligibility	Applicant household must:
	Establish Massachusetts residence
	Have net income ≤ 200% Federal Poverty Level
	Have total assets ≤ 1.5 times gross income OR $15,000 (whichever amount is greater)
	Not owe a debt to any LHA, unless a payment plan has been established
	Not include any members who currently use drugs or have used drugs within 12 months preceding application
	Not include any members who have engaged in criminal activity
Requirements for Continuing Eligibility	Households must re-establish eligibility (see above) annually
	Households must inform LHA of any changes in income or composition within 30 days of change
Mobile/Tenant Based Vouchers	Assistance is portable throughout Massachusetts
	Lower limit on household expenditure on rent is 30% of income
	There is no upper limit on household expenditure on rent as percent of income
	Household uses voucher to offset rent in private housing
	Household must ensure that the desired unit complies with local sanitary laws
	LHA determines a fixed value for each voucher based on household size, composition, income, and location of housing where voucher will be used
	If a household cedes its voucher, the LHA could re-issue the voucher to another eligible household, but currently there is administrative freeze prohibiting this option.
Project Based Vouchers	Assistance is not portable
	MRVP household pays maximum of 30% of income towards rent if utilities are paid separately or 35% of income towards rent if utilities are included
	Rental property owner contracts with the LHA to designate units for lease by MRVP households
	Rental property owner must ensure that designated units comply with local sanitary laws to be eligible to contract with LHA
	If MRVP household leaves the leased unit, the owner of the unit can terminate its contract with the LHA and rent the unit at market-rate

Sources: MRVP regulations 760 CMR 49. Available online at www.mass.gov/dhcd.

Program Utilization: Who uses MRVP currently and how?

The children most likely to experience the health impacts of MRVP policy are those that belong to families currently participating in MRVP and those whose families are experiencing homelessness, housing instability or other housing problems.

Households participating in MRVP

Interviews with local housing authorities (LHAs) conducted by the Child Health Impact Assessment Working Group provides insight into the types of households participating in MRVP and their experiences with the program.[ii] It should be noted that the availability of data on program participants and program utilization is not consistently available. The Department of Housing and Community Development and the local housing authorities administering MRVP are not required to track this information and are not provided with incentives to do so. Key data about MRVP households, gathered from LHAs, is summarized below:

- The majority of families participating in MRVP have children.
- Nearly all of MRVP households with children were homeless or faced severe housing cost burden (>50% of income spent on housing costs) prior to program participation.
- About half of MRVP households rely on wages as a primary source of income, while the other half relies on public benefits such as Transitional Aid to Families with Dependent Children, Supplement Security Income, Social Security, or Social Security Disability Income.
- Nearly all MRVP households participate in the program for more than five years
- Nearly all mobile voucher holders rent apartments at market rates (as opposed to apartments subsidized through funds separate from MRVP).
- Nearly all of MRVP households with mobile vouchers do not move from low income areas to higher income areas.
- About half of project-based units are in mixed-income developments (as opposed to low income developments).
- The majority of project-based units are in developments that are accessible by public transportation.

A 2001 study by the University of Massachusetts' McCormack Institute surveyed 1,165 families with children staying in 33 homeless shelters across the state.[120] The study's findings about the characteristics of these families are summarized in the table below:

[ii] See Appendix IV for LHA survey methodology

Table 3: Homeless households

Household Characteristics of Sheltered Homeless Families	
Head of household currently employed	13%
Head of household single	85%
Mean age of children in household	7.5 years
Education of head of household	
No high school degree/GED	48%
High school degree/GED	35%
Some college	14%
College degree	3%
Prior residence	
Rented home	26%
Doubled up with family or friends	31%
Other shelter	25%
Family has one or more special health care needs	10%
One or more members has a medical impairment	7%
One or more members has a mental health impairment	7%
One or more members has a cognitive/development impairment	2%
Family has some health insurance	96%

Source: U Mass McCormack Institute[120]

Households experiencing housing instability

Although they are not homeless, more than 100,000 non-elderly low income families in Massachusetts are experiencing problems with the quality or affordability of their current housing and are likely to be eligible for MRVP. To the extent that these families are in search of new housing that is both affordable and healthy, they will be affected by MRVP policy changes. Data collected by the Department of Housing and Urban Development and the University of Massachusetts McCormack Institute describes this population and the types of housing problems they face:

Table 4: Massachusetts Renter Households[iii]

	< 30% of Median Income 83,510 Families		30-50% of Median Income 62,660 Families	
Family Characteristics	Small Families 2-4 members	Large Families > 5 members	Small Families 2-4 members	Large Families > 5 members
Live in overcrowded, unaffordable or substandard housing with insufficient plumbing	76.1%	87.1%	65.8%	62.7%
Spend more than 30% of income on rent	71.9%	74.2%	60.7%	43.9%
Spend more than 50% of income on rent	55.9%	52.4%	14.7%	6.7%

[iii] Nearly all of the families described here with incomes less than 50% of the Massachusetts median income ($74,400/year) are financially eligible for MRVP because they are at or below 200% of the Federal Poverty Level. Only the families that have fewer than 4 members AND have income that is greater than or equal to 43% of the Massachusetts median may not satisfy the financial eligibility requirements for MRVP.

Source: McCormack Institute [5]; Department of Housing and Urban Development[121]

Proposed Changes to MRVP for Fiscal Year 2006

The Governor, Senate and House budgets introduced important proposals for changes in MRVP for FY 2006. The proposed changes and the final budget language adopted are described in Table 5. (See Appendix V for more details.)

Table 5: MRVP in FY2006 Budget (Line Item 7004-9024) --Key Budget Proposals and Final Budget Language

Program component	Proposed changes	Senate-House Conference Committee Proposals
Funding	Increase funding by $2 million to $26,283,345 *(Senate and House Budgets)*	$26,283,345
Work Requirements*	Require non-elderly, non-disabled household members to work or participate in sanctioned alternative activities: 20 hours/week if youngest child is age 1-6 years 24 hours/week if youngest child is age 6-8 30 hours/week if youngest child is age 9 or older *(Governor's Budget)*	No work requirements
Time Limits*	Impose time limits on assistance: 36-month limit on continuous use of benefits 60-month limit on lifetime use of benefits *(Governor's Budget)*	No time limits
Tenant Rent Contribution	Subsidize households with mobile vouchers so that they pay no more than 40% of income on rent *(Senate Budget)*	Subsidize households with mobile vouchers so that they pay no more than 40% of income on rent
Tenant Mobility+	Gradually increase the number of mobile vouchers in use: Require DHCD to re-issue mobile vouchers (within 90 days) that are ceded when households exit the program *(Senate and House Budgets)* No language regarding reissuing mobile vouchers *(Governor's Budget)*	Require DHCD to re-issue mobile vouchers (within 90 days) that are ceded when households exit the program
Administration	Increase administration fee from $25/voucher/month to $40/voucher/month *(Governor's and Senate Budgets)*	Increase administration fee to $32.50/voucher/month
Eligibility Re-determination Period	Re-determine eligibility semiannually rather than annually. *(Governor's Budget)*	Re-determine eligibility annually

Sources: Fiscal Year 2006 Conference Report http://www.mass.gov/legis/06budget/conference/fy06conference.htm; House and Senate Budget Proposals http://www.mass.gov/legis/06budget/house/, http://www.mass.gov/legis/06budget/senate/index.htm

* Component does not exist in the current program

+ Proposed change affects mobile/tenant-based voucher holders only

Other Affordable Housing Programs in Massachusetts

Housing Choice Voucher Program (Section 8)

Created in the 1970's, the federally funded "Section 8" Housing Choice Voucher Program is the main form of federal housing assistance that enables senior citizens, people with disabilities, and families with incomes less than 50% of the area median income (AMI) to rent modest housing in the private market.[122,iv] There are various types of vouchers available. This section describes the tenant-based voucher, which is the most common type. These vouchers allow participants to spend no more than approximately 30% of household income on rent. Nationally the gap between rents and incomes grew faster between 2001 and 2002 than at any time in more than 30 years and is particularly high in Massachusetts.[123]

Section 8 assistance does not begin to satisfy the housing demand among eligible families in the state. There are 71,492 households, the majority of which include children, with authorized Section 8 vouchers in Massachusetts.[124] There are over 50,000 households on one of the several statewide waiting lists for Section 8.[125] A 2004 US Conference of Mayors' report indicated that the Boston Housing Authority alone had 4500 families on the Section 8 wait list.[46] Households on these lists wait an average of 2 years for a voucher; in some high-need localities like Boston, the wait exceeds 4 years.[102]

In 2004, a change in the Section 8 funding formula resulted in the estimated loss of approximately 80,000 vouchers nationally in FY2005[126] and in reductions in payment standards for families already receiving assistance. Within Massachusetts, 2,833 vouchers were cut, resulting in an increased number of families on the waiting lists who could not obtain a voucher, compelling most housing authorities to close their waiting lists to new applicants indefinitely. [127] The reduced level of assistance to those households remaining in the program made it impossible for many of them to continue to use their vouchers in the private market. According to one estimate, the total effect of HUD's FY2005 voucher reductions was that 4,800 fewer Section 8 vouchers were used in Massachusetts in 2005 than in 2004.[128] The Bush administration's proposed budget for FY 2006 temporarily restores 1416 vouchers to Massachusetts, but also calls for sharp cuts in Section 8 funding in the next five years, predicted to result in loss of vouchers for over 10,000 families in Massachusetts by 2010.[127]

Rental Assistance For Families In Transition (RAFT)

The RAFT program is a homelessness prevention program that was approved by the Legislature and the Governor in 2004 to replace several state programs that allocated funds for first month's rent, disaster benefits, rent/mortgage arrearages, utility arrearages, security deposit guarantees, and appliance repair/replacement.[129] The purpose of the program is "to provide short term, limited financial assistance to enable families to retain housing, obtain new housing, or otherwise avoid homelessness." [130] RAFT can also be used for moving expenses. Distribution of RAFT funds is based on a first-come first-serve

[iv] Some specific categories of non-elderly, non-disabled families up to 80% of area median income are eligible to participate in the program. See 24 CFR 982 (A).

basis. It was approved as a one-year pilot program and received appropriations of $2 million. From September 2004 through March 2005, 1300 Massachusetts families were assisted by the RAFT program.[130]

RAFT is administered at the state level by the Department of Housing and Community Development (DCHD). The DCHD contracts with 9 regional nonprofit housing agencies (RNPs) that administer the program at the local level. Eligible families, with incomes less than 130% of the federal poverty level and that include a child under age 21 years or a disabled person, can receive up to $3000 in flexible funding. An applicant household must demonstrate that receipt of RAFT funds is sufficient to allow it to avoid homelessness. In general, this means that households are ineligible if they are paying more than 50% of their income for housing, although RNPs can make exceptions to this rule. Eligible families can access program funds more than once, but cannot exceed $1,500 within a twelve-month period.

Public Housing

Public housing refers to residential developments that are funded either by the state or the federal government and are administered locally by public housing authorities (PHAs). Massachusetts has approximately 90,000 units of public housing, of which 49,368 are state-aided and 40,362 of which are federally-aided.[131] Substantial variation in eligibility rules exists across the two categories of public housing.

Massachusetts' state-aided public housing is open to all households whose income is at or below 80% of Area Median Income (AMI), regardless of the immigration status of household members. Preference is given to households who are homeless, have been displaced by public action, or are facing an emergency situation such as domestic violence or medical crisis. Households with children pay approximately 30% of their income towards rent when residing in public housing. There are no work requirements or time limits on participation in the program for households that remain eligible.

Most federally-aided public housing is available only to households who have at least one household member with legal immigration status and whose income is at or below 80% of AMI. Preference criteria are determined by individual public housing authorities. Tenant rent share is usually 30% of adjusted household income (income less allowed deductions for dependents) for participating households with children where all members have legal immigration status. The tenant rent share is significantly higher for mixed immigration status households.[132] Adult residents of federally-aided public housing must participate in at least eight hours of work activity per month, unless they are elderly, disabled, pregnant, caring for young children or disabled household members, or live in a household where at least one member receives public benefits. Most Massachusetts households residing in federal public housing qualify for one or more of these exemptions, and therefore do not have to work as a condition of continued residence.[133]

3 Implications of Current and Proposed MRVP Components for Child Health and Well-being

Time Limits

Proposed policy change: Implementation of a 36-month limit on continuous MRVP voucher use and a 60-month lifetime limit.

The imposition of such time limits can be expected to increase the numbers of families who leave the program. It is unclear whether families who must give up MRVP vouchers due to time limits will be able to afford safe, stable housing. Whether families will be able to obtain safe, stable housing depends on several factors, including:

- Availability of affordable, decent housing in their area
- Current employment and ability to increase earnings based on prevailing local and state-level economic conditions
- Capacity to overcome barriers to sustained employment
- Ability or preference to move to areas with safe, more affordable housing

Detailed modeling of trends in these factors is beyond the scope of this report. However, the factors currently contributing to the affordable housing crisis in Massachusetts that makes rental assistance necessary are not likely to be affected by the imposition of time limits. Current evidence summarized in Section 1 suggests:

- Those families who are unable to obtain stable housing or who cannot pay market rate rents will be at risk for **housing instability and homelessness,** which has important implications for child health and well-being.
- Due to inability to afford decent housing, families may be forced to accept **substandard housing conditions**, putting their children's health at risk.
- Families who must pay an increased proportion of their income for rent will face the **household budget trade-offs** with other basic needs, such as food and health care.

Public assistance through cash and in-kind programs has been demonstrated to have a direct link to food insecurity. For example, following PROWRA, households of immigrants subject to restrictions in the legislation who lost eligibility to cash assistance, food stamps, and Medicaid experienced significantly higher rates of food insecurity than other similar immigrant households. Recent research on these effects documents that "a 10 percentage point cut in the fraction of the population that receives public assistance increases the fraction of the population that is food insecure by around 5 percentage

points."[134] For some households receiving/eligible for MRVP, this may be their only form of public assistance. Thus, households that lose MRVP benefits through work requirements, time limits, or eligibility redeterminations can expect to experience nearly 50% higher rates of food insecurity.

Time Limit Implications

- Families whose housing vouchers are discontinued due to time limits will likely have difficulty finding safe, affordable housing in the Massachusetts rental market, placing children's physical, mental and developmental health at risk due to housing instability or homelessness.
- Families will likely have to increase the amount spent on rent, putting their children's health at risk due to food insecurity and its related health effects or due to substandard housing, which increases the risk of injuries, infections, asthma, and lead poisoning.

Work Requirements

Proposed policy change: Introduction of work requirements for non-elderly, non-disabled household members. The amount of work varies from 20-30 hours per week depending on the age of the child. Parents with children less than 1 year of age are exempt.

The health effects of work requirements in housing subsidy programs have not been directly studied. However, there are several studies examining the impact of work requirements on children's health as a component of welfare reform, which offer insight into how MRVP work requirements might be experienced by low income families. The primary mechanisms through which work requirements would affect child health are through sanctions for non-compliance and unmet need for affordable, appropriate day care, including sick care for acutely ill children. Among low wage workers with limited leave, child illness is associated with difficulty finding and keeping a job.[135,136]

Welfare sanctions harmful to children

Under welfare reform many states adopted federal guidelines mandating work for parents of children older than 1 year of age in order to receive cash benefits.[137] Approximately one quarter of states adopted more strict guidelines, requiring that parents of children older than age 3 months work.[137] Although states were able to provide exemptions to disabled parents or those caring for a disabled family member, most states adopted relatively restrictive criteria. In Massachusetts, work exemptions were initially limited to parents whose children met SSI disability standards, a practice that was challenged in court.[138] Many chronically ill children who do not meet strict SSI disability criteria have significant health needs and require parental participation in frequent medical visits and involved home medical regimens to keep them healthy. Failure to comply with work requirements can result in sanctions – a reduction or termination of benefits.

Chronically ill and young children are particularly vulnerable to such sanctions. Two studies of children and welfare reform, one focused on young children and one focused on chronically ill children highlight relevant data:

- Child health is often cited as a barrier to parental employment among low income families.[139,136,140-142]

- Young children whose families experienced welfare sanctions were 50% more likely to experience food insecurity (insufficient food for adequate growth), and were 30% more likely to be hospitalized.[143,144]

- 60% of welfare recipients with chronically ill children have missed work due to their child's illness, placing them at risk for sanctions.[135]

It is reasonable to expect that parents of chronically ill children may find it difficult to meet the proposed work requirements in MRVP, making them vulnerable to losing their housing.

Affordable, quality day care needed to comply with work requirements is not consistently accessible to low income families.

The proposed MRVP work requirements also raise the question of child care availability and affordability for low income families. Although Massachusetts has better child care availability than many other states, there is still a shortage of affordable day care, especially for infants and toddlers.[137,145,146] Across the country, states cannot provide child care subsidies to all families who meet the eligibility criteria, resulting in waiting lists and co-payments to restrict access to limited child care funds.[145]

- As of December, 2004, Massachusetts has 13,795 children eligible for subsidized child care on the wait list, waiting for funds and/or slots to become available.[147,148] Almost 50% of these waiting children are infants and toddlers.[147]

- Poor neighborhoods in Boston where families can least afford child care have the longest waiting lists for subsidized child care.[148]

- Average annual child care fees for young children is about $5000, more than $6000 in 11 states and is even higher for infants.[149,150]

Inadequate or substandard child care poses a variety of risks, including injuries, communicable diseases and non-compliance with prescribed medical regimens.[136] The gap in available care is particularly striking for poor families who work non-day schedules since most child care providers are unavailable during these off hours.[137,142,145,151,152] For many families, this means that they will have to rely on unregulated daycare, which is more available during non-standard hours. This contributes to the use of lower quality day care by poor families, a factor that increases the risk of deleterious child health and developmental outcomes.[152,153]

Most low income employees work in sectors characterized by limited parental benefits or leave policies.[154,155] National data suggest that employed poor mothers and mothers of chronically ill children have less sick leave than other mothers do.[136] This disparity between the amount of illness poor families experience and the degree of work flexibility available to them, means parents are faced with the difficult decision of what to do when their child is sick or needs to go to the doctor and they are unable to take time off from work.

In the case of chronically ill children, flexibility in parental employment as well as appropriate child care are essential to maintaining reasonable health. For example, children with asthma who adhere to their medical regimen are more likely to have their disease well controlled.[156-158] Depending on the age of the child, parental time and

supervision is needed for the recognition of symptoms, administration of appropriate treatments and attendance at medical visits.[159,160]

Work Requirement Implications

- Data on work requirement sanctions in other programs suggest that particular groups of children, such as young children and chronically ill children will be vulnerable to adverse health consequences, including food insecurity and related poor growth and interruptions in health care.
- Depending on the adequate supply of affordable, appropriate child care, children whose parents do not have adequate child care will be subject to adverse health and developmental outcomes resulting from lower quality child care.

Shortened eligibility redetermination periods

Proposed policy change: Decrease redetermination eligibility period from every 12 months to every 6 months.

There are currently no specific data available on the impact of varying eligibility redetermination periods on the participation of eligible families in housing subsidy programs or the impact disenrollments has on their housing stability. However, there is evidence from two other programs serving low income families, Medicaid and the State Children's Health Insurance Program (SCHIP), that shortened redetermination periods result in increased levels of program disenrollments.[161-164]

- A recent study of enrollment patterns in the SCHIP highlighted administrative errors, miscommunication and difficulty meeting procedural requirements as contributors to disenrollments.[165]
- Passive reenrollment, in which families do not have to return a renewal form unless changes have occurred that could affect eligibility status, decreases the percent of children who are disenrolled at redetermination.[163,166]

A report on SCHIP concluded that since computer-generated redetermination letters were thought to be confusing to parents, current "systems are insufficient to ensure that eligible children retain the coverage for which they are eligible and that systems need to improve their ability to maintain current contact information and convey, in simple terms, the steps families must complete to renew their child's coverage." [162]

Although health insurance and housing subsidy programs are designed to meet different needs, they share a focus on similar populations and overall approaches to redetermination. The goal of maintaining program integrity through more frequent redetermination should be balanced by an understanding of the impact of increasing housing instability described in Section 1.

Shortened Redetermination Period Implications

Shortened redetermination periods may lead to disenrollments from MRVP due to procedural requirements, placing their children at risk due to adverse impact of housing instability, homelessness, and budget trade-offs, which results in child food insecurity.

Tenant Rent Contribution

Proposed policy change: Adjust voucher values so that families pay no more than 40% of their income for rent.

Massachusetts has the distinction of being one of the most expensive states for renters in the country.[2] In Massachusetts, the fair market rent varies from $654 in the Pittsfield metropolitan area to $1266 in the Boston area.[3] Families using MRVP project-based vouchers pay no more than 30-35% of their income on rent, depending on whether utilities are included. In contrast, families using tenant-based vouchers must pay at least 30% of their income on rent, but there is no upper limit. The Senate budget proposal to adjust voucher value so that a family would pay no more than 40% of their income on rent has important implications.

Increased economic demands on the limited budgets of low income households will result in trade-offs between fixed housing costs and other basic needs, such as food, clothing, heat and health care. Ninety percent of low income renter households with children are considered to be "shelter poor", which means that they can not meet these other basic needs after paying for their housing costs.[4] In Massachusetts, data from 1998 indicates that 39% of all renter households were shelter-poor, with a median income of $11,000.[5] For families with 3 or more people, 50% of them were shelter poor.

The budget trade-offs low income families face can be expected to affect child health through several mechanisms documented by evidence summarized in Section 1. Families with high housing costs:

- Will have less available income for food, contributing to food insecurity, which has numerous adverse effects on child health and well-being;
- Will have less available income for out-of-pocket health care costs and may forgo health insurance if it is available because they can not afford the premium;[19,105,167]
- Will be more likely to fall behind in rent or utility payments, contributing to housing instability, including evictions, doubling up with friends or family, or becoming homeless;
- Will be more likely to accept living in substandard conditions because they cannot afford to move, putting their children at risk of unintentional injuries.

Thus, housing program provisions that will limit family housing costs through capping family's rent contribution can be expected to positively affect child health. If the MRVP budget is inadequate to cover the costs of capping current voucher holder's rent

contribution, the funding available for additional vouchers would be reduced so that fewer families could benefit from MRVP. This possible reduction in MRVP vouchers could have a negative impact on child health.

Tenant Rent Share Implications

- There is strong evidence to indicate that low income families with high housing costs must make trade-offs between their housing expenses and paying for other basic needs, such as food.
- Children in families who lack housing subsidies are more likely to experience food insecurity and undernutrition which is associated with several adverse outcomes – chronic illness, poor growth, malnutrition, increased infections, increased hospitalizations, iron deficiency anemia and impaired cognitive development.

Tenant Mobility

Proposed policy changes: Reissue tenant-based/mobile vouchers when a household cedes its voucher voluntarily or due to time limits (House and Senate budget).

This proposal would have the effect of increasing the availability of mobile vouchers. Mobile vouchers offer several potential advantages over project-based housing for some families. First, mobile vouchers permit families to move out of areas of concentrated poverty, where more than 30-40% of residents are below the poverty level.[168-170] Second, they allow greater flexibility in responding to employment opportunities, and thus move families toward economic self-sufficiency. Third, families can choose to live in areas in which schools and community are better suited for their needs. Fourth, they accommodate changes in family configurations and responsibilities, such as relocating in order to provide care for an elderly parent or relative, or the addition of a child.[4]

However, research suggests that families face important barriers to using their mobile vouchers, including reluctance of landlords to rent to voucher holders, especially in tight housing markets, discomfort with moving to new areas, racial discrimination and discrimination against families with children.[171] Families who receive mobility counseling, including housing search and budget counseling, transportation to view units in lower poverty neighborhoods, expedited habitability inspections, training in landlord-tenant law and post-move support, were twice as likely to use their vouchers to move to a low poverty neighborhood.[171]

An important consideration in applying prior research to MRVP is that families receiving the mobile Section 8 vouchers studied in the Moving To Opportunity research paid a maximum of 35% of their income on rent, while families using mobile tenant-based MRVP vouchers are not limited in the proportion of their income they pay for rent. This lack of a rent cap effectively limits the family's ability to move out of high poverty areas to lower poverty areas with higher rents. The Senate budget proposal to limit the tenant rent contribution to 40% would be expected to improve mobility, with the potential benefits described in Section 1.

Currently, available data does not allow for strong predictions regarding the overall effect of increasing mobile tenant vouchers on child health. However, the data does suggest

potential positive effects for some physical, mental health and educational parameters if families are able to use mobile vouchers to move out of high poverty neighborhoods.

Tenant Mobility Implications

- Children in families that are able to use mobile vouchers to move to low poverty areas have better physical health, mental health and educational outcomes.
- Children in families who are not able to use their mobile vouchers to move out of high poverty areas may still experience the health benefits of increased household resources available for other basic needs, especially if there is a limit on the maximum family contribution to rent.

4 Summary

Housing has a substantial influence on child health and well-being. Based on a review of available evidence, we offer the following summary of the likely impacts of proposed changes to the Massachusetts Rental Voucher Program:

Instituting time limits for housing subsidies in a region that lacks affordable housing puts children at risk due to household budget trade-offs and exposure to substandard housing.

Families whose housing vouchers are discontinued due to time limits will likely have difficulty finding safe, affordable housing in the Massachusetts rental market.

These budget trade-offs could result in a 50% increase in food insecurity, which is related to malnutrition, poor growth and increased risk of illness. Living in substandard housing increases the risk of injuries, lead poisoning and asthma, among other effects.

Instituting work requirements will likely result in program disenrollments for some families resulting in housing instability. Without a supply of adequate, affordable child care, children will be at risk of poor health and developmental outcomes due to exposure to substandard care.

Depending on the adequate supply of affordable and adequate child care, children whose parents do not have access to such child care will be subject to adverse developmental outcomes resulting from lower quality child care. Particular groups of children, such as young children and chronically ill children will be more vulnerable to adverse health consequences, including food insecurity and related poor growth and interruptions in health care.

Decreasing redetermination period may increase the number of families who disenroll from the program, despite ongoing eligibility.

Decreased redetermination periods may increase the number of eligible families who are removed from MRVP due to procedural requirements, placing their children at risk due to housing instability, homelessness, and budget trade-offs between rent and other basic needs.

Proposals that increase housing instability or homelessness will adversely affect child physical health, mental health and school functioning.

These physical health effects include worse overall health status, decreased preventive primary pediatric care, increased emergency department visits and hospitalizations, increased hunger, food insecurity, and asthma. Mental health effects include depression and anxiety. Poor school performance leads to increased education costs of $6700 for each child needing special education and $6800 for each child who must repeat a grade.

Proposals that decrease tenant rent share will decrease the need for trade-offs between housing and other basic needs.

There is strong evidence to indicate that low income families with high housing costs must make trade-offs between their housing expenses and paying for other basic needs, such as food.

Children in families who lack housing subsidies are more likely to experience poor nutrition which is associated with several adverse outcomes – chronic illness, poor growth, malnutrition, increased infections, increased hospitalizations, iron deficiency anemia and impaired cognitive development.

Proposals that enhance tenant mobility may increase the family's ability to move to low poverty areas, which may improve child health outcomes.

Children in families with mobile vouchers with a capped family rent contribution will be more likely to move into low poverty areas, resulting in improved health, behavioral and school achievement outcomes.

For MRVP, it is unclear how benefits of mobility are offset by adverse effects of not having a maximum family contribution to rent. The overall positive impact of mobile vouchers is dependent to a great extent on whether families are able to move out of high poverty areas.

Children in families who are not able to use their mobile vouchers to move out of high poverty areas may still experience the health benefits of increased household resources available for other basic needs, especially if there is limit on the maximum family contribution to rent.

The Child Health Impact Assessment Working Group has identified important gaps in data available to analyze the impact of MRVP on families in the Commonwealth. The Department of Community and Housing Development should support the collection and tracking of data on MRVP enrollees so that the influence and impact of the program could be more directly monitored.

Summary of Potential Impact of MRVP Program Changes on Child Health

Program Component	Program Component or Proposal	Direction, Type, Extent of Impact *
Time Limits	Impose time limits on assistance: 36-month limit on continuous use of benefits 60-month limit on lifetime use of benefits *(Governor's Budget)*	Direction – Negative for disenrolled families Extent -- Significant Proposal will: 1. Create difficulty finding safe, affordable housing. 2. Increase proportion of income spent on rent. *Impact:* *⇑ Food insecurity for those who reach limit by 50%* *⇑ Environmental exposures to known hazards*
Work Requirements	Require non-elderly, non-disabled household members to work or participate in approved alternative activities: 20 hours/week if youngest child is age 1-6 years 24 hours/week if youngest child is age 6-8 30 hours/week if youngest child is age 9 or older *(Governor's Budget)*	Direction – Negative for disenrolled families Extent -Unclear. Depends on proportion not already working or subject to TAFDC work requirements. Proposal will: 1. Require families new to work force to find child care 2. Not provide increase in affordable child care *Impact:* *Families disenrolled for noncompliance will be at risk of housing instability and food insecurity will increase 50%* *Children may be placed in substandard child care.*
Increased Frequency of Eligibility Redetermination	Re-determine eligibility semiannually rather than annually. *(Governor's Budget)*	Direction – Negative for disenrolled families Extent – Moderate Proposal will: Result in disenrollments of families Increase proportion of income spent on rent for disenrolled families *Impact:* *Families disenrolled will be at risk of housing instability and food insecurity, with associated adverse child health effects.*
Tenant Rent Contribution Cap	Subsidize households with mobile vouchers so that they pay no more than 40% of income on rent *(Senate Budget)*	Direction – Positive Extent -Significant. Proposal will: 1. Decrease the proportion of income spent on rent 2. Increase ability to meet other basic needs *Impact:* *⇓ Food insecurity and ⇓ Housing instability with associated positive child health effects*
Tenant Mobility	Gradually increase the number of mobile vouchers actually in use:[+] Require DHCD to re-issue mobile vouchers (within 90 days) that are ceded when households exit the program *(Senate and House Budgets)* No language regarding reissuing mobile vouchers *(Governor's Budget)*	Direction – Unclear. Depends on whether families with mobile vouchers are able to move out of high poverty areas. Extent – Unclear Proposal may: 1. Increase tenant mobility out of high poverty areas *Impact:* *Girls: ⇓ Risky behaviors, ⇑ School performance* *Boys: ? effect on behavior problems*

* See Section 1 for discussion of evidence on which these conclusions are based.

[+] Currently, due to budget constraints, mobile vouchers are not reissued when households exit the program.

Appendices

I. Child Health Impact Assessment: Rationale and Methodology

Child health is inherently dependent on the social well-being of the family. Social or non-medical factors influence both the development of childhood disease and the severity of disease once it develops. Public health and health care are crucial vehicles for promoting child health and well-being. However, many of the social determinants of child health are not under the explicit purview of pediatricians or public health officials. Rather, there are many local, state and national agencies and departments that exert regulatory and programmatic control over these social determinants, and thus have a significant impact on child health. It is unclear to what extent these non-health related agencies consider the implications of their policies and regulations for child health and well-being.

In order to make the relationship of public policy to child health, especially socially or economically vulnerable children, more comprehensible to policy makers, and the public, in the fall of 2004, the Department of Pediatrics at Boston Medical Center, Boston University School of Medicine convened an interdisciplinary, inter-institutional working group to develop a Child Health Impact Assessment strategy (CHIA). This working group, which includes representatives from Boston University School of Medicine, Boston University School of Public Health, Brandeis University, Children's Hospital, Boston, Harvard Medical School, Harvard School of Public Health and University of Massachusetts, Boston, discussed the need to provide a formal Child Health Impact Assessment on various policies being proposed in the Commonwealth of Massachusetts. A CHIA is conceptualized as analogous to an environmental impact assessment, which is a required step in any project that might have a direct or indirect impact on the environment. The goal of a CHIA is to provide a mechanism to evaluate the impacts and implications of policy, regulations and laws on children's health and well-being, with a particular focus on policy arenas outside the traditional realm of public health and health policy, including: education, housing and landlord/tenant laws, immigration and naturalization, criminal justice, and employment and income supports.

Drawing on the expertise of a wide range of stakeholders in the university as well as the public and private sectors of the Commonwealth, The CHIA Working Group is committed to carrying out health impact assessments on public policies that impact children's health and exacerbate health inequalities. The CHIA process involves a practical, inexpensive, timely review of research evidence, a policy appraisal with participation of key stakeholders, and a report to the Commonwealth on the findings of the research and analysis, with recommendations. After reviewing many health impact assessment models previously developed in Canada and Europe, the CHIA Working Group decided to modify the European policy Health Impact Assessment for its purpose.[172-174] Although the health impact assessment concept has been implemented abroad, it has only been used sporadically in the United States.[175,176]

Child Health Impact Assessment – Pilot Analysis of the Massachusetts Rental Voucher Program

The CHIA Working Group recognized the need to demonstrate the utility and feasibility of the CHIA concept and therefore initiated a pilot analysis process. The criteria for the issue to be analyzed included: potential impact on children, availability of rigorous research and clinical data, saliency for policy makers and relevance to the Commonwealth. After careful review of potential topics, the CHIA Working Group chose the topic of affordable housing, in particular, the Massachusetts Rental Voucher Program for the pilot analysis. The Working Group determined that highlighting the connections between affordable housing and child health and well-being would illustrate the function of a child health impact assessment.

Child Health Impact Assessment Methods

The goal of CHIA is to provide compelling, quantifiable, objective evidence to policymakers about the potential child health and well-being impacts of a policy, to influence the consideration of child health impacts in general, and to reduce negative impacts on child health in the Commonwealth. The CHIA analysis is based on previously collected data and best available scientific evidence. The type of data collected includes: academic and other research, government databases, advocacy websites, as well as interviews with key stakeholders.

During data collection, CHIA collected evidence on the effects of MRVP affordable housing budget proposals on children's health determinants and children's health outcomes, including impacts on a child's basic needs including education, housing, food, access to health care, safety and stability, and the physical environment. A thorough literature search for appropriate evidence on housing, homelessness, housing mobility and stability, housing subsidies, and affordable housing was undertaken through Medline, PubMed, Web of Science, First Search, and Science Direct. The literature review was followed by extensive interviews to gather evidence from the experience, knowledge, opinions and perceptions of stakeholders and people with expert knowledge in the affordable housing area, including representatives of relevant state, regional and community agencies and advocacy groups. These interviews provided a broader picture of health determinants affected by MRVP proposals and provided a well-grounded understanding of affordable housing in Massachusetts and how stakeholders and experts think MRVP impacts on children's health outcomes and why. Research and interviews contributed to CHIA's prioritization of health impacts and provided a useful perspective on health inequalities.

II. The McKinney-Vento Homeless Assistance Act, Reauthorized January 2002

Subtitle B of title VII of the McKinney-Vento Homeless Assistance Act (42 U.S.C. Section 11431 (a)

SEC. 725. DEFINITIONS.

For purposes of this subtitle:

(1) The terms `enroll' and `enrollment' include attending classes and participating fully in school activities.

(2) The term `homeless children and youths –

(A) means individuals who lack a fixed, regular, and adequate nighttime residence (within the meaning of section 103(a)(1)); and

(B) includes–

(i) children and youths who are sharing the housing of other persons due to loss of housing, economic hardship, or a similar reason; are living in motels, hotels, trailer parks, or camping grounds due to the lack of alternative adequate accommodations; are living in emergency or transitional shelters; are abandoned in hospitals; or are awaiting foster care placement;

(ii) children and youths who have a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings (within the meaning of section 103(a)(2)(C));

(iii) children and youths who are living in cars, parks, public spaces, abandoned buildings, substandard housing, bus or train stations, or similar settings; and

(iv) migratory children (as such term is defined in section 1309 of the Elementary and Secondary Education Act of 1965) who qualify as homeless for the purposes of this subtitle because the children are living in circumstances described in clauses (i) through (iii).

III. Summary Comparison of Affordable Housing Programs

The Massachusetts Rental Voucher Program is one of three broad housing assistance programs available to residents of Massachusetts, Housing Choice Voucher Program (formerly known as Section 8), Rental Assistance to Families in Transition (RAFT), and Public Housing. The following chart describes the central features of these other programs:

	HCVP	RAFT	Public Housing
Administration	Federal: Department of Housing and Urban Development (HUD) Local: LHAs -Public housing authorities -Private non-profit housing agencies	State-level: DHCD Local: private regional non-profit housing agencies (RNPs) RNPs exercise substantial discretion in deciding applications; applications are decided case-by-case RNPs must obtain DHCD approval to award applicant families more than $1,500 in assistance	Funding source: two categories -Federally-assisted: joint federal and state funding -State-aided: state funding only Federal administration (where applicable): HUD State-level: DHCD Local: Public Housing Authorities (PHAs)
Requirements for Initial Eligibility	All households with children or elderly or disabled members are eligible; LHA's may choose to extend eligibility to other types of households Household must include at least one member that is a US citizen or eligible immigrant Gross household income < 50% Area Median Income (AMI) [75% of vouchers administered by a LHA are reserved for households with gross income < 30% AMI]	Household must include at least two people Household must include at least one dependent child under 21 OR a disabled adult Net household income < 130% FPL* Household must demonstrate that receiving assistance will allow it to avoid homelessness by retaining its current housing OR escape homelessness by obtaining permanent housing	Income must fall within HUD's "Low income Limits" for a local area Household generally must not have a history of non-payment of rent in previous residences, unless household was paying at least 50% of its income towards rent Household must not include any members who currently use drugs or have used drugs within the 12 months prior to application Household must not include any members who have engaged recently in criminal activity or threatening behavior towards LHA staff For Federally-assisted housing only: household must include at least one member that is a US citizen or eligible immigrant
Requirements for Continuing Receipt of Benefits	Households must re-establish eligibility (see above) annually Households must promptly inform LHA of any changes in income or composition	Not applicable: program offers one-time assistance	Households must re-establish eligibility (see above) annually Households must inform LHA of any changes in income within one month of the change

	HCVP	RAFT	Public Housing
Description of Benefits	Project-based assistance: -Assistance is not portable -Owner contracts with LHA to designate recently constructed or rehabilitated units for rent by HCVP households receiving project-based assistance -Household pays 30% of income towards rent Tenant-based assistance: - Assistance is portable throughout United States -Household pays 30% of income towards rent for eligible private housing, if the rent for the housing is within HUD's Fair Market standards -If rent for housing is greater than HUD's Fair Market standard, household pays >30% of income towards rent Family Unification vouchers Conversion vouchers Disability-related assistance Homeownership vouchers	Participants receive up to $3,000 to use towards housing-related expenses including, but not limited to: -Rental arrears -Utility arrears -Moving expenses -First/last months' rent -Security deposits -Furniture -Transportation to workplace	Household receives a unit in an LHA-administered low income housing development Assistance is not portable Tenant rent-share is as follows: -32% of net household income if tenant pays no utilities -30% of net household income if tenant pays some but not all utilities -27% of net household income if tenant pays all utilities Household may apply for a transfer to another LHA-administered unit for health or safety reasons or if there is a change in household size
Duration of Benefits	No limits on duration of benefits for continuously eligible participants	One-time assistance	No limits on duration of benefits for continuously eligible participants
Housing Standards	Prior to start of tenancy, LHA must inspect housing and certify that it meets Housing Quality Standards (HQS) established by HUD* Annually during tenancy, LHA must inspect housing to re-establish compliance with HQS	None specified	LHA must maintain housing that complies with local sanitary laws LHA must make repairs within a reasonable timeframe upon tenant's request LHA must re-key locks promptly and free of charge for a tenant who has obtained a restraining order against a household member
Funding	FY 2005: $14.7 billion FY 2006 (President's budget): $15.8 billion	FY 2005: $2 million -Assisted 1257 families FY 2006 (Governor's Budget): $2 million FY 2006 (House Budget): $3 million F& 2006 (Conference Committee): $5 million	

* Conference Committee Budget released on June 23 modifies income eligibility to include those with incomes less than 50% of area median income.

IV. Local Housing Authority Survey Methodology

In order to evaluate the impact of MRVP on child health in Massachusetts, the Child Health Impact Assessment Working Group believed it was necessary to obtain information on voucher utilization, characteristics of participating families and program implementation. Since there is no central repository in Massachusetts for the collection of these data in aggregate form, we conducted a survey among a sample of Local Housing Authorities (LHAs).

Sample selection: We chose a purposeful sample of LHAs, which included eight of the nine Regional Nonprofit Housing groups (RNPs) and ten Public Housing Authorities (PHAs). Since the RNPs cover the entire state of Massachusetts, all but one were chosen to represent the regional differences. (One RNP was omitted as it had only one client on MRVP). We included the ten largest PHAs for the survey, each serving more than 80 MRVP households. Of the total 18 LHAs selected for the survey, 10 responded, 5 RNPs and 5 PHAs.

Administration: We telephoned all LHAs selected for the survey and interviewed either the director of the agency or the employee in charge of MRVP within the agency. At the request of the respondent in three cases, we emailed the survey, and the respondent returned the survey to us.

Survey domains: The survey gathered information about MRVP participants in the following domains:

The proportion of MRVP participants that are families with children under 18

Demographic characteristics of participating families, including average income and source of income, and presence of chronic illness

Prior housing history of participating families, for experiences with homelessness, rent burden, substandard housing, and domestic violence

Participating families' experience with MRVP, including their general satisfaction with housing rented through MRVP, and their concerns about rent burden, poor conditions, and/or eviction

Characteristics of housing rented through MRVP, including poverty concentration in surrounding areas, and accessibility of project-based housing

Unit of analysis*:* To get an overview of utilization patterns statewide, the unit of analysis initially was the LHA, not individual program participants. In order to represent numbers of individuals as well, responses were weighted according to the number of vouchers administered by each LHA. This data is therefore representative of both regional and individual variations in the implementation and utilization of MRVP.

Limitations*:* Knowledge of respondents to the survey varied. Some had actually tracked the information we requested, and had precise answers, while others had not. Those who did not responded based on their overall experiences.

V. Summary Comparison of Governor, Senate and House Budget Proposals for Massachusetts Rental Voucher Program

Established in 1992 to merge the Chapter 707 program and the State Housing Voucher Program, the Massachusetts Rental Voucher Program (MRVP) provides rental assistance to low income individuals and families. The following chart describes central features of the current program and proposed changes for FY2006:

	MRVP	Governor's Budget 2006	House Budget 2006	Senate Budget 2006
Administration	Administered centrally by Department of Housing and Community Development (DHCD) Administered locally by Local Housing Authorities (LHA's): -Public Housing Authorities (PHAs) -Private Regional Non-Profit Housing Agencies (RNPs) Administrative fee: $25/voucher/month paid to LHA	Administrative fee: $40/voucher/month paid to LHA	No change from current program rules	Administrative fee: $40/voucher/month paid to LHA
Requirements for Initial Eligibility At the time of application for the program, households must verify that they fulfill all criteria listed to be eligible to participate in the program	Massachusetts residence Net income < 200% FPL Assets < 1.5x gross income *or* Assets < $15,000 Household must not owe rental arrears for public or publicly subsidized housing Household must not include any members who currently use drugs or have used drugs within the 12 months prior to application Household must not include any members who have engaged rin criminal activity	No changes from current program rules	No changes from current program rules	No changes from current program rules
Requirements for Continuing Receipt of Benefits	Households must re-establish eligibility (see above) annually Households must inform LHA of any changes in income or composition within 30 days of change	Households must re-establish eligibility semiannually Non-elderly, non-disabled household members must work or participated in sanctioned alternative activities: -20 hours/week if youngest child is age 1-6 years -24 hours/week if youngest child is age 6-8 -30 hours/week if youngest child is age 9 or older	No changes from current program rules	No changes from current program rules

	MRVP	Governor's Budget 2006	House Budget 2006	Senate Budget 2006
Description of Benefit: project-based assistance	Assistance is not portable Owner contracts with the LHA to designate units for rent by MRVP households MRVP household pays 30% of income towards rent if utilities are paid separately MRVP household pays 35% of income towards rent if utilities are included in rent If MRVP household leaves the leased unit, the owner of the unit can terminate its contract with the LHA and rent the unit at market-rate	No change from current program rules	No change from current program rules	No change from current program rules
Description of Benefit: tenant-based assistance	Assistance is portable throughout Massachusetts Household retains LHA-issued voucher and uses it to pay a portion of rent in private housing LHA determines fixed value of voucher based on household size, composition, income, and location of housing where voucher will be used Lower limit on household expenditure on rent: 30% of income No upper limit on household expenditure on rent as percent of income	Does not include language concerning reissuing mobile vouchers. Mobile vouchers have not been issued due to budget constraints, although LHAs are theoretically responsible for doing so.	Requires DHCD to reissue mobile vouchers within 90 days when households exit the program	Requires DHCD to reissue mobile vouchers within 90 days when households exit the program Voucher value must be adjusted so that household pays ≤ 40% of income on rent
Duration of Benefits	No limits on duration of benefits for continuously eligible participants	36-month limit on continuous use of benefits 60-month lifetime limit on use of benefits	No changes from current program rules	No change from current program rules
Housing Standards	Local board of health must certify that housing meets local sanitary code standards prior to establishment of lease	No change from current program rules	No change from current program rules	No change from current program rules
Funding	$24,283,345 in FY2005 Funds 4,715 vouchers (~60% of the 7,483 authorized vouchers) -3,172 project-based -1,543 tenant-based	$24,283,345 for FY2006	$26,283,345 for FY2006	$26,283,345 for FY2006

Sources:

Fiscal Year 2006 Conference Report http://www.mass.gov/legis/06budget/conference/fy06conference.htm;

House and Senate Budget Proposals http://www.mass.gov/legis/06budget/house/, http://www.mass.gov/legis/06budget/senate/index.htm

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