

The Suburbanization of Housing Choice Voucher Recipients

Kenya Covington, Lance Freeman, Michael A. Stoll¹

“Within suburbs, Housing Choice Voucher recipients are more likely than the overall population and the poor to live in low-income suburbs with inferior access to jobs.”

Findings

An analysis of the location of Housing Choice Voucher (HCV, the program formerly known as Section 8) recipients in the 100 largest U.S. metropolitan areas in 2000 and 2008 finds that:

- **By 2008 roughly half (49.4 percent) of all HCV recipients lived in suburban areas.** That represents a 2.1 percentage point increase in the suburbanization rate of HCV recipients compared to 2000. However, by 2008 HCV recipients remained less suburbanized than the total population, the poor population, and affordable housing units generally.
- **Black HCV recipients suburbanized fastest over the 2000 to 2008 period, though white HCV recipients were still more suburbanized than their black or Latino counterparts by 2008.** Black HCV recipients' suburbanization rate increased by nearly 5 percentage points over this period, while that for Latinos increased by about 1 percentage point. At the same time, the suburbanization rate for white HCV recipients declined slightly.
- **Between 2000 and 2008, metro areas in the West and those experiencing large increases in suburban poverty exhibited the biggest shifts in HCV recipients to the suburbs.** Western metro areas like Stockton, Boise, and Phoenix experienced increases of 10 percentage points or more in the suburbanization rate of HCV recipients.
- **Within metro areas, HCV recipients moved further toward higher-income, jobs-rich suburbs between 2000 and 2008.** However, the poor and affordable housing units shifted more rapidly toward similar kinds of suburbs over that period. By 2008 about half of suburban HCV recipients still lived in low-income suburbs.

Together, these findings indicate that HCV recipients are suburbanizing over time, alongside poor households more generally. However, the slow pace of the shift compared to that for the poor and for affordable housing suggests that suburbs have the capacity to absorb more HCV recipients. Moreover, within suburbs, HCV recipients are more likely than the overall population and the poor to live in low-income suburbs with inferior access to jobs. Policies that provide more incentives for multifamily housing, reevaluate existing zoning laws and development impact fees, facilitate the use of housing vouchers in new higher-income suburban locations, and enforce fair housing laws in suburban areas could give HCV recipients access to a broader range of high-quality residential environments.

Introduction

Policymakers and scholars have long been concerned about the geography of opportunity—about how characteristics of neighborhood and place can and do influence social and economic outcomes. For example, the notion of “spatial mismatch,” in which minority residents of segregated urban neighborhoods have limited access to increasingly suburbanizing jobs, and whether and how it impacts economic outcomes has been studied exhaustively.²

Federal housing policy has been concerned about the geography of opportunity as well, especially regarding the use of tenant-based housing subsidies (formerly known as Section 8 certificates or vouchers and now Housing Choice Vouchers (HCV)). Prior to the 1990s, it was extremely difficult for Section 8 recipients to use the certificate/voucher anywhere other than in the jurisdiction of the issuing housing authority. Research indicates that as a consequence Section 8 recipients tended to settle in central city neighborhoods that were disadvantaged and where their race/ethnicity predominated.³

However, during the 1990s, the U.S. Department of Housing and Urban Development (HUD) implemented a number of policy changes that may have dramatically affected the location choices of HCV recipients, and thus influenced their ability to move closer to opportunity, particularly economic opportunity within suburbs. One change that reflected the growing concern that HCV recipients were clustering in neighborhoods of concentrated poverty was the Mobility Counseling Program. Also known as the Regional Opportunity Program, it encouraged movement from high-poverty to low-poverty neighborhoods by counseling voucher recipients on opportunities away from poor neighborhoods.⁴

A second policy change was the streamlining of the process through which HCV recipients could use their voucher in a jurisdiction other than the one that issued the voucher. This process, known as portability, could have made it easier for HCV recipients to move into jurisdictions that they might not have moved to in the past.

Another important policy change was the shift from certificates to vouchers, which may have given assisted households considerably more choice about where to live. Whereas certificates place a ceiling on the amount of rent a household can pay (which could act to limit location choices), vouchers do not, as long as the household is willing to pay the difference, and pays no more than 40 percent of its income toward rent.⁵ By allowing households the option to pay more than the so-called “fair market rent,” vouchers should increase housing options, including in the suburbs. But we know very little about whether the expansion of geographic mobility features of the Housing Choice Voucher is indeed increasing variation in geography of residential choice among HCV recipients over time.

To the extent that the location options of HCV recipients have expanded geographically, their residential choices are likely to be influenced by patterns of metropolitan decentralization more generally, and of the poor in particular. For example, since 2000 the suburbanization of the poor increased markedly, at a pace exceeding that of the population as a whole, partly as a consequence of the continued suburbanization of jobs.⁶ Moreover, where HCV recipients locate within suburban areas is of critical importance as well, since such areas can vary widely regarding access to opportunity and jobs.⁷ For example, research documents greater employment growth, relative to population growth, in high- compared to low-income suburbs, suggesting that employment opportunities are greater within high-income suburban areas.⁸

In this paper, after presenting the data and methodology used, we document the suburbanization of HCV recipients over the 2000 to 2008 period, and whether this suburbanization differs by the race of the HCV recipient and by region. In addition, we consider how the suburbanization of HCV recipients compares to other groups such as the poor. We also describe the types of suburbs to which HCV recipients are moving, distinguishing among suburbs by differences in their household incomes and job accessibility. We close with some implications for public policy.

Methodology

This study analyzes the suburbanization of both Housing Choice Voucher recipients and select comparison groups between 2000 and 2008 in the country's 100 most populous metropolitan areas, and assesses the types of suburbs to which HCV recipients have moved.

We define suburbs as the balance of the metropolitan statistical area outside the region's primary city or cities.⁹ We allocate census tracts to cities or suburbs based on the location of their centroid.¹⁰

We measure the suburbanization of Housing Choice Voucher recipients using data from HUD's Picture of Subsidized Housing. This data set describes the characteristics of HUD assisted housing, including the type of program and population characteristics of the assisted households, at the census tract level. As such, the Picture of Subsidized Housing allows us to identify the geographic location of HCV recipients as well as key demographics such as their race and ethnicity. We extract this data for the years 2000 and 2008.

We focus on the 2000 to 2008 period so that we can match voucher data to census data in order to generate appropriate comparison groups. Two trends that influence the interpretation of the suburbanization rates of HCV recipients include the extent to which affordable housing is available in the suburbs (which in turn reflects a variety of factors such as development bias towards single family houses in these areas, etc.), and whether HCV recipients have access to this housing as a result of possible housing market or landlord rental discrimination, though we are not able to examine the latter question here.¹¹

To assess the availability of affordable housing in the suburbs we make two comparisons. First, we compare the suburbanization rate of HCV recipients to that of all poor individuals over the same period, using census tract data from Census 2000 and the 2005-2009 American Community Survey (ACS).¹² Although we do not assume that the poor are able to secure affordable rental units in suburbs, their ability to locate there suggests the availability of such housing options.

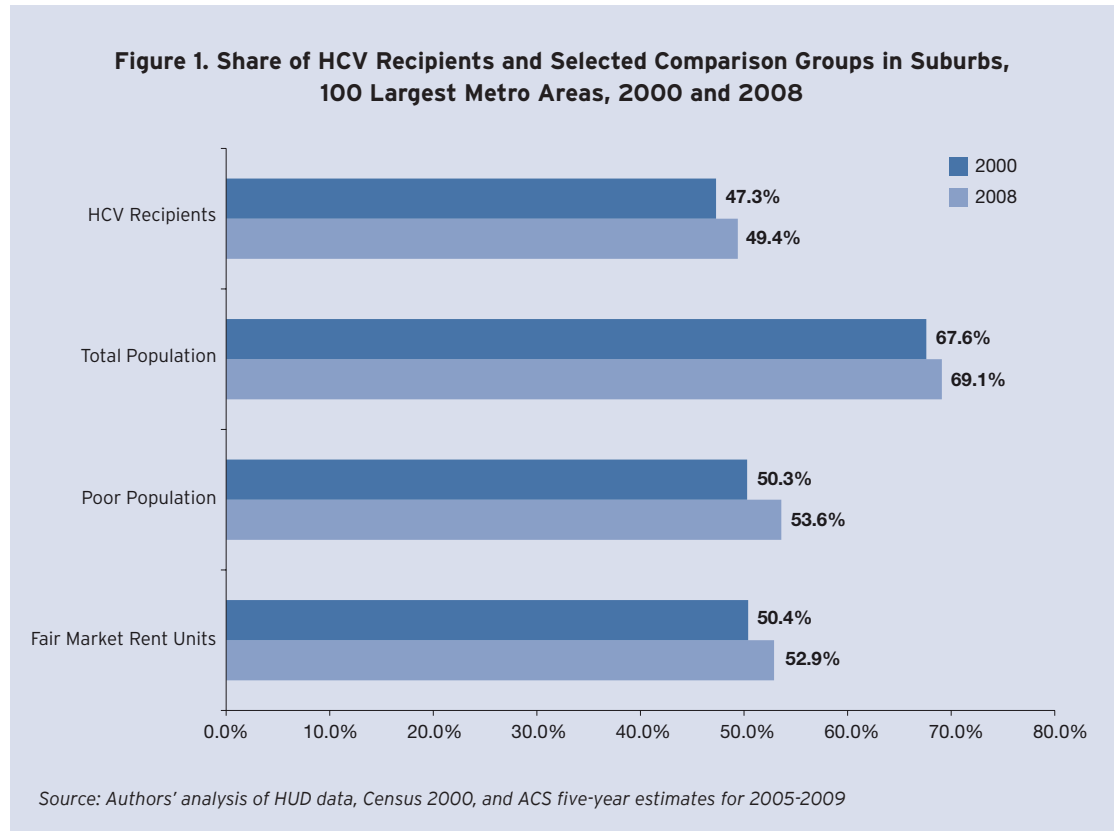
Second, we compare the suburbanization of rental units renting at or below Fair Market Rent (FMR) levels in suburban areas.¹³ We do this by identifying the number of rental units reported in Census 2000 and the 2005-2009 American Community survey that fall at or below the FMRs reported by HUD for those years for each respective metropolitan area (referred to here as FMR units). Whereas the comparison with suburbanization of the poor elucidates the extent to which poorer households in general are locating in the suburbs regardless of housing affordability, the comparison with units renting at or below metropolitan-specific FMRs indicates the availability of affordable housing options in suburbs.¹⁴

We characterize suburban areas by income level and by job accessibility, using median household income data from Census 2000 and the 2005-2009 ACS for each census tract in the 100 largest metro areas. We then calculate household income terciles (33rd, 66th percentiles) for each metro area for both years. Next, we define high-income census tracts as those that fall between the 66th and 100 percentile in the median income distribution of the metro area, moderate income between the 33rd and 66th percentile in the distribution and low income as below the 33rd percentile in the distribution. We also define high-income suburban areas as those with suburban census tract median income levels that fall above the 66th percentile of metro area, and so on and so forth for low- and moderate-income suburbs.¹⁵

We characterize suburban areas by their job accessibility using the same method. However, in this case we use ZIP codes instead of census tracts because the most current and detailed employment data available for all 100 metro areas come from the U.S. Department of Commerce's ZIP Business Patterns data. These data provide information on the number of firms in a ZIP code as well as their industry and employment levels. We define job accessibility as the ratio of people (ages 21 to 64) to total jobs in ZIP codes in 2000 and 2008 for the largest 100 metro areas in our sample.¹⁶ To generate an equivalent geographic comparison with the HCV recipient data, we convert census tracts to ZIP codes using a centroid-based allocation method, similar to that described above.

Findings

A. By 2008 roughly half (49.4 percent) of all HCV recipients lived in suburban areas. HCV recipients, like most American households, continued to suburbanize during the 2000s. In 2000, there were about 2.3 million people in HCV households, of whom 1.1 million lived in suburban areas. By 2008, the number of people in HCV households increased to 3.4 million, and about half (1.7 million) lived in suburban areas (Figure 1).



Examining HCV recipients' suburbanization rates relative to other comparable populations helps illuminate these findings. To do so, we identify three groups to which these results can be compared: the overall population, the poor population, and the availability of Fair Market Rental (FMR) units.

Although HCV recipients moved toward suburbs in the 2000s, they did so less rapidly than other groups. The increase in HCV recipients' suburbanization was actually lower than that for the two most appropriate comparison groups (i.e., the poor and FMR units; Figure 1.) Their change in suburbanization was statistically significantly lower than that for the poor overall, and only slightly lower than the change in the suburbanization of FMR units. The data also reveal that, by 2008, HCV recipients were less suburbanized than both groups. In 2005-2009, suburbs accounted for about 70 percent of all metropolitan residents, 54 percent of poor individuals, and 53 percent of FMR units.

Why the suburbanization rate of HCV recipients lags that of the poor is not entirely clear but could be related to a variety of factors including their inability to suburbanize earlier as a result of HUD housing policy restrictions, discrimination against HCV recipients in suburban housing markets, limited availability of affordable housing, or purposeful decisions by HCV households to remain in central cities, among other factors.

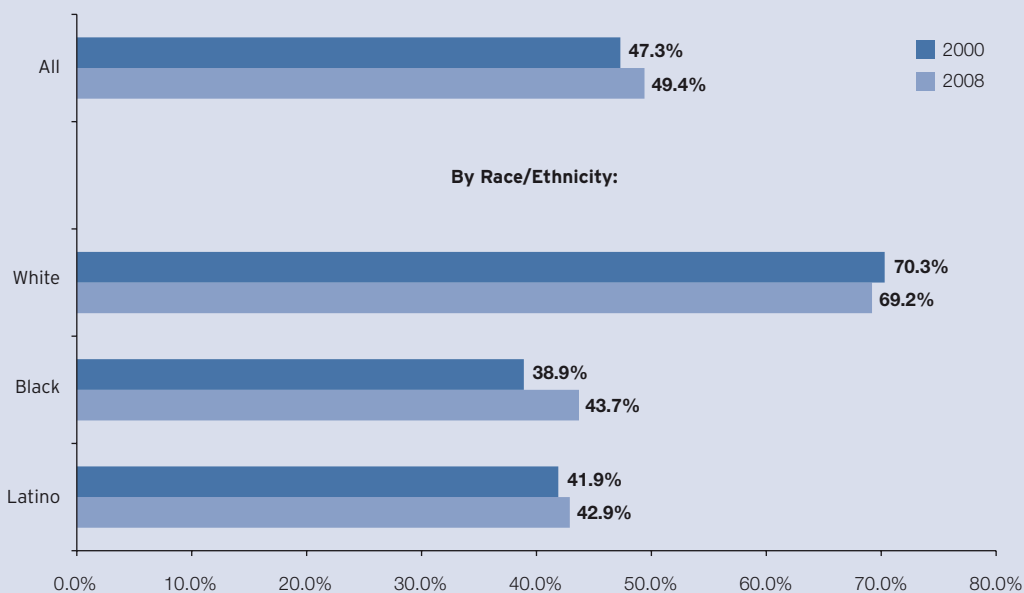
B. Black HCV recipients suburbanized fastest over the 2000 to 2008 period, though white HCV recipients were still more suburbanized than their black or Latino counterparts by 2008.

Notable differences exist in the number of HCV recipients by race and ethnicity and the extent to which they locate in suburbs. In 2000, there were about 1.2 million people in black HCV households, while the equivalent number in Latino and white households were 411,000 and 590,000, respectively. About 481,000 black HCV recipients lived in the suburbs, with the equivalent figures for Latino and white households at 169,000, and 416,000. By 2008, the number of people in black HCV households increased to 1.85 million, while that in comparable Latino and white households increased to 643,000 and 764,000, respectively. The numbers increased in suburban areas as well over this period. In 2008, 802,000 black HCV recipients lived in suburban areas while the comparable number for Latino and white HCV recipients was 275,000 and 528,000 respectively.

Given existing large racial and ethnic differences in suburbanization for the population as a whole observed in most metro areas, it is no surprise that racial and ethnic differences persist in the suburbanization rate of HCV recipients as well. Figure 2 documents the changes in HCV recipients' suburbanization rate over the 2000 to 2008 period by the race/ethnicity of the HCV recipient. The figure shows large racial and ethnic differences in the increases in the rate of suburbanization of HCV recipients over this period. The suburbanization rate of black HCV recipients increased by nearly 5 percentage points, while that for Latino increased by about 1 percentage point. This indicates that the overall increase in HCV recipients' suburbanization rate was fueled entirely by the increase in suburbanization of black, and to a lesser extent Latino, HCV recipients. White HCV recipients' suburbanization rate declined by about 1 percentage point over this period.

The sharp increase in black HCV recipients' suburbanization rate over this period could, on the one hand, reflect household decision making to move to areas with greater opportunity. On the other hand, this pattern may reflect the general trend in which overall black suburbanization rates have been greater than that of others over the recent period partly because blacks have been the least suburbanized among racial and ethnic groups, and thus have more "room" to suburbanize.

Figure 2. Share of HCV Recipients by Race and Ethnicity in Suburbs, 100 Largest Metro Areas, 2000 and 2008



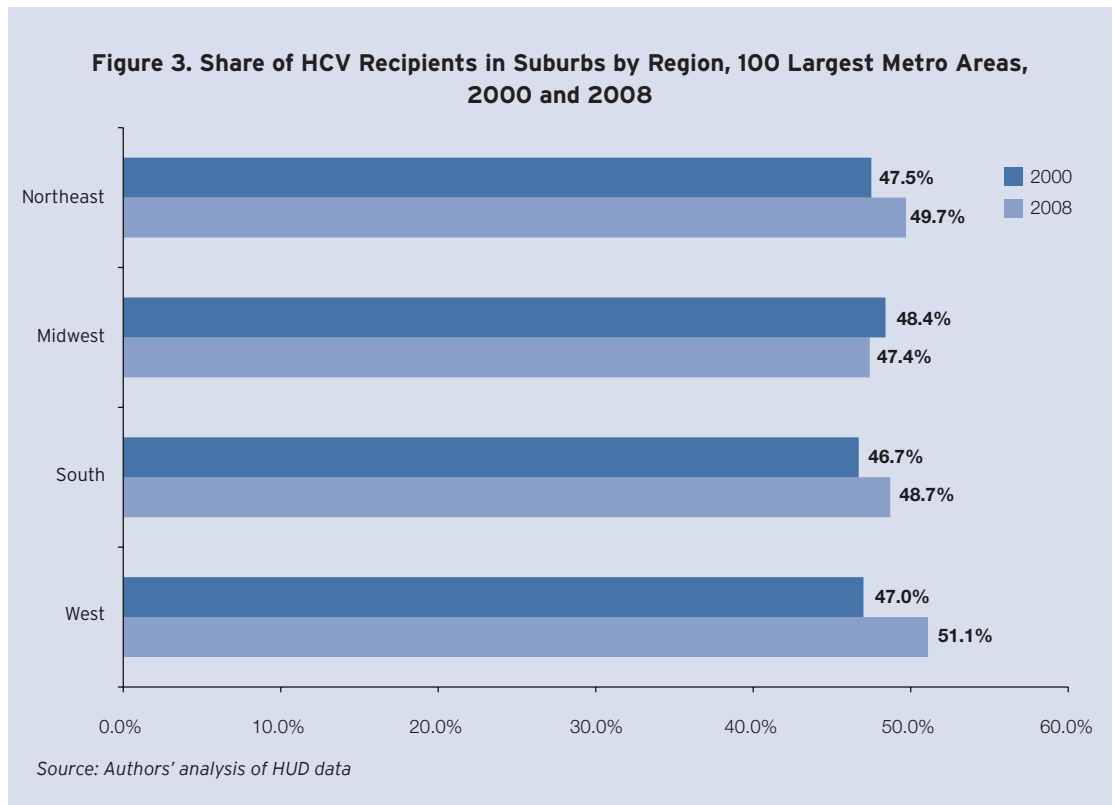
Source: Authors' analysis of HUD data

Still, by 2008, HCV recipients' suburbanization rates varied greatly by the race/ethnicity of the recipients. In 2008 white HCV recipients were still much more likely to live in suburban areas than their black or Latino counterparts despite more rapid suburbanization of the latter groups over the decade.¹⁷ These trends are also consistent with overall population trends in which blacks and, to a lesser extent, Latinos are less suburbanized than whites though the increases in their suburbanization over the last decades were much larger than that of whites.¹⁸

C. Between 2000 and 2008, metro areas in the West and those experiencing large increases in suburban poverty exhibited the biggest shifts in HCV recipients to the suburbs.

Patterns of HCV recipients' suburbanization differed greatly depending on the region.¹⁹ Figure 3 indicates that HCV recipients' suburbanization rates grew most dramatically in the West (by 4.1 percentage points). The reasons for this are not entirely clear, but the West was the only region where the increase in HCV recipients' suburbanization rate over the 2000 to 2008 period was greater than that experienced by all three comparison groups (Appendix Table A.1). On the other hand, the Midwest was the only region where the increase in HCV recipients suburbanization rate over this period was smaller than that experienced by all three comparison groups. The latter finding suggests that factors specific to the Midwest region—such as higher levels of racial segregation in housing markets in this region—may act to limit black and Latinos HCV recipients' suburbanization.

By 2008 metro areas in the West exhibited the highest suburbanization rates of HCV recipients, followed by those in the Northeast. Indeed, one could argue that the higher growth rates in sub-



urbanization of HCV recipients over the 2000 to 2008 period in the West helped push its regional suburbanization rate to the top by the end of the study period. At the same time, total population suburbanization rates are lowest in the West, indicating that by 2008, HCV recipients were more suburbanized in the West than what the overall regional patterns of suburbanization would suggest.

In what metro areas did HCV recipients' suburbanization rates grow the fastest or the slowest over the 2000 to 2008 period? Table 1 looks behind the aggregate national values and ranks the top

Table 1. Top and Bottom Metro Areas by Change in Share of HCV Recipients in Suburbs, 2000 to 2008

	HCV Recipients (%)	Poor Population (%)
<i>Largest Increase</i>		
1 Akron, OH	19.3	4.6
2 Atlanta-Sandy Springs-Marietta, GA	12.9	6.8
3 Lakeland-Winter Haven, FL	12.3	5.1
4 Birmingham-Hoover, AL	12.3	2.3
5 Phoenix-Mesa-Scottsdale, AZ	11.8	3.5
6 Boise City-Nampa, ID	11.7	3.4
7 Philadelphia-Camden-Wilmington, PA-NJ-DE-MD	11.5	3.0
8 Richmond, VA	11.4	5.9
9 Grand Rapids-Wyoming, MI	10.9	5.6
10 Stockton, CA	10.7	5.5
11 Raleigh-Cary, NC	9.8	0.9
12 San Francisco-Oakland-Fremont, CA	9.8	3.9
13 Bakersfield, CA	9.3	0.3
14 Honolulu, HI	9.2	1.6
15 Cleveland-Elyria-Mentor, OH	9.0	8.0
<i>Largest Decrease</i>		
86 Baton Rouge, LA	-5.5	0.2
87 Bradenton-Sarasota-Venice, FL	-6.1	0.5
88 Chicago-Naperville-Joliet, IL-IN-WI	-6.4	7.4
89 Tulsa, OK	-6.7	-1.7
90 Providence-New Bedford-Fall River, RI-MA	-6.9	3.7
91 Chattanooga, TN-GA	-7.4	1.1
92 Cape Coral-Fort Myers, FL	-8.1	-4.1
93 Augusta-Richmond County, GA-SC	-8.2	2.0
94 Greensboro-High Point, NC	-10.1	-0.2
95 Detroit-Warren-Livonia, MI	-10.6	4.2
96 Wichita, KS	-11.5	1.7
97 Palm Bay-Melbourne-Titusville, FL	-11.6	-4.2
98 Baltimore-Towson, MD	-12.9	8.2
99 Provo-Orem, UT	-16.0	4.6
100 Ogden-Clearfield, UT	-18.5	-0.3

Source: Authors' analysis of HUD data, Census 2000, and ACS five-year estimates for 2005-2009

and bottom 15 metro areas in the change in HCV recipients' suburbanization rates over the period. Suburbanization rates of the poor are presented for comparison as well because that group is the subset of the overall population with whom HCV recipients' socio-economic characteristics are most likely to match given the means test that is applied to HCV eligibility.²⁰ Not surprisingly, metro areas in the West, such as Honolulu, Bakersfield, and San Francisco, represent five of the top 15 areas with the biggest increases in HCV recipients' suburbanization rates over this period, while Southern metro areas represent six of these top 15 areas.

Southern metro areas are also disproportionately represented among areas with the smallest increases in suburbanization rates of HCV recipients over the period. Moreover, nine of the bottom 15 metro areas—all of which experienced decreases in the rate of suburbanization of HCV recipients—were located in the South. Declines ranged from 18.5 percentage points in Ogden to 5.5 percentage points in Baton Rouge.

Table 2. Top and Bottom Metro Areas by Share of HCV Recipients in Suburbs, 2008

	HCV Recipients (%)	Poor Population (%)	
<i>Highest Share</i>			
1	Miami-Fort Lauderdale-Pompano Beach, FL	87.8	80.3
2	Bradenton-Sarasota-Venice, FL	87.7	92.5
3	Poughkeepsie-Newburgh-Middletown, NY	86.1	89.6
4	Orlando-Kissimmee, FL	84.8	86.9
5	Scranton-Wilkes-Barre, PA	81.8	81.5
6	McAllen-Edinburg-Mission, TX	80.6	86.5
7	Atlanta-Sandy Springs-Marietta, GA	79.2	83.8
8	Columbia, SC	79.0	82.9
9	Cape Coral-Fort Myers, FL	77.1	79.2
10	Riverside-San Bernardino-Ontario, CA	75.7	79.3
11	Charleston-North Charleston-Summerville, SC	75.5	78.2
12	St. Louis, MO-IL	74.9	73.4
13	Providence-New Bedford-Falls River, RI-MA	73.5	76.7
14	Greenville, SC	72.9	89.1
15	Salt Lake City, UT	70.7	70.0
<i>Lowest Share</i>			
86	San Jose, CA	22.1	28.8
87	Albuquerque, NM	20.7	39.9
88	Fresno, CA	20.1	43.5
89	Memphis, TN-MS-AR	19.9	34.7
90	Colorado Springs, CO	17.3	27.3
91	San Antonio, TX	17.1	23.2
92	Indianapolis-Carmel, IN	16.1	30.8
93	Tulsa, OK	15.0	45.0
94	Jackson, MS	14.6	50.6
95	Tucson, AZ	13.7	33.5
96	Wichita, KS	12.7	27.8
97	Louisville, KY-IN	9.9	35.9
98	Toledo, OH	8.3	31.4
99	Jacksonville, FL	4.3	27.8
100	El Paso, TX	3.3	17.8

Source: Authors' analysis of HUD data, Census 2000, and ACS five-year estimates for 2005-2009

In keeping with these metro-level changes over the decade, by 2008 Southern metro areas were disproportionately represented in both the top and bottom metro areas when ranked by HCV recipients' suburbanization rates (Table 2). Indeed, Southern metro areas, such as Miami and El Paso, rank at the top and bottom of the list, respectively, of the 100 metro areas in the sample. Of the 15 metro areas in that list, nine are in the South. The strong representation of Southern metro areas in both lists likely offset each other, helping to explain why the average suburbanization rate of HCV recipients' in the South is very close to the average for the metro areas in the sample as a whole. (For details on all 100 metro areas, see Appendix A.)

The overall suburbanization of the poor that has been underway the past two decades may also influence the suburbanization of HCV recipients. There appears to be a positive correlation at the metro level between the change in suburbanization rates of HCV recipients and of the poor over the 2000 to 2008 period, and an even stronger positive association between suburbanization rates of the

poor and HCV recipients in 2008.²¹ In the first case, a 10 percentage point increase in the change in the suburbanization rate of the poor over the 2000 to 2008 period is predicted to increase HCV recipients' suburbanization rate by about 5.7 points over the same period (Appendix Figure A.1). In 2008, a 10 percentage point increase in the suburbanization of the poor is predicted to increase the suburbanization rate of HCV recipients by 10.5 percentage points, a much larger number than that for the prediction for the change in suburbanization.²²

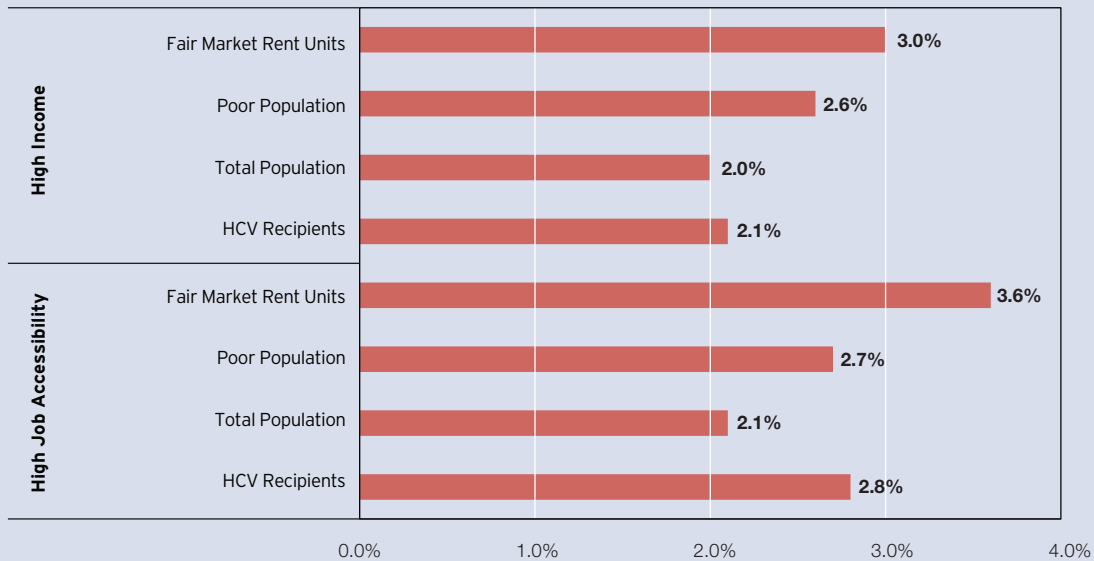
Alternatively, the implementation of HCV policies that introduced more mobility features to the program could have helped fuel the suburbanization of the poor more generally. Further analysis of the data indicates that a 10 percentage point increase in the change in the suburbanization rate of HCV recipients' over the 2000 to 2008 period is predicted to increase the suburbanization rate of the poor by 1 percentage point over the same period. Moreover, a back of the envelop calculation indicates that in the largest 100 metropolitan areas, 23 percent of the growth in suburbanization of the poor between 2000 and 2008 was made up of growth in the suburbanization of HCV recipients.²³

D. Within metro areas, HCV recipients moved further toward higher-income, jobs-rich suburbs between 2000 and 2008.

Suburban areas differ widely in their socioeconomic characteristics and in the types of opportunities they offer, with lower-income suburbs demonstrating slower employment growth (and faster population growth) over the recent decade that is likely to negatively influence employment opportunity and economic mobility prospects more generally.²⁴ Thus, this section explores the types of suburbs HCV recipients moved to over the decade, and whether their likelihood to locate in higher-opportunity communities differed from other groups.

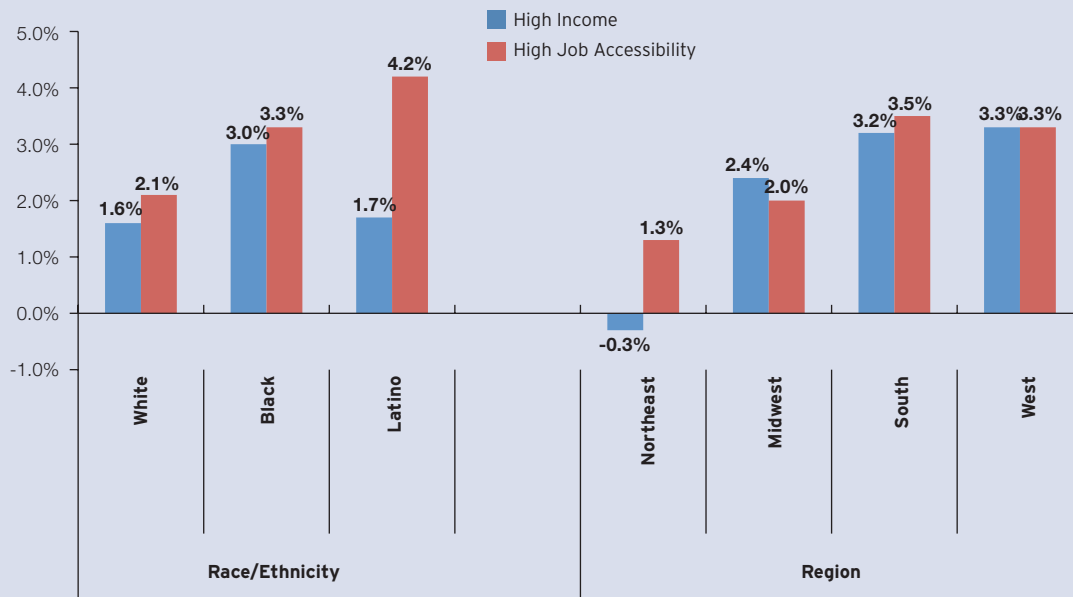
Figure 4 shows the change in the distribution of HCV recipients (and the comparison groups) across suburban areas over the 2000 to 2008 period. We focus attention on high-income suburbs and note that while HCV recipients made gains over this period in locating to high-income suburbs the pace of that change was not equal to that of the other comparison groups. The percentage of HCV recipients living in high-income suburbs increased by 2.1 percentage points over the period, while that for the poor or FMR rentals increase by 2.6 and 3.0 percentage points, respectively.

Figure 4. Change in Share of HCV Recipients and Selected Comparison Groups in High-Income and High-Job-Access Suburbs, 100 Largest Metro Areas, 2000 to 2008



Source: Authors' analysis of HUD data, Census 2000, and ACS five-year estimates for 2005-2009

Figure 5. Change in Share of HCV Recipients in High-Income and High-Job-Access Suburbs, by Race/Ethnicity and Region, 100 Largest Metro Areas, 2000 to 2008



Source: Authors' analysis of HUD data, Census 2000, and ACS five-year estimates for 2005-2009

Figure 4 also shows that HCV recipients made gains over this period in locating to high-job accessibility suburbs and that the pace of this increase was equal to or greater than that for the total population and the poor. The pace of that change, however, was not equal to that of FMR units indicating greater opportunity for HCV recipients to move to high-job accessibility areas.

Gains in suburbanization in higher-income and high-job accessibility suburban areas were greatest in the South and West (Figure 5). Moreover, the gains in living in both of these types of suburbs was fueled by black and to a lesser extent Latino HCV recipients, whose increases in locating to these types of suburban areas over this period was greater than that experienced by their white counterparts.

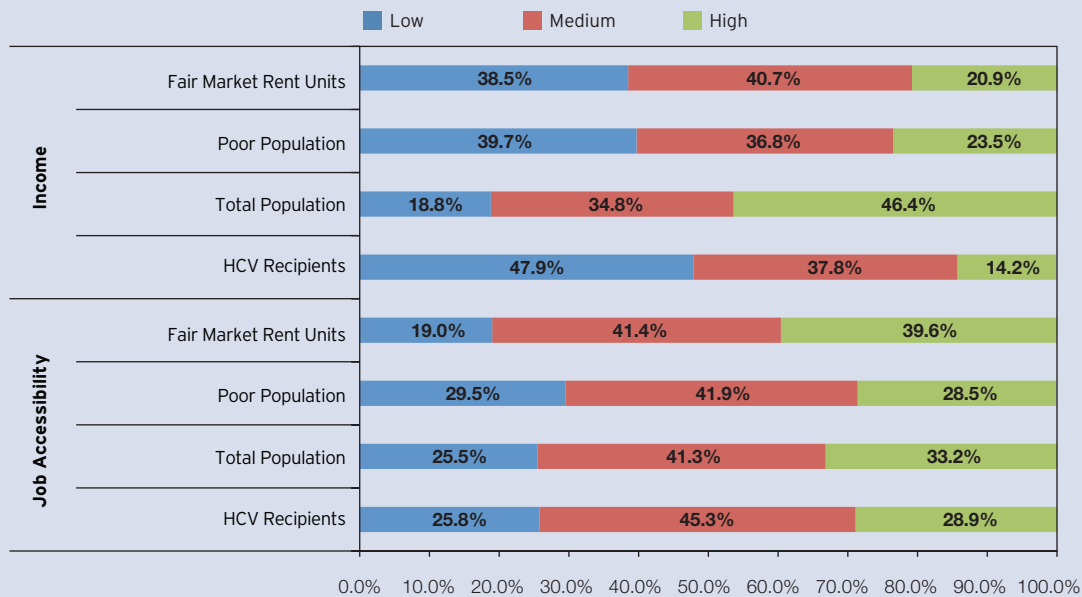
Despite the increase of HCV recipients locating to high-income suburban areas over the 2000 to 2008 period, by 2008 a plurality of recipients (48 percent) still lived in low-income suburbs (Figure 6). The top five metro areas in 2008 with the highest percentage of HCV recipients living in high-income suburbs include Des Moines, IA, Jacksonville, FL, San Antonio, TX, Wichita, KS, and Madison WI.

Moreover, in relation to the comparison groups, HCV recipients are disproportionately located in these suburban areas. A higher share of white HCV recipients live in high-income suburbs for reasons that are not altogether clear in these data but could include a variety of factors, such as family or social network ties to these areas, lack of information on housing options there by minority HCV recipients, or discrimination against these renters in these areas, among other factors.

Figure 6 also displays these patterns for suburban areas defined by their level of job accessibility. By 2008, a plurality of HCV recipients (45 percent) lived in suburban areas characterized by medium job accessibility. The top five metro areas in 2008 with the highest percentage of HCV recipients living in high job accessibility suburbs include Toledo, OH, Charleston, SC, Syracuse NY, Des Moines, IA, and Louisville, KY. Among the groups we examine including the poor, HCV recipients are among the least likely to live in high-job accessibility suburbs, though by only a slight amount.

These patterns are more pronounced in the Northeast and West, where an even higher percentage of HCV recipients live in low-income suburbs in 2008, possibly because of the higher cost of housing in these regions and because of the lower availability of FMR units in low-income suburbs in these

Figure 6. Distribution of Suburban HCV Recipients and Select Comparison Groups by Suburban Income and Job Accessibility, 100 Largest Metro Areas, 2008



Source: Authors' analysis of HUD data, Census 2000, and ACS five-year estimates for 2005-2009

Table 3. Distribution of Suburban HCV Recipients by Race, Region, and Suburban Characteristics, 100 Largest Metro Areas, 2008

	Income of Suburbs:			Job Accessibility of Suburbs:		
	Low Income	Medium Income	High Income	Low Job Accessibility	Medium Job Accessibility	High Job Accessibility
By Race:						
White	43.6%	39.1%	17.3%	14.3%	45.0%	40.7%
Black	46.1%	38.4%	14.5%	25.4%	44.9%	29.7%
Latino	50.5%	36.5%	13.0%	23.0%	49.2%	27.8%
By Region:						
Northeast	56.3%	32.8%	10.8%	16.1%	45.9%	37.9%
Midwest	41.7%	42.8%	15.5%	22.1%	46.1%	31.7%
South	43.5%	39.8%	16.7%	27.8%	46.4%	25.7%
West	47.5%	38.0%	14.4%	30.4%	43.2%	26.3%

Source: Authors' analysis of HUD data, Census 2000, and ACS five-year estimates for 2005-2009

regions (Table 3). The data also indicate that by 2008, black and Latino HCV recipients were somewhat more likely to live in low-income suburbs (as compared to their white counterparts). Indeed, 46 and 51 percent of these groups, respectively, live in low-income suburbs, with the equivalent figure for whites at 44 percent. Similar patterns by region and race bear out for job accessibility as well.

Conclusion

The findings presented in this report speak to two issues of significance to demographers and policy makers. First, the findings confirm the continuing pattern of increasing suburbanization even for relatively disadvantaged groups like HCV recipients. Second, while the HCV program undoubtedly produces more geographic opportunity than other housing assistance programs, there appears to be some room for improvement. We discuss these two points in more detail in this section.

America's urban centers have been suburbanizing ever since technology made it feasible for people to commute and communicate across sizable distances. Suburbanization first emerged among the elite who alone could afford the cost of commuting out of the city. Over the 20th century the suburbs became more accessible to wider swaths of the population as commuting costs declined, automobile ownership became ubiquitous, and government policy subsidized the suburban lifestyle.²⁵ The pattern of the more affluent suburbanizing first came to be associated with the image of central city poverty ringed by richer suburbs.

But the findings presented here echo other research that shows that the poor too are suburbanizing.²⁶ HCV recipients, whose low incomes make them among the poorest segments of society, are now almost equally likely to be suburban residents as they are urban, though these suburban areas tend to be in lower-income, perhaps older suburbs. Clearly, old notions that equate the central city with poverty and the suburbs with affluence are no longer apt. Many of the challenges associated with central city poverty (e.g. an eroding tax base, poor performing schools) will now be suburban challenges too. Whether or not suburban jurisdictions will fare better than central cities in handling their poorer populations is an important question deserving of further research.

The second issue that our research highlights is the extent to which the HCV program is successful in promoting a geography of opportunity by enabling poorer households to move to more affluent, job-accessible neighborhoods. Here the record is mixed. On the positive side of the ledger, the increasing HCV recipient access to suburbs can be taken as evidence that vouchers are enabling recipients to move to a broader array of neighborhoods. Nonetheless, HCV recipients were found to lag behind both the poor and units renting at or below FMR levels in their suburbanization into high-income areas. This finding echoes prior research that showed HCV recipients were not accessing high-opportunity neighborhoods as much as they could in theory.²⁷ As noted earlier, this could be for a number of reasons including landlord discrimination, lack of portability, and asymmetric information which can contribute to differences in housing search patterns.

To the extent that we wish to further expand the set of neighborhoods that HCV recipients reside in, several policy options are available. First, there is some evidence to suggest that mobility counseling, whereby HCV recipients are made aware of housing opportunities in low-poverty neighborhoods and local housing authorities recruit landlords in low-poverty neighborhoods to participate in the HCV program, can have an impact. Participants in mobility counseling programs were found to move to slightly less-disadvantaged neighborhoods compared to HCV recipients who did not receive such counseling.²⁸ This suggests expanding mobility counseling programs as a way of expanding access to more advantaged neighborhoods.

Second, the fair market rents effectively set a ceiling on the rents HCV recipients pay, although tenants can choose to pay more. But in some tight markets there may be little housing available below FMR levels and households may be unwilling or unable to pay more than the FMR. In such tight housing markets additional subsidies in the form of higher FMRs might be needed to enable HCV recipients to move to a broader array of neighborhoods. Moreover, HUD is currently exploring developing FMRs at the ZIP code level, and this could help in this regard by improving geographic information about rental options. Still, while improving availability and information about units below FMR in suburban locations should help increase rental options, they are not enough to prompt voucher holders to move there; they are but one factor among many that drive voucher-holders' location decisions. This suggests that to the extent that having families move to suburbs (at least those suburbs that could increase access to opportunity) is a desirable outcome, then pairing FMR changes with expansion of intensive counseling interventions, including post-move supports to help families adjust to their new neighborhoods, should have positive impacts.

Finally, there is evidence that landlords discriminate against voucher recipients specifically because the households hold a voucher.²⁹ A federal law that forbids discrimination against voucher recipients on the basis of the source of their income (i.e. the voucher) could potentially dampen such discrimination and go a long way toward increasing the geography of opportunity for voucher recipients.

Appendix

Figure A.1. Change in Share Living in Suburbs, HCV Recipients versus the Poor, 100 Largest Metro Areas, 2000 to 2008

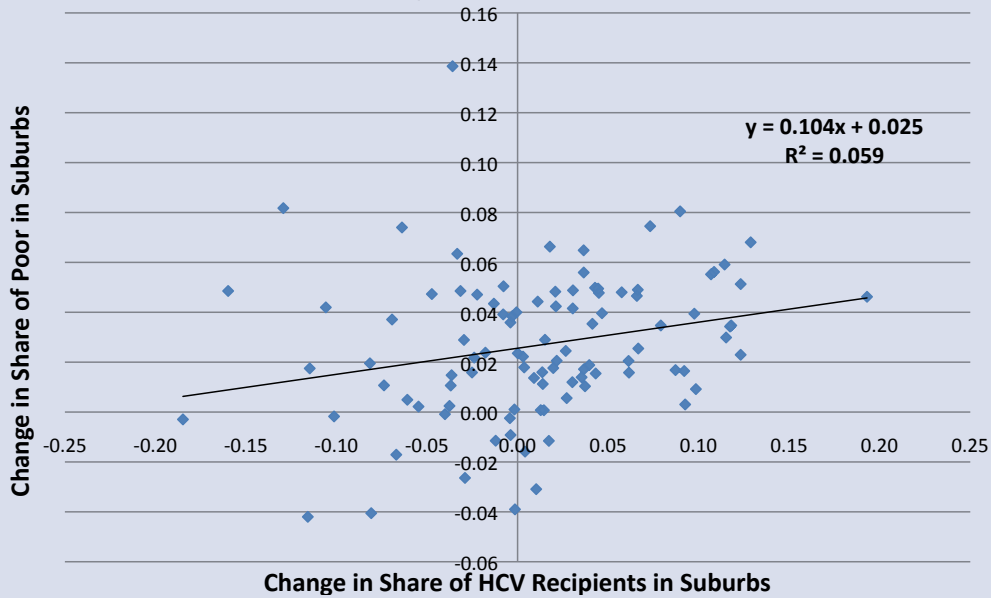


Figure A.2. Share of HCV Recipients versus Share of Poor in Suburbs, 100 Largest Metro Areas, 2008

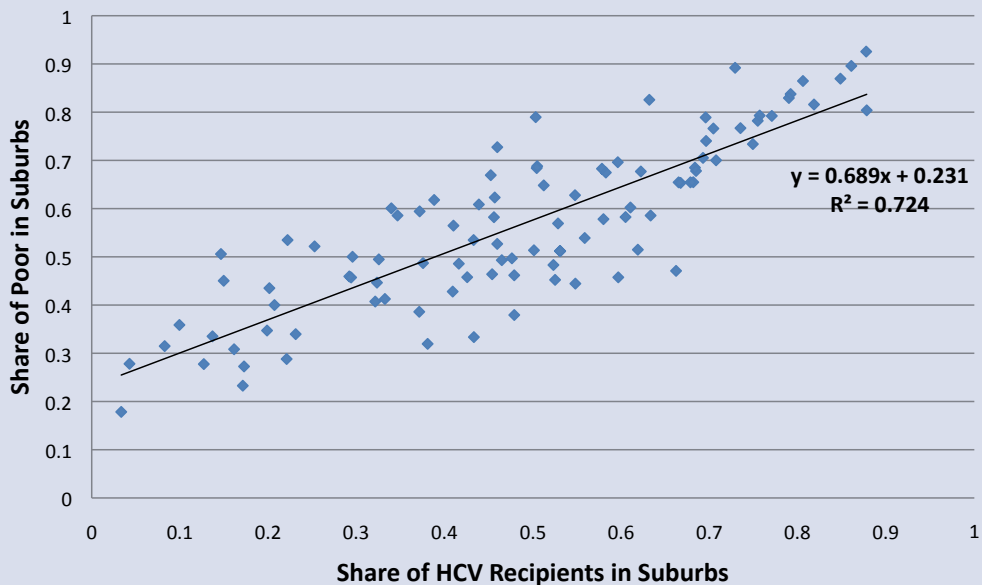


Table A.1. Difference Between the Suburbanization Rates of Housing Choice Voucher Recipients and Select Comparison Groups, by Region

Region	Difference in 2008			Change in Difference (2000 to 2008)		
	Total Population	Poverty Population	Fair Market Housing Units	Total Population	Poverty Population	Fair Market Housing Units
Northeast	20.7%	-1.5%	1.1%	-2.0%	0.3%	-1.5%
Midwest	24.2%	2.5%	5.4%	2.7%	6.1%	4.4%
South	22.1%	9.9%	7.2%	0.1%	1.4%	1.5%
West	12.9%	2.8%	0.5%	-2.3%	-1.4%	-1.7%

Source: Authors' analysis of HUD data, Census 2000, and ACS five-year estimates for 2005-2009

Appendix A. Share of Housing Choice Vouchers in Suburbs, 2000 and 2008

Metro Area	Distribution of Comparison Groups, 2005-2009				Share of Vouchers in Suburbs, 2000 and 2008			
	% Population in Suburbs	% Poor in Suburbs	% FMR Units in Suburbs	Total Vouchers, 2000	% Vouchers in Suburbs, 2000	Total Vouchers, 2008	% Vouchers in Suburbs, 2008	Change in Suburban %
Akron, OH	69.9	48.7	50.3	8,973	18.2	14,845	37.5	19.3
Albany-Schenectady-Troy, NY	88.4	74.0	77.7	12,594	70.0	16,294	69.6	-0.4
Albuquerque, NM	40.8	40.0	21.0	12,388	21.1	14,641	20.7	-0.4
Allentown-Bethlehem-Easton, PA-NJ	86.8	65.4	73.1	11,032	65.5	13,285	66.5	1.0
Atlanta-Sandy Springs-Marietta, GA	90.4	83.8	85.0	55,042	66.3	74,581	79.2	12.9
Augusta-Richmond County, GA-SC	62.5	52.2	45.5	7,499	33.4	15,440	25.2	-8.2
Austin-Round Rock, TX	59.5	42.8	34.9	7,639	33.6	16,090	40.9	7.3
Bakersfield, CA	66.1	66.9	66.8	7,826	36.0	9,211	45.2	9.3
Baltimore-Towson, MD	76.1	49.3	58.9	35,787	59.4	50,354	46.5	-12.9
Baton Rouge, LA	73.4	60.9	53.3	5,426	49.3	9,438	43.9	-5.5
Birmingham-Hoover, AL	79.1	59.4	56.4	11,793	24.8	17,897	37.2	12.3
Boise City-Nampa, ID	72.0	68.8	48.8	4,068	38.7	7,183	50.5	11.7
Boston-Cambridge-Quincy, MA-NH	83.8	68.5	72.2	83,318	64.0	112,069	68.3	4.3
Bradenton-Sarasota-Venice, FL	94.5	92.6	90.6	4,916	93.8	7,281	87.7	-6.1
Bridgeport-Stamford-Norwalk, CT	71.4	41.3	46.9	11,220	32.8	16,150	33.2	0.4
Buffalo-Niagara Falls, NY	75.8	49.5	54.5	23,148	33.3	31,396	32.5	-0.8
Cape Coral-Fort Myers, FL	74.2	79.2	81.1	4,084	85.1	449	77.1	-8.1
Charleston-North Charleston-Summerville, SC	81.4	78.2	71.8	9,607	72.4	13,327	75.5	3.0
Charlotte-Gastonia-Concord, NC-SC	68.4	62.3	53.4	11,832	49.0	21,652	45.7	-3.3
Chattanooga, TN-GA	66.0	53.5	51.5	4,603	29.6	8,452	22.2	-7.4
Chicago-Naperville-Joliet, IL-IN-WI	67.2	46.4	45.9	99,211	51.8	160,188	45.4	-6.4
Cincinnati-Middletown, OH-KY-IN	84.3	67.5	64.3	32,643	56.2	49,748	58.2	2.1
Cleveland-Elyria-Mentor, OH	79.1	53.9	58.9	34,059	46.9	52,713	55.9	9.0
Colorado Springs, CO	37.4	27.3	15.5	5,800	19.7	8,297	17.3	-2.4
Columbia, SC	86.4	82.9	79.1	9,516	79.8	12,124	79.0	-0.8
Columbus, OH	61.5	38.6	42.0	23,264	37.1	32,928	37.1	0.0
Dallas-Fort Worth-Arlington, TX	63.2	45.8	46.9	59,905	36.8	103,803	42.5	5.7
Dayton, OH	80.4	58.6	68.0	9,907	56.7	14,377	63.3	6.7
Denver-Aurora-Broomfield, CO	64.5	46.2	46.4	23,056	43.6	38,926	47.9	4.3
Des Moines-West Des Moines, IA	65.8	40.7	47.6	5,704	30.2	7,565	32.1	2.0

Appendix A. Share of Housing Choice Vouchers in Suburbs, 2000 and 2008 (continued)

Metro Area	Distribution of Comparison Groups, 2005-2009				Share of Vouchers in Suburbs, 2000 and 2008			
	% Population in Suburbs	% Poor in Suburbs	% FMR Units in Suburbs	Total Vouchers, 2000	% Vouchers in Suburbs, 2000	Total Vouchers, 2008	% Vouchers in Suburbs, 2008	Change in Suburban %
Detroit-Warren-Livonia, MI	76.4	49.7	61.7	21,096	58.2	59,382	47.6	-10.6
El Paso, TX	16.4	17.8	6.5	6,863	1.6	14,695	3.3	1.7
Fresno, CA	50.7	43.5	37.1	19,184	21.4	38,425	20.1	-1.3
Grand Rapids-Wyoming, MI	75.6	60.1	62.4	8,352	23.1	14,624	33.9	10.9
Greensboro-High Point, NC	54.9	45.7	40.7	4,015	39.5	9,380	29.4	-10.1
Greenville-Mauldin-Easley, SC	90.3	89.2	82.9	4,425	70.7	5,603	72.9	2.2
Harrisburg-Carlisle, PA	91.1	70.5	77.7	5,159	67.8	7,553	69.3	1.5
Hartford-West Hartford-East Hartford, CT	89.6	64.8	72.6	22,793	46.6	32,462	51.2	4.7
Honolulu, HI	58.7	51.5	41.3	11,104	52.7	13,382	61.9	9.2
Houston-Sugar Land-Baytown, TX	62.7	48.3	41.1	33,899	45.7	52,397	52.3	6.6
Indianapolis-Carmel, IN	52.6	30.8	29.7	9,098	19.1	15,712	16.1	-3.0
Jackson, MS	67.5	50.6	46.4	11,773	14.3	13,092	14.6	0.4
Jacksonville, FL	37.9	27.8	22.4	18,999	4.0	20,326	4.3	0.3
Kansas City, MO-KS	70.2	48.6	55.6	19,354	43.8	38,616	41.6	-2.2
Knoxville, TN	74.6	56.5	50.2	9,256	44.6	12,482	41.0	-3.6
Lakeland-Winter Haven, FL	83.8	82.6	73.6	3,270	50.9	4,681	63.2	12.3
Las Vegas-Paradise, NV	72.6	67.8	69.5	15,126	64.8	21,145	68.5	3.7
Little Rock-North Little Rock-Conway, AR	75.1	69.6	65.6	10,314	62.8	14,193	59.6	-3.2
Los Angeles-Long Beach-Santa Ana, CA	63.4	51.2	53.0	147,856	49.4	231,551	53.1	3.7
Louisville-Jefferson County, KY-IN	42.4	35.9	31.5	25,381	10.3	38,521	9.9	-0.4
Madison, WI	62.7	33.4	45.8	3,888	47.0	6,167	43.3	-3.7
McAllen-Edinburg-Mission, TX	81.9	86.5	76.4	7,953	81.8	13,736	80.6	-1.2
Memphis, TN-MS-AR	53.7	34.7	30.5	10,855	19.9	22,513	19.9	-0.1
Miami-Fort Lauderdale-Pompano Beach, FL	88.0	80.4	77.2	33,137	88.0	47,399	87.8	-0.2
Milwaukee-Waukesha-West Allis, WI	59.1	52.2	61.2	11,662	47.3	15,701	49.7	2.4
Minneapolis-St. Paul-Bloomington, MN-WI	78.7	51.2	55.7	39,054	51.3	50,087	53.1	1.8
Modesto, CA	64.9	62.8	58.7	6,384	46.0	10,546	54.8	8.7
Nashville-Davidson--Murfreesboro--Franklin, TN	61.6	50.0	44.0	16,843	26.9	22,073	29.5	2.7
New Haven-Milford, CT	85.3	68.3	70.2	15,648	62.5	26,989	57.8	-4.7
New Orleans-Metairie-Kenner, LA	71.5	58.6	60.4	20,915	38.2	19,625	34.6	-3.6
New York-Northern New Jersey-Long Island, NY-NJ-PA	54.7	32.0	33.6	338,338	36.5	461,015	38.1	1.5
Ogden-Clearfield, UT	84.1	60.2	59.2	4,433	79.5	5,749	61.0	-18.5
Oklahoma City, OK	52.7	44.6	43.2	16,954	36.1	28,596	32.3	-3.8
Omaha-Council Bluffs, NE-IA	52.7	34.0	38.5	12,752	19.6	17,179	23.1	3.5
Orlando-Kissimmee, FL	90.2	86.9	79.5	12,905	78.7	17,713	84.8	6.1
Oxnard-Thousand Oaks-Ventura, CA	56.3	45.2	47.8	10,871	52.6	13,291	52.5	-0.1
Palm Bay-Melbourne-Titusville, FL	81.6	78.9	84.6	2,577	81.1	5,277	69.6	-11.6
Philadelphia-Camden-Wilmington, PA-NJ-DE-MD	74.2	47.1	58.3	66,047	54.7	74,443	66.2	11.5
Phoenix-Mesa-Scottsdale, AZ	48.7	37.9	34.5	24,115	36.1	31,876	47.9	11.8
Pittsburgh, PA	86.6	76.6	78.8	30,388	64.3	35,286	70.4	6.2
Portland-South Portland-Biddeford, ME	88.2	79.0	72.5	5,690	48.9	7,024	50.3	1.4
Portland-Vancouver-Beaverton, OR-WA	67.5	56.9	53.8	23,418	53.1	34,118	52.8	-0.3
Poughkeepsie-Newburgh-Middletown, NY	95.6	89.6	87.4	8,624	82.4	16,739	86.1	3.7
Providence-New Bedford-Fall River, RI-MA	89.2	76.7	83.1	25,027	80.4	31,515	73.5	-6.9
Provo-Orem, UT	79.1	45.7	53.8	4,114	75.6	4,998	59.7	-16.0

Appendix A. Share of Housing Choice Vouchers in Suburbs, 2000 and 2008 (continued)

Metro Area	Distribution of Comparison Groups, 2005-2009				Share of Vouchers in Suburbs, 2000 and 2008			
	% Population in Suburbs	% Poor in Suburbs	% FMR Units in Suburbs	Total Vouchers, 2000	% Vouchers in Suburbs, 2000	Total Vouchers, 2008	% Vouchers in Suburbs, 2008	Change in Suburban %
Raleigh-Cary, NC	68.2	58.2	50.7	6,288	50.6	12,683	60.5	9.8
Richmond, VA	83.4	65.5	65.9	8,758	56.4	13,867	67.8	11.4
Riverside-San Bernardino-Ontario, CA	84.0	79.3	77.8	37,629	67.8	45,104	75.7	7.9
Rochester, NY	80.2	53.5	56.8	14,839	38.8	22,162	43.3	4.5
Sacramento--Arden-Arcade--Roseville, CA	74.8	67.7	65.3	23,256	55.6	35,012	62.2	6.6
St. Louis, MO-IL	87.3	73.4	73.0	28,691	71.8	51,178	74.9	3.1
Salt Lake City, UT	83.6	70.0	62.0	8,621	67.1	13,384	70.7	3.6
San Antonio, TX	35.7	23.3	18.7	23,726	14.4	39,920	17.1	2.7
San Diego-Carlsbad-San Marcos, CA	57.2	51.4	49.5	39,136	48.7	68,031	50.1	1.4
San Francisco-Oakland-Fremont, CA	67.3	57.8	50.2	74,353	48.2	94,854	58.0	9.8
San Jose-Sunnyvale-Santa Clara, CA	37.1	28.8	29.7	25,871	20.8	44,568	22.1	1.3
Scranton--Wilkes-Barre, PA	87.3	81.6	80.5	7,856	85.8	10,548	81.8	-4.0
Seattle-Tacoma-Bellevue, WA	72.6	65.3	59.8	38,551	65.6	48,701	66.7	1.1
Springfield, MA	79.4	61.8	72.8	19,644	41.7	24,391	38.8	-2.9
Stockton, CA	60.0	45.9	44.3	7,896	18.5	12,937	29.2	10.7
Syracuse, NY	78.4	52.7	57.8	13,748	45.0	14,606	45.9	0.9
Tampa-St. Petersburg-Clearwater, FL	76.8	68.4	66.0	25,480	48.3	40,993	50.4	2.1
Toledo, OH	52.9	31.5	35.9	6,164	10.0	9,721	8.3	-1.8
Tucson, AZ	48.5	33.5	23.6	7,703	9.6	13,302	13.7	4.1
Tulsa, OK	57.8	45.0	34.0	12,682	21.7	16,474	15.0	-6.7
Virginia Beach-Norfolk-Newport News, VA-NC	48.3	44.4	40.2	22,965	50.8	32,289	54.8	4.0
Washington-Arlington-Alexandria, DC-VA-MD-WV	82.3	65.5	66.1	54,540	63.7	78,251	68.2	4.5
Wichita, KS	44.0	27.8	26.1	2,258	24.2	6,751	12.7	-11.5
Worcester, MA	77.6	58.2	60.0	11,254	48.1	13,426	45.6	-2.5
Youngstown-Warren-Boardman, OH-PA	87.0	72.7	78.2	6,432	42.9	9,718	46.0	3.0

Source: Authors' analysis of American Community Survey 2005-09 five-year estimates and HUD data

Endnotes

1. Kenya Covington is an assistant professor in urban studies and planning at California State University Northridge; Lance Freeman is director and associate professor of the Urban Planning Program at Columbia University; Michael Stoll is professor and chair for the Department of Public Policy at UCLA.
2. See reviews of the "spatial mismatch" literature, e.g., Harry Holzer, "The Spatial Mismatch Hypothesis: What Has the Evidence Shown?" *Urban Studies* 28 (1) (1991): 105-122; Keith Ihlanfeldt and David Sjoquist, "The Spatial Mismatch Hypothesis: A Review of Recent Studies and their Implications for Welfare Reform," *Housing Policy Debate*, Vol. 9 (1998). For recent evidence on trends in spatial mismatch during the 1990s, see Steve Raphael and Michael

- A. Stoll, "Modest Progress: The Narrowing Spatial Mismatch between Blacks and Jobs in the 1990s," (Washington: Brookings, 2002). For evidence of spatial mismatch of the poor during the 1990s, see Kenya Covington, "Spatial Mismatch of the Poor: An Explanation of Recent Declines in Job Isolation," *Journal of Urban Affairs*, 31 (5) (2009): 559-587.
3. James E. Wallace and others, "Participation and Benefits in the Urban Section 8 Program. New Construction and Existing Housing" (Cambridge: Abt Associates, 1981).
4. HUD funded 16 housing authorities under the Regional Opportunity Program (ROC). The ROC ended in 1999. Since that time a handful of housing authorities have continued to operate mobility counseling programs often as a result of a court order.

5. Jeffrey M. Lubell, "Recent Improvements to the Section 8 Tenant-Based Program," *Cityscape* 5 (2) (2001): 123-126. While voucher recipients may spend up to 40 percent of adjusted gross income at the initial lease, there is no limit on the percentage of income they may devote toward housing in subsequent years, though the rent must be found reasonable by the housing authority.
6. Alan Berube and Elizabeth Kneebone, "Two Steps Back: City and Suburban Poverty Trends, 1999-2005," (Washington: Brookings, 2006); Steve Raphael and Michael A. Stoll, "Job Sprawl and the Suburbanization of the Poor," (Washington: Brookings, 2010); Elizabeth Kneebone, "Job Sprawl Revisited: The Changing Geography of Metropolitan Employment" (Washington: Brookings, 2010).
7. A key concern in analyzing data at the sub-metropolitan level is how to define these areas, especially those within the suburbs. For instance, some use county based definition, in which "first" suburbs are defined as central counties (excluding the central cities in those counties) and any county adjacent to the central city. But such a definition is problematic, in that adjacent counties (e.g., Montgomery County, MD, which is adjacent to Washington, DC) can often have quite heterogeneous populations. They can also have quite high average incomes. On the other hand, defining sub-metropolitan areas on the basis of municipalities is also problematic, as municipalities can vary enormously in size and jurisdiction. In this paper, we avoid these issues by aggregate data using census tracts, which are small enough to capture the enormous heterogeneity across areas.
8. Harry J. Holzer and Michael A. Stoll, "Where Workers Go, Do Jobs Follow? Metropolitan Labor Markets in the US, 1990-2000," (Washington: Brookings, 2007).
9. Metropolitan statistical area (MSA) definitions are consistent with the U.S. Office of Management and Budget definitions in 2008. Primary cities are defined according to the methods outlined in several Brookings publications (e.g., Berube and Kneebone, "Two Steps Back."), and include those that appear first in the official MSA name, as well as any other city in the MSA title that has a population of at least 100,000.
10. The alternative method is to assign census tracts to cities or suburbs based on their population distributions at the block level. In this way, an allocation factor is generated using this method that estimates whether the population density is greater in the city or suburban portion of the census tract, and is assigned as such. We decided against this approach because the population density of HCV recipients could not be determined since the lowest geographic level of information provided on residence is at the census tract level. Still, it is unlikely that differences in these methods in assigning census tract to cities or suburbs will significantly affect the results of the analysis. What is in favor of this approach is that it is consistently applied to each census tract that fall between these boundaries. To the extent that these central city/suburban boundaries fall inside these census tracts randomly, very little bias should be introduced in defining suburbs in this way.
11. We did attempt to examine whether housing market or landlord discrimination against HCV recipients limits their ability to move to suburbs. We did this by comparing the suburbanization rates of HCV recipients across metropolitan areas in states with ordinances preventing landlord discrimination on the basis of HCV reciprocity to those metro areas in states without these ordinances. We also examined the change in suburbanization rates of HCV recipients across metropolitan areas between 2000 and 2008 in states who adopted ordinances preventing landlord discrimination on the basis of HCV reciprocity over this period to those metro areas in states that did not. We did not detect any statistically significant differences in suburbanization rates of HCV recipients (or by the race of HCV recipients) in any of these comparisons. Despite this evidence, we cannot conclude that discrimination is not a factor in influencing the suburbanization rates of HCV recipients. Evidence at the state level may not be the best approach for examining this since state level ordinances may not be uniformly or effectively enforced. A better approach might be to examine these issues at a lower level such as the county or the city. However, no consistently significant relationship has been found between such ordinances and neighborhood poverty rates, racial composition, and voucher concentration; see Lance Freeman, "The Impact of Source of Income Laws on Voucher Utilization and Locational Outcomes," Report prepared for the U.S. Department of Housing and Urban Development. (Washington: 2011).
12. To be sure, HCV recipients will and do overlap with the category of the poor (and the total population), and thus the poor should not be considered a scientifically valid comparison group. Still, HCV recipients represent a small fraction of the poor, and the use of the poor for comparison purposes should be considered instructive of whether HCV recipients' locational choices follows that of the overall poor.
13. Fair Market Rents are used by HUD to determine the size of the subsidy that the voucher recipient receives.

Typically, the voucher recipient receives a subsidy that is equal to the difference between the FMR and 30 percent of their income. FMRs are set at the metropolitan level and are defined as the rent at which 40 percent of all rents for standard quality units in a given metropolitan area fall below. See U.S. Department of Housing and Urban Development, "Fair Market Rents For The Section 8 Housing Assistance Payments Program." (Washington: 2007) at <http://www.huduser.org/portal/datasets/fmr.html>. We also examined rental options at 20 and 50 percent above FMR since HCV recipients can choose to pay above FMR so long as they pay the difference and they pay no more than 40% of their income toward rent. Using this alternative approach at measuring FMR units did not change the results of the analysis.

14. We examine the suburbanization of all rental units in the metro area that rent at or below FMR. In this way, our analysis focuses only on the relative availability of FMR rental units to HCV recipients by geographic location in MSAs. To the extent that the absolute number of FMR rental units available to HCV recipients (or to the poor more generally) may be insufficient for all low-income individuals to find rental housing, our results may understate the problems they may experience in finding affordable housing in the suburbs.
15. Alternatively, we used only 2000 census tract data to define these tracts by their income terciles, and then assigned these codes to the 2008 census tract data. We also used 2005-09 census tract data to define these tracts by their income terciles. These alternative approaches did not change the results shown here.
16. We also experimented with job accessibility measures limited to low skill persons (a high school degree or less) and low skilled jobs (i.e., retail trade) because of the socio-economic characteristics of HCV recipients, who are more likely to search for and work in lower skilled employment. However, the qualitative results of this approach were not different than that showed here. Of course, this jobs to people measure of job accessibility is a crude measure of geographic job accessibility that does not take into account competing searchers for jobs in these areas or availability of nearby jobs outside of or contiguous to these zip codes. However, the results reported here are consistent with current research and our expectations, and thus can be considered instructive.
17. Suburbanization rates for all groups are weighted by the respective populations in each metro area. For example, HCV suburbanization rates are weighted by the number of HCV recipients in the metro area, suburbanization rates of the poor are weighted by the number of poor people in the metro area, and so on and so forth for the other groups included in the study. Weighting in this way permits us to interpret the patterns as the average degree of suburbanization experienced by the typical member of each group. Also, weighting the calculation of the suburbanization rate places more weight on metropolitan areas with large populations. For example, New York, Chicago, and Los Angeles, will all receive relatively large weights in the calculation of suburbanization rates (for each group, i.e., total population, the poor, HCV recipients) given the relatively large populations of these areas.
18. See Michael A. Stoll, "Race, Place and Poverty Revisited," in Ann Chih Lin and David R. Harris (eds.) *The Colors of Poverty: Why Racial and Ethnic Disparities Persist*, (New York: Russell Sage Foundation, 2008).
19. Metropolitan area size categories are defined by terciles for population size for the metro areas in the study, and the levels of these cutoffs are listed in the figure. these changes in suburbanization rates over the period and metro area size Figure 4 indicates that HCV recipients' suburbanization rates grew most dramatically in regions where their suburbanization rate was the highest in 2008; in the West (by 4.1 percentage points) and in medium sized metro area (by 3.7 percentage points). and the size of the metro area The results also show that suburbanization rates of HCV recipients are slightly higher in medium sized metro areas than elsewhere. For example, slightly more than 60 percent of HCV recipients live in suburban areas in medium sized metro areas, while about 40 percent do so in smaller metro areas.
20. In reality, eligibility for HCV is determined by the Public Housing Authority, and is based on gross income and family size; typically, the family's income may not exceed 50% of the median income for the county or metropolitan area in which the family chooses to live.
21. In the appendix, Figure A.1 presents a visual representation of the change in the suburbanization rate of the poor plotted against the change in the suburbanization rate of HCV recipients over the 2000 to 2008 period for each of the 100 metropolitan areas in the study. Figure A.2 presents a visual representation of the suburbanization rate of the poor plotted against the suburbanization rate of HCV recipients in 2008 for each of the 100 metropolitan areas in the study.
22. We examined similar graphical plots between the suburbanization of HCV recipients and of FMR units to explore whether HCV recipients suburbanization is influenced by

the availability of appropriate rental units. We did not find a similar strong positive relationship between changes in the suburbanization rate of HCV recipients and of FMR units. One reason could be because other barriers, such as landlord discrimination, may limit HCV recipients' access to FMR units rental in suburbs. Another reason could be because increases in the supply of such rentals occur over longer periods of time. Creation of rental units is dependent on a variety of other time consuming factors including developers' investment decisions, zoning and permitting issues, and other development regulations.

23. Between 2000 and 2008 in the largest 100 metro areas, the number of poor people in suburban areas increased by about 2.5 million. The number of people in HCV households increased by 572,000 over the same period, which makes up 23 percent of the absolute growth in the number of poor persons in this area over this period.
24. For example, see Holzer and Stoll, "Where Workers Go, Do Jobs Follow?"
25. Kenneth T. Jackson, *Crabgrass Frontier: The Suburbanization of the United States* (Oxford University Press, 1985).
26. Raphael and Stoll, "Job Sprawl and the Suburbanization of the Poor."
27. Kirk McClure, "The Prospects for Guiding Housing Choice Voucher Households to High-Opportunity Neighborhoods," *Cityscape* 12 (3) (2010): 102-124.
28. Mary K. Cunningham and Noah Sawyer, "Moving to Better Neighborhoods with Mobility Counseling," (Washington: Urban Institute, 2005).
29. J. G. Macdonnell and Bruce E. Kahn, "In Search of Decent Housing in the D.C. Metropolitan Area: The Affordable Housing Crisis for Section 8 Voucher Holders," (Washington: Equal Rights Center, 2005).

Acknowledgments

The authors owe a huge debt of gratitude to Elizabeth Kneebone of the Brookings Institution who graciously provided the census tract (ZIP code) to metropolitan area crosswalk data, and to Chanell Wheeler for excellent research assistance.

The Metropolitan Policy Program at Brookings thanks the Ford Foundation for its generous support of the program's research on city and suburban poverty and opportunity, the Annie E. Casey Foundation for its support of the program's research on low-income working families, and the John D. and Catherine T. MacArthur Foundation, the George Gund Foundation, the F.B. Heron Foundation, and the Heinz Endowments for their general support of the program, as well as members of the Metropolitan Leadership Council.

For More Information

Kenya Covington
Visiting Faculty
UCLA Luskin School of Public Policy
Associate Professor of Urban Studies
and Planning
California State University Northridge
kcovington@csun.edu
(818) 677-6463

Lance Freeman
Director and Associate Professor,
Urban Planning Program
Graduate School of Architecture,
Planning, and Preservation
Columbia University
lf182@columbia.edu
(212) 854-8495

Michael A. Stoll
Professor of Public Policy and
Urban Planning,
Associate Director of the Center
for the Study of Urban Poverty
UCLA
mstoll@ucla.edu
(310) 206-4774

For General Information

Metropolitan Policy Program at Brookings
(202) 797-6139
www.brookings.edu/metro

The Brookings Institution is a private non-profit organization. Its mission is to conduct high quality, independent research and, based on that research, to provide innovative, practical recommendations for policymakers and the public. The conclusions and recommendations of any Brookings publication are solely those of its author(s), and do not reflect the views of the Institution, its management, or its other scholars.

Brookings recognizes that the value it provides to any supporter is in its absolute commitment to quality, independence and impact. Activities supported by its donors reflect this commitment and the analysis and recommendations are not determined by any donation.

About the Brookings Metropolitan Opportunity Series

Launched in 2009, the Metropolitan Opportunity Series documents the changing geography of poverty and opportunity in metropolitan America, analyzes its drivers and implications, and offers policy recommendations to enhance the well-being of lower-income families and communities in both cities and suburbs. This study and other publications, speeches, presentations, and commentary in the series are available at: www.brookings.edu/metro/Metropolitan-Opportunity.aspx

In the Series

- *Missed Opportunity: Transit and Jobs in Metropolitan America*
- *Job Sprawl and the Suburbanization of Poverty*

Forthcoming

- *New Trends in Concentrated Poverty*
- *Job Sprawl in the 2000s (Before and After the 'Great Recession')*

BROOKINGS

1775 Massachusetts Avenue, NW
Washington D.C. 20036-2188
telephone 202.797.6000
fax 202.797.6004
web site www.brookings.edu



Metropolitan Policy Program

at BROOKINGS

telephone 202.797.6139
fax 202.797.2965
web site www.brookings.edu/metro