The Evolution of Income Support Policy in Recent Decades[*]

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I. Introduction

This paper documents the evolution of antipoverty programs in the United States, focusing particularly on the 1990s.[1] Antipoverty programs are designed to mitigate the most pernicious aspects of market-based economic outcomes – unemployment and low earnings. These programs compose society's "safety net" and each has different eligibility standards and benefit formulas. While they can be aggregated and categorized to summarize trends in coverage and generosity, a consequence of their patchwork nature is that the safety net may appear much different to a family in one set of circumstances than it does to a family in another. Thus, we strike a balance between providing an overview of the evolution of public spending on the poor and highlighting the changes that affected families in specific circumstances.

The magnitude of pre-tax and transfer poverty in the U.S. is striking. As shown in Figure 1, since 1979 between 18.6 and 22.1 percent of the population had pre-tax and transfer incomes below the poverty line since 1979 (also see Burtless and Smeeding, Chapter 1).[2] Figure 1 also plots a post-tax and transfer measure of poverty, which, when compared to the pre-tax and transfer measure, reflects the overall effects of the tax and transfer system on poverty. Taxes and transfers have a substantial effect, reducing poverty rates by 9.6 to 11.8 percentage points across years. The similarity of the time series patterns of the two measures plotted in Figure 1 is also striking, though the post-tax and transfer measure increased less (by 1.8 percentage points) during the 1990 recession than did the pre-tax and transfer measure. The consistency in the two series suggests there have been few changes in taxes and transfers affecting low-income families.

[1] In doing so we update papers by Burtless (1986, 1994) that document trends in public spending on the poor through 1986 and then through 1992.

[2] Pre-tax and transfer poverty is based on market incomes, ignoring all taxes and transfers. It differs from the conventional measure of poverty, which takes income before taxes, adds government cash transfers, and compares this income measure with the poverty line. Freeman (Chapter 4) discusses a similar pre-tax and transfer measure of poverty.

In fact, this consistency masks significant programmatic changes.

Before describing how the evolution of programs accounts for the reduction in poverty illustrated by these two series, we briefly discuss three factors – the economy, public opinion and trends in poverty rates for subgroups in the population – that provide context.

Poverty rates vary with economic performance. The sensitivity of market-based poverty to economic cycles is apparent in Figure 1: the poverty rate rose 2.9 percentage points during the severe recession in the early 1980s, and 3.3 percentage points during the milder (in aggregate) recession in the early 1990s.[3]

As income inequality increased over the last two decades, the relationship between aggregate economic performance and poverty weakened though it remains strong. Figure 2 plots the ratio of the poverty line and median income for a family of four on the left axis, and the official poverty rate (which accounts for cash, but not in-kind transfers or the tax system) for persons under 65 on the right axis. Changes in the series are strongly, positively correlated (the correlation coefficient is 0.81). The relationship between the two series shifted sharply between 1979 and 1982, when the poverty rate rose much more than would be expected based on its historical relationship to economic growth, but economic growth that benefits median income families still has important antipoverty effects.[4]

The antipoverty effects of the safety net will vary with Americans' attitudes toward welfare

[3] Real GDP (in 1996 dollars) fell 0.45 percent between the first and fourth quarters in 1980. It fell another 2.86 percent between the third quarter of 1981 and the third quarter of 1982. Real GDP fell 1.49 percent between the second quarter in 1990 and the first quarter in 1991. Data are from http://www.bea.doc.gov/bea/dn/gdplev.htm. The difference in apparent sensitivity of poverty rates to the business cycle in the 1980s and 1990s was due, at least in part, to the geographic dispersion of the 1990 recession. It was fairly light in the Midwest, which typically has somewhat lower poverty rates than the rest of the country, and it was more severe on the coasts. Los Angeles County, California, for example, had negative year-over-year job growth for 3 consecutive years, losing nearly 6 percent of its jobs between 1990 and 1991.

[4] The relationship between the economy and poverty has been a topic of considerable interest. See, for example Blank and Blinder (1986), Cutler and Katz (1991), Blank and Card (1993), Haveman and Schwabish (1999), Haveman (1999) and Freeman (Chapter 4).

and assistance to the poor, because attitudes influence the evolution of specific programs. Figure 3 plots the responses to two questions drawn from the General Social Survey, a personal interview of households conducted by the National Opinion Research Center (NORC) at the University of Chicago almost annually since 1973. The two questions start, "We are faced with many problems in this country, none of which can be solved easily or inexpensively. I'm going to name some of these problems, and for each one, I'd like you to tell me whether we're spending too much money on it, too little money, or about the right amount. Are we spending too much money, too little money, or about the right amount on …". The two lines beginning in 1973 plot the percentage of respondents saying "too little on welfare" (the bottom series) and "too much on welfare" (the top series). In 1984 the GSS started asking an identical question on "assistance to the poor." The lowest line (that starts in 1984) shows the percentage that says we are spending "too much on assisting the poor." The highest line (that starts in 1984) shows the percentage that says we are spending "too little."

The GSS responses are striking.[5] First, a near majority of respondents appear to simultaneously believe we are spending too much on welfare and too little on assisting the poor. The conflicting responses to welfare and assistance to the poor highlight tensions that arise when crafting the safety net between an instinct to help disadvantaged families and an unwillingness to do so through welfare programs.

Second, there was a sharp increase, starting in 1993, in the percentage of respondents who said spending on welfare was too high. The increase coincides with President Clinton's 1992 campaign pledge to "end welfare as we know it" and the legislative deliberations that culminated in the Personal Responsibility, Welfare and Opportunity Reconciliation Act (PRWORA), which

[5] See Bobo and Smith (1994) and the citations therein for a more thorough discussion of these issues and public opinion on poverty and race.

eliminated the federal Aid to Families with Dependent Children program. There was a comparable decline in the percentage of respondents who said we were spending too little. These patterns both influence and are influenced by public debates, but they document Americans' longstanding antipathy toward welfare.

Because antipoverty programs target specific population subgroups, it is helpful to look at their poverty rates. Figure 4 shows trends in the conventional (cash income) measure of poverty for persons older than 64, children under 18, persons 18 to 64, and for the full population. Two things stand out. Poverty rates for children are very high – nearly 20 percent of children are being raised in a poor family.[6] The 1998 child poverty rate (18.9 percent) is only 8.4 percentage points lower than the 1959 child poverty rate and is almost 5 percentage points *higher* than its lowest point in the late 1960s and early 1970s.

The second striking feature of Figure 4 is the decline in poverty rates for the elderly. In 1959, the elderly poverty rate was 35.2 percent; by 1998, it was 10.5 percent, equal to the poverty rate for prime-age workers. A complete explanation for the strikingly different patterns of child and elderly poverty rates would require analysis of saving behavior of prime-age workers, retirement decisions of the elderly, marriage and fertility patterns of workers with low human capital (see Cancian and Reed, Chapter 5), and the operation of low-wage labor markets. As we discuss below, however, some of the differences can be traced to policy choices.

Antipoverty policy is conducted against this backdrop of economic performance, attitudes and beliefs, and the shifting demographic composition of the poor. Many programs have resulted with different target groups and eligibility requirements. In our subsequent discussion, we separate these programs into "social insurance" and "means-tested transfers." Collectively

[6] Poverty rates are even higher for families with children under six, where nearly one quarter of U.S. children are being raised in poverty (Green Book, 1998, page 1293).

they compose the safety net.

II. Social Insurance

The distinguishing characteristics of social insurance programs are that they are universal, in that all individuals or their employers make contributions to finance the program and all people can receive benefits when specific eligibility requirements are met, and they have dedicated funding mechanisms where, at least in an accounting sense, social insurance taxes are remitted to trust funds from which benefits are paid.

a. Social Security and Medicare

The largest social insurance program is social security, formally known as the Old-Age, Survivors, and Disability Insurance program (OASDI). Social Security was founded in 1935 as one of President Franklin Roosevelt's New Deal programs and was designed to meet the unmet social need of older workers leaving the workforce without sufficient post-retirement income to be self-supporting.[7]

Figure 5 plots the time series of real social security (OASI) payments from 1959 to 1999 (DI benefits are not included in the series, but are discussed below). Real social security payments have grown sharply over the entire period, doubling between 1973 and 1999. Three factors are responsible for this increase. First, the number of retired workers covered by social security has steadily increased. Second, the social security taxable wage base grew steadily, as did real earnings. Third, legislated benefit increases frequently exceeded the cost of living into the early 1970s. Aggregate real social security benefits increased by roughly 170 percent between 1970

[7] In 2000, the OASDI program is financed by a 6.2 percentage point tax levied on employers and employees (for a combined 12.4 percent tax) on earnings up to $76,200. These tax receipts are credited to the social security trust fund. To receive benefits a worker must have at least 40 quarters of employment in jobs covered by the social security system (most jobs are now covered). Benefits are based on average indexed monthly earnings (AIME) for the highest 35 years of earnings (inserting 0's for monthly earnings if workers have fewer than 35 years of positive earnings) using a formula that gives low-income workers a greater share of their AIME than high-income workers. Workers (who are not disabled) can begin drawing benefits as early as 62. Benefits payments increase (nonlinearly)

and 1998, while real benefits per recipient increased by 64 percent.

Social security is a massive program and pre-tax and -transfer poor families receive half of its benefits. Consequently it has a major effect on poverty rates among the elderly. Aggregate OASI payments were $334.4 billion in 1999. Average social security benefits (including survivor's benefits) were $9,689 in 1998 and average benefits for a retired worker exceeded $750 per month ($1,300 for couples). Thus, it is not surprising that poverty rates for the elderly are low, as the poverty line for a single elderly person in 1998 was $7,818 and that for an elderly couple was $9,862.[8]

The elderly also receive substantial benefits from Medicare, which covers almost all people over age 65 and most people under 65 who are receiving Social Security disability benefits (DI). Medicare provides hospital insurance and, for some households, supplementary medical insurance.[9] Real Medicare outlays have increased more than tenfold from $16.9 billion in 1967 (the year the program started) to $233.4 billion in 1999. Real expenditures per Medicare enrollee increased almost six times over the same time period to $5,810 in 1998.

Fifty-two percent of Medicare benefits go to families whose pre-transfer incomes are below the poverty line. It is difficult to determine the specific antipoverty effectiveness of Medicare because it provides an in-kind benefit (medical care) and insurance.[10] There are several possible ways to value these benefits. One could value them at the cost to the government of their provision, the cost a recipient would have to pay to acquire comparable benefits, or the amount a person would be willing to pay for such benefits (which will be less than the cost to the

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as retirement is delayed until age 72, at which point benefits no longer increase with age of retirement.

[8] Recent work (see, for example, Coronado, Fullerton and Glass, 2000 and Gustman and Steinmeier, 2000) suggests that on a *lifetime* basis, social security does much less to redistribute resources from high- to low-income households than would be suggested by looking at the targeting of benefits in a single year. It is still useful to consider an annual time frame when considering poverty issues.

[9] It is financed by a 1.45 percent payroll tax on uncapped earnings levied on employers and employees (for a total tax of 2.9 percent).

government for many low-income recipients).[11] In Section IV, when assessing the antipoverty effectiveness of spending on the poor, we make illustrative calculations of the degree to which Medicare reduces poverty.

b. Behavioral effects

Considerable attention has been given to the behavioral effects of the annual $560 billion social security and Medicare expenditure. The literature on social security has focused primarily on its effects on capital accumulation and labor market behavior in the population at large.[12] In one of the few behavioral studies focusing on low-income people, Kahn (1988) raises the possibility that for workers with low levels of human capital, retirement with social security benefits may offer a higher standard of living than they would get if they continue to work. He presents evidence that an unexpectedly high fraction of those drawing social security benefits at age 62 are poor households who are unable to borrow against future social security.

Even though social security may affect retirement decisions, labor force issues are less important for the elderly than they are for prime-age workers. The elderly rarely make investments in education. Their lifetime saving decisions, which may have once been influenced by social security, have largely been made by the time they are eligible to receive benefits. Consequently, despite professional debates over the lifetime distributional effects of social security, its effect on poverty is straightforward. The social security system redistributes a large amount of money from workers to retired families. As the social security system has matured, poverty rates of the elderly have fallen precipitously.[13] The sharpest decline in elderly poverty

[10] The official poverty measure does not account for Medicare benefits.
[11] Smeeding (1982) provides a nice discussion of these issues.
[12] Medicare is discussed more extensively in Mullahy and Wolfe (Chapter 9). See Feldstein (1996) and Bernheim (1987) for a discussion of social security and capital formation, and Rust and Phelan (1997) for social security and retirement decisions.
[13] Advocates of social security privatization (see, for example, Feldstein and Samwick, 1998) suggest that we can do even better at a lower social cost, while others (see, for example, Aaron and Reischauer, 1999) argue, among other

rates occurred between 1959 and 1974 (see Figure 4), a period that coincides with extremely rapid growth in social security.[14]

c. Social insurance for prime-age workers

While social security and Medicare also provide benefits for non-elderly people through disability insurance and survivor's benefits, 87.1 percent of Medicare recipients were elderly in 1998, and 84.0 percent of social security recipients are elderly in 2000. In recent years, the elderly have typically received between 85 and 90 percent of all payments for both Medicare and social security.[15] Three smaller social insurance programs, unemployment insurance (UI), workers' compensation, and disability insurance (DI), target prime-age workers.

Unemployment insurance provides temporary and partial wage replacement to recently employed workers who become involuntarily unemployed.[16] While unemployment insurance allows families to smooth consumption during periods of involuntary layoffs (see, for example, Gruber, 1997), it has relatively minor antipoverty effects. Gustafson and Levine (1998), for example, suggest that only one-third of job separations for less skilled men and fewer than 16 percent of job separations for less skilled women meet the eligibility requirements for unemployment insurance.[17] Even fewer women who previously received welfare qualified. In 1992, a recession year, $43.9 billion in real unemployment insurance benefits were paid out, while real payments were $20.0 billion in 1998.

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things, that low-income, vulnerable families may be harmed by privatization.

[14] From 1959 to 1974, real social security spending increased 210 percent, a much sharper growth rate than other 15-year periods. For example, real social security spending increased 110 percent between 1970 and 1985, and 32 percent between 1984 and 1999. Since 1974, social security benefits have been indexed for inflation.

[15] Authors' calculations from data provided by the Health Care Financing Administration and Social Security Administration.

[16] The federal portion of unemployment insurance is financed by a 0.8 percent tax levied on employers on the first $7,000 of wages paid to each covered employee. The states levy additional, modest taxes to finance their programs.

[17] Although eligibility varies by state, typically one must have worked for at least two quarters of the previous year in covered employment, be actively seeking work, and have lost one's job through no fault of one's own. A worker can generally receive a maximum of 26 weeks of benefits and these benefits generally replace between 50 and 70

Workers' compensation provides cash and medical benefits to some persons with job-related disabilities or injuries and provides survivors' benefits to dependents of those whose death resulted from a work-related accident or illness. Benefit levels vary widely across states. Workers' compensation payments are large, equaling $42.6 billion in real terms in 1998. Because there is little Federal involvement in this system, it is difficult to find information on its antipoverty effects.

Disability Insurance (DI) is part of the OASDI program. Disability benefits are drawn when a covered worker is unable to engage in "substantial gainful activity" by reason of a physical or mental impairment, which is expected to last for more than 12 months or result in death.[18] Workers must have a minimum period of covered employment before being eligible; depending on the age at which a disability occurs, this ranges from 6 to 40 covered quarters. The disability insurance rules are stringent, with fewer than 50 percent of all applications being granted benefits; roughly 4.5 awards are made per 1,000 covered workers. Around 4.8 million disabled workers (or 6.5 million people when including spouses and children) receive disability benefits, which cost $51.3 billion in 1999.

d. Summary of social insurance

Social security, Medicare, unemployment insurance, workers' compensation and disability insurance are the major social insurance programs in the United States. Over time, the enormous increase in the value of their benefits has been driven largely by increases in social security and Medicare. The magnitude and growth of social insurance programs are not surprising as their

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percent of the individual's average weekly pretax wage up to some State-determined maximum.

[18] Substantial gainful activity means work activity that involves significant physical or mental effort and that is done for pay or profit. Work activity is gainful if it is the kind of work usually performed for pay or profit, whether or not a profit is realized. The Commissioner of the Social Security Administration prescribes by regulations the criteria for determining when earnings demonstrate ability to engage in substantial gainful activity for a person with an impairment other than blindness. These regulations are complex, though average monthly earnings (currently of $700) ordinarily demonstrate substantial gainful activity for people with an impairment other than blindness.

benefits are predicated on events that are salient for most Americans – retirement, unemployment, or a disability or work-related injury. They are universal for all contributors, meaning benefits are not asset and income tested. All have dedicated financing mechanisms. And, while social security may reduce national saving and hasten retirement, and while unemployment insurance may alter the intensity with which the unemployed search for jobs, there is no evidence that the social insurance programs encourage individuals not to marry, have children out of wedlock, or not work for extended periods in the paid labor market (unemployment insurance benefits are time-limited). Thus, the rationale and incentives of the programs do not appear at odds with societal norms of personal responsibility. Social security and Medicare have the added feature of lessening intergenerational care-giving responsibilities that children might have for their parents, which is popular with both parents and children.

III. Means-Tested Transfers

A relatively small fraction of social insurance payments go to younger poor families. Many other programs target the non-elderly poor or otherwise disadvantaged. These programs are financed by general revenues, rather than through dedicated financing mechanisms. Some are entitlements – meaning that all who satisfy eligibility requirements get benefits, regardless of the total budgetary cost – while others are not. They all have income and asset tests that must be met, hence the label means-tested transfers. The programs have explicit antipoverty goals. Together, they have a smaller budgetary cost than the social insurance programs.

a. Health care and the disabled

Medicaid, the largest means-tested transfer program (also see Mullahy and Wolfe, chapter 9), funds medical assistance to low-income persons who are aged, blind, disabled, members of families with dependent children, and certain other pregnant women and children. Asset and

income tests that vary across states determine eligibility. All families who received AFDC benefits were statutorily covered under Medicaid. TANF recipients are not automatically eligible. States, however, must cover families who would have been eligible under the AFDC rules in effect as of July 16, 1996, though states have the discretion to lower income eligibility standards to the levels in effect as early as May 1, 1988 (also see Pavetti, chapter 7).

More than 70 percent of all Medicaid recipients had income below the poverty line in 1997; fewer than 10 percent of Medicaid beneficiaries were 65 or older in 1995. Medicaid was expanded between 1986 and 1991 as Congress required states to cover pregnant women and children living in families with incomes up to 133 percent of poverty, and allowed expanded coverage to families with incomes of up to 185 percent of poverty. These expansions led to a large increase in the total number of Medicaid recipients to 40.6 million in 1998. Disabled and elderly families with little income and few assets also receive Medicaid, which, for example, often pays nursing home costs of the low-income elderly.

The trend in Medicaid spending in constant dollars is shown in Figure 6. After growing rapidly through the mid 1970s, Medicaid grew at annual rates between 0.6 and 9.7 percent between 1976 and 1989. The expansions to families with children and pregnant women in the late 1980s increased growth rates to 12.3, 21.1 and 25.3 percent in 1990, 1991 and 1992. Total real Medicaid spending increased from $20.8 billion in 1970 to $188.8 billion in 1998; it doubled in the 1990s. Attempts to assess the antipoverty effectiveness of Medicaid face the same difficulties that arise with valuing Medicare benefits. We briefly discuss the antipoverty effectiveness of Medicare and Medicaid in Section IV.

Supplemental Security Income (SSI) is a means-tested safety net program for the aged, blind and disabled. The disabled make up nearly 80 percent of SSI recipients. SSI is a federally

administered cash transfer program that began in 1974 with the consolidation of several existing such programs.[19] Subject to meeting the income, asset and categorical eligibility standards, an individual can receive a cash transfer of up to $500 per month, couples can receive up to 1.5 times that amount, and children can receive $250, although states are allowed to supplement these amounts.

As shown in Figure 6, SSI grew very slowly between 1974 and 1990, from $17.7 billion to $20.5 billion (in 1999 dollars). Between 1990 and 1994, program costs grew by 55 percent, making SSI one of the nation's fastest growing entitlement programs. A major factor driving this growth was the Zebley decision, a Supreme Court case that revised the childhood mental health impairment eligibility criterion to be consistent with the criterion that applies to adults. The Green Book (1998) reports that three groups accounted for nearly 90 percent of the program's growth during this time: adults with mental impairments, children and non-citizens. Since the mid 1990s, SSI has actually shrunk in real terms as efforts have been made to reduce the growth rate of SSI children and immigrants. SSI payments were $29.7 billion in 1999, benefiting 6.2 million recipients.

b. Cash means-tested transfers for able-bodies families

Aid to Families with Dependent Children (AFDC) was the central safety net program for poor families with children from 1936 to 1996 (see Pavetti, chapter 7 for more details). This program was primarily directed at single-parent families, though some two-parent families with an unemployed parent also received benefits. The program was a means-tested entitlement,

[19] In addition to meeting program standards for being blind or disabled, or being over 64, eligible people must meet income and asset tests. The income test restricts countable income to less than the 1999 Federal benefit rate of $500 a month. Countable income excludes $20 a month, the first $65 a month from earnings and 50 percent of earnings exceeding $65 per month, and food stamps. This implies that a person could have earned income of up to $1,085 per month and still be eligible for SSI. A couple with only wage income could have earnings of roughly $1,550. An individual also cannot have assets exceeding $2,000 ($3,000 for couples), though houses and generally automobiles do not count as assets. An applicant is expected to first file for all other available benefits, including disability

meaning that all applicants whose income and assets were below the stipulated levels could receive benefits. States determined benefit generosity that varied widely; funds were provided according to an uncapped federal matching formula.

PRWORA abolished AFDC and created Temporary Assistance for Needy Families (TANF), a set of block grants to states with few restrictions. States are required to spend at least 75 percent of their "historic" level of AFDC spending, a 5-year lifetime limit is imposed on receipt of federally supported assistance (though hardship exemptions are included in the law), and states have to meet certain targets in moving portions of their caseloads into specific work activities. Whether through AFDC-TANF changes, the longest economic expansion in U.S. history, sharp increases in the earned income tax credit, or a combination of these and other factors, welfare caseloads have fallen precipitously. Between January 1993 and December 1999, welfare caseloads fell by 52 percent, to 2.4 million families from 5.0 million.

Several commentators feared that TANF might set off a "race to the bottom," where states, fearful of attracting low-income families from other states, might lower benefits, which in turn would cause other states to lower theirs. While there has been a sharp reduction in AFDC/TANF spending beginning in 1997, as shown in Figure 7, the spending reductions are roughly proportional to the welfare caseload reduction.

Combined real spending on SSI and AFDC/TANF fell by roughly 2 percent in the last decade. In contrast expenditures on the earned income tax credit (EITC) grew sharply.[20] The EITC tax expenditure was $3.9 billion (in 1999 dollars) in 1975, the first year it was part of the

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insurance if they are eligible.

[20] The EITC is a refundable credit that taxpayers receive after filing a tax return each year. In 1999, taxpayers with two or more children could get a credit of 40 percent of income up to $9,540, for a maximum credit of $3,816. Taxpayers (with two or more children) with earnings between $9,540 and $12,460 receive the maximum credit. Their credit is reduced by 21.06 percent of earnings between $12,460 and $30,585. Taxpayers with one child could get a credit of 34 percent on income up to $6,800, for a maximum credit of $2,312. Childless taxpayers could get a credit of 7.65 percent on income up to $4,530, for a maximum credit of $347.

tax code, and $31.9 billion in 1999.[21] Real EITC spending increased 232 percent in the 1990s. No other federal antipoverty program grew at a comparable rate. In 1999 the value of the EITC exceeds the *combined* federal spending on TANF and food stamps by several billion dollars.

The 1986 Tax Reform Act roughly doubled the total cost of the credit by increasing its size and extending its phase-out range. The credit rate, maximum credit and spending increased every year from 1990 through 1996 as a consequence of the three-year phase-ins of legislative changes in 1990 and 1993. In 1999, 19.5 million taxpayers will benefit from the EITC.

The incentives embedded in the EITC differ from those in AFDC/TANF. Historically, AFDC recipients with no earnings received the largest payments. In contrast, the EITC encourages low-skilled workers to enter the labor market, since earnings are needed to receive the credit and the benefit rises with earnings up to about the poverty line. Supporters of the credit among Republicans and Democrats have embraced its pro-work features.[22]

c. In-kind means-tested transfers for able-bodied people

The safety net for the poor includes a set of in-kind benefits, the largest of which are food stamps, housing assistance, Head Start, and two nutrition programs: school nutrition programs and the special supplemental nutrition program for women, infants and children (WIC).[23] The evolution of expenditures for these programs is shown in Figure 8.

Food stamps are designed to enable low-income households to purchase a nutritionally adequate low-cost diet. The program is the country's single, almost-universal entitlement for

[21] See Hotz and Scholz (2000b) for a detailed survey of the earned income tax credit.

[22] In his first State of the Union Address, President Clinton said "The new direction I propose will make this solemn, simple commitment: by expanding the refundable earned income tax credit, we will make history; we will reward the work of millions of working poor Americans by realizing the principle that if you work 40 hours a week and you've got a child in the house, you will no longer be in poverty."

[23] This chapter does not discuss programs designed to enhance human capital (see Karoly, chapter 8 for more details).

those with low income and assets.[24]

After food stamp benefits were made uniform across the country and indexed for inflation in 1972, real spending grew sharply. A set of legislative changes in 1981 and 1982 cut food stamp spending by nearly 13 percent ($7 billion) below what would have been spent under prior law between 1982 and 1985. The program was liberalized by a series of changes in 1985, 1986 and 1987, which, when combined with the recession in the early 1990s, led to a sharp increase in total food stamp spending between 1988 and 1992.

Since 1994, real food stamp expenditures fell 38.3 percent. While overall poverty rates and child poverty rates trended downward in recent years (see Figure 4), they did not fall as rapidly. According to the General Accounting Office (1999), food stamp participation fell 27 percent from 1996 to 1999 to 18.2 million people, with these declines being "faster than related economic indicators would predict." The GAO speculates that some people who are no longer eligible for cash assistance may think they are also no longer eligible for other benefits. The fraction of children living in families with incomes below the poverty line receiving food stamps fell to 84 percent in 1997, from 94 percent in 1994, suggesting that new cracks in the safety net are developing.

The Department of Housing and Urban Development and the Farmers Home Administration administer the housing assistance component of the safety net. Housing assistance has never

[24] Families receiving SSI or TANF payments are generally automatically eligible for food stamps. Roughly speaking, families not receiving SSI or TANF must have incomes below the poverty line after taking into account a modest ($134 per month) standard deduction; work, dependent care and unusually large shelter expenses; and child support payments. Total income cannot exceed 133 percent of the poverty line. A family cannot have more than $2,000 of assets ($3,000 if the household contains an elderly member). Vehicles (under $5,000 in value) and houses do not count in the asset tests. Participating households are expected to devote roughly 20 to 25 percent of their total monthly income to food. Food stamps then make up the difference between the expected family contribution and the amount assumed to be needed to purchase an adequate low-cost diet. PRWORA retained the entitlement status of food stamps, but new restrictions disqualified most permanent resident aliens and mandated work activities for able-bodied adults without dependents, who are now generally eligible for only 3 months of benefits in a 36-month period if they are not working.

been an entitlement. Rather, eligibility is based on family characteristics and income relative to 80 percent of the local median. Local Public Housing Authorities allocate spaces to qualified applicants on a first-come, first-served basis, mediated by certain preferences. Waiting lists are common. Aid comes in two principal forms: project-based aid, where subsidies are tied to units specifically constructed for low-income households, and household-based subsidies, where renters choose standard housing units in the existing private housing stock. Since 1982 project-based aid has been curtailed in favor of rental subsidies. Housing assistance grew from $2.2 billion in 1970 (in 1999 dollars) to nearly $30 billion in 1995, and fell modestly after that. The number of recipients followed a similar pattern: in 1977, 3.2 million renters and homeowners benefited from federal housing aid; this number rose steadily to a peak of 5.8 million in 1995 and has fallen slightly since then. Federal housing subsidies are roughly $5,000 in annual benefits per recipient.

The school lunch and breakfast program is an entitlement that provides federal support for meals served by public and private nonprofit elementary and secondary schools and residential child care institutions that enroll and guarantee to offer free or reduced-price meals to low-income children. Participation in the school breakfast program has grown from about 800,000 in 1971 to 7.4 million in 1999 (based on a 9 month average). The school lunch program is larger but has grown only gradually; participation was 24.1 million in 1971 and 27.0 million in 1999. Current expenditures on both programs (combined) are around $7.4 billion.

The special supplemental nutrition program for women, infants and children (WIC) provides food assistance, nutrition risk screening and related nutrition-oriented services to low-income pregnant women, and low-income women and their children (up to age 5). WIC is not an entitlement. Participants receive vouchers for food purchase, supplemental food, and nutrition

information. In 1999 roughly 7.3 million women, infants and children received benefits from WIC at a cost of nearly $4 billion.

Around 850,000 children are enrolled in Head Start, which provides a range of services to children under age 5 and their families. Its goals are to improve social competence, learning skills, health and the nutrition status of low-income children so that they can begin school on an equal basis with their more advantaged peers. In real dollars, Head Start spending increased 136 percent between 1990 and 1999 to $4.7 billion.

d. Child care

Several federal child care subsidy programs target low-income families. Many of these were created since 1988. Since child care expenses are often seen as a deterrent to entering the work force, the emergence of child care subsidy programs is part of the general trend noted here and elsewhere toward work-based assistance rather than welfare.[25]

In 1988, the Family Support Act created two programs: the Aid to Families with Dependent Children Child Care and Transitional Child Care.[26] Two more new programs were implemented in 1990: the At-Risk Child Care and the Child Care and Development Block Grant. The first three programs mentioned served, respectively: families on AFDC participating in a job training program, families who had recently moved off welfare, and families at risk of going on welfare. The fourth program, the Child Care and Development Block Grant, provided additional funds to working, low-income families as well as funds to improve the quality of child care. In 1996, PRWORA consolidated these fragmented programs into the Child Care and Development Fund (CCDF).

[25] See Blau (2000) for further discussion of child care.

[26] One of the earliest major child care subsidies was the Dependent Care Tax Credit, enacted in 1954. Because it is a non-refundable tax credit, however, it provides little or no benefit to families with incomes at or below the poverty line.

In 1995, federal and state funding for all four programs totaled $3.4 billion in 1999 dollars. In 1998, total spending through the CCDF was $5.5 billion. Despite increased spending on child care subsidies in the last few years, the number of recipient children has remains essentially unchanged: 1.4 million children were served in 1995 by one of the 4 programs. In 1998, 1.5 million were served by the CCDF. The antipoverty effects of subsidized child care are unknown.

e. Child support[27]

The Child Support Enforcement and Paternity Establishment Program (CSE) was established in 1975 to aid custodial parents in collecting child support payments from non-custodial parents. Part of the impetus for the program was to replace public welfare benefits with parental support, although beneficiaries of the program are not limited to poor families; all custodial parents are entitled to assistance. Under the CSE, the federal government awards matching grants to the states that administer local programs. The role of the CSE is not to transfer money directly to custodial parents; instead it provides a collection of services to custodial parents, including aiding in establishing paternity, obtaining child support awards through a legal process, and collecting payments from non-custodial parents. The authority of the CSE has expanded continually over the years. In 1996, PRWORA consolidated federal child support funds into the TANF block grants. This legislation imposed more stringent requirements on the performance of state-run CSE programs in order for states to receive TANF funds. PRWORA also established a nationwide integrated, automated network to improve states' ability to locate non-custodial parents.

Total child support collections rose from $2.7 billion in 1978 (in 1999 dollars) to $12.8 billion in 1996, while total federal and state administrative costs increased over the same time

[27] Child support is not a means-tested transfer program; however, 37 percent of custodial parents were poor in 1997, and 80 percent had incomes below 300 percent of the poverty line (Lerman and Sorenson, 2000).

period from $797 million to $3.2 billion. Costs as a percentage of collections have fallen slightly from around 24 percent in 1980 to 20 percent in 1996. The increases in collections are driven primarily by increases in the number of custodial parents served. In 1978, there were 707 thousand cases where a collection was made. By 1996, this had risen to 3.5 million cases.[28] Average support payments per family have remained fairly constant. Between 1978 and 1995, the percent of custodial mothers receiving child support increased from 34.6 percent to 37.4 percent. Greater progress was made among poor mothers: only 17.8 percent of these families received child support in 1978; by 1995 this had increased to 26.5 percent. However, this is primarily due to an increase in award rates, rather than increased collection rates (Lerman and Sorenson, 2000).

Child support appears to have small antipoverty effects. According to Meyer and Hu (1999), child support payments in 1995 raised the incomes of between 6 and 7 percent of poor, female-headed families to a level above the poverty line. The authors suggest that antipoverty effectiveness has been growing over time.

f. Summary

Figure 9 summarizes the evolution of social insurance and antipoverty spending. Appendix Table 1 provides a more detailed breakdown of spending by program, Appendix Table 2 shows the numbers of recipients by program.

Social insurance – social security, Medicare, unemployment insurance, workers' compensation and disability insurance – is by far the largest category of spending. The cost of social insurance has risen steadily because of rapid increases in the cost of social security and Medicare. Total social insurance expenditures (in real dollars, excluding workers' compensation because of data limitations) rose at an annual rate of 6.9 percent in the 1970s, 3.1 percent in the

[28] Data on collections and administrative costs are from the Green Book, 1998.

1980s and 4.0 percent in the 1990s (through 1998).

The bottom two lines of Figure 9 show total spending on in-kind transfers (without Medicaid) and cash transfers. In kind transfers – the sum of school nutrition programs, WIC, Head Start, housing and food stamps – grew rapidly in the 1970s, at an annual rate (in real dollars) of 16.4 percent. This growth was driven primarily by food stamps and housing. In-kind transfers grew at an annual rate of 1.5 percent in the 1980s and 4.3 percent from 1990 to 1998.[29] Cash transfers – the sum of AFDC/TANF, the earned income tax credit and SSI – grew at an annual rate of 4.7 percent in the 1970s, 1.8 percent in the 1980s, and 4.2 percent in the 1990s.

The growth rates of both cash and in-kind safety net spending have increased significantly in the 1990s relative to the 1980s. Spending on cash and in-kind antipoverty programs excluding Medicaid is around $134 billion in 1999. Medicaid is an additional $190 billion. In the following section, we present some illustrative calculations of the degree to which these programs alleviate poverty.

IV. Effects of Antipoverty Policy

In this section we address the complex question: how does this wide range of programs affect poverty? The simple comparison of pre- and post-tax and transfer poverty rates in Figure 1 tells us what percentage of families and individuals were raised above the poverty line by the tax and transfer system. However, this type of analysis ignores the degree to which poverty may have been alleviated. An alternative way to examine the antipoverty effectiveness of tax and transfer programs is to look at the degree to which programs affect the poverty gap – the sum of the differences between market income and the poverty line for all families with incomes below the poverty line.

[29] As is clear from Figure 9, Medicaid is roughly the same size as the combined value of the other in-kind transfers. In-kind transfers including Medicaid grew at an annual rate of 12.3 percent in the 1970s, 3.7 percent in the 1980s

Our analysis of antipoverty effectiveness updates work by Weinberg (1985, 1987, and 1991) that measures the poverty gap using the Survey of Income and Program Participation (and its predecessor, the Income Survey Development Program) and then reports the degree to which antipoverty programs close the poverty gap. The analysis does not take into account behavioral responses to different programs. In the absence of social security, for example, some elderly people would continue to work in the paid labor market, thus reducing the pre-tax and transfer poverty rate and the poverty gap. Hence, the calculations provide an *upper* bound on the magnitude of the poverty gap and the antipoverty effectiveness of different programs.

We emphasize four questions. First, how large is the poverty gap, and how has it changed since 1979? Second, how effective are current programs in filling the poverty gap? Third, how has the antipoverty effectiveness of the tax and transfer system changed over time? Fourth, what are the differential effects of public policies across different demographic groups – the elderly, one- and two-parent families, and families without children? We conclude the section with a brief discussion of recent evidence about the effects of the tax and transfer system on labor supply, saving and family formation.

a. The Poverty Gap, 1997

We draw data for all families and individuals in April, 1997 from Waves 4 and 5 of the 1996 Survey of Income and Program Participation (SIPP). Because most programs determine eligibility on a monthly basis, we measure the poverty gap for a single month.[30] We do not consider the effects of the individual income tax, aside from the earned income tax credit. This omission has little consequence. Families with children who have income below the poverty line do not pay positive income taxes (even excluding the EITC), due to personal and child

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and 8.9 percent in the 1990s.

[30] April is chosen to be consistent with Weinberg's analysis of April 1979, 1984 and 1986.

exemptions, the standard deduction and $500 child credit. Low-income taxpayers without children and incomes near the poverty line pay small amounts of federal income taxes. Payroll taxes are more important, as all families pay the employee share of payroll taxes (7.65 percent) on the first dollar of earnings. To account for this in Table 1, we reduce wage and salary income reported in SIPP by 7.65 percent (the employee OASDHI tax rate) and self-employment income by 15.3 percent.

A challenging part of this exercise is the valuation of non-cash benefits. Because the value of food stamps does not exceed the food needs of the typical family, we value them at the cost to the government. Medicare and Medicaid are more difficult, as not all families consume health services. We assume that for most families, Medicaid is worth about the cost of a typical HMO policy (see Gruber, 2000 for a discussion of ways in which Medicaid is more valuable than private insurance and ways in which Medicaid is less valuable); for elderly or disabled families, we increase this by a factor of 2.5 to account for greater medical needs of these groups.[31] We value Medicare using 2.5 times the average cost of a fee-for service plan, adjusting for regional cost differences.[32]

We use Fair Market Rent (FMR) data from the Department of Housing and Urban Development to estimate the value of in-kind housing benefits. Specifically, housing benefits are assumed to be the difference between population-weighted average state-level (or major metropolitan area) FMRs, adjusted by the number of bedrooms needed to accommodate families of different sizes, and rents paid directly by families.

Table 1 summarizes our results. The first row indicates that 29.0 percent of families

[31] We have conducted a sensitivity analysis varying this factor from 1 to 5; our conclusions about the antipoverty effectiveness of Medicaid and Medicare remain essentially unchanged, despite variations in the dollar value of the program benefits.

[32] The data come from the Kaiser Family Foundation, 1999 Annual Employer Health Benefits Survey, available at

(including unrelated individuals) have pre-tax and transfer incomes below the poverty line. This rate is considerably higher than the 19.7 percent rate shown in Figure 1 for the pre-tax and transfer poverty rate for all persons. The discrepancy arises for two reasons. First, the family definition used here counts unrelated individuals as one-person families, and the pre-tax and transfer poverty rate of these families (many of whom are elderly) is higher than other families in the population. Second, underreporting of wages and salaries in SIPP is larger than it is for the CPS, the source of the underlying data for Figure 1.[33]

We estimate that the total pre-tax and transfer poverty gap is $19.6 billion in April, 1997, which is larger than the gaps Weinberg reported for 1979, 1984, and 1986: $15.4 billion (in 1997 dollars), $15.6 billion, and $13.9 billion, respectively. If the Weinberg numbers are adjusted for the larger number of families in 1997, the poverty gaps (other than 1986) are strikingly similar – $19.7 billion, $19.0 billion and $16.9 billion. This result is consistent with the stubborn persistence of poverty rates over time documented in this chapter and elsewhere.

The other entries of Table 1 show the antipoverty effectiveness of the tax and transfer system. Reading across the "all transfers" row, the first column shows $59.0 billion of benefits, or $1,104 per recipient family. Of these payments, 55.3 percent go to families with pre-transfer incomes below the poverty line, and 24.0 percent of total program dollars close the poverty gap.[34] These transfers fill 72.4 percent of the total poverty gap, which results in an after-tax and transfer poverty rate of 10.0 percent and a poverty gap of $5.4 billion.

As expected given their universality, the major social insurance programs – social security

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http://www.kff.org/content/1999/1538/.

[33] Hotz and Scholz (2000a) note that in 1990 and 1996 the SIPP reported roughly 91 percent of the control total wages and salaries, while the CPS reports 96 percent for 1990 and 102 percent for 1996. The Weinberg (1985, 1987 and 1991) studies have very similar discrepancies between the poverty rates of all families and CPS-based poverty rates of individuals.

[34] If a family has a poverty gap of $1 and the program provides $1,000 of benefits, only $1 of benefits would be included in the "percent of total used to alleviate poverty" column.

(including DI), Medicare, unemployment insurance and workers' compensation – are the least well-targeted programs, where roughly half the recipients (58 percent for workers' compensation) have incomes below the poverty line. Anywhere from 27 to 37 percent of total benefits directly close the poverty gap. Given the size of the programs, however, they have a very large effect on poverty rates, particularly social security and Medicare.

Of the other major programs (exceeding $1 billion), food stamps, AFDC and housing assistance are the most tightly targeted toward the poor, with more than 78 percent of benefits directly reducing the poverty gap. Medicaid, SSI and the EITC also have large antipoverty effects.

We now focus on how the effects of the tax and transfer system evolved over time. Table 2 compares our results for 1997 with Weinberg's estimates for 1979 and 1984 (Weinberg does not value in-kind benefits in 1986). There appears to be an extraordinary stability of the aggregate antipoverty effects of the tax and transfer system – in each year a little more than 70 percent of the poverty gap is filled. The stability reflects stagnant real incomes over this period and stable trends in antipoverty spending. However, if society's goal is the elimination of income poverty, the lack of progress over the past 18 years is unsettling.

Table 3 highlights gaps in the safety net by focusing on four types of families: elderly, non-elderly single-parent, non-elderly two-parent, and non-elderly childless families. The top row shows that $35.6 billion in transfers per month, primarily social security benefits, fill 99.0 percent of the poverty gap of the elderly.[35]

[35] Michael and Citro (1995) develops and the U.S. Census Bureau (1999) implements estimates of a new poverty measure that reflects a comprehensive measure of a family's access to resources, including work expenses and out-of-pocket medical expenses as well as taxes, cash and in-kind transfers. The poverty thresholds (and implicit equivalence scales) are also altered to reflect consumption needs of food, shelter, clothing and a little bit more. Incorporating the effects of medical out-of-pocket expenditures would raise the after-tax and transfer poverty rate of the elderly and hence reduce the anti-poverty effectiveness of the tax and transfer system.

Transfers appear well-targeted to non-elderly single-parent families – 77 percent go to poor families and 49 percent of the total dollars fill the poverty gap. While these transfers fill 79 percent of the poverty gap, 17.5 percent of non-elderly single-parent families remain poor. Transfers are somewhat less well-targeted to two-parent families – 49 percent of transfers to this group go to poor families, but their overall poverty rate is nevertheless low (6.5 percent).

Table 3 calls attention to possible cracks in the safety net for two groups. First, the tax and transfer system fills only 45.9 percent of the poverty gap for non-elderly childless families. Other than food stamps, these families have few sources of public assistance in the absence of a disability. Strengthening their safety net, however, runs the risk of creating incentives to not work or not invest in skills that could lead to future self-sufficiency. Second, after-transfer poverty rates remain very high for single-parent families with children.

b. Transfers and behavior

The behavioral responses to changes in the tax and transfer system have been at the heart of the policy debates shaping the evolution of antipoverty policy. The rapid increase in the earned income tax credit since 1986, for example, reflects that fact that the credit is widely perceived as being "pro-work." The momentum to "end welfare as we know it" in the early 1990s was fueled by a concern that AFDC created a cycle of dependency, encouraging some women to not work and to have children.

These concerns have received considerable attention in the academic literature.[36] Here we briefly outline the issues and describe recent evidence on three topics: labor markets, saving and family formation.

[36] In addition to the chapters in this volume, see, for example, reviews by Danziger, Haveman and Plotnick (1981) and Moffitt (1992). Recent surveys on specific programs include Currie (2000) for food and nutrition programs, Gruber (2000) on Medicaid, Hotz and Scholz (2000b) on the earned income tax credit, Moffitt (2000) on TANF, Olsen (2000) on housing assistance, and Burkhauser and Daly (2000) on SSI.

Labor markets

As the generosity of the safety net increases, work incentives are likely to decrease. Two distinct issues arise. First, with greater total resources, people are likely to consume more of everything they like, including leisure. Second, transfer program benefits are typically reduced as income increases, imposing high implicit tax rates on work. Dickert, Houser and Scholz (1995), for example, show that cumulative *average* tax rates exceeded 85 percent for some low-wage, single-parent families from New York working anywhere from 8 to 35 hours per week in 1990. If the marginal return to taking a full-time job for a single parent is only 15 cents per dollar of earnings, one might expect to see low levels of labor force participation.

They find wide variation in the work incentives that families face in different states. In high benefit states (like New York at the time), the after-tax return to work is fairly low, as substantial benefits are clawed back, while in low-benefit states (like Texas at the time), the after-tax return to work is high, as there are few benefits to lose. Thus, if labor market participation decisions are sensitive to the after-tax returns to work, more single mothers should work in low-benefit states than high-benefit states, all else being equal.

Dickert, Houser and Scholz find that a 10 percent increase in the after-tax wage results in a 2 percentage point (or 3.5 percent) increase in labor market participation among single parents.

Meyer and Rosenbaum (1999) seek to explain the factors driving the recent increase in labor force participation among single mothers. They find that EITC changes account for 63 percent of the increase in their employment rate from 1984 to 1996 and 37 percent of the increase from 1992 to 1996. Changes in maximum state welfare benefits and benefit reduction rates account for about 17 percent of the change between 1984 and 1996 and 20 percent of the change between 1992 and 1996. The effects of job training, child care and the Medicaid expansions appear to be

small. Other factors, the most important of which is the performance of the economy, account for the remainder of the changes.[37]

Over the last decade there has been extensive experimentation in welfare program design. Berlin (2000) discusses short-term results from three recent social experiments: Project New Hope in Milwaukee, Wisconsin; Minnesota's Family Investment Program (MFIP); and the Self-Sufficiency Project (SSP) implemented in Vancouver, British Columbia and parts of New Brunswick. Each evaluation was designed as a randomized social experiment. Each made work financially more rewarding for treatments relative to controls, and each offers incentives to hold full-time (or near full-time) employment. While results naturally differ across experiments, they provide additional evidence that work incentives can increase employment, earnings and total (earned plus transfer) income of families, particularly for single-parent, long-term welfare recipients.

Across non-experimental and experimental studies, we see a growing body of evidence that policies that increase after-tax wages have positive, significant effects on labor market participation. Both the older and recent studies find less evidence that changes in benefit rules in AFDC/TANF or food stamps have labor market effects of an economically important magnitude.

Savings

Many antipoverty programs have means and asset tests. Hubbard, Skinner and Zeldes (1995) construct a simulation model that predicts, in the absence of asset testing, that low-income families would save considerably more than they actually do. They suggest that families recognize that antipoverty programs could provide an alternative income source if needed, and so save less than they otherwise would, regardless of whether they ever draw program benefits.

[37] Ellwood (1999) reaches broadly similar conclusions, finding for the period from 1990 to 1998 that roughly "20 percent of the growth in work can be traced to the economy, perhaps another 50 percent is linked to welfare reform

Gruber and Yelowitz (1999) find that among the eligible population, Medicaid lowered wealth holdings by between $1,293 and $1,645 in 1993 and the expansions in Medicaid from 1984 to 1993 lowered wealth holdings by about 7.2 percent. Neumark and Powers (1998) find mixed evidence that SSI affects wealth and saving, but conclude that SSI reduces the saving of men nearing retirement. Powers (1998) finds modest, negative effects on wealth accumulation of AFDC asset tests.

Taken together there is some evidence, albeit far from definitive, that antipoverty programs reduce asset accumulation of low-income families. The welfare and policy implications of these results are not clear, however. The asset tests do not apply to net housing equity, for example, so families interested in accumulating wealth can purchase a home, or if they were already homeowners, reduce their mortgage debt. In addition, when risks are large and variable, market or social insurance is a more effective means of smoothing consumption than own saving, since idiosyncratic risk can be spread across many people in the population. Consequently, the asset response to antipoverty programs *could* be indicative of the welfare-enhancing properties of social insurance. Alternatively, program-induced failure to accumulate assets may prevent families from making investments in cars or safe neighborhoods that would allow them to enhance living standards.

Marriage and fertility.

Antipoverty programs provide a safety net, and hence at the margin, encourage independence. AFDC/TANF, Medicaid and housing assistance provide greater resources to single-parent families than they do to two-parent families, and hence may provide incentives to delay marriage, divorce or not marry. Program benefits and the EITC also generally increase with family size and hence provide incentives to have children.

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and the remaining 30 percent can be traced to the EITC and other work supports," (p. 25).

Moffitt (1998) surveys studies of the effects of welfare on marriage and fertility and concludes "a neutral weighing of the evidence still leads to the conclusion that welfare has incentive effects on marriage and fertility." It is also clear that studies are not able to explain the time-series increase in nonmarital fertility and the decline in marriage. Moffitt also notes that results tend to vary significantly based on the methodology used and other specification differences.

Summary

We conclude that the tax and transfer system has measurable effects on the behavior of low-income families. The strongest result appears to be the positive relationship between changes in the after-tax wage rates and labor force participation. This suggests that economic growth and policies like the earned income tax credit can increase labor force participation rates of those not currently working. While programs appear to have measurable, negative effects on asset accumulation, the magnitudes are generally small. This is perhaps not surprising, given the low levels of financial wealth accumulated by typical (not poor or working poor) families in the U.S. Moreover, it is not clear from a policy perspective whether the asset response to transfers is a good or bad result. Finally, much of the existing literature tends to find, at most, modest effects of antipoverty programs on marriage and fertility. There will continue to be active interest in these areas, however, and new developments could alter policymakers' (and our) views on these issues.

V. The Future of Antipoverty Policy

Predicting developments in any policy runs the risk of putting too much emphasis on recent events. Antipoverty policy is no exception. Nevertheless, we believe the "lessons" drawn from welfare reform, rightly or wrongly, will dominate antipoverty policy discussions for the

foreseeable future.

These lessons come in several pieces. First, benefits will continue to be linked with responsibility. This link is a natural consequence of the evidence (and perceptions of the evidence) on behavioral responses of antipoverty programs. Many of the incentives inherent in transfer programs – have children, not marry or divorce, and work less – are undesirable. Whether or not people respond to these incentives in an economically significant way is a topic of considerable research and debate. Policy debates, however, are often not settled on the basis of the best empirical evidence. For these debates, the mere existence of an adverse incentive can shape developments, particularly when coupled with the apparent lack of progress in eliminating poverty in America.[38] Thus, a considerable amount of momentum has developed around policies that emphasize "personal responsibility." These include expanding the EITC, increasing child support enforcement, and nascent efforts to enhance asset accumulation (through individual development accounts and social security privatization proposals). An interesting question associated with these developments is whether changes in administrative culture that emphasize work and personal responsibility can mitigate undesirable program incentives.

Second, we are unlikely to see a diminution of support for social insurance and the disabled. Leading social security privatization proposals now have "hold harmless" provisions where families can "opt into" the current, unchanged system. Social insurance continues to be popular. There seems to be little effort to reduce benefits targeted toward the disabled.

Third, large deficits throughout the 1980s and early 1990s led to budget rules that made it extremely difficult to initiate or expand existing spending programs. It also pushed selected items to the tax code, where policy initiatives could be characterized as "tax cuts" rather than

[38] Of course, antipoverty resources have not increased sharply over time and low-wage labor markets have not performed very well in recent decades, so the persistence of poverty is perhaps not surprising.

new spending. In the second half of the 1990s, we experienced a remarkable change in the fiscal condition of the federal government. With large, apparently ongoing surpluses, debates will develop over their appropriate use.

We have clear *opinions* about how this debate should go. We start with a set of facts. First, between 1971 and 1998, total spending on all cash and in-kind transfers (excluding social insurance and Medicaid) ranged between 1.3 and 1.9 percent of GDP. It is currently 1.52 percent of GDP, 0.24 percentage points lower than the fraction of GDP devoted to antipoverty spending in 1975, the last year of the Ford Administration. As shown in Figures 2 and 4, poverty rates were somewhat lower in 1975 than they were in 1998. Second, as discussed in Section IV, the $19.6 billion estimate of the poverty gap for April, 1997 is nearly identical to estimates of the poverty gap in 1979 and 1984, after adjusting for the overall size of the population (Weinberg, 1985, 1987). Third, as shown in Table 3, the aggregate effect of the tax and transfer system on the poverty gap appears almost unchanged between 1979 and 1997, with policy reducing the poverty gap by roughly 73 percent. While there have been changes in the antipoverty policy mix and changes in the composition of the poor, there has been very little change in aggregate antipoverty spending over the last thirty years, other than Medicaid, which has experienced the same rapid price inflation as other health-related activities; little change in the apparent antipoverty effectiveness of that spending; and little diminution of the poverty problem.

We offer three potential reasons for the apparent stability of anti-poverty spending over the last 20 to 30 years in the face of persistent and high, at least by international standards, poverty rates. First, the public and consequently politicians are indifferent about the poverty problem. Second, there was and remains a frustration that we have little sense of what works and considerable concern that some well-intentioned policies may have counterproductive

consequences. Third, the fiscal policy climate over much of the previous 30 years has been a mess. The 1970's were characterized by "stagflation," the simultaneous problem of high rates of unemployment and inflation. Economic policy in the 1980s and early 1990s was dominated by enormous, seemingly perpetual budget deficits.

The public opinion results shown in Figure 3 contradict the first potential explanation – public indifference – for persistent poverty. The majority of Americans consistently state that we are spending too little on assisting the poor when asked their opinions. We think the second explanation – the perception that we do not really know what is effective antipoverty policy – has been very important. There was widespread lack of support for the old AFDC program and, other than possibly Head Start, there were no large-scale programs over which there was widespread approval and evidence of success. The third explanation – first stagflation and then the fiscal straightjacket of deficits – also had an enormous impact on antipoverty policy.

The second and third fundamental factors have changed. The June, 2000 budget estimates forecast a 10-year, $1.87 trillion surplus. There is a large, and growing body of evidence that work-based antipoverty strategies like the earned income tax credit, the Canadian Self Sufficiency project, the Wisconsin TANF program (W-2) and the Minnesota Family Investment Program can have positive effects on labor market participation and increase the after-tax incomes of families in poverty. Essential features of these policies are the requirement that people work to receive benefits and that at least to a point, greater work effort increases the disposable income available to families. While these programs are not a panacea, there is consistent evidence from a number of studies with different methodological approaches that increasing the returns to work, increases labor force participation. We would like to see these program aggressively expanded and evaluated.

At the same time, the safety net needs shoring up. The safety net is providing less now than it has for decades to families with children who, for one reason or another, are unable or unwilling to work. TANF now has a five-year time limit. Food stamp participation by eligible families has plummeted in recent years. The consequences of these two changes have not yet been widely visible, since few families have reached time limits and the economy has been very strong. In contrast to observed political reality, we think ensuring a minimal standard of living for families and individuals, with and without children, is a Federal function. But if States are ceded this authority, they must be given the resources to care for their most disadvantaged citizens who, for one reason or another, are unable or unwilling to work. So far, the TANF block grants appear large enough to meet that challenge. Ensuring that this remains so during periods of weaker economic performance is imperative.

Major changes in poverty will not be achieved by simply reshuffling the 1.5 percent of GDP that is spent on cash and in-kind means-tested transfers (again, excluding Medicaid). If antipoverty spending as a fraction of GDP simply increased to its highest fraction over the last 30 years, of 1.91 percent, there would be an additional $34 billion for new initiatives. Using only 2 percent of the forecast surplus would add another $4 billion per year. So merely devoting a similar level of resources to non-health antipoverty policy as we have in the past during this time of unprecedented prosperity would add an additional $38 billion per year in cash and in-kind, means-tested antipoverty spending. Considerably more could reasonably be spent. The money could sensibly be used to (i) expand and export the innovative, successful state-level welfare reforms and provide new funding sources for ancillary child care and health insurance benefits to increase the attractiveness of work and (ii) augment the safety net, increase food stamp outreach, expand rental housing subsidies, and ensure states have sufficient resources to handle families

affected by TANF time limits in the way they see fit.[39]

In this time of unprecedented prosperity, a failure to make new investments will result large numbers of children growing up in households unable to afford adequate food, housing, shelter and activities that can enrich their lives. The consequences could be dire: an erosion of social cohesion, a waste of the human capital of a portion of our citizenry, and the moral discomfort of condoning poverty amidst affluence.

[39] As noted in Berlin (2000), states get conflicting messages under TANF, since they now have the flexibility to assist working-poor families with TANF funds, but doing so may keep the clock ticking on time limits. So if a breadwinner becomes unemployed, they may not be able to access benefits in the future. Some states have designed their programs to mitigate this problem by using one pool of funds to support work, and another to provide more traditional AFDC-like benefits.

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Table 1: Effect of Transfers on Poverty, April 1997 – All Families and Individuals

	Total Transfers ($ million)	Average Monthly Transfer per Recipient Family ($)	Percent of Total To Pre-transfer Poor	Percent of Total Used to Alleviate Poverty	Percent Poverty Gap Filled	Percent Poor, Post-Transfer
No transfers	0					29.0
All transfers	59,044	1,104	55.3	24.0	72.4	10.0
All cash transfers	34,133	687	53.1	32.5	56.5	16.7
All in-kind transfers	24,911	620	58.2	43.3	55.0	19.7
All income-conditioned transfers	8,196	478	77.0	64.3	26.9	26.1
Social Insurance						
Social Security (OASDI)	25,396	868	49.0	28.0	36.3	19.8
Medicare	18,573	655	52.0	36.2	34.3	22.4
Unemployment Comp	1,015	703	50.4	37.4	1.9	28.7
Workers Comp	918	1,107	57.9	26.6	1.2	28.8
Black Lung	37	438	84.5	69.1	0.1	29.0
Veterans Benefits	1,058	457	41.3	27.9	1.5	28.8
Means-tested transfers						
Medicaid	3,729	262	72.7	65.7	12.5	28.0
SSI	2,280	426	76.9	69.3	8.1	28.5
AFDC/TANF	1,111	363	87.4	83.9	4.8	28.9
EITC	1,893	105	61.0	53.9	5.2	27.8
General Assistance	202	251	85.4	83.1	0.9	29.0
Other welfare	100	332	66.4	61.1	0.3	29.0
Foster child payments	123	974	41.9	24.1	0.2	29.0
Food stamps	1,304	168	85.3	83.4	5.5	28.8
Housing Assistance	1,130	251	81.3	77.8	4.5	28.8
WIC	175	45	62.6	62.0	0.6	29.0

Poverty Gap: $19,610 million
Families: 111,375,693
Authors' calculations from the 1997 SIPP (waves 4 and 5).

Table 2: Comparison of Antipoverty Effectiveness of Taxes and Transfers, April 1997, 1984 and 1979 (real dollars)[40]

	Total Transfers	Average Monthly Transfer per Recipient	Percent of Total to Pre-transfer Poor	Percent Used to Alleviate Poverty Gap	Percent of Poverty Gap Filled	Percent Poor, Post-Transfer	Poverty Gap (millions of $)
1997	59,044	1,104	54.3	23.5	72.7	9.3	19,072
1984	36,938	1,027	57.1	31.1	73.6	10.9	15,602
1979	29,774	893	65.4	38.0	73.6	11.7	15,387

Notes: There are 111.38 million families and unrelated individuals in 1997, 91.39 million in 1984 and 87.07 million in 1979. Authors' calculations from the 1997 SIPP (waves 4 and 5).

[40] To maintain comparability with Weinberg (1985 and 1987), we exclude payroll taxes from our calculations of the effects of the tax and transfer system (they are included in Table 1). Weinberg (1991) does not value in-kind benefits, and hence is not comparable to the other studies. Dollar amounts are in 1997 dollars.

Table 3: Antipoverty Effectiveness of the Transfer System for Different Family Types, April 1997

	Number families (million)	Poverty Gap ($ million)	Poverty Gap per Family ($)	Total Transfers ($ million)	Average Monthly Transfer per Recipient Family ($)	Percent of Total To Pre-transfer Poor	Percent of Total Used to Alleviate Poverty	Percent Poverty Gap Filled	Percent Poor, Post-Transfer
Elderly families and individuals	21.9	6,275	286	35,616	1,645	53.2	17.5	99.1	1.0
Nonelderly single-parent families	11.3	4,308	380	6,894	776	76.6	49.2	78.8	17.5
Nonelderly two-parent families	26.0	2,638	101	5,603	624	49.1	29.3	62.2	6.5
Nonelderly childless families and individuals	52.1	6,389	123	10,930	783	51.8	26.9	45.9	13.8

Authors' calculations from the 1997 SIPP (waves 4 and 5).

Figure 1: The Effect of the Tax and Transfer System on Poverty

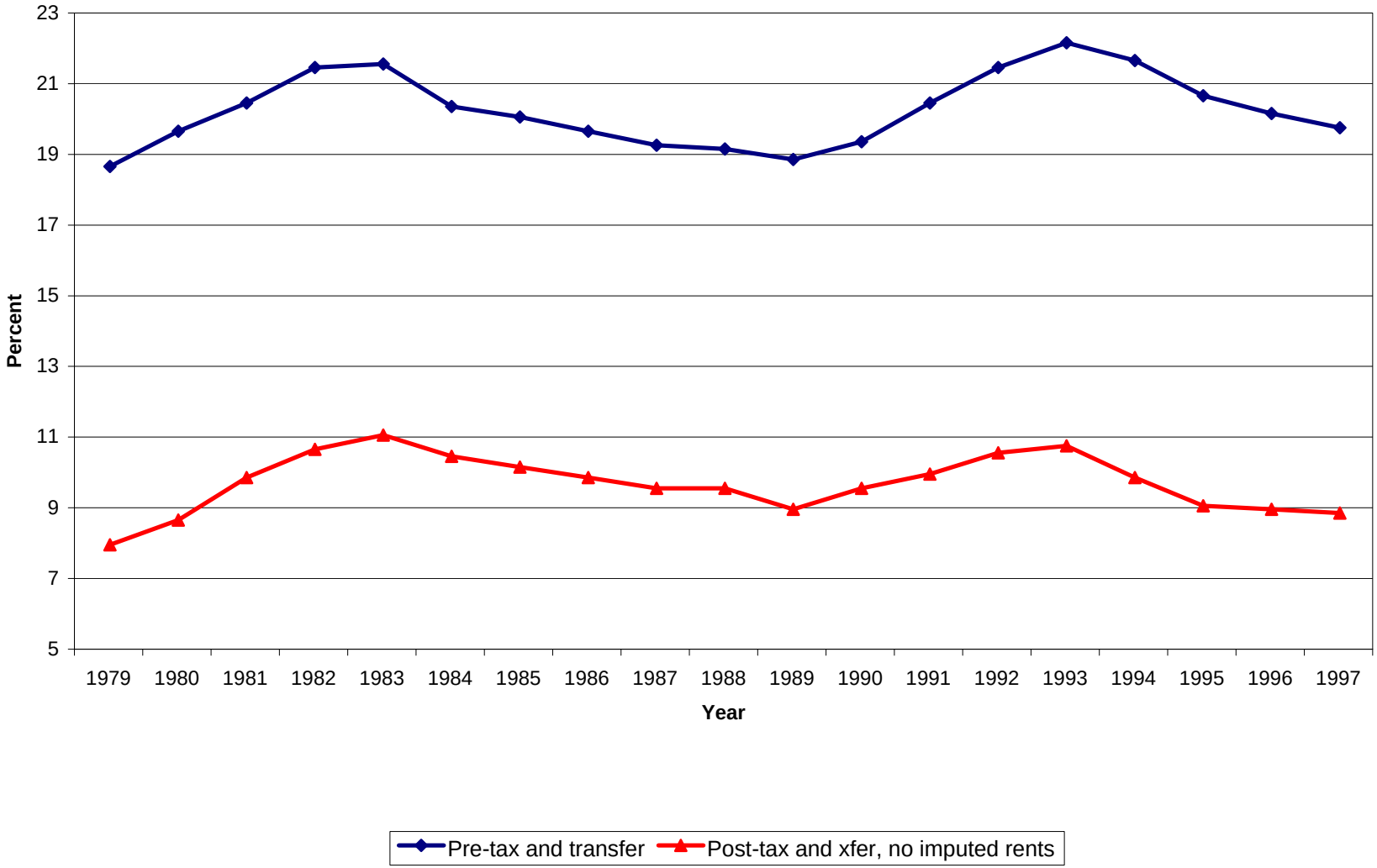


Figure 2: Poverty Rate and Median Income, 1967-97

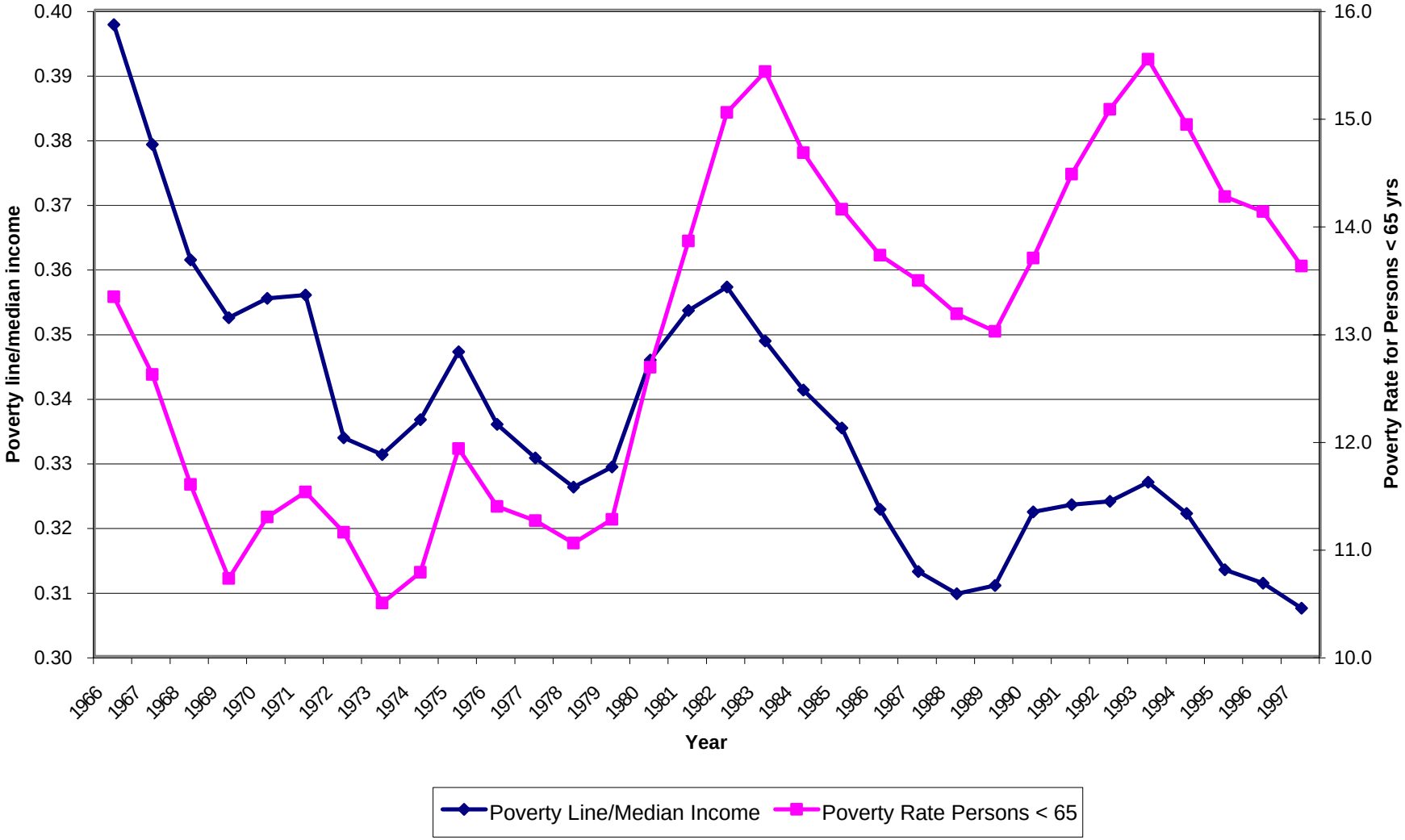


Figure 3: Public Attitudes on Welfare and Assistance to the Poor: GSS Data (no survey in 79, 81, 92 and 95)

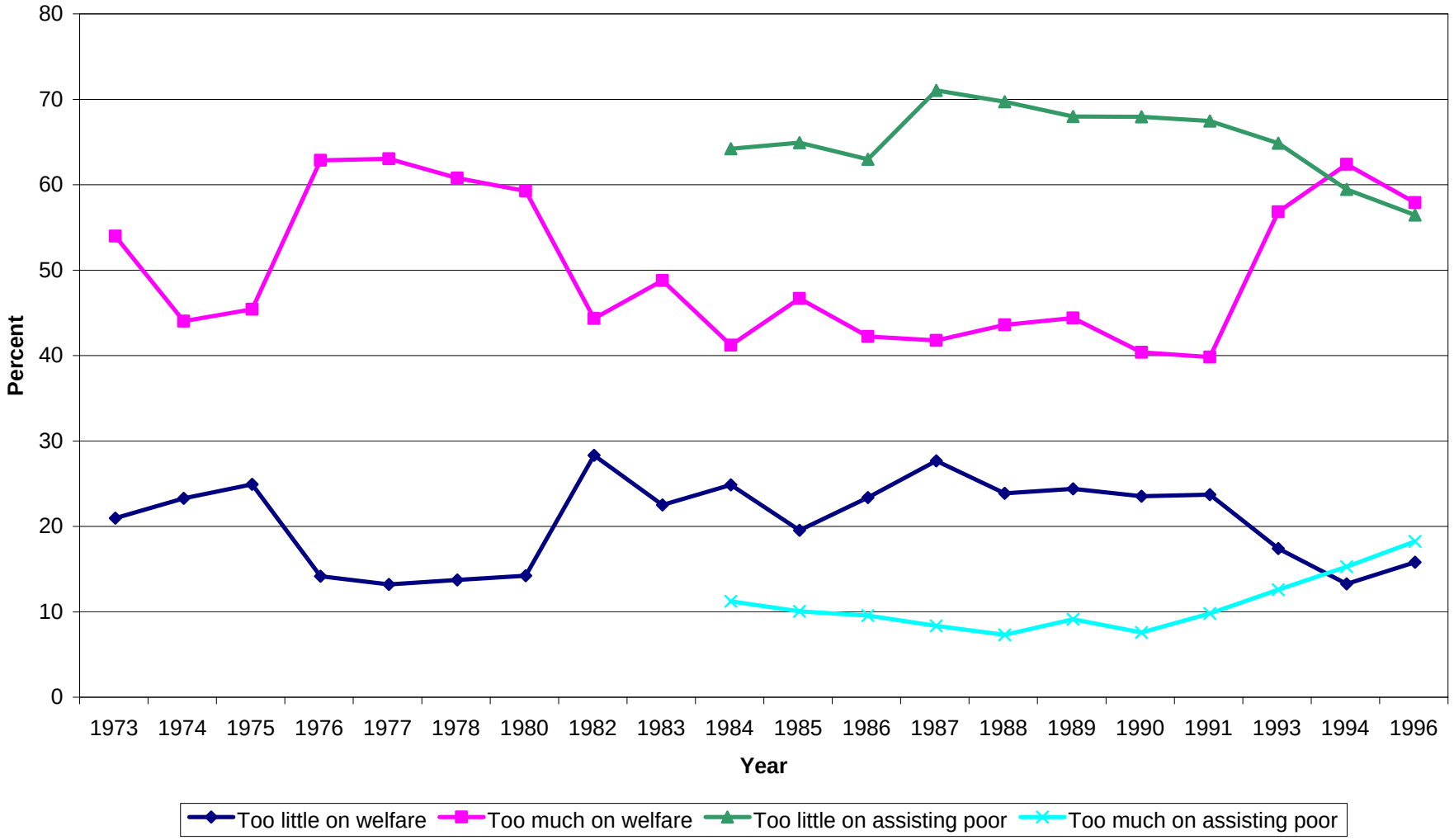


Figure 4: Child, Elderly and Aggregate Poverty Rates, 1959-1998

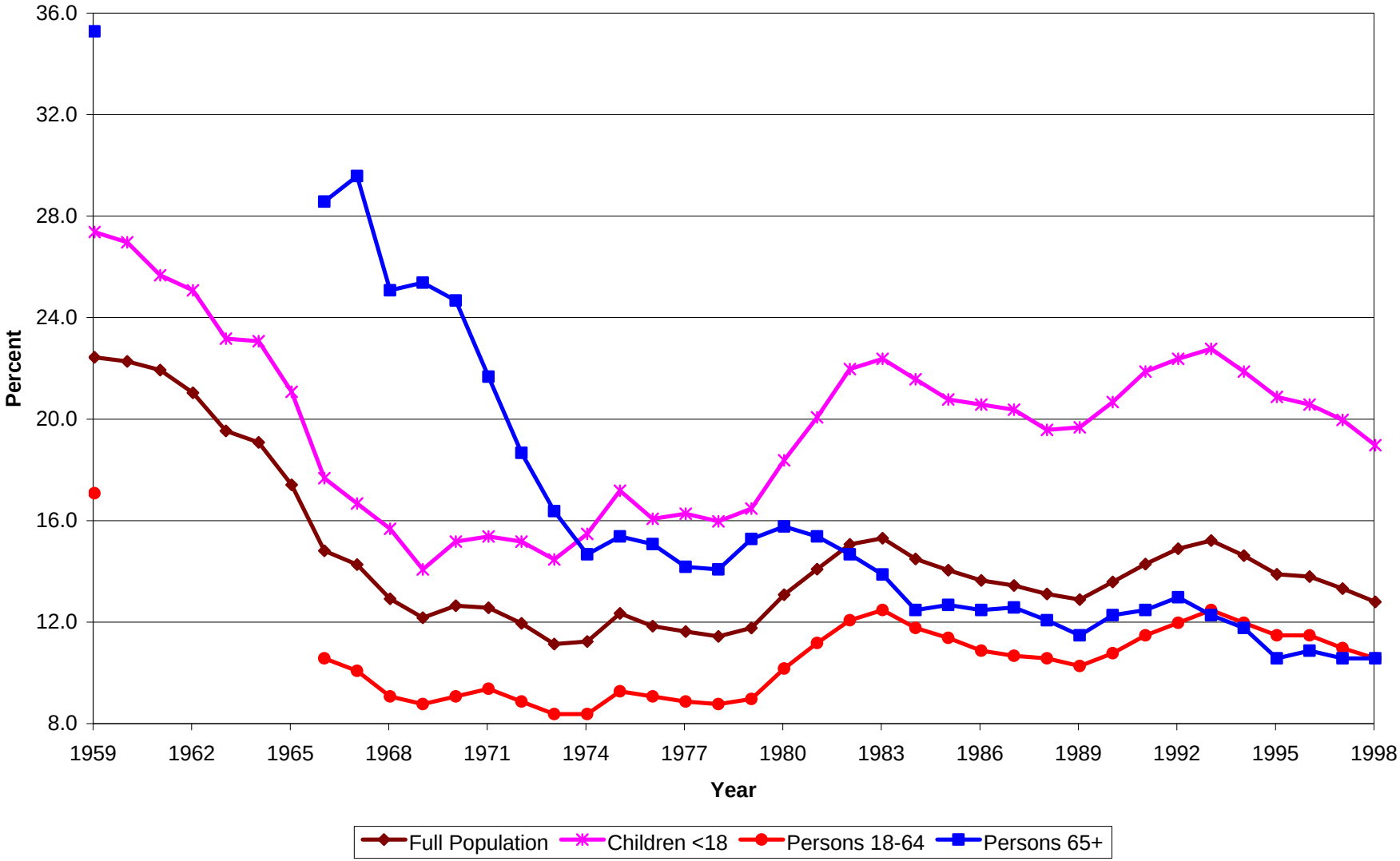


Figure 5: Total Benefit Payments on OASI, UI, DI, Workers' Compensation and Outlays for Medicare, 1970-99 (constant 1999 dollars)

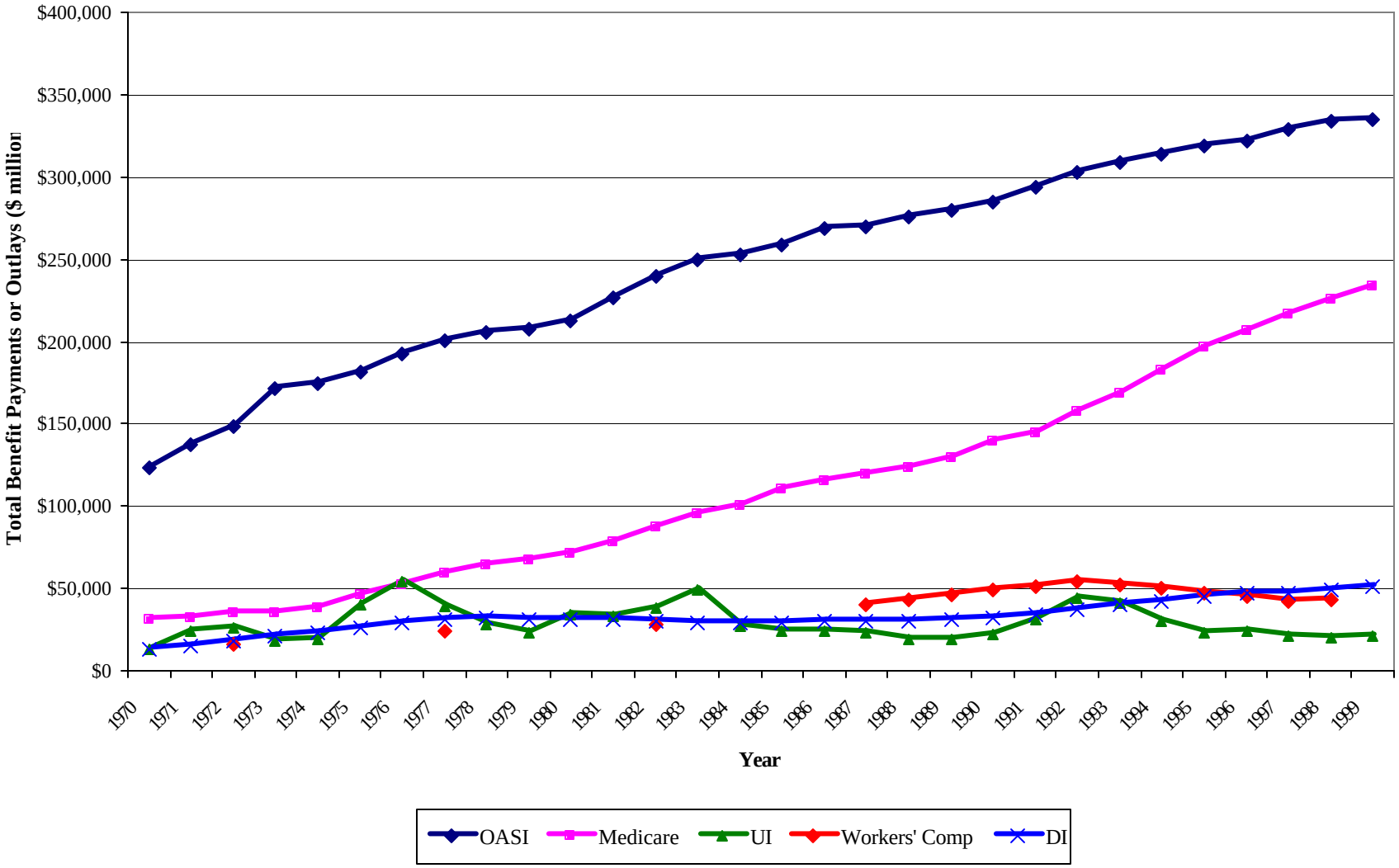


Figure 6: Total SSI Benefits and Medicaid Program Costs, 1970-99
(constant 1999 dollars)

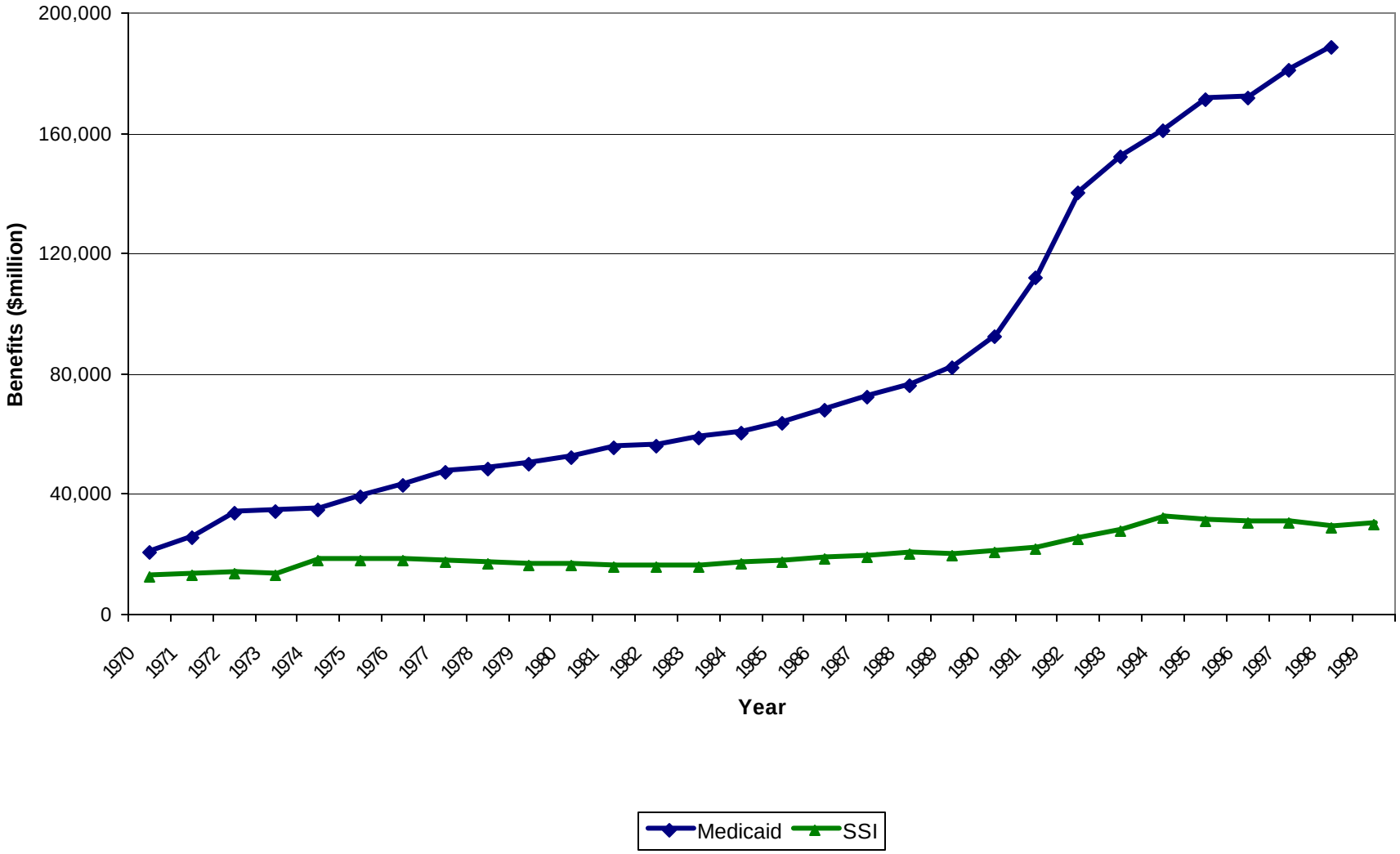


Figure 7: Total AFDC/TANF and EITC Benefits, 1970-99
(constant 1999 dollars)

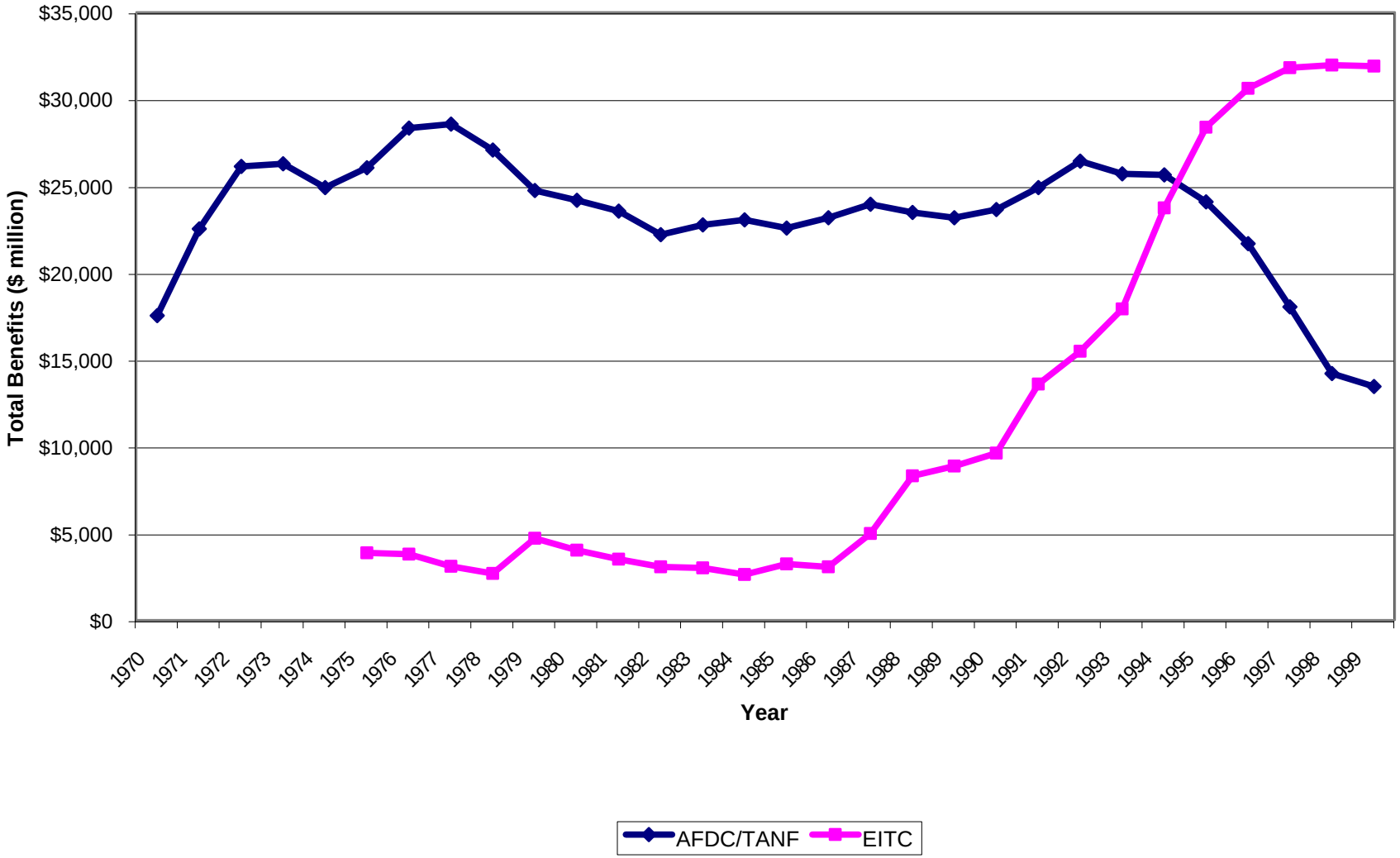


Figure 8: Total Benefits or Program Costs for Various In-Kind Programs, 1970-99 (constant 1999 dollars)

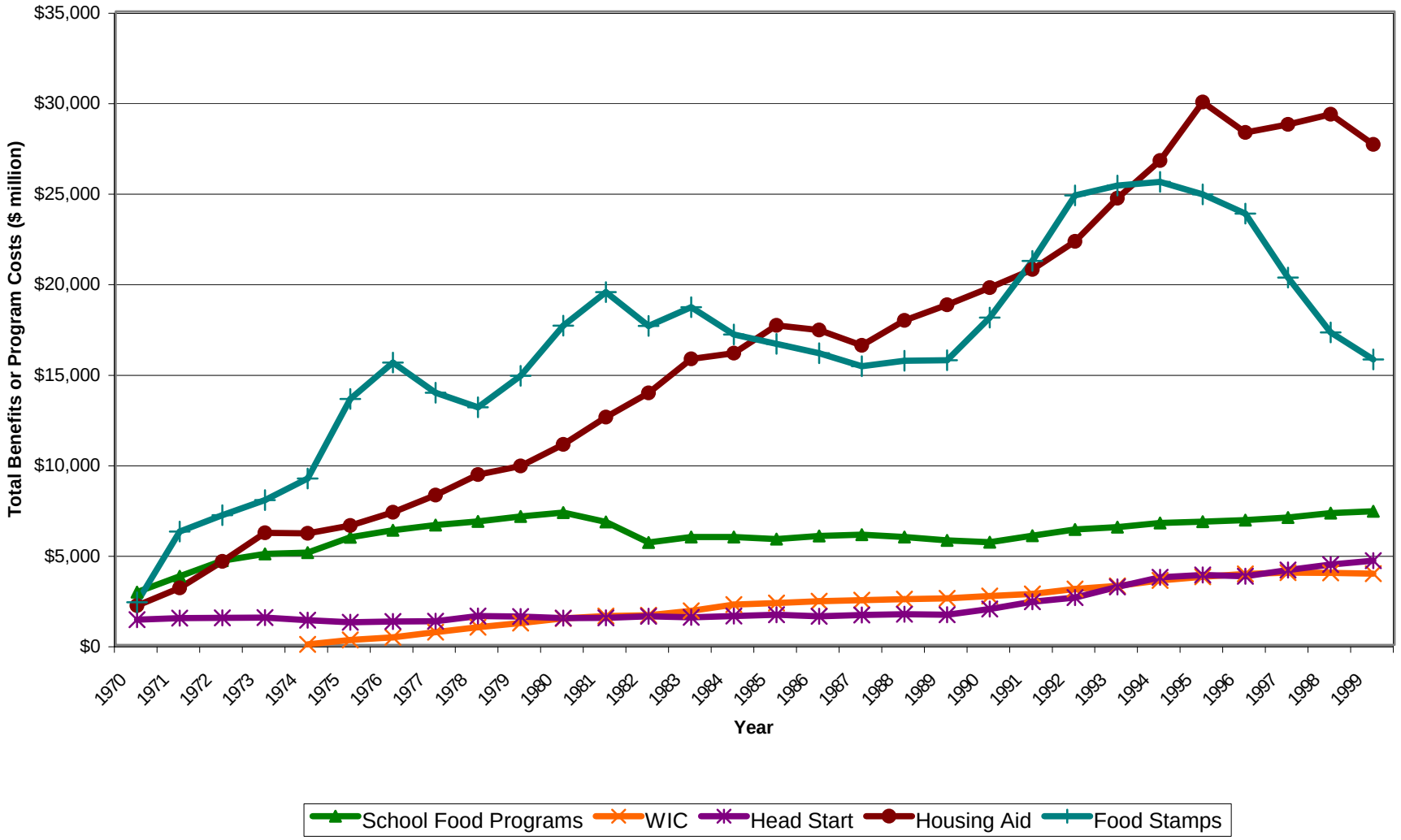
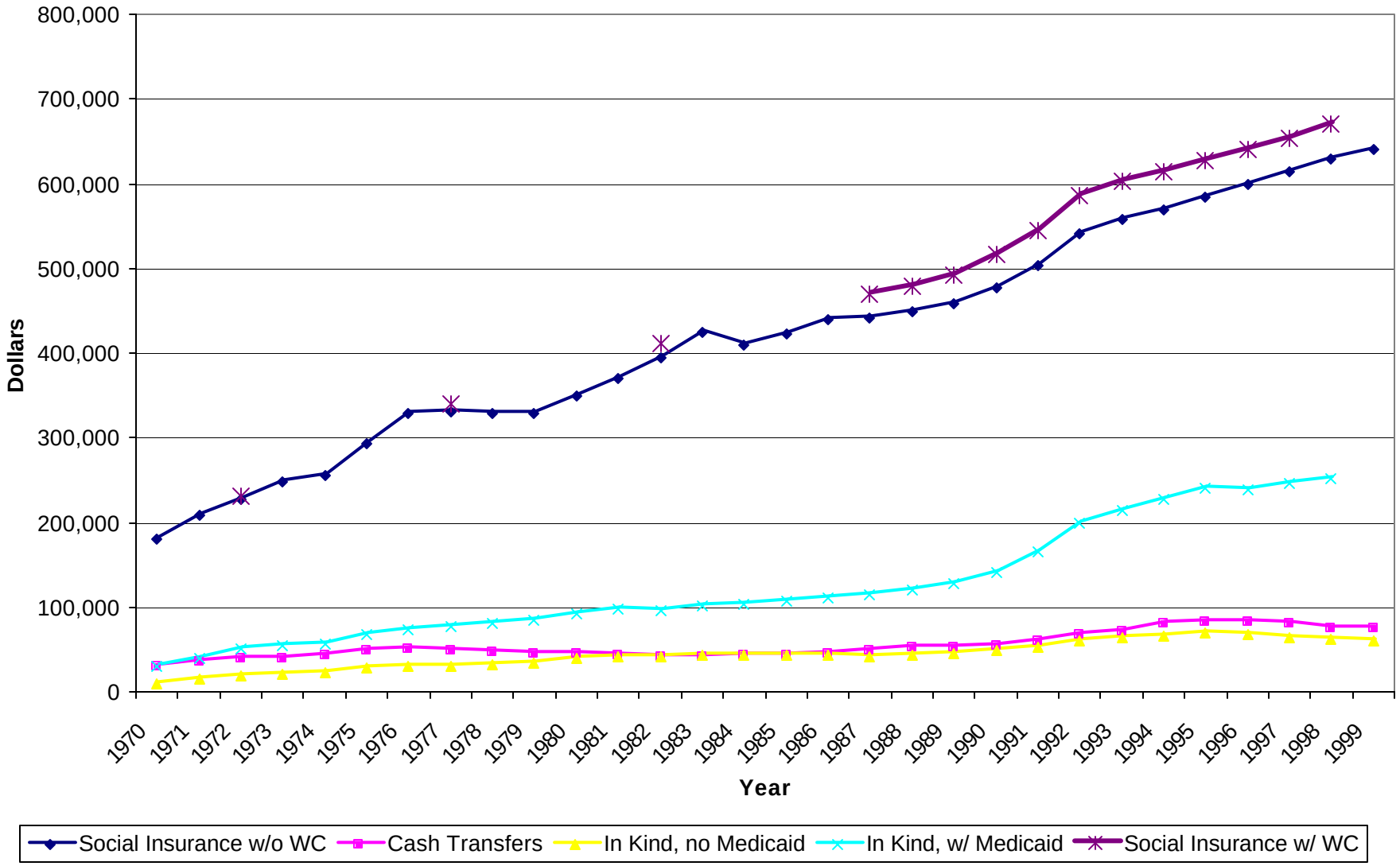


Figure 9: Total Social Insurance, Cash and In-Kind Means-Tested Transfers (1999 dollars)



Appendix Table 1:
Summary of social insurance and anti-poverty spending by program, 1970-99 (constant 1999 dollars, millions)

	Social Insurance					Means-tested Transfers								
Year	OASI	Medicare	UI	Workers' Comp	DI	Medicaid	SSI	AFDC/ TANF	EITC	Food Stamps	Housing Aid	School Food Programs	WIC	Head Start
1970	123,645	30,696	13,199		13,169	20,834	12,620	17,527		2,360	2,164	2,917		1,398
1971	137,447	32,394	23,649		15,459	25,405	13,188	22,530		6,264	3,151	3,785		1,481
1972	147,955	35,153	26,465	16,186	17,828	33,615	13,519	26,122		7,163	4,607	4,647		1,500
1973	171,632	35,568	18,337		21,455	34,187	12,825	26,277		7,998	6,195	5,022		1,504
1974	174,433	38,348	18,887		23,327	34,567	17,728	24,909		9,186	6,164	5,102	35	1,365
1975	181,182	45,775	39,656		26,055	39,132	18,202	26,049	3,871	13,580	6,587	5,950	277	1,251
1976	192,363	52,056	54,357		29,180	42,877	17,761	28,331	3,792	15,596	7,332	6,331	418	1,291
1977	201,000	59,242	39,398	23,725	31,514	47,019	17,336	28,558	3,098	13,930	8,267	6,625	704	1,306
1978	205,317	64,422	27,816		31,973	48,419	16,742	27,062	2,678	13,132	9,401	6,817	970	1,597
1979	207,805	66,888	22,574		31,457	49,923	16,235	24,735	4,709	14,871	9,877	7,098	1,206	1,560
1980	212,443	70,833	34,147		31,211	52,125	16,055	24,173	4,015	17,632	11,080	7,313	1,471	1,486
1981	226,889	77,871	33,575		31,522	55,674	15,749	23,542	3,504	19,482	12,575	6,797	1,597	1,501
1982	239,628	87,052	38,461	28,325	29,933	56,016	15,505	22,197	3,064	17,624	13,922	5,659	1,638	1,574
1983	250,071	95,123	49,458		29,322	58,471	15,730	22,760	3,002	18,654	15,805	5,961	1,883	1,525
1984	253,126	100,488	27,289		28,702	60,241	16,631	23,043	2,626	17,151	16,112	5,957	2,226	1,597
1985	259,128	110,546	24,532		29,164	63,353	17,125	22,575	3,233	16,635	17,654	5,845	2,306	1,664
1986	268,817	115,377	24,526		30,169	68,177	18,364	23,158	3,054	16,121	17,391	6,017	2,406	1,581
1987	269,323	119,729	22,695	40,062	30,082	72,365	18,993	23,938	4,973	15,399	16,540	6,083	2,463	1,658
1988	275,351	123,474	19,210	43,239	30,549	76,211	20,244	23,466	8,303	15,701	17,923	5,958	2,531	1,699
1989	279,427	129,725	18,729	46,105	30,731	82,287	19,760	23,163	8,861	15,720	18,781	5,779	2,567	1,659
1990	284,244	139,843	21,833	48,740	31,616	92,404	20,516	23,631	9,614	18,083	19,733	5,671	2,705	1,978
1991	294,102	144,048	30,717	51,582	33,836	111,946	21,992	24,899	13,584	21,209	20,743	6,029	2,815	2,387
1992	302,729	157,048	43,935	54,229	36,919	140,317	25,243	26,421	15,470	24,825	22,296	6,377	3,083	2,615
1993	308,762	168,166	40,884	52,263	39,889	151,929	27,870	25,694	17,913	25,372	24,669	6,499	3,258	3,201
1994	313,772	182,669	29,723	50,122	42,400	160,984	31,800	25,627	23,725	25,573	26,759	6,737	3,563	3,739
1995	318,860	196,877	23,290	47,414	44,709	170,967	30,744	24,085	28,374	24,885	29,995	6,805	3,762	3,863
1996	321,641	206,255	23,979	44,666	46,905	171,976	30,187	21,673	30,607	23,829	28,308	6,891	3,924	3,790
1997	328,333	216,736	21,378	42,129	47,394	180,935	30,571	18,038	31,800	20,293	28,746	7,043	3,990	4,132
1998	334,035	225,574	20,019	42,614	49,237	188,792	29,073	14,191	31,959	17,262	29,320	7,275	3,976	4,443
1999	334,437	233,400	21,356		51,331		29,749	13,449	31,900	15,766	27,645	7,379	3,939	4,660

Sources:
OASI: http://www.ssa.gov/OACT/STATS/table4a5.html, Total annual benefits paid from OASI Trust Fund (all types of benefits).
Medicare: Green Book, 1998, Table 2.1. Total Medicare Outlays.
UI: US Budget Historical Tables. Table 8.5. Outlays for Mandatory and Related Programs: Unemployment Compensation.
Workers' comp: http://www.nasi.org/WorkComp/1997-98Data/wc97-98rpt.htm and http://www.nasi.org/WorkComp/1994-95Data/wc94rpt.htm, Cash plus medical benefits.
DI: http://www.ssa.gov/OACT/STATS/table4a6.html, Annual benefits paid from DI Trust Fund, by type of benefit, 1957-99.
Medicaid: Green Book, 1998, Table 15.13. History of Medicaid Program Costs (Total Dollars, Federal Plus State).
SSI: Green Book, 1998, Table 3.24. Total Federal and State Benefit Payments.
AFDC/TANF: 1970-96: Green Book, Table 7.4. Total Federal and State Benefits (excludes administrative costs);

1997 and 1998 http://aspe.hhs.gov/hsp/indicators00/T_A_3.PDF (Cash and Work-Based Activities only); 1999, http://www.acf.dhhs.gov/programs/ofs/data/q499/table-f.htm
EITC: Hotz and Scholz, 2000b.
Food stamps: http://www.fns.usda.gov/pd/fssummar.htm, Total benefits.
Housing aid: US Budget Historical Tables. Table 8.7. Outlays for Discretionary Programs: Housing Assistance.
School food programs: http://www.fns.usda.gov/pd/cncosts.htm, Total Federal Costs (sum of Cash Payments and Commodity Costs).
WIC: http://www.fns.usda.gov/pd/wisummary.htm, Total program costs (food, NSA, includes administrative, preventative services, nutrition education).
Head start: 1999 Head Start Fact Sheet at http://www2.acf.dhhs.gov/programs/hsb/research/99_hsfs.htm, Congressional Appropriations.

Appendix Table 2:
Number of recipients by program, 1970-99 (thousands)

	Social Insurance				Means-tested Transfers									
Year	OASI	Medicare	UI	DI	Medicaid	SSI	AFDC/ TANF[1]	EITC	Food Stamps[1]	Housing Aid	School Breakfast[2]	School Lunch[2]	WIC	Head Start
1970	23,035	20,491		2,666		3,098	8,466		4,340			22,400		477
1971	23,888	20,915		2,930		3,172	10,241		9,368		800	24,100		398
1972	24,804	21,332		3,271	17,606	3,182	10,947		11,109		1,040	24,400		379
1973	25,953	23,545		3,561	19,622	3,173	10,949		12,166		1,190	24,700		379
1974	26,664	24,201		3,912	21,462	3,996	10,864		12,862		1,370	24,600	88	353
1975	27,509	24,959		4,352	22,007	4,314	11,165	6,215	17,064		1,820	24,900	344	349
1976	28,212	25,663		4,624	22,815	4,236	11,386	6,473	18,549		2,200	25,600	520	349
1977	29,069	26,458		4,854	22,832	4,238	11,130	5,627	17,077	3,164	2,490	26,200	848	333
1978	29,584	27,164		4,869	21,965	4,217	10,672	5,192	16,001	3,482	2,800	26,700	1,181	391
1979	30,236	27,859		4,777	21,520	4,150	10,318	7,135	17,653	3,749	3,320	27,000	1,483	388
1980	30,844	28,478		4,682	21,605	4,142	10,597	6,954	21,082	4,007	3,600	26,600	1,914	376
1981	31,474	29,010		4,456	21,980	4,019	11,160	6,717	22,430	4,139	3,810	25,800	2,119	387
1982	31,804	29,494		3,973	21,603	3,858	10,431	6,395	21,717	4,411	3,320	22,900	2,189	396
1983	32,221	30,026		3,813	21,554	3,901	10,659	7,368	21,625	4,668	3,360	23,000	2,537	415
1984	32,617	30,455		3,822	21,607	4,029	10,866	6,376	20,854	4,920	3,430	23,400	3,045	442
1985	33,120	31,083		3,907	21,814	4,138	10,813	7,432	19,899	5,080	3,440	23,600	3,138	452
1986	33,690	31,750		3,993	22,515	4,269	10,997	7,156	19,429	5,174	3,500	23,700	3,312	452
1987	34,126	32,411	7,500	4,045	23,109	4,385	11,065	8,738	19,113	5,301	3,610	23,900	3,429	447
1988	34,539	32,980	6,800	4,074	22,907	4,464	10,920	11,148	18,645	5,213	3,680	24,200	3,593	448
1989	35,012	33,579	7,000	4,129	23,511	4,593	10,934	11,696	18,806	5,295	3,810	24,300	4,118	451
1990	35,559	34,203	8,100	4,266	25,255	4,817	11,460	12,542	20,067	5,390	4,070	24,100	4,517	548
1991	36,074	34,870	10,200	4,513	28,280	5,118	12,592	13,665	22,624	5,465	4,440	24,200	4,893	583
1992	36,614	35,579	9,600	4,890	30,926	5,566	13,625	14,097	25,406	5,506	4,920	24,600	5,403	621
1993	36,990	36,306	7,800	5,254	33,432	5,984	14,143	15,117	26,982	5,625	5,360	24,900	5,921	714
1994	37,298	36,935	8,200	5,584	35,053	6,296	14,226	19,017	27,468	5,714	5,830	25,300	6,477	740
1995	37,529	37,535	7,900	5,858	36,282	6,514	13,652	19,334	26,619	5,792	6,320	25,700	6,894	751
1996	37,664	38,064	8,100	6,072	36,118	6,614	12,649	19,464	25,542	5,748	6,580	25,900	7,188	752
1997	37,818	38,445	7,500	6,153	34,872	6,140	10,936	19,490	22,858	5,751	6,920	26,300	7,407	794
1998	37,911	38,825	7,300	6,335	40,649	6,161	8,770	19,516	19,788		7,150	26,600	7,367	822
1999	38,072		7,400	6,524		6,221	7,203	19,542	18,188		7,400	27,000	7,311	

[1] Average monthly number of recipients

[2] Average monthly number of recipients, based on 9-month average.

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