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Big Choices in American Social Policy in the Twenty-First Century

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This paper provides an overview of U.S. social policy in historical and international context. It also identifies the major changes now underway in the U.S. and identifies key challenges and choices facing the nation.

I. U.S. Social Welfare Policy in Historical/International Context

In international comparisons, the U.S. is often considered to be a "laggard" in terms of social welfare policy because of the timing of the development of public social policy mechanisms and because of the relatively modest level of government funding dedicated to social programs. The U.S. did not establish Social Security until 1935 and has never adopted universal health care, while government-funded social insurance programs appeared in Western Europe in the late 1800s and some form of universal health coverage has been adopted by almost all industrialized countries.[1] Despite the willingness of many individuals to label the U.S. as a welfare laggard, in actuality, its social welfare state differs significantly from most welfare states in both design and purpose.

The three key features that distinguish the American welfare state from its counterparts in other industrialized countries include universal but relatively modest levels of public support for

the elderly and disabled, the absence of universal benefits for the working-aged population, and the expansive role of the private sector in benefit provision.

A. Benefits for the Aged

One way that social policy in the U.S. and many other industrialized nations differs relates to the populations eligible for universal support. In the U.S. beyond public education, the vast majority of public benefits and support is focused on the elderly. In many other welfare states, the purpose of benefits is to ensure that all citizens, young and old, enjoy an acceptable standard of living.

Virtually all older Americans who have worked as well as their dependents are eligible for Social Security cash benefits. In addition, very poor elderly with limited work histories are eligible for modest levels of federal Supplemental Security Income support. In terms of health care, virtually all older Americans are eligible for Medicare, a public program that provides health insurance coverage. In addition, the elderly poor often remain eligible for Medicaid, a federal-state program that supplements Medicare coverage.

Despite a preference for concentrating resources among the elderly overall, benefit levels remain relatively modest. Medicare only covers about half of the health care costs of the elderly. One way of measuring the adequacy of Social Security benefits is to consider the extent to which benefits replace earnings. Though the "replacement rate" of Social Security benefits, defined as benefits divided by earnings during employment, has increased significantly since 1940, the replacement rate for workers earning median wages retiring at age 65 is only about 40%, insufficient for many to live adequately in retirement.[2]

B. Benefits for Working-Aged Individuals

The absence of universal benefits for the working-aged population is another notable feature of the U.S. system. Benefits for the most impoverished working-aged individuals include cash and in-kind benefits, while those earning more may receive support through employers and the tax system.

Public programs that provide health insurance for working-aged adults and their families are limited primarily to poor and near-poor families. This is also true for most income assistance programs. Cash assistance for the working-aged population is available through the Temporary Assistance for Needy Families (TANF) program, a block grant administered by the states. TANF benefits and other in-kind programs provide individuals with very modest assistance. The maximum family monthly TANF payment (awards based on family of three) in 2003 varied across states, with Alaska ($923) and Mississippi ($170) providing the smallest benefits.[3] These benefits when combined with other in-kind benefits such as Food Stamps are often not sufficient for a family to secure the basic necessities of food, housing, child care, and health care.

The Earned Income Tax Credit (EITC) provides assistance to families at and just above the poverty line – "The Working Poor." Estimates indicate that the EITC has kept 4.8 million individuals including 2.6 million children from falling into poverty.[4] Implemented in 1975 but expanded significantly during the Clinton presidency,[5] EITC provides working families who would not otherwise pay taxes with a tax credit to supplement their income. The structure of EITC encourages work because up to a point, the more individuals work, the more they receive,[6] though like any program, it creates disincentives for others to work more and marry.[7] The maximum benefit for childless individuals in 2006 was $412, for one-child families was $2,747, and for families with two or more children was $4,536.[8]

In the U.S., benefits do abate poverty, but also encourage work.[9] Differing views on the scope of support has resulted in differing allocations of resources across nations. Many nations with large public expenditures provide comprehensive family benefits as well as programs for the aged. For example, in 1998, Sweden dedicated 10.5% of social welfare expenditures for its family policy, a package of benefits that includes parental leave policies, cash benefits for families, and comprehensive child care, and 23.7% of expenditures for old-age benefits. In the U.S., by contrast, benefits were tilted toward the elderly. Social insurance programs primarily benefiting the elderly received 34.4% of U.S. welfare spending while family programs received 7.1%.[10] The U.S. has never implemented many of the family supports utilized in Europe including universal health and child care. The U.S. preference for modest means-tested programs, in-kind programs instead of cash transfers, and almost no benefits for those without children is unique among developed nations.[11]

Another important source of benefits for the working-aged population comes from the non-profit sector, internationally known as civil society. Throughout history, non-profit organizations have provided social welfare services to cover gaps in government-provided social welfare systems in the U.S. and abroad.[12] The American non-profit sector exceeds the size of its counterparts in most OECD nations with the largest economies. This is to be expected, given the slow development of the U.S. welfare state and the historic role of non-governmental actors in providing services. Despite this, the U.S. does not have the largest non-profit sector; using 1995 data, the Johns Hopkins Comparative Nonprofit Sector Project ranked the U.S. non-profit sector fifth out of 28 developed and developing countries (see Table 1).

Table 1: The Size of the Non-Profit Sector, 1995

Country	**(% of Total Employment)**

Netherlands	12.5
United States	7.8
United Kingdom	6.2
Japan	3.5
Germany	4.9
Australia	7.2

Source: Lester M. Salamon and Helmut K. Anheier, "The Emerging Sector Revisited: A Summary," 1999, Available: http://www.jhu.edu/~cnp/pdf/esr.pdf, Accessed: 03/10/06, p. 6.

The non-profit sector in the U.S. has grown significantly in the past few decades. There are over 1 million charitable organizations in the U.S. (including faith-based organizations).[13] In twenty-five years, the size of the workforce employed at non-profit organizations doubled.[14] Growth in the American non-profit sector over the past fifteen years averaged 2.5%, greater than that of the business and government sectors.[15] Today, approximately 9.5% of total employment falls within the non-profit sector, for a total of 12.5 million people.[16]

C. Expansive Private Sector Role

The role of the private sector in benefit provision is perhaps the largest distinction between the social welfare systems in the U.S. and other industrialized countries. The U.S. differs from other nations in the share of expenditures provided by the private sector and because U.S. government tax and regulatory policies encourage the private sector to take a leading role in the provision of benefits. Though the U.S. ranked twentieth out of the OECD-23 in public expenditures for social welfare in 2001, total private expenses in the form of pensions and health benefits amounted to over 9% of GDP, compared to an OECD-23 average of 2.6%.[17] This high level of private benefit provision is the direct result of U.S. government policies to encourage firms to become active in the area of social policy through tax incentives and other subsidies.[18]

Table 2: Public and Private Social Expenditures, in % of GDP, 2001

	Public	**Private**	**Total**
Sweden	29.8	3.5	33.3

Germany	27.4	3.5	30.9
United Kingdom	21.8	4.4	26.2
Australia	18	4.9	22.9
Canada	17.8	4.5	22.3
Japan	16.9	3.5	20.4
United States	14.7	9.3	24

Source: OECD, Willem Adema and Maxime Ladaique, OECD Social, Employment and Migration Working Paper No. 29, Net Social Expenditure, 2005 Edition - More comprehensive measures of social support, Chart 2. Support for senior citizens and health benefits are key areas of social spending, 2005, Online, Available: http://www.oecd.org/dataoecd/56/21/35632949.xls, Accessed: 03/04/06.

II. Evaluating Outcomes

Lack of universal programs for working-aged individuals and a preference for private sector benefit provision have resulted in uneven benefit coverage. As a result, poverty and income inequality in the U.S. have not been addressed comprehensively through policy. In addition, with the absence of public provision of health care, the U.S. has a growing number of uninsured individuals and health care costs continue to escalate.

A. Uneven Benefit Coverage

Because publicly and privately-provided benefits are not identical in their effects, public benefits tend to be more universal in nature, are more visible to various constituencies, and tend to have greater levels of participation,[19] the outcome of private sector provision has been uneven benefit coverage and gaps for many low-income workers. Table 3 illustrates the growing gaps in health and pension benefits that have emerged among men of working age across income levels over the past three decades.

Table 3: Fraction of Male Workers at Different Wage Levels with Health and Pension Benefits, 1979 and 1996

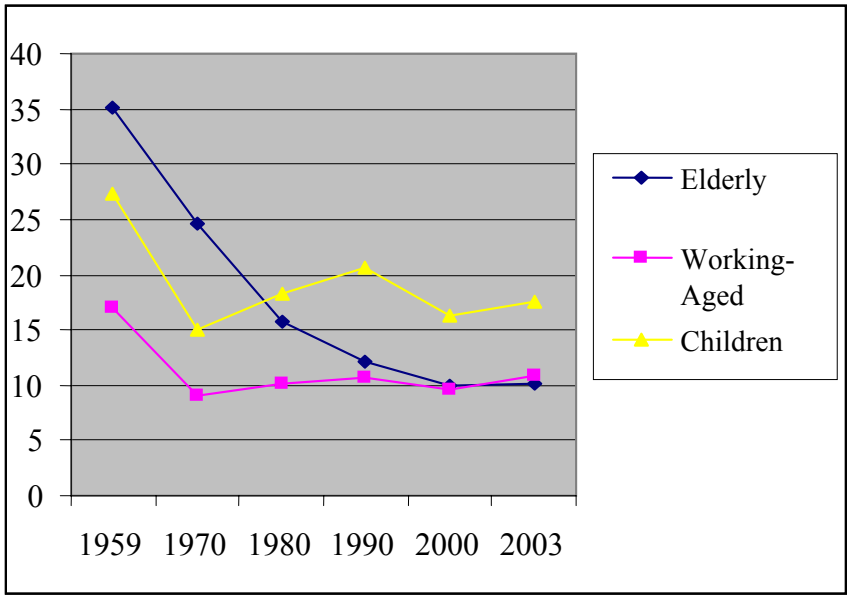
	Percentage with Employer- or Union-Supported Health Benefits		Percentage with Employer- or Union- Supported Pension Benefits	
	1979	**1996**	**1979**	**1996**
Men in the top third of wage distribution	85	78	76	71
Men in middle third of wage distribution	77	64	60	53
Men in bottom third of wage distribution	42	32	24	19
All men	68	58	53	48

Table reprinted: David T. Ellwood et. al., *A Working Nation*, 2000, Russell Sage Foundation (New York, NY): 13.

B. Poverty and Inequality

The choice to allocate a significant amount of resources to the elderly has predictably resulted in large declines in poverty rates among the aged, but poverty among other age groups remains significant (see Figure 1).

Figure 1: Historical American Poverty Rates (In Percentages)



Source: U.S. Census Bureau, "Income, Poverty, and Health Insurance Coverage in the United States: 2003, Table 8-2: Poverty Status of People by Age, Race, and Hispanic Origin: 1959 to 2003," Available: http://www.census.gov/prod/2004pubs/p60-226.pdf, Accessed: 03/05/06, p. 46.

While many explanations exist for U.S. levels of poverty and inequality, including the loss of manufacturing jobs, technology, globalization, and weak unions to counterbalance anti-labor practices,[20] the result has been diverging wages for upper and lower-income workers. Despite the fact that the U.S. has a 30% higher per capita income than other nations surveyed in the Luxemburg Income Study, an international poverty study, the U.S. has some of the highest rates of absolute poverty across age groups, as depicted in Table 4. [21]

Table 4: Poverty Rates by Country, 2000

	Total Population	Children
Germany	9.8	12.8
Italy	12.9	15.7
Japan	15.3	14.3
Sweden	5.3	3.6
United Kingdom	11.4	16.2
United States	17.1	21.7
Canada	10.3	13.6

Source: OECD, "OECD Social Indicators – 2005 Edition, Data Chart EQ1.1: Poverty rates and poverty gaps: proportion of the population, and gap as a percentage of the 50% median income poverty threshold, 2000 and mid-1990s," Available: http://www.oecd.org/dataoecd/34/11/34542691.xls, Accessed: 03/05/06.

The U.S. also leads in income inequality as depicted in Table 5.[22] Using data from 1963 to 1997, the University of Texas Inequality Project ranked countries by their inequality in manufacturing pay. It listed several Scandinavian countries including Sweden, Denmark, Norway, and Finland among the least unequal economies, while the United States had twice as much inequality as these countries, even though it fell into the category of moderate inequality.[23]

In Scandinavian countries and Germany, countries with strong unions and wage protections, these forces have not created significant inequality, but in the U.S., income inequality has been on the rise.[24] From 1979 to 2002, the share of pre-tax income earned by the upper income quintile increased by 15%, while the bottom four quintiles experienced declining shares.[25] The bottom quintile experienced a reduction from 5.8% of wages to 4.2% (a 27% decrease) in its share of pre-tax income.[26]

Table 5: Gini Coefficients by Country (Inequality Measure)

	2000
Germany	27.7
Italy	34.7
Japan	31.4
Sweden	24.3
United Kingdom	32.6
United States	35.7
Canada	30.1

Source: OECD, "OECD Social Indicators – 2005 Edition, Data Chart EQ2:1, Evolution of the gini coefficient between mid-1980s and 2000," Available: ttp://www.oecd.org/dataoecd/34/11/34542691.xls, Accessed: 03/05/06.

Poverty does not have to accompany inequality but it often does, and in the U.S. in particular, structural economic changes have occurred in tandem with demographic changes to the family. In the U.S., the risk of poverty is especially great for single-parent, women-headed families, as roughly half of these families live in poverty, compared to 9% of their two-parent counter-parts.[27] Inequality among families is becoming a more pressing policy concern, given

that the share of single-parent families is growing,[28] especially among certain racial/ethnic groups such as African Americans.[29]

The implications of this inequality and poverty are profound both in terms of social cohesion and the potential demands placed on the state. Political concerns emerge as the gap between rich and poor widens because prospects for upward mobility through traditional outlets such as work are limited. This raises questions about the state's role in addressing these trends. Growing inequality between families also implicates the future of social welfare policy, given that demographic changes to the family are not occurring across all races and socioeconomic statuses, but rather, are concentrated among certain populations.

C. Health Care

Two of the striking and unique features in the U.S. relates to the overall cost of health care and the fact that over 15% of the population has no health insurance. Worldwide, health costs are consequences of how medical systems are structured. In single-payer systems such as in Canada, the state controls health costs by setting rates and rationing services.[30] In countries with private-sector-driven models such as the U.S., health costs have escalated due to over-use of health care services, deployment of new technologies, and use of expensive emergency room care by an uninsured population of 45.8 million people.[31] The U.S. not only tops the list as the highest per capita spender (an average of $5,635, more than double the OECD median),[32] but the U.S. also spends the most as a percentage of GDP, at 15%, up from 13.1% in 2000.[33] More than half of the U.S. health care expenditures are private, and public spending in the U.S. as a percentage of total health expenditures is the lowest of all OECD countries (44.4% in 2003, compared with an average of 72.3%).[34]

Table 6: Total Expenditure on Health (In Percentage of GDP)

	1960	1990	2003
Canada	5.4	9	9.9*
Germany	N/A	8.5	11.1
Italy	N/A	7.9	8.4
Japan	3	5.9	7.9*
United Kingdom	3.9	6	7.7*
United States	5	11.9	15

* Estimate

Source: Organisation for Economic Cooperation and Development (OECD), "OECD Health Data 2005, Total Health Expenditure Per Capita, U.S. $PPP," October 5, 2005, Online, Available: http://www.oecd.org/dataoecd/60/27/35529803.xls, Accessed: February 22, 2006.

As health costs escalate, the number of uninsured Americans also increases. In 2004, 45.8 million Americans went without health insurance for the entire year, and millions more were underinsured or had lengthy gaps in coverage.[35] While a majority of American families receive insurance coverage from their employers, and most elderly and very low-income people have been covered by public programs such as Medicare and Medicaid, the uninsured, for the most part, pay for their health care out of their own pockets or through available charity care. Many of the uninsured are at significant financial and health risk, and the growth in the number of uninsured places growing pressures on our methods of financing health care.

III. Emerging Challenges

While many forces affect the social structures of developed nations today, aging, economic change and global integration, and health care costs are having the greatest effects. Many industrialized nations, including the U.S., are confronting degrees of one or all of these issues, which implicate not only their social structures, but also the provision of social policy.

A. Aging Populations

Demographic changes are underway worldwide, though the U.S. is in a relatively better demographic position than Europe. Table 7 illustrates that worldwide, the share of the population

over age 65 is projected to increase. The increase is not projected to be even, as some areas including Europe and North America will have approximately one-quarter and one-fifth of their populations over age 65 by 2030, while Latin America, Asia, and Africa will have much smaller shares of their populations over 65. Though many researchers believe the U.S. is better situated than its counterparts to support its aging population due to above replacement rate fertility levels for the native-born population and growing immigrant population,[36] these trends will continue to exert substantial pressure on social insurance and welfare programs.

Table 7: Population Aging by Regions of the World, % Over Age 65

Region	2000	2015	2030
Europe	15.5	18.7	24.3
North America	12.6	14.9	20.3
Oceania	10.2	12.4	16.3
Asia	6	7.8	12
Latin America/Caribbean	5.5	7.5	11.6
Near East/North Africa	4.3	5.3	8.1
Sub-Saharan Africa	2.9	3.2	3.7

*2000 data from the U.S. Census Bureau

Reprinted from: Robert L. Clark, Richard V. Burkhauser, Marilyn Moon, Joseph F. Quinn, and Timothy M. Smeeding, *Economics of an Aging Society*, 2004, Blackwell Publishing Company (Malden, MA): 30.

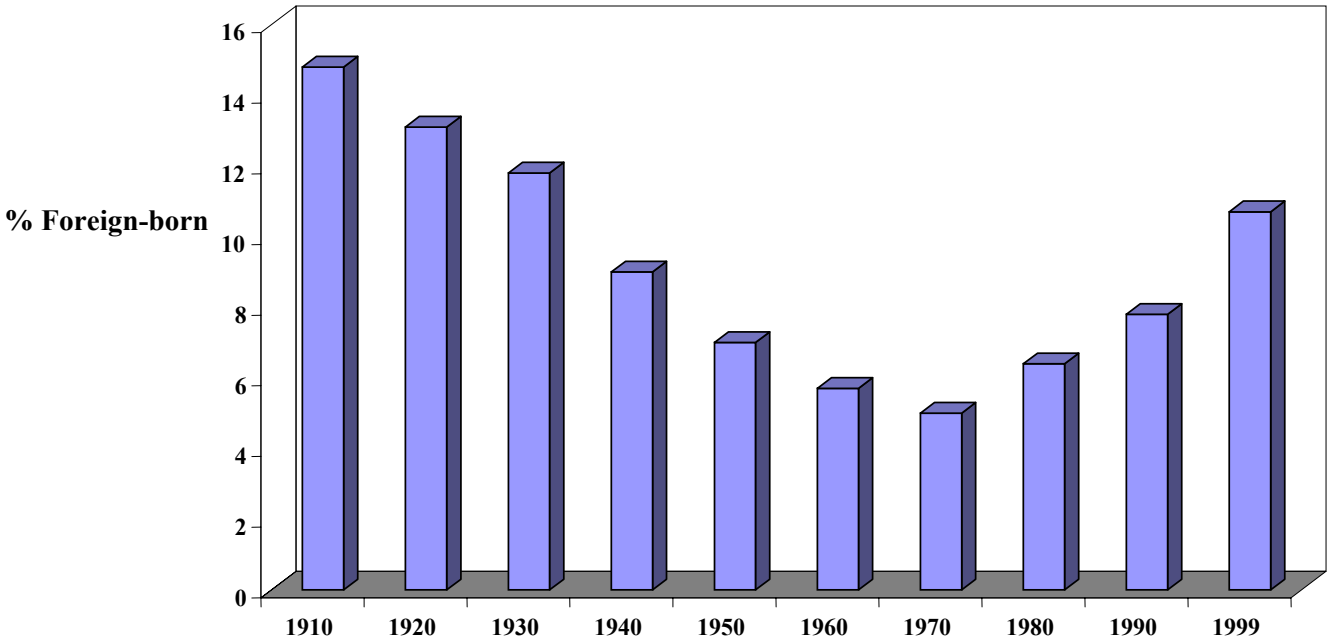
B. Structural Economic Change and Increased Economic Integration

Structural economic change and increased international economic integration with accompanying high levels of immigration are also shaping American society and social policy.[37] Increases in jobs in service-based industries and corresponding declines in manufacturing jobs,

technological innovation, free trade, migration, and outsourcing are some manifestations of these trends. As a result of these economic changes, firms in several industrial economies are less willing to provide defined-benefit pensions and health insurance for workers and retirees in order to remain competitive with the firms in many newly "emerging" economies and multi-national corporations that are excelling through low labor costs.[38] This potential for greater off-loading of benefits has significant implications for the U.S., given the historical role of the private sector in providing benefits. Retiree health benefits are especially vulnerable because unlike pensions, laws do not regulate their operation.[39] In addition to reducing benefit provision, these economic forces are diminishing job opportunities and wages for low-skilled American workers.[40] Given that these workers can no longer expect to receive high wage jobs, their reliance on the state for aid could increase.

Increased immigration has also coincided with these economic changes and greater global integration. At the beginning of the Twentieth Century, immigrants comprised about 15% of the U.S. population (see Figure 2). Though immigration levels dropped until the 1970s, in the past decades, levels of immigration have increased significantly. U.S. Census Bureau 2003 data indicate that immigrants comprise 11.7% of the total U.S. population (33.5 million people).[41] While immigrants contribute to their local economies, growth in immigrant populations, especially those with limited English proficiency, poses new policy challenges in meeting needs of immigrants and their children. Immigrant families are represented disproportionately among low-income and poor families in the U.S.[42] Half of immigrant children live below 200% of the poverty line, compared to 34% of non-immigrant children.[43]

Figure 2: Percentage of Foreign-Born in the United States, 1900-1999



Source: Roger Waldinger (Ed.), *Strangers at the Gate: New Immigrants in Urban America*, 2001, University of California Press (Berkeley and Los Angeles).

C. Health Care Costs Driving Policy

Given that health care consumed 15% of America's GDP in 2005, the highest share on record, escalating health care costs are driving budgets and social expenditures in the U.S. at the federal and state levels, forcing many trade-offs. At the federal level, Medicare and Medicaid are the fastest growing programs. At the state level, health budgets continue to eclipse most other categories of expenses, given that states shoulder a large portion of Medicaid costs. From 1997 to 2005, Medicaid costs increased steadily, with the rate of increase peaking in 2002 at 12.7%.[44] These cost increases create a new sense of urgency in containing health expenses[45] and result in lower spending in other policy areas.

IV. Major Changes Underway in the U.S.

The emerging challenges shaping social welfare policy have triggered a set of changes in the U.S. system. The private sector, though it has played a pivotal role in benefit provision in the past, is now reducing benefits for workers and retirees in response to pressure to remain competitive globally. Benefits for the working-aged population continue to advance in the direction forged by welfare reform legislation enacted in 1996. Current legislative initiatives also indicate the political preference for reductions in means-tested benefits and movement toward semi-privatization of retirement and health benefits.

A. Employer Role

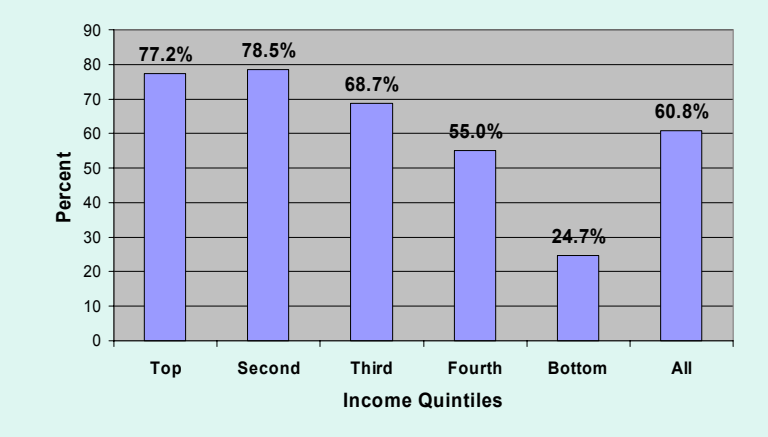
The private sector provides social benefits in many areas, but the three main responsibilities are employer provided pensions and health insurance for workers and retirees. There are significant changes taking place in all of these areas.

1) Employer-Based Pensions

In FY 2001, the U.S. government provided $85 billion in tax incentives to encourage employers to provide pensions to employees,[46] yet overall pension coverage is declining and a major shift is underway in the type of pensions available.

Two-thirds of retirees receive at least some of their retirement income from pensions,[47] though pension participation varies significantly by socio-economic status (See Figure 3). Low-income workers are less likely to have pensions than other workers because they are more likely to work in jobs where pensions are unavailable such as part-time positions or for small employers. Even when pensions are available, these workers are less likely to take advantage of them because they often lack the means to make contributions.[48]

Figure 3: Lifetime Participation in a Pension Plan by Income Quintile



Source: Alicia Munnell, James G. Lee, and Kevin B. Meme, *An Update on Pension Data*, July 2004.

A major trend in pension coverage has been an erosion in coverage in defined-benefit plans, in favor of defined-contribution plans like 401(k)s and Individual Retirement Accounts (IRAs). Contributing to the declining role of defined-benefit plans is the difficulty many employers, especially small firms, have in keeping their defined-benefit plans fully-funded and capable of paying benefits owed to retirees and coping with high administrative costs due to regulatory compliance.[49] As firms shifted to defined-contribution plans, the percent of workers covered by defined-benefit plans decreased from approximately 60% in 1981 to about 10% in 2003.[50]

Today's defined-contribution plans differ from defined-benefit plans in several ways. Proponents of defined-contribution plans tout their portability and greater personal control as benefits for young, mobile workers. The tradeoff for this flexibility is an increase in risk. Defined-contribution plans shift the risk from the employer to the individual; workers are not guaranteed a minimum monthly benefit.[51] Firms are not responsible for future benefit levels, even if workers experience losses in the market. In addition, many individuals liquidate all or some of their defined-contribution accounts long before retirement, a scenario that is impossible

with defined-benefit plans that provide benefits only upon retirement, though in some cases individuals can obtain loans.[52]

Most of those participating in defined contribution plans are of higher incomes. Figure 4 illustrates that the top ten percent of workers hold significantly more assets in their retirement accounts than low-income workers, whose contributions are only 1% of total retirement account assets. For the majority of workers, the amounts of their retirement savings are very modest.

Figure 4: Participation in Tax-Favored Retirement Accounts by Family Income, 2001

Accounts include 401(k) plans, other defined-contribution plans, IRAs and Keogh plans

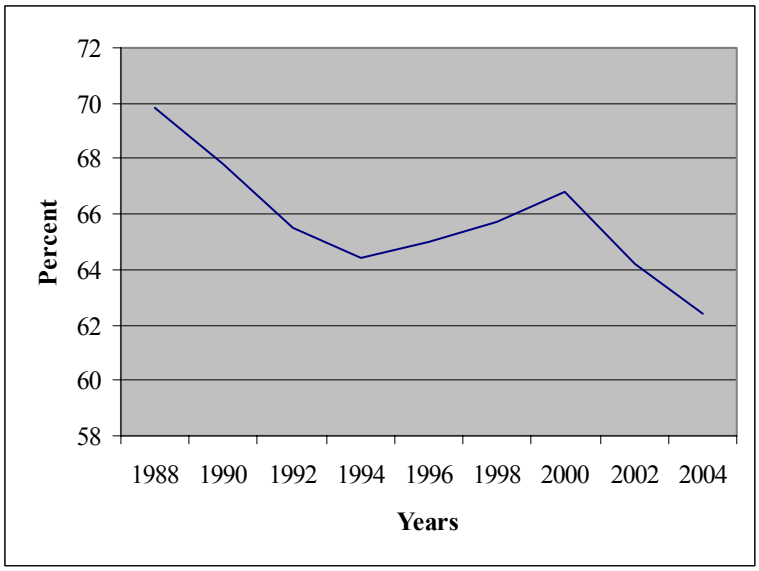
Income Group	Median Income	Account Holder Median Value	Percent of total account assets
Lowest fifth	$10,300	$4,500	1
Second fifth	$24,400	$8,000	4
Middle fifth	$39,900	$13,500	9
Next to highest fifth	$64,800	$31,000	19
Next to highest tenth	$98,700	$52,000	17
Top ten percent	$169,600	$130,000	50

Source: Peter Orszag, *Tabulations Using the 2001 Survey of Consumer Finances*, 2003.

2) Employer-Based Health Insurance for Workers

Employer-based health insurance has been the cornerstone of the US system for the past half century. Most Americans under the age of 65 obtain health insurance through their employer or a family member with employer-based insurance. However, work certainly does not guarantee access to this type of coverage. The proportion of the proportion of the population receiving health insurance from an employer declined from 70% in 1988 to 62% by 2004.[53]

Figure 5: Employer-Provided Health Insurance among the Non-Elderly



Sources: Paul Fronstin, *Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2005 Current Population Survey*, Issue Brief no. 287 (Washington, DC: Employee Benefit Research Institute, November 2005), Online, Available: http://www.ebri.org/pdf/briefspdf/EBRI_IB_11-20051.pdf, Accessed: February 24, 2006, p. 4.

Paul Fronstin, *Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2002 Current Population Survey*, Issue Brief no. 252 (Washington, DC: Employee Benefit Research Institute, December 2002), Online, Available: http://www.ebri.org/pdf/briefspdf/1202ib.pdf, Accessed: February 24, 2006, p. 4.

Overall, nearly 40 percent of America's 108 million workers (excluding the self-employed) did not have health insurance through their own job in 2004. Among these individuals without coverage through their jobs, 54.1% were employed at firms that did not provide health insurance to any of their workers, 15.2% were offered coverage but declined it, and 19% were ineligible for the plans sponsored by their firms.[54]

There have been recent signs of erosion in employer-provided health insurance coverage, particularly among small firms. For firms with between 3-199 employees, the percentage offering health benefits declined from 68% in 2000 to 59% in 2005.[55] In the last three years more firms are reporting that they have reduced their health benefits packages. Of surveyed employers in 2005, 42% of small firms and 74% of large firms were very or somewhat likely to

increase the amount employees pay for insurance, while 57% of small firms and 25% of large firms were not likely or not too likely to increase payments.[56]

In addition, as the cost of health insurance rises, employers are passing on more of the cost of that insurance to their employees. They do this in three ways: 1) by increasing the share of the monthly or annual premium that employees contribute, and 2) by offering plans that require employees to pay higher out-of pocket expenses for health care services, and 3) by reducing benefits packages.[57] In 1988, employees contributed 11 percent of the cost of single premiums and 29 percent of the cost of family premiums. In 2005, employee contributions accounted for 16 percent of single premiums and 26 percent of family premiums,[58] for an average annual cost to workers across all plan types of $610 and $2,713, respectively.[59]

Employees are also paying higher out-of-pocket payments for health services in the form of higher deductibles, co-payments or co-insurance rates.[60] In response to the 2002 annual employer survey on health benefits conducted by the Kaiser Family Foundation and the Health Research and Educational Trust, 29 percent of employers indicated that they had increased the amount that employees pay for health insurance, 28 percent of all employers had increased the amount employees pay for prescription drugs, 22 percent had increased the amount that employees pay for deductibles, and 20 percent had increased the amount of employee co-pays and co-insurance.

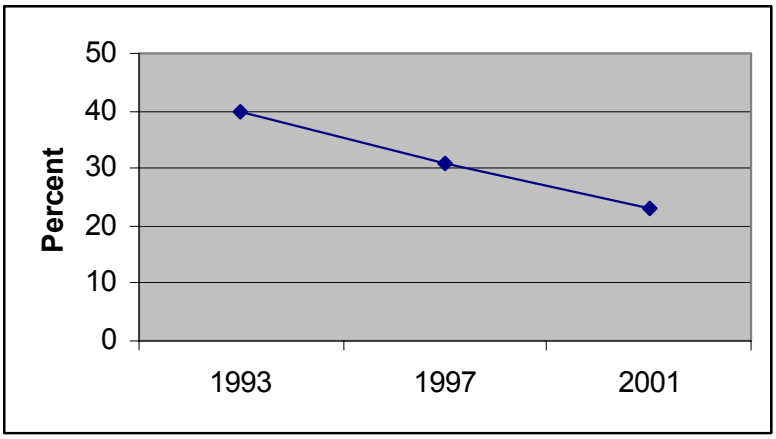
3) Employer-Based Health Insurance for Retirees

Employer provided health insurance for company retirees is experiencing even greater changes. The public component of retiree health insurance – Medicare – pays only a little over half of retiree medical expenses. For many older Americans, the only guarantee of financial security comes through a combination of savings and employer provided health insurance

benefits. But the medical benefits employers offer their retirees appear to be becoming a thing of the past.

Only twenty years ago, about two thirds of large companies offered health insurance to their retirees. Now, only a third of large employers provide supplemental coverage for their Medicare-eligible retirees. And a growing number of those are facing retiree health care costs that could prove financially untenable.

Figure 6: Provision of Retiree Health Benefits for Current and Future Medicare-Eligible Retirees by Large Firms



Source: Paul Fronstin and Dallas Salisbury, "Retiree Health Benefits: Savings Needed to Fund Health Care in Retirement," Issue Brief February 2003, Employee Benefit Research Institute, Online, Available: http://www.ebri.org/pdf/briefspdf/0203ib.pdf, Accessed: March 3, 2006, p. 6.

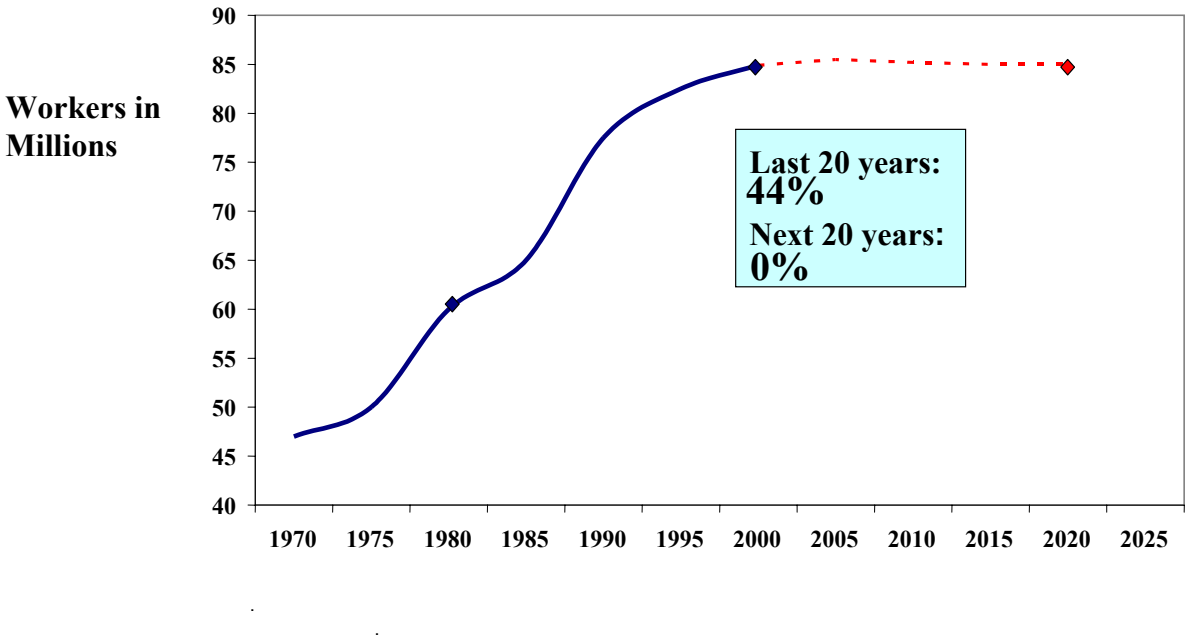
While federal laws protect pension plans to some extent, a similar safety net doesn't exist for health care benefits. As benefits disappear over time, so does the economic security of millions of retirees.

B. Changes to the Future Labor Force

Changes are also underway in the composition of the labor force, both in terms of its size and quality. Forecasters expect almost no growth in the size of the native-born labor pool over the next two decades (see Figure 7). Future growth in the size of the labor market will likely be due to immigration,[61] unless restrictive immigration policies are adopted. In addition to concerns

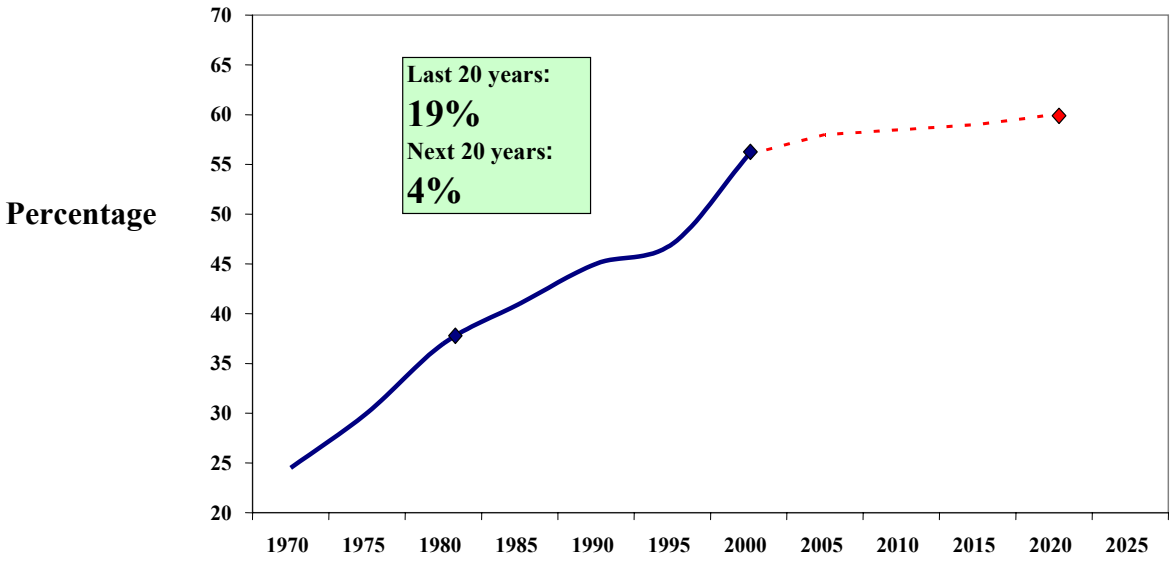
about a shortage of workers, another pressing issue is the quality of the labor pool. Between 2002-2012, forecasters predict 23.3% growth in professional occupations and 20.1% growth in service occupations.[62] Despite these needs, the number or workers with at least some education post-high school is only expected to grow by 4% over the next twenty years (see Figure 8). These changes in the composition of the labor force will not only affect the strength of the U.S. economy, but also limit the size of the workforce able to support social insurance programs and potentially increase reliance of some individuals on the state.

Figure 7: Growth in Native-Born Workforce, 25-54



Source: The Aspen Institute, Grow Faster Together, Or Grow Slowly Apart, How will America Work in the 21st Century?, 1998, Available: http://www.aspenwsi.org/publications/GrowFast.pdf, Accessed: 03/20/06, p. 2.

Figure 8: Increase in the Share of Workers with Post-High School Education



Source: The Aspen Institute, Grow Faster Together, Or Grow Slowly Apart, How will America Work in the 21st Century?, 1998, Available: http://www.aspenwsi.org/publications/GrowFast.pdf, Accessed: 03/20/06, p. 4.

C. Support for the Working-Aged Population

Over the past two decades, significant changes in the philosophy guiding public welfare benefit provision have occurred, resulting in declining levels of cash benefits and new restrictions for recipients. As these changes have occurred, the role of the non-profit sector, and specifically, faith-based organizations, has expanded.

In the U.S., the focus of welfare policy has focused increasingly on work, and the responsibility for poverty prevention shifted from the government to individuals and non-profit organizations. From the implementation of Aid to Families with Dependent Children (AFDC) during the New Deal to 1996, the government provided income support for low-income individuals as an entitlement, meaning that all who met enrollment requirements received benefits. Liberals and conservatives alike began to consider reform options given the emergence of data indicating that welfare did not lift people out of poverty and into self-sufficiency.[63] By

the 1990s, the country was prepared for reform and President Bill Clinton campaigned on the promise that he would "…end welfare as we know it."[64]

By 1996, Congress passed and President Clinton signed the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), significantly changing the nature of welfare benefits. This legislation replaced AFDC with the TANF block grant, meaning that states received a finite amount of funds and had to establish criteria for eligibility. The legislation's focus was on moving families off welfare and into work.[65] It included a five-year lifetime limit on welfare receipt and required all recipients to exit the rolls within two years, though some exceptions existed for mothers with young children. Criteria were established for approved work activities and states had a series of deadlines for moving single and two-parent families into work activities. To facilitate work, the legislation established funds for child care and transportation, though funding levels for these programs have not been sufficient to serve the population leaving the welfare rolls. TANF also established job training activities and most states focused resources on these activities.

As TANF work requirements became stricter, assistance to low-income families expanded in other ways, primarily through growth to the EITC and Medicaid.[66] Spending on these families from the 1980s to the 1990s increased from $5-7 billion to $50 billion,[67] with total benefits in FY 2005 at $39 billion.[68] Many states also expanded state-level EITC benefits during this time.[69] In addition to expansions in EITC benefits, Medicaid spending increased. In the past, Medicaid eligibility was linked to AFDC or Supplemental Security Income (SSI) receipt but during the 1990s, new requirements forced states to cover all children under age 18 in families living in poverty. This requirement combined with the fact that many states extended coverage to

children with family incomes above the poverty line resulted in large increases in enrollment and program expenditures.[70]

In the policy era after 1996, current debates have about income support for low-income individuals have not centered on whether to keep TANF or move back to a system like AFDC, but rather, on how to strengthen TANF's work requirements and if resources should be devoted to encourage marriage formation as a means of preventing poverty among single-parent households. TANF reauthorization during the budget reconciliation process for FY 2006 presented Congress and President Bush with the opportunity to reexamine welfare policy and is illustrative of the two biggest issues in modern welfare reform debates: how to strengthen work requirements and encourage marriage. TANF's reauthorizing legislation reinforced PRWORA's focus on work and personal responsibility, required that states move more of their caseloads into work activities or face increased penalties, and made an additional $200 million in matching funds available to the states for child care annually from FY 2006-10[71] and $150 million for marriage promotion and fatherhood programs.[72] It also provided President Bush with an opportunity to secure funding authorized for his marriage promotion initiative, a proposal intended to reduce the number of impoverished single-parent families.[73] In this policy environment support for EITC and other programs compatible with the work-focused PRWORA legislation remain important.

Over the past ten years as government-provided assistance to the working population has declined, the growth of the non-profit sector has been significant. While non-profit organizations, including faith-based organizations, have always played a part of social welfare provision in the U.S., in recent years, faith-based organizations have played a growing role, especially given increased federal funding. With TANF reform in 1996, states were given the

ability to enter into contracts with faith-based organizations to provide services.[74] Over the next four years, President Bill Clinton oversaw the passage of several laws collectively referred to as "Charitable Choice" that sought to give people the option to receive services from faith-based organizations under TANF, the Community Services Block Grant, mental health and substance abuse programs, and welfare-to-work activities, as long as these organizations do not use federal funds for "inherently religious activities."[75] In 2001, President Bush announced his Faith-Based and Community Initiative, and created an office to head the project and centers within ten federal agencies.[76] The purpose of the initiative was to eliminate barriers in the federal grants process for faith-based organizations that provide social services. Subsequently, several pieces of legislation passed Congress, resulting in greater amounts of federal funding for faith-based organizations. By FY 2004, 10.3% of the federal budget went to faith-based organizations.[77] These efforts have been controversial, with many challenging the appropriateness of federal funding to faith-based organizations and whether faith-based organizations can separate their religious and non-religious activities.

It remains likely that publicly-provided benefits to the working-aged population will continue to erode in upcoming years, though benefits such as EITC that reinforce the value of work may retain support among policymakers and the public. Some of the gaps in benefit provision will be filled by non-profit and faith-based organizations, though not all individuals will be able to benefit from these services.

D. Recent Legislative Approaches

In addition to TANF reauthorization, the federal budget process provides insight about the future of social welfare policy by illustrating the current priorities of the President and Congress. Trends emerging from the FY 2006 budget and the President's proposed FY 2007

budget include reductions in means-testing programs and a greater connection between their receipt and work, attempts to contain health costs, and increased emphasis on private accounts in the areas of pensions and health.

President Bush signed the FY 2006 budget bill into law on February 8, 2006. Several social programs experienced cuts including a $6.9 billion reduction in Medicaid and SCHIP funding, at least an $11.9 billion cut in student loan funding,[78] a $6.4 billion reduction in Medicare spending, and $2.6 billion in cuts from child support enforcement, foster care payments, and SSI.[79]

The FY 2007 budget process began in February with the release of the President's budget. President Bush proposed cuts for many social welfare programs including Medicare ($35.9 billion over five years and $105 billion over ten years, with additional regulatory cuts of $7.9 billion over five years and $19 billion over ten years), Medicaid ($14 billion over five years and $35.5 billion over ten years), Food Stamps ($656 million over five years), and housing subsidies for the disabled and elderly.[80] The SCHIP program would receive a sizeable funding increase for FY 2007, but would lose funding over the next four fiscal years.[81] For TANF-related programs, the President proposed $100 million to encourage healthy marriages and reduce out-of-wedlock births, $5 billion for child care, and $500 million fewer dollars for the Social Services Block Grant.[82]

President Bush again proposed the creation of personal/private accounts for retirement and Health Savings Accounts (HSAs). His plan for private pension accounts contains two parts, accounts in which workers could invest up to 4% of wages (up to about $1,000 per year) but workers would receive reduced benefits from the current Social Security system based on the amount contributed to personal/private accounts, as well as reductions in remaining benefits for

most workers earning over $20,000 annually achieved through sliding-scale benefit reductions/progressive price indexing.[83] Proponents of the combined approach point to two related benefits including resolving some of the long-term financing shortfall and preventing low-income individuals from experiencing large benefit reductions. Critics argue that the accounts do not solve the entire financial shortfall of Social Security, and that they entail too great of financial risks for retirees, especially for the most vulnerable retirees: low-income persons, women, minorities, and the disabled.

The President also proposed initiatives to foster increased use of HSAs, created through the Medicare Modernization Act in 2003, that would allow individuals to deduct their HSA premiums from their federal income taxes, make contributions to HSAs exempt from payroll taxes, and provide those that purchase HAS-compatible high-deductible health plans with a refundable tax credit. He also proposed raising the limit on how much individuals can contribute to their HSAs and supports efforts that would make plans more portable.[84]

V. Big Choices in Welfare Policy

It is clear that the employer-based system of social supports is undergoing a significant transformation, and global competitive pressures may hasten more changes in the future. It is less clear how U.S. social policy will respond to this transformation. Should the U.S. take steps to bolster the employer-based system? Should the U.S. significantly strengthen public programs to fill some of these growing gaps? Or should the U.S. take steps to encourage individuals to take more personal responsibility for basic social protections – in effect to use individual incentives and savings to replace some of the private sector social systems that are now in place?

The Bush Administration has been promoting changes along the lines of the third approach described above. Under the rubric of the "ownership society," the President's proposals

– to privatize part of the Social Security system, to greatly expand tax incentives for savings, to provide individual tax credits and medical savings accounts to encourage the purchase of individual low-cost health insurance, all coupled with reductions in support for public programs – would represent a significant change in the social contract.

Twice during the Twentieth Century, the federal government made major changes to the social contract. The basic framework of the U.S. system of social supports was largely determined by actions taken in the 1930s and the 1960s. Since the 1960's, only incremental steps have been taken. It is clear that the major trends underway necessitate further major changes. The key question is the overall direction these changes will take.

Perhaps most important to the authors is the question of the values and principles that underline the various reform proposals. Where would changes lead us as a society in the future? The core values question at the heart of future of American social policy seems clear: where do we as a society draw the lines of responsibilities for basic social needs – the public, employers or individuals? What do we want our society to provide to its citizens in these areas, and what are the values inherent in those choices?

It is clear that we face major choices in American social policy, and that the choices that we make will lead to very different outcomes and a different country.

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