Institute for Research on Povery
Discussion Paper no. 1350-08

Trends in Income Support

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September 2008

A version of this paper was presented at the Institute for Research on Poverty conference "Changing Poverty," which was held at the University of Wisconsin–Madison May 29–30, 2008, with financial support from the Assistant Secretary for Planning and Evaluation of the U.S. Department of Health and Human Services and the Russell Sage Foundation. A book containing revised papers from the conference titled *Changing Poverty* and coedited by Maria Cancian and Sheldon Danziger is forthcoming in fall 2009 from the Russell Sage Foundation. We are grateful to Mark Duggan, Jon Gruber, Bob Plotnick, Chad X. Ruppel, the conference organizers Maria Cancian and Sheldon Danziger, and conference participants for providing helpful advice.

Abstract

Antipoverty programs are designed to mitigate the most pernicious aspects of market-based economic outcomes—unemployment, disability, low earnings, and other material hardship. 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 different to a family in one set of circumstances than it does to a family in another.

The authors have three primary goals in this paper. First, they provide updated information on expenditures and recipients for a range of antipoverty programs, describing the evolution of the safety net over the past thirty-five years. Second, they use data from the Survey of Income and Program Participation (SIPP) to calculate the antipoverty effectiveness of federal programs for families and individuals in different circumstances. Third, they explore changes in the characteristics of recipients of means-tested transfers, tax credits and social insurance.

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Social insurance programs – social security, Medicare, unemployment insurance, and workers' compensation – are costly programs with much larger numbers of recipients. Despite the fact that they are not antipoverty programs per se, they have had a significant effect on poverty, particularly among the elderly. The antipoverty programs that constitute the safety net are collectively much smaller and have had varied support over time.

As noted in previous work (Burtless, 1986, 1994; Scholz and Levine, 2002), there has been a sharp reduction in cash entitlements for poor families and a very large increase in social insurance payments, particularly for the elderly, in past decades. The nature of programs has changed as well. Cash welfare benefits, for example, have been linked with work requirements, partly in response to evolving views about the nature of the poverty problem. Responsibility for antipoverty policy has broadened from the antipoverty agencies of the federal government (the Departments of Health and Human Services and Labor) to the states (through their administration of TANF and Medicaid) and to the tax code, as evidenced by the Earned Income Tax Credit (EITC) and the refundable child credit.

We have three primary goals in this chapter. First, we provide updated information on expenditures and recipients for a range of antipoverty programs, describing the evolution of the safety net over the past thirty-five years. Second, we use data from the Survey of Income and

Program Participation (SIPP) to calculate the antipoverty effectiveness of federal programs for families and individuals in different circumstances. Third, we explore changes in the characteristics of recipients of means-tested transfers, tax credits and social insurance. Moffitt (2003a, 2007) documents a large increase in total per-capita means-tested transfers, even in the decade following the 1996 welfare reform. He notes, based on aggregate data, that the shift in expenditures for different programs suggests that more transfers now go to workers and fewer to non-workers; more go to married couples and fewer to single mothers. Because aggregate transfers have increased, one can argue that society has become more generous over time. But some families have lost benefits while others have gained benefits as the safety net has evolved.

Social Insurance

Social insurance programs provide near-universal coverage since any individual (or their employer) who makes the required contributions to finance the programs can receive benefits when specific eligibility requirements are met. These programs have dedicated funding mechanisms where, at least in an accounting sense, social insurance taxes are remitted to trust funds from which benefits are paid.

It is often inefficient for individuals to self-insure for contingencies like an unexpectedly long life, end-of-life health shocks, or extended unemployment spells. Because of adverse selection problems – the tendency for the riskiest individuals and families to seek insurance, which makes the pricing of products unattractive to less risky families and individuals – private insurance markets are unlikely to work well. Social insurance programs, which are government run, near-universal, and uniform in their rules and benefits, provide the welfare-enhancing benefits of insurance, while overcoming the problems (through mandatory pooling) that arise in private insurance markets.

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 needs of older workers leaving the workforce without sufficient post-retirement income to be self-supporting.[1] Figure 1 plots the time series of real (inflation-adjusted) social security (OASI) payments from 1970 to 2006 (Disability Insurance benefits are not included in this series, but are discussed below). Real social security payments have tripled between 1970 and 2006 to $474 billion because of three main factors. First, the number of retired workers covered by social security has steadily increased as, over the years, the aged population has grown and state and local government workers, clergy, and other groups were brought into the system. 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; benefits were indexed to inflation beginning in 1974. Aggregate real social security benefits increased 5.6 percent annually in the 1970s, and 3.0 percent in the 1980s. Aggregate annual real benefits increased 1.8 percent in the 1990s and by the same amount between 2000 and 2006.

Because many retired elderly workers have little labor market and capital income, pre-tax and transfer poor families receive a substantial share of social security benefits. The official poverty rate for people age 65 and older was 9.4 percent in 2006.[2] It was 17.4 percent for

[1] In 2008, the OASDI program is financed by a 6.2 percentage point payroll tax levied on employers and employees (for a combined 12.4 percent tax) on earnings up to $102,000. 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). Workers (who are not disabled) can begin drawing reduced benefits as early as age 62; the normal retirement age is 67 for workers born after 1959. Benefits payments increase (nonlinearly) as retirement is delayed until age 72, at which point benefits no longer increase with age of retirement.

[2] The Census money income concept to measure poverty is pre-tax and includes earnings, unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates,

children under age 18 and 12.3 percent for all persons. The elderly poverty rate is the lowest, largely because of social security benefits, which averaged $11,566.[3]

The elderly also receive substantial benefits from Medicare, which provides hospital insurance and supplementary medical and prescription drug coverage for most people over age 65 and for most social security disability recipients under age 65.[4] Real Medicare outlays have increased more than tenfold from $41 billion in 1970 (the program started in 1967) to $413 billion in 2006. Real expenditures per Medicare enrollee increased almost five times over the same time period to $9,378 in 2006. In the late 1990s and early 2000s, Medicare growth slowed, as efforts were made to reduce Medicare hospital spending and control fraud and abuse. Spending increased sharply in 2006 with the implementation of Medicare Part D, a prescription drug benefit that is projected to cost more than $40 billion annually.

A substantial portion of Medicare benefits go to elderly families whose pre-transfer incomes are below the poverty line. The official poverty measure does not account for Medicare benefits because they are in-kind (via the provision of health care and insurance) rather than in the form of cash. Hence, they are difficult to value. Possibilities would be to value them at their cost to the government, the cost a recipient would have to pay in the private market 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 government for many low-income recipients).[5] It is also difficult to determine which individuals in a given family receive benefits. Below, when assessing the antipoverty effectiveness of spending, we make illustrative calculations of the degree to which

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trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources. See Meyer and Wallace (this volume) for more details.

[3] All dollar amounts are given in 2007 dollars, unless otherwise noted. Descriptions of statutory program rules refer to the year in question (in this example, 2008).

[4] 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).

[5] Smeeding (1982) discusses these issues. Burtless and Seigel (2004) discuss issues that arise in accounting for

Medicare reduces poverty.

The effect of social security on poverty is clear: as the social security system has grown, elderly poverty has fallen precipitously. The sharpest decline in the elderly poverty rate occurred between 1959 and 1974, a period that coincides with rapid growth in social security spending.[6]

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, 84.7 percent of Medicare recipients were elderly in 2004 and 71.9 percent of social security recipients were elderly in March, 2008.[7] Three smaller social insurance programs--unemployment insurance (UI), workers' compensation, and disability insurance (DI)--target prime-age workers; real expenditures on these programs are also shown in Figure 1.

Unemployment insurance is a state-level program that provides temporary and partial wage replacement to workers who become involuntarily unemployed and who have a recent history of continuous employment at moderately high wages.[8] While UI allows families to maintain their consumption during periods of involuntary layoffs (Gruber, 1997), it has relatively small antipoverty effects because so many unskilled individuals do not have the necessary employment history at high enough wages. The Government Accountability Office (2000) reports that in the 1990s, low-wage workers were twice as likely to be unemployed but less than half as likely to receive UI as other unemployed workers.[9] Unemployment insurance is highly cyclical. In 2003,

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health care spending and insurance when measuring poverty.

[6] 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 29 percent between 1991 and 2006.

[7] Authors' calculations from data provided by the Center for Medicare and Medicaid Services and the Social Security Administration.

[8] 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.

[9] Although UI eligibility varies by state, typically one must have worked for at least two quarters of the previous

a year of slow economic growth, $61 billion in real UI benefits were paid out, while real payments were $25 billion in 2000, a year with low unemployment.

Workers' compensation is a state-level program that provides cash and medical benefits to some persons with job-related disabilities or injuries and provides survivors' benefits to dependents of workers whose death resulted from a work-related accident or illness. Benefit levels vary widely across states. Workers' compensation payments were $59 billion in real terms in 2005; Meyer, Mok and Sullivan (2007) note that roughly half of total program costs are for medical care. Because there is little Federal involvement in this system, there is little information on its antipoverty effects. We speculate that any such effects are likely to be small, however, for the same reasons that UI has limited antipoverty effectiveness.

Disability Insurance (DI), a federal program that is part of the social security program, provides benefits when a covered worker is unable to engage in "substantial gainful activity" by reason of a physical or mental impairment that is expected to last for more than 12 months or result in death.[10] 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 average annual growth rate in real DI expenditures was 9.0 percent in the 1970s, 0.1 percent in the 1980s, 5.3 percent in the 1990s, and 6.2 percent between 2000 and 2006. Despite program growth, the DI rules are stringent, with fewer than 40 percent of all applications being granted benefits; roughly 5.4 awards are made per 1,000 covered workers. Around 8.6 million people (including children) receive disability benefits, which cost $95 billion in 2006.

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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 percent of the individual's average weekly pre-tax wage up to some state-determined maximum.

[10] Substantial gainful activity is defined as work that involves significant physical or mental effort and that is done for pay or profit. Complex regulations promulgated by the Commissioner of the Social Security Administration define disabilities and substantial gainful activity, though average monthly earnings above some threshold ($940 in 2008) demonstrate substantial gainful activity for people with an impairment other than blindness.

Most DI recipients are pre-tax-and-transfer poor.[11]

Summary of social insurance

Social security, Medicare, unemployment insurance, workers' compensation and disability insurance are the major social insurance programs. Over time, the enormous increase in their benefits has been driven largely by increases in social security and Medicare. Social insurance benefits are predicated on events that are salient for most Americans – retirement, unemployment, or a disability or work-related injury, and receipt of benefits does not depend on an individual's current total income but rather on past employment and earnings experience. 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 these programs encourage individuals not to marry or have children out of wedlock, and, with the possible exception of DI, they do not encourage individuals to spend extended periods out of the paid labor market (UI 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 the care-giving responsibilities that adult children might have for their parents, which is popular with both generations.

Means-Tested Transfers

Means-tested programs are financed by general tax revenues rather than through dedicated financing mechanisms; all limit benefits to those whose incomes and or assets fall below some threshold. Some are entitlements—all who satisfy the stipulated eligibility requirements get benefits, regardless of the total budgetary cost (e.g., Medicaid, Food Stamps). Other means-tested programs provide benefits only until the funds Congress or a state has allocated are spent,

[11] Autor and Duggan (2003) examine factors affecting DI caseloads over time.

even if some eligible participants are not served (e.g. State Child Health Insurance Program, Section 8 housing vouchers, TANF). Means-tested programs have explicit antipoverty goals. Together, they account for a smaller share of government budgets than the social insurance programs.

Health care and the disabled

Medicaid, the largest means-tested transfer program (Schwartz, this volume), funds medical assistance to persons who are aged, blind, disabled, or are certain other pregnant women or dependent children. Recipients must meet asset and income tests that are set by states. 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.[12] These expansions led to a large increase in the number of Medicaid recipients. About 23 million people received Medicaid in 1977 and 1988, but this number climbed steadily to 55.0 million in 2004. About 10 percent of Medicaid beneficiaries were 65 or older in 2005; they receive about 26 percent of Medicaid expenditures.

The trend in Medicaid spending is shown in Figure 2. Total real Medicaid spending increased from $28 to $320 billion between 1970 and 2006. After growing rapidly through the mid 1970s, Medicaid grew at annual rates between -0.5 and 8.8 percent between 1976 and 1989. The expansions of the late 1980s increased growth rates to 12.8, 21.4 and 12.l percent in 1990, 1991 and 1992. Spending fell in 2006, due largely to shifts in prescription drug costs to Medicare Part D and to a reduction in the growth of enrollments (Holahan, Cohen, and Rousseau, 2007; Swartz, this volume). Attempts to assess the antipoverty effectiveness of

[12] Throughout the paper, figures on Medicaid recipients and expenditures include those for SCHIP, the State Children's Health Insurance Program.

Medicaid face the same difficulties that arise with valuing Medicare benefits: it is not clear whether they should be valued at the cost to the recipient, the cost a recipient would have to pay in the private market to obtain similar benefits, or the amount a person would be "willing to pay," which itself is difficult to know.

Supplemental Security Income (SSI) is a means-tested, federally-administered, cash assistance program for the aged, blind and disabled. The disabled make up nearly 80 percent of recipients. The program began in 1974 with the consolidation of several smaller programs.[13] An individual who meets the income, asset and categorical eligibility standards receives a cash transfer of up to $637 per month; couples can receive up to 1.5 times that amount, and children can receive half that amount, although states are allowed to supplement these amounts. SSI (Figure 2) grew very slowly from $22 to $26 billion between 1974 and 1990 (in 2007 dollars).

Between 1990 and 1994, SSI costs grew by 55 percent, making it one of the fastest growing entitlement programs. A major contributing factor driving 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 SSI's growth during this time: adults with mental impairments, children and non-citizens. Since the mid 1990s, efforts have been made to reduce the growth in the number of children and immigrants covered by SSI, so real spending in 2006 is roughly equal to spending in 1994. In 2006, 7.2 million people received $40 billion in benefits.

[13] The SSI income test restricts countable income to less than the 2008 Federal benefit rate of $637 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 $1,359 per month and still be eligible for SSI. A couple with only wage income could have earnings of $1,997. An individual also cannot have assets exceeding $2,000 ($3,000 for couples), though houses and generally automobiles are not counted. An applicant is expected to first file for all other available benefits, including DI if they are eligible.

Cash means-tested transfers for able-bodied families

Aid to Families with Dependent Children (AFDC) was the central safety net program for poor families with children from 1936 to 1996 (Moffitt, 2003b). This program was directed primarily at single-parent families, though some two-parent families with an unemployed parent received benefits. AFDC was a means-tested entitlement, 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.

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 abolished AFDC and created Temporary Assistance for Needy Families (TANF), which provides block grants to states with few restrictions. States were required to spend at least 75 percent of their "historic" level of AFDC spending, a 5-year lifetime limit was imposed on receipt of federally-supported cash assistance (some hardship exemptions were allowed), and states had to meet targets for moving recipients into work activities. A combination of these AFDC-TANF changes, the longest economic expansion in history, sharp increases in the earned income tax credit, and other factors contributed to a 52 percent decline in welfare caseloads between January 1993 and December 1999. Despite the weak economy in the years after the recession in 2001, TANF caseloads did not increase substantially from their historic lows.

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 others states to lower theirs. In fact, total AFDC/TANF spending on cash benefits declined from a peak of about $40 billion in 1995 to about $20 billion in 2006 (Figure 3), but this reduction is roughly proportional to the welfare caseload reduction. Spending on other ancillary

services (e.g. child care, transportation) for welfare recipients and other low-income families has, in some jurisdictions, also increased since the mid-1990s.

The Deficit Reduction Act of 2005 reauthorized the TANF program and increased work requirements–50 percent of all adults in single-parent families receiving TANF benefits and 90 percent of two-parent households in a state must participate. These percentages are lower for states if their welfare caseloads fall below 2005 levels, but caseloads in that year were at historically low levels, so this provision is unlikely to substantially relax the work requirement constraint. It is likely that states will place even greater emphasis on increasing employment among TANF recipients, divert potential TANF applicants from the program, or both.

Real spending on AFDC/TANF grew by an annual rate of 0.3 percent in the 1980s and fell by 2.5 percent in the 1990s. It fell by 4.2 percent a year from 2000 to 2005, despite a weak economy. In contrast, expenditures on the earned income tax credit (EITC) have grown sharply from $5 billion in 1975 to $45 billion in 2006 (Figure 3).[14] Most of this growth occurred after 1987; real EITC expenditures grew at an annual rate of 9.1 percent in the 1980s (due to legislated increases in 1986), 12.5 percent in the 1990s (due to legislated increases in 1990 and again in 1993), and 3.0 percent from 2000 to 2005. No other federal antipoverty program has grown so rapidly since the mid-1980s. The EITC is now the nation's largest cash or near-cash antipoverty program.

The incentives embedded in the EITC differ from those in AFDC/TANF. AFDC recipients with no earnings received the largest welfare payments. In contrast, the EITC encourages low-

[14] The EITC is a refundable credit that taxpayers can receive after filing their tax returns. It seeks to encourage individuals with low earnings to increase their work hours. In 2008, low-income working families with two or more children could get a credit of 40 percent of income up to $12,060, for a maximum credit of $4,824, which stays at this level as earnings increase from $12,060 to $15,740. Their credit is reduced by 21.06 percent of earnings between $15,740 and $38,646. Those with one child can get a credit of 34 percent on income up to $8,580, for a maximum credit of $2,917. Childless taxpayers can get a credit of 7.65 percent on income up to $5,720, for a maximum credit of $438. See Hotz and Scholz (2003) for further discussion.

skilled workers to enter the labor market, since nonearners do not receive the credit and the EITC amount rises with earnings up to about the poverty line.

A child tax credit was created in the 1997 Taxpayer Relief Act. Until 2001, the credit provided little financial benefit for poor and near-poor families because of limits on its refundability. Beginning in 2002, the child credit was made at least partially refundable for taxpayers with children and with earned income exceeding $10,750 (indexed for inflation). In 2004, a year we focus on below, the credit was a maximum of $1,000 per child. For taxpayers with no other federal income tax liability, ten cents of child credit is paid (as a refundable credit) for every dollar earned in excess of $10,750, up to the total available child credit.

In-kind means-tested transfers for able-bodied individuals

The safety net for low-income families includes in-kind benefit programs, the largest of which are food stamps, housing assistance, Head Start, school nutrition programs and the special supplemental nutrition program for women, infants and children (WIC).[15] The evolution of expenditures for these programs is shown in Figure 4.

Food stamps are designed to enable low-income households to purchase a nutritionally adequate low-cost diet. It is the single, almost-universal entitlement for those with low income and assets. The maximum monthly food stamp benefit for a family of four was $542 in 2008.[16]

After food stamp benefits were made uniform across the country and indexed for inflation in 1972, real spending grew sharply. Legislative changes in 1981 and 1982 cut spending between

[15] Programs designed to enhance human capital are discussed in Jacob and Ludwig (this volume) and Holzer (this volume).

[16] Families receiving SSI or TANF also receive food stamps. Others must have incomes below the poverty line after subtracting a $134 per month standard deduction, 20 percent of earnings, dependent care and large shelter expenses, and child support payments. Total income cannot exceed 133 percent of the poverty line. A family must have less than $2,000 of assets ($3,000 if a member is elderly). Vehicles (under $4,650 in value) and houses do not count for the asset tests. PRWORA 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.

1982 and 1985 by nearly 13 percent ($7 billion) below what would have been spent under prior law. The program was liberalized in 1985, 1986 and 1987, which, together with the early 1990s recession, led to a sharp increase in total food stamp spending between 1988 and 1992. Between 1994 and 2000, real food stamp expenditures fell to $18 billion from $32 billion, even though only modest changes to food stamp program rules were made by the 1996 welfare reform (primarily affecting immigrant households). The General Accounting Office (1999) concluded that participation fell "faster than related economic indicators would predict" and speculated that some former cash welfare recipients thought they were also no longer eligible for food stamps.

Food stamp participation and spending increased sharply between 2000 and 2005. The caseload increased from around 18 million to 30 million; spending increased from about $18 billion to $31 billion (Rosenbaum, 2006). Factors affecting these developments include increases in the number of poor people over this period, the use of food stamps as federal disaster aid for Hurricanes Katrina, Rita, and Wilma and other natural disasters, and changes in the 2002 farm bill that restored food stamp benefits to some legal immigrants, allowed states to provide benefits to households that own a reliable car, and simplified application procedures.

The Department of Housing and Urban Development and the Farmers Home Administration are responsible for safety net housing assistance programs. Because these programs have never been entitlements, waiting lists are common. Aid comes in two principal forms: project-based aid, where subsidies are tied to units constructed for low-income households, and household-based subsidies, where renters choose 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 $3 billion in 1970 (in 2007 dollars) to $37 billion in 1995, and then fluctuated, reaching $39 billion in 2007 (Figure 4). The number of housing assistance recipients rose from 3.2 million

in 1997 to a peak of 5.8 million in 1995, before declining to 5.1 million in 2007. Federal housing subsidies provide roughly $7,720 in annual benefits per recipient.

The school lunch and breakfast programs are entitlements funded by the Department of Agriculture that provides federal support for meals served by public and private nonprofit elementary and secondary schools and residential child care institutions that enroll and 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 10 million in 2007. The school lunch program is larger, but has grown gradually from 24 million children in 1971 to about 31 million in 2007. Combined expenditures in 2007 were around $11 billion.

The special supplemental nutrition program for women, infants and children (WIC) provides vouchers for food purchase, supplemental food, and 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. In 2007 roughly 8 million women, infants and children received benefits from WIC at a cost of almost $6 billion.

Head Start, an early childhood education program launched as part of the War on Poverty, seeks 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 (Jacob and Ludwig, this volume). In real dollars, Head Start grew at an annual 9.9 percent rate in the 1990s. Program growth slowed considerably between 2000 and 2006, averaging 1.6 percent. Spending in 2006 was $7 billion for around 900,000 children.

Child care

Several federal child care subsidy programs target low-income families. Because child care expenses are often seen as a deterrent to mothers' entering the work force (Waldfogel, this

volume), the emergence of child care subsidy programs reflects the trend toward work-based assistance rather than cash welfare (Blau, 2003). In 1988, the Family Support Act created the Aid to Families with Dependent Children Child Care, which served AFDC parents who participated in job training, and Transitional Child Care, which served former welfare recipients.[17] Two more programs were implemented in 1990: At-Risk Child Care, which served families at risk of going on welfare and the Child Care Development Block Grant, which funds working, low-income families and provides funding to improve the quality of child care. In 1996, PRWORA consolidated all of these programs into the Child Care and Development Fund (CCDF).

According to Besharov, Higney, and Myers (2007), the child care development block grant more than doubled from $4 to about $9 billion (in 2007 dollars) between 1996 and 2000; then rose to $10 billion in 2005. After the 1996 welfare reform, states could spend TANF block grant money on child care; by 2000, they spent $3 billion. In 2005, 1.75 million children were served by the Child Care and Development Fund. The antipoverty effects of subsidized child care are not well known.

Summary

Figure 5 summarizes the evolution of social insurance and means-tested (antipoverty) spending. Appendix Table 1 presents spending by program; Appendix Table 2, the numbers of recipients by program. Spending on all social insurance programs now exceeds $1 trillion annually. These expenditures (in real dollars, excluding workers' compensation due to data limitations) rose at an annual rate of 7.2 percent in the 1970s, 3.3 percent in the 1980s, 2.9 percent in the 1990s, and 4.3 percent (in part because of Medicare Part D) between 2000 and

[17] The Dependent Care Tax Credit, enacted in 1954, is a non-refundable tax credit. However, it provides no benefit to families with incomes at or below the poverty line, because these families do not have positive federal income tax

2006.

The bottom two lines of Figure 5 show total spending on in-kind transfers (without Medicaid) and cash transfers. Means-tested in-kind transfers (the sum of school nutrition programs, WIC, Head Start, housing assistance, and food stamps) grew at an annual rate of 16.0 percent in the 1970s, 2.1 percent in the 1980s, 2.0 percent in the 1990s, and 5.1 percent between 2000 and 2005.[18] Means-tested cash transfers (the sum of AFDC/TANF, SSI, and the EITC) grew at an annual rate of 3.4 percent in the 1970s, 2.1 percent in the 1980s, 4.2 percent in the 1990s, and fell for the first time in 35 years between 2000 and 2005, despite a weak economy.

The growth rates of both cash and in-kind safety net spending increased significantly in the 1990s relative to the 1980s. In-kind programs continued to increase in the 2000s, while cash programs shrunk. Spending on cash and in-kind antipoverty programs excluding Medicaid is around $200 billion in 2005. Medicaid is an additional $333 billion in 2005. In the following section, we discuss the degree to which these programs alleviate poverty.

Effects of Antipoverty Policies

In this section we address the complex question: how do the social insurance and means-tested programs we have described affect the poverty rate and the depth of poverty among poor people? We examine the antipoverty effectiveness of these programs by measuring the degree to which they reduce the aggregate poverty gap, which is defined as the sum of the differences between market income and the poverty line for all families with incomes below the poverty line.[19] We measure the poverty gap using data from the first waves of the 1984, 1993, and 2004

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obligations.

[18] Medicaid is considerably larger than the combined value of the other in-kind transfers in recent years. In-kind transfers including Medicaid grew at an annual rate of 11.2 percent in the 1970s, 4.5 percent in the 1980s, 6.0 percent in the 1990s, and 6.2 percent between 2000 and 2005.

[19] The poverty lines are the official Census Bureau thresholds for each year. See http://www.census.gov/hhes/www/poverty/threshld/thresh04.html for the 2004 thresholds.

Surveys of Income and Program Participation (SIPP), a nationally-representative survey conducted by the U.S. Census Bureau. Each interview elicited information for the four months prior to the interview month. These surveys were conducted at similar business cycle points – October, 1983 was 11 months; February 1993 was 23 months; and February 2004 was 27 months following the trough of the prior recession.

We emphasize four questions. First, how large is the poverty gap, and how did it change between 1984 and 2004? Second, how has the antipoverty effectiveness of the tax and transfer system changed? Third, how effective are current programs in filling the poverty gap? Fourth, how do the effects of public policies differ across demographic groups – for example, the elderly, one- and two-parent families, and families without children?

Behavioral Responses

Our analysis does not take into account behavioral responses to different programs, so before beginning our discussion of the preceding questions, we briefly discuss behavioral responses to changes in the safety net for prime-age workers and how they would likely affect our results.[20] These responses have been at the heart of the policy debates shaping the evolution of antipoverty policy.[21] 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. Here we briefly outline issues related to three topics: labor markets, saving and family

[20] Feldstein and Liebman (2002) survey the behavioral effects of social security. Medicare is discussed in Schwartz (this volume).

[21] In addition to the chapters in this volume and work cited elsewhere in this chapter, see, for example, reviews by Danziger, Haveman and Plotnick (1981) and Moffitt (1992). Recent surveys on specific programs include Currie (2003) for food and nutrition programs, Olsen (2003) on housing assistance, and Daly and Burkhauser (2003) on SSI.

formation.

All open-ended means-tested transfer programs—that is, those that provide more benefits, the lower is family income—provide a disincentive to work because additional work necessarily reduces benefits received. Economists have put most of their emphasis on the importance of the "tax rate" in these programs, defined as the fraction of benefits that are lost as income rises, and have recommended that the tax rate be kept low to minimize work disincentives. Historically, tax rates have been very high for low-income families. For example, Dickert, Houser and Scholz (1995) showed that, in 1990, cumulative *average* tax rates (that is, tax rates summed over all programs a family participated in) exceeded 85 percent for some low-wage, single-parent families from New York working anywhere from 8 to 35 hours per week in. This implies that an extra dollar of earnings would only increase take-home income by 15 cents.

Since 1990, however, tax rates have been greatly reduced in the TANF program and the EITC expansion has lowered them even further. Tax rates for those with very low earnings are usually less than 30 percent and often be negative (i.e., benefits actually increase with earnings) because of the EITC (Coe et al., 1998).[22] These tax-rate reductions have increased employment rates over the late 1980s and 1990s (Meyer and Rosenbaum, 1999). A series of classical experiments testing the effect of increased financial incentives on the work effort of low-income families also showed that families respond positively to such incentives (Berlin, (2000).

Savings among low-income families can also be affected by antipoverty programs because eligibility requires low income and assets, which means that families will lose eligibility if they save enough to exceed these levels. Hubbard, Skinner and Zeldes (1995) construct a simulation model that predicts, in the absence of asset testing, that low-income families would save

[22] Families with somewhat higher earnings can still face high tax rates if they begin to pay federal and state income taxes, payroll taxes, have the EITC phased out, and perhaps have other benefits phased out.

considerably more than they actually do in the presence of asset testing, regardless of whether they ever draw program benefits. Nevertheless, the empirical evidence that asset tests discourage wealth accumulation is scant, at least for prime-age individuals (Hurst and Ziliak, 2006; Engelhardt et al., 2008).[23]

Antipoverty programs often provide greater resources to single-parent families than to two-parent families and so 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 additional children. Many studies have addressed the question of whether antipoverty programs affect behavior in the ways just described, and the results suggest that low-income individuals do indeed respond to these incentives but that the magnitude of the response is small (Moffitt, 1998).

We conclude that the tax and transfer system has measurable effects on the behavior of low-income families, with the strongest effects on reducing work effort. This implies that our estimates, given below, of the effect of antipoverty programs on the incomes of the poor are overstatements of their initial impact, because those programs may cause incomes to fall even further as work effort is reduced. Our impact estimates should consequently be regarded as upper bounds.

The Evolution of the Poverty Gap, 1984-2004[24]

Our market income measure aggregates wage and salary income, self employment income,

[23] It is also not clear that increasing saving for precautionary motives—that is, saving "for a rainy day"—should be encouraged, since such saving takes away from current consumption.

[24] Ziliak (2005) provides a wide-ranging discussion of issues that arise in measuring poverty and calculates the evolution of the aggregate poverty gap over time. Ziliak (2008), using data from the Current Population Survey, calculates the effects of various safety net programs on the poverty gap in 1979, 1982, 1989, 1991, 1999, and 2001, broken out by a wide range of household demographic characteristics. While Ziliak's conclusions differ from ours in some respects—he finds modest declines in poverty gaps over time where we find increases—he, like us, finds that a declining fraction of the poverty gap is being filled by transfers and that there have been marked changes in the distribution of inequality within subgroups (e.g., single mothers).

capital income (interest, dividends and rents), and defined benefit pension income. We do not consider the effects of the individual income tax, aside from the refundable EITC and child tax credits. Omitting the federal individual income tax has little consequence for poverty gap calculations because in recent years most poor families with children do not pay positive income taxes due to personal and child exemptions and the standard deduction. Low-income taxpayers without children and incomes near the poverty line pay small amounts of federal income taxes. In contrast, because all workers are subject to the payroll tax, we reduce reported earnings by 7.65 percent (the employee OASDHI tax rate) when measuring the poverty gap and percent poor.

We include the following programs in Table 1, which shows the evolution of the poverty gap between 1984 and 2004: social security (OASDI), unemployment compensation, workers compensation, SSI, AFDC/TANF, the EITC, the child tax credit, general assistance, other welfare, foster child payments, veterans' benefits, food stamps, WIC, and housing assistance.[26]

SIPP (and other nationally representative household surveys) underreport aggregate transfers (Meyer, Mok and Sullivan, 2007). However, the number of recipients and aggregate benefits for veterans' benefits, general assistance, other welfare, foster child payment, and OASI, fairly closely match the administrative totals (or the programs are small, in cases where administrative totals are not readily available).[27] Because noncompliance biases the administrative totals for the EITC, we do not adjust our SIPP-based EITC calculations, nor do we adjust our child credit calculations in 2004. We do not have good administrative data on the number of worker's compensation recipients, so we adjust reported benefits in the SIPP to match the cash receipts reported in Meyer, Mok and Sullivan (2007). For housing (and Medicaid in Tables 2 and 3), we impute recipients, based on the income, education, marital status, number of

[26] The child credit was enacted in 1997, so it is only reflected in 2004.
[27] The same is true for Medicare, which is reflected in Tables 2 and 3.

children, race/ethnicity, gender (of the family reference person), region, age (of the family reference person), age of children, and participation in other programs. In brief, we assign a propensity score to each non-recipient SIPP household, and impute average benefits to the non-recipients with the highest probability of receiving benefits, until we match the number of recipients in the administrative data. For ADFC/TANF, food stamps, WIC, disability insurance, SSI, and UI, we do the same, and then once we match the number of recipients in the administrative data, we adjust household benefits in the SIPP to match the aggregate benefits reported in the administrative data. Hence, for each program we consider, we (roughly) match both the number of recipients and aggregate (and average) benefits in the administrative data.

We exclude Medicare and Medicaid in Table 1 for two reasons. First, it is technically difficult to estimate the value of Medicare and Medicaid. Second, medical benefits and insurance are only imperfectly fungible with other expenditures. Hence, if resources are not available for food, shelter, and clothing, it is not clear that it would be appropriate to suggest that the insurance value of health benefits is sufficient to move an otherwise poor family above the poverty line. We do value Medicare and Medicaid when we focus on the effects of specific programs in 2004 in Tables 2 and 3.

All programs considered in Table 1 deliver cash benefits, except for food stamps and housing 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. We use Fair Market Rent (FMR) data from the Department of Housing and Urban Development and value in-kind housing benefits as the difference between rents paid by housing assistance recipients and the FMR in the state.[28]

[28] The state FMRS are population-weighted averages by county (or major metropolitan area). We adjust by the number of bedrooms needed for families of different sizes, assuming that childless individuals or couples live in a one bedroom dwelling and families with one or two children live in a two-bedroom dwelling. An extra bedroom is added for each child over two.

The first row of Table 1 shows the 2004 SIPP, when weighted, represents 124.5 million families (including unrelated individuals as one person families). Using our after-payroll-tax pre-transfer income concept, 30.3 percent are poor. The pre-transfer poverty gap, in 2007 dollars, is $30.2 billion a month, or $800 per poor family, suggesting that a perfectly targeted transfer of exactly that amount could eradicate poverty, assuming no other behavioral responses. Total transfers measured in SIPP (excluding Medicare and Medicaid) are $65.0 billion per month, or $845 per recipient family; of these transfers 54.0 percent are received by pretransfer poor families and 30.7 percent reduce the poverty gap.[29] The tax and transfer system closes 66.2 percent of the poverty gap, leaving 14.1 percent of families poor after the full effects of the safety net (excluding the value of medical benefits and insurance).

Rows 2 and 3 of Table 1 show the same results for 1993 and 1984. The fraction of all families with income below the poverty line is about 30 percent in each year. The poverty gap per family is also about $800 per month in each year. And, in each year between 66 and 73 percent of the poverty gap is filled by safety net programs.

Although the pre-transfer poverty rates across years are similar, the percentage of total transfers received by pre-transfer poor families and the percentage of total transfers used to fill the poverty gap have been falling over time. In 1984 38 percent of transfers filled the poverty gap, while only 31 percent did in 2004. For families who remain poor after transfers, the monthly poverty gap (of $580) in 2004 is larger than the monthly poverty gap (of $480) in 1984. This raises the possibility that transfers in 2004 moved more near-poor families over the poverty line, perhaps leaving those further away from the poverty line with even less assistance than before. We explore this possibility later in the paper.

[29] If a family has a poverty gap of $100 and the program provides $1,000 of benefits, only $100 would be included in the "percent of total used to alleviate poverty" column.

The Antipoverty Effectives of Specific Programs

Table 2 shows the antipoverty effectiveness of specific safety net programs in 2004 (in 2007 dollars). For this portion of the analysis, we also value Medicare and Medicaid. We assume that for most families, Medicaid is worth the cost of a typical HMO policy (see Gruber, 2003 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. We value Medicare using 2.5 times the average cost of a fee-for-service plan, adjusting for regional cost differences.[30]

Reading across the "all transfers" row (the sum of all social insurance and means-tested transfers shown in the table), the first entry shows $95.9 billion of benefits, or $1,238 per recipient family. Of these payments, 54.9 percent go to pre-transfer poor families, and 22.8 percent reduce the poverty gap. These transfers fill 72.5 percent of the total poverty gap, which results in an after-tax and transfer poverty rate of 12.0 percent (down from 30.3 percent) and a monthly poverty gap of $8.3 billion.[31]

The next rows show these effects for various programs and groups of programs. "All in-kind transfers" includes housing, food stamps, Medicare, Medicaid, and WIC. "Cash transfers" include all other means-tested transfers. The "All social insurance" and "All mean-tested transfers except the child credit and foster child payments" entries are self explanatory. We

[30] The data come from the Kaiser Family Foundation, averaging figures from the 2003 and 2005 Annual Employer Health Benefits Surveys, http://www.kff.org/insurance/7315/sections/upload/7316.pdf and http://www.kff.org/insurance/upload/Kaiser-Family-Foundation-2003-Employer-Health-Benefits-Survey-Section-1.pdf and http://www.kff.org/insurance/7315/sections/upload/7315Section1.pdf (accessed on April 27, 2008). For 1984 and 1993, we used similar information from http://www.kff.org/insurance/upload/The-1999-Employer-Health-Benefits-Annual-Survey.pdf
We were unable to disaggregate the fee-for-service costs by region for the earlier years. For the 1984 figures, we use the 1988 data and then deflate it using the medical CPI.

[31] The difference between the "all transfers" row in Table 2 and the 2004 data in Table 1 simply reflects the valuation of Medicare and Medicaid (in Table 2), which reduce poverty by 2.1 additional percentage points—14.1 to 12.0 percent.

focus on the effects of three sets of programs – all social insurance, and all means-tested transfers (excluding the child credit and foster child payments), and the combined effects of all programs. If there were no means-tested transfers in place, 51 percent of social insurance goes to the pre-transfer poor, these payments close 48 percent of the poverty gap, and they reduce the poverty rate from 30.3 percent to 18.8 percent. Similarly, if there were no social insurance programs in place, 74 percent of means-tested transfers go to the pre-transfer poor, these payments close 36 percent of the poverty gap, and they reduce the poverty rate from 30.3 percent to 23.5 percent. The *combined* effect of social insurance and means-tested transfers can be seen from the top (complete) line of Table 2. The effect of all transfers is to close 73 percent of the poverty gap and reduce the poverty rate from 30.3 percent to 12.0 percent.

As expected given their universality, the major social insurance programs – social security (OASI), disability insurance (DI), Medicare, unemployment insurance (UI) and workers' compensation – are not sharply targeted on pre-transfer poor households. Disability insurance and unemployment insurance are the exceptions, where 72 percent of DI benefits and 61 percent of UI benefits go to the pre-transfer poor. Around half of the other social insurance program benefits go to individuals or families with incomes below the poverty line. About half of DI and UI benefits and 14 to 28 percent of the other benefits reduce the poverty gap. Given the large size of the programs, however, they fill a substantial part of the poverty gap. For example, about half of all social security benefits go to the pretransfer poor; if we include disability insurance (looking at OASDI) they reduce the poverty gap by 40 percent.

Means-tested programs typically provide a larger share of their benefits to the pretransfer poor than do social insurance programs. For example, 87 percent of food stamp benefits go the pretransfer poor and 84 percent of them reduce the poverty gap. But, because food stamps are

much smaller than social security, they fill only about 6.3 percent of the poverty gap. Medicaid, SSI, housing assistance, and the EITC also close the poverty gaps by 4.5 to 8.2 percentage points.

The Effects of the Safety Net Programs by Family Type

Table 3 compares differences in the effects of safety net programs on elderly families and eight non-elderly family types: 1) single-parent, 2) two-parent, 3) childless, 4) white, 5) black, 6) Hispanic, 7) employed, and 8) unemployed. The top row shows that $48.6 billion in transfers per month, primarily social security and Medicare benefits, fill 95 percent of the poverty gap of the elderly, leaving them with a 7.8 percent post-transfer poverty rate. The second row shows that $11.3 billion in transfers are received by non-elderly single-parent families – 76 percent go to poor families and 37 percent reduce the poverty gap. Although these transfers fill 82 percent of the poverty gap, 13.8 percent of non-elderly single-parent families remain poor. The $15 billion in monthly transfers for nonelderly two-parent families reduces their poverty gap by 76 percent, resulting in a poverty rate of 5.1 percent.

Nonelderly black and Hispanic families and individuals have higher pre-transfer poverty rates than nonelderly white families, receive (on a per capita basis) more transfer payments and, for those who are poor, have similar depth of poverty (as measured by the poverty gap). Despite receiving more in average transfers, black and Hispanic families and individuals have post-transfer poverty rates that are around 3 percentage points higher than those of white families and individuals.

Table 3 calls attention to several holes in the safety net. First, the tax and transfer system fills only 50.7 percent of the poverty gap for non-elderly childless families, compared to 75.5 percent for two-parent families with children and 82.1 percent for single-parent families with

children. Other than food stamps, these families have few public assistance programs they can access in the absence of a disability, though as discussed above, strengthening their safety net runs the risk of creating incentives to not work or not invest in skills that could lead to greater self-sufficiency. Second, post-transfer poverty rates remain high for single-parent families with children (13.8 percent) as well as for black and Hispanic families (15.0 and 15.4 percent, respectively). Third, non-elderly families with no employed individuals have an exceptionally high post-transfer poverty rate, 44.1 percent. As we discuss in the next section, changes in the nature of the safety net over the past 20 years have increased the economic vulnerability of family heads who are unable or unwilling to work.

The Changing Nature of U.S. Antipoverty Programs

The safety net has changed in striking ways for the nonelderly. The changes are evident, in part, in Figure 3, which shows the reduction in AFDC/TANF expenditures, which historically went to nonworkers, and the increase in EITC benefits, which go overwhelmingly to low-income workers with children. Other than food stamps and housing benefits, nonelderly families or individuals with very low or no earnings and patchy employment histories have no safety net to draw on. We illustrate changes in the safety net for different groups of families with a series of figures that illustrate the average monthly benefits available to low- and moderate-income families.

Figure 6 shows the trend in average benefits (over all programs but excluding Medicare and Medicaid) received by non-elderly, non-disabled, single-parent families. On the horizontal axis, we classify families by their pretransfer income as a percentage of the poverty line – we focus on families with incomes between 0 and 200 percent of the poverty line.[32] On the vertical axis, we

[32] Among all families with incomes below twice the poverty line in 2004, about 29 percent had almost no reported income (zero to 25% of poverty), and 39 percent had incomes below 50 percent of poverty. The remaining 61

plot average transfer program benefits, excluding Medicare and Medicaid, but including all other transfers enumerated in Table 2. The three lines show average benefits (in 2007 dollars) for families in the 1984, 1993, and 2004 SIPP surveys.[33] Focusing first on the two lines in 1984 and 1993, we note that the largest benefits were received by those with no income and that average benefits fell as income as a percentage of the poverty line rose. This accords with the traditional structure of a transfer program, where benefits are phased out as income rises. In fact, the negative slope of the lines in Figure 6 reflects the fact that benefits are phased out as income increases, as we discussed earlier. The steepness of the line in 1984 and 1993 vividly highlights the weak incentives single parents faced to earn income in the paid labor market. In 1993, for example, families with no market income received around $1,200 of benefits but, as income increased to roughly 25 percent of the poverty line, average benefits fell to around $800.

The situation in 2004 was quite different, for the slope of the benefit line in the below 25 percent of the poverty line was actually positive, implying a subsidy to work (or a negative tax rate) on average. We noted that development earlier, and traced it to the EITC and reductions in TANF tax rates. At the same time, however, average benefits received by a single parent with no income were 45 percent lower than in 1993. This was, in some sense, the "price" of increasing work incentives (namely, making things relatively worse off for those at the bottom). We also note that the increases in benefits for higher income families, that is, the work incentives that are provided, extended all the way up through the highest income level shown in the figure (200 percent of the poverty line). The income increases are driven almost solely by the earned income tax credit and, as income gets higher, the refundable child credit.[34]

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percent were fairly evenly distributed between 50 and 200 percent of the poverty line.

[33] The data are smoothed with a Stata-supplied local polynomial function that uses an Epanechnikov kernel.

[34] Given the sharp increases in health care costs over time, the magnitude of the cross-year differences in Figures 6 through 9 are smaller, but the qualitative patterns are similar, if Medicare and Medicaid are included. For this

Figure 7 shows a similar pattern for married couples with children.[35] Average benefits for non-disabled, non-elderly married couples with children in 2004, with no income, are about 48 percent of the average benefits available in 1993. Once income exceeds roughly 40 percent of the poverty line, average benefits in 2004 are larger than comparable families received in earlier years.

Figure 8 shows average benefits for non-disabled, non-elderly childless families and individuals. Again, average benefits for those with very low or zero income are lower in 2004 than they were in earlier years. The EITC available to childless taxpayers, which was initiated in 1994, is starkly evident in the Figure. Otherwise, few benefits are available and this fact has not changed for 20 years.

There are substantial numbers of families or individuals reflected in Figures 6 through 8 with incomes below 25 percent of the poverty line (as low as 11 percent of the population with incomes below 200 percent of poverty for two-parent families in 1984 and 1993, to 32 percent of the population of childless individuals with income below 200 percent of poverty in 2004). The education of the "deep poor" rises over time, the number of children falls over time, and the fraction of employed families (defined as at least one person in the family being employed in all 4 months of the reference period) goes from 15 percent in 1984, to 10 percent in 1993, to 36 percent in 2004. Thus, it appears that the incidence of regular, but sporadic and poorly compensated work is much greater in the 2004 SIPP. This conclusion is tempered, however, by three considerations. First, the SIPP employment question changed in 2004. Second, surely families and individuals with incomes below 25 percent of poverty supplement public transfers with other "off-the-books" resources, but the SIPP provides no insight on this phenomenon.

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discussion we prefer the Figures without health care spending, because they aptly characterize the transfers household receive to provide food, shelter, clothing and other non-medical necessities.

Third, market income may also be underreported by low-income individuals and the magnitude of this underreporting may have changed over time in the SIPP.

The sample for Figure 9 is restricted to elderly families (or unrelated individuals). Unlike the striking changes for the poorest non-elderly families, the average benefits received by poor elderly families in 2004 are similar or slightly higher than those received in 1993 (and larger than those received in 1984). This is largely due to the fact that social security has been stable over this period. In contrast, the changes for non-elderly households are consistent with changing incentives embodied in the safety net: as greater emphasis has been placed on work, fewer benefits are available to those who, for one reason or another, are unwilling or unable to work.

The Future of Antipoverty Policy

Between 1975, the first year the EITC existed, and 2005, total spending on all means-tested cash and in-kind transfers (excluding Medicaid) averaged 2.0 percent of GDP, ranging between 1.8 and 2.5 percent. In 2005, it was 1.8 percent of GDP, near its 31-year low. Transfers now do less to close the poverty gap than they did before. As shown in Table 1, transfers reduce the poverty gap by 66.2 percent in 2004, while the comparable figures were 72.7 percent in 1993 and 70.9 percent in 1984. The difference between pre- and post-transfer poverty rates was 16.2 percentage points in 2004, 16.9 percentage points in 1993, and 15.4 percentage points in 1984. But the depth of poverty for those remaining poor appears to have increased substantially – the after-transfer poverty gap in 2004 (all in 2007 dollars) is $580, compared to $496 in 1993 and $479 in 1984. These patterns are driven by substantial changes in the antipoverty policy mix, which has resulted in large changes in the resources available to families and individuals in different circumstances.

The contrast in levels and to a lesser extent, trends, in social expenditures between the U.S.

[35] For clarity, the Y-axis scales differ in Figures 6 through 9.

and other industrialized countries is striking. Smeeding (2008) calculates a consistent set of social expenditures (including cash, near-cash, and housing expenditures) as a percentage of GDP for five groups of counties – Scandinavia; Northern Continental Europe; Central and Southern Europe; "Anglo" (Australia, Canada, and the U.K.); and the United States – between 1980 and 1999. Spending ranges between 2.7 to 3.6 percent of GDP in the U.S., a far lower level than every other country group. The other Anglo countries averaged between 4.8 and 7.8 percent of GDP, similar to the Central and Southern European counties. Northern Europe and the Scandinavian countries averaged between 8.1 and 15.3 percent of GDP. The trends across country groups vary, though most country groups increased expenditures as a share of GDP between 1980 and 1999. The U.S. did not.

Why has U.S. anti-poverty spending been low and relatively stable given its persistent and high poverty rates, at least by international standards? A number of factors are relevant. There may be indifference or antipathy to the poor on the part of the public (Bane, this volume). Voters and policy-makers may be skeptical that we know what works and may believe that some well-intentioned policies have counterproductive consequences. Lastly, the fiscal policy climate over much of the previous 30 years, with a respite in the 1990s, has been difficult.

If these are fundamental factors driving poverty policy, there is little that we see changing, with perhaps one exception. 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 both increase work and the after-tax incomes of poor families. These policies require that the poor work to receive benefits, but are structured so that greater work effort increases disposable income. Although such a work-based safety net aligns assistance with fundamental values of

Americans, we have not effectively struck a balance between supporting work and sensibly treating those families (and the children therein) who, for one reason or another, are unable or unwilling to work (Blank and Kovak, 2008).

Also, while the 1996 welfare reform increased work, the earnings of most individuals who left welfare were still well below the poverty line, even many years after their exit. Hence, the degree to which work can be the primary antidote to poverty depends on the ability of low-skilled people to maintain employment that, over time, leads to higher incomes that allow families to be self-sufficient. More work is needed to develop effective ways of increasing the earnings of disadvantaged workers (Holzer, this volume; Heinrich and Scholz, 2008).

Major changes in poverty will not be achieved by simply reshuffling the 1.8 percent of GDP that is spent on cash and in-kind means-tested transfers (excluding Medicaid). If antipoverty spending as a fraction of GDP simply increased to its *average* level over the last 31 years of 2.0 percent, there would be an additional $26.5 billion for new initiatives. These funds could be used to (i) expand successful state-level welfare reforms and provide new funding sources for child care and health insurance benefits that increase the attractiveness of work and (ii) augment the safety net, pursue effective human capital development, expand rental housing subsidies, and ensure states have sufficient resources to handle families affected by TANF time limits in the way they see fit.

In the absences of a renewed antipoverty effort, many households will continue to be unable to afford adequate food, housing, and shelter. Our high poverty rate contributes to 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.

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Table 1: Antipoverty Effectiveness of the Transfer System, 1984, 1993, and 2004[a]

	Number families (million)	Percent Poor, Pre-Transfer[b]	Average Monthly Market Income per Poor Family ($)	Monthly Pre-Transfer Poverty Gap ($ million)	Monthly Pre-Transfer Poverty Gap per Family ($)	Total Monthly Transfers ($ million)	Average Monthly Transfer per Recipient Family ($)	Total Transfers to Poor ($ million)	Average Monthly Transfer per Poor Family ($)	Percent of Total To Pre-transfer Poor	Percent of Total Used to Alleviate Poverty	Percent Poverty Gap Filled	Monthly Poverty Gap, Post Transfer ($ million)	Monthly Poverty Gap per Family, Post Transfer ($)	Percent Poor, Post-Transfer[b]
2004 SIPP	124.5	30.3	326	30,151	800	65,002	844	35,103	932	54.0	30.7	66.2	10,198	580	14.1
1993 SIPP	106.4	30.5	354	26,276	809	54,005	1,086	32,175	991	59.6	35.4	72.7	7,175	496	13.6
1984 SIPP	90.7	29.7	360	21,402	793	40,430	1,002	24,493	908	60.6	37.5	70.9	6,227	479	14.3

Source: Authors' calculations from the 1984, 1993, and 2004 SIPP (waves 1). Dollar amounts are in 2007 dollars, using the CPI-U.

[a] The transfers reflected in the calculations include those listed in Table 2, except Medicare and Medicaid.

[b] This poverty rate is for families and unrelated individuals: it reflects the fraction of families (including single-person "families") in poverty rather than the fraction of the total population in poverty; the latter is the more traditional measure, emphasized in other chapters of this volume.

Table 2: Effect of Transfers on Poverty, 2004 SIPP – All Families and Individuals

	Total Monthly Transfers ($ million)	Average Monthly Transfer per Recipient Family ($)	Percent of Total Transfers To Pre-Transfer Poor	Percent of Total Transfers Used to Alleviate Poverty	Percent Poverty Gap Filled	Monthly Poverty Gap, Post Transfer ($ billion)	Percent Poor, Post Transfer[a]
No transfers						30.2	30.3
All transfers	95,895	1,238	54.9	22.8	72.5	8.3	12.0
All Social Insurance	65,750	1,524	50.6	22.0	47.9	15.7	18.8
All cash transfers[b]	59,478	790	51.2	29.9	59.1	12.3	16.3
All in-kind transfers[c]	36,416	1,411	61.1	31.4	37.9	18.7	22.5
All means-tested transfers (except child care credit and foster child payments)	26,167	814	73.5	41.2	35.8	19.4	23.5
Social Insurance							
Social Security (OASI)	33,115	1,224	46.4	25.1	27.6	21.8	22.3
Disability Insurance	7,153	946	71.8	53.3	12.7	26.3	28.3
Medicare	17,074	2,131	47.7	16.9	9.6	27.3	27.2
Unemployment Comp	3,877	472	60.8	52.1	6.7	28.1	29.5
Workers Comp	2,654	3,909	52.4	13.7	1.2	29.8	30.0
Veterans Benefits	1,876	682	46.8	27.9	1.7	29.6	29.9
Means-tested transfers							
Medicaid	13,818	1,167	68.2	46.3	21.2	23.7	26.9
SSI	3,299	478	80.4	74.5	8.2	27.7	29.8
AFDC/TANF	922	435	87.1	83.3	2.5	29.4	30.2
EITC	2,326	120	65.4	57.9	4.5	28.8	29.2
Child tax credit	3,910	139	3.9	3.5	0.5	30.0	30.0
General Assistance	76	234	61.5	61.3	0.2	30.1	30.3
Other welfare	201	493	53.2	35.7	0.2	30.1	30.2
Foster child payments	68	741	23.9	13.1	0.0	30.1	30.2
Food stamps	2,252	241	87.0	83.7	6.3	28.3	29.9
Housing Assistance	2,825	547	86.6	79.8	7.5	27.9	29.7
WIC	447	106	58.5	56.7	0.8	29.9	30.2

Source: Authors' calculations from wave 1 of the 2004 SIPP. Dollar amounts are in 2007 dollars, using the CPI-U.

[a] This poverty rate is for families and unrelated individuals: it reflects the fraction of families (including single-person "families") in poverty rather than the fraction of the total population in poverty; the latter is the more traditional measure, emphasized in other chapters of this volume.

[b] Cash transfers include all programs listed under social insurance and the means-tested transfers headings, except housing, food stamps, Medicare, Medicaid, and WIC.

[c] In-kind transfers are housing, food stamps, Medicare, Medicaid, and WIC.

Table 3: Antipoverty Effectiveness of the Transfer System for Different Family Types, 2004 SIPP

	Number families (million)	Percent Poor, Pre-Transfer[a]	Monthly Poverty Gap ($ million)	Monthly Poverty Gap per Family ($)	Total Monthly Transfers ($ 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[a]
Elderly families and individuals	23.2	55.2	8,905	696	48,606	2,151	52.6	17.4	95.0	7.8
Nonelderly										
Single-parent families	10.6	47.8	5,123	1,014	11,276	1,119	76.1	37.3	82.1	13.8
Two-parent families	26.0	15.0	4,118	1,055	15,137	631	43.4	20.5	75.5	5.1
Childless families and individuals	64.7	24.6	12,005	754	20,876	1,005	57.2	29.1	50.7	16.0
White families and individuals	75.8	21.3	13,519	837	30,121	779	51.5	25.9	57.7	12.3
Black families and individuals	12.8	35.4	3,997	883	8,906	1,118	70.7	33.9	75.6	15.0
Hispanic families and individuals	12.8	32.8	3,729	891	8,262	1,004	63.9	31.1	69.0	15.4
Employed families	95.6	17.3	11,965	724	47,450	901	38.9	15.8	62.7	8.4
Unemployed, non-elderly families	12.1	83.0	10,290	1,029	13,973	1,681	90.2	49.0	66.6	44.1

Source: Authors' calculations from wave 1 of the 2004 SIPP. Dollar amount sin 2007 dollars, using the CPI-U.

[a] This poverty rate is for families and unrelated individuals: it reflects the fraction of families (including single-person "families") in poverty rather than the fraction of the total population in poverty; the latter is the more traditional measure, emphasized in other chapters of this volume.

Figure 1: Total Benefit Payments on OASI, UI, DI, Workers' Compendation and Outlays for Medicare, 1970-2007 (constant 2007 dollars)

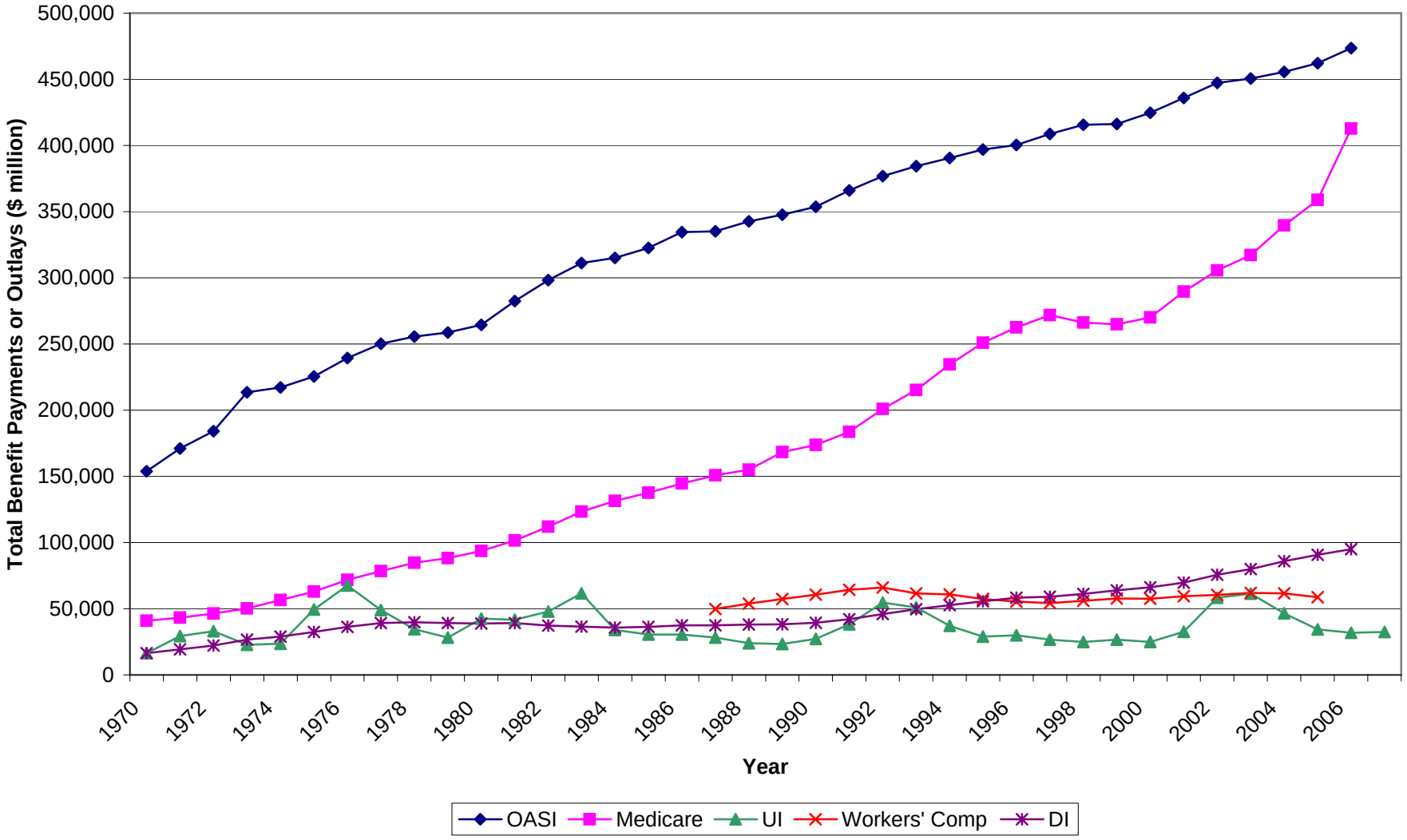


Figure 2: Total SSI Benefits and Medicaid Program Costs, 1970-2007 (constant 2007 dollars)

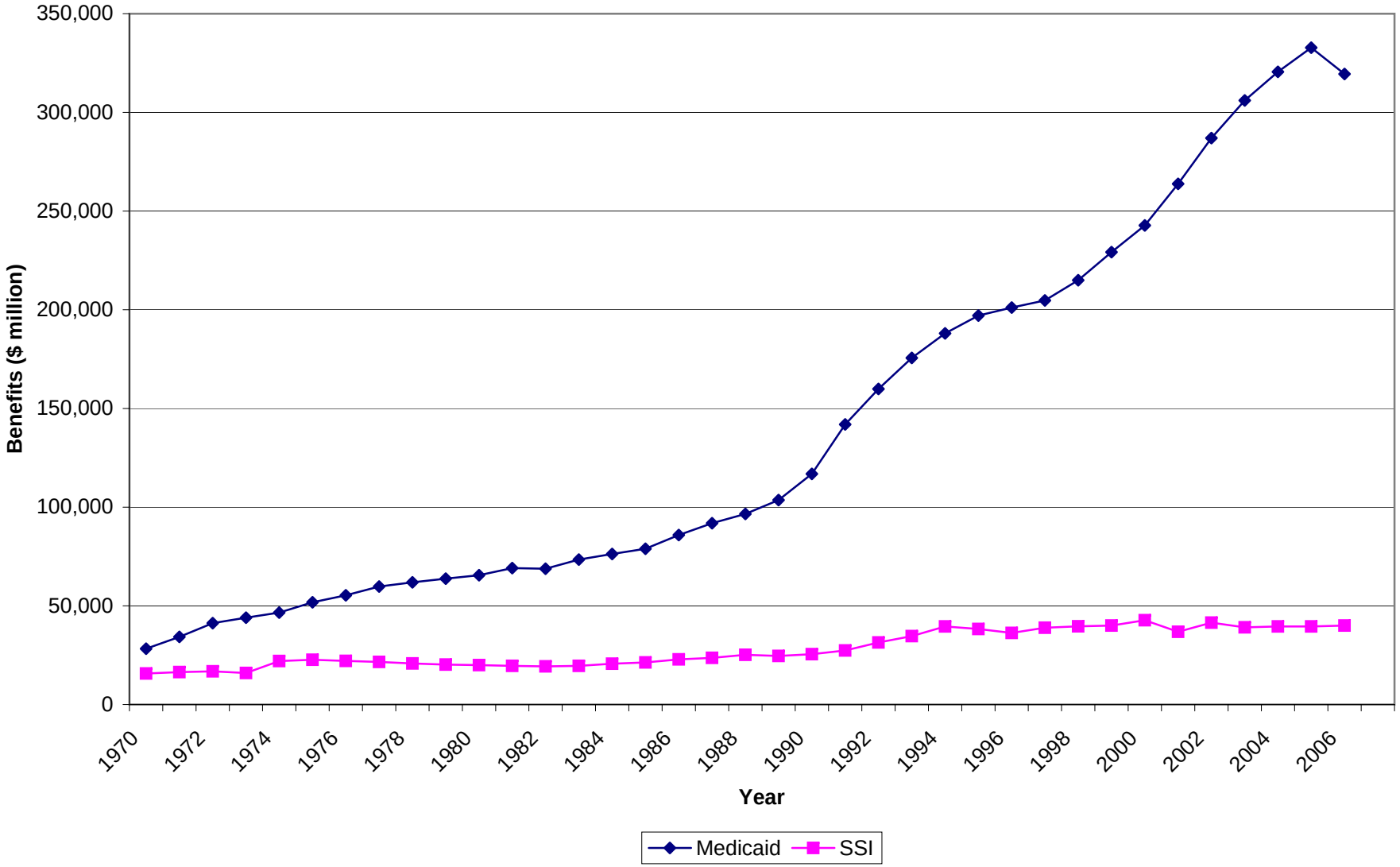


Figure 3: Total AFDC/TANF and EITC Benefits, 1970-2007 (constant 2007 dollars)

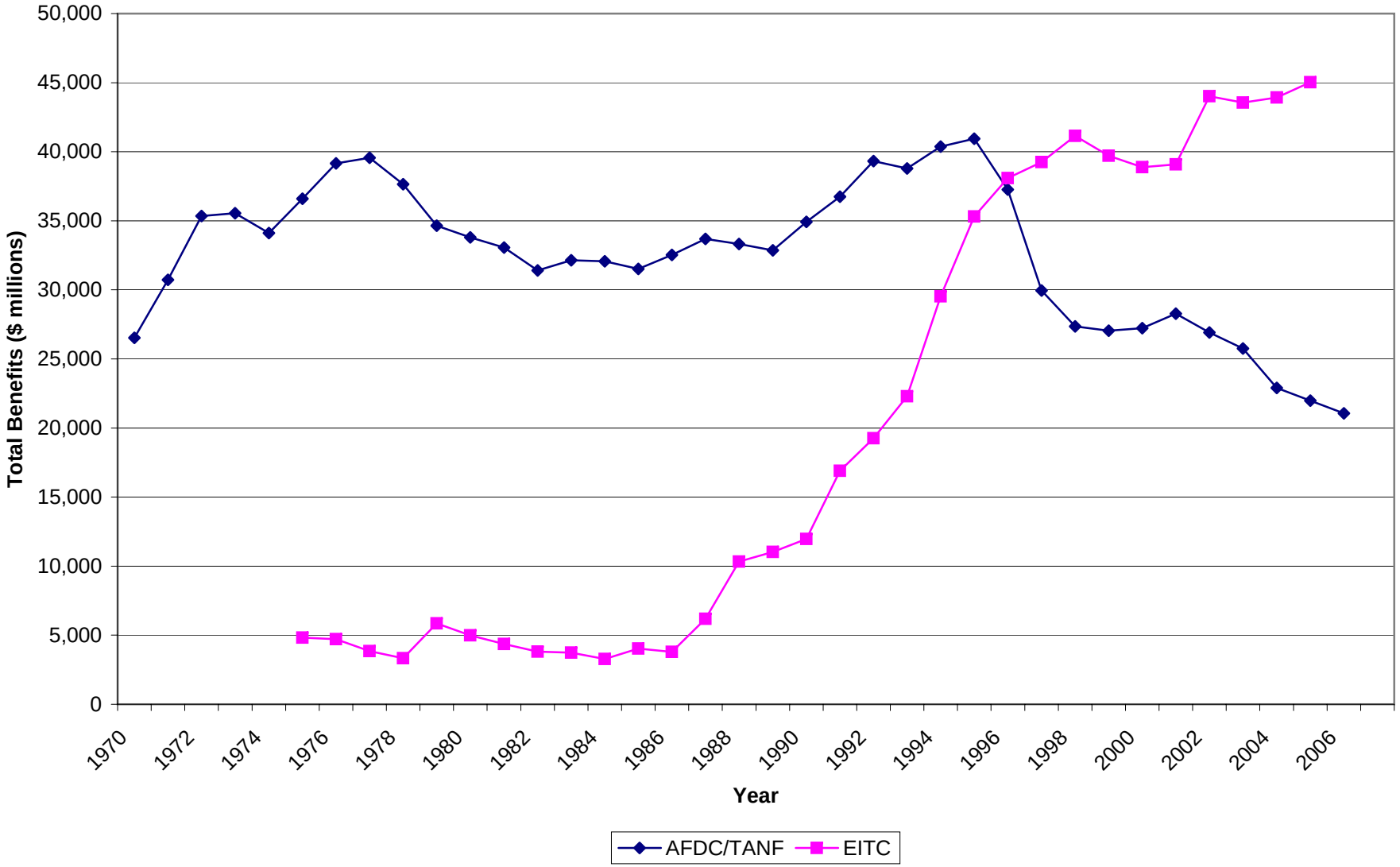


Figure 4: Total Benefits or Program Costs for Various In-Kind Programs, 1970-2007 (constant 2007 dollars)

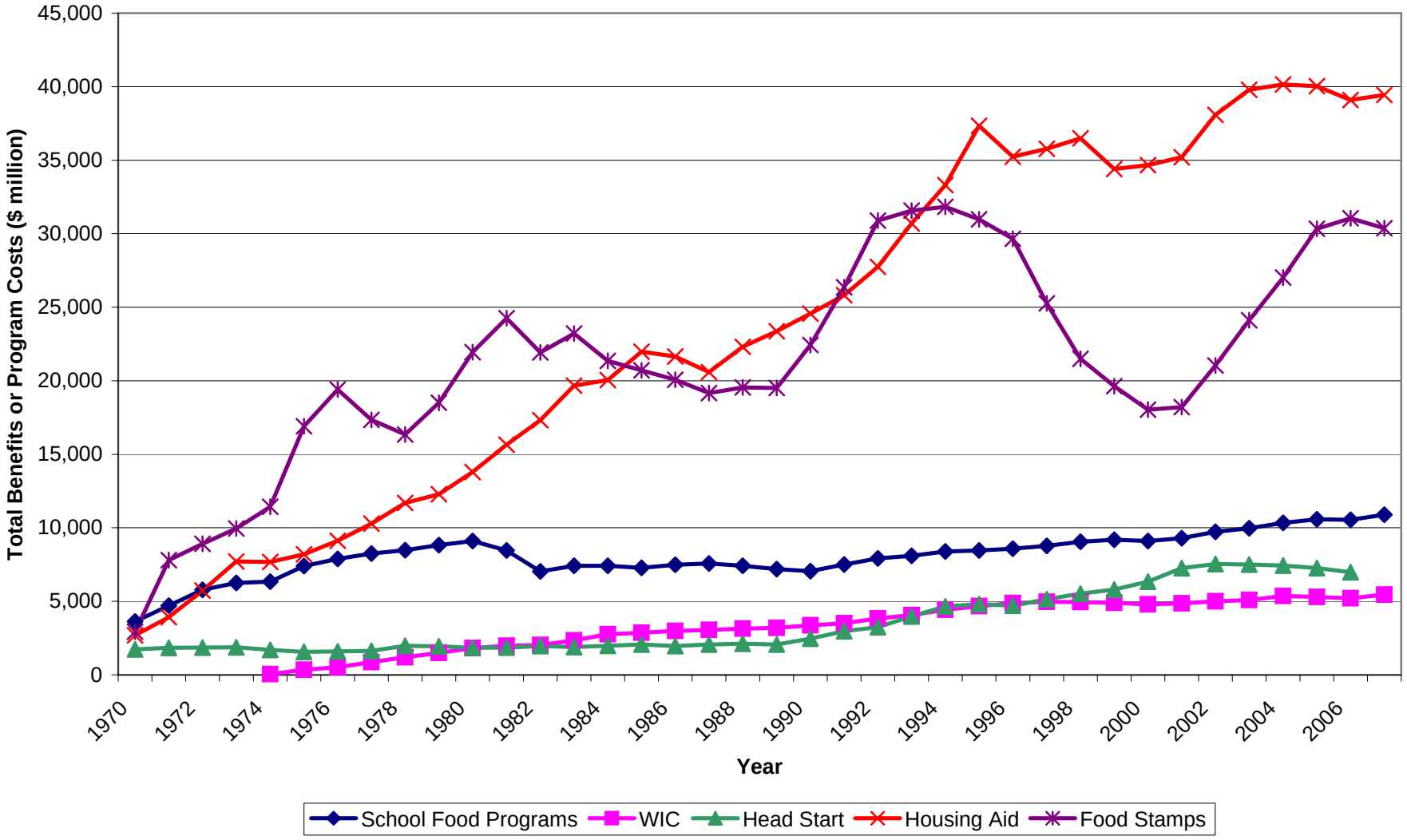
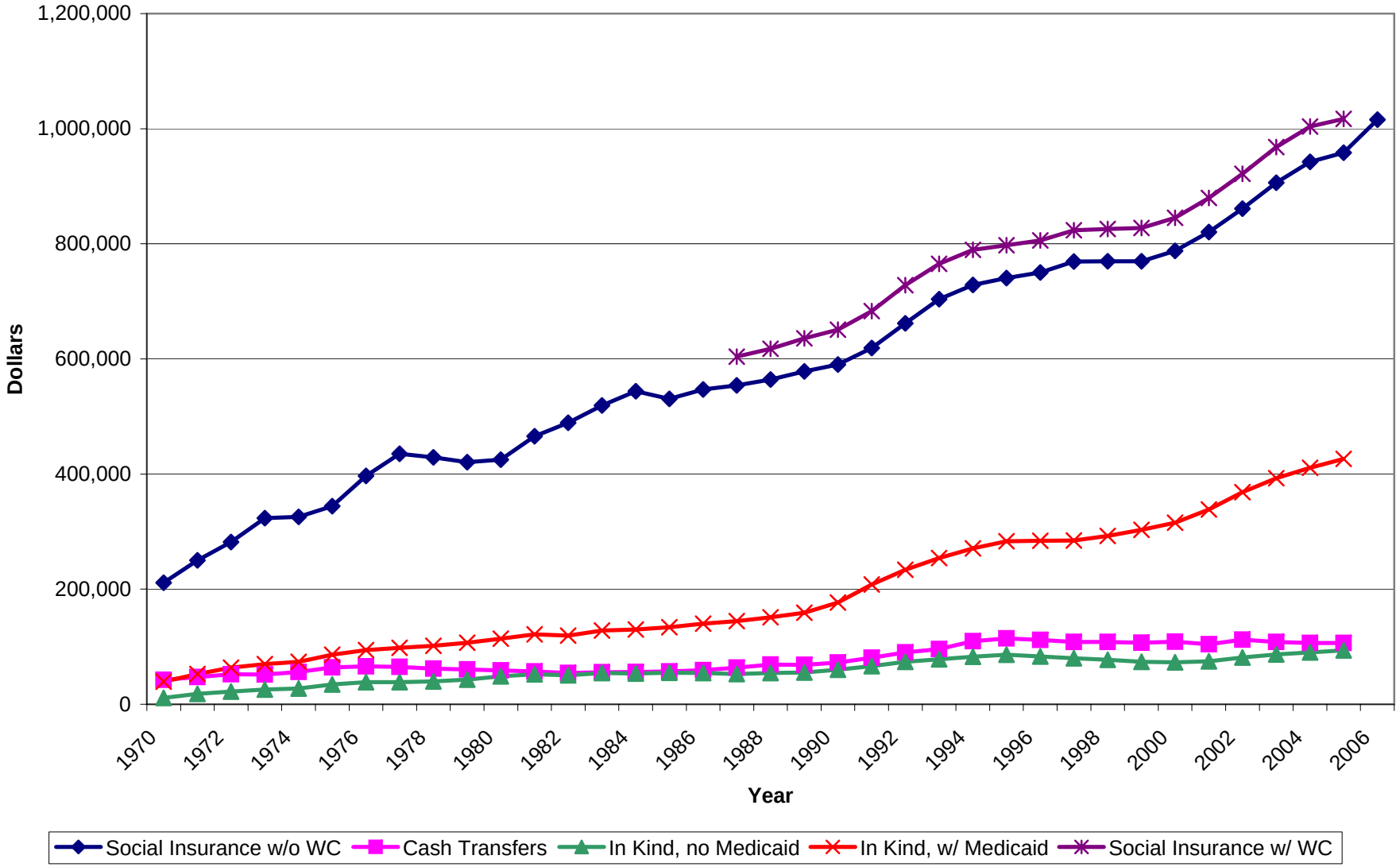


Figure 5: Total Social Insurance, Cash and In-Kind Means-Tested Transfers (2007 dollars)



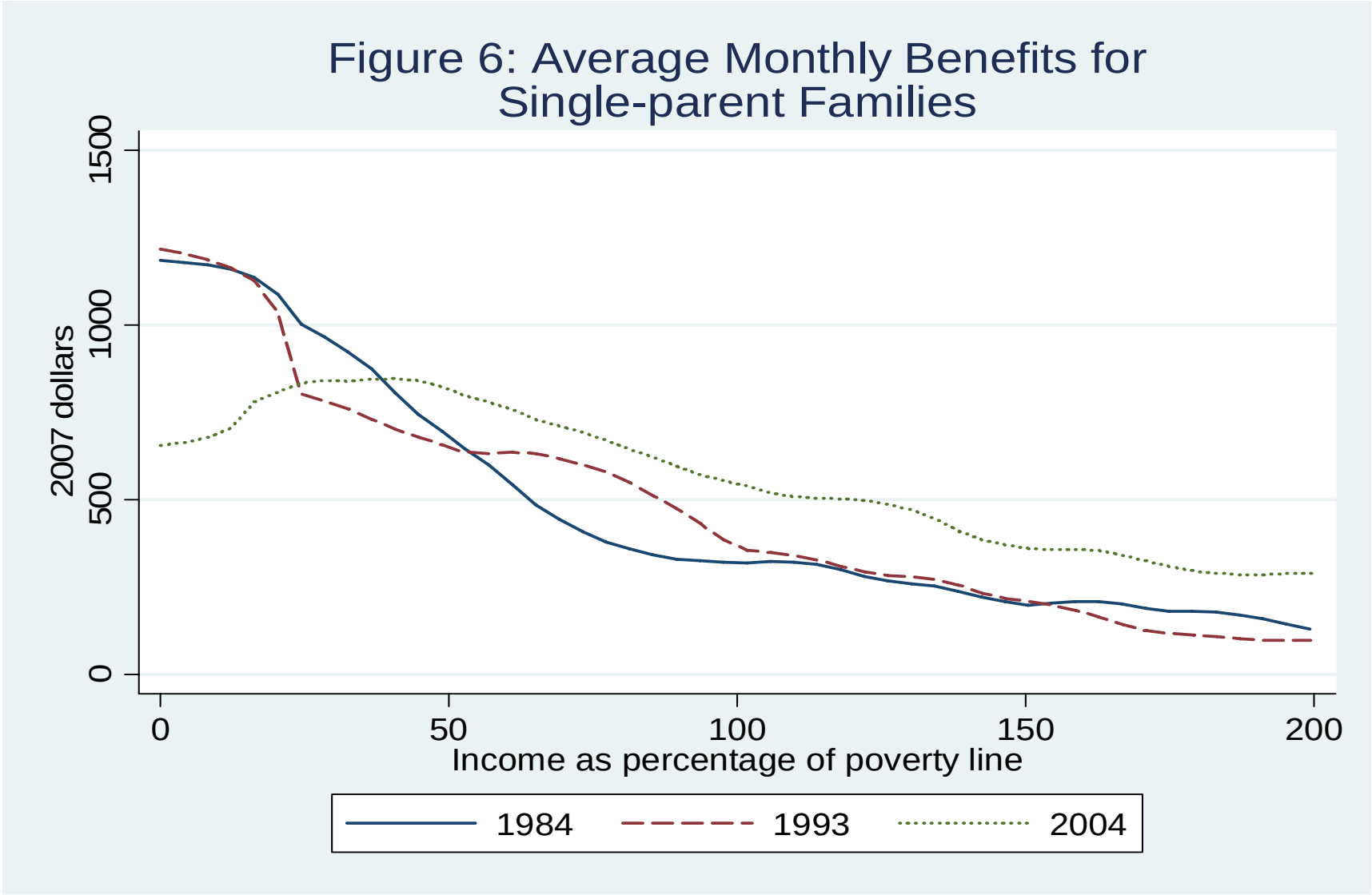


Figure 6: Average Monthly Benefits for Single-parent Families
2007 dollars
0
500
1000
1500
0
50
100
150
200
Income as percentage of poverty line
1984
1993
2004

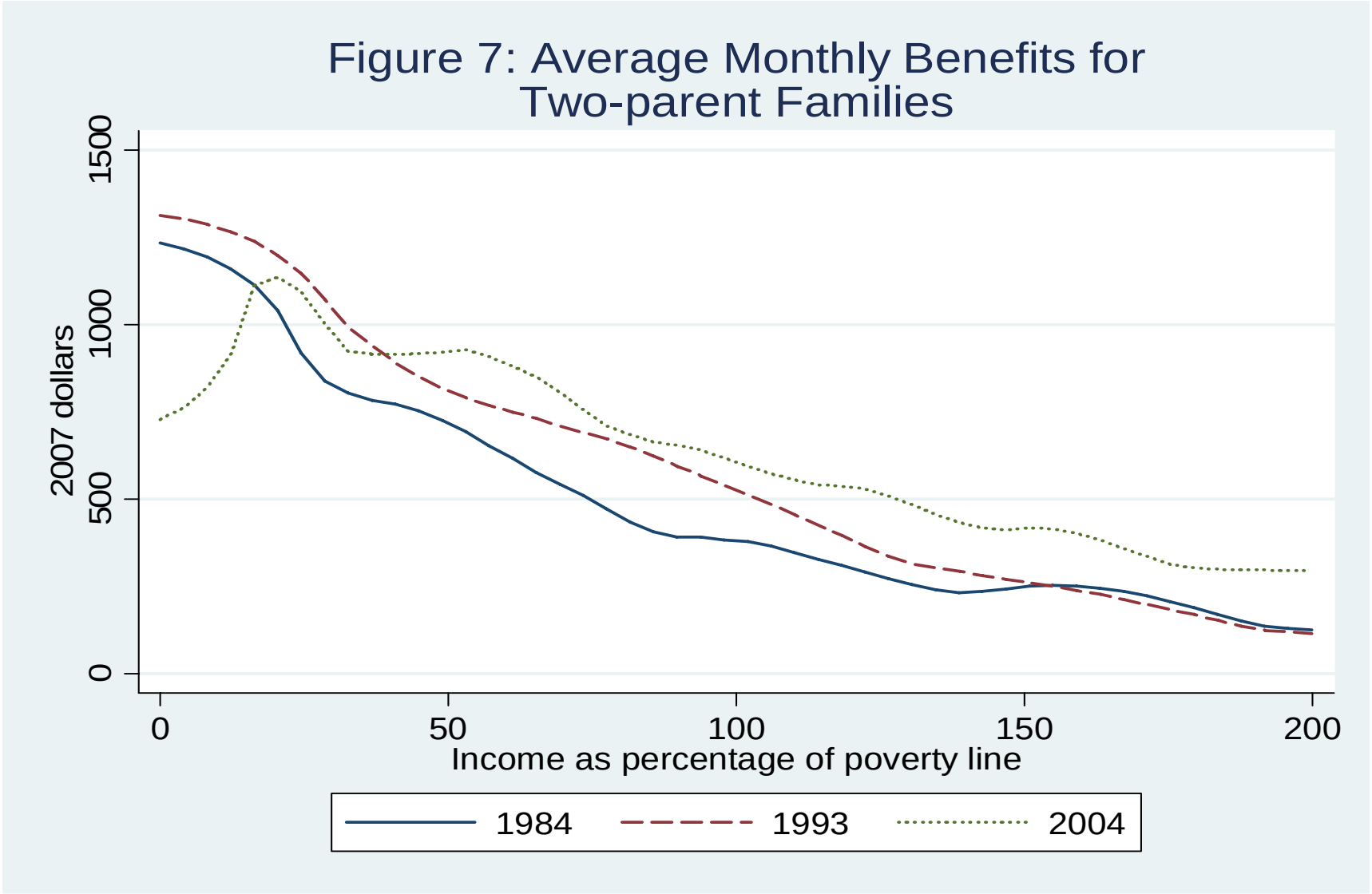
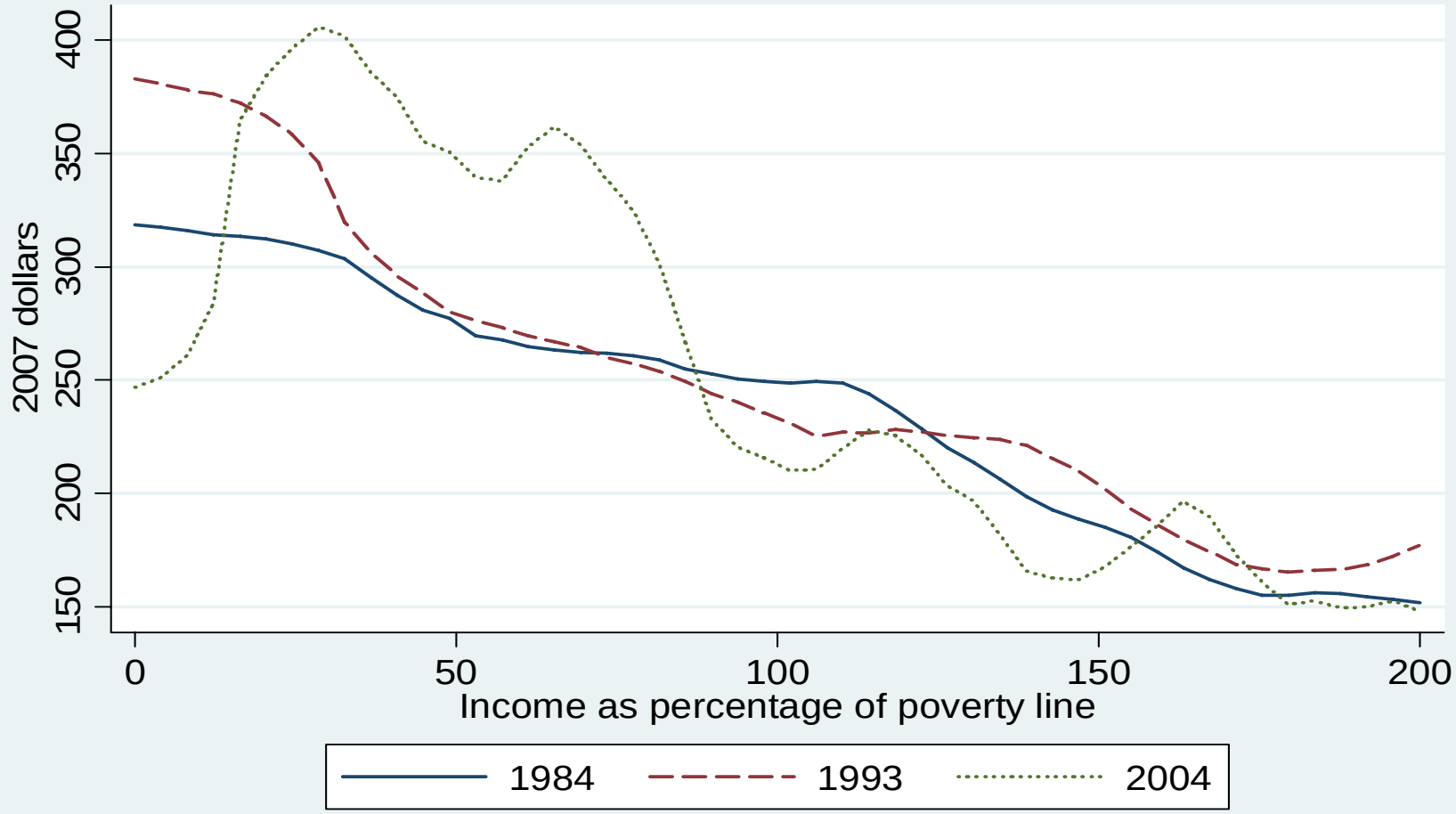


Figure 7: Average Monthly Benefits for Two-parent Families
2007 dollars
0
500
1000
1500
0
50
100
150
200
Income as percentage of poverty line
1984
1993
2004

Figure 8: Average Monthly Benefits for Childless Families



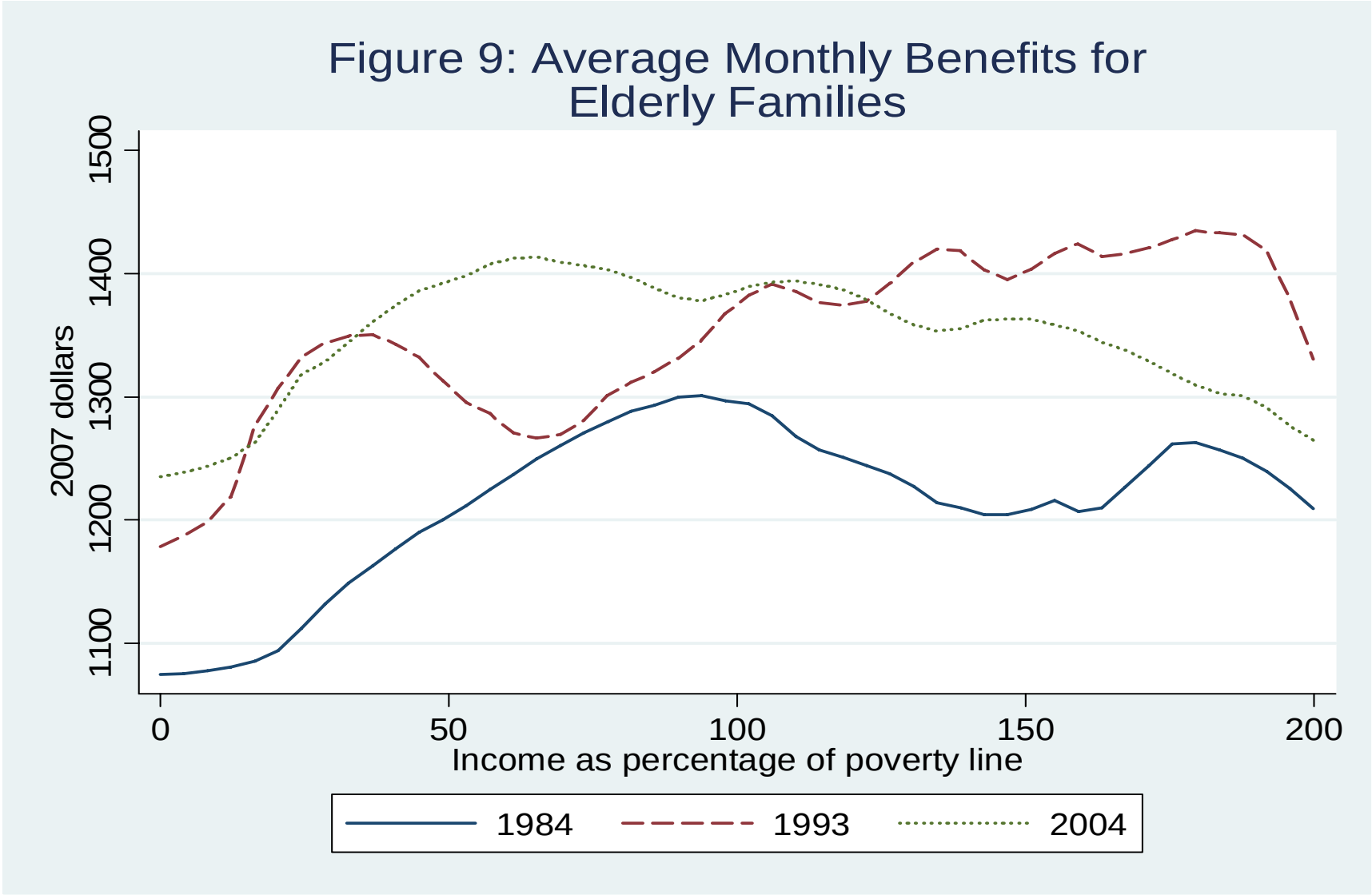


Figure 9: Average Monthly Benefits for Elderly Families
2007 dollars
1100
1200
1300
1400
1500
0
50
100
150
200
Income as percentage of poverty line
1984
1993
2004

Appendix Table 1:
Summary of social insurance and anti-poverty spending by program, 1970-2007 (constant 2007 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	153,882	40,998	16,427		16,390	28,264	15,706	26,522		2,938	2,693	3,631		1,740
1971	171,060	43,224	29,432		19,239	34,281	16,413	30,728		7,796	3,922	4,711		1,843
1972	184,138	46,255	32,937		22,188	41,235	16,825	35,337		8,915	5,734	5,784		1,867
1973	213,604	50,108	22,822		26,702	44,004	15,962	35,552		9,953	7,710	6,251		1,871
1974	217,091	56,474	23,506		29,032	46,574	22,063	34,113		11,432	7,671	6,350	44	1,699
1975	225,490	62,958	49,354		32,427	51,820	22,653	36,589	4,817	16,901	8,197	7,405	344	1,557
1976	239,405	71,764	67,650		36,316	55,348	22,104	39,154	4,719	19,410	9,125	7,879	520	1,607
1977	250,155	78,321	49,033		39,220	59,753	21,576	39,569	3,856	17,337	10,288	8,245	876	1,625
1978	255,527	84,807	34,618		39,792	61,904	20,836	37,649	3,333	16,343	11,700	8,484	1,207	1,988
1979	258,623	88,312	28,094		39,149	63,779	20,206	34,640	5,860	18,507	12,292	8,834	1,501	1,942
1980	264,396	93,556	42,498		38,844	65,504	19,982	33,806	4,997	21,944	13,789	9,101	1,831	1,849
1981	282,375	101,604	41,785		39,231	69,132	19,601	33,058	4,361	24,247	15,650	8,459	1,988	1,867
1982	298,229	111,905	47,867		37,253	68,780	19,297	31,398	3,814	21,934	17,326	7,043	2,039	1,959
1983	311,225	123,366	61,553		36,493	73,413	19,577	32,136	3,737	23,216	19,670	7,419	2,344	1,899
1984	315,028	131,424	33,963		35,721	76,297	20,698	32,067	3,269	21,345	20,052	7,414	2,770	1,987
1985	322,498	137,670	30,531		36,296	78,884	21,312	31,523	4,024	20,703	21,971	7,274	2,870	2,072
1986	334,557	144,525	30,524		37,547	85,856	22,855	32,530	3,801	20,063	21,644	7,488	2,995	1,968
1987	335,186	150,779	28,245	49,859	37,438	91,878	23,638	33,686	6,189	19,165	20,585	7,570	3,066	2,063
1988	342,687	155,088	23,908	53,813	38,019	96,538	25,195	33,329	10,334	19,541	22,306	7,415	3,150	2,114
1989	347,761	168,276	23,309	57,380	38,246	103,592	24,592	32,869	11,028	19,513	23,374	7,192	3,195	2,065
1990	353,755	173,717	27,172	60,659	39,347	116,856	25,533	34,929	11,965	22,436	24,559	7,054	3,367	2,462
1991	366,024	183,630	38,229	64,223	42,111	141,898	27,370	36,739	16,906	26,360	25,816	7,503	3,503	2,971
1992	376,761	200,981	54,679	66,001	45,948	159,884	31,416	39,320	19,253	30,895	27,748	7,929	3,843	3,254
1993	384,270	215,182	50,883	61,593	49,644	175,594	34,686	38,795	22,294	31,576	30,702	8,089	4,059	3,984
1994	390,505	234,580	36,991	60,834	52,769	188,054	39,577	40,369	29,527	31,827	33,303	8,384	4,434	4,653
1995	396,837	250,869	28,986	57,307	55,642	197,086	38,263	40,939	35,313	30,971	37,330	8,469	4,675	4,808
1996	400,298	262,644	29,843	55,450	58,376	201,091	36,247	37,257	38,092	29,654	35,231	8,577	4,883	4,717
1997	408,627	271,773	26,606	54,220	58,985	204,730	38,911	29,944	39,258	25,254	35,775	8,766	4,966	5,142
1998	415,723	266,125	24,914	55,953	61,278	214,967	39,629	27,365	41,138	21,485	36,490	9,055	4,949	5,530
1999	416,224	264,856	26,579	57,639	63,884	229,230	40,016	27,042	39,702	19,626	34,406	9,187	4,901	5,797
2000	424,685	270,147	24,975	57,433	66,150	242,736	42,689	27,221	38,887	18,041	34,663	9,099	4,795	6,342

2001	435,957	289,596	32,675	59,506	69,751	263,782	36,856	28,284	39,075	18,202	35,201	9,297	4,863	7,259
2002	447,382	305,527	58,391	60,412	75,659	287,003	41,456	26,920	44,026	21,041	38,087	9,722	5,002	7,534
2003	450,622	317,178	61,304	62,052	79,901	306,092	39,094	25,756	43,561	24,120	39,785	9,979	5,098	7,513
2004	455,606	339,535	46,522	61,548	85,837	320,552	39,586	22,900	43,931	27,022	40,145	10,335	5,364	7,436
2005	462,218	358,862	34,304	58,717	90,659	332,818	39,532	21,972	45,025	30,329	40,035	10,589	5,301	7,265
2006	473,572	412,721	31,932		95,015	319,476	39,997	21,052		31,047	39,084	10,542	5,217	6,979
2007			32,454							30,373	39,436	10,891	5,450	

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Appendix Table 2:
Number of recipients by program, 1970-2007 (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	6,397	2,666			8,466		4,340		450	22,400		477
1971	23,888	20,915	6,627	2,930			10,241		9,368		800	24,100		398
1972	24,804	21,332	5,713	3,271	17,606		10,947		11,109		1,040	24,400		379
1973	25,953	23,545	5,329	3,561	19,622		10,949		12,166		1,190	24,700		379
1974	26,664	24,201	7,730	3,912	21,462	3,996	10,864		12,862		1,370	24,600	88	353
1975	27,509	24,959	11,161	4,352	22,007	4,314	11,346	6,215	17,064		1,820	24,900	344	349
1976	28,212	25,663	8,560	4,624	22,815	4,236	11,304	6,473	18,549		2,200	25,600	520	349
1977	29,069	26,458	7,985	4,854	22,832	4,238	11,050	5,627	17,077	2,398	2,490	26,200	848	333
1978	29,584	27,164	7,568	4,869	21,965	4,217	10,570	5,192	16,001	2,643	2,800	26,700	1,181	391
1979	30,236	27,859	8,075	4,777	21,520	4,150	10,312	7,135	17,653	2,842	3,320	27,000	1,483	388
1980	30,844	28,478	9,992	4,682	21,605	4,142	10,774	6,954	21,082	3,032	3,600	26,600	1,914	376
1981	31,474	29,010	9,407	4,456	21,980	4,019	11,079	6,717	22,430	3,431	3,810	25,800	2,119	387
1982	31,804	29,494	11,648	3,973	21,603	3,858	10,258	6,395	21,717	3,619	3,320	22,900	2,189	396
1983	32,221	30,026	8,907	3,813	21,554	3,901	10,761	7,368	21,625	3,857	3,360	23,000	2,537	415
1984	32,617	30,455	7,743	3,822	21,607	4,029	10,831	6,376	20,854	4,081	3,430	23,400	3,045	442
1985	33,120	31,083	8,372	3,907	21,814	4,138	10,855	7,432	19,899	4,225	3,440	23,600	3,138	452
1986	33,690	31,750	8,361	3,993	22,515	4,269	11,038	7,156	19,429	4,336	3,500	23,700	3,312	452
1987	34,126	32,411	7,203	4,045	23,109	4,385	11,027	8,738	19,113	4,461	3,610	23,900	3,429	447
1988	34,539	32,980	6,861	4,074	22,907	4,464	10,915	11,148	18,645	4,530	3,680	24,200	3,593	448
1989	35,012	33,579	7,369	4,129	23,511	4,593	10,993	11,696	18,806	4,632	3,810	24,200	4,119	451
1990	35,559	34,203	8,629	4,266	25,255	4,817	11,695	12,542	20,049	4,710	4,070	24,100	4,517	541
1991	36,074	34,870	10,075	4,513	28,280	5,118	12,930	13,665	22,625	4,786	4,440	24,200	4,893	583
1992	36,614	35,579	9,243	4,890	30,926	5,566	13,773	14,097	25,407	4,830	4,920	24,600	5,403	621
1993	36,990	36,306	7,884	5,254	33,432	5,984	14,205	15,117	26,987	4,959	5,360	24,900	5,921	714
1994	37,298	36,935	7,959	5,584	35,053	6,296	14,161	19,017	27,474	5,035	5,830	25,300	6,477	740
1995	37,529	37,535	8,035	5,858	36,282	6,514	13,418	19,334	26,619	5,130	6,320	25,700	6,894	751
1996	37,664	38,064	7,990	6,072	36,118	6,614	12,321	19,464	25,543	5,104	6,580	25,900	7,186	752
1997	37,818	38,445	7,325	6,153	34,872	6,495	10,376	19,391	22,858	5,132	6,920	26,300	7,407	794
1998	37,911	38,825	7,332	6,335	40,649	6,566	8,347	20,273	19,791	5,082	7,140	26,600	7,367	822
1999	38,072	39,140	6,951	6,524	40,300	6,557	6,824	19,259	18,183	5,154	7,370	27,000	7,311	826
2000	38,741	39,620	7,033	6,673	42,887	6,602	5,778	19,277	17,194	5,104	7,550	27,300	7,192	858

2001	38,964	40,026	9,877	6,913	46,164	6,688	5,359	19,593	17,318	5,123	7,790	27,500	7,306	905
2002	39,223	40,489	10,093	7,221	49,329	6,788	5,064	21,703	19,096	5,268	8,150	28,000	7,491	912
2003	39,443	41,087	9,935	7,595	51,971	6,902	4,929	22,024	21,259	5,231	8,430	28,400	7,631	910
2004	39,738	41,693	8,369	7,949	55,002	6,988	4,745	22,270	23,858	5,172	8,900	29,000	7,904	906
2005	40,120	42,342	7,917	8,314		7,114	4,492	22,752	25,718	5,139	9,360	29,600	8,023	907
2006	40,503	43,252	7,351	8,619		7,236			26,672	5,192	9,770	30,100	8,088	909
2007	40,945	44,010		8,920					26,466	5,108	10,160	30,600	8,285	

[1]Average monthly number of recipients

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

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