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Minor Retrenchment or Major Transformation?

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Many scholars have characterized the United States as a welfare state "laggard," less generous than most other nations because of a peculiarly American set of historical circumstances and values. This article explores "American exceptionalism" in the context of welfare state reforms over the past two decades. The authors first describe recent social policy innovations in Western democracies, considering two competing views of welfare state change. The first asserts that welfare states have been fundamentally transformed into "enabling" states, characterized by efforts to promote work, privatize benefits and services, and target benefits to the most needy. The second holds that policy structures have remained essentially intact because of "path-dependent" processes that create institutional continuity. Although evidence for the United States is somewhat mixed, the general direction of policy decisions and current frameworks of policy debates is consistent with a transition toward an enabling state.

Keywords: *welfare state; Social Security; Medicare*

The period from the end of World War II until the early 1970s has sometimes been called the "golden age" of welfare states (Esping-Andersen 1999). In this era, most Western, capitalist democracies created national old-age pension systems, unemployment compensation programs, and national health benefits. Over time, these benefits became increasingly generous and comprehensive, expanding to include more of the working-age population and more uncovered groups, such as disabled adults. Although programs varied in scope and coverage as each country put a unique stamp on its social expenditures, what they shared was a doctrine of social insurance,

with its emphasis on income security across the life course, a recognition of shared risks, and an acceptance of an earned right to benefits.

In an international context, the United States has often been described as a welfare state "laggard" because of its less generous benefits and lack of a national health program (Quadagno 1999). The United States is also distinct because of its two-tiered structure, with some of its social welfare programs designed around a social insurance concept (Social Security, Medicare) and others based on a social assistance model (Aid to Families With Dependent Children [AFDC], Medicaid). Despite such differences, the United States, like its European counterparts, experienced the same expansionary tendencies in the post–World War II era.

The era of welfare state expansion came to an abrupt halt following an international oil crisis that battered the world economy in 1974 and then again in 1979. Even after the oil crisis abated, unemployment and economic stagnation persisted. What initially appeared to be a temporary aberration was gradually recognized as a permanent transformation created by the longer term trends of population aging, slowing economic growth, and globalization (Bonoli and Mach 2000). Increasingly, critics began to question the "rigidities" built into national welfare commitments. They charged that welfare states imposed high fixed labor costs on employers, contributed to mass unemployment and sluggish job growth, and resulted in stagnant or falling state revenues. By the 1980s, public debate focused less on the protection that welfare benefits provided against the risks generated by a capitalist economy and more on the concern that such benefits were causing some of the problems they had been designed to solve (Esping-Andersen 1999).

Many nations responded to demands for fiscal austerity by adopting measures to restrain the growth of the state and restore market forces. The question was whether the modifications represented a modest policy adjustment or the dawn of a new age (Beland and Myles 2004). According to one perspective, the new politics of the welfare state is primarily about institutional continuity. Thus, Pierson (2000) contended that welfare states are not amenable to radical restructuring, because the programs themselves create vested interests and economic incentives that prevent significant departures from existing institutional logics. In most cases, retrenchment represents a slowing of the rate of growth rather than a fundamental shift in program structure (Huber and Stevens 2000; Maarse and Paulus 2003). An alternative view is that the basic paradigm underlying the welfare state has been transformed. Called the "enabling state," this new policy paradigm involves restructuring benefits to delimit the scope of shared risks and impose more of the costs of protection on individual and families (Gilbert 2002).

Do current trends represent modest retrenchment and institutional continuity? Or has so significant a restructuring occurred that only a hollow shell of original welfare programs remains? In this article, we first describe general trends in welfare state policies in an international context. We then examine policy changes in American income support and health care programs to determine whether they represent a transition toward an enabling state. Indicators of an enabling state include such factors as whether policy innovations promote labor force participation and individual responsibility, whether there is a shift toward the privatization of benefits and services, and whether benefits are targeted more than in the past (Gilbert 2002; Pierson 2001). By contrast, institutional continuity is suggested if there are no "authoritative" formal changes in existing social welfare programs (Pierson 1994:182). The problem is how to determine empirically whether an authoritative change in the underlying structure of the welfare state has occurred. Is it the case that the concept of social insurance must be abandoned? What if different policy realms have moved in opposing directions? These are questions we consider as we evaluate the direction of recent trends.

The International Context

Welfare states in Europe and Great Britain have experienced extensive modification in the past three decades. In Great Britain, successive Conservative governments launched a series of assaults on social insurance programs in the post-"golden" era. Beginning in the 1980s, marketlike competition was injected into National Health Service practices, reductions in unemployment and antipoverty benefits encouraged the "work-shy" (the unemployed, lone mothers) to participate in the labor force, and workers were encouraged to contract out of the public social insurance program and contribute to private pension funds (Sass 2004). Tax incentives were also introduced to encourage people to purchase private health insurance, but they never caught on and were rescinded in 1997 (Quadagno and Street 2005; Ruggie 1996).

The Labour party that assumed control in 1997 retained Britain's commitment to private pensions, tightened access to disability pensions, and initiated welfare-to-work programs for the unemployed and the disabled but also guaranteed lower income workers a minimal retirement income and extended credits to caregivers and disabled citizens (Sass 2004).

Similar policy changes have been introduced in several European countries. Germany recently enacted new regulations that distinguish claimants

for disability benefits on the basis of how many hours they can be expected to work each day. Denmark, France, the Netherlands, Sweden, and Australia now require all recipients of disability and unemployment benefits to develop individualized action plans to return to work. Sweden enacted pension reform that reallocates 2.5% of payroll tax revenues from the public system to private individual investment accounts (Gilbert 2002).

In some respects, these policy measures appear to represent significant departures from previous practices in Great Britain and Europe. The Swedish pension reform could be seen as tantamount to revolutionary change in what was once the quintessential welfare state. Yet it is not certain whether these changes are transformative, involving an individualization of risk and a repudiation of social insurance principles, or merely pragmatic efforts to compensate for past failed strategies to reduce unemployment (Bonoli and Mach 2000). It is not invariably the case that measures to reduce dependence on disability and unemployment benefits, increase the average pension age, and encourage older workers to remain in the labor force signify a rejection of public responsibility for social risks. Given the high rates of disability and unemployment benefit take-up and the demographic pressures on public pensions, one could just as plausibly argue such measures reflect a realistic response to new economic and demographic imperatives.

Is the United States Becoming an Enabling State?

In the early 1990s, the United States experienced similar pressures on social welfare expenditures. The focus of concern was not unemployment and disability benefits, however, which had not grown significantly, but rather rising health care costs and the growing share of federal revenues consumed by Social Security and Medicare (Quadagno 2005). During his 1992 presidential campaign, Bill Clinton used Third Way rhetoric, but social welfare policy during his administration moved in contradictory directions (Beland, de Chantal, and Wadden 2002). Clinton's major domestic initiative, Health Security, sought to control health care costs and guarantee universal coverage (Quadagno 2005). Although Health Security was defeated before it even reached a vote in Congress, the new Children's Health Insurance Program (CHIP) was enacted. Under Clinton's welfare reform plan, AFDC was replaced with Temporary Assistance to Needy Families (TANF), but the earned income tax credit (EITC) was expanded. The question is whether a coherent underlying philosophy links these disparate policy decisions.

Income Support for the Poor

Welfare reform. The most celebrated (and reviled) policy decision of the 1990s was the enactment of the Personal Responsibility and Work Opportunity Act of 1996 (PROWA), which replaced AFDC, the cash assistance benefit for poor mothers and their children, with TANF, a program of block grants to the states (Mink 1998). TANF was hailed as a measure to increase labor force participation among poor women, a move based on the rationale that lower paying, entry-level jobs would be stepping-stones to better paying jobs in the future. To achieve this goal, TANF instituted stiffer work requirements, set a 60-month lifetime limit on welfare eligibility, and capped benefit amounts, regardless of family size. However, states had no obligation to provide education or job training to women displaced from welfare and, through block grants and waivers, were allowed to tighten federal limits even further (Eitzen and Zinn 2000).

If PROWA contained minimal work incentives, then what was its objective? The major focus of the legislation involved regulating the moral behavior of poor women. To promote this objectives, PROWA allocated US$100 million to reward states that reduced illegitimate births and provided US$50 million annually for abstinence education and marriage promotion programs. Some states added a monthly bonus to TANF benefits if a legal marriage took place (Reese 2005). Furthermore, the AFDC program that PROWA terminated was of little consequence in budgetary terms. Before TANF, AFDC consumed less than 1% of total mandatory federal spending, so its demise had virtually no impact on larger budgetary issues that could only be addressed by spending reductions in programs for the aged. PROWA's most significant effect was to signify that payments to mothers for care work provided in the home were no longer part of the social contract.

The working poor. The work incentive in TANF was made more palatable by the expansion of the EITC, a refundable tax credit for low-income working families with children that offsets the impact of payroll taxes. When the EITC was first enacted in 1975, it was a modest benefit, but it was expanded considerably in 1986 and then again in 1990 and 1993. By 1996, nearly 20 million families were receiving EITC benefits, and annual federal outlays approached US$25 billion, almost double AFDC expenditures (Myles and Pierson 1997).

The EITC has effectively raised the incomes of working, single mothers; raised more children out of poverty than any single government program; and offers avenues for upward mobility (Smeeding, Ross, and O'Connor 2000).

Because eligible families receive benefits if the value of the EITC is larger than the income taxes the families owe, the EITC also operates as a work incentive for people with low earnings (Greenstein and Shapiro 1998). The fact that the EITC is not counted as earnings against TANF in most (but not all) states further increases the work incentive for that population (Smeeding et al. 2000). The combination of work incentives and poverty reduction features make the EITC an optimal exemplar of an enabling state strategy.

Income Security for the Elderly

The aging of the baby boom generation combined with increasing longevity and declining fertility will cause the percentage of the U.S. population aged 65 and older to rise from 13% to 18% between 2010 and 2030, then continue its upward spiral through 2080 (Munnell 2004). As the ratio of retirees to the working-age population rises, Social Security costs as a share of the gross domestic product will increase sharply (Palmer 2005). Projections indicate that by 2042, payroll tax revenues alone will be insufficient to fully finance promised payments to beneficiaries.

Some modest changes have been made to improve the long-range solvency of the Social Security trust fund. The 1983 amendments to the Social Security Act raised the payroll tax, taxed the benefits of upper-income beneficiaries, and raised the age of eligibility for full benefits from 65 to 67 years but phased in beginning in 2000 so there would be no immediate political costs. Taxes on benefits were further increased in 1994. In 2000, the Social Security "earnings test," a benefit reduction for earned income, was eliminated for beneficiaries aged 65 to 69 years. Under the new rules, beneficiaries were allowed unlimited earnings from employment, with no reduction in benefits. Thus, a work incentive was inserted into the Social Security program, but it was done with a carrot, not a stick. Moreover, this "carrot" represented a net increase in costs over the long term.

Proposals to privatize Social Security began circulating in the late 1970s, but it was not until President George W. Bush publicly endorsed individual investment accounts for Social Security in his state-of-the-union address in 2005 that privatization moved to the forefront of the political agenda. Framing the debate in terms of creating an "ownership society," Bush proposed allowing workers to invest a portion of payroll taxes in these private accounts (Starr 2005). The American Association of Retired Persons (AARP) immediately announced that it would oppose Bush's plan, and liberals joined in the counterattack, charging that such accounts would subject

retirees to market risk (Aaron 2005; Baker 2005). As it became apparent that the President lacked congressional support for this initiative, he abandoned privatization as an explicit policy goal and focused instead on "saving" Social Security.

The failure of the first serious attempt to privatize Social Security confirms the argument that social policies that benefit sizable organized constituencies and embody long-term commitments are the most durable (Hacker 2004). Yet the debate over Social Security privatization has had a significant impact in less obvious ways. USA Next, a conservative group that supports privatization, began a campaign against the AARP, while Progress for America, another conservative organization, launched a US$2 million advertising campaign supporting Bush's privatization proposal. Furthermore, following years of claims that Social Security is unsustainable, younger Americans regard their potential claim on future benefits as tenuous at best. Equally important, other options for necessary Social Security reform have all but disappeared from the national political agenda. This leaves the Social Security policy paradigm transformed, perhaps laying the groundwork for successful privatization in the future.

Health Care

Medicaid and CHIP. Medicaid is the joint federal-state program of health insurance for the poor that originally was available to all AFDC recipients. In the 1980s, Congress enacted a series of measures that expanded Medicaid coverage for pregnant women and children and that also loosened the direct link between Medicaid and AFDC (Mann, Rowland, and Garfield 2003). Some states took advantage of the new rules to expand classes of Medicaid eligibility to subsidize coverage for entire families (Ku and Garrett 2000).

When PROWA was enacted, measures were included to prevent mothers who lost cash benefits from also losing health coverage. TANF was purposely decoupled from Medicaid entirely, and states were allowed to further expand Medicaid eligibility beyond the traditional welfare limits. Despite these efforts, one third of women who left TANF for work became uninsured, and many poor children lost health coverage (Garrett and Holahan 2000).

A new child health benefit, the CHIP, was enacted in 1997, partly as a response to a decline in children's coverage under PROWA reforms but more generally to reduce the number of uninsured children in working poor families. CHIP increased federal funds to the states for low-income children

and allowed (but did not require) states to cover children with incomes up to 200% of the poverty level, either by expanding Medicaid or by creating a separate program (Almedia and Kenney 2000). CHIP rules were later amended to allow uninsured parents to be covered along with their children. Immediately after CHIP was enacted, children's uninsurance rates decreased sharply, although many eligible children remained uninsured. However, during the recession of 2001 and 2002, many states tightened Medicaid and CHIP eligibility criteria and limited new enrollments. By 2003, three states had halted CHIP enrollments entirely, resulting in long waiting lists for thousands of eligible children (Cunningham 2003).

Efforts to expand health insurance coverage for low-income families and especially children in the 1980s and 1990s are consistent with the concept of an enabling state. TANF reduced the work disincentives in cash benefits by allowing mothers who entered the labor force to continue receiving Medicaid for an extended period and by providing alternative sources of health coverage for their children.

Medicare. When Medicare was enacted in 1965, it preserved a substantial role for the private sector as a way to minimize opposition from physicians and hospitals. Private insurance companies were given responsibility for handling claims and reimbursing providers. Private hospitals were reimbursed on a "cost plus 2%" basis, and private physicians were paid their "usual and customary" fees, with no upper limit. The legislation also left many health care needs uncovered, giving private insurers a predictable market for "Medigap" expenses. These arrangements meant that Medicare would not intervene in the health care system but merely serve as a neutral conduit through which federal funds would pass. Health care inflation was inevitable, given these arrangements (Quadagno 2005).

As medical costs outpaced inflation in other parts of the economy, Congress funded several cost control demonstration projects. One such project was adopted as part of the 1983 amendments to the Social Security Act. This little-noticed provision replaced Medicare's cost-based reimbursement system with the Prospective Payment System (PPS), which created fixed payment schedules for various diagnosis-related groups (DRGs), regardless of the actual cost of treatment (Morone and Dunham 1986). During the first year after the PPS was implemented, the average hospital length of stay for Medicare beneficiaries declined by over 15%. Within a few months, however, DRG "creep" began to occur as hospitals began reporting more high-cost cases in an effort to preserve revenues (Goldsmith 1984).

Since the 1990s, the primary thrust of Medicare legislation has been to expand the private sector role. The Balanced Budget Act of 1997 created Medicare+Choice, which allowed new types of health plans to participate in the Medicare program. These include risk-based health maintenance organizations (HMOs) and preferred provider organizations. Some policy makers viewed Medicare+Choice as a vehicle to provide richer benefits to Medicare beneficiaries than what was available in the traditional fee-for-service program, especially prescription drug coverage; others felt that Medicare+Choice would reduce costs by generating competition among various plans or even set the stage for the full privatization of Medicare. Yet because payments to private health plans are determined by law, not generated by market forces, the potential for competition is limited (King and Schlesinger 2003).

The Medicare Prescription Drug Improvement and Modernization Act of 2003 created a limited drug benefit for Medicare beneficiaries. The benefit pays 75% of a beneficiary's drug costs up to US$2,250 a year (Hacker and Marmor 2004). Then coverage stops until the beneficiary has spent another US$3,600, creating a so-called doughnut hole (Oberlander 2003). After that, Medicare will pay 95% of any additional prescription drug costs. Although the drug benefit does expand the government's role in health care provision, it also contains explicit provisions to encourage privatize the core Medicare program through incentives for higher income elderly to purchase private health insurance policies as a substitute for Medicare and $12 billion in subsidies to private HMOs to encourage them to offer policies that compete with traditional Medicare (Weissert 2004).

Long-term care. Until the mid-1980s, most private insurance companies were uninterested in long-term care insurance, because expenses were too unpredictable and the elderly too poor to make the product viable. Most people did not consider purchasing long-term care insurance until they had serious health problems that made them ineligible for coverage or until they were so old that the cost was prohibitive. The ground for long-term care insurance began to shift with the 1994 Republican "Contract With America," which included a provision to allow premium expenses for long-term care insurance to be deducted from income taxes. Using tax incentives to encourage the purchase of private insurance would stimulate the market and signal consumers that the government considered long-term care insurance a worthwhile product (Quadagno 2005). This provision was included in the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

HIPAA allowed people who itemized deductions on their income taxes to deduct any long-term care expenses and made employer contributions toward the cost of group long-term care insurance a tax deductible business expense, favorable tax treatment similar to that for employer-provided health insurance.

Over the next five years, long-term care insurance became the fastest growing insurance product. The market grew an average of 21% a year, with the biggest increase occurring in group insurance plans offered by employers (Roberts 2003). How the long-term care insurance market plays out remains to be seen. Whether the market will thrive once younger beneficiaries make claims is uncertain, given rapidly escalating costs for long-term care and the limitations imposed by policies. Many analysts regard long-term care insurance as a "good buy" for individuals with sizable estates to preserve. However, only 10% to 20% of households can afford the premiums, and the risk of an interaction between private long-term care insurance and Medicaid could leave some people who purchase private insurance considerably disadvantaged if their private coverage renders them ineligible for any Medicaid assistance should cost increases exceed policy limits (Merlis 2003).

Conclusion

Significant changes have occurred in the social programs of Western, capitalist democracies since the ebbing of the golden age of the welfare state. In many instances, these changes represented efforts to rein in the generosity or scope of benefits (or both), as was the case with state pensions in Britain, disability insurance in the Netherlands, and unemployment insurance in Switzerland. Often accompanying these changes were new incentives for those not employed to enter the labor force or, in the case of older workers, to continue working. Over the same period, new social insurance programs for long-term care were implemented in several countries.

In the United States, programs that were constructed during the New Deal of the 1930s and the Great Society of the 1960s were revamped in various ways. At issue is whether these changes represent a major policy paradigm shift or merely a reshaping at the margins. Some evidence suggests that the United States is moving toward becoming an enabling state, at least in those programs that target the working-age population. The demise of AFDC and the expansion of the EITC promote work and target benefits. Less clear are recent directions in the social insurance programs that mainly serve the older population. Social Security has thus far remained immune to

privatization proposals (although the options on the national political agenda have experienced a major transformation). Medicare has always incorporated the private sector into the administration of funds and the delivery of services, but recent policy measures have been designed to give the private insurance industry a much larger role. The incentives for private insurance built into the Medicare+Choice program and the 2003 prescription drug benefit legislation, if successful over the longer term (by no means a certain outcome), could undermine traditional Medicare and insinuate the private insurance industry deeper into the Medicare marketplace. That was the intent of the legislation. A similar policy objective has been inserted into long-term care for the frail elderly, which until the 1980s was funded primarily by a combination of private payments and Medicaid funds. Since then, policies have been designed to shore up the private insurance industry and crowd out a public sector solution. If private long-term care insurance continues to grow at a pace similar to the past few years, the federal government in the United States, in contrast to several other countries, will be unlikely ever to assume a primary role in meeting this social risk.

At a theoretical level, the evidence suggests that arguments emphasizing the institutional inevitability of modest reforms that preserve program structures to mesh with new conditions are difficult to judge and impossible to falsify. Do incentives for new private plans in Medicare represent a fundamental shift, or does the fact that most beneficiaries remain in traditional Medicare signify institutional continuity? Does the demise of AFDC support the trend toward an enabling state? It is difficult to say. The new TANF program includes explicit work incentives. CHIP enables parents to take low-paying jobs without losing health insurance for their children. Long-term care insurance and the EITC both exemplify an individuation of risk. Such trends are consistent with the enabling paradigm. One could just as plausibly argue, however, that there is evidence of institutional inertia. CHIP could be interpreted as an extension of the social insurance principle, because it incorporates a new beneficiary group into a public health insurance program, and its eligibility rules are considerably more lenient than traditional social assistance. Similarly, the periodic cutbacks in Medicaid and the demise of AFDC make sense within this framework, because neither was a social insurance program that could garner the political interest constituencies necessary to prevent retrenchment.

Cutting back programs (as in some U.S. and European policy areas in the 1980s and 1990s) is not the same as systemic retrenchment: institutional reforms that weaken the state's revenue base and undermine pro-welfare-state interest groups (Pierson 1994; Amenta, Bonastia, and Caren 2001). To

the extent that the United States and other Western countries faced similar challenges in the aftermath of the golden age, they took many similar steps to adapt to new social and economic imperatives. The question of whether the American welfare state is truly exceptional may be answered in the near future if the burgeoning deficit resulting from tax cuts and military spending undercut the resources necessary to fund social welfare benefits. Over the next decade, resource starvation may weaken the capacity of mature programs to withstand transformative change, with the fortunes of the American welfare state shaped as much by a lack of resources as by policy legacies. If nothing else, Social Security privatization has been legitimated as a reasonable policy response to population aging.

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