

NATIONAL
ACADEMY
OF SOCIAL
INSURANCE

**Report to the New Leadership
and the American People on
Social Insurance and Inequality**



January 2017

NATIONAL ACADEMY OF SOCIAL INSURANCE

About the National Academy of Social Insurance

The National Academy of Social Insurance is a nonprofit, nonpartisan organization made up of the nation's leading experts on social insurance. Its mission is to advance solutions to challenges facing the nation by increasing public understanding of how social insurance contributes to economic security.

Social insurance encompasses broad-based systems that help workers and their families pool risks to avoid loss of income due to retirement, death, disability, or unemployment, and to ensure access to health care.

The Academy convenes steering committees and study panels that are charged with conducting research, issuing findings, and, identifying policy option recommendations based on their analyses. Members of these groups are selected for their recognized expertise and with due consideration for the balance of disciplines and perspectives appropriate to each project.

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the American People on Social
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Executive Summary

The mission of the National Academy of Social Insurance is to advance solutions to challenges facing the nation by increasing public understanding of how social insurance contributes to economic security. On the occasion of the inauguration of a new President and the installation of a new leadership team to administer our nation's social insurance systems at the beginning of 2017, the Academy welcomes the opportunity to fulfill its mission by submitting this Report to the New Leadership and the American People on the current state and future direction of social insurance in the United States.

The Academy engaged the expertise of over 80 of its Members and partners in government, law, advocacy, and academia to develop informed analyses of the current challenges facing social insurance, as well opportunities for improvements. This Report provides accurate, non-biased, non-partisan analyses of social insurance from a variety of perspectives to inform the new leadership and the American people about the importance of this infrastructure, the crucial issues at stake in social insurance policy, and the possibility – and, in many cases, necessity – for reforms.

This Report is organized into two parts.

The first part of the Report takes stock of the policy challenges facing the social insurance infrastructure that protects against key risks facing American workers. Social Security, our major health insurance programs, and Unemployment Insurance together provide protection against the risks of old age, disability, sickness and involuntary unemployment. In a series of focused analyses of policy challenges facing these programs, the contributors develop a range of evidence-based policy options upon which policymakers could draw. This Report does not address the risk of becoming injured at work, because the social insurance system that protects against this risk, Workers' Compensation, is administered by the states with no current role for federal influence.

The second part discusses potential new directions for social insurance, taking into account changes in society in recent decades. Longer life spans, increased demands on families and caregivers, and changes in the structure of work have led to profound shifts in society that may require new forms of risk protection. This part of the Report discusses new frontiers for social insurance in which it could better protect Americans from these new risks: the financial and health risks associated with requiring long-term services and supports; risks to caregivers and those requiring care in an era in which

dual-earner households and single-working caregiver households have become more common; and the myriad risks associated with the growth of nonstandard work.

Strengthening Workers' Risk Protections

Social Security

A looming issue for Social Security is the projected long-term imbalance between program revenues and costs. Because of this imbalance and because, by law, Social Security cannot deficit spend (i.e., it cannot pay benefits in excess of its income and reserves), legislative action will likely need to be taken before 2034. Solvency is just one of several objectives that must be weighed in any package of reforms to Social Security; others are discussed below. A reform package may include some combination of revenue increases and benefit reductions, as well as some targeted benefit expansions.

Economic and racially grounded disparities have led to significant gaps in retirement wealth among Americans. However, the gap in pension/IRA wealth is much larger than that in Social Security wealth. Social Security has a mitigating effect on inequality in the distribution of retirement wealth. In addition, as a social insurance program, Social Security has further advantages over private, individual savings, including universal coverage, mandatory contributions, predictability, and security. A range of policy options are available to combat inequality in retirement wealth.

One group that faces particular challenges to achieving sustainable retirement security, despite decades of economic gains, is women. Women not only tend to reach retirement with fewer resources than men, but they also typically have to stretch their resources over a longer lifespan. On average, women also contend with larger medical expenses than men, in addition to facing the greater likelihood of losing a spouse. Social Security is the main source of retirement income for most seniors, but women are even more reliant than men on Social Security, because they have fewer other sources of retirement income. Their retirement security is further reduced by caregiving responsibilities during their working years and their longer life expectancies. There are many Social Security reform options available to strengthen women's retirement security.

The Social Security system provides essential protections against disability. The Social Security Disability Insurance (SSDI) program is projected to be able to pay full benefits through 2023. In the coming years, policymakers have the opportunity to implement sensible reforms both to improve the performance of the program in meeting the needs of people with disabilities, and to secure its long-term solvency. The Social Security Administration (SSA) currently

lacks the resources to keep up with the need for hearings to determine eligibility for disability benefits. SSA's annual administrative budget has declined 10 percent since 2010, leading to a 5 percent decline in SSA staff. The DI program already contains a range of features designed to incentivize work, such as continuing payments while a beneficiary receives vocational rehabilitation services and offering a trial work period during which benefits will not cease because of the beneficiary's earnings. But the program could still do more in this regard. Modest reforms to the system guided by a set of consensus principles would improve the ability of the system to achieve its objectives and extend solvency over the long term.

Health Insurance

The United States has long been an outlier compared to other economically advanced countries, spending more on health care while lagging behind in terms of health care coverage and key health outcomes such as life expectancy. To improve the quality of health insurance coverage in the individual market, the Affordable Care Act (ACA) included myriad reforms to protect consumers and improve quality. Analysis of the ACA's successes in achieving many of its stated objectives is necessary to understand what has worked, as well as what challenges have arisen that need addressing to further improve access to affordable health insurance coverage. The ACA has extended coverage to over 20 million Americans, vastly improved the quality and reliability of policies on the individual market, and played a role in reducing health care cost growth to the lowest levels in 50 years. This Report offers a set of options that can help guide policymakers as they seek to further improve coverage and lower the cost of health insurance. Policymakers would be well-advised to proceed with care, learning from experience and the best available evidence in this complex but vital policy area.

While health care is an indispensable component of health, social, economic, and environmental factors also play key roles in determining health and wellbeing. As the nation's largest public insurer of low-income and medically vulnerable individuals and families, Medicaid – working in combination with other programs that address social determinants of health – has the potential to play a strong role in any successful effort to improve both patient and population health. Certain key characteristics of Medicaid make it unique among insurers as a partner with other programs that address social determinants of health. Unlike private insurance, Medicaid is structured to offer coverage whenever the need for health care arises. The program insures a greater and more sustained range of clinical services that promote health, emphasizes coverage of preventive services, and covers treatments in community settings. Medicaid stands to gain real value from improvements to the social determinants of health and health care integration, particularly

given the populations and health needs the program insures. Strengthening Medicaid's power as an insurer and the efficiency with which it operates could be central to any plan to improve health, lower health care costs, and reduce inequality.

In addition to Medicaid, Medicare also serves as a critical protection for millions of vulnerable people who would otherwise be uninsured and unable to afford even basic health care. Although the program faces long-term budgetary challenges stemming from the aging of the population and the continued growth in costs throughout the health care system, Medicare does not face immediate problems, and many options are available for strengthening its finances.

A crucial issue affecting all areas of health policy is the increase in prescription drug prices. Americans pay higher prices and spend more per person for prescription drugs than any other developed country in the world, and spending is growing at a rapid and unsustainable rate. Policy challenges in this area include a lack of competition for existing branded drugs, the inability of Medicare to negotiate prices, and the prevalence of private rebates and drug coupons. By increasing transparency in pharmaceutical pricing and spending, enhancing the affordability of drugs for payers of all types, and improving market efficiency within the industry, major improvements in the current landscape are possible.

Unemployment Insurance

Almost all wage and salary employees work in employment covered by Unemployment Insurance (UI). Nationwide, 140 million jobs are insured by the UI system. Nearly all full-time and some part-time workers who meet basic criteria are potentially eligible for UI. However, in practice, actual eligibility for unemployment compensation among today's diverse workforce remains uneven. In addition, the administrative efficiency of state UI systems varies widely, and when the unemployment rate increases, state UI administrators are often unable to quickly and accurately handle a higher volume of claims.

UI was designed to serve as an automatic stabilizer in the U.S. economy during periods of recession. To operate as originally intended, there must be "forward funding" – that is, states must collect enough taxes in good economic times to pay benefits during recessions without having to borrow. However, most states are failing to adequately forward-fund their UI trust funds. Six years into the recovery from the Great Recession, two-thirds of state UI programs were still below the U.S. Department of Labor's minimum recommended trust fund ratio.

The Employment Service (ES) and Unemployment Insurance are partner programs. The ES has cooperated with UI by providing trained counselors to accept claims for benefits, check initial eligibility for UI, provide job-finding and placement services for UI claimants and local employers seeking to fill jobs, and validate continuing UI eligibility before paying benefits. Cost savings to the Unemployment Insurance system can be achieved by enhancing job-finding and placement services, and by exposing UI claimants to suitable jobs. However, the reduced availability of employment services over time, and the lack of work test enforcement, may contribute to longer unemployment durations.

Modernizing Workers' Social Insurance Protections

Long-term Services and Supports

The lack of a well-functioning long-term services and supports (LTSS) system is the cause of insecurity and anguish for millions of American families. Yet, LTSS is currently delivered in a piecemeal and costly fashion that prevents many from getting the support they need. This places a heavy financial, emotional, and physical burden on those families who assist them. Many Americans also underestimate the degree to which public programs will leave them exposed to LTSS risk. The key to any effective insurance program is spreading risk as broadly as possible, and there is no more effective way to spread risk than through a universal LTSS insurance program. The private market alone will be grossly inadequate to address the need for long-term services and supports across the nation. That said, if a catastrophic universal public plan were passed, private front-end LTSS insurance plans could play a meaningful role in filling the gaps in coverage that would remain. A range of other policy options are available as well.

Caregiving

Loss of earnings due to the need to pursue caregiving responsibilities is a risk covered to varying extents by social insurance in every advanced industrial country except the United States. Caregiving responsibilities take various forms: caring for children; family members with illnesses or disabilities; sick or aging parents; or an individual's own medical needs. In addition to the lack of supports for working caregivers, an affordable care infrastructure is available neither for young children, nor for persons with physical or cognitive impairments. As the Boomer generation ages out of its prime caregiving years into their years as care recipients, and the smaller birth cohorts of Generation X succeed them into their prime caregiving years, the caregiver ratio will worsen dramatically. Policy options to address this gap in social insurance protections include: a universal social insurance program for paid family and medical leave; tax and Social Security reforms to support caregivers; and affordable child care.

Nonstandard Work

Workers' traditional relationships with their employers have been fracturing over the past four decades. The trend away from traditional employment arrangements – in which workers are employed for long stretches of time with a well-defined employer – toward nonstandard work leaves workers increasingly exposed to economic risks. Some proposals to address the problem of providing workplace protections to an increasingly fragmented workforce have involved portable benefits via individual accounts to which employers and employees could contribute. Proposals for individual accounts may be appropriate for providing certain employment benefits not covered by social insurance, but are an inadequate substitute for the stability, efficiency, and adequacy provided by pooled-risk social insurance systems.

Introduction: From There to Here

Ever since human beings began living in complex societies, we have had to address the problem of how to provide risk protection to those in our communities facing economic ruin – the elderly, the sick, the injured, the disabled, surviving spouses and children, the unemployed, those requiring long-term care. In traditional societies, families and local communities were expected to provide for these needs. In the early-modern era, a patchwork of guilds, fraternal and mutual aid societies, charities, private insurers, and – in the last resort, poor relief – worked to address them.

That patchwork was stretched to the breaking point by the rapid urbanization, industrialization, social dislocation, individualization, and boom-and-bust market cycles of the industrial age. These forces transformed first Great Britain in the late 18th century, then Continental Europe and the United States in the second half of the 19th century. Working people no longer lived their entire lives in close proximity to their immediate families. Family farms, which formerly supplied a kind of cradle-to-grave social and financial support, were less able to sustain families over multiple generations. Industrial employers put a premium on younger, healthier workers and had little room for those who suffered injuries that prevented them from working, forcing many older people out of the labor force without the means to continue supporting themselves. Urban families struggled to make their wages cover the cost of supporting aged parents and other relatives. Unions collectively bargained with employers to regulate pay, working conditions, benefits, and other aspects of workers' economic security. Through the early 20th century, mutual aid societies also continued to provide security and fraternity to their members. They started by offering burial benefits and sickness funds, and later developed into offering in some cases life insurance, disability insurance, and accident benefits. These societies were typically rooted in a specific group's community: English, African-Americans, Irish, Poles, Germans, Italians, Jews, and Latin Americans all had mutual aid societies of their own.

During the early 20th century, states began to respond to the ubiquitous risk of injury at work with the establishment of Workers' Compensation programs. The first comprehensive Workers' Compensation law was enacted in Wisconsin in 1911. Nine other states

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passed regulations that year, followed by 36 others before the decade was out. Thirty states responded to growing old-age poverty with the creation of old-age pension programs in the two decades before passage of the Social Security Act of 1935.¹ Wracked by the sky-high joblessness of the Depression years, seven states enacted Unemployment Insurance programs.

The enduring misery of the Great Depression revealed that this piecemeal, unreliably funded approach to economic and health security was ill-suited to the modern age. It became apparent that more universal, mandatory, state or national systems were needed to address the risks posed by modern industrial society.

Social insurance modernized pre-modern, particularistic forms of community solidarity, transforming them into universal, efficient public programs well-suited to the modern economy.

National social insurance had emerged a half-century earlier in Western Europe, most notably in Bismarck's Germany. Bismarck used national social insurance to defend the capitalist system there from what he perceived to be the threat of the working-class movement – the strength of unions and the Social Democratic Party – which had gained ascendance at the time

by achieving social and economic protections through collective bargaining and electoral victories. Social insurance was also a key part of Bismarck's broader effort to build the nation. Social insurance modernized pre-modern, particularistic forms of community solidarity, transforming them into universal, efficient public programs well-suited to the modern economy.

Due to America's ethnic, linguistic and religious heterogeneity – the lack of what political sociologists call "a nation" – as well as the lack of anything resembling a federal government in the modern sense, it took several decades longer for national solutions to take root in the United States. But here, too, by the 1930s social insurance became integral to nation-building, and to building the social-policy infrastructure of capitalist, democratic society. Analogous to the German situation 50 years earlier, rather than turn toward socialism, as many other countries did during the Great Depression, the United States passed the Social Security Act of 1935.

¹ Social Security Administration, n.d., "Historical Background And Development Of Social Security," <https://www.ssa.gov/history/briefhistory3.html>.

What is Social Insurance?

Social insurance programs protect workers and their families against economic and health insecurity – typically wage loss or lack of affordable access to quality health care. Workers and/or their employers pay into social insurance programs when workers are able to work, and workers receive benefits

when they are unable to work (e.g. disability, injury at work, illness) and/or an insured risk transpires (e.g. unemployment, old age, death of a breadwinner). Through social insurance, individuals and households contribute resources to provide for needs and risks they generally could not cover on their own. This system – which in the United States includes Social Security, Medicare, Unemployment Insurance, and Workers’ Compensation – covers the vast majority of working Americans and their families.

Social insurance programs protect workers and their families against economic and health insecurity – typically wage loss or lack of affordable access to quality health care.

Why is Social Insurance So Effective at Protecting against Risk?

Insurance is designed to pool risks. Since most of the risks against which social insurance protects us against are universal (i.e., risks to which all of us are potentially exposed), national social insurance programs are the most effective means of pooling these risks. Private insurance cannot effectively address many of these risks, for a variety of reasons.² Among other things, private insurance cannot address risks that transpire in large number at the same time – like unemployment during recessions, or the aging of the Boomer generation as they begin to require long-term care (witness the collapse of the private long-term care insurance market).

Arguably the best definition of social insurance was formulated by Robert M. Ball, a long-time commissioner of Social Security and Administrator of Medicare and the Founding Board Member of the National Academy of Social Insurance. He delineates nine guiding principles:³

- It is *universal*: Everyone in paid employment is covered.
- It is an *earned right*: Eligibility for benefits and the benefit rate are based on an individual’s past earnings and contributions.
- It is *wage-related*: Benefits are calculated to maintain a relationship between an individual’s standard of living in and out of work.
- It is *contributory and self-financed*: Contributions pay for benefits. This gives contributors a moral claim on future benefits.
- It is *redistributive*: Lower-paid earners receive proportionately higher benefits than do higher-paid earners.

² Michael J. Graetz and Jerry L. Mashaw, 1999, *True Security: Rethinking American Social Insurance*, New Haven, CT: Yale University Press.

³ Leah Rogne, Carroll L. Estes, Brian R. Grossman, Brooke A. Hollister and Erica Solway, 2009, *Social Insurance and Social Justice: Social Security, Medicare, and the Campaign Against Entitlements*, New York: Springer Publishing, http://lghhttp.48653.nexcesscdn.net/80223CF/springer-static/media/samplechapters/9780826116147/9780826116147_chapter.pdf.

- It is not *means-tested*: Benefit eligibility and generosity are not determined by the beneficiary’s income or assets.
- It is *wage-indexed*: Benefits at the time of initial receipt are brought up to date with current wage levels, reflecting improvements in productivity and thus in the general standard of living.
- It is *inflation-protected*: Periodic cost-of-living adjustments (COLAs) keep benefits from being eroded by inflation.
- It is *compulsory*: All wage earners are required to participate, eliminating the problem of adverse selection (individuals deciding when and to what extent they want to participate) and providing further legitimacy to the program.

A program need not meet all of these criteria in order to be considered social insurance.

Social Insurance Strengthens the Economy

Universal social insurance programs funded by contributory taxes strengthen the economy in numerous ways: bolstering wages, helping small businesses, increasing productivity, reducing government bureaucracy, and stabilizing the economy during recessions.

Social insurance is good for the American economy as a whole, as well as for millions of Americans. Compared to alternative methods of promoting individual economic security – employer-based benefits, tax-favored, pre-funded individual savings accounts, and means-tested welfare programs limited to the poor – universal social insurance programs funded by contributory taxes strengthen the economy in numerous ways: bolstering wages, helping small businesses, increasing

productivity, reducing government bureaucracy, and stabilizing the economy during recessions.

Social insurance also helps small businesses, which cannot afford to compete with large employers for workers by offering generous employer-based benefits. At the same time, because it is portable and universal, social insurance indirectly promotes national economic productivity by reducing “job lock” – the reluctance of individuals to seek new jobs better matched to their skills because of their fear of losing benefits attached to their present employers. Moreover, while means-tested welfare programs are limited to the poor, universal, contributory social insurance programs do not require the expenditure of taxpayer money on a large and intrusive bureaucracy tasked with enforcing asset tests and other requirements, to prevent individuals from gaming means-tested systems.

The role of social insurance as an “automatic stabilizer” in the economy is often overlooked, but it is profoundly important. During recessions and depressions, the fact that benefit payments are not interrupted means that social insurance programs are “countercyclical” and tend to function collectively as an automatic stimulus to the economy. In contrast, pre-funded savings accounts that are invested in the stock market – both employer pensions and individual savings accounts – tend to make recessions worse, because their value collapses during downturns when they are most needed by individuals. The most effective automatic stabilizers in the economy are social insurance programs, particularly Unemployment Insurance, Social Security and Medicare.

1940s-1970s: Shared Prosperity with Increased Risk-Pooling through Social Insurance

In the four decades following passage of the Social Security Act, Americans incrementally increased the ways and scope in which they pooled risk through what experience was proving to be a highly effective tool – social insurance. The final state, Mississippi, passed Workers' Compensation legislation in 1948.⁴ (Worker's Compensation remains a state program with no federal administrative role to the present day, and hence will not be addressed in depth in the body of this *Report*, except in Section 6, which discusses nonstandard work.)

Exclusions in the Social Security Act for domestic and agricultural workers had left out most women and African-American workers from Social Security and Unemployment Insurance protections. In the case of Social Security, half the workforce, including the self-employed, was still left uncovered in 1950.⁵ There were no benefits for surviving family members, and no benefits for disabled workers, in the original Social Security Act legislation, either.

Over the next 35 years, however, Americans came to pool more risk using social insurance. Survivors benefits were added in 1939, incorporating life insurance protections into Social Security; agricultural and domestic workers and many of the self-employed were added in 1950; Unemployment Insurance coverage was extended to all employers with four or more workers in 1954, and to those with one or more in 1970; Disability Insurance was created in 1956; members of the armed forces were included under all of these programs the following year; and in 1965, Medicare was established to finance health care for retirees.⁶ Additional weeks of coverage were gradually added to Unemployment Insurance in most states.

⁴ Gregory P. Guyton, 1999, “A Brief History of Workers' Compensation,” *The Iowa Orthopaedic Journal*, 19:106-110.

⁵ Social Security Administration, n.d., “Detailed Chronology of Social Insurance & Social Security,” <https://www.ssa.gov/history/chronology.html>.

⁶ *Ibid.*

The share of the population over 65 living in poverty shrank from 35.2 percent to 14.6 percent from 1959 to 1982. This was an enormous boon not just for the elderly, but also for working families, who were now less burdened with the cost of caring for their aging relatives.

The development of Social Security over this period is especially noteworthy. Every few years after the passage of the Social Security Act in 1935, Congress had boosted Social Security benefits to keep retirees' purchasing power in line with inflation. Eventually, in 1972, Congress permanently tied cost of living adjustments (COLAs) to changes in consumer prices.⁷ Moreover, over time an ever greater share of the elderly had contributed to Social Security throughout their

careers and hence accrued significant benefits. The result was an enormous improvement in the standard of living of the elderly. The share of the population over 65 living in poverty shrank from 35.2 percent to 14.6 percent from 1959 to 1982.⁸ This was an enormous boon not just for the elderly, but also for working families, who were now less burdened with the cost of caring for their aging relatives.

1980s-Present: Growing Income Inequality and Transfer of Risk to Individuals

Since the early 1980s, there has been a course reversal away from risk pooling and back toward relegation of risk with individuals.⁹ In the private sector, unions have declined in scope and power. Employers, in response to a variety of pressures, have shifted from traditional pensions to individual accounts, so-called 401(k)-style plans. At the same time, Washington's policy focus has shifted to reducing the government's footprint by limiting growth in social spending and reducing taxes, shifting more responsibility – and risk – for old-age income from public provision to individuals and families. The survivor's benefit cut-off age for children of deceased workers was reduced from age 22 to 18 in 1982, eliminating benefits for 760,000 students in college.¹⁰ The 1983 Amendments to the Social Security Act gradually increased the eligibility age for full Social Security benefits from 65 to 67, taxed the benefits of high-income earners, and imposed a six-month delay on COLAs, among many other changes.¹¹ The higher eligibility age alone reduces monthly benefits for younger workers by 12.5 percent.

⁷ Ibid.

⁸ U.S. Census Bureau, 2016, "Historical Poverty Tables: People and Families - 1959 to 2015," Table 3: Poverty Status of People, by Age, Race, and Hispanic Origin: 1959 to 2015, <http://www.census.gov/data/tables/time-series/demo/income-poverty/historical-poverty-people.html>.

⁹ Jacob S. Hacker, 2006, *The Great Risk Shift: The New Economic Insecurity and the Decline of the American Dream*, Oxford: Oxford University Press.

¹⁰ Social Security Administration, n.d., "The History of Social Security 'Student' Benefits," Research Note #11, <https://www.ssa.gov/history/studentbenefit.html>.

¹¹ Social Security Administration, n.d., "Summary of P.L. 98-21, (H.R. 1900) Social Security Amendments of 1983-Signed on April 20, 1983," Legislative History, <https://www.ssa.gov/history/1983amend.html>.

These shifts have been occurring at the same time as we have transitioned from shared prosperity to increasing inequality in market income, and from the ubiquity of the standard employment relationship to a proliferation of nonstandard work. Together, these trends put a large share of the workforce in a precarious situation with regard to their economic and health security.

Social Insurance Today

Social insurance has been an integral part of American life for more than 80 years, and arguably, will play an even bigger role as the population ages and automation, global competition, rising inequality and other developments continue to transform the economy and create new risks for workers and their families. The numbers tell the story:

- 57 million people were covered by Medicare in 2016;¹²
- 41 million retired workers received old-age benefits in 2016,¹³ including over eight in ten persons over age 65;¹⁴
- 10.6 million disabled workers and their dependents received Disability Insurance in 2016;¹⁵
- 6.6 million Americans were beneficiaries of Unemployment Insurance in 2015;¹⁶ and
- 6 million surviving spouses and children of deceased workers received benefits.¹⁷

Social Security alone keeps 22 million Americans out of poverty, including nearly 15 million seniors and 1 million children.¹⁸ It is the most truly “universal” program this country offers, with 169 million workers paying payroll taxes – or more than 95 percent of the working population.¹⁹ And it is certainly among the most popular. In a 2013 public opinion survey by the Academy, 85 percent of Americans, cutting across age and income groups, said Social Security is more important than ever to ensure that retirees have a dependable income, while 77 percent said they were willing to pay more in payroll taxes if it was critical to preserving Social Security.²⁰

¹² Centers for Medicare & Medicaid Services, 2016, CMS Financial Report: FY 2016, https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CFORReport/Downloads/2016_CMS_Financial_Report.pdf.

¹³ Social Security Administration, n.d., “Number of retired workers and their dependents receiving benefits on December 31, 1970-2016,” Social Security Beneficiary Statistics, <https://www.ssa.gov/oact/STATS/OAbenies.html>.

¹⁴ Social Security Administration, 2016, *Income of the Population 55 or Older, 2014*, Washington, DC: Social Security Administration, Office of Research, Evaluation, and Statistics.

¹⁵ Social Security Administration, n.d., “Number of disabled workers and their dependents receiving benefits on December 31, 1970-2016,” Social Security Beneficiary Statistics, <https://www.ssa.gov/oact/STATS/OAbenies.html>.

¹⁶ U.S. Department of Labor, 2016, “Unemployment Insurance Outlook: FY 2017 Midsession Review,” Division of Fiscal and Actuarial Services, Office of Unemployment Insurance.

¹⁷ Social Security Administration, n.d., “Number of survivors receiving benefits on December 31, 1970-2016,” Social Security Beneficiary Statistics, <https://www.ssa.gov/oact/STATS/OAbenies.html>.

¹⁸ Kathleen Romig and Arloc Sherman, 2016, “Social Security Keeps 22 Million Americans Out of Poverty: A State-By-State Analysis,” Center on Budget and Policy Priorities, <http://www.cbpp.org/research/social-security/social-security-keeps-22-million-americans-out-of-poverty-a-state-by-state>.

¹⁹ Wayne Liou, 2016, “How Social Security Benefits Are Computed: In Brief,” R43542, Congressional Research Service.

²⁰ Elisa A. Walker, Virginia P. Reno, and Thomas N. Bethell, 2014, “Americans Make Hard Choices on Social Security: A Survey with Trade-Off Analysis,” National Academy of Social Insurance, <https://www.nasi.org/research/2014/report-americans-make-hard-choices-social-security-survey-tr>.

Paradoxically, while policymakers have leaned increasingly on tax breaks and subsidies to address the changing fortunes of working households, those shifts have only enhanced the role of social insurance. Social Security today provides 33 percent of all income for Americans over 65; for those in the bottom and second income quintiles, it supplies 81 percent.²¹ It is literally a lifeline for these individuals²² – and, in many cases, for their families. In 2015, 8.8 percent of Americans over 65 lived in poverty. Without the help of Social Security, the figure would have been 40.5 percent.²³

Unemployment Insurance is another indispensable resource for supporting low- and moderate-wage workers. Over 70 million American workers and their families, including more than 17 million children, were aided by UI extensions during the Great Recession.²⁴ In addition to the help UI benefits provide to individual workers and their families, extended UI benefits can raise Gross Domestic Product and increase employment.²⁵ Disability Insurance is another lifeline for older workers who experience injuries on the job, and beneficiaries receive Medicare after a two-year waiting period.

Swiftly rising healthcare costs and lack of health insurance coverage for millions of Americans led to passage of the Affordable Care Act (ACA) in 2010. Subsequently, subsidized health coverage under the ACA reduced the number of uninsured non-elderly Americans to 28.5 million, a decrease of nearly 13 million from 2013.²⁶



²¹ Social Security Administration, 2016, *Income of the Population 55 or Older, 2014*, Washington, DC: Social Security Administration, Office of Research, Evaluation, and Statistics.

²² Joshua Freedman and Michael Lind, 2013, “Beyond the Low-Wage Social Contract,” New America Foundation, <https://static.newamerica.org/attachments/1556-beyond-the-low-wage-social->

²³ U.S. Census Bureau, 2016, “Income and Poverty in the United States: 2015,” Impact on Poverty of Alternative Resource Measure by Age: 1981 to 2015, <http://www.census.gov/data/tables/2016/demo/income-poverty/p60-256.html>.

²⁴ Jason Furman, 2016, “The Economic Case for Strengthening Unemployment Insurance,” Council of Economic Advisers, https://www.whitehouse.gov/sites/default/files/page/files/20160711_furman_uireform_cea.pdf.

²⁵ Congressional Budget Office, 2013, “How Extending Certain Unemployment Benefits Would Affect Output and Employment in 2014,” Letter to Congressman Chris Van Hollen, December 3, 2013, <https://www.cbo.gov/sites/default/files/113th-congress-2013-2014/reports/44929-UnemploymentBenefits.pdf>.

²⁶ Kaiser Family Foundation, 2016, “Key Facts about the Uninsured Population,” <http://kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population/>.

Challenges Ahead

Given the growing needs for risk protection, and the potential of social insurance to help meet those needs, there is a compelling opportunity to take a fresh look at our social insurance programs, with an eye to strengthening and modernizing them. This *Report* offers policy options for accomplishing both goals.

Some social insurance programs are in need of strengthening in terms of their financing. Social Security's trust funds are projected to run out of reserves in 18 years. If Congress does not act before 2034, revenue flowing into the funds will only cover about 79 percent of scheduled benefits and administrative costs in that year.²⁷ Unemployment Insurance is not sufficiently prepared to weather the next recession.

Our social health insurance programs face a different set of challenges. Medicare, like the Affordable Care Act, has faced a similar set of problems as our entire public and private health care system: controlling health care costs. Prescription drug prices pose a particular challenge.

Proposals for reform of these programs must be considered in context. Social insurance does not operate in isolation: the performance of any contributory program is affected by the state of the economy, of wages, and of conditions faced by particular groups within the economy. Women, for example, face distinctive challenges preparing for retirement; among the most serious is the gender pay gap. Women also disproportionately serve as de-facto family caregivers, balancing these responsibilities with jobs. All too frequently, this imposes overwhelming pressures on households. Lack of access to paid family leave and affordable, quality child care, coupled with a shortage of paid caregivers, mean that women's employment histories are often interrupted or curtailed, further hindering their ability to accumulate sufficient private retirement savings or Social Security benefits.

The trend away from traditional employment and into nonstandard work creates new economic risks, while exposing many workers to risks not covered by social insurance. Alternative work arrangements, such as temporary, on-call, or contract work, make up 15.8 percent of the total workforce in 2015, up from 10.1 percent in 2005.²⁸ In particular, many workers now lack coverage by Unemployment Insurance and Workers Compensation.

²⁷ Board of Trustees, 2016, Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Federal Disability Insurance Trust Funds, Washington, DC: Social Security Administration.

²⁸ Lawrence F. Katz and Alan B. Krueger, 2016, "The Rise and Nature of Alternative Work Arrangements in the United States, 1995-2015," NBER, https://krueger.princeton.edu/sites/default/files/akrueger/files/katz_krueger_cws_-_march_29_20165.pdf.

Our nation's social insurance infrastructure forms the foundation of economic and health security for American workers and their families. Like all infrastructure, it must be periodically strengthened and modernized.

Our nation's social insurance infrastructure forms the foundation of economic and health security for American workers and their families. Like all infrastructure, it must be periodically strengthened and modernized if it is to continue to meet the needs of a changing society. This *Report* presents the new Administration and Congress with a range of evidence-based

policy options, developed by the nation's top social insurance experts, for doing so.



Part I: Strengthening Workers' Risk Protections

NATIONAL
ACADEMY
OF SOCIAL
INSURANCE

Social Security

Restoring Social Security to Long-term Balance

Restoring Social Security to Long-term Balance

Social Security is the leading source of income for most retired workers and their surviving spouses.¹ Currently, Social Security has three streams of revenue that are dedicated solely to financing benefits and associated administrative costs. Most of the funding comes from mandatory wage contributions made by employees, matched by their employers. The other two streams are interest on reserves held in the Social Security trust funds and revenue from counting benefits as income for the purposes of federal income tax liability. All three of these revenue sources flow into the Social Security trust funds.

To continue to provide adequate benefits over the long term, reforms will be needed. This section will focus on solvency. Other aspects of Social Security policy are addressed in the following three sections of this *Report*, which focus on the gap in retirement wealth, women's retirement security, and disability, respectively.

Policy Challenges

Long-term Solvency

When Social Security's annual income exceeds its annual outgo, the excess is held in trust and invested in government obligation bonds until needed. Social Security's trust fund reserves, currently \$2.8 trillion, in combination with its annual income, are projected to

Social Security's trust fund reserves, currently \$2.8 trillion, in combination with its annual income, are projected to be able to cover all scheduled benefits over the next 18 years.

be able to cover all scheduled benefits over the next 18 years. If Congress does not act before 2034, the reserves are projected to be depleted. At that point, incoming revenue would cover about 79 percent of scheduled benefits and administrative costs in that year (declining to 74 percent of benefits by 2090). By law, Social Security cannot deficit spend (i.e., it cannot pay benefits in excess of its income and reserves). Hence without legislative action, there would be an immediate 21 percent cut in benefits in 2034, and automatic cuts would affect all beneficiaries then and in the future.

¹ Eighty-four percent of all people over 65 and about 90 percent of surviving spouses over 65 receive income from Social Security. For three-fifths of both of these groups, Social Security makes up over 50 percent of their income. Social Security Administration, 2016, *Income of the Population 55 or Older, 2014*, Office of Retirement and Disability Policy, Tables 2.A1 , 2.B5, and 9.B3, https://www.ssa.gov/policy/docs/statcomps/income_pop55/.

Over Social Security's history, its actuarial valuation periods – the length of time into the future for which its actuaries project system solvency – have been as short as 30 years and as long as 80 years. Since 1965, Social Security's Board of Trustees has used a 75-year valuation period. All else being equal, ensuring the solvency of the system over longer periods is preferable to ensuring solvency over shorter periods. But policymakers should not become so fixated on achieving “sustainable solvency” – defined by the trust fund as having a positive balance throughout the 75-year projection period with stable or rising reserves – that they fail to achieve any compromise that extends Social Security's solvency.

Key Factors to Keep in Mind When Crafting Social Security Legislation

Achieving long-term solvency is a necessary but not sufficient step in providing retirement security to American workers. As such, solvency is one of several objectives that must be weighed in any successful package of reforms to Social Security. Other factors to keep in mind include the following:

Adequacy of benefits in context of broader retirement system

Currently, even if scheduled Social Security benefits were to be paid out in full, 52 percent of households would still be at risk of not having enough financial resources to maintain their living standards in retirement.² This figure is much worse for Americans of color and for people with low incomes. Among working households age 55-64, 62 percent have not been able to accumulate retirement savings equal to or greater than their annual income.³ Only four in ten have access to a traditional employer pension, which can provide an income stream for life,⁴ and these traditional pensions are steadily disappearing from the private sector.⁵ As policymakers consider proposals to improve the solvency of the Social Security system, they must recognize that Social Security is the only source of guaranteed, inflation-protected lifetime benefits on which most retirees can rely, absent radical – and historically unprecedented – changes in individuals' private savings habits.

Social Security is the only source of guaranteed, inflation-protected lifetime benefits on which most retirees can rely, absent radical – and historically unprecedented – changes in individuals' private savings habits.

² Alicia H. Munnell, Wenliang Hou, and Anthony Webb, 2014, “NRRRI Update Shows Half Still Falling Short,” Center for Retirement Research, <http://crr.bc.edu/briefs/nrri-update-shows-half-still-falling-short/>.

³ Nari Rhee and Ilana Boivie, 2015, “The Continuing Retirement Savings Crisis,” National Institute on Retirement Security, http://www.nirsonline.org/storage/nirs/documents/RSC%202015/final_rsc_2015.pdf.

⁴ Ibid.

⁵ Barbara A. Butrica, Howard M. Iams, Karen E. Smith, and Eric J. Toder, 2009, “The Disappearing Defined Benefit Pension and Its Potential Impact on the Retirement Incomes of Baby Boomers,” Social Security Bulletin 68(3), <https://www.ssa.gov/policy/docs/ssb/v69n3/v69n3p1.html>.



Earnings-relatedness of benefits

Some proposals would replace the current progressive, earnings-related benefit formula with a nearly flat benefit, regardless of earnings. Such reforms violate one of the core principles of today's social insurance programs: earnings-related benefits.⁶ A Social Security system with roughly flat benefits just above the poverty level would fail to fulfill its wage-replacement role, and leave middle-class workers and their families financially insecure in retirement, or in the event of disability or premature death. Social Security's political success as social insurance is due to the broad support the program receives from these middle-class workers and their families.⁷

Progressivity, individual equity, and social adequacy

The Social Security system as a whole is hard to characterize in terms of progressivity and regressivity. It is funded by a regressive tax – a flat rate paid by both employers and employees on the first \$127,200 of wage earnings in 2017 – to fund benefits based on a progressive formula.⁸ The progressivity of the benefit formula used to compute Social Security retirement benefits, in turn, is partly offset by the fact that groups with low socio-economic status have shorter life expectancies at 65 than do those with higher socio-economic status, and hence receive fewer years of retirement benefits, on average.⁹ On the other hand, low earners are more likely to become disabled or die prematurely, and thus are more likely to benefit from Social Security's disability protections and survivor protections for their families.

Some observers note that there is reason to increase the progressivity of Social Security to compensate for two trends in inequality: 1) growing inequality in the distribution of income; and 2) growing inequality in

⁶ Robert M. Ball, 2000, *Insuring the Essentials: Bob Ball on Social Security*, New York: The Century Foundation.

⁷ Andrea Louise Campbell and Kimberly J. Morgan, 2005, "Financing the Welfare State: Elite Politics and the Decline of the Social Insurance Model in America," *Studies in American Political Development* 19(Fall 2005).

⁸ The regressivity of the Social Security contribution tax is partially offset by the Earned Income Tax Credit (EITC), which is intended to offset part of the payroll tax liability for low-income workers. Social Security Administration, Office of Research, Evaluation, and Statistics, 1997, "Social Security Programs in the United States," SSA Publication No. 13-11758, <https://www.ssa.gov/policy/docs/progdesc/sspus/>.

⁹ National Academies of Science, Engineering, and Medicine, 2015, *The Growing Gap in Life Expectancy by Income: Implications for Federal Programs and Policy Responses*, The National Academies Press, p. 78, <https://www.nap.edu/download/19015>.

Throughout Social Security's history, policymakers have sought to balance individual equity (i.e., that benefit amounts are fair to all contributors based on earnings during their working years) with social adequacy (i.e., that benefits are sufficient for the lowest-wage workers and their families).

longevity by income, or in other words, high earners living longer than low earners. The latter trend increases the lifetime Social Security benefits of high earners relative to those of low earners. Greater progressivity in Social Security could be achieved by making changes to either contributions or benefits. The contribution structure could be made less regressive by raising or eliminating the cap on earnings subject to Social Security contributions, or by broadening

the base to include investment income, as in Medicare. The benefit structure could be made more progressive by increasing benefits for low-income beneficiaries or reducing benefits for high-income beneficiaries.

Congress should also keep in mind that, throughout Social Security's history, policymakers have sought to balance individual equity (i.e., that benefit amounts are fair to all contributors based on earnings during their working years) with social adequacy (i.e., that benefits are sufficient for the lowest-wage workers and their families).



The value of social insurance

Social Security does not meet all the wage-replacement needs of a worker's family in the case of his or her disability, death, or retirement. But the protection Social Security does provide is extremely valuable. A 30-year-old worker earning \$30,000-\$35,000, with a spouse and two young children, has earned Social Security benefits equivalent to over \$612,000 of life insurance

¹⁰ Clingman, Michael, Kyle Burkhalter, and Chris Chaplain, 2014, "The Present Value of Expected Lifetime Benefits for a Hypothetical Worker Dying or Becoming Disabled at Age 30," Unpublished memorandum, Baltimore, MD: Social Security Administration, Office of the Chief Actuary. The \$631,000 of disability benefits includes \$443,000 of Disability Insurance benefits, and \$189,000 of Old-Age and Survivors Insurance benefits once the disabled worker reaches the full retirement age.

protection and over \$631,000 in disability insurance protection.¹⁰ Most 30-year-old workers do not acquire close to this level of savings in private accounts; today the median retirement account balance is \$2,500 for all working-age households.¹¹ For many low- and moderate-income workers, the foundation for economic security for them and their families in retirement, disability, or death is social insurance, not individual savings. Savings can supplement, but not replace, Social Security's insurance protections – and indeed, this was the original intent of the program.

Policy Options

Several policy options exist to ensure that scheduled Social Security benefits can be paid beyond 2034. A complete reform package may include some combination of revenue increases and benefit reductions, as well as some targeted benefit expansions.

A complete reform package may include some combination of revenue increases and benefit reductions – as well as some targeted benefit expansions.

Achieving 75-year solvency solely via an increase in Social Security contributions would impose a significant additional tax burden on workers and their employers. If done via an across-the-board increase in payroll taxes under the existing tax cap of \$127,200, achieving 75-year solvency purely through revenue increases would require the equivalent of an immediate and permanent payroll tax rate increase of 2.58 percentage points – from the current 12.4 percent to 14.98 percent.¹² If done gradually, the increases would be smaller than 2.58 percent at the beginning and rise to more than 2.58 percent at the end of the projection period.

Relying solely on benefit reductions to achieve solvency would compromise Social Security's goal of providing a foundation of economic security in retirement. If done in an across-the-board fashion, the equivalent of an immediate cut of 16 percent for all current and future beneficiaries would be required (or about 19 percent if the cuts were applied only to those becoming initially eligible in 2016 or later).¹³ If the cuts were introduced gradually, they would be smaller at the beginning, but larger at the end of the projection period. Below are some options for addressing revenues and/or benefits. They are not exhaustive, nor are they recommendations. For a detailed analysis of

¹¹ Nari Rhee and Ilana Boivie, 2015, p. 10.

¹² Board of Trustees, 2016, Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Federal Disability Insurance Trust Funds, Washington, DC: Social Security Administration, p. 5.

¹³ Ibid.

how each of these revenue and benefit options would affect Social Security's finances, see the projections of Social Security's Office of the Chief Actuary.¹⁴

A Representative List of Options to Increase Revenue

- Lift the taxable earnings cap (which is \$127,200 in 2017) until it covers 90% of all earnings, or completely eliminate the taxable earnings cap.
- Gradually raise the tax rate for workers and employers.
- Dedicate a new source of revenue, such as the estate tax, a new wealth tax, a financial transactions tax, or a surtax on adjusted gross income in excess of \$1 million.
- Increase taxes on benefits for high-income beneficiaries.¹⁵
- Expand compensation subject to the payroll tax by taxing health insurance premiums or cafeteria plans.¹⁶
- Subject investment income to Social Security contributions.¹⁷

A Representative List of Options to Reduce Scheduled Benefits

- Raise the retirement age to 68, 69, or 70, and/or index the retirement age to longevity.¹⁸
- Use the Chained Consumer Price Index, which typically grows more slowly than the index currently used, to calculate annual cost-of-living increases.
- Change the benefit formula so that individuals with higher earnings receive lower benefits. Specifically, this could be designed to reduce benefits for those with earnings above the 60th percentile (or about \$51,000 in career average earnings).
- Change the benefit formula to boost benefits at the bottom and reduce them in the middle and top of the income spectrum.¹⁹
- Implement an annual benefit formula calculation to provide a relatively higher replacement rate to low-income earners who work for many years compared to high-income workers who work for fewer years.

¹⁴ Office of the Chief Actuary, 2016, "Individual Changes Modifying Social Security," Actuarial Publications, Social Security Administration, <https://www.ssa.gov/oact/solvency/provisions/index.html>.

¹⁵ Bipartisan Policy Center, 2016, *Securing Our Financial Future: Report of the Commission on Retirement Security and Personal Savings*, <http://cdn.bipartisanpolicy.org/wp-content/uploads/2016/06/BPC-Retirement-Security-Report.pdf>, p.98.

¹⁶ Kathleen Romig, 2016, "Increasing Payroll Taxes Would Strengthen Social Security," Center on Budget and Policy Priorities, <http://www.cbpp.org/research/social-security/increasing-payroll-taxes-would-strengthen-social-security>.

¹⁷ Benjamin W. Veghte, 2015, "Social Security in an Era of Rising Inequality: Implications and Policy Responses," *Poverty and Public Policy* 7(2).

¹⁸ Bipartisan Policy Center, 2016.

¹⁹ *Ibid*, p. 89. This proposal can be considered either a benefit cut or a benefit increase because it affects different beneficiaries differently. Thus, it is the only single-option method presented here to reallocate benefits while also maintaining net benefits.

A Representative List of Options to Increase Benefits (These will require additional revenue or require other benefits to be reduced.)

- Increase Social Security's special minimum benefit to pay 125 percent of the poverty level at full retirement age for someone who has worked 30 years or more.
- Increase monthly benefits for beneficiaries beginning at age 85.
- Provide Social Security earnings credits to parents with young children for up to five years.
- Increase all benefits by a certain percentage.
- Establish a new basic minimum benefit.²⁰
- Increase survivors benefits to help widows and widowers maintain their standard of living.²¹
- Reinstate student benefits until age 22 for children of deceased or disabled workers if the child is in college or vocational school.
- Use the Consumer Price Index for the elderly to calculate annual cost-of-living adjustments.

Options to increase benefits will require additional revenue or require other benefits to be reduced.



²⁰ Ibid.

²¹ Ibid.

Social Security and the Gap in Retirement Wealth

Social Security and the Gap in Retirement Wealth

On the rise since the late 1970s, inequality in income and wealth among Americans are today at historically high levels.¹ Compounding these broader economic disparities are persistent racial and ethnic gaps in income and wealth. Together, these inequalities have led to significant gaps in retirement wealth among Americans. As policymakers weigh Social Security reforms, it will be critically important to take into consideration the growing inequality in the distribution of retirement wealth.

Background

Social Security and retirement wealth

Economists traditionally measure wealth as personal assets (including income, in addition to the value of savings and other wealth components) minus debt, but exclude Social Security wealth – that is, the value of the benefits workers can expect to receive from the program. Yet Social Security's combined life insurance, disability insurance, and joint and survivor annuities are frequently the largest financial assets Americans have.

Social Security, pensions, and savings comprise the three primary components of retirement wealth.² Traditional pensions, which promise employees a lifetime joint and survivor annuity after retirement – or in some cases, optionally, a lump sum – have been steadily declining since the early 1980s.³ This is due in part to a shift in employment mix toward firms with industry, size, and union status historically associated with low pension coverage rates. Traditional pensions are being replaced by defined contribution plans – voluntary plans to which the worker contributes income pre-tax, often structured with no employer match or contribution.

Traditional pensions and employer-sponsored retirement savings plans have a variety of strengths and weaknesses. None of these private-sector vehicles have proven as effective as Social Security in providing retirement security to low- and middle-income households and households of color.

¹ Emmanuel Saez and Thomas Piketty, 2003, "Income Inequality in the United States, 1913-1998," *Quarterly Journal of Economics*, 118(1), 2003, 1-39; Tables and figures updated to June 2014. 2015. <http://eml.berkeley.edu/~saez/TabFig2014prel.xls>; Thomas Piketty and Gabriel Zucman, "Capital is Back: Wealth-Income Ratios in Rich Countries 1700-2010." <http://gabriel-zucman.eu/capitalisback/>

² Housing assets also play a role, but will not be discussed here.

³ "Pension Participation of All Workers, by Type of Plan, 1989-2013," 2013, Center for Retirement Research, <http://crr.bc.edu/wp-content/uploads/1012/01/Pension-coverage1.pdf>.

⁴ Edward N. Wolff, 2015, "U.S. Pensions in the 2000s: The Lost Decade?" *Review of Income and Wealth* 61:4.

Social insurance is particularly valuable to low-income households and people of color

Social insurance programs have unique advantages over individual savings in protecting workers against risks to their economic and health security – particularly for low- and moderate-income households, who are disproportionately people of color.

Social insurance programs like Social Security, Medicare, and Unemployment Insurance have unique advantages over individual savings in protecting workers against risks to their economic and health security – particularly for low- and moderate-income households, who are disproportionately people of color.^{5,6}

Universal coverage

Private retirement accounts have been unable to deliver retirement security to most Americans. The latest data from the Federal Reserve Board's Survey of Consumer Finances reveal that, in 2013, fewer than half (49.2 percent) of American households had any assets in private retirement accounts – the lowest figure since the 1990s.⁷ The typical working-age household has been able to accumulate only \$2,500 in private retirement savings – and the typical household nearing retirement (aged 55-64) only \$14,500; more than half (62 percent) of households nearing retirement have retirement savings that are lower than their annual income.⁸ Moreover, among those nearing retirement, only four in ten Black- and three in ten Latino-headed families owned a 401(k) or IRA-style retirement account in 2013, compared with nearly two-thirds of White families.⁹

Social Security, by contrast, provides near-universal coverage. This was not always the case. Prior to the 1950 and 1954 Amendments to the Social Security Act, the program excluded domestic and agricultural workers as well as migrant workers – groups that were disproportionately African-American and Latino.¹⁰ Since then, however, Social Security coverage has been gradually extended to cover virtually all those in paid employment, with the exception of some state and local government workers. That said, more

⁵ Rebecca Tippet, Avis Jones-DeWeever, Maya Rockeymoore, Darrick Hamilton, and William Darity, 2014, "Beyond Broke: Why Closing the Racial Wealth Gap is a Priority for National Economic Security," Center for Global Policy Solutions, <http://globalpolicysolutions.org/resources/beyond-broke-report/>.

⁶ Nancy Altman and Eric Kingson, 2015, *Social Security Works!: Why Social Security Isn't Going Broke and How Expanding It Will Help Us All*, New York: The New Press; National Academy of Social Insurance, 2008, *Social Security: An Essential Asset and Insurance Protection for All*, <https://www.nasi.org/research/2008/report-social-security-essential-asset-insurance-protection>.

⁷ The Board of Governors of the Federal Reserve System, 2013 Survey of Consumer Finances.

⁸ Nari Rhee and Ilana Boivie, 2015, "The Continuing Retirement Savings Crisis," National Institute on Retirement Security, <http://laborcenter.berkeley.edu/pdf/2015/RetirementSavingsCrisis.pdf>. Among the minority of households who do have private retirement savings, the median household headed by a person aged 55-64 had a combined 401(k)/IRA balance of only \$103,200 – enough to purchase an inflation-indexed joint-and-survivor annuity at 65 of just under \$500/month.

⁹ Authors' calculations using data from The Board of Governors of the Federal Reserve System, 2013 Survey of Consumer Finances.

¹⁰ David Stoesz, 2016, "The Excluded: An Estimate of the Consequences of Denying Social Security to Agricultural and Domestic Workers," CSD Working Paper No. 16-17, Center for Social Development, <http://csd.wustl.edu/Publications/Documents/WP16-17.pdf>.

work is required to improve employer reporting of domestic and agricultural workers, who are still disproportionately Latino.

Social Security has proven to be a far more effective tool for asset building among low- and middle-income households than private retirement accounts.

Mandatory contributions build assets

Low-income households, who are disproportionately households of color, have less disposable income to save for retirement than higher-earning households, making them less likely to contribute to voluntary retirement accounts. Compounding this barrier to voluntary savings, the incentives to save in the 401(k)/IRA system, as well as the availability of private pension plans like 401(k)s, are skewed toward higher earners. Social Security contributions are mandatory, both for employees and their employers. Due to its universal coverage and its mandatory contributions and employer matches, as well as its much lower administrative costs, Social Security has proven to be a far more effective tool for asset building among low- and middle-income households than private retirement accounts.

Pays out more when need is greater

Because Social Security is insurance that pools risk, it pays out more when certain defined risks occur. Hence, Social Security provides wealth when it is most needed. For example:

- If seniors live to 100, their Social Security benefits continue to fund this longevity, whereas they would likely outlive their 401(k)/IRA holdings. Most workers rely increasingly on Social Security as they age into their 80s and 90s.¹¹
- When a worker retires, if his or her spouse is also retired, an additional spousal benefit of up to 50 percent of the worker's benefit may be available.
- For workers with lower earnings, Social Security wealth is higher relative to contributions; that is, benefits replace a larger share of prior earnings.
- If a worker becomes disabled at a young age, Social Security wealth in the form of Disability Insurance is there to cover her. Once she reaches retirement age, her disability benefits convert to retirement benefits and take the place of the retirement benefits she was unable to accrue due to her inability to work.
- If the worker dies prematurely, leaving a spouse and/or children behind, Social Security wealth provides survivors' benefits.

These advantages are magnified for low- and moderate-income workers, who are disproportionately people of color.

¹¹ SSA, Office of Research, Evaluation, and Statistics, 2016, Income of the Population 55 or Older, 2014, Table 8.A1, https://www.ssa.gov/policy/docs/statcomps/income_pop55/2014/sect08.pdf.

Predictable and secure

Social Security benefits are not exposed to the ups and downs of the stock market. Because these benefits are backed by the full faith and credit of the U.S. government, Social Security wealth is more secure than private retirement wealth. Moreover, savings are less effective than insurance for events that can be projected by actuaries for groups, but are unknowable for individuals. While actuaries can with reasonable accuracy project how many of today's 21-year-olds will survive until retirement age and how long members of that cohort will survive beyond that point, that information is unknowable for any particular 21-year-old. That is another reason that insurance, in the form of Social Security, is a better vehicle for ensuring secure retirements than individual savings.

More redistributive than other vehicles for building retirement wealth

As long as income inequality persists, inequality in retirement wealth will persist. Nonetheless, one of Social Security's core objectives is to provide at least a minimally adequate monthly income in retirement even for those with low lifetime earnings. As noted above, the system achieves this by means of a weighted benefit formula: the benefits of lower-income workers replace a larger share of their prior earnings than for higher-income workers.

The Gini coefficient is a widely used measure of inequality, whereby higher values indicate greater inequality, and lower values less. By this measure, Social Security is a far more egalitarian vehicle for wealth building than the private retirement account system or the housing market. In 2010, the Gini coefficient for Social Security wealth among 47-64 year-old households was 0.31, compared to 0.76 for pension/IRA wealth.¹² Evidence is mixed on the extent to which Social Security is progressively redistributive over a lifetime, particularly in light of the tremendous rise in income inequality since the 1970s and the increasing correlation of life expectancy with income.



¹² Edward N. Wolff, 2015, "U.S. Pensions in the 2000s: The Lost Decade?" *Review of Income and Wealth* 61:4, 10.1111/roiw.12123.

¹³ See, for example, Bipartisan Policy Center Commission on Retirement Security and Personal Savings, 2016, "Securing Our Financial Future: Recommendations for Retirement Security and Personal Savings," <http://cdn.bipartisanpolicy.org/wp-content/uploads/2016/06/BPC-Retirement-Security-Report.pdf>.

No leakage or fees, and optimal decumulation

Another advantage of Social Security wealth compared to general retirement savings is that the assets cannot “leak out” over time through borrowing, ad-hoc withdrawals, or lump-sum payments at retirement – which many financial and policy analysts consider to be a highly problematic feature of many employer-based and traditional retirement plans.¹³

Social Security wealth constitutes the vast majority of retirement wealth for most low- and middle-income households.

Policy Challenges

Low- and middle-income households have little retirement wealth other than Social Security

Social Security constitutes the vast majority of retirement wealth for most low- and middle-income households. This is partly a result of their low earnings history¹⁴ and partly because they are less likely to have inherited wealth, retirement accounts, and other financial assets than higher-income families.^{15,16} Moreover, other than the wealthiest households, Social Security is a significant part of the retirement wealth of even upper-income households.

Social Security and broader retirement wealth can be estimated in a variety of ways and the estimates can vary considerably based on the method and data set chosen. However, two key metrics provide insight into the role Social Security plays in the retirement wealth gap: the ratio of Social Security to other forms of retirement wealth and the ratio of retirement wealth across wealth groups.

The best source of data on Social Security and other retirement wealth for workers aged 47-64 is the Survey of Consumer Finances (SCF).¹⁷ Social Security wealth can be defined as equal to the present value of expected Social Security retirement benefits over a worker’s (or couple’s) lifetime. The sum of traditional pensions, 401(k)-style plans, and assets in Individual Retirement Accounts (IRAs) can be termed collectively “pension/IRA wealth.” These two forms of wealth are compared in Figure 1, on the following page.

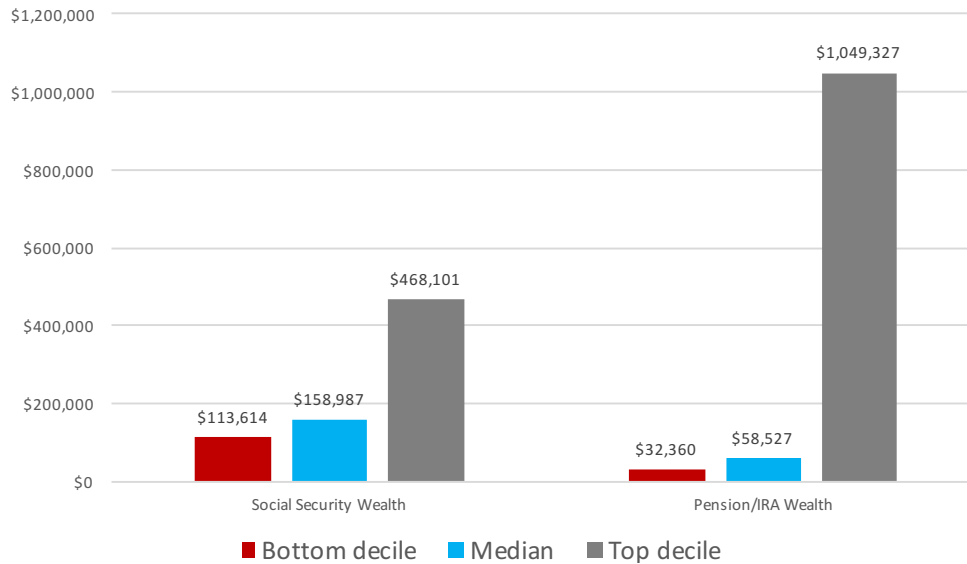
¹⁴ Social Security Administration, 2016, “Fact Sheets for Demographic Groups,” <https://www.ssa.gov/news/press/factsheets/demographic.htm>.

¹⁵ The Board of Governors of the Federal Reserve System, 2013 Survey of Consumer Finances, “Table 6: Family holdings of financial assets, by selected characteristics of families and type of asset.”

¹⁶ Jeffrey P. Thompson and Gustavo A. Suarez, 2015, “Exploring the Racial Wealth Gap Using the Survey of Consumer Finances,” Federal Reserve Board of Governors, <https://www.federalreserve.gov/econresdata/feds/2015/files/2015076pap.pdf>.

¹⁷ Edward N. Wolff first uses regression analysis to estimate people’s covered earnings through retirement. He then uses the imputed earnings histories to calculate the mortality-adjusted present value of Social Security wealth for current workers. The Survey of Consumer Finances asks current workers detailed questions about past, present, and future pensions. Wolff then uses this information, along with estimates of future earnings, to calculate the mortality-adjusted present value of pension/IRA wealth for current workers. For a more detailed account of his methodology, see Section III of Edward N. Wolff, 2015, “U.S. Pensions in the 2000s: The Lost Decade?” *Review of Income and Wealth* 61:4.

Figure 1. Social Security and Pension/IRA wealth for households aged 47-64 by income, 2013



Source: Edward N. Wolff's unpublished estimates from 2013 Survey of Consumer Finances.

Note: Income deciles split the population into ten equal parts. The wealth figures here are the average for the bottom and top ten percent of households aged 47-64.

The differences are substantial. Among pre-retired households in the 47-64 age group, the typical household, or what economists call the "median" or "the 50th percentile," has \$159,000 in Social Security wealth – 1.4 times that of the typical bottom decile household (\$113,600). The average top-decile household has \$468,100 – 2.9 times that of the median household. However, the gap in pension/IRA wealth is much larger. The median household holds \$58,500 in pension/IRA wealth – 1.8 times that of households in the bottom decile (\$32,400) – while the average top decile household's \$1,049,200 is almost 18 times that of the median household. Social Security thus helps to mitigate inequality in the distribution of retirement wealth.

Households of color have little wealth other than Social Security

The gap in overall wealth between racial groups is also stark. The net worth of the typical (median) White household in 2013 was 13 times that of the typical Black household – \$141,900 versus \$11,000 – and 10 times that of the typical Hispanic household, which held \$13,700. Between 1983 and 2013, the gap in wealth between Whites and African-Americans increased, with White wealth rising from 10 to 13 times that of Blacks while the gap between Whites and Latinos did not diminish.

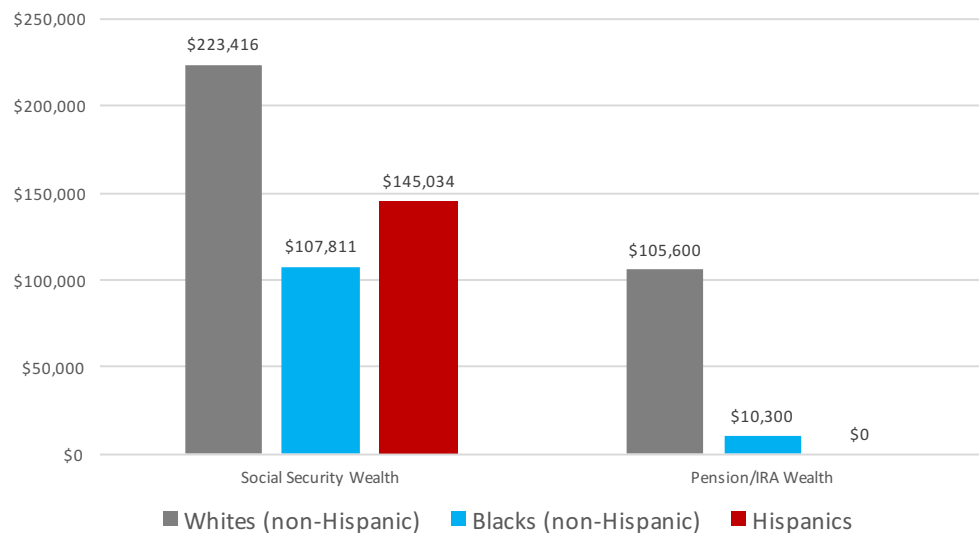
¹⁸ Rakesh Kochhar and Richard Fry, 2014, "Wealth Inequality Has Widened along Racial, Ethnic Lines since End of Great Recession," Pew Research Center, <http://www.pewresearch.org/fact-tank/2014/12/12/racial-wealth-gaps-great-recession/>.

The result is that households of color are far more dependent on Social Security than their White counterparts. This reflects, in part, the fact that they are less likely to possess inherited wealth, are less likely to work for employers who offer retirement accounts, and have historically suffered discrimination in housing markets.¹⁹ It also reflects lower earnings, which makes it harder for them to save for retirement.²⁰ Indeed, Social Security’s role in mitigating inequality in retirement wealth is even more pronounced for people of color.

The typical (50th percentile) White (non-Hispanic) household aged 47-64 has \$223,416 in Social Security wealth (Figure 2, below). This is one-and-a-half times that of the typical Latino household (\$145,034) and more than twice that of the typical Black household (\$107,811). The racial gap in pension/IRA wealth is much larger, however. The typical White household aged 47-64 holds \$105,600 in pension/IRA wealth – more than 10 times that of the typical Black household (\$10,300) – while the typical Latino household holds no pension/IRA wealth whatsoever.

The typical White household aged 47-64 holds \$105,600 in pension/IRA wealth – more than 10 times that of the typical Black household (\$10,300) – while the typical Latino household holds no pension/IRA wealth whatsoever.

Figure 2. Social Security and Pension/IRA Wealth for Median Households Aged 47-64, by Race/Ethnicity, 2013



Source: Edward N. Wolff’s unpublished estimates from 2013 Survey of Consumer Finances.

¹⁹The Board of Governors of the Federal Reserve System, 2013 Survey of Consumer Finances, “Table 6: Family holdings of financial assets, by selected characteristics of families and type of asset.”

²⁰ Social Security Administration, “Fact Sheets for Demographic Groups,” <https://www.ssa.gov/news/press/factsheets/demographic.htm>.

Wage stagnation and inequality harm retirement preparedness

Stagnant earnings for most workers,²¹ growing debt obligations,²² and rising living costs, especially for healthcare,²³ have limited the income that workers of all racial groups can save for retirement. After three decades of no growth in the aggregate income of the bottom 90 percent of Americans,²⁴ experts are now projecting that a majority (52 percent) of workers will suffer a decline in living standards in retirement²⁵ – and close to two-thirds if one also takes into account retiree health care costs.²⁶

Retirement risk shift toward individuals

Given the difficulty of accumulating other forms of retirement wealth and the increasingly critical role of Social Security, it is cause for concern that Social Security benefits are actually less generous than they were three decades ago. The 1983 Social Security Amendments scheduled long-term benefit cuts that are still phasing in.

Social Security benefits are actually less generous than they were three decades ago. The 1983 Social Security Amendments scheduled long-term benefits cuts that are still phasing in.

The cumulative effect of these cuts is that by 2050, benefits will be 24 percent lower, on average, than they would have been otherwise. Net Social Security benefits will be cut even more, given that Medicare Part B and D premiums, typically deducted from Social Security checks, are likely to increase.

²¹ Social Security Advisory Board, 2015, "2015 Technical Panel on Assumptions and Methods," p. 59 ("Compensation Share of GDP"), http://www.ssab.gov/Portals/0/Technical%20Panel/2015_TPAM_Final_Report.pdf?ver=2015-09-24-113145-693.

²² Robert B. Reich, 2011, "Hearing on the Endangered Middle Class: Is the American Dream Slipping Out of Reach for American Families?" Testimony for the United States Senate Committee on Health, Education, Labor and Pensions, May 12, 2011, <http://www.help.senate.gov/imo/media/doc/Reich.pdf>.

²³ Gary Burtless and Sveta Milushcheva, 2012, "Effects of Employer Health Costs on the Trend and Distribution of Social-Security-Taxable Wages," The Brookings Institution, https://www.brookings.edu/wp-content/uploads/2016/06/0509_health_wages_burtless.pdf.

²⁴ Thomas Piketty and Emmanuel Saez, 2003, "Income Inequality In The United States, 1913–1998," Quarterly Journal Of Economics 118(1), <http://eml.berkeley.edu/~saez/pikettyqje.pdf>. This refers to 90 percent of aggregate income growth, not 90 percent of earners. From 1948–79, the average annual income of all Americans grew by \$22,004; from 1979–2012, it grew by \$9,442. These averages mask distributional inequality; from 1979–2012, the aggregate income of the bottom 90 percent actually declined.

²⁵ Of today's working-age households, 52 percent are projected to fall more than 10 percent below the replacement rate required to maintain their pre-retirement standard of living. For a fuller explanation of the National Retirement Risk Index, see Alicia H. Munnell, Wenliang Hou, and Anthony Webb, 2014, "NRRRI Update Shows Half Still Falling Short," Center for Retirement Research, <http://crr.bc.edu/briefs/nrrri-update-shows-half-still-falling-short/>. The 52 percent figure is based on data from the 2013 Federal Reserve Board Survey of Consumer Finances.

²⁶ Before the Great Recession, the Center for Retirement Research estimated the share at risk of downward social mobility to be 43 percent prior to health and long-term care costs, and 61 percent with health and long-term care costs added: Alicia H. Munnell, Anthony Webb, Dan Muldoon, Francesca N. Golub-Sass, and Mauricio Soto, "Health Care Costs Drive up the National Retirement Risk Index," Center for Retirement Research, <http://crr.bc.edu/briefs/health-care-costs-drive-up-the-national-retirement-risk-index/>. In 2012, CRR updated its estimate prior to accounting for health and long-term care costs from 43 to 53 percent but did not update the share at risk after adding these costs. It is reasonable to assume that this figure would be around two-thirds: Alicia H. Munnell, Anthony Webb, and Francesca N. Golub-Sass, 2012, "The National Retirement Risk Index: An Update," Center for Retirement Research, <http://crr.bc.edu/briefs/the-national-retirement-risk-index-an-update/>.

²⁷ Virginia P. Reno, 2013, "Cutting Benefits Doesn't Strengthen Social Security: Americans Prefer to Improve and Pay for It," submitted to the Subcommittee on Social Security of the House Committee on Ways and Means, https://www.nasi.org/sites/default/files/research/Reno_Ways_and_Means_comments_benefit_cuts_Aug_2013.pdf. The measures which, taken together, are cutting Social Security benefits by 24.2 percent by 2050 consist of an increase in the retirement age (a roughly 13.3 percent cut), taxation of Social Security benefits (a 9.5 percent cut), and a permanent delay of the COLA from July to December (a 1.4 percent cut).

At the same time, within employment-based retirement plans, risk has been transferred from employers to workers.²⁸ In 1979, 38 percent of private-sector workers participated in a defined benefit pension plan that guarantees a retirement annuity for life. Today, only 14 percent do – and this decline is expected to continue.²⁹ Pensions have been replaced by individual accounts in defined contribution (DC) plans – chiefly 401(k)s and IRAs – that carry no commitments with regard to retirement security. The individual account model benefits higher earners more than low- and moderate earners, in three ways. First, higher earners (and Whites) are more likely to work for employers who sponsor retirement plans.³⁰ Second, the private-account model subsidizes individual savings through the tax code, whereby generally the higher one's income and marginal tax rate, the larger the subsidy – thus aggravating income inequality. Third, higher earners are more likely to be able to take advantage of the tax incentives because they have more disposable income.

Private account wealth is far less equally distributed than traditional pensions or Social Security wealth

Social Security wealth is much more equally distributed than individual retirement savings in 401(k)-style plans or IRAs – what might be called “DC plan wealth.” The top decile of wealth holders own 21.9 percent of all Social Security wealth – but 62.3 percent of individual retirement savings and 78.9 percent of all net worth. The top one percent own only 2.5 percent of Social Security wealth – but 12.1 percent of individual retirement savings and 37.6 percent of net worth.

The imbalance is even more dramatic when one looks at the lower levels of wealth distribution. The bottom 20 percent collectively account for negative 0.7 percent of all net worth and the bottom half 0.0 percent. For these working households, Social Security wealth is especially important. While the bottom quintile of wealth holders account for just 0.5 percent of individual retirement savings, they claim 11.3 percent of Social Security wealth; the bottom half collectively control 1.8 percent of private retirement savings but 29.6 percent of Social Security wealth.

As traditional defined benefit pensions and Social Security have been replaced by defined contribution plans, DC plans have not picked up the slack for the bottom two-thirds or so of the income spectrum. Among households aged 47 to 64, the bottom 20 percent of wealth holders claim 6.4 percent of traditional pension wealth – but only 0.5 percent of DC plan wealth.

²⁸ Jacob S. Hacker, 2006, *The Great Risk Shift: The New Economic Insecurity and the Decline of the American Dream*, Oxford: Oxford University Press.

²⁹ Employee Benefit Research Institute, n.d., “What are the trends in U.S. retirement plans?” FAQs About Benefits—Retirement Issues, <https://www.ebri.org/publications/benfaq/index.cfm?fa=retfaq14>.

³⁰ Craig Copeland, 2014, “Employment-Based Retirement Plan Participation: Geographic Differences and Trends, 2013,” EBRI Brief No. 405, Figures 1 and 2, pp. 9-11.

In contrast, the top decile of wealth holders claim 24.9 percent of assets in traditional pensions – but 62.3 percent of the value of DC plan wealth. Although the distribution of traditional pension wealth is still not progressive, lower-income groups would have been much better served by the retention of traditional defined benefit pensions plans and increased Social Security wealth.

Policy Options

Social Security faces challenges to both its long-term funding (for more on Social Security's financing challenges, see Section 1.a of this *Report*) and the adequacy of the benefits it provides. In addressing the one problem, policymakers must take care not to aggravate the other. Policymakers have a range of remedies available to them that, taken together, could address solvency while also reducing gaps in retirement wealth among Americans. The following are a list, by no means exhaustive, of some of these options.

I. Revenue options

Eliminate Social Security tax cap and credit contributions toward benefits

Social Security's revenue base could be broadened to encompass more of the earnings of high-income participants. This would simultaneously reduce the harm to Social Security's finances that has resulted from growing income inequality, and provide revenue

The payroll tax cap was eliminated for Medicare Part A (Hospital Insurance) in 1994 without any public backlash or clearly discernable impact on the economy.

to extend system solvency or fund targeted benefit expansions. Currently, earnings above \$127,200 are not subject to Social Security payroll tax. The payroll tax cap was eliminated for Medicare Part A (Hospital Insurance) in 1994 without any public backlash or clearly discernable impact on the economy. Indeed, by helping to shore up Social Security's finances and fund expanded benefits, eliminating the cap would stimulate economic growth by shifting income from high earners to seniors and people with disabilities, who have a higher marginal propensity to consume.

Incorporate high earners' investment income into Social Security

Both to mitigate income inequality and help Social Security keep pace with overall income growth, the investment income of high earners could be incorporated into the program's contribution and benefit base.³¹ The Affordable Care Act set the precedent for subjecting investment income

³¹ For Social Security, incorporation of investment income is more complicated than for Medicare. Medicare gives everyone the same benefit, whereas in the Social Security system, benefit levels are related to contributions. On labor income, employers and employees

to social insurance contributions with its Medicare Net Investment Income Tax (NIIT), which levies a 3.8 percent tax on the unearned income of those with modified adjusted gross income (MAGI) above \$200,000 (\$250,000 for couples).³²

II. Benefit options

Strengthen the minimum benefit

A special minimum benefit was added to Social Security in the 1970s to ensure that low-paid workers who work at least 30 years receive a benefit that provides a basic level of adequacy. Because the minimum benefit is currently not adjusted for wage growth, however, it no longer fulfills this purpose, and many long-term low-paid workers receive a Social Security benefit that still leaves them in poverty. There are a variety of proposals to update the minimum benefit to address this problem.³³ These proposals would set the benefit to the poverty level but index it to wage growth in the future to prevent it from deteriorating over time.

Grant caregivers partial Social Security earnings credits

The aging of the Boomer generation and an impending gap in the availability of paid caregivers is creating a crisis for many working households – and for society as a whole.³⁴ Social Security caregiver benefits would improve the economic security of individuals who temporarily leave the workforce to provide care for a family member. (For more on caregiving, see Section 5 of this *Report*.) One approach would be to grant Social Security earnings credits to workers who take time off to care for a child under the age of six³⁵ or an ailing family member of any age. If earnings in a given year fell below a certain amount – for example, 50 percent of the average wage – the worker

each pay a 6.2 percent contribution, known as FICA (after the Federal Insurance Contributions Act of 1935); the self-employed pay the entire 12.4 percent rate (the self-employed can deduct the employer half as a business expense, however). For high earners' investment income to count fully toward benefits, it would have to be subject to FICA at the 12.4 percent rate, since, in the case of investment income, there is no employer to pay half. One way to incorporate high earners' investment income into the Social Security contribution and benefit base, then, would be to subject this income to the combined 12.4 percent FICA rate. This is already done in the case of self-employment (Form C) earnings. That would represent a very large increase in the levies on high earners' investment income, however. A more moderate approach would be to subject high earners' investment income to half the total FICA rate – 6.2 percent – and, accordingly, count half of this income toward Social Security benefits. Such a proposal could be structured similarly to the Medicare NIIT (taxation of net investment income, owed by those with MAGI above \$200,000 [\$250,000]).

³² These threshold amounts are not indexed for inflation and hence will capture an ever larger segment of the top of the income distribution over time. The tax is equal to 3.8 percent of the lesser of either 1) a household's net investment income or 2) its MAGI (which includes investment income) in excess of the \$200,000/\$250,000 threshold. MAGI includes wages, salaries, other compensation, dividend and interest income, business and farm income, realized capital gains, and income from a variety of other activities. Net investment income includes interest, dividends, capital gains, nonqualified annuities, royalties and rents, and passive income from businesses, including those trading financial instruments or commodities. Mark P. Keightly, 2012, "The 3.8% Medicare Contribution Tax on Unearned Income, including Real Estate," Congressional Research Service, http://www.law.umaryland.edu/marshall/crsreports/crsdocuments/R41413_05182012.pdf.

³³ See, for example, Laura Sullivan, Tatjana Meschede, and Thomas Shapiro, 2009, "Increasing the Social Security Special Minimum Benefit and Updating SSI," National Academy of Social Insurance, <https://www.nasi.org/discuss/2009/03/increasing-social-security-special-minimum-benefit-and>; Bipartisan Policy Center Commission on Retirement Security and Personal Savings, "Securing Our Financial Future: Recommendations for Retirement Security and Personal Savings," June 9, 2016. <http://cdn.bipartisanpolicy.org/wp-content/uploads/2016/06/BPC-Retirement-Security-Report.pdf>; and SSA, Office of the Chief Actuary, 2016, "Individual Changes Modifying Social Security," Provision B5, <https://www.ssa.gov/oact/solvency/provisions/index.html>.

³⁴ Donald Redfoot, Lynn Feinberg, Ari Houser, 2013, "The Aging of the Baby Boom and the Growing Care Gap: A Look at Future Declines in the Availability of Family Caregivers," American Association for Retired Persons, <http://www.aarp.org/home-family/caregiving/info-08-2013/the-aging-of-the-baby-boom-and-the-growing-care-gap-AARP-ppi-ltc.html>.

³⁵ SSA, Office of the Chief Actuary, 2016, Provision B7.3.

would be credited with additional earnings to bring her or his earnings up to 50 percent of the average wage for the purpose of calculating Social Security benefits. Caregiver credits could be limited to a maximum of five years.

Caregiving supports would likely reduce the racial wealth gap. Social Security benefits are based on the individual's top 35 earnings years. Roughly the same proportion of White and Black Americans – approximately one-fifth of each demographic – are engaged in providing care for a family member.³⁶ But people of color are disproportionately lower earners and less likely to have a total of 35 earnings years. Therefore, caregiving years are more likely to add zeros to their earnings records, lowering their Social Security benefits.

Women disproportionately assume caregiving responsibilities: the latest time-use survey by the U.S. Department of Labor shows that women spend more than twice as much time as men caring for household members and more than 1.5 times as much maintaining the household.³⁷ Women of color are doubly burdened by the gender and racial gap in retirement wealth. (For more on women's retirement security, see Section 1.c of this *Report*.) Caregiver credits would therefore be particularly effective at reducing the retirement wealth gap experienced by one of society's economically most vulnerable subgroups.

Strengthen benefits for low- and moderate-income workers

Access to traditional pensions has been steadily declining and the vast majority of low- and middle-income workers have been unable to accumulate sufficient retirement account savings. Expanding Social Security benefits for these workers would bolster wealth-building among low-income workers in general and people of color in particular.

There are three ways to do this, two of which involve modifying the benefit formula.³⁸ The first step in calculating an individual's Social Security benefit is to determine his or her career average monthly earnings (Average Indexed Monthly Earnings, or AIME), adjusted for wage inflation. Next, a benefit formula is applied to determine the Primary Insurance Amount (PIA) – the benefit an individual would receive if he or she began receiving benefits at the Full Retirement Age. The formula is progressive: the PIA is the sum of 90 percent of the worker's career average monthly earnings up to \$856 (the first bend point in 2016); 32 percent of the amount between \$857 and \$5,157 (the second bend point); and 15 percent of average earnings above \$5,157, up to the taxable maximum of \$9,875.

³⁶ American Psychological Association, 2016, "Cultural Diversity and Caregiving," <http://www.apa.org/pi/about/publications/caregivers/faq/cultural-diversity.aspx>.

³⁷ U.S. Department of Labor, 2016, "American Time Use Survey Tables," Washington, DC: U.S. Department of Labor Bureau of Labor Statistics, <http://www.bls.gov/news.release/atus.t01.htm>: Table A-1.

³⁸ SSA, Office of the Chief Actuary, 2016, Provisions B1, B2, B3.

One way to improve benefits for low- and moderate-income earners would be to increase the PIA factor applied to the portion of career average monthly earnings below the first bend point above the current 90 percent. This would increase benefits for everyone, but workers with the lowest average earnings – including women and people of color – would see the largest percentage increase. A second way to improve benefits would be to raise the first bend point so that more earnings are multiplied by the highest PIA factor (currently 90 percent). This would increase benefits for all individuals with career average earnings above \$856 per month – but the largest percentage increase would go to workers with the lowest average earnings.

Reinstate student benefits

Under current rules, the child of a deceased or disabled parent may qualify to receive Social Security benefits based on that parent’s work record – but not beyond high school. Until 1983, benefits continued until age 22, provided the child attended college or vocational school. One proposal would restore the age limit to 22.³⁹ Studies have shown that this change could boost college attendance rates among Black and low-income students.⁴⁰ Since higher educational attainment is associated with higher earnings and greater wealth-building capacity, extending student benefits could increase opportunities for wealth-building among these groups.

Update survivors benefits

Social Security provides survivor benefits to widows and widowers age 60 or older and households with school-aged children or dependent elderly parents. For couples where only one spouse worked, the surviving spouse receives 100 percent of her deceased partner’s retirement benefit. However, for couples with similar earnings histories, the surviving spouse can lose up to half of the couple’s combined Social Security income, even though the household’s living costs decline much less sharply – a situation Social Security’s architects could not have anticipated 80 years ago. Households that rely on Social Security for most of their income are particularly hard hit by this situation.

One proposal to modernize survivors benefits would better serve dual-earning couples by providing surviving spouses 75 percent of the sum of the survivor's and deceased worker's retirement benefits, with the total survivors benefit not to exceed the benefit an average earner would receive.⁴¹

³⁹ SSA, Office of the Chief Actuary, 2015, “Individual Changes Modifying Social Security,” Provision D1; Bipartisan Policy Center Commission on Retirement Security and Personal Savings, “Securing Our Financial Future: Recommendations for Retirement Security and Personal Savings,” June 9, 2016. <http://cdn.bipartisanpolicy.org/wp-content/uploads/2016/06/BPC-Retirement-Security-Report.pdf>

⁴⁰ Alexander Hertel-Fernandez, 2010, “A New Deal for Young Adults: Social Security Benefits for Post-Secondary School Students,” National Academy of Social Insurance, <https://www.nasi.org/research/2010/new-deal-young-adults-social-security-benefits-post>; Susan M. Dynarski, 1999, “Does Aid Matter? Measuring the Effect of Student Aid on College Attendance and Completion,” National Bureau of Economic Research, Working Paper No. 7422, <http://www.nber.org/papers/w7422>.

⁴¹ SSA, Office of the Chief Actuary, 2015, “Individual Changes Modifying Social Security,” Provision D4.

black women are less likely to qualify for spousal benefits than their White or Hispanic counterparts, though about 50 percent would still benefit from this change. Because married black women contribute a larger share of family income than married women in other groups, the change would be particularly beneficial to them.



Conclusion

Sharpening divisions in income and wealth over the past four decades, layered over a long-existing racial gap in income and wealth, pose profound threats to retirement security for today's workers. Retirement security – and indeed, retirement itself – are becoming increasingly difficult to achieve for low- and middle-income workers. Social Security substantially reduces the gap in retirement wealth in America. As policymakers approach the next round of Social Security legislation, they should keep in mind the impact long-term trends in the distribution of market income have on workers' retirement preparedness, the impact of inherited wealth inequality, and the risk shift in our retirement system. Targeted reforms along the lines outlined here could reduce gaps in retirement wealth.

Strengthening Women's Retirement Security

Strengthening Women's Retirement Security

Background

Despite decades of economic gains, achieving financial security in retirement remains a challenge for many women. While a much larger share of women is in paid employment today compared with decades ago, the gender wage gap persists, and women still do most of the caregiving. Juggling work and caregiving responsibilities can negatively affect women's job prospects and earnings.

Changes in family structure can pose additional challenges to women's retirement security. More women today have never been married or are divorced, and more mothers are the sole breadwinner for their families. Additionally, as married couples have become more reliant on two incomes during their working lives, the loss of income and depletion of assets at the death of a spouse leaves many widows economically vulnerable.

Women not only tend to reach retirement with fewer resources than men, but typically also have to stretch their resources over a longer lifespan and contend with larger medical expenses, in addition to the loss of a spouse. Women 65 and older are more likely to be poor than their male counterparts. One in ten seniors—4.6 million people 65 and older—lives in poverty.¹ And two out of three poor seniors are women.² Older women tend to be poorer than men overall and by age, marital status (except for married women), and race and ethnicity. Gender is thus a significant factor in elderly poverty, although it is not the only one: for example, poverty rates for men (and women) of color are higher than rates for white women.

One in ten seniors—4.6 million people 65 and older—lives in poverty. And two out of three poor seniors are women.

Social Security is the main source of retirement income for most seniors. Women are more reliant than men on income from Social Security because they have fewer other sources of retirement income than men and

Women are more reliant than men on income from Social Security.

¹ Carmen DeNavas-Watt and Bernadette Proctor, 2015, *Income and Poverty in the United States: 2014*, Washington, DC: U.S. Census Bureau. <http://www.census.gov/content/dam/Census/library/publications/2015/demo/p60-252.pdf>.

² In 2014, 1.5 million men and 3.1 million women 65 and older were poor (U.S. Census Bureau, 2015, *Current Population Survey, 2015 Annual Social and Economic Supplement*, "Table POV-01: Age and Sex of All People, Family Members and Unrelated Individuals Iterated by Income-to-Poverty Ratio and Race," Washington, DC: U.S. Census Bureau, http://www.census.gov/data/tables/time-series/demo/income-poverty/cps-pov/pov-01.html#par_textimage_10).

live longer. Today, 27 percent of women 65 or older rely on Social Security for 90 percent or more of their income, compared to 21 percent of men.³ Social Security will be even more important in the future as a result of the disappearance of defined benefit pensions and decades of wage stagnation, which is making it hard for workers to save for retirement through a 401(k) or Individual Retirement Accounts (IRAs).



Several features of Social Security are especially valuable for women. Social Security provides secure and predictable retirement benefits that can't be outlived and are adjusted annually for inflation. Benefits are not subject to the ups and downs of the stock market or at risk of depletion prior to reaching retirement. Social Security is virtually universal, covering low-paid, part-time, self-employed, and temporary workers. It uses a progressive benefit formula that helps lower earners. And Social Security provides retirement benefits to spouses, surviving spouses, and divorced spouses, as well as disability and life insurance protection for families.

Provisions that increase benefits for low earners, caregivers, or older seniors, or modernize benefits for divorced and widowed beneficiaries, would address the challenges that women particularly face. But they would be available on a gender-neutral basis and would benefit other economically vulnerable groups, including people of color and people with disabilities.⁴

These targeted benefit enhancements would be available on a gender-neutral basis and would benefit other economically vulnerable groups, including people of color and people with disabilities.

³ Social Security Administration, 2016, Income of the Population 55 or Older, 2014, Washington, DC: Social Security Administration, Office of Research, Evaluation, and Statistics, https://www.ssa.gov/policy/docs/statcomps/income_pop55/: Table 9B1.

⁴ A set of recommendations for improving Social Security for seniors of color is substantially similar to the recommendations in this paper. See Commission to Modernize Social Security, Plan for a New Future: The Impact of Social Security Reform on People of Color (Oct. 2011), available at http://www.insightcced.org/New_Future_Social_Security_Commission_Report_Final.pdf.

Policy Challenges

The gender wage gap makes it harder for women to prepare for a secure retirement

The gap between women's and men's earnings is smaller than it was 50 years ago; however, in the past decade, progress in narrowing the gender wage gap has stalled. The impact of this stalled trend is that women have more difficulty saving adequate amounts in private retirement plans and receive lower Social Security benefits.



Overall, women and men who work for wages and salaries participate in employer-based retirement plans at nearly the same rates. But fewer than half of wage and salary workers ages 21 to 64 participate in an employer-based retirement plan.⁵ And because women typically have

lower earnings than men, their account balances are smaller. Among those with IRAs, the median account balance for men is 42 percent higher than the account balance for women (\$43,449 compared to \$30,660).⁶ The disparity is greater for workers near retirement. The median balance for men ages 60 to 64 is 57 percent higher than for comparable women (\$79,581 compared to \$50,667).⁷

Women have more difficulty saving adequate amounts in private retirement plans and receive lower Social Security benefits.

In addition to difficulties accumulating enough private retirement resources, women's Social Security benefits are generally lower because lower earnings also mean lower Social Security benefits. The average monthly Social Security benefit received by all women 65 and older is \$1,156 (\$13,872 annually),

⁵ Craig Copeland, 2014, Employment-Based Retirement Plan Participation: Geographic Differences and Trends, 2013, Employee Benefit Research Institute Issue Brief #405, https://www.ebri.org/pdf/briefspdf/EBRI_IB_405_Oct14.RetPart.pdf: Figure 22.

⁶ Author's calculations from Craig Copeland, 2014b, Individual Retirement Account Balances, Contributions, and Rollovers, 2013, Employee Benefit Research Institute Issue Brief #414, https://www.ebri.org/pdf/briefspdf/EBRI_IB_414.May15.IRAs.pdf: Figure 9. IRA balances include amounts rolled over from 401(k)-type accounts.

⁷ Ibid.

Women are twice as likely as men to receive a benefit that provides less than a poverty-level income.

which is 77 percent of the \$1,503 average monthly benefit for men 65 and older (\$18,036 annually).⁸ And women are twice as likely as men to receive a benefit that provides less than a poverty-level income: 38 percent of retired female workers,

compared to 18 percent of retired male workers, receive benefits below \$950 a month (\$11,400 annually).⁹



Women's retirement security is reduced by caregiving responsibilities

Although women have dramatically increased their work in the paid labor force over the past 50 years, they still shoulder most of the responsibilities of caring for children, elders, and other loved ones. The increase in labor force participation has been most dramatic for women taking care of young children. In 1976, 34 percent of mothers with children under age three were in the labor force; by 2012, this share had nearly doubled to 61 percent.¹⁰

Mothers are now the sole or primary breadwinner in 41 percent of families with children under 18, and co-breadwinners (contributing 25 percent to 49 percent of earnings) in another 22 percent.¹¹ Yet women still do most of the work inside the home. The latest time-use survey by the U.S. Department of Labor shows that women spend more than twice as much time as men caring for household members, and more than 1.5 times as much time maintaining the household.¹²

⁸ Social Security Administration, 2016, Annual Statistical Supplement, 2015, Washington, DC: Social Security Administration, Office of Research, Evaluation, and Statistics, [https://www.ssa.gov/policy/docs/statcomps/supplement/:Table 5.A16](https://www.ssa.gov/policy/docs/statcomps/supplement/:Table%205.A16). This figure includes individuals receiving benefits as retired workers, spouses, surviving spouses, and disabled workers.

⁹ Ibid.: Table 5.B9. The poverty threshold is \$11,367 annually, or \$947/month, for a single individual 65 or older.

¹⁰ U.S. Department of Labor, 2016, "Facts Over Time: Labor Force Participation Rate of Mothers by Age of Own Child," Washington, DC: U.S. Department of Labor Women's Bureau. https://www.dol.gov/wb/stats/LForce_rate_mothers_child_76_12_txt.htm

¹¹ Sarah Jane Glynn, 2014, Breadwinning Mothers: Then and Now, Washington, DC: Center for American Progress, <https://cdn.americanprogress.org/wp-content/uploads/2014/06/Glynn-Breadwinners-report-FINAL.pdf>

¹² U.S. Department of Labor, 2016, "American Time Use Survey Tables," Washington, DC: U.S. Department of Labor Bureau of Labor Statistics, <http://www.bls.gov/news.release/atus.t01.htm>: Table A-1.

Motherhood produces a wage penalty for most women, while fatherhood produces a wage bonus for most men.¹³ In addition, because of caregiving responsibilities, women are more likely than men to take time out of the paid workforce, working part time or leaving the workforce temporarily or permanently. Part-time workers earn less than full-time workers—and not just because they work fewer hours. Part-time workers are three times as likely as full-time workers to hold jobs with a low hourly wage. In a majority of occupations, part-time workers are paid less than full-time workers doing the same job.¹⁴ Part-time workers are also far less likely to have access to benefits such as paid sick leave, health insurance, and retirement plans.¹⁵ In addition, women remain far more likely than men to leave the workforce entirely to take care of home or family. In 2015, 15 percent of women ages 25 to 54 reported that they were not employed during the previous year to take care of home or family. Just 1 percent of men ages 25 to 54 reported that they were not employed for that reason.¹⁶ (For more information on caregiving, see Section 5 of this *Report*.)

Women are more likely to be single and heads of households, making it difficult to achieve and maintain retirement security

Over the past 50 years, women's family lives have changed along with their work lives. Between 1970 and 2015, the percentage of women who are married decreased from 62 percent to 51 percent, while the percentage of women who were never married or are divorced increased from 26 percent to 40 percent.¹⁷ During that same time period, the proportion of families headed by single mothers more than doubled from 12 percent to 26 percent.¹⁸ The decline in marriage has been greatest for some groups that are already at higher risk of poverty, including people of color and those with less education and lower incomes.¹⁹

These trends will decrease retirement security for many women. Part of the reason is that Social Security spousal benefits are not well-equipped to serve

¹³ Michelle J. Budig, 2014, "The Fatherhood Bonus and the Motherhood Penalty: Parenthood and the Gender Gap in Pay," Washington, DC: Third Way, <http://www.thirdway.org/report/the-fatherhood-bonus-and-the-motherhood-penalty-parenthood-and-the-gender-gap-in-pay>.

¹⁴ Anne Morrison and Katherine Gallagher Robbins, 2015, "Part-time Workers are Paid Less, Have Less Access to Benefits—and Two-Thirds are Women," Fact Sheet, National Women's Law Center, https://nwlc.org/wp-content/uploads/2015/08/part-time_workers_fact_sheet_8.21.1513.pdf.

¹⁵ *Ibid.*

¹⁶ Authors' calculations from Sarah Flood, Miriam King, Steven Ruggles, and J. Robert Warren, 2015, Integrated Public Use Microdata Series, Current Population Survey: Version 4.0, Minneapolis: University of Minnesota, <http://www.ipums.org>. The Integrated Public Use Microdata Series (IPUMS-USA) consists of more than fifty high-precision samples of the American population drawn from fifteen federal censuses and from the American Community Surveys of 2000-present. These samples, which draw on every surviving census from 1850-present, and the 2000-present ACS samples, collectively constitute one of the richest sources of quantitative information on long-term changes in the American population.

¹⁷ U.S. Census Bureau, 2016, "Families and Living Arrangements: Marital Status," Washington, DC: U.S. Census Bureau, <http://www.census.gov/hhes/families/data/marital.html>; Table MS-1.

¹⁸ U.S. Census Bureau, 2016, "Families and Living Arrangements: Families," Washington, DC: U.S. Census Bureau, <http://www.census.gov/hhes/families/data/families.html>.

U.S. Department of Education, 2012, "Fast Facts: Degrees Conferred by Sex and Race," Washington, DC: U.S. Department of Education, National Center for Education Statistics, <https://nces.ed.gov/fastfacts/display.asp?id=72>; Table FM-2.

¹⁹ Government Accountability Office, 2014, Trends in Marriage and Work Patterns May Increase Economic Vulnerability for Some Retirees, Report to the Chairman, Special Committee on Aging, U.S. Senate, GAO-14-33, p. 16, <http://www.gao.gov/assets/670/660202.pdf>.

women in these situations. Workers earn Social Security benefits for their spouse that can be worth up to 50 percent of the worker's benefit, and up to 100 percent of the deceased worker's benefit for a surviving spouse. However, these spousal benefits are not available to individuals who have never married or who are divorced without a marriage that lasted 10 years. Changes in marriage trends mean that fewer women, particularly fewer black women, will potentially qualify for these benefits.

Women's longer life expectancy means they are likely to have greater retirement needs than men but fewer resources

The average life expectancy at age 65 of women overall is longer than that of men (20.3 years compared to 17.8 years).²⁰ In fact, the average life expectancy at age 65 for black women (19.4 years) and Hispanic women (22 years) is longer than that of white, non-Hispanic men (17.8 years). In addition, in order to adequately plan for retirement, people need to consider the possibility that they may live longer than average. Nearly four in ten women and three in ten men who have reached 65 can expect to live past their 90th birthday.²¹

The longer life expectancies of women mean they are more likely to face higher medical expenses and need long-term care. Older women are more likely than older men to experience multiple chronic health conditions and functional limitations that require long-term care.²²

Policy Options

An array of policy options²³ is available to address these challenges to women's retirement security.

Improve benefits for low lifetime earners

Social Security benefits for women and other groups of workers with low lifetime earnings could be improved by reforming the Special Minimum Benefit (SMB), an alternative benefit formula based on the number of "years of coverage" rather than career average earnings, and improving regular Social

Social Security benefits for women and other groups of workers with low lifetime earnings could be improved by reforming the Special Minimum Benefit.

²⁰ Centers for Disease Control, 2015, United States Life Tables, 2011, National Vital Statistics Report 64(11), http://www.cdc.gov/nchs/data/nvsr/nvsr64/nvsr64_11.pdf: Table A.

²¹ Virginia Reno, Jasmine V. Tucker, and Elise A. Walker, 2014, When Should I Take Social Security Benefits? National Academy of Social Insurance Social Security Brief No. 43. https://www.nasi.org/sites/default/files/research/BRIEF_When_Should_Take_Social_Security.pdf.

²² Kaiser Family Foundation, 2013, "Medicare's Role for Older Women," Fact Sheet, <http://kff.org/womens-health-policy/fact-sheet/medicares-role-for-older-women/>.

²³ For a complete list of Social Security policy options to address women's retirement insecurity and the proposals' policy context, see Joan Entmacher, Mikki Waid, and Benjamin Veghte, 2016, "Overcoming Barriers to Retirement Security for Women: The Role of Social Security," National Academy of Social Insurance.

Security benefits for low earners. The SMB could be reformed by increasing the maximum value of the SMB; making the requirements for earning one “year of coverage” for the SMB the same as for one year of regular Social Security credits; and indexing the SMB to wages, which tend to grow faster than inflation.²⁴ The basic benefit formula for lower-income workers could be improved by increasing the amount of earnings credited to Social Security at the higher percentage rate that applies at the low end of the benefit scale.



Provide Social Security earnings credits for caregiving

To address the reduction in women’s retirement security due to the assumption of caregiving responsibilities, Social Security could provide earnings credits for caregiving. Modest Social Security earnings credits for a certain number of years could be made available in the regular benefit formula to workers with low or no earnings when they are providing care to a young child, older disabled child, or other dependent relative.

Reduce the marriage duration required for divorced spouse benefits

Social Security could address the challenges brought about by changing family structures by reducing the marriage duration required for divorced spouse benefits. A reformed divorced spouse benefit could allow divorced spouses and divorced surviving spouses married five to nine years to receive a partial benefit based on the former spouse’s work record.

Improve benefits for surviving spouses

Surviving spouses, especially widows, have higher rates of poverty than married persons. Under the current benefit formula, the surviving spouse of a dual-earner couple experiences a greater drop in household benefits at widowhood than does the surviving spouse of a single-earner couple. To make benefits for surviving spouses more adequate and equitable, surviving

²⁴ Glenn Springsteen, Kevin Whitman, and Dave Shoffner, 2014, Proposed Revisions to the Special Minimum Benefit for Low Earners, Washington, DC: Social Security Administration, Office of Retirement and Disability Policy Brief 2014-01, <https://www.ssa.gov/policy/docs/policybriefs/pb2014-01.html>.

spouses could receive the higher of the widow(er)'s benefit under current law or a new alternative benefit equal to 75 percent of the sum of the spouses' combined worker benefits. The improvement could be targeted to low- and moderate-income couples who are at greater risk of poverty and economic insecurity through a cap.²⁵

Increase benefits and maintain their purchasing power for vulnerable older seniors

Social Security could address the challenges women face because of their longer life expectancies by increasing benefits for vulnerable older seniors

Social Security could address the challenges women face because of their longer life expectancies by increasing benefits for vulnerable older seniors and basing Social Security's Cost of Living Adjustment on seniors' living costs.

For long-term beneficiaries with low benefits, benefits could be modestly and gradually increased starting around age

80. To render this change more progressive, the increase could be the same amount for all retirees in the same cohort, rather than a percentage of the individual's benefit.

Another way Social Security could address the problem of providing retirement income over longer life expectancies among women is to amend the way the cost-of-living adjustment (COLA) is calculated. Social Security provides an automatic annual COLA to prevent inflation from eroding the value of benefits over time. This protection is especially important to women, who make up 71 percent of beneficiaries age 90 and older.²⁶ However, the Consumer Price Index that Social Security uses to determine the COLA, the CPI-W, is based on the spending patterns of urban wage earners. Urban wage earners' consumption patterns are different from those of seniors, who spend twice as large a share of their budgets on health care as the population as a whole.²⁷ The cost of health care tends to rise more quickly than many other goods.

An alternative measure of inflation developed by the Bureau of Labor Statistics, the Consumer Price Index for the Elderly (CPI-E), takes account of the consumption patterns of older individuals. When health care costs rise much more rapidly than the costs of other goods and services, as they did

²⁵ Joan Entmacher, 2008, Strengthening Social Security Benefits for Widow(er)s: The 75% Combined Worker Benefit Alternative, National Women's Law Center. <http://www.nwlc.org/sites/default/files/pdfs/BenefitImprovementforWidowsFeb09.pdf>.

²⁶ Author's calculations from Social Security Administration, 2016b, Annual Statistical Supplement, 2015, Office of Research, Evaluation, and Statistics, [https://www.ssa.gov/policy/docs/statcomps/supplement/](https://www.ssa.gov/policy/docs/statcomps/supplement/:): Table 5.A10.

²⁷ Alicia Munnell and Anqi Chen, 2015, "Do We Need a Price Index for the Elderly?" Center for Retirement Research at Boston College Issue Brief 15-18, http://crr.bc.edu/wp-content/uploads/2015/10/IB_15-18.pdf.

between 1983 and 2002 and have recently begun to do again, basing the Social Security COLA on the CPI-E (or similar index designed to measure the spending patterns of the elderly) ensures that the value of Social Security benefits keeps pace with beneficiaries' cost of living.²⁸

Conclusion

Social Security has proven to be the most effective vehicle for the achievement of retirement security for most women. Enhancing Social Security benefits would be an effective strategy for improving retirement security for women and other economically vulnerable groups. To expand benefits and close the projected long-term shortfall would require increased Social Security revenue. For a review of revenue-raising options, which are beyond the scope of this brief, see the Academy report, *Fixing Social Security: Adequate Benefits, Adequate Financing*.²⁹

Social Security has proven to be the most effective vehicle for the achievement of retirement security for most women.



²⁸ Ibid.

²⁹ Virginia Reno and Joni Lavery, 2009, *Fixing Social Security: Adequate Benefits, Adequate Financing*. National Academy of Social Insurance Report, https://www.nasi.org/sites/default/files/research/Fixing_Social_Security.pdf.

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INSURANCE

Social Security Disability

Social Security Disability

Background

In the 2016 Social Security Trustees Report, the Social Security Disability Insurance (SSDI) program was projected to be able to pay full benefits through 2023.¹ In the coming years, policymakers have the opportunity to consider sensible reforms both to improve the performance of the program in meeting the needs of people with disabilities, and to secure its long-term solvency.

What is Social Security Disability insurance?

Disability Insurance (DI) is insurance against loss of earnings due to a severe medical impairment that results in a significant work incapacity. Workers earn disability insurance protection by having worked and paid Social Security taxes.² The test of work incapacity is very strict: benefits are paid, after a five-month waiting period, only to individuals who have a medically determinable physical or mental impairment that precludes any substantial work activity and that is expected to last at least a year or result in death in less than a year. Applicants meet the test only if their impairments are of such severity that they are not only unable to do their prior work, but also unable – considering their age, education, and work experience – to engage in any other substantial gainful work that exists in the national economy.³

Who receives Social Security Disability benefits?

In November 2016, 8.8 million workers received disabled worker benefits, as did 1.7 million of their children and more than 135,000 of their spouses. People who receive benefits are a subset of the tens of millions of adults who live with a disability. In 2010, 29.5 million adults ages 21 to 64 reported having a disability.⁴

Three-fourths of worker beneficiaries of Social Security disability are in their 50s and 60s.⁵ Before becoming eligible for benefits, two-thirds of these workers had unskilled or semi-skilled jobs.⁶ Less than one in six have a

¹ Board of Trustees, 2016, Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Federal Disability Insurance Trust Funds, Social Security Administration, Tables IV.B1 and IV.B4, <https://www.ssa.gov/oact/TR/2016/IrIndex.html>.

² To be insured, one must have worked at least one fourth of the time since age 21 and in at least five of the last 10 years (or in at least half of the time since age 21 if that is less than 10 years). In fact, recipients typically worked for most of their adult lives before becoming disabled; see Kathleen Romig, "DI Beneficiaries Have Extensive Work Histories," <http://www.cbpp.org/blog/di-beneficiaries-have-extensive-work-histories>.

³ Jerry L. Mashaw and Virginia P. Reno, eds., 1996, *Balancing Security and Opportunity: The Challenge of Disability Income Policy*, Washington, D.C.: National Academy of Social Insurance, pages 89-90, https://www.nasi.org/usr_doc/Balancing_Security_and_Opportunity.pdf; Social Security Act: Title II, §223 (d).

⁴ Matthew W. Brault, 2012, "Americans With Disabilities: 2010," U.S. Census Bureau, <http://www.census.gov/prod/2012pubs/p70-131.pdf>.

⁵ Social Security Administration, 2016, Annual Statistical Report on the Social Security Disability Insurance Program, 2015, Table 19, https://www.ssa.gov/policy/docs/statcomps/di_ast/2015/index.html.

⁶ Mark Trapani and Deborah Harkin, 2011, "Occupational and Medical-Vocational Claims Review Study," Presentation, Social Security Administration, <https://www.ssa.gov/oidap/Documents/PRESENTATION--TRAPANI%20AND%20HARKIN--OIDAP%2005-04-11.pdf>.

college degree.⁷ States in the South, Appalachia, and the industrial Midwest have higher-than-average rates of DI receipt.⁸

Benefits are modest but essential to disabled beneficiaries

Benefits for workers who become disabled replace about half of the worker's wages before becoming disabled.⁹ The average monthly benefit for disabled workers is about \$1,170, or \$14,000 a year. For 60 percent of beneficiaries, Social Security benefits are more than 75 percent of their total income. One in five DI beneficiaries lives in poverty.

Policy Challenges

Solvency

Although part of the Social Security program, the DI program is financed through a separate trust fund from Social Security old age and survivor benefits. The DI trust fund can pay full benefits through 2023, at which point the DI trust fund will be depleted and thereafter will only be able to finance around four-fifths of benefits through 2090.¹⁰ Under current law, DI benefits will therefore be reduced by approximately one-fifth unless legislative action is taken. Allowing for full payment of scheduled benefits will require action to increase revenue, reduce costs, share financial resources with the old age program (OASI), or some combination of these alternatives.

Understaffing and case backlog

In order to be certified as eligible to receive benefits and to begin receiving them, potential Social Security disability beneficiaries must first apply for benefits at a local Social Security office and then submit medical evidence of their disability to (or attend a medical evaluation with) a state Disability Determination Services (DDS) agency. The Social Security Administration (SSA) will then make a determination of eligibility for benefits based on this evidence. If a potential beneficiary believes that benefits were denied to her improperly, she may request a formal hearing with an administrative law judge to review the evidence. The Social Security Administration currently lacks the resources to keep up with the need for these hearings to determine eligibility for disability benefits. SSA's administrative budget has declined 10

⁷ Michelle Stegman Bailey and Jeffrey Hemmeter, 2015, "Characteristics of Noninstitutionalized DI and SSI Program Participants, 2013 Update," Research and Statistics Note No. 2015-02, Office of Retirement and Disability Policy, Social Security Administration, <https://www.ssa.gov/policy/docs/rsnotes/rsn2015-02.html>.

⁸ Kathy A. Ruffing, 2015, "Geographic Pattern of Disability Receipt Largely Reflects Economic and Demographic Factors," Center on Budget and Policy Priorities, <http://www.cbpp.org/research/geographic-pattern-of-disability-receipt-largely-reflects-economic-and-demographic-factors>.

⁹ Center on Budget and Policy Priorities, 2016, "Policy Basics: Social Security Disability Insurance," <http://www.cbpp.org/research/retirement-security/policy-basics-social-security-disability-insurance>.

¹⁰ Board of Trustees, 2016, Tables IV.B1 and IV.B4.

percent since 2010, leading to a 5 percent decline in SSA staff.¹¹ These budget and staffing cuts, moreover, are occurring at a time when caseloads are increasing due to Boomers being in their high-disability years. The average wait time for a hearing rose from 360 to 540 days between 2011 and 2016. The number of applicants awaiting a hearing has risen to over 1 million, an all-time high.¹²

Supporting work

The Social Security Disability Insurance program is designed to pay cash benefits to workers who have limited work capacity because of a disabling condition. Under some circumstances, however, workers might be able to do limited work, if they were to receive the necessary accommodations and supports. Providing adequate accommodations and supports for work is primarily a challenge for disability programs more broadly, not the Social Security DI program in particular. State and private disability insurance programs face the same challenges in helping beneficiaries to work if they are able. Federal and state programs, such as vocational rehabilitation authorized under the Workforce Innovation and Opportunity Act, are the primary source of employment services and supports for jobseekers with disabilities. The DI program already contains a range of features designed to incentivize work, such as continuing payments while a beneficiary receives vocational rehabilitation services and offering a trial work period during which benefits will not cease because of the beneficiary's earnings. The 2015 law that temporarily reallocated taxes between the retirement and disability programs also called for additional demonstration projects to accomplish this goal.¹³ But the program could still do more in this regard.

Reform Principles

In designing reforms to the DI program, some core principles serve as a guide. They fall into three categories: extending solvency; addressing understaffing and case backlog; and supporting work.

Solvency

Avoid sudden benefit cuts and seek to achieve long-term actuarial balance

The key to ensuring the continued ability of the system to provide disability protections to America's workforce lies in preventing sudden benefit cuts due to trust fund insolvency in the short term and achieving actuarial balance

¹¹ Kathleen Romig, 2016, "Budget Cuts Squeeze Social Security Administration Even as Workloads Reach Record Highs," Center on Budget and Policy Priorities, <http://www.cbpp.org/research/retirement-security/budget-cuts-squeeze-social-security-administration-even-as-workloads>.

¹² Ibid.

¹³ Bipartisan Budget Act of 2015, P.L. 114-74; Kathleen Romig, Demonstrations to Promote Work Among Disability Beneficiaries Likely to Produce Limited Results, February 11, 2016, <http://www.cbpp.org/research/social-security/demonstrations-to-promote-work-among-disability-beneficiaries-likely-to>.

The key to ensuring the continued ability of the system to provide disability protections to America's workforce lies in preventing sudden benefit cuts due to trust fund insolvency in the short term and achieving actuarial balance in the long term.

in the long term. The DI trust fund is projected to require action by 2023 to maintain scheduled benefits. Policymakers should thus seek to extend solvency in order to preserve current benefit levels, ideally over the long term.

Further strengthen program integrity, but recognize that eliminating all fraud will not yield significant cost savings
All Americans benefit from ensuring the integrity of their disability

protections. While reducing fraud in public programs is an inherently worthy goal, the cost savings from these efforts is not substantial. Disability insurance already has many safeguards against fraud and abuse, such as continuing disability reviews (CDRs) and strict eligibility standards.¹⁴ Fraud is not responsible for the system's funding shortfall.¹⁵ Proposals to further increase program integrity include increasing criminal penalties for fraud and improving Continuing Disability Reviews (CDRs).

Understaffing and Case Backlog

Ensuring the adequacy of resources to administer Social Security disability is a cost-effective proposition. Adequate funding can improve the timeliness of disability determinations, improve work supports, and deliver effective fraud detection.

Provide adequate resources to administer the program

The costs of administering Social Security Disability are already low; administrative costs were less than 2 percent of benefit payments in 2015.¹⁶ Ensuring the adequacy of resources to administer Social Security Disability is a cost-effective proposition. Adequate funding can improve the timeliness of disability determinations, improve work supports, and deliver effective fraud detection.

¹⁴ Kathy Ruffing, 2015, "Disability Insurance Has Many Safeguards against Fraud and Abuse," Center on Budget and Policy Priorities, <http://www.cbpp.org/blog/disability-insurance-has-many-safeguards-against-fraud-and-abuse>.

¹⁵ Bipartisan Policy Center, 2015, "Improve the SSDI Program and Address the Impending Trust Fund Depletion: Consensus Recommendations of BPC's Disability Insurance Working Group," <http://bipartisanpolicy.org/wp-content/uploads/2015/08/BPC-Economy-SSDI-Program.pdf>.

¹⁶ Board of Trustees, 2016.



Improve DI administrative and adjudicative processes

The application process could be made simpler and faster, and steps should be taken to improve the accuracy and consistency of decisions with the Social Security Act and SSA regulations, policies, and guidance. Doing so would benefit both applicants and the system itself by increasing program integrity in ways other than fraud detection and prevention.

Supporting Work

Emphasize early intervention to help people stay at their current job or find a new job quickly before entering the program

Among the most promising ways to promote employment among current and prospective disability beneficiaries is to promote attachment to employment in the first place. Integrating work supports into the program from the beginning of a person's experience with disability can maintain employment momentum and lessen problems with returning to work that may arise later.

Simplify the administration of SSDI and Supplemental Security Income (SSI) in ways that will more closely align work incentives

Proposals to improve integration between Social Security disability benefits and work incentives include:

- Establishing a special office to implement DI work-incentive programs and pilots;
- Routinely informing beneficiaries about work-incentive and support programs;
- Improving interagency coordination on workforce attachment;
- Providing workforce-transition support to beneficiaries whose benefits are terminated due to medical improvement; and
- Guaranteeing timely Continuing Disability Reviews.

Remove employment disincentives for those individuals who want to work

To encourage employment among Social Security disability beneficiaries, one proposal is to replace the all-or-nothing earnings limit (the level at which beneficiaries lose all benefits if they earn any more money at all) with a gradual reduction in benefits in proportion to additional earnings. This could reduce the disincentives to seek higher wages and reenter the workforce. The 2015 law directed SSA to conduct demonstration projects to test these approaches.¹⁷

Conclusion

Social Security disability is an essential protection for America's workforce. It helps sustain workers and their families when a worker's wages are lost due to disability. The system keeps millions of Americans out of poverty who would otherwise have no ability to earn income. By providing insurance against future risk of disability, it also provides peace of mind to the tens of millions of workers who are contributing to the system. Action is needed by 2023 to ensure its continued ability to provide this insurance protection and to deliver timely assistance to disabled workers. Modest reforms to the system guided by the principles outlined here would improve the ability of the system to achieve its objectives and extend solvency over the long term.



¹⁷ Bipartisan Budget Act of 2015, P.L. 114-74.

Health Insurance

**Improving Coverage and Cost through
Health Insurance Reform**

Improving Coverage and Cost through Health Insurance Reform

Before the election of Barack Obama in 2008, it was not uncommon for Democrats and Republicans to single out a similar roster of problems with the American health care system – high and rising costs and unmet needs. “Negative consensus” was how Paul Starr summarized the familiar litany a quarter century ago.¹ This common diagnosis of the systemic illness never gave way, however, to a shared agenda of a feasible remedy – even when there were overlapping ideas, such as the bipartisan use of subsidized insurance exchanges in Massachusetts and in the Affordable Care Act (ACA).

The political polarization that greeted the introduction, enactment, and implementation of the ACA after its passage in 2010 confirmed the futility of relying solely on a negative consensus to produce a shared agenda of reform. Following the ACA’s launch, the dire circumstances of America’s negative consensus eased considerably, as health-care cost inflation and gaps in coverage declined sharply, according to independent sources and abundant evidence.

The new President and Congress are committed to repealing the ACA. The key question facing policymakers is how to replace it. Although the negative consensus did not translate into agreement on reform, the new leadership is now coming to terms with the reality introduced over the past seven years of stronger coverage and lower health inflation. In the process, lawmakers must wrestle with a daunting question: How can they change the ACA without reversing progress that the law has achieved on coverage and cost control?

This section is directed at addressing this question. It focuses on policy changes that may enjoy support and prove feasible.

Background

The “negative consensus” prior to the Affordable Care Act

The ACA was passed after decades of proposals by both parties to mitigate a stubborn set of problems related to gaps in coverage and high and rising health care costs. Strikingly similar speeches from across the aisle lamented the gaps in affordable insurance coverage for working families and children, along with the catastrophic impacts of high health inflation on America’s economic competitiveness and workers’ economic security.

¹ Paul Starr, 1992, *The Logic of Health Care Reform*, Knoxville: Grand Rounds Press.

The United States has historically faced a massive gap in insurance coverage.

Tens of millions of uninsured Americans

The United States has historically faced a massive gap in insurance coverage. In 2013, one year before the major coverage provisions of

the ACA went into effect, more than 43 million adults under age 65 lacked coverage, and uninsurance rates had hovered above 15 percent for decades.² Poor and low-income adults, as well as people with serious pre-existing health conditions, were particularly likely to lack coverage, primarily because coverage was unaffordable or unavailable.³ Unlike other affluent countries, all of which have some type of universal health insurance framework that guarantees coverage, health insurance coverage in the United States has always been contingent and piecemeal – a patchwork of coverage through employers, Medicare, Medicaid, the Veterans Health Administration, and other programs. Those not covered through such larger systems were relegated to the very expensive and loosely-regulated private individual insurance market.

To reduce the coverage gap, the ACA used a variety of approaches, including: a major expansion of Medicaid to cover previously uninsured poor adults, new rules for insurers that prohibited turning individuals away due to pre-existing conditions or limiting access to basic services, a requirement that individuals obtain coverage or else pay a fine, tax credits and cost-sharing reduction payments to improve affordability, and the establishment of regulated health insurance exchanges to increase and streamline access to private insurance plans.

The Medicaid expansion extended coverage beyond specialized populations (e.g., children, pregnant women, persons with disabilities) to include all low-income adults under age 65. Due to a Supreme Court ruling following the passage of the law,⁴ however, states gained the option of choosing whether or not to participate in this expansion. To date, 31 states and the District of Columbia have implemented the Medicaid expansion, leaving 19 that have not. This has created an unexpected “coverage gap” of 2.6 million Americans in states that did not expand Medicaid – a number that includes those

² Robin A. Cohen, Michael E. Martinez, and Emily P. Zammitti, 2016, Health Insurance Coverage: Early Release of Estimates from the National Health Interview Survey, January-March 2016, National Center for Health Statistics, <https://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201609.pdf>.

³ Rachel Garfield, Rachel Licata, and Katherine Young, 2014, “The Uninsured at the Starting Line: Findings from the 2013 Kaiser Survey of Low-Income Americans and the ACA,” Kaiser Family Foundation, <http://kff.org/report-section/the-uninsured-at-the-starting-line-findings-from-the-2013-kaiser-survey-of-low-income-americans-and-the-aca-introduction/>.

⁴ 567 U.S. *National Federation of Independent Business (NFIB) v. Sebelius*, 2012, <http://www.supremecourt.gov/opinions/11pdf/11-393c3a2.pdf>.

individuals too poor to receive tax credits, but outside of the categories that qualify for traditional Medicaid coverage.⁵

To make health plans more affordable and accessible to low- and moderate-income individuals and families now required to comply with the new health insurance coverage requirement, the ACA also offered premium tax credits and cost-sharing reductions and established health care exchanges to facilitate the purchase of standardized health insurance plans for individuals not otherwise covered under a federal, state, employment-based, or group health insurance plan. Overall, the ACA has succeeded in extending coverage to over 20 million people, reducing the national uninsurance rate across all ages to 8.6 percent – the lowest in the country’s history – and to 11.9 percent among adults under age 65.^{6,7}

Inadequate policies left even covered Americans underinsured

Prior to the ACA, the health care plans that many people purchased on the individual insurance market – that is, plans not purchased through an employer or another group – often failed to cover the full range of health-related risks faced by consumers. Insurers often excluded coverage for pre-existing conditions, leaving many without insurance for the conditions that most required coverage. Since the individual market lacked a

Prior to the ACA, the health care plans that many people purchased on the individual insurance market – that is, plans not purchased through an employer or another group – often failed to cover the full range of health-related risks faced by consumers

broad risk pool with adequate enrollment of healthier consumers, carriers underwrote coverage in the individual market to the fullest extent possible. Health insurance companies could – and often did – deny applications for coverage based on an individual’s medical history, leaving others without coverage all together.⁸ Consumers who purchased plans on the individual market could suddenly see their coverage dropped if they became sick, based on allegations of omissions to their medical history forms from the insurance carrier. Women were frequently required to pay more than men for coverage.

⁵ For a more detailed discussion of the coverage gap, please see: Rachel Garfield and Anthony Damico, 2016, The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid, Kaiser Commission on Medicaid and the Uninsured: The Henry J. Kaiser Family Foundation, <http://kff.org/uninsured/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/>.

⁶ Cohen, Martinez, and Zammiti, 2016.

⁷ Research by The Commonwealth Fund found that, in 2013, marketplace enrollment accounted for between a 1.7 to 2.3 percent reduction in the uninsurance rate among adults under age 65, while Medicaid expansion further reduced the uninsurance rate by between 0.76 and 1.0 percentage points; Sherry Glied, Stephanie Ma, and Sarah Verbofsky, 2016, How Much of a Factor is the Affordable Care Act in the Declining Uninsured Rate? The Commonwealth Fund, <http://www.commonwealthfund.org/publications/issue-briefs/2016/dec/aca-declining-uninsured-rate>.

⁸ Michelle M. Doty, Sara R. Collins, Jennifer L. Nicholson, and Sheila Rustgi, 2009, Failure to Protect: Why the Individual Insurance Market Is Not a Viable Option for Most U.S. Families, The Commonwealth Fund, <http://www.commonwealthfund.org/publications/issue-briefs/2009/jul/failure-to-protect>.

And many plans did not cover common, critical health needs and services such as maternity care, prescription drugs, and mental health or substance abuse treatment.⁹

To improve the quality of health insurance coverage on the individual market, the ACA included multiple reforms to protect consumers. The law significantly limited the practice of underwriting by insurance carriers, but these were balanced with stabilizing influences, such as the formation of a single risk pool of consumers and an individual mandate for health insurance coverage to broaden the enrollee base. Although some existing plans that failed to meet these standards were “grandfathered” in by the ACA¹⁰ (and subsequent legislation), the ACA ended coverage exclusions and premium surcharges based on pre-existing conditions for all non-grandfathered plans in the individual market and for all plans – including grandfathered plans – in the group market. Today, insurance companies can no longer cancel an enrollee’s plan for any reason other than fraud or failure to pay.

To extend affordable coverage for young adults, the ACA allowed individuals under the age of 26 to remain insured through their parents’ health plans. Additionally, the ACA put into place some protections and limits on out-of-pocket health care costs for consumers. For example, the law eliminated annual and lifetime caps on coverage, capped out-of-pocket expenditures for in-network services, and prohibited insurers from selling coverage with an actuarial value below 70 percent. It also required insurers to spend at least 80 percent of premium revenue on care instead of administration, marketing, advertising, and profit. To encourage the use of preventive care, the ACA additionally mandated that plans offer many preventive measures, like annual check-ups, without cost-sharing.¹¹

High provider costs system-wide

A key argument made by supporters of the ACA was that the U.S. health care system pays much higher provider and pharmaceutical costs than those of any other country in the world. If not brought under control, these health costs threaten to consume

The U.S. health care system pays much higher provider and pharmaceutical costs than those of any other country in the world.

⁹ Heidi Whitmore, Jon R. Gabel, Jeremy Pickreign, and Roland McDevitt, 2011, The Individual Insurance Market Before Reform: Low Premiums and Low Benefits, *Medical Care Research and Review*, 68(5), 594-606.

¹⁰ A “grandfathered health plan” is a group health plan that was created, or an individual health insurance policy that was purchased, on or before March 23, 2010. If these plans or policies make certain significant changes by reducing benefits or increasing costs for consumers, they may lose their “grandfathered” status under the law.

¹¹ Robert Wood Johnson Foundation, 2011, What consumer protections are embedded in the Affordable Care Act?, Issue Brief, http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2011/rwjf71392.

an unsustainable share of federal and state budgets, and to erode Americans' already stagnant disposable incomes.¹² This policy challenge addressed by the ACA is beyond the scope of this section (for a discussion of reining in prescription drug prices, see 2.d of this *Report*).

The ACA included a variety of measures to help contain health care cost growth, particularly in Medicare and other public programs, but also across the entire health care system. These measures included: payment reforms that aimed to slow the growth in spending on providers and health plans contracting with Medicare; delivery system reforms that aimed to shift provider payments from a system of fee-for-service reimbursement to one that better focuses on episodes of illness or injury and care coordination across different providers and settings; and investments in prevention and public health that aimed to prevent costlier illness and injury in the long term.¹³



Policy Challenges

The ACA's implementation has revealed challenges that need to be addressed in order to further improve access to and the affordability of health insurance coverage.

Insufficient competition in the health care exchanges

While most of the ACA's health insurance marketplaces opened with competing health insurance providers, competition between insurance companies had dropped dramatically in many states since 2014. This drop has been particularly striking for sales going into 2017; over a third of exchange market regions will have only one insurance carrier within their marketplace.

¹² RAND, 2011, *How Does Growth in Health Care Costs Affect the American Family?*, http://www.rand.org/content/dam/rand/pubs/research_briefs/2011/RAND_RB9605.pdf.

¹³ Kersten Lausch, Erin Shigekawa, Daphna Stroumsa, and Ruth E. Tabak, 2014, *Cost Containment in the Affordable Care Act: An Overview of Policies and Savings*, Center for Healthcare Research and Transformation, <http://www.chrt.org/publication/cost-containment-affordable-care-act-overview-policies-savings/>.

This reduction is in large part the result of major insurance carriers pulling out of the marketplace, as well as the failure of the coops, which seriously underpriced the market in almost every state in which they operated.

Excessive risk burden for health insurance companies

In the first few years of offering health care coverage on the exchanges, many insurance carriers have experienced risk pools that include more sick individuals and fewer healthy people than originally expected. Individuals signing up for health insurance coverage have tended to be less healthy than those who have opted out of purchasing coverage, though the risk pool has become healthier over time since the first open enrollment period.^{14,15} Many carriers are responding to the burden of a costlier-than-expected risk pool by raising premiums.

Insufficient verification of special Enrollment Periods

A common concern among insurers is that the Special Enrollment Periods – qualifying times for purchasing plans on the health insurance exchanges outside of open enrollment due to major life events, such as giving birth or losing a job – are too flexible. As a result, insurers believe that consumers are purchasing plans only when they are sick and then allow the coverage to lapse after using it, which contributes to their costs.¹⁶ CMS has acknowledged that there are some concerns with the Special Enrollment Periods and is piloting efforts to address the issues, though the size of the effect that these special periods have had on raising costs remains controversial.¹⁷

Insufficient protections for insurers from the “Three Rs”

The ACA provided three premium stabilization programs for insurers – the “Three Rs” – Risk Adjustment, Reinsurance, and Risk Corridors. Yet, these have not been implemented as promised or lived up to their full potential. Risk Adjustment was designed to level the playing field among insurers, such that those who take on healthier-than-average enrollees would pay funds to CMS to compensate insurers with a greater proportion of higher-cost enrollees. Reinsurance was designed to protect high-risk consumers from excessive premiums by compensating insurers for any spending above a certain threshold on an individual enrollee. Risk Corridors were designed to protect plans from excess aggregate risk and thereby encourage lower

¹⁴ Centers for Medicare & Medicaid Services, 2016, Changes in ACA Individual Market Costs from 2014-2015: Near-Zero Growth Suggests an Improving Risk Pool, https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/Final-Risk-Pool-Analysis-8_11_16.pdf.

¹⁵ For further discussion of the risk pool balance in the exchanges, see: Timothy Jost, 2016, CMS Report Cites Flat Per-Enrollee Costs in ACA Marketplaces, *Health Affairs Blog*, <http://healthaffairs.org/blog/2016/08/11/cms-report-cites-flat-per-enrollee-costs-in-aca-marketplaces/>.

¹⁶ Chris Carlson and Kurt Giesa, 2016, Special Enrollment Periods and the Non-Group, ACA-Compliant Market, Oliver Wyman, <https://www.ahip.org/wp-content/uploads/2016/03/Oliver-Wyman-Analysis-of-SEP-Enrollment-in-ACA-Nongroup-Market.pdf>.

¹⁷ Centers for Medicare and Medicaid Services, 2016, Special Enrollment Periods for the Health Insurance Marketplace, Fact Sheet, <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-05-06.html>.

premium bids. The first two Rs worked roughly as expected, but Congress reduced promised and expected Risk Corridor payments through the appropriations process after the law and premium bids were in effect, and the House of Representatives has an ongoing lawsuit seeking to enjoin the cost-sharing reductions. As a result, the ensuing unexpected losses and uncertainty have intensified pressures for insurers to raise premiums and exit the marketplaces.¹⁸

Rising costs for consumers: Many consumers on the health insurance marketplace are, after two years of minimal premium increases, facing sharp increases in the price of coverage for 2017 – though these increases have been greatly cushioned by the tax credits available for coverage. Price hikes are particularly troublesome for the 20 percent of enrollees who do not receive premium tax credits and thus must pay the full cost of coverage. Increases in the premiums for coverage have been more prominent in some states than others, and are especially concentrated in states that elected not to expand Medicaid. Consumers have also seen higher cost sharing requirements through higher deductibles and co-pays as insurance carriers alter the design of their plans to control costs.

Burdensome application process for consumers

Consumer experience plays a critical role in determining whether or not uninsured individuals actually sign up for coverage through the new health insurance marketplaces. Yet, many who start the process of applying for coverage never complete it. For part-time workers or consumers with inconsistent work histories, the income estimator for tax subsidies is inefficient and is often unable to accurately estimate income. Health care navigators – individuals and organizations trained to assist with the process of securing coverage on the health care exchanges – are in short supply, and the exchanges are generally understaffed. When potential consumers do see their inherently complex plan options, moreover, many do not receive adequate explanation of the reasons for the costs or limits on provider networks.

The coverage gap

The ACA was designed to make private health insurance more affordable by offsetting costs for low- to moderate-income Americans through the subsidized exchange plans. The Medicaid expansion, in contrast, was designed primarily as a vehicle to extend coverage to uninsured poor adults. Yet, as a result of state decisions to reject Medicaid expansion, over two and a half million people still lack coverage. These individuals receive no federal support, even though individuals earning higher incomes (between 100-400 percent of the federal poverty line) are eligible for marketplace subsidies.

¹⁸ For a detailed explanation of the “Three Rs,” please see: Lisa Klinger, 2014, The “3 Rs”: Risk Adjustment, Reinsurance, and Risk Corridors, Leavitt Group, <https://news.leavitt.com/health-care-reform/3-rs-risk-adjustment-reinsurance-risk-corridors/>.

The family glitch

Premium tax credits are not available under the ACA to persons who have affordable employer coverage. When one family member has access to employer-sponsored coverage, the ACA determines whether the coverage is affordable based only on the cost of employer coverage for that individual – not for the cost of family coverage. Coverage that is affordable for an individual can frequently be unaffordable for full family coverage. Unfortunately, however, these family members are locked out of receiving tax credits for plans on the health care exchanges.

Policy Options

Faced with uncertain prospects of Congressional replacement, insurance companies would likely respond with extreme premium hikes, or even withdrawing from the marketplaces altogether. This would mean that the millions who have gained coverage for the first time in recent years would be forced to wait for hospitals or clinics to provide uncompensated care, often delivered too late, if at all.

If the ACA is to be wholly or partially repealed, Congress must replace it fully and swiftly to avoid chaos in the insurance markets and in the lives of the American people. Faced with uncertain prospects of Congressional replacement, insurance companies would likely respond with extreme premium hikes, or even withdrawing from the marketplaces altogether. This would mean that the millions who have gained coverage for the first time in recent years would be forced to wait for hospitals or clinics to provide

uncompensated care, often delivered too late, if at all.

In the following section, we assess a set of options under active consideration by Congress and the White House. In Section A, we begin by considering options that risk reintroducing the problems that the ACA was intended to address. We discuss both the reasons that lawmakers may find them attractive as well as their limitations for sustaining coverage and cost control. The subsequent section, further below, will identify options under active consideration by Congress and the White House. The final policy option is not currently under active consideration, but promises to advance the goals of improving coverage and controlling costs.

I. Policy options to repeal and replace the ACA

Eliminate the individual and employer mandates for health care coverage

Many opponents of the ACA deeply object to a federal mandate for the purchase of health insurance, and while most employers offer health insurance to their workers, they prefer flexibility to adjust those offers as market realities change. Under the ACA's employer mandate, employers with 50 or more employees must provide health insurance to a minimum of 95 percent of full-time staff, and must pay a fine if any of their full-time employees receive premium tax credits. The ACA's individual mandate, in turn, requires Americans who are otherwise uninsured and do not qualify for an exemption to either purchase coverage that meets a minimum set of standards or pay a fine. The goal of the employer mandate is to keep employers from dropping coverage once assistance is available in the individual market. The aim of the individual mandate, according to the American Academy of Actuaries, is to encourage enrollment of as many people as possible – particularly young and healthy people who are unlikely to purchase coverage without a mandate – to broaden the risk pool for insurance carriers and produce more stable premiums for everyone.¹⁹

Independent experts project a severe drop in coverage and higher premiums if the individual and employer mandates are terminated. The Congressional Budget Office has projected that repealing the individual mandate, along with the associated subsidy policies, would result in 22 million fewer Americans having health care coverage.²⁰

One of the most significant threats of terminating the individual mandate is higher adverse selection, in which people who are most at risk of high health care costs would be the most likely to enroll, while healthier individuals decide not to purchase coverage. Premiums for the remaining pool of enrollees would increase, further exacerbating adverse selection concerns. A premium spiral could result, with fewer and fewer covered individuals and higher and higher premiums.²¹

Continuous coverage requirements for insurance carriers

A continuous coverage requirement – a possible replacement for the individual mandate – is intended to protect consumers by requiring carriers to provide coverage for pre-existing conditions, as long as an enrollee had been covered continuously for at least one year. This would likely be a viable

¹⁹ American Academy of Actuaries, December 7, 2016, Letter to the U.S. House of Representatives Re: Consequences of Repealing ACA Provisions or Ending Cost-Sharing Reduction Reimbursements, http://actuary.org/files/publications/HPC_letter_ACA_CSR_120716.pdf.

²⁰ CBO, 2015, Re: Budgetary Effects of H.R. 3762, the Restoring Americans' Healthcare Freedom Reconciliation Act, as Passed by the Senate on December 3, 2015, <https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/costestimate/hr3762senatepassed.pdf>.

²¹ American Academy of Actuaries, 2016.

solution for people who are already covered at the time of implementation or who have the means to purchase coverage on their own.

Continuous coverage requirements are unlikely to be effective, however, at reducing the number of uninsured individuals, or even maintaining the currently record-low rates achieved by the ACA.²² The reality for low-income families – many of whom currently receive subsidies to purchase care – is that continuous coverage is difficult to maintain in the context of volatile job markets and income, as well as competing priorities such as food and housing. Moreover, this approach would fall especially heavily on individuals who are not able to afford coverage but then become sick. Individuals who are fortunate enough to remain healthy and choose to forgo insurance coverage will never have to pay the penalty of out-of-pocket health care costs. Thus, a continuous coverage requirement would effectively end up penalizing people just as a mandate penalty does – in many cases at a higher dollar amount – but doing so only after they have become sick or injured and need health care.²³

Coverage through high-risk pools for individuals with significant health issues

High-risk pools are designed to provide a backup source of coverage for individuals who would have trouble buying coverage in an individual market where insurers can charge higher prices – or even refuse coverage – for sicker enrollees. Thirty-five states developed high-risk pools in the years – and in some cases decades – prior to the ACA, and the federal government operated a temporary program in the early years of the ACA's implementation. High-risk pools have proven ineffective for two reasons. First, these pools were not adequately and reliably funded over the long term, which meant that the pools were unable to afford to extend coverage to many of the individuals these plans were designed to protect. In addition, high-risk pools tried to keep costs down by including high deductibles, low lifetime limits, and limited coverage for a population that was already sick.²⁴

Implement tax deductions or tax credits to subsidize health care costs

Replacement proposals often include tax credits or tax deductions to assist individuals and families with purchasing individual insurance coverage. Tax credits reduce how

Tax credits are more effective than tax deductions to assist individuals and families with purchasing individual insurance coverage.

²² Robin A. Cohen, Michael E. Martinez, and Emily P. Zammiti, Health Insurance Coverage: Early Release of Estimates From the National Health Interview Survey, January-March 2016 (National Center for Health Statistics, Sept 2016), <https://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201609.pdf>.

²³ Timothy Jost, 2016, Taking Stock of Health Reform: Where We've Been, Where We're Going, *Health Affairs*, <http://healthaffairs.org/blog/2016/12/06/taking-stock-of-health-reform-where-weve-been-where-were-going/>.

²⁴ Jean P. Hall, 2015, Why High Risk Pools (Still) Won't Work, The Commonwealth Fund, <http://www.commonwealthfund.org/publications/blog/2015/feb/why-high-risk-pools-still-will-not-work>.

much is owed in taxes by an actual dollar amount and are the most promising approach discussed by replacement proposals. Tax credits are more effective than tax deductions to assist individuals and families with purchasing individual insurance coverage. Tax deductions reduce an individual's taxable income but are less helpful for individuals below the tax filing limit – the population most in need of assistance.

A universal, fixed-dollar, refundable tax credit would provide needed relief to low- and moderate-income families trying to purchase private health plans. Such tax credits are administratively simpler than income-based subsidies because they do not require calculations based on earnings, which can be particularly difficult for those whose incomes are unpredictable from year to year. However, a universal tax credit may not be generous enough to make coverage affordable for those earning the least or those who are exposed to greatest health risks.

Another option is means-testing for a tax credit that would decrease as income increases. This would provide higher levels of assistance to those with the fewest resources. However, there is potential that such a policy could disincentivize efforts to increase earnings; therefore, a fixed dollar amount is more appealing to some analysts.²⁵

Another option would be to age-adjust tax credits to help higher-risk, older adults purchase coverage in an underwritten insurance market. Regardless of how a subsidy is structured, an important consideration will be how the rates will increase (or decrease) over time to adjust for changing costs of plans and general inflation.

Promote the use of Health Savings Accounts to make health care more affordable

One of the most common components of ACA replacement plans is a provision for Health Savings Accounts (HSAs) to cover out-of-pocket medical expenses. HSAs allow individuals and families to make pre-tax contributions to an interest-accumulating account and then retrieve money from that account to pay for health care needs, or for any reason upon reaching the age of 65. Withdrawing money for non-medical expenses prior to age 65 results in a substantial penalty (20 percent excise tax). These accounts are usually paired with a requirement for coverage through a high-deductible health plan.

Research demonstrates that HSAs encourage people to be more mindful of how much money they spend on health care and to actually spend less

²⁵ Timothy Jost, 2016, Taking Stock of Health Reform: Where We've Been, Where We're Going, *Health Affairs*, <http://healthaffairs.org/blog/2016/12/06/taking-stock-of-health-reform-where-weve-been-where-were-going/>.

overall.²⁶ Research also shows, however, that HSAs are most effective in reducing spending and boosting awareness of health care costs among higher-earning individuals. A 2006 Government Accountability Office study (as well as more recent studies) reports that most HSA participants earned more than \$75,000 per year in 2004, and the average adjusted gross income of tax filers reporting HSA contributions was \$133,000 – more than double the \$51,000 reported for all tax filers under age 65.²⁷ The same study also found that high-income individuals contributed nearly three times as much to HSAs than low-income individuals; for instance, HSA participants with incomes over \$200,000 contributed an average of \$3,010 in 2004, compared to \$1,370 for HSA participants with incomes below \$50,000. These higher contribution levels provide disproportionate tax benefits for high-earners, and in fact there is evidence that more than half of tax filers reporting HSAs in 2004 did not withdraw any funds from their accounts, suggesting that many are using HSAs as a way to reduce tax liability, instead of funding medical care. HSAs are not, then, a policy tool for sustaining the new levels of coverage achieved over the past seven years. People with chronic health conditions or other costly medical problems and low to moderate incomes who are unable to fund a health savings account would not receive the tax benefits of HSAs and would face new barriers to coverage.

If HSAs are pursued by Congress as part of high-deductible health plans, lawmakers should avoid a “one-size-fits-all,” blunt approach to cost sharing. A more promising idea is to promote value-based benefit designs in order to better ensure that people with chronic conditions seek the care they need. The progression of potentially costly chronic disease may be blunted by allowing high-deductible HSAs to cover the first dollar of expanded preventive care or essential treatments, such as eye exams and insulin for people with diabetes.²⁸

Allow individual market insurance plans to be sold across state lines

Allowing insurance plans to be sold across state lines to increase competition and reduce costs to consumers is a proposal currently receiving significant attention from lawmakers. The challenge with this proposal, however, is how to allow greater flexibility for insurance market competition without undue interference in long-standing state discretion to set the terms of insurance markets, including requirements to ensure the financial solvency of health plans or their coverage of all comers, including those with pre-existing

²⁶ One difficult question, however, is the degree to which this reflects the self-selection of healthier people into HSAs—more research is needed in this area.

²⁷ Government Accountability Office, 2006, “Consumer-Directed Health Plans: Small but Growing Enrollment Fueled by Rising Cost of Health Care Coverage,” GAO-06-514, April 28; U.S. Government Accountability Office, 2008, Health Savings Accounts: Participation Increased and was More Common among Individuals with Higher Incomes (GAO, April); Lorens A. Helmchen, David W. Brown, et al., 2015, “Health Savings Accounts: Growth Concentrated among High-Income Households and Large Employers,” Health Affairs, 34(9), 1594–98.

²⁸ Michael E. Chernew and A. Mark Fendrick, 2016, Improving Benefit Design to Promote Effective, Efficient, and Affordable Care, *JAMA*, 316(16), 1651-1652, <http://jamanetwork.com/journals/jama/article-abstract/2556007>.

medical conditions. Furthermore, forcing states to permit the sale of health plans across state lines would encourage insurers to be regulated in states with few consumer protections – and then those insurers could target the healthiest individuals in heavily regulated states with leaner policies. This would result in an even more segmented market, narrowing the risk pool and bankrupting local plans that could not relocate to lower-regulation states. As a result, while premiums for low-risk consumers would be reduced, those for sicker or lower-income individuals – or even those with moderate incomes who prefer the protection of more extensive health care coverage – would become even more costly.²⁹ Additionally, consumers who purchase coverage from out-of-state insurers would not have much recourse, if they ran into any issues, since they would have to appeal to a regulatory agency operating in another state.

Additionally, it is worth noting that states already have the authority to enact “across state lines” legislation, but only six have done so. Those states that allowed out-of-state insurers have little to show for it. Insurers did not enter the insurance markets of these states, or even express interest in doing so, due to practical problems associated with the local nature of health care, such as the costly tasks of contracting and building viable provider networks in another state.³⁰

II. Reforms to improve coverage and cost control

In lieu of a full repeal, lawmakers could elect to further reduce the number of uninsured Americans, improve the quality of individual health-insurance policies, and diminish health care costs by addressing the most widely recognized problems with the ACA.

Create more flexibility for consumers purchasing plans

Consumers are increasingly nervous over the limited number of choices available to them on the health insurance exchanges. To respond to their concern, and to boost competition between insurers, there are two strategies for increasing flexibility.

First, the federal government could offer subsidies for plans purchased on certain private health care exchanges, rather than just those purchased on the federal and state exchanges. There are several insurance companies and consultants that host their own private exchanges, just as some state governments do for their own employees. Many individuals and families use

²⁹ Linda J. Blumberg, 2016, Sales of Insurance across State Lines ACA Protections and the Substantial Risks of Eliminating Them, The Urban Institute, <http://www.urban.org/sites/default/files/alfresco/publication-pdfs/2000840-Sales-of-Insurance-across-State-Lines.pdf>.

³⁰ Sabrina Corlette, Christine Monahan, Katie Keith and Kevin Lucia, 2012, Selling Health Insurance Across State Lines: An Assessment of State Laws and Implications for Improving Choice and Affordability of Coverage, The Center on Health Insurance Reforms, Georgetown University Health Policy Institute, http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2012/rwjf401409.

private exchanges – and have done so for years – to find coverage. If private exchanges were to become eligible for subsidies, strong measures would need to be taken to ensure the quality of these exchanges and of the plans offered on them, as well as to deter fraud. This option would not only increase choices for purchasers, but also has the potential to mobilize health insurance brokers, resulting in greater investment in the marketplace and a potentially more robust workforce to assist consumers with the enrollment process.

Counting catastrophic coverage as a qualifying health plan still eligible for some level of subsidy could make insurance coverage affordable to younger and healthier consumers, improve the risk pool for insurers, and develop a habit and a cultural norm of being covered for individuals, who might then purchase higher-value plans over time as they age.

Second, the government could allow more flexibility in the metal level of qualifying plans. Particularly for younger and healthier individuals, the Silver Level plan can seem like an unaffordable expenditure for something that has insufficient practical value. Counting catastrophic coverage as a qualifying health plan still eligible for some level of subsidy could make insurance coverage affordable to younger and healthier consumers, improve the risk pool for insurers, and develop a habit and a cultural norm of being covered for individuals, who might then

purchase higher-value plans over time as they age.

Simplify the enrollment process for consumers

While efforts have been made over the years to simplify the enrollment process, further steps could be taken to assist potential consumers, particularly those who begin the process of finding coverage but give up mid-way through. Private health care exchanges may be more adept in improving the consumer experience. Government exchanges should be pressed to consider reconfigurations that improve assistance to potential consumers to help them find the right plan for their needs, and innovations to determine the amount of tax credits to be issued for workers with complicated or minimal past work histories.

Address issues with the Three Rs – Risk Adjustment, Reinsurance, and Risk Corridors – to protect insurance companies from taking on excessive and unsustainable losses

The Three Rs in the ACA were developed as risk mitigation policies with the intention of stabilizing premiums for consumers. While these policies were never fully afforded the opportunity to function as intended, there are policy options that could address the present issues.



The ACA's reinsurance program did cover excessive costs for a limited number of people facing significant health needs under the marketplace health plans, but the program was set to expire at the end of 2016. Offering an expanded and extended reinsurance option would give insurers a greater sense of security to continue offering plans on the exchanges.

Risk corridors were intended to redistribute gains from setting premiums too high and to mitigate losses from spending more on covering individuals than expected. The provision was modeled after the permanent risk corridor program under Medicare Part D, which has operated successfully for the past decade. Under the ACA's risk corridor program, insurance companies with gains higher than three percent were required to give up a portion of those gains to compensate companies that faced losses greater than three percent. However, companies facing a loss have, as of yet, only received about 13 cents on the dollar back from the government. Fully reimbursing these insurers as promised – and potentially expanding the program for another several years or permanently, as under Medicare Part D – would help to restore faith in the program and the stability of the marketplaces.

Encourage insurance companies that offer Medicaid managed care programs to also offer plans on the marketplace

Lawmakers could consider incentivizing insurance companies making bids on Medicaid plans to also offer care plans through the marketplace. Consumers on the edge of Medicaid eligibility and individual market insurance could benefit from having comparable plans available from the same carrier between Medicaid and the health exchanges. If carriers currently offering Medicaid managed care also offered exchange plans, they would potentially have a more stable base of consumers, who, in turn, would enjoy greater consistency in their coverage. Such a policy would reduce churning – or frequent changes between plans or in and out of coverage – and the resulting disruptions in care continuity for enrollees.

Allow greater state flexibility with strong minimum standards

Under Section 1332 of the Affordable Care Act, states can apply for a State Innovation Waiver to pursue distinctive strategies for providing residents with the same access to affordable health coverage they receive through the regular provisions of the ACA. In the context of a replacement plan, this state flexibility could be retained, though the standards for the breadth and affordability of coverage would need to be adjusted to reflect other changes made. At a minimum, states should be able to apply to use funding under the replacement plan to pursue policies that demonstrably increase the share of state residents who receive comprehensive health coverage relative to the baseline.

If carriers currently offering Medicaid managed care also offered exchange plans, they would potentially have a more stable base of consumers, who, in turn, would enjoy greater consistency in their coverage.

Use the purchasing power of government to reduce the growth of costs

The ACA made a number of changes in Medicare reimbursement that shifted the trajectory of its spending toward greater economy in the purchase of covered services and insurance. These approaches could be expanded and refined over time, most notably with regard to the purchase of prescription drugs under Part D of Medicare. Direct purchasing of medical devices and prescription drugs is common in other public health insurance systems in the United States – the Department of Defense and Department of Veterans Affairs (VA) both directly purchase prescription drugs (with a combined total expenditure of over \$10 billion in 2012), though the VA approach is generally considered more effective.

Another means of using government purchasing power would be to create various sorts of public insurance options. These could be developed at the state level under Section 1332, though states typically lack the experience, personnel, and administrative capacity to create strong purchasers. However,

An additional advantage of using Medicare's purchasing power to push back against high prices for services, drugs, and devices is that it could encourage private insurers to adopt similar innovations.

the federal Medicare program has a proven record of pursuing payment reforms that not only result in lower average prices than seen in the private sector, but also decreases in the variation of such prices across geographic locales and providers. An additional advantage of using Medicare's purchasing power to push back against high prices for services, drugs, and devices is that it

could encourage private insurers to adopt similar innovations. The successful competition in the Medicare program between traditional Medicare and private Medicare Advantage plans demonstrates the feasibility and advantageousness of public-private competition in health insurance markets.

Expanding Medicare's involvement in the market for services for non-elderly Americans could occur in several ways. A full-scale national plan, separate from Medicare, would be a substantial undertaking and is unlikely to be able to emerge in the near term given the other fundamental issues discussed in this *Report*. However, there are numerous demonstration approaches that could be adopted, including allowing consumers to buy into Medicare where health insurance competition is weak to nonexistent, or permitting "near-elderly" Americans not yet eligible for Medicare to buy into the program.



Conclusion

This *Report* offers a set of options that can help guide policymakers as they seek to improve coverage and lower the cost of health insurance. Health insurance reform is a complicated policy endeavor with many moving parts that must work together. Missteps could have devastating consequences for those who lose quality coverage or forgo necessary care because they can no longer afford the out-of-pocket costs. Policymakers would be well-advised to proceed with care, learning from experience and the best available evidence in this complex but vital policy area.

Health insurance reform is a complicated policy endeavor with many moving parts that must work together. Missteps could have devastating consequences for those who lose quality coverage or forgo necessary care because they can no longer afford the out-of-pocket costs.

**Better Leveraging Medicaid to Improve
Social Determinants of Health**

Better Leveraging Medicaid to Improve Social Determinants of Health

A vexing feature of the U.S. health care system is that despite having by far the highest costs in the world, our health outcomes have long lagged behind those of most other advanced industrial countries. Part of the puzzle can be explained by the fact that much of the cause of these poor outcomes lies upstream of our actual health care system – in the social determinants of health. For an in-depth analysis of how Medicaid can be better leveraged to combat social determinants of health, see the Academy's 2017 study panel report, *Strengthening Medicaid as a Critical Lever in Building a Culture of Health*.¹

While health care is an indispensable component of health, social, economic, and environmental factors also play key roles in determining health and wellbeing.^{2,3} Race, ethnicity, sex, socioeconomic status, and even geographic location are all associated with health and life prospects.⁴ Inequality in life expectancy by income is growing, as higher-income individuals benefit more than those with low incomes from rapid rates of improvement in life expectancy.⁵ Infant mortality rates, for example, correlate strongly with socioeconomic status, and three key drivers of infant mortality—maternal age, marital status, and education—are all strongly associated with family household income.⁶ Economic insecurity is also directly related to almost every other social determinant of health, from housing and food access to education and child care, as well as to an increased risk of poor mental health⁷ and other physical health disorders such as diabetes⁸ and heart disease.⁹

Inequality in life expectancy by income is growing, as higher-income individuals benefit more than those with low incomes from rapid rates of improvement in life expectancy.

¹ Sara Rosenbaum, Trish Riley, Alexandra L. Bradley, Benjamin W. Veghte, and Jill Rosenthal, 2017, *Strengthening Medicaid as a Critical Lever in Building a Culture of Health*, Washington, DC: National Academy of Social Insurance.

² JM McGinnis & WH Foege, 1993, Actual Causes of Death in the United States, *JAMA*, 270, 2207-2212.

³ Harry J. Heiman and Samantha Artiga, 2015, *Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity*, The Henry J. Kaiser Family Foundation, <http://kff.org/disparities-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/>.

⁴ CDC, 2013, *CDC Health Disparities and Inequalities Report: United States, 2013*, <http://www.cdc.gov/mmwr/pdf/other/su6203.pdf>.

⁵ National Academies of Sciences, Engineering, and Medicine, 2015, *The Growing Gap in Life Expectancy by Income: Implications for Federal Programs and Policy Responses*, Washington, DC: The National Academies Press, doi: 10.17226/19015.

⁶ Steven J. Haider, 2014, *Racial and ethnic infant mortality gaps and socioeconomic status*, <http://www.irp.wisc.edu/publications/focus/pdfs/foc311f.pdf>.

⁷ World Health Organization, 2007, *Breaking the Vicious Cycle between Mental Ill-Health and Poverty*, Accessed Jan. 21, 2016, http://www.who.int/mental_health/policy/development/1_Breakingviciouscycle_Infosheet.pdf.

⁸ Sandra A. Black, 2002, *Diabetes, Diversity, and Disparity: What Do We Do With the Evidence?*, *American Journal of Public Health*, 92(4), 543-548, <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1447113/pdf/0920543.pdf>.

⁹ Loucks, Lynch, Pilote, Fuhrer, Almeida, Richard, Agha, Murabito, and Benjamin, 2008, *Life-Course Socioeconomic Position and Incidence of Coronary Heart Disease: The Framingham Offspring Study*, *American Journal of Epidemiology*, 169(7), 829-836, <http://aje.oxfordjournals.org/content/169/7/829.full.pdf+html>.

Medicaid serves as a front-line responder for the country's most vulnerable populations and health problems.

As the nation's largest public insurer of low-income and medically vulnerable individuals and families, Medicaid – working in combination with other programs that address social determinants of health – has the potential

to play a strong role in any successful effort to improve both patient and population health. Medicaid serves as a front-line responder for the country's most vulnerable populations and health problems. As the source of health care financing for people who experience both elevated poverty and the associated health risks, Medicaid coverage is the primary means by which these populations gain access to health care. Moreover, in urban and rural communities with high concentrations of poverty, Medicaid functions as a key economic engine anchoring health care services in communities.



Over the past half century, Medicaid's importance has grown as a result of numerous social, demographic, and economic trends, as well as federal and state policy responses to these trends, which include an aging society and an increased demand for family caregiving, the greater survival rates of children and adults with disabilities, a weakening employer-sponsored insurance system (especially for low-wage workers), and broader economic shifts away from higher-paying jobs that carry good health benefits, especially in manufacturing. As Medicaid has expanded to meet these needs, the program has been at the forefront of initiatives to combine access to health care with broader efforts to combat underlying social risk factors. Indeed, many of these initiatives place strong emphasis on using health care as an entry point for more comprehensive responses to health and social risks.

Certain key characteristics of Medicaid make it unique among insurers as a partner with other programs that address social determinants of health. Unlike private insurance, which depends on specified "open enrollment" periods in order to manage health risks, Medicaid is structured to offer coverage at any time; enrollment is available whenever the need for health

care arises. Furthermore, Medicaid offers more comprehensive coverage, with lower cost sharing in recognition of the poverty and heightened health needs of program beneficiaries. Medicaid insures a greater and more sustained range of clinical services that promote health,

Medicaid offers more comprehensive coverage, with lower cost sharing in recognition of the poverty and heightened health needs of program beneficiaries.

including services for children and adults with severe disabilities such as extended mental health care and habilitative services. Medicaid also emphasizes coverage of preventive services, especially for children and adults of childbearing age. Unlike private insurance, Medicaid covers treatments in community settings – such as schools, Head Start programs, and adult day treatment settings – as well as in the home – through home-visiting programs for new mothers and infants. Because of the concentrated nature of poverty in many parts of the country, Medicaid is the chief source of health care financing for clinics, community health centers, and hospitals that serve as anchors for the community, frequently offering both health care and social services ranging from access to nutritious foods to education programs, job training, and connection to affordable housing.

In recent years, many states have undertaken service delivery and payment reforms in order to improve program quality and efficiency. States are now using Medicaid financing to achieve greater service integration, replace high-volume care with better-value care, and encourage health care systems to do a better job of aligning their own activities with those of social service programs in their communities through more active care management.

Policy Challenges

In positioning Medicaid as a more effective insurer that cooperates with social service programs in order to reduce social risk factors, states face certain challenges. Some of these challenges confront health insurance and health care generally, while others are unique to Medicaid. These unique challenges are the result of Medicaid's special mission and purpose as an insurer of populations made vulnerable by poverty, health risks and expanded medical needs, and a combination of factors that demand somewhat more comprehensive and flexible coverage.

Poverty

Medicaid is the nation's leading source of health insurance for low-income individuals and families. High levels of poverty increase demands on the Medicaid program and program costs. In addition, poverty is associated

Poverty is associated with a cascade of health risks that present significant challenges to securing adequate health care and maintaining optimal health.

with a cascade of health risks that present significant challenges to securing adequate health care and maintaining optimal health. These risks often increase the need for supportive care management that can connect beneficiaries to social services.

State costs associated with Medicaid, including program transformation

Medicaid imposes substantial expenditure obligations on states. While the federal government supported the cost of the Affordable Care Act's adult Medicaid expansion for the first three years of full implementation, federal support will begin to diminish somewhat in 2017, dropping to 90 percent in 2020. Except for the considerable number of children and adults falling within traditional eligibility categories but identified through the ACA's simplified outreach and enrollment efforts, the normal federal funding formula applies, and many important administrative costs accompany eligibility expansion.

Furthermore, state Medicaid transformation efforts require an upfront investment in the operational and information infrastructures that lie at the heart of the transformation effort. As with other forms of health insurance coverage, state Medicaid programs also need to be able to invest in the types of ongoing progress assessments that help identify which initiatives are working and which require modification.

The complexity of the transformation process

While the federal-state partnership for implementing Medicaid is a critical element of the program's success to date in improving the social determinants of health, this partnership does lead to some challenges as states attempt Medicaid transformation. Three of the most important federal challenges are: the need for a simpler process for obtaining special program waivers or demonstration approval, the need for a longer budget window for proving the effectiveness of transformation efforts, and an approach to measuring cost-effectiveness that takes into account reduced expenditures for social services, education, and/or the criminal justice system as a result of better access to comprehensive care in settings where health care services are partnered with preventive social interventions.

Funding the social services that promote health

Inadequate funding for social services interventions poses a substantial problem. At its core, Medicaid has a strong mission of improving the health of vulnerable populations; but above all, Medicaid is health insurance that faces the same cost pressures confronting all forms of health insurance, as well as unique pressures arising from its special characteristics. Medicaid's central

role is as a payer of clinical care for people entitled to coverage to receive care from qualified, participating providers. While Medicaid may be more flexible than other forms of insurance to carry out its unique missions, Medicaid is meant to work with social service programs, not to take their place. Medicaid can be a strong insurance partner, but where social risk factors are concerned, Medicaid cannot go it alone.

Expanding Medicaid coverage and making coverage more stable

As of January 2017, 31 states and the District of Columbia have opted to extend Medicaid to all eligible residents with low household incomes, not merely those falling under certain categories. Other states may still opt for such an expansion, and retaining this option to do so is

important, as it eliminates the risk of major coverage gaps among the poor simply due to life circumstances such as a minor child reaching age 18, an older adult who is laid off from a job with good health benefits, or the end of a post-partum coverage period for a new mother. Furthermore, continuity of coverage remains a challenge in Medicaid, since even small changes in monthly income can result in the loss of coverage. To this end, approaches that structure enrollment among working-age adults on an annual basis (perhaps with a buy-in option for those just above the eligibility cutoff), much as job-based insurance operates, would be an important improvement, just as continuous eligibility is now a state option for children.

31 states and the District of Columbia have opted to extend Medicaid to all eligible residents with low household incomes, not merely those falling under certain categories.

Excluding high-need populations

Many states face challenges associated with covering people who are not long-term U.S. residents or who do not lawfully reside in the U.S. These challenges must be addressed to help stabilize health care and to avert the financial burdens borne by certain safety net institutions and state and local governments.

A fragmented health care infrastructure

Limitations in data infrastructure and capacity also pose a barrier to Medicaid. The current fragmented delivery system often forces health care providers to operate in silos, particularly where integration of physical and behavioral health care is concerned. Developing interoperable data systems that can facilitate information sharing, with informed beneficiary consent, across all members of patient health teams, all while protecting privacy and security, is critical to the operation of a health system that can best deploy resources where they are most needed.

Misallocation of risks and rewards

State Medicaid investments in improving health may require capital and entail risk. The absence of a means for generating shared savings that could flow from broader social and health gains – a problem that has been particularly manifest in special demonstration efforts aimed at improving the quality and efficiency of health care for people dually eligible for Medicare and Medicaid, where savings are more likely to flow to the federal government – in turn limits the incentive to provide state Medicaid programs with the financial flexibility to invest in improvements.



Future Directions for Medicaid

As Congress and a new President embark on a major health reform effort, these challenges and others arise in making Medicaid a more efficient insurer, a stronger purchaser of high quality health care, and a better partner in more comprehensive health improvement efforts. To this end, certain considerations might help guide efforts to reshape Medicaid:

- Coverage that is accessible through a simplified and streamlined enrollment and renewal process, stable over time, and affordable for covered populations;
- A benefit design that emphasizes both the services needed to keep patients healthy as well as community-based long-term services and supports for children and adults for whom a standard insurance plan is not sufficient;
- Incentives for patients to use preventive care and to adhere to ongoing treatments for high-cost conditions that can be well-managed in community settings;
- Incentives for states to undertake payment and service delivery reforms that reward efficiency and quality outcomes, and to invest federal and state funds in health care further upstream (i.e., prevention); and

- Incentives for states to test new approaches to purchasing coverage and creating delivery systems that have the capacity to integrate Medicaid-covered health care services with other health, educational, housing, nutritional, and social services that help beneficiaries attain and maintain health.

Some of these reforms may require legislative changes, such as a continuous eligibility option for adults or creating new financial incentives for states to incorporate promising service delivery and payment reforms into Medicaid coverage and financing. Others, such as moving toward a longer and more inclusive budget window to measure demonstration cost savings or simplifying the waiver process, can be accomplished administratively. Some of these reforms can be enacted by states to make more effective use of program flexibility already built into federal law.



Conclusion

Over the past half-century, Medicaid has demonstrated resilience and a unique ability to respond to far-reaching changes in underlying economic, social, and health circumstances. As the nation continues to build health improvement strategies into the health care system itself, Medicaid – as the nation’s largest public insurer – will play a crucial role in transforming the delivery system.

Furthermore, more than any other insurer, Medicaid stands to gain real value from improvements to the social determinants of health and health care integration, given the populations and health needs the program insures. Strengthening Medicaid’s power as an insurer and the efficiency with which it operates thus should be central to any plan to improve health and reduce inequality.

Medicaid has demonstrated resilience and a unique ability to respond to far-reaching changes in underlying economic, social, and health circumstances.

Strengthening Medicare's Finances

Strengthening Medicare's Finances

Since 1965, the United States has pledged to provide health security in retirement to all Americans who have contributed to Medicare throughout their working lives. In 1972, Congress extended Medicare coverage to recipients of Social Security Disability Insurance.¹ The Medicare program embodies a solemn commitment to assure the elderly and disabled access to affordable health care of a quality available to the general population. In 2016, Medicare covered over 57 million people across the United States, the majority of them seniors.² It serves as a critical protection for vulnerable millions who would otherwise be uninsured and unable to afford even basic health care, despite having much greater health care needs. Even so, Medicare could do more to reduce the burden of high out-of-pocket costs on many beneficiaries, in order to maintain its commitment to provide health care coverage for the elderly and the disabled.

In addition to providing high-quality, affordable health insurance to otherwise vulnerable populations, Medicare has also outperformed private health insurance in holding down the growth of health care costs, an important policy concern. Between 1989 and 2014, Medicare spending per enrollee grew at an average annual rate of 5.5 percent, somewhat slower than the 6.3 percent average annual growth rate in private insurance spending per enrollee over these years.³ Although

Although Medicare poses long-term budgetary challenges stemming from the aging of the population and the continued growth in costs throughout the health care system, Medicare itself does not face immediate problems, and many options are available for strengthening its finances.

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Background

What is Medicare and How is It Financed?

Medicare has four major components. Medicare Part A, also known as Hospital Insurance, covers inpatient hospital care, hospice care, skilled

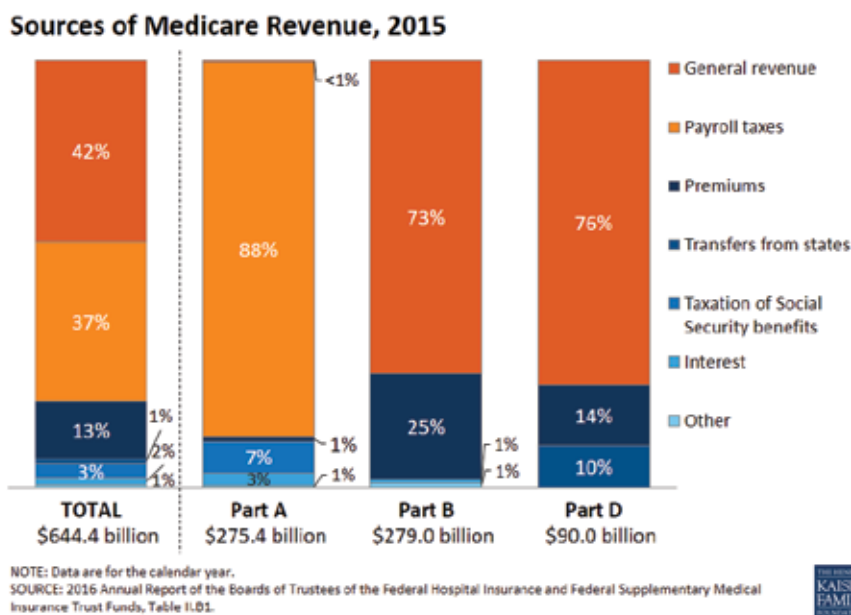
¹ Eligibility begins after a two-year waiting period, except in certain cases.

² Centers for Medicare & Medicaid Services, 2016, CMS Financial Report: FY 2016, https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CFOReport/Downloads/2016_CMS_Financial_Report.pdf.

³ Juliette Cubanski and Tricia Neuman, 2016, The Facts on Medicare Spending and Financing, The Henry J. Kaiser Family Foundation, <http://kff.org/medicare/issue-brief/the-facts-on-medicare-spending-and-financing/>.

nursing facility care, and some home-based care. Medicare Part B (Supplementary Medical Insurance) covers doctors' services and outpatient care, medical devices, and preventive care. Medicare Part D covers prescription drugs. Medicare Part C, more commonly known as Medicare Advantage, is an alternate source of Medicare coverage for Parts A and B – and often also Part D – that beneficiaries can opt to purchase from a private insurance company.⁴

Medicare Part A is financed primarily through a 2.9 percent payroll tax on earnings paid by employers and employees (1.45 percent each). Unlike the payroll tax for Social Security, which applies to earnings up to an annual maximum (\$127,200 in 2017), the 2.9 percent Hospital Insurance tax is levied on total earnings. The Affordable Care Act increased revenue for Medicare Part A through an additional 0.9 percent Medicare tax on earnings above certain thresholds (\$200,000/individual and \$250,000/couple). Payroll taxes account for 88 percent of Part A revenue (see figure below). Since 1993, Medicare Part A also receives revenue from income taxation of Social Security benefits (7 percent of Part A revenue).⁵ The Affordable Care Act also added a tax on the investment income of households with high earnings, termed the “unearned income Medicare contribution,” although this revenue does not flow to the Medicare program. Thus, Medicare taxes have increased on those with higher incomes, but remained steady for most workers.



⁴ Medicare.gov, n.d., What's Medicare?, <https://www.medicare.gov/sign-up-change-plans/decide-how-to-get-medicare/whats-medicare/what-is-medicare.html>.
⁵ The trust fund receives revenue from taxes on up to 85 percent of Social Security benefits for single taxpayers with incomes over \$34,000 and for taxpayers filing jointly with incomes over \$44,000. Social Security Administration, n.d., Taxation of Social Security Benefits, <https://www.ssa.gov/oact/progdata/taxbenefits.html>.

Medicare Parts B and D have a different financing model: roughly three-quarters of their funding comes from general federal revenues, and most of the remaining one-quarter comes from beneficiary premiums. Higher-income enrollees (more than \$85,000 for individuals and \$170,000 for couples) pay higher premiums, ranging from 35 percent to 80 percent of per capita costs, depending on their income.⁶

What is Medicare's Financial Outlook?

Medicare Part A (Hospital Insurance)

The 2016 report of Medicare's trustees projects that Medicare's Hospital Insurance (HI) trust fund will be able to pay 100 percent of costs through 2028, given current revenue sources. In 2028, when the HI trust fund is projected to be depleted, incoming payroll taxes and other revenue will be sufficient to pay 87 percent of Medicare hospital insurance costs.⁷ The shortfall will need to be closed through raising revenues, slowing the growth in spending, or both.

Medicare's Hospital Insurance (HI) trust fund will be able to pay 100 percent of costs through 2028.

These projections are highly uncertain and not a cause for alarm. Since 1970, the projected date of HI insolvency has been as near as two years away or as far as 28 years in the future.⁸ The latest projection falls in the middle of that range.

Medicare's Hospital Insurance trust fund's outlook has improved because of the ACA and MACRA. These laws changed provider payment rates, included measures to combat fraud and abuse, increased support for care coordination, and added a research and development program to drive innovation in alternative provider payment methods.

The program's outlook has improved because of the Affordable Care Act and the Medicare and CHIP Reauthorization Act of 2015 (MACRA). These laws changed provider payment rates, included measures to combat fraud and abuse, increased support for better care coordination, and added a research and development program to drive innovation in alternative provider payment methods. These measures cut

⁶ Cubanski and Neuman, 2016.

⁷ Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, June 22, 2016, 2016 Annual Report, <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2016.pdf>.

⁸ Patricia A. Davis, Medicare: Insolvency Projections, Congressional Research Service, October 5, 2016, <https://www.fas.org/sgp/crs/misc/RS20946.pdf>.

the projected HI 75-year shortfall from 3.88 percent of payroll subject to the Medicare tax, as estimated in 2009, to 0.73 percent, as estimated in 2016.

Medicare Part B (Supplementary Medical Insurance) and Part D (Prescription Drug Benefit)

Medicare Parts B and D can't run short of funds because they have a permanent appropriation to cover outlays in excess of beneficiary premiums. But they will impose growing costs on enrollees and taxpayers as a result of the growth of per-person medical spending and by population aging. Growth of prescription drug spending, because of expensive new drugs and price increases for older products, has become a particular concern for both Medicare and the entire U.S. health care system.⁹

Medicare Part C (Medicare Advantage)

The Medicare Advantage program is financed predominately by the other parts of Medicare. Medicare Advantage plans cover all of Part A, Part B, and (typically) Part D benefits. Enrollees typically pay monthly premiums for additional benefits covered by their plan, in addition to the Part B premium. Enrollment in Medicare Advantage has grown over the years, and now nearly one-third of Medicare beneficiaries (31 percent) are enrolled in an MA plan.¹⁰ Data on enrollment rates in Medicare Advantage over time suggest that as seniors age and become sicker, they tend to drop Medicare Advantage plans in favor of traditional Medicare.^{11,12}

Policy Challenges

Long-term revenue shortfall

As discussed above, the Medicare HI trust fund is projected to become insolvent in 2028. Even with strong economic growth and potential cost-savings through greater efficiencies in the health care delivery system, Medicare will require substantially more revenues over the coming decades than under current law.¹³

Growth of prescription drug and other spending

Medicare has been a leader in reforming the health care payment system to improve efficiency. Efforts should continue to focus on slowing health care

⁹ Aaron S. Kesselheim, Jerry Avorn, and Ameet Sarpatwari, 2016, The High Cost of Prescription Drugs in the United States, JAMA, 316(8):858-871, <http://jamanetwork.com/journals/jama/article-abstract/2545691>.

¹⁰ Cubanski and Neuman, 2016.

¹¹ Momotazur Rahman, Laura Keohane, Amal N. Trivedi, and Vincent Mor, 2015, High-Cost Patients Had Substantial Rates of Leaving Medicare Advantage and Joining Traditional Medicare, Health Affairs, 34(10), 1675-1681, <http://content.healthaffairs.org/content/34/10/1675.abstract?sid=225f9167-0749-445a-a660-80241597bc7d>.

¹² Cubanski and Neuman, 2016.

¹³ Final Report of the Study Panel on Medicare's Long-Term Financing, September 2000, "Financing Medicare's Future," National Academy of Social Insurance, https://www.nasi.org/sites/default/files/research/med__report_financing_NO.pdf.

cost growth, while improving the quality of care.¹⁴ Spending on prescription drugs is projected to grow especially quickly over the coming decade, with per capita spending expected to rise by 5.8 percent annually for Part D, versus 3.2 percent for Part A and 4.6 percent for Part B.¹⁵

The aging of the Boomer generation

With the retirement of the Boomer generation, Medicare enrollment is rising. The number of beneficiaries is projected to grow from 57 million in 2016 to nearly 90 million by 2040. More beneficiaries means increased program spending. At the same time, as Boomers retire, the workforce that pays Medicare Part A payroll taxes – and that contributes through income taxes to the general revenues which fund three-quarters of Medicare Parts B and D – is growing more slowly than it has in the past.



High and rising out-of-pocket costs

For many seniors and people with disabilities on Medicare, out-of-pocket health care spending is burdensome. Out-of-pocket spending includes premiums, deductibles, and co-payments, as well as spending on things that Medicare does not cover like dental, vision, hearing, and long-term care costs. Vulnerable populations – the near-poor, those in poor health, and the oldest beneficiaries – face the highest out-of-pocket cost burdens. In 2011, even with programs like Medicaid aimed at helping the low-income population, the poorest Medicare beneficiaries spent an average of 23 percent of their income on health care.¹⁶

¹⁴ Karen Davis, Stuart Guterman, and Farhan Bandeali, 2015, *The Affordable Care Act and Medicare: How the Law Is Changing the Program and the Challenges That Remain*, The Commonwealth Fund, http://www.commonwealthfund.org/~media/files/publications/fund-report/2015/jun/1821_davis_aca_and_medicare_v2.pdf.

¹⁵ Cubanski and Neuman, 2016.

¹⁶ Claire Noel-Miller, 2015, *Medicare Beneficiaries' Out-of-Pocket Spending for Health Care*, AARP Public Policy Institute: Insight on the Issues, <http://www.aarp.org/content/dam/aarp/ppi/2015/medicare-beneficiaries-out-of-pocket-spending-for-health-care.pdf>.

Policy Options

Increase the payroll tax rate for Medicare Hospital Insurance

Raising the Hospital Insurance payroll tax by 0.8 percentage points would eliminate the entire currently-projected shortfall in the Part A trust fund. This option would raise the Medicare Part A payroll tax from its current level of 2.9 percent to 3.7 percent, split between employer and employee (1.85 percent paid by each). Workers with earnings above \$200,000 (\$250,000 for married couples filing jointly), who owe the 0.9 percent additional Medicare payroll tax on earnings above the threshold, would see their Part A payroll taxes rise from 1.45 to 1.85 percent on their earnings below the threshold, and from 2.35 to 2.75 on their earnings above the threshold (their employers would pay 1.85 percent both below and above the threshold). Alternatively, the tax could be increased by a smaller amount starting now and gradually ramped up, so that the net present value was the same as that of an immediate increase by 0.8 percentage points.

Premium support

Medicare now provides a specified, largely uniform set of health benefits, which beneficiaries can receive either through traditional Medicare or a private Medicare Advantage plan. Under premium support, in contrast, Medicare would make a fixed dollar payment (often called a “voucher”) on behalf of each beneficiary toward the cost of health insurance — either a private plan or a form of traditional Medicare. The beneficiary would pay an additional premium if his or her plan cost more than the amount of the voucher.

Premium support would represent a major restructuring of Medicare and would have disparate effects on beneficiaries, depending on their place of residence and choice of plan. Proponents contend that it would reduce overall Medicare spending by increasing competition among health plans and making beneficiaries more cost-conscious. Opponents argue that it would largely shift costs to beneficiaries, particularly those who wanted to remain in traditional Medicare. Most premium-support proposals have not been fleshed out in detail, however, and these details would have important implications for beneficiaries and the Medicare program.¹⁷

Control health care spending growth

Policymakers should continue to seek new ways of slowing the growth in Medicare and other health care spending without shifting costs to vulnerable beneficiaries or harming the quality of care. Objectives could include

¹⁷ See: Gretchen Jacobson and Tricia Neuman, 2016, Turning Medicare Into a Premium Support System: Frequently Asked Questions, The Henry J. Kaiser Family Foundation, <http://kff.org/medicare/issue-brief/turning-medicare-into-a-premium-support-system-frequently-asked-questions/>.

reducing costs by increasing competition among health care providers and reducing financial incentives to deliver unnecessarily costly services. Specific policies could entail eliminating or reducing differences in payments across sites of service, ending overpayments to pharmaceutical companies for drugs prescribed to low-income beneficiaries, expanding the use of competitive bidding, reducing payments for medical education, and reducing coverage of bad debts. (For a discussion of policy options for reducing prescription drug spending, see Section 2.d of this *Report*.) Also, the Medicare Payment Advisory Commission (MedPAC), Congress' nonpartisan advisory body, issues two annual reports with recommendations on Medicare payment policies.¹⁸

Limit out-of-pocket spending

Unlike most private health insurance plans, Medicare does not have a cap on out-of-pocket spending for beneficiaries of Parts A and B, nor does it have a cap on Part D prescription drug spending. As a result, between premiums, cost sharing, and high prescription drug costs, Medicare beneficiaries pay a significant amount in out-of-pocket costs for their health care coverage, and that burden will only increase as health care costs continue to rise.¹⁹ One solution would be to add an out-of-pocket cap to spending on benefits received under Medicare Parts A and B and prescription drug costs under Part D. An alternative or companion option would be to offer tax credits that would kick in when an individual exceeds a certain spending threshold or be linked proportionally to the individual's out-of-pocket spending burden.²⁰ Another option would be to extend the availability of premium and cost-sharing assistance to more low-income beneficiaries through the Medicare Savings Programs and low-income drug subsidy.

Restore adequate administrative funding

Administrative funding has not kept up with the growing demands on the Medicare program. There are about the same number of employees at Centers for Medicare & Medicaid Services (CMS) now as in 1980, despite tremendous growth in the size of the Medicare and Medicaid programs, and growth in the operational responsibilities of CMS.²¹ At the same time as its employee base has stagnated, CMS's role as the administrator of Medicare and Medicaid is much more complex than in the past. In managing the Medicare program, Congress has mandated that CMS

¹⁸ Available at medpac.gov. See also Kaiser Family Foundation: Medicare Policy, 2013, Policy Options to Sustain Medicare for the Future, Section 2, <https://kaiserfamilyfoundation.files.wordpress.com/2013/02/8402-section-two.pdf>. Although this latter report is somewhat dated, there are comparable, current opportunities.

¹⁹ Marilyn Moon and Yan Wang, 2016, Who Pays for Medicare?, Center on Aging at American Institutes for Research, <http://www.air.org/system/files/downloads/report/Center-on-Aging-Who-Pays-for-Medicare-1-May-2016.pdf>.

²⁰ Yevgeniy Feyman, 2016, Out-of-Pocket Caps: The Wrong Way to Tackle High Drug Prices, Manhattan Institute, Issue Brief: Health Policy, <http://www.manhattan-institute.org/sites/default/files/IB-YF-0316.pdf>.

²¹ CMS is requesting funding for 4,112 direct Full-Time Equivalent (FTE) employees in Fiscal Year 2017. This number is less than the 4,961 FTE employees the agency had in 1980. CMS, n.d., "FY2017 CMS Congressional Justification of Estimates for Appropriations Committees," p. 6, <https://www.cms.gov/About-CMS/Agency-Information/PerformanceBudget/Downloads/FY2017-CJ-Final.pdf>; Thomas H. Stanton, 2003, "The Administration of Medicare: A Neglected Issue," *Washington and Lee Law Review*, 60(4): 1373-1416, p. 1380. <http://scholarlycommons.law.wlu.edu/cgi/viewcontent.cgi?article=1256&context=wlulr>

evolve from a “claims payer” to a “value-based purchaser” and has given it additional responsibilities, which require a larger workforce with greater expertise. And in addition to Medicare and Medicaid, CMS has a number of new responsibilities – such as administering the Children’s Health Insurance Program (CHIP), the health insurance Marketplaces created by the Affordable Care Act, Medicare Advantage, the Center for Medicare and Medicaid Innovation (CMMI), and much more. In addition to improving the administrative efficiency of the programs it manages, increasing administrative resources would partly pay for itself by enabling the CMS to reduce fraud and abuse.²²

Conclusion

Congress has taken action at every point in Medicare’s history to ensure that the program remains solvent, and that the nation’s promise of health security to those in retirement and those with severe disabilities is kept. The program is not in crisis, and not going bankrupt; rather, it requires modest measures to shore up its long-term finances, as has been done on numerous occasions throughout the program’s history. The conclusion of the Academy’s bipartisan study panel on the future of Medicare’s finances from over a decade ago remains true today: to sustain the commitment to provide standard health care to the elderly and to people with disabilities, significant increases in tax revenue will be required. Economic growth, increased cost-sharing, and efficiency gains alone will not suffice. The policy options discussed here should be considered in terms of their effects on both the solvency of Medicare and the health and financial security of seniors and people with disabilities.



²² Robert A. Berenson and John Holahan, 2011, “Preserving Medicare: A Practical Approach to Controlling Spending Timely Analysis of Immediate Health Policy Issues,” <http://www.urban.org/sites/default/files/alfresco/publication-pdfs/412405-Preserving-Medicare-A-Practical-Approach-to-Controlling-Spending.pdf>.

Reining in Prescription Drug Prices

Reining in Prescription Drug Prices

Americans pay higher prices and spend more per person for prescription drugs than any other developed country in the world,¹ and spending is growing at a rapid and unsustainable rate. Unlike other nations, our laws and regulations – and the way they are enforced – permit pharmaceutical manufacturers

Retail prescription drug spending rose nine percent in 2015, reaching \$325 billion and outpacing the rate of spending growth on all other health services

to set their own prices with little government oversight. Retail prescription drug spending rose nine percent in 2015, reaching \$325 billion and outpacing the rate of spending growth on all other health services.² According to the Centers for Medicare & Medicaid Services (CMS), the increase in spending “is attributed to the increased spending on new medicines, price growth for existing brand name drugs, increased spending on generics, and fewer expensive blockbuster drugs going off-patent.”³ Some of the key challenges for reining in prescription drug prices are discussed below, followed by a menu of policy options for addressing these challenges.

Policy Challenges

Lack of competition for existing branded drugs

One of the key drivers of prescription drug spending has been the steady rise in spending on brand-name prescription drugs. Pharmaceutical companies lack incentives to rein in pricing; in fact, they are often incentivized to do just the opposite. Price protections for pharmaceutical companies through federally conferred monopolies such as patents prevent robust free market competition and reduce the capacity for negotiations between payers (i.e., public or private insurers) and pharmaceutical manufacturers.⁴ Both new and existing branded drugs drive up costs. According to a recent study by the IMS Institute for Healthcare Informatics, over half of the total spending growth in 2015 was from new branded products, which accounted for \$24.2 billion of new spending growth; generic medicines contributed \$7.9 billion and protected brand⁵ medicines \$2.7 billion to growth, respectively.⁶

¹ A.S. Kesselheim, J. Avorn, and A. Sarpatwari, 2016, The High Cost of Prescription Drugs in the United States: Origins and Prospects for Reform, *JAMA*, 316(8):858-71, <http://bit.ly/2drTfrN>.

² CMS, National Health Expenditures 2015 Highlights, <http://go.cms.gov/2hB0tcB>.

³ *Ibid.*

⁴ Kesselheim, Avorn, and Sarpatwari, 2016.

⁵ Protected brand medicines are those that are over two years old and have not yet faced generic competition.

⁶ IMS Institute for Healthcare Informatics, 2016, Medicines Use and Spending in the U.S. – A Review of 2015 and Outlook to 2020, <http://bit.ly/2i2ij97>.

Monopoly power – Specialty drugs, orphan drugs, and evergreening

Innovation requires investments in research and development that pharmaceutical developers need to recoup when products go to market. There is, however, little to no transparency on the true costs of research and development for innovative products. Another factor driving high prices for many prescription drugs is monopoly power for specialty drugs,⁷ orphan drugs,⁸ and the evergreening of old prescription drugs.⁹ In 2015, specialty drugs accounted for 37.7 percent of drug spending and 11 percent of drug spending growth.¹⁰ Usage of these specialty drugs – and therefore spending – is projected to grow even faster in future years. Similarly, pharmaceutical companies can charge exceedingly high prices for orphan drugs that treat conditions affecting relatively small populations (under 200,000) of people in the U.S. For instance, treatment for a condition affecting fewer than 10,000 individuals costs, on average, upwards of \$200,000 per year.¹¹ The process of evergreening also results in higher prices by extending patent protections, which restrict or prevent competition (with only minor modifications of drugs that do not necessarily provide additional benefit for patients).¹²

Medicare cannot negotiate prices

One particular factor driving the American health care system's high costs, without improving quality, is a law passed by Congress which forbids the Secretary of Health and Human Services from negotiating prices directly between Medicare, the largest single purchaser of drugs, and pharmaceutical manufacturers.¹³ In contrast, other government health programs such as those administered by the Veterans Administration, the Department of Defense, and Medicaid have negotiating mechanisms in place to achieve lower drug prices.¹⁴ In total, federal programs cover over one-third of all Americans,¹⁵ and combining the forces of the various public insurers would provide the federal government with substantial negotiating leverage to lower drug prices.

Combining the forces of the various public insurers would provide the federal government with substantial negotiating leverage to lower drug prices.

⁷ There is no standard definition for a specialty medication, but they are generally considered to be high-cost prescription medications used to treat complex, chronic conditions. Medicare's definition of specialty drugs is based on price; pharmaceuticals costing \$600 or more per month are considered specialty. See: Centers for Medicare and Medicaid Services, 2015, Medicare Part D Specialty Tier, <http://go.cms.gov/2jczfX>.

⁸ An orphan drug is a pharmaceutical that remains commercially undeveloped owing to limited potential for profitability.

⁹ The term "evergreening" describes the practice of making incremental, patentable innovations for medicines, thereby preserving market exclusivity, without significantly bettering the standard of care.

¹⁰ Express Scripts, 2016, 2015 Drug Trend Report, <https://lab.express-scripts.com/lab/drug-trend-report>.

¹¹ Jerry Isaacson, 2016, Analysis of Orphan Drug Market, LifeSci Capital, <http://bit.ly/2hNyNBM>.

¹² Reed F. Beall, Jason W. Nickerson, Warren A. Kaplan, and Amir Attaran, 2016, Is Patent "Evergreening" Restricting Access to Medicine/Device Combination Products? PLoS one, 11(2):e0148939, <http://bit.ly/2j4aTm4>.

¹³ Medicare Modernization Act of 2003, §1860D-11(i). <http://1.usa.gov/1Y2QRmj>.

¹⁴ David Blumenthal and David Squires, 2016, Drug Price Control: How Some Government Programs Do It, The Commonwealth Fund, <http://bit.ly/2hO9FKV>.

¹⁵ The Henry J. Kaiser Family Foundation, 2015, Health Insurance Coverage of the Total Population, <http://kaiserf.am/2hNH7Bp>.

Private rebates

Private rebates are one tactic used by pharmaceutical companies to keep prices high. Companies set their initial prices higher, but offer various rebates to different private-sector payers (e.g., insurers), based on the maximum amount that a payer is willing or able to pay. In some instances, the savings from rebates are passed on to consumers, but overall, private rebates increase drug prices. Additionally, since rebates are considered proprietary information, manufacturers and purchasers are permitted to keep rebate amounts confidential. This lack of transparency prevents market forces from restraining drug prices.

Pay-for-delay

Reverse payment patent settlement, or pay-for-delay, is another strategy used to inflate brand name drug prices and reduce competition by keeping less expensive generic alternatives off the market for a longer period. The Hatch-Waxman Act of 1984, which was intended to increase competition in the drug market, ironically led to this strategy by allowing brand name manufacturers to pay generic companies to keep their lower-cost generic alternatives off the market.

Drug coupons

Coupons from drug manufacturers help some consumers with the cost of their prescriptions, but increase overall spending by incentivizing consumers and providers to choose expensive, brand name drugs over more cost-effective options such as generics. Drug coupons reduce price transparency and, as a result, brand name drugs may temporarily appear more affordable to consumers. However, over time, these coupons increase health care system costs, including consumer costs, since the higher drug costs are passed on to the insurer who, in turn, raises premiums for everyone.



Policy Options

This section lists policy options aimed at reining in the growth of prescription drug prices by increasing transparency, affordability, and market efficiency.

I. Transparency

Permit the Department of Health and Human Services (HHS) to review the accountability of prescription drug price increases

One policy option would be for Congress to permit the Secretary of Health and Human Services to review the justification of extremely high-cost or rapidly increasing drug prices. The law could set standards that would trigger a review process to establish justification for the high cost or price increase, such as a price increase of 10 percent or more over a 12-month period.

Require pharmaceutical companies to report rebate rates

Under current law, rebates are considered proprietary information and therefore are not subject to reporting requirements or scrutiny by the public, the federal government, or even other payers. The use of a rebate system, however, allows pharmaceutical companies to set a higher initial price for drugs, which they then are able to negotiate down with payers based on their power and ability to pay. One policy option to increase transparency, and thereby increase market efficiency, would be to require pharmaceutical companies to publicly report their rebate rates for different payers.

Require pharmaceutical companies receiving public research funds to report all spending publicly

One policy option to increase transparency would be to require any pharmaceutical company that receives public funds for research and development to publicly report their entire budget. Such reporting would increase transparency, painting a clearer picture of how much these companies are spending on research and development, advertising, administrative costs, and other non-research expenses.

II. Affordability

Authorize the Secretary of Health and Human Services to negotiate drug prices for Medicare

Along with growing public attention to escalating drug costs has come a parallel interest in allowing the federal government to negotiate prices with pharmaceutical companies. The concept of allowing the federal government to negotiate Medicare drug prices has broad (82 percent) public support.¹⁶

¹⁶ Ashley Kirzinger, Bryan Wu, and Mollyann Brodie, September 29, 2016, Kaiser Health Tracking Poll: September 2016, Kaiser Family Foundation, <http://kaiserf.am/2dkS0YB>.

Several different policy options and factors must be considered when extending powers of negotiation to the Secretary of HHS.

- **Price controls:** The most restrictive option would be for HHS to set a specific amount – such as a percentage of average costs or a maximum cap – on what the program will pay for prescription drug coverage. This option is similar to what most state Medicaid programs do to control costs.¹⁷ Opponents of HHS involvement in controlling Medicare’s drug costs frequently express concern over this particular policy option, and argue that price controls would compromise research and development and raise private sector drug costs.¹⁸ However, as discussed above, there is a lack of transparency regarding pharmaceutical research and development expenditures making it difficult to confirm the validity of such concerns with greater price controls.
- **Negotiation backed by arbitration:** In a true negotiation process, HHS and drug manufacturers could have a set period of time during which they need to come to an agreement on prices. Comparative effectiveness research, which compares the clinical benefits of multiple treatment alternatives, could inform HHS decisions regarding the value of new prescription drugs.¹⁹ If an agreement cannot be reached, an independent arbitrator could be appointed to decide between the two offers, or an independent expert could impose a third option based on research.²⁰
- **Public Medicare-sponsored Part D plan:** Another policy option would be to develop a public Medicare-sponsored Part D plan that would compete on the market with the private plans. In this context, public and private plans would negotiate separately with pharmaceutical companies to obtain the best prices for enrollees. Cost savings would be dependent on whether or not the government is, in fact, able to negotiate drug prices better than private plans currently are able to do.²¹

Another policy option would be to develop a public Medicare-sponsored Part D plan that would compete on the market with the private plans.

¹⁷ Ibid.

¹⁸ David Hogberg, 2007, Letting Medicare “Negotiate” Drug Prices: Myths vs. Reality, The National Center for Public Policy Research, <https://www.nationalcenter.org/NPA550MedicareDrugPrices.html>.

¹⁹ Topher Spiro, Maura Calsyn, and Thomas Huelskoetter, 2016, Negotiation Plus: A Framework for Value-Based Drug Pricing Negotiation, Center for American Progress, <http://ampr.gs/2jcfL8a>.

²⁰ Chuck Shih, Jordan Schwartz, and Allan Coukell, 2016, How Would Government Negotiation Of Medicare Part D Drug Prices Work?, Health Affairs Blog, <http://bit.ly/2ipqtYf>.

²¹ Ibid.

Subject companies receiving public research funds to legal price constraints
Federal funding, largely through the National Institutes of Health, plays a key role in new drug development.²² For example, one recent study found that public sector research institutions contributed to the discovery of more than 20 percent of all new drugs approved from 1990 through 2007, and this does not include public funding to private companies engaged in drug development. The Bayh-Dole Act, passed in 1980, does contain provisions to rein in high prices specifically for those drugs developed with federal funding. It states that almost any new drug invented wholly or in part with federal funds must be made available to the public on “reasonable terms.”²³ As a number of scholars^{24,25} and members of Congress have argued,²⁶ reasonable terms means reasonable prices. If the prices are unreasonable, the government can use its “march-in” rights to insist that the drug be licensed to other manufacturers.²⁷ If the company refuses, the government can then license it to third parties that will sell the drug at a more reasonable price. This law has been on the books for more than 35 years and yet these provisions have never been invoked. The current era of escalating drug prices would seem to provide justification for invoking this power.

To leverage and consolidate the negotiating power of the federal government to an even greater degree, one policy option is to combine all federal payers into a single negotiating body.

Negotiate drugs prices uniformly across all federal payers

To leverage and consolidate the negotiating power of the federal government to an even greater degree, one policy option is to combine all federal payers into a single negotiating body. Such a policy would involve Medicare, Medicaid,

the Veterans Health Administration, the Department of Defense, the Indian Health Service, the Federal Employee Health Benefit Program, and all other public payers in collaboratively negotiating drug prices with pharmaceutical companies, leveraging the bargaining power of all agencies collectively.

Remove mandatory coverage status

The policy of requiring insurers to cover particular drugs is an essential patient and consumer protection. Nevertheless, it can give pharmaceutical

²² Ashley J. Stevens, Jonathan J. Jensen, Katrine Wyller, Patrick C. Kilgore, Sabarni Chatterjee, and Mark L. Rohrbaugh, 2011, The Role of Public-Sector Research in the Discovery of Drugs and Vaccines. *New England Journal of Medicine*, 364(6), 535-41, <http://bit.ly/2hO1z52>.

²³ 35 U.S.C. §201 (f), <https://www.law.cornell.edu/uscode/text/35/201>.

²⁴ Peter S. Arno and Michael H. Davis, 2000, Why Don't We Enforce Existing Drug Price Controls: The Unrecognized and Unenforced Reasonable Pricing Requirements Imposed upon Patents Deriving in Whole or in Part from Federally Funded Research. *Tulane Law Review*, 75, 631. <http://bit.ly/2cQpBao>.

²⁵ Walter D. Valdivia, 2011, The Stakes in Bayh-Dole: Public Values beyond the Pace of Innovation. *Minerva*, 49(1), 25-46, <http://bit.ly/2h3Ngs5>.

²⁶ Letter to Secretary of Health and Human Services, Sylvia Burwell and Director, National Institutes of Health, Francis Collins by members of Congress, March 28, 2016, <http://bit.ly/2gVku9D>.

²⁷ 35 U.S.C. §203 - March-in rights, <https://www.law.cornell.edu/uscode/text/35/203>.

companies excessive leverage in negotiations with certain payers. Carefully limiting mandatory coverage status has the potential to strengthen the bargaining power of insurers over pharmaceutical companies, but must be accompanied by policies that promote access to essential medications, such as through patient-friendly appeal rights and other consumer protections.

Proscribe the use of rebates

Private rebates to payers give pharmaceutical companies disproportionate negotiating leverage since companies are able to set prices high and then reduce them according to the bargaining power of individual payers. Setting high baseline prices for drugs inevitably drives up costs and gives pharmaceutical companies a financial and bargaining advantage. Proponents argue that limiting or eliminating private rebates would level the playing field between payer and manufacturer and lead to true negotiation between the two groups, which in turn would lower prices for consumers. It is important that rebates through Medicaid and other federal or state programs not be included in such a policy option, rather applying only to private rebates.

Proscribe the use of copay coupons

Copay coupons – seemingly helpful tools for lowering prescription drug prices for consumers – are in fact raising overall health care costs for both individuals and insurers.²⁸ One strategy for reducing costs would be to forbid drug manufacturers from issuing copay coupons to consumers and providers. Since coupons hide the actual cost of prescription drugs from consumers and even providers, this policy option would also increase transparency. Consumers and providers could make decisions based on the true costs of their choices, and potentially make more financially conservative decisions, such as choosing a generic option over a brand name drug.



²⁸ P.A. Ubel and P.B. Bach, 2016, "Copay assistance for expensive drugs: a helping hand that raises costs" [published online October 11, 2016], *Annals of Internal Medicine*, doi:10.7326/M16-1334.

End corporate tax deductions for direct-to-consumer drug marketing

How direct-to-consumer (DTC) marketing affects the health of the American people is subject to a great deal of controversy. On the one hand, proponents of the practice argue that it increases consumer awareness of medical conditions and the drugs available to treat them. Opponents, however, argue that these practices drive consumers towards requesting higher-cost brand name drugs over equally effective lower-cost brand or generic drugs, and express frustration that money spent on marketing could be used for research and development, instead.²⁹ The United States is one of the few countries that allows DTC advertising (New Zealand is the only other developed nation that does).³⁰ In 2015 alone, pharmaceutical manufacturers spent more than five billion dollars on drug advertising.³¹ One policy option is to end corporate tax deductions for DTC drug marketing. These tax deductions incentivize spending on marketing, and their removal may shift spending from marketing to research and development.

Allow re-importation of drugs

Another option for containing growth in prescription drug costs would be to allow the re-importation of drugs from foreign countries. Allowing re-importation directly by consumers could potentially pose dangers to their health and safety if drugs and their supply chains were not adequately regulated. Allowing re-importation through well-regulated manufacturer, wholesale, and pharmacy pathways, however, could achieve cost savings without compromising safety. These large-scale institutions would be better equipped to monitor drug safety as outlined by the FDA under the Drug Supply Chain Security Act.³² Changing the law to facilitate re-importation could require provisions mandating that savings be passed on to consumers when setting drug prices.³³



²⁹ C. Lee Ventola, 2011, Direct-to-consumer pharmaceutical advertising: Therapeutic or toxic?, *Pharmacy and Therapeutics*, 36(10): 669-674, 681-684, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3278148/>.

³⁰ U.S. Food & Drug Administration, n.d., Keeping Watch Over Direct-to-Consumer Ads, Updated June 14, 2016, <http://bit.ly/2idFdGb>.

³¹ Rebecca Robbins, 2016, Drug makers now spend \$5 billion a year on advertising. Here's what that buys. *Stat News*, March 9, 2016. <http://bit.ly/2irKBH3>.

³² U.S. Food & Drug Administration, n.d., Are you ready for the Drug Supply Chain Security Act? Updated December 15, 2016, <http://bit.ly/2il5Qcz>.

³³ For further analysis of this issue, see: Monali J. Bhosle and Rajesh Balkrishnan, 2007, Drug reimportation practices in the United States, *Therapeutics and Clinical Risk Management*, 3(1), 41-46, <http://bit.ly/2ihNvSz>.

Cap out-of-pocket copays for prescription drugs

Another option for controlling drug costs is implementing a cap on out-of-pocket copay costs for prescription drugs across all insurers for any drug approved by the FDA. While such a policy has the potential to reduce costs in the short term, it could lead to negative long-term consequences such as increased premiums or the removal of certain drugs from coverage, either of which could increase out-of-pocket costs for consumers.³⁴ Therefore, it would be critical to pair such an option with a companion plan to control the baseline cost of drugs as well.

Restore the prescription drug rebate for dually eligible beneficiaries transitioning into Medicare Part D

One policy option to alleviate the costs of prescription drug spending in Medicare would be to restore the existing Medicaid rebates for people dually eligible for Medicare and Medicaid. When these individuals transitioned to Medicare Part D coverage after the benefit was established, these rebates were lost to the Medicare program but retained in state Medicaid programs. In 2013, the Congressional Budget Office (CBO) estimated that restoring this rebate for dual eligibles would generate about \$15 billion of savings per year. For further details, please see the CBO analysis.³⁵

Use the Center for Medicare and Medicaid Innovation (CMMI) authority to test new payment models for drug prices

The Center for Medicare and Medicaid Innovation (CMMI), developed as part of the Affordable Care Act, has been a launch pad for a variety of new ideas surrounding value-based pricing, reimbursement, and insurance.

Up until this point, however, the program has not been well utilized to push the envelope on Medicare Part D innovation, particularly related to prescription drug pricing. Experimenting with innovative policy ideas for value-based prescription drug payment plans and increased transparency in prescription drug pricing would be a promising role for CMMI in the future. Such innovations could be developed in collaboration with a diverse range of stakeholders to better ensure buy-in and successful implementation.

The Center for Medicare and Medicaid Innovation, developed as part of the Affordable Care Act, has been a launch pad for a variety of new ideas surrounding value-based pricing, reimbursement, and insurance.

³⁴ Yevgeniy Feyman, 2016, Out-of-Pocket Caps: The Wrong Way to Tackle High Drug Prices, Manhattan Institute, Issue Brief: Health Policy, <http://bit.ly/2ipgMsY>.

³⁵ Congressional Budget Office, 2013, Require Manufacturers to Pay a Minimum Rebate on Drugs Covered Under Part D of Medicare for Low-Income Beneficiaries, <http://bit.ly/2jgbCOT>.

III. Market efficiency

Shortening exclusivity periods

There are numerous factors lengthening exclusivity periods for new drugs, during which one drug company has a monopoly on that market for the length of the protection period. Such exclusivity is particularly problematic with the expanding class of biologic drugs, where the exclusivity period is currently set at 12 years. Even for more traditional drugs, however, the average duration of exclusivity periods is increasing as a result of extensions granted for such activities as testing an existing drug's effects on children. Reducing exclusivity periods would enhance market competition and permit more cost-effective generic drugs to reach the market sooner.

Prohibiting the pay-for-delay arrangements for manufacturers

The pharmaceutical industry's attempts to push back competition from generics are a substantial hurdle for reining in drug prices. A major source of this lack of competition is due to pay-for-delay arrangements, whereby manufacturers use settlement payments to incentivize competitors to delay the release of generic drugs. Prohibiting this cost-increasing form of monopoly building would increase competition in the pharmaceutical market and would likely lower costs across the board.³⁶

Scaling up cost-saving initiatives

When innovative ideas for cost-saving initiatives prove effective, it is critical that these options are not only recognized, but also scaled up to maximize savings. CMMI, state initiatives, accountable care organizations, and other innovators have likely discovered numerous successful methods of controlling prescription drug prices that simply have not been scaled up to their full potential. The federal government should consider investing in research, evaluation, and implementation plans to scale up successful local initiatives.



³⁶ Gregory H. Jones, Michael A. Carrier, Richard T. Silver, and Hagop Kantarjian, 2016, Strategies that delay or prevent the timely availability of affordable generic drugs in the United States, *Blood*, 127:1398-1402; doi: <http://dx.doi.org/10.1182/blood-2015-11-680058>.

Conclusion

The crisis of affordability surrounding prescription drugs is well established, and will escalate without action by the federal government. By increasing transparency in pharmaceutical pricing and spending, enhancing the affordability of drugs for payers of all types, and improving market efficiency within the industry, major improvements in the current landscape are possible. There is no silver bullet that will single-handedly provide relief for all the American people; however, a thoughtful package of policies can reduce the burden of drug costs on our government, economy, and citizens.

The crisis of affordability surrounding prescription drugs is well established, and will escalate without action by the federal government.

Unemployment Insurance

Unemployment Insurance

Introduction

Unemployment insurance (UI) is a shared federal-state system that provides partial wage replacement to workers who lose their jobs through no fault of their own and who are able to work, available to work, and actively seeking work. It also connects workers with reemployment services.

Virtually all workers face the risk of becoming laid off at some point during their careers. In 2014, 10.9 percent of those who worked or looked for work were unemployed at some point during the year.¹ When unemployment occurs, most workers find it difficult to make ends meet. Unemployment insurance is intended to help these workers stay afloat during the search for new employment.

Between 2008 and 2013, which included the years of the Great Recession, 24 million workers received extended and emergency benefits.

The number of workers meeting eligibility requirements and receiving UI benefits varies depending on how the economy is doing, as well as due to state differences in eligibility rules, benefit levels, and benefit durations. In 2015, when the unemployment rate was roughly half of what it was early in the economic recovery in 2010, 6.6

million workers applied for and received benefits. In comparison, 14.4 million workers applied for and received benefits in 2009 and joined millions more already receiving benefits. Between 2008 and 2013, which included the years of the Great Recession, 24 million workers received extended and emergency benefits.² The total system cost of UI benefits varies with changes in the number of recipients. In 2015, total benefits paid from the regular UI program were \$32.5 billion. In 2010, this figure, including all state and federal benefits, was five times as large at \$156 billion.³ These differences are partially the result of increased numbers of unemployed people and in part the result of temporary changes in the UI system during the recession.

The following sections of this *Report* describe and take stock of the UI system's benefits, administration, financing, and reemployment services. Within each section, a set of current policy challenges and reform options is presented.

¹ U.S. Department of Labor, 2015, "Work Experience Summary," Bureau of Labor Statistics, December 9, 2015, <http://www.bls.gov/news.release/work.nr0.htm>.

² These benefits are described in the following section. Council of Economic Advisers and the Department of Labor, 2013, "The Economic Benefits of Extending Unemployment Insurance," <https://www.whitehouse.gov/sites/default/files/docs/uiereport-2013-12-4.pdf>.

³ U.S. Department of Labor, 2016, "Unemployment Insurance Outlook: FY 2017 Midsession Review," Division of Fiscal and Actuarial Services, Office of Unemployment Insurance.

Unemployment Insurance Benefits

Unemployment Insurance Benefits

Background

Coverage of Employment

Almost all wage and salary employees work in employment covered by UI. Their employers are required to contribute to the state's account in the Unemployment Trust Fund (UTF) or, in the case of certain employers like non-profits or government agencies, reimburse the state's account in the UTF for benefits paid under the applicable state law. Nationwide, 140 million jobs are insured by the UI system.⁴ This means nearly all full-time and some part-time workers who meet basic criteria are potentially eligible for UI.

Benefit Eligibility

When workers become involuntarily unemployed, they can collect UI benefits if they meet two sets of requirements. First, they must have earned enough money while they were employed to demonstrate strong attachment to the labor force, as defined by the laws of the state in which they are seeking benefits. Second, they must show that the job separation was due to a lack of work (and not, for example, because they voluntarily quit for personal reasons not permitted by state law) and that they are able to work, available to work, and actively seeking employment.

Benefit Amounts and Durations

Nationwide, the average weekly benefit is about \$300, which replaces on average about half of a worker's prior wage up to a maximum benefit amount.

Regular benefits

The amount of weekly benefits individuals may be paid is primarily based on their past wages, up to a maximum weekly benefit set by the states. Nationwide, the average weekly benefit is about \$300, which replaces on average about half of a worker's prior wage up to a maximum benefit amount.⁵

⁴ Ibid.

⁵ Ibid.

Benefits under state UI law typically can be paid for up to 26 weeks, with a few states providing more than 26 weeks and a few providing maximum durations of fewer than 26 weeks.⁶ State unemployment compensation is paid out of a state's unemployment trust fund.

Benefits in economic downturns

During recessions, layoffs increase economy-wide and job opportunities decrease. Durations of unemployment spells increase as more unemployed workers compete for fewer jobs. Additional weeks of benefits are sometimes provided to workers during economic downturns when the unemployment rate is high. These additional benefits are provided in two ways.

First, the federal-state UI program has a built-in system enacted in 1970 called the extended benefits (EB) program that provides permanent authorization for additional weeks of benefit eligibility. Under the EB program, the number of potential weeks of benefits for which workers may be eligible in states meeting statutory unemployment-rate thresholds is automatically increased by up to 13 or 20 weeks above the usual number of weeks (typically 26). The federal government and the states each pay half of the cost out of their respective UTF accounts. These additional weeks of benefits are triggered state-by-state depending on the unemployment rate in a state. Extended benefits are offered in states in which the unemployment rate exceeds an overall threshold and exceeds the rate in the immediately preceding period.⁷

The second way the duration of UI benefits has been extended is through legislative action that authorizes additional weeks of benefits for workers who exhaust their regular state unemployment compensation eligibility. These benefits are typically paid from general

Emergency benefits are sometimes enacted much too late to be most effective in supporting workers and sometimes remain in effect too long in an untargeted fashion.

federal revenues appropriated by Congress. This policy mechanism, most recently known as Extended Unemployment Compensation (EUC), is generally reserved for nationwide economic downturns, such as the Great Recession, and their aftermath. Whereas the EB program is a permanent

⁶ These maximum durations apply to full unemployment benefits. In some states, beneficiaries can receive partial UI benefits for longer than 26 weeks: U.S. Department of Labor, 2016, "Comparison of State UI Laws," State Law Information, <https://www.unemploymentinsurance.doleta.gov/unemploy/statelaws.asp>.

⁷ States have two options for EB thresholds: one based on the insured unemployment rate (IUR) and the other based on the total unemployment rate (TUR). Under the first option using the IUR, states are eligible for federal cost sharing of EB when the number of UI recipients as a percentage of the total number of people working in jobs in which they would potentially be eligible for UI reaches 5 percent and this percent is at least 20 percent higher than it was during the same period in each of the previous two years. Under the second option using the TUR, EB triggers on when the number of all unemployed people as a percentage of the total labor force (both employed and unemployed) reaches at least 6.5 percent and is at least 10 percent higher than in the same period in either of the two preceding years. For a summary of the EB triggers, see Chad Stone and William Chen, 2014, "Introduction to Unemployment Insurance," Center on Budget and Policy Priorities, <http://www.cbpp.org/research/introduction-to-unemployment-insurance>.

fixture of the UI system and can trigger at any time in states in response to heightened need, EUC-type programs depend on laws passed by Congress and signed by the President for authorization. As a result, emergency benefits are sometimes enacted much too late to be most effective in supporting workers and sometimes remain in effect too long in an untargeted fashion.



Each of these two UI policy options that have been used to provide additional support to workers and the economy in a recession entail tradeoffs. In reforming our UI system, policymakers should keep in mind the advantages and disadvantages of EB and EUC.

Permanent Law Extended Benefits (EB) Program

- Advantages
 - may turn on sooner when the benefits can have a positive impact;
 - is better targeted to the workers and local economies in which wage replacement and economic stabilization are more appropriate;
 - is funded through federal and state trust fund reserves, so the benefits do not add to the federal deficit;⁸
 - is more predictable in its cost by relying on historical estimates to determine forward funding amounts.
- Disadvantages
 - as a forward-financed system, requires advanced taxation of employers to achieve solvency, resulting in money that is not circulating in the state and local economy;
 - does not provide federal lawmakers the political opportunity to take credit for helping the country in an ad-hoc fashion in a time of need;
 - because the amount of additional benefits and the triggers are set in federal statute and designed to meet the needs of a typical economic downturn, the benefit duration may not be optimal for the actual economic situation in a given state.

⁸ UI benefits do not add to the deficit when the budget is calculated as a non-unified budget.

Temporary Emergency Extended Unemployment Compensation (named EUC during the Great Recession)

- Advantages
 - does not require higher state contributions or federal UI taxes from employers before a recession;
 - may be designed to better target high-unemployment communities in states without high unemployment overall, which is important insofar as labor markets are somewhat local and vary significantly even within states;
 - allows Congress to present itself as acting in a time of need, in contrast to the EB program, which is permanently authorized without the need for new Congressional action.
- Disadvantages
 - because EUC is typically not forward-funded, the benefits provided may require spending offsets elsewhere or tax increases after the fact or greater reliance on federal debt to fund them;
 - emergency benefits have historically been enacted months—and even years—after the start of a recession, and may not be authorized when needed by Congress and the White House during future downturns.

Policy Challenges

Eligibility for unemployment compensation among today's workforce

Over the 80-year history of the UI program, there have been significant changes in the composition of the labor force and the types of work performed by American workers. These changes include: 1) the increase in the number of multiple wage earner households, 2) the increase in part-time work; 3) the continuing increase in older-worker participation in the U.S. labor force; 4) increased employment by women; 5) the growth of low-wage service industries; 6) the increase in the use of foreign and alien labor; and 7) the increase in workers not engaged in traditional employer-employee relationships (for more on this, see Section 6 of this Report).

Over the 80-year history of the UI program, there have been significant changes in the composition of the labor force and the types of work performed by American workers.

These changes in the workforce and the nature of work have raised questions about how UI eligibility rules should be specified. In most states, the percent of individuals receiving unemployment compensation in a particular week, compared to the total number of workers in that week who indicate in employment surveys that they have been seeking employment, is well below 50 percent.⁹ This could mean that unemployed individuals are choosing not to file for unemployment compensation, that they are not covered by the system, that they are not eligible for benefits based on existing rules, or that they are not receiving benefits for a number of other reasons.

Ineffective EB thresholds

A state's eligibility for federal cost-sharing of extended benefits depends on whether the state meets a set of criteria, or thresholds. Specifically, a state must have a high rate of unemployment overall as well as a high rate of unemployment compared to the immediately preceding ("lookback") period. As a result of this second criterion, states with sustained high unemployment rates are sometimes not eligible for EB because the current rate, while high, is not significantly higher than the immediately preceding period.

Policy Options

Ensure Appropriate Coverage of Workers in Today's Workforce

Below are some ways in which UI eligibility criteria could be changed by states in response to changes in the workforce. At a minimum, DOL could continue researching the challenging topic of UI eligibility for today's diverse workforce.



⁹ Claire McKenna and Rick McHugh, 2016, "Share of Unemployed Receiving Jobless Aid Remained at Record Low in 2015," National Employment Law Project, http://www.nelp.org/blog/presidents-budget-proposes-unemployment-insurance-reforms-as-share-of-unemployed-receiving-jobless-aid-remained-at-record-low-in-2015/#_edn4.

Alternative base periods

Normal monetary eligibility provisions look at earnings over a four-quarter base period, with a lag of up to six months. Alternative base periods look at earnings in the most recent four calendar quarters of earnings. These provisions tend to enable relatively new entrants and reentrants into the labor market, especially young and old workers and women, to qualify for unemployment compensation. In 2016, 40 states have alternative base period provisions in their state UI laws.

Eligibility for benefits by part-time workers searching for part-time work

Under current law, there is no difference in the threshold used for determining the amount of earnings needed to qualify for UI for part time workers or full-time workers. However, some part-time workers may not have sufficient work and earnings histories to be eligible for unemployment compensation.

Thirty states have adopted alternative provisions that allow former part-time workers not to be denied unemployment compensation while they search for part-time work.

Also, when these part-time workers become unemployed, some of them may not be able to work, be available to work, and actively seeking full-time (as opposed to part-time) work – and hence be ineligible for unemployment compensation. Thirty states have adopted alternative provisions that allow former part-time workers not to be denied unemployment compensation while they search for part-time work. States could evaluate alternative work-search and job-acceptance requirements for part-time workers.

Improve Design of EB Thresholds

If EB triggers were revised, there might be less of a need for EUC because extended benefits would be more appropriately triggered during recessions. In its FY 2017 budget, the Department of Labor proposed an EB program with different thresholds for different tiers of benefits to account for differences in the severity of unemployment across states.¹⁰ States with higher rates of unemployment would be eligible for longer durations of UI benefits.

¹⁰ Employment and Training Administration, Department of Labor, 2016, FY 2017 Congressional Budget Justification: State Unemployment Insurance and Employment Service Operations, <https://www.dol.gov/sites/default/files/documents/general/budget/CBJ-2017-V1-08.pdf>.

Unemployment Insurance Administration

Unemployment Insurance Administration

Background

Each state's UI administrative agency, under the oversight of the U.S. Department of Labor, is responsible for oversight of the integrity of the system and ensuring that benefit payments are timely and accurate.

The UI system is a shared federal-state responsibility. Claims for benefits are made through each state's UI offices. Each state's UI administrative agency, under the oversight of the U.S. Department of Labor, is responsible for oversight of the integrity of the system and ensuring that benefit payments are timely and accurate.

The U.S. Department of Labor (DOL) is responsible for the administration of the federal UI programs and oversees the conformity and compliance of the 53 "state" programs.¹¹ Conformity and compliance with federal law include such requirements as the categories of workers that must be covered by state programs, the structure of some aspects of state UI taxes, and the methods by which states may receive and pay back loans from the federal government to shore up their UI trust fund accounts. Within these parameters, states have wide latitude to determine UI eligibility, tax rates and bases, and levels of benefits.

Policy Challenges

Inefficient administration

The administrative efficiency of state UI systems varies widely. When the unemployment rate increases, state UI administrators are often unable to quickly and accurately handle the volume of claims. A key performance measure used by the federal government to determine state compliance with federal UI laws is the timeliness of benefit payments. During the Great Recession, in the first quarter of 2009, only 40 percent of states met the federal guideline.¹²

In addition to the timeliness of benefit payments, other federal guidelines involve the accuracy and integrity of benefit payments. These performance guidelines could be revised to encourage states to actively identify

¹¹ Under the UI program, states include the District of Columbia, Puerto Rico, and the Virgin Islands.

¹² Federal guidelines consider acceptable performance to be if a state makes at least 87 percent of first payments with 14/21 days of compensability. For the federal guidelines, see: U.S. Department of Labor, 2015, "Core Measures and Acceptable Levels of Performance," Unemployment Insurance Performance Management, State Workforce Agency Performance Reports, <http://workforcesecurity.doleta.gov/unemploy/performance.asp>. For state performance assessments, see: U.S. Department of Labor, 2016, "First Payments in 14/21 days," State Rankings of Core Measures, <http://workforcesecurity.doleta.gov/unemploy/ranking.asp>.

improper payments, more actively collect overpayments, and process claims improperly denied or underpaid.

Administrative burden of EUC

While federal lawmakers have a political incentive to retain the option to actively authorize EUC benefits in recessions, the complex structure of these benefits and the short timeframe within which they are expected to take effect put a strain on the state agencies that must administer them. Many state IT systems are several decades old and in the last recession were ill-equipped to handle the many congressionally ordered tiers of EUC benefits that required calculation of the duration of an individual unemployed worker's spell of unemployment. These systems could not be sufficiently recalibrated in time to effectively administer benefits under newly structured eligibility requirements that took effect the day they were enacted. As a result, some states struggled to accurately determine eligibility and to deliver EUC benefits to the qualified beneficiaries.

Policy Options

Improving Administration

Strengthen program integrity

DOL could require states to use penalties from UI overpayments only for UI purposes and require a percentage of the penalties to be used on program integrity measures. Overpayment amounts collected by state agencies could be made available to the state agency as administrative funding to further improve integrity efforts.

Enhance administrative oversight

The federal government has a key responsibility to ensure that states timely and accurately pay benefits. The Government Accountability Office has found significant customer service problems in state UI programs. To address these problems, DOL could provide training to ensure that all eligible workers are able to file for benefits, and DOL could make more affordable and effective customer service tools available to all states. These initiatives could be done at the same time DOL continues to support multi-state coordinated efforts to address potential claimant fraud and abuse including increasingly sophisticated

The Government Accountability Office has found significant customer service problems in state UI programs. To address these problems, DOL could provide training to ensure that all eligible workers are able to file for benefits.

technology-based efforts to identify illicit UI users.

Improve administrative efficiency

The federal government appropriates funding each year for administration of state UI systems. The federal government could help states streamline administration, thereby reducing program cost, by providing long term administrative funding for automated system design, implementation, and updating. This should be paired with an active oversight and research program to measure the impacts of technology on claimant experience and ability to access reemployment services.



Ease the Administrative Burden of Implementing EUC

Establish a pre-existing EUC structure to reduce state administrative uncertainty

Federal lawmakers could create a preexisting and permanent EUC program structure that could be activated in a recession. This plan would maintain the need for congressional authorization so that Congress could be credited with extending benefits in a crisis. Because the structure would be known ahead of time, states could make preparations for implementing this EUC program before an unemployment crisis. A challenge posed by this approach would be that different economic downturns or recessions may necessitate different UI policy responses that would be difficult to build into a permanent structure.

¹³ Upon the passage of the UI program as part of the Social Security Act in 1935, all wages were subject to UI taxes. The taxable wage base of \$3,000 was established in 1939.

Unemployment Insurance Financing

Unemployment Insurance Financing

Background

Unemployment insurance is funded by a federal tax paid by employers under the Federal Unemployment Tax Act (FUTA) and by employers' state contributions. The federal taxable wage base for UI has been in place since nearly the beginning of the UI program.¹³ It is currently \$7,000. This taxable wage base effectively serves as a floor below which states cannot lower their wage base. States must at least meet the minimum taxable wage base to maintain a UI system in compliance with federal law, under which employers may receive an offset credit to the federal unemployment tax. To maintain a qualifying program, states are also required to base employers' contribution rates on factors related to employers' experience with layoffs, known as "experience rating."

All state UI contributions (taxes) are required by federal law to be deposited into state accounts in the Unemployment Trust Fund (UTF) held by the U.S. Treasury Department. Employers pay UI contributions to state agencies that, in turn, transfer these contributions into the state unemployment benefit accounts maintained by the Treasury on behalf of the states. Employer tax rates vary with their payroll, experience rating, and contribution payments.

UI was designed to serve as an automatic stabilizer in the U.S. economy during periods of recession. To operate as originally intended, there must be "forward funding."

UI was designed to serve as an automatic stabilizer in the U.S. economy during periods of recession. To operate as originally intended, there must be "forward funding" – that is, states must collect enough taxes in good economic times to pay benefits during recessions without having to borrow. The advantage of this approach is to

reduce the need for states to more heavily tax employers during economic downturns and nascent recoveries to pay benefits, precisely when fiscal stimulus in the form of lower taxes may be more effective. In cases of severe downturns, the federal loan account in the UTF lends money to states whose UI accounts contain insufficient reserves to pay benefits. Ideally, a state's UI trust fund should have adequate reserves to provide benefits during a future recession without the need to raise taxes, reduce benefits, or borrow to pay unemployment compensation.

¹³ Upon the passage of the UI program as part of the Social Security Act in 1935, all wages were subject to UI taxes. The taxable wage base of \$3,000 was established in 1939.

Policy Challenges

Imbalance between revenues and costs

The UI system was established with the expectation that states would impose a state tax on wages paid by employers that is adequate to pay benefits. The federal taxable wage base has remained at \$7,000 since 1983. Three states set their taxable wage base at this level.

Insufficient forward funding

Most states are failing to adequately forward-fund their UI trust funds. Six years into the recovery from the Great Recession, two-thirds of state UI programs were still below DOL's minimum recommended trust fund ratio.¹⁴ As of January 2016, three states had failed to pay

Six years into the recovery from the Great Recession, two-thirds of state UI programs were still below DOL's minimum recommended trust fund ratio.

off their outstanding federal loans, and six additional states had outstanding private loans. Forward funding is essential to achieving the system's countercyclical function and to ensuring its long-term reliability in helping laid-off workers. By failing to build adequate reserves for the next recession, these states will have to borrow funds or rely instead on federal lawmakers to use general federal revenues or federal reserves (which also are typically insufficient) to pay EUC benefits. Weak federal incentives for adequate state financing along with frequent and plentiful federal EUC programs may exacerbate state underfunding.

The federal government could take steps to avoid the necessity of doing what it did in the Great Recession: 1) lending substantial amounts to state UI trust fund accounts for payment of benefits under the regular program, and 2) fully paying for both the permanent Extended Benefits program and any additional temporary emergency benefit programs at considerable cost to the federal budget.

¹⁴ Specifically, 35 states out of 53 have trust fund solvency levels below an average high cost multiple of 1.0. U.S. Department of Labor, 2016, "State Unemployment Insurance Trust Fund Solvency Report," <https://www.oui.doleta.gov/unemploy/docs/trustFundSolvReport2016.pdf>.

Policy Options

Address the Imbalance between Revenue and Costs

Increase the FUTA tax base

Increasing the FUTA tax base could provide more funds for federal appropriators to allocate to state administration. It could also encourage states with inadequate trust fund reserves and tax bases that are close to the level of the federal wage base to better fund their reserves through higher UI contributions.

Enhance guidelines for experience rating of employer contribution rates

State UI tax rates paid by employers increase with the employers' past level of UI benefit payments or a measure of the employers' reserves in their UI accounts. This "experience rating" system is meant to encourage employers to minimize the number of layoffs they conduct. Some states have tax rates as low as zero for employers that have favorable experience ratings, and have rates that exceed 5.4 percent for employers with unfavorable experience ratings. Some states have as few as two tax rates for employers, though most have many more rates that more closely track an employer's experience with layoffs. The experience rating system could be left as it is, although it does not adequately reflect layoff "experience" in some states. Alternatively, a federal guideline could be established providing a state experience rating goal to be used in periodic federal performance evaluations.

Create guidelines to encourage states to evaluate the impact of minimum tax rates and maximum tax rates

Currently there is no requirement that employers pay a minimum state UI tax, except that new employer contribution rates must be at least 1.0 percent. Some states allow a zero tax on the employers who have the best UI experience rating. A zero tax means that the risk of benefit payment to workers from those the employers is very low, but exposes the fund to some risk if those businesses have layoffs or close. Conversely, maximum tax rates mean that some employers with extensive experience with layoffs are not fully charged for those layoffs. A guideline to be used in evaluating performance could be developed as a basis for zero or minimum tax rates and maximum tax rates.

Implement employee taxes

Workers have a direct stake in being able to access unemployment insurance benefits when they become involuntarily unemployed, but only three states levy a UI tax on employees. A nationwide employee UI tax could be a method of restoring the trust fund solvency in the near future of the UI system and providing new funds for long-term benefit adequacy. It could also reduce

or eliminate the UI tax burden for employers. Employee taxes have been used successfully by UI programs in other industrial nations ensure adequate funding.

Enact "Reed-Act"-type distributions to state unemployment trust funds

Regular Reed Act distributions occur when the federal accounts in the UTF reach certain statutory levels. At that time, excess funds are distributed to state accounts in the UTF, prorated to each state's share of covered wages. Special Reed Act distributions can occur from federal accounts to state accounts by congressional action, regardless of whether there are excess funds in the federal accounts as defined by existing statute. Reed Act distributions can only be spent by states to provide UI benefits, administer UI, or provide employment services. Greater use of Reed Act distributions from the federal to state accounts could serve to improve the adequacy of funding for UI programs.

A nationwide employee UI tax could be a method of restoring the trust fund solvency in the near future of the UI system and providing new funds for long-term benefit adequacy.

Incentivize Forward Funding

To incentivize forward funding, the U.S. Treasury could pay higher interest rates on the state funds held by the federal government to states with more adequate trust fund reserves, and lower rates to states with poorer trust fund reserves.¹⁵ This way, states may face greater economic incentives when considering the trade-offs in building UI reserves in time for the next recession, as opposed to relying on borrowing after a downturn to finance their systems.

¹⁵ Adequacy of reserves is measured by a state's high-cost multiple (HCM), which represents a state's reserve ratio (its UI trust fund level as a percentage of total annual statewide wages) divided by the high cost rate (the highest historical ratio of benefits to wages for a 12-month period in that state). An HCM of 1.0 corresponds to sufficient reserves to pay benefits at the high cost rate for 1 year without relying on payroll tax revenue.

Reemployment Services

Reemployment Services

Background

The Employment Service (ES) and unemployment insurance are partner programs. The ES was established in 1933 by the Wagner-Peyser Act, and UI was established by the Social Security Act of 1935. By 1938, all states began paying UI benefits through public ES offices. Since that beginning, the ES has cooperated with UI by providing trained counselors to accept claims for benefits, check initial eligibility for UI, provide job-finding and placement services to UI claimants and local employers seeking to fill jobs, and validate continuing UI eligibility before payment of benefits. The latter function has come to be known as the “UI work test.” It is based on the principle that UI be paid only to involuntarily unemployed workers while they are engaged in active reemployment efforts.

A significant body of research finds that reemployment services can help UI beneficiaries get back to work quickly. Evaluation studies since the 1980s have shown that many displaced and experienced workers require only adequate screening and job search assistance (JSA) to return to employment.¹⁶ Additionally, randomized controlled trials testing strategies to renew linkages between

ES and UI have estimated shorter unemployment durations and lower UI benefit payment costs result from closer cooperation between reemployment and payment services.¹⁷ These results suggest that cost savings to the unemployment trust fund (UTF) can be achieved by providing job finding and placement services, and exposing UI claimants to suitable jobs. This is particularly true for younger and dislocated UI claimants.¹⁸

Cost savings to the unemployment trust fund can be achieved by providing job finding and placement services, and exposing UI claimants to suitable jobs.

Evidence of effectiveness for job search assistance targeted to displaced workers emerged in the final report of the New Jersey UI Reemployment

¹⁶ Walter Corson et al., 1989, “New Jersey Unemployment Insurance Reemployment Demonstration Project,” Unemployment Insurance Occasional Paper No. 89-3, Employment and Training Administration, U.S. Department of Labor; Terry R. Johnson et al., 1985, “An Evaluation of the Impact of ES Referrals on Applicant Earnings,” *The Journal of Human Resources*, 20(1): 117–137; Louis S. Jacobson et al., 2004, “Evaluation of Labor Exchange in the One-Stop Delivery System Environment,” Westat, Inc. ETA Occasional Paper 2004-09, U.S. Department of Labor, Employment and Training Administration.

¹⁷ Walter Corson, David Long, and Walter Nicholson, 1985, “Evaluation of the Charleston Claimant Placement and Work Test Demonstration,” Unemployment Insurance Occasional Paper No. 85-2, Employment and Training Administration, U.S. Department of Labor; Christopher J. O’Leary, 2006, “State UI Job Search Rules and Reemployment Services,” *Monthly Labor Review* 129 (6): 27–37.

¹⁸ Analyzing data from Washington State, Marta Lachowska, Merve Meral, and Stephen A. Woodbury found that for the dislocated UI applicants the work test reduced time to reemployment by 1 to 2 quarters, and increased post-UI job tenure by about 2 quarters. Marta Lachowska, Merve Meral, and Stephen A. Woodbury, 2015, “The Effects of Eliminating the Work Search Requirement on Job Match Quality and Other Long-Term Employment Outcomes,” Department of Labor.

Demonstration project.¹⁹ The findings were strengthened by a five-year follow-up study that found positive second-year effects from the job search assistance treatment. A demonstration testing targeted job search assistance supported the New Jersey results, and random trials in Kentucky provided further evidence in support of targeting reemployment services to those most likely to exhaust their UI entitlements.²⁰

Intensive services—staff assistance with finding and keeping a job—not only help people find a job, but also lead to higher earnings.

The most recent evidence of ES effectiveness comes from interim results from random trials in the national evaluation of services provided at American Job Centers. “Intensive services—staff assistance with finding and keeping a job—not only help people find a job, but also lead to higher earnings.”²¹

Policy Challenges

Inadequate funding for reemployment services

Revenues from the federal unemployment tax are paid into the UTF to finance Wagner-Peyser employment services, UI program administration, emergency loans to states, and the federal share of extended benefits. However, because the federal taxable wage has remained constant in nominal terms at \$7,000 since 1983 (meaning that it has eroded considerably in real terms), federal unemployment tax revenue has not increased to the point that federal appropriators have chosen to increase Wagner-Peyser funding. Dedicated funding through the federal unemployment tax may provide inadequate funding for reemployment services and administration of the work test.

Federal appropriations for Employment Service

Since 1984, federal Wagner-Peyser appropriations from the UTF for ES have fallen in real terms by more than half.

¹⁹ Walter Corson et al., 1989.

²⁰ Dan Black, Jeffrey Smith, Mark Berger, and Brett Noel, 2003, “Is the Threat of Reemployment Services More Effective than the Services Themselves? Evidence from Random Assignment in the UI System,” *American Economic Review* 93(4): 131-1327; Paul T. Decker, Robert B. Olson, Lance Freeman, and Daniel H. Klepinger, 2000, “Assisting Unemployment Insurance Claimants: The Long-Term Impact of the Job Search Assistance Demonstration,” OWS Occasional Paper 2000-02, Office of Workforce Security, Employment and Training Administration, U.S. Department of Labor; Walter Corson and Joshua Haimson, 1995, “The New Jersey Unemployment Insurance Reemployment Demonstration Project Six-Year Follow-Up and Summary Report,” USDOL/ETA, UI Occasional Paper 95-2.

²¹ Sheena McConnell Main Document Only. McConnell, Linda Rosenberg, Ronald D’Amico, Kate Dunham, Verenice Chavoya-Perez, Deborah Kogan, Melissa Mack, Marian Negoita, and Anne Paprocki. 2015, “Providing Public Workforce Services to Job Seekers: Implementation Findings on the WIA Adult and Dislocated Worker Programs,” report to the U.S. Department of Labor, ETA, OPDR. Washington, DC: Mathematica Policy Research.

Figure 1. UI and Social Security taxable wage bases and the ratio of total to UI taxable wages, 1937-2015



Source: Christopher J. O'Leary and Kenneth J. Kline, 2016, "Are State Unemployment Insurance Reserves Sufficient for the Next Recession?" Upjohn Institute Working Paper 16-257, Kalamazoo, MI: W.E. Upjohn Institute for Employment Research.

As a result of the decline in real Wagner-Peyser funding for employment services between 1984 and 2015, states have not adequately staffed employment centers. Instead, states have implemented technological solutions at the expense of one-on-one engagement. Automated initial UI eligibility systems have

not only compromised job search, they have also contributed to low rates of benefit receipt among the unemployed. Some states have gone further by replacing call centers for initial UI claims with entirely on-line and automated voice-response systems. In such cases, the absence of alternative points of access may deter individuals, especially individuals with limited literacy, limited English proficiency, or other labor market challenges, from properly completing UI applications for benefits.

The reduced availability of employment services and lack of work test enforcement may also contribute to longer unemployment durations.²²

²² Instead of funding the statutory Wagner-Peyser ES program, in recent years DOL has granted federal funds to states for new reemployment initiatives such as reemployment and eligibility assessments (REA). It is worth mentioning that this and other UI efforts like payment accuracy are fully funded, while the ES has not been sufficiently funded for years.

Automated initial UI eligibility systems have not only compromised job search, they have also contributed to low rates of benefit receipt among the unemployed.

Structural underfunding means the ES program cannot serve the full array of job seekers who could benefit from reemployment services. Most developed industrial nations provide a free public employment service as a right to all citizens. Indeed, most wealthy nations and many middle-income nations, are signatories to the 1948 International Labor Organization Convention 88 on public employment services.²³ The United States is not a signatory of ILO Convention 88, but has respected the principle of the Convention that all nations “shall maintain or ensure the maintenance of a free public employment service.” The idea is that labor force members should have a right to free labor market information and job matching services as a means to social participation. As President Eisenhower said, “state employment security offices are important for a smoothly operating free labor market in a growing economy.”²⁴

Disconnect between speeding the return to work and automated UI Administration

To be most effective, reemployment services should be delivered to UI recipients in the manner that is best suited to claimants’ needs.

To be most effective, reemployment services should be delivered to UI recipients in the manner that is best suited to claimants’ needs. Generally, these services are more effective when delivered in person, rather than remotely by phone or internet. Furthermore, any risk that paying cash benefits during joblessness might

prolong spells of unemployment—an effect known as moral hazard — is magnified when a vigorous reemployment effort is not supported by high quality comprehensive reemployment services. By July 2000, very few states were still taking UI claims one-on-one at employment offices. Most claims were being taken over the telephone through call centers or by internet, meaning that UI was operationally separate from the reemployment services and work test provided by the ES.

²³ ILO, 1988, C088 - Employment Service Convention, 1948 (No. 88), Convention concerning the Organization of the Employment Service (Entry into force: 10 Aug 1950), Adoption: San Francisco, 31st ILC session (09 Jul 1948) - Status: Instrument with interim status (Technical Convention).

²⁴ Federal Reserve Archive, 1960, Budget of the United States, Fiscal Year Ending June 30, 1961, Message of the President, p. M 60, Washington DC: Government Printing Office.

Policy Options

Extensive research has found that staff-assisted employment services are effective for returning UI beneficiaries back to work quickly—especially those most likely to become long-term unemployed. In our society, where work is the avenue to self-sufficiency, a free and open public labor exchange is essential to supporting broad based labor market success. To achieve this goal, a number of policy options could be pursued.

Address Funding Inadequacy to Improve Availability of In-Person Services for UI Claimants

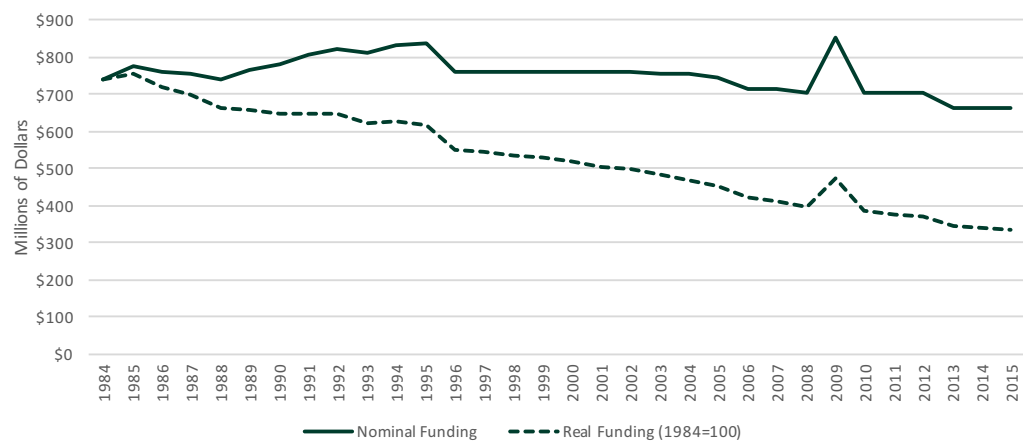
Increase funding for the Employment Service

To reverse the structural underfunding of the Employment Service, and to support adequate funding in the future, the FUTA taxable wage base of \$7,000 could be increased and indexed to wage growth, or tied to the Social Security taxable wage base. With sufficient FUTA funding, annual DOL Wagner-Peyser appropriations requests to Congress for the ES could return funding to 1984 levels in real terms and maintain that level in future years without additional strain on the federal budget.

Increase funding for Reemployment Eligibility Assessments and Reemployment Services

DOL could also increase funding for Reemployment Eligibility Assessments and Reemployment Services. This way, states would have funds to maintain statistical profiling systems, enhance targeted enforcement of the work test, and provide effective job placement services for UI beneficiaries at highest risk of long-term unemployment.

Figure 3. Wagner-Peyser Funding for Employment Services in Nominal and Real Dollars (1984=100)



Source: Christopher J. O’Leary and Stephen A. Wandner, 2016, “Unemployment Insurance Research and Reform,” prepared for the Association for Public Policy Analysis and Management (APPAM) fall research conference November 3–5, 2016.

Expand Programs that Speed Return to Work

Require states to establish Short-Time Compensation as an option for employers

Work sharing, also known as short-time compensation (STC), is one of the few public employment policies available to directly address declining labor demand. Under STC the cost of work reductions is shared by employers and workers by reducing work hours, instead of laying off workers and by partially replacing workers' income from those lost hours. Currently 29 states have STC plans. In those states, STC is used infrequently compared to regular UI, but usage dramatically increases when unemployment rises in recessions. State STC laws could require pass-through to employer accounts of any federal reimbursement of STC benefit charges. This is necessary for federal reimbursement of STC costs to be an effective instrument of fiscal policy and for short-time compensation for workers in times of economic crisis.

Require states to offer the option of Self-Employment Assistance

Self-Employment Assistance (SEA) is a small, but often effective program based on evidence from field experiments. UI beneficiaries at risk of long-term UI receipt can accept a waiver of the UI requirement to search for work while receiving benefits if they get entrepreneurial training and undertake efforts to set-up and start their own self-employment activity. The program is cost neutral because it is targeted to those most likely to exhaust UI benefits, and often saves UI benefit costs in future years. The federal government could require all states to make SEA an option for UI recipients who are identified early as being at high risk of long-term unemployment.

Allow states to offer targeted reemployment bonuses

Reemployment bonuses provide lump-sum payments to permanently laid-off workers who take new, full-time jobs within 6 to 12 weeks of beginning to receive UI benefits, and hold those jobs for at least three to four months. Reemployment bonuses are designed to be a positive way to overcome the moral hazard risk of prolonged unemployment from receiving UI. Results from initial experiments indicate that, on net, bonuses speeded return to work, but were cost neutral. Evidence from simulations "suggest that such a targeted bonus offer would yield

Reemployment bonuses provide lump-sum payments to permanently laid-off workers who take new, full-time jobs within 6 to 12 weeks of beginning to receive UI benefits, and hold those jobs for at least three to four months.

appreciable net benefits to the UI trust funds if implemented as a permanent program.”²⁵ The recommendation was for a low bonus amount of about three times the weekly benefit amount and a long qualification period of about 12 weeks. Using the 2016 national average weekly benefit amount, the bonus amount would average just over \$1,000. In sum, UI reemployment bonuses, if targeted to UI beneficiaries at high risk of long-term unemployment, could be a policy option to states allowed by the federal government.

Coordinate additional reemployment services with Extended Benefits

States facing a high rate of unemployment in a recession can be eligible for federal cost-sharing of Extended Benefits (EB), but do not automatically become eligible for more intensive reemployment services. Core reemployment services include such services as job referrals and résumé preparation assistance; intensive services include counseling and referrals to job training.²⁶ When states meet thresholds for high rates of unemployment that determine their eligibility for EB, they could also meet thresholds for receiving federal cost sharing of intensive reemployment services. By speeding workers’ return to work, this option could help to reduce the costs of the UI system during recessions and therefore mitigate the need for additional forward funding.

²⁵ Christopher J. O’Leary, Paul T. Decker, and Stephen A. Wandner, 2005, “Cost Effectiveness of Targeted Reemployment Bonuses.” *Journal of Human Resources* 40(1): 270-279.

²⁶ Christopher J. O’Leary, 2006, “State UI Job Search Rules and Reemployment Services,” *Monthly Labor Review* June 2006, Bureau of Labor Statistics, <http://www.bls.gov/opub/mlr/2006/06/art3full.pdf>.

Part II:
**Modernizing Workers' Social
Insurance Protections**

Long-term Services and Supports

Long-term Services and Supports

A key source of insecurity and anguish in the United States is the lack of a well-functioning system for financing and delivering long-term services and supports (LTSS) – the services and supports used by individuals of all ages with functional limitations and chronic illnesses who need assistance to perform routine daily activities. The country needs an LTSS system that is affordable, meets the needs of those requiring support, and preserves the independence and autonomy of frail older adults and working-age individuals with disabilities. Long-term care (LTC) is currently delivered in a piecemeal and costly fashion that prevents many from getting the support they need within their community, while placing a heavy financial, emotional, and physical burden on their families who assist them.

The country needs an LTSS system that is affordable, meets the needs of those requiring support, and preserves the independence and autonomy of frail older adults and working-age individuals with disabilities.

This vast unmet need and lack of coordination of supportive services results in preventable harm to those in need of care, which in turn often results in costly acute medical episodes, including hospitalizations. Aside from the harm to individuals, this inappropriate and unnecessary health care spending increases the financial burden on both Medicare and state Medicaid programs. As the Boomer generation ages, the population at risk for LTSS needs is growing rapidly, while the younger generation of potential caregivers is growing more slowly. The U.S. thus faces a looming crisis in providing and financing sufficient care.

While these challenges seem daunting, it is possible to design a financing system for LTSS that can promote efficiency in medical service delivery and provide important protections against catastrophic costs that far exceed the resources of most American families.

Background

What are long-term services and supports and why are they important?
The fundamental goal of long-term services and supports is to help individuals with functional limitations live their daily lives safely while maintaining quality of life and

Without access to appropriate, high-quality care, individuals with functional limitations may suffer further health deterioration, which in turn causes unnecessary health care spending.

maximizing independence in their preferred community setting. With access to care and supports, seniors and individuals with disabilities are better able to make choices about where they live and how they spend their time. Devastating and costly health incidents – such as falls and malnutrition – can often be prevented with proper services and supports such as personal assistance, home modifications for mobility impairments, and home meal delivery programs. But without access to appropriate, high-quality care, individuals with functional limitations may suffer further health deterioration, which in turn causes unnecessary health care spending.

Over half of all seniors are expected to experience a high need for LTSS assistance before they die, and many individuals with disabilities rely on these services throughout their lives.

Status quo is costly and unsustainable

Over half of all seniors are expected to experience a high need for LTSS assistance before they die,¹ and many individuals with disabilities rely on these services throughout their lives. But for both older and younger people with LTSS needs, costs are unpredictable and varied.

About one in six seniors and their families will spend over \$100,000 out-of-pocket for long-term care before they die.² For over 15 percent of seniors above the age of 65, the total cost of long-term services and supports across all payers will exceed \$250,000, and for 9 percent, out-of-pocket costs alone will exceed that amount.³ While this problem has been growing quietly for decades, it is becoming ever more severe as the private insurance market shrinks, high and rising costs make private long-term care insurance coverage unattainable for most people,⁴ and the caregiver gap continues to widen.⁵

Burden on states

As the Boomers get older and frailer, our current system of relying heavily on Medicaid to finance long-term services and supports will overburden states, likely at the expense of pursuing other critical budget priorities. In addition, increased need for Medicaid LTSS will put substantial strain on the program's ability to provide other forms of much-needed basic health care coverage for low-income individuals and families.

¹ Melissa Favreault and Judith Dey. 2015. Long-Term Services and Supports for Older Americans: Risks and Financing Research Brief. Office of the Assistant Secretary of Planning and Evaluation. <https://aspe.hhs.gov/basic-report/long-term-services-and-supports-older-americans-risks-and-financing-research-brief>.

² Ibid.

³ Ibid.

⁴ National Association of Insurance Commissioner (NAIC) and The Center for Insurance Policy and Research (CIPR), 2016, The State of Long-Term Care Insurance: The Market, Challenges and Future Innovations, http://www.naic.org/documents/cipr_current_study_160519_ltc_insurance.pdf.

⁵ Donald Redfoot, Lynn Feinberg, and Ari Houser, 2013, The Aging of the Baby Boom and the Growing Care Gap: A Look at Future Declines in the Availability of Family Caregivers, AARP Public Policy Institute, Insight on the Issues: 85, http://www.aarp.org/content/dam/aarp/research/public_policy_institute/ltc/2013/baby-boom-and-the-growing-care-gap-insight-AARP-ppi-ltc.pdf



Burden on Medicare

Financial strain also extends to the Medicare program when seniors and individuals with disabilities develop or exacerbate illnesses and injuries – particularly acute medical episodes such as falls or infections – due to a lack of appropriate, high-quality services and supports. The 15 percent of Medicare beneficiaries with chronic conditions who also have functional limitations, and therefore require long-term services and supports, account for almost one-third of all Medicare spending.⁶

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Toll on families

Many families are forced to make significant personal sacrifices to care for an aging loved one, taking away from their own financial security and health and often interrupting professional advancement.⁷ This is especially true for women, who are most likely to be the caregivers. While individuals have a personal responsibility to plan for their own future needs, and while families are responsible for caring for their loved ones, the financial, emotional, and physical burdens of prolonged LTSS need far exceed the capacity of many families. Private long-term care insurers have tried and failed to alleviate this burden, but are leaving the market given the challenge of the task.

Clearly, our current system of long-term care – or lack thereof – has become a substantial burden on the federal budget, state economies, and most importantly on the health and financial stability of countless individuals and families.

⁶ Harriet L. Komisar and Judy Feder, 2011, *Transforming Care for Medicare Beneficiaries with Chronic Conditions and Long-Term Care Needs: Coordinating Care Across All Services*, Georgetown University, http://www.thescanfoundation.org/sites/default/files/Georgetown_Trnsfrming_Care.pdf.

⁷ National Academies of Sciences, Engineering, and Medicine, 2016, *Families Caring for an Aging America*, Washington, DC: The National Academies Press, <https://www.nap.edu/catalog/23606/families-caring-for-an-aging-america>.

Every family in America faces the risk of caring for a loved one at some point in time, and most will struggle to make ends meet in doing so.

Working toward policies that improve access to LTSS will therefore be both a critical step towards improving health outcomes and a key strategy for reducing unnecessary health care spending. Many of the policy options suggested in this *Report*

will require some level of investment – but those investments will yield significant benefits for the health and financial security of our nation's most vulnerable populations, and may reduce other government spending. Every family in America faces the risk of caring for a loved one at some point in time, and most will struggle to make ends meet in doing so. There are many opportunities for cost-savings through more effective implementation of long-term care, as well, but investing in the financial security and health of American families is a worthy cause in and of itself – one that touches all and so one around which we all should be able to rally.

Policy Challenges

Expensive, fragmented LTSS financing

Today's system of LTSS financing is complicated, fragmented, inefficient, and expensive. Medicaid serves as the primary public payer, covering roughly one-third to half of all spending, but is available only on a means-tested, asset-tested basis for those at a certain threshold of financial and/or medical need.

The rest of LTSS financing comes from a variety of sources. Contrary to popular belief, Medicare does not cover LTSS services; rather, Medicare covers only post-acute care, focusing primarily on short-term needs. Private insurance, in turn, finances less than one-tenth of LTSS spending.⁸ Family out-of-pocket spending pays for as much as 40 percent of all paid care. The rest is funded by myriad sources, including the Veterans Health Administration, temporary disability insurance, and charity.⁹ The reality of LTSS costs to families extends beyond direct out-of-pocket spending on health services. This array of funding sources for LTSS leads not only to confusion, but also to inefficiencies in the coordination of care that likely elevate costs significantly.

⁸ Erica L. Reaves and MaryBeth Musumeci, 2015, Medicaid and Long-Term Services and Supports: A Primer, The Kaiser Commission on Medicaid and the Uninsured: The Henry J. Kaiser Family Foundation, <http://kff.org/medicaid/report/medicaid-and-long-term-services-and-supports-a-primer/>.

⁹ Kirsten J. Colello and Scott R. Talaga, 2015, Who Pays for Long-Term Services and Supports? A Fact Sheet, Congressional Research Service, <https://fas.org/sgp/crs/misc/R43483.pdf>.

Family caregivers suffer adverse health, financial, and professional consequences

Without a coordinated and efficient system of long-term services and supports, much of the responsibility for caregiving has fallen on family members and loved ones. Estimating the number of caregivers is a challenging undertaking, but research suggests that at least 17.7 million Americans are providing care to an aging loved one coping with functional limitations.¹⁰ While many of these family caregivers gladly give this care, they also face many challenges with, at best, exceedingly limited help. Most caregivers provide this assistance without any paid support. Family caregivers experience generally poorer health outcomes than their peers, and those health outcomes worsen as the intensity of their caregiving responsibilities increases.¹¹ In addition, many caregivers spend a substantial amount out-of-pocket to support their loved ones. For women in their 50s who leave the workforce to care for an aging family member, the average lifetime loss in earnings exceeds \$300,000.¹² These expenditures and disruptions in employment will inevitably affect their own long-term economic stability, in addition to any health consequences they suffer as a result of their caregiving work.

Private LTC insurance market failure

A private long-term care insurance market has operated for several decades, but has generally failed to make a sufficient dent in tackling the large-scale issue of financing long-term services and supports. Over the past decade, the market

for traditional policies has collapsed, with substantial declines in sales of policies and the number of carriers offering coverage.¹³ Carriers have been discouraged by such things as low interest rates on their reserves, higher-than-expected policy retention rates, and high and unpredictable payouts. Meanwhile, Americans generally do not appreciate the risk of needing LTC. The result is that premiums for private policies are unaffordable for most American families, while the coverage offered under the available plans is not sufficient to cover the risk of true catastrophic LTSS need. As a result, consumers recognize that purchasing coverage is often not worth the investment for the level of protection they would receive, further driving up the cost of private plans as only the consumers most at risk for using LTSS services decide to purchase plans.

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¹⁰ National Academies of Sciences, Engineering, and Medicine, 2016.

¹¹ Ibid.

¹² MetLife Mature Market Institute, National Alliance for Caregiving, and Center for Long Term Care Research and Policy, New York Medical College. 2011. The MetLife Study of Caregiving Costs to Working Caregivers: Double Jeopardy for Baby Boomers Caring for Their Parents. <http://www.caregiving.org/wp-content/uploads/2011/06/mmi-caregiving-costs-working-caregivers.pdf>.

¹³ NAIC and CIPR, 2016.

Limits to any voluntary insurance approach to LTSS due to cost, underestimation of risk

There are a variety of reasons why individuals and families struggle to save for future LTSS needs. First, at younger ages, people have more immediate financial concerns, such as the need to pay off college loans, raise a child, buy a home, or purchase health insurance. Second, the need for long-term services and supports is unpleasant to consider, and many underestimate the likelihood of requiring it. Moreover, even those who are aware of the need for LTSS coverage and turn to the private LTC insurance market often opt against purchasing coverage due to the lack of availability of affordable policies with stable premiums.¹⁴

The risk of needing care is unpredictable and can become catastrophic. While it is possible to use personal savings to cover some level of future care needs, most Americans cannot afford to fully self-insure against such a substantial risk. And it is virtually impossible to purchase a plan on the private market that covers extreme catastrophic risk, as an overwhelming majority of plans only cover up to five years of LTSS needs. This is the very reason that social insurance exists – to spread risk widely enough to provide adequate protection for the smaller proportion of individuals for whom the expensive, insurable event transpires.

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Working-age people with disabilities have needs that are distinct from those of elderly

Younger adults who experience a lifelong need for LTSS have fundamentally different needs from seniors. Most notably, many are seeking supports that enable them to participate in the workforce. Some public policy options that might help address the needs of seniors are not

well-suited to addressing those of working-age people with disabilities. For example, a universal social insurance program that requires many years of vesting does not meet their needs. Additionally, Medicaid waiver programs are not working well for people with disabilities; there are long waiting lists for people with intellectual disabilities in most states. Given past experience, any effort to render Medicaid more state-based is likely, especially in light of many states' balanced budget requirements, to fail to address the needs of working-age people with disabilities.

¹⁴ Diane R. Calmus, 2013, The Long-Term Care Financing Crisis, The Heritage Foundation: Center for Policy Innovation, No. 07, <http://www.heritage.org/research/reports/2013/02/the-long-term-care-financing-crisis>.

Policy Options

Develop a public, universal long-term care insurance program

The key to any effective insurance program is spreading risk as broadly as possible, and there is no more effective way to spread risk than through a universal program. Therefore, one model for addressing our current fractured system would be to develop a universal, catastrophic LTSS insurance program.

The key to any effective insurance program is spreading risk as broadly as possible, and there is no more effective way to spread risk than through a universal program.

Such a system could be designed in a variety of ways.¹⁵ Financing could come from a variety of potential sources, such as new payroll contributions (as for Social Security and Medicare Hospital Insurance), an income or other dedicated tax, general revenues, or some other kind of new levy. These taxes could potentially be paired with premiums paid by beneficiaries, as in Medicare Parts B and D. It may be possible to cover some costs through savings from Medicaid as well as lower Medicare health expenditures.

Eligibility thresholds could match those used for the Medicare program, applying to all seniors as well as individuals with disabilities who are either receiving benefits under Social Security or one of a few other public programs. Policymakers could consider more relaxed vesting periods and eligibility criteria for working-age people with disabilities requiring LTSS to participate in the labor market. Alternatively, however, the program could apply only to seniors. In some models, all Americans would be eligible for at least some catastrophic benefit as long as they worked for some period of time, much like Medicare Part A. Catastrophic coverage could kick in either after a period of time and/or a fixed amount of out-of-pocket LTSS spending. However eligibility thresholds are defined, they should be developed with caution to assure people of all incomes have adequate protection and do not discourage people from saving for retirement or other personal needs.

Another important subject to consider is how benefits would be delivered and what benefits would be covered. Benefits could be based on those currently covered under Medicaid, on an assessment of what is typically covered under private long-term care insurance plans, or an entirely new list of benefits could be developed.

¹⁵ For a detailed, bipartisan discussion of possible approaches to achieving a universal long-term care insurance program, please see: Long-Term Care Financing Collaborative, 2016, A Consensus Framework for Long-Term Care Financing Reform, <http://www.convergencepolicy.org/wp-content/uploads/2016/02/LTCFC-FINAL-REPORT-Feb-2016.pdf>.

Revitalize the private long-term care market for non-catastrophic risk

The private market alone will not be able to come anywhere close to addressing the need for LTSS across the nation. That said, the creation of a catastrophic universal public plan, for instance, could create a framework within which private front-end LTSS insurance plans could play a meaningful role, while ensuring that the highest risk and costliest individuals could still obtain affordable coverage. Some other reforms that could rekindle the private insurance market include:

- Encouraging employers to add LTC coverage to their employee benefits packages;
- Refundable tax benefits or subsidies for individuals to purchase private coverage;
- Increasing standardization of benefits;
- Setting premiums and benefits to slowly increase over time, making LTC insurance more affordable for individuals who purchase coverage at a younger age;
- Experimenting with hybrid products combining LTC insurance with other policies (e.g., life insurance, disability);
- Strengthening consumer protections to improve public perception of the private market.¹⁶

Create a federal reinsurance mechanism for private LTSS plans

An alternative to an individual catastrophic benefit would be federal reinsurance or stop-loss insurance for LTSS coverage offered by private plans. This approach would resemble Medicare Part D, which provides federal catastrophic insurance that caps private prescription drug benefits and individual out-of-pocket drug expenses. Stop-loss insurance would pay for LTSS expenses after a plan reaches some predefined amount. Reinsurance would spread the excess LTSS expenses among participating plans, and could include a provision that would cap private insurers, with the federal government paying annual losses for expenses in excess of the cap. This approach to catastrophic insurance would operate in the background to lower the cost and improve the benefits that would otherwise be available through private coverage.

Increase federal financing of state Medicaid programs for LTSS

States already bear a heavy burden when it comes to financing long-term care, and this burden will only increase as the Boomers become older and frailer. The burden will be spread unevenly across the country, as some states face larger populations of aging adults than others. Furthermore, there is tremendous variation among states in how many individuals who require LTSS receive them through the Medicaid program. On average, only about

¹⁶ Ibid.

half of low-income adults with long-term care needs actually receive support from Medicaid or other public assistance with LTSS costs.¹⁷

With such substantial rates of unmet need, the problem is not exclusively – or even primarily –

one of issues with Medicare or Medicaid, but rather of insufficient investment in LTSS. In addition to creating a new social insurance program, there are two possible avenues for addressing the impending surge in state burden for Medicaid long-term services and supports:

1. Establish a nationally uniform minimum benefit for low-income populations – namely those dually eligible for Medicare and Medicaid – through federal financing, which states could then enhance as needed by contributing their own funds to be matched by federal funds.
2. Enhance the federal Medicaid matching rate based on the proportion of a state’s population that is represented by low-income seniors.¹⁸

Pursue a public/private partnership

Another option would be some form of public/private partnership, either added on to an existing program, such as Medicare Advantage, or through an entirely new partnership program.¹⁹ In this option, LTSS services could be included in the package of Medicare Advantage services, which would blend LTSS services more efficiently and seamlessly with medical services.

Strengthen access to LTSS for working-age people with disabilities through Medicaid buy-in programs

Many working-age people with disabilities could increase their labor-market participation if they received the necessary supports. For example, some SSDI

beneficiaries also receive Medicaid, which funds the long-term services and

States already bear a heavy burden when it comes to financing long-term care, and this burden will only increase as the Baby Boomers become older and frailer.

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¹⁷ Included population is low-income adults above the age of 21 and below 250% of the federal poverty level with an activities of daily living (ADL) disability; Susan C. Reinhard, Enid Kassner, Ari Houser, Kathleen Ujvari, Robert Mollica, and Leslie Hendrickson, 2014, Raising Expectations: A State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities, and Family Caregivers (Second Edition), AARP, The Commonwealth Fund, and The SCAN Foundation, http://www.aarp.org/content/dam/aarp/research/public_policy_institute/ltc/2014/raising-expectations-2014-AARP-ppi-ltc.pdf.

¹⁸ For a detailed description and analysis of both options, see: Judy Feder and Harriet L. Komisar, 2012, The Importance of Federal Financing to the Nation’s Long-Term Care Safety Net, Georgetown University, http://www.thescanfoundation.org/sites/thescanfoundation.org/files/Georgetown_Importance_Federal_Financing_LTC_2.pdf.

¹⁹ Long-Term Care Financing Collaborative, 2016.

supports they need to engage in employment. Reentering the workforce may cause them to lose these supports in some states, or they may choose to suppress their earnings so as not to lose access to Medicaid LTSS. These are both untenable outcomes and formidable work disincentives. Medicaid Buy-In programs can, if properly designed, provide critical LTSS supports to working-age people with disabilities without the fear of losing access to them because of their assets or earnings.^{20,21}

Strengthen family supports

In order to provide the care that their loved ones need, family caregivers need greater protections both inside and outside of the workforce. Those who leave the workforce to care for a family member miss out not only on income and benefits, but also on contributing to critical protection programs such as Social Security. For those who do remain in the workforce, many face substantial barriers in terms of scheduling and workplace flexibility. (For an extensive discussion of policy options to protect and support caregivers, please see Section 5 of this *Report on Caregiving*.)



²⁰ Bipartisan Policy Center, 2015, "Improve the SSDI Program and Address the Impending Trust Fund Depletion August 2015 Consensus Recommendations of BPC's Disability Insurance Working Group," August. <http://bipartisanpolicy.org/wp-content/uploads/2015/08/BPC-Economy-SSDI-Program.pdf>

²¹ Jack Gettens, Denise Hoffman, and Alexis Henry, 2015, "Wraparound Health Insurance Cost and Utilization among Employed People with Disabilities," Mathematica Center for Studying Disability Policy.

Conclusion

The lack of an efficiently financed, well-functioning, and broadly accessible system of long-term services and supports is heavily burdening American families, state and federal budgets, and the economy as a whole. These problems will only worsen in the coming decades as the Boomers age into their 80s and beyond. At the same time, the economic contributions and quality of life of working-age people with disabilities remain unnecessarily limited. Congress has a range of policy options at its disposal to address the LTSS needs of seniors and working-age people with disabilities.

The lack of an efficiently financed, well-functioning, and broadly accessible system of long-term services and supports is heavily burdening American families, state and federal budgets, and the economy as a whole.

Caregiving

Caregiving

Background

Every advanced industrial (OECD) country except the United States has enacted social insurance programs to protect against the risk of lost earnings due to caregiving responsibilities.¹ Caregiving responsibilities can take various forms, including caring for children, family members with illnesses or disabilities, sick or aging parents, or

an individual's own medical needs. All other OECD countries provide paid maternal leave,² three-quarters cover any paid leave specific to the father or co-parent,³ and just over half cover some form of paid leave to care either for adult family members or partners.⁴ These countries insure the risk of caregiving through a range of different programs and to differing extents. In the United States, despite decades-long growth in female labor market participation, and a large and growing population of children with all parents in the workforce and of seniors requiring assistance with medical needs and/or the activities of daily living, we have yet to develop a national program to address even one of these caregiver risks.

Every advanced industrial country except the United States has enacted social insurance programs to protect against the risk of lost earnings due to caregiving responsibilities.

In addition to the lack of supports for working caregivers, an affordable care infrastructure is unavailable for young children and persons with physical or cognitive impairments. The United States compares quite poorly to other advanced industrial nations in terms of public spending to support a system of affordable child care and early education.⁵ While there are supports in place through Social Security Disability Insurance (SSDI) for individuals experiencing a serious disability that prevents them from working for at least one year or is anticipated to be fatal, there are no national programs in place to support workers who need time off to address shorter-term medical conditions. Additionally, the nation currently lacks an effective, affordable system of financing and providing long-term services and supports (LTSS), which is discussed in Section 4 of this *Report*. Such programs hold promise to

¹ OECD Family Database, 2016, PF2.5. Trends in parental leave policies since 1970, http://www.oecd.org/els/family/PF2_5_Trends_in_leave_entitlements_around_childbirth.pdf.

² Ibid.

³ OECD, 2016, Parental leave: Where are the fathers?, Policy Brief, <https://www.oecd.org/policy-briefs/parental-leave-where-are-the-fathers.pdf>.

⁴ Peter Moss, 2015, International Review of Leave Policies and Research 2015, http://www.leavenetwork.org/lp_and_r_reports/; OECD Family Database, 2016, PF2.3: Additional leave entitlements for working parents, https://www.oecd.org/els/soc/PF2_3_Additional_leave_entitlements_of_working_parents.pdf.

⁵ OECD Family Database, 2016, PF3.1. Public spending on childcare and early education, http://www.oecd.org/els/soc/PF3_1_Public_spending_on_childcare_and_early_education.pdf.

help alleviate financial burdens on caregiving families, contribute to higher workforce retention rates, give workers with disabilities supports that might enable them to remain in the workforce, and give families the peace of mind that long-term services and supports will be available if they or a family member require them.

The lack of financial support for family caregivers in the United States has both obvious and hidden costs for families and the American economy.

Why is action needed?

The lack of financial support for family caregivers in the United States has both obvious and hidden costs for families and the American economy.⁶

First, as the Boomer generation ages and the smaller birth cohorts of

Generation X succeed them into their prime caregiving years, the caregiver-to-care-recipient ratio will worsen dramatically.⁷ Many families will face a financial and personal dilemma: the choice between forgoing pay and benefits by scaling back or leaving work to provide care for a loved one, or leaving their loved one in the hands of paid caregivers so that they can continue working to afford the high cost of care. Other families may be forced to accept substandard care or forgo care altogether due to cost or employment limitations.

With the dramatic reduction in the availability of a full-time family caregiver, families now face a much greater risk of having to compromise either work or caregiving responsibilities.

American families have also been steadily moving away from having a primary stay-at-home caregiver, relying increasingly on either dual incomes or a single working head of household; 89.3 percent of families have at least one working parent,⁸ and 72.3 percent of families have no full-time stay-at-home parent – that is, they consist of both partners or

a single parent working.⁹ As more women have entered the workforce over the past half-century, they have become a linchpin of the economic security of low- and moderate-income families.¹⁰ While women still spend far more

⁶ United States Department of Labor, 2015, The Cost of Doing Nothing, <https://www.dol.gov/featured/paidleave/cost-of-doing-nothing-report.pdf>.

⁷ Donald Redfoot, Lynn Feinberg, and Ari Houser, 2013, The Aging of the Baby Boom and the Growing Care Gap: A Look at Future Declines in the Availability of Family Caregivers, AARP Public Policy Institute, Insight on the Issues: 85, http://www.aarp.org/content/dam/aarp/research/public_policy_institute/ltc/2013/baby-boom-and-the-growing-care-gap-insight-AARP-ppi-ltc.pdf.

⁸ Bureau of Labor Statistics, 2016, Table 4. Families with own children: Employment status of parents by age of youngest child and family type, 2014-2015 annual averages, United States Department of Labor, Accessed December 21, 2016, <https://www.bls.gov/news.release/famee.htm>.

⁹ Houser and Vartanian, 2012.

¹⁰ Heather Boushey and Kavya Vaghul, 2016, Women Have Made the Difference for Family Economic Security, Washington Center for Equitable Growth, <http://equitablegrowth.org/research-analysis/women-have-made-the-difference-for-family-economic-security/>.

time caring for both children¹¹ and adult care recipients,¹² men's role as caregivers has been steadily growing over time, as well.¹³ With the dramatic reduction in the availability of a full-time family caregiver, families now face a much greater risk of having to compromise either work or caregiving responsibilities. The costs of extensive long-term services and supports¹⁴ and full-time child care exceed the resources of most American families. In the vast majority of states, the cost of both center-based care (49 states and the District of Columbia) and licensed family care (45 states and the District of Columbia) for children fails to meet the Department of Health and Human Services standard of affordability, which is set at a maximum of seven percent of family income.¹⁵ Yet, few families are able to access child care assistance programs that subsidize the cost of care. Only 15 percent of children eligible to receive assistance were served in 2012; federal and state government spending on such programs hit a 12-year low in 2014.¹⁶

Policy Challenges

Workforce participation among caregivers

Engagement in the paid workforce is extremely common among family caregivers, which can include parents or guardians caring for children and individuals caring for an aging, disabled, or sick family member. Over half of individuals providing care for an aging family member, for instance, are also employed, and those numbers are predicted to increase over time.¹⁷ However, adults who have lower levels of education and income are less likely to be employed while caring for an aging senior.¹⁸

Some caregivers – particularly parents – leave the workforce by choice, either temporarily or permanently, to care for their families. But many caregivers are forced to reduce their workforce participation due to a lack of support for their family responsibilities, and this can have myriad repercussions. Employers lose skilled workers who must then be replaced and retrained. Families suffer a decline in income, both over the short and long term; even small amounts of time out of the workforce can impact pay and advancement

¹¹ Kim Parker and Wendy Wang, 2013, Modern Parenthood: Roles of Moms and Dads Converge as They Balance Work and Family, Pew Research Center, <http://www.pewsocialtrends.org/2013/03/14/modern-parenthood-roles-of-moms-and-dads-converge-as-they-balance-work-and-family/>.

¹² National Academy of Science, Engineering, and Medicine, 2016, Families Caring for an Aging America, <https://www.nap.edu/catalog/23606/families-caring-for-an-aging-america>.

¹³ Parker and Wang, 2013, National Alliance for Caregiving and AARP Public Policy Institute, 2015, Caregiving in the U.S.: 2015 Report, http://www.caregiving.org/wp-content/uploads/2015/05/2015_CaregivingintheUS_Final-Report-June-4_WEB.pdf

¹⁴ Judy Feder and Harriet L. Komisar, 2012, The Importance of Federal Financing to the Nation's Long-Term Care Safety Net, Georgetown University, http://www.thescanfoundation.org/sites/default/files/georgetown_importance_federal_financing_ltc_2.pdf.

¹⁵ Child Care Aware of America, 2016, Parents and the High Cost of Child Care, <http://www.usa.childcareaware.org/costofcare/>.

¹⁶ Hannah Matthews and Christina Walker, 2016, Child Care Assistance Spending and Participation in 2014, CLASP, <http://www.clasp.org/resources-and-publications/publication-1/CC-Spending-and-Participation-2014-1.pdf>.

¹⁷ National Academy of Science, Engineering, and Medicine, 2016.

¹⁸ National Academy of Science, Engineering, and Medicine, 2016.

opportunities.¹⁹ The worker also frequently loses access to the benefits associated with employment, including critical years of work for retirement savings, Social Security eligibility and benefit accumulation, and employer life and health insurance coverage. Some may lose access to public benefits such as Temporary Assistance for Needy Families (TANF). For families receiving child care assistance, loss of employment may lead to temporary or permanent loss of assistance, which may in turn lead to further disruptions for the child, the family, and future employment opportunities.

If U.S. women in their prime working years participated in the labor force at the same rates as Canadian or German women, the result would be more than \$500 billion of additional economic activity per year.

The consequences of reduced labor force participation among caregivers go beyond the economic security and wellbeing of individual families. Between 1990 and 2010, the United States' ranking of female labor force participation relative to other OECD countries fell from 6th to 17th place, and research suggests that 29 percent of that decrease can be attributed to a lack of work-family policies, including access to paid

family and medical leave.²⁰ The U.S. Department of Labor estimates that if U.S. women in their prime working years participated in the labor force at the same rates as Canadian or German women, the result would be more than \$500 billion of additional economic activity per year.²¹

Lack of access to paid family and medical leave

Despite strong evidence of a public policy gap that has substantial impacts on working people, children, older adults, employers, and the economy, little has been done at the federal level to alleviate the burdens experienced by working caregivers. A notable exception occurred with the passage of the Family and Medical Leave Act (FMLA) in 1993. The FMLA offers job-protected, unpaid time off to some qualifying workers experiencing the birth or adoption of a child, a personal medical emergency, or the illness of a close family member. However, while FMLA leave is a critical support for eligible families, these benefits are realistically unattainable for a large share of the workforce. Over 40 percent of employees are not eligible for coverage under the law due to strict requirements in terms of the duration of a worker's employment history and numerous employer criteria, such as the size of an employer.²² Moreover, those who are not white, highly educated, and of

¹⁹ White House Council of Economic Advisers, 2015, Gender Pay Gap: Recent Trends and Explanations, Issue Brief, https://www.whitehouse.gov/sites/default/files/docs/equal_pay_issue_brief_final.pdf.

²⁰ Francine Blau and Lawrence Kahn, 2013, Female Labor Supply: Why Is the United States Falling Behind?, *The American Economic Review*, 103(3), 251-256.

²¹ U.S. Department of Labor, 2015.

²² Jacob Alex Klerman, Kelly Daley, and Alyssa Pozniak, 2014, Family and Medical Leave in 2012: Technical Report, U.S. Department of Labor, <https://www.dol.gov/asp/evaluation/fmla/fmla-2012-technical-report.pdf>.

higher socio-economic status are less likely to be able to afford to take unpaid leave, even if it is offered to them.²³ As of 2016, only 14 percent of civilian employees had access to paid family leave through their employer to care for new children or seriously ill relatives; just 38 percent had employer-sponsored temporary disability insurance to care for their own serious health issue; and close to one-third of workers (32 percent) did not have a single paid sick day for their own illness, with even lower access rates among low-wage workers.²⁴ Even for those who have access to some form of paid leave, take-up rates have been relatively low for myriad reasons including low wage replacement rates, fear of job loss or being passed up for promotions and raises, and lack of awareness of paid leave policies.²⁵



Effects of paid leave (or lack thereof) on the economy, health, and businesses

The dearth of access to paid leave for family caregiving has a profound effect on both the economic and health security of working families. Research on paid leave for new parents has shown that, one year following the birth of a child, mothers who use paid leave are more likely to remain in the workforce and have higher wages than women who do not.²⁶ Paid leave also affects infant health as rates of breastfeeding, immunization, and routine check-up participation increase²⁷ while post-natal mortality

Mothers who use paid leave are more likely to remain in the workforce and have higher wages than women who do not.

²³ Christopher J. Ruhm, February 2016, What Americans Can Learn from California about the Advantages of Paid Parental Leave, Scholars Strategy Network, <http://www.scholarsstrategynetwork.org/brief/what-americans-can-learn-california-about-advantages-paid-parental-leave>.

²⁴ Bureau of Labor Statistics, 2016, National Compensation Survey, Table 32. Leave benefits: Access, civilian workers, March 2016, <https://www.bls.gov/ncs/ebs/benefits/2016/ownership/civilian/table32a.htm>; and Table 16. Insurance benefits: Access, participation, and take-up rates, civilian workers, March 2016, <https://www.bls.gov/ncs/ebs/benefits/2016/ownership/civilian/table16a.pdf>.

²⁵ For an analysis of low take-up rates, see: Aparna Mathur, 2016, The Problem With Paid Family Leave: Access Is Not The Same As Take-Up, Forbes, <http://www.forbes.com/sites/aparnamathur/2016/03/04/the-problem-with-paid-family-leave-in-the-u-s-access-is-not-the-same-as-take-up/#44fb8edb608a>.

²⁶ Houser and Vartanian, 2012.

²⁷ Lawrence M. Berger, Jennifer Hill, & Jane Waldfogel, 2005, Maternity Leave, Early Maternal Employment and Child Health and Development in the US, *The Economic Journal*, 115(501), F44, doi: 10.1111/j.0013-0133.2005.00971.x.

decreases²⁸ when new parents have access to sufficient paid time off to care for their newborn. And because women are more likely than men to reduce their labor force participation in order to provide elder care, they are more likely to experience negative economic effects as a result. Women age 55 to 67 who provide elder care to their parents reduce their work hours by 367 hours per year, or 41 percent, on average.²⁹

Despite initial fears that paid leave would burden employers, businesses overwhelmingly report neutral or even positive effects from paid family and medical leave on employee productivity, profitability/performance, turnover rates, and morale, according to research in California – one of the few states that offers paid family and medical leave, and the one that has done so longest.³⁰

Public budgets could also find some relief from a paid family and medical leave system self-funded through social insurance. Where paid family and medical leave is available, both mothers and fathers who return to work after taking paid leave have been found to be less likely to utilize public assistance programs than those who do not take leave.³¹ Additional support to facilitate family-provided care where appropriate would likely result in significant health-care cost savings by preventing costly illnesses and accidents, improving health outcomes, and potentially reducing unnecessary institutionalization of family members who are sick, aging, or living with a disability.

Impact of caregiving on long-term financial security

Some working caregivers make significant sacrifices to care for loved ones, leaving their jobs or cutting down on hours to provide care. Roughly half of caregivers who leave the workforce to care for an aging family member do so not by true choice, but rather because limitations in the flexibility of their workplace prohibited them from providing sufficient support to their family member. One study estimated that adult caregivers over age 50

Roughly half of caregivers who leave the workforce to care for an aging family member do so not by true choice, but rather because limitations in the flexibility of their workplace prohibited them from providing sufficient support to their family member.

²⁸ Christopher J. Ruhm, 2000, Parental leave and child health, *Journal of Health Economics*, 19(6), 931-960, http://libres.uncg.edu/ir/uncg/f/C_Ruhm_Parental_2000.pdf.

²⁹ Richard W. Johnson and Anthony T. Lo Sasso, 2006, The impact of elder care on women's labor supply, *INQUIRY: The Journal of Health Care Organization, Provision, and Financing*, 43(3), 195-210.

³⁰ Eileen Appelbaum and Ruth Milkman, 2011, Leaves that Pay: Employer and Worker Experiences with Paid Family Leave in California, <http://cepr.net/documents/publications/paid-family-leave-1-2011.pdf>.

³¹ Houser and Vartanian, 2012; U.S. Department of Labor, 2015.

who leave the workforce to care for an aging parent will lose over \$300,000 in lifetime earnings and benefits.³² In most cases, caregivers who leave the workforce or reduce their hours and earnings also suffer a decline in their future Social Security benefits, since benefits are based on the average of a worker's top 35 years of earnings. (For further discussion of this topic, see Section 1.c of this *Report on Women's Retirement Security*.)

Lack of access to affordable, quality care

Child Care: The years prior to a child's introduction into the American formal education system lay the foundation for their cognitive, social, emotional, and linguistic development. Yet, many children are subjected to factors that harm or limit their development. These factors range from poverty³³ to exposure to adverse childhood experiences – the potentially traumatic childhood experiences that can have a long-lasting negative impact on health and well-being³⁴ – to exposure to highly limited vocabularies and social interactions.³⁵

While many of these problems originate within the home, they are often compounded by the lack of affordable, quality child care. Particularly in the earliest years prior to entry in the formal educational system, many families are faced with a difficult, and often

Only one in six eligible children receives assistance under the Child Care and Development Block Grant program.

painful, choice when it comes to arranging care for their children: exit the workforce, potentially sacrificing income and career development, or commit substantial family resources to paying for child care, often putting other family necessities in jeopardy for care that may or may not provide the enrichment that children need to succeed. Given that the average price for full-time, center-based care for a child under five years old is \$9,589,³⁶ families with fewer resources often struggle significantly to pay for child care. Additionally, the existing subsidies for child care – while critical for those receiving them – cover less than half of children eligible for the services.³⁷ Fewer than 1.4 million children received federally funded child care assistance through the Child Care and Development Block Grant (CCDBG) in an average month in 2015; this is the smallest number of children served in the program

³² Peter Arno, Deborah Viola, and Quihu Shi, 2011, *The MetLife Study of Caregiving Costs to Working Caregivers: Double Jeopardy for Baby Boomers Caring for Their Parents*, Westport, CT: MetLife Mature Market Institute; Center for Long Term Care Research and Policy, New York Medical College; and National Alliance for Caregiving, <http://www.caregiving.org/wp-content/uploads/2011/06/mmi-caregiving-costs-working-caregivers.pdf>.

³³ Godwin S. Ashiabi and Keri K. O'Neal, 2007, *Children's Health Status: Examining the Associations among Income Poverty, Material Hardship, and Parental Factors*, PLOS ONE, <http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0000940>.

³⁴ Vincent J. Felitti, Robert F. Anda, Dale Nordenberg, David F. Williamson, Alison M. Spitz, Valerie Edwards, Mary P. Koss, and James S. Marks, 1998, *Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults: The Adverse Childhood Experiences (ACE) Study*, *American Journal of Preventive Medicine*, 14, 245–258.

³⁵ Adriana Weisleder and Anne Fernald, 2013, *Talking to Children Matters: Early Language Experience Strengthens Processing and Builds Vocabulary*, *Psychological Science*, 24(11), <http://journals.sagepub.com/doi/full/10.1177/0956797613488145>.

³⁶ Brigid Schulte and Alieza Durana, September 2016, *The New America Care Report*, New America/Better Life Lab, https://www.care.com/media/cms/pdf/FINAL_Care_Report_09-27-2016.pdf.

³⁷ United States Government Accountability Office, 2016.

in 17 years. Only one in six eligible children receives assistance under the program.³⁸ Furthermore, only 11 percent of child care establishments nationwide have been accredited, and there is substantial variation among states in terms of both quality and availability of care.³⁹ Recognizing the importance of quality child care to children's development, federal CCDBG and state policies are increasingly raising the bar on child care quality. The ongoing tension between the need for high-quality care to benefit children and families and eroding access to child care assistance have left child care providers, families, and children in a challenging place.



LTSS: Despite the efforts of family members, many people who require LTSS go without the care they need. Almost three-quarters of severely impaired older people – with limitations in three or more basic tasks of daily living – report soiling themselves, going without bathing or eating, having to stay in bed or indoors, or experiencing other hardships because a task is too difficult for them or because no one is available to help them.⁴⁰ Although data are less readily available, younger people with LTSS needs undoubtedly face similar problems. Many younger adults with disabilities also face challenges in receiving sufficient supports to facilitate their participation in the labor force.

Lack of sufficient training and support for family caregivers

Support systems for families providing care are lacking in the U.S. Availability of such supports could improve health and developmental outcomes. For example, numerous home visiting programs that assist new parents with providing engaging, supportive care for their infants have been tested and proven lastingly effective for improving children's outcomes.⁴¹ Similarly, with

³⁸ Christina Walker and Hannah Matthews, January 2017, CCDBG Participation Drops to Historic Low, <http://www.clasp.org/resources-and-publications/publication-1/CCDBG-Participation-2015.pdf>.

³⁹ Schulte and Durana, 2016; for an extensive analysis to the U.S. landscape for child care, please see Chapter 3 of: Ajay Chaudry, Taryn Morrissey, Christina Weiland, and Hirokazu Yoshikawa, 2017, *Cradle to Kindergarten: A New Plan to Combat Inequality*, Russell Sage Foundation; as well as Schulte and Durana, 2016.

⁴⁰ Vicki A. Freedman and Brenda C. Spillman, 2014, *Disability and Care Needs Among Older Americans*, Table 8: Percentage of 65 and Older Population With Any Adverse Consequence in the Last Month Related to Unmet Need, by Demographic Group, *The Milbank Quarterly*, 92(3), 509-541, <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4221755/table/tbl8/>.

⁴¹ Sarah Avellar, Diane Paulsell, Emily Sama-Miller, and Patricia Del Grosso, 2014, *Home Visiting Evidence of Effectiveness Review: Executive Summary*, Mathematica Policy Research, http://homvee.acf.hhs.gov/HomVEE_Executive_Summary_2013.pdf#exec_summary.

the proper training and support, families caring for aging family members or those with disabilities could provide better care tailored to the recipient's needs. Since access to such services is limited, research on their effectiveness is sparse; however, the limited evidence suggests such programs could reduce costs by reducing re-hospitalizations, delaying institutionalization, and shortening the length of hospital stays.⁴² Additionally, these caregivers are frequently excluded from the clinical space. Yet care recipients, caregivers, and the clinical care team alike could benefit immensely from enhanced engagement with caregivers, as they are often responsible for managing the treatment plan laid out by the medical team.

Policy Options

One of the most expensive and inefficient policy approaches available would be to continue the status quo, with a lack of policies to address the nation's need for paid family and medical leave and affordable care options.⁴³ A range of policy options is available, however, to address these needs, which fall into several categories: paid family and medical leave, affordable child care, modernizing America's existing social insurance infrastructure to better include caregivers, and providing supports to family caregivers.

Paid Family and Medical Leave

Universal social insurance program for paid family and medical leave

In other advanced industrial nations and in the existing state-level programs in the U.S., nearly all systems of paid family and medical leave are structured as social insurance programs funded by payroll taxes. Utilizing a social insurance approach has several important advantages:

- **Universality:** Social insurance programs are designed to cover a broad risk pool: nearly everyone subject to the risk contributes either directly and/or through their employer, and all those who contribute benefit from the insurance protection. This universality garners social insurance programs strong

Social insurance programs are designed to cover a broad risk pool: nearly everyone subject to the risk contributes either directly and/or through their employer, and all those who contribute benefit from the insurance protection. This universality garners social insurance programs strong public support.

⁴² For an extensive discussion of this subject, please see Chapter 5 of *Families Caring for an Aging America* (National Academy of Science, Engineering, and Medicine, 2016).

⁴³ U.S. Department of Labor, 2015.

public support. Workers of all backgrounds face a variety of potential care risks over the course of their careers, such as: needing to take time from work to care for a new child; caring for a family member dealing with a medical condition or being moved into a nursing home; or caring for oneself while recovering from an illness or injury. To achieve true universality and to meet the needs of modern families, gender-neutral benefits would reduce gender-based employment discrimination and improve economic outcomes for families.⁴⁴ It is important to note, though: the more risks covered, the higher the employee and/or employer contribution required.

- **Portability:** Workers do not lose social insurance coverage when they change jobs; contributions and benefits are portable across jobs and available even for those who work part-time or are self-employed.
- **Self-funding:** Most paid family and medical leave systems are financed by payroll contributions by employees, employers, or both.⁴⁵ The level of contributions that fund the program are determined based on the expected costs paid out in benefits and administration. Such a financing structure does not burden public budgets, because spending on benefits does not exceed program revenue.
- **Efficiency:** A universal, public social insurance program for paid leave would be far more efficient to administer than a private one, which employers would have to administer. Consider the example of retirement provision: Social Security has administrative costs of less than one percent, whereas the administrative costs in private 401(k) plans are up to 30 times higher when marketing, advertising, profit, fees, etc. are taken into account.

Funding through general revenues

Another possible financing mechanism would be earmarked general revenues. This financing structure would only provide sufficiently stable funding if a dedicated funding stream were established to finance benefits. While this is a less commonly used mechanism for funding a paid leave program, there have been a few notable examples in other policy domains, such as gas taxes dedicated to funding highway construction and repairs, or The Passenger Fee that taxes airline travel to provide funding for the Transportation Security Administration (TSA).⁴⁶ It is unclear, however, what type of tax would be best suited to this earmarked use.

⁴⁴ In one study, for each month that a father stayed on leave, mothers' earnings increased by 6.7%. See: Elly-Ann Johansson, 2010, The Effect of Own and Spousal Parental Leave on Earnings, Working Paper, IFAU: Institute for Labour Market Policy Evaluation, <https://www.econstor.eu/bitstream/10419/45782/1/623752174.pdf>.

⁴⁵ The currently functioning programs in California, Rhode Island, and New Jersey, as well as the program passed but as yet to be implemented in New York state, are all funded through a payroll tax on employees, with some employers also making contributions in New Jersey. The program just recently passed in Washington, D.C., will be funded through an employer-sponsored payroll tax.

⁴⁶ For more information, please refer to the TSA's security fees page: <https://www.tsa.gov/for-industry/security-fees>.

Administration by the Social Security Administration

Successful administration of a paid leave program requires advanced technology and skilled staff. A national program will require the capacity to track wage data, as well as some method of verifying the need for benefits to be paid out to workers. Rather than developing a brand new program, many recent proposals have suggested attaching a paid family and medical leave benefit onto the established infrastructure of Social Security, to be administered by the Social Security Administration (SSA).

Many recent proposals have suggested attaching a paid family and medical leave benefit onto the established infrastructure of Social Security, to be administered by the Social Security Administration.

The trust fund for paid leave would be separate from the Old Age and Survivors Insurance and Disability Insurance trust funds. It would fund paid family and medical leave administration, and not add unfunded mandates to SSA. There are several advantages to this approach. First, by leveraging SSA's existing administrative structure, the new paid leave program could hit the ground running and ramp up quickly. Second, SSA already has field offices designed to be accessible by every community across the country; this would be extremely expensive and inefficient to replicate. Third, as a wage replacement program, SSA already collects data on the wages of all working Americans. Finally, incorporating paid leave within Social Security could strengthen intergenerational solidarity and public support for both programs.

Other federal agencies could also administer a national paid family and medical leave insurance program given the time and resources to do so; however, properly funding SSA to administer this new program is likely the most efficient option.



Reform Unemployment Insurance to cover paid family leave

Another option for creating a paid family and medical leave program would be to apply Unemployment Insurance (UI) protections to workers who leave the workforce temporarily to provide care for a family member. This option would be better targeted towards workers who have shorter-term family commitments (e.g., the birth of a child or a family member recovering from surgery) to stay consistent with the intended short-term nature of UI protections.

The downside of implementing paid leave through UI would be that it runs counter to the purpose of UI, which is to insure some wages for workers who are involuntarily unemployed but who remain able and available to return to work. In the UI system, employers who lay off more workers typically pay higher contributions to the system. This “experience rating” serves to discourage employers from taking advantage of the UI system, and also helps balance the system’s finances. If workers could take leave for reasons unrelated to employer layoffs, that would complicate the system’s financial operation.

Given the current landscape of UI benefits, it is likely that the wage replacement rate of paid family and medical leave through UI would be too low to adequately support lower-income families. Moreover, there is considerable variance between states, both in terms of benefits as well as in the technology and capacity in state information technology; this would render paid leave administered through UI extremely uneven across the country. Finally, UI data is incomplete; data for state and local workers, some federal workers, and nonprofit employees are not automatically included in UI files, making the calculation of program costs and benefits very difficult. (For more on Unemployment Insurance, see Section 3 of this *Report*.)

Proposed alternatives to a national paid family and medical leave program

Several alternatives to a government-sponsored paid leave program have been proposed, including tax-exempt parental leave savings accounts, tax credits to businesses voluntarily offering paid leave to their employees, and compensatory time (also known as “comp time”) to allow workers to earn time off that could be used in the future. These alternatives present a number of challenges, and are less likely to result in widespread access to paid leave when compared to a social insurance program.

The creation of tax-exempt savings accounts, which facilitate individual cash contributions that could be withdrawn when taking family leave, would help some families. It is unlikely, however, that low-income workers – who are the least likely to currently have access to employer-sponsored paid leave – would be able to take advantage of such a program. Similarly, there is little evidence to suggest that tax credits intended to partially offset the

costs to businesses that choose to create their own paid leave programs would change employer behavior. Current comp time proposals also have limited coverage, and limit the amount of time that can be accrued to four weeks. These approaches, while intended to address the underlying concerns outlined in this chapter, would not have the same reach or potential impact as a social insurance program.

Protect leave-takers from retaliation

Regardless of what type of paid family and medical leave system is adopted, it is critical that it support the job security of those meeting the eligibility requirements.⁴⁷ Even when paid family and medical leave is available to employees, many are afraid to utilize the benefits to which they are entitled out of fear of retaliation from their employer.⁴⁸ Such retaliation could come in the form of being directly fired, or through more subtle means such as being passed up for promotion or a pay raise. A national paid leave program would need to address the issue of job security to make sure that workers felt safe taking qualifying leave. This could be achieved either by providing explicit job protection for all workers who utilize paid leave, or through an anti-retaliation clause. For example, the paid family and medical leave program in Rhode Island ensures job protection for workers taking leave to care for a new child or family member, as will New York's policy once implemented. An additional strategy for protecting workers could include outreach campaigns to increase visibility and educate employees and employers on the rights of and benefits available to workers.

Tax and Social Security Reforms to Support Caregivers

Caregiver tax credit

For families paying for care for a child or an adult family member who is ill, aging, or living with a disability, some relief could be offered through a caregiver tax credit. While the impact of such a measure would be small in comparison to many of the other, larger-scale policy options, a tax credit could work in collaboration with those other policies to reduce the financial burden of caregiving. Since many families do not make sufficient income to pay taxes, in order to help low-income families, such a credit would need to be refundable.

⁴⁷ Eligibility criteria under the existing state paid leave programs differ by location. In California, workers must have earned a minimum of \$300 during the base period (first four of the last five completed quarters). In New Jersey, a worker must have completed at least 20 calendar weeks of covered New Jersey employment and earned at least \$168 per week, or have earned at least \$8,400 through covered employment in the base period. In Rhode Island, a worker must be employed in Rhode Island and have earned at least \$11,520 in the base period, or have earned at least \$1,920 in at least one quarter of the base period, with total base period taxable wages of at least 150 percent of their highest quarter of earnings, and with total taxable wages during the base period of at least \$3,840. In New York, to be eligible for temporary disability, a worker must have been employed with a covered employer for a minimum of four consecutive weeks (or 25 days of employment for part-time employees), and to be eligible for paid family leave a worker must be currently employed by a covered employer and have been employed for at least 26 consecutive weeks (or 175 days of employment for part-time employees).

⁴⁸ Applebaum and Milkman, 2011.

Social Security credits for caregiving

When care can be provided by a family member, it removes the family's cost burden of paying for professional child care, institutionalization, or

One policy option for enhancing the retirement security of caregivers – and acknowledging the many sacrifices that they make for their family and society – would be to institute a caregiving credit under Social Security.

home care workers. In many cases, it also reduces the federal and state government cost burden on programs such as Medicaid or child care subsidies. Yet, caregivers often face a double risk when they exit the workforce or reduce their hours to care for a family member, first from lost wages and benefits, and second from a decline in their retirement security. Therefore, one policy option for enhancing the retirement security

of caregivers – and acknowledging the many sacrifices that they make for their family and society – would be to institute a caregiving credit under Social Security. This credit would count years spent outside of the workforce providing care for children and/or family members as years contributing to the caregiver's future Social Security benefits.

Affordable Child Care

Child care subsidies for lower-income families

One option for addressing the child care crisis in the U.S. would be a policy to guarantee that low- and middle-income parents would have to pay no more than a certain maximum percentage of their income on child care services. The current federal benchmark for affordability in child care is seven percent of a family's income – well below the average share that families are currently paying in some states. Building on our current child care assistance programs, public subsidies could expand to finance the difference between what families can afford to pay and the actual price of such care, as is currently done in many other advanced industrial countries.⁴⁹ This would ensure that the cost of child care does not exceed what is affordable and affect the ability of families to pay for other necessities such as rent, food, and health care. One potential risk with this approach is that providers might take advantage of the subsidies to artificially inflate the cost of care, as many universities have arguably done in response to student loans, and that taxpayers would end up subsidizing not just needy families but providers as well. However, this is far from the reality of the child care sector currently, as many providers who accept subsidies are often unable to break even, and the child care workforce is largely composed of low-wage jobs.

⁴⁹ OECD Directorate of Employment, Labour and Social Affairs, 2014, "PF3.4: Childcare Support," https://www.oecd.org/els/soc/PF_3_4_Childcare_support_May2014.pdf.

Such a child care subsidy for low- and middle-income families could be coupled with a benefit for those who exceed the threshold for guaranteed subsidies, such as a tax credit for child care payments and/or a dependent care savings account into which families could contribute pre-tax dollars to pay for child care.



Universal Family Care

Public policy proposals tend to address the various caregiving needs families face discretely, through separate programs for child care, paid leave, and long-term services and supports. But from the perspective of families, these needs are interrelated – they are all part of the larger challenge of reconciling work and family needs across generations and stages of life. A proposal designed to match families’ holistic, intergenerational challenges is Universal Family Care (UFC).⁵⁰ UFC would be an integrated social insurance fund that would cover three key family needs: paid family and medical leave, child care, and long-term services and supports. By pooling risk for a diverse range of needs through contributions from all workers (with or without contributions from their employers), a self-funded UFC program could protect families from the often extremely high costs of care for children and adult family members with functional limitations, and would enable more caregivers to remain in the workforce throughout the desired length of their careers. A program such as UFC would allow workers to make contributions during their working years to help finance the care needs of their children (through paid leave and/or affordable child care) and family members (through long-term services and supports), as well as their own care needs in old age. This ambitious proposal is in its early stages of development, however, and more research and analysis needs to be done on how it could be successfully implemented.

⁵⁰ Universal Family Care was conceptualized by Caring Across Generations and the National Domestic Workers Alliance. As with any new program, the process of developing the details of such a policy would require collaboration from diverse stakeholders.

Supports to Family Caregivers

Including caregivers in the health care team

Under current policy and practice, caregivers are often excluded from the clinical space, particularly when caring for an ill or aging adult family member.

A systematic policy of excluding caregivers from the clinical space represents a missed opportunity for improving the quality of care that patients receive.

Protecting a patient's privacy is an important goal, but a systematic policy of excluding caregivers from the clinical space represents a missed opportunity for improving the quality of care that patients receive. Caregivers may be managing the patient's medication, have knowledge about the side effects

that a patient has been experiencing, or remember details and incidents that have been forgotten or overlooked by the patient. Additionally, it is often the caregiver who must implement the instructions given by a medical professional, but then they are not included in the conversation when those directions are given.

An expert panel of the National Academies of Science, Engineering, and Medicine recommends that caregivers be better supported and included by the clinical care team so that they can efficiently both give and receive critical health-related information.⁵¹ This would improve the timeliness and appropriateness of the care patients – particularly those with functional limitations – receive. To encourage this change in practice, Medicare and Medicaid could reimburse medical professionals for time spent communicating with caregivers.

Provide and conduct research on training and support programs for caregivers

Congress and the Department of Health and Human Services (HHS), as well as state health departments and individual community health leaders, could consider scaling up interventions already known to be successful at improving health and other outcomes for either or both the care recipients and the caregivers themselves. Such programs could include home visiting programs for parents with newborns⁵² and the National Family Caregiver Support Program (NFCSP) established under the Older Americans Act.⁵³

In addition, HHS could conduct or finance research studies to test the effectiveness of new and innovative, or existing but under-evaluated,

⁵¹ To read an extensive discussion of the supports that could better integrate caregivers into the health care team, please refer to: National Academy of Science, Engineering, and Medicine, 2016, Families Caring for an Aging America, <https://www.nap.edu/catalog/23606/families-caring-for-an-aging-america>.

⁵² Avellar, Paulsell, Sama-Miller, and Del Grosso, 2014.

⁵³ National Academy of Science, Engineering, and Medicine, 2016.

programs for supporting caregivers. This could lead to a cataloguing of which programs are most effective and evidence-based, which in turn could determine their eligibility for federal or state funding. An evidence-driven list of effective programs would help the federal government and states to decide which programs could be considered for integration into the health care and long-term care infrastructures.

Improving labor practices supporting direct care workers

Often a critical piece of the caregiving team puzzle comes from direct care workers, who can either supplement or take the place of family caregivers. Unfortunately, these caregivers often receive very low pay and benefits, which in turn can harm their ability to provide care, whether for clients or their own families. Not until 2015 did home care workers become eligible for coverage under the Fair Labor Standards Act (FLSA), which provides workers with minimum wage and overtime protections. Still, many direct care workers struggle with erratic schedules, low wages, and a lack of inclusion in the benefits structure awarded to most employees.⁵⁴ With the aging of the Boomer generation, the need for paid care workers will only continue to grow sharply in the coming years. (For a detailed discussion of this issue, see Section 6 of this *Report*, which addresses the risks of nonstandard work.)

Conclusion

Providing support to workers caring for a child, an ailing loved one, or their own medical condition has the potential to strengthen labor force participation, protect the long-term economic security of families, and improve both the quality of care and the quality of life in caregiving families. The United States has not yet enacted effective national policies to address these needs. This *Report* offers a range of evidence-based policy options that can help guide policymakers as they look for ways to support families as they cope with the challenges of reconciling work and caregiving.

⁵⁴ Paraprofessional Healthcare Institute (PHI), 2016, U.S. Home Care Workers: Key Facts, <http://phinational.org/sites/phinational.org/files/phi-home-care-workers-key-facts.pdf>.

Nonstandard Work

Nonstandard Work

Workers' traditional relationships with their employers have been fracturing over the past four decades.¹ The trend away from traditional employment arrangements, in which workers are employed for long stretches of time with a well-defined employer, toward nonstandard work leaves workers increasingly exposed to economic risks.² Programs such as Unemployment Insurance (UI) and Workers' Compensation rely on the

existence of an identifiable employer to assess risk, equitably allocate costs, and minimize moral hazard. In nonstandard work, however, there is often no easily identifiable employer.

The trend away from traditional employment arrangements, in which workers are employed for long stretches of time with a well-defined employer, toward nonstandard work leaves workers increasingly exposed to economic risks.

At the same time, the growth in nonstandard work arrangements, especially the large and unprecedented increase since the Great Recession, creates an opening for policymakers. Existing social insurance programs such as Unemployment Insurance, Workers' Compensation, health insurance, and paid leave could be reformed to increase economic security for all workers. Such changes could extend social protections to workers outside of full-time wage and salary employment and ensure that all workers have the prospect of economic security.

Policy Challenges

The nonstandard workforce is growing

There are many ways to estimate the number of workers in "contingent" or "nontraditional" employment. In its Contingent Worker Survey (CWS) from 2005, the Bureau of Labor Statistics (BLS) provided three different estimates of the extent of employment in contingent, or time-limited, work, based on relatively narrower or broader definitions of contingent work.³ In addition, BLS estimated the number of workers in certain alternative arrangements, regardless of whether the arrangement was contingent.

¹ Between 2005 and 2015, a period which included the Great Recession, all net job growth occurred in nonstandard work, while the number of standard jobs slightly decreased: Lawrence F. Katz and Alan B. Krueger, 2016, "The Rise and Nature of Alternative Work Arrangements in the United States, 1995-2015," NBER, https://krueger.princeton.edu/sites/default/files/akrueger/files/katz_krueger_cws_-_march_29_20165.pdf.

² Ibid.

³ Bureau of Labor Statistics, 2005, "Contingent and Alternative Employment Arrangements," Economic News Release, <https://www.bls.gov/news.release/conemp.nr0.htm>.

On contingent work, BLS estimated on the low end that 1.8 percent of the total employed workforce were wage and salary workers who expected their jobs to last for an additional year or less and who had worked at their jobs for one year or less, not including independent contractors. On the high end of BLS's contingent-work estimates was the finding that 4.1 percent of the total employed workforce reported that they did not expect their job to last, whatever the timeframe might be. This larger estimate included workers who had been an independent contractor for less than a year and did not expect to be an independent contractor for more than a year.

With regard to alternative arrangements, BLS estimated that 10.7 percent of the employed labor force was in so-called alternative arrangements.

With regard to alternative arrangements, BLS estimated that 0.6 percent of the employed workforce were workers provided by contract firms, 0.9 percent were temporary help agency workers, 1.8 percent were on-call workers, and 7.4 percent were independent contractors. In total, 10.7 percent of the employed labor

force was estimated to be in so-called alternative arrangements. Not all of these workers were considered contingent, however, as some of them did not report time-limited contracts. Independent contractors were most likely to be in the construction and professional services sectors and were more likely than workers in all other arrangements (including traditional employment relationships) to be white, over 55 years old, and – except for workers provided by contract firms – were more likely to have at least a Bachelor's degree than workers in traditional arrangements.

A 2015 update of this study conducted by academics outside of BLS showed substantial increases over the past ten years in the percent of the workforce employed in alternative work arrangements. The estimate of workers provided by contract firms nearly doubled – the largest increase of all the alternative arrangements measured – to 3.1 percent of the employed labor force. Temporary help agency workers increased to 1.6 percent of the employed labor force, on-call workers increased to 2.6 percent of the employed labor force, and independent contractors increased to 8.4 percent of the employed labor force.⁴ Overall, the percent of the employed labor force in alternative arrangements increased 56 percent between 2005 and 2015, from 10.1 percent to 15.8 percent. While the labor market is constantly shifting workers between sectors and types of work arrangements, given the

⁴ Lawrence F. Katz and Alan B. Krueger, 2016, "The Rise and Nature of Alternative Work Arrangements in the United States, 1995-2015," NBER, https://krueger.princeton.edu/sites/default/files/akrueger/files/katz_krueger_cws_-_march_29_20165.pdf. The estimates from 2005 used for comparison by the authors vary slightly from the BLS estimates published in 2005 because of updates in the data.

current structure of the labor force, all of the employment growth from 2005 to 2015 was roughly equal to the growth of alternate work arrangements.⁵

Other analyses of the nonstandard workforce have come to different conclusions about its size.⁶ A 2015 study by the Government Accountability Office estimated that 40.4 percent of the employed workforce were contingent workers in 2010.⁷ This estimate includes independent contractors, self-employed workers, and standard part-time workers, regardless of how long their current work is expected to last. Other analysts count workers with irregular schedules, whatever their job classification, as nonstandard.⁸ None of these estimates, however, directly sheds light on the effect of digital platforms like Uber on the labor market, which to date are only a small share of the workforce. The JPMorgan Chase Institute estimated that 0.5 percent of adults (both officially employed and unemployed) participated in online labor platforms in June 2016.⁹

Nonstandard workers face unprotected risks

Many nonstandard workers lack access to valuable employer-based benefits, such as a retirement plan or health insurance. They often also lack social insurance protections against workplace injury, disability, and involuntary unemployment, even though they are affected by these risks at least as much as traditional workers. Different forms of nonstandard work pose different policy problems. Indeed, in cases of voluntary self-employment, where an individual purposefully structures an arrangement as an independent contractor, no public policy problem may exist at all. This is often the case with doctors, lawyers, or others engaged in white-collar professions who decide to leave a firm in older adulthood, scale back their workload, and increase their flexibility by continuing to work as consultants. On the other hand, workers classified as independent contractors are sometimes dependent for most or all of their income from one employer, but are not compensated as employees. They are often not affluent and are cut off from the risk pooling of social insurance programs, which puts them in a precarious situation due to exposure to the uninsured risks of injury, sickness, disability, unemployment, and financial insecurity in old age.

⁵ Ibid.

⁶ Estimates are sensitive to how a particular analysis defines nonstandard work and to which data sources it uses. In an independent survey conducted by the McKinsey Global Institute, the Institute found that independent workers made up 27 percent of the working-age population in the U.S., compared with their analysis of existing government and private data sources, which showed that independent workers made up only 22 percent of the working-age population: McKinsey Global Institute, 2016, "Independent Work: Choice, Necessity, and the Gig Economy," <http://www.mckinsey.com/global-themes/employment-and-growth/independent-work-choice-necessity-and-the-gig-economy>.

⁷ Government Accountability Office, 2015, "Contingent Workforce: Size, Characteristics, Earnings, and Benefits," <http://www.gao.gov/products/GAO-15-168R>.

⁸ Nancy K. Cauthen, Annette Case, and Sarah Wilhelm, 2015, "Promoting Security in a 21st Century Labor Market: Addressing Intermittent Unemployment in Nonstandard Work," Family Values @ Work, http://familyvaluesatwork.org/wp-content/uploads/2015/05/nonstandard_work_final-1.pdf.

⁹ Diana Farrell and Fiona Greig, 2016, "The Online Platform Economy: Has Growth Peaked?" The JPMorgan Chase Institute, <https://www.jpmorganchase.com/corporate/institute/document/jpmc-institute-online-platform-econ-brief.pdf>.

All told, nonstandard workers of various kinds experience many forms of risk, including:

Income volatility and inadequacy are heightened risks for nonstandard workers because they lack consistency of employment, while also missing out on traditional workplace protections that lower the risk of job or income loss.

- *Income risk.* The risk common to all nonstandard workers is income risk, in a threefold sense: the risk of losing access to income altogether; the risk of volatility in income from month to month; and the risk of income inadequacy. Income volatility and inadequacy are heightened risks for nonstandard workers because

they lack consistency of employment, while also missing out on traditional workplace protections that lower the risk of job or income loss.

- *Health risk.* The Affordable Care Act (ACA) addressed the health risk faced by nonstandard workers by providing new subsidized options for insurance coverage, albeit imperfectly (for a detailed analysis of the ACA, see Section 2.a of this *Report*). The percentage of full-time independent workers/freelancers who report having health insurance increased from 64 percent in 2013 to 82 percent in 2015.¹⁰ If the ACA were repealed, depending upon the replacement, many of these workers could lose coverage and be exposed to increased health and economic risk.

Independent contractors miss out on employer contributions to Social Security and lack employer-provided retirement plans.

- *Retirement risk.* Nonstandard workers face an elevated risk of financial insecurity in retirement.¹¹ Independent contractors miss out on employer contributions to Social Security and lack employer-

provided retirement plans. Even part-time employees with an identifiable employer often lack access to workplace retirement plans. Only about a quarter of part-time workers have access to a 401(k)-type plan at work.¹²

¹⁰ MBO Partners "State of Independence 2016," <http://www.smallbizlabs.com/2015/09/freelancers-embrace-health-insurance.html>. Full-time independent workers are defined as those who work at least 15 hours a week as independent workers/freelancers (self-employed, independent contractors, etc.) in an average work week.

¹¹ William G. Gale, Sarah E. Holmes, and David C. John, 2016, "Retirement Plans for Contingent Workers: Issues and Options," The Brookings Institution, <https://www.brookings.edu/wp-content/uploads/2016/08/rsp923paper1.pdf>.

¹² Bureau of Labor Statistics, 2016, "Retirement benefit combinations: Access," Employee Benefits Survey, <https://www.bls.gov/ncs/ebs/benefits/2016/ownership/civilian/table03a.htm>.

- *Unemployment risk.* Independent contractors are ineligible for Unemployment Insurance because they are legally self-employed, even if they are economically dependent on a particular client for work or their business dries up through no fault of their own. In addition, many other nonstandard workers face challenges to accessing UI benefits because they often do not meet eligibility requirements, which are designed for traditional, full-time workers.
- *Injury risk.* Many nonstandard workers cannot seek Workers' Compensation if they are injured on the job because they fall outside of mandatory coverage laws, leaving those workers to shoulder the costs of health care and lost wages on their own.
- *Tax-compliance risk.* Nonstandard workers also face tax-compliance risks. These include not being informed of the need to pay quarterly self-employment and income taxes and then being penalized at tax time; having to borrow to absorb a very large tax shock when taxes are due, with the associated interest costs; and facing criminal penalties for underreporting their income because of an inability to come up with a tax payment at the end of the year. If they underreport, even if they are not penalized for doing so, their lifetime financial security will be adversely affected by lower Social Security benefits in disability or old age.

Policy Options

Leverage the portability and universality of social insurance

Social insurance programs ensure that workers are protected against unforeseen economic hardship due to a temporary or permanent inability to work. A suite of programs provides these protections. Workers' Compensation and Social Security Disability Insurance (SSDI) replace lost wages due to disability. Unemployment Insurance replaces lost wages due to involuntary unemployment during employer downsizing or economic downturn. Social Security old-age insurance is the cornerstone of retirement security for most workers. These and other social protections have ensured that workers, especially those in low-paying, poor-quality jobs, have some assurance of economic security in a competitive economy.

Some proposals to address the problem of providing workplace protections to an increasingly fragmented workforce involve portable benefits via individual accounts to which employers and employees could contribute. These accounts could theoretically provide an individual, matched savings-based alternative to traditional social-insurance programs and employer-provided benefits. Proposals for individual accounts may be appropriate for providing certain employment benefits not covered by social insurance,

but are an inadequate substitute for the stability, efficiency, and adequacy provided by pooled-risk social insurance systems. Many Americans are already unable to save enough for even the expected risk of retirement.¹³ Only a tiny fraction of the workforce would be able to save enough on their own to provide for themselves and their families at the same level as current social insurance programs do in the event of unforeseen unemployment, disability, or poor health. Ultimately, insurance is required to help workers weather foreseen and unforeseen risks in an efficient and equitable way.

Even though most of the American social insurance system was designed well before the rise of non-standard work, programs like Social Security and Medicare are in many ways ideally suited to the needs of the 21-century workforce.

Even though most of the American social insurance system was designed well before the rise of nonstandard work, programs like Social Security and Medicare are in many ways ideally suited to the needs of the 21st century workforce. These programs are portable, covering workers as they move from one employer to another. Policymakers should thus consider ways to build on this successful social insurance model.

Workers' Compensation and Unemployment Insurance are two social insurance programs that have not transferred as readily to nonstandard work because they require an identifiable employer to assess risk and apply the corresponding premium assessments.¹⁴ But solutions could be designed to make this requirement more flexible. New York City's Black Car Fund offers one example. The Fund provides Workers' Compensation insurance to black car taxi drivers by establishing an intermediary organization that takes the place of a traditional employer for the purposes of state Workers' Compensation law.¹⁵ Similar intermediary employers could be established in other sectors as well.

An important consideration in providing social insurance protections to nonstandard workers is avoiding, whenever possible, the loss of contributions traditionally paid by the employer. The entire burden of social insurance contributions is untenable for most low- to medium-wage nonstandard workers. As one alternative, the organizations contracting with workers could

¹³ Jack VanDerhei, 2015, "Retirement Savings Shortfalls: Evidence from EBRI's Retirement Security Projection Model," EBRI Issue Brief No. 410, Employee Benefit Research Institute, https://www.ebri.org/publications/ib/index.cfm?fa=ibDisp&content_id=5487; Alicia H. Munnell, Wenliang Hou, and Anthony Webb, 2014, "NRRRI Update Shows Half Still Falling Short," Center for Retirement Research, <http://crr.bc.edu/briefs/nrri-update-shows-half-still-falling-short/>.

¹⁴ In some states, statutory employee laws require certain classes of workers to be considered employees for the purposes of social insurance programs. California is one example of these states: California Employment Development Department, 2011, "Statutory Employees," Information Sheet, http://www.edd.ca.gov/pdf_pub_ctr/de231se.pdf.

¹⁵ New York State Workers' Compensation Board, n.d., "Workers' Compensation Coverage: Black Car Operators," <http://www.wcb.ny.gov/content/main/onthejob/CoverageSituations/BlackCarOper.jsp>.

match workers' contributions on a pro-rata basis. Another is to have the consumers buying the goods or services of the worker cover some or all of the cost of the worker's contributions.

Establish "independent worker" status

Some analysts have proposed creating a third category of worker between employee and independent contractor – the "independent worker."¹⁶ This could allow some benefits and social insurance contributions to flow from the employer to the employee without requiring the employer to maintain full employee status for the employee. This status could be written into social insurance laws to provide some level of protection otherwise not available to nonstandard workers. One potential problem with this approach is the possibility that a new employment classification would merely expand the possibilities for misclassifying workers as something other than employees in order to reduce employer costs, as has already happened with many independent contractors.¹⁷

Enact a system of portable "safety net" benefit accounts

Others have proposed a system of portable, pro-rated "individual security accounts" to which entities of any kind that use the labor of workers would contribute a "safety net fee" in proportion to the number of hours (or where appropriate, total earnings) that the worker is paid by that entity.¹⁸ For example, a worker who is employed 20 hours a week by one employer, another 10 hours per week by another employer, and also receives 1099 contract income from a third source would earn 50 percent of her benefits from the first employer, 25 percent from the second, and another percentage based on her gross income from the entity with which she contracts for work. In total, this worker would earn over three-fourths of her full benefits (based on a forty-hour work week).

In this way, such accounts could facilitate contributions from multiple businesses to work-based social insurance coverage, such as Social Security, Medicare, Unemployment Insurance, and Workers' Compensation, by passing through the "safety net fee" to existing social insurance programs. Accounts also could be used for leave benefits provided through state-based social insurance programs, such as paid sick leave, or to pre-fund leave benefits, including vacation. They could be used to fund savings-based benefits, like retirement savings.

¹⁶ Seth D. Harris and Alan B. Krueger, 2015, "A Proposal for Modernizing Labor Laws for Twenty-First-Century Work: The 'Independent Worker,'" Discussion Paper 2015-10, The Hamilton Project, The Brookings Institution, http://www.hamiltonproject.org/assets/files/modernizing_labor_laws_for_twenty_first_century_work_krueger_harris.pdf.

¹⁷ Benjamin Sachs, 2015, "Do We Need an 'Independent Worker' Category?" On Labor, <https://onlabor.org/2015/12/08/do-we-need-an-independent-worker-category/>.

¹⁸ Steven Hill, 2015, "New Economy, New Social Contract: A Plan for a Safety Net in a Multiemployer World," New America, <https://www.newamerica.org/economic-growth/policy-papers/new-economy-new-social-contract/>; Nick Hanauer and David Rolf, 2015, "Shared Security, Shared Growth," Democracy, Summer 2015, No. 37, <http://democracyjournal.org/magazine/37/shared-security-shared-growth/>.

Contributions to these accounts could be made not only by the worker, but also by other entities, such as the firms or individuals that contract with the worker, which can in turn pass some of the cost onto consumers. There are many questions to consider when implementing a system of portable benefits or shared accounts. Among them are whether the funding will be mandatory, what classes of workers will be covered, how much oversight the government would require, how to adapt current rules such as experience rating for Unemployment Insurance contributions to a multiple employer and independent contractor setting, and what benefits would be provided.¹⁹

Other reform options

A range of other policy options are available to enhance the economic security of nonstandard workers, including:

- Reform the eligibility criteria for partial UI benefits – currently available to some part-time workers – to account for the volatility of nonstandard work.²⁰
- Better enforce laws regulating employee classification.
- Make employee status the statutory presumption for workers, requiring active steps to achieve independent contractor status.²¹
- Improve tax compliance year-round among independent contractors so as to facilitate social insurance contributions and to reduce expense shocks from taxes. Intermediaries that use workers' labor could withhold taxes on behalf of the worker and could make employer contributions to social insurance programs.²²
- Extend Family and Medical Leave Act (FMLA) protections to part-time workers (for more on family and medical leave, see Section 5 of this *Report*).²³
- Make self-employment assistance (SEA) available for unemployed workers in all states. SEA allows workers receiving Unemployment Insurance to work full time in starting their own business while still receiving UI benefits. This small change would provide at least a minimum level of support in the new economy for workers transitioning from traditional employment into ever-more-prevalent nontraditional employment situations.²⁴

¹⁹ A more complete list of questions to consider in implementing portable benefits is provided in Shayna Strom and Mark Schmitt, 2016, "Protecting Workers in a Patchwork Economy," The Century Foundation, <https://tcf.org/content/report/protecting-workers-patchwork-economy/>.

²⁰ Andrew Stettner, Michael Cassidy and George Wentworth, 2016, "A New Safety Net for An Era of Unstable Earnings," The Century Foundation, <https://tcf.org/content/report/new-safety-net-for-an-era-of-unstable-earnings/>.

²¹ AFL-CIO, 2013, AFL-CIO Legislative Guide, <http://www.aflcio.org/content/download/1728/15559/file/2013%20Legislative%20Handbook%20-%20Chapter%206.pdf>.

²² Harris and Krueger, 2015. It is worth noting that many of these proposals, including tax changes and shared security accounts, would not help the many nonstandard workers who are undocumented immigrants and therefore lack Social Security numbers.

²³ AFL-CIO, 2013.

²⁴ Christopher J. O'Leary and Stephen A. Wandner, 2016, "Unemployment Insurance Research and Reform," Presented at the 38th Annual Fall Research Conference of the Association for Public Policy Analysis and Management.

- Enact statutory employer laws to automatically classify certain classes of workers – for example, 1099 employees in certain industries like transportation, home services, or delivery – as employees for the purposes of social insurance programs.²⁵
- Require employers to offer additional work first to existing part-time employees before hiring new employees or using contractors or a temporary services or staffing agency to perform work.²⁶



Conclusion

The growth of work outside the standard employment relationship has exposed millions of workers and their families to new risks and has heightened existing ones. The uncertain future of the individual health insurance market in the context of current efforts to repeal the Affordable Care Act compounds this insecurity. Efforts to provide adequate economic protection to the nation's growing nonstandard work force could build on the successful models of Social Security and Medicare, which provide universal, portable, flexible coverage to workers in all employment relationships. Extending Unemployment Insurance and Workers' Compensation protection to nonstandard workers could be accomplished by letting workers buy into existing national programs in these areas, with matching contributions coming from intermediary employers, consumers, unions, or the government. Moreover, the eligibility criteria for Unemployment Insurance and SSDI could be reformed to better account for the volatility of income in the nonstandard sector. With most net job growth occurring in the nonstandard sector, policymakers should develop systems to protect against the risks these workers face in the coming years.

²⁵ Rebecca Smith and Sarah Leberstein, 2015, "Rights on Demand: Ensuring Workplace Standards and Worker Security in an On-Demand Economy," National Employment Law Project, <http://www.nelp.org/content/uploads/Rights-On-Demand-Report.pdf>.

²⁶ See, e.g., San Francisco, California, San Francisco Police Code Art. 33F, § 3300F.3 (2015).

Conclusion: From Here to There

Conclusion: From Here to There

Over the past four decades, our country has witnessed dramatic changes. The information technology revolution and economic globalization have transformed the competitive landscape faced by many businesses. Unions have declined in membership and power. The manufacturing sector has declined, and the service and financial sectors have gained significance in our economy. In part due to these factors, income and wealth inequality have grown to historic proportions.

At the same time, the American workforce and the nature of work have changed. Most women are no longer available to function as full-time, stay-at-home caregivers, and fewer households conform to the traditional two-parent, single-earner model. Workers can no longer expect to remain with a single employer over the course of their careers, and most can no longer expect to receive a pension. Nonstandard employment has become more prevalent, leaving many workers newly unprotected against the risks of unemployment or injury at work. Multi-generational caregiving responsibilities are becoming much more common.

Throughout this *Report*, we have analyzed the salient policy challenges that have emerged in the wake of these changes in our economy and society. Some are challenges to our existing social insurance infrastructure. Others are economic or health security risks that have yet to be systematically addressed by social insurance in the United States.

Strengthening Social Insurance in Era of Inequality

This *Report* discusses a number of options for strengthening and adapting social insurance. One, for example, is to shore up the finances of Social Security. Many of the options for achieving this goal are designed to place little or no additional pressure on low- to moderate-income working Americans. Examples are: lifting the taxable earnings cap to cover all earnings; extending payroll taxes to cover investment income; or changing the benefit formula to boost benefits at the bottom of the income spectrum and reduce them in the middle and upper levels.

Some combination of these and other changes could improve the long-term solvency of Social Security and at the same time improve the adequacy of benefits in targeted fashion. Increasing Social Security's special minimum benefit to 125 percent of the poverty level at full retirement age, for example, would greatly help the many recipients who live close to the poverty line – disproportionately Americans of color. Increasing survivor benefits and reinstating student benefits until age 22 for children of deceased or disabled

workers would help millions of younger Americans to better prepare themselves for the 21st century workplace. Providing partial Social Security earnings credits to parents of young children, or to those who are caring for aged relatives, would enable them to devote more time to their families for a period of years, without worrying that they are dramatically undercutting their retirement security.

As we move toward a majority-minority society, a diminishing share of households will have the resources to endure economic downturns.

America's workforce is changing. Beginning in 2020, the majority of new job entrants will be workers of color. As we move toward a majority-minority society, a diminishing share of households will have the resources to endure economic downturns. This has implications not only for these households' economic security, but

also for social cohesion and macroeconomic stability.

The nature of unemployment itself has been changing. There has been a decline in temporary layoffs and a sharp increase in permanent layoffs, meaning that displaced workers need help finding new jobs in new occupations and industries – we cannot simply wait for the old jobs to return. A lack of job opportunities that provide secure career pathways for young people also raises the possibility of unemployment cycles that are substantially different from those of the past, and different from those against which the UI system was designed to protect. Social insurance best serves as a force for economic cohesion when it supports workers in all segments of the economy and facilitates opportunities for upward mobility.¹

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Medicare and Medicaid are both extremely successful programs – both in providing health security to millions of vulnerable Americans, and in containing health-care costs. Still, the key to strengthening all health insurance in the United States – both public and private – is to contain the growth in health-care costs. And because health care absorbs more and more of older households' income, getting these costs under control is also critical to maintaining living standards in retirement.

¹ William Spriggs, 2016, Acceptance Speech on the Occasion of Receiving the Robert M. Ball Award for Outstanding Achievements in Social Insurance, National Academy of Social Insurance, June 21, 2016.

Synergies from Strengthening Social Insurance

Social insurance and other benefit programs are in many ways intimately connected with one other. As this *Report* has shown, the existing approach to funding and delivering long-term services and supports is an overburdened patchwork of Medicaid coverage, disappearing private-sector coverage, and private savings. Revitalizing this market – for instance, by creating a public, universal long-term care insurance program; increasing federal financing of Medicaid long-term care programs at the state level; or creating incentives for employers to add long-term care coverage to their benefits packages – would help prevent a crisis for millions of aging workers and their families. It would also help lower Medicare's cost burden, since high-quality long-term care services and supports lower the incidence of falls and other health problems – and the cost to Medicare of covering them.

Improvements in long-term care coverage are critical for holding down costs in other parts of the social insurance system. As are modernizations of Unemployment Insurance. Reforms reviewed in this *Report* include: changing the rules to allow former part-time workers to receive unemployment compensation while they search for part-time work; adjusting the earnings requirements to make workers in alternative work arrangements eligible; and redesigning the extended benefits that kick in during economic downturns.

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Tailoring UI to better fit the circumstances of today's workforce would have the added advantage of increasing the ability of households to make it through periods of unemployment, without having to liquidate personal savings or the equity in their homes. This would make it more likely that workers and their families enter retirement with sufficient assets to support

The availability of affordable child care and paid parental leave would help women to maintain more consistent and higher-paid employment histories, which in turn would boost their Social Security and UI benefits.

themselves. To fund these improvements and make the entire UI system more financially robust, a dedicated unemployment tax on employees, similar to the Social Security payroll tax, could be considered.

Similarly, the availability of affordable child care and paid parental leave would help women to maintain more consistent and

higher-paid employment histories, which in turn would boost their Social Security and UI benefits.

Effective Administration is Critical

Modernizing social insurance involves operational matters as well. Efficient, cost-effective administration is critical to any program's success. In this respect, there is much to be done. Even though Social Security's old-age and disability protections are low-cost programs to administer (the operating budget for Old-Age and Survivors' Insurance amounts to only 0.9 percent of overall Social Security spending and the administrative costs of Disability Insurance come to just 2 percent of benefits), budget cuts at the Social Security Administration forced a hiring freeze in 2011. This in turn has led to a deterioration in phone service, the closing of field offices, and a slowdown in the awarding of benefits, along with longer wait times for disability claims.²

Neither has administrative funding of Medicare kept up with growth in the size of the program, despite the fact that both the Social Security Administration and the Centers for Medicare & Medicaid Services (CMS) administer a far more complex array of programs and benefits than was the case decades ago. Unemployment Insurance also experiences underfunding and time lags in awarding and paying benefits. Since the program is administered at the state level, UI structures vary in different parts of the country. Some have not been modernized in many years and cannot easily be extended to provide more weeks of benefits during a surge in joblessness – directly stymieing efforts at national economic recovery.

Solutions to these problems differ. To relieve the backlog in disability claims may require hiring more administrative law judges to rule on applications. To address inaccuracies and outdated information in Social Security's database, the agency may have to conduct reviews based on cross-checks with the states and CMS.³ Improving federal administrative oversight of state unemployment programs, complemented by new federal funds for automated system design, implementation, and updating could improve UI's performance.

One critical factor in making all social insurance programs more administratively efficient and effective may be better funding. A bigger operational budget could enable Social Security, for example, to hire more staff, expand its physical presence around the country, adequately staff its phone center, improve the accuracy and integrity of benefits, and lower

² Kathleen Romig, 2016, "Budget Cuts Squeeze Social Security Administration Even as Workloads Reach Record Highs," Center on Budget and Policy Priorities.

³ Social Security Administration Office of the Inspector General, 2016, "Using Medical Claim Data to Identify Aged Title XVI Recipients Who Are Deceased," audit report, <https://oig.ssa.gov/sites/default/files/audit/full/pdf/A-08-14-24122.pdf>.

response times. Similarly, job-search assistance has proven to be cost effective by reducing durations of unemployment. Training could be effective as well, if properly targeted.

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Social Insurance: A Dynamic, Efficient Approach to Securing Risk in the 21st Century

Some believe that the strongest danger facing us is financial insolvency of Social Security and Medicare[, but] the biggest danger facing us is that we will forget why we have social insurance, and why its preservation is necessary not only to a civilized society but also to the very market economy that has provided us with so much wealth.

Universal social insurance programs strengthen the economy by helping small businesses, increasing productivity, and stabilizing the economy during recessions. By efficiently pooling risk to provide protection to the growing set of risks workers face, social insurance can strengthen both our capitalist economy and our democracy. "Some believe that the strongest danger facing us is financial insolvency of Social Security and Medicare[, but] the biggest danger facing us is that we will forget why we have social

insurance, and why its preservation is necessary not only to a civilized society but also to the very market economy that has provided us with so much wealth."⁴

In a fast-changing world, policymakers are now seeking tools to help them navigate the risks facing the economy, workers and their families in the 21st century. This *Report* offers an extensive menu of evidence-based options for policymakers to consider when doing so.

⁴ E. J. Dionne, Jr, 1999, "Why Social Insurance?" National Academy of Social Insurance, https://www.nasi.org/sites/default/files/research/ss_brief_6.pdf.