

**THE FUTURE *of*  
SOCIAL INSURANCE**  
Insights from the Pandemic

*Reflections from  
15 Years of Ball Award Recipients*

EDITED by THOMAS N. BETHELL



NATIONAL  
ACADEMY  
OF SOCIAL  
INSURANCE

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NATIONAL  
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OF • SOCIAL  
INSURANCE

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# Acknowledgments

Since 2004, the annual *Robert M. Ball Award for Outstanding Achievements in Social Insurance* has been presented to individuals who have made a significant impact on the U.S. social insurance system.

2020 is no ordinary year. In a first for the Academy, the Robert M. Ball Award event has been transformed into a campaign – in recognition of the societal impact of the COVID-19 pandemic, and what this means for the role of social insurance in our society.

The 2020 Ball Award Campaign for Social Insurance, in addition to recognizing the contributions of Jacob Hacker and Virginia Reno as recipients of the *2020 Ball Award*, is designed to:

- › Help stimulate responses to the current economic and health crisis;
- › Seize on the increased awareness among policymakers and the public of the need to build and strengthen systems that improve economic security; and
- › Reflect on the ways our social contract could be improved.

We hope to bring all stakeholders together at this critical juncture to highlight the role of social insurance and support the Academy’s work.

We gratefully acknowledge the work of our Leadership Committee and thank all who have already sponsored and contributed to the *Campaign for Social Insurance*, with special thanks to our top sponsors as of September 30, 2020:

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# Robert M. Ball Award Recipients

**STEPHEN C. GOSS**

*2004*

**BRUCE C. VLADECK**

*2005*

**MONROE BERKOWITZ**

*2006 (died in 2009)*

**HENRY AARON**

*2007*

**PETER DIAMOND**

*2008*

**ALICIA H. MUNNELL**

*2009*

**JOHN ROTHER**

*2010*

**ROBERT D. REISCHAUER**

*2012*

**ALICE M. RIVLIN**

*2013 (died in 2019)*

**MARILYN MOON**

*2014*

**KAREN DAVIS**

*2015*

**WILLIAM E. SPRIGGS**

*2016*

**NANCY ALTMAN**

*2018*

**STUART H. ALTMAN**

*2018*

**CARROLL L. ESTES**

*2019*

**THEODORE R. MARMOR**

*2019*

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## Foreword

**“THE FUTURE OF SOCIAL INSURANCE: INSIGHTS FROM THE PANDEMIC”** is a collection of essays by previous recipients of the National Academy of Social Insurance’s Robert M. Ball Award for Outstanding Achievements in Social Insurance.

When each of the fourteen prior recipients who are still with us was asked to contribute to this collection, the response was rapid and enthusiastic. Their willingness to be part of this project is a testament to the memory of Bob Ball, Founding Chair of our Academy, and to the work of our Academy itself.

The result is a truly compelling collection of provocative reflections on key aspects of social insurance in today’s world of nearly unfathomable economic and health catastrophes.

Heartfelt thanks to the Ball Awardees for their essays, and to Tom Bethell for his masterful editing of this compendium and his wonderful introduction. Without Tom graciously agreeing to serve as editor, this compendium would not have been produced so expeditiously.

Thanks also to our 2020 Ball Award recipients, Jacob Hacker and Virginia Reno, for selflessly agreeing to reframe this year’s award into a broader Campaign for Social Insurance, of which this compendium is a key component. Virginia and Jacob will be delivering their acceptance speeches at a virtual Ball Award event this fall.

Thanks also to Fay Cook, the Academy’s Distinguished Visiting Fellow, and Barbara Goldschmidt, the Academy’s Program Coordinator, for helping as part of the compendium production team along with Tom and Virginia. Kristine Quinio, the Academy’s Director of Development, and Meghan Griffin, the Academy’s Digital Communications Associate, have packaged the compendium for wide-spread dissemination to Academy Members, supporters, and the public.

The Academy dedicates this compendium to the memory of Bob Ball, whose vision continues to inspire our work, and to two prior Ball Award recipients who are no longer with us: Monroe Berkowitz (2006 honoree, who passed away in 2009) and Alice Rivlin (2013 honoree, who passed away in 2019).



William J. Arnone  
Chief Executive Officer



### **WILLIAM ARNONE**

*has served as Chief Executive Officer of the National Academy of Social Insurance since 2016. As one of the nation’s leading experts on retirement security and employee benefits law, he has over 35 years of experience in retirement income policy/planning and financial literacy, including assisting large organizations in the realignment of their defined benefit, defined contribution, and hybrid plans with their business imperatives and human resource objectives. He leads and/or participates in all of the Academy publications, study panels, and events. He is one of the Founding Members of the Academy.*

## Introduction

*Thomas N. Bethell*

**I**t was Bob Ball's firm, lifelong belief that we're all in this together. That was the "core idea" of wage-based social insurance, in his view: "that we earn the right to benefits, and that we ensure ourselves of access to those benefits when the time comes by being part of a larger pool. We're all in this together."

What a charmingly naïve belief, yes?

I mean, here we are in late 2020, still caught up in a global pandemic, and we can't agree on how to cope with it. And here we are, living through a year seared by protests about the savage treatment of African Americans and others at the hands of the police — part of the incendiary legacy of the 400 years of racism that has undermined the premise and promise of the allegedly *United States of America* — and we can't agree on what's to be done about *that*.

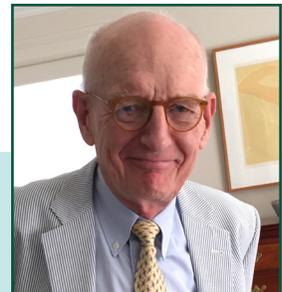
*All in this together? Seriously?*

And yet.

And yet Robert M. Ball was anything but naïve. Throughout his nearly 70-year-career — almost evenly split between building, administering, and guiding Social Security and Medicare (1939-1973) and then promoting and defending the programs (1973-2008), including as the founder and guiding spirit of the National Academy of Social Insurance — Bob Ball brought to every task a cool, sophisticated, clear-eyed, well-prepared and well-thought-out position on what needed to be done and — just as important — how to get there. *Nothing* he did was done naïvely or without deep forethought, and anyone who ever worked with him was likely to feel at least some awe — to the extent that even today, more than a decade after his death at age 93, some of us find ourselves contemplating the acronym *WWBD* — *What would Bob do?*

There may be some answers to that question in these pages.

**T**he focus in these essays is on an uncertain but navigable future. Bob would approve. He thought of social insurance as necessarily, unavoidably, a work in progress — often infuriatingly slow progress. Personally, I would much prefer to get there in one fell swoop: to wake up some bright morning and discover that I lived in a country wholeheartedly committed to protecting everyone against the risks that we all either share or at least should care about. Yes, the risk of losing a job or needing costly health care, but also the risk of being born into poverty or living in a marginalized community with poor schools and services and no grocery store charging fair prices within walking distance. The risk of being saddled with a stunted education. The risk of being abused, or worse, because



**THOMAS N. BETHELL**, the volunteer editor of this compendium, is a Washington, D.C., writer-editor and policy consultant who served until recently as a Senior Fellow at the National Academy of Social Insurance. He began working with Bob Ball in 1989, when they collaborated on *Because We're All in This Together: The Case for a National Long Term Care Insurance Policy*, a report for the Families USA Foundation.

of skin color or gender or sexual orientation. The risk of growing old alone and forgotten in some grim understaffed nursing home. I fantasize about living in a country where any and all such risks have been universally recognized and addressed, head-on, once and for all – because we finally had the good sense to grasp that ultimately, like it or not, red or blue or whatever, we are all bobbing around in this one lifeboat together.

Bob took the longer, calmer view. But it was also an opportunistic view, informed by the lessons he absorbed from the period of American history through which he lived. He saw cataclysms as catalysts. He knew that if there had been no Great Depression in 1933 we would never have enacted Social Security in 1935; that if there had been no presidential assassination in 1963 we would never have set aside politics-as-usual long enough to enact Medicare in 1965. I wonder what opportunities he might detect in the confluence of cataclysms in 2020.

There may be some answers to that question in these pages.

Since 2004 the National Academy of Social Insurance has annually presented the Robert M. Ball Award to someone whose career has exemplified the kind of clear thinking and passionate commitment to social insurance that Bob personified. The fourteen living recipients of the Award are represented here, in (mostly) short pieces responding to the Academy’s request for their thinking about what we might, looking ahead, take away from the pandemic. Their contributions are arranged alphabetically by author. We considered listing them chronologically, by the year when each was honored. That would have put Steve Goss, the Chief Actuary of the Social Security Administration, at the head of the line – which had some appeal, because Steve brings a uniquely actuarial perspective to his task. Like the man he once worked with, he takes the exceptionally long view:

*The COVID-19 pandemic reminds us that all things are in delicate balance. Our lives, our society, our planet are all the result of a remarkable series of past events which can and will be altered in the future. There are no guarantees for the future. Change is inevitable. But our preferences and actions will determine how we adapt to changes.*

In that paragraph I can hear an echo of Bob Ball’s confidence in our collective ability to eventually make the most of whatever we may encounter. And if there is a single thread that runs through all of the essays in this compendium, it is that social insurance, while promising no panaceas, can help move us closer to the goal of creating a society in which we all contribute to creating an umbrella big enough and strong enough to shelter us all. Admittedly that work will never be finished, but in a variety of ways all of the pieces in this collection will help us contemplate the possibility that we can extract something constructive from the cataclysmic year 2020 – and that social insurance will continue to be a work in progress.

For their insights and wisdom, and their shared commitment to the notion

*“If there is a single thread that runs through all of the essays in this compendium, it is that social insurance, while offering no panaceas, can help move us closer to the goal of creating a society in which we all contribute to creating an umbrella big enough and strong enough to shelter us all.”*

that we're all in this together, our thanks to Henry Aaron, Nancy Altman, Stuart Altman, Karen Davis, Peter Diamond, Carroll Estes, Steve Goss, Ted Marmor, Marilyn Moon, Alicia Munnell, Bob Reischauer, John Rother, Bill Spriggs, and Bruce C. Vladeck.

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## The social safety net: the gaps that COVID-19 spotlights

Henry J. Aaron

The COVID-19 pandemic belongs to a class of newly salient risks against which America's current collection of safety-net programs provides inadequate protection. These risks include major pandemic illness, increasingly frequent and severe natural disasters — including those associated with global warming — and the abiding threat of terrorist attack, including from lethal biological agents. Increasingly complex supply chains, expanded individual travel and labor migration, and the increasingly lethal instruments available to extremist and terrorist groups all contribute to these risks.

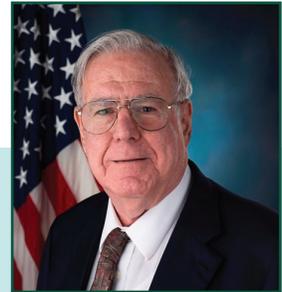
Until recently none of these risks seemed likely to cause national disruption. Now they do, and Congress needs to act to set up programs and procedures to deal automatically with them. Each risk threatens widespread economic disruption, mass illness, and death — and no current program is adequately designed to ameliorate their effects.

These newly salient risks should not sidetrack ongoing debates about how best to ensure that all Americans have financial access to health insurance and about the desirability of new safety-net programs such as guaranteed basic income, universal child care, and comprehensive long-term care. Nor should these risks be allowed to downgrade the need to assure adequate financing and other steps to strengthen Social Security, Medicare, and other social insurance programs. Indeed, the economic collapse caused by COVID-19 will move closer — by one or possibly two presidential terms — the depletion of the reserves of Social Security and Medicare Hospital Insurance.

COVID-19 has revealed serious shortcomings of the current safety net to cope with the consequences of mass unemployment, a problem that until now most of us thought fiscal and monetary policies could forestall. COVID-19 shows that such confidence is baseless. It shows, further, that current institutions are not well structured to cope with three major consequences of mass unemployment: loss of income, loss of access to health insurance, and disruption of public services provided by state and local governments.

### INCOME LOSS

The principal government programs assisting those with low cash income, whether endemic or resulting from mass unemployment, are the Supplemental Nutrition Assistance Program (SNAP, once called Food Stamps), Supplemental Security Income (SSI), and Unemployment Insurance (UI). These programs ramp up automatically when incomes decline, to help people individually and to maintain overall spending. Although SNAP and SSI rolls expand during periods of economic distress, benefits are low relative to most workers' earnings, and asset tests mean that most of the newly jobless are ineligible for



**HENRY J. AARON** is the Bruce and Virginia MacLaury Senior Fellow in the Economic Studies Program at the Brookings Institution, where he has worked since 1968, serving as its director from 1990-1996. He is a Founding Member of the Academy and was its first vice-president. He received the Robert M. Ball Award in 2007. The views presented here are the author's own and do not necessarily reflect those of the trustees, officers or other staff of the Brookings Institution. The author wishes to thank Gary Burtless and Robert Greenstein for helpful comments and suggestions and Thomas N. Bethell for editorial assistance.

SSI benefits and in some states for SNAP. UI is quickly available, regardless of past income or assets, but it normally serves only a minor fraction of the unemployed even in normal times. Most workers are not — or *think* they are not — eligible. Many find compliance requirements onerous and do not apply.

As COVID-19 triggered unprecedented increases in unemployment, expenditures under these three programs rose automatically, but only enough to replace a small share of lost income. Pandemic-related claims overwhelmed state UI offices. Inadequate staffing, outmoded computer systems, and insufficient data made it impossible to promptly process applications and to increase benefits by anything other than a lump-sum amount. The result was hastily enacted and clumsily administered legislation that enabled a huge increase in payments through the UI program which spared millions an abrupt slide into poverty. But this legislation is scheduled to expire long before economic recovery is underway, and as of this writing (June 2020) it is unclear whether that legislation will be extended, even in modified form.

Because other COVID-like economic shocks must be regarded as likely, it is imperative for Congress to pass permanent legislation establishing a nationwide framework for economic assistance in a future emergency. It is at least as important to invest now in the data and computer capacity necessary to provide aid promptly and in a targeted manner. As each future crisis will have its own characteristics, Congress will likely see fit to modify any legislation it passes now. But it would be far better to have in place both a framework for action and the administrative infrastructure to carry it out before a crisis hits than to continue cobbling together responses in haste.

Whether such aid is provided directly to people or is channeled in part through employers to forestall unemployment, advance preparations will enable aid to be provided more promptly and effectively than was the case with COVID-19. Just as closure of public gatherings early in 2020 would have saved tens of thousands of people from death and countless more from illness, so too the prompt provision of economic assistance can avoid or ameliorate mass economic hardship when future calamities strike.

#### FINANCIAL ACCESS TO HEALTH CARE

**T**he linkage of health insurance coverage to employment for most Americans — other than the elderly, poor, and people with disabilities — is seen by many as an atavism. Under current policies, this linkage of jobs to health insurance means that COVID-19 will cause millions of workers to lose coverage.

Although replacing the current system with government-managed health insurance would assure continuity of coverage, such a course has serious drawbacks. They include the need to massively restructure nearly one-fifth of the U.S. economy and to roughly double government spending and taxation — actions that would likely crowd out other important priorities for government action. In his essay in this compendium, Stuart Altman explains other problems associated

*“COVID-19 has revealed serious shortcomings of the current safety net to cope with the consequences of mass unemployment, a problem that until now most of us thought fiscal and monetary policies could forestall. COVID-19 shows that such confidence is baseless.”*

with the termination of private insurance. He also reminds us that other countries achieve universal health insurance coverage through mixed private/public systems, some not fundamentally different from our own.

Fortunately, continuity of health insurance coverage can be ensured for all Americans by taking four steps that are less disruptive and costly than a total overhaul. Funding for Medicaid should be modified so that all states find it attractive to extend coverage up to 138 percent of the federal poverty level. Affordable Care Act marketplace subsidies should be deepened and made more broadly available. The small share of the legally resident population that might not enroll voluntarily in a private plan or be covered by a public plan should be automatically enrolled in a backup plan.<sup>1</sup> Coverage of undocumented immigrants can be achieved by creating a path to citizenship. Such extensions — built on existing employer-sponsored coverage, Medicare, Medicaid, and other public health insurance programs — would ensure that every American has insurance regardless of employment status or economic circumstances.

#### STATE AND LOCAL PUBLIC SERVICES

The fiscal vulnerability of states and localities to economic downturns is well understood. Income and sales tax revenues decline when economic activity slows. When people lose jobs, however, demand for most state and local government services remains constant or actually increases. Furthermore, states operate under balanced-budget requirements. Deficits cause credit-rating agencies to downgrade state debts, which boosts future borrowing costs. Previous economic downturns have rapidly depleted rainy-day funds and forced painful curtailment even of essential services. The COVID-19 downturn is much larger than any post-World-War-II recession. The full consequences for state and local finances have yet to be determined, but current projections indicate a fiscal gap of more than \$615 billion over the period from 2020 through 2023.<sup>2</sup>

Without sizeable assistance from the federal government, disruption of state and local government services will be massive. Such federal assistance can take several forms. Analysts have long recommended countercyclical revenue sharing, with grants to all states triggered when unemployment exceeds a threshold. Until now, the need for such aid has not been seen as sufficient to drive resolution of the analytically complex and politically difficult decisions regarding triggers and allocation formulas. Widespread recognition of the newly salient risks that the nation faces should end delay in designing and enacting such legislation. Instead of, or in addition to, such general assistance, the federal government could increase grants for particular functions, such as elementary and secondary education or health care. The federal government could also vary its share of Medicaid spending based on unemployment rates, nationally or state-by-state, or on some other measure of economic activity.<sup>3</sup> The framework for such assistance should be put in place now to deal with future contingencies.

## CONCLUSION

The COVID-19 crisis has revealed serious shortcomings in the U.S. social safety net. It has *not* revealed serious shortcomings in our core social insurance programs. As has always been true — and as provided for under law — these programs require periodic scrutiny in light of continuing social and economic developments.<sup>4</sup> Social Security and Medicare Hospital Insurance require periodic attention to align revenues and expenditures under the special discipline imposed by trust fund financing. But the challenges to the social safety net from large-scale disruptions such as COVID-19 lie elsewhere: in the perennially flawed UI program which requires ad hoc legislation every time it is needed most — during economic downturns; in the heightened importance of ensuring that unemployment does not cause loss of health insurance; and in the fragility of state and local finances when under assault by a major recession.

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Henry Aaron's essay “The social safety net: the gaps that COVID-19 spotlights” was published by the Brookings Institution on June 23, 2020 at <https://www.brookings.edu/blog/up-front/2020/06/23/the-social-safety-net-the-gaps-that-COVID-19-spotlights/>

## Addressing ‘unpalatable realities’ laid bare by today’s crises

Nancy J. Altman

Like today’s pandemic-driven economic collapse, the Great Depression exposed long-simmering problems. In words that could have been spoken today, Mary Dewson, one of the three-member Social Security Board (later replaced by a single commissioner) explained in 1938:

*“The widespread anguish following the economic collapse...blew away the rosy fog which we had permitted to obscure...unpalatable realities.”*

Among those pre-Depression realities, suddenly brought into sharp focus by the economic collapse: no job security, no health security, no food security, no old-age security, and vast inequality. It sounds familiar.

President Franklin D. Roosevelt and his advisers knew that when the immediate crisis had passed, the nation could not and should not simply return to what came before. The nation had to address those “unpalatable realities” if we were to be better prepared the next time. Secretary of Labor Frances Perkins put it bluntly:

*“We cannot be satisfied merely with makeshift arrangements which will tide us over the present emergencies. We must devise plans that will not merely alleviate the ills of today, but will prevent, as far as it is humanly possible to do so, their recurrence in the future.”*

The Roosevelt administration responded boldly, with much more than “make-shift arrangements.” Its solution to the unpalatable reality of old age insecurity was Social Security.

Prior to its enactment, the only choice that most Americans generally had as they reached old age was to move in with their adult children or go, literally, to the poorhouse. Prior to the Great Depression the insecurity of the aged was hidden in the shadows, but came into stark view when their adult children, on whom they depended, found themselves without work, not just for a few weeks or months but year after year.

For men and women in such straits it was an often desperate struggle to put food on the table for their young children, let alone support their aged parents. The result: between 1929 and 1933, the U.S. poorhouse population jumped by 75 percent – and the overwhelming majority of those “inmates,” as residents were generally called, were old. Indeed, the hardest hit during the Great Depression were the old.

In stark contrast, during the Great Recession of a decade ago, and during the current recession, Social Security’s earned benefits were paid on time and in full, never missing a payment. In a reversal of the Great Depression, those monthly benefits, though modest, allowed many seniors to maintain their independence and even help their adult children and grandchildren to weather the hard times.



**NANCY J. ALTMAN** is President of Social Security Works and chairs the Strengthen Social Security coalition. Social Security and private pensions have been the focus of Altman’s career for over 40 years. She served on the faculty of Harvard University’s Kennedy School of Government, teaching courses on Social Security and pension policy. In 1982, she served as assistant to Alan Greenspan while he chaired the bipartisan commission that developed the 1983 Social Security amendments. In 2017, Democratic House Leader Nancy Pelosi appointed Altman to a six-year term on the Social Security Advisory Board. Altman is a Founding Board Member of the Academy. She was a co-recipient (with Stuart Altman) of the Robert M. Ball Award in 2018.

## IMAGINE

**I**magine how much worse the economic harm wrought by the pandemic would be without Social Security. Imagine how much worse the nation's already appalling income inequality would be. And imagine how much more of a solution Social Security could provide if its modest benefits were increased and the wealthiest among us were asked to contribute somewhat more.

Unemployment compensation is not generally thought of today as "Social Security," but it was part of the Social Security Act of 1935 and it was part of Roosevelt's vision of basic economic security. The current crisis has exposed the need to improve and fully federalize our current joint federal-state unemployment insurance system. Still, even with its flaws, if there were no unemployment insurance, today's economic hardships would be unimaginably worse.

FDR's concept of economic security also included universal health insurance. Facing overwhelming opposition from the medical establishment, he withdrew his proposal in 1935 but continued until his death to support the idea, as did his successor, President Harry Truman. Unable to enact it in one piece, proponents settled, many years later, for starting with those most in need of care, and President Lyndon Johnson finally oversaw the enactment of Medicare for seniors in 1965 (people with disabilities were added in 1972) as well as Medicaid for lower-income Americans.

It was one of Bob Ball's greatest achievements as the nation's longest-serving Social Security Commissioner to oversee the implementation of Medicare and Medicaid. Imagine how much worse off millions of Americans would be without the health coverage enacted in 1965. Imagine how much better off the nation would be during the present crisis if the logical next steps envisioned by Mr. Ball and others — improving Medicare and extending its protection to all ages — had been enacted at any point during the ensuing 55 years.

In addition to universal health insurance, Roosevelt wanted to provide coverage for both permanent and temporary disabilities. Congress did enact long-term disability coverage in 1956 — although, as applicants know, benefits can be exceedingly difficult to qualify for. Still waiting to be enacted is temporary disability coverage: withdrawal from work due to illness, accident, or family need. How enormously valuable that wage replacement would be during all kinds of economic weather.

## THINK BIG

**T**he coronavirus pandemic has thrown a harsh spotlight on these serious gaps. Millions of Americans can't afford to take off work while ill. That is deeply inhumane. During a pandemic it also endangers every single one of us, even those who are fortunate enough to be broadly insured. The virus does not discriminate.

While the current Congress did enact a makeshift fix, passing a paid sick leave law that expires in a few months, that won't help if the coronavirus recedes

*"Imagine how much worse the economic harm wrought by the pandemic would be without Social Security. Imagine how much worse the nation's already appalling income inequality would be."*

during the summer and then comes back during the flu season. What then? More makeshift arrangements? Imagine if, instead, Congress had amended the Social Security Act to include paid sick leave and family leave.

When Roosevelt signed the Social Security Act of 1935, he explained that the new law “represents a cornerstone in a structure which is being built but is by no means complete.” That was true, and now is the time to think big, as he did — and as Bob Ball did — to build on the cornerstone that was laid down many years ago. The challenges are great but no greater than those of the past. They include: individuals and families who are food-insecure, housing-insecure, and at risk of losing loved ones to rampant racism and violence perpetrated by police who are paid to protect us all. We are in urgent need of increased physical and economic security for everyone.

If today’s generations can rise to that challenge, future generations grappling with their own crises will look back on our time with the same sense of awe and gratitude we feel toward Franklin Roosevelt — and Bob Ball.

## Why a public/private universal health insurance system is still the right approach

*Stuart H. Altman*

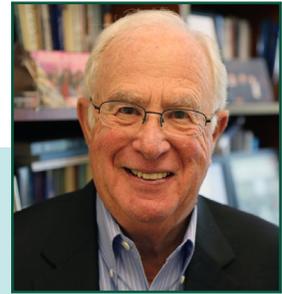
With millions of Americans losing their jobs *and* their employment-based health insurance during the pandemic, it is easy to argue that the entire employer-subsidized health insurance system should be abolished and replaced by a government-financed single-payer approach. I disagree.

Yes, we need to have a much stronger safety net supported by an expanded social insurance system. But where possible we should continue to rely on private funds generated by employers and employees. Without these private funds I fear we will have a chronically underfunded public health care delivery system for most Americans and a separate system for individuals who have the means to pay for superior care.

On a personal note, I have just gone through a major illness which cost several hundred thousand dollars. Nowhere in that ordeal did my family have to worry about paying the bill. I was well covered by Medicare and supplemental private insurance. As we recover from the terrible ordeal of COVID-19 and the realization that countless Americans will face staggering healthcare expenses, I can only hope that they will be as fortunate in their health insurance coverage. Alas, I know this is not the case. Millions of Americans are denied even the legislatively mandated social insurance coverage afforded by the original Affordable Care Act (ACA) law – and I recognize that full ACA coverage still leaves gaps that I didn't face. Yes, these gaps need to be filled, but I reject the idea that the best way to plug them is to destroy the ACA and put in its place a government-financed health insurance system.

Universal coverage does not necessarily mean an all-government-financed system. Several of the best European systems, such as in Germany, Switzerland, and the Netherlands, rely on private coverage paid for by employers and workers. In Germany, the split in premium payments between the two is 50/50, with the premium amount set by the federal government. Overall health spending is controlled by government through the level of premium income. These systems appear to have functioned better during the COVID-19 crisis than those supported primarily by government. This is no accident. Systems financed by government often face budget limits which have limited the availability of hospital ICU beds and expensive equipment. (The COVID-19 problems in the U.S., although extensive, are not directly related to what we spend on our healthcare system.)

The inevitably limited budgets of government-financed systems are my main concern about moving to a health system too reliant on government payments. Yes, I believe strongly in a social insurance system, and in safety-net programs for those who need them. And yes, as the coronavirus crisis abates we will need



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a transition approach that includes greater public funding. But as our economy improves and Americans get back to work, we should expand the public/private coverage of the ACA.

To understand why, look at what is happening in our current financing system. Since the mid 1970s, states have put tight limits on Medicaid provider payments. Today, Medicaid pays 80 percent or less of what hospitals believe are their costs of providing care. Since 2010, Medicare has fallen into the same pattern. (While I do believe that we can provide good health care for less, there are limits to how much less.) In 2018, Medicare payments averaged less than 90 percent of hospital costs. So how do hospitals survive if not prosper? They charge privately insured patients up to 300 percent above Medicare rates. A recent RAND study of private insurance payments to hospitals in 25 states found that they averaged 240 percent above Medicare rates.<sup>1</sup> If these hospitals had been paid only Medicare rates, their revenues would have fallen by 50 percent. There is little question that government-supported patients are subsidized by private payments. What would happen if the higher private payments disappeared?

Some have suggested creating public-option plans that compete with private insurance and pay providers close to Medicare rates. Washington State enacted such a plan. But it was forced to set hospital payments at 160 percent of the Medicare rates, and to generate sufficient acceptance by providers it may need to pay closer to 180 percent. That raises concerns that the premium for the public plan will not be much lower than private premiums, with the result that few will join.

Let me be clear: I do not believe we should continue to accept the high prices charged by most hospitals. Prior to COVID-19, many states passed legislation setting growth benchmark limits on total medical spending, particularly private insurance premiums. Value-based private insurance had also gained more acceptance. These options were designed to bring down medical spending in an orderly way without negatively affecting access or quality of care. These constraints should continue in the future.

So, as we think about a post COVID-19 world we should build upon the original ACA structure; we should expand and solidify the social insurance segment by lowering the age of Medicare eligibility to 60 for those not working, and assure that all Americans have access to the Medicaid provisions of the original ACA; we should expand subsidized private insurance to limit the cost-sharing provisions for low-income individuals and end part-year or minimal-coverage plans. Most importantly, we should restore the mandate that every American must have adequate coverage. A comprehensive but balanced public/private system offers the best safeguard that a high-quality delivery system will be maintained and available to all.

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*“Universal coverage does not necessarily mean an all-government-financed system. Several of the best European systems, such as in Germany, Switzerland, and the Netherlands, rely on private coverage paid for by employers and workers.”*

## Medicare as a safety net in national emergencies

*Karen Davis*

The COVID-19 pandemic has highlighted the importance of Medicare as a safety net in times of natural or man-made emergencies. Few anticipated the possibility of a virus that would infect over 4 million people in the U.S. and leave over 150,000 dead. Medicare's elderly and disabled beneficiaries have been at greatly heightened risk during the pandemic, and the nation's health system was thrown into chaos in parts of the country by the sudden surge in patients — of all ages but predominantly elderly — who have required intensive care.

This is unlikely to be a one-time crisis, nor is it clear when the pandemic will end. We can expect future global emergencies whether driven by outbreaks of new diseases, climate change and global instability, natural disasters, or terrorism. So this is an opportune time to reflect on the importance of a social safety net that guarantees access to health care for all, ensures adequate income for food and shelter, and mobilizes communities to band together to combat threats to the well-being of everyone — including the most vulnerable because of poverty, age, medical conditions, or disability.

Several conclusions seem self-evident:

- › Health insurance coverage and access to care for all is a basic requisite of a humane society.
- › Investment in public health and advance planning for national emergencies should be priorities, to minimize and mitigate the impact of their occurrence.
- › No one should be impoverished and unable to obtain food or shelter as the result of losing a job or having inadequate health insurance (or none).

I will focus here on the first of these urgent policy priorities — on how we can create a health care safety net capable of protecting everyone from the financial and health care consequences of serious illness or injury.

The U.S. is alone among industrialized nations in failing to provide such a health care safety net for all. Fortunately, Medicare, enacted in 1965 as part of President Lyndon B. Johnson's vision for a Great Society, for more than 50 years has provided vital health insurance coverage for the program's elderly and disabled beneficiaries. But Medicare's fabric has frayed and needs updating to ensure adequate financial protection to those it covers. Actions to strengthen it can also serve as a guide for covering others at risk when disaster or medical emergency strikes.

### IMPROVING MEDICARE COVERAGE

At a time of increasing calls for Medicare for All, or Medicare as a Choice for All, it is important to address the inadequacy of Medicare's benefits after five decades of rising health care costs.



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By design, Medicare covers those with the greatest need for health care — those age 65 and over and those under 65 with permanent and total disability. This is the same group with the greatest risk for mortality in the current COVID-19 pandemic.<sup>1</sup> The Centers for Disease Control estimates that 8 out of 10 COVID-19 deaths are persons age 65 and over.<sup>2</sup> COVID-19 mortality rates among those 85 and over are 8 times higher than those aged 50-64<sup>3</sup>, and 89 percent of COVID-hospitalized adults have had pre-existing medical conditions.<sup>4</sup>

We need to recall that even prior to the COVID-19 pandemic, Medicare beneficiaries with limited incomes and serious health problems were facing financial hardship for out-of-pocket health care expenses and premiums for Medicare and supplemental coverage.<sup>5</sup> With no ceiling on out-of-pocket costs for covered benefits, a high deductible for hospital episodes, and no coverage for needed benefits such as dental, vision, and hearing care as well as long-term services and supports for disabled beneficiaries, Medicare leaves enrollees exposed to potentially staggering costs unless they buy expensive supplemental coverage. The Part A hospital deductible is currently \$1,408 per hospitalization, and while Part B physician services are covered after meeting a \$198 annual deductible, beneficiaries then pay 20 percent of all covered charges (including the costs of surgeons and physician-administered drugs for cancer treatments).

This lack of comprehensive protection has long been recognized as a flaw in Medicare's design. Because of it, 90 percent of beneficiaries obtain supplemental coverage through retiree health plans, Medicare Advantage managed-care plans, other private coverage, or Medicaid.<sup>6</sup> The cost of paying premiums for Medicare Part B for physician services and Part D for prescription drugs as well as supplemental coverage consumes a large share of most beneficiaries' incomes.<sup>7</sup>

Among Medicare beneficiaries with incomes below 150 percent of the federal poverty level, two-thirds have three or more chronic conditions and/or serious physical or cognitive impairments that make them especially vulnerable to health and financial risks. More needs to be done to reduce the financial burden of health care and coverage on all beneficiaries, with special provisions to assist those who are most at risk, and to shore up the solvency of Part A, which finances hospital and post-hospital care through payroll tax revenues that are hit hard by high unemployment.

### NEEDED POLICY CHANGES

Several policy changes would help ensure the affordability of care and coverage for Medicare beneficiaries. These include:

1. replacing the Part A deductible with a \$100 per hospitalization co-payment and setting a ceiling on total out-of-pocket costs<sup>8</sup>;
2. providing assistance with cost-sharing and premiums for all Medicare beneficiaries with incomes below 150 percent of the federal poverty level<sup>9</sup>;
3. expanding Medicare benefits to include dental, vision, and hearing services and personal care at home<sup>10-11</sup>;

*“This is an opportune time to reflect on the importance of a social safety net that guarantees access to health care for all, ensures adequate income for food and shelter, and mobilizes communities to band together to combat threats to the well-being of everyone — including the most vulnerable because of poverty, age, medical conditions, or disability.”*

4. merging the Part A and Part B trust funds and ensuring financial solvency through additional general revenue financing.

#### EXTENDING THE MEDICARE SAFETY NET

Medicare is a building block that can also provide coverage to those at risk in times of national emergencies or serious health conditions or injuries. One option for ensuring more affordable plan choices for people under 65 would be to offer an improved Medicare Extra plan, including prescription drug coverage, to those insured in private individual marketplaces and the small-group market. This plan could include optional dental, vision, and hearing care and personal care for those who are disabled.

Medicare has the strong advantages of low administrative costs and broad provider networks. Improving traditional Medicare and then offering it as a choice could help to stabilize the insurance market for those seeking individual coverage or small employer groups who are not yet eligible for Medicare. The expanded choice would be especially attractive to older adults who are preparing for coverage under Medicare when they retire.

Medicare for All proposals call for full replacement of all other insurance sources by a tax-financed single-payer program with a comprehensive benefit for everyone. Key challenges to replacing existing coverage in one comprehensive step include (1) the loss of employer health benefit contributions as a source of financing and (2) displacement of current coverage under employer plans that cover 159 million people and state-run Medicaid programs that cover 44 million people.

A less disruptive option would be to offer Medicare Extra as a choice in the individual and small-firm insurance markets. Such an incremental approach would, however, require reform of Medicare's core benefit design to avoid the need for supplemental coverage. If Medicare included a limit on out-of-pocket costs and replaced the hospital deductible with a modest hospital copayment, Medicare's core benefits would provide more affordable coverage to current beneficiaries as well as those under age 65 offered a choice of Medicare Extra.

Improving Medicare benefits by limiting patient out-of-pocket costs would provide much-needed financial protection for financially strapped Medicare beneficiaries. Fully half of all Medicare beneficiaries have savings below \$75,000 and live on modest or low incomes. Putting a limit on out-of-pocket costs, if combined with expanded low-income premium subsidies as people age into Medicare, would safeguard low-wage retirees as they lose income from employment.

#### BUILDING ON MEDICARE OFFERS A WAY FORWARD

Building on what now exists, including Medicare's strengths of low administrative cost and its provider payment system, the nation could move either incrementally or through comprehensive reform to an administratively more efficient, easier-to-navigate, and lower-cost health care system. In sum,

redesigning Medicare and offering it as choice to the under-65 population could create a health care safety net that would protect everyone in time of national emergency — especially those currently most at-risk because of inadequate health insurance coverage.

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## A social insurance view of bankruptcy law

*Peter Diamond*

When applications for unemployment insurance swamped the system's administrative capacity, it seemed that bankruptcy applications might do the same. Viewed as giving people a fresh start, personal bankruptcy should be considered an integral part of social insurance — it aims at helping people while correcting for market incompleteness.

In the standard model of economic equilibrium, individuals choose labor supplies and consumption demands that satisfy their lifetime budget constraints. The model has no role for a bankruptcy procedure, because satisfying a lifetime budget constraint implies borrowing only what can be paid back with certainty.

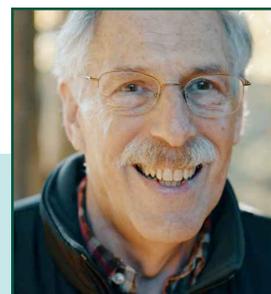
Incomplete markets prevent insuring against all possibilities. An incomplete market equilibrium would be very inefficient if borrowing were limited to what could be repaid with certainty. In practice, people borrow knowing they might not be able to pay back. And people lend knowing that they may not be fully paid back. So, rules are needed to cover failures to pay; good bankruptcy rules help both economic efficiency and income distribution.

Historically, bankruptcy arrangements have included debtors' prisons and selling debtors into slavery. In the U.S. today, federal bankruptcy law uses two options. A debtor can give up all resources except those exempted, thereby settling debts (Chapter 7); a debtor can propose a repayment plan accepted as sufficient by the court (Chapter 13). What resources to exempt in Chapter 7 and what repayment plans to accept in Chapter 13 are social insurance questions, and can be approached in optimal taxation terms.<sup>1</sup>

Viewed as social insurance, it is ironic that the fees paid to the courts and to lawyers are high enough to deter some people from applying for bankruptcy protection; they are referred to as people too poor to go bankrupt. Means-tested subsidization of the cost of bankruptcy would be a natural social-insurance addition. And, temporary rules for bankruptcy in and after a pandemic would recognize that it is harder to fulfill a Chapter 13 payment plan then.

Chapter 13 success could be made more resilient to fluctuations in the debtor's future income by combining income-contingent debtor payments along with the current rules for creditor receipts. To accomplish this, the federal government could offer the debtor an asset swap. With the swap, the federal government would receive the income-contingent payments from the debtor, while making the standard payments to the creditors. As the creditors already bear the risk of failure of the repayment plan, the government would stop payments to the creditors if the debtor did not make the required payments to the government.<sup>2</sup>

As an example, the debtor might pay  $X\%$  of taxable income in excess of  $\$Y$ . With a stochastic model of debtor incomes and repayment behaviors, the government could equate the expected present discounted values (EPDV) of its receipts and payments. Successful completion of the debtor's repayment plan



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would then be less sensitive to the state of the economy, an issue of particular importance during and after a pandemic. Such contingent payments offer the debtor better timing of payments (smaller when incomes are smaller). A key element would be the discount rate used in designing the plan. The government could design the plan to break even in expected value over all such swaps, based on the Treasury's interest rate. For a debtor with a higher discount rate and income that was expected to rise, this would be a smaller EPDV as larger later payments were more likely than with the standard approach. Moreover, explicit subsidization of repayment could be part of a general stimulus program.

Beyond improving bankruptcy for individuals there would be value in doing something similar for small businesses trying to survive in the ongoing pandemic.<sup>3</sup> Indeed, the pandemic challenges us to develop new economic survival strategies. A social-insurance approach to bankruptcy is worthy of further investigation.<sup>4</sup>

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*"Viewed as social insurance, it is ironic that the fees paid to the courts and to lawyers are high enough to deter some people from applying for bankruptcy protection; they are referred to as people too poor to go bankrupt. Means-tested subsidization of the cost of bankruptcy would be a natural social-insurance addition."*

## Social insurance: proof of concept

Carroll L. Estes<sup>1</sup>

**B**ob Ball's social insurance vocation inspires across generations. He literally saved Social Security as we know it, with fidelity to Roosevelt's intention: "...The Social Security Act marked a great advance in affording more equitable and effective protection to the people of this country against widespread and growing economic hazards. The successful operation of the Act is the best proof that it was soundly conceived. ...[W]e should be constantly seeking to perfect and strengthen it in the light of our accumulating experience and growing appreciation of social needs."<sup>2</sup>

**Large scale social forces drive the need for social insurance.** COVID-19 and widespread economic and social pain underscore systemic institutional sources of inequality by race, ethnicity, class, gender, ability, age, and identities of indigenous and immigrant peoples.<sup>3</sup> Pandemics, economic recessions, depressions, mass unemployment, and wars cannot be fixed by the hardiest working individuals. Social stress, poverty, abuse, childhood trauma, unsafe neighborhoods, and low educational status may deplete and hasten cellular mutations, illness, death, and poor life quality.

The state, the market, and policy are deeply implicated in social insurance and its cumulative advantages and disadvantages. The segregated origins of Social Security<sup>4</sup> reflect the early exclusion of black and brown workers, stunting opportunities and economic and health security. Women were recognized in their traditional (white) nuclear family. Over time this has locked out recognition of women of color, single motherhood, and no- or low-wage carework. Women's reproductive labor is not counted as work.

"Individual responsibility" narratives occlude systemic racism and sexism residing in present social insurance, as Hacker's *Great Risk Shift* documents.<sup>5</sup> Herd and Moynihan's *Administrative Burden*<sup>6</sup> depicts the stigma, criminalization, welfare ungenerosity, and cruel quirks. Individual self-esteem, opportunity, and "take-up" of benefits by those earning and needing them are depressed.

**Deconstruction of the Social** characterizes the processes that detach risk and responsibility from the larger force fields in which they are co-constructed and embedded. Ideals of social citizenship are deformed through discourses of dirty "aliens," blocking inclusion and citizenship paths. Social differences harden into concrete structural racial and gender divisions. Payroll tax caps, "waiting" for benefits (e.g., disability) to kick in, and erosions in minimum benefits foreclose savings and possible wealth creation for the 96 percent.

Political attacks against the idea of "entitlement" undermine trust in government except as a last resort, also promoting thought censorship.<sup>7</sup> Welfare becomes Temporary Assistance for Needy Families (TANF) through safety-net



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sabotage. Child poverty and food insecurity haunt families as income, wealth, and health inequities spiral. A 2016 Federal Survey of Consumer Finances shows that an astounding 37 percent of blacks and 33 percent of Hispanics had *zero or negative net worth*.<sup>8</sup> “Systemic and structural racism,” “extreme poverty,” “deaths of desperation,” and “white privilege” become vocabularies of motive for ejecting the *status quo*.

**Social insurance is commitment to social and individual responsibilities, sanctioned by law, norms, mutuality and community.** “Tough times require strong Social Security benefits.” Rockey Moore presents a plan for African Americans, Hispanic and white Americans.<sup>9</sup> Social Security is 90 percent of income of more than half of Hispanics and similar high percentages of older blacks and Asians. “*Social Adequacy*” is a guiding measure of the income to provide for the basic needs of the protected population. “The intergenerational compact” describes “the fundamental obligation of the government and citizens of one time and the government and citizens of another time to maintain a contributory social insurance system.”<sup>10</sup>

**Re-constructing social insurance equity and justice pathways is possible,** as think-tanks, actuaries and scholars know. The Social Security Administration (SSA) (1) delivers millions of beneficiary checks on-time, despite hurricane, wind and fire; and (2) contrary to hype, SSA and CMS (Medicare and Medicaid’s agency) can *turn on a dime* activating the small tweaks and radical rule changes by presidential fiat and other power sources.

Social Security and Medicare offer founding principles, space and place for provisions, metrics of re-imagined systemic and structural change – the *potentia*<sup>11</sup> of which has been previously non-existent, unthinkable. Poverty under Social Security is an anachronism, abhorrent. Highly contentious, Social Security formulae for COLAs and poverty are unrealistically low. Shorter life expectancy, longer disability, widowhood and children intensify the preeminence of social insurance as a societal asset for people of color through reinstatement of student benefits, crediting lost caregiving “zero years,” universal family and medical leave, long term care and social supports (LTSS), and child care.

Hillary Clinton: “Women’s rights are human rights.”<sup>12</sup> Economic vulnerability is harshest for women of color, single mothers, and intergenerational caregivers. Women “#SayHerName.”<sup>13</sup> See: *Building Bridges, Not Walking on Backs: A Feminist Recovery Plan for COVID-19*.<sup>14</sup>

Movements for opening the Medicare window include eligibility for those age 50, “buy-ins,” universal coverage, expanded Federal-state Medicaid, and rescuing Parts C and D (managed care and drug benefit).

**Reclaiming the social, the communal, collective, and commons** is to reprise, respect, and reactivate the role of government for the present and precarious future. Unwavering public opinion strongly supports social insurance.

*“Reclaiming the social, the communal, collective, and commons is to reprise, respect, and reactivate the role of government for the present and precarious future. Unwavering public opinion strongly supports social insurance. Millennials and Gen Z are all in.”*

Millennials and Gen Z are all in.

Millions of jobs are produced and protected by the spending and economic cycling of earned Social Security benefits by American workers and families. Last year Social Security paid out approximately \$1 trillion dollars in benefits, which generated approximately \$1.9 trillion dollars in 2019 US economic activity. State and local economies increasingly depend on this beneficiary spending.<sup>15</sup> Medicare and Medicaid add \$1.5 trillion for insurers, hospitals, clinics, home care and nursing homes and health workers, which cycles through the economy generating additional trillions in health spending. But unlike Social Security, which provides direct payments to beneficiaries, the multi-billions of dollars that flow through Medicare and Medicaid are siphoned off as profits and excess compensation to medical-industrial complex stakeholders. Current policy imposes the unacceptable structural and systemically induced unfairness between the haves, the have nots and the have mores.

**The social insurance *proof of concept*** is the continuity, stability and security of the reciprocal social compact between governments and promised guaranteed earned benefits to which we contribute across our lifetimes and generations. Universal risk pooling corresponds to the urgency of re-engaged social citizenship. Instantiation of rights-based frameworks seek systemic and structural means to human dignity, equality, opportunity, and democracy. Silent dialogues of discriminations scream out in raised voices everywhere.

Race, ethnicity, class, genders, disabilities, age, indigenous, native and immigrant peoples require recognition. Privatization robs the land, air, water, nature resources (the commons belonging to all of us), and the fruits of our labor. Time's up to end what the Rev. William J. Barber calls "policy violence."<sup>16</sup>

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## Social insurance and our delicate balance

*Stephen C. Goss*

**T**he COVID-19 pandemic reminds us that all things are in delicate balance. Our lives, our society, our planet are all the result of a remarkable series of past events which can and will be altered in the future. There are no guarantees for the future. Change is inevitable. But our preferences and actions will determine how we adapt to changes.

Social Security and Medicare are not legal enforceable contracts. They are, like all laws, statements of intent by our elected representatives that will be altered over time. Benefits in the law are commitments but not immutable promises. Each generation will, by its actions, determine what level of income will be available for all members of our society, and will by its preferences decide how what is produced will be shared.

Since Social Security was enacted in 1935, many unforeseen changes have occurred that have altered our society and our possibilities. Among the most significant is the changing age distribution of our population caused by the drop in the birth rate after 1965 (the end of the baby boom that followed World War II). This change in the age distribution of our population was the primary factor in the rising cost of the Disability Insurance program as a share of national income between 1990 and 2010. Many believed that the program was out of control — but, as foreseen and predicted, stabilization of the age distribution under 65 has halted this rise. But this changing age distribution will require further reconsideration and realignment of our sharing of income among workers, retirees, survivors, disabled individuals, and other members of our society as the share of our population over age 65 increases through the year 2035, and then stabilizes.

The existence of social insurance does not alter the need for this realignment of the income sharing in our economy, rather it provides a mechanism to realize our collective preferences for realignment. The amendments to Social Security enacted in 1983 were an important first step in this realignment, creating a balance between reductions in benefits and increases in tax revenue reflecting the preference of the generations represented in Congress at that time. Between now and 2035 further changes and realignment will be needed, because the increasing share of our population that is over 65 is making the currently scheduled tax rates inadequate to fully finance currently scheduled benefits.

### STANDING THE TEST OF TIME

**S**ocial insurance has provided the mechanism to create a balance between the recognition of and respect for a strong national work ethic, and the desire and obligation to care for and share with retirees and those otherwise unable to work. This balance has stood the test of time and is broadly accepted and supported across generations and segments of our population. There should be no



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doubt of its continued existence and strength, or of our ability to make changes as needed, directed by the collective preferences of generations to come. The efficiency of Social Security is unparalleled, with administrative costs well below one percent of benefits paid. The near-universal support for the program is no surprise.

The COVID-19 pandemic is an additional challenge for our society, requiring additional actions based on our collective preferences. The delicate balance of all aspects of our economy and our society is again being tested. Like the Great Depression, wars, globalization of the economy, shift of jobs to a service economy, and the deep recession of 2008, the pandemic requires current generations to reassess and adjust the balance in many aspects of our existence.

Whether the pandemic will be brief and recovery fast and complete is as yet unknown. The biology of the virus and our actions will determine that. But through this and other challenges to the balance of our existence, social insurance (including unemployment insurance) has provided and is providing a stabilizing force. The need for social insurance is clear to all inasmuch as challenges do not affect us all equally, or predictably. Together, with continued sharing of what we have produced based on the preferences of each generation, we will continue to be able to meet this and future challenges to our delicate balance.

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## Reimagining the future of social insurance in the wake of the pandemic

*Theodore R. Marmor*

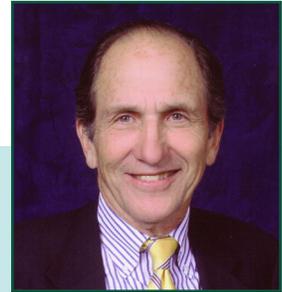
Understanding the fundamentals of social insurance should precede any discussion of its future. The basic purpose of social insurance is to anticipate risks and protect against them by providing economic security. It is to *prevent* individuals — and their families — from falling into destitution rather than trying to rescue them after they have fallen.

The principal threats to economic security are risks that are easily understood: the death of a family breadwinner, sickness, disability, involuntary unemployment, outliving one's savings, and being born into a poor family. Social insurance programs typically condition benefits on some level of prior contributions toward the support of the program. The more universal both contributors and beneficiaries are, the closer the program is to the ideal social insurance model.

The central image of social insurance that distinguishes it from welfare is the earned benefit. Individuals earn the right to receive benefits by making financial contributions to the program. The contributions may take the form of income taxes, although more typically proportional taxes support the programs, as with the Federal Insurance Contributions Act (FICA) payroll tax that supports Social Security and Medicare hospital insurance. The basic idea is for a beneficiary to contribute through taxation while working, in exchange for protection while out of work. Equitable treatment, not the equalizing of incomes, is the controlling standard.

Redistribution of income is clearly one consequence of such programs, but it is not their primary aim. The model of redistribution is not intended to be from rich to poor, but rather from more fortunate to less fortunate. Social insurance retirement programs distribute income over the life cycle of individuals (contributions while working, pensions when old). The relevant question for proponents of social insurance is the adequacy of citizen protection from the predictable risks of modern industrial societies. Seen this way, social insurance simply extends the security objectives of private insurance to circumstances where the risks cannot be insured privately or the purchase of adequate levels of commercial insurance is unlikely.

In contemporary America, the philosophy of social insurance has become most obvious in the Social Security, Medicare, and Unemployment Compensation programs. These programs protect against the changing fortunes characteristic of volatile market capitalism. They do so prospectively, placing a platform under family income, rather than subjecting would-be beneficiaries to demeaning tests of means or assets. In that sense they are entitlements, paying benefits to which recipients believe they are entitled by virtue of their



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contributions, with program obligations regarded as legitimate claims on future governmental revenues.

### COPING WITH A CONUNDRUM

Social Security was enacted 85 years ago; Medicare was enacted 55 years ago. Regrettably, the passage of time has dulled what were once vigorous debates about the need for social insurance programs and their merits. Most Americans today probably could not offer a working definition of social insurance or identify the programs that best fit that definition, while earlier generations understood and debated the concept as a crucial issue in domestic politics. Strangely enough, as social insurance programs were enacted and then expanded to occupy their present prominent place in our public life, Americans' understanding (and even recognition) of the term "social insurance" atrophied. Indeed, the term has all but disappeared from our public discourse. Yet support for social insurance programs has remained overwhelmingly solid despite dramatic declines in Americans' trust of government.

This conundrum — widespread support for social insurance accompanied by widespread confusion about what it actually is — imperils policy debates about its future. For some years these debates about competing philosophies of social welfare provision have been colored by our deeply ideological politics. Those who favor smaller government and market solutions based on individual initiative and effort remain prominent in our public social policy conversations. Social insurance advocates have had to defend both social insurance proposals and established programs from intermittent charges of "socialism" and, in recent years, from steady attacks on social insurance programs' allegedly inevitable unaffordability. These political battle lines are well-entrenched and spring from profound ideological differences. Defenders of social insurance cannot ignore these claims. They tend to ensure that needed expansions of social insurance programs require decades of incubation and compromise to become operational programs.

The economic devastation wrought by the COVID-19 pandemic underscores the need to accelerate that frustrating timetable and put in place additional protections such as universal health coverage and greater retirement security for gig workers and others not covered by traditional employment. To get there, however, proponents of social insurance solutions must effectively address two of the most widely disseminated critiques of social insurance's two largest budget items: the Social Security retirement program and Medicare. The crux of the first of these critiques is that both programs are arguably unaffordable now and sure to become more so as the numbers of eligible older Americans grow. Critics cite projections that pension spending will rise faster than earmarked payroll taxes and that outlays for medical care will strain the federal budget to the point of crisis. For many, the second critique is philosophical: the assumption that social insurance programs are beyond the proper role of government. Their view is that limited government should attend to those who fall into poverty, not

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replace the role of family savings, private pensions, and private insurance. Public pensions and Medicare, for such critics, violate standards of both affordability and desirability.

Social Security's defenders may never win over critics who truly believe that the program should not even exist, but in the wake of the pandemic, with most Americans generally in search of more rather than less security, such critics will have difficulty gaining or maintaining traction. Thus for Social Security the most plausible future is one of incremental adjustment at most. A program that has commanded majoritarian support for decades, has been free of scandal, and has a growing population of beneficiaries is not a realistic candidate for transformation or substantial change. There are areas where incremental adjustment will be on the public agenda: changing family arrangements, the expansion of women in the employed labor force, and so on. In the near term the challenge for Social Security's defenders may be to combine more education about social insurance fundamentals with debunking myths about a program that can in fact be maintained in long-term balance without major adjustments.

#### THE QUEST FOR POLITICAL ACCEPTABILITY

The most prominent criticism of Medicare, by contrast, is more fiscal than fundamental. Citing forecasts of Medicare spending — along with comparable concerns about national expenditures — the repeated claim is programmatic unaffordability. How can a program growing demographically with outlays rising on average at twice the growth rate of national income avoid fundamental change?

Those favoring limited government repeatedly claim that competition among private health insurers and increasing patient cost-sharing will produce effective constraints. But those remedies have had little success so far, either in the U.S. or in other wealthy democracies. The central conclusion of cross-national research in medical care finance appears to be this: When every dollar of medical expenditure is a dollar paid to a medical care worker, countervailing power — or budget limits and bargaining — is a necessary prerequisite for successfully limiting the growth of per capita health spending. To assess the plausibility of this diagnosis, consider that the United States and Canada spent comparable proportions of national income from 1950 to 1970. Then, from 1970 to 2018, Canadian outlays increased from roughly 7 percent of GNP to 11 percent. U.S. outlays, by contrast, increased from a comparable 7 percent to 18 percent. Constraint, in short, is possible, but also controversial. Cost control has to be costly to somebody or it is not cost control.

Political acceptability, not ideal policy proposals, is crucial to both the short and long term. And since increases in both areas of social insurance are bound to grow, the prospects of budget strain are realistic. Spending increases of two to three percent of GDP on Social Security pensions over the long term would not, given the support cited, violate the criterion of political feasibility. But spending

two or three percent more than American income growth year after year for Medicare challenges the belief that the program could remain unscathed.

The problem with this line of argument is fundamental. It rests on the assumption that an American tax phobia simply will not permit increases in taxation to fund even widely supported programs. Major tax increases are indisputably hard to enact. Yet there is evidence from national crises — from depressions to war to pandemics — that the tax phobia diagnosis is overstated. The question implied for the medical care part of the discussion is whether political bargaining will produce repeated disappointment or hard-won progress.

Seeking the ideal balance point between reasonably burdensome taxation and its principal benefit — an economy that functions for the greater good and protects against universal risks — the rest of the OECD nations have shown what is possible and also the variability that is possible. We need to reject the notion that it can't happen here. The pandemic is rewriting the script, creating an opportunity to reimagine the range of steps that are both doable and desirable, buttressed by a public opinion strongly committed to protecting the core of social insurance ideas and programs.

## What will we learn from the coronavirus crisis?

*Marilyn Moon*

**T**he onslaught of the coronavirus has highlighted glaring gaps in the social safety net in the United States and underscores lessons that hopefully can be learned from this tragedy.

Unfortunately it was inevitable that our public programs would not be up to the challenge. Americans like to think that people can take care of themselves, are often skeptical of government, and are readily persuaded that safety nets are for the weak and the less worthy. Consequently, much of the help being offered in this crisis relies on systems that are meant to punish and demean applicants — programs poorly staffed, relying on outmoded technology and imposing formidable demands on recipients for compliance and accountability. Stringent limits on length of benefit receipt and requirements to re-apply frequently are also common features.

Safety-net programs are operated so as to deter people from inappropriately seeking aid. By making it hard to obtain benefits, they are designed to minimize the chance of anyone getting aid who does not “deserve” it, thereby discouraging participation — on the part of deserving recipients as well. Even in this time of crisis, some public officials oppose programs that they believe discourage people from working (at the same time that health officials have been urging workers to stay home) and/or that they perceive as providing overly generous benefits (a bad joke for anyone who has to depend on them).

Our experience with COVID-19 highlights the problems that such a philosophy creates: hundreds of thousands of people have had difficulty getting unemployment benefits, small businesses have found it hard to work the system to get the loans they were promised, and the SNAP Program (food stamps) has not been sufficiently expanded to reach all those in need. The result: long lines of desperate families forced to seek food aid from charities for the first time, people desperate to return to work when aid fails them or falls short — despite exposing them to workplace health risks — and an inevitable increase in inequality caused by the fact that those with resources and savvy can work the system while the most vulnerable are left with less. Also highlighting our grim state of readiness are the pressures on health care systems to respond — particularly in states that failed, pre-COVID, to expand Medicaid — and the lack of strong public health programs that could ramp up quickly in times of crisis.

Contrast these harsh and dysfunctional safety-net programs with social insurance like Social Security and Medicare. These programs treat beneficiaries as having a legitimate claim on benefits and are broadly accepted as reasonable building blocks for income and health security. (Certainly this is in part a reflection of the contributory nature of the programs, though Medicare is heavily financed by general revenues.) Social Security and Medicare emphasize inclusion rather than exclusion. But while these programs are extremely popular, they



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have limited reach and are seldom used as models for other programs.

I would like to believe that we are ready to learn a major lesson from our current crisis: to start using Social Security and Medicare as models of respectful support for people in need. And we can build in rules for safety-net programs that automatically expand benefits when certain conditions are met, thus avoiding long delays and ensuring that efficient systems for distribution are in place rather than forcing the need for hasty legislation.

Now is also an opportune time to rethink the types and levels of resources needed and for whom in times of emergency, rather than continuing to rely on ad hoc responses — and the goal should be to ensure that help is far-reaching rather than focused on restricting access.

We need to recognize that such changes would be entirely consistent with basic self-interest. *We all benefit from an economy that does not collapse when work is disrupted.* So it's crucial to have strong protections that trigger quickly for those with limited resources to fall back on. For example, the ad hoc checks sent out by the IRS to supplement peoples' incomes could be refined to become a national program to make emergency aid available. Such an income replacement program in reserve could offer a simpler, fairer approach and we could count on it being there when the need arises.

Another key area of society's self-interest is protection for health needs. We will all be kept safer by ensuring that everyone has access to high-quality health care that includes vaccinations, testing and surge capacity. A national priority should be to make at least some basic care readily available. This surge capacity should be part of a public health program available to all, perhaps as part of an expanded (and less stigmatized) Medicaid program that further builds on the Affordable Care Act's intent to simplify and expand eligibility.

Our fixation as a country with "just in time" responses and excluding the "unworthy" from aid blinds us to the need for an inclusive system that instead emphasizes helping those in need, no stigmas attached. We need to remove our blinders.

Finally, when the dust settles, we will likely see that our terrible national problem of inequality — long on the rise — will have gotten worse. Despite providing some protections for the vulnerable, benefits paid during the pandemic will not have been sufficient to slow or counter the trend toward ever-greater inequality. The undeniable fact is that those who can work from home, count on savings, and manipulate the nation's complex system of benefits will have fared better than the rest. We need to tackle inequality directly, but at the very least we should resolve not to let a national emergency make matters even worse.

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## Social insurance is the best way to save — now more than ever

*Alicia H. Munnell*

Social insurance is the best way to protect people against risks small and large, predictable and unforeseen, routine and calamitous. It provides a framework for broad-based participation, contributions from both the high-paid and low-paid, and a steady source of benefits when the time comes. Given the nation's current challenges, social insurance is needed now more than ever.

At the routine level, it makes less sense than ever for people to save individually for unemployment or retirement. To protect themselves from the risk of being unemployed for an extended period, individuals would have to put aside a large nest egg, at the sacrifice of current consumption, for a contingency that is unlikely to occur for most — pandemics aside. Because of the nation's enormous increase in inequality, the vast majority of Americans simply cannot afford to prepare for such a contingency.

Retirement, in contrast, will occur for most. But in today's low-interest-rate environment, provision for retirement is best addressed through social insurance, not individual saving. When the interest rate adjusted for inflation on government securities is essentially zero, society gains by saving collectively and reaping a return equal to the growth rate of the economy. Social Security has always been a valued mechanism to compel people to undertake saving that they likely would not have done on their own, so that they have a base income on which to rely in retirement. Today, given that economic growth exceeds the rate of return, Social Security is also the most efficient way to save.

In addition to the changing economics, the realization that the country is vulnerable to calamitous events also makes social insurance more valuable than ever. The financial collapse in 2008–09 saw the bursting of the housing bubble and a 50-percent decline in the stock market. As a result, the two major sources of retirement saving other than Social Security were gutted. Moreover, the ensuing recession meant that many older workers lost their jobs and were unable to find new work. Millions were forced to rely on Social Security sooner than planned. It provided a steady base of retirement income for those whose 401(k) plans had taken a beating; it provided assured income for those with disabilities; and it served as a safety net for unemployed older workers, who in large numbers claimed retirement benefits as soon as they became eligible for them at age 62.

The current pandemic and the shutdown of the economy also highlight the value of a social insurance savings program. When virtually all other sources of income suddenly stop, Social Security continues to pay benefits for the retired and those with disabilities and once again acts as a safety net for the older



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unemployed. The steady stream of income not only provides security to individual households but also serves as a source of continued demand to stabilize the economy. On the unemployment front, the pandemic has unfortunately exposed many of the inadequacies of our system of unemployment insurance. But that failure only underscores that we need a comprehensive unemployment insurance program now more than ever.

In an environment where social insurance has demonstrated its worth for both routine and calamitous risks, two conclusions emerge. First, we need more, not less, social insurance. People need a larger base of retirement income when the collapse of financial markets cuts their retirement holdings in half or when prolonged unemployment forces them to consume their nest eggs. And workers need a robust unemployment insurance system to ensure that they have funds to tide them over when jobs dry up. Second, our social insurance programs need to have a firm financial footing. Social Security faces the most egregious and yet manageable shortfall — egregious in the sense that it has been known for decades that costs exceed scheduled revenues and more funding is needed.

The urgency for action has increased as the trust fund assets that are being used to bridge the gap are projected to be depleted in 2035 (or possibly a bit sooner, depending on COVID-19's ultimate economic impact), at which point Social Security will be able to cover only about 75-80 percent of scheduled benefits. Yet the problem is manageable, with the current long-term shortfall equal to roughly one percent of GDP.

We can afford to finance our social insurance programs properly — and we need them now more than ever.

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## Preparing for the next economic collapse: should social insurance play a bigger role?

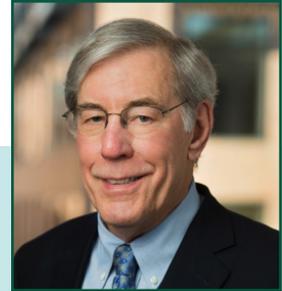
*Robert D. Reischauer<sup>1</sup>*

In the last decade and a half, the U.S. economy has experienced near-catastrophic collapses twice. The first, the Great Recession, was spurred by inadequate regulation of financial institutions and real-estate speculation; the second was brought on by public officials' decisions to curtail economic activity in response to the coronavirus pandemic. Policymakers responded to the challenges posed by these crises by enacting a number of new, ad hoc measures thrown together during the confusion of economic free falls and by modifying the eligibility and generosity of several existing safety net and social insurance programs. In both cases the responses were delayed by the inevitable wrangling over the appropriate size and duration of the rescue packages, disagreement over the programmatic vehicles through which assistance was to be provided, and clashes around which specific individuals, institutions and public entities should be eligible for the aid. Once these issues were resolved, a lack of accurate information needed to distribute assistance to all those eligible challenged full and timely implementations of assistance.

When the current crisis is under better control, policymakers should consider whether the experience of the past decade and a half is an aberration or the “new normal.” Are sudden, deep and widespread economic collapses once in a lifetime events or likely to occur every decade or so? If the latter is more likely the case, the obvious next questions are whether we should take steps to better prepare for future occurrences and what that might entail. Should social insurance approaches play a bigger role in government's response?

While pandemics and widespread financial institution implosions are rare events, there are many other threats, each relatively unlikely, that could seriously undermine the nation's ability or desire to engage in normal economic activity for a prolonged period. For the most part these do not include natural catastrophes (earthquakes, hurricanes, droughts, floods, volcanic eruptions, etc.) which do not have national or international scope or significant duration. Rather the other threats are more likely to involve destruction perpetrated by rogue states and affiliated non-state terrorist groups. They could involve widespread sabotage of the electric grid or the water supply, destruction of the Internet or other widely used communication networks, compromises of the integrity of financial markets, germ warfare, or nuclear contamination.

The combined probabilities of these risks together with the huge and long-lasting economic and societal costs of deep economic contractions might justify preemptively adopting measures to shorten their durations and ameliorate their damage, which includes reduced long-run economic potential and



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the stunted lifetime opportunities of cohorts who enter the labor force during prolonged periods of slack.

While the federal government's responses to the Great Recession and the COVID-19 recession were significant, they were far from optimal. Overall, they took too long to enact and implement, created unnecessary uncertainty with respect to the magnitude and duration of assistance for beneficiaries, were underfunded and exacerbated partisan conflict.

### A MANDATORY RESPONSE

We could do better by preemptively authorizing a mandatory response to the next catastrophic downturn. This would involve several steps, the first of which would be to specify beforehand a set of objective conditions that would automatically activate an economic recovery effort. These would consist of national threshold measures of the level and change in employment, unemployment, income, and economic activity.

The second step would be to specify the specific programs and policies that would make up the recovery package designed to address the next catastrophic downturn. Drawing from recent experience, these might include such policies as an increase in the Medicaid matching rate (FMAP), supplemental unemployment compensation benefits, grants to all adults and children below specified income limits, assistance for subnational governments, and aid to small businesses.

A third step would be to establish numerical triggers that would automatically turn each element of the special assistance both on and off. This contrasts with the current practice of authorizing special benefits for fixed periods of time — e.g., through July 31 or until the end of 2020 — without knowing whether the conditions motivating the assistance will still be extant, significantly ameliorated or worsened by the termination date. Not only does the current practice create detrimental uncertainty and anxiety for beneficiaries, it exacerbates partisan conflict and gaming as the termination date approaches.

A final step would be to specify beforehand what temporary expansions, if any, would be made in program eligibility and benefits. These might include unemployment benefits for gig workers and independent contractors who ordinarily are not eligible for regular unemployment compensation, relaxed income limits and household composition rules for recipients of SNAP and subsidized housing benefits, or more flexible access to Affordable Care Act plans for those who lose their health insurance when they become unemployed.

This step would allow those responsible for administering the various programs the opportunity to develop the programmatic capability and informational infrastructure necessary to implement the new benefits in a timely manner.

The circumstances surrounding each catastrophic collapse of the economy are unique, which will lead some to argue that each rescue package should be designed anew. While that position has merit, recent experience suggests that there is a common set of measures with broad public support that are aimed at

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reducing individual hardship and boosting aggregate demand that should be implemented without delay. If this were done automatically, lawmakers could focus their attention on additional measures designed specifically to address the special aspects of the new crisis. For example, significant portions of the CARES Act and the other legislative responses to the 2020 collapse dealt with health policy and the legislation precipitated by the Great Recession focused on shoring up financial institutions and housing markets. But crafting these new and often controversial measures should not, as has been the case recently, delay the basic relief. Furthermore, lawmakers would of course be free to fine-tune elements of the core measures if that would make them better fit the particular challenges of the then-current situation.

If lawmakers choose to preemptively enact a package of measures designed to combat future major economic collapses, there remains the question of how it should be structured. Would the response be stronger and gain broader public support if certain key elements were designed under social insurance principles?

#### **ROLES FOR SOCIAL INSURANCE**

Social Security, Unemployment Compensation, and Medicare have played significant roles in the most recent federal countercyclical efforts. During the Great Recession, the Social Security program served as a useful vehicle for conveying tax relief to workers through The Tax Relief, Unemployment Insurance Reauthorization, and Job Creation Act of 2010 (Public Law 111-312) which reduced OASDI payroll tax rates on workers by two percentage points for 2011. The 2020 CARES Act provided additional liquidity to employers by allowing them to defer payment of the employer portion of their OASDI payroll tax liability incurred between March 27, 2020, and December 31, 2020 until December 2021 and December 2022. Because the Treasury offset the full costs of these initiatives with general revenue transfers to the Trust Funds, neither initiative affected Social Security's financial position.

Modifications in Unemployment Compensation, usually taking the form of extending, at federal cost, the duration of benefits, have been a component of many federal responses to economic weakness. In addition to a 13-week extension of benefits (Pandemic Emergency Unemployment Compensation) lasting through the end of the year, the response to the coronavirus recession included a significant expansion of coverage, extending benefits to many who are not eligible for regular state-administered unemployment compensation because they are self-employed, independent contractors, or have inadequate work histories (Pandemic Unemployment Assistance). CBO has estimated that some 5 million workers will obtain coverage under this provision. An even more radical policy in the CARES Act is the additional \$600 federal payment added onto every weekly state unemployment check through July 2020.

Not surprisingly given the cause of the current economic collapse, Medicare has played a role in the federal response. To help hospitals and other providers,

Medicare payment rates for COVID-19-related as well as some other interventions have been raised and sequestration cuts have been deferred. To help patients, benefit coverage — particularly telehealth visits — have been expanded and patient cost-sharing for some therapies have been reduced.

Increasing the importance of social insurance could be accomplished either in an incremental fashion or through a radical redesign of how the nation deals with major economic downturns. An incremental approach would involve adopting modest changes to existing social insurance programs such as Gene Steuerle's proposal that would make it easier for Social Security-eligible individuals under the full retirement age who find themselves unemployed to cycle on and off Social Security and be allowed to receive partial benefits.<sup>2</sup> Similarly, workers age 62 or more who lose their employer provided health insurance could be offered temporary Medicare coverage even though they had not reached their 65th birthday if that was preferable to coverage through an ACA plan. In response to the increase in Disability Insurance applications that occurs during periods of extreme unemployment, speedy provisional approval might be granted to certain classes of applicants.

A more radical social insurance-type approach would be to establish a trust fund dedicated to a core set of programs designed to respond only to major economic contractions. As suggested earlier, the parameters of these programs and the conditions under which they would be activated would be established in legislation enacted when the trust fund was created. The core set of programs should be limited and chosen after objectively evaluating the effectiveness of the measures used to combat the Great Recession and the coronavirus recession. The core set might include cash grants to individuals like the \$1,200-per-adult Recovery Rebates; an unemployment compensation enhancement package that extended the duration of benefits, expanded eligibility to defined uncovered groups and supplemented state-determined payments; a small-business loan program like the Paycheck Protection Program; and a facility that provided grants or loans to subnational units of government. The trust fund would be supported by a portion of the receipts from some new broad-based tax like a value-added levy or a carbon tax and its reserves would be capped.

While the obstacles that this proposal would face come readily to mind, it is worth concluding by listing its possible advantages. First and foremost, it would speed the implementation of significant measures that could reduce the duration and severity of the economic collapse. Second, it would reduce the uncertainty among individuals and businesses concerning what types of assistance would be available when a deep downturn occurred and how long the assistance would last. Third, agencies responsible for administering the assistance would be better prepared to do their jobs efficiently and accurately, reducing both confusion and fraud. Fourth, partisan wrangling over the details of what should be a unifying national effort to save the economy would be reduced. And finally, the public and businesses, knowing that they would be the beneficiaries at a time of severe distress of the taxes paid into the trust fund, might reduce their aversion

to policies that would improve, on average, the nation's fiscal position.

**ENDNOTES**

- 1 The views expressed in this article should not be attributed to the Urban Institute, its sponsors, staff, or trustees.
- 2 Eugene Steuerle, "The COVID-19 Crisis Reveals the Need to Let Eligible Workers and Retirees Take Partial Social Security Benefits," *The Government We Deserve* (<https://blog.governmentweddeserve.org/>), June 10, 2020.

## Social insurance needs to be flexible going forward

*John C. Rother*

When Americans think of social insurance, we're likely to think of the nation's most successful social program — Social Security. Its terms have come to define our notion of social insurance: payroll contribution funding, benefits based on contributions, trust fund public accounting, and extra consideration for those with lower incomes. But those characteristics, even though successful and widely accepted, need not limit our thinking about the role of social insurance in the future.

In an economy where an increasingly substantial portion of income is not wage-based, where the gap between the very rich and everyone else has grown tremendously, and where lifespans have dramatically lengthened for some but not at all for others, we need to rethink how social insurance should adapt. In addition, the major threat facing most older people in the future will be the cost of health care, not hardcore poverty. Meanwhile the economy — long before the onset of COVID-19 — has been rapidly shrinking the ranks of workers who have lifetime career jobs and can count on a defined-benefit pension.

How can social insurance adapt to this new environment? Social Security's financing and benefits can be tweaked, but that alone will be totally inadequate to achieving any meaningful level of retirement security — let alone lifespan security — for future generations of Americans. A broader vision of social insurance is necessary.

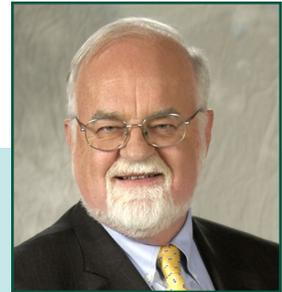
We need to start well before “retirement age,” whatever that still means. A combination of a higher minimum wage, more aggressive opt-out portable savings arrangements, and comprehensive health coverage and benefits for working-age people can build a foundation for successful aging. These won't all be social insurance programs, but together they will provide the necessary basis for stronger social insurance later in life.

Our goal needs to be a universal set of workforce and family security policies that can greatly strengthen risk protection through the life course. In other words, what successful European societies already have in place.

Stronger employment programs and policies, going beyond just anti-age-discrimination, are also needed. These would include promotion of part-time, second-career, and other work opportunities for people as they age.

The cost of health care will be the principal challenge to a secure future for everyone, but especially for older people with chronic conditions. And as we are learning today, good health and well-being over the life course is a function of many “social determinants” beyond just medical care.

Social insurance, more broadly imagined, could be a primary tool for dealing with these challenges. But we will need to think more creatively about what it means. Perhaps various forms of contributory financing other than payroll taxes could still preserve the “earned benefit” character of social programs. Carbon



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taxes, or value-added taxes, could still be seen as contributory by all. Perhaps universal benefits, combined with a progressive tax code, could preserve the universality of program benefits. And perhaps more aggressive use of program management, particularly in health care, could make our costly medical system more affordable by expanding Medicare's reimbursement limits to private insurance and using its purchasing power to lower pharmaceutical costs. In other words, what Germany does today.

Social insurance can be a powerful tool to better meet the challenges facing Americans — especially older Americans — now and into the future. To help fashion this new generation of programs and policies, we only need to open up our imaginations about how social insurance can adapt. And then help build the broad-based, generationally cross-cutting coalitions that will be needed to turn visions into reality within our currently battered and fractious political system.

*“A combination of a higher minimum wage, more aggressive opt-out portable savings arrangements, and comprehensive health coverage and benefits for working-age people can build a foundation for successful aging. These won't all be social insurance programs, but together they will provide the necessary basis for stronger social insurance later in life.”*

## Reclaiming a vision that lost its way

*William E. Spriggs*

**F**or almost 50 years, from Social Security's enactment in 1935 until 1983, it was a program constantly amended to become more inclusive, equitable, and encompassing. Changes were always about expanding the scope of the program, never about limiting it. The program grew because it became clear over time that we had important unfinished business. That included expanding coverage to protect workers who had been initially excluded, notably farm laborers and domestic servants, disproportionately African American.

Initially President Franklin D. Roosevelt intended to cover them. That would have evoked the wrath of the deeply racist southern Democrats who held sway in Congress. But it didn't come to that, because FDR didn't insist. It's also true that most economists of the day had been trained to believe that extending benefits to "less desirable races" would hurt the economy in the long run; so they were not inclined to advocate their inclusion. The result was that in 1935, despite objections from the civil rights organizations that testified for their inclusion, Congress excluded an estimated 65 percent of the African American workforce of the day from Social Security coverage.

It took nearly 20 years to get those workers covered — think how many had died in the meantime, deprived of the Social Security income protections and benefits that most workers by then could take for granted — and it took still longer to cover workers who could no longer work because of becoming disabled, typically if not always because of unsafe, unhealthy, or unduly demanding working conditions.

Along the way, coverage was added for workers who had disabilities that limited their competitiveness in the labor market. And, as inflation eroded benefit levels, Congress periodically raised benefits to maintain their purchasing power and protect the dignity and lifestyles of seniors.

So the program grew, always with the goal of increasing equity, fairness, and inclusion. Then, in the 1980s, we made a terrible mistake, allowing the program to become reconceived as something fixed, even on the defensive, instead of constantly becoming more inclusive, equitable, and encompassing.<sup>1</sup>

We need to reclaim that earlier vision — and improve on it.

### AN UNSTABLE, TOP-HEAVY ECONOMY

**A**s incomes rise and the lifestyle needed to participate in a demanding market-based economic system rises, clearly more risks need to be insured against. It is the same as when you go from early adulthood to taking on home ownership and other assets. You expand your private insurance. When you buy a \$350,000 home you can't continue to carry renter's insurance, and you can't carry the same \$20,000 life insurance you had when you were single but now make



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\$75,000 and have a spouse and child. So, too, must our social insurance expand.

Two key things have happened since the 1980s. First, inequality has exploded. This leaves far more people in a constant state of precariousness. High levels of inequality chase the affordability of basic needs like housing and child-rearing beyond reach for more people, because an increasing share of the market for health care and housing and education is driven by the high end of the income distribution. This makes our economy less stable — and it is now top-heavy and easy to knock over, more prone to collapses that put savings and incomes at risk.

The labor market has failed to deliver the same growth in wages for the typical worker that had marked the post-World War II economy up to the 1980s. This century has greeted workers with a resounding thud. Today there are fewer workers on payrolls than in 1999. And median family incomes had just climbed back to their peaks of 20 years ago, before today's economy sent them crashing back down.

It was not clear in 1983 that union density would collapse as it has. With unions all but gone, so has the share of households protected by defined-benefit retirement plans. That loss of corporate obligations has been shifted to corporate profits, while for workers it has meant another risk added to their plate. While once it was common to think of the typical retiree as having a pension plus Social Security, that is no longer an accurate or useful framework.

Our knowledge of the extent and persistence of racial wealth disparities is greater than in 1983. We have more data, clearly showing that the gaps are intergenerational, that they cannot be closed by increasing educational attainment levels, and that the gaps have been growing wider. As a larger share of the population will be from among communities without individual wealth holdings, the economy as a whole will be more fragile. Social insurance is a critically important way to improve the resiliency of modest household finances and thereby contribute to addressing inequality.

### CONFRONTING THE UNDERLYING 'I CAN'T BREATHE'

Second, globalization has clearly created global risks that no individual or group can possibly insure against: pandemics that are easily spread, unnatural weather disasters linked to global warming. And these risks can be very large for the economy, as we now see.

Too often we have seen natural disasters strip away our sense of security that our local government will be there to maintain basic services. Katrina's devastating impact on New Orleans has been repeated with the fires that eradicated Paradise, California. Part of our personal wealth is tied to local infrastructure, including public infrastructure. When that community infrastructure is weakened, the loss is costly even if someone's house is not damaged.

So we need more social insurance, and it must address the underlying racial inequality — or leave us with no tools to overcome a permanent level of racial inequality which is largely the result of program inequities that included Social

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Security. So far, there is little evidence that the typical worker will ever have the earnings gains to conquer the rising risks through their own savings initiatives.

Our vision for the future of social insurance must be as expansive as it once was. And it must have the goal of protecting all of us — not just some of us — against broadly shared risks. That means thinking not only of social insurance at the federal level. It also means addressing the huge inequalities that we have in state and local government. It means ensuring the fair and adequate functioning of basic community services.

Otherwise our society will never remove its knee from George Floyd's neck.

#### ENDNOTES

1. The changes in 1983 were presented to the American people as the result of a great compromise between those who were long-time supporters of expanding Social Security and those who were more conservative, wanting to move the system from a pay-as-you go to a pre-funded system, as an attempt to resolve the almost biennial crisis the program faced to adjust benefits and FICA contributions. The result was that the delicate balance that was reached claimed to put the program on sound footing for 75 years by slowly raising the retirement age for the baby-boomers and significantly raising the FICA contribution to create a large trust fund to help pre-pay their benefits. Changing the program was viewed as reopening a settled debate. This changed the focus of the debate to the strength of the trust fund, inevitably leading to debates on how to cut benefits to sustain the trust fund or abandon the compromise and declare social insurance as a failed experiment that should be converted to private accounts. Long forgotten were the constant increases in FICA contributions that had expanded program coverage (although at the cost of those increases being perennially attacked as unfair tax increases). With most Americans seemingly unaware that the retirement age was raised from 65 to 67 for the baby-boom generation, the trust fund could be depicted, albeit inaccurately, as facing a shortfall because Americans were living longer. Too rarely were Americans made aware that the much bigger problem was the unprecedented rise in income inequality that had started around 1980.

## Nursing home deaths: the safety net unravels

*Bruce C. Vladeck*

The tragic and — at least in hindsight — partially preventable calamity of more than 31,000 COVID-19-related deaths in U.S. nursing homes has come as little surprise to the very few people outside the nursing-home industry itself who pay it much attention. Nursing homes have long been the disfavored stepchildren of health care policy, a status that has only been reinforced in recent decades by the policy consensus that care of the frailest elderly and disabled Americans should be moved out of such institutions altogether, in favor of home and community-based services (HCBS).

Indeed, the figures are dramatic: the number of long-stay nursing home residents in the United States — about one million — has hardly increased since the 1980s, and today there are more than twice as many individuals receiving publicly-financed HCBS, along with millions more receiving it with private financing.

Home and community-based care is the overwhelming preference of individuals and their families, but we know substantially less about what is actually happening to patients in HCBS settings than we do about those in nursing homes. We do know that regulatory oversight of HCBS is substantially weaker and less systematic than the inadequate system of overseeing nursing homes, that the dynamics of supply and demand have meant that expanding HCBS instead of nursing-home care has not saved public financing programs any money, and that some proportion of the individuals who have died in hospitals or at home from COVID-related causes were clients of HCBS programs — although it will take years of research, if it's ever performed, to establish even a rough quantitative estimate.

In short, care of the frailest elderly and disabled members of our society is — with some laudable exceptions — one of the weakest links in a badly fraying social safety net. Some of the problems arise from the inherent difficulty of taking care of adults with such complex needs, but more arise from increasingly generic problems of social insurance in contemporary America. Three of those problems must be called out.

### THE STATE OF THE STATES

Although their role is often ignored in Washington-centric policy discussions, state governments are central to the administration of the safety net of social insurance and related programs. Medicaid is, of course, by far the largest and most obvious such program, but state governments still play the central role in administering Workers' Compensation, Unemployment Insurance, disability insurance, and what's left of direct cash assistance through Temporary Assistance for Needy Families (TANF) and Supplemental Security Income (SSI). But state governments, all but one of which must operate under constitutional



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balanced-budget requirements, suffered an enormous blow from the 2008 recession, from which many have not fully recovered. The impact of public-sector job losses, combined with the success of well-organized right-wing efforts to take control of state legislatures, has been widely recognized in discussions of public education and higher education, but its effects on human services have been no less dramatic.

For long-term care, the erosion in states' capacity to govern has created a triple whammy. First, state governments have the primary responsibility for enforcing quality standards in health services, even for those paid by Medicare or private insurers, and the state agencies responsible for those activities have almost uniformly lost staff and have cut back on the frequency and thoroughness of basic inspections. Second, the capacity of state Medicaid agencies to actually manage the care delivery and clinical operations in their programs has also eroded dramatically. They have responded by largely contracting out program administration to what the late Congressman John Dingell used to describe as "the tender ministrations of private insurance companies." Despite many bumps along the road, Medicaid managed care has worked reasonably well for moms and kids, but long-term care is a much more complex service and administrative challenge — and no one really knows how it's working because the data collected on HCBS quality is so limited and unreliable. Third, and most basically, while the relationship between expenditure levels and quality of care is problematic and far from linear, squeezing budgets through intermediary private corporations in the absence of strong quality measurement and enforcement all but guarantees that the most costly patients will be underserved.

#### WORKFORCE ISSUES

**B**oth in nursing homes and HCBS, the overwhelming proportion of actual patient care is provided by aides, disproportionately women of color, paid at minimum wage or below, usually without health benefits or paid time off, with minimal or no training and few opportunities for advancement. Under the circumstances, the fact that most aides provide care as well as they do is a remarkable tribute to their compassion, commitment, and fundamental decency. As labor markets tightened in recent years, however, and as many states raised the minimum wage for both institutional and in-home nursing aides in an environment of constrained Medicaid payment rates, failure to meet even ludicrously minimal staffing standards became pervasive in the nursing-home industry, and also led to significant service cuts in long-term at-home managed care. Staffing shortages contributed directly to the extraordinary COVID-related death rates in nursing homes; they almost certainly have in HCBS as well.

#### FACING REALITY

**M**ost basically, Medicaid is fundamentally an inadequate vehicle for financing high-quality long-term care, whether in nursing homes or

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beneficiaries' homes. Private long-term care insurance has repeatedly failed to deliver on its promises or to catch on with consumers, and the future outlook is even more bleak, given that the next generation of long-term care patients will have even less money and assets than those currently in the system. On the other hand, a stable, long-term financing and regulatory system for long-term care is not a particularly difficult conceptual or intellectual challenge.

Such a system, though, like those in place in most of the civilized industrial nations of the world, would necessarily require a new source of government revenues and possibly new administrative structures. It might also disadvantage or even eliminate private firms that are now flourishing financially under the status quo. As such, it appears to fall outside the realm of currently permissible political discourse in contemporary America, just as other hallmarks of modern civilization such as universal health care or child care or paid time off for employees receive serious consideration in only a few very blue jurisdictions. It's perhaps too soon to tell whether Americans will respond to the coronavirus crisis by demanding substantive changes. Until the current political logjam breaks, however, tens of thousands of our frailest citizens will suffer, and thousands will continue to die unnecessarily.

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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.

Robert M. Ball founded the National Academy of Social Insurance in 1986 to encourage the establishment of a robust scholarly community that would continue to protect and strengthen the programs he championed. Today, the Academy has a diverse Membership of more than 1,000 experts in the fields of Social Security, Medicare, Medicaid, Unemployment Insurance and Workers' Compensation.

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