

A man in a dark suit is pushing a large, metallic dollar sign off the edge of a rocky cliff. The background features a stylized American flag with stars and stripes. The scene is dramatic, symbolizing the weight of financial obligations.

On the Edge:

**AMERICA
FACES THE
ENTITLEMENTS
CLIFF**

Mark E. Litow & Merrill Matthews, Ph.D.

ON THE EDGE: AMERICA FACES THE ENTITLEMENTS CLIFF

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Introduction

The United States is approaching an “entitlements cliff.” That is certain. The only question is whether the U.S. economy will happily jump off the cliff, unknowingly meander over the edge, be pushed off—or recognize the imminent danger and find a way to stop its fall at the last possible moment. Time for that last option is running out.

Everyone knows the story. Congress creates a new entitlement program promising that it is much needed, financially sound and even that it will likely create jobs and spur economic growth. While some programs are needed, and may even create some jobs and economic growth, they are never financially sound. In these pages we offer a financially sustainable solution.

When entitlement programs begin facing the inevitable financial problems, the government redirects more and more taxpayer dollars to them. However, taking that money out of the private sector hinders economic growth, reducing tax revenue and job creation, which leads to more people depending on safety net entitlement programs that provide just enough assistance to allow them to get by.

Because the benefits are often scaled back if the recipients earn just a little more, they have an economic incentive to limit their income. As a result, the programs create a culture of dependency that can be passed down from parents to children, who themselves often become trapped in poor housing and low-performing school districts with little hope of ever escaping.

Entitlement-program defenders claim they only seek a “fair” or “just” society, which they assert is more economically prosperous than a free society. They believe that when the government picks who prospers, more people prosper. That asking “the wealthy to do a little more,” in the words of one former president, means everyone will do better.

Theirs is a long-term strategy to take from the haves and give it to the have-nots in the hope of reducing the number of have-nots. What usually happens is that we have just as many or more have-nots and often fewer haves.

Fortunately for the United States, solid U.S. economic growth, at least for most years prior to the Great Recession and the Obama economy, has helped to postpone the entitlements cliff. Financially speaking, a country can redistribute more income if it has a robust economy that produces growing tax

revenues—though whether redistributing that money is good policy is a different question.

But the redistributionists are never satisfied; they always want to give away more. In 2015, the federal and state governments spent \$1.1 trillion on means-tested welfare programs, larger than the total GDP of all but 15 countries, and that does not even include the two largest entitlement programs, Social Security and Medicare.¹ And yet the redistributionists clamor that it isn't enough.

Unfortunately, many politicians and voters are willing to embrace the redistributionist approach. Sympathy is cheap, entitlement programs are not.

Over the past 50 years, beginning with the 1965 creation of the Medicare and Medicaid programs and President Lyndon Johnson's "War on Poverty"—a "war," incidentally, that we have lost, badly—Washington and state governments have dramatically expanded the entitlement state.

The pleas for help often come from rent seekers and advocacy groups that benefit from the creation of entitlement programs, but also from ill-informed economists and politicians who argue that taking a dollar from Peter and giving it to Paul stimulates the economy. Well, it stimulates Paul's economy; Peter's not so much.

Many politicians and the media have embraced those arguments and regurgitated them ad infinitum so that they have become part of the conventional wisdom. To question those

1. Federal Budget in Pictures, The Heritage Foundation. <http://federalbudgetinpictures.com/means-tested-spending/>

assumptions is to demonstrate beyond question how unsophisticated and cold-hearted the skeptic is. And yet those policies did not work in the past and do not work now.

It is a testament to the failure of any rational political system that some economists, politicians and the media can continue to promote failed redistributionist policies in the face of all the evidence to the contrary and still be taken seriously. Those redistributionist policies have brought the U.S. to the entitlements cliff, which is one reason why on November 8, 2016, the American people shouted “enough!” They elected Donald J. Trump president of the United States.

His victory was a slap in the face of the conventional wisdom. He wanted to cut entitlement spending—Social Security and Medicare excepted—not grow it. He wanted to grow the economy by lowering tax rates, especially on corporations, simplifying the tax system, and rolling back burdensome regulations. And he called out media organizations that constantly misreported or refused to report the damage caused by the entitlement state.

Remaining a healthy distance from the entitlements cliff—along with its high levels of unemployment, economic stagnation, poverty and civil disobedience—should be of the utmost importance to society. Doing so requires dealing with a multitude of existing entitlement programs that may be very popular, but that we can no longer afford. While avoiding the fall may not be entirely painless, the longer we wait the further the fall—and the bigger the crash at the end.

This book attempts to inject a factual, demonstration-based and objective voice into the entitlements debate. The only way

to solve the problem long term is to gradually shift to a system of privately funded or temporary, means-tested safety nets.

The stakes are too high to give into the subterfuge that is all around us. The economic and actuarial issues facing our nation and the world are rapidly approaching a crisis point after many decades of irresponsible policies and actions by elected officials and others.

Politicians and the public have managed, with few exceptions, to avoid facing the truth regarding the inevitable collapse of programs such as Social Security and Medicare because the crisis was always decades into the future. The people who will have to deal with the collapse, when it comes, either were not born yet or did not vote.

Stopgap measures, along with other gestures in the general direction of fiscal prudence, have kicked that can down the road again and again. That road is coming to an end sooner rather than later. At the end of that road there is no warning sign or protective rail—only a cliff with a yawning economic abyss.

The proposals in this book are an effort to save us from that abyss.

PART I

WHY ENTITLEMENT PROGRAMS FAIL

Entitlement programs have become an unsustainable financial strain on every developed economy, dragging those economies to the precipice of the fiscal cliff—if they haven't already fallen off. This book's theme is that when politicians set up entitlement programs to provide welfare, health care and pension benefits to certain populations, they overpromise benefits, underfund the programs, and misalign incentives—if not initially, then soon afterward. Over time, future elected officials expand the programs to cover more people with richer benefits, far outpacing the financing needed to sustain them.

Chapter 1

Entitlement Programs Are Not Actuarially Sound

Developed economies have come to believe they need to provide adequate—and in some countries, generous—safety net programs that ensure the poor, seniors and the sick have access to basic services. Thus, every developed economy has embraced entitlement programs. But very few created those programs based on actuarially sound principles that would ensure the programs remain solvent in good times as well as bad, and promote economic growth rather than deter it.

The fact that entitlement programs have become an indispensable part of modern society is not going to change. What can and should change is the way they are designed, managed and funded. Such programs should be guided by at least three basic principles.

(1) Government-run, means-tested welfare programs should be temporary, targeted to those most in need, and structured to help the beneficiary exit the program as soon as possible. The goal should be self-sufficiency, not perpetual dependency accompanied by a plethora of excuses.

(2) Social insurance programs that provide health care and pension benefits in retirement should be personal, private and prefunded by the individual, which could include employer contributions. While the government could, and probably

should, play a safety-net role by topping up the benefits of low-income workers and ensuring against institutional financial failure, it must get out of the business of being the public's primary pension plan and health insurer.

(3) All government efforts to meet social insurance and welfare needs must follow actuarially sound principles—as do the vast majority of private sector plans. In short, if a government safety-net program isn't actuarially sound it should be restructured—or better yet, turned private.

Governments that embrace these principles for entitlement programs would dramatically improve their fiscal stability. They would, over time, eliminate or substantially reduce their long-term unfunded liabilities, could significantly lower their tax rates (in part because people would be putting money in their own accounts rather than the government's), and they would see an explosion in economic growth.

Where the U.S. Went Wrong

The U.S. has never embraced these principles.

The chart below summarizes the estimates of federal, state and local costs for welfare, Social Security, Medicare, and all other entitlement programs combined, including pensions, for selected years. Welfare includes Medicaid. "Other" not only includes pension costs of federal, state and local government employees, active and retired, but also an allocation of administrative and interest costs consistent with the percentage of total entitlement costs. The sum of all costs in each year is contrasted with GDP to provide a measure of the magnitude and change over time of entitlement costs.

Table 1.1
Estimated Aggregate Entitlement Spending
 (trillions of dollars)

	1980	1990	2000	2010	2015
Welfare	\$0.30	\$0.59	\$1.08	\$2.16	\$1.68
Social Security	\$0.13	\$0.25	\$0.42	\$0.76	\$0.88
Medicare	\$0.03	\$0.11	\$0.22	\$0.53	\$0.66
Other	\$0.13	\$0.37	\$0.57	\$0.87	\$1.19
Total Entitlement Spending	\$0.59	\$1.32	\$2.29	\$4.32	\$4.41
GDP	\$2.86	\$5.98	\$10.29	\$14.96	\$17.95
Ratio (spending to GDP)	\$0.207	\$0.220	\$0.223	\$0.288	\$0.246

The aggregate cost of these programs from 1980 to 2015—including local costs, which most analyses do not include—has increased by about 20 percent as a share of GDP. These programs now make up roughly one-fourth of GDP, which means taxpayers collectively must come up with this amount—or borrow the money—every year to cover those costs.

The average annual increase in this ratio has been .5 percent per year on a compounded basis. Continuation of this percentage brings us to roughly 27 percent by 2030.

Many people receive benefits under multiple programs at the same time, which makes it difficult to identify the total number of people receiving benefits or the amount of benefits they receive. We know, for example, that there are some 75 million people on Medicaid at some point during a year. And we know there are some 50 million seniors age 65 and older on Medicare and another 9 million under 65 who are disabled.

However, 6 million seniors on Medicare are considered poor and are also enrolled in Medicaid, creating the potential for double counting. Given the overlaps, trying to divine how many people are receiving benefits is a bit of a guessing game.

The federal government spent about \$2.5 trillion (excluding an allocation of some administrative and interest costs and subtracting Medicare premiums) on entitlement programs in 2017, which is just under 13 percent of the country's \$19.2 trillion GDP. States and local governments spent an additional \$500 billion.

In this case, we are limiting the scope of entitlement programs to Social Security, Medicare, Medicaid and the Children's Health Insurance Program (CHIP), the Affordable Care Act's health insurance subsidies, the Veterans Administration, disproportionate share hospital (DSH) payments, and other means-tested welfare programs such as unemployment, food stamps, housing and energy assistance, etc.

Many countries in Southern Europe and Japan spend even larger percentages of their GDP on entitlements, and have larger net deficits than the U.S. does. The consequence of their largess in these areas has been stagnant if not depressed economies, with some combination of high unemployment, flat or declining living standards, and increasing numbers of those being at or near the poverty line. Obviously, the result was exactly the opposite of what those countries had intended when they created their various entitlement programs.

While U.S. living standards and deficits have fared better than most, the country seems to be on a similar path. One reason for the difference between the U.S. and other countries is

that the U.S. historically has been more concerned about the economic consequences of an expansive entitlement system. Plus, voters generally preferred government-sponsored safety net programs to be small and targeted—a stopgap measure as opposed to a permanent alternative. But that entitlement resistance may be changing, as millions more Americans appear to increasingly embrace entitlements not as a safety net, but as a way of life. Indeed, that shift may be a result of so many people receiving some type of government-provided benefits.

So the U.S., like other developed countries, has become an entitlement state. But while we could have implemented reasonable programs that ensured that seniors and the poor had a viable, actuarially sound safety net that still encouraged work, saving, investment and personal responsibility, Congress refused to do so. Rather, it passed entitlement programs that discourage work, promote dependency, drain federal coffers and are financially unsustainable. And worst of all, our elected federal, state and local politicians, with some notable exceptions, keep trying to apply a Band-Aid to a mortal wound in the hope of postponing the financial day of reckoning.

Chapter 2

The Cost of Entitlement Programs Always Exceeds Projections

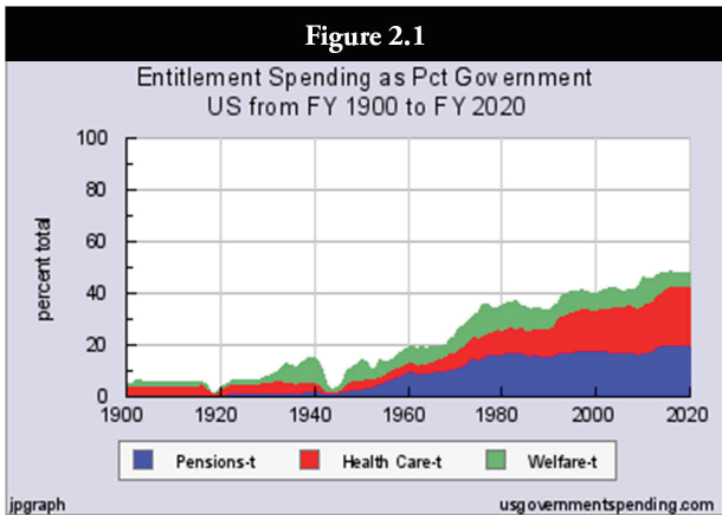
This chapter addresses the real political problem underlying the entitlements cliff: Safety net programs are set up, or later expanded, based on political considerations rather than economics and actuarial science. Politicians have an electoral incentive to overpromise entitlement benefits and underfund the programs. And so elected officials (or political parties) assure the public that they can do an incredibly efficient job of meeting certain needs at a much lower cost than if the private sector did it. However, little if any attention is paid to the side effects of such expansions, particularly to the behavioral response of various populations.

Of course, there is often extensive scrutiny and political debate when a new entitlement program is considered, and so in order to get the program passed proponents are limited in how much they overpromise. Once a program has operated for a while, it is often easier to expand beyond its original purpose. Expansion proponents assure the public that doing so will work out because either the change will cost little or nothing, or costs will be offset by new revenues or eliminating “waste, fraud and abuse.”

Finding a U.S. entitlement program that has remained the same over time is about as difficult as finding one that will be solvent over the long term—and for the same reason.

Entitlement programs are virtually always sold to the public as being necessary, affordable and limited. Since lawmakers nearly always break their promise on the “limited” part and ignore or bury other considerations, the programs soon become unaffordable.

As Figure 2.1 shows, entitlement spending has grown to roughly 50 percent of federal spending, and the spending does not include certain federal expenditures such as veterans health benefits, so this figure is arguably understated. If we include all the costs included in the definition used in Chapter 1, \$2.5 trillion, the result is roughly 61 percent, and this still excludes some administrative and interest costs. Regardless of the definition used, the level will only grow unless Congress takes steps recommended in this book.



Programs Always Expand

As we said, major entitlement programs may begin as focused and limited programs, but politicians and bureaucrats quickly look for ways to expand them, in some cases in ways that have little or no connection to the original purpose of the program.

Social Security Expansion

Social Security was originally sold as a safety net program for low-income seniors who had little or no money for retirement. Initially, the senior had to quit working—that is, actually *retire*—in order to receive any benefits. Of course, life expectancy was much shorter when the legislation passed in 1935—age 58 for men and 62 for women vs. 76.2 for men and 81.1 for women today.² And that increasing life span has certainly added to the cost of the program.

In addition, Congress has also expanded Social Security, and the taxes needed to pay for it, numerous times. Once the basic Social Security legislation passed, Congress and the president, both Republicans and Democrats, saw it as a perpetual Christmas tree where they could keep piling up the presents—while pushing the costs to future generations. For example:³

- In 1939 Congress expanded Social Security to provide benefits for families of deceased workers and for retirees' dependents.

2. Social Security Administration, "Life Expectancy for Social Security," <http://www.ssa.gov/history/lifeexpect.html> and Centers for Disease Control and Prevention, Life Expectancy, <http://www.cdc.gov/nchs/fastats/lifexpec.htm>

3. Social Security, "Detailed Chronology of Social Insurance & Social Security." <https://www.ssa.gov/history/chrono.html>

- President Harry Truman instituted the first Cost of Living Adjustment (COLA) in 1950, which allowed retirement benefits to grow with the cost of living for the first time.
- President Eisenhower in 1956 signed into law benefits for a new, nonelderly group of people: Disabled workers between the ages of 50 to 64. Thus, Social Security was no longer strictly a retirement benefit.
- And in 1972 Richard Nixon provided retirees with a 20 percent benefit increase and signed legislation that made COLAs automatic each year.

Medicare Expansion

The same is true for Medicare, which passed Congress in 1965. In 1972 President Richard Nixon signed into law two major expansions of Medicare: eligibility was extended to people with long-term disabilities (those who had been receiving Social Security Disability Insurance for two years) and to patients with end-stage kidney disease.⁴ There is no natural connection between kidney dialysis and health insurance for seniors, since kidney failure strikes all ages. And yet today Medicare covers about 90 percent of U.S. patients needing dialysis.

In addition:

- Medicare expanded home health services in 1980, and hospice for the terminally ill was added in 1982.
- In 1990 the government expanded Medicare coverage to include mammography and some mental health services;

4. Kaiser Family Foundation, “Medicare Timeline.” <https://www.kff.org/medicare/timeline/medicare-timeline/>

and the Medicaid program was expanded to cover the out-of-pocket costs for low-income seniors on Medicare.

- And in 2003 Congress passed a prescription drug benefit for Medicare beneficiaries.

Medicaid Expansion

Being a federal and state health insurance program for the poor, Medicaid gets expanded from both ends. The program passed in 1965 and gave states considerable flexibility over who and what Medicaid would cover. And to some extent, that is still true today. But almost immediately after passage, Congress began passing laws that mandated states cover certain populations and medical conditions. For example:

- In 1967 Congress required Medicaid to cover Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services for children up to age 21.
- In 1984 under President Ronald Reagan, Congress tied Medicaid to the federal cash assistance welfare program known as Aid to Families with Dependent Children (AFDC). States were required to cover AFDC-eligible, first-time pregnant women and children up to the age of five. The next year Congress expanded the mandate to cover all AFDC-eligible pregnant women.
- By 1990 Congress mandated states cover children ages six through 18 if they were in households making less than 100 percent of the federal poverty level (FPL).
- However, not all expansion attempts have been successful. President Jimmy Carter tried to push through his Child

Health Assessment Program to cover 700,000 children under the age of 6, but Congress didn't pass it.

The biggest federal expansion of Medicaid was included in the Patient Protection and Affordable Care Act (ACA). The law required states to expand coverage for all low-income adults up to 138 percent of FPL. If states refused the expansion, they would lose their entire federal Medicaid matching funds, known as FMAP. Currently, FMAP is much more than a “match” for many states, providing between 50 cents and 75 cents of every Medicaid dollar the state spends.

The ACA dramatically increased the FMAP, covering 100 percent of the costs for the first few years for those newly eligible and enrolled in the program, then gradually declining to 90 percent. In other words, while the federal government was demanding that states increase their Medicaid enrollment—initially projected to be about 16 million more Americans—the feds planned to pay for the lion's share of the cost of expansion.

However, as part of the state-based challenge to the constitutionality of the ACA, the U.S. Supreme Court ruled that Congress exceeded its power in demanding that states accept the expansion or lose all of their Medicaid funding. States can choose to expand; Washington just can't force them to.

Funding Rarely Meets Expanded Outlays

Once entitlement programs are entrenched, politicians start trying to expand them, which costs more money. To address the funding shortfall, they usually either raise taxes or cut benefits, especially for higher-income people. Most often, they

just try to ignore the problem so that future generations will have to deal with it.

Raising Taxes

The Social Security payroll tax began in 1937 and was focused on providing seniors with at least a minimal retirement income. Congress imposed two FICA tax increases in its first 20 years, rising from 1 percent to 2 percent for both employer and employee. The maximum income that could be taxed increased three times, from \$3,000 to \$4,200, during that period. Then Congress created the Disability Insurance (DI) program in 1957, which added 0.25 percent to the payroll tax, creating a combined old age and disability tax of 2.25 percent for both employer and employee.

But it didn't stop there. Over the next decade, the Social Security payroll tax increased four more times and the income cap grew to \$4,800, at which point Congress passed Medicare and added the Hospital Insurance (HI) payroll tax to the Social Security tax. Since the passage of Medicare, Congress has increased the Social Security payroll tax more than 10 times, and the Medicare payroll tax increased seven times, not including the 3.8 percent increase passed by the Affordable Care Act on high-income earners. Plus the cap on taxable income for Social Security has increased significantly—to \$128,700 in 2018. Medicare had the same cap as Social Security for many years, but that was eliminated in 1993, so that there is no cap on the Medicare payroll tax today.

Cutting Benefits

Even as Congress has expanded Social Security benefits, it has cut them for higher-income individuals. In 1983 the Greenspan

Commission, headed by future Federal Reserve Bank Chairman Alan Greenspan, recommended a gradual increase of the Social Security retirement age from 65 to 67.

In addition, Social Security beneficiaries must pay income taxes on part of their Social Security benefits if they make more than \$25,000 for an individual and \$34,000 for a couple. Pushing back the age at which a worker can claim full retirement and taxing benefits are effective cuts in benefits.

More recently, Congress effectively cut Medicare benefits by significantly increasing the amounts higher-income seniors must pay in Part B and Part D premiums.

Numbers Still Don't Add Up

And yet, even with Social Security's multiple tax increases and occasional benefits cuts, revenues have not kept pace with the expected future outlays. Today, the Social Security Trust Fund trustees estimate that the fund will be exhausted by 2034, at which point there will only be enough money to pay beneficiaries about 75 cents on the dollar, declining to 72 cents by 2087.

In projecting Social Security's long-term unfunded liabilities—i.e., what the government owes to current and *future* retirees versus what it expects to receive in payroll taxes—the trustees say in their 2017 annual report, “Through the end of 2092 [i.e., the 75 year projection], the combined funds [OASI and DI] have a present-value unfunded obligation of \$13.1 trillion.”⁵

5. 2018 OASDI Trustees Report
https://www.ssa.gov/oact/TR/2018/II_D_project.html

With respect to Medicare the trustees claim the 75-year unfunded liability of the three programs combined (i.e., Parts A, B and D) is \$48.9 trillion.⁶

Safety Net Expansions Have Unintended Consequences

Expanding safety net programs beyond their initial intent creates a number of other economic problems. For example, Medicare and Medicaid expansions are sometimes paid for by cutting provider reimbursements, which can affect access to a provider. In addition, expanding welfare benefits can have the undesirable effect of discouraging welfare recipients from leaving the program. Those perverse incentives are likely one reason why the labor participation rate was around 62.5 percent in recent years, the lowest since the 1970s. It has only recently begun to grow under the Trump economy.

Ironically, when program changes do not have the desired effect—and they usually don’t—proponents suggest even more rules, regulations or tax increases to fix the previous fixes. And so the complexity, inefficiency and costs grow.

Those demanding fiscal prudence and responsibility are in a no-win situation. When the economy is doing well and entitlement spending is temporarily manageable, the big-spenders argue the country has a moral obligation to expand one or more entitlement programs because “*we can afford it.*” But if the economy is tanking and people are losing their jobs and the entitlement programs are financially struggling to keep up,

6. The 2017 Annual Report of the Board of Trustees of the Federal Hospital Insurance and Federal Medical Insurance Trust Funds, July 13, 2017, p.211. <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2017.pdf>

those same big-spenders argue the programs must be expanded because of the pressing need.

And while they may push for some immediate tax increases to offset some of the additional costs, in almost all cases the real costs are pushed out into the future, leaving taxpayers with trillions of dollars in unfunded future liabilities.

PART II

THE AMERICAN ENTITLEMENTS CLIFF

We use the “cliff” metaphor because people are familiar with, and fear, the prospect of physically falling off a high point and descending rapidly until they hit bottom. It is not an exaggeration to say falling off the entitlements cliff could be devastating financially, both to individuals and the country.

Chapter 3

America Is Approaching an Entitlements Cliff

In this chapter we lay out the financial challenges facing U.S. entitlement programs and show how much these programs are costing taxpayers and why they, as established and funded, reduce employment and economic growth.

The Entitlement Population

Most people think of entitlement programs as Social Security and Medicare for seniors, Medicaid, and perhaps a few other means-tested welfare programs such as food stamps. But there are many more, including veterans benefits, unemployment, the children's health insurance program, disability income, the GI Bill and Head Start. As such, when considering the costs of entitlements, the definition of what is included and excluded is important.

The following table lists the major U.S. entitlement programs, including both means-tested and non-means tested.

U.S. ENTITLEMENT PROGRAMS

(some are only federal, others federal and state)

Major Social Insurance and Means-Tested Programs

- Social Security
- Medicare
- Medicare Prescription Drug Benefit—Low-Income Subsidy
- Medicaid
- Temporary Assistance for Needy Families (TANF) (cash aid)
- Earned Income Tax Credit (refundable component)
- State Children’s Health Insurance Program (CHIP)
- Supplemental Security Income
- Supplemental Nutrition Assistance Program (SNAP)
- Special Supplemental Nutrition Program for Women, Infants and Children (WIC)
- Affordable Care Act Health Insurance Subsidies
- Veterans Health Services and Assistance

Smaller Means-Tested Programs

HEALTH CARE

- Family Planning
- Consolidated Health Centers
- Transitional Cash and Medical Services for Refugees
- Ryan White HIV/AIDS Program
- Breast/Cervical Cancer Early Detection
- Maternal and Child Health Block Grant
- Indian Health Service

FOOD AND NUTRITION ASSISTANCE

- School Breakfast Program (free/reduced price components)
- National School Lunch Program (free/reduced price components)
- Child and Adult Care Food Program (lower-income components)

- Summer Food Service Program
- Commodity Supplemental
- Food Program Nutrition Assistance for Puerto Rico
- The Emergency Food Assistance Program (TEFAP)
- Nutrition Program for the Elderly

EDUCATION

- Indian Education
- Adult Basic Education Grants to States
- Federal Supplemental Educational Opportunity Grant
- Education for the Disadvantaged— Grants to Local Educational Agencies (Title I-A)
- Title I Migrant Education Program
- Higher Education—Institutional Aid and Developing Institutions
- Federal Work-Study
- Federal TRIO Programs
- Federal Pell Grants
- Education for Homeless Children and Youth
- 21st Century Community Learning Centers
- Gaining Early Awareness and Readiness for Undergraduate Programs (GEARUP)
- Reading First and Early Reading First
- Rural Education Achievement Program
- Mathematics and Science Partnerships
- Improving Teacher Quality State Grants
- Academic Competitiveness and Smart Grant Program

HOUSING

- Single-Family Rural Housing Loans
- Rural Rental Assistance Program
- Water and Waste Disposal for Rural Communities
- Public Works and Economic Development
- Supportive Housing for the Elderly
- Supportive Housing for Persons with Disabilities
- Section 8 Project-Based Rental Assistance
- Community Development Block Grants
- Homeless Assistance Grants
- Home Investment Partnerships Program (HOME)

- Housing Opportunities for Persons with AIDS (HOPWA)
- Public Housing
- Indian Housing Block Grants
- Section 8 Housing Choice Vouchers
- Neighborhood Stabilization Program-1
- Grants to States for Low-Income Housing
- Weatherization Assistance Program
- Low-Income Home Energy Assistance Program (LIHEAP)

SOCIAL SERVICES

- Tax Credit Assistance Program
- Additional Child Tax Credit
- Head Start
- Indian Human Services
- Older Americans Act Grants for Supportive Services and Senior Centers
- Older Americans Act Family Caregiver Program
- Child Support Enforcement
- Community Services Block Grant
- Child Care and Development Fund
- Developmental Disabilities Support and Advocacy Grants
- Foster Care
- Adoption Assistance
- Social Services Block Grant
- Chafee Foster Care Independence Program
- Emergency Food and Shelter Program
- Legal Services Corporation
- Social Services and Targeted Assistance for Refugees
- Foster Grandparents

TRAINING

- Community Service Employment for Older Americans
- Workforce Investment Act (WIA) Adult Activities
- Workforce Investment Act (WIA) Youth Activities
- Job Corps

The U.S. Census Bureau says 108 million Americans in 2011 lived in households where at least one person (though there could be several) participates in a means-tested program.⁷ That number grew rapidly under President Obama:

- Medicaid grew from nearly 50 million to 76 million people—and counting;
- Disability beneficiaries increased from 7.5 million to 8.8 million; and
- The food stamp program grew from 32 million Americans to 47 million, though it has since declined to about 38 million.

There is some overlap in these benefit recipients, because many of the poor receive benefits from more than one program. Avoiding double counting is difficult. We estimate that when all means-tested and non-means-tested programs are combined, perhaps 160 million to 170 million—about half the total population—are receiving some type of government-provided benefits.

The Budget Challenge

The budget implications of these programs are enormous. For fiscal year 2017, the federal government spent nearly \$2.5 trillion of its \$3.98 trillion budget on entitlement programs, including administrative costs and roughly \$700 billion for means-tested welfare programs. Add in \$263 billion interest on the federal debt, and benefits for veterans and public health and we have almost \$2.9 trillion, while gross annual revenue was only \$3.3 trillion.

7. Terence P. Jeffrey, “Census Bureau: Means-Tested Gov’t Benefit Recipients Outnumber Full-Time Year-Round Workers,” CNS News, October 24, 2018.
<https://www.cnsnews.com/news/article/terence-p-jeffrey/census-bureau-means-tested-govt-benefit-recipients-outnumber-full>

In other words, under a favorable definition more than 70 percent of total federal revenue goes to paying for entitlement programs and interest on the debt. With a more inclusive definition, the figure is almost 90 percent. And without a strong economy in 2017, these percentages would be even higher.

The State and Local Governments' Role

So far we have only focused on federal entitlement spending, but the states and local governments also play a big role, primarily with means-tested programs.

A few years ago the Congressional Research Service (CRS) released a white paper quantifying total federal welfare spending. The Senate Budget Committee (Republican staff) then added in state (but not local) spending. CRS found that total federal means-tested spending for fiscal year 2011, excluding veterans' programs, was \$746 billion. When state spending was included, total welfare spending increased to \$1.029 trillion.⁸

In 2017 we calculate that states spent nearly \$500 billion on means-tested welfare programs. Adding state to federal means-tested spending brings the total to about \$1.1 trillion, and that's in a strong economy where unemployment is at historic lows.

Who's Going to Pay?

Who is paying for all of those benefits? Not some 70 million children who do not work or have low-paying, part-time jobs. Nor are those 50 million seniors paying much in taxes. Nor are

8. CRS Report: "Welfare Spending the Largest Item in the Federal Budget," U.S. Senate Committee on the Budget, October 18, 2012 <https://www.budget.senate.gov/newsroom/budget-background/crs-report-welfare-spending-the-largest-item-in-the-federal-budget>

low-income workers. According to the Tax Foundation, of the 141 million tax returns in 2015, 50 percent had adjusted gross incomes of \$39,275 or less. The top 50 percent of taxpayers paid 97.2 percent of all income taxes.⁹

The Negative Economic Impact

The federal government faces a serious economic challenge in trying to address this excessive safety net and the resulting shortfalls. Attempting to collect enough money to sustain this level of entitlement spending will only result in a reduction in work effort, reduced employment opportunities, and more people moving onto entitlements. Therefore, if one is concerned with income inequality, the goal should be strong economic growth with a balanced safety net.

Solutions to Meet the Challenge

Here are the three changes that must occur if we are to address the entitlement problem:

Entitlement Spending Must Be Cut

Nearly 70 percent of current federal spending if not more is on entitlement programs. State and local spending is substantially less (15-20 percent), but that excludes pension costs. That level of federal spending is unsustainable, especially since it is approaching total revenues.

9. Erica York, "Summary of the Latest Federal Income Tax Data, 2017 Update," The Tax Foundation, January 17, 2018. <https://taxfoundation.org/summary-federal-income-tax-data-2017/>

Policies That Encourage Economic Growth Must Be Implemented

We cannot return to a sustainable financial path by only cutting benefits, nor should we. We need to grow our way out of the entitlements cliff. But to do that, Congress will have to do a complete 180-degree turn on its spending habits.

Economic growth will increase federal revenue; raising taxes may or may not have the same affect. That is because higher taxes in many cases will (1) encourage people to shelter more of their income to minimize the tax increases; (2) enter the entitlement system (retirement or welfare); or (3) discourage work and investment, further exacerbating problems.

President Trump and Congress took a major pro-growth step when they lowered the corporate and personal income tax rates. And while they made gains in eliminating some of the current tax breaks, simplification did not go far enough.

Several Programs Must Transition to Prefunded Personal Accounts

The private sector has been shifting from defined-benefit retirement plans to defined-contribution plans. That is the best way to provide retirement benefits while eliminating long-term unfunded liabilities for a company. And yet federal, state and local governments have been very reluctant to take that step for government employees. Similarly, Congress has adamantly opposed making that transition for Social Security and Medicare.

We will never solve Social Security and Medicare's long-term unfunded liability problems until we establish a system of prefunded personal accounts that belong to the worker. Any solution that maintains the current defined-benefit

structure—unless it is for a small number of the poorest Americans—is only postponing the inevitable financial day of reckoning.

Chapter 4

The Impending Bankruptcy of Social Security

Congress has passed numerous payroll tax increases over the years in order to shore up Social Security's trust fund, but to no avail—at least not actuarially speaking. The program is in the worst financial shape it has ever been, facing a shrinking workforce and trillions of dollars in unfunded liabilities. President Reagan even appointed a blue-ribbon committee, headed by Alan Greenspan, in the early 1980s to devise a long-term solution to Social Security's financial challenges. The committee came up with a plan, which passed Congress, and yet Social Security's imminent financial shortfalls soon reemerged.

Republicans are pushing to reform Social Security, but most of their proposals only cut benefits. That solution only delays the financial collapse. We briefly outline and discuss the history of the payroll tax and benefit changes, and demonstrate why Congress needs fundamentally to rethink how the country's retirement safety net is funded.

U.S. Retirement Picture

Americans' biggest financial worry is they won't have enough money for retirement. A Gallup poll found that 59 percent of those surveyed were either very or moderately worried they

would run out of funds.¹⁰ Their concern is well placed. Social Security—along with many government-employee retirement plans, especially at the state and local level, and many union pensions—has overpromised benefits and underfunded the system. The result is the large majority of Americans could be in for a rude awakening at some point in the future.

We say the “large majority” because nine out of 10 Americans over the age of 65 participate in Social Security.¹¹ And Social Security is the king of underfunded pension programs; it currently has at least \$32 trillion in unfunded liabilities—that is, money it is obligated to pay but doesn’t, and will not, have the assets to cover.¹²

But isn’t Social Security required to pay retirees what it has promised? No. In 1960 the U.S. Supreme Court ruled in *Fleming v. Nestor* that no one has a private property right to their Social Security check.¹³ “To engraft upon the Social Security system a concept of ‘accrued property rights’ would deprive it of the flexibility and boldness in adjustment to ever changing conditions which it demands,” declared the Court. In other words, Congress can change Social Security’s benefits, or end the program altogether, any time it wants.

10. Andrew Dugan, “Retirement Remains Americans’ Top Financial Worry,” Gallup Economy, April 22, 2014. <http://news.gallup.com/poll/168626/Retirement-Remains-Americans-Top-Financial-Worry.aspx>

11. “Social Security: Fact Sheet,” <https://www.ssa.gov/news/press/factsheets/basicfact-alt.pdf>

12. “The 2017 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Federal Disability Insurance Trust Fund.” P. 4. <https://www.ssa.gov/oact/tr/2017/tr2017.pdf>

13. Social Security Online, Supreme Court Case: Fleming vs. Nestor <https://www.ssa.gov/history/nestor.html>

Of course, there is a big difference between what politicians can do and what they will do. They almost certainly won't just end Social Security, but they could—and have—changed the benefits structure in various ways that reduce benefits for at least some recipients.

The Cato Institute's Michael Tanner has written: "Social Security is not an insurance program at all. It is simply a payroll tax on one side and a welfare program on the other. Your Social Security benefits are always subject to the whim of 535 politicians in Washington. Congress has cut Social Security benefits in the past and is likely to do so in the future. In fact, given Social Security's financial crisis, benefit cuts are almost inevitable. Several proposals to cut benefits, from increasing the retirement age to means testing, are already being debated."¹⁴

We wouldn't go so far as to call Social Security "welfare" as Tanner has done. Workers pay their Social Security payroll taxes, usually for decades, before retiring, whereupon they can get at least some of that money back. Social Security has no asset test and a very limited income test—i.e., benefits are taxed. But Tanner's point is essentially correct: Social Security is a pay-as-you-go system. The payroll taxes received go right back out to pay current retirees' benefits—if there are enough funds.

Indeed, the Social Security trustees—a bipartisan group of economists and others who monitor the program and publish an annual report on its financial status—have for years been warning that they expect the trust fund to have only enough funds on hand to pay full benefits until around 2034.

14. Michael D. Tanner, "Is There a Right to Social Security?" Cato Institute, November 25, 1998. <http://www.cato.org/publications/commentary/is-there-right-social-security>

After that Social Security will only be able pay about 75 cents on the dollar. Of course, several things could, and probably will, change between now and then. A much stronger economy could lead to more payroll tax money going into the system, which could postpone that date, but a weaker economy could have the opposite effect.

And Congress might pass legislation that could either enhance the program's finances or hurt them. For example, Congress passed legislation effective in 2011-12 that lowered the employees' portion of the payroll tax by 2 percentage points, from 6.2 percent of their income to 4.2 percent. That change reduced the amount of money going into Social Security, which, other things being equal, worsened the program's financial standing.

Urban Institute tax economist Eugene Steuerle estimates that a married couple, both of whom made the average income (\$47,800 in 2015 dollars per his estimate) who turn 65 and retire in 2030 will pay in about \$834,000 in payroll taxes over their working careers and receive \$1.35 million in benefits from the two programs (\$731,000 from Social Security and \$621,000 from Medicare).

If there is only one worker in the family, the taxes paid are significantly less, but the benefits received are only a little less, since one eligible spouse qualifies both for benefits. Steuerle estimates that a one-earner family making the average wage will pay in \$416,000, but receive \$1.2 million in benefits (\$586,000 for Social Security and \$621,000 for Medicare).

Thus, a working couple with both making the average income retiring in 2030 can expect to net about \$516,000 more in

benefits than they pay in payroll taxes. And a one-earner couple would receive \$784,000 more.¹⁵

The point is that Social Security might be there when you retire—if you haven't already—or it might not.

Social Security Faces the Fiscal Cliff

The Social Security program, as it currently exists, exhibits many of the problems with government-created entitlement programs. Congress has:

- Expanded the program's reach to cover more people than initially intended.
- Increased funding over the years, but not by enough to solve its long-term fiscal shortfalls.
- Implemented a financing shell game (e.g., the Social Security Trust Fund) that allows defenders to claim it is more fiscally sound than it really is.
- Created a program popular enough that few, if any, politicians are willing to attempt anything besides tweaking the program at the edges and thus let it continue its financial death spiral.

And because the program is so large—\$922 billion paid in total benefits in 2017—fiscal mismanagement can have outsized effects on the federal budget.

15. C. Eugene Steuerle and Caleb Quakenbush, "Social Security and Medicare Lifetime Benefits and Taxes," Urban Institute, September 2015. https://www.urban.org/research/publication/social-security-and-medicare-lifetime-benefits-and-taxes/view/full_report

Tax Rates as a Percent of Taxable Income

Calendar Year	Rate for Employees and Employers, Each		
	OASDI	HI	Total
1937-49	1.000	--	1.00
1950	1.500	--	1.500
1951-53	1.500	--	1.500
1954-56	2.000	--	2.000
1957-58	2.250	--	2.250
1959	2.500	--	2.500
1960-61	3.000	--	3.000
1962	3.125	--	3.125
1963-65	3.625	--	3.625
1966	3.850	0.350	4.200
1967	3.900	0.500	4.400
1968	3.800	0.600	4.400
1969-70	4.200	0.600	4.800
1971-72	4.600	0.600	5.200
1973	4.850	1.000	5.850
1974-77	4.950	0.900	5.850
1978	5.050	1.000	6.050
1979-80	5.080	1.050	6.130
1981	5.350	1.300	6.650
1982-83	5.400	1.300	6.700
1984	5.700	1.300	7.000
1985	5.700	1.350	7.050
1986-87	5.700	1.450	7.150
1988-89	6.060	1.450	7.510
1990 and later	6.200	1.450	7.650

Source: Social Security Administration

As the table shows, Congress has increased payroll tax rates numerous times, and the total income it applies to has increased from \$3,000 in 1937 to \$128,400 in 2018. And yet despite the payroll tax rate and taxable-income increases, Social Security is in dire financial condition.

Financial Shell Game

However, it's much worse than the \$32 trillion that Social Security's trustees admit to. That's because they include in their calculations Social Security's Trust Fund, which reportedly holds about \$2.9 trillion. But does that trust fund represent real assets, or is it, as many critics have claimed, little more than a Ponzi scheme?

The Ponzi scheme is named after convicted money swindler Charles Ponzi, whose investment schemes in the 1920s made him millions—until it all collapsed, costing others millions. The federal government's Security and Exchange Commission helpfully explains the scam:

A Ponzi scheme is an investment fraud that involves the payment of purported returns to existing investors from funds contributed by new investors. Ponzi scheme organizers often solicit new investors by promising to invest funds in opportunities claimed to generate high returns with little or no risk. In many Ponzi schemes, the fraudsters focus on attracting new money to make promised payments to earlier-stage investors and to use for personal expenses, instead of engaging in any legitimate investment activity...With little or no legitimate earnings, the schemes require a consistent flow of money from new investors to continue. Ponzi schemes tend to collapse when it becomes difficult to recruit new investors or when a large number of investors ask to cash out.¹⁶

16. "Ponzi Schemes," U.S. Securities and Exchange Commission.<https://www.sec.gov/fast-answers/answersponzihtm.html>

The scheme can work only as long as more and more people pay into the system, or until the public knows the truth. Early investors can make out like bandits, while the later investors are robbed.

That's pretty much how Social Security works. Of course, unlike Ponzi, Social Security doesn't have to "solicit new investors"; federal law requires the vast majority of Americans to be an "investor." But even that won't save the system. Fewer workers are paying in as the baby boomers retire, demanding their retirement benefits. There were some 16 workers per beneficiary in 1950; Social Security claims there will only be about 2.6 full-time workers by 2020.¹⁷

And though the Social Security Administration doesn't promise high returns—one of Ponzi's major schemes promised a 50 percent return after 45 days—it does promise little or no risk. Well, sort of.

The agency sends regular statements to workers reviewing their income history and projecting their expected monthly benefits at retirement. This scenario sounds pretty safe and secure—except for the asterisks highlighting the fine print, which reads: "Your estimated benefits are based on current law. Congress has made changes to the law in the past and can do so at any time. The law covering benefit amounts may change because, by 2034, the payroll taxes collected will be enough only to pay about 75 percent of scheduled benefits."

17. Gayle L. Reznik, Dave Shoffner, and David A. Weaver, "Coping with Demographic Challenge: Fewer Children and Living Longer," *Social Security Bulletin*, Vol. 66, No. 4, 2005-06. <https://www.ssa.gov/policy/docs/ssb/v66n4/v66n4p37.html>

How many people would open a retirement savings account in a bank that told them they might only receive 75 cents for every dollar they invested?

Now look at that SEC definition of fraudsters taking investors' contributions "to use for personal expenses, instead of engaging in any legitimate investment activity." Arguably, that is exactly what Social Security does.

The federal government borrows the money credited to the Social Security Trust Fund—that \$2.9 trillion—and uses it to pay current government expenses, similar to the Ponzi scheme. It does not "engage in any legitimate investment activity," as most people would define that term, because when the government borrows money from Social Security, it gives the trust fund an IOU, complete with interest—3.154 percent in 2016. But those IOUs, referred to as "Specials," are not negotiable in the marketplace as are most "legitimate investments." When the government needs to draw down on those notes the money to pay the trust fund debts must come from borrowing or new taxes. The federal government has no extra assets sitting in an account. Indeed, it has to borrow hundreds of billions of dollars just to pay its current expenses.

Yes, Social Security deposits are guaranteed by the "full faith and credit of the federal government," though currently it may be fair to say that there's more faith than credit. Investors also had faith in Charles Ponzi, in part because of positive press defending his actions and his company. Plus, early skeptics were criticized for raising concerns. Sound familiar?

And, yes, there are real differences between a Ponzi scheme and Social Security:

- Ponzi schemes don't rely on tax dollars, Social Security does.
- Ponzi schemes are voluntary, Social Security isn't.
- Ponzi schemes are illegal, Social Security isn't.

Reasonable people claim that the current Social Security structure is different and better than a Ponzi scheme because the federal government stands behind the promises. But claiming that it has worked for millions of Americans in the past begs the more important question: Is it going to work in the future? The Social Security Administration makes clear that it reserves the right to default on those promises. And if it does, we'll see one more difference between Social Security and Charles Ponzi: No politician who defended Social Security will ever go to jail.

Political Unwillingness to Fix Social Security

All of these problems are fixable if there were the political will to do it. To date there hasn't been, or at least not enough of it.

President George W. Bush took a halfhearted and poorly planned stab at real reform in 2005 and Democrats beat him and Republicans over the head with it. Bush and company largely avoided defending the benefits of people having their own personal accounts apart from the government. Nor did they discuss how the federal budget would be affected over time by such a change, including changes needed in accounting provisions. Rather, the administration talked mostly about Social Security's financial troubles and the need to cut benefits and make changes to the annual Cost of Living Adjustments.

And, by the way, people could have private accounts. In short, Bush emphasized the pain and minimized the gain (i.e., the personal wealth created by a lifetime of investing), and Democrats made the most of it.

Chapter 5

The Impending Pension Crisis

And it's not just Social Security. Many public sector pensions at the state and local government levels have also shunned sound actuarial principles in their defined-benefit pension plans. Many assumed unrealistically high returns on their investments and then did not contribute additional funds when it became clear their plans were underfunded. As a result, state and local pensions face a cumulative unfunded liability of an estimated \$6 trillion—with some states and cities in much worse shape than others.¹⁸

Private Sector Pensions

For discussion purposes we'll divide private sector pensions into two groups: Those that function like traditional defined-benefit plans versus the defined-contribution plans that have become the primary retirement-plan vehicle over the past few decades.

American Express created the first pension plan in the U.S. in 1875. By 1899 there were 13 such plans in the country. The pension effort got a boost in 1913 when the Sixteenth

18. "Unaccountable and Unaffordable 2017," American Legislative Exchange Council, December 2017. https://www.alec.org/app/uploads/2017/12/2017-Unaccountable-and-Unaffordable-FINAL_DEC_WEB.pdf

Amendment created the federal income tax, which allowed businesses to deduct pension contributions as a business expense. Even so, by 1940 only 15 percent of all workers were part of a pension plan, which is one of the reasons why President Franklin Roosevelt pushed for a federal retirement program—Social Security, which passed in 1935 but didn't start paying retirees until 1940. Ida May Fuller received the first monthly check, for \$22.54.

However, World War II provided a significant boost to employer-provided private sector pensions, just as it did health insurance. When the federal government imposed a wage freeze to control wartime inflation, employers started offering pensions and health insurance in an effort to attract and keep good workers. In 1943, the War Time Labor Board ruled that fringe benefits were not subject to the wage freeze, and thus began the U.S. employer-based health insurance and retirement systems. By 1950, 25 percent of all workers were covered by an employer pension plan; by 1960 that figure was up to 41 percent, and 45 percent by 1970.

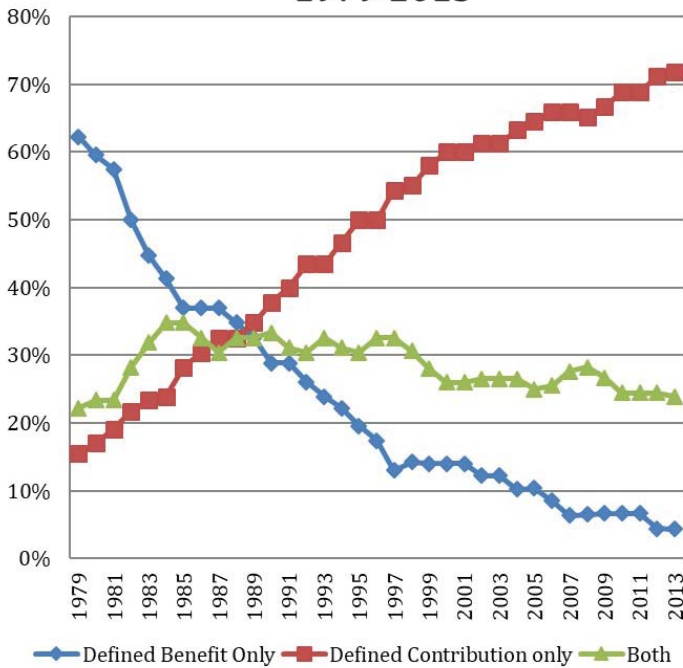
Federal pension law took a major step forward with the Employee Retirement Income Security Act (ERISA) of 1974, which established a number of pension plan rules to ensure they were properly monitored and funded. Congress has continued to make incremental changes to the private sector pension system over the years, but the defined-benefit plan that was the hallmark of the private pension system has steadily declined as more and more companies have transitioned to defined-contribution plans.

The two primary defined-contribution plans are the 401(k) and the IRA. Congress created the 401(k) in 1978, but it sat

largely unnoticed until an investment advisor realized it could be a new and important tool for workers to set aside tax-deferred money into a private account. Today the 401(k)—along with its nonprofit-organization equivalent, the 403(b)—has become the primary vehicle for private sector employer-based retirement plans.

Figure 5.1

**Percentage of
Private-Sector Workers
by Type of Private Pension Plan,
1979-2013**



According to the Employee Benefit Research Institute (EBRI), in 1979 fully 62 percent of private sector workers who participated in only one employer-provided pension were in defined-benefit plans, while only 16 percent had a defined-contribution plan. Another 22 percent participated in both. By 2011, 69 percent had defined-contribution plans vs. 7 percent who had only a defined-benefit plan—more than reversing their previous positions—and 24 percent had both. (see Figure 5.1)¹⁹

While the invention of the 401(k) was big, the invention of the individual retirement account (IRA) was even bigger. Congress created tax-deferred IRAs as part of the 1974 ERISA law. People wanted a retirement option that was not dependent on the financial health of their employer—and they still do.

However, Congress seemed to think it fixed pension-plan problems with its ERISA reforms and so restricted the original IRAs, which had a \$1,500 contribution limit, to workers who did not have an employer-provided pension. That changed in 1981 under President Reagan's Economic Recovery Tax Act, which allowed all workers up to age 70½ to contribute up to \$2,000 tax-deferred for themselves and \$250 for a spouse. There have been several adjustments to IRA regulations since then, some better some worse, but IRAs have become an indispensable part of the retirement landscape. About 42.5 million Americans kept about \$7.5 trillion in their IRAs in 2016.²⁰

19. "U.S. Retirement Trends Over the Past Quarter-Century," Fast Facts from EBRI, June 21, 2007. (EBRI had more recent data, but that apparently is no longer publicly available.) https://www.ebri.org/docs/default-source/fast-facts/fastfact_56_retrnds_21june07.pdf?sfvrsn=30c5372f_2

20. "The Role of IRAs in US Households' Saving and Retirement, 2016," Investment Company Institute, ICI Research Perspective, January 2017. <https://www.ici.org/pdf/per23-01.pdf>

Table 5.2 Biggest Pension Failures

Firm and Year Terminated	Total Claims (Billion)	Vested Participants	Average Claim Per Participant
1. United Airways (2005)	\$7.3	122,541	\$59,217
2. Bethlehem Steel (2003)	\$3.7	91,312	\$40,021
3. US Airways (2003,2005)	\$2.7	55,770	\$48,412
4. LTV Steel (2002,2003,2004)	\$2.1	83,094	\$25,694
5. Delta Air Lines (2006)	\$1.7	13,028	\$133,533
6. National Steel (2003)	\$1.3	33,737	\$37,811
7. Pan American Air (1991,1992)	\$0.8	31,999	\$26,285
8. Trans World Airlines (2001)	\$0.7	32,236	\$20,717
9. Weirton Steel (2004)	\$0.6	9,410	\$68,064
10. Kaiser Aluminum (2004,2007)	\$0.6	17,727	\$33,694
Top 10 total	\$22	490,881	\$43,816
All other total	\$13	1,097,767	\$12,155
Source: Emily Brandon, "The 10 Biggest Pension Failures," <i>U.S. News & World Report</i> , Sept., 2009. https://money.usnews.com/money/blogs/planning-to-retire/2009/09/04/the-10-biggest-pension-failures			

But the most important element of 401(k) and IRA plans is that they are prefunded. When employers make a contribution to their employees' 401(k)s, they are expensed immediately

and there is no long-term obligation for the company. In good years, companies contributing to their employees' 401(k)s may choose to give more; in lean years they may give less—or nothing at all if it's a really tough year. And, since the money goes into the employees' account, if the company fails employees still have their retirement money independent of the company's survival. Table 5.2 identifies some of the massive private sector pension failures.

There is a government safety net for private pensions, the Pension Benefit Guaranty Corporation (PBGC), created as part of the 1974 ERISA law. Similar to the way the Federal Deposit Insurance Corporation (FDIC) guarantees bank deposits, the PBGC guarantees pension plan benefits up to a limit. Those costs are covered by employer-paid premiums. If a bank or pension fails, the federal agency steps in to pay, subject to certain limits and restrictions.

In the case of banks, the program has worked reasonably well. For pensioners, particularly for larger multi-employer plans backed by strong constituencies, the results have not been good. It seems that the same government that has so much trouble establishing actuarially sound entitlement programs has trouble establishing an actuarially sound pension-program safety net, too.

The PBGC's June 2014 financial report highlighted some of the problems.

Despite substantial economic and market gains, multiemployer pension plans covering about 1.5 million people are severely underfunded, threatening benefit cuts for current and future retirees. By comparison, the financial situation

for private single-employer plans, which cover about 30 million participants, is projected to improve.

According to the report:

The financial condition of PBGC's insurance program for single-employer plans is likely to improve over the next decade. Under current estimates, the FY 2013 deficit of \$27.4 billion is projected to narrow to, on average, \$7.6 billion by FY 2023. It is highly unlikely that the single-employer program will run out of funds in the next 10 years.²¹

While it is true that the PBGC was hit hard by the 2007 recession, with multiple pension-plan failures, that is exactly when a safety-net program should be able to meet pensioners' needs. Virtually anyone could set up a safety net that performs well in good economic times and is only occasionally called on to bailout some pensioners. The real actuarial challenge—the one that politicians seem so reluctant to embrace—is a system that survives when an economic downturn hits, which is when it is most needed.

If the U.S. economy were to enter a sustained period of strong growth —e.g., in the 3 percent to 4 percent range or better—the PBGC's funds could become more financially secure. If the country were to enter another recession in the near future—always a possibility—the PBGC might fail. Failure would mean Congress coming to its financial rescue or pensioners would simply get less than they are qualified to receive under current standards.

21. "PBGC Report Shows Improvement in Single-Employer Plans, but Underscores Increased Risks to Some Multiemployer Plans," Pension Benefit and Guaranty Corporation, June 30, 2014. <http://www.pbgc.gov/news/press/releases/pr14-08.html>

So while we can say that the private sector pension system has performed better than public sector pensions, private sector defined-benefit pensions still struggle with unrealistic actuarial assumptions. And companies still fail, especially in economic downturns, putting their employees' pensions at risk. Plus, those long-term obligations can put a crimp in a company's stock price, because it isn't always easy to know how big a role those unfunded obligations will play in the future. That's why so many companies have shifted to defined-contribution pension plans, and why the federal, state and local governments should do the same.

Public Sector Pensions

Private sector defined-benefit pension plans may be facing financial challenges, but those pale in comparison to public sector pensions, such as state and local pension plans. A recent analysis puts total unfunded liabilities for state pension plans at \$6 trillion.²²

One reason is that public sector unions are wedded to the defined-benefit approach, and have continually fought efforts to replace them with defined-contribution plans.²³

And those unions push unrealistic accounting methods that exacerbate the problems. For example, most actuaries now think that plans should estimate annual asset growth in the 3

22. American Legislative Exchange Council, "Unaccountable and Unaffordable," Dec. 2017. https://www.alec.org/app/uploads/2017/12/2017-Unaccountable-and-Unaffordable-FINAL_DEC_WEB.pdf

23. Though unions seem willing to allow 401(k) plans as an add-on to the defined-benefit plan, they strongly resist replacing defined-benefit plans.

percent to 6 percent range, rather than the 7 percent to 8 percent that was used in the 1990s and 2000s. But attempts to make that change usually result in strong union resistance. If the pension plan assumes, say, 7 percent annual growth from interest and investments, it will need to take less money from workers or the employer (in this case state or local government) in order to be financially sound. But that is only if the government makes its pension contributions. During the economic downturn, many state and local governments simply did not make their required contributions to their pension plans.

Thus, the unions have a vested financial interest in pushing for higher assumed gains because their members will theoretically have more money in their pockets. And if the pension plans assume wrong, the unions believe they can fall back on political pressure to get the government to bail them out—and they might be right.

But there has been pushback. Many state and local governments recognize that pension and health care retirement benefits are sucking up a growing share of their revenue. The New York Times points out: “More than 40 states have taken steps in recent years to rein in mounting public employee pension costs that threaten to strangle government services. But pension experts say that while some of those overhauls have whittled state shortfalls, even drawing upgrades from bond-rating agencies, many of them have simply deferred pension costs to the future.”²⁴

Some state and local governments are trying to pass some of those costs on to union workers, whereupon the unions claim

24. Lyman and Walsh, “Public Pension Tabs Multiply as States Defer Costs and Hard Choices,” New York Times, February 24, 2014.

the government is engaged in “union busting” and trying to hurt working families. Others may try to raise taxes to cover part of the shortfall, but none of the options are particularly attractive to state and local politicians who have staked their careers on essentially buying public sector employees’ votes.

Financial Perspective

Public sector pension plans, in general, are in much worse shape financially than most private sector plans, which these days are overwhelmingly defined-contribution plans. Many states are facing unfunded liabilities far beyond anything they can cover without dramatic changes. For example, according to the American Legislative Exchange Council, Connecticut’s unfunded pension liability in 2017 was \$248 billion, New Jersey’s was \$249 billion, Illinois’s was \$388 billion and California’s was \$988 billion—almost \$1 trillion.²⁵ These shortfalls are nothing less than financial malpractice. And the only positive thing we can say is, they aren’t as bad as Social Security.

25. American Legislative Exchange Council, “Unaccountable and Unaffordable,” Dec. 2017. *ibid*

Chapter 6

The Welfare Debacle

If poverty still exists in the U.S.—and it does—it’s not for lack of spending money. The federal and state governments have spent more than \$22 trillion on anti-poverty programs since the War on Poverty began 50 years ago, according to a 2014 Heritage Foundation report, and poverty is still very much with us.²⁶ We estimate that an updated figure is around \$29 trillion. And that doesn’t include local welfare spending.

What have we gotten for it? The poverty rate was already declining when Congress declared the War on Poverty. As Figure 6.1 shows, it has fluctuated between 11 percent and 15 percent for 50 years, and stands at about 12.7 percent in 2016.²⁷

U.S. Welfare History

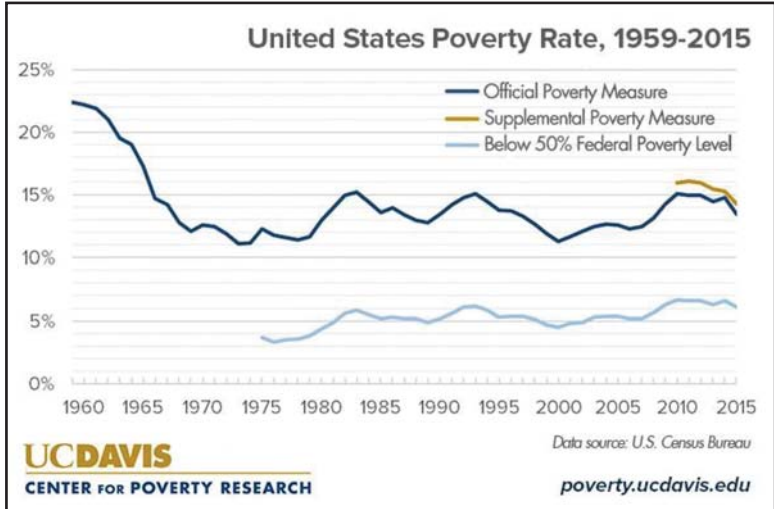
Early welfare in the U.S. was primarily based on local government efforts and private charities. During the Progressive Era, several states became more involved. By the mid-1920s, 40 states had established some “public relief” programs to help mothers and children, but these were small and contained. It

26. Robert Rector and Randy Sheffield, “The War on Poverty After 50 Years,” The Heritage Foundation Backgrounder, No. 2955, September 15, 2014. http://thf_media.s3.amazonaws.com/2014/pdf/BG2955.pdf

27. U.S. Census Bureau, Income, Poverty and Health Insurance Coverage in the United States: 2016, Release Number: CB17-156, September 12, 2017. <https://www.census.gov/newsroom/press-releases/2017/income-poverty.html>

wasn't until the Great Depression that the federal government became heavily involved in relief efforts.

Figure 6.1



Both Presidents Herbert Hoover and Franklin D. Roosevelt passed legislation that provided money to the states for public relief. And the Social Security Act of 1935 included funds to be distributed to the states to help the aged, mothers and children, and the blind. But the biggest federal effort to address the problems of the poor came with President Johnson's War on Poverty.

Welfare for Families and Children in Need

We focus on three subdivisions: food-assistance programs such as food stamps (SNAP) and student lunch and breakfast programs, various types of social services, and energy assistance. These programs, with the exception of energy assistance, existed in 1960 or earlier, but were very small and were

generally available on an extremely limited basis to those with severe needs.

The number of people on these programs has grown substantially, and many people move in and out and may be receiving benefits from a number of them at any one point in time.

A quick look at SNAP tells quite a story. Note in Table 6.1, the large participation increase in 1980, a result of President Jimmy Carter’s poor economic policies that led to high unemployment and grotesquely high inflation. In 1990, the number was slightly lower than in 1980, but there was no return to anything close to ‘70s levels. Meanwhile, the average benefit had increased substantially.

	1970	1980	1990	2000	2005	2010	2014
Participation (millions)	4.3	21.1	20	17.2	25.6	40.3	46.5
Average Benefit (annual)	\$127	\$414	\$701	\$871	\$1,115	\$1,605	\$1,504
Cost (billions)	\$0.55	\$8.7	\$14.1	\$15.0	\$28.6	\$64.7	\$70.0

A primary reason for the 2000 participation decline was the 1996 welfare reform legislation, which imposed a work provision on most Temporary Assistance for Needy Families (TANF) recipients. Of course, the economy also took off in the late 1990s, fueled by the dot-com bubble, which eventually popped. But it highlights an important point: A growing

economy will create jobs for marginal and displaced workers. The best way to ensure that safety nets are temporary is to embrace policies that promote economic growth.

But look at the change beginning in the early 2000s. Policy-makers at the state and local level were slowly undermining the welfare reforms of the 1990s. Participation went up and so did the average benefit.

Of course, there were two recessions in the 2000s, from March to November 2001, and from December 2007 to June 2009. Typically, the number of welfare recipients goes up during recessions, and that was true in both of these cases. But when the recovery began, the number of beneficiaries and the related costs should have decreased; they didn't. Both remained much higher for much longer than normal, and have only recently begun to decline.

	1960	1970	1980	1990	2000	2010	2015
Federal	\$1	\$1	\$21	\$40	\$60	\$178	\$187
State	\$2	\$6	\$19	\$41	\$42	\$61	\$58
Local	\$2	\$6	\$13	\$23	\$30	\$43	\$40
Total	\$5	\$13	\$53	\$104	\$132	\$282	\$285

The chart above shows estimated costs for selected years between 1960 and 2015 for total federal, state and local expenditures for all of the family and children categories combined. The SNAP program is just one part of this package, albeit the largest part. The small increase in federal spending from 2010 to 2015 might seem encouraging, but remember the economy

was in much better shape in 2015 than in 2010, so it should have declined.

Welfare Related to Unemployment

This category includes two subdivisions: Cash payments and tax credits for people with very low incomes, with many people receiving benefits under multiple programs. These beneficiaries may also receive employment training. However, weekly unemployment insurance payments are not included (unemployment insurance is a separate program funded by employer contributions).

The cash payment programs are made under TANF. Tax credits include the Earned Income Tax Credit [EITC] and child tax credit for those with qualifying income levels. Payments under these programs are generally quite modest, although like other programs they have increased over time.

The largest program under this unemployment category is Supplemental Security Income (SSI). It was initiated in 1972 to replace a patchwork of programs that provided income to supplement low-income individuals, primarily those receiving Social Security benefits. As such, in the mid-1970s more than 50 percent of the roughly 4 million receiving benefits were elderly with very few children. Those under age 65 were generally disabled and largely unable to work. Today, the number of people on the program has doubled, to more than 8 million, with more than 50 percent of those receiving benefits under age 65. Thus, the program has in essence recreated the patchwork it was intended to replace by overlapping with many of the under-age-65 programs. (see Table 6.3)

Table 6.3
Supplemental Security Income
Participation and Costs

	1980	1990	2000	2010	2015
Number. of Recipients (millions)	3.8	4.20	6.2	8.0	8.2
Average Benefit (annual)	\$2,400	\$2,100	\$5,300	\$7,100	\$6,500
Cost (billions)	\$9	\$20	\$33	\$57	\$53

Because the SSI benefit is a graded benefit it will tend to go down when the economy is improving, as it did in 2015.

Table 6.4
Unemployment Welfare Costs
(federal and state, in billions)

	1960	1970	1980	1990	2000	2010	2015
Federal	\$1	\$2	\$17	\$15	\$18	\$151	\$118
State	\$2	\$3	\$12	\$15	\$23	\$144	\$110
Total	\$3	\$5	\$29	\$30	\$41	\$295	\$228

As Table 6.4 highlights, the large increase in costs in 2010 was a result of the deep recession that began in late 2007. The cost of these programs has now come down.

Health-Related Welfare

Health-related welfare programs encompass a wide variety of benefits, including acute services for the poor and disabled

individuals, chronic services for long term care and conditions requiring expensive drug protocols.

In 1960, only a few programs existed in this category, and the country spent a total of around \$6 billion on them. But Medicaid was introduced in 1965 and a dramatic expansion ensued. Then came the Affordable Care Act (ACA), which further expanded Medicaid, so that by 2017, costs for the federal and state portions reached about \$650 billion for Medicaid, the Children's Health Insurance Program, and some selected ACA subsidies.

Medicaid has three major categories: (1) health insurance, which used to be largely restricted to poor mothers and children, but which the ACA expanded to include poor males and women who were not mothers; (2) cash payments for the disabled poor; and (3) long term care services for the poor living in nursing homes and assisted living centers.

When people think of Medicaid, they tend to think only of the health insurance portion for women and children. But prior to passage of the ACA, a little less than 30 percent of the Medicaid budget paid for the acute care health insurance portion; a little more than 30 percent provided for disabled; and around 40 percent of the Medicaid budget went towards long term care. So while the large majority of Medicaid beneficiaries were mothers and children receiving health coverage, they used less than a third of the money, while the smaller number of disabled and long term care beneficiaries accounted for about 70 percent of Medicaid funds.

Of the three categories, long term care costs grew most rapidly. However, ACA expansion is changing those dynamics.

The increase in costs has been a result of a rapid expansion in Medicaid eligibility and benefit packages for the under-age-65 population. Below are the data by selected years showing enrollment, average cost, and total cost. Within these numbers, long term care enrollment has been around 2 million and increasing slowly, so that most of the increase in costs from 2010 to 2015 has been due to enrollment in acute and disabled populations.

Table 6.5
Medicaid Participation and Cost

	1970	1980	1990	2000	2010	2015
No. of Recipients (millions)	14.0	19.6	22.9	34.5	54.6	67
Average Benefit (annual)	\$470	\$1,170	\$3,540	\$4,810	\$7,600	\$8,955
Cost (billions)	\$3	\$23	\$81	\$166	\$415	\$600
<i>Values rounded to nearest million for recipients and billions for costs.</i>						

The average annual cost of long term care is approaching \$90,000 per recipient. By contrast, disabled care costs are approaching \$20,000 per year per beneficiary and acute services are in the neighborhood of \$4,000.

Table 6.6 shows costs in mostly 10-year increments from 1960 to 2015 for federal, state, local, and total expenditures for all health care welfare costs, including Medicaid.

Table 6.6
Health Care Welfare Costs (in billions)

	1960	1970	1980	1990	2000	2010	2015
Federal	\$2	\$ 6	\$22	\$ 56	\$147	\$306	\$344
State	\$2	\$ 6	\$20	\$ 46	\$119	\$212	\$275
Local	\$2	\$ 4	\$12	\$ 23	\$ 39	\$ 63	\$ 75
Total	\$6	\$16	\$54	\$125	\$305	\$581	\$694

In summary, health-related welfare programs have clearly become the largest of all and are out of control. Their development has followed the pattern typical of these programs: Gradual and continual expansion, overlap in many programs, poor incentive structures, and basic non-application of actuarial principles that should underpin such programs. Hence, they too are financially unsustainable.

Housing-Related Welfare

The housing category includes 17 separate programs of which the largest are the Section 8 Vouchers, Section 8 Rental Assistance, and Public Housing. All of the programs in this category are quite small compared to the largest programs in the prior three categories.

Based on data we have found, the approximate breakdown of participants and costs across all housing categories for 1980 to 2015 are as follows:

Table 6.7
Subsidized Housing*

	1980	1990	2000	2010	2015
Number of Recipients (millions)	4.3	5.5	8.2	11.3	11.5
Average Benefit (annual)	\$3,000	\$4,000	\$5,000	\$7,500	\$7,800
Cost (billions)	\$13	\$22	\$41	\$85	\$90
<i>*Rounded, rough estimates based on various data sources.</i>					

The increase in average benefit appears to be a little less than the cost-of-living estimates from Social Security. As such, the increase in this category appears to be derived from an expansion of programs along with population growth. For example, during the period 1980 to 2015, the U.S. population increased only 42 percent, whereas the number of recipients has increased by 167 percent.

Table 6.8 shows costs for selected years from 1960 to 2015 for federal, state and local total housing expenditures.

Table 6.8
Housing Welfare Costs (billions)

	1960	1970	1980	1990	2000	2010	2015
Federal		\$1	\$6	\$8	\$19	\$38	\$50
State			\$1	\$2	\$3	\$10	\$10
Local	\$1	\$2	\$6	\$12	\$20	\$37	\$30
Total	\$1	\$3	\$13	\$22	\$41	\$85	\$90

While left-leaning critics, such as Senator Bernie Sanders, claim the country needs to spend more on welfare, we believe these numbers demonstrate we already spend a lot. The real challenge is how we can achieve better results for less money.

Chapter 7

The Health Care Debacle

Health care is a perfect example of our theme. The federal government first became heavily involved in health care in 1965, with the passage of Medicare and Medicaid. Actual spending quickly exceeded projections, and the government eventually had to try and slow that pace by imposing price controls on both programs, which predictably didn't work. But even as spending exploded, Congress expanded the programs to cover more people.

As a result, Medicare is in much worse financial shape than Social Security, and Medicaid consumes an ever-expanding percentage of federal and state budgets. And even though health care spending growth has been so rapid that the country is financially straining to cover the costs, many households face serious treatment challenges and financial hardships, which have pushed millions into bankruptcy.

But Washington didn't learn its lesson. In passing the Affordable Care Act, Democrats in Congress went to extreme budget shenanigans in order to claim the program was fully funded, even though almost everyone recognized the problems.

Although the 20th century began with very low health care costs (less than 2 percent of GDP), and costs remained low until roughly half way through, health care is quickly approaching a crossroad of unaffordability from both a

personal and government perspective. Until about mid-century, individuals or their families paid largely if not entirely out of pocket (OOP) for the care they received. But by the end of the century, a third party paid almost all of the costs.

The transition from OOP to third-party payment initiated an explosion in health care spending, far above the additional costs imposed by new technology and procedures. And as health care costs grew, people demanded even more comprehensive health coverage to insulate them from the rising costs. That trend of increasing coverage led to a health care entitlement mentality in which most Americans increasingly think they should be able to walk into any doctor's office, hospital or pharmacy and someone else should pay most, if not all, of the bill.

The Affordable Care Act exacerbated that mentality by creating a new health care entitlement for millions more Americans. And it demonstrated that all of those politicians who pledged the ACA would lower costs had no idea what they were saying.

The Early History of Health Insurance

Prior to 1930, there was little health insurance in the United States, along with very little medical technology. Government health care expenditures were small, but so were private medical costs. Life expectancy in the 1920s and early '30s was a little under 60 years of age and did not change substantially until after World War II. Limited information is available on the total public and private cost of health care during this period, but costs were clearly well below 2 percent of GDP.

Beginning in the 1930s, Blue Cross plans began to emerge, initiated by hospitals as a way to both protect patients against

unexpected hospital bills, while ensuring hospitals had a steady income stream during the Great Depression. Employer-provided coverage was rare and spread slowly, but that pace picked up during World War II, when the Internal Revenue Service announced that employer funds spent on employee health coverage were tax deductible to the employer and excluded from employee taxable income, a decision that Congress later put into law.

As World War II ended, health care spending in the United States remained close to, if not under, 2 percent of GDP. While employer-provided coverage was growing, most people still lacked insurance. And the insurance coverage that was available tended to be limited to more catastrophic costs such as hospitalization.

Employees and their unions soon began pushing for benefit increases, and soon employers became the primary source for providing health insurance for Americans under age 65—about 90 percent of all private coverage today.

The premium tax exclusion meant employees could spend a dollar of the employer's money pretax, but only perhaps 60 cents or 70 cents after tax if they chose to buy their own coverage.

Most economists see employer health insurance contributions as a substitute for wages while most employees see them as *additional money* they are extracting from employers. The workers' attitude helps explain why some unions have been willing to go on strike for weeks, even months, whenever employers suggest raising employee copays or coverage contributions, even if by very modest amounts.

As employer-provided coverage increased, out-of-pocket spending decreased, from about 48 percent of total health care spending in 1960 to 12 percent in 2010. (see Table 7.1)

	Total Spending	OOP	Ratio
1960	\$ 27,359	\$ 13,051	47.7%
1970	\$ 74,853	\$ 25,105	33.4%
1980	\$ 255,784	\$ 58,396	22.8%
1990	\$ 724,277	\$138,643	19.1%
2000	\$1,377,972	\$201,475	14.6%
2010	\$2,604,131	\$339,422	11.8%
2017	\$3,527,293	\$588,851	16.7%

*Source: National Health Expenditure Data 1960-2017
(millions of dollars)*

Thus, no one should be surprised that health care spending trends suddenly and dramatically began increasing faster than wage growth. However, the increased out-of-pocket cost sharing due to the ACA’s very high deductibles (especially in the Bronze plans) since 2014 are likely putting some downward pressure on health care spending.

Turns out that people like being able to pay for health insurance and health care services with someone else’s money. Who knew?

Expanding health coverage created a “moral hazard”—which in economic theory is the notion that when people are insulated from the cost of their behavior they are more likely to take more risks.

By separating the health care consumer from the health care payer, patients no longer cared how much health care or health insurance cost. And when health care consumers weren't interested in the price of care, then neither were health care providers—whether hospitals, doctors, medical device manufacturers or pharmaceutical companies. The *best care*, not the *best value*, became the health care system's driving force.

Early Efforts (and Desires) for Socialized Medicine

The postwar spread of private health insurance did not go unnoticed by those who wanted the government rather than the private sector providing health care, and so the push for socialized medicine was on.

There had been early efforts, often led by unions, to implement some version of a national health care system as far back as the Progressive Era in the early 1900s. President Franklin Roosevelt was generally supportive of the idea, but never strongly backed legislative efforts. That changed when President Harry Truman took over after FDR's death. Truman wanted a national health care system and worked to get one. However, the U.S. was in the midst of the Cold War with the USSR, and a national health care system sounded like socialized medicine—because it was. Republicans and conservative Democrats both opposed that movement on principle, but also did not want to move the country closer to Soviet policies, which was seen as the kiss of political death. But if Congress and the president weren't up for nationalizing the whole health care system, they were willing to take the first step—for seniors and the poor.

Enter Medicare and Medicaid

Most seniors and the poor were outside the workplace—or at least full-time work—and so had little or no access to employer-provided coverage.

Although about half of seniors had private health coverage when Medicare passed in 1965, many of them were paying for it themselves. Indeed, the primary purpose for creating the AARP (American Association for Retired Persons) was to create an association where retired teachers could buy health insurance.

Medicare provides seniors with government-funded coverage when they turn 65. The program covers hospital costs (Part A, which mandates participation if you take Social Security benefits), physician costs (Part B) and prescription drugs (Part D). The last two are voluntary, but require seniors to pay a monthly, government-set premium). All three require cost sharing but the out-of-pocket levels are relatively low compared to most current health insurance policies.

Defenders of the legislation denied, at least publicly, that (1) Medicare would take the country closer to socialized medicine, (2) that the government would eventually impose price controls, and (3) that health care costs would explode. They were WRONG on all three counts. For example, the House Ways and Means' initial cost estimates of Medicare Part A was \$9 billion by 1990; the actual cost was \$67 billion, a multiple of 7.5—and that didn't include Part B.²⁸

28. Robert J. Meyers, "How Bad Were the Original Actuarial Estimates for Medicare's Hospital Insurance Program?" *Actuary*, Vol. 29, No. 2, February 1994, p. 6.

Medicaid eligibility was initially tied to the receipt of cash welfare payments. It was seen as a program smaller than Medicare, and it was something of an afterthought.

The debate and passage over these two programs conforms exactly to the pattern we have laid out for entitlement programs. Proponents argued that (1) society had an obligation to provide both populations with quality, comprehensive health care (health coverage was just a way to access the care) and (2) the cost of both programs would be affordable and sustainable over the long term. Neither projection was true—not even close.

That's because both programs completely disregarded important actuarial principles. People are insulated from most costs, especially in Medicaid, and so patients have little incentive to try to seek value for their health care dollars. Just as importantly, Congress has repeatedly expanded both programs—even as it has cut back on how much the government will pay for care.

The Post-Medicare Years, 1966-1980

In these years, the government was busy expanding Medicare and Medicaid even as it was imposing more laws, restrictions and mandates on insurance coverage for those under age 65 and for Medicare supplemental policies, which were created to fund gaps in Medicare coverage. For example:²⁹

- In 1973 Congress expanded Medicare to include disabled individuals under the age of 65 who satisfied certain eligibility criteria, as well as speech and physical therapy,

29. "Medicare: A Timeline of Key Developments," Kaiser Family Foundation. <http://kaiserfamilyfoundation.files.wordpress.com/2005/06/5-02-13-medicare-timeline.pdf>.

some chiropractic services, and coverage for end-stage renal disease.

- Medicare deductibles—\$40 a year for Part A and \$50 for Part B, with a Part B premium of \$3 per month—were either not changed, or changed by less than health care cost inflation, which meant that Medicare benefits effectively grew richer over time.
- In 1980 coverage for home health services was expanded, and the federal government began regulating insurance policies designed to fill in the gaps in Medicare coverage, which insulated seniors even more from health care costs and so encouraged overutilization of care—which drove up Medicare spending even more.
- The age of eligibility for benefits under Medicare was not changed even though life expectancy grew roughly two years longer, establishing an imbalance between revenues and expenditures.
- As the population has aged, Medicare’s benefit structure has not changed, even though those living into their 80s represent a different risk group than those in their 60s—e.g., they rely more on medication to improve their lifestyle and longevity, which leads to longer lifespans, more active lifestyles and even more Medicare spending.
- Medicaid eligibility was expanded many times to groups such as pregnant women, those receiving Social Security supplemental benefits, and others.
- The services covered by the Medicaid program also expanded over the years, as did the ability to secure such benefits. For example: Washington mandated Early and Periodic

Screening and Treatment (EPST) for children in 1967; states were given the option of covering intermediate care facilities and certain services and institutions caring for people with mental disabilities in 1971; states had to cover the people in the newly created Supplemental Security Income program in 1972; Congress required medically necessary abortions to be covered beginning in 1977.

- And as another example that governments expand their safety net programs but don't pay for them, Congress passed legislation in 1981 that reduced the federal government's Medicaid matching share for three years as part of a federal budget savings effort. And it repealed a requirement that states pay hospitals the Medicare payment rate.

Such changes increased utilization, moral hazard and anti-selection, in essence undermining whatever actuarial principles survived in the programs.

As Table 7.2 shows, by the late 1980s health care spending trends had exploded. When Theodore R. Marmor published *The Politics of Medicare* in 1970 (revised version in 1973), he drew stark attention to the immediate surge in hospital costs

Hospital price increases presented the most intractable political problem for the Johnson administration. In the first year of Medicare's operation, the average daily service charge in America's hospitals increased by an unprecedented 21.9%. Each month the Labor Department's consumer price survey reported further increases, and by the summer of 1967 President Johnson asked HEW Secretary John Gardner to "study the reasons behind the rapid rise in the price of medical care and to offer recommendations for moderating that rise." ... In the State of the Union Address, January 17, 1968, President Johnson illustrated how the government's expanding role in financing personal health

services had enlarged its responsibility for controlling price increases; measures would be proposed, the President promised, to “stem the rising costs of medical care.”³⁰

Table 7.2
Summary of GDP, Health Care Expenditures,
And Corresponding Ratios and Rates
For United States by Selected Periods
1920-2017

Years	(1) GDP in Billions	(2) Health Care Expendi- tures in Billions	(3) Health Care to GDP**	(4) Annual Growth in GDP	(5) Annual Growth in Health Care	(6) Excess of Growth in Health Care to GDP***
1920	\$ 88.4	\$ 1.4	.016	-	-	-
1945	\$ 223.0	\$ 6.0	.022	3.8	4.9	1.1
1965	\$ 719.4	\$ 42.0	.058	6.0	11.4	5.1
1980	\$ 2,788.1	\$ 256.0	.092	9.5	12.8	3.1
1995	\$ 7,419.7	\$1,027.0	.139	6.7	9.7	2.8
2010	\$14,508.2	\$2,598.8	.179	4.6	6.4	1.7
2017*	\$19,200.0	\$3,527.0	.184	4.1	4.5	0.4
1945- 2010				6.6	9.8	3.0

*From Concerned Actuaries estimate for 2017.

** $(1)/(2)$

*** $(1+(5))/(1+(4))-1$

More recently, Massachusetts Institute of Technology economist Amy Finklestein has published a few papers quantifying

30. Theodore F. Marmor, *The Politics of Medicare*, Aldine Publishing Company, Chicago, Revised American edition 1973, pp. 86-7.

the cost impact of the Medicare program. Medicare provides a unique scholarly opportunity because millions of Americans entered the health insurance market at one time, with all of them getting essentially the same type of coverage. As an economist, Finklestein wanted to know what health insurance coverage does to health care spending. As she summarizes:³¹

This paper investigates the effects of market-wide changes in health insurance by examining the single largest change in health insurance coverage in American history: the introduction of Medicare in 1965. I estimate that the impact of Medicare on hospital spending is substantially larger than what the existing evidence from individual-level changes in health insurance would have predicted. ... A back of the envelope calculation based on the estimated impact of Medicare suggests that the overall spread of health insurance between 1950 and 1990 may be able to explain at least forty percent of the increase in real per capita health spending over this time.

Medicare and Medicaid spending both exploded because of the continuing violation of actuarial principles and inefficiencies that had been germinating for many years. As GDP grew and inflation accelerated, health care expenditures and trends accelerated at even faster rates.

Government Expands Its Health Care Involvement, 1981-1995

Conservatives look fondly at the 1980s as a time when President Ronald Reagan began to scale back the federal government, especially with respect to taxes. Not so in health care;

31. Amy Finkelstein, "The Aggregate Effects of Health Insurance: Evidence from the Introduction of Medicare," National Bureau of Economic Research Working Paper No. 11619, September 2005. <http://www.nber.org/papers/w11619>

both the federal and state governments kept passing laws and imposing regulations that made health care, and thus health insurance, more expensive.

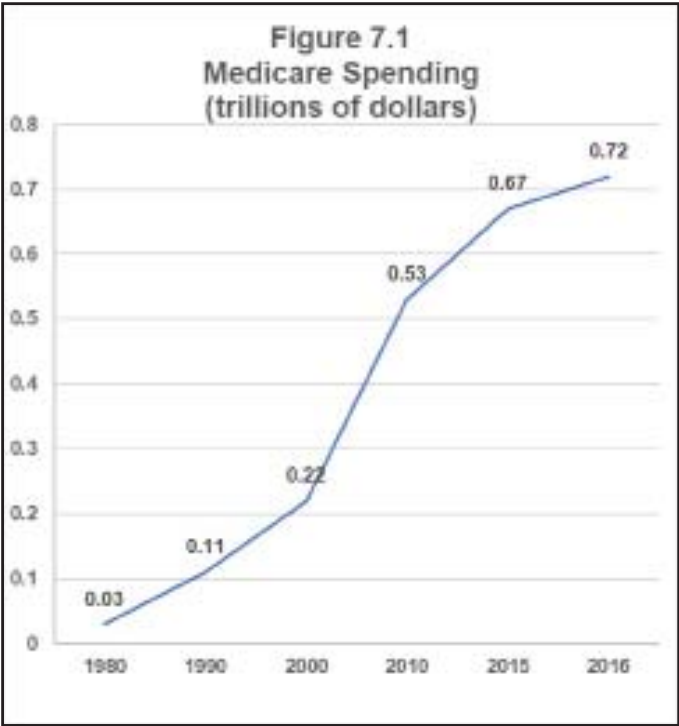
Let's start with the federal government, which passed and implemented diagnosis-related groups (DRGs) in Medicare in the early 1980s. Immediately after passage Medicare began exceeding all cost predictions. Washington's solution? The same "solution" elected officials have proposed in country after country, decade after decade, when their underfunded and overpromised entitlement programs exceeded cost estimates: price controls. But this being the United States, and with Republicans in charge of the White House and Senate at the time, they couldn't call it price controls; they called it DRGs. And the most amazing thing is they tried to sell it as the free market solution.

The DRG system moved various hospital-related diagnoses of illness or sickness into groups of hospital risks, whereby Medicare would only pay set amounts consistent with these conditions. This change initially required and created huge changes in the delivery of services. Medicare hospital costs leveled out for about five years, but then began to quickly rise again. This change was also a precursor to some elements of managed care.

DRGs are a government-set price for various hospital procedures covered by Medicare. Defenders claimed that hospitals that were able to provide the service for less than the DRG-determined price would make money; those that didn't would lose money. Thus, DRGs were all about competition and efficiency, defenders said. Of course, there is nothing unusual about a customer saying he is willing to pay \$X for some

product or service, and seeing if any vendors are willing to meet that price. But in that instance, vendors can choose to participate or not; virtually all hospitals treated Medicare patients, and so had little choice but to accept the government's price controls.

However, providers quickly learned how to survive under the new system. Terms like “cherry picking” and “cream skimming” entered the medical vocabulary. In addition, hospitals learned how to “upcode” patients, that is, ascribing a DRG that would cover a little more serious condition.



While hospital utilization started falling almost immediately after the implementation of DRGs, physician and outpatient hospital costs started escalating rapidly after a pause of a few years. (see Figure 7.1) That is, health care providers found ways around hospital price controls by providing more services in their offices or non-hospital settings. The Medicare system was not set up to distinguish whether hospitalization or other types of care were more appropriate, those decisions had always been left up to the doctors.

The result was that the implementation of DRGs moved people from one type of delivery format to another without necessarily considering appropriateness of the setting and its implications. That's not to say care was worse; it may have turned out better—or at least more convenient for patients. The point is *price controls always change behavior*.

Even so, Washington decided to double down and impose a type of price control on physicians. In 1984 Congress passed the Deficit Reduction Act, which froze physicians' fees, but that didn't solve the cost problem so in the early 1990s Congress created the resource-based relative value schedule (RBRVS) for Medicare Part B physician charges.

RBRVS created specific prices for physician services, varying with type and intensity of the service. Like DRGs, it was effectively a price control created by Medicare to control spending—although few called it that because of the negative connotation of the term price control. But when the government implemented the RBRVS system, every participating doctor had to accept the government-set price; there was no negotiation.

Again, the initial effect of the RBRVS under Part B was to control spending, but the lower reimbursements paid by Medicare resulted in providers changing some of their practices. In other words, price distortion simply added a new set of distortions to the already distorted health care system.

But even as Congress was trying to control Medicare costs, it was expanding benefits. In 1985 Congress passed the Consolidated Omnibus Budget Reconciliation Act, which mandated that newly hired state and local government employees participate in Medicare. Because the government, in the aggregate, loses money on every Medicare beneficiary, adding more beneficiaries does not enhance the program's finances—like the old quip when a business owner complains that he's losing money on every widget he sells and someone suggests he can make it up in volume.

Plus, in that same year, Congress passed EMTALA (Emergency Medical Treatment and Labor Act), which required hospitals that accept Medicare and Medicaid payments—which is virtually all of them—to treat anyone coming to the emergency room, regardless of insurance coverage or ability to pay. While EMTALA was a type of safety net, it created a perverse economic incentive: Lower-income people knew that if they didn't have health insurance they would be treated anyway, thereby discouraging some from getting coverage (even when they were eligible for Medicaid).

In addition to Medicare expansion, states and the federal government were also expanding Medicaid.

- In 1984 Congress required state Medicaid programs to cover pregnant women eligible for Aid to Families with Dependent Children (AFDC, but now the TANF program) and women in two-parent families where both were unemployed, and children up to age five in AFDC-eligible families. Over the next four or five years, Congress kept expanding the income and other limits.
- In 1986 Congress authorized Medicaid to cover certain illegal immigrants if they gained legal status under a new immigration law.
- And with a major expansion in 1988, Congress required state Medicaid programs to pay low-income seniors' Medicare premiums and cost-sharing.

However, Medicaid also revised how state reimbursements could be calculated, which created incentives for states to provide more services so that the federal government would make matching payments, thereby creating more abuses. In defense of the states, however, they may have felt somewhat justified gaming the system since the federal government had strapped them with so many additional Medicaid costs.

The Federal Government's Hand in Health Care Grows, 1996-2009

We chose 1996 as the start date for this portion because it marked the year when the federal government decided to get heavily involved regulating health insurance, with the Health Insurance Portability and Accountability Act (HIPAA). Prior to the passage of HIPAA, the government was involved in the health insurance market, but it was almost entirely state

governments, especially in mandating insurers cover specific medical therapies and diseases.

In addition, several states decided to pass ClintonCare-like health care reform bills in the early 1990s that imposed significant mandates and restrictions on health insurers, such as requiring those selling coverage to individuals to accept any person who applied and limiting insurers' ability to adjust the premium based on preexisting medical conditions and health status. It was an attempt to create a health insurance safety net at virtually no cost to the state government by forcing the risks and losses on health insurers.

But the failure of ClintonCare to pass at the federal level energized those members of Congress who wanted to get as close to a single-payer health care system as they could to look for incremental steps. HIPAA, also known as Kassebaum-Kennedy (after Kansas Senator Nancy Kassebaum and Massachusetts single-payer supporter Senator Edward Kennedy) got the federal government heavily involved in regulating health insurance. While the law didn't create a new health care entitlement—it mostly focused on increasing health insurance regulations, which would ultimately be paid for in higher premiums by the very people it was supposed to help—HIPAA opened a door for the comprehensive law that passed 14 years later, the Patient Protection and Affordable Care Act.

In 1997 Congress became even more involved with health care by passing the state Children's Health Insurance Program (CHIP), which was intended to provide health insurance for low-income children in families that weren't poor enough to qualify for Medicaid.

Turning back to Medicare, in 1997 Congress passed Medicare Part C as part of the Balanced Budget Act, a program intended to give seniors a private sector Medicare option, but it was also an effort to slow the growth of Medicare spending. Part C allowed seniors to choose a participating private, managed care health plan, and Medicare would pay the health plan a flat fee to cover all of that senior's health care needs for a year. The fee was set at 95 percent of the average cost of a senior's care. By paying less than the average cost, Congress hoped to save money. However, critics of Part C—who realized it opened a private sector door into a government-run system—began to assert that only the healthiest seniors were signing up for it, and their costs were much less than 95 percent of average costs. So, they contended, Medicare was actually losing money on Part C. This was a debatable claim, but the criticism said more about the fear some had in expanding the private sector into Medicare than any actual financial losses.

Congress also passed the Sustainable Growth Rate legislation (SGR) in 1997. The problem that Congress was trying to address, yet again, was increased Medicare spending. The legislation provided that if Medicare spending rose faster than a specified amount, doctors' reimbursements would be cut the next year to offset the financial losses.

Well, Congress seldom hit the SGR target, which meant physician reimbursements were cut—or should have been. Turns out that Congress likes cutting doctors' Medicare reimbursements *even less* than it likes increasing Medicare spending. And from 2002 until 2015 Congress stepped in 17 times to stop the reimbursement cuts. But those potential cuts accumulated over time, reaching a point where doctors' Medicare fees would be cut by 30 percent at one point, then declining to about 20

percent when Medicare spending began to slow. But because Congress continually overrode the spending cuts, no money was ever saved. Finally, in early 2015, legislation, referred to as the “Doc Fix,” passed to reverse the cuts, while not fully paying for them.

The SGR is one of the better examples of how Congress, and governments in general, claim they have taken a major step to reduce entitlement spending, and when the savings don’t emerge, play fiscal games to avoid having to deal directly with the problem.

Another major step was the inclusion of Medical Savings Accounts (MSAs) as part of HIPAA. The law allowed for high deductible insurance, coupled with a tax-free savings account, which was used to pay small and routine out-of-pocket costs, providing an economic incentive for the consumer to spend more carefully. However, HIPAA imposed a number of restrictions on MSAs—a requirement demanded by Senator Kennedy, who strongly opposed a consumer driven option—which discouraged widespread adoption.

But when Congress passed the Medicare Prescription Drug, Improvement, and Modernization Act in 2003, it included a new and improved version of MSAs known as Health Savings Accounts (HSAs). HSAs are more flexible and practical and they have been much more widely adopted by employers and the public. Their creation has encouraged more people to be value-conscious shoppers in the health care marketplace, which has helped slow the growth in health care spending.

While government health care advocates seem to think that expanding Medicare and Medicaid can only have a positive

impact because it gives more people government insurance, doing so puts upward pressure on commercial market premiums because both programs underpay for medical services. Those costs get shifted to private health insurance—nearly \$90 billion in both 2006 and 2007—driving up private sector premiums and increasing the number of uninsured.³²

The irony behind this cost shifting cannot be overstated. Many politicians for years criticized the high cost of health insurance compared to what they argued was the lower cost of Medicare and Medicaid because the government runs those programs. But one reason the private sector costs more than it otherwise would is the government's imposed artificially low price controls shift costs to the private sector making health insurance *more* expensive.

Another benefit of the Medicare Prescription Drug Act: It created the Medicare Advantage program, a much-improved version of Medicare Part C, and so more insurers and seniors wanted to participate in it. More importantly, seniors seem to like Medicare Advantage, with about one-third of seniors voluntarily choosing it over traditional Medicare.³³

The addition of Medicare's Part D drug benefit in this period filled a need for many seniors, but significantly increased the government's financial obligations. However, unlike most other Medicare enhancements, the drug benefit has cost less than expected, which is likely due to cost sharing and private sector competitive bidding.

32. Doug Trapp, "Low Medicare, Medicaid pay rates impacts private costs," *American Medical News*, January 5, 2009. <http://www.amednews.com/article/20090105/government/301059985/6/>.

33. Kaiser Family Foundation, "Medicare Advantage," October 10, 2017. <https://www.kff.org/medicare/fact-sheet/medicare-advantage/>

The Federal Government’s Hand in Health Care in 2010 and Later

The Patient Protection and Affordable Care Act passed in March of 2010, fundamentally changing virtually all sectors of the U.S. health care system—mostly for the worse. If we were looking for a prime example of this book’s thesis, it would be hard to find a better one.

For one thing, it expanded Medicaid to an initially estimated 26 million people. And to lure the states into accepting the expansion, since the federal government couldn’t just tell them they had to expand, the law’s drafters decided to pay 100 percent of the costs for the newly eligible Medicaid enrollees for the first three years, declining to 90 percent a few years later. And Democrats did that knowing that Medicaid had already become one of the biggest expenditures in state budgets. There was no reform of Medicaid, no effort to apply actuarial rules.

The ACA created an entitlement to “affordable” health insurance that had never previously existed. From the beginning, Democrats, bureaucrats, labor unions and left-leaning economists and policy wonks who defended the president’s bill made claims that were demonstrably false or ill-informed.

Defenders claimed that it was paid for based on a 10-year budget timeline assessment, required for such legislation. But they frontloaded many of the taxes and pushed off many of the law’s costs until the future. Congress has since repealed some parts of the law whose only intent was to increase federal revenue, such as the CLASS Act and the 1099 tax, but there have been no financial offsets to replace those loses. And

Congress is receiving much less revenue than expected from the 20 or so taxes created under the law.

Another source of federal revenue under the ACA was the financial penalty imposed for not having qualified coverage, but only about a third of the uninsured paid the penalty. The rest were able to qualify for an exemption. However, even that revenue stream ends in 2019, since Congress zeroed out the penalty for not having Obamacare-qualified coverage.

The politicians also added costs, such as HHS's decision that contraception is a form of preventive care, which made all types of contraceptives free for policyholders. While a change like that probably wasn't a huge new expense, given the fact that most insurers already covered most forms of contraception and that most contraceptives are relatively inexpensive, this becomes just one more example of the arbitrary expansion of an entitlement program.

Besides understating the costs, Obamacare defenders overstated the benefits. They repeatedly made claims that the bill would fix problems that were either minimal or non-existent. For example, President Obama included as one of his eight "consumer protections" a provision that a health insurer could not cancel a policyholder's coverage if that policyholder wanted to renew it. But that had been federal law under HIPAA for 14 years and in most states long before that.

The consumer protection most cited by the president—and the one that was most commonly used to justify the need for a massive overhaul of the health care system—was the provision that required health insurers to accept anyone who applied, regardless of a preexisting condition, and a policyholder could

not be charged more because of that condition. While it was true that some uninsured Americans who developed a significant medical condition and didn't have access to employer coverage had difficulty buying a policy, those numbers were relatively small and that problem could have easily been fixed.

Guaranteed issue—in which an insurer must approve an applicant regardless of health—was already federal law for employer-based (i.e., group) health insurance. And some 35 states had a state-created high-risk pool that provided coverage to uninsurable individuals, while another six or seven states imposed guaranteed issue in the individual market. So while it wasn't perfect and some tweaks were needed, the uninsured had a reasonable, albeit sometimes expensive, option in nearly all of the states. Ensuring those safety-net options were also affordable for lower-income individuals would have gone a long way toward fixing the uninsurable problem.

Finally, let's look at the ACA's budgeting scam. It is hard to overstate the fiscal importance of a paper released from the Office of the Actuary for the Centers for Medicare and Medicaid Services (CMS). And yet the document received only a shoulder shrug from the media and a complete blackout from Democrats. It's easy to see why.

The back story is that a group of trustees monitor the Medicare program and release an annual report outlining the program's current and projected fiscal condition. (The same is true for Social Security.)

However, the trustees' projections must follow whatever the law says. So, for example, if federal law says Medicare will only be allowed to grow by some designated annual growth

rate, that's what the trustees have to assume in their projections—regardless of whether they believe those spending limitations will actually occur.

Fortunately, Medicare's Office of the Actuary doesn't have to live in a political dream world. The office began releasing annually a "memorandum" to highlight the challenges—to put it mildly—the government faces in adhering to the Medicare and Medicaid growth rates imposed by Obama's health care law. In about 20 pages, the actuary's office explains in very diplomatic terms why a person would be a fool to believe the trustees' report.³⁴

The Trustees Report is necessarily based on current law; ... however, the projections shown in the report are clearly unrealistic. The purpose of this memorandum is to present a set of Medicare projections under hypothetical alternatives to those provisions to help illustrate and quantify the potential magnitude of the cost understatement under current law.

For example, in 2009 the average amount the government reimbursed hospitals caring for Medicare patients was about 67 percent of what private health insurance would have paid; Medicaid rates were about 66 percent, according to the actuary.

Medicare reimbursed physicians about 80 percent of what private insurance paid, while Medicaid paid only about 58

34. John D. Shatto and M. Kent Clemens, "Projected Medicare Expenditures under Illustrative Scenarios with Alternative Payment Updates to Medicare Providers," Centers for Medicare and Medicaid Services, Office of the Actuary, May 18, 2012. <https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/reportstrustfunds/downloads/2012tralternativescenario.pdf>

percent (2008). Those low Medicaid rates help explain why it's so hard for the poor on Medicaid to find a doctor who will treat them.

While Obamacare requires some physician payment increases for a few years—a political move intended to assuage opposition from states and health care providers—all of that changes in the long term. The memorandum explains that the law requires the trustees to assume a steady decline in hospital reimbursement rates for both Medicare and Medicaid—to about 39 percent of what private insurance would pay in 2086.

Worse yet, the trustees must assume that physician reimbursements under Medicaid will drop to 55 percent of private health insurance by 2086, while physicians serving Medicare patients “would eventually fall to 26 percent of private health insurance levels.”

Those assumptions reduced Medicare's long-term unfunded liability by \$53 trillion. What a deal! (The unfunded liability had been estimated by the trustees in 2009 at about \$90 trillion.) And it's all because Obamacare demands the number crunchers to assume the government will be paying so much less for health care services.

The Medicare actuary (rightly) doesn't believe the government will actually make those cuts. And so he took the unprecedented step of releasing an alternative (read: realistic) scenario. To grasp how radical this project was, imagine a Fortune 500 company releasing its financial statement highlighting how well the company is doing, and then the company's CFO holds a separate call with the media to explain why it's all a ruse.

The actuary says that hospital expenditures are “projected under current law [i.e., Obamacare] to rise from about 3.8 percent of taxable payroll ... to 6.3 percent in 2085.” The actuary thinks 9.9 percent is more realistic. Current law projects that Medicare physician spending will grow from 1.48 percent of GDP to 2.52 percent by 2080. The actuary thinks, with several variables considered, that 4.39 percent of GDP is more realistic.

The memorandum closes by warning that “readers should interpret the current-law Medicare projections cautiously.” That’s an understatement! “For example, the 2011 Trustees Report showed estimated Part B [physicians] expenditures of \$220.5 billion for 2012. The actual amount is now expected to be \$246.9 billion, which is \$26.4 billion or 12 percent higher than last year’s estimate ...”

In short, the Affordable Care Act exhibits every aspect of a new entitlement that has overpromised and underdelivered. As recent CMS assessments have revealed, the number of exchange enrollees has always been fewer than predicted and is steadily declining. Premiums have skyrocketed.³⁵ The pools are shrinking, younger people are fleeing, and most individuals have only a few health insurer choices. The only reason the exchanges haven’t collapsed completely is the government (i.e., taxpayers) is paying the lion’s share of the premium for 87 percent of the enrollees.

35. Centers for Medicare and Medicaid Services, “Early 2018 Effectuated Enrollment Snapshot,” July 2, 2018. <https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/2018-07-02-Trends-Report-1.pdf>

PART III

STEPPING BACK FROM THE CLIFF

The primary reason the United States, and most other developed economies have stumbled up to the edge of the entitlements cliff is they have ignored standard actuarial principles. The result is financially unsustainable entitlement programs. But perhaps even more importantly, they have created economic incentives to remain in the safety net programs and exacerbated income inequality—the very problems they were trying to solve.

Chapter 8

Understanding Safety Nets

In this chapter we lay out the principles for a true safety net—one that meets people’s needs, is actuarially sound and sustainable, and encourages able-bodied people to leave the safety net and return to the workforce as soon as possible. We also discuss why people unable to work should be in distinct safety nets and not combined with able-bodied individuals.

Two Kinds of Safety Nets

We highlight two basic but very different types of safety nets. One is usually long term while the other is meant to be temporary but often isn’t. The long-term safety net may be prefunded by workers, while the temporary safety net is typically funded by income transfers.

In the U.S., Social Security and Medicare are the most prominent examples of a long-term safety net. They were established to provide seniors, who often have fixed and limited incomes, with a basic retirement income and health care needs. There is no means test to qualify for these two programs, though some of the benefits have means-tested elements. Once in the program, the senior usually remains until death. And because workers pay a Social Security and Medicare payroll tax, there is a perception that they have paid for (i.e., prefunded) their benefits, even though both programs utilize a system of transfer payments from current workers to recipients, just like most welfare programs.

The temporary safety net is meant to meet a temporary need and not become a long-term entitlement. Various means-tested programs such as food stamps, low-income housing, Medicaid, unemployment benefits and disability—what we generally refer to as welfare—are meant to help specific people in need. But the idea was always that the large majority of those receiving benefits would eventually get back on their feet, find a job, finish school and might even recover from a disability, or at least be able to do a different kind of work that isn't hindered by the disability. Unfortunately, the “temporary” intention has largely been lost. People going on means-tested benefits often never leave. Indeed, *they become a family legacy* as one generation after another become cradle-to-grave welfare recipients.

In addition, there should be a long-term safety net for people who are permanently disabled and incapable of work until they are eligible for the aged benefits. Like the temporary safety nets, this one would be funded almost entirely with income transfers, but there would be little or no expectation that this population will eventually return to work—if the beneficiaries ever worked at all.

Principles of a Sustainable Safety Net

Creating sustainable and affordable safety nets that encourage economic growth instead of harming it requires understanding the principles of such systems and their interaction with the economy.

The actuarial profession defines private or public financial security systems (FSSs) as personal or governmental arrangements that mitigate the impact of unfavorable outcomes on members of an “at-risk group” through risk transfers. The system should distinguish between situations necessitating

an immediate risk transfer, usually considered as one year or less, and an advance risk transfer that frequently covers many years.

Creating a sustainable long-term safety net is a challenge because it requires balancing contributions and costs, which are generally tied to economic conditions. Safety-net expenditures can have a major impact, positive or negative, on those conditions. A recession or slow-growth economy leads to more people riding in the economic cart. Good policies spur economic growth and lead to higher rates of employment, more tax revenue and fewer people in the cart.

Thus strong economic growth tends to reduce the need for safety nets at a time when the government is best able to fund them; tight economic times lead to more demands on safety nets at a time when the government has less revenue to cover the increased needs.

Simply providing more and more benefits to people is a formula for long-term imbalances. Resolving the funding imbalance eventually means some combination of decreasing benefits or demanding more revenues. In the second instance, increasing taxes or premiums can discourage workers whose productivity funds the programs, slowing economic growth.

The basic goals of any FSS, as stated by the Committee on Risk Classification of the Society of Actuaries (SOA), are as follows: ³⁶

36. Mark Allaben, et al., "Principles Underlying Actuarial Science," Society of Actuaries, July 2008.

A. Coverage is available only to those in the at-risk group who desire it:

Benefits for this category should only be for basic needs, such as food, clothing, shelter, health care and education. Providing coverage for items such as cell phones or transportation, unless the latter is related to a basic and pressing need, does not meet such a test.

B. The promised benefits are meaningful and accessible to those in need:

In a number of instances, governments may provide a safety net that promises the moon but delivers very little. For instance, in South Africa during the 1990s, people were promised access to treatment for health care, including AIDS. But the country had few facilities outside of large metropolitan areas, and the number of medical personnel available to treat such patients was extremely limited.

In Medicaid, many physicians refuse to participate in the program due to low reimbursement levels. As a result, people are often unable to see a physician, which means that the emergency room becomes their de facto primary care provider.

C. The system is fiscally sound so that its promises are fulfilled:

A safety net's success depends on having the resources to fulfill its promises. Frequently, promises exceed expected revenues.

The government of Argentina took the pensions of individuals to satisfy the government's funding needs. And don't assume that something similar can't happen in the

U.S. Congress has borrowed all of the surplus funds in the Social Security trust fund to pay current obligations, and the Supreme Court has ruled that Congress has the power to cut Social Security benefits at any time. As another example, there are long waiting lists of patients trying to get care in Canada's health care system, but services are often limited because government funds are limited.

In addition to the SOA's principles we add:

- Public resources should be integrated with private resources—e.g., private pension plans, life insurance benefits, etc.—to prevent duplication of effort and cost, as well as to avoid an incentive for collecting additional benefits.
- Any FSS should build on a free market system rather than detracting from it, using public resources only to the extent necessary.
- It must include an incentive to leave the system as soon as possible.
- To the extent possible, it needs to mainstream those in the safety net with serious challenges—physical or mental—so that they can move back into the private sector.
- Benefit funding for social needs should come from public dollars rather than trying to impose those costs on business.
- Reasonable incentives should be incorporated to encourage people to spend or accumulate money as though it were their own while providing the ability to receive timely and good quality care or services.

For those with a permanent need, the safety net should be designed to create a subsistence floor. Most people have

temporary needs, not permanent ones. Unfortunately, the history of U.S. safety nets provides little reason to think the government will closely monitor and shut off benefits when the recipients no longer qualify. So there needs to be an inducement, such as a work requirement, to encourage people to exit the safety net and become part of productive society.

Private safety nets also must concern themselves with subsidies, risk transfers, incentives and an exit strategy—when applicable—just as public systems do. And recognizing that private and public systems often overlap is important in order to avoid making the public system too generous. Government safety nets should establish a floor and nothing more.

Risk Transfers

Risk transfers and related subsidies and funding approaches are critical in designing a sustainable safety net. Recognizing the actual purpose of a safety net or other personal or financial security system requires recognition of the type of risk and funding needed.

Some systems transfer a portion of the risk to a third party while keeping some of the risk with the individual. For instance, employer defined-benefit plans transfer much of the retirement risk to the employer. However, if the employer is bankrupt or reduces benefits, the risk may be transferred back to the individual or the government, e.g., the Pension Benefit Guarantee Corporation. In other words, *not all safety nets are safe*.

Safety Nets as Enablers or Ensnarers

Most countries want their safety net programs to provide basic temporary benefits to help people as they find a job, get additional training, pay their bills, get health care, or recover from

an injury or disability. But the fact that many of these countries have created generations of welfare recipients, sometimes living under the same roof, tells a different story. While the benefits may not be much, they are enough—especially if there is some unreported outside income—to ensnare generations of families.

By contrast, Singapore espouses an enabler safety net model that holds individuals responsible for saving for, and obtaining most of, their needs and services, both for themselves and their families.

For decades Singapore has relied on its Central Provident Fund (CPF), where workers contribute 20 percent of their income, and employers up to 17 percent, to a CPF account. Six percentage points of that contribution is dedicated for health care, referred to as a Medisave Account.

CPF funds can be used for retirement, the first-time purchase of a home, education, health care, or to meet financial needs when unemployed. Plus, CPF funds can be shared with other close family members, such as parents. Thus, Singapore essentially requires almost everyone to prefund personal accounts, and use those funds to meet needs that countries in the West would normally meet by setting up a public welfare program.

A prefunded system does not completely eliminate the need for a safety-net system; for example, some people might not be able to work enough to adequately fund the CPF account. Others, for various reasons, may exhaust their CPF funds. So a back-up safety-net system is certainly appropriate. But such a system would be a fraction of the size and cost of the kind of safety nets that most developed countries have created.

Perverse Incentives in the Ensnarer System

One key difference between the enabler and the ensnarer approach is that enabler systems empower individuals while ensnarer systems empower bureaucrats and governments. Most safety nets are set up to be ensnarers. For example:

- Some safety nets provide higher total incomes, when all benefits are included, than some could otherwise earn themselves in the marketplace given their skill sets. Many people receive welfare, health benefits and other assistance that can be worth in excess of 50 percent of the average worker's income. Meanwhile, those outside of these safety nets must pay taxes (income, payroll, sales, etc.) to cover the costs of those benefits and any health insurance premiums for themselves. So they are in essence paying twice.
- From a purely financial perspective, these costs may mean a person has to make something closer to two-thirds to three-fourths of the median income before working looks better than not working.
- Once people go without working for a year or two their employment prospects suffer.
- The safety net provides a false sense of protection against failure since safety nets can fail financially.
- Some safety nets create an incentive to divest of any assets, or hide them, in order to qualify for benefits.
- Because safety net-provided money is, in a sense, "free," benefit recipients may be less prudent with it than they are with their own money. Most people can tell stories of being in a checkout line with someone using food stamps to buy soft drinks, ice cream and other goods that are empty calories.

- Because safety-net recipients vote, and especially because voters often reward those politicians who claim to be using tax money to help the poor, elected officials have a professional incentive to ratchet up welfare spending and claim the country can afford the additional costs, even though the politician often has no idea what the real cost will be or whether the country can afford it.

How Safety Nets Should Change in a Dynamic Environment

Risks are dynamic, they can and do change over time. Any change in the frequency or levels of severity of outcomes can change corresponding expenditures and the need for offsetting revenues. Such changes may require a change in the way risks are grouped.

In addition to changes in the risks themselves, aspects of the method used for assigning risks to various safety nets may need to change over time. The system may, for example, depend on the identification and evaluation of risk characteristics, such as age or a definition of disability for Social Security, or level of income for welfare-type benefits. And the relationship between risk characteristics and the frequency and level of severity of each outcome may change over time. For example, “attained age” is a risk characteristic associated with providing a life annuity, but the expected longevity after attaining a specific age has increased steadily over the years.

For safety nets that deal with risks over a long time frame, the possibility of changes in the covered risks themselves, or in the factors used to evaluate risks, poses a significant challenge. In

many private systems, the reassignment of risks by the provider after coverage is issued is either not permitted or not feasible. If, in addition, terms of coverage cannot be changed, the challenge is magnified. This is the case in certain forms of life insurance, in which all aspects of the policy are guaranteed at issue and, as is the case in the U.S., the provider is not allowed to cancel coverage after issue except for premium non-payment, fraud or misrepresentation.

Other forms of insurance do not permit reclassification of risks, but allow for an update of certain terms of coverage. In participating life insurance, for example, the “dividend” paid to the policy owner is adjusted to account for the actual experience of the policy’s risk class. Many forms of individual health insurance allow for increases in the price of coverage based on the experience of the risk class. Individual experience is not taken into account except as it contributes to the aggregate experience of the risk class.

While the ability to update terms of coverage while maintaining original risk-class assignments works well for some coverages, if participants are free to discontinue coverage, this structure can lead to “rate spirals,” in which participants with “improved” risk status replace the original coverage with new, cheaper coverage, and the experience of the remaining risks becomes increasingly unfavorable over time.

Even if an FSS can require participation, as the Affordable Care Act did for a while, inflexible risk classification can create issues over time. For example, originally, the U.S. Social Security system treated all participants equally with respect to contribution rate, benefit formula, and the starting age for unadjusted

benefits. However, Congress eventually introduced birth year as an additional risk characteristic so that benefits started at a later age for some. In effect, this amounted to a subdivision of previously established risk classes.

An inappropriately designed safety net or other FSS can lead to risk selection problems, including moral hazard and adverse selection. Any of these problems create more cost or expenditure and create the potential for less participation by those who will be subsidizing the extra costs.

To address all of these considerations and issues, the more flexibility that can be built into the system for future changes the better. All safety nets should be frequently monitored and rebalanced as appropriate, taking into account their purpose, objectives and principles. Guarantees that create significant imbalances for any reason can have serious long-term consequences, such as large funding deficits, reductions in, or even loss of, coverage, or failure of the system.

For example, the U.S. Medicare and Social Security systems have well-documented imbalances in their trust funds relative to the present value of future liabilities. These imbalances are arguably caused by multiple factors.

Both Medicare and Social Security are pay-as-you-go social insurance programs, so that a decline in the workforce and an increase in the number of retirees—in part because of longer life spans—create an imbalance.

Had Congress wanted to maintain actuarial balance, it would have had to postpone the retirement age, increase worker

contributions (i.e., a payroll tax increase) or find some way to cut benefits—all of which Congress has done at various times, just not enough to fix the shortfalls. But none of those options are politically appealing to most elected officials, and so the imbalances grow.

The point is that politically based safety nets are inherently difficult to adjust over time because politicians fear voter retribution, which is why establishing prefunded safety nets avoids most of those problems. Once people have enough money in their retirement account, they can retire regardless of their age.

Balancing Interests in a Safety Net

The question when establishing a safety net is what is the right balance? The first step is to identify the goal to be achieved. After that, construct a gradually building system that seems affordable and follows the principles outlined in this book.

For instance, once South Africa freed its economy from the wrath of apartheid it tried to implement an entire series of medical coverage and provider safety nets immediately. The country made promises of good care for everyone, including those suffering from AIDS in the next two years. But in the process, a whole series of laws were passed that violated the basic principles we have outlined here, including laws that required health care providers to participate for little benefit in treating poor AIDS patients and those with serious diseases. As a result, the country saw a huge exodus of many medical providers and suppliers. Indeed, the country became the main supplier of new medical personnel to developed countries around the world, and thereby lost personnel needed to treat these people and train others. At the same time, the country created a series of

insurance reforms that likewise resulted in fewer, instead of more, people having coverage, again because the elected officials wanted a quick fix for their problems and ignored basic actuarial and economic principles.

When safety nets are overextended and undermining the economy the first thing to do is stop digging. However, most governments just continue to dig, though perhaps at a slightly slower rate.

Chapter 9

Embracing Actuarial Principles

Governments could save themselves a lot of grief and headaches if only they embraced sound actuarial and economic principles when they created new entitlement programs—but they almost never do. They tend to rely on the most optimistic of economic scenarios regarding economic growth and return on their investments. And when the economy underperforms their projections, the programs get in financial trouble. On the other hand, when the economy is doing well and the entitlement programs appear adequately funded, politicians push to expand the programs, adding costs but often not adding revenues, or at least not enough.

What are the key elements that help ensure financially sound public and private benefit systems?

Risk Classification

Risk classification is the process of assessing how much risk a person or a group brings to the insurance pool and assigning that person to a “risk class” for the purpose of pricing a policy.

To take an extreme example, people living on the coast of Florida have a much higher risk of hurricane damage to their homes than people living in Nebraska. Combining those property insurance pools would lower the cost for Floridians, but it would significantly raise the cost for Nebraskans, who

would feel like they were being gouged. The challenge for any type of insurance is finding the right mix of risk and pricing it accurately.

A financial security system (FSS) that reasonably estimates expected costs to provide the promised benefits is more likely to fulfill its promises and remain financially stable. When prices do not reflect expected costs, “adverse selection” is likely to occur. That is, high-cost people will want to join the pool because they perceive it as a good deal, creating a disproportionately larger number of expensive participants. That disparity increases premiums, which leads to some of the low-cost participants leaving, making the insurance pool smaller and more expensive.

Of course, risk rating raises concerns that those with significant risks won't be able to afford coverage. To address that problem, the government could provide subsidies to offset some of the costs of the higher risks, which helps keep premiums reasonable for low-cost risks. The Patient Protection and Affordable Care Act included several types of subsidies in an attempt to minimize adverse selection created by the legislation, though it failed miserably. Premiums exploded and the exchanges never achieved an optimum mix of healthy and sick.

That is because it can be very difficult to determine who to subsidize and by how much. If the subsidies are coming from the government, insurers are at the mercy of bureaucrats and elected officials who may decide to increase, freeze, reduce or eliminate the subsidies for political rather than actuarial reasons.

There was also a cross-subsidy in the ACA that takes money from health insurers that have a smaller number of high-cost

people and transfers it to those with a larger number. But this type of provision only masks rather than mitigates the potential for adverse selection.

In addition, insurers need to be able to “refine” risk classes. As time passes and changes occur, the initial risk classification should also change so that long-term balance can be achieved. For example, as people live longer, medical breakthroughs emerge and demographics change, so the potential risks change (e.g., fewer epidemics but more old-age related problems). Actuaries may need to reassess the risks over time and adjust premiums accordingly.

Adverse Selection

Adverse selection (or anti-selection) is when a person “selects against” an insurer by:

- (1) Choosing a coverage option that charges a lower premium than the risk the person brings to the pool, or
- (2) Declining coverage that the customer thinks is priced too high.

In a traditional insurance market—that is, where the government isn’t mandating who the insurer must take and what must be charged—adverse selection arises due to what economists refer to as an “asymmetry of knowledge.” Insurance applicants know more about their current situation than the insurer and can use that information to their advantage. The goal of the insurer is to ask questions or find other ways that will significantly reduce that asymmetry by discovering if there are potential red flags.

With respect to health insurance, that could mean questions such as: Does the health insurance applicant have a current medical condition such as high blood pressure, smoke heavily, have a strong family history of breast cancer, or whether she is pregnant? If so, the insurer may want to have a phone interview to get additional information. Getting answers allows the insurer to develop a more accurate premium. If the information is scanty, the insurer may choose to limit its risk by reducing the applicant's choices, imposing riders or restrictions, charging a higher premium or declining coverage—if the law allows, which the ACA generally does not.

While we cannot eliminate asymmetry, the insurer wants to minimize it as much as possible without going to extreme efforts that can cost both time and money. At some point in the future, our genetic make-up may be stored in a database or our medical history may be in one place that an insurer can access. But for now, answering a series of questions may be the simplest and cheapest way to gather needed medical or other information without invading an applicant's privacy.

Moral Hazard

While insurance is an important financial-protection product, it can lead to perverse behavior by insulating people from the cost of their actions. Insurance's potential for encouraging questionable or reckless behavior is known as "moral hazard." For example, people who build a beach home on the east coast of Florida risk losing that home in a hurricane. Property insurers will sell them a policy to cover that loss, but it will be costly because the risk is high. That high cost will deter some people from building on the beach.

If politicians in the state were to decide those premiums were too expensive and either imposed premium price controls or subsidized the insurers so that the premiums were much lower than the risk these families face, it could encourage more people to live on the beach or build more expensive homes, which could mean even more costly devastation the next time a hurricane hits.

From a public policy standpoint, insurance that reflects the risk a person brings to the pool discourages risky behavior, and so minimizes the potential for moral hazard.

Actuarial Soundness

Actuarial soundness simply means that the premiums will cover the cost of the insured risks, plus administrative costs and profit, over a long period of time.

The problem is that when politicians set up social insurance programs (health or income security), they pay little attention to actuarial soundness. Indeed, they have a vested political interest in ignoring such principles. Very few constituents would consider it a major achievement if politicians were to make available a health or income security policy (or flood or crop or hurricane insurance, for that matter) at a price the public could buy it in the private market. Politicians only benefit by claiming that they are providing something that is significantly better than what is available on the market. That usually means politicians will have to either push the price down with price controls or subsidize the coverage, either with tax dollars or by cross-subsidizing the policy.

How Actuarial Principles Are Abused

One of the most serious problems across all of these areas has been the abuse of risk classification fundamentals in the name of fighting discrimination. For instance, some jurisdictions have argued for or passed laws prohibiting life insurance premium differentiation based on gender (a risk characteristic), considering it discrimination. And the ACA prohibited gender-based considerations in assessing health insurance premiums.

This effort occurs despite the overwhelming evidence that females live longer than males in virtually every country. Ignoring long-standing risk classification principles then leads to additional moral hazard, as individuals being undercharged tend to increase the amount of insurance they carry. The opposite occurs for those being overcharged.

For financial security systems to be successful and achieve the desired coverage objectives, price and benefit promises, they must be allowed to price risk based on actuarial factors devoid of politics. If it can be easily demonstrated that Group A will, on average, have a shorter life span than Group B, regardless of whether that difference is a result of A's gender, age, income, health status, drug or alcohol use, ethnicity, or behaviors of choice such as smoking, then Group A should be charged a higher premium.

Refusing to allow for actuarially based risk classification does not necessarily mean that one favored group (e.g., women) will be charged less, it will more likely mean that another group will be charged more. Insurers need to collect enough premium to pay the claims—and that fact is true regardless of the

makeup of the insured pool. If women live longer than men, on average, then it makes sense to charge them less for life insurance because they bring less risk to the insurance pool. But if the government requires insurers to charge everyone the same, thereby not “discriminating,” as the government sees it, then the insurer will likely balance out the costs by charging women a little more and charging men a little less—or simply raising the women’s premiums to equal men’s.

Arbitrarily manipulating risk classification for political purposes can also lead to “cherry picking” or “cream skimming”—both refer to attempts to select the best risks. While both can and do occur, such steps aren’t necessarily bad if they support risk classification and, therefore, keep adverse selection and other inefficiencies from escalating.

Risk Classification Is an Ongoing Process

Peoples’ risk characteristics change over time for a multitude of reasons, and that means that their FSS needs may, and probably will, change also. Those systems that do not reflect such changes can create large imbalances of revenue and benefits and lead to serious long-term consequences. A system should, therefore, be adaptable to these types of changes, and at the same time reasonably reflect how stakeholders might react if displeased with some needed changes. Some developments that could necessitate changes are:

Inflation: If inflation is higher than predicted, people may need to save more to compensate for the reduced value of their money. In addition, health care costs have been growing at a much faster rate than inflation, which means more money should be set aside for future health care needs.

Investment Earnings: Financial institutions and pension funds invest their clients' money in the hope of providing a good return in future years. If a financial institution or pension overestimates returns, which many state and local public pension funds have often done, there will not be enough funds to cover all the pensioners' needs.

A similar problem plagued the long term care insurance industry during the 2000s. Actuaries overestimated returns for investments and some companies faced severe financial crises when policyholders started needing long term care.

Cost of Living: Another problem is underestimating cost-of-living increases. If inflation turns out to be much higher than anticipated, the policyholder may have insufficient funds available in retirement, even if the financial institution hit its investment-return targets.

Demographic Changes: Demographics change, whether it's improving life expectancy, an aging population, family size and make up, or population shifts to other regions. These types of changes will affect actuarial assumptions, and actuaries must take them into consideration as they plan. For example, when Social Security was created, relatively few Americans lived much past the retirement age of 65. Today life spans are much longer, and yet the only demographic change has been to gradually raise the full retirement to age 67.

Changes in Health Status: Broad changes in health status can affect safety-net programs. For example, far fewer Americans smoke today than 40 years ago. That change has a very positive impact on health status and longevity. On the other hand, the U.S. obesity rate has increased significantly, which may greatly increase health care costs.

Changes in Income or Assets: People with disposable income are more willing to spend on health care than the poor. While the population's income and assets have increased over time, they have grown at a slower rate than health care costs, which means people are less able to afford such expenditures, reducing the continuity of care services and creating more people needing public programs.

Benefit and Related Provision Changes: Elected officials can increase or decrease safety-net benefits over time through changes to benefit levels and eligibility provisions, often without adequately adjusting the revenue streams funding the programs. Those changes—often defended by very optimistic actuarial assumptions meant to please the public—can lead to significant future financial shortfalls.

Reimbursement Changes: Elected officials often need to find budgetary savings, and cutting reimbursement levels to service providers, such as physicians and hospitals, or for products such as pharmaceuticals, is one of their default practices. While those cuts may or may not save the government money, they can certainly reduce access to needed providers, services and products, which can ultimately increase costs in other ways.

The point is that there are multiple ways in which actuarial assumptions and safety-net program costs change over time. Some are self-inflicted wounds, as when elected officials decide to include expensive new mandated coverages without providing adequate long-term sources of funding. Other changes are natural, the result of a population aging or a reduced birth rate leading to fewer workers paying into the system. And sometimes even the best of actuaries operating

under the best of assumptions can miss the mark, leaving their beneficiaries exposed. Private sector benefit programs try to assess these changes honestly, because the companies' continued financial solvency depends on it. Public programs have been much less willing to make honest actuarial assessments and needed changes.

Price Controls as a Solvency Strategy

Public health care systems insulate people from the cost of care. The result is that people tend to use more care than they otherwise would, which drives up total health care spending. However, elected officials can't allow those increases to go unchecked because taxpayer-funded public programs are on the hook for the vast majority of the costs—and there is never enough money to go around.

One of the mechanisms employed to keep those costs down in many countries is government-imposed price controls. For example, as discussed in previous sections, in the U.S. the government created a system of diagnosis related groups (DRGs) that stipulate how much Medicare will pay for certain diagnoses. But imposing price controls led providers and beneficiaries to alter their practices to maximize their reimbursements under the new system. In other words, price controls didn't work.

Alternatively, governments can discontinue or reduce the volume of such services, decrease the quality and intensity of the service, or force other changes designed to rebalance the equation. Such changes often increase system inefficiency, which drives up costs. Virtually all government social insurance programs end up imposing such limits in varying degrees.

Rationing as a Solvency Strategy

Rationing limits the use of services and, therefore, health care costs, by imposing arbitrary limits on availability. Some of these imposed barriers may help control costs or reduce access to quality services, or both. They may also help reduce unneeded services. But rationing can just as easily lead to denying access to needed services and prescription drugs and ultimately harm patients. And when access is delayed or denied because a patient is uninsured, the results can have serious consequences to the health of the patient and the cost of the entire system.

Managing Care as a Solvency Strategy

Aggressively managing specific types of risks with serious or chronic conditions can have a significant impact on health care costs. However, the issue with such limitations has often been that they are applied too broadly to a population with dissimilar risk characteristics, and in these instances varying responses have created more of a price-control effect.

When DRGs are applied to hospital inpatient services within Medicare, they can delay shifting the patient to more needed hospital outpatient and physicians' services. These types of delays have resulted in cost increases for outpatient and physician services, which have, in many cases, offset the cost decreases on the hospital side, and arguably increased long-term costs.

Because politicians typically reject actuarial principles when setting up health and pension benefits, public sector programs almost always fall short financially. The politicians would rather have votes than a financially sound system.

Chapter 10

The Entitlements Cliff and Income Inequality

Income inequality is one of the hot-button issues in the U.S. and most economically developed countries. The concern is that the rich are becoming richer and the poor and middle class are becoming poorer, and that government-imposed policies are needed to reverse this trend.

Those citing a growing income-inequality problem claim it can be reduced by increasing the incomes of the poor and middle class, or decreasing the incomes of the rich—or some combination of the two. The preferred way of achieving the first goal is income transfers from taxpayers or businesses. The preferred way of achieving the second goal is higher taxes on the rich.

The Zero-Sum Game

The biggest ideological hurdle to overcome in the income-inequality debate is the belief that there is only so much wealth to go around. Thus, the only way for Peter to have an extra dollar is to take one from Paul. This economic fallacy, referred to as a “zero-sum game,” drives most of the public policy solutions for reducing income inequality.

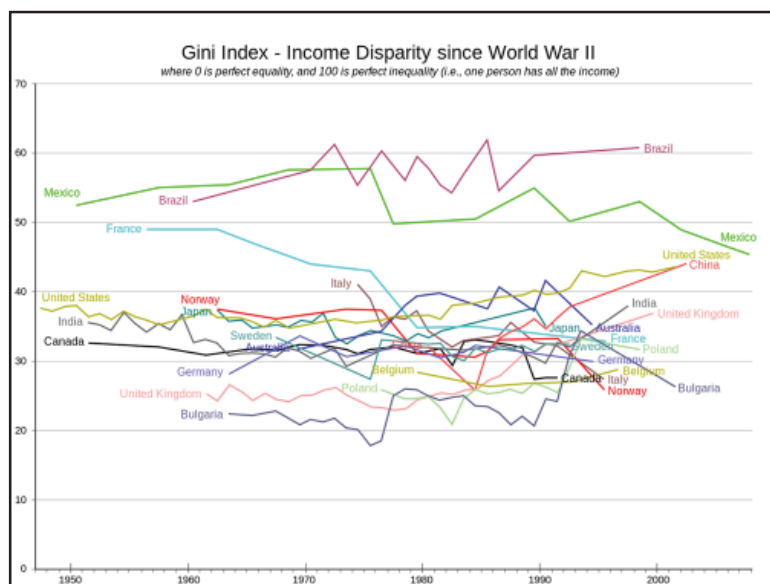
But taking a dollar away from one person and giving it to another does not increase the size of the economy. It’s simply

an accounting function shifting a dollar from one account to another. Thus, when President Obama asserted that the way to grow the economy was to build more U.S. roads and bridges, he was simply proposing a zero-sum effort to take dollars away from taxpayers and give them to ... other taxpayers.

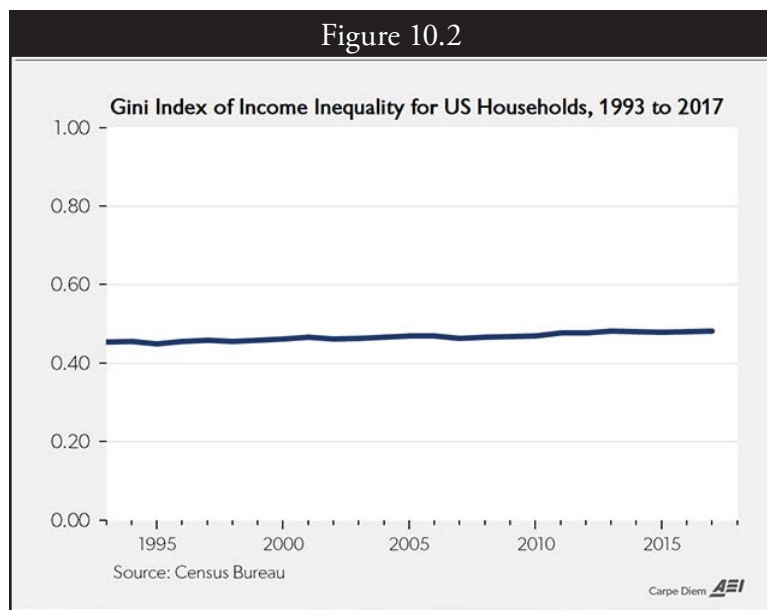
How Big a Problem Is Income Inequality?

One of the problems with the income-inequality debate is it has become completely politicized, which means serious policy discussions about whether, and to what extent, income inequality exists and is or is not getting worse are largely ignored by the media. They want headline-grabbing statements from politicians and economists who claim that income inequality is worse than ever.

Figure 10.1



Consider the Gini Index, a 100-year-old economic formula widely used by economists for determining income inequality.³⁷ A glance at a multi-country Gini Index chart that includes most of the largest economies does show a gradual increase in U.S. income inequality since 1960. However, as Figure 10.2 shows, U.S. income inequality has been flat for decades.



One important factor often overlooked is to what extent a country offsets income inequality with safety-net programs. A particular household may seem poor if only work-related income is measured, but may look much better off once

37. Wikipedia. https://en.wikipedia.org/wiki/Gini_coefficient#/media/File:Gini_since_WWII.svg

safety-net transfer payments are included, which in the U.S. they often aren't.³⁸

While safety-net programs are not a substitute for a good job, they can provide help in difficult times. The problem with so many of them is that they tend to become permanent, and even considered a right by the people who receive them. Once that happens, as it usually does, those receiving benefits, as well as the various interest groups that claim to speak for the poor, demand more generous outlays. And they begin funneling political support to politicians who will vote to increase funding, regardless of whether the increases are financially sustainable. Thus begins the downward cycle that pushes a safety-net program, and eventually the country, to the fiscal cliff.

The Forgotten Factor: Wealth

President Barack Obama, and many other politicians, focused on need and income, not wealth, even though there are people with substantial assets who receive taxpayer-funded subsidies. For example, the Affordable Care Act provides subsidies to individuals and families based only on their income. So a person might have retired at, say, the age of 55 having invested large portions of his or her income in a private retirement account. He could have millions of dollars in savings and yet draw taxpayer-provided subsidies to pay for Obamacare because he has very little income.

38. Mark J. Perry, "Census data released today show continued gains for middle-class Americans and little evidence of rising income inequality," American Enterprise Institute, September 12, 2018. (Fifth graph) <http://www.aei.org/publication/some-charts-from-the-census-data-released-this-week-on-us-incomes-in-2017-showing-impressive-gains-for-americans/>

The role of safety nets is to provide income to help people over a difficult period, such as a job loss, a disability, perhaps a catastrophic medical expense, etc. Safety nets do not build wealth; productive income and investing build wealth. The only real solution to income inequality and the growing entitlement crisis is to build wealth so that safety nets are needed less, by fewer people and for shorter periods of time.

The easiest way to build wealth is to help people save and invest over their working careers. But where will people who are living from paycheck to paycheck find the additional money to set aside? The answer is they don't have to find extra money; workers are already setting aside 15.3 percent of their income every payday. As we explain in a later chapter, the government just needs to allow them to put that money into a personal retirement account that can be invested and grow with the economy.

Families that build up significant assets during their working careers don't need a government safety net, *because their financial assets are their safety net*. The real solution to the entitlements cliff is, therefore, a population in which the vast majority has significant assets set aside in private accounts that belong to them.

Performance of the U.S. Safety Net

We have created a model that examines the various U.S. safety net programs' impact on economic activity over more than three decades: 1980-2014. It includes tax rates, participation in the economy and safety nets, average-income patterns, gross national deficits, and gross needs for capital by these safety nets. Summarizing what we found:

- Average safety-net benefits for the under-age-65 working population have grown between 1980 and 2014 from 23 percent to 39 percent of average income.
- Households in the safety net have increased from 22 percent to 35 percent, and that number is likely higher now that the Affordable Care Act is providing health insurance subsidies to millions of Americans.
- The average per-household cost to taxpayers of all safety-net benefits, including Social Security and Medicare, has increased from \$6,400 in 1980 to almost \$36,000 in 2014—an average annual increase of 5.2 percent.
- While GDP grew at an average annual rate of 4.1 percent per household from 1980 to 2014, the per-household safety-net cost to taxpayers grew at 5.2 percent.
- However, these numbers do not include Social Security’s and Medicare’s unfunded liabilities, which are growing at a considerably faster pace.

The U.S. Safety Net’s Impact in Four Tables

Table 10.1:

The following table shows the average and median gross income levels for four different years over a 34-year span. The cost-of-living figure reflects the changes from the previous year listed.

While the average and median gross income levels have increased significantly over nearly 35 years, the average has increased faster than the median, which means that higher-income households have seen larger percentage increases than lower-income households, and that trend is accelerating.

	1980	1990	2000	2014
Average	\$19,030	\$32,679	\$49,645	\$67,206
Median	\$16,463	\$28,603	\$41,721	\$50,419
Average-to-Median Ratio	0.87	0.87	0.84	0.75
Cost of Living Trend		0.047	0.028	0.016

The table also shows that the trend in the cost-of-living increase has declined. But note how the spread—the gap between the average-to-median ratio and cost of living—has decreased. In fact, the trend in median income is lower than that for the cost of living from 2000 to 2014. This effectively means the lower-income households have seen expenditures grow faster than their gross incomes.

Other studies have confirmed our analysis. For example, the Pew Research Center says that in 1971, 61 percent of the population was in the middle class, as defined by Pew.³⁹ By 2015, only 50 percent was middle class. But that doesn't mean everyone is getting poorer. The combined upper-middle and highest class grew from 14 percent in 1971 to 21 percent in 2015, while the lower-middle and lowest class grew from 15 percent to 29 percent. In short, while some people are doing better over the past three to four decades, an even larger percentage is in worse shape.

This income stagnation is one of the reasons Donald Trump was elected president. Both he and Barack Obama, when he

39. Rakesh Kochhar and Richard Fry, “5 Takeaways About the American Middle Class,” Pew Research Center, December 10, 2015. <http://www.pewresearch.org/fact-tank/2015/12/10/5-takeaways-about-the-american-middle-class/>

was president, complained about it. Obama's policies exacerbated the problem; at this writing Trump's policies appear to be addressing it.

Table 10.2:

The second table shows combined federal, state and local government expenditures per household for all eight welfare categories, including other health care costs. Costs for senior benefits are excluded.

	1980	1990	2000	2014
Average Expend/ Household for Safety Net.	\$2,175	\$3,677	\$6,083	\$15,944

Note that average per-household safety-net expenditures have increased by more than 600 percent over 34 years.

Table 10.3:

This table shows our estimates of economic activity (productivity of people working), proportion of people receiving safety-net benefits, ratio of average safety-net benefits to gross average income, public debt, total debt including unfunded liabilities, and average unfunded liability per household.

These figures indicate a decrease in economic participation between 1980 and 2014, with a commensurate increase in safety-net participation. Public debt has risen significantly during those 34 years, fueled in part by the rise in safety-net spending. The result of this unchecked spending boom is that the per-household share of federal debt, including Social Security's and Medicare's long-term unfunded liabilities, rose to \$758,000 by 2014, according to our estimates.

Note that each household's portion of the government's unfunded liabilities increased by nearly 12-fold over 34 years.

	1980	1990	2000	2014
Economic Activity Participation	0.939	0.939	0.935	0.925
Proportion in Safety Nets	0.22	0.25	0.28	0.35
Ratio of Average Safety Net Benefits	0.23	0.24	0.25	0.39
Growing Debt (trillions)				
Public Debt	\$0.7	\$2.4	\$3.4	\$12.5
Total Debt including Unfunded Liabilities	\$5	\$18	\$35	\$94
Federal Debt per Household (thousands)				
Debt Per household with Unfunded Liabilities	\$61.0	\$191.5	\$324.1	\$758.2

Table 10.4:

Safety nets and the tax system are intertwined, a point often ignored by many analyses. Both provide feedback loops that affect people's decisions about how much, or whether, to work. Rising income can reduce safety-net benefits, but it can also increase taxes. Those who constantly call for increases in the number and benefits of safety-net programs, and those who always want more and higher taxes—the two groups are often one in the same—fail to acknowledge that benefits and taxes interact, multiplying the work-discouraging impact.

Our analysis of the composition of current U.S. safety nets, as projected for 2019, shows a serious problem has emerged for those with modest incomes: *They choose safety-net benefits over work.*

2019 Projection for Under-Age-65 Population of Wage Levels and Corresponding Safety Net Benefits and Taxes by Household

Annual Wage	Probability	Income Tax Rate	FICA Rate	Safety Net Benefits	Marginal Tax Rate	Net Income
\$4,296	0.050	0	0.0765	\$34,174	0.077	\$38,141
\$12,888	0.075	0.013	0.0765	\$31,227	0.439	\$42,958
\$21,480	0.098	0.028	0.0765	\$29,512	0.327	\$48,737
\$30,071	0.113	0.044	0.0765	\$27,536	0.388	\$53,995
\$38,663	0.100	0.059	0.0765	\$19,881	1.079	\$53,313
\$47,255	0.081	0.074	0.0765	\$9,813	1.391	\$49,955
\$55,847	0.060	0.089	0.0765	\$0	1.391	\$46,593
\$64,439	0.046	0.104	0.0765	\$0	0.280	\$52,782
\$73,031	0.037	0.120	0.0765	\$0	0.310	\$58,710
\$81,622	0.028	0.135	0.0765	\$0	0.340	\$64,378
\$90,214	0.020	0.150	0.0765	\$0	0.371	\$69,784
\$98,806	0.01	0.165	0.076	\$0	0.393	\$75,002
\$107,398	0.009	0.180	0.074	\$0	0.413	\$80,046
\$115,990	0.008	0.193	0.073	\$0	0.417	\$85,058
\$124,582	0.005	0.204	0.072	\$0	0.411	\$90,118
\$133,173	0.004	0.215	0.071	\$0	0.426	\$95,052
\$141,765	0.004	0.234	0.071	\$0	0.591	\$98,564
\$201,452	0.247	0.285	0.065	\$0	0.458	\$130,895
Average						
\$82,153				\$12,845		\$71,795

The table above shows an estimated aggregation of all under-age-65 U.S. households according to selected wage categories, taxes (income and FICA combined), and marginal tax rates for

each additional dollar of wage. We include welfare benefits for health care—including public health (but excluding long term care)—housing, food, employment, energy and cash benefits. These are projected to total \$1.29 trillion in 2019. We exclude social services, education, pension and veterans' benefits. This table demonstrates a very serious problem. People have a strong economic incentive to keep their wages limited up to a certain level so that they can maximize their total net income—i.e., all safety-net benefits included and after taxes.

In this demonstration, households making roughly \$30,000 in pre-tax income have a net income, when all safety-net benefits are included and taxes are paid, of almost \$54,000. After the worker passes the \$30,000 level, his total income—after-tax, plus-benefits—begins a gradual decline, though it remains higher than wages alone. It isn't until the worker passes about \$50,000 in wages that his earned income exceeds his after-tax income plus benefits.

Of course, we are dealing with averages and aggregates. Households vary significantly, such as where they reside, the size and make-up of a household, health status of members, assets held, ages and safety nets applicable, and potentially other factors. For that reason, each household will have different thresholds and points at which incentives come into play. Some may face little or no disincentives to work more, while others face even stronger disincentives.

What has happened is that generous safety-net benefits, combined with the “employment penalty”—i.e., the financial downside of declining safety-net benefits and increased taxes when income improves—has created a disincentive for

lower-income individuals to work more or seek better jobs and pay. That doesn't mean that millions of working Americans are refusing pay increases or stating outright that they don't want a better job. The impact is more subtle. In some cases they might recognize that additional hours worked or an increase in pay would cost them particular benefits, such as Medicaid, but in other cases it will only affect workers at the margin. Why put in a few extra hours of overtime, they may ask, if it means I lose some of my benefits?

In our modeling, people in the \$30,000-to-\$50,000 income range would want to weigh very carefully the impact of additional on-the-books income. That is even truer today because the Affordable Care Act provides taxpayer-backed subsidies and assistance to millions of low- to upper-middle income workers. An income increase of a few thousand dollars—normally a very good thing—could lead to the loss of valuable benefits, if the worker were to, say, pay higher taxes and lose a significant portion of his or her ACA subsidies.

In summary, our analysis implies:

- The bottom quintile is doing better than some imply due to the increased influence of safety nets.
- The middle class is being squeezed, with some people moving up and others down. Those moving toward the bottom are increasingly entering various safety-net programs.
- Our safety-net system is unsustainable. The government has overpromised the benefits and underfunded the costs. However, the solution is ***not to put more money in the system***. More money extracted from the private sector and funneled to the safety net will limit economic growth by

discouraging work, saving and investment. Indeed, the safety-net system needs to be restructured significantly so that costs and taxes can be lowered and economic growth returns.

Said differently, our research indicates that overly generous and misaligned safety nets discourage work and deter economic growth, which leads to reduced investment capital and a lower labor force participation rate, which reduces tax revenues and, therefore, puts additional strains on safety-net finances. In short, the U.S. safety-net system—and just about every other country’s system, for that matter—creates a vicious negative feedback loop.

Focusing on Wealth Creation as a Means of Reducing Economic Inequality

For an alternative system to remedy these problems, it must balance the need for a viable safety net with incentives that encourage those in the system without permanent disabilities to return to some form of productive work as soon as possible. Frankly, the only way to ensure a financially stable safety net is to make sure it hasn’t become a hammock.

Everyone needs the opportunity to create wealth, not more dependency on government subsidies. One key to creating greater wealth opportunities and funding the safety net is to have a vibrant employment environment. Under normal conditions, employers want to hire and grow their business, people want to work and improve their status, and consumers want to spend their income on things that they believe make their lives better. If people aren’t doing those things, there’s a reason—and government interference is usually at the heart of it. Governments need a system to enforce contracts, protect

against fraud and provide minimal, basic regulations. But other than that, *government should get out of the way and let people engage in commerce.*

The other keys to creating wealth opportunities are dramatically restructuring the current risk-transfer system and allowing people to provide for their future needs by putting their current payroll taxes into personal accounts that belong to them. Meeting current financial needs by transferring most or all risk to future generations—as the U.S. has done for decades—is a formula for wealth reduction, which effectively fuels economic inequality.

Modifying the Current Model

To reverse the economic inequalities noted above there are four categories of fundamental reforms that must be made:

1. *Improve educational opportunity:* This means both more education and training, but perhaps even more importantly, an improvement in outcomes. The U.S. spends tremendous amounts of money on education, but we simply are not getting our money's worth. Some public education systems do a very good job of preparing students for college and to compete in the global economy. Others have done a deplorable job, leaving kids uneducated, untrained and unexcited about their prospects. Reforming the worst schools has proven to be almost impossible, as entrenched, unionized rent seekers fight reforms that would challenge the status quo by increasing choice and opportunities. Give people choices about how they spend their education dollars—or better yet, just give them their education dollars—and let the rewards, or lack thereof, flow to them. The educational system must change or the public should prepare to live with poor performance and income inequality.

2. *Improve incentives to work:* The regulatory excesses in safety nets and the work environment are staggering, creating strong disincentives to work and incentives for many to use more safety-net benefits for longer periods of time. Fortunately, President Trump has begun the process of rolling back those regulations and disincentives, but there is still a long way to go.
3. *Reform the subsidy and risk-transfer systems:* Subsidy programs must be part of a larger picture that is both actuarially and economically sound—that is, able to remain financially stable for years, in both good economic times and bad. Safety-net programs and economic policies must encourage people to work and leave the safety net as soon as possible. And risk-transfer systems must be both sustainable and properly integrated with subsidy systems. Violating actuarial and good economic principles have just the opposite effect—and yet that is what almost every safety-net and related risk-transfer program does.
4. *Move to prefunded accounts where possible:* Elected officials and the public need to understand that the best antidote to poverty is wealth. And the best way for people to create wealth is to set aside a portion of their earnings in personal retirement accounts that grow with the economy. U.S. workers already “save” 15.3 percent of their income; it’s just that most won’t get market returns on those funds and they cannot call that money their own. Making that one change would, within a generation, create a nation of millionaires, boost the economy by shifting all of that private capital to productive use, and help reduce income inequality. Income transfers from one person to another—which is the financial basis for nearly all safety-net

programs—*do not create wealth*. They only transfer wealth from one person's pocket to another's.

The bottom line is that to reverse economic inequality takes a combination of all four of these changes. These factors are not the only ones, but get them right and most of a country's other economic problems will decline, especially if the country maintains pro-growth economic policies. There is simply no substitute for good economic and actuarial policies. Politicians can make a number of errors in other areas if they have implemented pro-growth economic policies with sound subsidy and risk-transfer systems—because they will have a growing revenue stream to fund their policies. But embracing slow-growth economic policies, including poorly designed subsidy and risk-transfer systems—which is what most countries have done—creates strains everywhere.

PART IV

CREATING A SUSTAINABLE SAFETY NET

Our goal in the next four chapters is to outline a sustainable safety net that will:⁴⁰

- Provide for seniors and the temporarily and long-term needy;
- Dramatically increase the number of wealthy Americans by allowing people to save and invest some of their money currently being transferred to the government;
- Remain financially stable in both good economic times and bad;
- Minimize economic distortions that encourage or require the inefficient use of capital; and
- Embrace pro-growth policies that grow the economy and reduce the need for safety nets.

40. Throughout these chapters, various assumptions correspond to our best estimates of savings and costs. These chapters point out some of the more salient assumptions and related provisions, but in many instances detail is not included. We have prepared a supplemental document available online entitled “Details on Assumptions and Related Calculations,” which provides much more detail on the calculations.

Chapter 11

A Safety Net for Seniors

The majority of federal entitlement spending is on Social Security and Medicare, an estimated \$925 billion and \$702 billion, respectively, in outlays in calendar year 2017—a total of \$1.63 trillion. Solve those two programs’ financial problems and the country will take a huge step toward long-term financial solvency.

And the only way to solve the programs’ financial challenges is to move to a system of prefunded accounts that are owned by individuals, not the government. Workers should be allowed to put their Social Security and Medicare payroll taxes into a personal account that would grow with the economy. Such proposals always raise concerns about account management and accusations of being a “risky scheme,” to use former Vice President Al Gore’s term. Fortunately, there are several options available to address the inherent risks that come with people managing their own accounts and occasional stock market declines.

But contrast the concerns and risks associated with prefunded personal retirement accounts with what the government has done for decades—and continues to do. As we have demonstrated in previous chapters, politicians have repeatedly expanded senior safety-net programs for political purposes—for example, so they can claim they are helping seniors so voters should reelect them—exacerbating the programs’

long-term financial instability. These politically motivated steps have not been based on sound actuarial principles, leaving a huge financial hole for future generations to address.

Setting up an actuarially sound prefunded system from scratch is relatively easy. Workers just entering the labor force would begin contributing to both their income and health care retirement accounts and continue with those contributions over their working lives. Those who haven't reached a designated threshold of savings by retirement would have their accounts topped up by the government.

Unfortunately, we aren't starting from scratch; hundreds of millions of Americans have been paying into both Medicare and Social Security for decades. In both programs, current contributions pay for current retirees and disabled individuals. Moreover, the Medicare FICA tax only covers hospital expenses. Physicians and prescription drug costs are paid for by seniors' premiums, which cover about one-fourth of the costs, and hundreds of billions in taxpayer dollars. The result is that the country faces trillions of dollars in unfunded liabilities—and the liabilities are growing.

So we will first present the ideal retirement system, one that the country should have embraced—and many people called for—in 1935 when Congress passed Social Security. Then we will discuss an approach to transition from the current to the new system.

The Ideal Retirement Account Option

The most responsible option is to let individuals manage their own retirement funds, just as they manage their IRA accounts. Of course, individuals can, and often do, make bad investment

decisions—as do some of the brightest and most experienced money managers. And it may be imprudent, not to mention politically impossible, to allow account holders to speculate on anything with their retirement accounts. The biggest problem isn't with most people investing too speculatively, but too conservatively, and not earning a sufficient return. But, if allowed, some would invest in very risky options and perhaps lose all of their retirement funds.

One often-discussed solution is to restrict investment to a limited number of approved, broad-based mutual funds, such as S&P 500 or Russell 2000 index funds. That way the money grows broadly with the economy, and people don't have the option of trying riskier investments. Because we're talking about decades of investment growth over a working career, not a year or two when a stock market decline can really hurt a nest egg, the vast majority of people would retire with very large accounts, in the hundreds of thousands, if not millions, of dollars.

Alternatively, the accounts could be managed by a financial planner, as are three Texas counties that, as we discuss later, opted out of Social Security in 1981 and 1982. Exactly how the accounts are managed and invested are details—important details to be sure, but details. Setting up a system where workers' FICA contributions are safe, protected and invested is not difficult.

The bigger question is what to do with low-income workers whose contributions have remained low for their entire working careers, or for those who work occasionally or not at all. For example, though it's not as common as it used to be, some spouses never enter the workforce. As a social insurance

program, Social Security's distribution formula is adjusted to bump up benefits to low-income workers at the expense of higher-income workers. And one need not work an entire career: Social Security only requires workers to contribute for 40 quarters to qualify for full benefits. And Social Security allows a stay-at-home spouse to share the benefits of a working spouse.

We provide two possible solutions to this problem. The first option is to set a floor for workers' annual contributions. That is, actuaries would determine a minimum amount workers would need to deposit annually in their personal Social Security and Medicare accounts. If a person's deposits by year's end don't meet that threshold, the government would make up the difference, thereby ensuring that every person ends each year with a minimum contribution. Alternatively, actuaries could determine a minimum amount necessary for those who have reached retirement age—rather than on an annual basis—and provide a one-time deposit to those accounts so that they meet an asset threshold.

The current 40-quarters rule—or some designated minimal amount of time worked—would only apply to those who haven't reached the minimum threshold by the time they want to retire. Anyone who has reached or surpassed a minimum level of assets in a personal Social Security and Medicare retirement account—which could vary based on age—could retire regardless of how old the worker is. When the money in the retirement account belongs to the individual, it's nobody's business when someone retires. Our modelling of costs savings assumes this scenario.

Creating an account threshold at retirement also addresses the problem of a stock market decline. Even if the market were to decline and stay down for a few years before a low-income worker's retirement, the government would top it up to the threshold.

For spouses who stay at home and aren't personally employed in the labor force, they still have a property right in their partner's benefits, even if the partner dies. And they would have any funds they contributed themselves to their own retirement account if they had worked some years before or after a period of staying at home.

Parts of the Senior Safety Net

There are at least two, but possibly as many as four, components to the Senior Safety Net.

- Retirement Income
- Medical Care
- Long Term Care
- Life Insurance

The current FICA payroll tax is 15.3 percent, split evenly (i.e., 7.65 percent) between the employer and employee—though high-income earners pay a little more in Medicare taxes due to the Affordable Care Act. Of that amount, 12.4 percentage points go to the Social Security Trust Fund and 2.9 percentage points to the Medicare Trust Fund.

Currently, Social Security provides for retirement income, survivorship benefits, a death benefit of \$255, and disability benefits to those who qualify. The Medicare payroll tax

pays for hospital expenses, known as Part A. Medicare also pays physicians' bills (Part B) and prescription drugs (Part D), but seniors must voluntarily choose to join both Parts B and D. Seniors pay monthly premiums for both programs, which cover 25 percent of each program's costs. The other 75 percent is paid by taxpayers out of general revenues.

For very poor seniors, Medicaid pays their Part B and D premiums and Part A deductible, and it covers long term care costs after seniors needing nursing home care have exhausted their assets—or hidden their assets so that it appears they don't have any.

Creating a private retirement system that covers these elements may seem daunting at first, but it's easier than it looks. The Alternate Plan used by three Texas counties is able to combine retirement income, a generous term life insurance policy, and a disability policy for the same 12.4 percent of income workers currently pay in Social Security payroll taxes.⁴¹ All the Alternate Plan needs is a few tweaks to become a viable private sector alternative to Social Security.

The Alternate Plan Explained

Unlike a traditional IRA or 401(k) plan, where accountholders can actively manage their investments, Alternate Plan contributions are pooled, like bank deposits, in a savings account, and top-rated financial institutions bid on the money. Thus, it is based more on a banking model than an IRA model.

41. Merrill Matthews, Jr., "No Risky Scheme: Retirement Savings That Are Personal and Safe," Institute for Policy Innovation, Policy Report 163, January 2002. Note: Some numbers have been changed to reflect change over time. https://www.ipi.org/ipi_issues/detail/no-risky-scheme-retirement-savings-accounts-that-are-personal-and-safe

Those institutions guarantee a base interest rate. Over the last decade, the accounts have earned between 3.75 percent and 5.75 percent every year, with an average of around 5 percent. Any new plan could allow rates to change to some degree depending on the environment.

The 1990s often saw even higher interest rates: 6.5 percent to 7 percent. Thus, when the market goes up, employees make more; but when the market goes down, employees still make something, virtually eliminating the problem of workers deciding not to retire because of a major drop in the market.

Our proposal provides this type of plan for all three forms of protection: retirement income, aged medical care, and long term care.

Under the Alternate Plan for retirement income, retirees typically do much better than those who retire under Social Security. According to First Financial's calculations, the company that manages the plan, based on 40 years of contributions.⁴²

- A lower-middle income worker making about \$26,000 at retirement would get about \$1,007 a month under Social Security, but \$1,826 under the Alternate Plan.
- A middle-income worker making \$51,200 would get about \$1,540 monthly from Social Security, but \$3,600 from the Alternate Plan.
- And a high-income worker who maxed out on his Social Security contribution every year would receive about

42. Matthews, "Social Security by Choice." https://www.ipi.org/docLib/20120323_2012_03_05_AmSpectator_Matthews.pdf

\$2,500 a month from Social Security compared to \$5,000 to \$6,000 a month from the Alternate Plan. While these benefits would obviously vary depending on the specifics of any legislation, we would still expect the average Social Security benefit under the proposed plan to significantly exceed the average benefit of the current system. What the Alternate Plan has demonstrated over 35 years is that personal retirement accounts work, with many retirees making more than twice what they would have under Social Security.

In other words, a reformed retirement plan for seniors based on the Alternate Plan would provide substantial retirement assets, as well as the other benefits provided by Social Security. And it could be done with virtually no change in the current payroll tax.⁴³ The key difference is that the money would be going primarily to private investment and insurance rather than the government.

The Alternate Plan Isn't Just Income

Social Security is not just a retirement fund. It is social insurance that provides a death benefit, survivors' insurance, and a disability benefit. When financial planner Rick Gornto devised the Alternate Plan for Galveston and two other Texas counties, he wanted it to be a complete Social Security substitute.

Survivor's Benefits

Part of the Alternate Plan's employer contribution provides a term life insurance policy, which pays four times the employee's salary tax free, up to a maximum of \$215,000. That's nearly 850 times Social Security's death benefit of \$255.

43. There would be a small increase if the long-term care provision were included.

However, Social Security does provide funds for families with children that have lost a primary provider. Depending on the age and number of children, that benefit could be thousands of dollars over many years. The Alternate Plan's term life insurance policy helps offset those costs. The cost of the policy comes out of the workers' 12.4 payroll tax, so there is no extra cost to the worker.

A Long Term Care Option

Currently, Medicare only provides a limited long term care benefit for those needing rehabilitation. Poor seniors can access long term care through Medicaid, but finding a nursing home or assisted living center that will take Medicaid can be a challenge—and a disappointment. Fortunately, long term care insurance could be added to our Senior Safety Net. The best option would be to allow workers to choose a policy and offset the cost by choosing a smaller life insurance benefit or less money going to retirement.

Creating a Personal Retirement Plan

The key point here is to let workers choose, within certain guidelines, how they want to allocate their Social Security FICA tax between retirement income, life insurance, disability and possibly long term care. People with different risk tolerances may want some flexibility in their benefits. Those with a family history of chronic disease may want more disability or long term care insurance. Those with a family history of heart disease may want more life insurance. Young families may want to devote less to long term care and more to life insurance to provide for the family in case of an untimely death.

Workers who have become empty nesters and are heading towards retirement may want less life insurance and more long term care coverage, especially if they have set aside significant assets in their personal retirement account.

Other Alternate Plan Opportunities

Roughly 25 percent of public employees—about 6 million people—are part of state and local government retirement plans outside of Social Security. Many of those plans are facing serious unfunded liability problems, just like Social Security. But the good news is those state and local plans do not have to wait for Congress to act—they can switch to the Alternate Plan immediately. However, state and local plans currently participating in Social Security are stuck without new legislation. The Greenspan Commission, led by then soon-to-be Federal Reserve Chairman Alan Greenspan, closed that opt-out window in 1983.

Immigrant Workers

Immigrants who have permanent resident status should be allowed to participate in this reformed Social Security model. After all, they are simply setting aside the money they have earned into a personal retirement account.

Those with only temporary status, or those who are here illegally but have the right to work (e.g., the so-called Dreamers), should be allowed to participate without the possibility of the government top-up if they retire with less than the set threshold.

An Alternate Plan for Medicare

But can something similar be done for Medicare? Yes, and under exactly the same parameters. Workers' 2.9 percent

Medicare payroll tax could be set aside in a personal account. As with our Social Security reform, the government could set a floor, whether that determination is on an annual basis or when a person reaches the prescribed eligibility age is a political decision. A worker who has reached the financial threshold for his or her age would be able to retire and begin drawing on those assets, regardless of the retiree's age.

Two decades ago, making this transition to prefunded Medicare accounts might have seemed impossible because Medicare had always been a defined-benefit plan. How do you set money aside for a defined-benefit plan when similarly situated people can use vastly different levels of benefits in any given year?

But when Medicare+Choice passed in 1997, followed by the much better Medicare Advantage program in 2003, at least part of Medicare became a defined-contribution plan. All workers pay into Medicare, but when they turn 65, about a third of them voluntarily choose to join a private sector Medicare Advantage plan.

Under Medicare Advantage, the government writes a check to the private sector health plan of the senior's choosing. That health plan must then provide comprehensive health care for the senior. Such an approach is, in effect, a defined-contribution plan.

But if a worker is going to set aside money in Medicare for 45 years, only to have the government write an annual check to a health insurer upon retirement, then workers should be allowed to set their own money aside and as a retired senior write their own check to a health plan. For those who want to

remain in traditional Medicare—which should be an option, at least for some period of time—actuaries could set a premium for them. Thus, the Medicare Advantage legislation has opened the door for privatizing Medicare.

However, a problem arises with Medicare that doesn't exist in Social Security. Seniors who join Medicare Parts B and D pay premiums, but those premiums only cover about one-quarter of the programs' costs. The federal government uses general revenues to cover the remaining three-fourths. Thus, we are spending much more than the 2.9 percent Medicare payroll tax and seniors' Parts B and D premiums to cover seniors' health care bills.

Those hidden Medicare costs make transitioning to a prefunded system more difficult because the government is significantly subsidizing current retirees' health care costs. But policymakers need to realize that we are spending that money now, it's just coming from current taxpayers.

Under a reformed Medicare system, taxpayers could continue to pay the costs they are now paying—i.e., the 2.9 percent FICA tax while working, with the federal government supplementing whatever is needed to hit an actuarial threshold at retirement. And they could pay their portion of the Part B and D premiums when they join Medicare.

Or we could require a larger contribution to workers' Medicare retirement account—one that would reflect the total estimated cost of needed care, including Parts B and D. Taxpayers ultimately are covering the cost either way. Our modeling adopts this latter approach.

Cost Estimates for Medicare

What is that additional cost? Currently, about 42 percent of Medicare spending (about \$293 billion of the total estimated \$702 billion in federal money spent on Medicare in 2017) is on hospitals and related costs under Part A. Just under 44 percent (\$309 billion) is spent on physicians and associated Part B costs, and about 14 percent (\$100 billion) goes for Part D prescription drugs.⁴⁴

If the political powers that be decided that there would be too much public resistance to raising the Medicare FICA tax to cover all future costs, then workers would continue to make their 2.9 percent payroll tax contribution to Medicare Part A and the government would continue to cover the majority of Parts B and D costs each year. If, on the other hand, the decision were made to increase the Medicare payroll tax so that when workers retire they would have enough, based on actuarial estimates, to cover all of their health care spending, then we estimate that the Medicare payroll tax would need to be an additional 1.9 percent of employees' income.

But remember, this isn't a new tax; it's a replacement for current taxes. General tax revenues currently pay for the federal government's share of Parts B and D. Transitioning to a system where workers prefund all of their Medicare expenses would require more being deposited in workers' personal health care retirement account, but that additional contribution should be largely offset by a reduction in other taxes that are used to cover most of Parts B and D costs.

44. Juliette Cubanski and Tricia Neuman, "The Facts on Medicare Spending and Financing," Henry J. Kaiser Family Foundation, June 22, 2018. <https://www.kff.org/medicare/issue-brief/the-facts-on-medicare-spending-and-financing/>

What Happens if Personal Accounts Are Exhausted

Accounts established for retirement and aged medical and long term care may be exhausted by individuals for various reasons. In particular, those with minimum accounts upon retirement who outlive the average life expectancy are at the greatest risk. Our plan includes a separate safety net called the Fallback Safety Net to cover costs in such scenarios. This safety net, and its provisions, are discussed in more depth in Chapter 14.

A Pro-Growth Boost to the Economy

If workers were essentially funding all of their retirement needs through their personal accounts, it means some \$1.6 trillion (in 2017 dollars)—combining Social Security and Medicare and ignoring the optional long term care provision—or more than 40 percent of total federal revenue, would be redirected from the government to private investment over time. The ultimate infusion alone is roughly 7.5 percent of GDP, and would increase investment in the economy.

But even if elected officials decided to only allow workers to set aside funds equaling their current Social Security and Medicare payroll tax of 15.3 percent, roughly \$1.2 trillion would still be flowing into private sector investment every year and would remain there until retirees gradually draw down their accounts. The pro-growth economic benefits of such a change cannot be overstated. This one change would be the biggest annual boost to an economy the world has ever seen.

Estimates from Our Model

Our assertion is that a Senior Safety Net based on personal retirement accounts that workers contribute to over a lifetime will provide retirees with significant funds that would be used

for income and to pay for health care and possibly long term care. The new system would effectively replace what we provide for seniors today through Social Security, Medicare and, for poor seniors who need nursing home care, Medicaid-funded long term care. And it would provide a life insurance benefit greater than the death and survivors' benefits that exist today under Social Security.

In our modeling, the Senior Safety Net provides a minimum threshold benefit for all workers who enter the program at age 25. Those with higher incomes and those whose working career contains few or no interruptions will likely have higher balances at retirement, just as current Social Security beneficiaries who had higher incomes receive larger stipends.

For modeling purposes, we assume current beneficiaries would have their promised benefits continue unchanged. For those who are still working at the time of implementation, we assume some mix of personal accounts and standard Social Security and Medicare benefits.

Of course, an alternative approach is to make personal accounts only available to those newly entering the workforce. Thus, everyone who has paid into Social Security and Medicare would continue unchanged. We did not model that option.

The Senior Safety Net design reflects the estimated amount of money needed to cover income and medical needs at retirement. It reflects how much money workers would have to save over their working careers in order to reach this threshold. Those who have assets that exceed the threshold amount could retire at any age. But we realize that not all people would have adequate funds and so we include a one-time top-up to

retiring seniors' income and health care accounts. However, that means that the government would still need a defined retirement age for those whose accounts must be topped up. We gradually raise that age to 75 as discussed in the additional comments following the tables.

In addition, our modeling includes all Medicare costs from Parts A, B and D.

In Table 11.1, we break down the distribution of the Social Security (12.4%) and Medicare (2.9%) FICA taxes.

It shows the estimated allocation of FICA taxes to benefits, including the fallback provision plus disability and life insurance. We include long term care, but suggest that should be optional. That is, a person could divert some of his income savings, for example, to long term care.

Table 11.1			
	Social Security	Medicare	Long Term
Disability	.014		
Retirement	.080		
Medical/LTC		.045	.028
Fallback Safety Net	.004	.003	.003
Life Insurance	.002		
Total	.100	.048	.031

Thus 8 percentage points of the 12.4 percent Social Security tax would be allocated to savings; 1.4 percentage points would go toward disability, and life insurance and the Fallback Safety

Net would receive .2 and .4 percentage points each. That's a total of 10.0 percentage points of the current 12.4 percent—for a savings of about 2 percentage points.

But we aren't out of the woods. Medicare needs about 4.8 percent of income to cover all seniors' health care costs. However, the current Medicare FICA tax, which only covers hospital expenses, is 2.9 percent—nearly 2 percentage points less. So the additional 2 percentage points from Social Security could cross subsidize the Medicare costs.

To make the point plain, our modeling implies that the current 15.3 percent FICA tax, if set aside in personal accounts and allowed to grow over a worker's career, *would be enough to provide more retirement income, more generous life insurance and disability benefits AND pay all Medicare expenses currently paid by the government.*⁴⁵

Savings or costs are shown separately for Social Security (Table 11.2) and Medicare (Table 11.3) below and on a combined basis. The optional long term care provision is not reflected in our estimates below. But if the long term care option is implemented, we would not expect any material long-term savings or additional costs since the transition from the current to the new system is anticipated to produce costs roughly equivalent costs (most long term care costs today are covered by Medicaid).

45. Assumptions underlying these estimates are available in the Detail Assumptions document.

Table 11.2
Social Security Projected Benefit Savings
(billions of dollars)

	Disability Benefit Savings	Increase in Eligibility Age	Death Benefit	Subtotal
2019	\$ 5.3	-\$7.0	-\$7.6	-\$9.3
2025	\$43.3	-\$35.4	-\$9.1	-\$1.2
2035	\$91.6	\$90.4	-\$12.2	\$169.9
2045	\$113.9	\$296.0	-\$16.4	\$393.5
2055	\$138.8	\$268.4	-\$22.1	\$385.1
2065	\$222.9	-\$69.4	-\$29.8	\$123.7
2068	\$253.2	-\$265.6	-\$32.5	-\$45.0
All Years 2019- 2068	\$5,786.1	\$5,969.0	-\$859.5	\$10,895.6

Table 11.3
Medicare Projected Benefit Savings
(billions of dollars)

	Disability Benefit Savings	Increase in Eligibility Age	Aged Medical Utilization	Medicare Premiums/Revenue	Medicaid Subsidy	Subtotal	Grand Total 11.2 & 11.3
2019	\$13.6	-\$3.8	\$3.3	-\$2.3	-\$0.8	\$10.0	\$.7
2025	\$62.1	-\$15.4	\$28.6	-\$20.1	-\$6.7	\$48.5	\$47.3
2035	\$108.6	\$135.0	\$107.9	-\$69.0	-\$23.0	\$259.6	\$429.4
2045	\$143.1	\$438.3	\$223.6	-\$154.6	-\$51.5	\$598.9	\$992.4
2055	\$187.1	\$588.1	\$392.2	-\$298.8	-\$99.6	\$769.1	\$1,154.2
2065	\$244.4	\$565.9	\$637.8	-\$535.3	-\$178.4	\$734.4	\$858.0
2068	\$264.8	\$480.4	\$730.7	-\$631.4	-\$210.5	\$634.0	\$589.0
All Years 2016-2068	\$7,058.2	\$16,581.5	\$12,872.8	-\$9,912.4	-\$3,304.1	\$23,295.9	\$34,191.5

Additional comments on Tables 11.2 and 11.3 are:

- The Social Security disability savings of nearly \$6 trillion reflect a grade in over 10 years to the estimated 30 percent ultimate savings level in disability costs as compared to the current level.
- The estimated savings of over \$10.9 trillion in Social Security as shown above covers a period of over 50 years and is primarily attributable to the change in eligibility age from age 66 to age 75. This change is intentionally greater than the projected actual life expectancy is anticipated to increase during this period, or in essence a partial catch up for the tiny increase in the eligibility age for Social Security benefits from 1935 to 2015 versus what has actually occurred.
- The additional death benefit cost of almost \$1 trillion reflects the increase in the Social Security Death Benefit from \$255 to \$10,000.
- The Medicare disability savings of over \$7 trillion reflect that Medicare disability is moved to part of the under age 65 or eligibility age health care or welfare system as applicable. This change is discussed as part of both the Welfare Safety Net in Chapter 12 and such costs are included there; this change is also discussed as part of the Health Care Safety Net reforms in Chapter 13.
- The estimated savings of over \$23 trillion in Medicare as shown above covers a period of over 50 years and the change in cost due to the change in eligibility age from age 66 to age 75 is more than \$16 trillion of this change. As for Social Security, this change is intentionally greater

than the change in actual life expectancy anticipated to increase during this period, or in essence a partial catch up for no increase in the eligibility age for Medicare from 1965 to 2018.

Chapter 12

A Welfare Safety Net

Government-provided, and therefore taxpayer-funded, welfare should be sufficient to meet basic needs, only available to the poor and, most importantly, temporary for the vast majority of recipients. Every working-age person who doesn't have a physical or mental condition that effectively precludes them from work should be expected to work if they receive government financial help. It might be a standard job or it might be a make-work job. "Workfare," as it is sometimes called, is the best way to separate those who can get a job from those who can't.

Of course, the Senior Safety Net discussed in the previous chapter is different. It is not welfare but a decades-long, personal wealth-building program to address the financial needs primarily of seniors. It is only a "safety net" in the sense that it is mandatory and replaces the defined-benefit plans of Social Security, Medicare and optionally long term care. People are free and encouraged to save even more money for retirement or health care-related costs outside of the safety-net system. However, those seniors who exhaust their assets in retirement and thus become poor would have the fallback option to become part of the Welfare Safety Net.

The U.S. has created multiple, often redundant welfare programs. We propose combining those programs into a cash grant that could be used to pay for food, utilities, housing and health insurance—in short, what multiple welfare programs now cover.

Able-bodied recipients would be required to work to receive benefits. If they have a low-paying job, they would receive a sliding-scale supplement, which is essentially how the Earned Income Tax Credit has operated for decades.

If they do not have a job, they will have to perform some work at the welfare agency's direction to receive benefits. If a welfare applicant cannot find a job—and it can be a struggle for those who have been out of the workforce for a while—social workers will help connect beneficiaries with interested employers. The employer must provide a new job—i.e., an existing worker can't be laid off to make room for the welfare beneficiary. The new worker's job would be funded by his welfare benefits. After a certain period of time—e.g., four to six months—the employer must decide if he will hire that subsidized worker. If not, the welfare recipient works with the agency to find another job.

If there are no jobs available for subsidized work, the welfare recipient will be assigned to work in some manner for a portion of the week.

Of course, there are some who, for various reasons—e.g., expectant mothers in their third trimester, people with health issues, and those who are in a substance abuse program—may not be able to go to work immediately. There should be at least temporary exemptions for them. And, of course, there should be long-term or permanent exemptions for those with serious health or mental challenges.

But new mothers would be expected to go back to work shortly after giving birth, just as new mothers who have jobs are expected to do. Those with disabilities would also be expected

to work, if and when they are able, even if a recent disability means the individual needs to look for a different type of work compatible with the disability.

Those with serious mental or physical disabilities would need to be evaluated by a doctor on some periodic basis. Obviously, some people have debilitating conditions that would preclude them from ever working or returning to work, though that number is relatively small.

To be clear, the purpose of work is not punishment; in welfare it serves three purposes:

1. It discourages people from gaming the system. If a person is going to have to work to receive benefits, then most people who can find a job will do so.
2. It keeps those who don't really need government help out of the system and frees up money and social-worker time for those who do need help. In other words, the system can be more generous and helpful by keeping it focused on those who need it.
3. Most importantly, work is dignifying. There seems to be an attitude among critics that requiring people to work for their benefits is degrading or punishing. In fact, it just recognizes a fundamental principle: People gain dignity and self-esteem from working.

What if someone refuses to work? That is their prerogative; they just do not qualify for taxpayer-funded benefits. That doesn't necessarily leave them with no help. Our proposal has no impact on private or state and local public organizations

that provide food and shelter options for poor individuals. Many of the poor today remain outside of the formal welfare system, and we would expect that to happen under the new system also.

How Welfare Needs Will Be Met

Governments create multiple—and often overlapping—welfare programs to meet a range of people’s needs. Each of those programs has a bureaucratic constituency that works to keep its particular program alive—or expanded.

The real crux of our proposed Welfare Safety Net is to take virtually all of the various welfare programs and meld them into something similar to Nobel Prize-winning economist Milton Friedman’s Negative Income Tax.

In the previous chapter we identified the basic elements for a Senior Safety Net; here are the basic components for a Welfare Safety Net.

- Income
- Health Coverage
- Disability

Income

When people leave their jobs, either voluntarily or involuntarily, they may need to access funds to buy food and pay current expenses. Thus, the first line of defense against poverty after drawing down normal savings should be an individual’s personal retirement account discussed in the previous chapter, with a time limit of, say, one year. Only after that time period should people be allowed to turn to welfare.

The reason for this approach is simple: It makes very little sense for working-age people with significant assets to be on welfare, especially since someone who has paid into their personal retirement account for, say, 20 to 30 years could have a sizable account.

But what about their retirement? Wouldn't that approach allow people to exhaust their retirement funds? As we mention in our Senior Safety Net solution, the government would top up retirement accounts that haven't reached a targeted threshold.

Of course, the U.S. already has a Negative Income Tax working model: The Earned Income Tax Credit, which has been around since 1979. The program provides cash to individuals on a sliding scale and the recipients determine the best use of the money. What Friedman was adamant about was that society shouldn't embrace both cash grants and subsidy programs at the same time—which, of course, is exactly what the U.S. has done.

A system of cash benefits is much more useful than one with multiple programs that try to provide for a variety of needs, such as food stamps, help with utilities, housing and other needs. As Friedman once pointed out, a welfare beneficiary may have important needs other than what bureaucrats are willing to provide, such as paying for auto insurance so he or she can drive a car to work or buying a new set of work-appropriate clothes.

The current EITC is only available to those who have a low-income job, supplementing their paychecks. The EITC might still be the vehicle to provide cash benefits in a reformed welfare system, but recipients who could not find a job would have to participate in workfare.

To be clear, this approach is not equivalent to the guaranteed basic income proposal. What we are proposing is means-tested welfare. And those with assets in their personal retirement account cannot participate in welfare until they have been out of work for a while.

Now, it must also be noted that the EITC program has been plagued with fraud. A 2017 Treasury Department study found that 24 percent of EITC distributions, or \$16.8 billion, were improperly issued in 2016.⁴⁶ And the IRS claims it can't do much about the problem because the agency doesn't have enough people. But that answer is no excuse. While fraud and errors may not be entirely eliminated, a minimally competent government agency should be able to reduce it dramatically. One option is to provide the assistance through some type of electronic benefits transfer (EBT) card that would only work at established businesses, which would also allow social workers to check the welfare recipient's transactions.

Health Coverage

But what about Medicaid? Can that be part of the cash-grant program? Yes, though to ensure the money is used on health insurance it would not be sent directly to the beneficiaries but to their health plans or a Health Savings Account (HSA).

For those receiving health insurance coverage, as opposed to long term care coverage, through Medicaid, we can follow

46. "Revised Refundable Credit Risk Assessments Still Do Not Provide an Accurate Measure of the Risk of Improper Payments," Treasury Inspector General for Tax Administration, Ref. No. 2017-40-030, April 28, 2017. <https://www.treasury.gov/tigta/auditreports/2017reports/201740030fr.pdf>

the Medicare Advantage model. Beneficiaries can pick their health plan—whether an HMO model or a Health Savings Account plan—and the money would be sent to the insurer to cover all health care needs for the year. If we moved to a system where the federal government block grants Medicaid funds to the states, then the states could write the check to the appropriate entity. Such plans should include incentives for insureds to spend the money as though it was their own. And if a person spends less than the designated amount for qualified coverage, the difference should be deposited into their own personal HSA-type account.

Moving to an all-cash welfare benefit, with a portion of that cash going to an approved private health plan, would resolve the problem of the “Medicaid cliff,” where a person’s income passes a certain point and that individual loses all Medicaid coverage at once. Like the EITC, earning more income would lead to a reduction in the total cash benefit, but that doesn’t necessarily mean a loss of private Medicaid coverage; the recipient would just have less discretionary cash left over after the private Medicaid coverage is paid for.

However, if the beneficiary has access to employer-based coverage—the amount of which should be added to income for qualification and distribution purposes—then the beneficiary could opt out of Medicaid and receive that money in cash. Including the employer’s health coverage costs as part of the employee’s total compensation eliminates the welfare distribution inequity that would come from two people earning the same wages, but one receiving a lot more cash because his employer pays for health care.

Disability

The disability benefits provided in the Social Security portion of the Senior Safety Net will cover people who are working and become disabled (worker's compensation is a separate issue, but it is already covered by the private sector). In our proposal, the private sector disability insurer has an incentive to ensure the disabled person is doing his best to recover and return to work if and when that's possible. If not, the disability coverage remains in effect until the person reaches retirement age, whereupon the disabled person would be able to transition to the Senior Safety Net system, which provides income for living and health care needs.

We also include a disability benefit as part of the Welfare Safety Net for those who are unemployed. For health care or other items the amount of increase in the "cash" payment assumed in our modeling is 50 percent for a qualifying disability, but this number should be made to vary based on circumstances, including Social Security disability benefits.

The provisions for various disability scenarios should cover all of the disability-related programs now covered by the government, while allowing for additional disability protections as needed. For example, Medicare covers those with end-stage renal disease—i.e., kidney failure requiring dialysis. But there is no reason for that program to be in Medicare, especially if Medicare were to become a worker-funded personal retirement account. Such services need to be put in welfare where they belong.

As mentioned in the Senior Safety Net section, long term care services due to disability after retirement would be either paid for out of their personal retirement accounts or their (optional) long term care insurance or covered by Medicaid if applicable.

Combining the Programs

We suggest combining most means-tested welfare programs, including the EITC, into one sliding-scale cash grant that will decline as a beneficiary's income rises. The level of benefits would be politically determined, but it should be at least the federal poverty level—not including a reasonable health insurance subsidy—with a cap on the number of people in a family (e.g., four) so that there is no economic incentive to have additional children just to receive more benefits.

So, for example, the average 2016 FPL for one person was \$11,770, \$15,930 for two and \$20,090 for three. Assuming a 20 percent allowance for health insurance, the respective values are \$14,124, \$19,116 and \$24,108. For those doing government-provided work because they couldn't find a job, the cash allowance, plus health insurance, would be their income.

When they find a job and begin to bring home income, the welfare benefits would decline based on a predetermined scale that would allow them to benefit by earning more money. The health care values below reflect an average across those without and with disabilities.

As their income increases, they would lose some of their cash benefits. But they could still transfer some of those benefits to their health insurance to ensure they maintained coverage. But the key is the worker would decide where and how to spend the money: more on rent and less on transportation; more on transportation and less on health insurance, etc. By pegging benefits to the federal poverty level, providing cash instead of numerous targeted programs, requiring work as a condition of receiving benefits—except for those with a significant disability—and by reducing the number of bureaucrats

needed to manage the system, we would dramatically lower welfare spending, while ensuring that people who are willing to do something would stay above the poverty line.

Estimates from Our Model

The Welfare Safety Net design reflects the estimated amount of money needed to cover basic needs and medical costs for the poor and low-income workers. Savings reflect the difference between projected costs for our system over 50 years versus projected costs for the same activities in the present system.

Under our proposed Senior Safety Net, we suggest raising the full retirement age over several years, from the current 66 (and heading to 67) to 75 for those who do not have enough money to meet the financial threshold. Those with more than the threshold amount could retire at any time.

Raising the federal retirement age means lower-income Americans would likely be in the Welfare Safety Net longer than they would be today. However, due to the reduction in benefits as income rises, the average benefit would likely be lower.

Our program is estimated to produce savings as shown below in Table 12.1.

We estimate that welfare spending over 50 years without reform would be about \$270 trillion. If we had not raised the full retirement age to 75, our reform would save about 9.3 percent. But since we do, the Welfare Safety Net would save a little over \$6.15 trillion over 50 years, about 2.3 percent of current spending trends.

Table 12.1
Welfare Safety Net Costs (in billions)

	Current Health Care and Cash Benefit Trend**	Increasing Eligibility Age to 75	Total*
2019	\$102.0	-\$3.9	\$98.3
2025	\$159.0	-\$34.5	\$124.5
2035	\$284.1	-\$109.7	\$174.3
2045	\$461.8	-\$188.0	\$273.8
2055	\$710.8	-\$584.5	\$126.3
2065	\$1,055.8	-\$1,129.2	\$-73.3
2068	\$1,182.7	-\$1,284.2	-\$101.5
All Years 2016-65	\$25,166.2	-\$19,012.4	\$6,153.8

*Column (1)-(2).

** LTC benefit changes for seniors are not included.

Chapter 13

The Health Care Safety Net

This chapter explains how the country can transition from the ever-expanding government role in health care to a private alternative that increases access to health care, lowers costs and improves quality—all the things the Affordable Care Act was supposed to do but failed.

Ideally, Congress should repeal the ACA, but so far it has only been able to take small steps: repealing the penalty for not having qualified coverage, eliminating or postponing some of the ACA's taxes, and President Trump has expanded options for association health plans and short-term health plans.

While these are positive steps, they may be insufficient to allow a vibrant post-Obamacare health insurance market to emerge. Even so there may be ways to mitigate the ACA's damage and achieve many if not most of the same goals of expanding the number of people with good health coverage and spurring economic growth.

One of the problems is that there are millions of uninsured Americans who should be in the health care safety net but aren't. And there are millions who have no business being in the health care safety net but are. For example, there are people with significant assets who hide them so that a family member can enter a nursing home paid for by Medicaid. And there are millions who are uninsured and will likely stay

that way because health insurance premiums are too expensive, even with federal subsidies, or they simply choose not to obtain coverage.

Reinstituting Actuarial Principles in Health Care

The history of the U.S. health care system, and especially health insurance, with its myriad violations of sound actuarial principles, has left us with a convoluted, costly and inefficient system. Starting over is impractical. So whatever we do will likely mean re-introducing, to the extent possible, sound actuarial and economic principles within the current system. That would mean:

(1) Creating Health Care Consumers — We must incorporate incentives that encourage beneficiaries to spend health care dollars as though they were spending their own money—and tax-preferred Health Savings Accounts (HSAs) do exactly that. In other words, let consumers be consumers, in health care as in every other segment of the economy.

(2) Pre-Funding the Medicare Part A Trust Fund — Any surplus money in the Medicare Part A Trust Fund that isn't spent is borrowed by the federal government and replaced with a government IOU. It's time to transition to real pre-funded Medicare accounts. Why are workers putting money into a government account their entire working life so the government can pay health care claims or hand a private sector health plan an annual check once a year (as in Medicare Advantage) after the worker turns 65? Better to let workers put their Medicare payroll tax in a personal retirement account that would grow with the market and let them pay their health care bills or premiums themselves.

(3) End Government Mandates — Finally, the history of the government’s growing involvement in the health care system has been one of mandates, price controls and one-size-fits-all solutions. It has ignored the fact that people are individuals with different wants and needs. Other sectors of the economy are looking at how to individualize their products, and so should health care and insurance.

Elements of a Health Care Safety Net

The Affordable Care Act has changed health care expectations. It mandated guaranteed issue and modified community rating. And it provides subsidies for low- and middle-income families to help them pay for health care. Any revised, sustainable system would likely have to factor in the public’s post-Obamacare expectations.

A viable Health Care Safety Net would rely on:

- Private sector health insurance that underwrites policies, which includes charging applicants more or denying coverage in the individual market because of preexisting conditions (though some form of risk transfer to mitigate the full cost of some policies might be allowed);
- Subsidies for lower-income families to buy coverage;
- Incentives to remain in the health insurance system; and
- A high risk pool for the uninsurable.

Private Health Insurance

Private health insurance has been the foundation of the U.S. health care system. It worked well for decades, but began to

encounter problems as employers, often pressured by unions, began providing comprehensive coverage with very low out-of-pocket costs. The more insulated people were from the cost of health care the more they spent. By the 1980s, major health insurers began turning to managed care to control costs, which created huge tensions between patients, health care providers and third-party payers (i.e., employers, the government and insurers). There is nothing wrong with private health insurance or managed care if used properly, but the economic incentives must be structured to encourage patients to be value-conscious shoppers in the health care marketplace—just like they are in other sectors of the economy.

To achieve that value-conscious goal, we build on the consumer-driven health care plan (CDHP) model that includes high deductible health insurance—which could include managed care and other risk-control techniques—and Health Savings Accounts. Ironically, the exploding premiums created by the Affordable Care Act are pushing many people into high deductible plans, though those are often non-HSA-qualified plans. Current HSA restrictions should be loosened or eliminated so that anyone who wants an HSA can have one.

Ideally, individuals should be allowed to choose their own policy. Those in the individual health insurance market have always been able to do so, and employers have increasingly been providing employees with more than one health insurance option.

There is still the problem of workers losing their policy when they change jobs, though COBRA allows workers to continue their policies for up to 18 months if they pay the entire

premium themselves.⁴⁷ In other words, allowing workers to choose their policy and take it with them when they leave an employer—at least for a while—would be the best option.

The Role of Subsidies

No private health insurance system will cover most people without some type of subsidy for low-income workers who buy their own policies, and voters generally support such subsidies. The numbers are relatively small. Historically there have been between 15 million and 17 million people in the individual market; now there are about 10 million in Obamacare health insurance exchanges, and a little more than 5 million with individual coverage outside the exchanges.⁴⁸ About 85 percent of those in the exchanges receive taxpayer-provided subsidies. Of course, there are still nearly 30 million uninsured, some of whom would benefit from the subsidies if they bought coverage, but they choose not to.

The government can provide those subsidies directly, as Obamacare does, or indirectly through the tax system. Conservatives have generally proposed either a tax deduction for buying health insurance or a refundable tax credit. The tax deduction is easier from an administrative standpoint and is less subject to fraud, but it wouldn't help most lower-income workers because they pay little or no income tax.

47. COBRA only applies to employers with 20 or more employees.

48. Ashley Semanskee, et al, "Data Note: Changes in Enrollment in the Individual Health Insurance Market," Kaiser Family Foundation, July 31, 2018. <https://www.kff.org/health-reform/issue-brief/data-note-changes-in-enrollment-in-the-individual-health-insurance-market/>

A refundable tax credit may be the more popular solution because it provides cash for a lower-income person to pay for coverage. The downside is that it is an easier and more lucrative vehicle for committing fraud.

The government already provides a deduction for health insurance (to the self-employed), a tax exclusion to employees with employer-provided coverage, refundable tax credits (through the EITC program) that people can use to pay premiums, and direct health insurance subsidies (through Obamacare exchanges). We think the refundable tax credit is the most effective way to subsidize coverage, but all of these approaches are possible and workable.

High Risk Pools

Congress should remove guaranteed issue and community rating from the individual health insurance market and allow health insurance to function as a real insurance market.

However, since the public wants people to have access to health insurance even if they have a medical condition, there must be some kind of safety net to ensure everyone has access to coverage. The public policy challenge facing elected representatives is to develop a safety net that provides quality, affordable coverage for the uninsurable, and yet allows the market to work for everyone else.

The best solution is to return to a system of state-based high risk pools or a single, federal high risk pool. Prior to the ACA, 35 states had high risk pools, and Obamacare created a separate, temporary federal high risk pool slated to end when guaranteed issue began in 2014. However, the Obamacare high risk

pool never experienced the number of predicted applicants and soon ran into funding and management issues.

The state pools were created by state governments, and they relied on a health insurer operating in the state (usually the state Blue Cross insurer) to administer them. The insureds paid premiums, usually 50 percent to 75 percent more than a standard risk would pay for traditional coverage. And yet all high risk pools lost money because people in the pool had serious medical conditions. States subsidized their pools in various ways, mostly by assessing insurers operating in the state, but some used general revenue or lottery proceeds.

Unfortunately, those state high risk pools either dissolved or went dormant as a result of Obamacare. There was no point in maintaining them in light of Obamacare's guaranteed issue provision. If we return to relying on standard actuarial principles for health insurance, either the state high risk pools would need to be revived or a federal high risk pool created.

To be sure, some of the high risk pools worked very well, others didn't. But we know what it takes to create a well-functioning risk pool, whether at the state or federal level, and those "best practices" should be part of any reform plan.

We also address the higher premiums associated with high risk pools. Under our proposal, those in the individual market who have been denied health coverage because of a medical condition would receive a larger tax credit to compensate for that additional cost.

If there were political opposition to stand-alone high risk pools, the uninsurable could be placed in the Federal Employee

Health Benefits Program that currently operates like a health insurance exchange across the country for millions of federal employees and their dependents.

With the current ACA mandate of guaranteed issue and community rating, the government must try to force everyone into the system to keep people from gaming it—i.e., waiting until they have a medical condition before enrolling.

If Obamacare were repealed, the safety net would have a relatively small number of people. That's because more than one-third of the U.S. population is in one of the government-run programs: Medicare, Medicaid, CHIP, military coverage and the veterans health care system. All of them are guaranteed issue; if you qualify you get in regardless of a medical condition.

Another 160+ million Americans and their dependents have health insurance through their employer. Employer-based health insurance is also guaranteed issue; if you take a job and you want your employer's coverage, you can join it regardless of a preexisting condition—though there may be a short waiting period.

Thus, what we're talking about is the 15 million to 17 million people in the individual health insurance market now and the roughly 30 million uninsured—though perhaps a quarter of the uninsured are illegal aliens and very unlikely to spend their money on health coverage. The vast majority of the uninsured and those with individual coverage are healthy and able to buy an underwritten policy.

Our Model for a Sustainable Health Care Safety Net

Our model for a sustainable Health Care Safety Net for those under the full retirement age—which gradually rises from 65 to 75 under our plan—has only two legs:⁴⁹

- A sliding-scale, refundable tax credit for all people below a specific income with adjustments allowed for specific risk factors, and
- A system of state-based high risk pools, though one federal high risk pool would also work.

Taking the tax credit approach would require eliminating the current health insurance tax exclusion. People would pay income taxes on the amount an employer spent on their health insurance, but they would receive a tax credit to offset that eliminated tax break. Depending on people's income and other factors, the tax credit could be more valuable than the current exclusion.

Ending the current tax exclusion is not an effort to subtly destroy the employer-based health insurance system. We expect most employers would continue to provide group health coverage, at least for the foreseeable future, because they see it as a way to attract and keep good employees. Even so, we are trying to create a system where individuals are more involved in their coverage selection process, have more choices and are able to carry that policy with them if they leave their employer. In other words, we aren't looking to end employer-based coverage, we just want employees to bring consumerism to health insurance.

49. Those at or above the full retirement age will fall under the Senior Safety Net.

If ending the tax exclusion for employer-provided coverage is politically impossible, then our proposed tax credit should be provided on the same terms mentioned above to those who do not have access to employer coverage, which would include employees who work for companies that do not provide coverage and the self-employed.

If the tax exclusion for employer-provided coverage is retained, we would recommend implementing “Large HSAs.” That is, employers could deposit what they are spending on health coverage into employees’ Health Savings Accounts. Employees could use those tax-free funds to buy into their employers’ plan or purchase their own plan in the individual market.

In addition, as part of the Welfare Safety Net, a Medicaid recipient would receive a subsidy to purchase health insurance on the private market, money that would go directly to the insurer of the beneficiary’s choice. In other words, if a low-income worker has access to employer-provided insurance, he would receive the refundable tax credit like all similar workers. If not, both the worker and the unemployed on Medicaid, would receive a grant through the Medicaid program.

In our modeling:

- The tax credit contribution for individuals and families replaces the premium tax exclusion and varies some by income, age, and health status up to the eligibility age, and are increased as time passes.
- The health insurance portion of Medicaid is replaced by a subsidy or a refundable tax credit.
- There is a gradual reduction in the contribution as income increases.

- Disabled individuals eligible for welfare benefits have their health care subsidy increased by 50 percent. Those individuals with disabilities that are not permanent in nature should be part of the private market, whether they are subsidized through the welfare system or not.
- People who have been denied coverage by two companies—or charged excessive premiums—are eligible for the high risk pool. Those premiums would be 50 percent higher than a standard risk, but low-income families would also, under our welfare reform plan, have additional funds to cover the costs.
- Benefits should vary by region consistent with the cost of medical care.

All of the savings or costs associated with this change in health care policy are included as part of the changes shown in Chapters 11 (Senior Safety Net) and 12 (Welfare Safety Net). As such, no savings or costs are included in this chapter.

Chapter 14

The Safety Net in Its Entirety

Our safety net system addresses the three major areas that societies try to cover: seniors, the poor and health care. What we have done differently is to create a system that is actuarially sound and financially sustainable over the long term—and will provide better benefits for the vast majority.

Additionally, the added tax revenue from increased economic growth and the reduction in federal spending would begin to whittle away at federal debt—as long as Congress could constrain its spending binge.

Three Simple Safety Nets

Compared to the current multiple, overlapping, inefficient, underfunded and fraud-ridden safety-net system, our proposal is simple and financially sound. Workers' FICA contributions would be directed into personal retirement accounts, their Senior Safety Net, that would belong to each worker and would grow with the economy. For those who reach retirement age without having achieved a financial threshold in their accounts, the government would top up the account. This change alone would redirect trillions of dollars from the federal government to capital accounts, vastly increasing the country's store of capital while dramatically shrinking the size of the federal budget. Of course, this process occurs gradually over time as we outline in Chapter 11.

Our Welfare Safety Net discourages long-term welfare dependency and moves able-bodied people back into the workforce. That change not only reduces federal welfare spending, but grows federal revenues as more people become taxpayers rather than tax-takers.

And our Health Care Safety Net turns health care into a consumer-driven system where insurance becomes real insurance once again and individuals manage their smaller and routine health care expenditures through their tax-free Health Savings Account or other innovative measures.

Taken together, these three safety nets dramatically reduce the size of government as well as the number of people dependent on it. It limits the role of government in our lives and our pocketbooks. And it leaves more money in the private sector that can be used for investment and growing the economy.

But before we discuss the integration of these alternatives, there is one more safety net we need to propose: a back-up safety net in case seniors exhaust their retirement accounts. Think of this as the safety net's safety net.

Federal Fallback Safety Net

A risk with all individual prefunded retirement accounts is that people could run out of money before they run out of years. While this problem could be addressed by requiring retirees to use part of their funds to buy a basic lifetime annuity, we don't necessarily advocate this approach. We suggest a program whereby the government pays benefits when an individual's account is exhausted: the federal Fallback Safety Net (FSN).

The idea is simple. If seniors exhaust their Senior Safety Net funds because of longevity or higher-than-normal expenses, etc., the federal government would step in and provide some cash assistance.

How to pay for this program? We suggest two possibilities. Our preferred option is to pay for it out of general revenues, just as we do most current welfare programs. It is welfare after all because the recipients have exhausted their assets.

The other possibility is to draw a portion from the dedicated FICA tax. The estimated FICA tax needed to cover the cost for all three programs—Social Security, Medicare and optional LTC—combined is .5 percent with an equal matching amount from the employer, or 1.0 percent total. If LTC were excluded, it would only be about .7 percent total.

If the money were to come from FICA contributions, it would go into a separate account that would be part of the federal budget. Given the length of time between the contributions and actual usage, the money should be invested, and that investment income would be critical to the adequacy of the accounts. Of course, the downside is by taking money out of workers' FICA contribution, there is less available for them to save for retirement. On the other hand, current FICA taxes cover people to the end of their life, so an argument could be made that retirement-related funds are the logical place to cover seniors who exhaust their personal accounts. Our modelling uses this approach, but only for those exhausting Social Security and Medicare accounts, not long term care optional accounts.

While there will surely be people who exhaust their Senior Safety Net accounts, we expect that number to be small. The average family, in which one or more adults work 40 years or more, would have significant balances at retirement and would not any need any subsequent federal help.

But even with the Fallback Safety Net, we anticipate that federal welfare spending would decline under our plan, both because the work requirement will weed out many who shouldn't be on welfare and the ability to build wealth through a lifetime of personal retirement account deposits will mean that more people retire with significant assets.

While a reform program such as we have proposed in this book can account for major segments of the population, it can't account for every individual. Some people will slip through the cracks—they do now and they will in any reformed system. Some won't have health insurance and will need costly health care. Some will refuse to work but will still need food and shelter. People will still face bankruptcy and find themselves at the mercy of family and friends. We expect a system of private charities and state and local public services would fill this void, as they do now.

Our goal has been to create a financially sustainable system that gets the economic incentives right. And if you get the incentives right, most—though not all—of the problems will solve themselves.

Combining the Safety Nets

Combining the three primary safety nets—seniors, welfare and health care—into a seamless and logical application of actuarial and economic principles is a challenge. In our modelling

of the reforms above, we have constructed several scenarios where this outcome occurs. In one particular scenario, where all elements of our proposed reform are implemented, including the Fallback Safety Net and elimination of the premium tax exclusion but excluding optional long term care provisions, the savings to total government budgets is estimated at \$62.4 trillion over 50 years. This scenario creates marginal tax rates that increase as income increases but never exceed 50 percent.

One of our themes is that both taxes—including income and FICA—and welfare benefits are affected by tax brackets and welfare income thresholds. Congress passed major tax reform legislation in December of 2017. This was a good step forward in encouraging economic growth, but deficient from the perspective of addressing budgetary issues and net-income discontinuities.

As members of Congress explore entitlement reform and tax changes, they need to ensure that earning more does not lead to an income or welfare cliff that discourages people from working and earning more. The current tax rates and welfare thresholds do exactly that, as we demonstrated in Chapter 10, exacerbating government budget concerns and work incentives.

Rather, as incomes and taxes rise, and as a result welfare benefits fall, net income should continue to rise at every income level.

Potential Savings

Given all of the changes made in our proposed reforms relative to the current system, we believe that economic activity would increase significantly. In addition, the government would save an enormous amount of money. Our modeling

estimates suggest government savings of 10 percent or more of total entitlement expenditures are possible over 50 years.

None of these savings estimates include any reforms in public pension plans. But the impact of such reforms could have large implications for government budgets, particularly state and local ones.

Another advantage of the improving situation with higher wages, more availability of revenue and reduced safety-net benefits would likely be higher interest rates. Such increases would allow pension plans, particularly public plans with large deficits, to narrow such gaps through higher investment earnings. Of course, higher interest rates means more interest due on government debt. Which is why economic growth must be undertaken commensurate with a plan to get government deficits under control.

For all of these reasons, facilitating economic growth should be a major focus of future policy planners. But this must be undertaken while bringing the entitlement system and deficits under control. We believe a potentially attractive way to do this is to restructure safety nets consistent with the principles and practices presented in this book.

Conclusion

The United States is approaching an entitlements cliff. Economists and public policy experts know it. Most politicians know it, though many refuse to admit it publicly. And the public is aware of it. A 2018 a Gallup poll found that 51 percent of Americans aged 50-64 worry “a great deal” about the Social Security system, though that is down from a high of 59 percent in 2013.⁵⁰ Not surprisingly, lower-income Americans are more worried than those with higher incomes.

As we have tried to demonstrate throughout this book, the public is right to be concerned—and should be even more concerned than they are—about Social Security, Medicare, Medicaid and the whole host of means-tested entitlement programs, including Obamacare subsidies.

50. Justin McCarthy, “Adults Nearing Retirement Worry Most About Social Security,” Gallup, April 6, 2018. <https://news.gallup.com/poll/232172/adults-nearing-retirement-worry-social-security.aspx>

We have argued that whenever elected officials create entitlement programs, they claim they are and will be actuarially sound. Relatively soon thereafter, those officials change the benefits or eligibility provisions, or both. The changes increase costs and enrollment. Meanwhile, promises of sound management are broken. When the financial cracks emerge, as they always do, elected officials blame others and either deny there is a problem or pass legislation to mask or postpone the financial day of reckoning.

Occasionally, elected officials will reform an existing entitlement program that does move in the direction of improving financial soundness—as when President Clinton and the Republican-controlled Congress passed welfare reform in 1996. But bureaucrats and subsequent elected officials then try to chip away at or water down those reforms, returning the program to the status quo ante—if not worse.

In following this approach, the U.S. has spent trillions of taxpayer dollars on entitlement programs, created large amounts of debt, and faces trillions more in unfunded liabilities. Meanwhile, millions of seniors try to survive on rather paltry Social Security checks, the poverty rate has remained essentially unchanged for decades, and generations of families are in a poverty trap.

Rather than accepting responsibility for the perverse incentives they created in entitlement legislation, many politicians decry the capitalist system and blame “greedy” companies and CEOs for stagnant wages and the difficulty lower-income individuals have moving up the economic ladder. But as we demonstrate in the book, when existing means-tested entitlement programs

are integrated with income taxes, some workers may find it in their economic interests to remain in a lower-income level if earning more money means losing some much-needed benefits, especially health insurance.⁵¹

Any entitlement reform needs to integrate safety-net benefits with income and payroll tax rates to ensure that earning more makes a family better off, not worse off.

The only way to escape this dead-end street is to embrace a prefunded Senior Safety Net that allows working Americans to set aside their own money in their own accounts that invests in and grows with the economy. And for those who do face financial hardship, the government should provide a temporary, work-related, means-tested program for all able-bodied people. Individuals with physical or mental challenges that preclude a work option should have access to distinct safety nets that provide for their needs.

Finally, the U.S. should move away from the faltering patchwork of programs and rules that exist today and properly integrate safety nets and subsidies, the tax code and private health insurance, so that welfare, the health insurance market and the economy can function properly. Many such changes will need to take place over time, and some may seem politically difficult if not impossible. Failure to take these steps will ultimately lead to a very unpleasant scenario, such as a deep recession or worse.

If Congress were to implement these changes, it would dramatically reduce the size of government and its role in our

51. For more information about our modeling, please see the appendix.

finances and our lives. In addition, we expect an economic explosion the likes of which the country has never seen, as trillions of dollars enter capital markets instead of government coffers. And we would see millions of Americans start the slow but steady climb toward financial independence as they begin creating wealth that belongs to them. Remarkably, the government balance sheet would improve.

Avoiding the entitlements cliff is not difficult, it just takes adopting actuarially sound programs. The real difficulty is in persuading politicians to do it. They apparently like having control of your money—and ultimately your lives. We believe the country, and individuals, would be better off if that power were in your own hands.

Appendices

Appendix A: Brief Overview of Our Model Linking Safety Nets to Economic Performance

We have developed a simplified economic model that links safety-net programs over time to economic performance. Unlike most assessments, our model incorporates personal tax rates. In the real world taxes interact with safety-net benefits such that an additional dollar of earned income could mean less total income.

We point out that all developed economies have safety-net programs intended to meet the needs of certain vulnerable populations. If those programs fail to meet a minimum threshold that would provide for basic needs, then many people would be unable to take advantage of opportunities in an economy.

However, creating limited, insufficient safety nets is not the norm. Rather, most developed economies have created very generous safety nets that seem to grow more generous as time passes, generating a population that is chronically dependent on government, reducing the productivity of individuals and the economy, and imposing deficits for future generations to address.

Often, the overhangs from the under- and over-developed safety nets have fairly long-term horizons, and the model does not fully reflect this.

Our modeling demonstrates that safety nets have an impact on economic performance. Properly constructed, safety-net

benefits can and should spur economic growth, but they can also discourage growth if beneficiaries are financially penalized for working harder and earning more.

The model projects results backward using the costs incurred by and participation in various safety nets and sectors of the economy, while reflecting assumptions based on behaviors of people in various settings. The model was tested by comparing actual results to those projected.

The model shows that safety nets increase the potential for economic growth if they are modest in nature and create the appropriate and aligned incentives.

We used the model as developed to create estimates for 2019 as found in Chapters 10, 14 and Appendix E, which explore the relationship of safety net benefits, taxes, level of income and economic growth for the current system and our proposed alternative.

Our models as employed in this book—there were several models because of the different tasks to be addressed—do not reflect the potential growth of economies due to all factors that may affect an economy. Rather, they focus on a selected number of factors, which in the case of the United States are believed to be significant drivers of what is happening today.

The link between the illustrative results in this Appendix and those in actual experience as specified are income levels and wage growth, numbers using safety nets, average benefit levels, participation in the job market and payment of taxes, and the overall growth in GDP.

Various monetary considerations such as the money supply and other factors such as supply and demand are ignored for simplicity. The results in our demonstrations as compared to actual results strongly suggest that failure to rein in safety nets to a more appropriate level with aligned incentives will lead to limited economic growth, income inequality, and reductions for many in the standard of living—all of which were, not surprisingly, primary themes in the 2016 presidential election.

For more details, call or write the authors.

Appendix B: Brief Overview of Advance Funding Models for Social Security, Medicare and Long Term Care and Proposed Assumptions

The model used for simulating senior safety-net benefits under the proposed alternative plan in Chapter 11 uses an individual approach, with expected assumptions as to contributions and costs under applicable scenarios across the applicable populations.

We separately tested Social Security, Medicare and optionally long term care across the eligible populations using assumptions as to contributions and costs reflecting applicable population characteristics, wages, working versus non-working populations, and trends.

The model used for analysis of our Senior Safety Net provisions estimates the annual revenue needed, including investment income, to support benefits starting at eligibility age 75, or 50 years after implementation of our proposed plan. In all cases, the model assumes contributions start at age 25 and

are made for 50 years, ceasing thereafter. Contributions accrue with investment income at 4 percent annually.

All costs reflect currently estimated 2019 levels adjusted under the Senior Safety Net as fully implemented.

Almost all contributions to personal accounts vest 100 percent at attainment of the eligibility age for benefits, but are 0 percent vested prior to that age. This assumption, combined with other proposed program changes, allows the federal budget to gradually accommodate the transition to private accounts and realize the estimated savings projected in our modelling.

Savings/cost projections for the first 50 years after implementation of the Senior Safety Net reflect all assumptions related to changes in the eligibility age, contributions anticipated from workers, changes in benefit provisions, the proposed vesting schedule, federal safety net rules, and other provisions. This includes people already on benefits, those in transition and those age 25 or under at the implementation of the Senior Safety Net.

The models used estimate the level of contributions needed to support the Senior Safety Net if implemented from inception, or for all those at age 25 at that time. Costs of other groups are covered in part by the new contribution levels and otherwise through the current system provisions, including the continued accumulation of deficits.

Status quo assumptions reflect a continuation of patterns established and in place.

Projections of savings/costs reflect a comparison of contributions and costs under the Senior Safety Net versus the status quo system across all participants.

For more detail and rationale for all assumptions, including those related to the federal safety net, contact the authors.

Appendix C. Welfare Reform Model and Assumptions

Our model of the Welfare Safety Net costs reflect expected costs based on changes in eligibility, payment levels to those in need, and a grade down of benefits as described in Chapter 12. Our system gives individuals much more control over their choices and spending, and the expected changes in beneficiary behavior is reflected in our estimates of the Welfare Safety Net costs versus the status quo.

Our Welfare Safety Net envisions the government providing funds for those unable to pay for general needs (food, clothing, shelter and energy, health care and optionally education), while establishing a work requirement as noted in Chapter 12. The funds are distributed based on a sliding scale determined by need. However, decreases in safety-net benefits in all cases decrease at equal to or less than 50 percent of earnings after all taxes, so that the person is encouraged to work more. The lower the percentage decrease in safety net benefits the greater the incentive to earn more. Today, the decrease in safety-net benefits at some levels of income are much greater than the additional dollars earned.

Our Welfare Safety Net removes virtually all tax credits or exemptions from taxes, with the exception of incentives for savings related to retirement and old age health costs. It also removes most direct payments to providers for food, energy, and health care with the possible exception of a proportion of health care, housing and social service expenditures (and optionally education).

The model costs reflect a blend of federal, state and local governments consistent with provisions today, unless otherwise noted as part of our Welfare Safety Net proposal. The categories of benefits as they exist today are as defined in Chapter 12. For more detail on methods, assumptions or results beyond that found here or in Chapter 12, contact the authors.

Appendix D: Health Care System Models, Including Medicare, Medicaid and Under-Age 65 or Eligibility Age Expenditures and Assumptions

This Appendix provides limited information on specific provisions, assumptions and methods relating to expenditures anticipated in the Health Care Safety Net versus expenditures under the current system. Methodology and assumptions for funding or contributions toward the costs for health care benefits for seniors are under the Senior Safety Net and discussed in Appendix B. Health care costs and benefits for the poor are in Appendix C.

The model used for health care reproduces total national health care expenditures for 2017 by market, and these values are projected forward using assumptions as to estimated cost trends

by type of service, population growth and behavioral factors as deemed appropriate. Estimates reflect the use of numerous data sources as well as experience and judgment.

Markets include individual, small group, large group, uninsured, Medicaid, Medicare and others. Numerous splits are available within these markets, as modeling reflects, age/gender, income levels, benefit design differences, utilization corresponding to benefits, managed care levels, eligibility provisions, health status, provider reimbursement levels and provider/supply availability. Costs are calibrated across all such characteristics.

Modeling also reflects assumptions as to the impact of changes in behavior by various stakeholders on costs, coverage, access, health status and economic impacts (via interaction with the model in Appendix A).

Modeling results for the Health Care Safety Net show costs savings as indicated in Chapters 11, 12 and 14. However, our health care proposal is not just about costs. As compared to the current system, this plan is also expected to provide a better balance of supply and demand for services by improving (1) population health status; (2) incentives concerning provider availability; (3) incentives for consumers to become more informed purchasers of services; and (4) government debt. Plan provisions include rules for providers, insurers or employers as applicable, consumers and government.

For more detail on specific provisions underlying the Health Care Safety Net, contact the authors.

Appendix E: Integration of Safety Net Reforms with Tax Code Revisions and Related Assumptions

Chapter 14 reflects the aggregation of all changes proposed in Chapters 11-13, plus the Federal Fallback Safety Net, plus the following additional components:

- (1) The addition of a tax code integrated with all of the safety-net benefits so as to create incentives to work and gradually exit the safety net, or at least reduce reliance on it where feasible; and
- (2) Estimate of the anticipated change in economic growth and GDP and its impact on revenues and costs for the 50-year projection period.

This combination of features allows all benefits to be properly coordinated. The intent is to avoid double paying in certain situations, while providing appropriate incentives to exit safety nets where feasible. Such a system requires appropriate balancing of safety-net benefits with incentives to work, taxes, and provision of and access to services. This balancing requires not only careful diligence in setting up programs but continued monitoring of results as compared to expectations, and revising programs where results are not conforming with expectations.

These additions are supported by an expected cost-type model reflecting assumptions and methods consistent with the models and assumptions presented in Chapters 10-13 and the above Appendices. Expected costs for the Federal Fallback Safety Net are reflected in Chapter 11. The impact of (1) and (2) above on economic growth under our comprehensive proposal—The

Senior Safety Net, Welfare Safety Net, Health Care Safety Net and Federal Fallback Safety Net—are estimated by applying the model used in Chapter 10 and Appendix A to anticipated results from the proposal without economic growth. All such methods and assumptions corresponding to Chapter 14 savings estimates and models referenced in the Appendix are available from the authors. This includes a list of any additional considerations relevant to implementing the comprehensive safety-net plan.

About the Authors

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Mark E. Litow is an actuary who retired from the firm of Milliman, Inc. in 2011, a world-wide consulting firm with over 2,500 employees. He was a principal of the firm for many years specializing in health care reform and special risk situations.

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He has contributed chapters to several books, including *Physician Assisted Suicide: Expanding the Debate*, *The 21st Century Health Care Leader* and, in 2009, *Stop Paying the Crooks* (on Medicare fraud).

He has been published in numerous journals and newspapers, including the *Wall Street Journal*, the *New York Times*, *Forbes*, *The Hill*, *Investor's Business Daily*, *USA Today* and the *Washington Times*. In 2008 and again in 2014 the BBC invited him to star in a program on welfare reform in Great Britain, specifically Wales.

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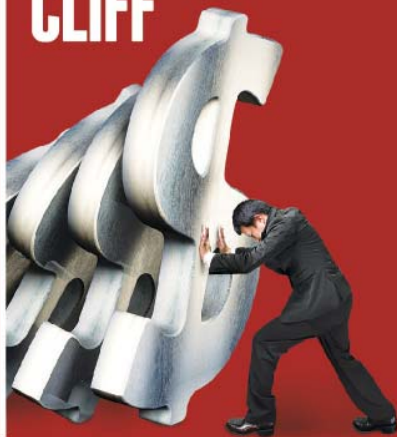
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Entitlement programs have become an unsustainable financial strain on every developed economy, dragging those economies to the precipice of the fiscal cliff—if they haven't already fallen off. This book's theme is that when politicians set up entitlement programs to provide welfare, health care and pension benefits to certain populations, they overpromise benefits, underfund the programs, and misalign incentives—if not initially, then soon afterward. Over time, future elected officials expand the programs to cover more people with richer benefits, far outpacing the financing needed to sustain them.

This book exposes those practices and provides actuarially sound, long-term solutions.

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