



C H A P T E R 7

PRESERVING AND MODERNIZING THE SAFETY NET

Today's dynamic, global economy, driven by rapid technological change, offers abundant benefits and opportunities—but also entails many risks. The Great Recession has made clearer than ever that a strong and flexible economy requires a robust safety net to protect families against major risks and to reduce the likelihood that temporary economic shocks will inflict permanent harm on families and the economy.

In the first weeks after President Obama was inaugurated, the President and the Congress enacted policies to expand and strengthen the safety net in response to the ongoing economic crisis. The American Recovery and Reinvestment Act of 2009 (the Recovery Act) provided increased funding for a number of key safety net programs, including unemployment insurance (UI), Temporary Assistance for Needy Families (TANF), Medicaid, and the Earned Income Tax Credit (EITC). These and other safety net programs have been critical in cushioning American families from the effects of the Great Recession and in stabilizing the economy by supporting aggregate demand.

One way to gauge the impact of the safety net is to consider the number of American families that would have been in poverty were it not for the support provided by specific programs. These effects are significant. In 2010, the official poverty rate was 15.1 percent, which translates to roughly 46 million people living in poverty. According to U.S. Census Bureau estimates, were it not for unemployment insurance benefits, 3.2 million more Americans would have been in poverty in 2010. This figure includes about 2.3 million nonelderly adults, 900,000 children, and 100,000 adults age 65 and older. Among families participating in the program, the receipt of UI benefits has the effect of cutting the poverty rate roughly in half (Gabe and Whittaker 2011).

Data Watch 7-1: The Census Bureau’s Supplemental Poverty Measure

The official poverty measure was developed in the 1960s. According to this measure, a family is considered to be poor if its before-tax income falls below a “poverty line” that varies according to family size and composition.

In 2011, the Census Bureau released an alternative to the official poverty measure that presents a more complete picture of poverty and of the effects of policies to support low-income families. This Supplemental Poverty Measure (SPM), developed early in the Obama Administration, is based on an approach recommended in 1995 by the National Academy of Sciences. Like the official poverty measure, the supplemental measure compares the resources available to a household with a threshold level of income that takes into account household composition. It differs from the official measure, however, both in how it calculates resources and in how it sets the thresholds. The supplemental measure adds in-kind assistance such as nutritional assistance and subsidized housing to household resources and subtracts necessary expenses such as taxes, child care, and other work-related expenses, as well as medical out-of-pocket costs. Its thresholds are calculated differently than those for the official poverty line, and they reflect geographic differences in housing costs.

Overall, 16.0 percent of all Americans were estimated to be in poverty in 2010 according to the supplemental measure, compared with 15.2 percent using the official methodology.^a Differences between the two measures vary across demographic groups. For example, because they disproportionately benefit from programs like the Earned Income Tax Credit (EITC) and the Supplemental Nutrition Assistance Program (SNAP), children are more likely to be in poverty according to the official measure, which does not account for support from these programs. By contrast, the poverty rate for elderly Americans is higher according to the supplemental measure, since unlike the official measure, it subtracts out-of-pocket medical expenses from income.

The supplemental poverty measure allows researchers to isolate more accurately the effects of a specific policy, source of income, or category of expense on the prevalence of poverty. Among the programs studied by the Census Bureau, the EITC has the largest antipoverty effect; according to the supplemental measure, in the absence of the tax credit, an additional 6.1 million people would have been in poverty in 2010. Accounting for medical out-of-pocket expenses in the supplemental measure, on the other hand, moved 10 million individuals into poverty in 2010.

^a This official estimate differs from the usual published rate (of 15.1 percent) as unrelated individuals under 15 years of age are included in the universe.

The official definition of poverty does not account for the effect of taxes paid and tax credits, such as the Earned Income Tax Credit. Nor does it incorporate the value of in-kind benefits. As a result, the official measure does not reflect the benefit that American families receive from the EITC or important safety net programs, such as the Supplemental Nutrition Assistance Program (SNAP), on the official poverty rate. However, such a calculation is possible using an alternative measure of poverty, known as the Supplemental Poverty Measure (Data Watch 7-1). Using the supplemental measure, the Census Bureau estimated that in the absence of the EITC another 6.1 million Americans, nearly half of them children, would have been in poverty in 2010. In that same year, SNAP benefits lifted 2.9 million adults and 2.2 million children out of poverty. Considered all together, it is estimated that the social insurance and means-tested transfer programs that make up the safety net reduce the number of Americans falling below the poverty line by more than half (Ziliak 2011).

Safety net programs can improve economic efficiency by supplementing private markets if they fail to provide adequate insurance against major economic risks. A fundamental market failure common to both insurance and annuity markets is adverse selection, which arises when consumers know more than insurers about their own risk—their expected medical claims, their likelihood of becoming unemployed, or their expected longevity (Rothschild and Stiglitz 1976). If insurance or annuity contracts are priced according to the average risk in a population, coverage will be attractive to those who know that they are at high risk and unattractive to those who know that they are at low risk. To the extent that high-risk consumers are more likely to purchase insurance, the cost of coverage will rise, which in turn will make coverage even less attractive to their low-risk counterparts. The gravity of the adverse selection problem will vary across types of insurance and, for a given type, across market segments. Some types of insurance, such as unemployment insurance, have virtually no private market. Private health insurance and annuity markets exist, though not without substantial support from tax and regulatory policies; even with this support, coverage remains costly and incomplete.

In addition to addressing specific types of market failure, a strong safety net can promote growth and entrepreneurship. By providing a basic level of security, well-designed safety net programs help create an environment that encourages people to engage in value-creating activities such as changing jobs or starting a new business. A strong safety net is especially important in a global economy in which international trade and financial integration can bring both substantial benefits and increased risk. Robust cross-country evidence finds that economies that have stronger safety nets

also tend to pursue more efficient economic policies (Rodrik 1998). Safety net programs also protect workers and their families from the labor market disruptions that can arise from technological change and other sources of fluctuation in demand. Finally, safety net programs can be an important component of automatic stabilizers—providing expansions in aggregate demand that help counteract the weakening of the economy during economic downturns.

An effective and efficient safety net must adapt and evolve in response to changes in technology and economic conditions. This chapter provides an overview of the key components of the safety net in the United States, emphasizing recent policy developments and proposals to keep the nation's safety net strong.

UNEMPLOYMENT INSURANCE

Unemployment insurance has long been an essential component of the safety net for workers who have lost a job through no fault of their own. In the recent period of high unemployment, the basic UI program and emergency extensions have provided critical support for millions of American families. In 2010, almost 10 percent of households received UI benefits—and that share is expected to fall back toward the pre-recession average of about 4 percent as the economy recovers.

Unemployment insurance is a joint Federal-state program that covers nearly all civilian workers. During normal economic times, workers and employers contribute to state systems that pay benefits to unemployed workers for up to 26 weeks. During periods of high unemployment, extended benefits (EB) are available to workers who have exhausted regular UI benefits, with the costs normally shared between the Federal Government and states. Benefits are determined as a function of past wages, up to a cap. Although key program parameters vary across states, on average UI benefits replace roughly half of a recipient's lost earnings. In 2011, the average weekly benefit was roughly \$300.

Historically the Federal Government has funded benefits for extended periods while the economy recovers from a serious downturn. It did so once during the 1950s, once during the 1960s, twice during the 1970s, and once each during the early 1980s, the 1990s, and the early 2000s. In each instance since the 1970s, extended benefits have been reauthorized, usually multiple times, in reaction to continued weakness in the labor market. In June 2008, Congress enacted the Emergency Unemployment Compensation (EUC) Program that added 13 weeks of Federally funded UI benefits. As the labor market continued to deteriorate, Congress extended the program

for workers in the hardest-hit states several times. In addition, starting in February 2009, Congress provided full Federal funding of extended jobless benefits. Together these policies allow workers in high-unemployment states to qualify for up to 99 weeks of benefits.

The Economics of Unemployment Insurance

Unemployment insurance benefits enable workers to minimize disruptions in spending caused by unanticipated income shocks (Baily 1978). Economic research indicates that this consumption-smoothing effect is important. According to one study, in the absence of UI, a typical family whose household head becomes unemployed lowers spending on food by 22 percent, while a family receiving UI benefits spends only 7 percent less on food (Gruber 1997). In addition to helping families whose income has been reduced due to job loss, by providing income to families that they can spend, UI benefits mitigate the impact of the recession on the broader economy.

These benefits must be weighed against the cost of longer spells of unemployment potentially induced by the availability of UI—although in the current environment, any effect on spell length is likely to be comparatively small. Theoretical models of labor supply and job search predict that unemployed workers covered by more generous UI systems can take longer to find a new job (see, for example, Mortensen 1977). More recent work has shown that it is important to distinguish among reasons why UI increases the duration of unemployment. Traditionally, economists have interpreted the relationship between UI and duration in the context of a worker's choice between work and leisure, assuming that UI reduces the effort devoted to job search. An alternative view, given that a large fraction of unemployed workers have limited assets, is that UI benefits allow workers to meet their basic needs while they search for a job that is a good match for their talents (Chetty 2008). Better matches generally translate to higher wages (leading to higher tax revenues), increased job satisfaction, and greater employment stability (which reduces employers' hiring costs).

The empirical research literature on the relationship between UI benefits and unemployment duration is sizable. Recent research suggests that UI benefits have small effects on unemployment duration even when the economy is strong (Card and Levine 2000). In periods of high unemployment, the consumption-smoothing benefit of UI will be especially valuable to workers, and any negative effects on worker search effort will be less important because of the scarcity of jobs (Kroft and Notowidigdo 2011; Schmieder, von Wachter, and Bender 2012). Consistent with this premise, research suggests that the recent expansion of extended and emergency benefits has had a minimal effect on the duration of unemployment spells and

the unemployment rate (Farber and Valletta 2011; Rothstein 2011; Daly et al. 2012). Moreover, to the extent that the extension of benefits has affected the measured unemployment rate, it has done so not by reducing the probability that unemployed workers look for and find jobs, but by reducing the number of unemployed workers who have given up on searching for a new job (Rothstein 2011). This finding is important in light of evidence suggesting that during periods of high unemployment, many older workers who exhaust their UI benefits end up applying for Social Security Disability Insurance (Rutledge 2011).

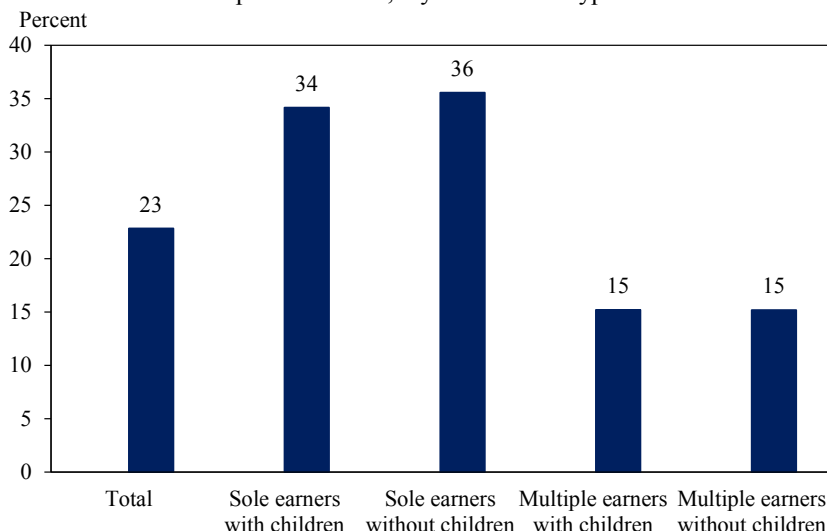
Recent Trends in UI Receipt and Its Effect on Household Income

The share of households receiving UI rose from 4.1 percent in 2007 to 9.6 percent in 2010. Over the same period, the average annual amount received by households benefiting from UI rose from \$4,400 to \$8,340, mainly because of longer duration of benefit receipt but also because of the extra \$25 in weekly benefits provided through FY 2010 by the Recovery Act. This money was crucial to keeping many families in their homes and able to pay other household expenses. As noted, UI lifts millions of families out of poverty. However, because a large share of benefits flows to middle-income workers, these antipoverty effects understate the economic impact of the program on participants. Households that received UI benefits in 2010 had a median income of \$55,000 the previous year, which is only slightly less than the median income of working households that did not receive UI. Among all recipients, UI payments represented 23 percent of household income in 2010. The share of income represented by UI ranged from 15 percent for multiple-earner households without children to almost 36 percent for households with a single worker and no children (Figure 7-1).¹

In addition to providing income insurance to families of unemployed workers, the UI system helps the economy as a whole (Auerbach and Feenberg 2000). Unemployment insurance is an automatic stabilizer that leans against the negative cycle of increased unemployment leading to reduced consumption, which leads to a further decline in economic activity. Since unemployed workers tend to spend rather than save their benefits, the impact on aggregate demand is fairly immediate. Because of the way that the emergency and extended benefits programs increase economic activity, they generate partially offsetting income and payroll tax revenues for the Federal Government and help state and local budgets by increasing sales tax revenues. In addition, without the income support provided by these

¹ Because previous research suggests that recipients tend to understate the amount of unemployment benefits they receive (Meyer, Mok, and Sullivan 2009), these figures can be seen as lower-bound estimates of the effect of UI on household income.

Figure 7-1
Share of Household Income from Unemployment Insurance among
Recipients in 2010, by Household Type



Source: Current Population Survey, Annual Social and Economic Supplement.

programs, more families would draw on other public programs. For these reasons, the Congressional Budget Office notes that extending UI benefits is the most timely and cost-effective policy for increasing economic activity and employment (CBO 2011).

Policy Innovations

The U.S. unemployment insurance system dates to the Great Depression of the 1930s. Originally, most covered workers were employed in manufacturing. At its inception, the UI system allowed for income smoothing for workers who would ultimately return to their old job or one like it. Research based on data from the early 1980s suggests that at that time 60 percent of UI spells ended with the worker being recalled to his or her original job (Corson and Nicholson 1983; Katz and Meyer 1991). Today, temporary layoffs are less common; increasingly, workers receiving UI benefits have been dislocated as the result of structural changes in the economy and must find a new industry or occupation. In many cases, wages in the new jobs these workers find are significantly lower than their former wages. Thus, workers today need income support while they are searching for a new job, but they also need training, job search support, and other assistance to help ease what can be a difficult transition.

The first step to modernize the unemployment insurance program was taken in the UI Modernization Act, a part of the Recovery Act. The UI Modernization Act made \$7 billion available to states that made reforms to their UI programs. States could receive a part of the incentive payment for using the most recent quarter as a part of the base period of earnings on which UI eligibility and benefit amounts are determined. This made it more likely that recent labor market entrants would meet the minimum earnings threshold for UI eligibility. States could receive the other part of their apportioned payment by adopting two of the following policies: allowing workers who were employed part-time previously to continue receiving UI while looking for part-time work, providing UI benefits to those who left their jobs for certain compelling family reasons, allowing workers to continue receiving UI for an additional six months if in an approved training program, and providing additional benefits for households with more dependents. These small incentive payments resulted in 36 states changing their UI laws.

Building on these reforms, in the American Jobs Act the President called for further steps to improve the unemployment insurance program and expand reemployment services and job training, and has made these reforms a part of the FY 2013 Budget proposal. Although most UI policy innovations target workers who have already lost their jobs, another important policy goal is to reduce the number of workers who are laid off in the first place. One promising initiative is work-sharing. Under a work-sharing arrangement, workers whose hours are reduced in lieu of temporary layoffs receive partial UI benefits while remaining on the job and keeping their skills sharp. By allowing employers to retain skilled workers at reduced hours rather than laying them off, work-sharing makes it easier and less costly for employers to scale up production when orders increase. Twenty-four states now have work-sharing programs, and in the American Jobs Act, President Obama proposed incentives to help expand the program to more states.

Workers who have been laid off need help finding a new job. The American Jobs Act included the Reemployment NOW program, a set of reforms to help UI claimants get back to work more quickly. The FY 2013 Budget continues this support. As a part of this initiative, the Administration has proposed requiring states to provide reemployment services, such as career and job search counseling, skills assessments, and assistance in identifying helpful resources to EUC recipients to speed their return to work. Face-to-face contacts also provide an opportunity to assess recipients' eligibility for UI benefits. Research suggests that these services can lower program costs by reducing spells of UI receipt and eliminating payments to ineligible individuals (Black et al. 2003).

Because entrepreneurship is key to a dynamic economy, a modern UI system should make it easier for displaced workers to start their own businesses. The Administration has proposed allowing states to use Reemployment NOW funds to expand Self-Employment Assistance programs that pay UI benefits to recipients who are working full-time to establish a new business. Seven states already permit a similar use of unemployment insurance benefits. Under this program, entrepreneurship training would be facilitated through One-Stop Centers in collaboration with the Small Business Administration. A demonstration project, Growing America Through Entrepreneurship (Project GATE), provided training and one-on-one counseling to anyone interested in creating, sustaining, or expanding a small business. A recent study found that GATE had a positive effect on new business starts for unemployed participants and higher total earnings after five years than a comparison group (Michaelides and Benus 2010).

For jobless workers seeking to change occupations, lack of experience can be a significant barrier. With Reemployment NOW funds, states could experiment with Bridge to Work programs, which would allow EUC recipients to get short-term work-based experience that helps them maintain or enhance their skills. Under this program, private employers would be able to take on EUC recipients for up to 38 hours a week for a trial period of up to eight weeks with the workers receiving compensation through the EUC program. In addition, all program participants would be covered by workers' compensation and be guaranteed at least the minimum wage.

Finally, to support state creativity and flexibility, upon approval of the Secretary of Labor, states would be permitted to use Reemployment NOW funds to implement their own innovative strategies for connecting the long-term unemployed to employment opportunities.

In addition to these efforts that build upon the existing Federally-financed unemployment compensation system to help with getting the long-term unemployed back to work, the President's Budget includes other important and complementary initiatives that will contribute to the goal of ensuring that every American who wants a job can find one. As discussed in Chapter 6, these initiatives include streamlining training and employment services so that job seekers can visit a single location or go to a single web site to find the help they need; providing a universal core set of services to serve all dislocated workers; and introducing a new Pathways Back to Work fund to support employment opportunities for low-income youth, low-income adults and the long-term unemployed.

OTHER SAFETY NET PROGRAMS

Several means-tested programs also provide support to American families, especially those who have experienced adverse economic shocks. Table 7-1 reports the number of participants and Federal cost of several important programs. One of the largest Federal programs targeted at low-income families is the Earned Income Tax Credit, a refundable tax credit for low-income workers. The assistance is available only to those with earnings, and the amount of the credit increases with a worker's earned income up to a maximum level and then phases out at higher income levels. The maximum benefit amount increases with the number of children in the family, and the income level at which the credit begins to phase out differs according to taxpayer filing status (single or married couple filing jointly). As part of the Recovery Act, Congress created a new category with a higher credit for taxpayers with three or more children, providing those families as much as \$600 extra, and increased the income level at which the credit phases out for married couples filing jointly by \$3,000 over 2008 levels. The Tax Relief and Job Creation Act of 2010 extended these changes through 2012. Over 26 million working families and individuals received the EITC on their 2010 tax return, with the average claimant receiving \$2,220.

The benefits of the EITC go beyond the amount of the credit received. Studies have found that the EITC increases participation in the labor market (Eissa and Liebman 1996; Meyer and Rosenbaum 2000), improves maternal health outcomes (Evans and Garthwaite 2010) and helps low-income individuals acquire additional experience that contributes to higher earnings growth (Dahl, DeLeire, and Schwabish 2009).

The Supplemental Nutrition Assistance Program (SNAP) is another critical safety net program targeted at low-income families. SNAP benefits are funded by the Federal Government and administered by states. Families and individuals qualify if their income and assets are sufficiently low. Participants usually receive their benefits on electronic benefit transfer cards that can be used only to purchase food. Nondisabled adults who have no dependents and who are not working or participating in a work training program can usually receive SNAP benefits only for three months over a three-year period.

Roughly half of all SNAP participants were children, and more than three-quarters of all participant households included a child, an elderly person, or a disabled nonelderly person. Roughly a quarter of all children participated. In FY 2010, the average household participating in the SNAP program received monthly benefits worth \$287; 40 percent of participating

Table 7-1
 Number of Participants and Total Federal Expenditures for Safety Net Programs, 2010

	Participants (millions)	Federal expenditures (billions of dollars)
<i>Social insurance</i>		
Medicare	47.5	522.8
Old Age and Survivors Insurance	43.8	584.9
Unemployment insurance	10.4	158.3
Social Security Disability Insurance	10.2	127.7
<i>Means-tested transfers and credits</i>		
Medicaid/Children's Health Insurance Program	58.3	281.9
Supplemental Nutrition Assistance Program	40.3	68.3
Earned Income Tax Credit	26.8	59.5
Supplemental Security Income	7.9	47.8
Public and assisted housing	4.7	37.9
Temporary Assistance for Needy Families	4.4	18.1

Note: Recipients are counts of individuals except for recipients of EITC (tax filing units) and housing (families). Expenditures for UI, Medicaid/CHIP, SNAP, and TANF are for fiscal year 2010, and the number of recipients is the average of point-in-time recipients over fiscal year 2010. Public and assisted housing includes only programs operated by the Department of Housing and Urban Development, and recipients and expenditures are for fiscal year 2010. The number of SSI recipients is as of December 2010. For all other programs, the number of recipients represents those participating at any point in the (calendar) year. Federal expenditures include grants to states.

Source: Center for Medicare and Medicaid Services, Social Security Administration, Department of Labor, Office of Management and Budget, Medicaid Payment Advisory Commission, Department of Agriculture, Internal Revenue Service, Department of Health and Human Services, Department of Housing and Urban Development.

households received the maximum benefit for their family size—for example, \$668 a month for a family of four.

Both participation and expenditures are strongly countercyclical in the SNAP program, increasing during economic contractions and decreasing during expansions. Current projections are that SNAP enrollment will begin falling next year, as the economy continues to recover. Thus, like UI, SNAP not only provides direct benefits to participant households, but also has a stabilizing effect on the economy by limiting declines in consumption during economic downturns.

The Recovery Act established the Emergency Contingency Fund for state Temporary Aid for Needy Families programs, which provided \$5 billion to states for increased spending for basic assistance, nonrecurrent short-term benefits, or subsidized employment. States expanded efforts in all three areas, including committing \$1.3 billion to the largest targeted employment initiative in the history of welfare reform. Thirty-nine states in addition to the District of Columbia, Puerto Rico, and the Virgin Islands established subsidized employment programs, with an estimated 260,000 job slots created for adults and youth, many of them involving subsidies that created jobs with private sector employers. While most of these subsidized employment

efforts were not sustained at previous levels after Recovery Act funding ended, many jurisdictions have maintained programs at a smaller scale. Based in part on the success of this initiative, the President has proposed the Pathways Back to Work Fund (discussed in Chapter 6) that would provide employment opportunities for low-income individuals and the long-term unemployed.

Housing is the largest component of virtually every family's budget, especially low-income families. The Federal safety net includes several programs designed to ensure that financial stress does not result in homelessness. Stable housing allows families to weather labor market shocks and is a precondition for children's educational success. In addition to the 2.3 million families assisted by the Department of Housing and Urban Development's project-based rental assistance and public housing programs, the largest Federal program aimed at low-income households is the Housing Choice Voucher program. The Housing Choice Voucher program served 2.1 million families in FY 2010, of which 90 percent included children, the elderly, or individuals with disabilities. As discussed in Chapter 4, the Administration has also developed new programs that help unemployed homeowners avoid foreclosure.

Two other programs that are critical to the safety net provide benefits to Americans with disabilities. Social Security Disability Insurance (SSDI) is a social insurance program designed to offset the loss of wages of workers with long-term health conditions that prevent "substantial gainful activity." Individuals with adequate Social Security-covered employment history, or children (disabled before age 22) of a retired, deceased, or disabled worker entitled to Social Security benefits, are covered by the program. Beneficiaries receive a cash benefit based on their income before becoming disabled, adjusted upward by wage inflation. In December 2010, more than 10 million people received SSDI benefits. Recipients become eligible for Medicare after two years, offsetting the loss of employer-sponsored health insurance.

A second Federal program that assists persons with disabilities is Supplemental Security Income (SSI), a means-tested entitlement program that provides cash benefits to needy aged, blind, or disabled individuals. In December 2010, roughly 7.9 million Americans received SSI benefits; of that total, about 6.6 million qualified on the basis of a disability. The program is a particularly important source of income for older working-age adults: roughly one-quarter of all participants are between the ages of 50 and 64.

A recent study illustrates how critical these programs are to their participants (DeCesaro and Hemmeter 2008). Using data from 2002, the study shows that nearly a quarter of SSDI and roughly half of SSI beneficiaries had family incomes that fell below the Federal poverty level. However,

the programs play an important role in keeping their beneficiaries out of extreme poverty, which is defined as having an income below 50 percent of the Federal poverty threshold. According to this study, the majority of SSDI recipients relied on that program for at least 75 percent of their income. While only 5 percent of SSI beneficiaries were in extreme poverty, taking away SSI benefits would have raised that figure above 40 percent.

HEALTH INSURANCE

In March 2010, the President signed into law the Patient Protection and Affordable Care Act (the Affordable Care Act). When fully implemented, the Affordable Care Act will significantly strengthen the health care safety net, substantially increasing the number of Americans with health insurance and providing new protections and benefits to those who are already insured. The Affordable Care Act builds on and maintains the strengths of the current private system of employer-sponsored health coverage and insurance provided through Medicare, Medicaid, and the Children's Health Insurance Program (CHIP). Therefore, the changes brought about by the new law need to be considered in the context of the current system.

The Economics of Employer-Sponsored Health Insurance

One of the defining features of the U.S. health care system is the central role played by employers. Today, roughly nine in ten Americans with private health insurance obtain their coverage through the workplace, either through their own employer or through the employer of a family member. Employer-sponsored insurance is generally much less costly for workers—who pay for coverage through reductions in their wages as well as direct premium contributions—than coverage purchased directly in the individual market. There are three main sources of savings.

First, employer-sponsored group coverage greatly mitigates the problem of adverse selection. Because employer-sponsored groups are formed for reasons other than purchasing health insurance, they represent stable risk pools. Employer policies themselves contribute to this stability and to the spreading of risks. Within firms, the amount that employees are required to contribute toward premiums generally does not vary with health risk. Common employer and insurer policies—such as limiting periods when employees can sign up for coverage and requiring a minimum employee participation rate—prevent employees from declining coverage when they are healthy and joining the plan only when they need medical care.

A stable risk pool translates to lower administrative costs as insurers need to devote fewer resources to underwriting. Administrative savings also

come from economies of scale in marketing and administration. Because important costs vary with the number of contracts rather than the number of individuals covered by a contract, it is less expensive on a per-person basis to sell to a group of 1,000 than to sell to 1,000 individuals.

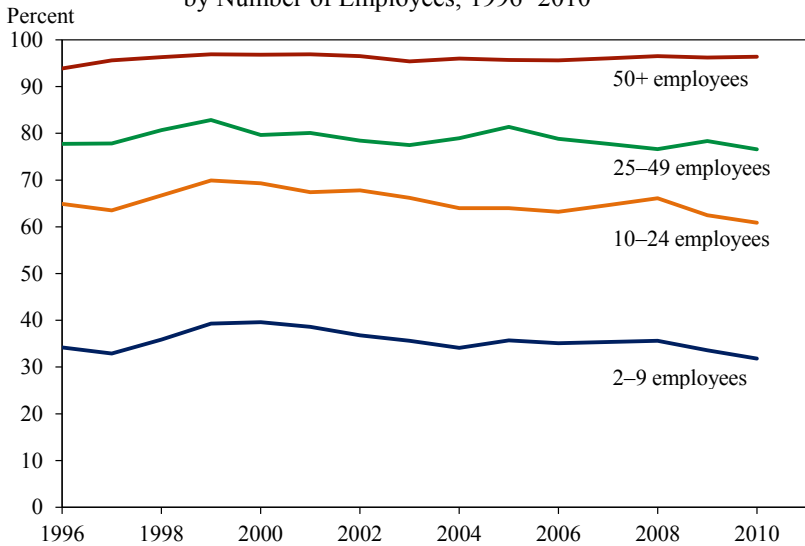
Third, because employer expenditures on health insurance premiums are exempt from Federal and state income taxes and Social Security payroll taxes, employer-sponsored insurance can effectively be purchased with pretax dollars. For a typical worker in the 15 percent tax bracket, the tax exclusion reduces the cost of insurance by roughly one third (Gruber 2010). Overall, the estimated FY 2011 tax expenditure associated with the exemption from Federal taxes is \$282 billion.

Although the cost savings associated with employer provision of insurance can be large, the savings are not evenly distributed among employers. The advantages of more efficient risk pooling and economies of scale in marketing and administration increase with firm size. The value of the tax exemption is not explicitly tied to firm size, but because compensation tends to be higher in larger firms, this advantage is correlated with size as well. As a result, the larger the firm, the greater the probability it will offer health insurance. Figure 7-2 illustrates that, whereas nearly all firms with more than 50 employees offer health benefits, less than half of those with 2 to 24 employees do. Between 2000 and 2010, the share of private sector establishments with fewer than 50 workers that offer health insurance benefits declined from 47.2 percent to 39.2 percent.

Firm size affects more than just whether workers are offered coverage. Among firms that offer insurance, large firms are substantially more likely to offer a choice of plans: more than 80 percent of private sector establishments with 1,000 or more employees offered a choice of health insurance options in 2010, compared with 18 percent of establishments with 50 or fewer employees. Employees who have a choice of plans tend to report greater satisfaction with their insurance coverage and their health care (Schone and Cooper 2001). And some very large firms have actively promoted strategies to improve health care quality and patient safety.

Over the past two decades, rising health care costs have eroded the accessibility of employer-sponsored health insurance, especially for middle-class families who experienced relatively little income growth over that period. Figure 7-3 plots the percentage of workers who lack health insurance (left axis) against an estimate of their per capita health spending divided by their median income (right axis). Because the growth in health spending is a principal determinant of rising insurance premiums, this ratio can be seen to capture changes in the affordability of health insurance. The figure indicates that during the 1980s insurance became less affordable as health care costs

Figure 7-2
 Percentage of Private Sector Establishments Offering Health Insurance
 by Number of Employees, 1996–2010



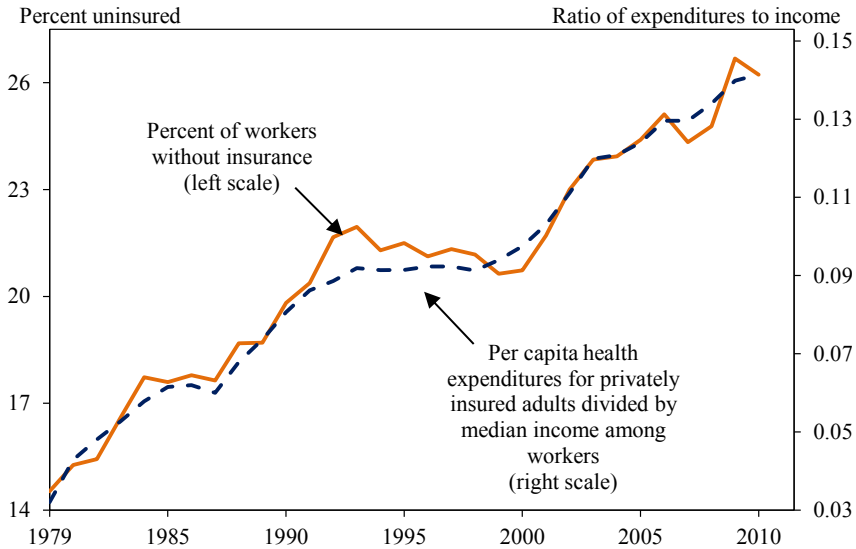
Source: Medical Expenditure Panel Survey, Insurance Component.

grew faster than median incomes and the percentage of workers without coverage grew. In the mid-1990s, health care spending grew less rapidly and a strong economy caused median income to rise. As a result of this confluence, the affordability index remained relatively constant, and insurance coverage stabilized. However, health care cost growth picked up again in the late 1990s and has outstripped income growth for the past decade, causing coverage to decline once again.

Medicaid and CHIP: A Health Care Safety Net for Children

As insurance coverage has declined among working-age adults over the past two decades, coverage among children has actually increased because of expanded eligibility for public programs. Until the mid-1980s, Medicaid eligibility was tied to eligibility for Aid to Families with Dependent Children, the cash welfare program. Starting in 1986, the two programs were delinked, and income eligibility limits for Medicaid were increased. The most significant eligibility expansions came as part of the Omnibus Budget Reconciliation Acts of 1989 and 1990. As the data in Figure 7-4 depict, with these expansions the share of children without health insurance began to decline, even as the share of uninsured adults rose. By 1997, while 18 percent of nonelderly adults were uninsured, the share of children who were uninsured was 14 percent.

Figure 7-3
 Percentage of Workers Without Health Insurance and the Ratio of Per Capita Health Expenditures to Median Income, 1979–2010

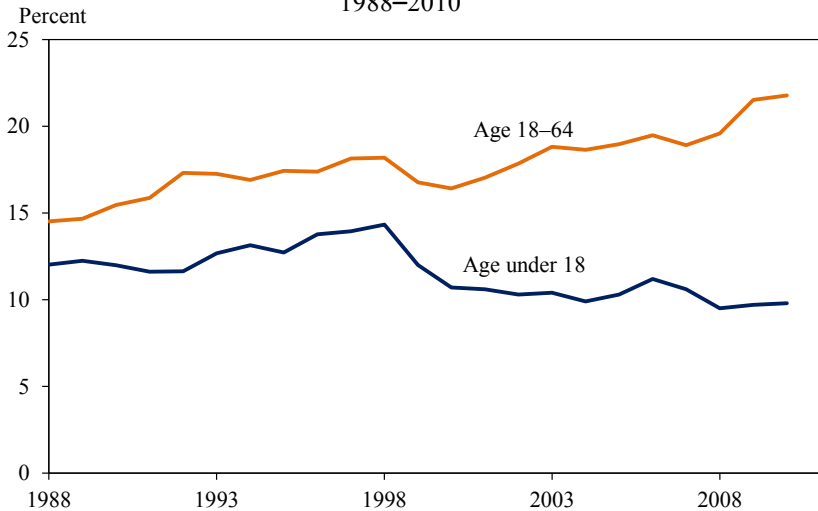


Source: CEA extension of Gilmer and Kronick (2009).

That same year, Congress established the State Children’s Health Insurance Program (initially referred to as SCHIP, now CHIP) as part of the Balanced Budget Act of 1997. Like Medicaid, CHIP is funded jointly by states and the Federal Government, although CHIP allows states more flexibility in designing their programs. States began implementing CHIP in late 1997, and by 2000 every state program was up and running. Today, the income eligibility limit in 47 states and the District of Columbia is 200 percent of the Federal poverty level or greater. As a result of Medicaid and CHIP, the percentage of children who are uninsured has fallen since the late 1990s and is now less than half the adult rate.

President Obama has built on the success of Medicaid and CHIP by making these programs even stronger. In the early days of the Administration, the President signed the Children’s Health Insurance Program Reauthorization Act of 2009, which extended funding for CHIP through September 2013. This legislation also introduced administrative reforms that improve program effectiveness, including new performance bonuses for states that successfully increase coverage by streamlining eligibility and enrollment procedures. Also in 2009, the Recovery Act provided additional support to states by boosting the Federal share of Medicaid at a time when program enrollment was increasing and state budgets were in crisis. Between 2008 and June 2011, over

Figure 7-4
 Percentage of Children and Adults Without Health Insurance,
 1988–2010



Note: Data for 1988 to 1998 adjusted to reflect CPS's 2011 revision to the health insurance editing process.

Source: Current Population Survey, Annual Social and Economic Supplement.

4.4 million children gained coverage through Medicaid and CHIP. In 2010, the Affordable Care Act extended funding for CHIP through 2015.

Because of Medicaid and CHIP, insurance coverage of children tends to be less sensitive to changes in macroeconomic conditions than that of adults. Research suggests that, holding other factors constant, a 1 percentage point increase in the national unemployment rate translates to almost a 1 point decrease in the percentage of nonelderly adults and children covered by employer-sponsored insurance (Holahan and Garrett 2009). Without a strong public insurance safety net for adults, more than half of the working-age Americans who lose employer-sponsored insurance during an economic downturn end up uninsured. For children, however, the loss of private coverage is mostly offset by an increase in public insurance. This discrepancy between the experience of adults and children will change with the full implementation of the Affordable Care Act, described below.

Many studies indicate that the expansion of Medicaid and CHIP has also significantly improved access to health care. One study using data from the 1980s and early 1990s found that eligibility for public insurance roughly halved the probability that a child failed to have at least one physician visit a year (Currie and Gruber 1996a). Other research shows that increased Medicaid eligibility for children leads to an increase in hospitalizations

overall, but a decrease in “preventable” admissions (that is, those that are avoidable if a child receives appropriate primary care) (Dafny and Gruber 2005). Improved access to care translates into better health outcomes, ranging from improvements in subjective health status (Currie, Decker, and Lin 2008) to reduced child mortality (Currie and Gruber 1996a, 1996b).

Expanding Health Care Coverage: The Affordable Care Act

The Affordable Care Act builds on the strengths of employer-sponsored insurance and on the success of earlier expansions of Medicaid and CHIP to expand and strengthen the health care safety net. By 2019, the Affordable Care Act is expected to increase the number of Americans with health insurance by more than 30 million. Roughly half of the coverage gain will come from raising Medicaid eligibility limits to 133 percent of the Federal poverty level. Because income eligibility limits for CHIP in all states already exceed this level, the law will expand Medicaid coverage mainly among nonelderly adults. Although the primary responsibility for administering Medicaid will remain with the states, funding for the expanded coverage will come almost entirely from the Federal Government.

Most of the remaining coverage gains will come from private insurance purchased through state-level Affordable Insurance Exchanges. Individuals and families with incomes up to 400 percent of the Federal poverty level who do not have access to affordable employer-sponsored coverage that meets a minimum value will be eligible for premium tax credits that they can use to purchase coverage through an Exchange. These new tax credits are targeted at lower- and middle-income families who currently receive little or no benefit from the large tax subsidies that implicitly support the system of employer-sponsored insurance. The Affordable Care Act also establishes a Small Business Health Insurance Options Program (SHOP) in each state that gives small employers and their employees access to private health insurance plans and small business health insurance tax credits as well.

The state-level Exchanges will extend to workers at small firms, the self-employed, part-time workers, and nonworkers many of the advantages of employer-sponsored insurance already enjoyed by employees of large firms: more efficient risk pooling and greater administrative economies of scale than are available in the current individual and small group market. Within an Exchange, consumers and employers will be able to choose from a broad menu of plans. To improve consumer choices, Exchanges will provide transparent information on premiums, benefits, cost-sharing, and plan quality—information that will help cut the high consumer search costs that push up premiums in the small group and individual health insurance markets (Cebul et al. 2011). By creating a marketplace in which consumers

can easily compare plans on the basis of price and quality, the Exchanges should increase competition among insurers. Considerable evidence from large employers shows that when employees are given a choice of health plans and clear information about premiums and benefits, they switch plans in response to small differences in premiums (Buchmueller 2009).

The Affordable Care Act establishes new consumer protections for health insurance coverage purchased either through an Exchange or in the outside individual or small group market, many of which are already in effect today. Insurers will not be allowed to deny or limit coverage on the basis of an individual's health status. Within certain limits, premiums may vary by age, geography, and smoking status, but not by individual health status, gender, or other factors. The Act also includes a requirement that individuals who can afford insurance maintain minimum essential coverage. These market reforms fill an important gap in the health care safety net.

Provisions of the Affordable Care Act Now in Place

Many of the insurance market reforms, along with the expansion of Medicaid and the creation of the Exchanges, will not take effect until 2014. Some provisions of the Affordable Care Act, however, have already been put into place. Insurers are now prohibited from retroactively cancelling coverage because of honest mistakes made on the application. The Act also eliminates lifetime dollar limits on essential health benefits and restricts the use of annual dollar limits. (Annual benefit limits will be eliminated completely by 2014.) Since July 2010, consumers who are uninsured and unable to get insurance because of a pre-existing condition can find subsidized coverage through the Pre-Existing Condition Insurance Plan. This temporary program gives uninsured individuals with costly conditions access to affordable insurance until the full set of consumer protections takes effect in 2014. As of the end of 2011, 45,000 individuals were enrolled.

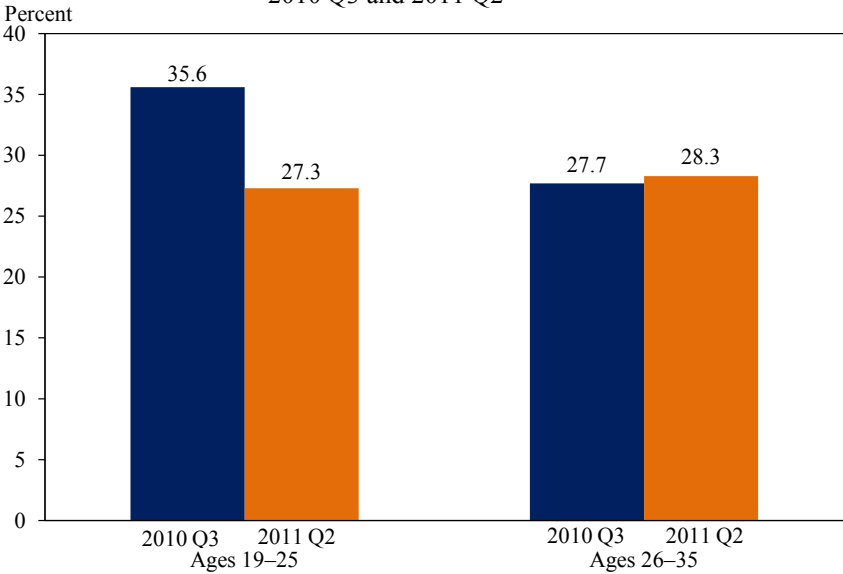
Another coverage-related provision of the law that is already in force allows young adults to remain on their parents' private insurance policies until they reach age 26. This policy targets a population that is disproportionately uninsured. Although one reason large numbers of young adults have no health insurance is that people in this age group tend to be in good health and do not perceive a need for health care (the "young invincibles" hypothesis), a second important reason is lack of access to affordable coverage, because many young adults have not yet settled into full-time jobs that offer health benefits. As a result, the probability of being uninsured jumps between the ages of 18 and 19, as many young adults lose coverage under their parents' employer-sponsored insurance. This loss of coverage

translates to a significantly lower use of health care services (Anderson, Dobkin, and Gross 2012).

The dependent coverage provision of the Affordable Care Act took effect on September 23, 2010. Data from several independent sources indicate that the policy has significantly increased the insurance coverage of young adults. Figure 7-5 presents data from one such source, the National Health Interview Survey, highlighting the change in insurance coverage for youth age 19 to 25 in comparison to a slightly older group, age 26 to 35. Because these two groups should face roughly similar labor market conditions, the experience of the older group provides a sense of what would have happened to the younger group had this provision of the Affordable Care Act not gone into effect.

Estimates from the third quarter of 2010 show that 35.6 percent of the younger group was uninsured, compared with 27.7 percent of the older group. Between the third quarter of 2010 and the second quarter of 2011, insurance coverage was essentially unchanged for the older group. In contrast, among the younger group the share uninsured fell 8.3 percentage points. This change translates to a gain in health insurance coverage for approximately 2.5 million people. Because even before this policy, college students were able to stay on their parents' insurance plans or obtain coverage through their school, the coverage gains arising from the Affordable

Figure 7-5
Percentage of Young Adults Without Health Insurance,
2010 Q3 and 2011 Q2



Source: National Health Interview Survey.

Care Act have been concentrated among non-students and recent graduates. Many of these newly insured young adults are from lower middle-class families who are working to maintain their position in the economy in the face of not only the recent economic downturn, but long-run forces that have been working against the middle class for decades.

The Economic Benefits of Expanding Insurance Coverage

Expansion in health insurance coverage from the ACA can be expected to positively affect access to care, health, and financial security. These effects and the impact of other provisions of the Affordable Care Act will be important topics of research (see Data Watch 7-2).

Research on previous coverage expansions suggests that health insurance can significantly improve all three outcomes. As noted, considerable research has examined the benefits of health insurance for children. One recent study (Finkelstein et al. 2011) examines the effect of insurance coverage on low-income adults. The study, which uses data from Oregon's Medicaid program, has two especially notable features. First, its population sample is similar to the group that will gain Medicaid coverage as a result of the Affordable Care Act. Second, because of budgetary constraints, access to Medicaid coverage was determined randomly by a lottery, in the same way patients are assigned to treatment and control groups in a randomized control trial. As a result, the study avoids the fundamental problems of inference inherent to observational studies.

The study finds that in the program's first year insurance coverage significantly increased the use of outpatient and inpatient care and of prescription drugs. The added care led to increases in the share of men and women screened for high cholesterol and high blood sugar and in the share of women receiving mammograms and Pap tests. The study also noted significant gains in several self-reported measures of physical and mental health. These findings are especially striking because the health benefits of improved access to care are likely to grow over time.

In addition to improving access to appropriate care, health insurance protects individuals and families from the financial risk associated with uncertain and potentially catastrophic medical costs. Today few uninsured families have the resources to cover the cost of a serious illness. According to one recent study, about a third of uninsured families have no financial assets at all, and the average uninsured family can afford to pay only 12 percent of the cost of a single hospitalization (Chappel, Kronick, and Glied 2011). The Oregon study used several financial outcomes to assess economic benefits of insurance. It found that individuals with health insurance were less likely to have unpaid bills sent to a collection agency and that they were significantly

Data Watch 7-2: Health Data for Policy

Health policy formulation and evaluation requires high-quality data on a broad range of outcomes. Federal surveys have provided the basis for a large research literature that informed the design of the Affordable Care Act. These surveys along with other Federal data programs will be important resources for monitoring the impact of the Act.

One objective of the Affordable Care Act is to substantially increase the number of Americans with health insurance. The National Health Interview Survey (NHIS) sponsored by the Department of Health and Human Services (HHS) and three other surveys conducted by the Census Bureau—the Current Population Survey’s Annual Social and Economic Supplement, the Survey of Income and Program Participation, and the American Community Survey—provide data on various aspects of insurance coverage. Increased insurance coverage should lead to improved access to care and improved population health. The NHIS and another HHS survey, the Household Component of the Medical Expenditure Panel Survey (MEPS), combine information on insurance coverage with information on medical care utilization and health status. Another component of the MEPS surveys employers on key features of the health insurance they offer employees. Additional information on utilization comes from HHS surveys of health care providers, including office-based physicians, ambulatory care facilities, and hospitals.

Two Federal data programs—the National Health Expenditure Accounts, produced by the Centers for Medicare and Medicaid Services, and the National Income and Product Accounts, produced by the Bureau of Economic Analysis—provide independent estimates of national health spending. Efforts also are under way at the Bureau of Labor Statistics to improve the collection of health data to better measure health sector prices and productivity (Bradley et al. 2010). Current initiatives by Federal agencies and academic researchers are aimed at developing data systems that support disease-based estimates of health spending (Aizcorbe, Retus, and Smith 2008). Research in this area focusing on selected conditions has shown that disease-based measures allow for a more nuanced understanding of what drives the growth in health spending. The results suggest that failing to account for changes in the inputs used to treat a particular condition and for improvements in health outcomes leads to an overestimate of health care inflation and an underestimate of productivity gains in the health sector (Aizcorbe and Nestoriak 2011). Whether this conclusion can be generalized is the subject of ongoing research.

less likely to report having to borrow money or skip paying other bills to pay medical expenses. These findings are consistent with earlier research showing that the advent of Medicare in 1965 generated large benefits in the form of reduced exposure to out-of-pocket medical expenditure risk (Finkelstein and McKnight 2008).

The benefits of the Affordable Care Act's coverage expansion are likely to spill over to the labor market as well. Because small firms cannot offer health insurance that matches in cost and quality the insurance offered by larger firms, they often find it difficult to compete with large firms in attracting and retaining workers. Similarly, the lack of affordable insurance options in the individual health insurance market poses a barrier to workers who would like to start their own business, work part-time, or retire before they are eligible for Medicare. Indeed, numerous studies find that the link between health insurance and full-time employment distorts decisions regarding labor supply, job mobility, and retirement (Gruber and Madrian 2004). By improving the health insurance options available to small employers and expanding the availability of affordable individual coverage, the Affordable Care Act should greatly reduce if not eliminate these distortions.

The Affordable Care Act and Medicare

Given the high and uncertain medical expenses faced by seniors, the health insurance coverage that Medicare provides for individuals age 65 and older is a critical component of the health care safety net. The inability of private markets alone to provide adequate health insurance coverage for seniors is a classic example of adverse selection (Akerlof 1970). Indeed, before Medicare was enacted in 1965, only an estimated one-quarter of seniors had meaningful private insurance (Finkelstein 2007). Today Medicare covers roughly 40 million elderly Americans and 8 million people under age 65 who qualify on the basis of disability.

Although the Affordable Care Act's coverage expansions and insurance market reforms are targeted at nonelderly Americans, the new law has important implications for Medicare as well. It provides new benefits to seniors by eliminating cost sharing for recommended preventive services, adds an annual wellness visit, and reduces out-of-pocket costs for prescription drugs in the Medicare Part D coverage gap. By the end of 2011, more than 24 million elderly Americans have benefited from the elimination of cost sharing for preventive benefits, and 3.6 million beneficiaries have received \$2.1 billion in drug discounts.

The Affordable Care Act also puts in place several strategies for reducing the growth in Medicare spending. Such efforts to "bend the cost curve" are essential to maintaining the long-run fiscal status of the program

and reducing long-run Federal budget deficits. The Act includes important changes in the way Medicare pays doctors, hospitals, and other health care providers to create strong incentives for providers to redesign the way they deliver care, both to improve health and to use scarce resources more efficiently. The Medicare Shared Savings Program, for example, encourages physicians, hospitals, and other organizations to form Accountable Care Organizations (ACOs) to provide cost-effective, coordinated care to Medicare beneficiaries. Both the Shared Savings program and a similar Affordable Care Act initiative developed through the Center for Medicare and Medicaid Innovation (the Innovation Center) reward ACOs that are able to reduce the growth in health care spending while achieving high standards for clinical quality and patient satisfaction.

The mission of the Innovation Center is to help transform the Medicare, Medicaid, and CHIP programs to deliver better health care, better health, and reduced costs. The center's portfolio of initiatives includes demonstration projects that test new strategies for providing higher-quality health care more efficiently. These strategies include models of enhanced primary care; the use of episode-based bundled payments to improve care coordination; and a challenge grant program that will award up to \$1 billion in grants to applicants who will implement the most compelling ideas for delivering better health, improved care, and lower costs to people enrolled in Medicare, Medicaid, and CHIP. Because of Medicare's outsized role as a purchaser of health care, these initiatives are likely to spur similar innovations by private insurers.

RETIREMENT SECURITY

For older Americans, retirement savings in combination with Social Security benefits are a critical element of the safety net. These savings and benefits together allow retirees to maintain the living standards they had during their working lives and to protect themselves against downturns in the financial markets, unexpectedly high health care costs, and the risk of running down one's assets. In addition, some Americans elect to accumulate additional savings in hopes of bequeathing assets to their heirs. From a broader societal perspective, private retirement savings fuel capital accumulation. Capital thus accumulated leads to greater investment, which in turn leads to a more productive workforce and stronger economic growth. In this sense, saving not only bolsters the standard of living in retirement for participating workers but also raises the quality of life for future generations.

Over the years, policymakers have implemented a variety of policies to encourage capital accumulation, to protect retired households against

economic shocks, and to increase the likelihood that Americans enjoy the same quality of life during retirement that they enjoyed during their working years. The most prominent of these programs is Old Age and Survivors' Insurance, also known as Social Security, which pays retiree benefits to more than 95 percent of elderly individuals in the United States. Social Security is the nation's retirement security bedrock, paying out \$596.7 billion to 44.4 million beneficiaries in 2011—an average annual benefit of \$13,561. Social Security payments, combined with private savings and employer-provided retirement benefits, provide sufficient income to enjoy a comfortable retirement, and for many others, make the difference between meeting basic needs and living in poverty. In 2010 Social Security income lifted an estimated 13.8 million elderly Americans out of poverty. The program also provides a key safety net for survivors of deceased workers, helping roughly 6 million surviving spouses and children.

Even as Social Security helps provide a stable source of income in retirement, tax preferences for retirement saving give working-age households greater incentive to accumulate assets toward retirement. Most tax-preferred accounts allow workers and their employers to make pre-tax contributions to a retirement account and also allow earnings on those contributions to accumulate tax-free; other accounts allow after-tax contributions to grow and be withdrawn tax-free. Many American households have responded to these tax incentives by building assets toward retirement, with total balances in defined-contribution and individual retirement accounts (IRAs) rising to nearly \$9.2 trillion in 2010. The overall tax expenditure for the principal retirement saving incentives is substantial, totaling almost \$120 billion in fiscal year 2010.

Declining Retirement Preparedness

Despite the availability of tax-related incentives to spur saving, many households have not accumulated sufficient assets to overcome the potential risks faced in retirement. By some estimates, the proportion of households with adequate retirement saving has been in decline for decades. As illustrated in Figure 7-6, the share of households “at risk” of experiencing marked declines in consumption in retirement rose from 31 percent in 1983 to 51 percent in 2009, with much of the recent change owing to declining housing values.² For members of Generation X (individuals born between

² These estimates are based on the National Retirement Risk Index (NRRI) produced by the Center for Retirement Research at Boston College. For each household, the NRRI estimates household income in retirement (based on projected assets at retirement) as a share of pre-retirement earnings; this percentage represents the replacement rate of pre-retirement earnings. Each household is assigned a benchmark “adequate” replacement rate; households that are more than 10 percent below the benchmark are deemed to be “at risk.”

the mid-1960s and 1972), the situation is even more troubling, with nearly three in five households in that age group in danger of becoming unable to maintain their living standard in retirement (Munnell, Webb, and Golub-Sass 2009).

Although retirement preparedness has been in decline in the aggregate, specific demographic groups are particularly vulnerable. Single individuals and low-income households are all especially likely to enter retirement with insufficient assets. For example, one estimate for 2009 identified 60 percent of low-income households as inadequate savers, compared with 42 percent of high-income households (Munnell, Webb, and Golub-Sass 2009). Another estimate found that 60.2 percent of single men had insufficient retirement wealth to maintain preretirement consumption, compared with 45.2 percent of married couples (Haveman et al. 2006).

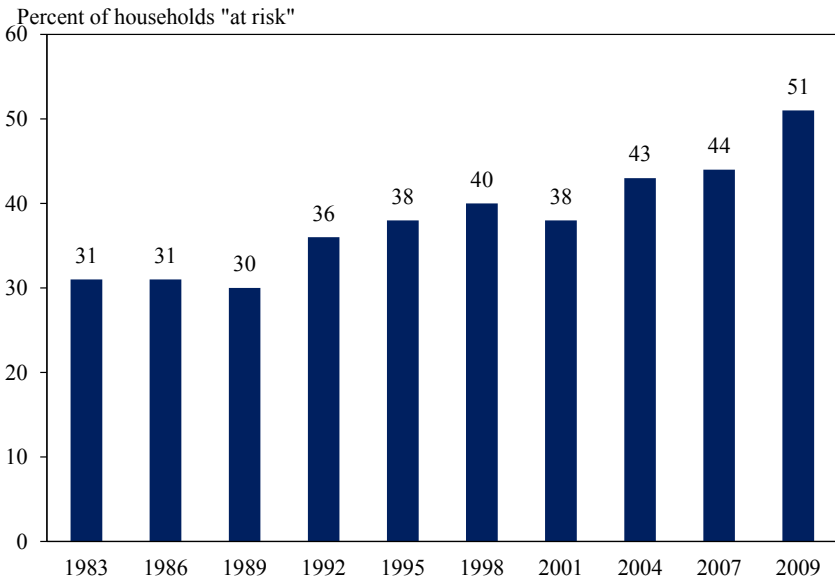
Recent economic shocks have impacted individuals nearing retirement. Between 2007 and 2009, Americans aged 55 to 64 saw their real median household income decline by 5 percent and their median net worth fall 15 percent—from \$258,000 to \$222,000 (Bricker et al. 2011). In addition, the value of housing—a key source of wealth for older Americans—has dropped 34 percent since the housing market’s peak in April 2006. The value of financial assets also declined precipitously following the financial crisis and has yet to rebound fully to pre-recession levels. The combination of declining asset values and lower income has further weakened retirement preparedness.

Challenges to the Retirement Safety Net

Several developments have contributed to the problem of inadequate retirement saving. A first-order concern is declining participation in employer-sponsored retirement plans. Between 2000 and 2010, the share of private sector workers between the ages of 21 and 64 who participated in an employer-sponsored retirement plan fell from 48 percent to 39 percent.

The past several decades have also seen changes in the nature of private employer retirement plans. The share of private-sector workers covered by defined-benefit pension plans fell from 38 percent in 1980 to 20 percent in 2008 as many private employers switched to defined-contribution plans like 401(k) plans. Section 401(k) and other defined-contribution plans offer workers particular benefits, such as portability, high potential for growth, and flexibility. However, the shift to 401(k) plans (and to a lesser degree a shift from traditional defined-benefit pensions to hybrid defined-benefit plans such as cash balance plans) has also transferred substantial risk away from employers, placing greater responsibility on workers to accumulate and manage assets and exposing them to greater financial risk.

Figure 7-6
The National Retirement Risk Index, 1983–2009



Source: Munnell, Webb, and Golub-Sass (2009).

To take full advantage of the wide array of incentives for retirement saving, workers must assess complex details associated with establishing an account, making contributions, managing investments, and eventually making withdrawals. In the face of complex saving and investment decisions, some workers put off enrolling in employer-sponsored retirement programs or taking advantage of tax-preferred saving vehicles outside of employment. Such delays are costly in terms of lifetime asset accumulation. (See Economics Application Box 7-1 for more information on common mistakes made by retirement savers.)

Another challenge to the retirement safety net is the uneven distribution of the benefits of the tax code's generous incentives for retirement saving. Because these tax incentives are often provided as a deduction or exclusion from income, they are most valuable for taxpayers in higher tax brackets. In the aggregate, these incentives flow disproportionately to upper-income households; almost 80 percent of the total tax benefit is projected to go in 2012 to the richest 20 percent of households and more than 40 percent to households in the top 5 percent of the income distribution (Toder, Harris, and Lim 2011).

The availability of employer-sponsored retirement saving options also varies by firm size. As with health insurance, small employers face significant challenges in establishing retirement plans. High per-participant

administrative costs, frequent employee turnover, uncertain revenues, and lack of familiarity with plan design and characteristics all discourage small business owners from providing retirement plans. Their inability to provide these plans not only threatens retirement security for employees of small businesses but also can make small businesses less attractive to workers than larger employers are.

These obstacles to retirement saving keep account balances low for many households. In 2011, more than half of all workers reported that the total value of their household's savings is less than \$25,000; 29 percent said they have less than \$1,000 in savings (Helman, Copeland, and VanDerhei 2011). Although some of these workers may participate in defined-benefit pensions, others will enter retirement with little income outside of Social Security. One analysis of households aged 65 to 69 in 2008 showed that the median household had just \$15,000 in financial assets and \$5,000 in private retirement assets (Poterba, Venti, and Wise 2011). Most households in the sample had more wealth in housing equity than in liquid assets (Table 7-2).

One of the toughest retirement challenges involves uncertainty about how long retirees are likely to live. With extended longevity comes the possibility that an individual will live longer than expected and will thus outlive his or her accumulated assets. This possibility increases as the time between retirement and expected age of death lengthens. In 1970 a worker retiring at age 65 could expect to live another 15.2 years; by 2008 that figure had grown to 18.7 years. Although extending life expectancy is an exceptional achievement for the United States, it also increasingly exposes retirees to the risk of outliving their assets outside of Social Security. In 2010, just 17 percent of Americans aged 65 to 69 relied on Social Security for more than 90 percent of their income, but the share almost doubled, to 33 percent, for Americans age 80 and older (Figure 7-7).

Another serious risk is costly health shocks. Even with the protection provided by Medicare, many retirees face high out-of-pocket health expenditures, diminishing their retirement assets and threatening their well-being. Recent research estimates that for a 65-year-old couple, the expected present value of lifetime out-of-pocket medical costs exceeds \$250,000, with a 5 percent risk that expenses will exceed \$570,000 (Webb and Zhivan 2010). As discussed in Data Watch 7-1, out-of-pocket health costs can push retirees into poverty.

The risk of large health expenditures and the possibility of outliving one's assets force retirees to face difficult decisions about how much of their assets to consume in any given year. Uncertainty about lifespan, inflation, investment return, and unexpected medical expenses makes the "decumulation decision"—how much to withdraw from accumulated

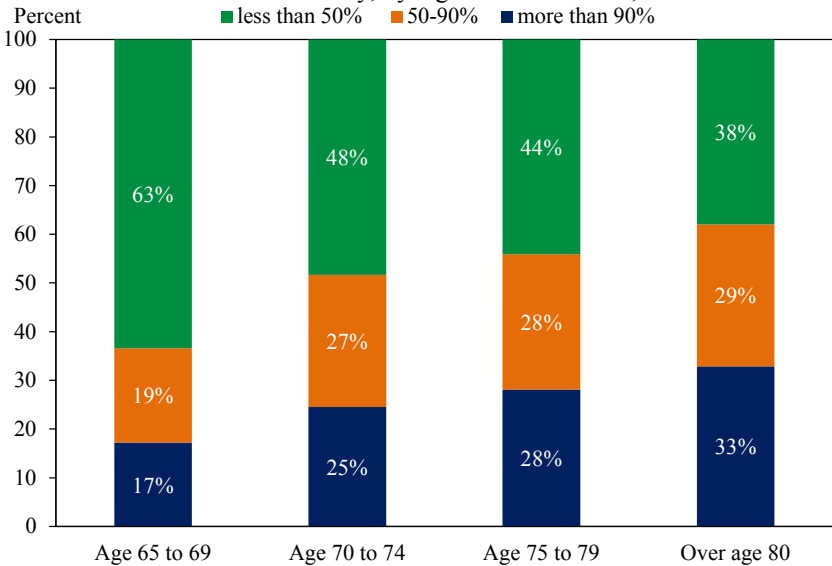
Table 7-2
 Distribution of Wealth Components for Households Aged 65–69, 2008
 Thousands of dollars

Percentile	Financial assets	Personal retirement account assets	Financial + personal retirement account	Housing equity	Defined-benefit pension	Social Security	Net worth
10	0.0	0.0	0.0	0.0	0.0	0.0	197.0
20	0.3	0.0	0.8	5.0	0.0	154.3	297.3
30	2.0	0.0	5.5	42.0	0.0	214.5	413.6
40	6.0	0.0	20.0	80.0	0.0	267.9	564.0
50	15.0	5.0	52.0	120.0	0.0	315.3	731.1
60	32.0	28.8	104.0	162.0	25.3	379.0	898.4
70	70.0	75.0	195.0	229.5	116.8	463.3	1,146.4
80	145.0	142.0	375.0	349.2	238.5	542.9	1,483.4
90	358.0	347.0	711.0	585.0	468.9	643.1	2,103.0

Source: Poterba, Venti, and Wise (2011).

saving—exceptionally complicated. Retirees who live longer than expected might find themselves with insufficient assets in the later years of life, at a time when they are most vulnerable and in need of a reliable stream of income. While private annuities can serve to mitigate many of these risks, annuities markets face a host of obstacles including regulatory barriers,

Figure 7-7
 Percent of Individuals with Various Shares of Family Income from Social Security, by Age of Householder, 2010



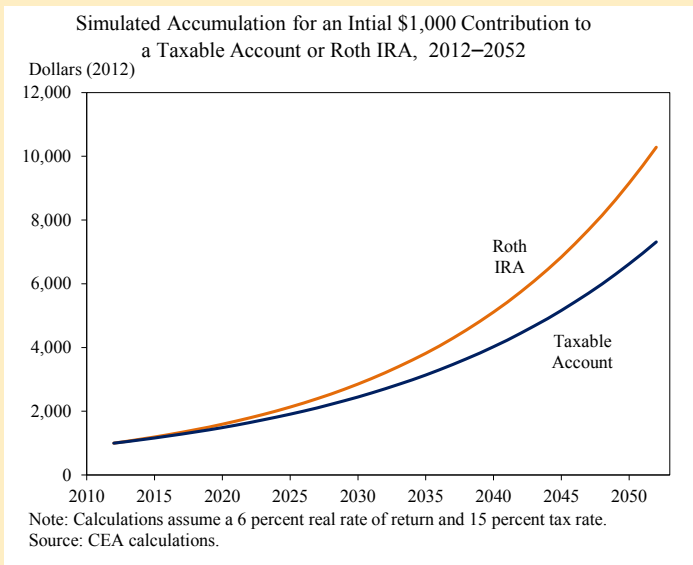
Source: Current Population Survey, Annual Social and Economic Supplement.

Economics Application Box 7-1: Financial Literacy and Common Mistakes Made by Retirement Savers

A generation ago, when many workers were covered by defined-benefit plans, retirement savings decisions were relatively easy. Today, workers must take much more responsibility for ensuring that they have adequate income throughout retirement. Achieving that goal requires avoiding some mistakes commonly made in saving for retirement. Below is a list of five mistakes that people often make.

Missing out on the tax benefits of saving. The tax code affords strong incentives for retirement saving. Participation in an employer-sponsored retirement plan or individual retirement account can yield thousands of dollars of extra retirement wealth over time. In addition, low- and middle-income households can take advantage of the Saver's Credit, which effectively provides workers with a Government match on new saving.

Workers can substantially increase their retirement savings by contributing early and taking advantage of tax benefits for retirement saving. For example, if a 25-year-old contributes \$1,000 toward retirement in a taxable account, that \$1,000 can be expected to grow to approximately \$7,300 in today's dollars by the time the worker reaches age 65. Taking advantage of tax benefits for saving can substantially increase this amount. If the same worker contributes \$1,000 to a Roth IRA, that \$1,000 can be expected to grow to nearly \$10,300 in today's dollars by the time the worker reaches age 65. As illustrated in the figure below, the benefits of tax-preferred saving increase over time.



Failing to participate in an employer-sponsored retirement plan. Some employer-sponsored retirement plans provide an employer match for money that an employee deposits into a retirement account. Taking advantage of an employer match is one of the best ways to leverage retirement contributions and rapidly accumulate saving. Many workers, especially new hires and young employees, however, leave this “free money” on the table by failing to sign up for a retirement plan. In 2001, only 57.5 percent of workers aged 20–29 participated in a company retirement plan even when one was offered (Kawachi, Smith, and Toder 2006).

Failing to diversify retirement savings. Investment needs and risk appetites vary across households. However, concentrating all assets in one particular type of investment can prove risky, especially if that asset is stock in an employee’s company. One study found that in 2002, nearly 4 million workers invested in excess of 80 percent of their employer retirement plan assets in own-company stock (Mitchell and Utkus 2002). In general, investors can protect themselves against risk by spreading their assets across various types of investments.

Losing investment returns to high fees. High fees can inhibit rapid accumulation of retirement wealth. Savers should pay attention to all investment fees, including those charged at purchase of a mutual fund, ongoing fees, fees charged by brokers and registered investment advisors, and fees charged on the purchase of annuity products. Although these fees are ordinarily charged for legitimate services provided, investors should incorporate the cost of fees in their purchase decisions.

Cashing-out retirement savings. When workers leave a job, some fail to rollover their pension wealth into an IRA and pay a penalty for cashing out their retirement savings. These leakages in retirement savings make it difficult to arrive at retirement with adequate amounts of savings. In 2006, workers aged 15 to 60 cashed out \$74 billion in retirement assets when changing jobs (GAO 2009).

Failing to protect against longevity and health care risk in old age. As lifespans increase, more Americans will face the prospect of running out of money in old age. Planning for and protecting against the risk of outliving family assets as well as the need for long-term care is an essential part of the retirement security picture.

behavioral aversion to annuities, and inadequate savings to purchase an annuity (Benartzi, Previtro, and Thaler 2011).

Policies to Address Retirement Saving Challenges

The President has proposed several policies to bolster Americans' retirement saving behavior and lead to a more secure retirement for millions of families. Perhaps the most significant policy is the establishment of automatic IRAs for tens of millions of workers. This proposal builds on a broad literature showing that automatic enrollment can dramatically increase participation rates in workplace retirement plans. For example, Madrian and Shea (2001) show that the participation rate after one year of employment at a large corporation increased from 37.4 percent to 85.9 percent following the adoption of automatic enrollment.

The President's proposal would require most firms without qualified employee retirement plans to offer employees an automatic IRA option. By default, automatic IRA contributions would be funded by payroll deductions equal to 3 percent of pay, unless employees opted out of the program or elected to contribute a different amount. Firms would not contribute on behalf of the employee, and companies offering the automatic IRA to workers could claim a tax credit for the employer's associated expenses up to \$500 for the first year and \$250 for the second year along with an additional tax credit of \$25 per employee—up to a maximum of \$250 a year for six years.

The automatic IRA would transform the retirement saving landscape. Employees who previously accumulated little or nothing toward retirement would begin accumulating assets immediately. Upward of 40 million workers, all previously ineligible for workplace retirement saving plans, would be covered by the new proposal. About 80 percent of these workers would be low- and middle-income employees with less than \$50,000 in annual wages, indicating that the IRA would primarily be targeted at workers who are more likely to have accumulated little savings.

The Administration also proposes to increase the tax credit for small businesses that adopt, for the first time, a qualified employee retirement plan. Under current law, small businesses can receive up to \$500 in tax credits—each year for up to three years—for establishing an employee retirement plan. The President proposes to double the maximum credit to \$1,000 annually to provide a stronger incentive for small employers to establish workplace retirement plans.

The Administration's Budget eases the compliance burden for retirement savings by exempting retirees with modest accumulated saving from minimum required distribution (MRDs) rules. MRDs are established to ensure that retirees with high accumulated retirement assets direct those

assets towards retirement, and not use retirement accounts to shelter their income from estate taxes. The Administration proposes to exempt retirees with less than \$75,000 in retirement savings from these rules. This move would simplify tax compliance for millions of elderly Americans, who would no longer need to calculate the amount and timing of their minimum required payouts. It would give millions of seniors greater freedom of choice as to when and how rapidly to spend their limited assets in retirement, while also adding flexibility to purchase lifetime income products—such as longevity annuities—that might violate MRD regulations.

The Administration has made a commitment to financial literacy as a means of assisting Americans in making sound decisions regarding saving and investment. In 2010, the President signed an Executive Order creating the President’s Advisory Council on Financial Capability to assist the American people in understanding financial matters and making informed financial decisions. In addition, the Wall Street Reform and Consumer Protection Act of 2010 created the Consumer Financial Protection Bureau, which is charged with educating consumers about financial matters and enabling them to make sound financial decisions. And, in 2011, the Financial Literacy and Education Commission, established to coordinate Federal efforts to promote financial literacy, developed a new national strategy to enable Federal agencies to coordinate and promote all the Federal initiatives aimed at helping Americans make better financial choices.

Taken together, these policies will lead to a more inclusive retirement saving landscape. Workers who would defer retirement saving because of financial inertia or behavioral obstacles will automatically be put on a path toward better saving. Easing MRD rules will simplify financial decisions in retirement for millions of elderly Americans. A coordinated national financial literacy campaign will help Americans become more active savers and will lead to improved investment decisions and smarter consumer behavior. More active saving, coupled with improved investment behavior, will increase the level of assets earmarked for retirement saving, leading to a more stable retirement for millions of Americans.

CONCLUSION

A strong and dynamic economy requires a robust and modern safety net to protect families against economic shocks and to provide a level of security that promotes entrepreneurship and economic growth. The challenging economic times of the past decade have made clear the important role that public policy can play in this area. In particular, unemployment insurance benefits, the Earned Income Tax Credit, and the Supplemental

Nutrition Assistance Program have kept millions of American families out of poverty. Medicaid and the Children's Health Insurance Program have ensured that children are able to maintain health insurance coverage even if their parents lose access to employer-sponsored plans.

New policy initiatives will further strengthen the safety net. Although the current system of unemployment insurance has provided critical support for dislocated workers, the system can be modernized and improved. The President has proposed a number of innovative programs that would make it easier for jobless workers to invest in new skills or even start their own businesses. These proposals build on current programs that have been proven to work.

The Affordable Care Act represents the most significant improvement in the health care safety net since the advent of Medicare and Medicaid in the mid-1960s. By 2019, the Act is expected to increase the number of Americans with health insurance by over 30 million, and it will put in place new consumer protections ensuring that health insurance coverage remains available and affordable for all Americans regardless of an individual's health status or medical history.

In the area of retirement security, the President has proposed a number of policies that will boost retirement savings, making it more likely that Americans will enter retirement with adequate assets to maintain their desired level of consumption. These efforts to strengthen the safety net will provide tangible benefits for the economy and families in the coming decades.