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**Can We Afford Our Parents' and Grandparents' Retirement
Part 2: "Always Choices: How Should We Reform These
Programs?"
National Academy of Social Insurance (NASI)
August 3, 2007**

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[START RECORDING - PART 1]

RACHEL SHIFFRIN: Alright. We're going to get started. So, we've heard a lot this morning about all the federal programs and the impact that the baby boomers will have on these federal programs in our society. So we're left wondering whether there will, in fact, be financial stability in our future. We're going to turn to this afternoon's panel to examine the solvency of these federal programs. First we'll start with Nancy Altman, and Nancy will focus her discussion on the financial viability of social security. Ms. Altman is currently the chairwoman of the Board of Directors at the Pension Rights Center, and has been working in the area of private pensions and social security for 30 years. Ms. Altman has worked on Ellen Greenspan's 1983 Social Security Reform Commission, taught Retirement Policy at Harvard's Kennedy School of Government, and has just written a book titled, The Battle for Social Security. She does believe that this insurance program can be stable with a few minor adjustments so I'm sure we're all eager to hear what these adjustments will be so we can continue to receive social security into our retirement.

NANCY ALTMAN: As everyone in the room knows, as we've been talking about this morning, I think as everyone in the country knows, social security is facing a long-range deficit. The latest trustees' report projects a deficit over the next 75

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years of 1.95% of taxable payroll. Let me just unpack that for a few minutes. Think about that, 1.95% of taxable payroll over 75 years. 75 years? Three-quarters of a century? Why so long? Most federal spending isn't projected out more than 10 years. If social security projections were taken out only 10 years social security would have a 4.5 trillion dollar surplus. It would look pretty good. No private sector plan makes that long of projection. In fact, no other country, as far as I know, other than Canada, makes a projection 75 years out for their social security program. The answer to the question why we have 75 years projections in this country is really a reflection of the conservative and prudent management of the program. In 75 years, a worker just entering the workforce today at age 20 will still be alive, 95 at the end of the valuation period. So a 75 year valuation period more than covers both the working years and retirement years of virtually every participant in the program. Again, it's a conservative, prudent choice to make sure that this program will be there permanently for my parent's generation, for my generation, for your generation, and for our children's generation. We know that over 75 years, we're not going to be 100% accurate. We can't solve the problem once and for all and never look at it again, but it gives us a very long time horizon to make the kinds of minor adjustments that need to be made to keep the program on a sound financial footing. That's the 75 years.

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Let me talk, just for a second, about the percent of payroll, since you will be doing an exercise, I think, where you're going to be talking about that. Income and expenditures for 75 years involves literally trillions of dollars. Susan Daniels, this morning, talked about trillions-shock. To make the numbers easier to work with, experts in the field, historically, have expressed cost, revenue, income, out-go, and proposals for change in terms of percentage of payroll. They're really funtable [ph]. Percentage of payroll can be turned into dollars and dollars can be turned into percentage of payroll. It's just that they're easier to work with. Think of it the way that astronomers use light years rather than using miles or kilometers. It's the same kind of concept.

So let me give you a little bit of perspective on this 1.95% of taxable payroll that the actuaries are now projecting over the next 75 years. The size of the deficit, while serious enough to take action, is not particularly large or troubling by historical standards. We've often had that kind of a deficit before congress has acted and put the program in balance and the program has never missed a payment. We've got this 1.95% of taxable payroll deficit over the next 75 years. What do we do about it? How do we eliminate this gap between incomes and out-go? Many policy makers seem to believe that the only solutions involve either tax increases, and I liked the comment that was made by the law student that really these

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used to be thought of as contributions as a parenthetical, the FICA tax, which is the payroll tax, it stands for Federal Insurance Contribution Act, but the common parlance today is to talk about tax increases. The only solutions, often policy makers think of, are tax increases or benefit cuts. But that's not accurate. There are other possibilities. The deficit can be reduced by neither raising taxes nor benefit cuts. For example, we could increase the return on those 4.5 trillion dollars that we are going to be accumulating over the next 10 years. The reserves under current law are restricted to investment and bonds, and actually they're even more restricted. It's in U.S. treasuries. Most pension plans diversify their portfolio and invest in equities and bonds. Historically, equities have had a larger return. This ideal of investing some of the reserves in the stock market was first floated in the 1930s, and you could imagine if that idea had been jumped on in that park. The social security trust funds, having been holding stocks since the 1930s, would have pretty good income. One of the proposals that's currently around is to put 20% of the current reserves, of gradually building it up slowly, in a very safe, broadly based, indexed stock fund with lots of safeguards, federal reserve board kinds of management, and so forth to keep it from government involvement and in corporations. If that were done, that would solve about a fifth of the problem.

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Another kind of proposal that brings more revenue to the system without tax increases or benefit cuts is to expand the coverage of the program. The program is intended to be universal. The only major group not now covered under social security is about 25% of state and local employees. There is no reason, no real policy reason, why they should be treated any differently from any other worker in the country. If they're brought in because of the way that it works where you've got more people paying in at the beginning and fewer getting benefits, and also because this group tends to be slightly higher in their pay scale, that has a bit of a benefit for the social security trust funds. It's good policy. It's not a tax increase. It's not a benefit cut.

You could also find new sources of revenue. President Bush has proposed repealing the Estate Tax. One idea is to instead of repeal it, convert it into a dedicated social security tax the way that the FICA tax now is. Now, interestingly, you can actually do that as a tax cut from current law. It's not a tax increase; it's a tax cut, and still take care of about a quarter of the existing deficit.

Another possibility, another source of diversion is general revenues. In the 1940s there was a provision in the law that to the extent there wasn't enough revenue in social security to pay benefits; general funds would make up the difference. That lasted for the decade of the 1940s. If that

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were in the law today, the program would by definition be imbalanced. So those are ones that don't involve tax increases or benefit cuts.

There are also a set of proposals that have an impact on benefits or an impact on taxes but they really have sound policy reasons independent of simply trying to bring more revenue into the program. One example of that is that every year the people, who are receiving benefits, receive an annual cost of living adjustment. It's based on the Consumer Price Index. Some have argued that Consumer Price Index is actually too generous. Others argue it's not generous enough. Obviously it makes sense to have an accurate cost of living adjustment. One of the proposals by the Department of Labor is to use this chain CPI, which is a complicated concept but if that is used, the projections by the actuaries are that it would save money because benefits would go up more slowly. It is a benefit cut but one would argue that it actually is more accurately trying to carry out policy.

But beware. There are other kinds of proposals that sound like good policy changes but actually really are simply benefit cuts. There has been some discussion in the last panel and before about rising the retirement age. On the surface, it makes sense. People are living longer. People are healthier. Why not they work longer? The problem is that the way social security is structured, that what looks like simply raising the

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retirement age. When all the smoke clears, all you've really done is cut benefits so that under current law with this current increase in benefits, somebody retires at 62, somebody retires at 65, somebody retires at 70, someone retires at 80, and the only impact is that they will get fewer dollars than they got before. It's simply an across the board benefit cut. There are other ways to encourage workforce participation by the elderly. I think we fool ourselves if we think rising the retirement age will do that, and not simply reduce benefits.

Now none of these proposals I've talked about, I would argue, change the fundamental character of social security but there are other proposals around that do. I am a supporter of the program and I urge each of you, if you do support the program, in your discussions, after this session, to think about the extent to which proposals are in keeping with the fundamental structure and the fundamental values of the program or at odds with it.

Another proposal that sort of makes, again, a kind of, when you look at it quickly, makes some sense, is to say: You know Bill Gates is getting social security. Does Bill Gates really need social security? Maybe we should have some kind of limits so that the highest paid people just don't get any benefits. The problem is that changes the fundamental nature of this program. The idea of social security is that it's insurance. No one would think that if Bill Gates paid premiums

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for fire insurance and his house burned down, you know Allstate should come to him and say: Gosh, we just looked at your bankroll. I don't think we're going to pay off this account. The problem is that whether you set that limit at \$10,000.00, \$100,000.00, \$1,000,000.00, \$10,000,000.00, it changes the nature. It turns the program in an odd way into a means tested program. People are not entitled simply because they've earned it by their work effort. They now have to show they really don't have as much money as you might think they have and they really could use this money. It's a fundamental change. It changes the program in an odd way from welfare to what is now insurance.

Another proposal that was put forward in 2005 was the so-called Progressive Price Indexing where benefits for the lower paid people went up more quickly than benefits for the higher paid. This too has a similar kind of effect where, over time, you eventually have flat benefits for everyone.

Then there are other changes that affect the program that really don't even help the deficit situation and that are private accounts. It fundamentally changes the program without alleviating the deficit.

Now let me now announce my own view. I believe that benefits right now are actually too low. Particularly in light of what is happening in the world of private pensions where traditional pensions are being frozen and terminated and 401Ks

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are not up to filling in the gap. In addition to the very rapid rise in Medicare costs which are coming directly out of people's social security benefits. I also think that the rate of taxation rank and file workers is too high, or is at least high enough. Therefore, with that all in mind, my preferred solution has three parts. The investment in the stock market that I talked about, though with all the safeguards. Deduction of the Estate Tax, and another proposal that was eluded to in the last panel. That is that 90% of restoring the taxable wage base to where it used to be, which is covering 90% of covered wages but which no longer does because the highest paid workers have had their salaries increased more than the lower paid. It's a kind of complicated concept but it's the 90% mark was something congress endorsed in the 1970s and tried to make automatic and permanent and it just hasn't worked. I talk about the other parts that we talked about in the panel before about raising the cap completely and so forth, which I am not as in favor of but I'm happy to talk about that more in the questions. I see I'm just about out of time. Let me close by a plea. That is as you embark on the exercises this afternoon, and as you think about as voters, and policy makers, and policy analysts, about social security and think about how we close this 1.95% gap. Please remember there are real people behind the numbers. Two-thirds of the elderly receive half or more of their income from social security. One-third of the

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people who receive benefits are children of disabled and deceased workers, and are the disabled themselves and their families. There are real workers struggling to get by who are paying those taxes. It's important to close that gap. I am absolutely convinced if there is the political will there is no economic reason why we can't do it. I think we should do it in a careful way which takes into account the values of the program and all of us. We're all in a common boat here, all of us who are seeking the American dream. Thank you. [Applause]

RACHEL SHIFFRIN: Now I'm going to introduce Marilyn Moon, who is the current Vice President and the Director of Health Programs at the American Institute for Research. She is a nationally known expert on Medicare and social insurance. Dr. Moon has an extensive background in health policy for older adults, as well as the general population, through her experience as a senior fellow at the Urban Institute and Public Trustee for the Social Security and Medicare trust funds. Dr. Moon was a founding member of NASI, and she served as President of the Board of Directors from 2005 to 2007. Dr. Moon has a number of publications including a recent one titled, A Place at the Table: Women's Needs and Medicare Reform. I hope she will touch on this gender issue as she discusses health care spending in the broader society. Dr. Moon.

MARILYN MOON: I think I just destroyed part of the conference area here. I was more powerful than I realized. I

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apologize for being late. The traffic out there was not too nice and tempers were a little frayed. It's going to have an effect on one of the proposals I'm going to talk about so you'll hear about that in a few minutes. Think Hummer if you want to understand what that means.

The issue of Medicare is an even tougher one than social security. Social security is kind of the granddaddy of social insurance programs, and it's the one that traditionally has been much harder politically for people to deal with for one main reason. That is that there is an intermediary between the benefits that people receive and the government and that is the providers of healthcare services. Traditionally, you can tweak the program, the Medicare program, by either tweaking a little bit providers of care or by tweaking beneficiaries. From that standpoint, it is a little bit less of a direct impact on individuals and, in fact, if you listen to a lot of the debate, it's often, well, we'll reign in the excess spending of hospitals for example. It certainly can have an impact on care and certainly those lobbies yell pretty loudly when they're unhappy as well. I think it takes a little bit away from that direct connection of saying we're going to cut benefits, which make social security often difficult to deal with. The problem though with Medicare in terms of my statement that it's harder to deal with, is that ultimately the problem is really larger. The problem is larger because Medicare has never been very

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generously funded. Its FICA taxes, its federal income contribution rate are only 1.45% for both workers and employers. That's considerably less than social security but it is growing at a much more rapid rate. Now that payroll tax pays only for what's called Part A of Medicare. If you ask an older person or a person with disabilities who is on the Medicare program, A-B doesn't mean much to them. It's really more of a financing issue in many ways. Part B is financed by general revenues and individuals contributions through premiums into the program. Part B has always been viewed a little bit as voluntary but it's such a good deal for beneficiaries that almost everyone signs up unless they're still working for example or have other situations that mean that they don't need Part B. Part B is really the physician and ambulatory side, and ironically one of the things about Medicare is that while Part A was kind of the original idea, hospital insurance, much of our care in the United States since Medicare was passed in 1965, has shifted out of hospital settings and into more outpatient settings, either in the hospital on out-patient surgery, or in surgery centers, or even in the physician's office. It's getting to the point where you can almost think of having gallbladder surgery where you just lie in the backseat of the car, and drive through kind of like a car wash, and then you're on your way home after that. What that has meant, is there has been a shift in terms of the burdens, and

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more sensitivity over time to the general revenue contributions that people are paying. Historically, Medicare is also different in the sense of there has been a major change that some people make a great deal of, and that is the contribution that individuals make fell from 50% of the cost of Part B down to 25%. Good deal, yes? Except that when you shift the shares as much as they have shifted. In 1966, an individual would pay about 12.5% of the cost of their care and through premiums, and today it is down to an incredibly low 12%. It really hasn't affected very much. Sometimes people will say let's go back to the old days when beneficiaries contributed 50% of the cost of Part B. Unfortunately, because of the change in shares, it means something a little bit different.

Financing is very tough because you're going to gore somebody's ox. Somebody is going to have to pay one way or another in terms of less care; less support for the care, i.e. less to the providers of services; foregone care, if we tighten up on restrictions, sometimes that's care that may be unnecessary but in other cases it may very well be necessary, especially if we deal with this with a very heavy hand; or taxpayers. One way or another there are going to unhappy campers out there. On the other hand, my husband always tells me it's less of an issue now that his parents have passed away that when you guys think about this, you've got to get it right because otherwise Mom and Dad will be living with you, and

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there is some truth to that. One of the things that have really been a major change over time in the United States is the fact that families live independently, which is a difference from a long time ago. The bad news then was that people didn't live that long. The good news was that if they were living with you, they didn't live that long either. While many families get together and like living together, that's not always the case and it doesn't always work out very well. So this is going to be a serious issue. It's going to continue to arise and it's going to arise in a drip, drip, drip fashion because it's been easier for Medicare to find ways to come about with changes. In part because healthcare has been changing and we've shifted the things around a little bit, and so there have been more changes over the years in Medicare than in the social security system. Again, that sometimes can be bad and sometimes can be good.

Just to give you an example one of the ways in which the health care system changed substantially was when Medicare went to what called a Prospective Payment System. A Prospective Payment System, for hospitals, meant that instead of paying what hospitals sent in as a bill, and then perhaps discounted a little bit, what we essentially said was, if you're in the hospital for a standard appendectomy, it should cost about this amount and that's what you get paid. Some people will stay a little longer, some people will stay a

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little shorter, some people will have complications and it will balance out. That works pretty well, actually, for large hospitals. It's never worked as well for smaller ones with less to average over in a lot of ways. That changed health care substantially in the United States. For one thing if you change it in a program as big as Medicare which pays for almost a third of all hospitalizations in the United States, then you know it's going to have an impact. Most physicians don't say, hmm, Marilyn you look like you're about 65 so I'm going to treat you this way, while if you were 64 I would treat you a different way. For the most part, care is given and care given. One of the things that this did was reinforce a trend that was already happening in terms of shortening the lengths of stay in hospitals. If you look at the data, people in the United States stay in hospitals for a much shorter period of time than anywhere else in the developed world, much less than in a lot of other countries where people talk about a rationing of care and so forth. Part of that is just the way we provide care in the United States. Part of it is because now hospitals have an incentive to get you out as quickly as possible.

In many ways that has led to more efficiencies and it's been a good thing. But it's also meant arbitrary changes that have sometimes been harmful for people. I only had one impact on the health care system in a dramatic way that I know of, and that is a few years ago, many years ago now, when PPS

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(Prospective Payment System) first went in hospitals, my grandmother was hospitalized. She had broken her hip a couple of weeks before and she had a stroke. She was really quite ill. They came in after three days and said your DRGs are up, we're discharging you, and oh by the way, we have this little unit over here where if you pay out of pocket, we'll keep you for a few more days. My mother called me in a panic and I said, say the magic words, I want to appeal to the PRO. My mother said, what on earth is that? I said you don't need to know, just say, I want to appeal to the PRO. And indeed they did, and they all ran around in a frenzy, and came back and said, okay, she can stay two weeks. That's probably not the right amount of time either but one of the things that happen when you make big dramatic changes are you gets sometimes over-reactions and under-reactions. One of the important things about changes is we're going to make in the Medicare program over time is try to think about those unintended consequences. We don't always do it very well and when I say we, I mean we as a society through our policy makers. We could certainly do it a lot better. It's also very important to understand that if you say you're going to change substantially the Medicare program in terms of how it treats patients, it's going to have a trickle down effect on everyone.

Moreover, it's also important to know that the things that drive Medicare costs, drive costs for everyone else as

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well. So it's in many ways good to think about health care change in the health care system as a whole rather than just in Medicare. For one thing, it keeps it from being just a two-tiered system over time, but for another, it also means that you're recognizing that the whole system will be affected in some way, and you think about the unintended consequences of whether one group gets favored over another over time as well. That's a very important thing to keep in mind when you think about the changes that are going to occur.

The other thing that's important to keep in mind is that when you begin to push down on the providers of care, when you begin to say we're going to pay less to doctors, we're going to pay less to hospitals; they have a chance to respond as well. They're not required to provide care to Medicare beneficiaries for example, and they can and have to some extent decided not to take Medicare beneficiaries in some cases. To the extent to which we also further fragment the Medicare system by creating private plans, that danger is also greater. It's hard to say, I won't treat any Medicare patient when that's 30% or 20% of your business. If you say, I'll only take the patients that come to me through Medicare but are in private plans from ETNA, etcetera, that's another key issue. That's an issue that can affect beneficiaries. Medicare's strength in many ways has been because it serves everyone, and it serves very healthy 65 year olds, and very healthy 90 year

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olds, and very sick 90 and 65 year olds as well. That's very important to the success of the program.

One way in which we have talked about, as a society, changing the Medicare program to try to save costs has been to put people into private plans. To privatize if you will, Medicare, or to provide an option for that. Unfortunately, like a lot of policy, we don't do it very well. If we had done it very well, we would have the evidence to say, whether or not Medicare beneficiaries are actually being treated better or worse in one system or another. If they go into a private plan and get all of their care there, or if they stay in the sort of traditional Medicare program where you can go to doctors and hospitals pretty much wherever you want to. The difficulty is that traditionally we have overpaid those private plans. On the great wonderful idea that if you get everybody into private plans and you overpay them, eventually they'll find deficiencies and you can cut back on the payments. Now we did that early in the 1990s and these private plans were growing enormously. The problem is that they were growing enormously because they were overpaid. They were turning around and offering extra benefits to beneficiaries so they were happy. When Medicare said, whoops, in 1997, we're overpaying these plans, let's cut back. The plans left in droves and people left them in droves because they were no longer getting extra benefits and there was no longer this extra cushion. We're

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doing exactly the same thing now; we're on the same track where we're overpaying plans 12% on average, and in some cases as much as 25% to 40%. Yes. Those plans look like a very good deal to some beneficiaries but they're a very bad deal for the program as a whole.

It's possible we could do private plan options and have them work out well. We don't know very much about that. I think it's good to have private plan options, especially for people who traditionally have been in managed care plans and like that model. I don't think it's a good idea to force people into those kinds of plans.

That leaves me with talking about passing on the costs to beneficiaries or to tax payers. Take your choice. Either one has its problems.

Now Nancy had talked about something I liked, the Estate Tax, too. We had to struggle which one of us got the Estate Tax. My all-time favorite has always been to say, we should raise the gasoline tax, and half of it goes, now even more, to improving the infrastructure in bridges and half of it goes to Medicare. The impact would be that it would drive up the cost of gasoline and we'd get those horrible Hummer's off the road that were messing me up today. We would have better energy conservation, we would be a better society, and we would help pay for the Medicare program. \$3.00 a gallon for gas made that a little bit unpopular. I still think it's not a bad

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idea. It has some regressive aspects. It hurt's people in some places more than in others, but it is an idea whose time has come in many ways and we're just avoiding it. We could raise the payroll tax just a little bit for Medicare. I think that's not a bad idea but the things that are going to be done to beneficiaries, we have to be very careful about. Just as Nancy talked about raising the age of eligibility having a problem, it creates even more problems for Medicare program because we take 65 and 66 year olds who, if they're out of the labor force, will have a heck of a time getting decent insurance anywhere in the private market. The private individual insurance market is totally broken in the United States. We would be taking the folks who are the cheapest to the Medicare program and tossing them into a system that doesn't work. That's one objection I have. The other is we could get about 5% of Medicare beneficiaries off the roles that way and we would save 2% of Medicare's costs. It's really not worth it unless we're willing to take on health insurance all over the United States, reform in every state, etcetera, which I'm okay with.

The other is, again, the issue of income testing and so forth, has the problems that Nancy talked about so I'm not going to talk about that more, although, we're moving in that direction now. We're moving in that direction in a way that's not terrible, it's asking for higher premiums from higher

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income beneficiaries except we're not going to get much money out of it because we're going after people at \$90,000.00 of income and more. Unfortunately, there are just not enough even hundred-thousandaires among the senior and disabled population to make that much of a winner. We could make a lot of money that way if we took it down to \$25,000.00 or \$35,000.00 a year, but we're not talking about rich folks in that case. I think that this is a shared kind of problem. It's a problem that has implications for all of you; we're all likely to have to pay a little more. I think a shared solution is the right solution. I believe, for a lot of reasons I'd be happy to talk about further, that we don't want to dismantle the basic Medicare program. Thank you. [Applause]

RACHEL SHIFFRIN: Thank you Dr. Moon. Now we will hear from Tom Miller, who will discuss market solutions and individual mandates to health policy questions. Mr. Miller is a resident fellow at American Enterprise Institute. He is also a Senior Health Economist for the Joint Economic Committee of the U.S. Congress. While on the committee, he worked on social security reform legislation and organized a number of hearings that focused on reforms in private health care markets. Mr. Miller's most recent publication examines the presidential hopeful's health care discussion and the possibilities for substantial changes of the future of health policy. This is a

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timely topic that I'm sure everyone here is interested to hear more about.

TOM MILLER: That is a good step. Watch that Ted. It'll be a great leap forward, let me get this. Thank you very much. It's good to be here. As I was saying to Nancy beforehand, I guess I'm an outlaw with regard to Power Point but I often quote Lord Actin who used to say, absolute power corrupts, absolute power corrupts, absolutely, and Power Point corrupts pointlessly. [Laughter]

Now the question is, I guess, can we afford our parents' and grandparents' retirement? The answer, of course, is yes and no. Yes, we can. We just can't pay for very much else if we do it. Let me give a couple of limits, or hedges, or disclaimers before starting. I actually did used to work on social security. I drafted, I think, the first bill on Progressive Price Indexing, also I had longevity indexing in it, private accounts as well. Having built upon that massive success two years ago, I thought I'd move on to the easier question of Medicare. Marilyn didn't touch on Medicaid and I'm not going to either, although it's a serious problem, it has different dimensions to it. Just very quickly, we spend too much time thinking about the low income, below 65, our disability is an important part that we really don't have good answers to. It's somewhat of a matter of care coordination and getting the direct beneficiaries involved in their care. The

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long-term care, which is changing in terms of how it's delivered, essentially we've got to kind of cut out some of the mis-incentives where we have in fact overlapping public and private coverage. If you want people to take care of themselves, you can't make it be stupid to, in effect, pass up the entitlement that's under Medicaid, even for the middle class eventually.

I'll say a little bit on the private health markets. This will be focused more on the Medicare side. This is a bit of sketch because I'm Mr. Market today so it's a bit of an appetizer. You know, for every answer you get, there's five more questions in terms of how would you do it and what about this, what about this, what about this? I'll at least give you some ways to think about market approaches toward health care. Quick overview is, you know, why should we even think about a change at all from what we're doing? It's working so great, isn't it? Why markets as opposed to another approach? What are the comparative advantages of markets as opposed to different versions of politics as usual? What can markets do? What can't they do? What are the limits? What objectives are we trying to actually carry out? How do you do it? Some challenges, some limits and lessons of what are the barriers to getting too far but getting a start, and a little bit of the building blocks for moving in that direction.

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Why do we want to change at all? Well, you've probably had a lot of discussion today about hard numbers and different elements so I'll just quickly say that costs are growing faster than the economy is. You can try that for a long time. The average for Medicare is about 2% to 2.5% above real GDP growth. It's a little different from year to year. It's somewhat similar in private health care markets, but at a certain point, you can go a long way but you can't go forever. Uneven quality, geographic variation, the different numbers in terms of about the 30% estimate, you can go higher or lower, the darkness analysis in terms of variation around the country where you're paying more for care in one place but not even getting as good care in some cases. Certainly not all of that is justified. Can you squeeze that out? Inadequate or unknown value, not only you maybe get only about half of the right care, that's if we even know what the right care is. That's the broader health care system as a whole. It indicates that we've got a lot we could tighten up for a better standard of care in actual delivery. The demographic imbalances are the minor part of the problem compared to the secular increase in health care costs, but they complicate and make it even harder, in particular, when we look at the Medicare situation. We have some costs which are out there in the pay-as-you-go financing, which is just leveraged for future bills coming. I stopped counting with the unfunded liabilities, what do you want 75

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years, infinite horizon? It's big enough to know that it's too big. Also in health care across the board, and Medicare as well, as a highly regulated program, there are a lot of barriers to positive entry or innovation by other players. The incumbent interests, they can complain about not being well-fed all the time, but there is a great resistance to substantial change within this market place as opposed to the transformations that have occurred in other industries who have been troubled at times in the past.

As I said, we can't go on forever. On the other hand, these entitlement programs seem like a good idea at the time. The problem is, by the time you're getting over the cliff, it's a little too late to notice that the water is too shallow to do some swimming.

Why markets? Markets, more than the government programs, tend to prospectively acknowledge there is some resource limits. You have got to get something more out of what you have and it's not indefinite. Someone's got to pay for it and you'd like to know what you're getting for it in return. Markets also tend to be better at improving value across a continuum of preferences. There's not one single setting that matches every bodies' preference but if you have legitimate, robust, competitive markets with honest disclosure, transparency, etcetera, which may be a bit of a stretch, then you begin to get a little bit better matching between what

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someone says they're will to commit some resources to or would better match their circumstances, as opposed to a more uniform type of program. What we want though, is real competition, and Marilyn certainly pointed out that some of the financing of private plans in Medicare has been well short of that kind of level playing field; you know straight-forward real competition. Also, responsible choices, not a 100 choices but more than one is needed. We're not going to have anybody walk into the market place if you have more of a private choice slate in the Medicare program, if you look at the history of Medicare Part D with the drug plans; they're gradually dwindling down so it's not going to be every multitude of slightly differentiated plans. The choices should be more than one if less than 100 of qualified competitors to get out on the field. Markets are better at providing incentives to people, to on the margin recognize that it makes a difference as to the choices you make. You do better if you perform better. You do better if you make better choices in terms of a consumer.

Accountability. It also means you get to expand your market share if you do a better job of performance, but if you don't, you lose market share, and you go out of business. The government doesn't go out of business. It finds someone else to find the costs to impose upon.

Flexibility, experimentation, innovation. Any public program is a large elephant that can change gradually and

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slowly. A vote of congress, you can do a lot of things through regulations but it tends not to probe on the edges where a small success or failure can occur and then can be either brought up to a larger scale or a smaller scale. You probe on the edges.

Information discovery processes is what markets do best because there is no one single answer there but a lot of multiple players can ultimately collectively provide that kind of development of information we need. I didn't put it down here but actually markets also have the ability, if it's done the right way, to play the role of the bad guy a little bit easier than a politically accountable program can. If you prospectively offer choices to people, who may offer a little bit less at a lower price, and you get some buying into it, it's possible to actually change the scope of entitlement as opposed to when it's a legislative provision.

The comparative advantage continuum. When you have fair market, think about the goods you buy. You actually have more power voting with one dollar each time out in the market place and many times over and over again is how markets change, as opposed to waiting for that one grand consensus at the ballot box, and then perhaps once every ten years you can get all the forces of law to pass legislation which marginally changes a large program like Medicare. The question is you can get small, gradual, probing change as opposed to thinking the

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once in the generation, a consensus on what happens through mobilizing more than 50%. It's usually a super majority to make major changes in public programs.

The other thing we overlook is we get a lot of beating up on private insurance for its administrative loading costs. Why am I paying all this money if I don't get this much in health care benefits? What we forget is there is a different type of administrative load on public financing. It's the extraction costs of raising taxes. It costs a lot more than one dollar to raise a dollar in taxes. It reduces wealth, it has other secondary effects. It's costly to publicly finance something. In fact, that load is greater than the load of private insurance if you look at it in an integrated basis.

Also, markets can operate better on a bottom-up basis than on a top-down basis, which tends to be more of the governmental political side. You're finding prices rather than setting prices, as we do in Medicare, despite all the data that comes in to Med-Pack. Ultimately they are administered prices. You have risk and reward incentives versus instead trying to instead balance off interest groups. Also, markets will tend to pay more attention to who is the customer. Who is the boss because they are the folks controlling the money, as opposed to those who are more politically accountable?

Compounding investment growth means that by operating through private markets, you're able to invest that money in

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other wealth creating activities along the way, as opposed to if you're publicly financing things, you're in effect, taxing the creation of wealth. You're not creating any new wealth in that regard.

Now let's talk about matching up objectives and instruments. You divide this. Marilyn put this pretty much as a choice between getting less or paying more. Certainly we've tried that in different ways. Lowering costs can mean simply reducing payments to providers, limiting services. That's done in the private sector as well, but more so in public programs. Increasing income to the health sector can either happen publicly through taxes or raising your premiums. My wife always thinks the problem is insufficient income, never too much spending. The third alternative, and it's not inexhaustible, it can't do miracles, is to improve efficiency. We want to get better value for what we're getting in health care and more transparent trade-offs. So that for the set amount of money, you get more for the dollar. That's a different way of thinking that it's simply a shortage of income or you're simply going to have to get less. The question is what's a different match-up? There is more than one match-up in that regard. You want to match lower costs with improved outcomes. If we go to markets and we're trying to facilitate newer pathways, not miracles, but at least a step in the better direction. If you want to reduce demand, how would you try to

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do that? We could certainly like to think we'll be earlier and smarter with getting that person exactly before they're sick, and they'll be healed perfectly, and they won't have as many costly conditions. There are certainly some efforts in that regard. You can try to target populations at risk. The folks who are going to have the high cost, chronic conditions, are a major medical catastrophe. Care coordination, very lacking in most of our health care system. I wouldn't exalt the private sector much more over Medicare, but at least there are efforts to try to do that because it's not paying for fee-for-service items but potentially thinking about the whole continuum of care across that bundle. You can try to enhance the effective benefits, those that really come closer to paying for themselves. That they're worth covering as opposed to things that are a little bit more marginal. A shorter duration of chronic care costs. We're actually seeing evidence this is happening in any case demographically in Medicare, but the idea is that if you can keep people healthy for most of their lives, yes, everyone unfortunately I hate to tell you, is going to die in the end, but if you just die in the end, it costs a lot less over your entire lifetime than if you're loading those costs over a longer period of time. Sometimes it's referred to as morbidity compression. It's happened to some degree in the aging population. However, there are some problems with some

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younger populations now having a little bit more problems with disability.

Value based cost sharing incentives. It's not stupid cost sharing which just says, here is a \$1,000.00 or \$2,000.00 deductible. We don't know what is worthwhile. It's the idea of targeting. You pay more for things that are in effect worth less in health care benefit value, and you have in effect a lower cost of things that are much more therapeutically effective or worthwhile. All those things, you have more flexibility in a market set of arrangements than you can through a public program. Efficiency gains, also, and we're trying to pay for performance in both the public programs and the private programs. The early experience with the public programs shows it's a little difficult to do. The idea is to focus on out-puts and not in-puts. You want to reduce the extremes of the out layers in care, and you want to extend the time horizons so that when someone is thinking about what they're choosing today, it has repercussions down the road. Provider profiling is another area we're trying to focus on, the more efficient providers of care, and to prioritize and target what you've got.

In other ways, different delivery systems that focus more upon a lifetime of care that are a little bit more incentive compatible with what will actually pay off over the long-term rewarding non-health care in-puts, and other ways to

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pool people with the evaporation of retiree health. We don't really have a way to create groups in Medicare but it's a different type of innovation that could be attempted.

Facilitating newer pathways to find better value for real costs of care. Bundled pricing is a different way to itemize pricing which is largely what the Medicare program is, although we do have the DRGs and the hospitals side. How much is subsidized is the question. Once you can discover what the care costs for a set amount of benefits, it's a separate decision as to how much you want to pay for publicly. We don't actually know, prospectively, what it costs for a given set of benefits. We adjust the figures in Medicare after the fact.

Actionable transparency and real choices for consumers. Now pre-funding is a tougher nut to crack but it's a good ambition, which is to fund some of the costs of your later care when you're older, in advance. We've got difficulties in terms of transition costs but the idea of more of a life cycle orientation to how you're going to finance your care. It's a little fairer to younger generations over time. It provides a little bit better balance between the taxes funding, which tends to create greater deadweight losses as opposed to a limited amount of protection you want for your longer term costs. What are the limits and safeguards on doing all of this, and challenges? Medicare fee-for-service is a big incumbent and it's not going to move. Seniors aren't going to

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move to a great degree except in the march. This is an evolutionary change. When you do this, it exposes and confronts all the existing cross-subsidies in the system, which helps some people and not others but they're not as well known until they get out in broad daylight.

There are many shortcomings in the current private insurance system. I'm talking about a market based private insurance system as opposed to the one we probably have right now. Government has not been a reliable business partner and that tends to make private investors more suspicious about making a heavy investment in getting into Medicare. Time inconsistency is the problem of what we say we will do today, we want to re-neg on tomorrow, and that affects not only our health habits, but also our decisions in terms of health care. Consumers and patients have mixed capabilities. As you get older, there are fewer folks who are going to want to change and going to have the capabilities to change. You need some surrogates, some extra support to help them out, and not everybody is going to be a free market consumer. You want to target the low income, high cost, high risk people, and not pay everybody else as much. You need a lot of decision support, some regulatory guardrails. It's just not some kind of type of Hobbesian state of nature, social Darwinian world. It's to get something that is more market-like in health care rather than market-light.

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What are the major proposals, and I'll just do this real quickly. This goes back to the late 1990s, the main idea is premium support, which in essence is saying, we're still publicly supporting people's health care but we're having it delivered through more private channels on more of a competitive playing field. Medicare fee-for-service could still compete on this basis, and probably be a dominant player for a long time. This was first proposed by a 1999 Brode Thomas Commission, there are several iterations of it, he has not gotten all the way on politics, Ted will probably indicate why, but it's a way to say, if you can do a better job, go ahead and get more customers. If you can't, we're not going to subsidize you unduly as we're doing in Medicare advantage right now. You have a basic tier of benefits, which is what is subsidized, and there are supplemental tiers which are based upon people's willingness to pay for something extra if they want to get it. It's pro-market as opposed to pro-business and that's the better vision, although a lot of the entrenched interest would just be happy to get larger subsidies. You have more integrated benefits and cost sharing as opposed to figuring out which part of the alphabet you're in, A, B, D, E, or F in the future. It's one single program where things tend to work together on the private side. You may be, in effect, capitating patients with a support payment as opposed to the other approach of just capitating providers. The variation to

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this on the private sector side, which kind of brings this all together, is the idea of evolution from current employer sponsored insurance, more of a defined benefit program, to define contributions. We're not there yet but similar to what is happening in financial markets for retiree pensions. It's the same idea. You've got to have some safeguards in this. Risk adjustment means that not everybody gets the same defined contribution, but you're able to decentralize the trade-offs in the march. You get more predictable budgeting and financing, and you start a whole process of bundling, unbundling, and re-bundling what is the current health care package. You get a convergence between financial services and risk management, and also gradually a convergence between public markets and private markets.

There are larger things we need to do in private health care, as I summarized. Tax reform is a large issue in terms of at least equalizing tax treatment of all purchasers, if not reducing the total amount of the subsidies. A need-based subsidy is more important than subsidizing everyone. More information increasingly instead of more regulation is an alternative to help consumers. Data aggregation is a tough one. Medicare has the data. The private markets have the ability to use it more nimbly. We need to combine the two to get a common pool of data to make these types of value measurements and then competing interpretations. New

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intermediaries remains a little speculative, but the insurers may not be the answer in terms of being that interface that deliver the best care that you want. Upstream and downstream incentives are something that we need to pay attention to. It's the care that's being delivered to you that matters the most, as well as what you did before you saw the doctor. We tend to focus a lot more on the financing and the insurance, which is just stuck in the middle, as opposed to what's actually going to affect your health outcomes.

So I'll wrap up at that point. In essence, we need much more than what we've done thus far. Not just private insurance subcontractors for political contractors who give you form over substance. It's not really true markets or real reform. Someone is, though, going to have to pay more or get less. If we want to fix the real problems, we need better value care; that's what is hurting the whole system overall. We can outrun it with more revenue but using more private markets could help us move in that direction. Thank you.

[Applause]

RACHEL SHIFFRIN: And finally, we will hear from Ted Marmor, Professor Emeritus of Public Policy in Management and Law at Yale University. He will discuss the politics of Medicare, which is coincidentally the name of his second edition book; just one of his 11 authored or co-authored books. Professor Marmor has taught at the Universities of Wisconsin,

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Minnesota, and Chicago, and like Ms. Altman, Harvard's Kennedy School of Government. He has testified before congress about medical care reform and social security and welfare issues. He has worked as a consultant to the government in non-profit agencies. Mr. Marmor.

THEODORE MARMOR: Well, as I look out on you, I wonder what possibly are you thinking, after this barrage of materials all day, and Tom Miller's evidence that economists are paid by the number of Power Point slides they can put up. I'm going to begin with a story to try to change the tone a little bit. I'm going to make three points about the politics, both of Medicare primarily, but social insurance programs, including social security as well. The story has no bearing whatsoever on the politics of this subject but is important at this stage of a conference. This is a story about how not to take health too seriously. It's bad for your health. This is a true story about Dr. Swinsson [ph], a Swedish GP who came in to his office Monday morning, and his chief nurse said how agitated a 94-year-old male patient was who simply barged in and went into his office and insisted on seeing the doctor. So Swinsson went in and said, what can I do for you? Well, said the 94-year-old male patient, is it true what this journal on prevention has said. Well, what does the journal on prevention say? It says that if I become a vegetarian, if I give up smoking my beloved cigars, if I no longer drink, and if I forego sexuality

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completely, and if I walk three miles a day, is it true that I will live 3.4 years longer? Swinsson rubbed his chin and he said, probably, but what's the point? [Laughter]

So, what's the point about talking about politics in this context? I want to make three overall points, and I'll illustrate them insofar as I feel that they're required, and if the time permits.

Point number one, both about Medicare's politics and about social security's politics. You will understand not very much about those politics if you think they are mostly technical disputes about which, or what, particular policy will do to particular groups. It's true that there are these policy disputes, and it's true that, for example, different forms of financing will have different distributive consequences. It must be the case. That's not what this fight is a fight about. At its root, both the contemporary disputes about Medicare, particularly going back to the struggle over the 2003 Medicare Modernization Act and in the struggle over social security financing reform over the last few years, in both of the those areas, both the defeat of the Bush reform ideas for social security financing and the victory of the republican congress in changing Medicare in 2003, both of those, in my view, and this is my view not as an advocate, although I'm plenty of that in other context, this is my view as a political analyst. That is that I make bets about this. I'm willing to bet people

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about what happens, and I make money at it because Washington participants don't remember earlier bets and I do. The point I want to make, the fundamental point, is this, what's at root here is a dispute about what the proper role of government should be in providing protection of income against various risks to the income of families and individuals. I don't care how you want to put it; that's what the fight's a fight about and there are two stylized positions on this that, of course, have some problems about particular disputes. One is what we call, and don't talk enough about, the traditional social insurance conception of the role of government. There the idea is that if we all suffer the probability, some probability of a risk to family income, then we ought to pool to deal with it. We ought to pool while we work, and pool in a relationship to our income, that could be proportional, it could be progressive, and it could be flat, but ideally, in relationship to our income proportional or progressive. When the risks hit, we draw from that pool. That's the underlying understanding of the Social Security Retirement Plan, the survivor's insurance, the disability program, and Medicare as well. That's why Part A is paid for on the FICA tax, in addition to the FICA at 1.45% on both, that Marilyn said. On the other side, you can, in fairness, what's the competing view? The competing view is that that's too broad a role for government. What's more, if the government plays that broad role, then for example, private

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market solutions are going to be less prominent in that. If you believe as Tom was just suggesting to you, I was going to call it the theology of markets, but if you believe in the philosophy of markets as Tom was suggesting, and if you take seriously the comparative advantages in theory, as opposed to the comparative advantages in practice in the medical care world, then you regard this as an over-extension of the role of government and you think that the proper role of government is two-fold. Help people who have by some risked income fallen through the cracks and end up under where they want to be and on some kind safety net that's there. Not something that they can count on but something they fall into, and you try to create in the areas of risk management, the conditions of markets as Tom was trying to do. In the end, I may say a word or two about my view about those two positions, but for the moment, the political point I want to make is, don't be naïve. Don't be taken in by the policy babble. Don't be deluded by people whose job it is, whose professional occupation is, to make sure that you're bored to tears by lots and lots of details about lots of things other than what's absolutely crucial. That's point number one.

Point number two is that while those are the fundamental matters at hand, the debates over Medicare, over universal health insurance and over social security. In my judgment, as an analyst now, not as an advocate, are beset by

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myths. It's also the third point I was going to make which I may not get to. Part of the mystification of these debates is that the myths that are generated by others, utterly understandable interest groups, that want to protect their interest, are actually amplified by an aspect of the press core in the United States, the faith that balance and objectivity involves giving equal time to two sides of any argument. Just think for a moment, if one side of the argument is spouting nonsense and the other part of the argument is spouting sense, the truth doesn't lay half way in between. As Jim Hightower said much more pungently years ago, the only things in the middle of the road are yellow lines and dead armadillos. Keep that in mind.

If I were to think about myths and the even-handed about that, here are some that I would want you to keep in mind. Let's, and I'm going to try to be an equal opportunity hostile critic here for just a moment, as an analyst, when someone tells me, or reports on the news, or claims in an argument that the really important point about medical care reform now is to make sure that seniors or others have a choice of an insurance plan, my truth barometer goes crazy. Americans do not demand choice of insurance plan because that's not the choice that they really care about. What they really care about is being able to go to, or continue to go to, any institution with which they have some relationship over time,

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whether it's religious, or personal, or neighborhood, or family, or whatever. It doesn't follow that people who value that choice, which is fully provided for in traditional Medicare, it doesn't follow that you necessarily get value for money for that choice. If value for money is understood by an analyst to the outside, rather it's a component part of medical insurance, not the income protection side, but equally important matter of giving people the security that in areas of illness and injury, they can go to the people they care about. One of the things that has happened in the last 10 years, and has been forgotten in some of the debates on the part of choice advocates, is just how much anger there has been in American politics over the limitations of choice of caregiver represented by so-called managed care plans. That's on the one side. That's the market celebration of insurance plans. The irony, think of it for a moment, here it is, in the name of choice, people are proposing restrictions of choice. It's Orwellian. As an analyst, it is, I sometimes say, it's the medicine [ph] version of Medicare reform. You destroy its component parts in order to save it. Save it from what?

On the other hand, it's also true that those people, who in the case of Medicare, are saying that traditional Medicare has been based on social insurance principles, and it's just fine. I'm not saying that Marilyn defended this position but some people do. Say that to protect Medicare, to

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protect it from market assaults, puts very little spotlight on a very important problem with Medicare as it's now structured. That is that by not doing much about the fairness and responsiveness with which prescription drugs were handled in the period between 1966 and the present, we are left with a program now, Medicare Modernization Act, which has many, many parts to it that are tax by stealth on the social insurance principles that we are talking about. In particular, the one that Marilyn mentioned, which I urge you to think about politically, not in terms of value points alone, but politically. What happened in the MMA regarding high income elderly? Well, what happened, very importantly, the suggestion was made that in order to have the right distributional consequences, have higher income people pay more for Medicare, you should triple their premiums. Arguments going back to the original proportions and so on remain. Keep your mind on the centralities here. Go back to my first point about the fundamentals of social insurance. If you have a voluntary program, highly subsidized but a voluntary program, and you tell the upper 1% or 2% of the income distribution for the age group 65 and over, that they're going to have triple their premiums, and what's more, you freeze that. If you try to freeze that over time so more and more people come into that income group, what does that do for the constituency of Medicare? It fragments it. It splits people from the higher

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income group from the rest. In the same analogous ways to having them go to private insurance plans, does the same thing. In the name of tax fairness, you produce constituency changes in the group that thinks that Medicare is theirs. That's the important point. In the second point related to it, is insofar as you do that, you do almost nothing significant for the financing of Medicare. The inability to keep the eyes on the fundamentals, the mystification that goes left and right is, I think, a crucial part of the politics. What would I say in closing about these politics is this, the reason that Medicare Advantage Plans are getting such a beating in the U.S. congress right now is because of the 2006 congressional elections. The reason that 2003 legislation passed is because the Republican congress was highly disciplined about pushing its way. The important thing to take away from the politics of Medicare and social security is you have to keep your eye on who's in charge and who's in power. That's a much more important predictor of the kinds of changes that are needed than any technical analysis.

One last point, this section, and this is now turning to what I do in my normal speeches in which I'm much more of an advocate and critic, the whole day seems to have been organized around this presumption that there is a big question about whether social security and Medicare are going to be around over the longer run. If you think politically, this is a very

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odd view. My generation is going to be joined by new baby boomers retiring. We're going to shift from 12% of the population being over age 65 to 18% over this period of time, and you people are worried about the program going away? What's the political logic that led to this kind of presumption? You might be worried about the opportunity costs, what else will happen, but the idea that a growing part of the population, wealthier than it was before, more organized, more likely to vote, is going to come listen to Tom and wonder about the idealized advantages of markets, it's not a very realistic presumption politically. Thank you. [Applause]

RACHEL SHIFFRIN: Thank you very much to our panel. Now it's time to turn over to questions. We have a little time for a few questions, if you would please state your name, and your university and if you have a question directed for a person, you know the drill.

GRAHAM GRIFFITHS: My name is Graham Griffiths. I am from the University of Washington and I am an intern at the Social Security Administration. I have two questions for Mr. Miller. The first is that I would just like to thank you for your talk. I thought it was informative but, as an economic student, I both come across arguments for the advantages of markets, but I think a lot of the prominent economists are also beginning to question whether markets work in all contexts, and health care is one of them. The particular advocate that I'm

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thinking of is Paul Krugman, and so I would just like if you could maybe take what you think are the most cogent criticisms of markets in the health care arena are and respond to them. Also, our last speaker brought up the point of the kind of political issues behind creating this doubt that maybe social insurance programs are going to continue and that many of the changes that are being made to the social insurance programs could be viewed by either realistic or paranoid people, depending on your view, as ways of undermining these programs. How would you respond to those types of analyses?

TOM MILLER: Sorry, I didn't realize you couldn't hear. There are market failures and there are government failures, and they each have their respective role. Neither one have completely perfect records. The way to think about it though, is that because they have their comparative advantages, I don't think we should approach a mutual hostage theory that everybody has to be in one. What I was laying out to you was unlike what we have in the Medicare Modernization Act. The concept of where markets can work and where people want to choose them, where they're actually performing better, or at least people think they are. You are allowed to express your preference to go ahead and do that. Markets tend to be more accountable in the short-term than governments are in the long run. So, it's a question of whether you make those kinds of adjustments. The larger issue about the sustainability of social insurance, of

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course, our basic systems aren't going to disappear. Even if you have a shortfall, and its being run in terms of social security first and Medicare second, there will be some money around. The question is on what terms are those programs operating? We have an inflated level of expectations that health care will always be better, it'll always be getting additional support. As the underlying base of financing in the private economy, which is what these programs live off of, has less strength comparatively as we're overtaxing it. Then you find out that the deal you signed onto doesn't deliver as much of the anticipated benefits as you expected. It's a downsizing rather than an elimination that we're coming to terms with. The question is that when you're in that world, would you rather have that downsizing done with a late-stage brute force approach through legislation or would you rather have a number of gradations and contours in it so that you can sort it out a little more gradually over time.

MARILYN MOON: Could I respond briefly also? There are many ways in which I agree with Tom about the markets and when they can work, you should be using them. The health care area though is a very troubling one and I think one for which better information is going to be a problem for a long time and it's something we should spend money and resources on. I'll give you just one example. The competition that exists out there right now across these Part D plans, one of the difficulties is

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if you look for example at them, almost every single plan covers the drug Nexium. Nexium is probably the most over-covered, inappropriately covered, drug we have because there is an over-the-counter version of Nexium called Prilosec. It used to be the purple pill. Nexium is now the purple pill. When asked about this, one insurance executive said, we agree we shouldn't be covering Nexium but it's one of those things that cause people to choose our plan and therefore we're going to cover it. We are not getting, in a market system now, good decisions being made in terms of the offerings that should be. I think we need to emphasize some of the things that Tom was talking about in terms of getting good care for your dollar but we're going to have to work at it a lot harder and we can't just rely on the private sector to deliver that.

TOM MILLER: That information creation is partly a public good. We do have to invest in it's the ability to have units and measurements to then say, okay, we may have different views as to what it all means but we don't have that in place yet and Medicare certainly has to be a prime mover in that regard. The other thing is that, and if you're talking about other areas of economics, whether it's Freakonomics or rational expectations. People are not totally rationally cunning, calculators. You're allowed to make a subjective decision. It's your choice, it's your life, it's your health, but in the same way that some people may want to go to that friendly

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doctor, even though it turns out there in the lowest 10% of performers in their area. That's your choice. You may have to internalize some of the consequences of that because you're not getting as good care. Just allow people to make choices based on their preferences but at least tee it up where you have a chance to make a more intelligent choice if you want to.

MALE SPEAKER: Okay. I have a question for Nancy Altman. You discussed that progressive indexing in your opinion would distort the insurance component of social security, but why don't you think that the Estate Tax, which is completely sort of outside of what we generally consider our system of social insurance, why do you think that wouldn't do the same thing?

NANCY ALTMAN: Thank you. There's a policy justification for the Estate Tax. In the early start up years of social security, the decision was made by policy makers to allow those close to retirement to be able to retire with adequate benefits, even though they only had a few years under the system and were not able to fully pay for their own benefits. It's akin to private pension plans grandfathering in and giving past service credits to elder workers. In the private pension sector those costs are amortized over a number of years and ERISA requires that. In social security, they've never been amortized; they've just been passed along. As a consequence, it's a benefit to society that those close to

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retirement were able to receive adequate benefits. It should be something that's paid by all of us in a progressive way. If we don't change the financing, it's paid simply through wages. It makes sense that for a portion of those costs to be paid through a progressive tax and the Estate Tax is very progressive. It does raise a question because social security has always been financed primarily through a FICA tax. I don't think that changes the character of the program. The so-called progressive indexing, I prefer to call it half price-indexing, half wage-indexing, because I don't think it's progressive, but it really, I think, distorts the system. It turns the program, instead of a wage related program into a flat benefit, and it would be very easy at that point just to insert a means test and, I think, there would be reason for it. So, that's why I draw that distinction, but I see the point that you're driving at.

FEMALE SPEAKER: Hi. This question is for Dr. Marmor. You spoke of the opportunity costs and the likelihood that social security and Medicare will stick around because of the voting power that the boomer generation and your generation hold. If that's the case, what social programs, not necessarily social insurance programs, do you think that the boomer generation would give up? Or essentially, what programs do you think may lose financing in the future because of the

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voting power that those interested in retaining social security and Medicare has?

THEODORE MARMOR: I don't think the baby boomer generation is at all preoccupied with this question of the opportunity costs. They're going to be preoccupied with protecting the programs that are crucial to their well-being, both income and health. What I meant by bringing that up was to say, I actually share Nancy's view, that our retirement provision is actually inadequate to a world in which the private retirement is both organized primarily for upper income people and secondly is being changed anyway and transformed for medium wage earning people. On the medical care side, there is no special problem about Medicare. There is a special problem about the cost of medical care in the United States and unless you address that, there is no particular mechanism available to Medicare. They can squeeze and shift costs but we will face, as I think Tom and I agree, we will face significant opportunity costs all across the board if we continue to have medical inflation at the rate we do. That just follows. It is worth saying in this context for the people of your age, you know, the discussion in the United States about both of these kinds of programs is extraordinarily parochial. You would think we're the only people in the world who ever faced this matter. You want to keep in mind a couple of things. For those of you who have been reading and hearing a lot about the

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demographic pressures at work, think for a moment that if demography were destiny, what would have been the case for Northern Europe over the last 20 years when they shifted to a degree of population aging that we are anticipating over the next 20 years? Did the Norwegian, Swedish, and German medical care systems turn upside down? No. Did their pension schemes run out of money? No. Small adjustments on both counts, with a lot of conflict because as I think it's fair to say that you all should take for granted, every time a dollar doesn't go into the hands of somebody that's an income loss for them. In the medical care world, as I often say, the most important law of medical policy is that the costs of medical care constitute the income of people in the medical care industry. Anybody who thinks it's easy to do that is living in a dream world. To take the medical care area, coming to the United States to talk about efficiencies in medical care is like going to a whore house to discover chastity. I mean it really is unbelievable. It is ridiculous. It's not magic how you deal with the costs of medical care. It is not the case that no place else in the world has figured out how to get people to behave in ways that does something about their health or to cope with the rising pressures of technology. We just have a system in which has become outstanding at shifting costs from one person to one party, one interest group to another. The important point here is de-escalate the, what I would call, future dread. Stop

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thinking about, as Nancy said, 75 years. Nancy thinks it's prudent; I think it's crazy to think about things 75 years in advance. As if you could make any point commentary whatsoever. All you can do is lots of sensitivity analysis, and that's a useful thing to do, but nobody, you need medical care, if you think the 75 year forecasts are really crucial for present decision making. It's psychiatric intervention that you need. Okay. That's one. So de-emphasize this panic stricken, look your eyes over other systems among the industrial democracies, see what they have done, the variety of things they have done. There is a menu out there, very extensive, very difficult to assemble the coalitions to produce any one version of that and for goodness sakes, listen carefully, to Tom Miller's listing from the comparative advantages of markets and then discount it by the probability that any of those arrangements can actually happen in the world. It's one thing to talk about the theoretical advantages of markets, but you find me any OECD country, any OECD country that is committed in the medical care world, to a thorough growing market approach in which people are calculating all the time about which particular mix of outlays and benefits they're going to do. Nobody has done it. Now, if nobodies done it, Tom, he may be living in a special world there, the Miller fantasy world.

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TOM MILLER: It's also a world in which the economic prospects of the United States are much brighter than those of those European nations.

THEODORE MARMOR: But causes medical care arrangements, no.

NANCY ALTMAN: I'd like to make one other point in answer to that question and that is that Ted was making an observation about voting power of certain blacks but he was not making a point, I don't think, about a kind of intergenerational struggle. It's not that the baby boomers and those over there are going to take theirs and have no regard for the others. I think all of us on this panel have children. I was gratified in the private accounts debate that I would read grandparents who would say, well, we don't want private accounts. We know our benefits are protected but we have grandchildren we're concerned about and grandchildren who are concerned about their parents and grandparents. The thing that I value most about social security is that it pulls us all together. We're in a common boat for a common purpose. It unites us. I think it brings out the best in us and I believe that one of my concerns about the recent debate is all of the talk about its unsustainable. Again, we have to separate social security from Medicare and Medicaid and that's a health care issue but when you're talking about social security. When people talk about it being unsustainable, I see it simply as a

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scare tactic. It's a way to say to younger workers, well, here's your choice. You get nothing or you could have a private account. You either dismantle what you're going to get nothing from or you have. As I've said before, I think the issue is a political issue and not an economic issue.

RACHEL SHIFFRIN: Well, thank you so much to our panel. If we could go ahead and give them a round of applause.

[Applause]

[END RECORDING]