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Can We Afford Our Parents' and Grandparents' Retirement?
Part 1: "The Big Federal Programs: Social Security, Medicare, and Medicaid"
The National Academy of Social Insurance (NASI)
August 3, 2007

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KARI RAICHERT: Alright, as they said; my name is Kari Raichert; and I am an intern at the National Council of Larisa [ph] and it is sponsored by the National Academy of Social Insurance.

I have the honor of introducing our panel that will be talking about the bigger programs: Social Security, Medicare, and Medicaid.

Additionally, we have speakers that will be talking about how these programs are important to specific communities.

I think that you are really going to enjoy this panel. I will be introducing the entire panel first. Then, we will hear from each guest speaker; an after that we will have the opportunity for questions and answers; so be thinking of some questions as you hear our panel talk.

Our first panel today is Juliette Cubanski. Is that correct? I just wanted to make sure that I had her last name right. Great, I'm excited to hear from Ms. Cubanski. Something interesting I learned about her was that she was a Peace Corp volunteer before getting in to help policy.

Currently she has a wealth of knowledge and experience in the health policy field and currently she is the principle policy analyst for the Medicare Policy Project here at the Henry J. Kaiser Family Foundation.

Among the many publications and accomplishments the Juliet Cubanski as had, she was the principle coordinator at the California Health Policy Roundtable Project at UC Berkeley.

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Our second panelist today is Virginia Reno who will be talking about Social Security and pension. We are lucky to have Ms. Reno here as she brings a valuable perspective to the table with all of her professional experience.

It was interesting to learn that Ms. Reno was also a Peace Corps volunteer. She spent two years in the Peace Corps as a 4th grade teacher in West Africa.

Currently she is the Vice President for Income Security at the National Academy of Social Insurance. Along with many other accomplishments in the field of social insurance, Ms. Reno has held various research and policy positions at the Social Security Administration and was one of the founding members of the National Academy of Social Insurance.

Next on the panel, we have Margaret Simms; who will be discussing the importance of these programs to women, older women, and minorities.

I was interested to learn that Ms. Simms also spent two summers as an intern with [inaudible] as she mentioned. She was an intern with the Agency for International Development in a Department of State before launching into poverty reduction in urban economic development.

I am excited to hear Ms. Simms today. With her education and professional background, she will be providing an important perspective.

Currently, she is a Senior Fellow at the Urban Institute developing its low income working family's project. Among her many publications and accomplishments, Ms. Simms has experience

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as a professor and serves on the Board of Directors as President at the National Academy of Social Insurance.

Our fourth panelist today is Susan Daniels who will be talking about the importance of these programs to individuals with disabilities.

We are fortunate to be able to have; hear from is Susan Daniels today. She has had a tremendous influence on social security policy.

Currently, she is a consultant at Daniels and Associates and among her many accomplishments Ms. Daniels has served as Deputy Direct Commissioner for disability and income security programs at the Social Security Administration and in working with the Clinton Administration; she spearheaded the Administration's disability and employment reform activities.

Ms. Daniel's work led to the passage of the Ticket To Work and Work Incentive Improvement Act.

What a great panel that we have here today and I am excited to hear from them; so let's get started and I will turn the podium over to Ms Cubanski.

JULIET CUBANSKI: That is great, thank you. Thank you, Kari, for your kind introduction; and the correct pronunciation of a last name; that was great.

Good morning. It is great to see you all here. My role this morning is to give you an overview of the basics of the Medicare and Medicaid programs; who these programs serve; what benefits are covered; how the programs are financed; and what are some of the important issues and challenges facing these programs

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all in 15 to 17 minutes, which is a lot of ground to cover in a relatively short period of time.

So, I apologize in advance if I am speaking to quickly; but, there's plenty of time for Q and A at the end of the session. So, save your questions for then.

First let us consider why Medicare and Medicaid are essential to both policy and budget debates occurring at the Federal and state government levels.

One key reason is that these programs play a valuable role in guaranteeing Health Security for millions of Americans, almost 100 million in total.

Both programs were established in 1965. Medicare is a social program for insurance for people that are 65 and older; and was expanded to cover younger beneficiaries with permanent disability.

Medicare covers individuals without regard to their income or their medical history and automatically covers people when they become eligible, which for most is when they turn 65.

Today, Medicare covers an estimated 44 million people including 7 million people with disabilities.

Medicaid has become a lynch pin in our system covering help and long-term care services for many of the sickest and poorest Americans and filling critical gaps in the private Health Insurance market.

The structure of Medicaid is a bit more complicated than Medicare sense states administer Medicaid within broad Federal guidelines and states and the Federal government share in the

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financing of the Medicaid program.

Today, Medicaid covers 55 million low income people, including 28 million children, 7 million elderly, and 8 million disabled.

Another one of the major reasons why Medicare and Medicaid attract the attention of Federal and State policymakers is that together these programs account for 20-percent of Federal spending.

For 2008, Federal spending on Medicare will be almost 400 billion dollars. In 2005, Medicare I counted for almost 1/5 of personal Health Care spending in the United States.

Federal expenditures for Medicaid will be over 200 billion dollars in 2008; but, states also spend up to 100 billion dollars of their own money on Medicaid so the total expenditures will exceed 300 billion dollars.

Medicaid accounts for 18-percent of national Health Care spending on personal Health Care and is about 44-percent of Federal grants to state and local governments.

So, partly because of the share of the Federal budget pie that these programs consume; they attract a lot of attention both from people who want to limit or shrink the Federal spending on these programs as well as those who want to protect their revenue streams.

So, that is enough of mine. Let me just give you an overview of Medicare. When talking about Medicare, it is really important to remember the diverse needs and circumstances of the 44 million people on the program.

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Because Medicare covers people 65 years and older and people with permanent disabilities; the Medicare population tends to be sicker and have greater health needs than other people.

As this exhibit shows, nearly half of the people on Medicare have low incomes below 200-percent of poverty; about 1/3 have multiple chronic conditions; and about 1/3 also have in cognitive limitation which makes it difficult for them to manage their Health Care, their insurance choices or even pay their bills without assistance.

Medicaid covers a wide array of medical benefits primarily for acute care needs but also some limited long-term care services.

It is divided into four parts. Part A is the component of the program that pays primarily for inpatient hospital services and is more formally called the hospital insurance program.

Once people turn 65, they are entitled to Part A if they or their spouse have paid payroll taxes for 10 years or more.

Part B is a supplemental insurance program which pays for outpatient services, physician visits and preventive services primarily.

Part C refers to the part of the program called Medicare Advantage which delivers Medicare benefits primarily to Medicare beneficiaries and about 8 million are currently enrolled in these plans.

They are primarily managed care plans like HMOs or PPOs; I will say a bit more about Part C in just a minute.

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Part D finally is the voluntary prescription drug benefit which was created under the Medicare Modernization Act of 2003 and implemented in 2006.

Prior to that point, Medicare beneficiaries did not have access to prescription drug coverage through the Medicare program. If they wanted drug coverage, they had to seek it through other primarily private sources.

Beneficiaries now can get the Medicare drug benefit by enrolling in a private stand alone prescription drug plan or a Medicare Advantage plan that offers prescription drugs.

The Part D benefit also includes a substantial financial help for people with low incomes.

So, one important thing to note here is that while Medicare covers a relatively generous set of benefits; there are some gaps in coverage. Most notably long-term care such as long-term nursing home stays.

In 2006, Medicare benefit payments totaled 374 billion dollars. Part As inpatient hospital services comprise the largest share of Medicare benefit payments, followed by Part Bs physician and other at patient services.

In 2006, spending on the drug benefit accounted for about 8-percent of total benefit payments but with this addition, with the addition of drug coverage a composition of Medicare expenditures is expected to change and the congressional budget office is projecting that by 2010, in just a few years, prescription drugs will account for about 20-percent of Medicare benefit payments.

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So, over the past decade there has been a concerted effort to expand the role of private plans and Medicare.

The Medicare Modernization Act created the drug benefit but also expanded the various types of plans that were able to provide benefits through Part C; the program known as Medicare Advantage.

The law also increased payments to these plans to encourage their participation and to increase beneficiary enrollment.

Enrollees usually pay a monthly premium play and to joined the Medicare Advantage plan and they get coverage for all of their medical benefits that is through the plan typically an also including prescription drugs. Medicare pays these plans a fixed amount per enrollees to provide these services.

Enrollment in Medicare Advantage plans as this exhibit shows has been increasing dramatically in recent years and is now at an all time high of 8.7 million in beneficiaries which means that one out of every five Medicare beneficiaries is enrolled in a medic area advantage plan today and the department of health and human services has projected that in a few years about 25-percent of all Medicare beneficiaries will be enrolled in a Medicare and vintage plan if there are no changes made to the program.

And is this exhibit shows about 90-percent of people on Medicare now have prescription drug coverage; but, about 24,000,000 people enrolled in the Part D plan, which is a pretty remarkable turn out for the drug benefit in the past couple of

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years.

Others are receiving coverage from employer plans, the Veteran's Administration and other sources. Employer plans continue to be one of the primary sources of the prescription drug coverage for retirees as well as beneficiaries who are still working.

But, around 4 million people on Medicare are still without any form of drug coverage. A key question that we have really not answered yet is why these people have not signed up for coverage. Common wisdom suggests that many simply think that they do not need it because they do not take that many prescription drugs but some may actually not be aware of the benefit despite all of the outreach efforts that have occurred.

And in terms of the programs financing, funding comes primarily from payroll tax revenue use, general revenue use and premiums paid by beneficiaries.

Part A is financed largely through a dedicated tax of 2.9-percent of earnings which is the payroll tax paid by both the employers and employees.

Part B is financed through a combination of general revenues and premiums paid by beneficiaries. And Part C does not have its own funding stream. Part D is financed through general revenues, beneficiary premiums and a small share from the states.

So, now you are all experts in Medicare; let me turn to Medicaid. Medicaid place several important roles in the Healthcare System.

First, Medicaid covers more than 40-percent of non

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elderly Americans living in poverty and about 1/4 near poor.

Medicaid is the largest source of Health Insurance for children in the United States. In total, it covers over 40 million in low income families.

Most low income families cannot get private coverage; either their employers do not offer it or they cannot afford the premiums in cost sharing; so Medicaid is not a substitute for available private coverage for these people but rather provides them with a vital source of safety net coverage.

Second, Medicaid also provides health and long-term Health Care coverage for eight million low income Americans with disabilities and chronic illnesses and more than seven million of Medicare's 44 million enrollees who qualify for Medicaid in addition to Medicare because of their low incomes.

For these people Medicaid provides important financial protection and also certain benefits the Medicare does not cover especially long-term care services.

Third, Medicaid is also the nation's major source of coverage and financing for long-term care as a just suggested; coverage which neither Medicare nor private insurance provides and a very substantial way.

And lastly, because Medicare is financed jointly by the Federal government in the states; the program provides critical financing at the state and local level to support the healthcare safety netting infrastructure for low income and uninsured people.

Medicaid is an entitlement program like Medicare that is

all individuals who qualify or are entitled to enroll into and obtain medical benefits covered in their state.

But, in order to qualify for Medicaid individuals must meet income and asset requirements and also fall into one of the categories of eligible populations.

States must cover certain mandatory populations, including pregnant women and poor children. States also have flexibility to expand Medicaid eligibility beyond Federal minimum standards to certain optional groups.

But, as this exhibit suggests Medicaid coverage is not universally available to all people with low incomes partly because incomes and categorical requirements with strict eligibility for Medicaid a substantial share of non elderly Americans below or near poverty remain uninsured.

This is particularly the case for parent of poor children who may be eligible for Medicaid, adults without children and legal immigrants.

While Medicaid is really the backbone of children's coverage in the United States providing insurance coverage to 28 million children and the state's Health Insurance program for ASCHIP which was established as part of the balanced budget act of 1997 is designed to be healed on Medicaid providing coverage to children who live in families that earn too much to qualify for Medicaid but not enough to purchase private insurance.

The programs do work together but there are some important differences between Medicaid and ASCHIP. I think one of the most important things to point out here is that Medicaid

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is an entitlement program and state are guaranteed Federal payments with no preset limits to pay for Medicaid benefits.

In contrast, under ASCHIP Federal financing is capped both nationally and the state level so states receive Federal matching payments only up to their capped amount and under ASCHIP states also have the ability to control enrollment by using enrollment caps.

Medicaid like Medicare covers a broad range of health and long-term Care Services. Medicaid is a particularly important source of comprehensive care for children and of long-term care mental Health Services Health Care needed by people with disabilities.

Most services are provided through private healthcare delivery systems, private plans and doctors in private practice. And, just like states must cover certain mandatory populations; they must also cover certain mandatory services spelled out on the left hand side of the slide here. These mandatory services are spelled out and Federal law.

States can also choose to cover certain additional services and are entitled to receive matching funds for these optional services.

As a result of the discretion given to the states in terms of what they cover, the scope of Medicaid benefits vary considerably across the states.

In 2005, the total Federal and state Medicaid spending was over 300 million. Medicaid expenditures are distributed across the array of services that I just mentioned; about 60-

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percent for acute care and 35-percent for long-term care as well as a small share for supplemental payments to hospital that serve a disproportionate share of low income or uninsured patients. These are called DISH payments.

That was the overall spending picture. This exhibit shows Medicaid enrollment and spending by eligibility group, which is you can see vary considerably.

While children and their parents make of the majority of the Medicaid population; the majority of Medicaid spending actually goes to word services for the elderly and people with disabilities.

The children, parents and pregnant women make up 3/4 of the population but only account for 30-percent of Medicaid's been, while the remaining quarter of the elderly and people with disabilities account for about 70-percent of Medicaid spending on services.

In terms of the financing of the Medicaid program, and as I said it is financed jointly by the Federal government and the states; the Federal government matches state spending at least dollar for dollar.

A Federal share for Medicaid spending is determined by the Federal Medical assistant's percentage which is known as FMAP, which varies by state based on a state's per capita income relative to the national average.

The FMAP is at least 50-percent in every state and is higher in relatively poor states, reaching 76-percent in the poorest state.

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Federal matching dollars are guaranteed to stay on an as needed uncapped basis. And approached which directs funding based on actual reader than an estimated need. States commit substantial resources to Medicaid on average about 80-percent of their general funds, making it the second largest item in their budget following elementary and secondary education.

So, with the basics under your belts; it is time to take a look at the future in Medicare and Medicaid.

As health costs rise, and the U.S. population ages many people will turn of these programs as their primary source of Health Insurance and other into Medicaid because of gaps in the private system or the Medicaid is a polar of their Health Security and retirement. Both of these programs have been successful by many standards but they also face challenges in the future years.

Medicaid plays a critical role along with Social Security in helping to provide retirement security for older Americans. However, the aging population and coupled with the continued rise in Health Care cost puts a strain on the programs financing.

Medicare faces some of the challenges that will need to be addressed including dealing with fiscal pressures without shifting excessive costs onto beneficiaries, setting fair payments to private providers plans, monitoring in improving the drug benefit and assessing the role in the value of private Medicare plans by the.

In terms of Medicaid, the state budgets tend to write a fiscal roller-coaster especially with regard to Medicaid

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spending. But, many states are now experiencing a more positive fiscal climate which has left them to mixturize towards coverage expansions, including building on their Medicaid programs.

Especially with the decline in job based insurance initiatives to expand coverage of the uninsured are taking shape in a number of states.

At the same time, there are ongoing pressures and Medicaid which are expected to persist switch to a large degree or similar to the pressures facing Medicare particularly how to deal with rising healthcare costs, and as the baby boomers age supporting their long-term care needs.

So, in terms of what is on the horizon for these programs, there is a current debate over the reauthorizationship of ASCHIP and the fate of private plans and Medicare which are two of my most hotly debated health policy issues going on right now.

And the end, there are these long-term issues as I just said, there are rising healthcare costs putting pressure on these programs, demographic pressures which place pressure on Federal and state budgets as well.

And so ultimately I think understanding the vital roles that these programs play in the needs of the people that they serve will help to assure them in the coming years as we can formulate public policy soundly to meet the opportunities and the challenges ahead for these programs.

So, with that I hope that I have given you the basics in a way that you can understand these programs and I look for to

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your questions. Thank you.

VIRGINIA RENO: Thank you Michael. It is a pleasure to be here today. Little did I know that I would be following another Peace Corps volunteer to the podium?

But, there must be something about service and the Peace Corp that leads people to these public policy issues.

My assignment this morning is to give you a premier on Social Security and 15 minutes and I thought that would be an awesome job until I saw my colleague do both Medicare and Medicaid in 15 minutes.

I am going to flip through very quickly and then I hope that we will have time for questions and discussion once all of the speakers have spoken.

First, very basically, the fundamental question; who gets Social Security? Well, today nearly 50,000,000 people which is about one in six Americans or nearly one in four households has someone that is receiving Social Security.

They include retirees and their dependents; elderly widows and widowers; young widowed spouses and young children of working parent who has died; and disabled workers, these are people who have prior work history and sustain significant impairments to their ability to work receive Social Security as well as their dependent children.

How much does the system pay? A benefits themselves are not particularly generous but it the same time they added to a lot of money in a Federal program.

The average benefit for retired workers is about $1000 a

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month or a little over that. Similar benefit is the average for aged widows and widowers. Disabled workers without dependent receiving benefits, the average benefit are a little lower or just under $1000. A widowed mother with two children was three people are eligible for benefits; the average benefit is about $2100 a month; and for disabled worker with spouse and children eligible, the average is about $1600 a month.

Social security benefits replaced wages and the benefits are based on the workers prior wages from which they paid Social Security taxes.

They replace wages and a progressive way so that high earners get higher dollar benefits but the replacement rates are lower for higher earners.

This chart illustrates wage levels, that all black bars are the wage levels and the shorter blue bars are the social security benefits. So, for a low earner is making about 16 to 17,000 dollars per year, the benefit replaces more than half of their earnings. That is if a person retires at the full benefit age of 66.

For an average earner, making about $37,000 per year; the benefit replaces about 40-percent of their wages. For someone who had always earned near the maximum that is covered in tax for social security purposes; the replacement rate is between 25 and 30-percent.

So, that is a progressivity story of the wage related benefits. Because it is big and broad, Social Security has an important impact on reducing poverty in the United States.

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It lifts about a million children under the age of 18 out of poverty three benefits that are payable to the children of workers who are disabled, deceased or retired. It also lifts about 13,000,000 seniors out poverty.

Without social security, nearly half of the people over 65 would have incomes below the poverty line, but with benefits counted just between eight and 9-percent of the elders had incomes below the poverty line.

When we talk about poverty, I think it is also important to think about what the poverty line means. I know that there was a hearing this week which some of you may have attended that was trying to think about what we mean by poverty.

There has also been recent research trying to look at how much does it take to make ends meet as distinct from what is the threshold that we have officially defined as poverty.

In 2007, the poverty threshold for person living alone is about $10,000 per year. For a family of three it is about $17,000 per year. And as we think about trying to live on the economy and income, we begin to understand why sometimes in the Federal guidelines and programs people talk about multiples of the poverty threshold to try to get closer to a sense of adequacy.

You research has been looking at how much income does it actually take to make ends meet? Wider opportunities for women has been doing research both for working age families and now for seniors on those topics and the latest study there showed that for seniors it to between 1½ and three times the poverty

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threshold to have enough income to make ends meet without turning tested benefits for support.

The next couple of slides are looking at the role of Social Security and the total incomes of people 65 and older.

What this pie chart shows, is the share of the aggregate dollars received from all sources by married couples and unmarried individuals age 65 and older.

Social security is the biggest individual share an almost 40-percent. Pensions are second at 20-percent: then earnings from continued work for those that are not fully retired are a little over ¼ in income from assets which is interest, dividends, rental income if you own property and those sorts of things. Finally there is a little 3-percent that comes from supplemental security income which is a means tested benefits for the poor as well as all other miscellaneous sources.

This rather awesome array of pie charts actually tales of very simple story. The bottom two pies, the two pies on the bottom; first of all, this divides seniors into five equal groups based on their total income. A two pies at the bottom are the bottom two quintus of the income distribution and that is the bottom 40-percent of elders.

And the key point here is this sense of security, the blue part is more than 80-percent of the total income. They get very little from other sources except the very lowest one on the bottom rights has a fairly sizable piece for supplemental security income.

The metal pie, which is kind of the middle of the senior

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population, still gets nearly 2/3 its income from Social Security; but pensions, that kind of purple bar started to fill a bigger role.

The one on the top rights is the necks of the highs income group and those are people whose total incomes are between 25 and about $44,000 per year.

In that group, Social Security is about half of their income but pensions are filling a larger role as our earnings the yellow wedge and as that income.

It is really only when we get to the top income group, those with incomes over about $44,000 a year this something other than Social Security is the biggest source and it is interesting that that because source in this case is earnings because these are seniors who are not yet fully retired.

The other interesting thing about that top group is that it appears to be the only group where Social Security the blue part and pensions the kind of burgundy part an income from assets the light blue part or all about that equal size.

We hear about a three legged stool of retirement income of social security, pensions and savings and it seems to be there for the top income group; but there certainly are not equal pieces for the rest of the population.

Now, getting to the other side of the corn; we have talked about who gets and how much of people receive; who pays for Social Security? I think most of you know that workers pay through payroll taxes.

Each worker pays 6.2-percent of earnings up to a cap

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which this year is $97,500. Employers match that amount so the total tax rate on wages is 12.4-percent.

There is an additional tax for Part A of Medicare which the prior speakers spoke about for Part A so that the total tax for workers is 7.65 and matched by employee years for a total of 15.3.

Where does the money go? This is a question that people outside of Washington often ask. Well, legally it is credited to a social Security Trust fund and out of that fund; money is authorized to pay Social Security benefits that are specified in the law, the so called entitlements in the administrative cost of the Social Security program.

Anything left it is not needed to pay benefits or administrative costs in a given year is invested in U.S. Treasury securities and every year that the chief actuary of the Social Security program repairs report looking at the current and projected future status of the trust funds.

How much goes for administration? This is something that people rarely talk about and it often is a surprise to people on the streets but the truth is that less than 1-percent of the revenue in this system goes to pay for administration, that is for those 60 are 70,000 people that work for the Social Security Administration in Baltimore and throughout the state's and field offices and disability determination offices and so forth, the computers the buildings the whole thing.

Part of the reason that the 1-percent is so small is because the program is big but it is also the an indication that

the system is very efficient in terms of its very clear and simple mission of paying benefits to those who are entitled under the law.

Now, what is the status of these trust funds? When the mere term social security is in remarkably good shape; in the 2006 calendar year, income into the trust funds exceeded out going for benefits and administration so that 190 billion dollars were added to the trust funds.

At the end of 2006, the accumulated assets and the trust funds were about two trillion dollars.

The question he is how do actuaries project the future because they do project the long-term future for the next 75 years and sometimes even further.

It is the long-term projections that people most often focus on when they expressed concerns about Sosa Security.

Well, every year the actuaries update what is not about history, they take about any changes in the program and they rethink and review and possibly revise their assumptions about the future.

And then, items that they need to make assumptions about for the future include things that affect the size of the population and things that affect the economy, that is on the population side, how many people will be born, death rates, immigration rates which are particularly difficult to estimate and marriage and divorce rates.

In terms of the economy, they have to come up with a reasonable assumptions about how many people will be an employee

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or unemployed, what wage levels will be, what inflation will be, how much product if any will grow and what interest rates will be, not just for the next five years and 10 years that they make assumptions for the next 75.

Due to uncertainty, they project three scenarios: a low cost, a high costs and the best estimate; and also due to uncertainty they update the 75 year forecast every year.

Well, what does the best estimation for the long-term? According to the 2007 trustees report, annual surpluses will continue that is each year more money will come into Sosa Security that goes out and two of 2017 and consequently those reserves of 2 trillion dollars will continue to grow.

In 2017, for the first time tax income will be less than the benefits paid out that there's still interest income and the reserves themselves they can be used to help pay benefits the and enter the future years.

By 2041, under the latest forecasts, the trustees estimate that the reserves will be depleted; that is those two trillion now that are going to grow for the next 10 years will be in the ultimate lease the ants and at that time tax income will continue to come in but it is projected to cover only about ¾ cost of that time.

Well now, we said that there were three scenarios; what did the other areas show? Under the high cost scenario the reserves will be depleted sooner instead of 2041 it is estimated by 2030.

The reserves will be depleted sooner instead of 2041 is

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estimated at 2030 that is 23 years from now in and of the low costs an area the funds are adequate for the next 75 years and beyond.

While the Social Security actuaries made the official forecasts the congressional budget office and the last few years has also started making long-term forecast for Social Security. And, their latest forecasts in 2006 estimated that the reserves will be depleted in 2046, which is a little longer than the actuaries best estimate is still on the same ball park.

I think that the key point from all of these different scenarios about the future is that it is uncertain and no one knows for sure that that is why it's important to continue to make these projections every year.

I was and Bill was talking about Social Security and pensions and this is a shot at pensions. But, we can certainly talk about that more in the remaining part.

A key development with pensions first of all I think one of our earlier speaker said that only about half of the workers are covered by pensions on their jobs and a key development in the pension world is that plans are shifting from defined benefits where employers took responsibilities for promising a specified benefits to a 401K type plans which I am sure that many of you are familiar with.

The 401Ks are like a personal savings account and as such individual workers take on both the risks and the rewards of investment returns.

There are other risks associated with a 401 K approach as

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opposed to defined benefits including the temptation to spend the money for other purposes when unexpected things happen that money is there and if you pay a tax penalty you can use it for the purposes.

And finally, the challenge with a defined benefits of these 401 K type plans is that when people do retire with a nested in a 401 K plan, how to make the money last for the rest of your life?

Well, one way that you can do that is to buy an annuity from an insurance company. An annuity is a product that insurance companies sale were essentially you give them your pot of money and the insurance company gives you a contract this is I will pay you x amount of dollars for the rest of your life so the insurance company is betting on how long you will live.

To illustrate where we are currently with a 401 K balances, the typical for a one Kay balance for households approaching retirement who have those kinds of accounts is about $60,000.

The lifetime income that could produce in an annuity is about $325 per month so it takes a lot of money and the savings accounts to produce a significant amount of income for life.

I'm going to stop here that you will be talking about solvency options for Social Security later in the day. I hope also as you think about the future of retirement security that you also look at the challenge of how to ensure that people have adequate requirement income when we consider both what is available from Social Security and pensions; not only for today's

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retirees but for boomers who are approaching retirement and for people like your cells for a new retirement is still a long way off.

MARGARET SIMMS: Good morning again. My role here is to comment on how the system affects certain populations differently and I think I would just speak from here. I have a few comments to make and then we will highlight some of the difference is that people are affected by Social Security and the various health programs.

I draw and my remarks all the work that has been done by number of organizations that along with NASI have been grantees of the Ford foundation and I will just mention a couple of things about the initiative that Lolo Chezacoti [ph] at the Ford foundation put together.

She worked in Washington for a long time as a policy analyst and one of her concerns as the she looked at the future of Social Security and some of the social insurance programs is the populations who are just proportionally affected by changes in these programs may not be as aware of the programs and the implications of change and were generally that the broad policy population may not be aware either of the differences and impact and differences and an outraged that might be necessary in order to give various populations the kind of information that they need to allow them to make conform decisions both the citizens and as individuals making decisions about their future.

We have a lot of data and a lot of information about generally who is eligible for programs and only people there are

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that not all groups are the same.

People's life circumstances lead them to differences and both the eligibility and in terms of benefit levels and I just want to talk about a few.

Drawing on some work that the joint center for political economic studies previously were or did it under the Ford foundation grant was to look at the knowledge and expectations of African Americans with regard as Social Security in particular.

And, what was found is that generally African Americans were more knowledgeable about disability then requirements and about survivors' benefits than retirement because they were more likely to be or know someone who was a recipient.

African Americans are twice as likely to receive disability benefits and the more likely to receive survivors' benefits.

For example, 29-percent of African Americans are receiving benefits for disability recipients as opposed to 14-percent for whites and 16-percent for survivors as opposed to 13-percent for whites.

And that percentage is higher for children who are survivors of workers who are covered by Social Security.

While Social Security benefits are lower for African Americans than for whites, these benefits constitute a larger share of their retirement income that is the case for whites.

Their benefits are lower because benefits of tide the earnings and as Virginia lay out because of the way of which replacement is done, they get a larger share of past earnings but

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their actual monthly benefits are lower than those who had higher earnings.

They also are less likely to have income from other sources so you had the pies that showed the different portions coming from social security, from assets, from earnings and from pensions and African Americans are only half as likely to have acid income as our whites and there are about 70-percent less likely to have pension income. And, the amounts that they usually receive from those sources are also lower.

When asked about their expectations, it is very interesting that African Americans and I think this reflects the population as a whole, that two out of every five African Americans expect savings and investments to be the major source of their retirement income rather than Social Security.

And, the prevalence of this response is higher among younger people that it is among older people because their time horizons are longer than they expect that they will be able to build up their assets

However, in fact, they are doing very little to build of these other sources of retirement income in part because of their discretionary, current discretionary income from earnings does not allow them to do that.

In raising just some issues that you will grapple with this afternoon, I would like to point out a few issues with regard to various changes that might make—one that you have been presented with our two pieces of information about retirement ages.

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One is the age of which you can or first eligible for benefits which is 62 and that is not changed but that age you do get partial benefits.

So, if Bill Clinton or George W. Were actually draw on their Social Security next year, they would get a lower lifetime monthly than they would if they waited until full benefits and 66 when they're first eligible.

The issue here or one of the issues is that because African Americans are more likely to become disabled in part because of chronic health conditions and in part because they may have been in jobs that were more physically demanding and therefore when they develop health problems they're just in the normal course of aging, they're less able to perform.

They could, prior to 62 apply for disability, but disability is not an entitlement program and it is not automatic and the way that retirement benefits are.

There's a lengthy process that is now getting longer and of course you may hear more about that. And, so that the chances of actually getting on disability maybe 50-percent for people who have no other source of income, making it the 62 is very important; so that if you raise the early retirement age, you may leave a portion of people who have not qualify for disability but may be unable to work past 62; it gives them a longer risk period in terms of income or getting retirement income and I think that is something that you should think about.

If you start dealing with these questions of what do you do about the retirement age? I would just like to raise a couple

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of issues with regard to the Health Insurance as was noted that recipients of Medicaid are people who are low income and those in which proportionately going to be the minorities and also may be disproportionately female, that because Medicaid is a state share program, there are questions about distributions of the population.

African Americans and Latinos are not evenly spread across the country and they are heavily concentrated in certain states and especially for African Americans, they may be concentrated in states that have low income and low resources; so, in thinking about questions of Federal vs. State shares of cost those are some things to give some consideration to.

Other things that maybe considerations that go beyond today's, or questions of access as you think about how you change your provider payments and restrictions, there are some issues already about the availability of the providers in certain communities.

Now, let me mention just a few things because I do not want talk too long about women and older women.

Women are more likely to be dependent on Social Security than their male counterparts and that is true regardless of marital status.

Married women and unmarried women living alone in a draw here from the Institute of Women's poverty research which is another member of this group; that married women and unmarried women living alone get close to half of their income from Social Security compared to about a third of income from their male

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counterparts.

Of the gap, it is even larger for unmarried women living with others who often are older so that we now divide; you may think elderly is just a market which you get past 65 you are all old but those of us who get closer to that now think of old and very old so as the age expectancy increases and as those of us making policy get older, we think of those over 85 is being old and the rest of us are just a little pass middle age.

And for the very old you'll find that women have often depleted the other assets that they may have brought into retirement and may have outlived and spouses and outlived their spouses assets and they are even more dependent on Social Security even though their payments may be even smaller.

Historically, they have also had smaller earnings are lower earnings and shorter earnings histories because of movement in and out of the workforce as they raise families.

That is also been to contributory to lower benefits and I do not know whether there is a reliable projection as to what will happen in the future but there is a long discussion and you may well look at IWPRs website about the impact of divorce on women's access to both Social Security and pensions.

There are some laws mail that protect women from being excluded but you have to as I think Heidi Hartman [ph], the President at IWPR says the you have to stick with a guy for 10 years so being married a two man for five years in each did not count and with that I have been told that my time is up and I think that is a good point there.

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SUSAN DANIELS: Well, hi. I'm Susan Daniels and I absolutely believe that you probably are now and what I would call the 60 shock.

Whenever you come around anything related to Sosa Security or Medicare and Medicaid, they start talking trillions of dollars and hundreds of billions of dollars and you and I have no idea what that is.

So, what I do all of the time when I am thinking about this stuff is that a slice off the last six zeros and that comes to me as though like $1000 or $10,000 you can envision $10,000 can't you; or a home $100,000, you can envision that right?

All of these trillions just robbed me crazy and even when I work for Social Security I still couldn't figure it out.

So, the first thing that we do when people like us start talking to you about policy and money is slapped all of the last six to zeros and use that to cut a treat your 1 trillion shock and which you obviously have.

The second thing is that I know that I am going to be the absolutely, least likely to be listened to speaker because your blood sugar is as low as it is going to get in the morning and you are right about ready for break and lunch so I will think of something that is really fun to talk about.

Social Security and disability just is not fun. I mean it is very unsexy and it is very dull and so I was trying to think of how I could jazz this up a little bit.

Let us start talking first of all about the word disability. How many people here, no someone or have heard the

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phrase on disability?

Raise your hand if you know somebody who is on disability? Now what the hell does that mean? Right? You kind of get a picture of a person sitting on a cart and are disability so that they're on disability. What is that mean to be on disability?

Well, that were disability is going to throw you policy wise right into all kinds of really steep the discussions. So, but is kind of take that word disability and let us segregated out.

Let us use the word disability in the meaning of the broadest number of people who have something about their body or their mind that does not work right.

These are the people who are covered under the Americans with disabilities act. Have you heard of an ADA? Raise your hand. The Americans with disabilities act okay, right.

Now, that says that there's a certain number of people and our country who have some limitations and they are protected in their civil and human rights under this.

So, you won a big broad definition that would cover people who are working and people who are not working and children and old people and young people and black people and white people and male and female and the whole thing.

And you'll that to be the broadest possible use of the word disability. So, from now on when you are talking to me and I am talking to you; when I say that were disability, I mean those people covered under the Americans with disabilities act.

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Now, for reasons that are only historical and linguistic, Social Security adopted the word disability for one of its programs, which by the way does not include all of those people out there covered by Americans with disabilities act.

What it does, is Social Security covers you when you're working and you are unable to work not any, just a little bit, were some but a substantial gainful amount.

And, it provides you with some long-term income if for whatever reason and this particular reason has to be a medical or physical or mental impairment.

Now, that is not really hard to figure out a doctor Just has to say it. Okay. A doctor has to say okay your kidneys are dead. Oh man, you have a spinal cord injury, holy smokes you are schizophrenic.

Some kind of doctor has to say that. And, if they say that; that is not it. You do not just get on disability that way that is not enough. Then, that impairment has to render you unable to earn at this point about $750 a month. Maybe it is even higher. Maybe it was $800 a month.

Now, you might be working at $600 a month or $400 a month. Well, that is not substantial according to social security.

So now, you have to have a doctor's certified broken thing; the inn, you have to not be earning over $800 a month; and then someone has to judge if you can do any work in the American economy given your impairment and your age, education and work experience.

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Okay. That is yet. That is was Social Security mains when it says you qualify for disability. Again, it does not mean that you will use a wheelchair and it does not mean that you have diabetes; unless those things render you are unable to make substantial gainful activity which is about $800 per month and given your age, education and work experience; there are no jobs that you can actually do.

That is a pretty narrow number of people, very small. But, those people really need income. Right? Really bad. And by the way, most people that are on Social Security disability; how about saying that, on Social Security disability; they did not earn that much when they were working.

Right? I mean they did not. They were not that well off. Because the people that are well off with the ADA definition of disability are working.

They had education; they had opportunities in the workforce, so they're not going Home Social Security, they're working. It is the people who given their age, education and work experience they cannot find jobs in the economy or that they do not exist that they can do.

So, let me give you a typical guy on SSDI, Social Security Disability Income Insurance. Okay this guy is about 53, he was driving a truck most of his life; and overtime his back got worse and worse.

Then, sometime it took a vacation with his family and he is already makes $28,000 a year and he is in an automobile accident.

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Now, his back is really bad and a really hurts and he is really not very strong anymore. And, so he cannot climb up into that cab and he cannot sit that cab for 12 hour stretches and driving a truck.

Now, when you look at Yelm you are not going to see all of this highfalutin hardware like I ride around in. No. You are going to see who looks like a normal guy. But, no; he did not graduate from high school, so he cannot go be an accountant and senate a desk now and he does not have scales in any intellectual areas and he is already 55; what is he going to do?

Well, are you not lucky that he has been paying Social Security in his payroll taxes and he is covered for income until you reach is the retirement age?

So, we have a group of Americans, not a huge number, who in fact have hit a really bumpy road in their lives and most of them were not doing so well in anyway, not all of them but most of them; and most of them were not high wage earners.

You know the doctors, the lawyers, the bonds traitors and all of those people. They could go back to work if something bad happens to them. Those are easy jobs. Yeah, they are.

Driving a truck 12 hours a day and climbing up and that cab and slinging pieces of metal on high-rise buildings and taking care of people in nursing homes as a nursing aide; those are physically demanding jobs.

And, I know that you while do not believe this but as you get alder you become a lot less able to do that over and over again every day. It becomes more difficult.

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So, the social security disability program is all about replacing the income of people who have some beer work impairments. And, that is the word that I like to use when I talk about Social Security.

So, when you see social security disability or that I am on disability then you need to think that this person has severe work impairment.

Now, this person is also probably covered by the ADA; but the ADA is the ocean. Social security is a little tiny bay on the side where some people qualify.

Now, that program, Social Security Disability Insurance or severe work impairments are paired up with its sister program that Juliet told you about. Medicare. So, and I have to tell you that this is really, really crazy; but after you have been receiving Social Security disability insurance for after two years; you qualify for Medicare.

Why two years? Well, because that benefit is so fabulous. Medicare is so good that people might, you know they just might, I do not know, come up with something begets them into the DI a program.

Because a lot of people, most people with disabilities already work. So, what they cannot get insurance the arm. Well, for the first month you have DI, Disability Insurance; then, hey that package is really good looking.

So, they put those two year waiting period in so that you do not get a ride away but of course it is when you really need it. Right?

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At first, a year so that is a public policy discussion that people are having and have been having for a long time.

There are reasons why a but we do not have it. So, that DI program has its big sister Medicare. Now, we also have another program in our country and Social Security ones that program but it is not part of Social Security.

You guys are good at writing checks so you write these checks too. There is a poverty program in this country that covers the elderly and people who have severe work impairments and it is called SSI.

By the way, most people on SSI and/or SSDI do not know which programs they are on. So they do not know if they're on the insurance program that they paid in too or the one that is a public welfare program.

And this program used to be a state run program until the '70s; and then the Federal government absorbs the main part of it and Social Security handles the accounting and the check writing and the determining of the eligibility for those folks.

Now, guess what they get? They get the state program Medicaid. So, most people who qualify for SSI, which is the program for people who are very poor and have not worked previously enough years.

Well, that program has its sister health program Medicaid. So, now the package comes together and how do most people get into that medical from the work nt door that they have to come through? Social security.

So, there is an enormous incentive if you are uninsurable

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to try to go through that door so that you can get some type of coverage.

So, here's the big picture. For the first 20 years of your life, you are a drain on your society and your family because you do not earn much.

For the next 45 years, you are expected to work and put out and contribute and earn money. So, you go for the first 20 years to learn and the second 45 are earn and the and guess what you are so lucky you are liable to live another 20 to 25 years after you are finished earning and that is the returning part.

All of us up here are trying to figure out a way for you to have something to live on when that happens.

I am glad to pay my Social Security taxes. It funded my mother's life. And, even though she is now deceased it was a pleasure to return to her. So, thanks.

KARI RAICHERT: Thank you to all of our speakers for sharing your wisdom. We do have about 20 to 25 minutes for questions so I am going to go ahead and open it up. If you could just state your name, what university you are from, a note if your question is directed toward a specific speaker please.

FEMALE SPEAKER 1: [Inaudible] To Dr. Cubanski and Ms. Reno; could you give us more contexts about how they are handling these issues abroad? How they're handling the Medicaid, Medicare and Social Security abroad?

VIRGINIA RENO: Well, in terms of Health Insurance most other western kind of industrialized countries have National Health Insurance Systems so they do not really have the sort of

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bifurcated [ph] systems that are specifically targeted toward specific segments of the population.

When Medicare and Medicaid were passed in 1965; there was some hope of kind of a foot in the door for a National Health Insurance System in this country; but that failed to materialize so those programs have survived to this day because they do provide critical sources of support for millions of Americans but we have not had that success to follow through with more of a national Insurance System like other countries have.

Ms. Reno: I think that with Social Security or old age pensions and disability pensions are common throughout the western and European countries and most developed countries have some form of social insurance programs.

It is often in many European countries there is a very strong commitment to what they call the social solidarity of social insurance. The money that is paid in two it is called not taxes but contributions.

People see it as a contribution while I am working for a benefit for when I no longer am. And in many countries, they spend a larger share of their gross domestic product on what is the equivalent of old age survivors and disability insurance which is the equivalent of our social Security System.

We now spend about 4.5-percent of GDP and it is common for other countries to spend six, seven, or 8-percent. When Social Security ad in the future, becomes more costly and rises to a little over 6-percent of GDP, that is still less than European are other developed countries spend on their social

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insurance.

MADELINE TASKEA: Hi, my name is Madeleine Taskea and I work at Avalier Health which is a health policy consulting firm and I am also an undergrad at Tufts University and I have a question for Ms. Cubanski about Part D and what you see the future of Part D being and do you think that they're going to expand the program or increased the doughnut hole and how you see that in the future of our generation?

JULIET CUBANSKI: Well, I think in terms of the future of Part D that the benefit is just a couple of years old so people are still getting experience with how this benefit works and the insurance industry itself is still getting experience with how to manage the benefit.

The doughnut hole, I did not really have a chance to talk in much detail about Part D. I could've given an entire 15 minute presentation on just that Part of the Medicare program itself.

But, for those of you that may not be familiar with the concept of the doughnut hole; the prescription drug benefit has a standard design that was established in the law and the doughnut hole is a gap in coverage were Medicare beneficiaries who are enrolled in a play and with a doughnut hole actually have to pay for 100-percent of the cost of their drugs after a certain level and date they pay that 100-percent until they reach catastrophic spending level.

The doughnut hole is about $3,000 gap in the benefit so it is a substantial amount of money for people who still continue

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to need the prescription drug coverage that their plan provides so it is quite a contentious problematic aspect of the benefit design and most of these Part D plans actually have coverage gaps so for most of these people enrolled in the plan it is a future that they will encounter and it grows in size every year.

The reason why was established is because there just simply was not enough money in the budget to provide a sort of comprehensive benefits from the first dollar to the catastrophic a level.

And it would basically just cost a lot of money to do anything about shrinking the size. Given the debate going on about funding for ASCHIP, I think that it seems difficult to imagine a scenario in which the billions of dollars could be found to fill the doughnut hole.

But, CMS, the centers for Medicare and Medicaid Services is trying to provide some incentives to plans to offer some coverage in the gap so that there will be more plans that may step up and offer coverage for generics and maybe some main brand drugs as well because for the plans that have tried to offer this coverage of the doughnut hole, they have lost a lot of revenue because people who sign up for these plans need a coverage so they're going to have higher spending relative to other people.

These plans are more expensive but it turned out to be revenue losers for these insurance company is so we're not sure yet what we're going to see next year because plans can change their signs every year and whether we see more plans offering coverage in the doughnut holes is still an open question at this

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point.

And so I think that feature is there to stay and I think that although in that ASCHIP reauthorization bills, there are some changes to Medicare on the house side that they really have not done anything about the doughnut hole.

So, I think it is still a wait and see.

BOB ROSENBLAD: Bob Rosenblad of National Academy. I want to ask Susan Daniels a question.

When I was covering this for the L.A. Times, about every year and a half to two years, I would write a story about disability and I remembered that I interviewed you and I would go in, and it did not matter who was running the program whether it was other Democrat or Republican administration, people would always say that it is disgraceful that we have as long waiting list of people that are really sick and people that need to get on disability and we're going to do something about it, whether to improve the computers or whatever.

USA Today just had a series just a couple of weeks ago saying that there are all of these longsuffering people out there waiting to get on disability, why I can you not shorten the waiting times?

SUSAN DANIELS: It is all about money. This decision to determine that a person has a mental or physical impairment that renders them unable to do substantial gainful activity given their age, education and work experience, requires putting together a whole lot of information about the person.

Medical information, vocational information, earnings

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capacity information and that takes money. Now, when you go in to file for retirement; all they need to know is your Social Security number and your birthday, they can configure everything from that.

But, disability is a matter of judgment. Someone has to be trained that knows how to do this and then they have to assemble the information and then they have to render the decision and then the American people, God bless us all; we have the right of due process if we do not agree with the decision, we get to say you are wrong Social Security and I want you to reconsider this case.

And we have that right all of the way through the courts. So, the process based on the process and the complexity of gathering the information and making it makes cents is a long and devious and expensive process.

Now, at Social Security today, most of the work what most of the people are doing, most of the money of administering Sosa Security is in the disability program.

I mean really, retirement is like a turnkey operation. Put in your Social Security number, put in your date of birth and voila.

It is pretty simple. Right? But, disability is not sample. It requires a series of judgments made by people who have to be trained to do that and be and these people have to be paid.

So, the backlog I have to say is a money problem. If Social Security had enough program to hire and of people in

trying them and keep them, they could make these decisions more quickly. That is one thing.

If Americans are willing to give up some of their constitutional rights to due process, we could go a lot faster.

But, I do not see anybody volunteering for that. Right? If you do not like what the government does, or decision that it makes then you have all rights right now to say that I do not agree and I won another decider.

Now, we're talking about a substantial amount of money and access to Health Care and people fight like crazy for it.

Now, if it were easy it would be fast and it is fast. For some people it is very fast. You walk in there with a fabulous portfolio of medical information and all of a documented from recent medical records and your earnings rates for the last six months and a nice work history, the things that you have done in the past and your education; you could probably get disability in two months.

But, most people do not come in with that. Most of the people who come through the doors come in many of them with mental impairments and they do not even know what doctor that they saw. They went to some clinic. They wanted this clinic and that clinic and that emergency room and their medical records are a mess.

Somebody has got to get them all in figure them out. So this is time and time and time and time. And it is terribly frustrating. You could do it faster if you had more people doing it and if people came me and with better portfolios, disability

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portfolios that would be grainy end; but, they do not.

And the facts are that most of us are slobs when it comes to keeping up with our medical records. Could any of you turn around right now in right down the name, phone number and address of your Physician, the one that you usually see, your general practitioner? Nope. I could not either.

So, I think Mr. Rosenblad, that they answer is money and bind necessary circumstance a tricky difficult process. It is tricky and difficult. And so a tricky, difficult process with none of the people doing it and maintaining your civil rights to due process which you are not likely to give up; I think makes it very difficult.

Male could it be faster, you bet it could be. And is it too long, Oh my God, yes. Especially for the people with the least amount of wherewithal to put it all together. Right? The person with the most mental illness and the person with the worst diabetes and who has no energy and who sight is going; they meet it the most but it is the hardest to get.

So, I am very empathetic with it and everyone is looking for the magic bullet. I am afraid to say that it is not here.

JOE RAJOSKI: This question is for Virginia. I am Joe Rajoski or Syracuse University.

This is regarding the 401 K average amount that people between the age of 55 and 64 have, the $60,000. What is causing that low amount? Are people just not aware of how to save or how to manage a 401 K? And, there has been a lot of talk about auto enrollments in these plans and do you think that will make a

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substantial difference?

VIRGINIA RENO: That is the median amount for house calls that contain 55 to 64. That is some reason to be optimistic about the future that it may be a bit better because that 401 K's really began in the early 1980s, which is 27 years from now; it is not 40 years from now.

So, if people have a chance to start younger, they may do better. But, there are a number of studies that have done reasons Y those amounts are so small.

First of all, a 401 K requires the decision on the Part of the worker to put money aside when we all have other pressing demands for our money including paying for a house and paying off education and debts paying for the education of our children when we are at that age.

So, it is hard to say and many employers do not match and some do. There is the temptation to take the money out when you change jobs. That is a real temptation. And, it is hard to know how to invest it wisely.

Some people tend to be too conservative because they do not like the idea of losing money and others may invest heavily in company stock, which because they think they understand what their own company is doing but it is probably the riskiest thing to do since not only are you saving your paycheck but your savings are all wrapped up in the well being of the company.

So, people make mistakes all along the way. It could be somewhat better in the future and some of the auto enrollments may help but it still takes a lot of saving 3-percent of a modest

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salary to even get to $60,000.

PATTY PATTERSON: Can I just add one thing to that?

VIRGINIA RENO: Please do. This is-

KARI RAICHERT: Would you introduce yourself?

PATTY PATTERSON: I am Patty Patterson with Deloit Consulting [ph] and 401 K's is an area that I work in as well as try to do Health Care guidelines.

So, I am frequently a mile wide in and he inched deep. But, people do not understand the power of saving early in the magic of compounding.

That is why a particularly for this crowd the most valuable money that you will ever save is the money that you save now. And, I cannot remember off of the top of my head the multiplier fact but go to any little websites that deals with 401 K's and they will show you how important that first few years of your savings no matter how small they are; are of the ultimate buildup.

VIRGINIA RENO: I would like to give you an example of that. My God child is getting ready to go to Saudi, not Saudi, to Cairo [ph] for one year to Arabic; and when she was christened; I started putting $25.00 a month in an account. Now, she is 20 years old, $25.00 a month; I mean come on week its knees that there really. Right? I mean that is a good meal on a Friday night, without liquor.

So, she has a whole year of income for the year that she is in Cairo just from that and it is about $12,000.

So, I mean that was just 20 years of a tiny little bit of

money and I think that it is really important to say the early. Even when you think you cannot, if you can only does $10.00 a month do it and if he can all only do $20.00 a month that will be even better and $25.00 is even greater and $100 would not kill you.

KARI RAICHERT: We have time for about one more question.

PAUL JOYCE: My name is Paul Joyce, and I just finish my master's in public policy and I hope that you do not mind me sticking with the same topic but your last slide Ms. Reno was about 401K risks and if you would like to answer this too you are welcome but as I understand it when people get older and nearer to retirement; a common strategy is to shift your portfolio out of stocks and into bonds and it seems to me that when the whole baby boom generation over a period of 10 and years or so start shifting out of stocks that that would put a lot of downward pressure on the stock market and that someone's whose retirement security depends a lot on individual personal accounts and less on Social Security; that is a major concern. Do you think that it is a justified concern?

JULIETTE CUBANSKI: There is always a risk in investing. No matter what; but, I think that as you get alder sure you would want to shift some of your investments but no one has ever advise that you should shift all of them.

And I do not think that we're likely to see this huge collapse in the market or let me put it this way; we're not likely to see such a collapse simply because I am getting older and taking my money out.

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Because I am still going to want to have some money in there in stocks to generate larger amounts of money. Virginia.

VIRGINIA RENO: I think that this is not my area of expertise but I think that I certainly would not disagree with you.

I think that it is also important to realize that the baby boom when moved into retirement gradually; they only go their year by year by year. And there's much more going on there that affects our stock market is well as simply that [inaudible] people are getting older.

SUSAN DANIELS: I would just add that what happens to the stock market next year is not going to be what affects what you have when you are ready to retire because the stock market is going to go up and down and up and down and you need to be looking at the long-term and not at any given year.

If you go to a financial analyst, many of them will tell you to have a balanced portfolio so that you will not be shifting back and forth and you will not be expecting that what the stock market does tomorrow will tell you what will happen 40 years from now or where will be 40 years from now when you are ready to star repositioning your portfolio.

KARI RAICHERT: We do have time for another question.

MALE SPEAKER: My name is [inaudible]. I work for [inaudible] and one of the concerns of Congress right now is the potential agreement with Mexico and Social Security and part of the problem is because there is all of this is that one of these come from the senior citizens' needs. What is your opinion about

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this and international social security agreements? Are they fair for the United States and what is also your opinion on benefits to noncitizens?

JULIETTE CUBANSKI: Wow. I have to confess that I am not an expert on the details of the totalization agreement with Mexico but as a general rule, the purpose of these totalization agreements is very beneficial. The idea is for people that have worked in both countries and under both Social Security Systems that those two Social Security Systems can somehow get together to figure out how a person can get a reasonable benefit from one are the other or both without losing out or being overcompensated.

So, that is a good purpose but as for the details of working those out, I do not know about any of the details of the current agreement with Mexico.

VIRGINIA RENO: The idea is to be fair of people that move across borders during their working years and they should be covered under Social Security whether they're working in their own country or whether they're working abroad.

KARI REINHART: Alright. One last question and then we will be able to [inaudible].

ELIZABETH SOTO: Hello, my name is Elizabeth Soto. I am a senior at the University of California at Riverside and I am in training with the office of minority health.

And contacting CMS for some information on the number of people who are eligible for Medicare and Medicaid but not enrolled, I could not get a number so my question is in an effort

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to not only insurance quality Health Care but merely access; is anyone interested in finding out how many people are eligible but not enrolled in any of the programs and kind of in a side to, actually I just forgot my question; but if you could answer that.

JULIETTE CUBANSKI: Well, in terms of Medicare, because eligibility is pretty automatic when you turn 65 in enrollment are relatively automatic as far as Medicare goes the vast majority of people who are eligible are enrolled in the program.

Medicaid is definitely a different story. There are the estimates I think are about eight million children who do not have Health Insurance and ¾ of whom qualify for Medicaid or ASCHIP.

There are certainly a fair number of people who simply do not know about their eligibility. They may not think that they qualify or they may not know if their incomes are low enough and so they do not know to apply for these programs.

I think that there are also people that do not want to sign up for help from Federal and state governments.

So, I think the estimate certainly vary in terms of who is eligible but not signed up because it is really difficult to know who these people are and where they are in how to reach them.

In terms of Medicare, there is another piece of the Part D drug benefit that I did not really talk about too much which is this low income subsidy that is eligible or people who have low incomes are eligible to sign up for this extra help paying for their Part D premiums and cost sharing.

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There are about roughly three million people according to government estimates that are available for this benefit but are not signed up for it and again we're not exactly sure why the part of the issue is how to find these people and how to get them into the system and it is really difficult because you have to do a lot of one on one outrage and that I think is a rather expensive endeavor.

ELIZABETH SOTO: I am sorry but very briefly, my second question was related to Part D and I think that it may relate to Ms. Simms.

In my personal experience, a lot of Latino older women really did just sign up for Part D because they were scared.

I think that the whole campaign that CMS did was successful in terms of expressing a sense of urgency meeting to have to enroll.

But, not many people know about it and they are just really scared; so is there anyone that is advising CMS or is CMS really looking into other strategies for how to reach that 10-percent that is not getting enrolled in Part D and not really making it like a negative, really bad—

MARGARET SIMMS: Well, there actually was some urgency associated with signing up because for people who did not have other resources of drug coverage is that war is good as the Medicare drug plans were offering; there was a late enrollment penalty.

So, there was a time. Where people had to sign up when they were eligible which ended on May 15 of 2006. So, the word

about the late enrollment penalty really did effectively I think bring a lot of people into the Part D program because if they did not sign up and they did not have another source of drug coverage at a point in the future if they went to sign up for the benefits and they did not have a source of drug coverage for certain period of time, they would have to pay a premium penalty for every month that they did not have coverage for the rest of their lives or for as long as they were enrolled in the Part D program.

So, there was definitely a sense of urgency but it wasn't just because they wanted to scare people into signing up but it was sort of typed as financial penalty and there are a lot of outreach campaigns at the state and local levels that are working with state Health Insurance programs. Every state has one and there are counselors and their area agencies on counseling and I think that CMS is doing a really tremendous job in terms of trying to get people to sign up for this benefits, but it is difficult because I think a lot of people that still have not signed up; there are a lot of plans, there are about 50 plans in every state and that is just on the stand alone drug plan side.

So, sorting through all the information and making a choice can be a difficult process for people who may not have family members to help them sort out all of the different plans and sign up for what they think is the right one.

So, because the process can be somewhat complicated; I think that that has been an intimidating factor for a lot of people that have not yet signed up.

So, it is really what proved to be successful I think was

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the one on one outrage and sitting down with someone that they could talk you through, okay what drugs are you taking? Where do you get your prescriptions field? And really just helping people to make a personalized decision that they would feel comfortable with. So I think that that is the sort of help that is really important to get the people that have not yet signed up for the drug benefit into the system.

MALE SPEAKER: I could provide a little more information on that. There are about 4 million people that would qualify for completely free drugs under Part D. They would have zero premiums and a zero co pay and completely free.

These people a very hard to reach because they're often poor and they often do not read the paper and may not watch television and may not speak English.

CMS latest effort is to having buses running around the country and going to health fairs and working with church groups and other public outreach organizations but it is very tough.

These 4 million, you almost have to go one by one into the neighborhood and knock on doors and it is very hard to reach them.

MARGARET SIMMS: And actually, this is something the Social Security Administration got involved in because the Social Security Administration was actually charged with administering the low income subsidy portion of the Part D program.

They mailed out millions of letters to people that they thought may qualify and got some good response but they're still just a concerted effort on the part of hundreds of organize

sessions across the country to get the valuable benefit to the people who are as I said eligible but not yet enrolled.

JULIETTE CUBANSKI: If I could just talk for a minute are two about some work that the Joyette Center [ph] did. We surveyed seniors about their knowledge of the program before the deadline and before the initial enrollment deadline and found that African Americans for example were half as likely to be aware of the program as were whites.

The information that was distributed and how was distributed did not resonate with them and we engaged with a group of the Black Women's Agenda was choose a consortium of women's organizations many of them with local chapters around the country to do some outreach efforts and various contexts and one of their interesting things that one of the senior analyst, Wilamina Lay [ph] went out to one, I think it was in Detroit and they set up an information center in a Senior Citizens Center or actually they were drawing not only the seniors but the people who work there and the children of the seniors who are the people that they turn to for information and advice.

And, she said that one man showed up with his enrollment papers and he said to her, you have to help me figure this out; I want the program that Montel Williams endorsed on his program.

Which tells you where people get their information and Wilamina said; well, I do not know what the program he did endorsed was but these are the kind of things that you need to look for.

So, you have to look for who are their trusted sources of

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information and use those as ways to get to them and certainly in minority communities, having things on the website is not going to be the way to get information out.

JULIETTE CUBANSKI: Can I, before we break, actually, I have been asked by my colleagues to do a bit of shameless self promotion for Kaiser EDU, which is an online resource that provides tutorials and other information on health policy and resources for students and faculty so I encourage you to go there and you can get more information about Medicare and Medicaid and long-term care and people with disabilities and lots of great health policy information and resources.

So, it is just www.KaiserEDU.org. Thank you.

KARI REICHERT: Please join me in thanking our panel again.

[END RECORING]

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