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# Social Security Reform: What are the Options?

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## **Introduction**:

Welcome to the IWU Roundtable, one of the series of public dialogues sponsored by the faculty at Illinois Wesleyan University. Each roundtable features extended deliberation on an issue of public concern. Today's discussion is *Social Security Reform: What Are the Options?* This IWU Roundtable wills set the Social Security issue in the context of public opinion, the strategies of the political parties, and recent changes in the Medicare program. The goal of the discussion is to help citizens understand the political and economic challenges which confront the effort to reform Social Security and healthcare.

**Greg Shaw**: Good morning and thank you for coming at this hour. I am Greg Shaw, Associate Professor of Political Science and I am joined by two colleagues.

**Susan Swanlund**: Hello, I am Susan Swanlund, Assistant Professor of Nursing.

**Terry Renner**: Hello, I'm Terry Renner, Professor of Political Science.

**Shaw**: It is my task to get us started in the way of setting out some issues, some problems, and some questions, and so we'll take just a few minutes to talk about some of the highlights there, I'll try to be brief.

As you all know, unless you have been hiding under a rock, there is a great discussion in this country about physical insolvency of Social Security inasmuch as the time is fairly near when we will reach a position when there is simply not enough money coming in to Social Security to pay current benefits. And so, as it turns out, since about the early 1970s, we've been at a ratio of approximately three workers in the workforce for each retiree. So, if you want to think of that one retiree standing on shoulders, you've got three, and it has been that way since the early 70s, and that indeed has produced surpluses for the system. But that surplus status will change dramatically starting in about a half-dozen years, as the baby boomers begin to retire, around 2010 or 2011.

The Social Security trustees, the group to whom we look for straight answers about the insolvency, indicates that beginning in about 2018 the retirement fund will begin running a deficit, by 2030 the ratio of current workers to current beneficiaries will begin to shift closer to 2:1, and that by 2041 the fund will reach insolvency, so there simply won't be any more money in that fund to pay benefits.

Understand if you step back away from those particular figures and look at the big picture, this is really one part of the government owing another part of the government money. So, that's another perspective, another lens to view this through.

In the light of George Bush's effort to sell a reformed proposal, it's perhaps useful to stop and think what the public thinks of all this, so just a bit of public opinion data here: the percentage of Americans who believe Social Security is "in crisis" has actually declined slightly in the past decade, from about a third to about a quarter now. So, despite objective evidence, that the problem, the horizon for Social

Security is actually getting closer to us, despite that, people are becoming somewhat less alarmed about it and I'm here to alarm you a bit this morning (laughter).
Thinking about the framing of the question slightly differently, asking people how much of a top priority is it to work on that, about a 70 percent of people, to the credit of the public, about 70 percent of people think that working in Social Security to reform it should be a top priority for a congressman/ president. That figure is roughly stable over the last decade and these are questions that are pulled unfairly, frequently and so forth.

However, a minority of people are either somewhat or very confident that Social Security will continue to pay benefits comparable, into the future, comparable to today's benefits. And so there's a sense out there, although in a fuzzy way, that Social Security is in trouble.

Understand also, in terms of larger context, Social Security is only one piece of this puzzle as the country's demographics change and as other things that we spend our money on as a collective change. Social Security is actually the easier piece, Medicare being the more complicated piece. So if you want to talk about a hard issue, don't pick up Social Security, pick up Medicare, and Susan will discuss that some (laughter) and just couple of metrics to put this in context: currently Medicare consumes about 2.6% of gross domestic product. 75 years from now, which is the far horizon of what the trustees project, try to project for, these actuaries – their crystal balls are only so good; by 2080 we expect to spend 14% of GDP on Medicare alone and if that number doesn't mean a lot to you, consider that currently the federal government budget is about 18% of GDP, so the idea of spending most of the federal budget on MediCare ought to be unsettling to you, and if it's not, you're not paying enough attention, ok? (quiet laughter) So we can't sustain it, something has to give.

Briefly, a collection of ideas addressing Social Security, and you've probably heard of some of these but i just want to throw some things for your consideration: you can raise the retirement age (people live longer, arguably they should expect to work longer). In 1900, people born in 1900, could be expected to live on average 47 years. People born today can be expected to live 76 years, and so perhaps it's reasonable to ask people to work longer, and indeed congress has changed the age for four retirement benefits over time and by the time anyone born after 1960, including myself – I have to be 67 now for retirement benefits – but, perhaps we should consider stretching that out further. We could change or eliminate the early retirement option. Presently, for a sacrifice of a small percentage of your benefits, you can retire early and in fact, Americans like this idea and the retirement age has actually been getting younger because people like the idea of retiring early, they want to spend their summers doing other things.

To the extent that people view Social Security as a core part of their retirement financing, something like an unequal partner with a 401K, then that line of thinking goes against any notion of curtailing Social Security to be merely a safety net, right? And so I want to argue that Social Security should not be a 401K, right. It should be a safety net, not a major leg of the stool of your retirement financing. I'm sorry if I'm about to offend anyone here (laughter), so that's something to think about.

Increase of tax rate: this something that actually most Americans say they are willing to do and poll results show that over and over and over no matter how you ask the question. George Bush has said that's one point on which he does not want to give, he's opposed to that, but again, it's an option. Currently, that rate is 12.4% split evenly between employers and employees, but perhaps we should consider raising that again. And again, inasmuch as we need to solve an insolvency problem and certainly the public would be willing to go with that.

We could raise or eliminate the cap of the portion of income that is subject to the income tax. Currently it's $90,000 a year. This would, arguably, fly in the face or rather further aggravate any resentment there is among high income earners who realize currently the program is redistributive, right? Because the higher your income, the less payback you get as a percentage of your income. And so, the program is already redistributive and potentially would aggravate that.

We could reduce benefits, again, we could conceive of this idea in a strongly stated wat that Social Security is not a main leg of your retirement, it's a safety net and perhaps we could consider that. This would of course hurt middle and low income workers the most since those are the people that rely on Social Security for the biggest portion of their retirement income at present. So we'd want to think about that carefully.

And then of course, we could just say it's one part of the government owing another part of the government money, so just close the gap with general revenues. This would cost a lot of money. On the order of coming up on $4 trillion dollars, 4 *trillion* with a "t", over the next 75 years, so that's very expensive and we do very expensive things routinely so that's an option, we can talk about that.

Briefly, a couple of words about Bush's proposal to partially privatize Social Security. It seems to me that there is a disconnect in this idea in that partially privatizing may indeed encourage Americans to do a better job at savings, which is something we all know Americans need to do. Presently the average American household saves between 2% and 3% of its annual income, that's pathetic right? Contrast that with the early 1980s when we hit a high water mark of almost 11%. And so for a variety of reasons that am not an expert on, Americans do not save very well, and so surely we need to prompt them to do better on that. Not only in the interest of cash income during retirement, but also to address the troublesome issue of how in the heck to pay for medical care. So we need to work on that. But, talking about that does not speak much at all to the fiscal insolvency problem. In fact, allowing workers to divert part of their FICA taxes into a privatized fund actually hastens the day of insolvency for Social Security. And so, I think most Americans understand this, inasmuch as – George Bush has, aside from September 11th, has never enjoyed a net positive rating on approval for handling Social Security. Americans simply trust the Democratic Party to do that better, regardless of how you ask the question. And so the president seems to be in a situation where the public isn't particularly interested in buying what the public has to sell. And that's a thing he's going to have to work around. Perhaps one tactic to do would be something on the order of – well, recall why the Marshall Plan was the Marshall Plan, not the Truman Plan, right? (Laughs) So perhaps it's a matter of semantic salesmanship. But in any case, the current approach, which I think has run aground on the shoals of electoral politics coming up on

midterm elections, we need to reconsider how to readdress that and particularly how to address the insolvency issue. And so, let me stop there and share some of this time with my colleagues, so, Susan? You want to get some issues on the table about Medicare?

**Swanlund**: Sure, sure. Thanks Greg. I'd like to give a little bit of a background before i get into some of the issues that are dealing with Medicare at the current point. On December 8th –and probably a lot of you know this– of 2003, President Bush signed the MediCare Prescription Drug Modernization Act. This applied to all Medicare beneficiaries, whether they were enrolled in a traditional fee for service or whether they were enrolled in a private health plan. And at that time, Bush made this statement, he said, "Medicare was enacted to provide seniors with the latest in modern medicine. In 1965, with its enactment that meant house calls, and, for operations, long hospital stays. Today, modern medicine includes outpatient care, disease screenings, and prescription drugs. Medicine has changed but Medicare has not. Until today." And with that in 2003, that was the largest expansion of Medicare since its enactment in 1965. Today, this is called Medicare Part D. I'm sure you all have heard of that or read about it in the papers. But to better understand that and to understand some of the, even, terminology they use with Medicare in Part D, i think it's important to go back and just briefly review A, B, and C.

Medicare, of course as you all know, is available to those that are disabled over the age of 65 and Part A is actually the hospital insurance, which covers hospital costs, skilled nursing facilities, and some of those related expenses. The participants do not pay a monthly premium because they or their spouse have already paid through their payroll taxes while working and they are automatically enrolled in Part A.

Part B is the medical insurance that covers physician's fees, lab fees, other non-hospital expenses. There is a premium, there is a voluntary enrollment Part B. The premium in 2004 was about $66 a month. In 2005, it was about $78 a month, and also in 2004, there was a $100 deductible. Medicare Part B, which is kind of interesting, has a late enrollment penalty. If the older person does not enroll in Part B when they first become eligible, they may get a 10% fee enacted upon that. The premium may go up by 10% for each 12 months of delay, and then they would pay that extra amount for as long as they keep Part B.

And then, Part C, is actually what we call "Medicare Choice" or the "Medicare HMO". I say all that just to kind of give you a background because Part D is actually the part that came out because of that Medicare Modernization Act and it established the prescription drug benefits, but also made some changes to B and C. In Part B, it increased the deductible to $110, it provided for income-based premiums, so for those over $80,000 a year and it provided some added coverage, and then also renamed Part C to "Medicare Advantage."

And Part D was –is–the prescription drug benefit. Since this was enacted in December of 2003, for 2004 and 2005, there was a temporary benefit, called the, "Medicare Drug Discount Card", which seniors could take advantage of. Now effective January 1th, 2006, would be what they call, the "Prescription Drugs Plans" or the PDPs. Anyone who has Part A or Part B is eligible for this Part D, but basically there's two types of plans that come with Part D. They can enroll in a True Prescription Drug Plan, where they

have the traditional Part A and Part B, but of this, of the traditional Prescription Drug Plan, there are at least 40 different plans available, only about half of which are national and a lot of the experts are predicting that their plans should be national plans, so that they still have coverage when they travel to Florida or when they move to a different state. The other type, under Part D, is called the MAPD, the "Medicare Advantage" – which is part of that Part C– and this replaces the Medicare Choice and includes more than just drugs, it is more like an HMO, so it does include doctor's visits and hospital stays. So there's two different ways that now older adults can get prescription drug therapy or they can elect to stay with their supplemental insurance if that still provides prescription drug therapy.

However, there are some problems or issues that, I guess, come up because of this Part D and most of them are for the beneficiary. One of them is costs: the costs may differ depending on which of those 40 plans they choose. Another is coverage: there can be a large gap in coverage, which I'll go into a little bit later, where the participant still pays a monthly premium, but they actually do not have coverage for prescription drug benefits. Enrollment: there some very very strict enrollment periods and there's also a penalty if they do not enroll at their specific time of enrollment. And another one is drugs available: not all drugs are available on all of the different plans. SO those are some of the problems or issues that come up for older adults.

And then for the government, there are also some issues. Costs are basically some of the main problems for the government. The Congressional Budget Office estimates that cost for ten years may range from 395 billion to over 500 billion dollars to implement this plan– and actually that's even with the beneficiaries putting out 130 billion over that time period. The other one is: for those employers that choose to keep their plan, to keep their Prescription Drug Plan as part of their supplemental insurance, the government will provide to those employers 28% of what they are paying for prescription drug coverage for their retirees and that is at no tax to those employers. So there is, you know, a quite a bit of money going out to implement this. Overall though, there is a lot of other really specific things I want to say, but I think I'll let some of the other issues get on the table and then I'll come back and discuss some of the specifics.

**Renner**: Actually, my take is going to be a little different. I want to talk a little about the nature of the politics surrounding Social Security and the impediments in effect to reform, as well as, Medicare. Just in terms of a few empirical clarifications, if you have to try and solve one of these two problems, the one that you solve that is *easy* is Social Security. Medicare is a hornet's nest. Like many of the things that Professor Shaw has mentioned, in terms of the possible policy options, we don't need all of those. We could, actually if you had a situation like we had 25 years ago or so, where we had Bob Dolan to O'Neil would say, "Hey, you don't beat me up, I don't beat you up, let's have a bipartisan commission, we all come out of there we cut a deal, you know, we dance we laugh we schmooze, then we go home happy," and then at least we make the system okay for at least a short period of time, they thought it was longer, the demographics were more harmful. The current environment in Washington doesn't allow that.

For example, if you just raise the $90,000 cap itself to $200,000 that would pretty much take care of Social Security for the foreseeable future, maybe not 50-60 years out, but certainly for the foreseeable future. If you raised the cap and taxed all income, then it would run surpluses throughout the next century. Now that's also a politically-rough question. The majority of Americans seem to favor that, the democrats are not going to go off on a limb and say, "Oh sure, let's raise your taxes and the administration isn't going to support that." You'll probably wind up, my guess is, in the long run, would have some version of a bipartisan commission after there is a meltdown and charges and countercharges where we'll have something where we tinker a little bit with the early retirement age, maybe put it up to 65, add an extra year or two and then maybe raise the ceiling, play around with it, so that it's a hodge-podge that nobody really wanted, but basically ties the system with gum and duct tape. And so that's a lot easier, for example, than Medicare, which is this very serious problem and if we don't move toward cost containment in our health care policy, I'm not sure how the entire system, private or public, is going to be sustained.

But just a couple of things. First of all, when we also talk about Social Security, the year 2041 or '42 or 2052, depending on whose estimates, the year in which the Social Security fund will technically become insolvent. But what it means, in the worst case scenario, is when we do absolutely nothing, we don't bring out the gum and duct tape, we'll pay $0.75 on the dollar for current benefits. That's the absolute worst case scenario. So, certainly Social Security is in crisis. If that's in a "crisis", then I'm not sure what we would describe the situation to Medicare – Katrina[3]– I mean we certainly have a very substantial situation there.

Now with all that being said, policy change is always difficult. But it's particularly difficult in a hard policy area like Social Security and probably impossible in Medicare given our current political climate. Our current political climate is one in which we leave in Washington no opportunity to be disingenuous behind; we leave no opportunity to be excessively partisan behind. And this is reflected in our congress, in our campaigns, in the Supreme Court, campaign consultants, it's also reflected in presidential debates.

If you go back 45 years ago, I just had my American Government students watch this the other day, they were just amazed: the Kennedy and Nixon debates. They said something and they acknowledged the differences, they tried to clarify choices, rather than, basically as consultants tell you, "The average American watches the TV debates for 23 minutes, so if you want to say something, you say it over 23 minutes", you know: Social Security lockbox, kinder gentler nation, fuzzy math. So you know, they say these things over and over and it's quite unfortunate that we're scripted excessively partisan and we're not getting to the core of many problems. And Ii think that's something we can all think about changing in America. Specifically, when it comes to Social Security, why did the president's plan fail? Well for a lot of reasons.

First of all, again, both sides were disingenuous. And the president's plan to some degree was disingenuous, the democrats didn't really offer a response– I was going to say that that's bad– and they didn't fall into the trap of saying, "Okay here's our plan," because any plan that really addressed the

costs or any financial situation would involve pain. The president's plan on the surface which was actually never really written down, it was a concept and the plan specifics were to follow later, wound up being one that the administration was never really able to sell to the majority of Americans.

Even though I've got some information here if anybody wants it, they're some of the documents – there's a 103 page document that the House Republicans and Senate Republicans were given on how to market Social Security. There are sample constituent letters, words not to use, personalization not privatization– forget privatization even exists in your vocabulary, talking simple language, keeping numbers small, etc., say it the way they can hear it."

For example, most Americans will say, "Building well sounds unattainable. Especially the context of Social Security." But on the other hand, putting aside a nest egg sounds like common sense. So when all the press releases and the president's website, you know, all of these poll-tested code languages all there. In the way that when you're running a campaign, it seems to just– especially the administration of 2004 was very good at executing their campaign strategy, it didn't work well here in fact I think it's a campaign strategy– it didn't work very well here, in fact, that's probably an understatement.

I would disagree slightly with my colleague, Professor Shaw, and that is it doesn't look like it's dead rigor mortis has set in (laughter), I mean it's going nowhere, there's nobody on capital, they're not even talking about it other than the extent to which republicans are worried democrats are going to beat the hell out of them, you know, next year in the midterm elections, or *au repos,* it's dead. And so why is it the– if you look at the fundamentals, if there's a choice in America between making Social Security a 401k plan and a safety net, the evidence is overwhelming. Up to 85-88% of people say, "Social Security, regardless of its contours, ought to be some kind of safety net rather than being something that encourages savings or investment," there seems to be more support for doing that on the tax side of the equation rather than the existing Social Security system. So, the administration was running upstream there. Even at the point they announced that, there was initial fanfare, there was a little bit of an uptake from the support, depending on which survey you look at, somewhere between 40-43% of people at its peak said they were in favor of what they thought the president' plan. When you mentioned three clear costs, at least half of that 43% abandoned the president's plan or whatever that word was, personalization. And essentially one of the ones to have the highest hit-kill ratio was if you were going to get a lower guarantee benefit, which was of course part of the core.

Another thing, if you had to have another government, department, or agency, which of course would be inevitable if it was in a separate department or something aside from Social Security, to implement the program, about half of those, you know, abandon it. There were management fees, which I think would be the most minimal associated with that, even that seemed to have another half of people abandon it. So once the costs were played out, your peak of 40-43% went down to the 'teens very quickly. And so, from the standpoint of tactics, I would think, especially since the Bush administration is very careful, they would have picked another fight or tried perhaps a different tactic. So in that sense, the sense that democrats were disingenuous too and just beat up on the administration, and did not offer an alternative, it was only a matter of time. Again, probably by May, the president's plan had went

"one foot in a grave and the other on a banana peel", and the democrats were shoving. So, it was something that is now pretty much linked to so-called, "Hilary Care" in '94. And there are some, certainly some lessons that were learned from the administration's attempt in the second year of the Clinton administration to reform health care. They had a very precise plan, a lot of details, but they started out with about 60-67% of Americans supporting it. So the devil was in the details and support quickly plummeted down to about below 40% for the president's plan and provided the opposition with ammunition. It was a similar situation! The president though that this was something important, it was a crisis, you could get it through congress, his party had both houses of congress, similar to right now. But you're not going to get members of your own party to walk a plank on something that they realize is very very costly politically, and that's something, you know, fortunately or unfortunately, depending on your perspective, you know what happened in your situation.

One of the other things is, the president certainly talked about and the talking points are clear, Social Security is in crisis. And whether it's a crisis, or whatever the word is, it's certainly a problem. The difficulty is is his plan definitely didn't address that. In fact, as Professor Shaw has noted, the particular plan would have accelerated by up to twenty years at that time or the system would have become insolvent. And so for a lot for reasons, the Social Security this year did not work, it's not going to happen next year – it's midterm election year– there's no incentive to grow a backbone and it's not going to occur as we go toward the 2008 presidential elections. So as many other things in American politics, we'll just postpone the day where we actually have to deal with the problem, and my guess is the earliest is 2009.

**Shaw**: You know Terry, I don't think I disagree with you so much about the possibilities for reform because we have a couple of different models, you know, we have instances where Americans seem as crisis-driven people. So we wait until the verge of a meltdown and then we wake up and say, "Uhh we should work on this!" And so that's one model that will perhaps unfold, that will until you get to 2020, 2030, whatever it may be, until it's undeniable.

However, there is the case in 1983, as you referred to earlier, bipartisan commission headed up by Alan Greenspan and they went into the closet, worked out some plans, and addressed the insolvency problem there. I suppose one could argue to that, that indeed, that look like crisis, absolutely at the moment, more so than it perhaps does now, and that's from a social science perspective, that's a confounding variable in the analysis, but I think there is a model for re-approaching this business of Social Security.

As you say though, you are right, this is the easier piece of the puzzle. And so, fine let's go ahead and do the easy piece first. At some point we're going to have to get around to healthcare and I guess my question for the both of you is: to what extent can we grapple with the growing notion of health care as a human right, as a basic human right? Because there are implications for that, right, if you assume that then you start spending a lot of money. And to a second degree, if healthcare costs have gone up and people are not retirees, are not in a position to pay for this out of pocket, given the shrinking or perhaps shrinking Social Security, the pinching crisis that is unfolding in corporate America. How do we deal with the escalating costs of healthcare as a function of technological spread

as opposed to just a demographic shift? And so, I don't know if either one of you want to try and tackle one or both of that.

**Swanlund**: Well I think that you've brought to very important points: technology and demographics and it is technology that is allowing our population to live longer and actually it's predicted that by 2030 about 20% of the United States will be over the age of 65. The 20% will be taking advantage of the Social Security, whatever state it's in at that point of time –

**Renner**: And those people vote.

**Swanlund**: –right! They do, yes. They do. And also taking advantage of medicare and all the different parts of medicare and also in terms of technology. Technology has enhanced their ability to live longer lives. Though they may live with many chronic diseases, they consider themselves healthy and they want to keep going and they want to keep doing whatever they need to do to maintain their health and they'd like to keep their independence as well.

So you asked the question of health insurance as a national right or civil right. Well definitely I think those over the age of 65, they absolutely believe that's what they are entitled to and what they have paid into. What I did want to bring up though were some of the issues related to implementation and costs about Medicare Part D. And part of these are issues because the older age group does take such a large percentage of medications, a large number individually per day and as a group, a large percentage of those that are prescribed every year. And because of that there are a lot of costs associated with that.

For the beneficiary, because there are so many plans, in the original- I hate to use the word "generic"- but the one that Medicare thinks would be used the most often, the PDP, the Prescription Drug Plan, because there's at least 40 plans in there. The premiums can vary anywhere about $13-$64 per month. It's anticipated that the average costs will be about $32 per month which would leave to about $420 per year.

There is one huge issue within costs for the beneficiary, maybe you've heard about this. Most experts are calling it the donut hole and this come about in actually the analysis of the cost to the beneficiaries. Well besides their $420 per year in their premium, they'll also have a $200 deductible. And then up to $2,250 in terms of their drug expenses, Medicare will pay 75%, the beneficiary will pay 25%. Between the amounts of $2,225 and $5,100, there is no coverage and then after $5,100, Medicare again picks up for 95% of the expense, and the beneficiary picks up 5%. But what's significant about that expense is a level for up to $2,250 and $5,100 is the older adult is still paying premiums, but there is no coverage for their drugs through those PDPs. And several of their search information that i read, there's very few policies out there where you are paying into a premium without a coverage coming back or a gap in coverage.

Another initial problem is the enrollment, of course, it's voluntary like Part B. There's a six month initial period, which is starting very soon: November 15th of 2005, will go until May 15th of 2006. And within once an older person is enrolled, they'll have the right to change their plans annually. And there may be some special enrollment periods. For example, if a person does move, they may be able to change plans. However, there's a penalty for late enrollment. Again, this was kind of established by the precedent for the penalty in Part B enrollment. If the beneficiaries do not sign up by May 15th, 2006 and if they are at that age level, then their premium might go up, which would be 1% for each month that they are eligible before enrollment. So if they wait 60 months, their

premium could go up 60%. And also there's another question, what if that older person doesn't take any medication right now? What if they don't? Do they still enroll? Because if they are eligible and they don't enroll, premiums will go up.

The other issue that I mentioned earlier is drugs available. The plan should have provided formularies in October, a lot of pharmacies have not seen formularies for those 40 different plans. Most plans cover the 100 top prescription drugs, and there are approximately 145 different therapeutic classes of drugs available and these plans should have at least two drugs from each of those classes. And there are six classes that most drugs have to be available in and these classes are antidepressants, antipsychotics, anticonvulsants, the HIV and AIDS immunosuppressants, and the cancer drugs. But again, there are some problems. Lexapro is the most commonly prescribed antidepressant in older adults, especially in long term care settings, and this drug isn't covered. Some of the other drugs not available are a class called benzodiazepines, this has Valium, Xanax, antianxiety drugs, barbiturates are not covered, over the counter drugs of course are not covered, cosmetic drugs, and also vitamins are not covered. But I did want to point out, as Greg said in the beginning, the high technology does lead to additional rising costs. We are keeping people alive longer with chronic health problems they do take medication, they do want to take medication, so it seems that the technology plus the demographics are adding into the some of the expenses.

**Renner**: One of the things that is certainly very clear from all of what you've mentioned, and it's certainly a theme with any kind of health care reform, is just how complicated it is.

**Swanlund**: It is.

**Renner**: You can't just say okay, again like in Social Security, raise retirement age here, let's cut the deal, make it a year her a year there, you know, shave here, add a $20,000 ceiling –

**Shaw**: Right, right.

**Shaw**: –and make it all happen. And you're just talking about prescription drug policy–

**Swanlund**: Right! That's it.

**Renner**: So if you don't have one size fits all, you don't have ten sizes fits all with healthcare policy, which is why we are in a current political environment where we can't deal with something that actually, whether is crisis or not, is comparatively easy. God know how we're going to handle healthcare! And the plan itself is kind of a hodge-podge. You know, it's a wave with blue smoke and mirrors, trying to create the illusion that there's some real benefit out there, it's a comparatively minor benefit, extremely complicated. Many people are opting not to use it. But the –again, I am extremely pessimistic about any kind of systematic health care reform, regardless of what that would be, I think we're going to be dealing with it unfortunately like this, with something that deals with it in a piecemeal approach and that will create as many problems, if not more than the current system. If we look at where both of these originated, we had two explosions of policy innovation in America, probably you know every event in American history if you think about it, the Civil War and the changes we had very quickly after Reconstruction, the south went back to pretty much the way it had been, but the 1930s and the 1960s, and that's where we had the explosion of new programs that the federal government had never been involved in the past, including Social Security and the wave of mostly social civil rights policy, and in the case of Medicare in the 1960s. And so said something like, "A New Deal, 25% unemployment, people eating dogs and cats on the streets", and the

1960s was a social turmoil and a president who gets to run for re-election, Lyndon Johnson, during his honeymoon period after you know the sitting president was assassinated and his popularity was at the high note. Those were two narrow windows where we had dramatic policy change, unusual policy change in America, don't hold your breath for those confluence of factors to come back and fix these in the future. And I think that is really unfortunate, and as Greg pointed out, I think you are trying to get to the broader debate, is healthcare a fundamental right? Well, in America there are no economic rights in our constitution, we are unique among Western democracies, usually at least education, healthcare are right there with freedom of speech and some of the other civil rights and liberties that are articulated in the constitutions of other democracies. That's not the case here. The Supreme Court has made it clear, education is not a fundamental right, it wouldn't even be litigated if you tried to claim that healthcare was. So, politically, you might be able to get massive agreement that yes all Americans ought to have x y or z with education, but try to get proper tax reform to fix that, we might agree in the abstract that all Americans should have access to quality healthcare, whatever that is, and as you're pointing out, the devil's in the details, so then what does that look like, who is going to pay? It's inevitably going to be distributed, there are going to be winners and losers, and given that we have an excessively partisan environment in Washington that I think in most cases people are talking past each other, deliberately talking past each other, and not handling the problems that we have in front of us.

**Shaw**: You know, you said, "the devil is in the details", I think that's important in it's own right and I'd go one step further, the devil *is* the details in as much as Americans don't like partisan bickering and arguing among policy wonks and so forth, they just want government to fix the problem, right? And so, Representative Brady, you probably get a lot more positive responses from constituents when you can intervene on the part of constituents versus the DMV versus talking about the machinations of the structure of our education program in the state, right? People don't want to talk about that, they just want to fix the problem. And so, the devil *is* the details. Now if you believe that, what I just said, that sets up a fairly negative or pessimistic implication in that you're asking people to partisan congress who are deeply polarized, to address questions where oxen will be gored and to do this basically in public, right? Doesn't look promising to me.

Now maybe the salvation–and you can write this down, some of the few times I'll say this in public [laughter]. Maybe our salvation will be corporate America coming and saying, "Guys, this is killing us," right, "Health care costs and pensions are killing us, we need to get on the stick and do something about it." And so maybe there will be a silver lining, I'm trying to be optimistic here this morning [laughter]. But perhaps that's maybe where things go.

**Renner**: We're in the Wesleyan bubble we can be optimistic [laughter].

**Shaw**: At some point we need to invite these folks to talk.

**Interviewer**: Professors Shaw, Swanlund, and Renner take questions from the audience.

**Interviewer**: The first question is: Why doesn't the government use a flat amount or voucher system to pay for medical care?

**Shaw**: I am not aware of that in the American case. All of the cases that we've had in this country have been cases of paying providers to provide some level of service and trying very hard not to intervene in the relationship

between the provider and the patient, that's been the philosophy all along. There may be international cases about…

**Renner**: … -other impulses in congress. No but have been in the past, the vouchers, the difficulty of course of them is they really expose the details. And that is, if you give somebody a $2,000 credit for buying health care, for some people that's fine. As you get older, it's not, or if there are some unusual circumstances. Now then, how do you create that? That voucher system is like the federal government in the 1960s stopped delivering surplus food for the poor and they said, why do we do this we got distribution systems, they're called grocery stores. Right, you know? We can give them these things, they're not checks, food stamps, we don't need to set up a federal bureaucracy to go deliver these things. And so, in sense, the idea is probably attractive to many, just when you figure out, "Okay, what is that? And do we say, "Well if you got this condition, you get more" and you get to the same scenario where you're trying to –if there's an inflexible or a flexible amount to it, which would be necessary to most people who have the greatest need –I think, were you citing me the statistic that sometimes the largest percentages in less than all of your health care costs are in your last few weeks of life?

**Swanlund**: That's exactly right. It could be last weeks or last months of life. I've read that for several years and I've actually seen it. A lot of times and the largest expenses, even to Medicare, it maybe be to any insurance company, but to Medicare would be in the last several weeks of life with the attempts to sustain and then finally making the decision.
**Renner**: You get into other moral, really hot, religious-political questions when you begin to go down those paths–

**Swanlund**: That's right, that's exactly right.

**Renner**: –my mother passed away, for example, five years ago. She was absolutely convinced she didn't want to be sustained artificially. So then, do you therefore in the legislation say, well if you want to be sustained artificially, then you don't get any benefits. Try getting that into federal policy.

**Swanlund**: Right.

**Renner**: And then you know, you have the right to die, she's– that led her right into this, and it's, and it is an ultimate hornet's nest.

**Interviewer**: What's your assessment of the All-Kids law, the new state health insurance for children which was recently passed by the Illinois General Assembly?

**Shaw**: On a couple of levels it sounds like a good idea. It's universal and people like universal programs because they present themselves as a leveled playing field of sorts, you know, not the standing idea that there's some distribution of income that makes that thing go, right? So people like that. People are being treated fairly.

One of the strengths of Social Security –why up until the last decade or so, it was referred to as the political third rail, right, touch it and you die– is the idea that it's universal therefore we're all in this together, there's an intergenerational and interclass compact here. So that's strong.

The other idea is prevention. I'd much rather see us spending money to keep kids healthy to head off much more costly problems later, so I think that's fabulous. Into the extent we can do that, in that model, congratulations, and it's remarkable you did it in three days–

**Renner**: Well you probably haven't adjusted the cost [laughter].

**Shaw**: –right, right.

**Swanlund**: Or the implementation.

**Renner**: Or the implementation, right.

**Shaw**: You know, there's this tension in terms of– I'm sure this happens at the state level and at the national level, and it's interesting to contrast Bush's pitch on Social Security versus Clinton's pitch on health care. Right, Clinton was a detailed guy, gives us a fourteen-hundred page long bill on healthcare in excruciating detail: this this and this is how you do it. Well you do that and what happens? You give your opponents lots of targets to shoot at and that's just what happened. Bush tried a different approach, I think he learned from what happened to Clinton. He said, okay here's a vision, here's some broad principles, now congress let's work on this. That didn't work so well either for reasons that we've talked about and so–

**Renner**: I would say morally and politically, I would absolutely think that All-Kids would be the thing to do and I would certainly, you know, if I were in your situation I would certainly work for it. But– and it was certainly successful in Vermont, it's one of the things Howard Dean used to run on– there have been more than a few people that have suggested that that's something the governor thinks that he might be able to run on for some broader office, that's a whole other story.

And that may be his motivation, but certainly in my situation, I was in a single parent household and my mother and I were on and off welfare until I was 15. In fact, we were fortunate that when I was poor, when we were poor, I was not living in Illinois at that point which used to cover kids' dental care. So, I didn't go to a dentist until I was 21. So the extent –it was not a pretty sight (laughter) but anyway, fortunately I flossed (laughter)– so I certainly have some general, personal port for that and its concept. I have trouble believing that in three days you have dealt with all of the things that are necessary. You got to– there's costs associated: who's going to pay the bill, and you ought to be able to come up and say, alright this is how it's going to work. In the long run, we're going to save, we're going to raise these fees or these taxes, and we're going to use this particular approach. You gotta be upfront! Because if you say there's no real costs to this, well just how do you finance it, borrowing again from the pension fund or delaying payments, (laughter) whatever that the governor did because I cannot imagine he was upfront about anything with respect to the cost. So you gotta do that. Otherwise, people are going to be disillusioned, program becomes a political target, and I don't think the community is served in the long run if you don't make those tough choices.

Interviewer: Isn't the real problem with health care that the politicians and the government don't have an incentive to address the real problems?

**Renner**: As a matter of process, I think you are on to something absolutely very important. There's a flip side to this arguably, and this also addresses your question about government. We probably should not think of

government as blanket evil or blanket unfortunate necessity or something like that. Actually you know, we can point to a lot of tremendous successes: public education, the interstate highway system, etc. And in fact, we use the government on a regular basis to give people an incentive to do good things right not only through philanthropic giving, we penalize early withdrawals from IRAs so that's an incentive to get with it and to save on one's own for that leg of the stool for your retirement funding, right? And people do that, they respond appropriately. We exempt incomes spent on interest for home mortgages, right? So through that mechanism we encourage people to buy their own homes and sit on top of some equity right, and arguably that's a good thing, we give people tax breaks to get hybrid cars. So I see government as a tool to not only provide the safety net we talked about, but also as a tool to encourage people on the private side to do what's good for them and the bigger picture, what's good for us. Because people who own homes in retirement are less vulnerable and less likely to end up in the bottom of the safety net than people who don't have that buffer against poverty. And so to the extent we can use government to prompt people to do good decisions, I'm a big believer in that.

**Interviewer**: It takes hours to understand the Medicare Part D handbook the government is sending seniors. Isn't the program simply too complex and confusing?

**Swanlund**: You are not alone. In fact that is what the majority of older adults are saying, that they are very confused about this situation, and I've been going to some of the educational sessions about Part D and what I hear them saying is, you need to get on the internet and find out. A lot of older adults did not grow up–

**Renner**: There's a setup (laughter).

**Swanlund**: –Yeah. That's a big obstacle to try and even find someone to help them and so many did not even receive the handbook that you're talking about. I wish I would have brought it because most people that talk to have not received it and it was due out back in October I think with all the formularies and options it would have.

**Interviewer**: How does the fact that the nation is divided 50/50 politically influence the health care debate?

**Renner**: I don't know that most Americans– we're certainly split 50/50 in terms of the parties, but on a lot of core issues, I don't think that we're anywhere near as divided. I think to some degree parties exaggerate those differences and that doesn't mean that with tough choices we're going to be able to get more than 55% or 60% of Americans to agree on something, but there are a lot of things that you can. For example, and it's not a direct example, but on the McLean County Board there are 12 republicans and 8 democrats. There has never been, never been a party line vote, going back in two terms of mine off the county board.

**Interviewer**: Politicians seems to do a better job at the local level. Is the key obstacle to reforming health care the federal elections system?

**Renner**: There are several reasons for that, very very complicated. I would say that some of the Cliff notes version of that is yes there are somewhat different issues that you deal with at the state level and at the federal level. But there are some clearly distributed issues that we dealt with here, you know, at the county level. And you don't have anybody else to mandate (laughs), you're at the pavement to… you know… payment at the county level or local politics. But the other thing is, there's so much money required to run for state representatives, state senator, and God knows I can tell you there's a lot of money to run for congress. And given that, you are much more dependent on the interest groups who fund campaigns, and there are no raging moderates out there willing

to open up their checkbook (laughter). And I can tell you, having gone through a packed trip of Washington, the financial consultant that came with me kept yelling at me, "Don't be honest!" use those three sentences, don't get into any– they don't want to hear anything other than you're going to do that one thing that you agree with them on, it was…umm… in many respects, it was disheartening. So basically, if you have 435 people in the House, all who have to raise at least a million dollars per campaign cycle, some of them maybe even more than that, they're going to be beholden to special interests regardless of whether or not they're a social issue or corporate special interest or whoever. And so they feel the need to be a mouthpiece in order to make sure they deliver on that and I think that's unfortunate, that plus campaign consultants who are consistently going to tell you, you know, if you can't fit it on to two bumper stickers, be quiet, you'll lose everybody (laughter). Boil it down, keep it simple, tactically, screw the opposition, you know, figure out a way to do that. And I think that's unfortunate. You have less of that at the local level. I think that's true.

Interviewer: Whatever happened to the idea of Social Security as a safety net?

**Shaw**: Several responses, a part of it was in early 1970s when congress institutionalized annual COLAs, Cost of Living Adjustments. Up to that point, congress had given cost of living adjustments on a periodic basis. They tend it just before the beginning of Christmas, not an accident, but somebody irregular, that built of course on the notion of the 1960s of addressing senior poverty, senior poverty/senior citizen poverty rates were horrendous and the war on poverty, you can say what you want about that, one of the things which it did was to dramatically reduce senior citizen poverty and Medicare, Medicaid and the institutionalization of COLAs in the early 70s was part of that. That of course in turn builds expectations. Right? People are like, "oh give me this thing, I like that, give me more of that!" So that was part of it.

Another part of it though, why is it the feet of folks now who argue for building this sort of "ownership society" is the phrase that's sort of kicked around now right. The idea behind that sounds intuitively appealing, but it's a bit of a taunt to people who really need that program because people who desperately need Social Security and retirement have not been in a position to develop ownership of much resources through their working years and so–but was that objection notwithstanding, it's still the case that the more we talk about privatizing wealth, the more we are tempted to get away from Social Security as a safety net.

I think one of the implications of the war on poverty and the efforts that followed have been a growing resentment of actually trying to help poor people and even though we've achieved some success in there, there's resentment about that because Americans love this myth of "up-by-the-bootstraps" individualism. I think we forget where we came from and so people have this notion that– it connects with the idea that Americans are ideologically conservative but programmatically liberal. We profess these sort of individualistic conservative values but when it comes down to the programs, we want those. And so, there's this tension that runs through us as well. I don't know that there's a simple answer, I think there's been an evolution to this changing way that we view Social Security. And that's probably not a complete answer to your question, but I hope it's at least partial.

Interviewer: Who decides which drugs appear on the Medicare Part D formulary?

**Swanlund**: Well there would actually be forty different formularies, there's just at least 40 and those criteria I gave you were guidelines and actually criteria that the 40 formulaires had to establish, so 40 different plans. So what's in that book, I think it's called, *Medicare in You*, is that the name of that book?

**Shaw**: Short title, long book, huh?

**Swanlund**: And like I said, a lot of people had not gotten it, those formularies should be listed in there so that the older adult is supposed to make an informed decision between November 15th and May 15th, as to which–

**Renner**: What exactly is not in the book that is in the law that is prohibited that we do here at Illinois Wesleyan University, that you do at McLean County, that most businesses do, that the defense department does, the veteran administration does, and that is they use numbers to negotiate lower prices with the drug company, with providers, and that is expressly prohibited by this law and that's why cost containment is not part of the picture.

**Swanlund**: –right.

**Interviewer**: Is there a problem with cost shifting in the new Medicare plan?

**Shaw**: Presumably at some point, corporations will rebel. I mean here at Illinois Wesleyan two years back, we had a 15% increase in our health insurance premium, contrasted with the cost of living rates in our salary equal to the rate of inflation. At some point, you start losing ground and at some point I'm going to hold some faith that the companies are going to make something, they're going to shake things up and make something happen, but I don't know when that's going to happen.

**Renner**: It's also difficult from the standpoint of local government. It was a similar situation in McLean County or any local government 75-80%, school districts usually 83% of your budget is toward personal compensation benefits. And when your benefits sigh, particularly health care goes up by double digits and your property taxes go up by 2, 3, 4%, you've got a budget problem every year and it's pretty big.

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