



2004 Elections: How will they impact old age policies?

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BINSTOCK: My name is Bob Binstock, and I am here on behalf of the Public Policy Committee of the Gerontological Society, which is sponsoring this symposium in conjunction with the Alliance for Aging Research, a nonprofit organization here in Washington that many of you may be familiar with.

This program is going to be Webcast as part of the so-called SAGE Crossroads series, which the Alliance for Aging Research puts on.

The project, SAGE Crossroads, is a joint undertaking of *Science* magazine and the Alliance for Aging Research.

For those of you who are interested in maybe seeing yourself on the Webcast or replaying some of this for others, the address for SAGE Crossroads is SAGECrossroads.net. The Webcast will be on November 29.

I am grateful to Debbie Zeldow of the Alliance for Aging Research, who helped us put this together and did a lot of hard work, and helped us to secure some distinguished panelists for this discussion of post-election perspective on the presidential election, and the implications for old-age policies.

Our speakers today, I would like to introduce now, and then call on Sherry to get the introductions out of the way, so you will be familiar with who they are.

On my left is Dean Rosen, who has served over in the past decade in a variety of senior legal and health policy positions in both the public and private sectors. He has had a hand in nearly every major piece of federal legislation on health care passed during that period, including the recent Medicare Modernization Act of 2003.

Mr. Rosen currently serves as health policy director for U.S. Senator, the Majority Leader, William H. Frist, M.D. From April 2001 until January 2003, he was staff director for the United States Senate Subcommittee on Public Health, which was chaired by Senator Frist, the Senate's only physician.

Before joining the Subcommittee, Mr. Rosen was senior vice president of policy and general counsel for the Health Insurance Association of America. At HIAA, Mr. Rosen played a central

2004 Elections: How will they impact old age policies?

role in the association's policy formation process and also represented the association on all legal matters.

To his left is Robert Rosenblatt, currently a senior fellow at the National Academy of Social Insurance, which I am sure many of you know is a think tank dealing with Social Security, Medicare and related issues.

He's the author of *A Reporter's Guidebook to Social Insurance*, which appears on the academy's Web site, NASI.org. He's a columnist on health care issues for the Web site of the California Health Care Foundation, and he was a Washington correspondent of the *Los Angeles Times* from 1976 to 2002, where he covered economics, health care, and issues dealing with the baby-boom generation.

Finally, and perhaps best—

[Laughter]

BINSTOCK: —we have with us Abigail Trafford, who is the author of *My Time: Making the Most of the Rest of Your Life*, published by Basic Books earlier this year.

The book explores the bonus decades that come after middle age, an unprecedented period of vitality, thanks to the longevity revolution. Ms. Trafford is also chronicling this new life stage in a weekly column entitled, "My Time," that appears in *The Washington Post* health section.

For fourteen years she was *The Post's* health editor, and under her guidance, the health section won ten Penny-Missouri awards for excellence in feature journalism.

So join me in welcoming this panel and we'll start off with Mr. Rosen. What we are going to do is have presentations or discussions for about twenty minutes apiece, fifteen-twenty minutes, and then open things up very much with the audience and maybe back and forth among panel members.

Mr. Rosen?

ROSEN: Thank you. Thank you for having me here. Thanks to SAGE Crossroads and the Alliance for Aging Research. I appreciate being invited today to talk a little bit about post-election perspectives, and where we may be going in the future.

I guess in the previous panel there was a discussion of the election and the results, and the senior vote, and the impact on the election, and we are going to look at slide afterwards. So I am very interested in that.

I do have to say, I think Abigail is the best panelist, too, because my daughter's name is also Abigail. I left her at home today to come here, so I think Abigail is probably going to be the best on, too!

[Laughter]

ROSEN: And also, my mother-in-law is here today, which means two things: One, she reminded me on the way in that she's in the younger category of the aging population—very young category!

And two, it means that you have to be a little bit nice to me today, too!

But I want to talk a little bit about what the election results mean in terms of aging policy, primarily on the health side. Bob is going to probably focus more on some of the Social Security and

entitlement issues, which I'll touch lightly on. But, again, try to look a little bit ahead at what it means.

One thing I should say is that I was up very late last night because the Senate just adjourned for the 108th Congress. We didn't actually finally adjourn. It's a very complicated situation which isn't worth going into. But we just kind of tripped over the finish line on the way out the door in not being able to pass finally the Omnibus Appropriations Bill.

But I sort of feel like we are in a strange interim period, here, between the election and being able to just finally end the 108th Congress and get on with the next one.

I also saw some of the Sunday shows this morning. John McCain was on one of them, and they were already asking him, "Are you going to run for president in 2008?" I think, to his credit, he said, you know, "Jeez, we haven't even inaugurated George W. Bush, yet, so..." We are in sort of this—an interesting and strange period, but I will try to do my best to sort of look ahead.

One, obviously, with the president retaining the White House and the House staying in Republican hands, that obviously will have some significant implications for where we go with health, Social Security entitlement and other policies in the years ahead.

The Senate, where I spend most of my time toiling, is, in some ways, kind of a more interesting scenario because not only did Republicans hold on to the Senate, but we increased our margin from 51-49, essentially, to 55 Republicans, 48 Democrats, and one Independent. While it's not a 60-vote margin, which is sort of a filibuster-proof majority in the Senate, it will mean a big difference. It is very, very hard—really just takes one member or two members of a sometimes unruly caucus to lose discipline or lose control over the agenda. That means there are a lot of things that we couldn't get passed because of the very, very close margins. We did get stymied on a number of things in this Congress, although we had some big successes.

Having 55 votes will be very, very interesting in the Senate. It is the first time in, I guess, about a dozen years it's been that way, and so it will mean, I think, a number of things and have a number of ramifications in terms of our ability to sort of move agenda forward.

It is not—it's a little bit of a blessing and a curse because the public expects that with a Republican president, a Republican House and a Republican Senate with a wider margin, that we'll just be able to get sort of everything done and it will be easy.

But as we saw just last night, when we tried to get out and pass an Intelligence Reform Bill, which we couldn't do, and tried to pass—at least yet—and tried to pass a Omnibus Appropriations Bill, even though it will clearly pass in the next few days—it's not always that easy.

So I think there is a little bit of a lesson there, at the end of the 108th, which will foreshadow next year.

I want to talk about a couple of issues, just again, kind of looking ahead in terms of what we'll be doing or what I think we may be doing, and what general direction things will take. And obviously, let Bob and Abigail share their perspectives, which I think will be interesting to sort of hear the commentary on it.

The first thing I would say, and probably the most significant area where I still think we will see focus in the next couple of years, is in the area of Medicare. I want to talk about that for a second.

The Medicare Prescription Drug and Reform Bill, the Medicare Modernization Act, which passed last Congress, was really the most significant change, the most significant improvement to the Medicare program, since the program was enacted in 1965. It was a major accomplishment in a very divided Congress. It was something that we'd been talking about doing for a long time,

2004 Elections: How will they impact old age policies?

adding drug benefit to Medicare and making some of the improvements that were made in the bill. But it was something that we were able to accomplish last year.

In the Senate, it was a relatively bi-partisan process. It wasn't unanimous, by any stretch of the imagination, but in terms of the leading Democrats on the Finance Committee in the Senate, the Policy Committee in the Senate on the Democratic side, it was more or less a bipartisan accomplishment.

We are going to spend a lot of time, I think, in the next couple of years implementing that bill, trying to do outreach on that bill, trying to do education on that bill, and trying to implement the law that provides the promised benefits to seniors.

So the first time there is a voluntary prescription drug benefit for seniors, which will begin in 2006, which means that in the year 2005 there will be a lot of focus and a lot of activity on implementing it.

I think—back to my first point, the reelection of the president and the—basically maintaining control of both the House and the Senate, means that I think, unlike the situation we would have had had Senator Kerry been elected and/or the Senate flipped to the Democrats, I think you will see things proceed along the path that we started. There will clearly be some bumps in the road as there always are. No law is perfect. This one is not perfect by a long shot.

But it is a major improvement and, again, I think we will move along toward doing it.

Some of the other things people don't focus on, because you focus a lot on the drug benefit, which is a big piece, is better prevention in the law, screening for cardiovascular and diabetes, a "Welcome to Medicare" physical for seniors who turn sixty-five. Also, there is significant additional funding for rural health care providers, a greater focus not only on prevention but also on disease management, chronic care management, paying for performance.

I think you will start to see—and I mention this not only because we are going to implement the law, but I think that a number of these things are trends in terms of where I expect that we will look in terms of both entitlement reform more broadly and Medicare more specifically in the future—a focus on prevention, on disease management, on chronic care management, on paying for performance.

For the first time, we linked payment to hospitals in the bill to quality reporting. It was a relatively small step, but it's the first time we have ever done that. We usually just pay according to a formula and the hospitals and the physicians provide whatever care they have.

We have very little by way of measuring that, but I think that you will see that built upon in the future.

We also, for the first time, and I know that this was controversial with a number of folks, began to means test or affluence test the program itself, first in terms of the Part B premium that you will pay for physicians, so that the higher income, the top 3 percent of folks in Medicare income-wise will begin, gradually, over time, to begin paying more for their premium than lower income seniors.

In fact, we also means tested the benefit, the drug benefit itself. Why did we do that? I want to talk about it for a second, because I think it's an important perspective, and I think it says a lot about where we may be heading on health policy and on retirement and aging policy, as well.

The bill spent \$400 billion—will spend \$400 billion over the next ten years on the drug benefit alone. That's a staggering sum. It's the largest entitlement expansion, as I said, since 1965.

2004 Elections: How will they impact old age policies?

Yet, it's only going to cover about a quarter or a fifth of all seniors' drug costs over the next ten years. Seniors are expected to spend about a trillion dollars on prescription drugs over that decade.

So what did Congress do? And we've been criticized for this, where we left gaps in the benefit and the infamous donut hole in the benefit.

But if you look at what Congress did, the benefit is heavily focused on folks with lower incomes, and heavily focused on seniors who have higher drug costs, catastrophic costs. So for seniors who have lower incomes, for example, there will be no premium or very low premiums, no gap in coverage, and very, very low co-pays, either one or three dollars or at the most five dollars for brand-name drugs.

So the benefit for everybody else does have some gaps. There is no question about it. But it picks up about 75 percent of costs up to about \$2,000 and then picks up greater costs once you hit a catastrophic cap. But it is very, very focused again on trying to take that \$400 billion, which is a huge sum, particularly looking at the deficit situation, and trying to focus it where there is the greatest need.

We are going to move forward and implement that law. I think it will move at a pace more or less as planned. And in the mean time, folks do have the opportunity to get an interim coverage with a drug card, which has been confusing to seniors, but it was important, I think, to Congress and to the president to sort of get something out right of way.

The card will sort of segue into the broader program beginning in 2006. But for the remainder of 2005, the drug card will be available.

I'll just say one quick thing about it, and then just generally talk about entitlements. But again, a lot of sort of criticism about it was confusing to seniors to choose among all these various discount cards. There is no question that the program could have been simpler.

This is what happens when we enacted the law less than one year ago—in fact, next year is the one-year anniversary of the bill passing the House and the Senate.

Within six months we had these drug discount cards available. We had enrollment events in Tennessee. One woman who participated in an event in Chattanooga or Knoxville, I should say, came up to us and said, you know, she had not come because she had been so confused about all the news she'd seen and all the criticism of the drug card. She happened to be a low-income senior. When she enrolled she saved about 86 percent, she saved about 86 percent a year off her drug card. She is going to save about \$230 a month, almost \$3,000 a year.

So there are significant savings. It's one of those areas where I am hopeful that, post-election, Republicans and Democrats in the aging community and others are going to be able to work together to try to educate seniors about the benefits that are available—that would be a significant focus.

Let me just mention two other quick things, and then I will sit down. One, beyond Medicare, I wanted to talk just a second about the general direction that I think health policy and retirement policy will take post election looking at the landscape.

Then I did want to talk for a moment about some of these other issues, including entitlements. First of all, the president talked a fair amount about it during the campaign, but I think that what you will see is, particularly in terms of health care, a focus that is much more on ownership and control, a focus more on the individual patient and the individual consumer, and as well as a system that is more provider friendly.

2004 Elections: How will they impact old age policies?

I think there's a recognition, and you see some of this in Medicare, that in—at least under a Republican Congress and a Republican president—that individuals, given the right information, given the right financial support, given the right tools, are able to make decisions generally for themselves, in terms of what kind of health care is best for their needs. This carries over, I think, in retirement policy, too.

But those tools are absolutely critical. That's why beginning to measure quality in the Medicare program, providing that information is critically important. That's why moving forward with electronic health records and electronic prescribing of drugs is critically important, in terms of trying to make that ownership and that control and that choice really real and really meaningful for folks.

At the same time, and this is true of Medicare as well, you don't hear a lot of rhetoric any more, at least you don't hear it from Bill Frist, about government not having a role. I mean, this is, again, a Republican Congress that enacted the largest entitlement expansion in two generations.

There is clearly a role for government, and there's clearly a role for government to provide those tools, but also that safety net. I think that's a general direction you'll see moving forward on some of the health care policy, greater health savings accounts, outreach to children, help in terms of liability costs, and help in terms of small business.

On the entitlement side, and I did want to talk about that for just a second, where are we going to go? And I know, as I said, Bob's going to talk about this a little bit more.

Clearly, I think we've started along a path in Medicare. I don't see us turning 180 degrees and starting to have massive cuts in the program, at least in the short term. But I do think that we are going to continue along this path. We are going to require everyone, I think, to pay a little bit more.

We are going to look very closely at what kind of quality we are getting from our providers. I think we are going to begin, and I am certainly not so security expert (sic) but I think clearly you are going to start to talk about a more comprehensive entitlement reform, looking at Medicaid, in addition to Medicare, and looking at Social Security.

I don't want to talk about the details. I know Bob will. One, I don't know the details yet. The president hasn't proposed it. But a couple of facts, just to say, why are we doing this now?

The president took office. We had a six trillion dollar surplus in the year 2000. We now have a three trillion dollar deficit. That's number one.

Number two, I think you've probably heard or you've read that in the Omnibus Bill that we passed last night, the Appropriations Bill, we generally held spending to about 1 percent on most of the domestic programs, with the exception of Defense and Homeland Security.

But even if we are to stay very fiscally conservative on all of those discretionary spending programs, that's still only about 17 percent of the overall budget. So if you are going to begin to look at entitlements, you are going to look at deficit. If you are going to look at where we are going in terms of a country, in terms of our fiscal policy, you really do need to at least examine these programs.

In addition to that, obviously you have a generational shift. We've got about 40 million seniors today, with the sort of foothills of the baby boom generation, and will for the next decade or so 77 million, so the program is going to essentially double and, at the same time, the number of active workers who are paying into these programs is not going to grow.

So there is a significant imperative to look at it. I think there is a moral imperative. I think we will.

Some additional issues I think we'll focus on, and these are things that Senator Frist has said that he wants to try to accomplish before we go—I think we will begin to look more at giving people more tools for long-term care. We, obviously, I don't think have the resources or the—really, right now, the political will to set up a massive new government sort of long-term care program. But there are some bipartisan bills that have been introduced in the last couple years that have now passed, that I think provide grounds for some real progress in terms of providing some support for caregivers through either tax credit or tax exclusion, as well as increased tax benefits, above-the-line deduction for long-term care. I think that we will focus much more on that, particularly as we get into Medicaid policy.

Because, obviously, people, when they think about Medicaid, think about kids and pregnant women, low-income families. But really, the Medicaid program, even though it's about one-third of the people, two-thirds of the cost is in the long-term care area.

Clearly, as we get into Medicaid reform and we get into some of the entitlement issues that I'm not sure will pass, but will be addressed, we are going to clearly have to get into these issues, not just of acute care health care, but also into long-term care.

Let me stop there because there will be a number of other things, I think, on our plate. What I wanted to do generally was sort of talk a little bit about Medicare and where I see that going, entitlements, and I think, more importantly, try to give you a general direction and philosophy as to where the Republicans may go.

So I look forward to the other comments, and will be happy to take questions. Thank you.

[Applause]

BINSTOCK: Many thanks, Dean. Now we will hear from Bob Rosenblatt.

ROSENBLATT: Thank you. It's a pleasure to be here. I spent my career as a reporter, and reporters love to speculate and gossip. So it's not too soon to talk about the 2008 elections!

[Laughter]

ROSENBLATT: Dean works for somebody who is very important, very smart, a physician, so he understands these issues personally as well as professionally as senatorially. If he does a good job, and if somehow Social Security is reformed, whatever you think that means, and Medicare is put on a sound footing, Bill Frist, in 2008 becomes a very strong contender for the Republican nomination.

That should be in the back of everyone's mind as you watch what unfolds for the next four years.

I want to talk a little bit about values, which has been overused in terms of this election. But these issues will become about values and the values are this:

There are two ways to look at it. You can believe in the ability of government to do good things for people, to provide a safety net, to take care of the poor, to provide protection for the uncertainties that life brings. Then you would say you believe in Franklin Roosevelt, and Lyndon Johnson and the New Deal and Medicare and Social Security.

Or, you can believe—and all of us have both of these beliefs—that the promise of America is individualism, that all of us came from people who came to America to get away from something, to get away from persecution, from the czar, whatever. And that America gives you the chance to make it on your own unfettered. So if you believe that, you don't like the government, you don't like these social programs.

We are now in a period of our history where people who believe in the individual anti-government view are in the ascendant. The Democratic Party had about a 20-point advantage a generation ago. About 20 percentage points more people identified as Democrats than Republicans. Now, it's about even. Just about even. And the Republicans—there's just about parity in the state legislative seats.

The president of the United States, who was elected to a second term, is a strong believer in the individual point of view. And the conservative—the right wing of his party is an even stronger believer in that.

If any of you have a chance to see Grover Norquist on television—you should see him. He's sort of the philosopher bad boy of the Republican right. He's very colorful in his quotes. Anyway, what Grover Norquist says is, "We want to get the country back to where it was before that thug, Teddy Roosevelt, began attacking the business community!"

[Laughter]

ROSENBLATT: And Grover Norquist says, "Our ideal voter is someone, is a couple who home-schools their children and have a concealed weapon carry permit."

AUDIENCE: That's it!!

ROSENBLATT: They don't want the government messing with them. OK. So how does the ownership society fit into this? That basically you have the stake in your retirement and in your health care.

In retirement you have an individual account under Society Security. In health care you join a Medicare HMO. Or, if you are below Medicare age, you take out a health savings account, which is a high-deductible insurance policy combined with a retirement account. And if you stay healthy and you invest it well, that money will be yours to spend when you are sixty-five, along with your regular IRAs.

So here is what I think is going to happen. Of course, if I am wrong, forget about it; but if it turns out I'm right, then you can say, "Wow, that guy was really smart!"

[Laughter]

I don't have any leaks from the White House, but I know some of the people who work there, and I have known them in different incarnations. I think this is what they are going to do:

First, on Social Security. Any plan will exempt people fifty-five and over, and when they talked about it last time, they used that because that's when you sort of start thinking about maybe you might retire. At sixty, you get seriously thinking about it. But fifty-five is when you begin to think about it.

So any plan fifty-five and up untouched, stay in the present system, get your benefits.

If you are under fifty-five you would be a voluntary participant in these accounts. It's not clear what it would be. It might be, let's say, 2 percentage points of your payroll taxes. If something like this, I think, would be very hard to pass in a year or two. I think what the president can do is use the bully pulpit and push this idea so that it becomes popular with younger voters.

I don't think he can get it done in 2005, and then in 2006 there is another election. So I think he can push it hard and sort of get the acceptance, the idea of accepting it.

2004 Elections: How will they impact old age policies?

Of course, the Democrats will say, "It's terrible! It wrecks the budget, because it will add two trillion dollars to the cost to the deficit." Which is true. But if you are a believer in this, as Grover Norquist is, he will say, "Well, Social Security is \$14 trillion in deficit for the indefinite future, so \$2 trillion doesn't matter."

So again, it's not about numbers. It's about values. Either you believe Social Security is a good way to take care of people in retirement, or you don't. So if you are watching it, don't get bogged down in the numbers.

As somebody once said, "First we pick our political party, usually influenced by how we grow up. Then we find the arguments to explain why our candidate is really a good one."

So this is, I think, really a values thing.

If you are a defender of Social Security, you can make very plausible arguments about how you tweak the system. You raise the wage base, and you do a few other things and the system is in balance forever. If you don't like it, you say, "It'll collapse."

The system—the Social Security trustees put out a report every year which has to project it for 75 years in the future, which is kind of silly, because you can't—no one knows what anything will be like.

Anyway, this is over Social Security. That will be that fight. And something like this, I think because it's such a big change, couldn't just be pushed through with a party-line Republican vote. It would have to get a consensus. So there will be a lot of discussion, but I don't think anything will be done on Social Security.

There is another retirement issue which is very important, but for some reason only gets mentioned on the business pages. There is something called the Pension Benefit Guarantee Corporation, which guarantees the defined benefit pension of 41 million workers.

The legacy companies like United Airlines and US Airways are in trouble because they can't compete with the low-cost nonunion carriers. So they are walking away from their pensions, dumping it on the federal government. So the federal government may have to bail out a lot of these companies.

Right now there are a million people who are getting their pensions through the federal government from bailed-out companies. This will become—I am surprised this hasn't become a political issue yet. It seems to just be on business pages.

I have a neighbor who spent his career working for US Airways—about 30 years, and he has four or five more to go. He was going to get a pension of \$70,000 a year, which is a wonderful pension. US Airways dumped its pension plan. Under the government bailout, you can only—the most you can get is \$44,000 but—pilots have to retire at sixty, which is considered early retirement under federal rules, so he is going to get \$28,000.

Needless to say, he now has his resume out because \$28,000 is a big drop from \$70,000.

All right. So that's the other pension issue that is going to be important to keep a look at, to keep an eye on in this Congress.

On health care, Dean explained a lot of what has gone on with Medicare and the Prescription Drug Bill.

A couple of other things to keep in mind: Medicare is a very fast growing part of the budget. It makes the Social Security problem look easy. They are thinking about, to control the budget,

maybe having a tougher—cutting back payments to providers. They can't do it to doctors, because they already tried to do it and the doctors successfully lobbied. They are going to get an increase, rather than a cut back.

So they are probably going to go after hospitals. And that—I don't know how that will come out, because the hospitals have an extremely powerful lobby of their own. But one of the things the administration would like to do is slow down the growth of Medicare because of budget considerations.

The other big issue is Medicaid, which covers 51 million people. Medicaid now costs—this is an amazing thing—for the first time Medicaid now costs the states as much as education. Add up everything the states spend from K-12, and colleges and Medicaid costs just as much. In Tennessee, where they are having a big fight about TennCare, that program—Tennessee's version of Medicaid—takes 33 percent of the state budget. Nobody knows what to do about this, because as unemployment goes up people that lose their jobs lose their health insurance, if they get poor enough they go on Medicaid.

There are rumors going around that the administration is going to try to block grant Medicaid as a budget savings. In other words, say to the states, "Here is the dollar limit on what you get. That, and no more."

The difference is, right now Medicaid is an entitlement. If you meet the income requirements you qualify. It doesn't matter how many people there are or what the spending is. Under a block grant you get X billion/million dollars and you've got to decide which people to cut off.

This fight will involve, will be a very interesting one, because the advocates for Medicaid, the policy people who work for the poor, will be aligned with the drug companies and the hospital companies, and the hospitals, and the doctors, because they have a common interest. If Medicaid is block granted, the drug companies don't make as much as they would and the hospitals don't see—don't get paid for as many people.

So the liberals and the business interests have a common concern. Right now there are meetings going on in Washington where they are nervously trying to figure out if the administration's going to propose a block grant.

So that will be a huge fight, and, again, nobody has figured out how to control the cost of medical care. It's just—we have all of these wonderful procedures and drugs, which enable people to live longer, but they cost a lot of money.

On the Medicare drug bill, Senator Frist was particularly important because without his participation it wouldn't have passed.

Senator Frist and Speaker Hastert spent a lot of time wooing Bill Novelli, the head of AARP, to persuade him to back their bill. In fact, they took the bill out of the hands of Congressman Thomas, who was the head of the subcommittee, and they gave AARP some important concessions. In return, they got passage of the bill.

The drug benefit is going to be—is very good, helps a lot of poor people. It's not all that good for the middle class because of the donut hole, and that's why so many of the AARP members were upset with it.

The Democrats were particularly angry and got almost hysterical about it because the president took away what would have been one of their best issues. But they were successful in basically making so much noise about it that they neutralized the Republicans getting any advantage from it. So there was no—there was no advantage to either party in the Medicare bill.

But I would point out to those of you in the advocacy community, many of whom I know I've discussed this with, is that you shouldn't automatically assume that if the Democrats say something is good, or bad, that that makes it so. I would point out that this bill gives a huge amount of money to pay for drugs for poor people, and this was not in Medicare before and because it happened under a Republican administration, perhaps you should think about giving credit where credit is due.

Next year the full benefit will take effect for all—for everyone on Medicare. It is very complicated. I would recommend that those of you who have a personal or professional interest go to accesstobenefits.org, which is a Web site by a coalition of groups trying to explain this. Or benefitscheckup.org, run by the NCOA. And you can actually punch in the drugs that people take, and even the location that the drug store in your city—and find it. It's not that easy. I spent two or three hours on it, and I am going to be spending part of Thanksgiving with my ninety-two-year-old mother-in-law and her eighty-seven-year-old sister figuring out exactly which drug stores to go to. But you can—you can get help that way.

The other thing is, when in doubt check out Costco. This is an unsolicited commercial, and I don't know why it is, but Costco has amazingly good prices for prescription drugs.

Anyway, I will end on that note. But keep in mind that all these fights are about government, about how we will pay for the retirement of the baby boom and the health care of the baby boom, and it's always going to be about should you and your family and your children pay for it, or should the government pay for it? The tension between the two will determine our politics probably for the next thirty years. I'm glad to argue or entertain questions. Thank you very much.

[Applause]

BINSTOCK: Thank you, Bob. And now Abigail. We look forward to hearing what you have to say.

TRAFFORD: Well, now, I'm going to be completely provocative and throw out that I think the elections didn't address aging issues at all! By that I mean there was—we didn't address, in a sense, what I think is the new face of aging. What's really going on with longevity?

I mean, you all know this. Researchers say that we have gained ten biological years in the last couple of generations; we have recalibrated the calendar of aging. What this means is that a sixty- or a seventy- or an eighty-year-old today, on average, is ten or so years younger than the grandparents.

We haven't figured out how our policies need to change. What policies need to change? What needs to be strengthened? What new policies need to be brought in to address this, in a sense, changing face of aging?

Instead, we still go with a lot of the stereotypes of whom we are talking about when we talk about older Americans. I have to say that not—in the presidential campaign, neither one got it. Now, you would notice that when they would talk about seniors and senior issues, there was always the image of seniors wearing Medicaid—Medicare t-shirts, sort of, with their hand out. And the candidates say, "You know, we are going to take care of seniors. My plan's going to be better than the other guy's plan."

So older people were seen, are seen as a problem and only as a problem.

What I'd like to throw out is what's changed in our society is that older people aren't just a problem. In fact, older people with this increased health can be an asset. How do we factor that into the policies that we are going to create over the next four, eight, twenty years?

2004 Elections: How will they impact old age policies?

It's sort of is a reverse. It's sort of like, "Don't just ask what the country can do for seniors. Let's ask what the seniors can do for the country."

I, frankly, don't see a lot of leadership and imagination to come up with policies that enhance the potential in, and contribution of, older Americans, you know, at the same time maintaining the safety net of the traditional programs.

There are few things that I saw. I don't know if you all saw Granny Voter. But this is a group of grannies who wanted to say, "Hey. If you are talking about issues that are meaningful to us, don't just talk about Medicare and Social Security. We want you to talk about the deficit, because we take the long view. We are worried about our grandchildren. Let's talk about education as a senior issue, because we know that education is important for grandchildren." I can go on—environment.

I am just trying to sort of provoke all of us to think of older people in a different way.

As to what do I see happening since the election? Well, sort of the trends, I think, on the ground—certainly in gerontology, certain among aging agencies—that I see sort of a tension building up with this dual mission.

I mean, obviously, a main goal is serving the very frail fraction. This is about social justice. But there is this other that keeps cropping up, which is, how do you engage the healthy majority? This is about opportunity.

I think that we are going to go through sort of a long shake out as we try to find both policies and programs and agencies to, in a sense, meet these dual challenges.

I am going to give an example of this, of what I hear is going on with senior centers, that a lot of them are struggling with just the term "senior." They don't like what "senior" says to them. So what they did in Arizona is they've started sort of a public-private partnership with public—with the libraries—and created—they call them life-option cyber cafes in public libraries!

[Laughter]

TRAFFORD: But, in a sense, they also provide additional services of senior centers. I think a lot of—in other words there is a lot of a churn going on, which I think is very exciting.

There is a dual mission here. We are sort of searching for both leadership and programs, and agencies too, in a sense, to recast how we are going to support what I think is the new face of aging.

But what do I see in the elections? I see that probably the action is going to happen outside of Washington. It's going to be at the local level and grassroots level. In Washington we are much too preoccupied with the war and the economy and traditional programs.

What I fear in this vacuum is that when we talk about the healthy aging, is that we'll say, "Oh, well, I guess they don't need Medicare. We can cut it more for them." Or even, you know, "We'll let them wait longer before they are going to get their benefits."

I think that—I hope we don't go down that route, because really, these programs—the other thing that I see in going around and sort of looking at this new face of aging, is how wonderful these programs have been in changing the lives of older Americans.

So here's what would be my hope: I would love to hear a president get up and launch a program, sort of like they launched the Peace Corps, as a way of saying, "We want some national service from talented people to give to their country," and have the starting age be fifty. Use people who

2004 Elections: How will they impact old age policies?

are coming out of retirement or who, in the whole sort of insecurity of the workplace, are fifty to fifty-five and need work, and have something to give.

I would love to see sort of a Peace Corps program, an AmeriCorps program. Now, we have AmeriCorps, but it is more focused on youth. But there is a fraction; about 10 percent are people over fifty.

You might say, "Well, why do they need an educational credit?" Well, guess what? Of course they want an educational credit. They'd love to get an educational credit at fifty so they can get—go to get new training or take a new course. There is also a system of turning this educational credit over to your grandchildren.

This is very popular. I would say that this would be a great program, and I would love to see some action that sort of addresses this new face of aging.

I'd love to hear that education departments are looking to life-long learning and not just looking at education as, you know, for something for young people. Let's expand it out.

Then I go to Medicare. See, I take a totally different view, in a way, of Medicare. I think Medicare's been such a success that—but look at it, certainly, amend it, reform it. But this is a great program. A lot of people in their fifties, who are—get out of their workplace or lose their job or are forced to retire early—one of the biggest problems is health insurance.

Well, I think—why don't we take a success, which is Medicare and extend it out to people who are fifty-five? I mean, these are—I don't expect any of this, really, in the short term, because I think our country is so much focused on other things. But I throw out these types of programs as a way of saying, "When we think about aging issues, let's think about potential."

Of course we have to take care of the needy among us. That's a given. But we also have this new opportunity, in legislation and in programs and in dialogue, to talk about, "OK, what are we going to do now that we have much healthier generations of older people?"

Then, instead, when I hear always that again is looked on as a problem, as in, "What are we going to do with the aging of the population?" Well, you know, maybe it's time to say, "Hey, there's opportunity here. Isn't it great? We've got an aging population. Let's see what we can do with it."

So that's my challenge to the political scene.

[Applause]

BINSTOCK: Well, I think we've been given a lot of food for thought and questions here. We have plenty of time for interaction, both with audience and panel, and among the panelists that things can get heated up on some issues.

I see there is a question in the back.

AUDIENCE MEMBER: My question is for Mr. Rosen. Despite the presence of your mother-in-law in the room, it's a little pointed.

ROESN: You can be mean.

AUDIENCE MEMBER: I'm sorry?

ROSEN: No, I'm saying you can—you can be as hard as you want. It's all right.

AUDIENCE MEMBER: OK. You mentioned that the Medicare Modernization Act of 2003 is not perfect. I find myself in full agreement with your statement.

I'd like you to particularly address a provision of that bill which has been sticking in the craw of a lot of people who didn't think it was a wise policy, and that's the provision that prohibits Medicare from negotiating with the pharmaceutical companies for price. I would like you to address that in light of the established pattern of pharmaceutical industry contributions, particularly to the Republican party.

Now, I think that Mr. Rosenblatt used the phrase "giving the credit where credit is due." But I don't think that this is exactly what he had in mind. So please help me with this.

ROSEN: Sure. Well, I am glad we agree on the first point—that the program's not perfect. I suspect that may be the only thing we agree on about the Medicare law.

But let me address your question. There's a provision in the Medicare bill that's gotten a lot of focus in the light of the election, that said that Medicare—the Medicare program shouldn't interfere with negotiations between private pharmacy benefit managers or health insurers or health plans and the drug companies.

And that's what the provision said. The philosophy, the—I think the political attack against that provision was that somehow the folks who wrote this bill were trying to protect the drug companies, and, therefore, they wanted to keep drug prices high. So they would do anything, including putting a provision in that said that the government should just keep its hands off and just pay whatever the drug companies charge. So that I think, is sort of the argument that has been out there, I guess, that sort of—I guess it's sort of background.

The reality is, and I think this is sort of fundamental to understanding how the program is set up. The reality is that the drug benefit is different, is going to be different. It's going to be administered differently than the way we generally pay out Medicare for hospitals, the way we generally pay for durable medical equipment or other benefits.

It is going to be paid for by— basically unleashing private sector competition to negotiate with drug companies—the whole structure of the bill. And by the way, the very first drug bill that was introduced by the democrats, was introduced a couple of Congresses ago by Senator Daschle, when he was the Majority Leader of the Senate, and by the leadership in the House, the Democratic leadership in the House at the time, had the same exact provision. The reason was nothing nefarious, I don't believe, but the reason was the whole structure of these bills didn't have the government in the driver's seat of defining what kinds of benefits people could get in terms of particular drugs or particular formularies for drugs or directly negotiate. What it did was it basically set the rules by and which private companies, pharmacy benefit managers, HMOs and insurance companies, could go out and negotiate and compete and the philosophy which, granted, people agree with in our Party and some people disagree with.

But again, this was all the bills—if you go back and look at them, was that private sector was going to do a better job of negotiating prices than Medicare will. That was the philosophy. More the facts behind it. So we submitted a bill to the CBO. We asked them. If you go to the Congressional Budget Office Web site, you can see there is a letter to my boss, Senator Frist, and we asked them, "If you took out this provision and you didn't have this provision and it is not a provision of the bill, would it save Medicare money? Would we somehow alleviate all the benefits with the government negotiation? Would it lower costs and then therefore reduce government spending? The answer was, "No. It wouldn't save one penny." That's the document. Folks can go look at it and CBO on CBO's Web site.

You know, they could be wrong. But the nonpartisan experts looked at it and said that the philosophy, and we don't know because the bill hasn't been implemented yet, but at least the facts on the ground were right, that where the private sector competes, seniors are going to win.

One other fact—I will mention it again. People who argue with the philosophy, as there are no doubt folks in this room—and in other places—that believe that the government will do a better job in negotiating lower rates. No question that that's a philosophy. But I guess the other fact I'd throw in is that if you just look at the three biggest pharmacy benefit management firms in the country right now, each one of them, in terms of their private sector business, either before—they may have Medicare beneficiaries enrolled, each one of them has well in excess of 40 million people that they now negotiate on behalf of.

So the argument that you could have government come in and say, "We've got 40 million people. Give us your best price." I guess my answer would be, when you've got, let's just say five companies or three companies that right now 80 million or 100 million or 60 million people that they are negotiating on behalf of—and they added to that 10 million or 5 million or 20 million seniors—end up competing, by the way, against other competitors who offer the lowest price, I think they are going to do a better job.

That is the philosophy of the bill and now it's the philosophy of Democrat bills and Republican bills going way back, regardless of where their campaign contributions are coming from.

AUDIENCE MEMBER: Thank you. I appreciate many other people have comments. I just thought I'd —let's say that the experience with the Veteran's Administration would paint a very different picture.

First of all, the three large negotiators that you have just mentioned have not been successful at holding down drug prices for the private consumer. The Veteran's Administration purchasing these drugs from the drug companies does represent a significant savings. So there is a pattern that may suggest the government is capable of doing good negotiating.

ROSEN: I think that the veteran's program is interesting because the veteran's program, and I think, again, you can say that that is the way we should have gone with Medicare, but when both did that—both Republicans and Democrats said this unanimously, that the veteran's program doesn't negotiate. The veteran's program basically says that if you don't sell at this price, the best price that we're able to negotiate, you are going to set it a—you're going to pay—I'm sorry, the government's going to pay a predetermined amount. So it's a price cap.

Frankly, again, rightly or wrongly, the philosophy was we weren't going to have a price cap in Medicare for prescription drugs, and folks on both sides of the aisle felt strongly about it.

BINSTOCK: Bob or Abigail? Did you want to say anything in relation to that particular item? Ok, Then we'll go to the -.

AUDIENCE MEMBER: As a reality-based scientist, I try to bring a little historical perspective to—I am sure it is familiar to most people in the audience—of what life was like before Social Security, before Medicare.

Medicare was enacted—I was a professor in high school and I sort of remember and I did research for my dissertation on why Social Security was enacted in the first place. Poor houses, Alms houses people dying. What we have—what Abigail has been talking about—is the fruit of all of these activities, the phrase that leaps to mind, "Killing the goose that laid the golden egg."

I prefer the policy to be driven by evidence, not by theory, possibility, philosophy. The evidence is these programs have worked. They have worked tremendously and it is not inevitable. There are many countries in the world that don't have higher life expectancy, that aren't increasing the gap between mortality and the onset of morbidity. Jim Fries gave a talk yesterday. Every year it's going down. Mortality is going down 1 percent a year. Morbidity disability is going down 2 percent a year. It's—just—does anyone think this just happened?

This is what has been done 'til now. You reverse it? You lose it! That's all I wanted to say.

BINSTOCK: Any responses to that? Bob?

ROSENBLATT: Nobody doubts the efficacy of the programs. In fact, Social Security, when the poverty rate among people over sixty-five was 35 percent in 1959, and then when the automatic cost-of-living adjustments came in 1972 it had a huge effect and the rate of poverty is now 10 percent lower than that of the general population, and Medicare has been a great boon.

Nobody's contesting that. The argument, and that's why I called it values, the argument is about what can, should, will be done to these programs in the future. That's the basis on which it's being fought. Nobody's saying, "Let's bring back alms houses."

There is a real argument over the best way to do it for the future, and that is, again, I don't think one can't prove that with number. One can only try to persuade the majority of the American people as to the point of view.

It's very much a philosophical debate.

BINSTOCK: Well, I said I wouldn't be an interlocutor like Morton Kondracke would have been. But I think I will be able to a little there.

Maybe nobody's thinking about work houses and poor houses and boarding out poor, elderly people to the lowest bidder in the community. But what if the consequences of the programming styles people are thinking about, in fact, lead to that? Which is, I think, the point being made by the questioner.

ROSENBLATT: Um, What if it leads to that? Well, that's obviously something we don't want to happen.

The argument, for example, about Social Security and private accounts—most people are pretty bad at investing. Most people think, as I can tell you from my own experience, most people make pretty bad choices.

The question is, how much is the risk of losing the money, is that justified by the philosophy? And I think that the hope is that people make the right choices. They may not. They may not.

But we are going to have this argument.

(INAUDIBLE CROSS COLLOQUY)

AUDIENCE MEMBER: That's crazy. They don't make the right choices, and then what?

ROSENBLATT: Well, as a matter of fact—

AUDIENCE MEMBER: They die?

ROSENBLATT: No. Wait a minute. As a matter of fact, in the privatization plans there is sort of a kind of—I won't say sneaky—but there is a sort of behind-the-scenes recognition that people don't really make all that good choices. So all of the privatization proposals will really limit your range of investments to four or five basic mutual funds.

So they are saying, "Well, we'll give you choice but your choice will have to go into one of these, and then it's limited."

So I think even the advocates of privatization, will—when pressed, they won't give people complete freedom.

ROSEN: I guess let me—let me add one thing at the risk of bodily harm.

[Laughter]

ROSEN: It is that I think the—I think if you look at Medicare as an example, thinking that it's sort of ironic that—that we expanded Medicare by, depending on who you believe, \$400—\$500 billion within the next decade, and the concerns that somehow we are going to hurt people by losing that because they are not getting as much as they would like in a lot of cases.

But I think the issue is that there is, in my view, always going to be a safety net and I think if you listen to folks in both parties, as Bob has said, there are a few voices, but there are very few, that are saying, "We never ought to have these programs in the first place. These programs are terrible programs." You really don't hear that, you hear, I think, "these are great programs, they have done exactly what you said." But that facts on the ground are changing. When Medicare was created, hospital stays and a physician's knife were the most important tools. Right now if you ask almost any physician in America, prescription drugs are at least as important as a surgeon's knife. At the time Medicare was created and Social Security was created we had four workers for every retiree. Now it's close to three to one and then two to one. The point is, the fact is things are changing. Philosophies were fought out, they were fought out in 1965. The facts are changing and there clearly is going to have to be a balance between protecting the health, security, and financial security (inaudible)...

TRAFFORD: ...making choices. And I think as Bob pointed out, you know, if you are not good at investing in the stock market, you probably are not going to make choices about your investments. It is the same with health care. I mean, I think it's hard to make health choices today.

When we talk about giving people tools, information, I think we have an information overload. There are so many sources of information. I think that consumers are saying, "Who do we trust here?" Even recently when they—the action recently of the FDA, just reports of how a drug got approved and has been used by millions of people, and yes, there were problems with it and it's taken off—I think consumers are sort of saying, "Hey, you're asking me to be smart, but I am not getting information, and what's more, if I'm in trouble—if I'm sick, I'm not in a situation where I can make good choices. That's why I need doctors. That's why I need people to help me make my choices.

BINSTOCK: In the back, please.

AUDIENCE MEMBER: I am reminded of Senator Moynihan often saying, "We are all entitled to our own opinions but not to our own set of facts." I think about the dissonance between facts, opinion, and reality in some of the policy discussions.

With Social Security, the fact is we have created huge deficits again in general revenues, and we are at war. At the same time, we have a system where some are proposing to move towards partial privatization, and to finance that most of us know the facts are, one has to have a transition period that would be very expensive and draw on general revenues.

Beyond whether we like it or not, it does not solve the financing problem in Social Security. An honest debate would say it makes it much harder to address, even if we liked moving towards private accounts.

Similarly, we hear in the discussion how African Americans, how Hispanic populations, how poor populations will benefit from a privatization, which is pretty far from the reality of what a privatization will do.

Again, some people may do better but we can be sure that lower income workers will lose the benefit of the tilt in Social Security that protects people who have worked many years very hard, at low wages, and provides a proportionately larger benefit to low wage workers.

My question, it's a long way coming, it's to Bob—it's always to Senator Frist's aide. Bob, you said you didn't think we would be moving through a financing of Soc—a financing reform. I suspect you are right. I've been asking the same question. I've been wondering, "What are we going to do with this huge deficit? How are we going to get—how are we going to move into a financing reform?" I think it's only going to be—I think it may just be politics. I guess the question I have is how much of this is seen as a wedge issue, within Republican circles, to drive a wedge between younger and older constituencies?

There is an old article written at the end of 1983, by Stewart Butler and I forget who. Another person was very involved. It's called, "A Stalinist Approach to Deconstructing Social Security."

The idea was you argue for change on moral terms. It's unfair to minorities. It is unfair to this group. It's unfair to single groups.

But then you push a legislative agenda that creates these—pushes these new ideas, and pushes these contradictions to the benefit of moving towards partial privatization.

So how—how explicit is this?

BINSTOCK: Well, we've got another panelist in the audience.

AUDIENCE MEMBER: Sorry Bob.

[Laughter]

ROSENBLATT: Well, I'll try to answer. Let me think about this. OK.

It is not a Wall Street plot to privatize because Wall Street already has all of us who have decent 401Ks. In other words, Wall Street, Fidelity, Vanguard don't want to touch you unless you've got two to three thousand. Nobody wants somebody with \$500 in their account.

So it is a—and I won't call it a, you know, conspiracy, and I won't call it, you know, Stuart Butler running it. I think it is a, again, I keep sounding the same things, it's philosophy is if you don't like the government you don't like anything the government does.

And people who don't like the government don't like Social Security. I covered the Greenspan Commission in 1983, and Bill Archer, from Texas, was arguably the most conservative member of the commission. At one meeting he started talking about private accounts. Everyone said, "Yeah, Bill. That's fine. Thank you."

And that was the end of it, because it was regarded as a really kooky, goofy idea. It wasn't even something that you would put—you might put it in the thirty-sixth paragraph of a thirty-seven paragraph story.

Well, times have changed; and the people who don't like government who really believe in this with great sincerity. And they have the ear of the president of the United States, and they have a large number of members of the Congress. So I think that they will be arguing about it, pushing for it.

And by the way, the big fight on all of these will be in the Senate because the House, the nature of the House is there are no—there are only forty or fifty competitive seats. Either you are a Democrat who always wins with 60 percent or you are a Republican who always wins with 60 percent. So the real argument over this will be in the Senate, with people like Senator Frist.

BINSTOCK: Another question?

AUDIENCE MEMBER: Let me turn to an area where there is bipartisan inaction for the last couple of decades, and that is geriatric training.

We all know because of the demographics and the baby-boomers, we are going to double our aged population. Yet the number of geriatricians today is fewer than they were six, seven years ago. And the number continues to decrease.

And neither party, Republicans or Democrats, Senate or House, or the Executive Branch, have really done much to change that. And we are not talking just about physicians. We are talking about nurses and pharmacists and the other members of the geriatric team.

We need to do more. Every medical school in this country has a Department of Pediatrics. Five out of 144 have a Department of Geriatrics. We have known this for a number of years, and we are not doing anything about it. I address that to all of you.

ROSENBLATT: Just briefly, I was looking at the figures the other day. We have had this huge increase in the number of doctors in the United States over the last thirty years, a tremendous increase. They all want to be specialists and make a lot of money. Apparently geriatrics is not attractive. But I guess when the—more of the baby-boomers retire, people of necessity will have to become geriatricians. But you—there's no way you are going to get any big programs through Congress, because we already spent a lot of money on training a lot of doctors and none of them wanted to do this.

So it'll—I think in response to the way things usually happen, there will be a demand for doctors and nurses to do that because there will be a lot of people who need that care.

AUDIENCE MEMBER: But let me go a little further. Everyone doesn't need a geriatrician.

But we are talking about formal training in geriatrics. Everybody gets a rotation at pediatrics. Virtually no one is required to get a rotation in geriatrics, even though most of those physicians, internists and family practitioners, and others will be caring for the elderly.

ROSENBLATT: Well, there are always deans in the med schools.

AUDIENCE MEMBER: Well, what about the Hill? Are there opportunities to address this on the Hill?

TRAFFORD: Not for what I see. I think this has been a recurring problem. I mean, you have had Bob Butler talk about this now for years. And to go around to all the people who are sitting in medical on the Hill and say, "We need to have training in geriatrics."

I think it's this large—raises a larger issue, which is, in a sense, ageism in the culture. And I would sort of throw it back again. Where's the leadership, in a sense, just to, in these programs, to address some of the culture of ageism that is really detrimental to our society?

It's also just nuts, when you look at the demographics.

ROSEN: I guess I'd just say—I actually agree with you. I'm not sure, you know—and I think that we do need to—I mean we haven't seriously look at graduate medical education, you know, in a serious way in terms over overall policies since 1995 or 1996.

At the time we looked at it, we actually had the ability to have some additional funds devoted to it. Back to 1995 and 1997. They are no longer available and we just haven't come back to it.

There's been talk about it, but there really hasn't been a significant way to address it.

I think—I have seen the statistics that Bob references, too, but I have also seen some studies fairly recently. I'm not sure whether they are right or wrong, but they talk about a large gap in terms of the number of physicians that are going to be there, leaving aside what their training may be. And we know that we already have shortages in nursing and shortages in pharmacy and a whole host of other areas, too. Complex factors.

I think it is one of those areas I'm not sure you can address, you know, totally with a government policy. But I do, you know, agree with this Bob, and I do think that the teaching institutions, academic institutions, teaching hospitals and others, have some responsibility, too, to counter this.

But you are right. There has been a lack of leadership, whether it has been private or public and it's an issue that really deserves, I think, more from us.

BINSTOCK: Other questions?

AUDIENCE MEMBER: Yes, just that the possibility of the block grant for Medicaid. I believe that many of the states are paying over 50 percent for nursing home care—Medicaid. Projecting that in the future with more people in nursing home, and this administration needs to be less divisive and think about what's going to happen on the state level as an unintended policy implication of people fighting for those Medicaid dollars with many of those—many older people in the nursing homes who are going to need that.

ROSENBLATT: I think that Republican governors will probably block Medicaid, block grant, as they have in the past. But it will be a tough fight.

BINSTOCK: Well, I'll take advantage of being the chair to ask a question.

As you know, we've all heard about the 45 million uninsured in this country, and of course we know that Senator Frist is a physician, who undoubtedly cares if people get health care. What plans does he have to address the fact that 45 million people are uninsured and depending on the employer-based system—which is a marked failure for them—and our two big interventional programs, Medicare and Medicaid, not helping them out.

Does he care? And how would he address that?

ROSEN: I guess—well, just—let me begin by answering with one just sort of interesting anecdote. I was in Ohio talking about health care issues right after the election. And we were doing some focus groups that were just sort of what did people sort of vote on in the election, and kind of delve a little bit more into health policy, in part to give us some insight where to—where to lead.

And this was sort of interesting as a segue to your question. I'll be through in a second. But this is a focus group of people in Ohio and they were swing voters, generally leaned Republican, but they were swing voters.

The question was, what do you remember—this was a week after—less than a week after the election. What do you remember of Senator Kerry's plans to address the uninsured? What do you remember of President Bush's plans to address the uninsured?

So I thought, you know, these people are going to be pretty articulate about it. I mean, after all, both presidential candidates had visited the state like 35 or 40 times. And these were the people they were talking to. These were the swing voters.

I think two people remembered one provision from Senator Kerry's plan and the one person who remembered something from President Bush's plan said, "What I remember about President Bush was that he didn't like what Senator Kerry proposed!"

[Laughter]

ROSEN: So we have a challenge in talking about these issues with the public.

But we need—actually Senator Frist gave a speech and the Press Club in July where he sort of talked about a vision, his vision for health care for—into the twenty-first century, and it was a speech that we are now—have submitted to the *New England Journal of Medicine* for publication. He laid out a number of proposals with regard to the uninsured.

I think that the primary goal is, was to try to help people who are vulnerable and who are falling through the cracks. And I think recognizing that we do need to set some priorities because, for all of the reasons we talked about.

You know, there is a wealth of need, whether it's in Social Security, homeland security, defense, war, Medicare. There are a lot of competing priorities.

But he did set some, and primarily focusing on trying to get everyone coverage or have everyone have life-long access to affordable coverage. But I think the focus was really beginning with kids, trying to get—trying to get kids who are eligible—there are over 5 million children, nearly 6 million, who are eligible for government programs but not signed up for coverage, that are part of that 44, 45 million coverage, trying to expand Medicaid and asked to give states some flexibility for low-income folks, and at the same time, giving low-income individuals a tax credit and giving them the ability to choose whether they want to take that money into Medicaid or whether they want to take that money in the private sector.

Giving people, by the way, on Medicaid, the opportunity to decide whether they want to stay with that government program or whether they want to choose enroll, maybe, in the employment (inaudible).

So we've outlined his priorities. I should say that we don't, we didn't propose anything that would get everyone covered. Neither of the presidential candidates did either. Senator Kerry would have spent about a trillion dollars over the next decade and leave about half of those uninsured without coverage.

So it gives you more of a magnitude as to how difficult it is to get coverage. But I think our focus was on trying to give people who didn't have the economic wherewithal the ability to do it.

And we actually put on the table, in terms of risk taking, a couple of things that were relatively controversial. And just I'll mention two of them.

One was to—what was one? One was to take folks who were at a higher income level and to say that, "You have some societal responsibility—particularly where you have kids and they don't have their own option, you get yourself covered." Maybe we ought to use the tax code, at least as an incentive, and maybe there ought to be some consequence that if you're making, let's say, \$100,000 or \$200,000 or \$250,000 a year—and again, there is a significant proportion out of

everyone being insured—they have some responsibility. Because if they are out of the system, and they get hurt, the government's going to pay for them.

So, I'm not sure that is going to fly, but it was something that we did mention. It's a higher income partly uninsured.

And another thing, when you mentioned the employment system, one of the things that is different from the time that Medicare and Medicaid were enacted too, is that it's rare now—it used to be—it used to be the norm, but it's rare now, that people coming (inaudible) worked for the same employer for their entire life. And there are a number of things that go into that to try to get people to support that they can change jobs if they want to leave jobs. And one of the things that we really proposed to look out was the hundreds of billions that we spend every year in terms of subsidizing employer-provided insurance, and trying to give individuals some more of that—that—some more of that funding and trying to make it more equitable.

Right now the system, the tax system that we have, which I think is part of the problem in terms of the cost of coverage, is heavily tilted toward upper income people, it heavily finances more expensive policies, and frankly is the most regressive part of the tax code.

So we (inaudible). It's a long answer but—I invite people, again, to look at it. We thought a lot about it and tried to impress (inaudible).

BINSTOCK: One last question, and then we'll wrap it up.

AUDIENCE MEMBER: If the seniors—let's say that the 50 and over population of the country spoke with one voice and said, "We want to make sure that the doctors in this country are trained to take care of old people, and we know they are not being trained to do that now—we want to elect Congressman and Senators who will make sure that will happen." Would that make any more difference? Would that persuade the Congress to be more interested—take more responsibility for that?

ROSENBLATT: Health care is always on the list, but it's never the reason that people cast their vote. It's—people do not vote on that basis. They may say they are concerned, but that's not how they vote.

ROSEN: I actually take a more optimistic view on that, which is I think that in—I am not sure you could ever get everyone over fifty to speak with the same voice, but I think that involvement of folks like those in this room, and people who have just been to this conference, makes an enormous difference.

And you know, the major senior organizations and the major folks who represent anybody in this town can make an enormous difference.

I can tell you that it is not at the top of the list with ALP or maybe it isn't at the top of the list of other folks. So I actually think it is a —it is a significant issue. It's not an issue of physicians, by the way. It's an issue of non-physicians in terms of caregivers' increasing the in-home based settings. And I think it would make an enormous difference basically if that issue bubbled up when you folks talk to your representatives.

And I do think, as I said before, that the responsibility does also lie with the folks, with the physician community, with the educational community too, who recognize this need.

TRAFFORD: I also think that people over fifty are going to start speaking up much louder and find coalitions and it's this change in themselves. That's hopeful.

2004 Elections: How will they impact old age policies?

BINSTOCK: Well, on that note—hopeful note—I call this to a close. I would like to thank our panelists for taking time out of their Sunday afternoon to be here with us.

I think it was a stimulating program, hotter at some points than others. I hope we treated you and your mother-in-law reasonably well.

I think you all for coming, reminding you if you wish to see a few shots of yourselves on the Webcast, it will be on November 29. But to those of your friends and colleagues who may be interested, it can be accessed on the Web site SAGECrossroads.net.

So on behalf of the Alliance for Aging Research and the Public Policy Committee of the Gerontological Society, thank you all for coming.

[Applause]

END OF TAPE