

Medicare: It's not just another program

Citizen dialogues on paying for health care in retirement

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Foreword

From 2007-2009, Viewpoint Learning, in partnership with the Concord Coalition's Fiscal Wake-Up Tour, conducted a series of in-depth dialogues with the public and leaders in a project titled: "The America We Want."¹ These dialogues considered different scenarios for America's finances and future. Participants considered what sort of country they wanted to see in 20 years, what role they thought the federal government ought to play and how best to pay for that future. The results of these dialogues can be found in the report "Changing Expectations: Americans Deliberate Our Nation's Finances and Future."²

While the "America We Want" dialogues considered all areas of federal spending along with taxes and debt, the findings on Medicare were of particular interest. Much of our future financial obligation – as well as the future of our social contract – is directly tied to predicted increases in Medicare spending.

To learn more about how Americans think about Medicare, what sorts of reforms they might be likely to support and under what conditions, the Fiscal Wake-Up Tour partners commissioned an additional series of dialogues specifically focused on Medicare reform. These dialogues – conducted in Phoenix AZ, Oak Brook IL, Columbia MD and Houston TX – were initially designed as internal research to provide the FWUT partners with a deeper understanding of how Americans resolve or at least begin to

work through some of the difficult choices and tradeoffs involved.

While the initial intent was to use these results for internal purposes, after observing the difficult and confrontational debate around health care this summer, the partners decided to make these findings public as a useful contribution to the broader conversation. Any realistic discussion of fixing our health care system and bringing costs down across the board must include a discussion of Medicare. People in the dialogues certainly made this connection, repeatedly emphasizing the importance of linking Medicare reform to a broader restructuring of our state and national health care system.³

More broadly, these dialogues model a different kind of conversation about a difficult public issue. We were struck by the powerful mistrust and anger that surfaced in this summer's town hall meetings often short-circuiting any real dialogue. The tone of these meetings was in stark contrast to the Medicare dialogues described in this report. Participants in the Medicare dialogues – liberals, conservatives, young and old – took in one another's perspectives and found common ground about the nature of the problem, the implications of doing nothing, and some approaches they all would be willing to support. They certainly did not agree on everything, and they did not resolve every tradeoff. But they went a very long way in their 8-hour sessions, and there is much to be learned from their discussion.

In particular, the dialogues demonstrate that it is possible to engage diverse perspectives on a difficult subject like Medicare and to reveal powerful common ground on which leaders can base real reform.

There are many ways to have this conversation. Some, as has been painfully demonstrated, do not bring out the best in us. But some do. This report demonstrates how leaders can help move the public along the learning curve towards thoughtful judgment and sustainable solutions on one of our country's most difficult challenges.

1. *The Fiscal Wake-Up Tour is a joint initiative of the Concord Coalition, the Brookings Institution, the Heritage Foundation, and the Peter G. Peterson Foundation (www.concordcoalition.org/act/fiscal-wake-tour); Viewpoint Learning conducted the dialogues in conjunction with the Concord Coalition, the Brookings Institution, the Heritage Foundation and Public Agenda.*

2. *The report is available on the Viewpoint Learning website: www.viewpointlearning.com/publications/reports/AWW_FINAL-1.pdf*

3. *We explored the question of state and national health care reform in depth in a separate multi-state project titled "Voices for Health Care: Engaging the Public to Advance Significant Health Care Reform": www.viewpointlearning.com/publications/reports/VFHC_FinalReport.pdf*



Medicare has formed the backbone of Americans' retirement health care since 1965. But in recent years the program has come under increasing strain from an aging population and a dramatic increase in health care costs. Even before last fall's economic meltdown, experts from across the political spectrum warned of an unfolding calamity: our obligations to seniors are outstripping the means we have to pay for them.

But the Medicare crisis is a slow-motion calamity, unfolding in a timeframe of years, not months, and on an almost unfathomable scale. While the public is concerned about Medicare and health care more generally, few people have any sense of the scale or the urgency of the problem.

And decisions need to be made soon. As time passes the fiscal challenge grows ever more intractable and we have fewer options for dealing with it. In addition, these issues are so complex and challenging that it will take some time for

the public to come to grips with the issues and reach stable judgment. This process cannot be sidestepped. To be sustainable in a democracy today, any major policy decision needs to meet two tests – it must be technically feasible and it must reflect the underlying values of the public. To craft sustainable solutions and help the public along its learning process, leaders need greater insight into where Americans are likely to go on these questions and how they would resolve the difficult issues at stake.

This project was designed to provide some of that insight. The effort builds on the findings of a recent project Viewpoint Learning conducted in partnership with the Concord Coalition's Fiscal Wake-Up Tour, as well as Public Agenda, The Brookings Institution and The Heritage Foundation. That two-year project, called "The America We Want," examined Americans' vision for the nation's finances and future in a range of areas including Medicare, Social Security, defense, other

federal activities and the federal debt. Results of that study included suggestive findings about Americans' priorities for Medicare.¹ Given these findings and the importance of the issue, the FWUT partners commissioned four daylong Choice-Dialogues across the country to provide deeper insight into the public's key priorities on Medicare reform and engage the public in working through alternative approaches to paying for health care in retirement.

While the initial intent was to use these results for internal purposes, after observing the difficult and confrontational debate around health care this summer, the partners decided to make these findings public as a useful contribution to the broader conversation. Any realistic discussion of fixing our health care system and bringing costs down across the board must include a discussion of Medicare. People in the dialogues certainly made this connection, repeatedly emphasizing the importance of linking Medicare reform

1. For a complete report on the findings of the "America We Want" project, see *Changing Expectations: Americans deliberate our nation's finances and future*. Viewpoint Learning, September 2008. www.viewpointlearning.com/publications/reports/AWW_FINAL-1.pdf

to a broader restructuring of our state and national health care system.²

More broadly, these dialogues model a different kind of conversation about a difficult public issue. We were struck by the powerful mistrust and anger that surfaced in this summer's town hall meetings often short-circuiting any real dialogue. The tone of these meetings was in stark contrast to the Medicare dialogues described in this report. Participants in the Medicare dialogues – liberals, conservatives, young and old – took in one another's perspectives and found common ground about the nature of the problem, the implications of doing nothing, and some approaches they all would be willing to support. They certainly did not agree on everything, and they did not resolve every tradeoff. But they went a very long way in their 8-hour sessions, and there is much to be learned from their discussion.

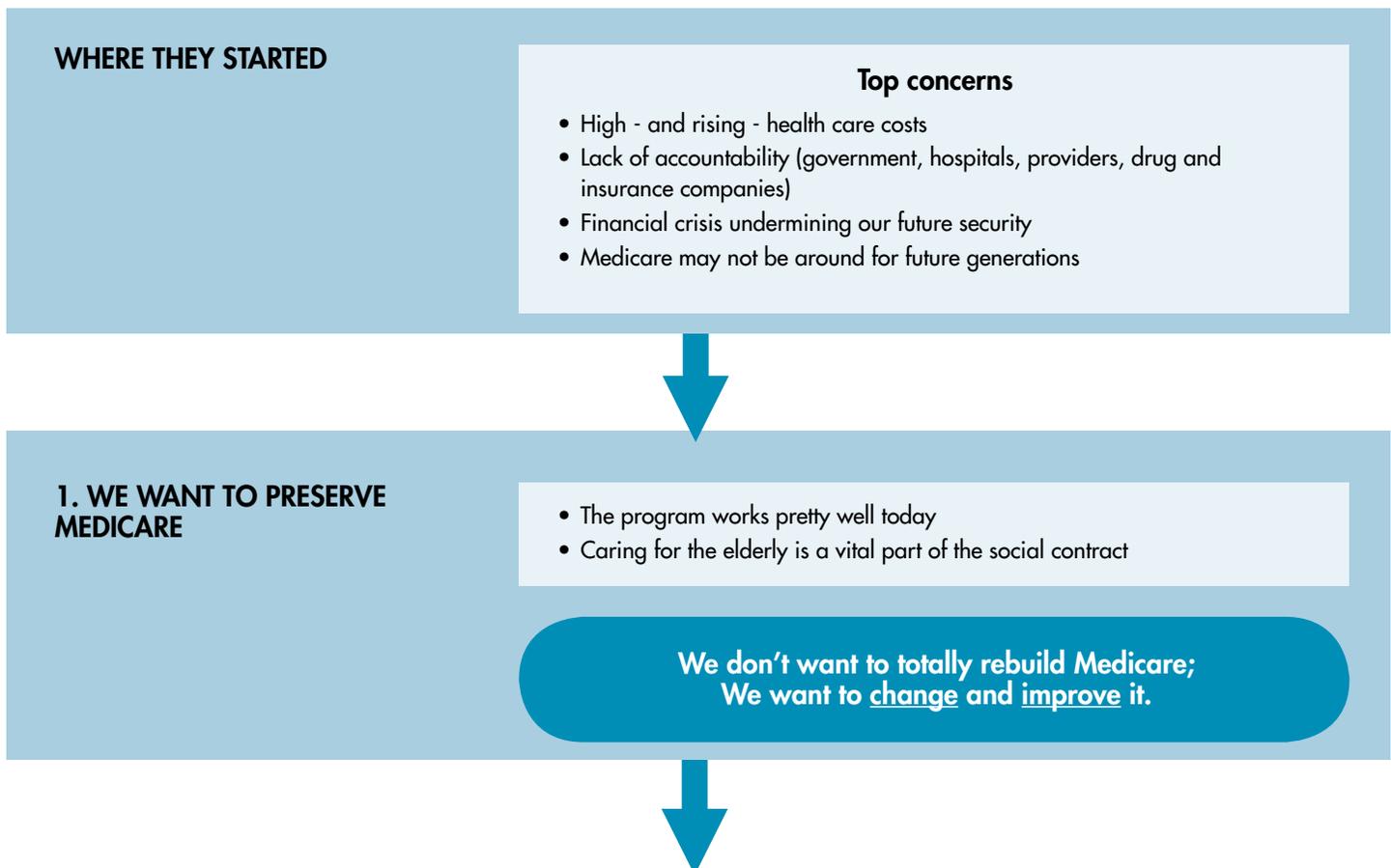
Choice-Dialogue Findings

Dialogues were held in Phoenix AZ, Oak Brook IL, Columbia MD and Houston TX – each conducted with a randomly selected representative sample of 35-40 citizens.

As a starting point for their conversation, participants were presented with four scenarios of how Medicare might be improved: 1) Voluntary reductions, 2) Pay for the current system, 3) Set priorities to make the best use of limited resources, and 4) Strengthen personal responsibility and choice. These scenarios provided a starting point from which participants began to connect the dots between their personal experience and larger systemic issues. These were only a starting point – participants were

encouraged to mix and match elements from different scenarios and to add their own.

As they moved from initial opinion to final judgment, participants struggled with tradeoffs and worked to reconcile different approaches with their deeply held values. A qualitative and quantitative analysis captures how their views shifted over the course of the day and how they moved along the learning curve. These findings were consistent across all four dialogues — each group of participants reached very similar conclusions following a similar sequence of steps outlined in the following chart. Each number on the chart corresponds to a section of the General Findings in the main body of the report, and is elaborated there.



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2. BUT WILL THE CURRENT SYSTEM WORK INTO THE FUTURE?

- Medicare is not self-sustaining (FICA, premiums, other out-of-pocket expenses only cover 60% of cost)
- Changing demographics: fewer workers supporting more retirees
- Health care costs going up faster than inflation
- National debt is already large and growing - we shouldn't add to it
- America has promised more than we can pay for - just keeping benefits at today's levels will cost much more in the future

THE STATUS QUO IS NOT SUSTAINABLE.

We need to make some major changes if we are to preserve Medicare in some recognizable form for future generations

3. WHAT KIND OF CHANGES CAN WE ACCEPT?

Some things are essential

Seniors *MUST*

- *Be able to see a doctor when they need to*
- *Be protected from high cost of hospitalization and other treatments*
- *Be covered for preventive care*

But we will accept some other changes

- Allow Medicare to negotiate for prescription drugs
- Encourage hospice care rather than heroics at the end of life
- Only cover treatments proven effective
 - Who decides what's effective? Independent commission of citizens, doctors, health care experts
 - Patients and doctors must be able to appeal decisions
- Emphasize preventive care and personal responsibility
 - Cover checkups, screenings, immunizations, disease management
 - Education on nutrition, self-care, wellness
 - Financial incentives for preventive care & healthy behavior
 - Initial health assessment when seniors enroll in Medicare
- Increase eligibility age from 65 to 67
 - Must be phased in
 - People who become disabled before retirement age must continue to be eligible for disability benefits under Medicare

4. PAYING FOR IT

**Some of these changes will reduce costs, others will cost more.
If current revenue isn't enough, where should the money come from?**

• Should we borrow the money?

- **NO** – we don't want to increase the debt

• Should we rely on voluntary reductions?

- **NO** – they are a nice idea, but they won't do enough to fix the problem

• Should we cut other spending?

- **YES** – especially wars in Iraq & Afghanistan
- We may support additional cuts beyond this; no matter what, Medicare should be given high priority
- Cut waste and inefficiency

What if that's not enough?

• Have seniors pay more in premiums and co-pays?

- **Not across the board** – must protect low-income seniors
- OK on a sliding scale so that wealthier seniors pay more

• Increase taxes? ONLY IF:

- Medicare meets our core criteria (covers hospitalization, necessary medical expenses, preventive care)
- Fraud & waste in Medicare system are addressed
- There is greater accountability and transparency
- New taxes are earmarked for Medicare

IF these conditions are met, we will pay more taxes to keep Medicare benefits at current levels (79% agree)

- National sales tax (2-3% sales tax on goods & services)
- Increase in payroll tax
- Sin taxes on alcohol/tobacco



4. PAYING FOR IT (cont'd)

Can the market play a role in paying for it? (e.g. HSA's, individual accounts)

- These do offer greater flexibility and freedom of choice

BUT

- We don't trust market forces to protect the public interest
- Many seniors may be worse off

Market-based reforms have potential as add-ons to the current system, but they shouldn't replace it

**Medicare is not just another program
It's a vital part of the social contract**

This series of dialogues holds important lessons for leaders and advocates who want to build public support for significant Medicare reform. The findings indicate how Americans are likely to move along the learning curve in the future given time to work through the implications of proposed reforms. It also suggests what leaders can do to affect, advance and accelerate the public's movement along the learning curve and help build broad-based public support for change.

Working within the public's framework

Citizens and experts often approach issues with different assumptions, frameworks and terminology – and when these are at cross-purposes, misunderstanding and mistrust can result. In the course of the dialogues we noted some signal examples where the public's frameworks and assumptions do not mesh with experts'. Experts, even those actively reaching out to the public through public forums, can easily overlook these differences. Citizens who choose to participate in public forums on fiscal issues and entitlements usually have some familiarity with the language and frameworks of policy making – but

the randomly selected citizens who attend a Choice-Dialogue have the same widely varying levels of knowledge and sophistication that are found in the general population. This is the framework that leaders must understand if they are to help the broader public advance along the learning curve. In particular:

- ***Different understanding of what Medicare benefits are (and what it means to limit them):*** Many experts and policymakers think of Medicare "benefits" as a specific package – who is eligible, what services are covered, and the subsidy that offsets the cost of premiums. However, the public defines "benefits" both more narrowly and more broadly. On the one hand, the public defines "benefits" as covered services only and pays little attention to the other technical elements. More broadly, though, the public sees "benefits" as the assurance that seniors will get needed care and be able to live with some degree of dignity and security. In the public's view "limiting benefits" implies refusing to treat people who are sick.

This distinction arose in the Choice-Dialogues. When asked whether we should restrain Medicare costs by

"limiting benefits," participants soundly rejected the idea. They did not want a system that would pull the plug on someone with a good chance of survival, or that would refuse to treat costly conditions just because they were expensive. But they did come to accept other measures – for instance, raising the retirement age, encouraging hospice care and evidence-based medicine – without seeing them as limits on benefits in the same way. Participants were well aware that the measures they supported would scale back eligibility and lead to real changes in what kinds of treatments seniors were offered. But they saw these measures not as an attack on benefits as they defined them, but as reforms that made sense in their own right (for example, raising the retirement age to reflect the realities of 21st century aging, encouraging more sensible end of life care, etc.).

It is important to be aware how the public interprets any discussion of benefits, and to frame any changes as valuable in their own right, not as reductions in benefits. To win public support, any proposed changes also need to respect (and be seen to respect)



Americans' core value that seniors be protected and cared for. A good starting point would be to establish that this value is one that you share — it is common ground. The question then becomes how best to realize that value.

- **The real cost of health care.** Very few participants had a clear sense of how much health care actually costs in America or how those costs are distributed. Most thought of it in terms of how much they spend on premiums and out of pocket expenses, and they assumed that this money accounted for most health care dollars spent, both on Medicare and on health care in general. Similarly, very few were aware of the extent to which Medicare benefits are subsidized. Most were surprised to learn that more than 40% of dollars spent on Medicare come out of general taxes, and this information caused them to rethink their assumptions. If all they were paying only added up to a bit more than half of what health care for the elderly really costs, then perhaps the problem was bigger than simple waste, fraud or greed.

Leaders hoping to move the public along the learning curve should keep in mind that most Americans have only a limited picture of what Medicare really costs, how those costs are distributed and how

the pieces of the system fit together. They may be familiar with individual pieces of the puzzle but they will need help connecting the dots. This is work that needs to be done before advancing major reforms.

- **Scale:** Participants readily understood that Medicare faces a funding crisis, yet many found it difficult to grasp the scale of the problem. The amounts at stake were so unimaginably huge that participants frequently used 'billions' and 'trillions' interchangeably.

We found that some kinds of information were more effective in helping participants understand the magnitude of the problem:

- **Cost of the bailout vs. cost of Medicare.** Many were struck by the fact that the entire financial bailout package (\$700 billion at the time of the Choice-Dialogues) would pay for less than 2 years of Medicare today. This comparison brought home the size of the Medicare budget.
- **The dwindling ratio of workers to retirees.** Many people had heard in a general way that Americans are living longer and having fewer children, but had not considered the effect this was having on Medicare and other entitlement programs. Learning that

Medicare is a pay-as-you-go system and seeing the changing ratio of workers supporting each retiree (from 5:1 in 1960, 3:1 today, and only 2:1 in 2030) had a powerful impact. This was a demographic fact that could not be dismissed.

- **How much it will cost to maintain benefits at current levels.** Many participants were not unduly surprised to learn that on average workers pay \$2,300/year to fund Medicare, and they assumed that these amounts would go up some in the future as a result of inflation. But they were dismayed to learn that the aging population and rising health care costs would cause this figure to nearly triple over the next 20 years, at which point it would cost an average of \$6,000/year just to maintain current benefit levels. This information made the aging society and the rise in health care costs much more concrete for many participants and gave them a better framework for considering changes in the program.
- **On the other hand, some pieces of information did not help participants get a better sense of scale.** For instance, participants were told that the total unfunded obligation will total \$34 trillion over 75 years (or \$170,000 for every man, woman and child in America). But the concept was too abstract, the numbers too large and the timeframe too long to provide a useful framework for discussion.

Communicating the magnitude of the challenge more effectively, using some of the measures outlined above, can help to build the public understanding and support needed for significant reform.

• **Health care (and especially Medicare) is not a commodity.** In these dialogues on Medicare, and in others we have conducted on health care more generally, we have seen a growing belief among Americans that health care should be regarded less as a commodity and more as a right – and that making sure all American seniors have good care is an important priority. Over the course of the day even participants who initially doubted that Medicare would still be there when they retired became less concerned about this possibility. In part this may be because they saw their own conviction – that Medicare is a promise that must be kept – reflected in what most participants were saying. To win public support, proposals for major reform to Medicare need to recognize the extent to which Americans see Medicare as an essential part of the social contract and not just as another government program.

• **Market-based reforms.** The current financial crisis makes moves towards market-based reforms less likely to win public support. Americans are deeply concerned about what the economic turmoil will mean for their financial security and their prospects for the future, and are almost daily inundated by stories of organizations and individuals in the market betraying the trust placed in them. In this context, people are less willing to trust programs crucial to their health or wellbeing to the market.

At the same time, the public does seem to be willing to consider a role for market-based reforms as add-ons to the existing system. Positioning such reforms as ways to strengthen the current system rather than replace it is more likely to win public support and move the public along the learning curve. As the Bush Administration's Social Security initiative shows, advancing reform measures before the public is

ready to accept or even consider them is likely to backfire. This is true even if the proposal is one the public might have ultimately supported given time and effective leadership.

This research indicates that younger people may have a somewhat different view of market-based reforms. While more research is needed to understand whether this is an age-related perspective that will change as people get older or a signal of generational change, it suggests that the public may be open to a further exploration of this issue in the future.

Participants went a long way along the learning curve in these Choice-Dialogues. As they worked through the possibilities and tradeoffs they showed strong support for maintaining Medicare in a recognizable form, even if that required them to pay more taxes. But they could not get to a fully sustainable solution in a single step: in particular, the level of taxation most were willing to countenance at this point is unlikely to be enough to meet future needs. It will take some time for the magnitude of the future Medicare obligation to sink in - and it is not yet clear which way the public will go when it does. As they move further along the learning curve in years to come, Americans may become willing to pay significantly more if that is what is required to preserve Medicare in a recognizable form. Or they may become more willing to consider additional changes in what Medicare offers.

Building public support for significant reform means helping the public advance along this learning curve. This will include using the public's language rather than expert terminology (about questions like benefits), helping the public better understand the real cost of Medicare and the scale of the fiscal challenge before advancing major reforms, and acknowledging that the public places a



high value on helping seniors and does not see Medicare as a program like the others. More generally, it will involve understanding how people process information, the steps they take as they work through the issues, and how to sequence the conversation in a way that keeps pace with the public's learning process.

Just as important, this research suggests that it is possible to engage diverse perspectives on a difficult subject like Medicare and to reveal powerful common ground on which leaders can base real reform. There are many ways to have this conversation. Some do not bring out the best in us, as was painfully evident in this summer's town hall meetings. But some do. This report demonstrates how leaders might help move the public along the learning curve towards thoughtful judgment and sustainable solutions for one of our country's most difficult challenges.



Medicare has formed the backbone of Americans' retirement health care since 1965. But in recent years the program has come under increasing strain from an aging population and a dramatic increase in health care costs. Even before last fall's economic meltdown boosted the deficit to even more dizzying heights, experts from across the political spectrum warned of a looming calamity: our obligations to seniors are outstripping the means we have to pay for them. We are rapidly approaching the point where continuing to pay for Medicare in its current form will require some kind of dramatic changes – drastic cuts in other programs (such as education, defense, infrastructure and the environment), major increases in taxes, or a huge increase in the national debt. Difficult decisions must be made about the future of Medicare and health care more generally.

But the Medicare crisis is a slow-motion calamity, unfolding in a timeframe of years, not months, and on an almost

unfathomable scale. And the escalating economic crisis has focused national attention away from longer-term considerations and toward the urgent issues facing us in the next few years. While the public is concerned about Medicare and health care more generally, few people have any sense of the scale or the urgency of the problem.

And decisions need to be made soon. As time passes the fiscal challenge grows ever more intractable and we have fewer options for dealing with it. In addition, these issues are so complex and challenging that it will take some time for the public to come to grips with the issues and reach stable judgment. This process cannot be sidestepped. To be sustainable in a democracy today, any major policy decision needs to meet two tests – it must be technically feasible and it must reflect the underlying values of the public. Even the best technical solution will founder without public support. To craft sustainable solutions and help the public

along its learning process, leaders need greater insight into where Americans are likely to go on these questions and how they would resolve the difficult issues at stake.

This project was designed to provide some of that insight. The effort builds on the findings of a recent project Viewpoint Learning conducted in partnership with the Concord Coalition's Fiscal Wake-Up Tour, as well as Public Agenda, The Brookings Institution and The Heritage Foundation. That two-year project, called "The America We Want," examined Americans' vision for the nation's finances and future in a range of areas including Medicare, Social Security, defense, other federal activities and the federal debt. Results of that study included suggestive findings about Americans' priorities for Medicare.¹ Given these findings and the importance of the issue, the FWUT partners commissioned a new series of dialogues to examine public views and values on Medicare in greater depth.

1. For a complete report on the findings of this project, see *Changing Expectations: Americans deliberate our nation's finances and future*. Viewpoint Learning, September 2008. http://www.viewpointlearning.com/publications/reports/AWW_FINAL-1.pdf

The goal of this project was to dig deeper on specific issues surrounding Medicare reform:

- What sort of health care benefits do Americans believe should be available to senior citizens after they retire?
- How should these benefits be paid for?
- What are the proper roles of government, individuals and the private sector in providing benefits for seniors?
- What conditions does the public have for accepting reform?
- Do people of different backgrounds (age, income, education, political affiliation) have different views on these issues?

Polls and focus groups can reveal something about how Americans will respond to these questions today – but what leaders really need to know is where the public is (and is not) willing to go moving forward. How do the public's opinions develop as they wrestle with tradeoffs and work to reconcile different options with their deeply held values?

While the initial intent was to use these results for internal purposes, after observing the difficult and confrontational debate around health care this summer, the partners decided to make these findings public as a useful contribution to the broader conversation. Any realistic discussion of fixing our health care system and bringing costs down across the board must include a discussion of Medicare. People in the dialogues certainly made this connection, repeatedly emphasizing the importance of linking Medicare reform to a broader restructuring of our state and national health care system.²

More broadly, these dialogues model a different kind of conversation about a difficult public issue. We were struck by the powerful mistrust and anger that surfaced in this summer's town hall meetings often short-circuiting any real dialogue. The tone of these meetings was



in stark contrast to the Medicare dialogues described in this report. Participants in the Medicare dialogues – liberals, conservatives, young and old – took in one another's perspectives and found common ground about the nature of the problem, the implications of doing nothing, and some approaches they all would be willing to support. They certainly did not agree on everything, and they did not resolve every tradeoff. But they went a very long way in their 8-hour sessions, and there is much to be learned from their discussion.

About the learning curve

More than 50 years of research, led by Viewpoint Learning Chairman Daniel Yankelovich, has demonstrated that public opinion on complex issues evolves in stages. From an initial stage of highly unstable “raw opinion” the public moves through a series of steps in which they confront tradeoffs, establish priorities and reconcile choices with their deeply held values. This process can take anywhere from days to decades. Only when the public understands and accepts responsibility for the consequences of their views, can we say that this “learning curve” is complete.

Choice-Dialogues™ were developed by Viewpoint Learning to engage representative samples of the public in working through their views on complex, gridlock issues. Going far beyond polls and focus groups, Choice-Dialogues accelerate the learning curve on a research scale. Dialogue participants come to understand the pros and cons of various choices, struggle with the necessary tradeoffs of each, and come to a considered judgment – all in the course of a single eight-hour day. When conducted with a representative sample, ChoiceDialogues provide both a basis for anticipating how the broader public will resolve issues once they have the opportunity to come to grips with them, and insight on how best to accelerate the general public's learning curve.

2. We explored the question of state and national health care reform in depth in a separate multi-state project titled “Voices for Health Care: Engaging the Public to Advance Significant Health Care Reform”: www.viewpointlearning.com/publications/reports/VFHC_FinalReport.pdf

CHOICE-DIALOGUES ON PAYING FOR HEALTH CARE IN RETIREMENT

In Fall 2008 Viewpoint Learning, sponsored by the Fiscal Wake-Up Tour partners, conducted four daylong Choice-Dialogues on how to pay for health care in retirement.

Dialogues were held in Phoenix AZ, Oak Brook IL, Columbia MD and Houston TX – each conducted with a randomly selected representative sample of 35-40 citizens.³

As a starting point for their conversation, participants were presented with four scenarios of how Medicare might be improved: 1) Voluntary reductions, 2) Pay for the current system, 3) Set priorities to make the best use of limited resources, and 4) Strengthen personal responsibility and choice. (See box at right.) These scenarios provided a starting point from which participants began to connect the dots between their personal experience and larger systemic issues. These were only a starting point – participants were encouraged to mix and match elements from different scenarios and to add their own.

Specific Findings

Participants were asked to evaluate the four scenarios at the very start of the dialogue – before hearing key background information or sharing stories and initial impressions with other participants. Participants were also asked about potential ways of dealing with rising Medicare costs. When conducted with a random representative sample, these “first impression” responses reflect how the general public reacts to such proposals at the early stages of the learning curve. Choice-Dialogue participants then went beyond this top-of-mind reaction and spent the rest of the day testing and developing their initial opinions, working

FOUR SCENARIOS

1. VOLUNTARY REDUCTIONS

In the first scenario we will continue on our present course and rely on the voluntary actions of Americans to reduce the projected huge increases in Medicare spending – giving people the tools and encouragement to take those actions. We will not rush to increase taxes or cut Medicare benefits.

In this scenario, those eligible for Medicare will be encouraged to select less comprehensive coverage. They can choose to have the savings deposited into individual health and education accounts for their families, or into a government fund that will invest in future generations and pay down the debt. Only if these voluntary reductions are not enough will we consider more drastic reforms.

2. KEEP OUR PROMISES TO THE ELDERLY: PAY FOR OUR CURRENT SYSTEM

In the second scenario we will give priority to keeping our promises to the elderly in return for their lifetime of contribution.

In this scenario, as the population ages and health care costs continue to climb, we will spend more to maintain the existing retirement health benefits provided by Medicare and Medicaid. We will strengthen accountability for how these programs are conducted.

We will do this in ways that do not increase the national debt. To pay for this, federal taxes will increase and spending in other areas will be cut.

3. SET PRIORITIES AND MAKE THE BEST USE OF LIMITED RESOURCES

In the third scenario we will make the best use of limited resources by setting priorities both within Medicare and for federal spending in general. Medicare will no longer automatically be funded before other spending priorities. We will reduce the huge growth in projected spending on Medicare through significant reforms that will direct resources to those who need them most, and to treatments and services that have been proven effective.

By controlling retirement health care costs, this scenario will free some resources to be used for other priorities, especially investments to benefit future generations (e.g., research, health care for children, environment, education and infrastructure development).

4. STRENGTHEN PERSONAL RESPONSIBILITY AND CHOICE

In the fourth scenario we will give priority to strengthening personal responsibility and choice. We will enable individuals to take greater responsibility for their own retirement health care and other important aspects of their lives.

In this scenario Medicare will be transformed over time from a program that provides defined health care benefits, to a program that enables people to use the Medicare taxes they now pay to purchase the health care coverage they want. These reforms will reduce federal spending on retirement health care, while preserving a safety net for those in need.

3. A more complete description of the Choice-Dialogue methodology appears in Appendix A, along with dates and locations of each session.

SCENARIO EVALUATIONS	initial mean	final mean
1. Voluntary reductions	4.8	4.9
2. Keep our promises to the elderly: pay for the current system	6.4	7.3
3. Set priorities and make the best use of limited resources	5.5	7.1
4. Strengthen personal responsibility and choice	5.7	6.1

Participants were asked to rate each scenario independently on a scale of 1-10, 10 being totally positive and 1 being totally negative. The initial mean for each scenario indicates participants' average rating of the choice in the morning; the final mean represents participants' average rating of the same scenario at the end of the dialogue.

Should we deal with rising costs by...	% support (initial)	% support (final)
... Having seniors pay more of the costs of Medicare	14	15
... Reducing/limiting Medicare benefits	29	20
... Raising taxes	31	67
... Lowering federal spending in other areas	78	88

through what they want to see in the future and how to pay for it. At the end of the day's dialogue, they evaluated the same scenarios again (as well as filling out a longer and more detailed questionnaire). The shifts between the initial and final responses provide a quantitative measure of people's movement along the learning curve over the course of the day. (See tables above.)

Initially, participants showed a clear preference for Scenario 2: living up to the promises implicit in Medicare and finding a way to pay for the current system. The only measure participants supported to pay for rising Medicare costs was to shift dollars from other federal programs. They did not support reducing benefits, raising taxes or having seniors pay more out of pocket. This initial judgment represents where many Americans currently stand when asked to give a snap judgment of Medicare: keep benefits much as they are, and pay for increased costs by eliminating

waste and unnecessary spending in other areas.

By the end of the dialogue, participants' views had deepened considerably as they worked through the issues. While they still strongly supported Scenario 2's emphasis on keeping promises to the elderly, they also showed sharply increased support for Scenario 3, which emphasizes making better use of limited resources, setting priorities and controlling costs. They still strongly supported paying for rising costs by cutting federal spending in other areas.

In the dialogues' most striking shift, participants became dramatically more willing to pay more in taxes, going from 31% support to 67% support. Interestingly, their support for cutting costs by reducing Medicare benefits (already low at the outset) dropped somewhat: as they learned more about what the program does, participants became even more convinced that current

benefits were reasonable and necessary, and that providing them should take priority over other government activities or keeping taxes low. This response also seems to be an artifact of the way participants defined 'benefits': not as specific services, but as a broader assurance that seniors will get needed care. While participants did ultimately support some significant changes in Medicare, they generally viewed these changes not as limitations on benefits as they defined them, but as reforms that made sense in their own right. (This point is discussed in more detail later in the report.)

As they moved from initial opinion to final judgment, participants struggled with tradeoffs and worked to reconcile proposals with their deeply held values. A qualitative and quantitative analysis captures how their views shifted over the course of the day and how they moved along the learning curve. The findings summarized below were consistent across all four dialogues.⁴

Where they started:

As they began the day, dialogue participants varied widely in their knowledge and concern about paying for health care in retirement. Predictably, older participants had given more thought to Medicare, while many younger participants readily admitted they knew little about it. These younger participants faced an especially steep learning curve with regard to what Medicare is, how it works, and the key issues surrounding health care in retirement. It is important to note that participants of all ages did not approach the Medicare question from a policymaker's perspective, or by considering institutional and systemic issues. Instead, they framed the issue in terms of their own familial ties and obligations – what are our obligations to parents, children, neighbors and the larger society?

4. Unless otherwise noted, all figures represent the combined results from all four Choice-Dialogue sessions. Complete quantitative results can be found in Appendix B.



"I'm 49 years old, recently laid off after 26 years on the job. I'm concerned about my kids and my wife. My dad was a blue collar worker, he had a fine pension, he had all his medical paid up. I'm a white collar worker, but I was losing money on the job, not getting raises, not [keeping up with] the cost of living. I think that at too many businesses the top levels are allowed to featherbed and it leaves the majority of us holding the bag, and that just can't keep on."⁵

Some concerns were widely shared even at the beginning of the dialogues:

- **High and rising health care costs.** Almost all participants (94%) were at least somewhat concerned about their future health care costs, and seven out of 10 (69%) were "very concerned." Many found it difficult at first to look beyond the short term urgency of high medical bills (especially in a worsening economic climate) and consider the long term solvency of the system.
- **Lack of accountability in government, hospitals and the pharmaceutical industry.** Participants repeatedly expressed concerns over what they saw as a Byzantine and unaccountable health care system. Most felt that the medical industry (especially the pharmaceutical companies) puts profits before people. Many also felt that fraud and abuse in the system, especially on the part of doctors and hospitals, was driving up Medicare costs.
- **No Medicare for future generations.** Many worried that future generations would not have Medicare coverage. Several younger participants said flatly that they did not expect to receive any benefits (Medicare or Social Security) when they reach retirement age.
- **The financial crisis.** The financial crisis loomed large throughout these dialogues. The first Choice-Dialogue was held one day after the government announced its \$700 billion bailout of the financial industry, and subsequent sessions were conducted in the shadow of rapidly worsening economic

news. Many participants were deeply concerned about what the turmoil would mean for their financial security and their prospects for the future. This likely made some less open to risk and to changes in the social safety net.

"The most surprising thing to me was that the people who are on Medicare in this room were actually happy with their coverage. Honestly I was shocked to hear that."

Working through the future of Medicare and how to pay for it

1. Desire to maintain Medicare in some recognizable form:

At the start of the day many participants had only a very vague impression of what Medicare is and how it works, and they were interested to hear from participants who knew about the program first-hand. Most people with direct experience of Medicare were happy with the benefits they or their family members received. At the beginning of the day 36% of all participants – and 52% of those already on Medicare – said the program works pretty well as is; only 16% of all participants (and no one over 65) said it needs to be completely rebuilt. As they heard others' experiences, younger participants quickly came to share in the generally positive view – they were impressed (and often

Do you think the Medicare system....	% agree (initial)	% agree (final)
... works pretty well and requires only minor changes	36	40
... requires major changes	49	49
... needs to be completely rebuilt	16	9

5. Participant comments illustrating key points are taken from all four Choice-Dialogues.



“We want to uphold the promise that people have lived by all their life – that there will be coverage for them, they will taken care of health-wise when they get to retirement. We believe that promise should be kept and that everyone should have a basic level of coverage.”

surprised) by the relatively high level of satisfaction expressed by Medicare recipients.

More broadly, participants felt that we have an obligation to care for the elderly. This was also reflected in participants’ steady support of Scenario #2 (Keep promises to the elderly; pay for the current system), which was the highest ranked scenario throughout the day. At the end of the day, three-quarters of participants (76%) – including majorities of all income groups, education levels, ages and political orientations – said that “everybody is entitled to the same level of health care”; only 23% viewed it as a commodity where those who could pay more should get something better.

Participants saw Medicare as a vital part of this social contract – and they felt that Medicare must be maintained even if this meant that the broader public subsidizes benefits for the elderly.

As they developed a clearer understanding of what Medicare offered and heard from people who liked the benefits they had, participants became firmer in their desire to maintain the program in some recognizable form. Participants wanted to change and improve the existing system, not completely restructure it: the number of people saying the system “needs to be completely rebuilt” was low

at the outset and dropped over the course of the day (16% initial, 9% final).

2. But the status quo is not sustainable

But while participants wanted to maintain Medicare in a recognizable form, they soon realized this would be far more difficult than they had originally thought. Most were surprised to learn about the challenges facing the system. In particular they were surprised by:

- **The fact that Medicare is not self-sustaining:** Many had assumed that they paid enough in FICA taxes to cover the cost of Medicare. They were surprised to learn that FICA taxes, premiums, co-pays and other out-of-pocket costs paid by beneficiaries add up to less than 60% of Medicare dollars spent, with the rest being paid out of general taxes.
- **The dwindling ratio of workers to retirees:** While 5 workers supported each retiree in 1960, today that ratio is only 3:1 and by 2030 it will be down to 2:1.
- **How fast health care costs are rising:** Many had encountered this in their own lives (e.g. through rising insurance premiums or steep medical bills) but

most had not previously connected the dots and seen the problem as systemic.

- **The unfunded obligation:** On average workers now pay \$2,300/year to fund Medicare, but this is projected to rise to \$6,000/year by 2030 just to maintain benefits at current levels. As participants took in this trendline they began to seriously question how we would pay for Medicare into the future.
- **The national debt:** Many participants knew that the U.S. has a sizable national debt, but few had given much thought to the implications. Looking at projections of federal spending in coming years, they were dismayed to see interest making up a larger and larger share of the budget and they worried that this would crowd out other important priorities.

These facts led to a growing realization that the status quo is not sustainable: some major changes would be needed.

Participants quickly agreed that any changes must be phased in over a long period of time – no one wanted reforms that would pull the rug out from under people already or soon to be retired. The question was how to shape a system that would be sustainable over coming decades.



3. Changing Medicare to help sustain it in a recognizable form

Participants then began to consider what kinds of changes to Medicare would allow it to continue in recognizable form while making the system sustainable for future generations.

Most people did not think current Medicare benefits are excessively generous. They said the program was doing what it should by covering necessary medical costs like doctor visits, hospitalization, prescription drugs. Some groups felt Medicare should cover more, especially in terms of prescription drugs and preventive care. But all participants across the board agreed that at a minimum seniors should be able to see a doctor, be protected from the high cost of hospitalization and treatments, and have coverage for preventive care.

This conviction probably played a role in participants' response to the question of whether we should control Medicare costs by "limiting benefits": only 29% supported this approach at the beginning of the day, and even fewer (20%) at the end. Participants may have interpreted "limiting benefits" as cutting back on core services and undermining the basic assurance that seniors will get the care they need.

But participants were open to considering other changes that they did not interpret as limiting benefits, as long as these changes would make the system more sustainable and efficient in their own right. Over the course of the day, participants struggled with tradeoffs and arrived at a set of changes that they could support:

- **Allow Medicare to negotiate prices for prescription drugs (94% support).** Participants overwhelmingly agreed that it made sense to use the government's bargaining ability to reduce the price of medication. Many were outraged at drug companies' huge profits, and had no qualms about reining them in. When asked about possible negative impacts on R&D, most were not concerned – they did not believe that this would have any major effect on companies' willingness or ability to bring new drugs to market.
- **Encourage hospice care instead of heroic measures at end of life (85% support).** Participants were surprised to learn that one-quarter of Medicare spending goes to care for people in the last year of life, and they questioned whether focusing so intensely on end-of-life care was the best use of resources. The subject of end of life care sparked some of the most intense conversations of these dialogues. Younger people in particular were likely to say that seniors should be able to opt for unlimited heroic treatments if they or their families wanted them. Older participants tended to take a more moderate view, describing cases in their own families where heroic measures only prolonged suffering. As they discussed the issue, most ultimately agreed that hospice and palliative care should be more widely accepted and available.

But while participants overwhelmingly supported encouraging hospice over heroics and nearly two-thirds (65%,

including nearly half of participants over 65) said they would be willing to accept some limits on end of life care for themselves, they were not willing to make that decision for others. Instead they said we must find better ways to support people facing the end of life so that it is easier for people to make the choices that will work for them and their families. This will require not only better education about options, but also a change in how medicine is practiced and a broader shift in our culture's attitude. As a first step, participants suggested that people be asked to indicate their preferences for end of life when they enroll in Medicare, and that they be given information and support to help them make those decisions.

"I think if we educate seniors, some of them would want to have living wills and Do Not Resuscitate orders. Sometimes when it gets to that point those things aren't in place so families don't make that decision. But I think that if we provided more education or sent people out to help people write these things more people [would have them], especially Baby Boomers who are used to being independent and having their dignity."

• **Only covering treatments scientifically proven effective (68% support).** Most participants agreed on principle that Medicare dollars should be targeted to treatments that have been proven effective. But as they drilled down on this question, issues of trust and concerns about bureaucracy and its assumed focus on the bottom line over individual patients' health came to the surface. They wanted to make sure someone they trust and who knows them imposed these limits. While most indicated they would accept their doctors' decision about appropriate treatment, they were not so willing to accept decisions made by a faceless medical review board. Nearly two out of three (62%) felt that the doctor's judgment should prevail in decisions about treatment.

- They were NOT willing to impose strict limits on services according to a prioritized list created by an independent commission (30% support, 69% oppose). This struck participants as too extreme. They were concerned that vital treatments would be left off the list and new treatments would not be added. Many also felt that this approach left no room for doctors to innovate or try unusual approaches that could work



"Who decides what should be covered and what shouldn't? Who's going to play God? That's where we hit a wall because ... doctors right now are getting paid by drug companies to push their drugs. That's what gets me, that's my dilemma. Who's going to be the fair person?"

in a given case. And participants were deeply suspicious of who would decide what to include.

- When participants were pressed on the question of who they would trust to make such determinations, their top answers were citizens, health care experts, and doctors. Elected, civic and business leaders were much less trusted. But participants were worried that even "more trusted" agents could be corrupted by outside interests like drug companies and insurance industry lobbyists.
- Nonetheless, they recognized that unlimited coverage for everyone was impractical and costly – some limits would need to be set. Ultimately they agreed that they would be willing to move towards an "evidence-based" approach only if it included a robust appeals process so that their doctors could go to bat for them if they needed a non-standard treatment. They recognized that this would add costs and complication, but they needed assurance that reasonable treatments would not be denied to save money.

• **Emphasize preventive care and personal responsibility.** Participants agreed that improving preventive programs would improve seniors' quality of life while also reducing Medicare costs in the long run. (56% said covering preventive care was "essential"; another 33% said it was "very important.")

- When asked for a more precise definition of 'preventive care,' most participants first listed checkups, immunizations, screenings, and care for chronic conditions.
But they quickly agreed that relying on medical professionals to catch problems early was not by itself enough: preventive care should also teach people to take better care of themselves and help them do so. Most participants agreed that Medicare should cover health education in areas like nutrition, exercise, managing chronic illness, or stopping smoking. Several people noted that this education needs to extend beyond the medical realm to include education about how the system works and how to effectively manage one's finances and plan for health care in retirement.
- Preventive care fit with participants' ongoing emphasis on personal responsibility. Most participants felt that people could and should do more to keep themselves healthy and they wanted Medicare to encourage that. Some suggested making preventive care mandatory, by fining or otherwise penalizing people who skip regular checkups or screenings. However, most felt that this was too punitive and instead suggested using incentives — for example those who get preventive care would pay lower co-pays and premiums.

A: "You need to have some personal responsibility for your actions. If you are not eating right, not working out, constantly engaging in activities that are bad for your health and then you expect that I'm going subsidize that bad behavior?"

B: "But [making it] mandatory is a little scary to me. I think an incentive to get people to lose weight or quit smoking is OK – but for them to say to you, you're not covered if you don't quit smoking, that's just [too much].... Maybe there should be different levels of plans or costs, and if you're compliant with your plan then you get a reduction or something like that."

- There was also strong support for requiring an initial health assessment and screening on enrollment in Medicare. In addition to identifying potential health problems as early as possible this would allow doctors and patients to start working on preventive care and disease management as soon as people enter the system.

- **Gradual increase in the Medicare eligibility age from 65 to 67 (68% support).** In earlier research on the federal budget and the future of Social Security and Medicare, many participants resisted increasing the retirement age, feeling that this placed too great a burden on seniors, especially those in physically demanding jobs. Recent polls show a similar attitude on the part of the general public.⁶

Participants in the current project shared these concerns, and many – especially the young – were initially resistant to the idea of raising the retirement age. But by focusing on Medicare in these dialogues without the added questions around Social Security and other federal programs, participants were able to develop a deeper understanding not only of the challenges facing the program but also of the disability protections it contains for people who are unable to work. Six out of ten participants (61%) felt that the aging population is one of the top reasons behind the increase in Medicare costs. Given that people are living longer, and often remaining healthier, most ultimately concluded that it would be necessary to raise the retirement age, provided that current provisions for disability remain in place to protect people who become physically unable to work.⁷

4. Paying for it

At the beginning of the day few participants had even considered the possibility of spending more on Medicare, but as they learned more and connected the dots most began to rethink that assumption. Many were especially struck to learn that just keeping benefits at current levels would require the average annual amount paid in per worker to more

than double over the next 20 years. And while participants felt that some of the measures they laid out above would help control costs (like raising the retirement age) they recognized that others (like a major expansion of preventive care) would probably cost more, at least in the short run. If current revenues were not enough to cover these costs then more money would have to come from somewhere. The question was where.

- **Do not increase the national debt.** Participants agreed quickly that they did not want to borrow this money and add to the national debt. 70% said they were 'very concerned' about the national debt, and another 25% were 'somewhat concerned.' Some pointed to the graph showing projected interest payments on the debt in coming years – passing more of these costs on to their kids and grandkids struck them as both misguided and wrong. The financial crisis and the bailout added to their conviction – participants agreed that finding another \$700 billion was going to make an already bad budget situation even worse.
- **Cuts in other spending.** Participants' first choice was to pay for Medicare benefits by making cuts in other government programs: at the beginning of the day

"I think that the thing that surprised me the most was how much of our money is going to pay off our national debt. That chart was just a shock for me to look at. I'm still going to be putting money into the system. But most of it will be going to pay that off."

6. For instance, in a November 2006 Kaiser Family Foundation/Harvard School of Public Health poll, 70% of respondents opposed raising the retirement age.

7. Support for this proposal was strong across all age groups except for the very youngest participants (under 30), who were narrowly opposed (47% support, 53% oppose). Most of these young people did not seem concerned that they themselves would have to wait an extra two years before becoming eligible for Medicare. Instead, they gave the impression that they simply saw 65 as "old" – people who reach that almost unimaginable age probably wouldn't be able to work and shouldn't be expected to. In short, they seemed motivated by protectiveness towards their elders rather than self-interest.



"We all talk about there's no money. There's no money for Medicare, there's no money for this and no money for that. But within in a week's time you could get \$700 billion to bail out rich fat cats and CEOs. And the war, too. The money's there, it's just being used inappropriately."

"I hope decision-makers think about the earmarks that they set aside for things that I think are quite unimportant. We need to prioritize money more to the most important things, and Medicare and the health [care] system I think should be on the top."

78% supported this approach, and by the end support had grown to 88%. When asked what specifically should be cut, the most common responses were the wars in Iraq and Afghanistan. Beyond this, participants were less certain; they did not agree on major cuts in other government activities in the limited time available. The discussion of what other activities might be cut and what should have priority for government spending could easily have been the subject of a dialogue in its own right.

All participants emphasized the need to make spending more efficient and get rid of waste. A few pointed again to the bailout as evidence that there is more wiggle room in the budget than we think – somehow the government can always find more money when it has to! Even when other participants noted that much of the bailout money is being borrowed, most agreed with the underlying point that there are inefficiencies and waste in current government spending and that those must be addressed first. Across the board participants agreed that Medicare is a high priority and should take precedence over other spending – and their increased support for cutting other programs should be understood in this light.

- **Increasing taxes.** But as participants learned more about how government spending is currently allocated they saw there were fewer obvious places to cut than they had hoped: cutting the 'usual suspects' citizens often raise as examples of government extravagance (e.g. the space program or foreign aid) would not make much of a dent. And as it became clearer how much would be required just to maintain the level of benefits they wanted to see, they began to realize that spending cuts alone – no matter how drastic – could not preserve Medicare. They themselves would have to pay more in taxes.

"I don't think anybody would mind paying if they knew what they were paying was going to what they wanted to pay for. I don't think anybody would mind increasing taxes if they really knew where their money was going."

But they were not willing to pay more for just anything - over the course of the day it became clear that the Medicare system for which participants would be willing to pay more in taxes would have to include a number of essential elements. Specifically, it would need to:

- Protect seniors from financial ruin as a result of medical problems (67% say this is "absolutely essential," 24% "very important").
- Pay a major share of hospital costs (61% say "absolutely essential")
- Cover the cost of preventive care, like flu shots and mammograms (56% say "absolutely essential")
- Pay a major share of the cost of doctor visits, laboratory services and medical equipment (50% say "absolutely essential")
- Address fraud and waste in the Medicare system (participants ranked this as the second most important cause of high costs, second only to drug and insurance industry profits)
- Increase accountability and transparency about how money is spent.

"We're going to have to pay more if we want this, and the sales tax, while it's not necessarily the best solution because it's such a regressive tax, is the kind of approach that we're going to need. Everyone is going to have to pay higher taxes in some form or we're not going to get what we want."

Provided that these conditions were met participants were willing to pay more for Medicare:

- **79% said they would be willing to pay more taxes to keep Medicare benefits at their current level.**
 - Once participants agreed in principle that they would be willing to pay additional taxes they struggled with the specifics. Most began with the lowest-hanging fruit – taxes targeted at other people and at undesirable behaviors. In every dialogue, participants suggested **sin taxes** on alcohol and tobacco. Not only would this bring in revenue, they reasoned, it would also discourage smoking and drinking and make the population healthier. Many also looked for ways to shift the burden to wealthier people by taxing yachts or other luxury goods. However, as they compared the amount that this would bring in with what was needed they soon recognized that this would not make much of a dent in the projected shortfall. This was not a problem that could be passed on to other people. Nor should it be – since Medicare was a benefit that all Americans share, they themselves would have to step up to the plate.
 - As participants considered what kind of tax would be fair and effective, most gravitated towards a **sales tax**. In large part this was because of sales taxes' simplicity, transparency and universality. The strongest support was for a 2-3% national sales tax (75% support, strong across income, age and political lines). 37% supported a higher national sales tax of 5-7%; only 16% supported a 10% tax.
 - Most participants also supported increasing the **payroll tax** rate (63% support). This form of taxation was familiar and most agreed that a small increase would not be an excessive burden. However the lowest income participants (those making less than \$30,000/year) were split in their support and the youngest (under 30 years old) were narrowly opposed.
 - In every dialogue participants were clear that any new taxes must be specifically dedicated to Medicare. They called for strong oversight to make sure that leaders would not be able to raid the funds for other purposes. In addition, participants wanted stronger accountability for how Medicare is run. They supported the idea of a review board to oversee how Medicare is administered and arbitrate disputes over coverage. Specific suggestions included governmental oversight boards, a stronger role for the GAO, and watchdog groups. Most groups emphasized that Medicare oversight must be insulated from the political process to minimize the influence of special interests, and all envisioned a strong role for ordinary citizens in this oversight, whether through some kind of jury system or by other means.

"I think some senior citizens should be on [this commission]. A person who's using the benefits. We're talking about medical needs, ethical needs, financial needs, social services, old people's needs. We have to have some old people on there."

- **Trust and accountability:** Participants agreed that there must be some kind of independent oversight commission to make decisions about how Medicare dollars are spent and make sure the system is well run, but they struggled with the question of who they would trust in that role and whether unbiased oversight is even possible. Many felt that in recent years both elected leaders and the private sector have completely failed to protect the public interest, and that even the once-trusted medical profession is in danger of being corrupted by drug and insurance companies. As a result most were skeptical that elected, civic or business leaders could be trusted on such a commission: instead, their first choice



How willing would you personally be to take the following steps as a way of reducing the cost of Medicare and the financial burden on future generations?	Very willing (%)	Somewhat willing (%)
... Agree to limits on care for terminal illness	21	44
... Choose catastrophic insurance that kicks in only after medical expenses exceed 10% of annual income	18	42
... Pay a larger share of the cost of coverage through higher deductibles, premiums or co-payments	7	42
... Accept reduced prescription drug coverage	12	26



was ordinary citizens. While most agreed that technical and medical expertise would be needed to make good decisions – and so doctors and health care experts should be included as well – participants’ top priority was to make sure that ordinary people’s concerns would be represented.

- **A sliding scale.** In addition to paying more in taxes, half of participants (49%) said that they personally would be willing to pay more of the cost of coverage through premiums, deductibles and co-pays. However, only 15% supported requiring this of all seniors because of concerns about the impact on low-income retirees. Instead, a strong majority (68%) favored a more progressive approach of scaling

“[People] should pay more into it the more they make because they have more to give. Maybe a person who makes a very meager income cannot pay as much, but they deserve the same care.”

Medicare premiums to income. This support was equally strong among higher income participants who would have to pay more.

A minority of participants felt it was unfair to charge some people more for the same benefit. But as they looked more closely, participants noted that in fact no one is paying the full cost of their benefits – only about 60% of Medicare costs are covered by recipients themselves. The question then became whether Americans should subsidize benefits for upper income seniors, and most ultimately agreed that it made sense for wealthier individuals to pay more of their share.

Participants’ willingness to pay more increased significantly over the course of the day: at the start of the dialogue only 31% supported paying for Medicare with increased taxes; by the end of the day, that had risen to 68%. Support for raising taxes rose dramatically in every dialogue and across all ages, incomes and political orientations; the shift was most notable among conservatives, who started out strongly opposed and wound up strongly favorable (moving from 19% support for raising taxes to 63%).

“We want the individual ... not just to have the choice of a provider, but have the choice of the type of healthcare. We want the government to be the bank, not the decision-maker about the healthcare.”

Role of the market

- **Vouchers/Individual accounts.** Some participants saw a role for vouchers and individual accounts (10% supported them strongly, another 31% supported them somewhat). Supporters liked the flexibility and freedom offered by a voucher system – especially the ability to choose a provider and a health care plan. Many also did not want the government making decisions about coverage.

But when asked to make a choice 74% said that we should keep Medicare as a government program that provides the same benefits to all; only 24% supported giving seniors funds and allowing them to choose the coverage they want and can afford. Participants were concerned

that most seniors would be worse off if such a system replaced Medicare, and they did not trust private insurers to provide adequate coverage. In addition, many were very wary of approaches that make Medicare benefits less secure, pointing to the recent stock market crash as an object lesson in the dangers of trusting vital benefits to the vagaries of the market.

Most groups concluded that they were open to giving people greater choices, but that vouchers and individual accounts should be considered only as supplements to the current system, not as a replacement.

- **Health Savings Accounts (HSA's).**

Most supported making HSA's more widely available and more flexible (e.g. increasing the amount of money that can be put in each year). However, participants saw them as supplements to a government-run Medicare plan, not as an alternative. Some also were concerned that dramatically expanding HSA's would mostly provide a tax shelter for the wealthy.

- **Voluntary reductions.** Many participants said that voluntary reductions could play a role in controlling costs, and many were willing to consider at least some reductions themselves. As discussed earlier, a

"If you opt out, can you opt back in? I was with the idea, and then I thought, okay, I got my money in the stock market, and we went down 1000 points. And I don't have any money anymore. Now what?"

strong majority (65%) said they would be willing to accept limits on care for terminal illness; a majority also said they would be at least somewhat willing to consider catastrophic insurance that would kick in only after medical expenses exceed 10% of their annual income. About half of participants said they might be willing to pay higher out-of-pocket costs, but only a minority (38%) would be willing to pay more for prescription drugs.

However, most did not think that voluntary reductions by themselves were an adequate solution to the problem of spiraling Medicare costs for a number of reasons. Some said that while they would be willing to opt out of some aspects of Medicare (e.g. by accepting catastrophic coverage), they would want

to be able to opt in again if their health or their financial situation deteriorated. Others said that they would opt out only if they received a voucher or credit for the amount saved. In either case the net savings were likely to be minimal.

This is not just about Medicare

Participants were asked to focus their discussion specifically on the future of Medicare. But participants in all four locations felt that it is important to consider retirement health care in the broader context of health care in the U.S., and these broader issues surfaced repeatedly. They felt that some problems facing Medicare are the result of failures in the broader health care system – if we want to fix Medicare we must address these issues as well. Two themes were especially important:

- **We need to fix our health care system.**

Many participants felt that the U.S. health care system is broken, with costs out of control and ever more people with inadequate coverage or none at all. One result of this system failure, they said, is that too many Americans are already in poor health when they reach retirement. They wanted better and more affordable health care for all Americans. As a first step to easing the strain on Medicare, they felt it would be a good

"Quite frankly, we're not talking about my future. We're talking about yours. . . . And you have to decide, do you want to get the same kind of care that I'm getting now, or do you want to lessen that degree of care? Do you want for yourself less than I have?"



Do you favor/oppose gradually replacing guaranteed Medicare benefits with vouchers and individual accounts that seniors can use to buy health insurance?	Age <30	Age 30-49	Age 50-65	Age 65+	All participants
% favor (strongly/somewhat)	53	54	32	8	41
% oppose (strongly/somewhat)	48	47	65	91	58

Which do you think is better?	Age <30	Age 30-49	Age 50-65	Age 65+	All participants
Keeping Medicare as a government provided program with the same benefits for all	62	70	81	91	74
Giving seniors some funds to pay for health insurance and then leaving it up to them to decide how much coverage they need and can afford	35	28	16	9	24

investment to prioritize prevention and healthy behaviors for all Americans. As several people pointed out, age 65 is too late to begin emphasizing preventive care.

- **We need to educate younger Americans.** Participants also felt that many younger Americans are not well prepared for what they will face in retirement, and that everyone – young and old alike – needs to be given the tools and training they need to take on more personal responsibility for their health and well-being. They felt this was especially important when it comes to end-of-life issues and financial planning, and they wanted seniors and people entering the system to have a much clearer sense of their options. Many said they had learned a lot from the dialogue itself, and they hoped that more people would have a similar opportunity. (At the end of one session a participant asked to take some of the materials home so her grandchildren could start learning about Medicare.)

Younger people's perspective

The above conclusions were shared by participants of all ages, incomes and political orientations. Young and old people shared significant common ground on most issues being considered. However we did note that young people – especially those under 30 – viewed some issues through a slightly different lens.⁸ Because of the small sample these findings must be treated with caution, but the overall pattern merits further research.

- **Health care a way into the issue.** Younger participants tended to find their way into this unfamiliar issue by thinking about it in terms of health care. While they knew relatively little about the debt, the federal budget or Medicare, most young participants had some experience with – and concerns about – the U.S. health care system. Many had had troubles with finding accessible and affordable care (younger participants were significantly more likely to be uninsured).

- **Less knowledge and experience.** The broader health care issue gave younger people a handle on some aspects of the Medicare problem, but their learning curve was especially steep. Many younger participants had given little thought to retirement, Medicare or government programs before the dialogue, and they had little real world experience to help them bridge the gap. In these instances having the opportunity to talk with older people was especially powerful in showing younger people why Medicare mattered, what was at stake for their future and in shaping their opinions.

Younger people were particularly struck by older participants' experiences with Medicare. Most participants who were on Medicare themselves were quite satisfied with the program and younger participants were impressed ("Where do I sign up?" one joked).

- **Less support for increases in payroll tax.** Participants under 30 showed less support for increased payroll taxes. This

8. Participants under age 30 made up 22% of the total sample, proportional to their representation in the over-18 population of the United States.

may have been in part because these taxes heavily impact lower income wage-earners, and they (as a relatively low income group) would be directly affected.⁹

- **Less support for raising the retirement age.** Among participants under 30, 47% supported raising the retirement age to 67; 53% opposed it (by contrast, 68% of participants in the aggregate supported raising the retirement age). We often noted that when young people talked about Medicare in these dialogues they described it as something affecting other people, not themselves. This suggests that their opposition may have been motivated more by a desire to protect their elders than by concern that they themselves would have to work longer once they grew older themselves.
- **More likely to express interest in vouchers or individual health accounts.** Support for vouchers and individual health accounts was related to age. More than half of participants under 30 – and similar numbers of those between 30 and 49 – expressed some interest in replacing Medicare benefits with a system of vouchers (vs. much smaller numbers in the older age groups). Similarly, younger participants were more likely to say it would be better to give seniors funds to pay for health insurance and allow them

to decide what kind of coverage they need and can afford – though a large majority in all age groups still preferred keeping Medicare as a government program that provides the same benefits to all.

There seemed to be two main reasons for this difference:

- Many younger participants were openly skeptical that Medicare would still exist by the time they reached retirement age, especially at the beginning of the day. This widespread sense that they would have to fend for themselves may have increased the appeal of an approach that maximized individuals' control over their health care.
- We have seen in other contexts that younger people are generally less risk-averse than older people. It may be that younger participants did not share their elders' concerns about making Medicare benefits less secure - either because they were less concerned about that risk or because they were confident that they would have time to adjust if negative circumstances arose.

"I'm making peanuts right now, but I'm willing to give a little of those peanuts for the future."

Younger participants were willing to pay more sales tax to support Medicare, even if they do not receive the benefit in the short term. As groups discussed the idea of an increased sales tax to pay for Medicare, facilitators specifically asked younger participants for their thoughts. Even when it was pointed out that they would be paying a tax dedicated to health care for seniors for decades before they would receive a direct benefit, younger participants said they were willing to do so. Most felt they had a responsibility to help care for their elders, and this conviction strengthened as they spoke with other people in their groups and got a fuller understanding of how important Medicare benefits were to their sense of security and well-being.

As noted earlier, the sample size is small; these findings should be taken as promising indications for further investigation. More research will be needed to determine whether some of these factors, in particular the different attitudes towards market-based approaches, will change over time or whether they signal a generational shift.



9. While as might be expected the under-30 group had lower incomes than other cohorts, a correlational analysis shows that this difference on payroll tax is associated more strongly with age than with income. Those over 65 were almost as likely to have low incomes, but since more of them were retired they would be less affected by a payroll tax.



CONCLUSIONS

This series of dialogues holds important lessons for leaders and advocates who want to build public support for significant Medicare reform. The findings indicate how Americans are likely to move along the learning curve in the future given time to work through the implications of proposed reforms. It also suggests what leaders can do to affect, advance and accelerate the public's movement along the learning curve and help build broad-based public support for change.

Working within the public's framework

Citizens and experts often approach issues with different assumptions, frameworks and terminology – and when these are at cross-purposes, misunderstanding and mistrust can result. In the course of the dialogues we noted some signal examples where the public's frameworks and assumptions do not mesh with experts'. Experts, even those actively reaching out to the public through public forums, can easily overlook these differences. Citizens who choose to participate in public forums on fiscal issues and entitlements usually have some familiarity with the language and frameworks of policy making – but the randomly selected citizens who

attend a Choice-Dialogue have the same widely varying levels of knowledge and sophistication that are found in the general population. This is the framework that leaders must understand if they are to help the broader public advance along the learning curve. In particular:

- ***Different understanding of what Medicare benefits are (and what it means to limit them):*** Many experts and policymakers think of Medicare “benefits” as a specific package – who is eligible, what services are covered, and the subsidy that offsets the cost of premiums. However, the public defines “benefits” both more narrowly and more broadly. On the one hand, the public defines “benefits” as covered services only and pays little attention to the other technical elements. More broadly, though, the public sees “benefits” as the assurance that seniors will get needed care and be able to live with some degree of dignity and security. In the public's view “limiting benefits” implies refusing to treat people who are sick.

This distinction arose in the Choice-Dialogues. When asked whether we should restrain Medicare costs by “limiting benefits,” participants soundly rejected the idea. They did not want a system that would pull the plug on someone with a good chance of

survival, or that would refuse to treat costly conditions just because they were expensive. But they did come to accept other measures – for instance, raising the retirement age, encouraging hospice care and evidence-based medicine – without seeing them as limits on benefits in the same way. Participants were well aware that the measures they supported would scale back eligibility and lead to real changes in what kinds of treatments seniors were offered. But they saw these measures not as an attack on benefits as they defined them, but as reforms that made sense in their own right (for example, raising the retirement age to reflect the realities of 21st century aging, encouraging more sensible end of life care, etc.).

It is important to be aware how the public interprets any discussion of benefits, and to frame any changes as valuable in their own right, not as reductions in benefits. To win public support, any proposed changes also need to respect (and be seen to respect) Americans' core value that seniors be protected and cared for. A good starting point would be to establish that this value is one that you share — it is common ground. The question then becomes how best to realize that value.

- ***The real cost of health care.*** Very few participants had a clear sense of how much health care actually costs in America or how those costs are distributed. Most thought of it in terms of how much they spend on premiums and out of pocket expenses, and they assumed that this money accounted for most health care dollars spent, both on Medicare and on health care in general. Similarly, very few were aware of the extent to which Medicare benefits are subsidized. Most were surprised to learn that more than 40% of dollars spent on Medicare come out of general taxes, and this information caused them to rethink

their assumptions. If all they were paying only added up to a bit more than half of what health care for the elderly really costs, then perhaps the problem was bigger than simple waste, fraud or greed.

Leaders hoping to move the public along the learning curve should keep in mind that most Americans have only a limited picture of what Medicare really costs, how those costs are distributed and how the pieces of the system fit together. They may be familiar with individual pieces of the puzzle but they will need help connecting the dots. This is work that needs to be done before advancing major reforms.

- **Scale:** Participants readily understood that Medicare faces a funding crisis, yet many found it difficult to grasp the scale of the problem. The amounts at stake were so unimaginably huge that participants frequently used ‘billions’ and ‘trillions’ interchangeably.

We found that some kinds of information were more effective in helping participants understand the magnitude of the problem:

- **Cost of the bailout vs. cost of Medicare.** Many were struck by the fact that the entire financial bailout package (\$700 billion at the time of the Choice-Dialogues) would pay for less than 2 years of Medicare today. This comparison brought home the size of the Medicare budget .
- **The dwindling ratio of workers to retirees.** Many people had heard in a general way that Americans are living longer and having fewer children, but had not considered the effect this was having on Medicare and other entitlement programs. Learning that Medicare is a pay-as-you-go system and seeing the changing ratio of workers supporting each retiree (from



5:1 in 1960, 3:1 today, and only 2:1 in 2030) had a powerful impact. This was a demographic fact that could not be dismissed.

- **How much it will cost to maintain benefits at current levels.** Many participants were not unduly surprised to learn that on average workers pay \$2,300/year to fund Medicare, and they assumed that these amounts would go up some in the future as a result of inflation. But they were dismayed to learn that the aging population and rising health care costs would cause this figure to nearly triple over the next 20 years, at which point it would cost an average of \$6,000/year just to maintain current benefit levels. This information made the aging society and the rise in health care costs much more concrete for many participants and gave them a better framework for considering changes in the program.
- **On the other hand, some pieces of information did not help participants get a better sense of scale.** For instance, participants were told that the total unfunded obligation will total \$34 trillion over 75 years (or \$170,000 for every man, woman and child in America). But the concept was too abstract, the numbers too

large and the timeframe too long to provide a useful framework for discussion.

Communicating the magnitude of the challenge more effectively, using some of the measures outlined above, can help to build the public understanding and support needed for significant reform.

- **Health care (and especially Medicare) is not a commodity.** In these dialogues on Medicare, and in others we have conducted on health care more generally, we have seen a growing belief among Americans that health care should be regarded less as a commodity and more as a right – and that making sure all American seniors have good care is an important priority. Over the course of the day even participants who initially doubted that Medicare would still be there when they retired became less concerned about this possibility. In part this may be because they saw their own conviction – that Medicare is a promise that must be kept – reflected in what most participants were saying. To win public support, proposals for major reform to Medicare need to recognize the extent to which Americans see Medicare as an essential part of the social contract and not just as another government program.

• **Market-based reforms.** The current financial crisis makes moves towards market-based reforms less likely to win public support. Americans are deeply concerned about what the economic turmoil will mean for their financial security and their prospects for the future, and are almost daily inundated by stories of organizations and individuals in the market betraying the trust placed in them. In this context, people are less willing to trust programs crucial to their health or wellbeing to the market.

At the same time, the public does seem to be willing to consider a role for market-based reforms as add-ons to the existing system. Positioning such reforms as ways to strengthen the current system rather than replace it is more likely to win public support and move the public along the learning curve. As the Bush Administration's Social Security initiative shows, advancing reform measures before the public is ready to accept or even consider them is likely to backfire. This is true even if the proposal is one the public might have ultimately supported given time and effective leadership.

This research indicates that younger people may have a somewhat different view of market-based reforms. While more research is needed to understand whether this is an age-related perspective that will change as people get older or a signal of generational change, it suggests that the public may be open to a further exploration of this issue in the future.

Participants went a long way along the learning curve in these Choice-Dialogues. As they worked through the possibilities and tradeoffs they showed strong support for maintaining Medicare in a recognizable form, even if that required them to pay more taxes. But they could not get to a fully sustainable solution in a single step: in particular, the level of

taxation most were willing to countenance at this point is unlikely to be enough to meet future needs. It will take some time for the magnitude of the future Medicare obligation to sink in - and it is not yet clear which way the public will go when it does. As they move further along the learning curve in years to come, Americans may become willing to pay significantly more if that is what is required to preserve Medicare in a recognizable form. Or they may become more willing to consider additional changes in what Medicare offers.

Building public support for significant reform means helping the public advance along this learning curve. This will include using the public's language rather than expert terminology (about questions like benefits), helping the public better understand the real cost of Medicare and the scale of the fiscal challenge before advancing major reforms, and acknowledging that the public places a high value on helping seniors and does not see Medicare as a program like the others. More generally, it will involve understanding how people process information, the steps they take as they work through the issues, and how to sequence the conversation in a way that keeps pace with the public's learning process.

Just as important, this research suggests that it is possible to engage diverse perspectives on a difficult subject like Medicare and to reveal powerful common ground on which leaders can base real reform. There are many ways to have this conversation. Some do not bring out the best in us, as was painfully evident in this summer's town hall meetings. But some do. This report demonstrates how leaders might help move the public along the learning curve towards thoughtful judgment and sustainable solutions for one of our country's most difficult challenges.

Choice-Dialogue: THE METHODOLOGY

Choice-Dialogue methodology differs from polls and focus groups in its purpose, advance preparation, and depth of inquiry.

PURPOSE

Choice-Dialogues are designed to do what polls and focus groups cannot do and were never developed to do. While polls and focus groups provide an accurate snapshot of people's current thinking, Choice-Dialogues are designed to predict the future direction of people's views on important issues where they have not completely up their minds, or where changed circumstances create new challenges that need to be recognized and addressed. Under these conditions (which apply to most major issues), people's top-of-mind opinions are highly unstable, and polls and focus groups can be very misleading. Choice-Dialogues enable people to develop their own fully worked-through views on such issues (in dialogue with their peers) even if they previously have not given it much thought. By engaging representative samples of the population in this way, Choice-Dialogues provide unique insight into how people's views change as they learn, and can be used to identify areas of potential public support where leaders can successfully implement policies consonant with people's core values.

ADVANCE PREPARATION

Choice-Dialogues require highly trained facilitators and (above all) the preparation of special workbooks that brief people on the issues. These workbooks formulate a manageable number of research-based scenarios, which are presented as a series of values-based choices, and they lay out the pros and cons of each scenario in a manner that allows participants to work through how they really think and feel about each one. This tested workbook format enables people to absorb and apply complex information quickly.

DEPTH OF INQUIRY

Polls and focus groups avoid changing people's minds, while Choice-Dialogues are designed to explore how and why people's minds change as they learn. While little or no learning on the part of the participants occurs in the course of conducting a poll or focus group, Choice-Dialogues are characterized by a huge amount of learning. Choice-Dialogues are day-long, highly structured dialogues – 24 times as long as the average poll and 4 times as long as the average focus group. Typically, participants spend the morning familiarizing themselves with the scenarios and their pros and cons and developing (in dialogue with each other) their vision of what they would like to have happen in the future. They spend the afternoons testing their preferences against the hard and often painful tradeoffs they would need to make to realize their values. To encourage learning, the Choice-Dialogue methodology is based on dialogue rather than debate – this is how public opinion really forms, by people talking with friends, neighbors and co-workers. These 8-hour sessions allow intense social learning, and both quantitative and qualitative measures are used to determine how and why people's views change as they learn.

STEPS IN A Choice-Dialogue PROJECT

1. ARCHIVAL ANALYSIS OF POLLS (OR CONDUCTING A SPECIAL ONE) AND OTHER RESEARCH TO PROVIDE A BASELINE READING ON WHAT STAGE OF DEVELOPMENT PUBLIC OPINION HAS REACHED.

2. THE IDENTIFICATION OF CRITICAL CHOICES AND CHOICE SCENARIOS ON THE ISSUE AND THEIR MOST IMPORTANT PROS AND CONS, AND THE PREPARATION OF A WORKBOOK BUILT AROUND THOSE SCENARIOS IN A TESTED FORMAT FOR USE IN THE DIALOGUES.

3. A SERIES OF ONE-DAY DIALOGUE SESSIONS WITH REPRESENTATIVE CROSS-SECTIONS OF THE POPULATION

Each dialogue involves about 40 participants, lasts one full day and is videotaped. A typical one-day session includes the following:

- Initial orientation (including the purpose of the dialogue and the use to be made of the results, the nature of dialogue and ground-rules for the session, introduction of the issue and some basic facts about it);
- Introduction of the choice scenarios on the issue, and a questionnaire to measure participants' initial views;
- Dialogue among participants (in smaller groups and in plenary) on the likely good and bad results that would occur as a consequence of each choice if it were adopted, and constructing a vision of the future they would prefer to see;
- A second, more intensive round of dialogue among the participants (again both in smaller groups and in plenary) working through the concrete choices and tradeoffs they would make or support to realize their vision;
- Concluding comments from each participant on how their views have changed in the course of the day (and why), and a questionnaire designed to measure those changes.

4. AN ANALYSIS OF HOW PEOPLE'S POSITIONS EVOLVE DURING THE DIALOGUES

We take before and after readings on how and to what extent people's positions have shifted on each choice as a result of the dialogue. This analysis is both quantitative and qualitative.

5. A BRIEFING TO LEADERS TO MAKE SENSE OF THE RESULTS

The briefing summarizes what matters most to people on the issue, how positions are likely to evolve as surface opinion matures into more considered judgment, the underlying assumptions and values that shape that evolution, and the opportunities for leadership this creates.

Dates and Locations of Choice-Dialogues

Phoenix, AZ: September 20, 2008

Columbia, MD: October 4, 2008

Oak Brook, IL: October 11, 2008

Houston, TX: October 18, 2008

QUANTITATIVE FINDINGS

Ratings of the four scenarios:

In each Choice-Dialogue, participants were surveyed twice, once at the beginning of the day and again at the end. They were asked to rate their response to each scenario independently on a scale of 1 to 10, 1 being totally negative and 10 being totally positive. The initial mean for each scenario indicates participants' average rating of the choice in the morning; the final mean represents participants' average rating of the same scenario at the end of the dialogue.

	initial mean	final mean
Voluntary reductions	4.8	4.9
Keep our promises to the elderly - pay for the current system	6.4	7.3
Set priorities and make the best use of limited resources	5.5	7.1
Strengthen personal responsibility and choice	5.7	6.1

ADDITIONAL QUESTIONS

11. Do you think the Medicare system...

	initial	final
works pretty well and requires only minor changes	36%	40%
requires major changes	49	49
needs to be completely rebuilt	16	9

12. Each of the following has been proposed as a way of dealing with rising Medicare costs. Please indicate how strongly you favor or oppose each one.

12a Reducing or limiting Medicare benefits

	initial	final
favor strongly	4	4
favor somewhat	25	16
oppose somewhat	33	35
oppose strongly	38	44

12b Having seniors pay more of the costs of Medicare

	initial	final
favor strongly	2	1
favor somewhat	12	14
oppose somewhat	40	42
oppose strongly	47	42

12c Raising taxes

	initial	final
favor strongly	2%	16%
favor somewhat	29	52
oppose somewhat	36	19
oppose strongly	34	12

12d Lowering Federal spending in other areas

	initial	final
favor strongly	41	59
favor somewhat	37	29
oppose somewhat	12	7
oppose strongly	10	4

13. Which comes closer to your point of view?

Everybody is entitled to the same level of health care	76%
Medical care is like anything else you buy - those who can pay more should be able to get something better	23

14. Please indicate how important you think each of the following factors is in driving up the cost of Medicare.

14a People getting medical treatments they don't really need

one of the most important things behind the increase	41
important but not one of the top factors	45
a relatively minor factor	12

14b Drug and insurance companies making too much money

one of the most important things behind the increase	83
important but not one of the top factors	13
a relatively minor factor	3

14c Doctors and hospitals making too much money

one of the most important things behind the increase	49%
important but not one of the top factors	38
a relatively minor factor	12

14d Older people getting better medical care than before

one of the most important things behind the increase	22
important but not one of the top factors	38
a relatively minor factor	40

14e An aging population

one of the most important things behind the increase	61
important but not one of the top factors	32
a relatively minor factor	6

14f The use of expensive new drugs, treatments and medical technology

one of the most important things behind the increase	51
important but not one of the top factors	40
a relatively minor factor	6

14g Fraud and waste in the Medicare system

one of the most important things behind the increase	71
important but not one of the top factors	19
a relatively minor factor	8

14h The cost of end-of-life care

one of the most important things behind the increase	46
important but not one of the top factors	42
a relatively minor factor	11

ChoiceDialogues were held in Phoenix, AZ; Columbia, MD; Oak Brook, IL; and Houston, TX. Total sample = 155

<p>15. Each of the following has been proposed as a way of dealing with rising Medicare costs. Please indicate how strongly you favor or oppose each proposal.</p> <p>15a Creating a sliding scale for Medicare premiums - the more income seniors have, the more they must pay</p> <p>favor strongly 23%</p> <p>favor somewhat 45</p> <p>oppose somewhat 19</p> <p>oppose strongly 11</p> <p>15b Increasing the payroll tax rate employers and workers pay to fund Medicare</p> <p>favor strongly 20</p> <p>favor somewhat 43</p> <p>oppose somewhat 21</p> <p>oppose strongly 14</p> <p>15c Only covering medical services and treatments that have been scientifically proven most effective</p> <p>favor strongly 24</p> <p>favor somewhat 44</p> <p>oppose somewhat 23</p> <p>oppose strongly 8</p> <p>15d Gradually raising the age when a person can receive Medicare benefits from 65 to 67</p> <p>favor strongly 32</p> <p>favor somewhat 36</p> <p>oppose somewhat 14</p> <p>oppose strongly 17</p> <p>15e Limiting the budget for Medicare and funding only high priority services</p> <p>favor strongly 5</p> <p>favor somewhat 25</p> <p>oppose somewhat 38</p> <p>oppose strongly 31</p>	<p>15f Encouraging hospice care rather than heroic measures in end of life care</p> <p>favor strongly 51%</p> <p>favor somewhat 34</p> <p>oppose somewhat 10</p> <p>oppose strongly 5</p> <p>15g Using the buying power of Medicare to get reduces prices on prescription drugs</p> <p>favor strongly 73</p> <p>favor somewhat 21</p> <p>oppose somewhat 3</p> <p>oppose strongly 2</p> <p>15h Gradually replacing guaranteed Medicare benefits with vouchers and individual accounts that seniors can use to buy health insurance</p> <p>favor strongly 10</p> <p>favor somewhat 31</p> <p>oppose somewhat 22</p> <p>oppose strongly 36</p> <p>16. Which comes closer to your point of view?</p> <p>Only treatments that have been proven effective should be covered by Medicare 38</p> <p>Medicare should cover any treatment that is recommended by your doctor, not rely on outside judgments of how effective it is 62</p> <p>17. Which do you think is better?</p> <p>Keeping Medicare as a government provided program with the same benefits for all 74</p> <p>Giving seniors some funds to pay for health insurance and then leaving it up to them to decide how much coverage they need and can afford 24</p>	<p>18. If an independent commission is established to make recommendations about Medicare budgets and coverage, WHO should be included on that commission? (Pick no more than THREE)</p> <p>elected officials 3%</p> <p>civic leaders 3</p> <p>health care experts 16</p> <p>business leaders 2</p> <p>doctors 13</p> <p>medical researchers 9</p> <p>ordinary citizens 16</p> <p>other 2</p> <p>no answer/more than three answers 37</p> <p>19. How willing would you personally be to take the following steps as a way of reducing the cost of Medicare and the financial burden on future generations?</p> <p>19a Pay a larger share of the cost of coverage through higher premiums, deductibles or co-payments</p> <p>very willing 7</p> <p>somewhat willing 42</p> <p>somewhat unwilling 30</p> <p>very unwilling 21</p> <p>19b Accept reduced coverage for prescription drugs</p> <p>very willing 12</p> <p>somewhat willing 26</p> <p>somewhat unwilling 31</p> <p>very unwilling 31</p> <p>19c Agree to limits on care for terminal illness</p> <p>very willing 21</p> <p>somewhat willing 44</p> <p>somewhat unwilling 20</p> <p>very unwilling 16</p> <p>19d Choose catastrophic insurance that kicks in only after medical expenses exceed 10% of annual income</p> <p>very willing 18</p> <p>somewhat willing 42</p> <p>somewhat unwilling 25</p> <p>very unwilling 14</p>
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<p>20. How important is it to you that each of the following be included as Medicare benefits?</p> <p>20a Pay a major share of hospital costs</p> <p>absolutely essential 61%</p> <p>very important 23</p> <p>somewhat important 12</p> <p>not very important 3</p> <p>20b Pay a major share of the costs of doctor visits, laboratory services, medical equipment</p> <p>absolutely essential 50</p> <p>very important 30</p> <p>somewhat important 16</p> <p>not very important 4</p> <p>20c No limitations on choice of doctor or hospital</p> <p>absolutely essential 44</p> <p>very important 27</p> <p>somewhat important 23</p> <p>not very important 6</p> <p>20d Pay a major share of the costs of prescription drugs</p> <p>absolutely essential 40</p> <p>very important 39</p> <p>somewhat important 18</p> <p>not very important 2</p> <p>20e Cover the cost of preventive care (mammograms, flu vaccinations etc.)</p> <p>absolutely essential 56</p> <p>very important 32</p> <p>somewhat important 8</p> <p>not very important 2</p> <p>20f Pay a major share of the costs of home health care and nursing care</p> <p>absolutely essential 25</p> <p>very important 40</p> <p>somewhat important 31</p> <p>not very important 4</p>	<p>20g No need for approvals or referrals to see a specialist</p> <p>absolutely essential 20%</p> <p>very important 38</p> <p>somewhat important 27</p> <p>not very important 15</p> <p>20h Coverage that protects seniors from being financially ruined as a result of medical problems</p> <p>absolutely essential 67</p> <p>very important 24</p> <p>somewhat important 6</p> <p>not very important 2</p> <p>21. How willing would you be to pay higher taxes to maintain Medicare benefits as their current level?</p> <p>very willing 28</p> <p>somewhat willing 51</p> <p>somewhat unwilling 10</p> <p>very unwilling 10</p> <p>22. One proposal for raising additional funding for Medicare is placing a national sales tax on goods and services. Please indicate whether you favor or oppose each of the following:</p> <p>22a A 2-3% national sales tax on goods and services</p> <p>favor strongly 30</p> <p>favor somewhat 45</p> <p>oppose somewhat 8</p> <p>oppose strongly 14</p> <p>22b A 5-7% national sales tax on goods and services</p> <p>favor strongly 11</p> <p>favor somewhat 26</p> <p>oppose somewhat 23</p> <p>oppose strongly 33</p>	<p>22c A 10% national sales tax on goods and services</p> <p>favor strongly 5%</p> <p>favor somewhat 11</p> <p>oppose somewhat 19</p> <p>oppose strongly 56</p> <p>23. Are you generally satisfied or dissatisfied with the total amount you pay for your health care?</p> <p>generally satisfied 67</p> <p>generally dissatisfied 31</p> <p>24. How concerned are you about the health care costs you and your family might face in the coming years?</p> <p>very concerned 69</p> <p>somewhat concerned 25</p> <p>not very concerned 5</p> <p>25. How concerned are you about the costs of the national debt?</p> <p>very concerned 70</p> <p>somewhat concerned 25</p> <p>not very concerned 5</p>
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DEMOGRAPHIC INFORMATION

D1. Your gender

male	44%
female	56

D2. Your age

18-29	22
30-49	39
50-65	24
over 65	15

D3. The highest level of schooling you have completed:

less than high school graduate	4
high school graduate	16
some college	29
college degree	26
graduate study/degree	25

D4. Do you currently have health insurance?

yes	85
no	15

D5. What is the source of your primary health insurance coverage?

n = 131

your employer or union	36
spouse/parent's employer or union	28
Medicare	17
Medicaid	4
a plan you bought yourself	11
other	5

D6. Annual household income from all sources before taxes:

under \$20,000	12
\$20,000 - \$29,999	8
\$30,000 - \$49,999	28
\$50,000 - \$74,999	18
\$75,000 - \$99,999	16
\$100,000 or more	15

D7. In general, would you describe your political views as:

very liberal	4%
liberal	27
moderate	42
conservative	18
very conservative	7

D8. Ethnicity

White	49
African American	21
Hispanic/Latino	19
Asian	7
Other	3

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