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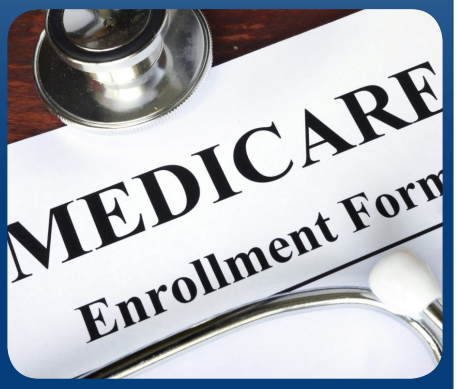
CITIZEN CABINET INITIATIVE

AMERICANS ON SOLVING THE MEDICARE SHORTFALL



A survey of registered voters nationwide, and in California, Florida, Maryland, New York, Ohio, Oklahoma, Texas and Virginia

Conducted by the Program for Public Consultation, School of Public Policy, University of Maryland

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OCTOBER 2017

INTRODUCTION

Medicare provides health insurance coverage to 55 million Americans, but its long-term fiscal health is a well-known problem. According to the Medicare Trustee's projections, Medicare's hospital fund will exhaust its reserves in 2028, which will lead to significant cuts in benefits and/or increases in premiums.

In September 2017 the government's Centers for Medicare and Medicaid issued a request for input on how to deal with Medicare's problems.

In recent years Medicare experts have proposed numerous changes meant to improve Medicare's finances. Some of these were incorporated into the Affordable Care Act. However, many other proposed reforms have not been taken up by Congress.

A major reason that Medicare has not been addressed is a widespread assumption that the American public is not willing or able to face the issue and thus bringing it up is too politically risky. In past polls, seven in ten Americans have said that what Medicare provides is worth its cost to taxpayers.[i] At the same time, when asked whether changes will be necessary in the future or not to keep Medicare financially sound, three quarters have said that changes will be needed.[ii]

Citizen Cabinet surveys take an approach that goes beyond initial reactions. Rather than a series of separate questions, respondents go through a process called a 'policymaking simulation' in which they are asked to go into a problem-solving mode. The objective is to put respondents in the shoes of a policymaker. Respondents are given a background briefing, presented arguments for and against policy options, and then finally make their recommendations.

Given current policy crosscurrents, it is little wonder that even raising the subject of Medicare policy seems to open the door to anxiety among the public and among Medicare recipients. This consultation seeks to provide a framework that lets the public consider multiple possible changes that experts have evaluated and scored, without being locked into an "either/or" choice of keeping everything the same versus changing the nature of Medicare.

DEVELOPMENT OF THE POLICYMAKING SIMULATION

The present policymaking simulation includes eleven different options estimated to aid Medicare's fiscal condition over the next 25 years, as the baby-boomer generation passes through the program.

These options selected were previously scored by the Congressional Budget Office (CBO), except for one scored by the Medicare Payment Advisory Commission or MEDPAC, another independent agency that advises Congress. They considered sixteen reform options which fell under four categories:

- Reducing Medicare's Net Payments for Benefits
- Reducing Payments to Providers
- Increasing Revenues
- Controlling Costs in Other Ways

No premium support-type option was offered, because those discussed in Congress are not sufficiently developed to be submitted for scoring.

A unique feature of policymaking simulations is that the content is reviewed for accuracy and balance. In developing this policymaking simulation, it was reviewed by:

- key majority and minority Congressional staffers who deal with Medicare; and
- experts from the Brookings Institution, the National Academy of Social Insurance, and the Committee for a Responsible Federal Budget

Final responsibility for the design and content of the simulation rests entirely with the PPC.

DESIGN OF THE POLICYMAKING SIMULATION

Introduction to Medicare and the Shortfall

The Medicare program was briefly introduced and explained as "the federal program that was established in 1965 to provide health care for Americans age 65 and older." Medicare's shortfall was then explained as follows:

When the Medicare Trustees have looked at Medicare's expenses for the next 25 years, they find that there is a **shortfall.** This shortfall is the gap between Medicare's commitments to retirees and the amount of projected revenue. Over the next 25 years, this shortfall averages $230 billion a year. Medicare can cover this long-term shortfall by either reducing its costs or increasing its revenues, or a combination of both[1].

Respondents then saw a series of graphs and charts, as the simulation explained some of the shortfall's causes:

- The projected increase in the absolute number of Americans over 65, from now to 2060
- The growth in Americans' average life expectancy--projected to hit 80 years by 2020
- The rise in overall healthcare costs, which is faster than the general rate of inflation
- The falling ratio of workers paying Medicare's payroll tax to each Medicare recipient

Respondents were then given an overview of Medicare's costs and revenues. They learned that Medicare's costs come from covering part, but not all, of the cost of three types of services:

- Outpatient treatment, such as in doctor's offices
- Prescription drugs
- Inpatient treatment in hospitals and rehabilitation centers

And that Medicare's revenues come from three sources:

- A Medicare payroll tax funding the Medicare Trust Fund for hospital insurance: All employed people have 1.45% of their work income deducted from each paycheck. The employer also matches this amount. People with incomes over $200,000 also pay an extra amount. The money is then used to pay for Medicare's hospital insurance program.
- General revenues: The federal government finances a percentage of the program's costs from its general revenues; this percentage is supposed to remain under half of the total costs.
- Premiums: People on Medicare pay a monthly premium for coverage of outpatient services and another for prescription drugs, which is supposed to cover about one quarter of the program costs.

Presentation and Initial Assessment of the Reform Options

Respondents were presented 11 different types of reform options. Four of them included two to three gradated sub-options. Thus, a total of 16 options were considered. Each option was scored in terms of the percentage of the shortfall it would cover. The reform options fell under four broad

[1] The amount of savings and/or revenue needed to cover this period's shortfall is derived from the extra points of taxable payroll needed to cover hospital insurance (Part A), plus the amount of savings/revenue required to keep the general federal revenue share of outpatient care (Part B) at the called-for limit of 45% of the cost of the program. This total amount is $6.34 trillion over 25 years, which comes to an annualized average of $230 billion.

categories:

- Reducing Medicare's Net Payments for Benefits
- Reducing Payments to Providers
- Increasing Revenues
- Controlling Costs in Other Ways

These options were previously scored by the Congressional Budget Office (CBO), except for one scored by the Medicare Payment Advisory Commission or MEDPAC, another independent agency that advises Congress.

For each option, robust arguments were presented for and against it. The arguments were distilled from actual ones made in the policy discourse, then vetted by experts and congressional staffers. Respondents evaluated each in terms of whether they found the argument convincing or not.

Respondents then evaluated the reform option on a scale of 0 to 10, with 0 being completely unacceptable, 10 being completely acceptable and 5 being just tolerable.

Making Final Recommendations

After considering each option separately, all of the options were presented together in a single spreadsheet, with the percentage of the shortfall each would cover. Respondents were then asked to make their final recommendations by selecting among the options the ones they would recommend to their member of Congress. An interactive feature gave respondents immediate feedback on the impact of their choices on the shortfall.

Because not all of the options for addressing Medicare were presented in the process, and covering the shortfall with the available options was challenging, respondents were not urged to try to cover the full shortfall. They were told that "These are not all the proposals that have been put forward," but that they "represent a major starting point for dealing with the problem."

FIELDING OF SURVEY

The policymaking simulation was fielded as a survey with the national Citizen Cabinet, a citizen advisory panel consisting of a probability-based representative sample of registered voters.

Recruitment
The national panel of 7,959 respondents was recruited from the larger panel of Nielsen-Scarborough, which was recruited by mail and telephone using a random sample of households. Additional recruiting of 251 respondents in Maryland, Oklahoma and Virginia by telephone and mail was conducted by Communications for Research. The survey itself was conducted online.

Total Sample: 8,210
National Sample: 7,959
Margin of Error: +/- 1.1%

State Samples:

State	Sample Size	Margin of Error
California (CA)	813	+/- 3.4%
Florida (FL)	519	+/- 4.7%
New York (NY)	437	+/- 4.3%
Ohio (OH	686	+/- 3.7%
Texas (TX)	449	+/- 4.6%
Maryland (MD)	427	+/- 4.7%
Oklahoma (OK)	416	+/- 4.8%
Virginia (VA)	408	+/- 4.9%

Field Dates:
Fielded by Nielsen-Scarborough:
Aug 24, 2016 – Oct 10, 2016

Fielded by Communications for Research (CFR):
Oct 21 – Nov 11, 2016

Weighting
The sample was subsequently weighted by age, income, gender, education, race, and in the case of the national sample by geographic region. Benchmarks for weights were obtained from the Census' 2014 Current Populations Survey of Registered Voters. Some state samples were also weighted by party identification, where available, using each state's political affiliation statistics from its department of elections for registered voters.

SUMMARY OF FINDINGS

General Views of Medicare and the Shortfall

Very large and bipartisan majorities, nationally and in all eight states as well as nationally, expressed positive views of Medicare. Approximately six in ten had heard at least 'some' about the Medicare shortfall.

Overview

After considering sixteen different reform options for addressing the Medicare shortfall, seven were recommended by majorities which would shrink Medicare's projected shortfall by 30 percent. Five of the majority recommendations were by bipartisan majorities. Eight additional proposals were rated by majorities as at least tolerable --which combined with those recommended would reduce the shortfall by 96%.

Reducing Medicare's Net Payments for Benefits

Encouraging Use of Generic Drugs

One of the most widely recommended reform proposals was to reduce Medicare payments for benefits by encouraging Medicare recipients to use generic drugs, a measure that would cover two percent of the shortfall. This was recommended by seven in ten overall, and by the same number of Republicans and Democrats. More than eight in ten found the proposal tolerable.

Increasing Outpatient Deductibles

Respondents considered a complex proposal that would reduce Medicare's costs by increasing the amount of deductibles for outpatient services, but would compensate by lowering the deductible for hospitalization costs and capping all out-of-pocket costs (reducing the shortfall by 4.5%). This proposal was recommended by a modest majority, driven largely by Republican support. Democrats and independents were divided. However, seven in ten found the idea tolerable, including seven in ten Democrats and two thirds of independents.

Raising Eligibility Age from 65 to 67

A proposal for reducing benefits that was not recommended by a majority, except a slight majority of Republicans, was to gradually raise the age at which people become eligible for Medicare from the current 65 to 67 over the next 13 years, reducing the shortfall by five percent. However, two thirds found the idea tolerable.

Reducing Payments to Providers

Reducing Payments to Drug Companies

Another proposal that was recommended by large majorities was to require drug companies to accept getting less money for drugs that go to people with modest incomes. The proposal calling for drug companies to get 17% less money from people with modest incomes (reducing the shortfall three percent) was endorsed by seven in ten overall and by the same number of Republicans and Democrats. More than eight in ten found the idea tolerable. A higher level of the proposal, by which the drug companies would get 20% less money (reducing the shortfall seven percent), was less popular—less than half recommended it. However, about seven in ten rated it a six or higher and more than eight in ten found it tolerable.

Reduce Payments to Hospitals to Equalize With Doctors' Offices

Another popular proposal is to reduce payments to hospitals to equalize them with the payments made for the same services when conducted in doctors' offices (reducing the shortfall two percent). Substantial majorities overall and from both parties recommended this proposal. Nearly two thirds gave it a six or higher and eight in ten found it tolerable.

Increasing Revenues

Increasing the Medicare Payroll Tax Rate

A proposal to increase revenues by raising the Medicare payroll tax on current earners received large bipartisan support and was the majority-approved proposal making the biggest reduction in the shortfall. Increasing the payroll tax 0.1% from 1.45% to 1.55% (reducing the shortfall 11.3 percent) was recommended by two thirds, and by the same number of Republicans and Democrats, with eight in ten finding it tolerable. Raising the rate 0.2% (reducing the shortfall 22.6 percent) was recommended by less than half, but a slight majority overall gave it a six or higher and seven in ten found it tolerable. Raising the rate 0.3% (reducing the shortfall 33.9 percent) was not recommended by majorities, but was found tolerable overall by about six in ten and by both parties, though not recommended by majorities.

Increasing Medicare Premiums for Higher Earners

Another popular proposal was to increase Medicare premiums that cover outpatient services for those with incomes over $85,000 ($170,000 for married couples). Six in ten overall, including Republicans, recommended raising premiums by 15% (covering 3.5 percent of the shortfall). Eight in ten found the idea tolerable. Raising such premiums by 30 percent (covering 7 percent of the shortfall) was recommended by just one in four, but a slight majority overall and nearly six in ten Democrats rated it six or higher. Seven in ten found the idea tolerable, including two-thirds of Republicans.

Increasing Standard Premiums

An idea that received a lukewarm response was to gradually increase standard Medicare premiums paid by seniors for Medicare coverage. Currently standard premiums cover 25 percent of the cost to the government. Raising the standard premium to cover 30 percent, which would raise the standard premium by 15 percent from $136 to $170 a month, would cover 16 percent of the shortfall. This proposal was recommended by just four in ten, but almost six in ten found it tolerable. Support for raising premiums further to cover 35 percent of the costs (raising premiums by 30 percent) was recommended by very few and found tolerable by only four in ten.

Controlling Costs in Other Ways

Limiting Medical Malpractice Suits

A proposal for limiting costs by limiting medical malpractice suits (also known as tort reform) was recommended by a majority. The proposal would cap awards for damages for pain and suffering at $250,000, and for punitive damages at $500,000 and is estimated to cover four percent of the shortfall. While recommended by nearly two thirds of Republicans, this was true of just under half of Democrats and independents. However, three quarters overall, including two thirds of Democrats and independents, found the proposal tolerable.

Lowering Medicare's Subsidy to Teaching Hospitals

A proposal not recommended by a majority was to lower Medicare's subsidy to teaching hospitals that covers part of the costs of training doctors from 5.5% to 2.2%, covering five percent of the shortfall. However, a slight majority of Republicans did recommend it, a slight majority gave it a six or higher and three quarters found it tolerable.

Limiting Medigap

An unpopular proposal is to limit the amount of Medigap coverage that seniors can buy from private companies to cover the payments that Medicare does not cover, as a way to encourage seniors to be more restrained in their use of medical services. Just one in four recommended this idea. A bare majority found it tolerable and three in ten rated it six or higher.

Varying Attitudes by Age

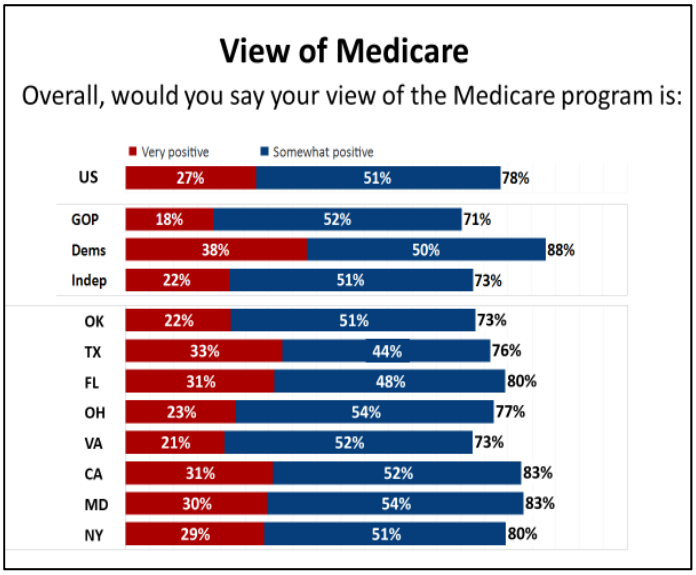
Surprisingly, for some options that would affect benefits to current Medicare recipients, seniors were as willing or more willing to make changes as younger people.

FINDINGS

General Views of Medicare and the Shortfall

Very large and bipartisan majorities, in all eight states as well as nationally, expressed positive views of Medicare. Approximately six in ten had heard at least 'some' about the Medicare shortfall.

At the beginning of the survey respondents were simply asked about their general view of Medicare, "the federal program that was established in 1965 to provide health care for Americans age 65 and older." Eight in ten (78%) expressed a positive view of Medicare, with 27% saying "very positive." Only 21% had a negative view (very, 3%). Seventy-one percent of Republicans and 88% of Democrats viewed Medicare positively. Among the states, this ranged from 73% positive in Oklahoma and Virginia to 83% in California and Maryland.



Respondents were told: "the Medicare Trustees project that unless changes are made to Medicare's costs or revenues, eventually Medicare will have to start cutting back the benefits it provides" and asked how much they had heard about this problem. Fifty-eight percent had heard "a lot" (20%) or "some" (38%); 42% had heard "a little" (29%) or "nothing" (13%). There were no meaningful partisan differences.

Medicare's shortfall was then explained, introducing the annual average figure for the shortfall of $230 billion:

When the Medicare Trustees have looked at Medicare's expenses for the next 25 years, they find that there is a **shortfall.** This shortfall is the gap between Medicare's commitments to retirees and the amount of projected revenue. Over the next 25 years, this shortfall averages $230 billion a year. Medicare can cover this long-term shortfall by either reducing its costs or increasing its revenues, or a combination of both.

Asked whether this seemed higher or lower than they had expected, or about the same, almost half (48%) said it seemed higher. A third said it was about what they had expected (33%). Only 6% felt the shortfall was lower than they had expected. Partisan differences were minimal.

Overview of Responses to Options for Addressing Shortfall

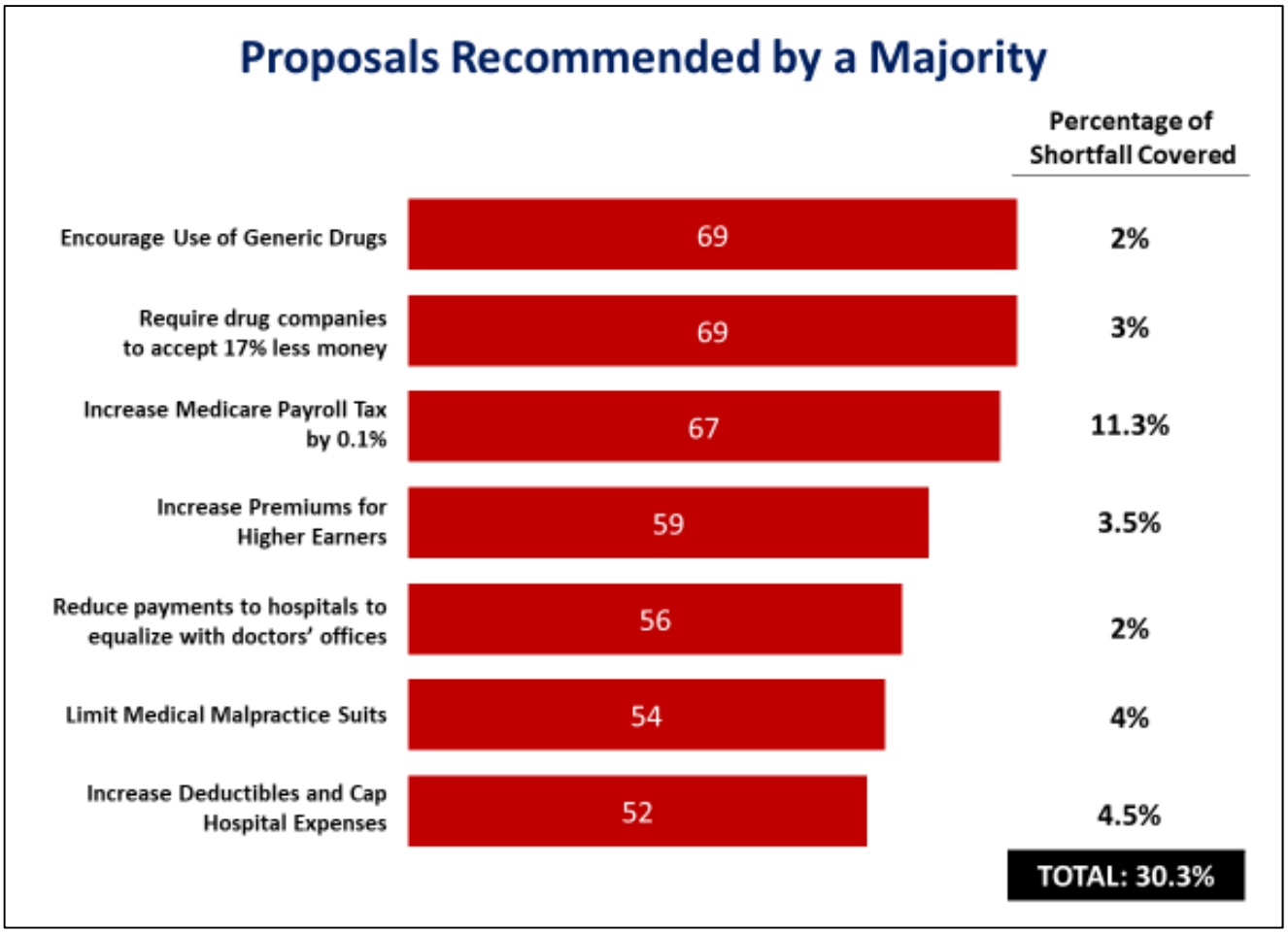
After considering sixteen different reform options for addressing the Medicare shortfall, seven were recommended by majorities, which would shrink Medicare's projected shortfall by 30 percent. Five of the majority recommendations were made by bipartisan majorities. Eight additional proposals were rated by majorities as at least tolerable, which, combined with those recommended, would reduce the shortfall by 96%.

Respondents were initially briefed on each proposal, asked to evaluate arguments for and against it and then assessing its acceptability on a 0-10 scale in which 0 meant 'not at all acceptable,' 10 meant 'very acceptable' and 5 meant 'just tolerable.'

In the end, respondents were shown all sixteen proposals again, with the percentage of the shortfall covered, and asked to select the ones they would recommend to their member of Congress. An interactive feature gave them immediate feedback on the total percentage of the shortfall covered as they went along.

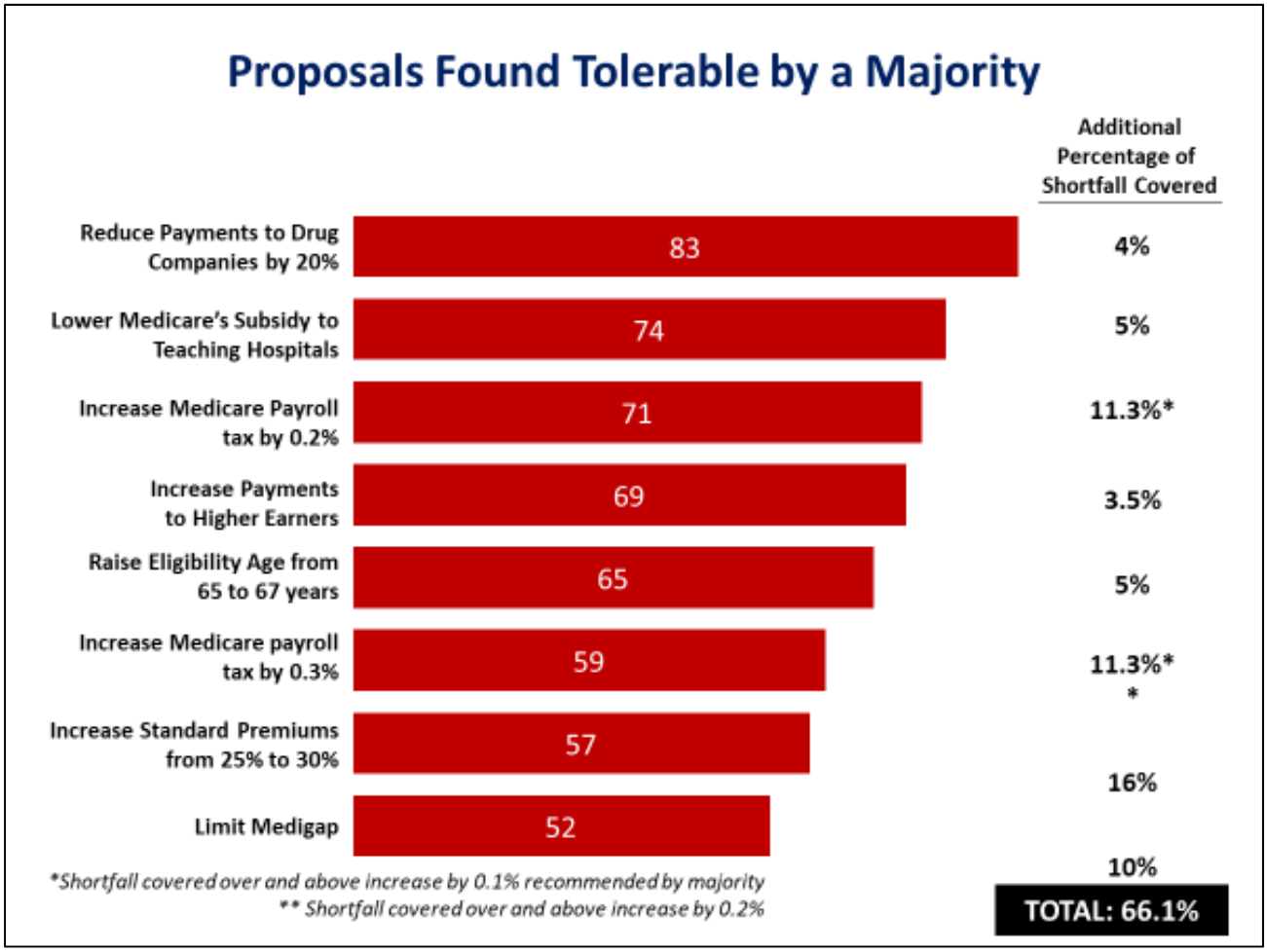
Because not all of the options for addressing Medicare were presented in the process, respondents were not urged to try to cover the full shortfall. They were told that "These are not all the proposals that have been put forward," but that they "represent a major starting point for dealing with the problem." This may help explain why the number of options recommended, was less than the number rated as acceptable (6-10).

Seven options were recommended by majorities, which together would cover 30.3% of the shortfall.



Eight other options were found tolerable by majorities. Combined with those options that were recommended, these options would cover 96.4 percent of the shortfall.

The great majority of proposals got some degree of serious consideration, but one was essentially ruled out by a majority—nor rated as at least tolerable. This was to raise the standard premium paid by most recipients so that it would cover 35 percent of average costs, instead of the current 25%. Only 4 in 10, without partisan differences, rated this at least tolerable.



REDUCING MEDICARE'S NET PAYMENTS FOR BENEFITS

Encouraging Use of Generic Drugs

One of the most widely recommended reform proposals was to reduce Medicare payments for benefits by encouraging Medicare recipients to use generic drugs, a measure that would cover two percent of the shortfall. This was recommended by seven in ten overall, and by the same number of Republicans and Democrats. More than eight in ten found the proposal tolerable.

Respondents were presented a proposal for having Medicare cover a smaller portion of the price of brand name drugs while covering the full cost of those drugs' generic equivalents. They were told this would cover 2 percent of the shortfall, on average $5 billion a year.

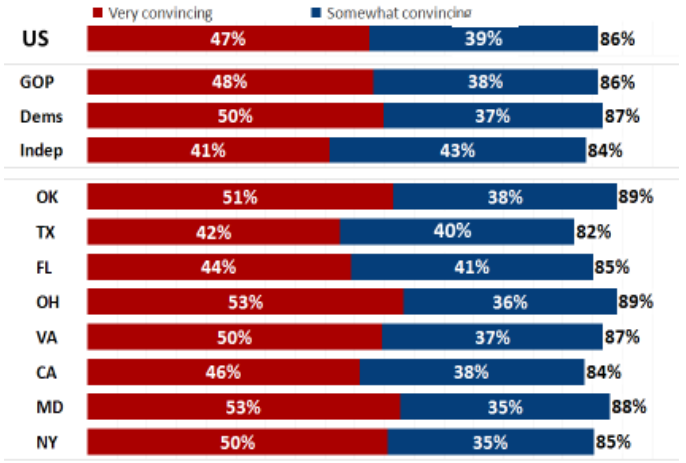
Respondents were told the proposal "is meant to encourage some Medicare recipients to switch from brand name to generic prescription drugs when an equivalent one is available." They were shown an example of how the proposal would work in the table below:

	Current Policy	Proposed Policy
Generic drug	$1.20	$0.00
Brand-name drug	$3.60	$6.00

The argument favoring the proposal emphasized that, as well as saving Medicare money, it would eliminate many co-payments for Medicare recipients, and that this is known to help patients stick with their medication program. This argument was widely embraced, with 86% finding it convincing.

Argument in favor:
Encourage use of generic drugs

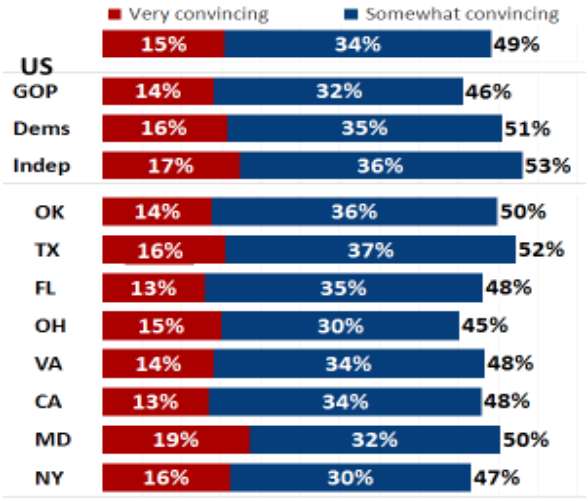
This proposal is good for both Medicare recipients and the Medicare program. It would make it possible for recipients to receive the same prescription drugs they receive now, but at a lower cost because the copayment could be eliminated. What's more, seniors are more likely to stick with a prescribed medication plan when they do not have to make a copayment—which would be good for their health, saving money for Medicare. This would be in addition to the money Medicare saves by reducing wasteful payments for expensive brand-name prescription drugs.



The argument against the proposal invoked medical concerns about fine points of generics: whether in the case of multiple prescriptions, "changing to the generic drug might produce some new unexpected interaction." It concluded that "doctors need flexibility" in prescribing either brand or generic versions, without worrying about the end price. This produced a divided response.

Argument against: Encourage use of generic drugs

Changing from brand name drugs to generic drugs is not the big solution some people think it is. In some cases, doctors are unsure that the generic drug will be as effective as a brand name version. Also, when Medicare recipients are taking multiple prescriptions, changing to the generic drug might produce some new unexpected interaction. Doctors need flexibility in prescribing either brand or generic drugs, without having to worry what their patient can afford.

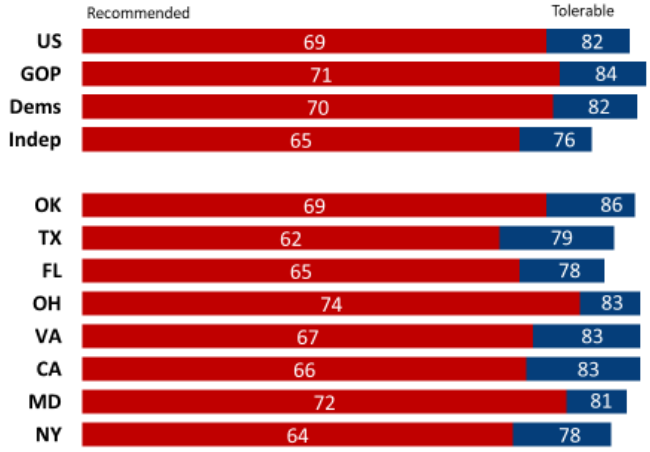


At the end, asked to make their final recommendations, adopting the proposal on generics was recommended by a highly bipartisan seven-in-ten majority.

After the arguments, respondents were also asked to rate the proposal's acceptability on the 0-10 scale (with 5 being 'just tolerable'). Four in five found it at least tolerable and nearly two in three gave it a rating of six or higher.

Conclusion: Encourage use of generic drugs

Medicare would cover a smaller portion of the price of brand name drugs, thus increasing the copayments the patient would pay. At the same time, Medicare would cover the full cost of the generic equivalent (thus eliminating the copayment).



Increasing Outpatient Deductibles

Respondents considered a complex proposal that would reduce Medicare's costs by increasing the amount of deductibles for outpatient services, but would compensate by lowering the deductible for hospitalization costs and capping all out-of-pocket costs (reducing the shortfall by 4.5%).

This proposal was recommended by a modest majority, driven largely by Republican support. Democrats and Independents were divided. However, seven in ten found the idea tolerable, including seven in ten Democrats and two thirds of independents.

Respondents were told that currently there are two separate deductibles, one for hospital care and another for outpatient care. There are no annual caps on a Medicare patient's co-pay expenses. They were shown the current system and the proposed system in the following table:

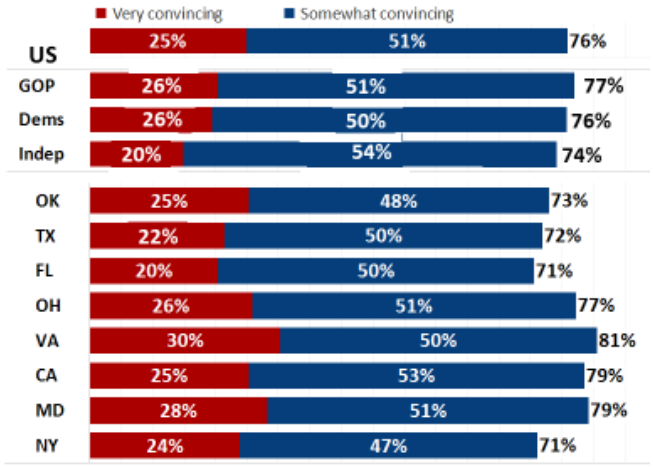
	Deductible	Additional Costs	Cap
Current Outpatient	$147 per year	20% of additional costs	No cap
Current Inpatient	$1260 per hospital stay	Additional copayments after 60 days, gradually increasing	No cap
Proposed Inpatient and Outpatient	$550 per year total	20% of additional costs	$5500

Thus, in the proposal, a Medicare recipient could well pay more over the course of a year, but would be protected against catastrophic costs. This proposal would cover 4.5% of the shortfall.

The argument favoring the proposal focused on the gain to Medicare recipients from imposing a cap, simplifying the costs recipients can expect and removing the financial worry from a long hospital stay. Three in four (76%) found this convincing (25% very), while 23% did not. Party differences were minimal.

Argument in favor: Increasing outpatient deductibles

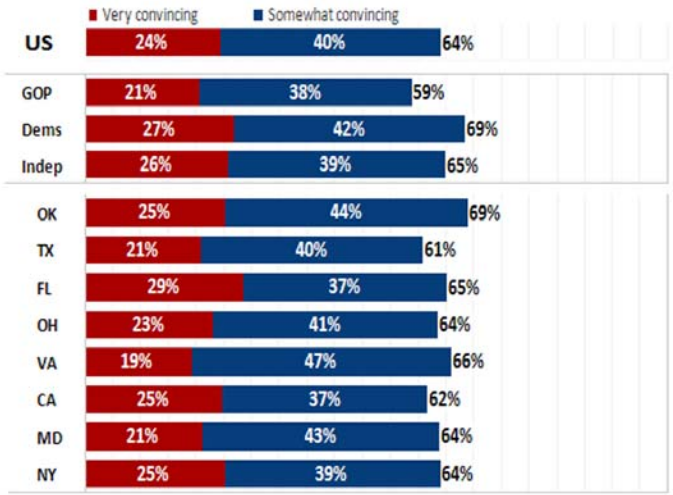
This proposal not only saves Medicare money, it makes things better for many Medicare recipients as well. While recipients will have to pay more for their outpatient deductible, it dramatically lowers their deductible for hospitalization and puts a cap on their annual out-of-pocket spending. This simplifies things for recipients and they would no longer have to worry that with a long stay in the hospital they might end up going bankrupt.



The argument against the proposal focused on its requirement that recipients pay all of the first $550 in medical costs for the year. It asserted that people on modest incomes may avoid going to the doctor under these circumstances, with dire consequences. A lesser 64% found this argument convincing (very, 24%), with 35% finding it unconvincing. Democrats were ten points more likely (69%) to find it convincing than Republicans (59%).

Argument against: Increasing outpatient deductibles

While this proposal may save Medicare some money, most Medicare recipients will be required to pay more for outpatient services, because they will have to pay 100% of the first $550 of medical costs. As a result, many people--especially those on modest incomes--may not go to the doctor when they have some symptoms. They may end up waiting until the problem is much more serious. The consequences could be grave, even fatal.



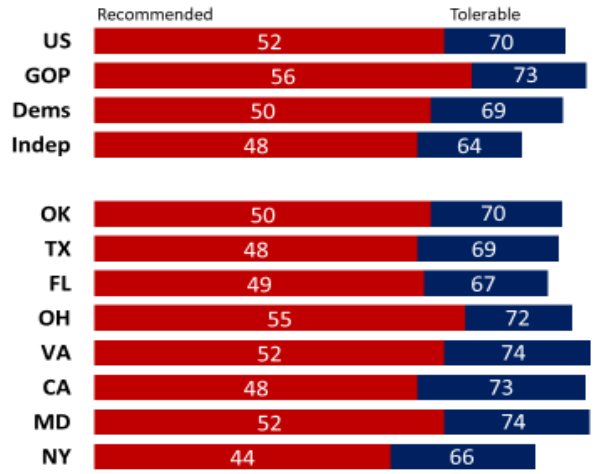
In the final recommendations, changing the structure of deductibles in Medicare was chosen by 52%. A slightly larger percentage of Republicans (56%) selected it; Democrats were divided, while about half of independents (48%) chose this proposal. Three states—Ohio, Virginia, and Maryland—had modest majorities recommending it; in Oklahoma, this was 50%. Slight majorities did not recommend it in Texas (52%), Florida (51%), and California (52%), with 56% rejecting it in New York.

Asked how acceptable (0-10) these changes to deductibles would be, seven in ten (70%) said they

would be at least tolerable; 46% gave it a six or higher. A majority of Republicans (52%) gave it a six or higher, while independents were less enthusiastic, with just 39% giving it above a six. In all states, about two-thirds or more said the change would be at least tolerable, but in most, less than half gave it above a six. The exceptions were Virginia and Maryland (both 51%).

Conclusion: Increasing outpatient deductibles

Right now, Medicare patients pay a $147 deductible for outpatient services and a $1,260 deductible for hospital costs, as well as a portion of costs above the deductible, with no cap. The proposal is to have just one deductible for $550 and a cap of $5,500 for out-of-pocket costs.



Raising Eligibility Age from 65 to 67

A proposal for reducing benefits that was not recommended by a majority, except a slight majority of Republicans, was to gradually raise the age at which people become eligible for Medicare from the current 65 to 67 over the next 13 years, reducing the shortfall by five percent. However, two thirds found the idea tolerable.

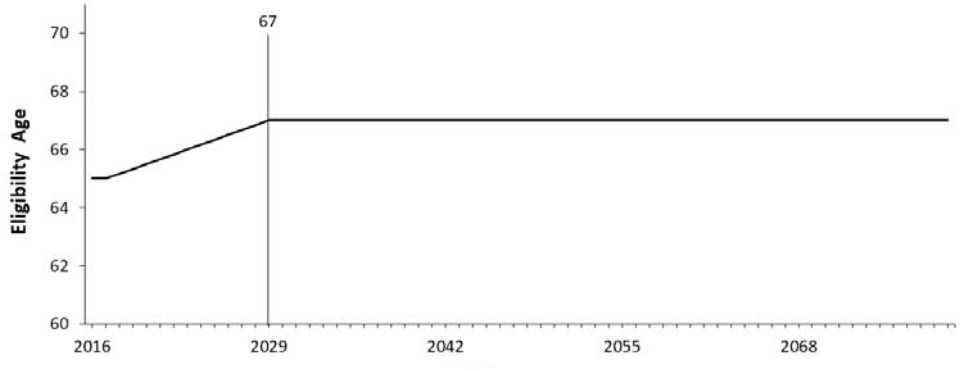
Respondents were told:

> *Currently, the age at which people become eligible for Medicare is 65. One proposal is to gradually raise the age of eligibility from 65 to 67. Beginning in 2016, the eligibility age would be increased by two months each year until 2029. This change would not affect current recipients of Medicare.*

They were also shown a graph to illustrate that the rise in eligibility age would be gradual and then stop (see box below).

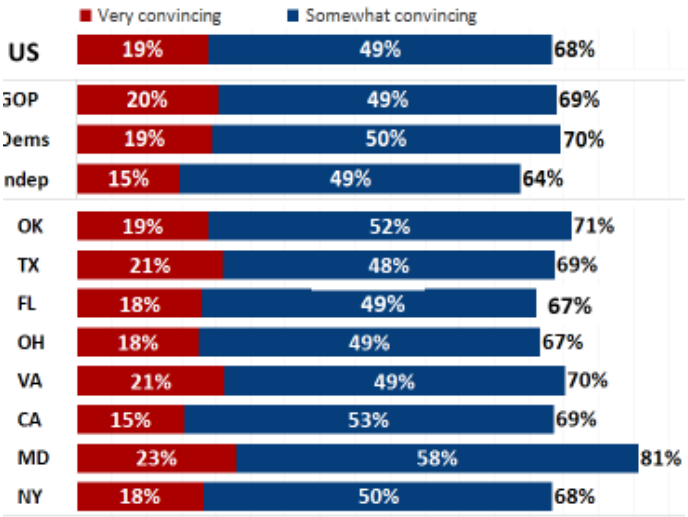
Finally, respondents learned that this proposal would save Medicare enough money to cover 5% of the shortfall. The argument favoring a rise in the eligibility age pointed out that people's lifespans are now longer; that the change will be gradual; and that 65-year-olds on average are healthier today than they were in the early years of the program. This was found convincing by two thirds (68%) and unconvincing by 31%. Party differences were minimal.

Proposal: Starting in 2016, Gradually Raise Age of Medicare Eligibility from 65 to 67 in 2029



Argument in favor: Raising Medicare eligibility age

The whole idea of Medicare was that people would be making contributions to their retirement needs over their working life. But because people are living longer now, the amount they contributed during their working years is not enough. Thus, it is necessary for them to take care of their medical insurance needs a little longer, and the change will phase in very gradually, leaving plenty of time to plan. Furthermore, people turning 65 today are much healthier and better off economically than they were in the 1960s when the program began.



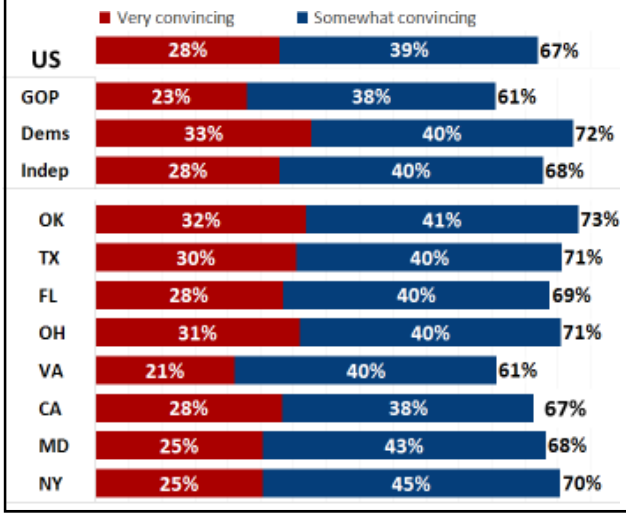
The argument against the proposal said that at age 65, paying for two more years of private insurance could be very expensive, forcing people to keep working—especially at lower income levels, where the increase in longevity is much less marked. This argument did as well as the pro argument, with a similar two thirds (67%) finding it convincing, while 33% did not. It was 11 points more persuasive for Democrats (72%) than for Republicans (61%).

In their final recommendations, a majority (54%) did not choose to raise the eligibility age, while 46% did. A slim majority of Republicans (52%) did raise the age, as did 43% of Democrats. In no state did a majority recommend it.

Asked how acceptable (0-10) it would be to raise the age of eligibility, two thirds (65%) said it would be at least tolerable. A little under half gave it a six or above (44%). Republicans were almost 10 points more likely to give the proposal a six or higher than Democrats (51% to 42%). Among the states, the sense that the proposal was tolerable ranged from 59% in Ohio to 71% in Virginia--the only state with a majority giving it a six and above.

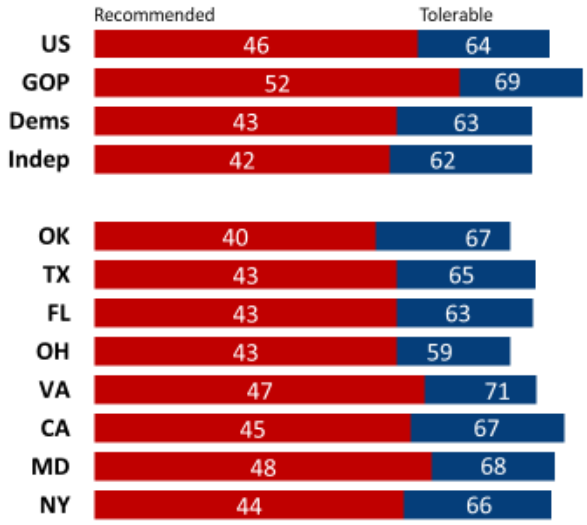
Argument against: Raising Medicare eligibility age

Many older people would be hit hard by this delay. They have planned for their old age assuming that Medicare would be there when they turn 65. Two more years of private insurance would be very expensive. Many of these people would have to keep working, some of them in physically demanding jobs, which could be hard on their health, increasing their healthcare needs. Furthermore, while some people are living longer, this is much less true for people at lower income levels, so it is not fair to delay Medicare coverage for them.



Conclusion: Raising eligibility age from 65 to 67

Beginning in 2016, the eligibility age would be increased by two months each year until 2029, when it would reach age 67.



REDUCING PAYMENTS TO PROVIDERS

Reducing Payments to Drug Companies

Another proposal that was recommended by large majorities was to require drug companies to accept getting less money for drugs that go to people with modest incomes. The proposal calling for drug companies to get 17% less money from people with modest incomes (reducing the shortfall three percent) was endorsed by seven in ten overall and by the same number of Republicans and Democrats. More than eight in ten found the idea tolerable (85%). A higher level of the proposal, by which the drug companies would get 20% less money (reducing the shortfall seven percent), was less popular—less than half recommended it. More than eight in ten found it tolerable (83%) and about seven in ten gave it a six or higher.

Respondents were presented the proposals as follows:

> *Drug companies would be required to accept getting less money for the drugs that go to people with modest incomes or they would be excluded from Medicare.*

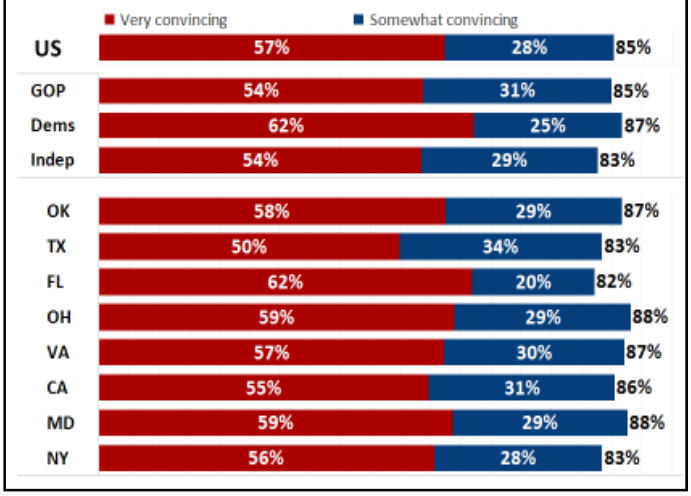
One proposal is for drug companies to get 17% less money. This would save Medicare an average of $7.5 billion, or 3% of the shortfall, annually.

Another proposal is for drug companies to get 20% less money. This would save Medicare an average of $16.1 billion, or 7% of the shortfall, annually.

The argument favoring this proposal focused on the point that private companies, the Veterans Administration and Medicaid, already negotiate with drug companies over prices, but Medicare does not. A remarkably high 85% found this argument convincing (57% very), with no meaningful party differences. Only 14% found it unconvincing.

Argument in favor:
Reducing payments to drug companies

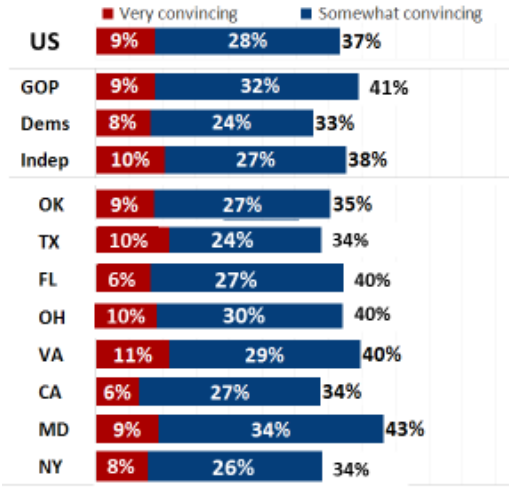
Private insurance companies already negotiate with drug companies to get the cost of drugs down, as well as the Veterans Administration and Medicaid. Medicare does not do this, which is one more reason that the pharmaceutical industry has much higher profit margins than most other industries. There is really no reason why drug companies, often aided by government-funded basic research, have to keep making so much money while Medicare can't make ends meet.



The argument countering the proposal described Medicare as "a huge customer in the health insurance market" that would be in a position to dictate its will, saying that drug companies would have to cut back on basic research, ultimately hurting patients. This argument was rejected to a striking degree—something unusual in a policy simulation. Only 37% found it convincing with a remarkable 63% finding it unconvincing.

Argument against:
Reducing payments to drug companies

Medicare is such a huge customer in the health insurance market that it is really unfair for Medicare to threaten to cut off a drug company, if the company doesn't lower the price of its product. This is heavy-handed government, and it violates the principles of the free market. Furthermore, to make up for the losses they would suffer, drug companies would have to charge everyone else more and/or cut back on spending for research and development of new drugs. If research and development were cut, this would hurt people with illnesses for which there are currently no drugs available.

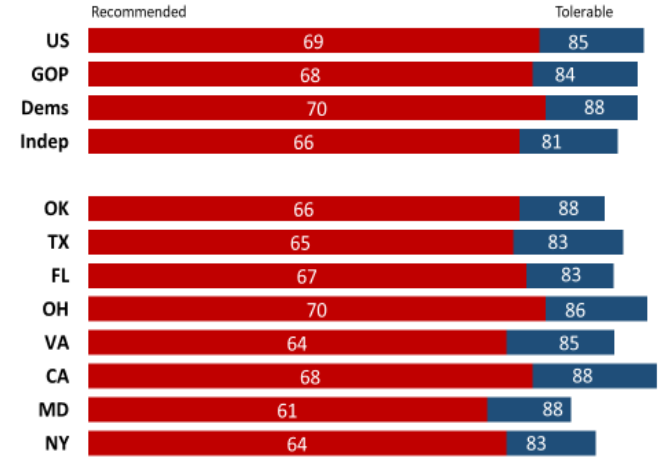


Respondents were then offered two versions of this proposal: one reducing the money drug companies would otherwise receive by 17%, covering 3% of the shortfall, and the second reducing this money by 20%, covering 7% of the shortfall.

When asked for their final recommendation, seven in ten recommended that drug companies should receive at least 17 percent less money, but only 42% went further and wanted to them receive 20 percent less money. This was true of all party groups, but Democrats were somewhat higher for the 20-percent option (at 47%) than Republicans (at 38%). Support across the states varied from 61% in Maryland to 70% in Ohio. Only 4 in 10 choose the 20% level, with support from states varying from 38% in Maryland and Virginia to 44% in Florida and Ohio. However, when asked to assess how acceptable this policy is, support was considerably greater. The 17% version was tolerable to 85%; the 20% version to 83%. In both cases, almost seven in ten gave it a six or higher. The states showed no meaningful differences.

Conclusion:
Require drug companies to accept 17% less money

Require drug companies to accept less money for drugs that go to people with modest incomes, or be excluded from Medicare. For those drugs, have drug companies **end up getting 17% less money.**



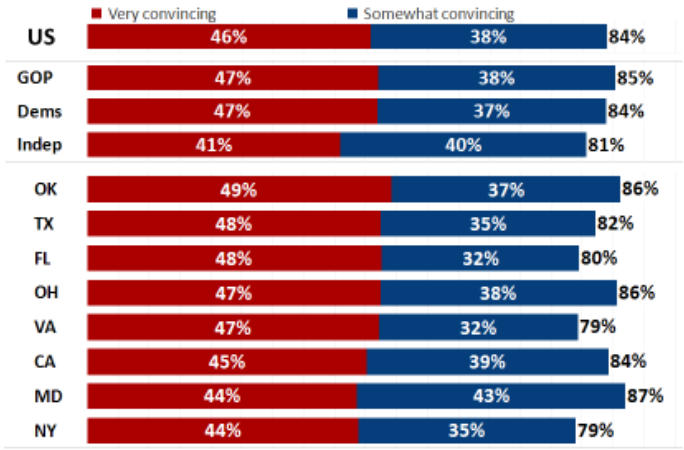
Reduce Payments to Hospitals to Equalize With Doctors' Offices

Another popular proposal is to reduce payments to hospitals to equalize them with the payments made for the same services when conducted in doctors' offices (reducing the shortfall two percent). Substantial majorities overall and from both parties recommended this proposal. Eight in ten found it tolerable and nearly two thirds gave it a six or higher.

The argument favoring this proposal for reducing payments to hospitals said that "many of these services are as simple as tests, x-rays and ordinary visits," and argued that Medicare should not be used as a vehicle for providing government support to hospitals. Over four in five (84%) found this argument convincing, with no difference between the parties.

Argument in favor: Reducing payments to hospitals to equalize with doctors' offices

It makes no sense for Medicare to pay more, often double, for medical services just because they are performed in a hospital. Many of these services are as simple as tests, x-rays and ordinary visits. Doctors' offices have shown that it is possible to deliver high quality service at a lower cost. Perhaps hospitals do need support from government, but using Medicare to do this is not the right way to go about it.



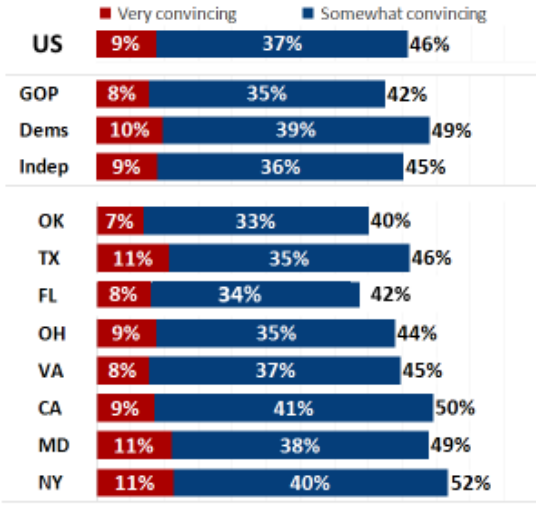
The argument against the proposal laid out reasons that hospitals are different and need a higher reimbursement rate: that by law hospitals must keep standby capacity for handling emergencies, and that patients who go to a hospital for care are more likely to have emergencies. However, the argument did not do very well, with 53% finding it unconvincing (convincing 46%). It was unconvincing to more Republicans (57%), while Democrats had a divided response.

In the end, the option to equalize what hospitals and doctors' offices receive for providing some services to Medicare was recommended by 56%, with no significant party differences. Majorities of 53-58% recommended it in seven states; in New York, this was 50%.

Asked for their initial evaluation four in five said this proposal was at least tolerable (81%), and 63% rated it with a six or above. The two parties were virtually the same. In all states, this was tolerable to about four in five or more. Majorities in all states, ranging from 58% in New York to 72% in Oklahoma, gave the proposal a six or higher.

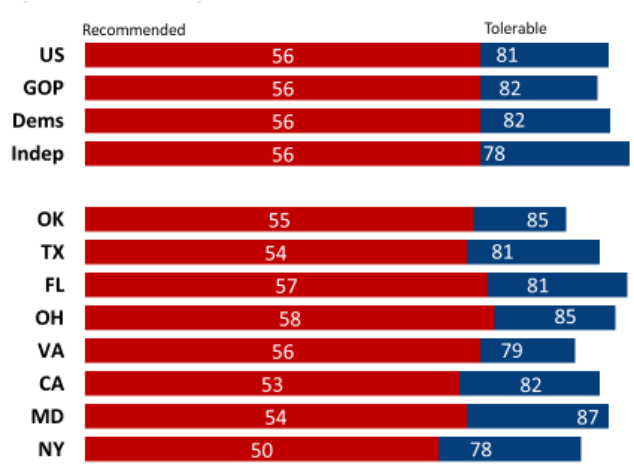
Argument against: Reducing payments to hospitals to equalize with doctors' offices

There are good reasons why hospitals should be reimbursed more than doctors' offices. By law, hospitals have to keep standby capacity for handling emergencies at all times. Medicare patients who come to a hospital for services tend to be poorer, sicker and more prone to emergencies than Medicare patients who go to a doctors' office, so the treatment can take longer and be more demanding. Medicare reimbursements should reflect these facts.



Conclusion: Reducing payments to hospitals to equalize with doctors' offices

Lower the payment to hospitals for services to Medicare patients to make it equal to the amount paid to doctors' offices for the same services.



INCREASING REVENUES

Increasing the Medicare Payroll Tax Rate

A proposal to increase revenues by raising the Medicare payroll tax on current earners received large bipartisan support and was the majority-approved proposal that made the biggest reduction in the shortfall. Increasing the payroll tax 0.1% from 1.45% to 1.55% (reducing the shortfall by 11.3 percent) was recommended by two thirds, and by the same number of Republicans and Democrats, with eight in ten finding it tolerable. Raising the rate 0.2% (reducing the shortfall 22.6 percent) was recommended by less than half, seven in ten found it tolerable, and a slight majority (51%) overall gave it a six or higher. Raising the rate 0.3% (reducing the shortfall by 33.9 percent) was also found tolerable overall by about six in ten and by both parties even though it was not recommended by majorities.

Respondents were informed that:

> *Currently, Medicare's hospital insurance program (Part A) is financed by payroll taxes. All wage earners pay 1.45% of their wages and the employer pays 1.45% of those wages as well. People with high incomes (over $200,000) pay an extra 0.9%, including on investment income.*

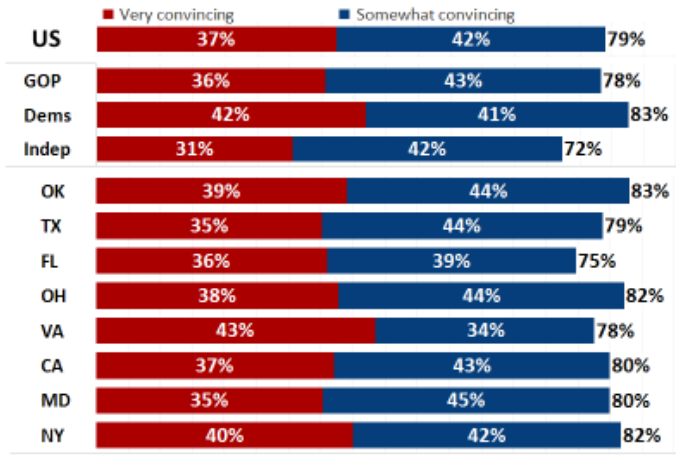
Respondents were shown the table below to help them understand the costs and effects of such an increase.

Increasing the Medicare Payroll Tax of the Average Wage Earner (about $50,000/year)			
Increase in tax	$/year increase for each beneficiary	$ amount raised to cover the shortfall	% of shortfall covered
0.1%	$50	$26 billion	11.3%
0.2%	$100	$52 billion	22.6%
0.3%	$150	$78 billion	33.9%

The argument in favor of a payroll tax increase pointed out that all Americans benefit from Medicare in different ways: "It benefits people who have elderly parents and provides all Americans with the security of knowing that they will be cared for when they get older." It characterized the current payroll tax as "quite modest." This argument was found convincing by eight in ten (79%), with little difference between Republicans and Democrats; independents were slightly lower at 72%.

Argument in favor:
Increasing the Medicare payroll tax

Medicare is a very valuable service for all Americans. It benefits people who have elderly parents and provides all Americans with the security of knowing that they will be cared for when they get older. The amount that Americans currently pay—1.45% of their wages—is really quite modest, and it is affordable for this amount to go up slightly. This is a better approach than putting the burden on the people who are already elderly, many living on fixed incomes.

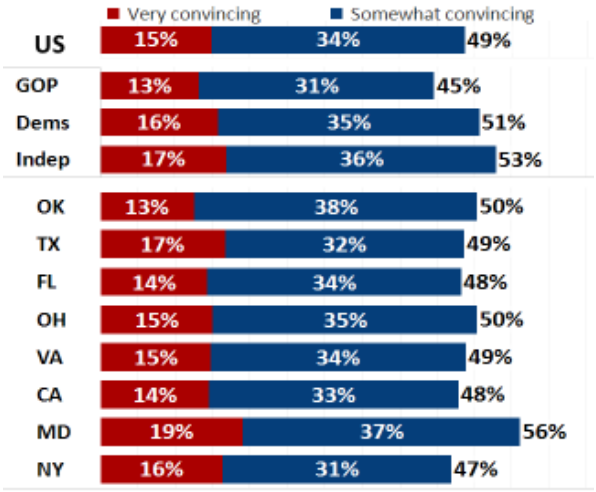


The argument against a payroll tax focused on the low-income and younger workers who would feel the increase more acutely, saying "It's just not right to have young low-income workers, who are just starting out, take on a greater burden to take care of retiring baby boomers, who are in most cases better off." This argument was not seen as convincing by a majority: only 49% thought so (15% very). Half (50%) found it unconvincing. Among Republicans, 54% found it unconvincing, while 51% of Democrats did

find it convincing, as did 53% of independents. Only one state, Maryland, had a majority (56%) finding the argument convincing; all other states were in the 47-50% range.

Argument against:
Increasing the Medicare payroll tax

This is not a fair way to solve the problem of Medicare's shortfall. Medicare already puts a greater burden on low-income workers. This is because Medicare taxes wages more heavily than other forms of income, which better-off people are more likely to have. Raising the rate would make this even worse. It's just not right to have young low-income workers, who are just starting out, take on a greater burden to take care of retiring baby boomers, who are in most cases better off.



Having evaluated arguments about the basic idea, respondents were asked about three levels of a possible payroll tax increase: 0.1, 0.2, and 0.3 percent.

When asked for their final recommendations, two in three (67%) chose the 0.1 percent payroll tax increase or more. Forty-one percent chose a 0.2 percent hike or more and only 20% chose 0.3 percent. Republicans and Democrats were the same, but independents were lower, with 61% choosing the 0.1 percent level. In the states, those who recommended a 0.1 percent payroll tax increase ranged from 59% in Texas to 69% in Ohio and California.

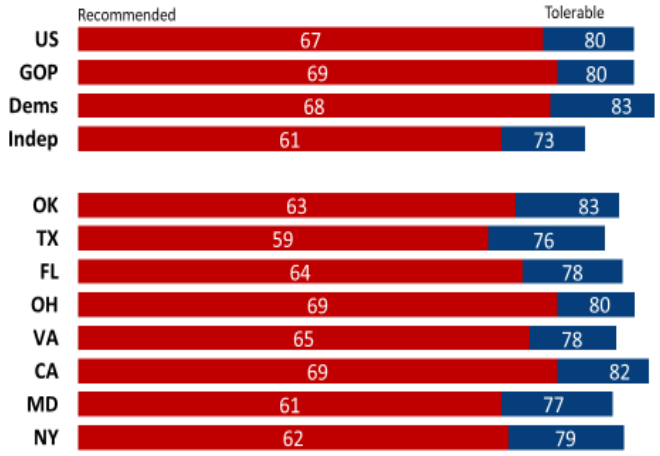
However, majorities found all of the proposals at least tolerable, with essentially a ten-point drop in support for each higher level. Four in five (80%) thought a 0.1 percent increase tolerable, and three in five (61%) rated it a six or above. For a 0.2 percent increase, 71% found it tolerable and a bare majority (51%) gave it a six or higher. For a 0.3 percent increase, 59% found it tolerable and 39% gave it a six or higher. For each level, independents were slightly more reluctant by about 7 points, while Republicans and Democrats were closer to the full sample.

In the states, at least three in four found a 0.1 percent increase tolerable ranging from 76% in Texas and 83% in Oklahoma. While majorities in all states rated this a six or higher, the number ranged widely from 53% in Maryland to 68% in Oklahoma. For a 0.2 percent increase, states ranged from 67% tolerable in Maryland and New York to 73% tolerable in California, and in only three states did modest majorities (51% or more) give it a six or higher—Oklahoma, Ohio and California. For a 0.3 percent increase, states ranged from 55% tolerable in Florida, New York, and Maryland to 63% tolerable in California, while no states had a majority giving it a rating of six or above.

While the least well-off would be the most affected by such an increase, 60% of those with incomes below $30,000 a year chose a 0.1 percent increase. At the highest income level (those above $150,000) a larger 72% chose a 0.1 percent increase. However, in no income group did more than half recommend a 0.2 percent increase.

Conclusion:
Increasing the Medicare payroll tax 0.1%

The first version increases the amount that wage earners and employers pay by 0.1%. For the average wage earner who earns about $50,000 this would mean an increase in payroll taxes of $50 a year. This would cover 11.3% of the annualized shortfall ($26 billion).



Increasing Medicare Premiums for Higher Earners

Another popular proposal was to increase Medicare premiums that cover outpatient services for those with incomes over $85,000 ($170,000 for married couples). Six in ten overall, including Republicans, recommended raising premiums by 15% (covering 3.5 percent of the shortfall). Eight in ten found the idea tolerable. Raising such premiums by 30 percent (covering 7 percent of the shortfall) was recommended by just one in four, but a slight majority overall and nearly six in ten Democrats rated it six or higher. Seven in ten found the idea tolerable, including two-thirds of Republicans.

In preparation for considering the proposal for increasing Medicare premiums for higher earners respondents were given a short briefing on the current structure. They were informed that Medicare premiums cover outpatient services (not hospital costs), and that the average cost to Medicare of a recipient's outpatient services, including drugs, is $544 a month. They learned that about one quarter of the costs are paid for by premiums paid by Medicare recipients and the rest is paid by the Federal government from general revenues such as income taxes. They were also told that:

> *Recipients with higher incomes already pay more than the standard premium, depending on their level of income. These upper-income recipients include about the top 6% of all recipients.*

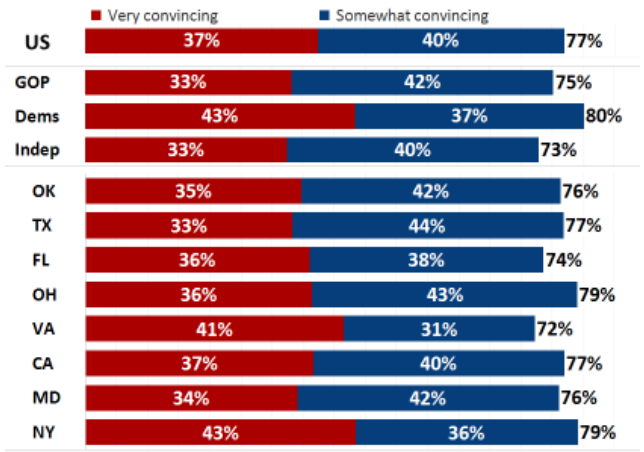
Respondents were shown a table laying out the current progressive structure of premiums and what premiums would be if they were rise 15% or 30% for those with incomes $85,000 and more.

Single beneficiaries earning	Married couples earning	Current premium	15% increase	30% increase
$85,000 or less	$170,000 or less	$136	n/a	n/a
$85,000-$107,000	$170,000-$214,000	$191	$218	$248
$107,000-$160,000	$214,000-$320,000	$272	$316	$354
$160,000-$214,000	$320,000-$428,000	$354	$408	$460
More than $214,000	More than $428,000	$435	$490	$544

The argument in favor of a premium increase for higher-income recipients focused on its affordability for these groups: "even with these slightly higher premiums they are getting a great deal—they would only be paying a small percentage of their income." Three in four found this convincing (77%; 37% very) while 22% found it unconvincing. There was no meaningful difference by party.

Argument in favor:
Increasing premiums for higher earners

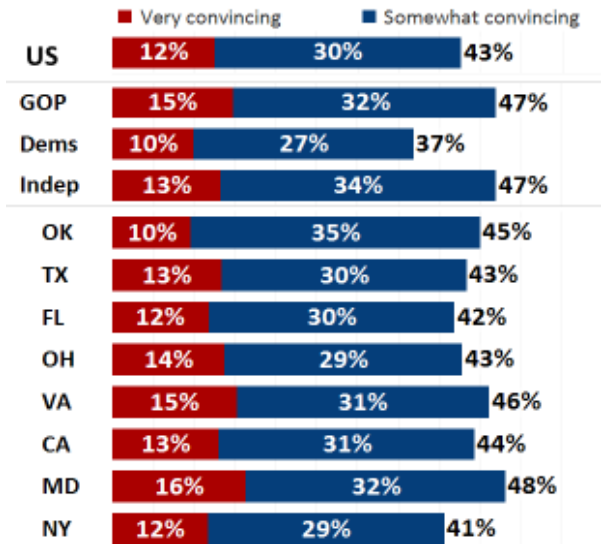
It would be nice to be able to give every senior outpatient services, with them only paying low premiums. This is simply not realistic. People with high incomes can afford to pay a bit more, and even with these slightly higher premiums they are getting a great deal--they would only be paying a small percentage of their income.



The argument against such a rise was that this group is already doing its share, paying higher income taxes and absorbing the premium hike they received in 2010. Only 43% thought it convincing, while a 56% majority found this unconvincing. Among both Republicans and independents, 52% found it unconvincing (Democrats, 62%).

Argument against:
Increasing premiums for higher earners

Throughout their lives, people with higher incomes already pay higher income taxes and Medicare payroll taxes, both of which help support Medicare. They also already pay higher premiums for outpatient care than others do, and furthermore these premiums already went up in 2010. Raising their premiums even higher would be going too far.



An overall majority of 59% recommended a 15 percent increase in premiums for higher incomes, while only a quarter recommended a 30 percent increase. The 15 percent increase was recommended by 58% of Republicans, 63% of Democrats, and 54% of independents.

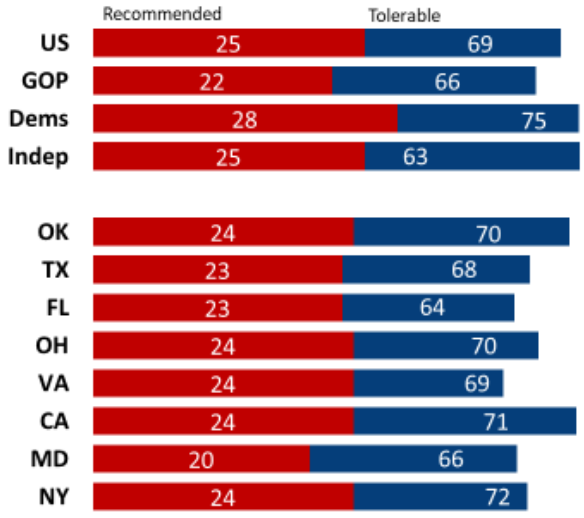
Interestingly, respondents with incomes above $150,000 were just as supportive of this change as the full sample. State majorities recommending the 15 percent increase ran from 53% in Texas to 61% in Ohio.

Asked to assess the proposal—for a 15 percent increase—78% found this tolerable and 60% gave it a six or higher: party differences were minimal. All states had majorities giving it a six or above, ranging from 55% in Florida to 63% in Oklahoma.

For a rise of 30 percent, 69% found this tolerable and a bare majority—51%—gave it a six or higher. It was tolerable to majorities of Republicans,

Democrats and Independents, but only 47% of Republicans rated it six or higher compared to 58% of Democrats. In all eight states, at least three in five found it tolerable. Majorities in Texas (51%), Ohio (53%), Virginia (55%) and New York (56%) gave it a six or higher.

Conclusion:
Increasing premiums for higher earners
Increase premiums for higher-income seniors by **about 30% over the present level**, covering about 7% of the shortfall (an average of $16 billion a year).



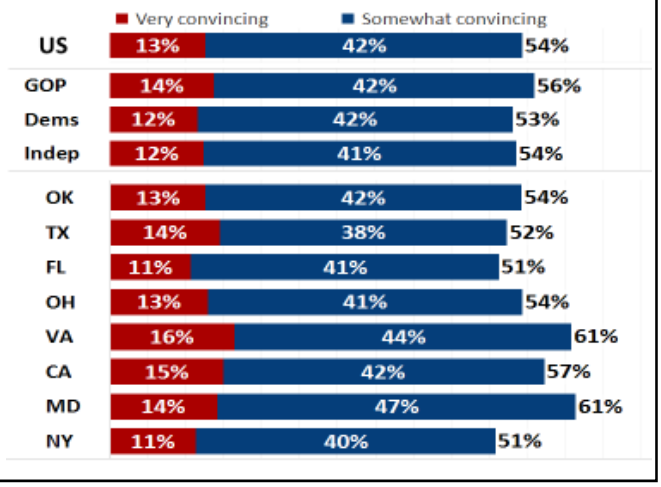
Increasing Standard Premiums

An idea that received a lukewarm response was to gradually increase standard Medicare premiums paid by seniors for Medicare coverage. Currently standard premiums cover 25 percent of the cost to the government. Raising the standard premium to cover 30 percent, which would raise the standard premium by 15 percent from $136 to $170 a month, would cover 16 percent of the shortfall. This proposal was recommended by just four in ten, but almost six in ten found it tolerable. Support for raising premiums further to cover 35 percent of the costs (raising premiums by 30 percent) was recommended by very few and found tolerable by only four in ten.

Respondents were briefed on the fact that currently standard premiums cover 25 percent of the cost of Medicare. They were then told that an increase to the 30-percent level would bring the standard premium from $136 a month up to $163 a month in current dollars, covering 16 percent of the shortfall. In a stronger version of the proposal, it would rise to $190 a month and cover 32 percent of the shortfall. (This change would not affect either high-income or low-income recipients.)

The argument favoring the proposal pointed out that the amount of costs covered by the standard premium has declined from 50 percent in 1965 to 25 percent today, while the percentage of the population on Medicare has grown, and said that "Clearly, the people who are benefiting from Medicare need to take on a larger share of the costs of the program." A modest majority (54%) found the argument convincing, while 45% did not. Response varied between the states with the argument found the most convincing in Virginia and Maryland (61%) and least convincing in Florida and New York (51%).

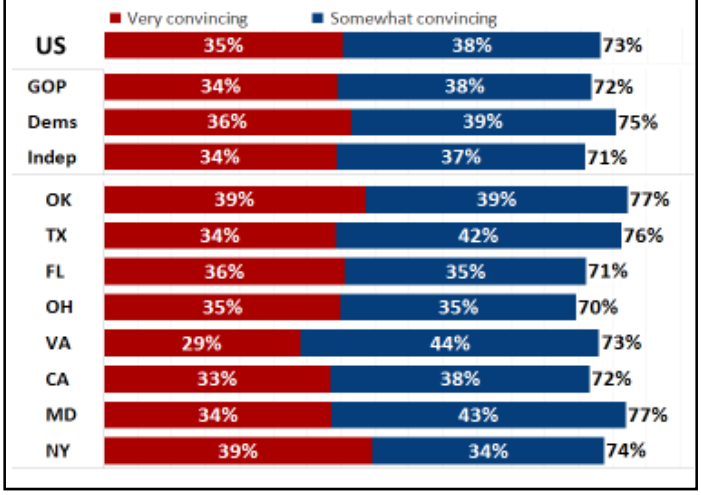
Argument in favor: Increasing standard premiums
When Medicare began in 1965, the standard premium covered 50% of the average costs of providing healthcare to seniors. Over time, Congress reduced the percentage that seniors covered until it was 25% in 1997. Since then healthcare costs have grown, and the percentage of the population on Medicare has grown, but there has been no increase in the percentage seniors pay. Clearly, the people who are benefitting from Medicare need to take on a larger share of the costs of the program.



The argument against the proposal stated that since the median income of seniors is only $24,150 and the value of their past savings is less for many than what had been predicted during their working years, this proposal is unfair. Three in four (73%) found this convincing and again, party differences were minimal.

Argument against: Increasing standard premiums

Most Americans have been planning their retirements on the assumption that Medicare would be there for them when they reach age 65. In recent years, the economy has been growing so slowly that the value of the savings of many seniors is less than what was predicted. The cost of standard Medicare premiums has already been going up faster than inflation as healthcare costs have risen. It is really unfair to expect seniors—whose median income is just $24,150—to take on a bigger share of the cost of Medicare by raising those premiums even further.



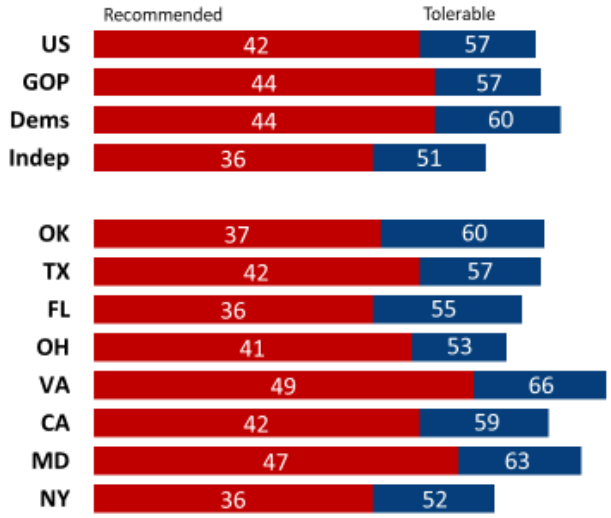
In the end, no group had a majority recommending an increase to standard premiums. It was not chosen by 58%, including 64% of independents, nor by a majority in any state.

However, asked how acceptable (0-10) the proposal was for a rise to the premium covering 30 percent would be, 57% called it at least tolerable, though only 35% gave it a six or higher. Republicans and Democrats were very similar, but among independents a lower 51% said the proposal was tolerable. The sense in the states that 30-percent coverage rise would be tolerable ranged from 52 percent in New York to 66 percent in Virginia. In no state did a majority, give it a six or higher.

Respondents were also asked about a higher rise to 35-percent coverage of Medicare's costs. Only 40% said this would be tolerable, and 58% called it unacceptable (0-4). Majorities rated it as unacceptable in every state except Virginia (47% unacceptable).

Conclusion: Increasing standard premiums

Over a five-year period, gradually increase standard premiums to cover 30%, rather than 25%, of the average cost of providing healthcare for seniors. This would mean that the standard premium would go up by one fifth, rising from $136 a month to $163 a month (in current dollars).



CONTROLLING COSTS IN OTHER WAYS

Limiting Medical Malpractice Suits

A proposal for limiting costs by limiting medical malpractice suits (also known as tort reform) was recommended by a majority. The proposal would cap awards for damages for pain and suffering at $250,000, and for punitive damages at $500,000 and is estimated to cover four percent of the shortfall. While this proposal was recommended by nearly two thirds of Republicans, this was true of just under half of Democrats and independents. However, three quarters overall, including two thirds of Democrats and independents, found the idea tolerable.

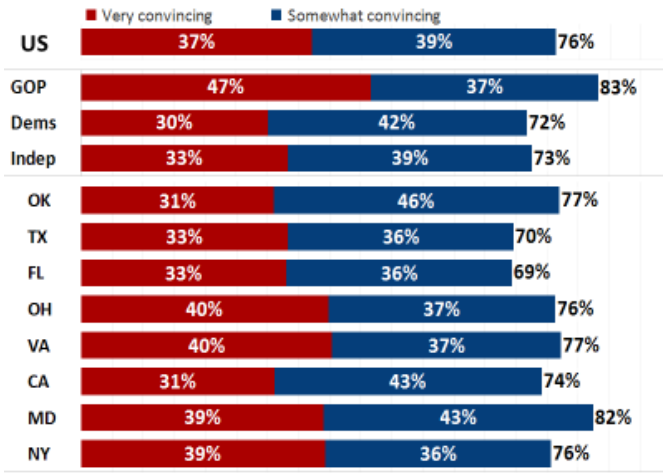
Respondents were told that "in recent years there has been an increase in… malpractice awards… [leading] to higher malpractice insurance premiums for doctors," and that these premiums have been passed on in the form of higher medical fees, thus affecting Medicare. The proposal described to them would:

- Cap awards for damages for pain and suffering at $250,000.
- Cap awards for punitive damages at either $500,000, or twice the amount of the award for economic damages—whichever is greater.

The argument favoring the proposal said that it would both slow down a key driver in the growth of healthcare providers' costs, and reduce doctors' 'defensive medicine' practices, such as ordering up minimally necessary tests. This was called convincing by 3 in 4 (76%), with Republicans higher (83%). In all states, the argument was convincing to seven in ten.

Argument in favor:
Limiting medical malpractice suits

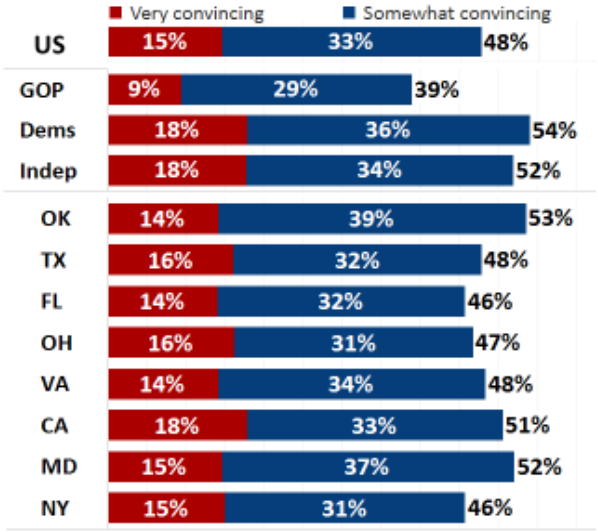
This proposal is good for both patients and the Medicare system. A cap on lawsuits will mean lower medical malpractice insurance premiums for providers, which will help to keep Medicare's healthcare costs under control. Furthermore, doctors will no longer feel pressured to prescribe unnecessary medical tests and services for fear of being sued, and will focus on their own best medical judgment instead.



The argument against the proposal focused on victims of medical negligence who might not be compensated adequately, plus the relaxation of doctors' caution. Surprisingly, it was called unconvincing by a modest majority (something which happens only infrequently in a policy simulation). Only 48% found it convincing, while 51% found it unconvincing. However, 54% of Democrats did find it convincing, as did independents (51%). The argument was convincing to modest 51-54% majorities in Oklahoma, California and Maryland, while in the other states it was convincing only to 46-48%.

Argument against: Limiting medical malpractice suits

This proposal is bad for patients who have been the victims of medical negligence, because limiting their ability to sue can prevent victims from receiving adequate compensation for their injuries. This proposal will also make doctors less cautious than they are today because they will have less of an incentive to check for a wider range of risks to the patient, resulting in greater harm in the long run.

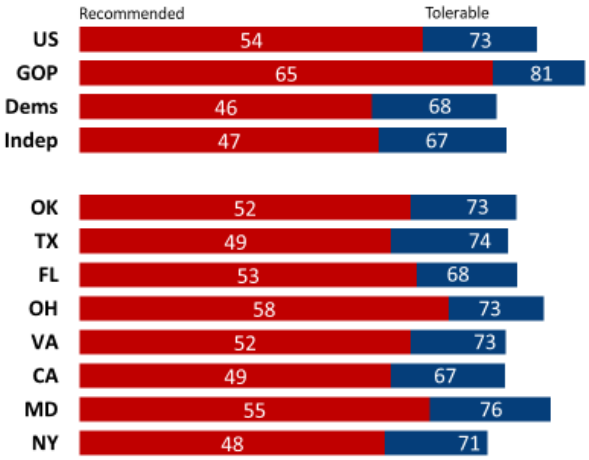


In their final recommendations, 54% chose limits on medical malpractice suits, covering 4% of the shortfall, but this was not bipartisan: it was chosen by 65% of Republicans, but only 46% of Democrats and 47% of independents. Majorities recommended the proposal in Ohio (largest majority at 58%), Oklahoma, Florida, Virginia and Maryland. Texas, California, and New York were all just under half (48-49%).

When asked how acceptable (0-10) they found the proposal to limit awards in malpractice suits, 73% found it at least tolerable, and a 55% majority gave it a six or higher. However, there were distinct party differences: 68% of Democrats and 67% of independents said the proposal was at least tolerable as well as 81% of Republicans. Sixty-seven percent of Republicans gave it a six or higher, but just under half of Democrats and independents did. The proposal was tolerable to about seven in ten in every state. Clear majorities gave it a six or higher in six states, but not California (49%) and Florida (50%).

Conclusion: Limiting medical malpractice suits

- Cap awards for damages for pain and suffering at $250,000.
- Cap awards for punitive damages at either $500,000, or twice the amount of the award for economic damages—whichever is greater.



Lowering Medicare's Subsidy to Teaching Hospitals

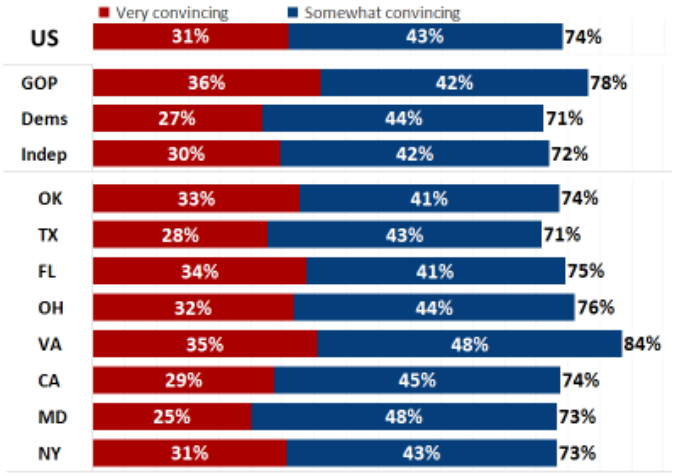
A proposal that was not recommended by a majority was to lower Medicare's subsidy to teaching hospitals that covers a part of the costs of training doctors from 5.5% to 2.2%, covering five percent of the shortfall. However, a slight majority of Republicans did recommend it, a slight majority gave it a six or higher and three quarters found it tolerable.

Respondents were told that currently, Medicare subsidizes teaching hospitals by paying 5.5% of the costs of training doctors. The proposal is to lower this subsidy rate to 2.2%.

The argument favoring the proposal emphasized that this problem has been studied by a Congressionally-chartered commission, which declared the subsidy rate is too high, and this is one more economic pressure on the Medicare system. This was convincing to three in four (74%), and

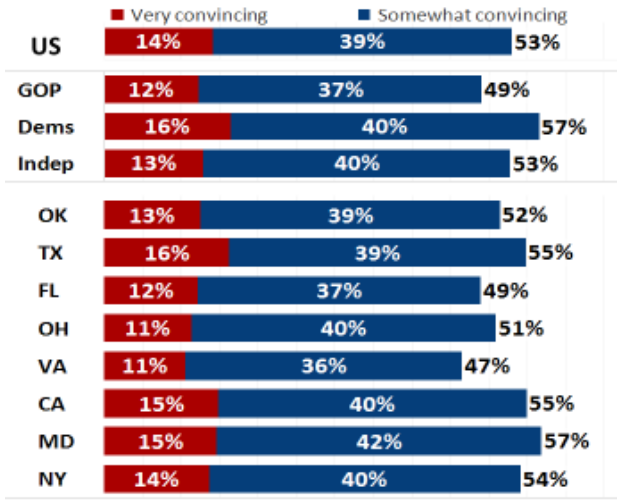
slightly more convincing to Republicans (78%) than to Democrats (71%).

Argument in favor:
Lowering Medicare's subsidy to teaching hospitals
A Congressionally-chartered commission determined that the subsidy given to teaching hospitals does not need to be as high as it is. Medicare already has a lot of economic pressures on it. It's time to cut the fat. This is an extra burden that should be lightened.



The argument against the proposal put its weight on the supply of doctors in the U.S. and the importance of maintaining the medical education pipeline for the future quality of healthcare. This was convincing to a majority, but only a modest one (53%; unconvincing, 46%). Republicans were divided, while the argument did slightly better among Democrats (57%).

Argument against:
Lowering Medicare's subsidy to teaching hospitals
This proposal is bad for hospitals, for Medicare and for health care in the United States--we already have a shortage of doctors. The quality of healthcare in the next twenty years, and our ability to control healthcare costs in general and for Medicare, depend on developing a next generation of doctors.

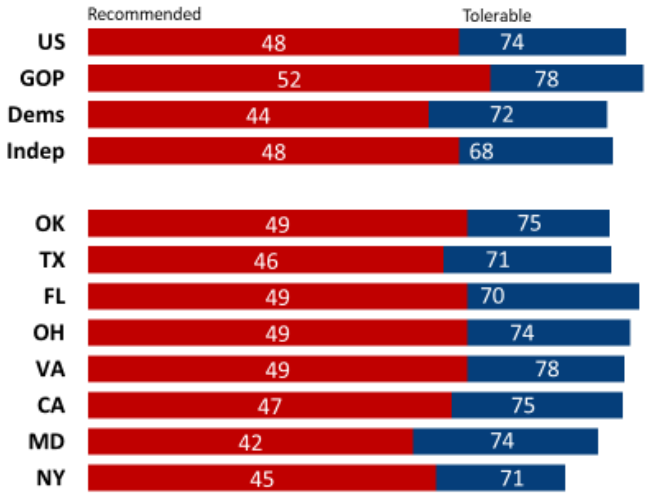


However, in selecting their recommendations, a majority chose not to reducing subsidies to teaching hospitals. Only 48% selected this option, while 52% did not. Among Republicans, a modest majority (52%) selected it; among Democrats, 56% declined. In no state did a majority recommend it.

When asked how tolerable reducing Medicare's subsidy to teaching hospitals would be, 74% said it would be at least tolerable and a modest majority (52%) gave it a six or higher. 58% of Republicans and 49% of Democrats gave it a six or higher, but large majorities in both parties said it was tolerable. About seven in ten called it tolerable in all eight states.

Conclusion: Lowering Medicare's subsidy to teaching hospitals

Lower the subsidy Medicare currently provides to teaching hospitals from about 5.5% to 2.2% of the cost of training doctors.



Limiting Medigap

An unpopular proposal is to limit the amount of Medigap coverage that seniors can buy from private companies to cover the payments that Medicare does not cover, as a way to encourage seniors to be more restrained in their use of medical services. Just one in four recommended this idea. A bare majority found it tolerable and three in ten rated it six or higher.

Respondents were told that:

> *Medigap is extra health insurance that Medicare recipients can buy from a private company to pay health care costs not covered by Medicare. Medicare recipients ordinarily do pay deductibles and copayments. However, with a Medigap policy typically they do not. Research has shown that when seniors have Medigap insurance, and do not have to pay deductibles and copayments, they do go to the doctor more often, which costs Medicare more money.*

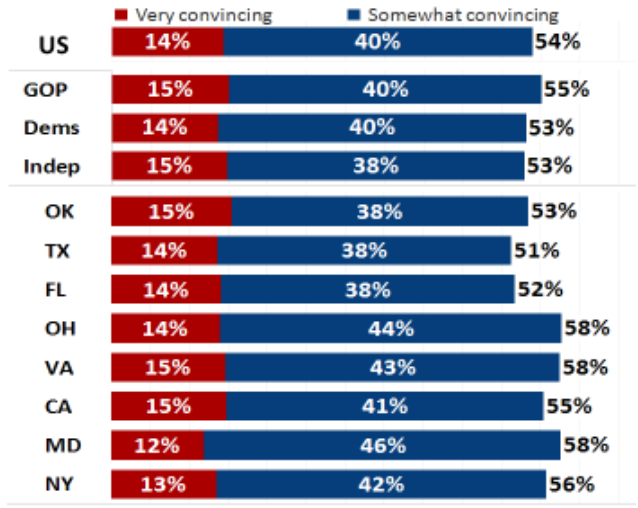
In the proposal, Medigap would not be able to cover a Medicare patient's first $550 in costs, and could not cover more than half of the next $4,950.

Because this would tend to make Medigap users more restrained in their use of medical services, it is estimated that savings from the proposal would cover 10% of Medicare's shortfall.

The argument that favored the proposal explained that research has shown that seniors with Medigap insurance wind up using more medical services—according to one study, 33 percent more—and that this drives up costs for everyone else. A modest majority of 54% found this convincing, while 45% did not. There were no partisan differences.

Argument in favor: Limiting Medigap

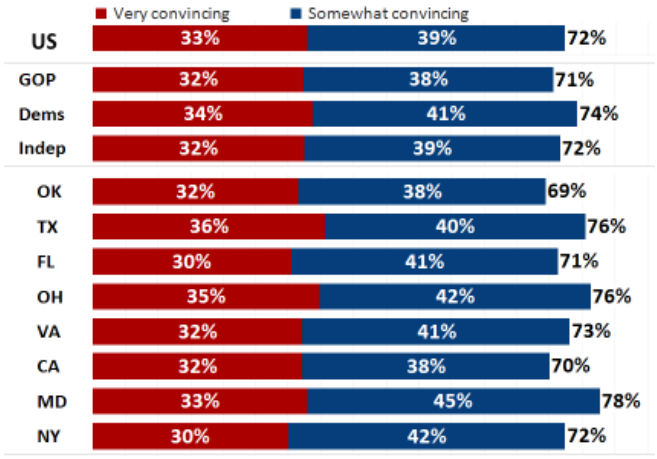
Research has shown that seniors with Medigap insurance wind up using more medical services--33% more, according to one study. And because the federal government pays for the majority of those extra services, it drives up the costs of Medicare for everyone, as well as depriving the health care system of limited resources. By requiring seniors with Medigap coverage to pay a minimum amount for services, they will be more restrained when deciding whether to go to the doctor.



The argument countering the proposal focused on the values seniors may experience from having Medigap insurance—being certain of their annual costs and being able to afford getting conditions diagnosed and treated early. This was convincing to almost three in four (72%) and unconvincing to 26%, with minor partisan differences.

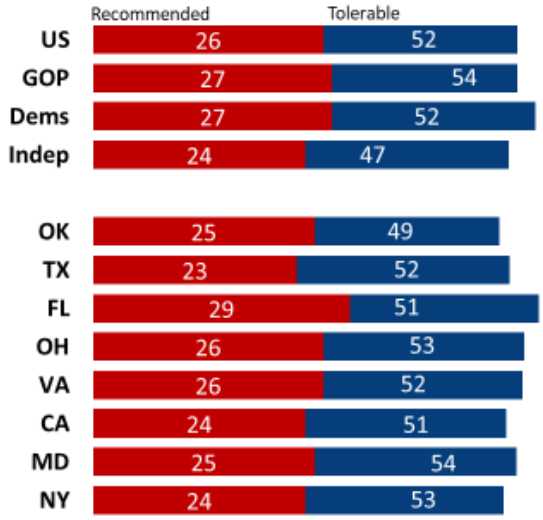
Argument against: Limiting Medigap

Seniors should have the right to have as much Medigap insurance as they feel they need. It gives seniors peace of mind to know how much their health costs will be for the year, so they can budget. Remember that many of these seniors are on low fixed incomes. Also, requiring seniors to make copayments for the services they get may discourage them from getting their conditions diagnosed and treated early. This will damage their health and create other medical costs.



Conclusion: Limiting Medigap

Limit Medigap insurance so that it cannot cover the first $550 of payments Medicare recipients would normally make. For the next $4,950 of possible payments that recipients would normally make, Medigap coverage would be limited to covering 50% of that amount.



In their final recommendations, only 26% chose the option of limiting Medigap insurance; and there were no partisan differences. This option was also rejected in all of the states. It received the lowest support in Texas (23%) and the most support in Florida (29%).

Asked to rate the proposal's acceptability, a slim majority of 52% found it just tolerable. Slight majorities in seven of the eight states said it was tolerable.

Varying Attitudes by Age

Surprisingly, for some options that would affect benefits to current Medicare recipients, seniors were as willing or more willing to make changes as younger people.

Given that current Medicare recipients have a baseline of expectations based on the services they currently receive, one might expect that they might be more resistant to changes. However, that did not prove to be the case. On a number of proposals, seniors (age 65 and over) were the most willing to opt for change compared to other age groups, while younger people, especially those 18-24, were much more cautious in recommending changes.

An extraordinary 90% of seniors view Medicare positively, with 45% viewing it very positively. This is a significantly larger majority, by 20 points, than those in all other age groups. The lowest majority was 70% (18% very positive) among those 35-44.

Generic drugs: 71% of seniors recommended increasing co-pays on brand-name drugs and cutting them to zero on generic equivalents; 71% rated it six or higher. But among 18-24 year-olds, 65% recommended it while only 54% gave it a six or higher—the lowest age group in this regard.

Increasing premiums paid by higher-income seniors: Seniors were the group most willing to endorse at least a 15% hike in premiums paid by seniors with incomes over $85,000. Seventy-one percent of seniors recommended this and 69% gave it a six or higher. Only 52% of 25-34 recommended this step with 53% giving it a six or higher.

Limits on malpractice suits: Most seniors favored tort reform, more enthusiastically than any other age group—though it would potentially limit their compensation if they were the victims, and though seniors are more exposed than others due to their greater need for medical services. Sixty-nine percent of seniors recommended tort reform and 70% gave it a six or above, while only 46% of those 18-24 recommended it and 43% gave it a six or higher. No group younger than 45 recommended tort reform.

Other reforms that do not explicitly affect current Medicare recipients, but have the potential to do so also received high levels of support from seniors.

Reducing the money drug companies receive: Three in four seniors (75%) wanted to cut by 17% what drug companies receive from prescriptions for Medicare recipients with modest incomes; 76% gave it a six or higher, a slightly bigger percentage than any other age group. Among those 18-24, a lesser 56% recommended this—almost 20 points lower--and 59% gave it a six or above. Perhaps even more striking, the argument offered against the proposal—raising the concern that "drug companies would have to charge everyone else more and/or cut back on spending for research and development of new drugs"—was rejected by fully two thirds of seniors (67%), but just a modest majority of those 18-24 (53%).

Reducing payments to hospitals for some services, equalizing them with doctors' offices: Here again, seniors were like those 45 and over in recommending this step (59%). Sixty-nine percent of seniors gave it a six or higher. Among those 18-24, only 49% recommended it and 47% gave it a six or above.

Voice Of the People is a non-partisan organization that seeks to re-anchor our democracy in its founding principles by giving 'We the People' a greater role in government. VOP furthers the use of innovative methods and technology to give the American people a more effective voice in the policymaking process.

VOP is working to urge Congress to take these new methods to scale so that Members of Congress have a large, scientifically-selected, representative sample of their constituents—called a Citizen Cabinet—to be consulted on current issues and providing a voice that accurately reflects the values and priorities of their district or state.

The **Program for Public Consultation** seeks to improve democratic governance by consulting the citizenry on key public policy issues governments face. It has developed innovative survey methods that simulate the process that policymakers go through—getting a briefing, hearing arguments, dealing with tradeoffs—before coming to their conclusion. It also uses surveys to help find common ground between conflicting parties. The Program for Public Consultation is part of the School of Public Policy at the University of Maryland.

ACKNOWLEDGEMENTS

This project is supported by generous grants from the Democracy Fund, Hewlett Foundation and the Circle Foundation.

The survey was fielded to a national panel by Nielsen Scarborough, with thanks to Scott Willoth, Neil Schwartz and Robert O'Neill. Additional respondents were recruited in Virginia, Maryland and Oklahoma by Communications for Research, Inc. with thanks to Colson Steber and Chris Kreiling.

Richard Parsons, VOP's Executive Director, and Rich Robinson, VOP's Director of Communications, managed communications with U.S. Congressional offices and the press, and contributed to the writing of the report.

Allison Stettler managed the panel development and the design and production of the report with assistance from Richard Wyche.