



Lessons from Medicare for Health Care Reform

By Marilyn Moon

Executive summary

Medicare has operated successfully for over 40 years by offering essentially universal coverage to people 65 and over. The program covers some of the sickest and frailest of the U.S. population, along with a substantial number of disabled Americans. While Medicare provides an example of a universal, public health insurance program, health care reform will likely take the form of a system offering the choice of multiple private—and perhaps a public—health insurance plans.

Nonetheless, Medicare’s experience offers a number of key lessons—both positive and negative—that can help in the development of affordable health coverage for all Americans.

The following lessons can help inform the creation of health reforms that learn from and build upon Medicare’s successes and failures.

- A standard benefit package should be sufficiently comprehensive to enable enrollees to forego supplemental coverage. If supplemental coverage is available, it should “wrap around” the standard package.
- Premium and cost-sharing subsidies should be easy to obtain and sufficient to provide meaningful financial protection. Administrative barriers to enrollment and unduly restrictive eligibility rules ultimately limit access to coverage.
- A commitment to choice, particularly choice of health plans, requires a commitment to regulation and oversight—specifically, reasonable rules for plan marketing efforts, an investment in consumer information, and an appropriate degree of standardization (and therefore comparability) across plans.

- Strong data reporting requirements for health plans will strengthen our understanding of key dynamics within the health care system.
- Consumers need help in navigating the health care system and in understanding how better information can help in decision making.
- Increased attention to innovation within public programs, supported by investment in research on what works, can lead the entire system toward greater efficiency and quality.
- Flexibility should be encouraged within appropriate boundaries. Private and public plans should have the ability to develop innovative payment systems and other improvements, but not at the expense of providers' and patients' rights.

Medicare's successes

Medicare has been highly successful in providing coverage and facilitating health care for its beneficiaries. Nearly all doctors, hospitals, and other providers of care participate in the program, and in fact, Medicare's popularity among its beneficiaries is often greater than that of those covered by private health insurance.¹ The program is an accepted and integral part of the health care system.

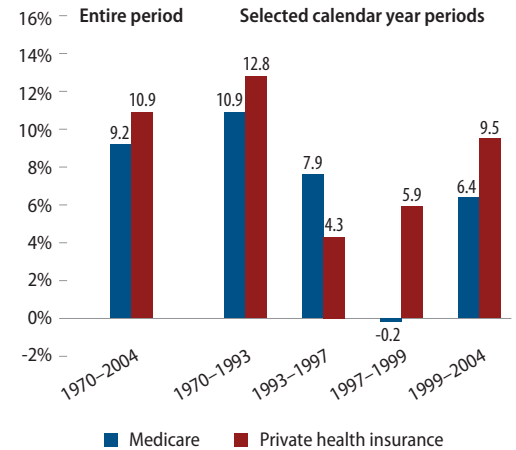
Medicare has struck a successful balance between being a prudent payer of services and offering reimbursements at a high enough level to retain participating providers. Indeed, the Medicare Payment Advisory Commission tracks the generosity of payments and surveys physicians on their willingness to take Medicare patients. The commission has found that, while some problem areas exist in terms of geography and type of service, Medicare beneficiaries normally receive mainstream care with reliable access to providers.² As with Medicare, any system that seeks to manage the costs of care must be vigilant about maintaining comprehensive provider participation to ensure access for consumers. But there is nothing inherent about a universal, public health insurance program that leads to delays in access to care.

A number of studies have shown that Medicare has done modestly better than private insurance in controlling the growth of per capita costs over time.³ This is well illustrated by a recent chart from the Centers for Medicare and Medicaid Services (see Figure 1). For the most part, Medicare and the private sector grow somewhat in tandem, but since Medicare is such a large part of the health care system, this is not surprising. As indicated in Figure 2, the costs of both Medicare and the rest of the health care system are expected to increase over time.

Medicare's administrative costs make up a substantially lower share of the program's spending than private insurers' administrative costs. Medicare's most ardent supporters point to estimates of its administrative costs in the range of 2 percent of total spending on Medicare.⁴ It should be noted, however, that this figure understates actual expenses. Since Medicare enrollment comes through the Social Security Administration, for example, it bypasses one major expense—the cost associated with finding and enrolling beneficiaries. Even so, its costs are still substantially lower than that of private plans (see Figure 3 on page 4).⁵

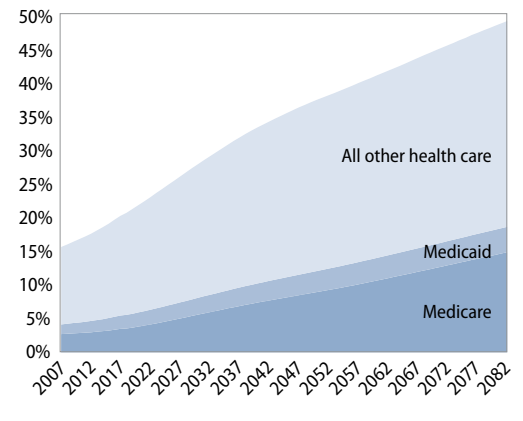
Average annual growth in Medicare and private health insurance benefits per enrollee: selected periods

Except for 1993–1997, Medicare has grown slightly slower than private health insurance.



Source: CMS, Office of the Actuary, National Health Statistics Group.

Projected spending on health care as a percentage of gross domestic product



Source: CMS, Office of the Actuary, National Health Statistics Group.

Another successful aspect of Medicare is the extent to which it has contributed to new payment systems. The way in which Medicare pays hospitals—on a per-stay basis rather than by reimbursing on a system that charges for each service or treatment delivered—helped to change the way that care is delivered in the United States. We’ve all heard the horror stories of hospitals charging \$5 for an aspirin. The Medicare system solves this problem by paying an average amount for a stay based on the diagnosis at admission, giving hospitals an incentive to provide care more efficiently, use fewer resources, and discharge the patient in a shorter period of time.

Key lessons from Medicare

As the preeminent American example of how to provide universal health insurance coverage to a subset of the population, Medicare offers a number of key lessons for health reform advocates. The original program design—a defined benefit package, available to all eligible individuals at a uniform premium, that provides access to a wide range of health care providers—has evolved over time to include alternative delivery systems, additional insurance options to supplement the basic benefit package, premium and cost-sharing subsidies for lower-income enrollees, and innovative approaches to provider payment. The degree to which Medicare has met, and continues to fulfill, its mandate to finance health care for millions of older and disabled Americans brings into focus policy approaches that are also likely to work for a younger, working-age population. Similarly, Medicare’s shortcomings highlight some potential pitfalls for health reformers, and point the way to alternative approaches.

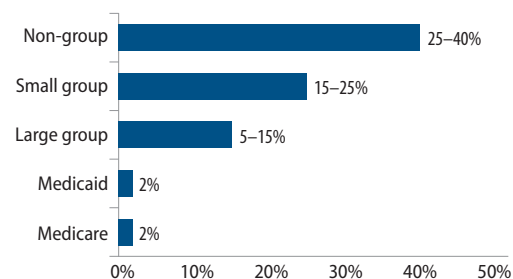
Options to supplement a basic benefit package can work.

A major debate over universal health insurance is how comprehensive the benefits should be. If the benefits are too generous and inclusive, the program can become very expensive. If they are too limited, people may want to opt out of the program altogether. The Medicare program illustrates that it is possible to allow supplementation of the benefit package, giving individuals or their (former) employers the option to have more coverage, or “wrap around” the basic benefits.

The Medicare approach has been to require that providers accept the basic Medicare coverage and its payments as prescribed by law, and that supplemental benefits are limited to services not covered by Medicare or to its various deductibles and cost-sharing. As a consequence, all beneficiaries have access to the basic set of benefits: Providers do not discriminate against those who have only Medicare as might be the case if, for example, supplementation came to be used to get faster care or access to particular physicians.

Only two percent of premiums in Medicare and Medicaid are spent on non-medical expenditures

Percent of premiums spent on non-medical expenditures



Source: K. Davis, B.S. Cooper and R. Capasso, *The Federal Employees Health Benefit Program: A Model for Workers, Not Medicare* (New York: The Commonwealth Fund, Nov. 2003); M.A. Hall, “The geography of health insurance regulation,” *I*, March/April 2000; 19(2): 173–184.

Except for those who opt out of taking Medicare payments, the basic benefits are available at a predictable price. In other countries where consumers can use supplementation to fully circumvent the government option, a two-tier system of care can begin to develop with some providers taking only private-pay patients or effectively allowing such patients to jump the queue for elective services.

The Medicare program has not been undermined by private supplementation. Yet when Medicare beneficiaries also have a supplementary plan, the program itself becomes less efficient and more complex. Beneficiaries must essentially deal with two sets of insurers and their varying rules. This adds to administrative costs and to confusion among beneficiaries.

Medicare's benefit package has proven to be less comprehensive than that offered to most working families, making it necessary for most beneficiaries to seek at least some supplemental benefits. Expanding coverage enough so that some beneficiaries could choose to forego supplemental coverage would improve upon the already successful program.⁶ A similar supplementary program for younger families would need to be similarly sensitive to individual needs and strike the right balance of comprehensiveness.

Complexity undermines effectiveness.

Medicare is a complicated program with many disparate components. What most people think of as the basic program is actually two separate parts with a range of varying requirements for cost-sharing, coverage, and benefit eligibility. A private plan option has also been added to the mix, allowing people to pick a private insurer to rely upon for all Medicare benefits. Now called Medicare Advantage, these private plans range from traditional health maintenance organizations to private fee-for-service plans. HMOs offer a clear set of choices, but many other plans add little value to the system. And when a prescription drug benefit—Medicare Part D—was added to Medicare in 2003 legislation, a whole new set of complications arose requiring individuals to sign up for a private drug plan subsidized by the federal government. Beneficiaries now face many choices and decisions in the process, and many beneficiaries now end up with three plans: traditional Medicare, a Medigap policy to fill in the Medicare cost-sharing, and a drug policy.

By separating various aspects of the plan into parts with separate entities involved—private Part D plans and supplemental insurers—the incentives for providing the best possible care are also fragmented. For instance, research has indicated that adherence to drug regimens can reduce health complications that lead to hospitalizations and other costs of care. But the drug plans do not have an incentive to take this into account since they are not liable for the higher costs that occur elsewhere. As a consequence, they are not as likely to encourage regular drug use and compliance or to choose the most effective drugs for beneficiaries. Avoiding complexity not only helps consumers understand their benefits, but it is also an important consideration for assuring an efficient system of care as well.

Legal and administrative barriers undercut low-income assistance.

Medicare has tried a variety of approaches to provide additional subsidies for low-income beneficiaries for whom the cost-sharing and coverage gaps pose barriers to getting care. Initially, the Medicaid program, which was established at the same time as Medicare, was thought to be the answer for filling the gaps in Medicare. But Medicaid is run by the states, which often maintain intimidating enrollment processes and establish low eligibility thresholds for income and assets. As a result, many individuals who are technically eligible do not enroll in Medicaid. And these protections still exclude from eligibility many individuals who face very high costs as a share of their income—costs for Medicare’s premiums and cost-sharing and for services Medicare does not cover.

At the end of the 1980s, Congress added low-income protections to Medicare, although these new programs were also administered by the states. These programs—which today are known as the Medicare Savings Programs—expanded help with Medicare premiums and cost-sharing to individuals with somewhat higher incomes and resources than the previous thresholds in many states, thus making more people eligible for help. The benefits were reduced as people’s incomes rose to fill in Medicare’s gaps for those with incomes up to 100 percent of poverty and phased out at 135 percent (or about \$14,000 in income for a single person in 2009)—a low threshold, given the high out-of-pocket health care costs for this group. Moreover, the legislation did little to ease the sign-up process because people still had to contend with Medicaid’s usual barriers to enrollment. Applicants must generally make several visits to the “welfare office” and must provide substantial documentation about their income and assets.

Finally, in the Medicare Modernization Act of 2003 that created a drug benefit for Medicare, Congress also created help with drug benefit premiums, deductibles, and cost-sharing for people with income below 150 percent of the poverty level, and charged the Social Security Administration with outreach and enrollment responsibilities. While locating enrollment with SSA addressed the problem of the stigma associated with going to the welfare office to enroll, SSA was poorly equipped to handle the inquiries and process for outreach. Despite a number of efforts to reach the low-income population, participation remains well below the number of people who are projected to be eligible for such coverage.

Several things could be done to increase participation in Medicare and a potential reformed health system. The existence of an asset test that requires considerable documentation is a likely barrier to beneficiaries. A number of states have discussed eliminating these assets tests, and in some cases have done so for younger families. There simply are not very many people—including seniors—who have low incomes but substantial amounts of assets, so the invasive questions and heightened scrutiny of asset tests may do more to discourage applicants than protect public resources from ineligible enrollees. Moreover, those who do have assets generally have them in the form of retirement savings that must be stretched over 15 to 20 years.

Another way to increase enrollment is to increase the income eligibility limit. In the case of older Medicare beneficiaries who often average over \$3,000 in costs for standard health care services (ignoring any long-term care costs), it is probably inadequate to limit eligibility to those with less than \$17,000 of income, or 150 percent of poverty. Ironically, many reform proposals call for premium subsidies and cost-sharing protections for younger families that extend to 200 to 250 percent of the poverty range—a more generous level of protection for those who tend to have even lower levels of health care spending.

Some states have had success with programs that make it easy to enroll, but they penalize individuals if it is later discovered that they have higher incomes. Pennsylvania's PACE program of low-income subsidies for drug coverage uses this approach and reports few problems of ineligible people participating.⁷ It is appropriate to consider whether we care more about making sure that those who need coverage can get it or about making sure that no one ineligible slips into the system. If the emphasis is on the former, the barriers to signing up should be substantially reduced.

If even aggressive outreach fails to improve enrollment, an important question to be answered is whether the basic benefit is sufficiently generous to give people access to care. For example, a high deductible might be chosen to hold down the overall costs of care, but it could then create a major barrier to service use for low-income families. Thus, if outreach programs fail to enroll people in special subsidy programs, it may be necessary to make the basic benefits more generous and avoid high deductibles.

Choice creates a number of challenges.

One of the buzzwords in health care reform is the desirability of choice to avoid a “one-size-fits-all” approach to health plans. The hope is that competition and choice can foster innovation and greater efficiency in care over time, reduce the role of government in health care, and minimize micromanagement from politicians. But these advantages must be weighed against the problems and challenges that choice can create, including undesirable types of competition such as risk selection and fraudulent claims, and higher administrative costs. Within Medicare, the private plan options (Medicare Advantage) and Part D (drug) plans illustrate some of the challenges facing broader health care reform.

Fundamentally at issue are the kinds of choices the system offers, how consumers understand those choices, and the consequences of the choices they make. The most successful private plans in Medicare have been those that offer access to the historically successful health maintenance organizations, which invest in the care management many advocate for in the entire health care system. But Medicare Advantage offers additional types of plans that add confusion but little value, particularly in the case of private fee-for-service, or PFFS, options. Ironically, these less managed private plans have grown the fastest in recent years—reflecting the extra benefits offered as a result of special subsidies created by the 2003 legislation.⁸

Sometimes choice is discussed in terms of allowing people to only pay for the benefits they want. Younger Medicare beneficiaries may not value home health care as much as older beneficiaries, for example, and so may not want to pay for it. And indeed, some of the PFFS plans offer higher cost-sharing for those services but lower cost-sharing in other areas that may be attractive to younger, healthier beneficiaries. However, enabling this type of choice, as Medicare has done, allows insurers to cherry-pick the population to attract healthier beneficiaries, which undermines the basic concept of insurance—the sharing of risks across as broad a population as possible. Such activity has been well documented among the private plan options in Medicare, despite Medicare’s attempts to adjust payments based on risk. The result has been that poor risks—sicker people—end up being served by the traditional Medicare program and plans serving patients less costly than average collect overpayments.

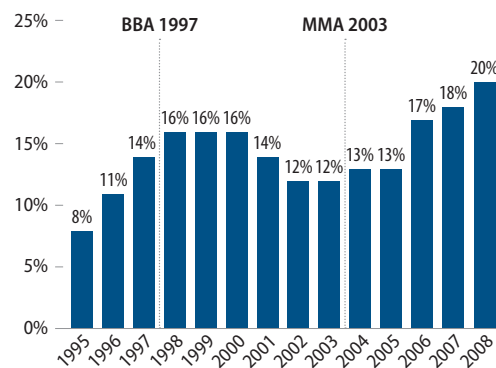
To most beneficiaries, choice most likely means choice of providers of care. But the concept of plan choice actually conflicts with provider choice. Competition among private plan options is intended to encourage plans that limit costs by limiting choice—negotiating lower rates with limited networks of care providers. In fact, much of the dissatisfaction of beneficiaries who enroll in private plans comes when they discover that their choices are more limited than in traditional Medicare, which offers the greatest choice of providers.

Choice can also lead to instability. While the goal of adding private plans as an option for Medicare was to encourage competition to keep costs low and allow beneficiaries to choose among a range of options, enthusiasm for these choices has never been at the level that some expected. Only when these plans have received extra payments allowing them to offer additional benefits have they grown in popularity. However, government payments to the plans have gone up and down—and plans have come and gone as a result. Enrollment rose when payment became overly generous in the 1990s, crashed when those payments were cut back, and rose again after legislation in 2003, when excess payments again became the norm.⁹ These trends show up clearly in Figure 4. The disruptions caused by the swings in payment generosity were a source of great dissatisfaction to many beneficiaries. Creating a true level playing field and offering stability in the choices available will be important for both satisfaction and smooth operation of a reformed health care program.

Consumers’ preference for stability may also undermine the competition that choice aims to put in place. Few Medicare beneficiaries change plans during open season, even when it might be advantageous to do so.¹⁰ Although a beneficiary’s drug plan premium may rise substantially compared to other drug plans in their area, for example, many report that they do not want to learn a new system and deal with a new insurance company. As a consequence, plans do not have as much incentive to improve or hold down costs. And even when some plans become a better deal, if beneficiaries remain in existing plans, bad plans can sur-

Enrollment in Medicare-managed care plans as a percentage of total Medicare beneficiaries, 1995–2008

FIGURE 4



Source: Centers for Medicare and Medicaid Services, managed care enrollment data—data for 1995–2002 are as of December 1 of each year; data for 2003–2007 are for the quarter ending in December of each year; data for 2008 are as of February 2008.

vive for a long time. Choice may be helpful for some, but problematic for others; options that allow considerable choice must focus on protecting patients. Evidence suggests that younger families may be more willing to change plans to follow incentives, but oversight will nevertheless be needed to assure that competition is serving its goal.

Consumer information needs improvement.

Although the Medicare program for the aged and disabled is one of the federal government's most popular and successful programs, it does an insufficient job of helping beneficiaries navigate the complicated world of health choices and benefits. From the outset, Medicare has been a complex program separated into two parts and offering benefits that each come with their own restrictions and cost-sharing rules.

Beneficiaries are often barraged with offers from private plans—both the comprehensive Medicare Advantage plans and the standalone private drug plans—that hold open enrollment periods at the end of each year. Some people stay with the same plan; others accept the first option that comes their way. Both groups may end up with plans that have become much less desirable over time or that do not meet their specific needs.

This year the drug plan options vary substantially in how much their premiums have changed, with some growing only modestly and others more than doubling in price. And drug plans can add or delete drugs from their lists of what is covered, affecting how well they meet the needs of beneficiaries. Finally, plans available for beneficiaries who qualify for low-income subsidies have changed substantially, forcing some of the most vulnerable beneficiaries to learn all the rules of a new drug plan each year.

On their own, plans cannot be counted upon to provide accurate information. In the spring of 2008, Medicare halted advertisements for private plans after misleading information was provided to beneficiaries. More recently, insurance brokers have come under fire for Part D marketing.

The federal government offers some help as beneficiaries navigate their choices, but this help is poorly coordinated and often inadequately executed. Instead of being a role model for the private sector as it could be, Medicare has offered an example of “what not to do.” Hearings in the summer of 2008, for example, included reports of the large number of incorrect answers given to beneficiaries who call the “1-800-Medicare” hotline. Moreover, Medicare has to compete with information provided by private plans that have a stake in placing a positive spin on their own offerings. Medicare expends a large amount of money on providing information but it does not spend those resources wisely.

Improving this situation would entail doing a better job of testing materials and training those who provide information on Medicare. This should not be left solely to private plans

to provide information in a choice environment; instead the managing group—in this case the Medicare administration—needs to recognize that choice leads to complexity and beneficiaries need help in making comparisons. Moreover, these materials need to be aimed at a variety of audiences, not all of whom are highly sophisticated in making choices.

Oversight and standardization of private plans can also help. The Medicare supplemental plans that have been in existence since the beginning of the program created many problems and abuses before better controls and regulation were added to help individuals understand differences and make good comparisons. Recent experience with Medicare Advantage and the drug plans suggest that further refinement of regulation and information creation is needed. In particular the large number of drug plans has confused beneficiaries.

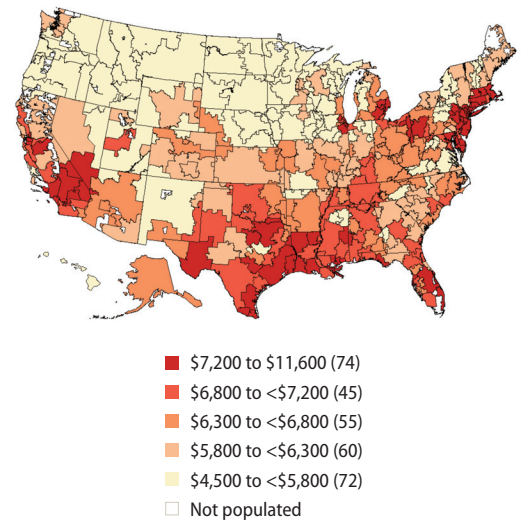
One role that employers play in our current system is to offer help to employees in sorting out their health care options and in choosing the plans that compete for the opportunity to offer their plans to employees. This role is similar to what Medicare has tried to do, but usually on a smaller scale and tailored to the particular workforce. Any system that creates universal coverage with a choice of plans must find ways of offering information to those who are not being served by employers, or, if the employer-based system declines further, to most Americans. Medicare’s experience demonstrates that this is a very challenging task.

Standard benefits don’t lead to uniform use.

The data available on Medicare service use, and hence cost by county, state, or hospital service area indicate enormous variations. Data on Medicare variations in the traditional fee-for-service program are particularly relevant since, technically, the benefit package is the same across the United States. These differences have been well documented and cannot be readily explained by the prices of services or the mix of patients alone. The use of services under Medicare varies by region of the country and has led to a great deal of attention to the question of what is the “right” level of spending (see Figure 5). There is no consensus, and we do not yet know whether the low or high spending areas should be the norm. This underscores the fact that there is no consensus on best practices and that more work is needed in that area.¹¹

Reducing variation in use and cost may produce substantial savings in our health care system. But in practice, only a small percentage of the care that is delivered in the United States has been subjected to rigorous analysis both for its basic effectiveness and its value relative to other treatments, a field commonly called comparative effectiveness. To realize savings will require a far greater investment in data and research to identify and promote best practices.

Medicare spending per capita in the United States, by hospital referral region, 2003



Source: Centers for Medicare and Medicaid Services, managed care enrollment data—data for 1995–2002 are as of December 1 of each year; data for 2003–2007 are for the quarter ending in December of each year; data for 2008 are as of February 2008.

Data and information can help improve health care delivery.

Much of what we know about many key questions regarding our health care system comes from Medicare data. These data allow researchers to study how quickly various procedures are disseminated across the United States once they are covered by Medicare, where outcomes are best for particular treatments, how frequently procedures are performed by a hospital, and other useful metrics. Most of the work on regional variations in health care delivery, spending, and quality of care comes from Medicare data. Using the data allows objective reviews of what is happening in the health care system and holds the promise of identifying areas that need attention or identifying potential overuse of services, for example.

In contrast, private health insurers view such information as proprietary and either do not share it or charge large fees for its use. Even the private plans that operate within the Medicare program provide little or no information on care delivered, meaning that we cannot compare use of services between those in the traditional fee for service portion of Medicare and those in Medicare-approved private managed care plans. Although states collect data on the Medicaid program, it is not easily compared across states or used for analytical purposes. For a range of purposes, including transparency of what care we are receiving as a country, it is important to require basic data reporting. Medicare's traditional program serves as a model for what can be achieved at a low cost.

Investment in what works is needed.

A key to reducing costs in the future is to invest in research into what works in health care. It is essential to have better knowledge of the effectiveness of the many types of services available to consumers. Medicare, like the rest of the healthcare system, is expected to grow largely because of the growth in the number of services and those services' increasing complexity.¹² But little is known about the effectiveness of these treatments, tests, and drugs.

Medicare has cautiously moved in this direction. It has a committee of experts to make national coverage determinations. These actions are, however, subject to political pressures and influence. Moreover, Medicare has the potential to be a source of new ideas and information that can benefit the country as a whole, but the budget for such activities has substantially deteriorated over the years. Indeed, in many of its demonstrations, where Medicare could be a major leader in identifying new and innovative approaches, the demonstration is often required to save money or at least be budget neutral from the very beginning. Many good ideas require investment of resources and time to achieve long-term improvements; they may not even reach the testing stage if the constraints are too severe.

The Medicare program should be spending more on research and demonstration activities and on oversight of the program overall. Furthermore, Medicare could serve as a role model for identifying new ways to streamline and improve the delivery system and

benefit assessment to reduce unnecessary care in the system. Better norms and standards of care could provide quality of care protections to all Americans. Investment in outcomes research, disease management, and other techniques to improve patient treatment will require a substantial public commitment.

Investment in research on what works is best thought of as a public good. Private insurers or states that invest in these activities are unlikely to devote enough resources, and their returns on such an investment will be limited to the patients they serve. Moreover, competing studies by competing insurers makes little sense. Even if not housed in Medicare, this research should take place on a national level.¹³

Flexibility must be aimed at improving quality, not just lowering costs.

One of the advantages touted for private plans is their ability to be flexible in making decisions. It is easier for them to introduce changes at a more rapid pace and allow exceptions to stated policy. This decision-making ability allows private insurers to respond more quickly than a large government program to adopt innovations and to intervene when treatments may be unnecessary. However, private insurers' flexibility can also be used to exclude physicians or procedures arbitrarily as a means of avoiding, rather than managing, costly care.

Medicare may need more flexibility to promote quality. But some of its rules may also prevent the flexibility to arbitrarily deny care. This can help both beneficiaries and providers. Physicians cannot be dropped simply because they serve a sicker group of patients and hence help to raise plan costs. Denial of services receives a more formal review under Medicare than for many private plans. The challenge for health reform is to find the right balance between flexible decision-making and protective rules.

Micromanagement by politicians can create problems.

From the very beginning, the Medicare program has been complicated by politics. The split between Parts A and B represented a political compromise that did not put a premium on creating an understandable program. And a substantial amount of tinkering with specifics over the years has served little legitimate purpose.

One good example is the issue of oxygen. The cost of providing oxygen to Medicare beneficiaries is substantially higher than the prices that private insurers have been able to attain. In fact, some legislators have used the oxygen example as an indication of why a public program does not work. In reality, it is an example of how political micromanagement impedes rational program management. It was the U.S. Congress that dictated the terms of payment for oxygen—not Medicare administrators. Similar restrictions on

payments and even on establishing demonstrations for understanding how Medicare might change over time have been introduced by legislation.

Congress must find a reasonable balance between oversight of and interference with Medicare, and for any universal system of reform that might be introduced. Simply relying on private plans does not necessarily solve the problem. The rules in the 2003 legislation that brought extra payments to private plans at the expense of traditional Medicare serve as a reminder that political interference can occur for private plans as well as for a public one. This is not an easy challenge but ought to be part of any discussions of reform.

Conclusion: Medicare's lessons should inform policy development

Medicare's lessons are readily applied to today's health reform debate. Policy implications include:

- A standard benefit package should be sufficiently comprehensive to enable enrollees to forgo supplemental coverage. If supplemental coverage is available, it should “wrap around” the standard package.
- Premium and cost-sharing subsidies should be easy to obtain and sufficient to provide meaningful financial protection. Administrative barriers to enrollment and unduly restrictive eligibility rules ultimately limit access to coverage.
- A commitment to choice, particularly choice of health plans, requires a commitment to regulation and oversight—specifically, reasonable rules for plan marketing efforts, an investment in consumer information, and an appropriate degree of standardization and therefore comparability across plans.
- Strong data reporting requirements for health plans will strengthen our understanding of key dynamics within the health care system.
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- Increased attention to innovation within public programs, supported by investment in research on what works, can lead the entire system towards greater efficiency and quality.
- Flexibility should be encouraged within appropriate boundaries. Private and public plans should have the ability to develop innovative payment systems and other improvements, but not at the expense of providers' and patients' rights.

Medicare's lessons are readily applied to today's health reform debate. The program has grappled with many of the issues that now face policymakers engaged in health reform, including the issues of choice among private options and the potential role of a public plan option. Medicare's experiences also highlight problem areas that still need to be addressed for any reform to be successful, including how to hold down the growth of health care costs, how to keep politics out of decision making, how much regulation and oversight of private plans is needed, and how to protect the needs of the ultimate client—the U.S. population.

About the author

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Dr. Moon has served on a number of boards for nonprofit organizations, including the Medicare Rights Center, and the National Academy of Social Insurance. She also served as a Senior Fellow at the Urban Institute and from 1993 to 2000 wrote a periodic column for the *Washington Post* on health reform and health coverage. She is a member of the Institute of Medicine.

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