I’m not in favor of voucherizing Medicare. We have a fine system, and it should be a model for how we provide coverage for a lot of people in this country.

JAMA: What has the Center for Medicare and Medicaid Innovation (CMMI) accomplished in the past few years?

DR BERWICK: The center has really stimulated I think an unprecedented amount of activity around the country in the localities, very local activities, to come up with new ways to give and support care. A great example has been the Partnership for Patients. That was a program that I established when I was administrator, a $1 billion investment in reducing unnecessary readmissions to hospitals and in preventing so-called hospital-acquired conditions. These are injuries in hospital care like bedsores and central-line infections and medication errors. The interim results of the partnership were just reported a couple of months ago, and they’re quite stunning. We have double-digit improvements—reductions in complications in hospitals, readmission rates the lowest they have been on record, I think—and a lot of progress in the nation on patient safety, and that’s just one contribution of CMMI. It also has fostered experiments with new payment systems like the pioneer accountable care organizations, like the big bundle-payment experiment that is showing some pretty good results, so I think it’s been a very, very wise investment in reinventing care.

JAMA: Do you have any other thoughts about Medicare on the 50th anniversary of this program?

DR BERWICK: The thing we need to focus on in all this political wrangling and rhetoric is the majesty of Medicare [at 50 years]. In 1965 we took elders in our country who would have woken up in the middle of the night worried they’re going to go bankrupt from their incipient health problems, people who couldn’t get insurance, people who were really frightened, and we took away that fear. We provided a sense of security for elders in this country. [T]hat provides a lesson for us. Medicare and Medicaid were steps in this country toward health care as a human right. I deeply believe that health care is and should be honored as a human right, and I hope we take heart and encouragement and commitment from that decision made a half century ago and now move this country forward to what all developed nation democracies now have, which is health care that really can reach every single person with the same sense of security and support. [W]e need to be proud of what we did 50 years ago, and we can make ourselves proud by building on that so that everybody can have the care they want and need.

The JAMA Forum

Medicaid at 50: Time for a Major Overhaul

Stuart M. Butler, PhD

It’s understandable that attention was heavily focused on imagining alternative futures for the Affordable Care Act (ACA) given the US Supreme Court case King v Burwell. (This case challenged the legality of making tax subsidies available for people to buy health insurance through the federal exchange in states that have decided not to run their own exchanges.) But it’s now time to look hard at Medicaid, the joint federal-state program for lower-income Americans. Medicaid needs urgent attention—and some basic thinking.

Medicaid’s Cost and Scale

The cost and scale of Medicaid has been growing sharply, due in part to newly eligible people in those states that have chosen to raise the income eligibility cap under the ACA. This is increasing concerns among state treasurers and federal budget analysts. According to the most recent federal estimates, Medicaid costs are expected to rise at an annual average rate of 7.1% over the next decade (http://bit.ly/1Lb919R) to a program that already consumes 24.5% (http://bit.ly/1Lb1SOY) of state expenditures, often crowding out funds for education and other vital services. It’s also estimated that almost 81 million individuals could be Medicaid beneficiaries by 2022—nearly 18.5 million of them as a result of expansions under the ACA.

These growth projections for Medicaid help explain why so many states—especially Republican-controlled ones—have resisted accepting an enhanced federal share of the cost under the ACA to expand Medicaid. (Coverage for individuals who become eligible under the ACA expansion is fully funded by the federal government through 2016, then phasing down to 90% by 2020.) Some of these states were opposed in principle to Medicaid expansion, but others feel they just cannot count on the promised federal financial commitment in the future.

Complicating the picture further is that the State Children’s Health Insurance Program (SCHIP, or CHIP) is due for congressional reauthorization this year. Although separate from Medicaid, CHIP is designed to cover the insurance cost of
children in uninsured households with incomes that are modest and yet exceed the limit for Medicaid.

A Complicated and Expensive Political Brew
The interplay between Medicaid, the ACA, and CHIP is a complicated and expensive political brew facing Congress. Whether or not the Supreme Court strikes a blow at the ACA’s state exchange subsidies this summer, it is essential for Congress to remake Medicaid, and CHIP, into a more rational and efficient structure.

Such a redesign requires 3 steps:

1. Encourage those states unwilling to expand traditional Medicaid under the ACA to adopt a well-designed “private option” instead.

Several states, including Arkansas, Tennessee, and Utah, have already been negotiating with the federal government to gain waivers from the ACA’s Medicaid expansion language. They want to use the federal money envisioned for Medicaid expansion to enroll families instead in private coverage through the ACA exchanges or employer-sponsored plans. But the waiver process is long, arduous, and uncertain. So a sensible step, which has a reasonable prospect of bipartisan support and a presidential signature, would be to enact legislation making private option statutorily available as an alternative to traditional Medicaid expansion—without the need for a waiver from the administration.

2. Split Medicaid into 3 separate programs, tailored to 3 different populations.

Medicaid today tries to do 3 things: (1) It provides hospital and physician services to low-income able-bodied households (primarily with dependent children). (2) It provides services to low-income, disabled Americans who do not qualify for Medicare. (3) It pays for long-term nursing home care for low-income elderly. But each of these 3 groups needs different things and their needs should be addressed separately.

First, it’s time to blend Medicaid for able-bodied households, together with CHIP, into the tax credit and subsidy program created under the ACA for private plans obtained through the exchanges or through the place of work. In this way, all able-bodied families would become eligible for income-related subsidies for coverage of their choosing. Current Medicaid funds spent on this population would be folded into premium subsidies for exchange plans.

Second, the disabled and other high-cost individuals with multiple needs—including housing and social services that contribute to their overall health—should be retained in a revamped Medicaid program. This “Medicaid 2.0” would provide much greater flexibility for states to combine health, housing, and other funds and to experiment with better ways to serve that population. With this group of high-cost Americans addressed separately from the able-bodied population, the exchange insurers could cover today’s Medicaid population with reasonably priced plans.

And third, it’s time to stop trying to serve the long-term care supports and services of America’s elderly within Medicaid—a program created originally to provide acute care services to the working-age poor. Instead, that portion of Medicaid should become part of a completely revamped strategy for addressing the overall supports and service needs of the elderly. Fortunately, there is a growing sense of urgency and determination in the public policy about pursuing such a strategy (http://bit.ly/1BzLa5i).

3. Use the Section 1332 of the ACA to experiment with Medicaid and the ACA on a grand scale.

Section 1332 of the health reform law allows states to apply for sweeping waivers from many of the mandates and other provisions of the ACA and to coordinate those waivers with the other waivers available under CHIP and even Medicare (http://bit.ly/tuEJD9F). States can begin using such waivers in 2017, and could combine ACA waivers with the Section 1115 waivers (http://bit.ly/1CCrcbz) available under Medicaid (Section 1115 waivers allow states to make changes in the eligibility criteria and delivery of their state Medicaid program, provided there is no net cost to the federal government).

With these waivers available to them, states can explore sweeping changes in their Medicaid programs and can design those changes in tandem with a radically different version of the ACA within the state after 2017.

Medicaid celebrates its 50th birthday this year. And yes, the program has done much to address the health needs of millions of lower-income Americans. But it is time for a top-to-bottom overhaul.

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