Medicare 2.0—A Vision for the Future of America’s Health Insurance Plan

Medicare is one of the great successes in American social policy. It provides universal health insurance to Americans older than 65 years and others while controlling costs better than private insurance and improving health equity. But health care has advanced in countless ways in the half century since Medicare’s passage, and although Medicare has undergone numerous changes since its enactment, these reforms have too often come in a piecemeal fashion that reflects the vagaries of political history more than a concerted attempt to optimize the program for modern needs.

It is time for “Medicare 2.0”: a redesigned Medicare program that meets today’s health care challenges in a comprehensive, cost-effective, and equitable way. Medicare 2.0 includes 5 major reforms to the traditional Medicare program. At a time when private Medicare Advantage plans are growing rapidly, Medicare 2.0 offers an urgent blueprint to preserve and strengthen the public Medicare program for future generations. What follows is a road map that organizes disparate Medicare reform proposals into a unified vision for this health insurance plan.

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Recommendations

Transform and Simplify Traditional Medicare Into a Single, Comprehensive Plan

In traditional Medicare, most beneficiaries carry 4 distinct insurance plans: Part A for hospital services, Part B for physician services, Part D for prescription drugs, and supplementary insurance through Medigap, Medicaid, or other private sources. Even with this portfolio, many older adults still lack coverage for many services critical to health. This patchwork system has led to costly administrative complexity, confusion among beneficiaries, and inequities in access to care.

No US resident should need to have multiple health insurance plans. Medicare 2.0 should have a single, comprehensive benefit structure that covers physician and hospital services, prescription drugs, dental, vision, hearing, and long-term services and supports (LTSS) with a unified cost-sharing structure. Recognizing the significant financial resources needed to meet LTSS needs, a sensible starting point is to prioritize coverage for home and community-based services, which are cost-effective and preferred by many patients and families.

Significantly Reduce Out-of-pocket Costs for Patients

Today’s Medicare is a high-deductible health plan: the standard combined deductible for Parts A, B, and D in 2022 is as much as $2269, and there is no limit to annual out-of-pocket costs. Beyond deductibles, patients face an array of other out-of-pocket spending, including 20% coinsurance for physician services and copayments for extended hospitalizations and skilled nursing facility stays. High deductibles and cost sharing keep patients away from effective care and have a disproportionate effect on seniors with lower incomes.

Medicare 2.0 should minimize or eliminate financial barriers to care. One promising option is to require no cost sharing for beneficiaries under a certain income threshold, such as 138% of the poverty level to match current Medicaid criteria. Other beneficiaries could be provided coverage with no deductible, zero copayments for primary care and other especially high-value services, a package of prescription drugs at no cost, and an out-of-pocket cap indexed to income. Replacing private Medigap coverage with universal low cost sharing would make Medicare 2.0 both more equitable and more efficient.

Modernize Prescription Drug Policy

Medicare 2.0 should build on the reforms of the Inflation Reduction Act to negotiate the price of prescription drugs by both increasing the number of medications eligible for negotiation and pursuing negotiations for newly launched drugs. The negotiation process should consider whether a medication’s primary patent has expired (ie, drugs that forestall competition only with secondary patents and other “evergreening” strategies should be paid for at lower rates). Medicare should also be empowered to engage in innovative purchasing strategies, such as subscription-based models in which a fixed sum pays for all the drugs used by the Medicare population in a given period, direct contracting with manufacturers to produce generic drugs, and bulk purchasing to create stockpiles of drugs important for public health.

Medicare 2.0 should offer a package of high-value medications at zero out-of-pocket cost. Analogous to the rigorous evidence reviews and recommendations prepared by the US Preventive Services Task Force, a “US Chronic Disease Task Force” could be created to review the evidence for the clinical benefit of different...
Medications in treating common chronic conditions. Medications receiving an A or B recommendation could enter the drug negotiation process with the goal of offering the medication to all Medicare beneficiaries at zero out-of-pocket cost.

Place Primary Care at the Center of the Health Care System

The Centers for Medicare & Medicaid Services (CMS) has significant influence on the types of health care professionals trained in the US through the graduate medical education funding scheme. Medicare 2.0 should leverage this influence to significantly expand the primary care workforce, with a particular emphasis on increasing the number of primary care physicians, nurse practitioners, and physician assistants trained in community health centers and other underserved settings. CMS should also empower all Medicare beneficiaries to declare a primary care clinician.

Medicare 2.0 should significantly increase payments for primary care to make it a more attractive career option, improve prevention, reduce emphasis on procedural interventions, and expand the nation’s primary care infrastructure. In the short term, this process would be facilitated by enhancing the capacity of CMS to develop payment rates that encourage more robust primary care rather than reflexively adopting the payment rates recommended by the specialty-heavy Revenue Update Committee. In the longer term, the traditional fee-for-visit strategy of paying for primary care should be transformed to reflect and accelerate best practices for modern, integrated primary care practice.

Reinvent Medicare as an Agency That Finances Population Health, Not an Insurer That Reimburses for Services

Under Medicare 2.0 CMS should be an activist deeply invested in community health centers and other underserved settings. The traditional insurance model risks directing resources away from underserved communities because payments are often benchmarked to past spending. Especially given stark historical inequities, payment policy should not try to perpetuate prior spending patterns; instead, it should actively direct spending to where it is needed most, which will often involve increasing spending on historically marginalized groups. The “health equity benchmark adjustment” included in the recently announced ACO REACH program is in this spirit.

To ensure that these increased resources actually reach patients in need, a complementary strategy is to strengthen requirements for representation of patients’ and communities’ interests in the governance of health care organizations. Taking inspiration from the federally qualified health center model, health care delivery organizations accepting population-based payments from Medicare could be required to have a meaningful percentage of the governing board made up of community representatives and patients, including those with disabilities and chronic illness and people in marginalized populations.

Implementation

These reforms could be advanced together or stepwise as political conditions allow. Some elements of this agenda could be pursued by executive action—and indeed the CMS 2022 Strategic Framework is synergistic with these proposals—but most of these reforms will require new legislation. The budgetary effects of Medicare 2.0 will depend on the particulars of policy design, but in general some aspects would be expected to reduce federal spending (eg, expanded drug negotiation, administrative simplification, focusing on prevention and on improving the quality of care) and others would increase spending (eg, reducing out-of-pocket costs, enhancing benefits). As with any legislative reform, policy makers and the public must weigh the value of spending increases under Medicare 2.0 against other uses of public funds, including health and social spending for younger US residents.

Conclusions

More than 50 years after its enactment, traditional Medicare remains a bright spot in the US health care system. It is a testament to the fundamental strength of the social insurance model that this remains true despite massive changes in the practice of medicine and the delivery of health care writ large. Medicare 2.0 would build on these historic successes to make the country’s premier health care program more efficient, patient centered, comprehensive, and equitable.

ARTICLE INFORMATION

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REFERENCES


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