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Private Power in Public Programs: Medicare, Medicaid, and the Structural Power of Private Insurance

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Research Article

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Abstract

In 2019, nearly 70 percent of Medicaid beneficiaries received their health insurance coverage through a private, managed care organization (MCO). Twenty-five years earlier, 9.5 percent of Medicaid beneficiaries were enrolled in MCOs. This dramatic growth in Medicaid managed care enrollment represents the delegation of significant power by federal and state governments over a critical social program to private actors and market forces. Medicare, too, experienced a similar pattern of transformation. Together, Medicaid and Medicare, two critical pillars of American social policy, paid more than half a trillion dollars to private insurance companies in 2019 to provide public health insurance to 75 million people. This manuscript examines the policy consequences of building private firms directly into the structure of American social policies. In contrast to existing work on "submerged" or "delegated" policies, this manuscript highlights the structural power that such policies bestow on the government's private partners and develops a new theory of structural power in which firms are able to constrain health policy reform through their threats to disrupt the delivery of public policies and social benefits to millions of people across the United States.

Over the past twenty-five years, private insurance companies have gained a tremendous responsibility and financial stake in America's publicly financed health insurance programs. In 2019, nearly 70 percent of Medicaid beneficiaries received their health care coverage through a private managed care organization (MCO) like UnitedHealth or Wellcare.[1] As a result of this heavy reliance on MCOs, more than 280 private insurance companies were collectively paid in excess of $300 billion by state and federal governments to provide health insurance to 53 million Medicaid beneficiaries.[2] Thirty years earlier, less than 10 percent of Medicaid beneficiaries were enrolled in MCOs.[3] Medicare followed a similar pattern of transformation. Between 1989 and 2019, enrollment in Medicare Advantage (MA)—the current name of Medicare's private insurance option—grew from 1.1 million beneficiaries (or 3 percent) to more than 22 million beneficiaries (or 34 percent).[4] Despite the lower enrollment numbers compared to Medicaid, spending on MA totaled $250 billion dollars in 2019. Together, Medicare and Medicaid paid more than a half a trillion dollars in 2019 to private insurance companies to provide health insurance benefits to 75 million people across the United States. Both the revenue and responsibility for providing health benefits are now sources of power and policy influence for private insurers.

The dramatic enrollment growth in private Medicare and Medicaid plans over the past quarter century represents the delegation of significant responsibility over critical social programs to private actors and market forces.[5] As a result, both the operation and politics of America's public health insurance programs were transformed. Neither Medicare nor Medicaid were initially constructed with this level or type of private plan participation.

[1]"Total Medicaid MCO Enrollment," *KFF*, August 21, 2020, https://www.kff.org/other/state-indicator/total-medicaid-mco-enrollment/.

[2]"Annual Medicaid & CHIP Expenditures" [State Overviews], Centers for Medicare & Medicaid Services, https://www.medicaid.gov/state-overviews/scorecard/annual-medicaid-chip-expenditures/index.html; "Total Medicaid MCOs," *KFF*, 2022, https://www.kff.org/medicaid/state-indicator/total-medicaid-mcos/.

[3]Centers for Medicare & Medicaid Services (CMS), *A Profile of Medicaid: Chart Book 2000* (Washington, DC: Health Care Financing Administration, 2000), https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/TheChartSeries/downloads/2tchartbk.pdf.

[4]Thomas G. Mcguire, Joseph P. Newhouse, and Anna D. Sinaiko, "An Economic History of Medicare Part C," *The Milbank Quarterly* 89, no. 2 (2011): 289–332; Meredith Freed, Jeannie Fuglesten Biniek, Anthony Damico, and Tricia Neuman, "Medicare Advantage in 2022: Enrollment Update and Key Trends," *KFF* (blog), August 25, 2022, https://www.kff.org/medicare/fact-sheet/medicare-advantage/.

[5]MCOs do not, however, operate with complete freedom within either program, but are governed by federal and state regulatory powers and oversight mechanisms included in the contractual arrangements between MCOs and federal and state governments. Despite the regulatory powers and oversight, MCOs do maintain broad powers and responsibility for monitoring access and quality, as well as in setting benefits and costs within Medicare, in particular.

Both programs have always relied on private actors to function, most notably through the provision of health care by private hospitals and providers but also on private insurance companies to shoulder much of the early administrative responsibilities. In performing this administrative role, private insurers have long acted as what Christy Ford Chapin describes as the "semiformal appendages" of the state.[6] Private plan participation in the form of providing insurance benefits to Medicare and Medicaid enrollees, however, goes well beyond simply providing administrative capacity for a new federal program. In building private insurers more directly into the structure of public insurance programs, private actors were given new and more direct responsibility over the health of millions of beneficiaries. The payment structures of both programs were also altered, and the universality of Medicare was broadly transformed as an increasing number of beneficiaries were split among private plans, receiving different benefits and facing different costs compared to traditional Medicare.[7] In changing the immediate operations of both programs, the expansion of private plans within Medicare and Medicaid gave insurers a new source of power and policy influence that helped reshape American health care politics.

Often the result of little-noticed regulatory changes or legislative reforms buried in massive spending bills, the role of private insurers within Medicare and Medicaid remained marginal through the early 1990s. By 1997, however, enrollment in Medicare and Medicaid managed care grew to 14 percent and 47 percent of beneficiaries, respectively.[8] Private insurance companies were no longer just the semiformal appendages of the state, but were now built directly into the structure of Medicare and Medicaid. These often overlooked policy changes not only transformed the operations of both programs, but also built private insurers into the structure of public health insurance. As a result, the insurance industry gained a new type of power over the direction of health care reform. This new power is used to preserve a delegated form of public insurance not because this piece of the welfare state supports the goals of business, but because Medicare and Medicaid have *become* the business of the insurance industry.

In this article, I examine the expanding role of MCOs within Medicare and Medicaid and argue that the large role assumed by MCOs within both programs gives the industry an underappreciated level and new form of structural power over health care policy in the United States. While the structural power of business is typically described as coming from their position as major employers and sources of economic growth in capitalist democracies, the new form of structural power identified in this article is unique to delegated forms of policymaking. In the case of delegated policymaking like that seen in Medicare and Medicaid, business gains a new source of structural power because of its privileged position *inside* major social programs. In building MCOs into the structure of Medicare and Medicaid, and giving them responsibility for the health of millions of beneficiaries across the United States, delegated policymaking gives MCOs the ability to create electorally consequential disruptions to the health of those beneficiaries. If in the face of unfavorable policy decisions, for example, MCOs choose to reduce benefits, increase premiums, or no longer participate in certain Medicare or Medicaid markets, the result would be to disenroll and disrupt the health and health insurance of hundreds of thousands of beneficiaries. The ability of MCOs to disrupt the health and health care of millions of people across the United States can, I argue, be effectively used to constrain and reshape the policy agendas of both parties. The structural power of insures has pushed Medicare away from its liberal, social insurance origins, but that same power has also acted to constrain conservative efforts to retrench Medicare, block grant Medicaid, and repeal the Affordable Care Act (ACA). In protecting the ACA, for example, private insurers helped to protect a set of programs with broadly positive effects on the health and economic security of individuals and states.[9] Indeed, the ACA's Medicaid expansion, in which most of the newly eligible population was enrolled in a Medicaid managed care plan, has produced significant reductions in mortality.[10] The reliance on private plans is, therefore, associated with and partly responsible for numerous recent policy successes. However, in displaying a similar dynamic to that described by Paul Frymer in the realm of nineteenth-century land policy and management, the same reliance on private actors that has helped deliver these policy successes also hinder broader and more transformative policy reform.[11]

Because delegated forms of policymaking like that seen in Medicare and Medicaid create uniquely close connections between political and economic systems, this article situates these developments within the framework of American and comparative political economy.[12] Doing so helps to explain how the reliance on private insurers has reshaped the power and preferences of organized actors, created new political and policy constraints for elected officials, and influenced the direction of health care reform in the United States. In viewing delegated policymaking through the lens of American political economy, we also see with greater clarity how this form of policymaking creates unique forms of interconnectedness between American capitalism, electoral democracy, and the development of American public policy. During a period in which some have described business power as in decline, the increasing reliance on delegation in American health care policy over the last thirty years has seen the reemergence of interest group influence and the ascendance

[6]Christy Ford Chapin, *Ensuring America's Health: The Public Creation of the Corporate Health Care System* (Cambridge, UK: Cambridge University Press, 2015).

[7]Theodore R. Marmor and Jerry L. Mashaw, "Understanding Social Insurance: Fairness, Affordability, and the 'Modernization' of Social Security and Medicare," *Health Affairs* 25, no. 3 (2006): 114–34; Andrew S. Kelly, "Boutique to Booming: Medicare Managed Care and the Private Path to Policy Change," *Journal of Health Politics, Policy and Law* 41, no. 3 (June 1, 2016): 315–54, https://doi.org/10.1215/03616878-3523934.

[8]McGuire et al., "An Economic History of Medicare Part C"; CMS, *A Profile of Medicaid*.

[9]Madeline Guth, Rachel Garfield, and Robin Rudowitz, "The Effects of Medicaid Expansion under the ACA: Studies from January 2014 to January 2020" (San Francisco: KFF, March 2020). https://www.kff.org/medicaid/report/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review/.

[10]Guth et al., "The Effects of Medicaid Expansion."

[11]Paul Frymer, "'A Rush and a Push and the Land Is Ours': Territorial Expansion, Land Policy, and U.S. State Formation," *Perspectives on Politics* 12, no. 2 (2014): 119–44.

[12]Jacob S. Hacker, Alexander Hertel-Fernandez, Paul Pierson, and Kathleen Thelen, "The American Political Economy: A Framework and Agenda for Research," in *The American Political Economy: Politics, Markets, and Power*, ed. Jacob S. Hacker, Alexander Hertel-Fernandez, Paul Pierson, and Kathleen Thelen (Cambridge, UK: Cambridge University Press, 2022); Peter Swenson, "Misrepresented Interests: Business, Medicare, and the Making of the American Health Care State," *Studies in American Political Development* 32, no. 1 (2018): 1–23, https://doi.org/doi:10.1017/S0898588X18000019; Pepper D. Culpepper, "Structural Power and Political Science in the Post-Crisis Era," *Business and Politics* 17, no. 3 (October 2015): 391–409, https://doi.org/10.1515/bap-2015-0031; Pepper D. Culpepper and Raphael Reinke, "Structural Power and Bank Bailouts in the United Kingdom and the United States," *Politics & Society* 42, no. 4 (December 1, 2014): 427–54, https://doi.org/10.1177/0032329214547342.

of business power.[13] To understand how business "get their way" in American health care policy, it is necessary to recenter organized interests in accounts of health care policy, expand our definition of power and consider the ways in which delegated forms of policymaking produce a new form of structural power. When the structural power of private insurers is considered, and when the empirical record includes instances of private insurers threatening to disrupt critical social programs, as well as evidence of the internalization of those threats by elected officials, a more accurate historical account of health reform is produced. Moreover, doing so will allow for a more complete assessment of how the power of MCOs influences the contemporary reform agenda, including efforts to increase the generosity of the ACA, implement a public option, or establish "Medicare for All." In building MCOs directly into the structure of Medicare and Medicaid, delegated policymaking established a deeper and more complex connection between political and economic systems, generating a new form of power for organized interests and representing yet another distinctive characteristic of the American political economy.[14]

It was the interconnectedness of political and economic systems that made it possible for the initial enrollment boom to occur in the absence of a proximate legislative change.[15] It is, in part, the absence of a proximate legislative change that may help explain why the initial enrollment booms and policy changes are often absent or marginalized in accounts of American health care reform. As a result of missing or marginalizing this developmental phase in American health care, existing accounts have tended to minimize the power and influence of interest groups and overstated the level of partisan policy disagreement.[16] The political power that was produced by the expansion of private plans within public insurance programs was used to build a broadly bipartisan coalition in favor of the continued expansion of private plans. The bipartisan coalition helped protect against efforts to slow or reverse the growth of private plans, while also protecting against conservative efforts to introduce more direct competition or retrench either program. Beginning in the 1990s, interest group power was no longer declining, and private plans were no longer only a "Republican vision."[17] By adopting a broader definition of power and operating with a more complete consideration of the rapid growth of MCOs within public insurance programs, we see more clearly the changing interests of private insurers, the new mechanisms through which those interests are protected, and how the growing power of the insurance industry constrained the policy preferences of both parties.

In the sections that follow, I first resituate the expansion of private Medicare and Medicaid plans within the broader literature on American health policy. In doing so, the earlier emergence and a deeper form of interconnectedness between public insurance programs and private insurers becomes more visible. In taking a longer view of this developmental process, and in giving greater attention to what were less heralded but still critical episodes of reform, I show how delegated policy designs can generate a new type of structural power that has constrained the policymaking preferences of both political parties. I then review the mechanisms of political power that are commonly associated with the different variants of delegated policymaking, highlighting the near complete focus on instrumental power and introducing a new theory of the structural power of delegated policymaking. I then return to the definitions of instrumental and structural power and offer a new, extended definition of structural power that takes into consideration the unique interconnectedness of political and economic systems that delegated forms of policymaking produce. More specifically, in bridging the literature on delegated governance and American and comparative political economy, I develop a new theory of the structural power of delegated policymaking and show how the financial and market-based decisions of the government's private partners can cause electorally consequential disruptions that act as an important constraint on policymaking in the United States. I then test the theory by applying a series of propositions generated from the work of Pepper Culpepper to the cases of Medicare and Medicaid.[18] The final section concludes with a discussion of the broader constraining power of MCOs and avenues for future theory development and testing.

1. Reevaluating the Rise of Private Plans in Public Insurance: Ascendent Power and Shifting Coalitions

Private insurers have long influenced the structure and trajectory of public health insurance programs in the United States. It was, for example, the "insurance company model" of delivery and financing that was adopted by the designers of Medicare and Medicaid.[19] In Christy Ford Chapin's account of the rise of the insurance company model, she shows how even during the earliest days of Medicare and Medicaid, when insurance companies acted only as the "semiformal appendages" of public insurance programs, there was both a deep "intertwining" of public and private authority and a unique interconnection between political and economic power in American health care policy. Yet despite this long history, the increasing reliance on private insurers in the actual delivery of Medicare and Medicaid benefits marked the beginning of a new type of involvement by private insurers inside public health insurance programs. With insurance companies now occupying a considerably larger and more expansive role within Medicare and Medicaid, the intertwining of public and private authority and economic and political power is both deeper and qualitatively different from that which characterized the first twenty-five to thirty years of Medicare and Medicaid. It is, therefore, necessary to reevaluate this newer form of delegated policymaking within Medicare and Medicaid and examine how the expansion of private plans within both programs has reshaped political power and contestation within American health care policy. To do so requires a more expansive accounting of the power private insurers gain from delegated policy designs and the mechanisms by which that power influences the direction of reform. It is also necessary to resituate the rise of private Medicare and Medicaid plans within the broader history of American health care reform.

[13]Jonathan Oberlander, *The Political Life of Medicare* (Chicago: University of Chicago Press, 2003); Eitan Hersh, "The Political Role of Business Leaders," *Annual Review of Political Science* 26, no. 1 (2023), https://www.annualreviews.org/doi/pdf/10.1146/annurev-polisci-051921-102505.

[14]Hacker et al., "The American Political Economy."

[15]Kelly, "Boutique to Booming."

[16]Jacob S. Hacker, "Privatizing Risk without Privatizing the Welfare State: The Hidden Politics of Social Policy Retrenchment in the United States," *The American Political Science Review* 98, no. 2 (2004): 243–60; Paul Starr, *Remedy and Reaction: The Peculiar American Struggle Over Health Care Reform* (New Haven, CT: Yale University Press, 2013); Oberlander, *The Political Life of Medicare*; Theodore R. Marmor, *The Politics of Medicare* (New York: Aldine De Gruyter, 2000).

[17]Starr, *Remedy and Reaction*.

[18]Culpepper, "Structural Power and Political Science in the Post-Crisis Era."

[19]Chapin, *Ensuring America's Health*.

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Accounts of health care reform are often considered as a series of historical eras, demarcated by presidential or congressional elections or major reforms.[20] As a result, this type of approach may miss longer-running developmental processes and place too much causal weight on elections and public opinion. Perhaps, most importantly for the cases under examination here, such accounts undervalue less prominent episodes of reform and those that take place across multiple political venues and between economic and political systems. In short, existing accounts may undervalue the exact instances in which structural power is most influential and most evident.[21] Paul Starr, for example, describes the period between 1995 and 2006 as a time of surprisingly little change.[22] Starr describes the late 1990s—a period that saw the enactment of policies that secured and expanded the position of private insurers within public health insurance programs—as a period of policy stalemate.[23] Jacob Hacker and Theodore Marmor similarly described Medicare during this period of policy and political transformation as being in a "holding pattern."[24] In her discussion of the policy developments following the initial enactment of Medicare and Medicaid, Christy Ford Chapin largely leaves out the period of private plan expansion, with her account jumping from Clinton's failed Health Security Act in 1993 to the passage of the ACA in 2010.[25] Such accounts overlook or undervalue a policy and political transformation that began in the early 1980s, accelerated through the 1990s, and transpired across multiple political venues and across political and economic systems.[26] More importantly, perhaps, is how such omissions contribute to a misreading and mischaracterization of the shifting political coalitions, political power, and political interests that shaped, and continue to shape, subsequent episodes of health care reform.

Some accounts of this period of American health care do identify and highlight the legislative changes of the late 1990s. However, such accounts also tend to underplay the extent to which these changes signify how a broader political change had already taken place within health care policy. Theodore Marmor, for example, identifies the puzzling Democratic policy shift contained in the Balanced Budget Act (BBA) of 1997, but places much of the reason for the seemingly sudden embrace of private Medicare plans on President Clinton's desire for a balanced budget.[27] To reach a balanced budget and achieve a favored legacy, the Clinton administration had to achieve reductions in Medicare spending and needed Republican support. The latter was achieved, according to Marmor, with Democratic concessions on expanding the role of private insurers in Medicare. The "framework for debating Medicare's future" had certainly changed, but the Clinton administration's desire for a balanced budget cannot fully explain the broad support for private plans coming from congressional Democrats.[28] Nor can it explain the repeated bipartisan efforts to bolster private plan participation following the passage of BBA 1997—particularly once it became clear that boosting private plan involvement would not, in fact, reduce Medicare expenditures. Instead, to fully understand the narrowing menu of policy options and the existence of Democratic support for such a fundamental shift away from Medicare's social insurance legacy, it is necessary to give greater attention to the shifting politics caused by the growth in private plans that had already occurred by 1997.

In missing or misunderstanding how the initial growth of private plans caused a political and policy shift among Democrats, it becomes more likely that this developmental process has been mischaracterized as a wholly Republican vision or strategy. At its foundation, such mischaracterizations are the result of an incomplete assessment of the political power of private insurers, the source of that power, and the mechanisms by which that power influenced and constrained policy options. In maintaining a view that private plans were a type of Trojan horse policy deployed by Republicans, we lose sight of how the new power of private insurers reshaped political interests and won broad bipartisan support beginning in the late 1990s. We miss prominent Democrats working to bolster private plan payments and stabilize the market amid fears of potential disruptions to care. The introduction and growth of private plans within public insurance programs was not the result of a one-off change that tricked or deceived Democrats. It was the product of a longer-running developmental process that expanded and secured the role of private insurers and repeatedly gained the active support of Republicans and Democrats during the late 1990s and early 2000s. This developmental process also helps explain how a long-running political consensus that governed Medicare, in particular, could collapse in 1994 and be reconstituted just a few years later around proposals to expand the role of private plans.[29]

When the growth of private plans is seen as a purely Republican strategy, the logical continuation of that premise is to assume that private insurers and their Republican allies would use this initial beachhead to push toward a broader retrenchment and privatization of public insurance.[30] Jacob Hacker, for example, describes conservatives as aggressively pursuing "the transformation of contracting into a full-fledged system of competing, risk-bearing private plans, which they hope will undermine the universal constituency that has blocked direct benefit cuts in the past."[31] While theoretically logical and supported by New Gingrich's often quoted desire to let Medicare "withering on the vine," neither Medicare nor Medicaid followed this type of trajectory.[32] Instead, after being increasingly built into the structure of Medicare and Medicaid, the revenue-generating

[20]Ibid.; Starr, *Remedy and Reaction*; Oberlander, *The Political Life of Medicare*; Marmor, *The Politics of Medicare*.

[21]Hacker et al., "The American Political Economy."

[22]Starr, *Remedy and Reaction*, 131.

[23]Ibid., 145.

[24]Hacker, "Privatizing Risk"; Marmor, *The Politics of Medicare*.

[25]Chapin, *Ensuring America's Health*.

[26]Kelly, "Boutique to Booming."

[27]Marmor, *The Politics of Medicare*.

[28]Ibid., 179.

[29]In *The Political Life of Medicare*, Jonathan Oberlander has argued that throughout much of its history, Medicare was governed by a "political consensus." During this period, any changes made to Medicare were all made within Medicare's original social insurance structure. This political consensus, according to Oberlander, broke down after the 1994 elections. According to Oberlander, the 1994 elections and the Republican Revolution brought the era of bipartisan consensus and compromise to an end.

[30]Marmor and Mashaw, "Understanding Social Insurance"; Jonathan Oberlander, "Voucherizing Medicare," *Journal of Health Politics, Policy and Law* 39, no. 2 (April 1, 2014): 467–82, https://doi.org/10.1215/03616878-2416348; Hacker, "Privatizing Risk."

[31]Hacker, "Privatizing Risk," 253.

[32]Adam Clymer, "Organized Labor Goes on the Offensive, and the Republicans Cry Foul," *New York Times*, July 20, 1996. Gingrich's original quote is from a speech to the Blue Cross/Blue Shield conference in October 1995. In the speech, Gingrich describes a strategy for delivery of transformative change to Medicare through an incremental approach. "Now we don't get rid of it in round one because we don't think that's politically smart, and we don't think that's the right way to go through a transition. But we believe it's going to wither on the vine because we think people are voluntarily going to leave it—voluntarily." The quote was later used against Gingrich and Republicans in an AFL-CIO advertisement during the 1996 election. Gingrich and Republicans, however, contended that Gingrich was talking about the Health Care Finance Administration, not

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and profit-seeking interests of private insurers became highly aligned with protecting both programs from political attack or retrenchment—including any conservative efforts to erode benefits or adopt a "full-fledged" system of contracting and competition. The interconnectedness between the economic interests of MCOs and the current delegated policy framework has, therefore, also operated to constrain Republican efforts at retrenchment and full privatization. As will be discussed in more detail below, America's Health Insurance Plans (AHIP), the insurance industry's leading lobbying group, has consistently made clear its preference for the current delegated framework, with its limited risk and administratively set prices. Although assessing the true preferences of business can be difficult, in the case of private insurers, there is, perhaps, no better indicator of their preferences than their own investment and growth strategies.[33] Private insurers, for example, have targeted those firms with high exposure in the Medicare and Medicaid for acquisition, demonstrating a strong support of the current structure of both programs and their revenue-generating potential.[34] Centene's $17.3 billion acquisition of WellCare in 2020, for example, created the biggest Medicaid MCOs and was described by the company as part of an "aggressive" strategy to become a leader in the Medicare market. If assessments of health policy development are undertaken without a complete consideration of the evolving interests of private insurers, and without consideration of the growing structural power that protects those interests, observers are likely to miss or mischaracterize the efforts of private insurers to constrain both conservative efforts at retrenchment and progressive efforts for expansion. In 2017, when the Trump administration and congressional Republicans sought to repeal and replace the ACA and transform Medicaid into a block grant, private insurers were among the law's most ardent supporters, fighting against the Republican efforts to end the ACA and retrench Medicaid.[35] The ability of private insurers to constrain both Republican and Democratic health policy agendas lends support to the general notion that the American state is severely limited in its ability to intervene in the American health care system.[36] Ironically, in this case, the state's ability to intervene in the American health care system is constrained because of how deeply the American health care system is embedded within the American state.

While the efforts by private insurers to defend the ACA and Medicaid against retrenchment are generally supportive of Peter Swenson's notion that business is not uniformly hostile to the American health care state, it is necessary to recognize that private insurers are using their power to support and defend the maintenance of a particular form of the American health care state—one that increasingly delegates authority to and enriches private insurers.[37] It is also important to recognize that the evolving interests of private insurers are served by the expansion of delegated forms of policymaking within the current confines of Medicare and Medicaid. Private insurers are considerably less supportive of expanding these programs. Private insurers are, therefore, more inclined to use their power to protect against a proposed payment reduction or the elimination of a currently covered population than to lobby for expanding Medicare eligibility or benefits. Insurance companies, for example, opposed efforts in 2021 to add vision and dental coverage to Medicare, fearing that the manner in which new benefits were added would reduce plan payments and make private plans relatively less attractive to beneficiaries.[38] The interests of private insurers are in maintaining the status quo of delegated policymaking in American health care policy. The structural and instrumental power they gain from these arrangements give them an increasingly broad base of power from which to influence future policymaking in this direction.

The reframing of the rise of private plans within the history of American health care policy also requires that interest groups, particularly private insurers, be placed more centrally in explanations of health care reform since the 1990s. In doing so, it is also necessary to fully consider the type of power that private interests wield, the source of that power, and the mechanisms by which that power shapes public policy. In his detailed account of the first thirty-five years of Medicare's political development, Jonathan Oberlander argues that the fiscal constraints within Medicare limited the potential for interest groups to shape Medicare policy.[39] As a result, Medicare policy, according to Oberlander, largely deviated from the policy preferences of the most powerful interest groups associated with Medicare—the elderly and the American Medical Association. For much of the period under consideration in Oberlander's *The Political Life of Medicare*, enrollment in private Medicare plans was modest, which meant their relative political power was also modest. By the 1990s, however, the power of interest groups was ascendant. While interest groups and private insurers became more central actors in explanations of the 2003 Medicare Modernization Act (MMA), the absence or minimization of their influence and role within public insurance over the prior decade clouds the story of the early 2000s, the MMA, and subsequent reform. Among the conclusions or predictions that need reassessment following the growth of private plan enrollment is that any emerging power of interest groups in the early twenty-first century would be contingent on the partisan makeup of Congress and the White House.[40] In the reform episodes that will be explored in greater

Medicare. The final sentence, in which Gingrich describes people voluntarily walking away, however, indicates that the ultimate target was, in fact, Medicare.

[33]For a discussion on Medicare and the policy preferences of business, including a discussion of the methodological challenges of identify the true preferences of business, see David Broockman, "The 'Problem of Preferences': Medicare and Business Support for the Welfare State," *Studies in American Political Development* 26, no. 2 (2012): 83–106; Swenson, "Misrepresented Interests."

[34]Paige Minemyer, "Centene to Purchase WellCare in $17.3 Billion Deal," *Fierce Healthcare*, March 27, 2019; Paige Minemyer, "How the WellCare Acquisition Is Driving Centene's Approach to Medicare Advantage," *Fierce Healthcare*, October 8, 2020; Paige Minemyer, "Anthem Completes Acquisition of Puerto Rico-Based Medicare Advantage, Medicaid Plans," *Fierce Healthcare*, June 30, 2021; Reed Abelson and Michael J. De La Merced, "WellPoint to Acquire Amerigroup Amid Health Care Overhaul," *New York Times*, July 9, 2012; Bruce Japsen, "Medicare Advantage Mergers and Acquisitions Poised to Take Off," *Forbes*, May 20, 2021; Shelby Livingston, "Why Molina Is on a Medicaid Plan Buying Spree," *Modern Healthcare*, September 29, 2020.

[35]Andrew S. Kelly, "Finding Stability and Sustainability in the Trump Era: Medicare and the Affordable Care Act in Historical Perspective," in *American Political Development and the Trump Presidency* (Philadelphia: University of Pennsylvania Press, 2020), 130–50.

[36]Herschel Nachlis, "Pockets of Weakness in Strong Institutions: Post-Marketing Regulation, Psychopharmaceutical Drugs, and Medical Autonomy, 1938–1982," *Studies in American Political Development* 32, no. 2 (2018): 257–91.

[37]Swenson, "Misrepresented Interests."

[38]Robert King, "AHIP: Adding Dental, Vision, and Hearing Benefits Could Boost Medicare Advantage Costs without Benchmark Changes," *Fierce Healthcare*, August 24, 2021.

[39]Oberlander, *The Political Life of Medicare*.

[40]Marmor, *The Politics of Medicare*; Oberlander, *The Political Life of Medicare*; Jonathan Oberlander, "Through the Looking Glass: The Politics of Medicare Prescription Drug, Improvement, and Modernization Act," *Journal of Health Politics, Policy and Law* 32, no. 2 (2007): 187–219.

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detail below, I will demonstrate that the influence of private insurers over the direction of policy did not become dependent on the partisan makeup of government. I will also demonstrate how this broad power can, in part, be explained by the unique political power that insurers generated as a result of being built into the structure of Medicare and Medicaid—a power that can be effectively exerted across political and geographic space.

2. Public-Private Partnerships and the Power of Organized Interests

At all levels of the American federal system, governments have long relied on private actors to deliver public goods. Variations of this type of policy approach are visible in policy areas as disparate as early American state building, the delivery of social services in the Progressive Era, and more contemporary policy areas such as the provision of retirement and health care benefits.[41] Such policies differ in the directness and the proximity of the partnerships, and they carry labels such as "hidden," "submerged," "divided," and "delegated." But all raise concerns about the significant political power such policies bestow on private actors—a power that can be used to maintain policies that are inefficient and ineffective and that favor the most affluent.[42] By shifting our collective focus from the size and generosity of the American welfare state to a more nuanced analysis of the exact design of the policies that comprise it, scholars of the "submerged" or "delegated" welfare state have provided pathbreaking insights into the genesis of American social policy and, perhaps more importantly, into the unique political and policy feedbacks they produce. To fully understand how delegated policies have empowered private actors and given them influence over the direction of policymaking in the United States, it is useful to distinguish between the types of power such policies generate and how that power is used to influence the policy process.

There are three primary mechanisms by which submerged or delegated policies are commonly seen to generate private power. First, by using private companies to deliver public services, public policies become more complex and the role of government as the ultimate source of benefits is obscured from the general public.[43] If the complexity of a policy's design prevents the general public from identifying the source or nature of a benefit, the public will not be able to effectively mobilize in support of or opposition to a particular reform. By reducing the "universe of political participants," as Jacob Hacker writes, policy complexity weakens the collective action of the general public and strengthens the instrumental power of private interests.[44] Second, by using private companies to delivery public services, industries generate revenues from state and federal governments that are reinvested in political influence.[45] As Kimberly Morgan and Andrea Campbell describe, private actors can increase their voice and influence in the political process by investing their superior financial resources in ever-increasing campaign contributions and lobbying activities.[46] Third, when delegated policies deliver "half solutions" with outcomes deemed "good enough," the result can be to demobilize broader reform efforts and reduce the salience of a particular reform.[47] As beneficiaries reduce their political participation in response to the enactment of a half solution, the continued campaign contributions and lobbying activities of private interests become relatively stronger. Each of these three mechanisms of power and policy influence focus on how delegated policy designs affect the campaign contributions and lobby activities of private actors. As such, the existing scholarship on delegated policymaking focuses almost entirely on the instrumental power that delegated policy designs generate. Delegated policymaking, however, also generates a form of structural power that has not yet been fully considered. Existing theories may, therefore, actually underestimate the power and influence that private actors gain as a result of delegated policy designs.

As public policy in United States has become more reliant on private companies in the direct and indirect provision of public benefits and social protections, the ability of private companies to disrupt the lives and livelihoods of citizens has significantly increased. In other words, as companies like Humana and United Health are built into the structure of publicly financed health insurance programs, their decisions to increase premiums, reduce benefits, or leave a particular county or state can create disruptions that may directly harm the health and health care of millions of Medicare and Medicaid beneficiaries. When a plan leaves a particular county or state, beneficiaries must navigate switching plans, a process that beneficiaries describe as "difficult and overwhelming."[48] Switching plans may require beneficiaries to find new doctors, pharmacies, and other sources of care, while also learning to navigate a new managed care system that may have different approaches to delivering care. In addition, changing managed care plans may entail changing benefits and increased costs.[49] Because the decision of an MCO to leave a given insurance market can lead to disruptions in benefits, costs, and

[41]Colin D. Moore, "State Building through Partnership: Delegation, Public-Private Partnerships, and the Political Development of American Imperialism, 1898–1916," *Studies in American Political Development* 25, no. 1 (April 2011): 27–55, https://doi.org/10.1017/S0898588X11000034; Andrew S. Kelly, "The Political Development of Scientific Capacity in the United States," *Studies in American Political Development* 28, no. 1 (April 2014): 1–25, https://doi.org/10.1017/S0898588X13000151; Elisabeth S. Clemens, "Lineages of the Rube Goldberg State: Building and Blurring Public Programs, 1900–1940," *Rethinking Political Institutions: The Art of the State* 187 (2006): 189; Jacob S. Hacker, *The Divided Welfare State: The Battle over Public and Private Social Benefits in the United States* (Cambridge, UK: Cambridge University Press, 2002); Christopher Howard, *The Hidden Welfare State: Tax Expenditures and Social Policy in the United States* (Princeton, NJ: Princeton University Press, 1997); Suzanne Mettler, *The Submerged State: How Invisible Government Policies Undermine American Democracy* (Chicago: University of Chicago Press, 2011); Kimberly J. Morgan and Andrea Louise Campbell, *The Delegated Welfare State: Medicare, Markets, and the Governance of Social Policy* (Oxford, UK: Oxford University Press, 2011).

[42]Hacker, *The Divided Welfare State*; Howard, *The Hidden Welfare State*; Mettler, *The Submerged State*; Morgan and Campbell, *The Delegated Welfare State*.

[43]Mettler, *The Submerged State*, 3.

[44]Hacker, *The Divided Welfare State,* 44.

[45]Morgan and Campbell, *The Delegated Welfare State*.

[46]Ibid., 52; Mettler, *The Submerged State,* 31.

[47]Morgan and Campbell, *The Delegated Welfare State*, 191–92.

[48]Gretchen Jacobson, Christina Swoope, Michael Perry, and Mary C. Slosar, "How Are Seniors Choosing and Changing Health Insurance Plans?" *KFF*, May 13, 2014, p. 14, https://www.kff.org/medicare/report/how-are-seniors-choosing-and-changing-health-insurance-plans/.

[49]Mark Duggan, Jonathan Gruber, and Boris Vabson, "The Consequences of Health Care Privatization: Evidence from Medicare Advantage Exits," *American Economic Journal: Economic Policy* 10, no. 1 (February 2018): 153–86, https://doi.org/10.1257/pol.20160068; Haiden A. Huskamp, Deborah W. Garnick, Kristina W. Hanson, and Constance Horgan, "State Health Care Reform: The Impact of Withdrawals by Medicaid Managed Care Plans on Behavioral Health Services," *Psychiatric Services* 52, no. 5 (May 1, 2001): 600–602, https://doi.org/10.1176/appi.ps.52.5.600; Jacobson et al., "How Are Seniors Choosing and Changing Health Insurance Plans?"; Peter T. Kilborn, "Largest H.M.O.'s Cutting the Poor and the Elderly," *New York Times*, July 6, 1998; Jeannie Fuglesten Biniek, Anthony Damico, Juliette Cubanski, and Tricia Neuman, "Medicare Beneficiaries Rarely Change Their Coverage During Open Enrollment." *KFF* (blog post), November 1, 2022, https://www.kff.org/medicare/issue-brief/medicare-beneficiaries-rarely-change-their-coverage-during-open-enrollment/.

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providers, such decisions carry with them the ability to create electoral punishments. Delegated policies, therefore, give private interests a unique power to constrain and influence policy that goes beyond lobbying and campaign contributions. Delegated policies, I argue, create a new form of structural power.

3. Delegation, Disruption, and a New Form of Structural Power

The electoral hopes of policymakers in capitalist democracies are dependent on the continued investment of large companies and capital holders.[50] It is this dependence that has been described as giving business a unique, structural power over policymaking. Because the state depends on business to generate growth, Culpepper and Reinke write, "the ability of companies not to invest can cause damage to the economy and thereby to the politicians governing it."[51] Policymakers' desire to avoid economic disruption and maintain power, therefore, requires that they only enact policies that will encourage capital investment and maintain or increase employment and shareholder value. If policymakers enact or offer support for policies that business finds threatening, business can deliver their punishment by exiting the state or withholding investment. Business is able to deliver this punishment by doing nothing more than engaging in a core function—namely, the withholding of investment when a policy or regulatory environment is deemed to be unfavorable. By the very nature of how business is built into the structure of capitalist democracies, they gain political influence without even attempting to do so.[52]

At its essence, the structural power of business is a product of business's ability to create electorally consequential disruptions. In most conceptualizations, the core function at the heart of business's ability to cause electoral consequential disruptions—and, therefore, at the heart of its structural power—is its decision of whether or not to invest capital. The potential to trigger politically and electorally consequential social disruptions is not, however, limited to the ability to make decisions that cause economic decline. This is particularly true when we consider just how deeply the delegated forms of policymaking have become ingrained into the structure of American public policy. As a result of delegated forms of policymaking, firms have been given vast responsibilities for delivering critical social protections like Medicare and Medicaid. A decision to reduce benefits, increase premiums, or disenroll vulnerable populations from social programs can be just as disruptive and politically influential as the ability to cause economic decline. It is the ability to directly disrupt the operation and output of social programs like Medicare and Medicaid that gives private actors structural power in delegated policies. Unlike the classic theories of structural power that see structural power as fixed or more recent treatments of structural power that see structural power as varying with the ability of firms to credibly threaten to exit, the theory presented here posits that the extent of structural power can be increased or decreased by the design of public policies.[53]

Identifying, isolating, and assessing the causal effect of structural power is, however, methodologically challenging. It is, at times, difficult to differentiate between structural and instrumental power, with questions raised as to the value of making such a distinction at all.[54] In addition, even when structural power can be clearly defined and identified, it can be difficult to link the structural power of a particular set of actors to a specific policy outcome. The challenge of linking structural power to a particular outcome arises for two primary reasons. First, when the mechanism linking structural power to a particular outcome is an implied or internalized threat, it may be impossible to uncover the observable evidence required to construct a strong causal chain. Second, any evidence of structural power may appear to be observationally identical to evidence of instrumental power.[55] In addition to identifying the particular challenges that confront researchers interested in structural power, Culpepper has also identified a set of empirical questions or tests meant to help researchers address these challenges.

In outlining an approach to identifying and assessing the causal effect of structural power, Culpepper begins by identifying an empirical question to be used to assess the ability of business to control the agenda.[56] Can it be empirically shown that the potential for business action precluded policy options that had been previously considered? The second challenge or critique to theories of structural power arises from the need to identify variation in structural power. Often, Culpepper observes, structural power is interpreted to imply a deterministic relationship between the structural power of business and business's ability to prevail in all political confrontations. That business's ideal policy point is not always enacted is, at times, taken as evidence that structural power is not present and that business is no different from other interest groups. This observation generates the next empirical question: Does variation in structural power probabilistically lead to variation in political outcomes? Finally, to address the challenges of attributing structural power to particular outcomes, Culpepper suggests identifying how structural power is distinct from the preferences of the electorate. Does structural power result in policy outcomes that are favorable to business, but unpopular with the general public?

From Culpepper's criteria and questions, it is possible to establish a set of observable implications by which the structural power of MCOs can be assessed using the cases of Medicare and Medicaid. First, if MCOs possess a structural power that operates through a threat to disrupt the health and health care of public health insurance beneficiaries, the historical record should show Democratic and Republican policymakers constraining their menu of policy options and doing so while voicing concerns about health care disruptions. Second, if the structural power of MCOs increases with the number of covered lives, there should be evidence of greater structural power in constituencies with larger private plan enrollments. Finally, if MCOs possess structural power that allows them to constrain policy options and influence the direction of reform, the historical record should contain evidence of policy decisions that favor MCOs, even if those decisions contradict the preference of the general public or are made over the policy preferences of elected officials. To assess these propositions, the balance of this article will examine several key political confrontations involving Medicare and Medicaid over the past thirty years.

[50]Charles Edward Lindblom, *Politics and Markets: The World's Political-Economic Systems* (New York: Basic Books, 1977).

[51]Culpepper and Reinke, "Structural Power and Bank Bailouts," 428.

[52]Culpepper, "Structural Power and Political Science in the Post-Crisis Era," 405.

[53]Ibid.; Lindblom, *Politics and Markets*.

[54]Culpepper and Reinke, "Structural Power and Bank Bailouts"; Andrew Hindmoor and Josh McGeechan, "Luck, Systematic Luck and Business Power: Lucky All the Way down or Trying Hard to Get What It Wants without Trying?" *Political Studies* 61, no. 4 (December 1, 2013): 834–49, https://doi.org/10.1111/j.1467-9248.2012.00981.x.

[55]Culpepper, "Structural Power and Political Science in the Post-Crisis Era," 396.

[56]Ibid., 394.

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4. Setting the Menu of Policy Options: The Balanced Budget Act of 1997

In 2021, more than 40 percent of Medicare beneficiaries were enrolled in a Medicare Advantage (MA) plan.[57] Private Medicare plans have not always been so popular or so integral to the functioning of Medicare. First enacted in 1982, and initially referred to as TEFRA HMOs (health maintenance organizations) or Medicare HMOs, enrollment in private Medicare plans remained below 5 percent of beneficiaries until the mid-1990s.[58] In these earlier years, politicians, MCOs, and beneficiaries remained skeptical of the program, with both MCOs and beneficiaries hesitant or unsure of participation. Between 1993 and 1999, however, enrollment in private Medicare plans more than tripled, expanding from 5 percent of beneficiaries in 1993 to 18 percent by 1999. Quite suddenly, MCOs were responsible for the health care of one in every six Medicare beneficiaries. In these years of double-digit annual growth rates, the politics of Medicare changed.

The ability to constrain the menu of policy options from which policymakers can choose is, perhaps, the greatest manifestation of power.[59] As enrollment increased through the 1990s, and MCOs gained greater responsibility for the health care of American seniors, MCOs began to accrue precisely this type of power. The potential to disrupt the health care of this ever-growing population of American seniors, gave MCOs power and influence over the health policy agenda. MCOs were certainly investing more resources in a larger army of lobbyists and making larger campaign contributions, but the ability to respond to the enactment of a disfavored policy by increasing premiums, reducing benefits, or withdrawing completely from a Medicare market also gave MCOs a unique power to constrain policy options. Bruce Vladeck, who served as the administrator of the Health Care Finance Administration (HCFA, now the Centers for Medicare & Medicaid Services [CMS]) during the Clinton administration, described this power as the "defensive sway" of MCOs.[60] The threat of disenrolling beneficiaries, increasing premiums, or reducing benefits provides MCOs with political power and a useful threat. In describing how MCO enrollment affected the health policy environment of the late 1990s, Vladeck described how rapid enrollment growth made it "politically much tougher for me to try to throttle back because you're cutting an existing entity and enterprise in certain markets more and more."[61] Vladeck's assessment of the political position of MCOs in the late-1990s was an acknowledgment that as Democrats approached health care reform in the late 1990s, the disruptive power of MCOs meant that a more aggressive approach against private Medicare plans was not a leading option. Vladeck's characterization was an acknowledgment by a high-level Democratic policy official that the disruptive power of MCOs was enough to constrain Democratic policy options at a critical health policy juncture.

Far from throttling back on private plans, the BBA of 1997 sought to double enrollment in private Medicare plans.[62] As part of this bipartisan policy effort, the Medicare provisions of the BBA also expanded the realm of private plan options available to beneficiaries, introducing the more flexible options of preferred provider organization (PPO) and provider-sponsored organization (PSO) plans into Medicare. By expanding the type of plan options and giving beneficiaries more flexibility in choosing a physician or location of care, the program became less restrictive and more appealing to previously hesitant beneficiaries. The BBA also introduced the name Medicare+Choice for Medicare's private plan program—reflecting the more conservative policy rhetoric that private plans increased "choice." As enrollment in MCOs increased through the 1990s, the Democratic policy position shifted toward favoring the growth of private Medicare plans. This shift occurred despite the challenges such growth presented to the traditional function and operation of Medicare.

What happened to Medicare was neither the result of a conservative, Trojan horse policy meant to deceive Democrats, nor was it fully the product of a pragmatic trade-off to achieve a legacy-defining balanced budget for President Clinton.[63] Neither of these explanations can account for the broad bipartisan support in Congress for the BBA 1997, its Medicare provisions, or the subsequent legislative efforts to revive and stabilize the program ahead of the Medicare Modernization Act (MMA) in 2003. Nancy-Ann DeParle, who followed Bruce Vladeck as HCFA administrator, described the Medicare+Choice provisions as "perhaps the most-celebrated feature of the much-celebrated Balanced Budget Act of 1997."[64] Robert Pear, writing in the *New York Times,* described the legislation as creating a "supermarket of health insurance" that would surely increase enrollment.[65] What is made clear in such declarations and descriptions by leading policy officials and the popular press is that the intent and expected outcome of the BBA's Medicare provisions were not hidden or disguised. The goals were highly visible and embraced by a broadly bipartisan contingent of legislators. With the clear intention of expanding and broadening enrollment in private plans, the Medicare provisions of the BBA passed out of the Senate Finance Committee 18–2 and the House Ways and Means Committee 36–3. The legislation was then "enthusiastically" signed by President Clinton.[66] President Clinton was certainly eager for a policy legacy, but it is difficult to explain the broad-based congressional support enjoyed by private plans as reflecting Congress's support for Clinton's policy legacy. When the subsequent legislative efforts in 1999 and 2000 to pump money back into private Medicare plans are also considered, it becomes even more difficult to explain these health policy developments as either reflecting a purely Republican vision or as part of a policy trade-off for a balanced budget. Instead, the growth of private Medicare plans through the 1990s, as Vladeck described, helped to narrow the policy agenda in the late 1990s. What is visible in the BBA and in the subsequent efforts to stabilize and boost enrollment is that a broader and earlier political and policy shift had already taken place within Medicare by the late 1990s.

[57]"Medicare Advantage," *KFF* (blog).

[58]The name TEFRA HMOs comes from the legislation that initially created private Medicare plans—the Tax Equity and Fiscal Responsibility Act of 1982.

[59]Peter Backrach and Morton S. Baratz, "Two Faces of Power," *American Political Science Review* 56, no. 4 (1962): 947–52.

[60]Bruce Vladeck, personal communication with author, June 5, 2013.

[61]Ibid.

[62]Sandra Christensen, "Medicare+Choice Provisions in the Balance Budget Act of 1997," *Health Affairs* 17, no. 4 (June 5, 1998): 228, https://doi.org/10.1377/hlthaff.17.4.224.

[63]Marmor and Mashaw, "Understanding Social Insurance"; Starr, *Remedy and Reaction*; Hacker, "Privatizing Risk."

[64]Nancy-Ann DeParle, "As Good as It Gets? The Future of Medicare+Choice," *Journal of Health Politics, Policy and Law* 27, no. 3 (2002): 495.

[65]Robert Pear, "Beyond Medicare: New Choices in Health Insurance," *New York Times*, August 10, 1997.

[66]DeParle, "As Good as It Gets?" 505.

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Despite the intentions of the BBA in 1997 to expand private Medicare plans, the BBA produced unexpectedly severe payment reductions to private Medicare plans.[67] The unintended damage that the BBA did to private Medicare plans has, at times, been taken as an indication of the political weakness of the private Medicare program and the inability of the insurance industry to influence policy during this period. Paul Starr, for example, describes the BBA's private Medicare provisions as boomeranging and only "superficially" achieving the goal of opening Medicare to more private plan options.[68] Such conclusions, however, focus too much on the unintended outcome of the BBA and undervalue its clear policy intentions. Commentators and analysts, from the *New York Times* to the Congressional Budget Office, all believed that the BBA would only accelerate and broaden enrollment in private Medicare plans.[69] The enactment of a policy with such goals is more indicative of the power and place of private Medicare plans than the unintended payment reductions and plan exodus that actually resulted. Moreover, while not immediately causing the dramatic enrollment surge that was expected, the BBA's structural changes, together with the legislative efforts to stabilize the program in 1999 and 2000, helped set a foundation for future private plan growth. In addition, the legislative aftermath of the BBA's severe payment cuts and the rush to stabilize the program provide more opportunities to observe the structural power of private insurers at work.

Following the unexpectedly severe payment reductions caused by the BBA, Congress passed the Balanced Budget Refinement Act (BBRA) in 1999 and the Benefits Improvement and Protection Act (BIPA) in 2000. Both were intended to increase payments to private plans, stop the exodus of plans, and entice plans and beneficiaries back into the program.[70] The rush to implement these legislative fixes to the BBA demonstrates the structural power of MCOs in two primary ways. First, the benefit cuts and disenrollments that followed the BBA's payment reductions provide a clear example of the level of disruption that plans were capable of creating. No longer a theoretical threat or outcome, the disruptions caused by insurer reactions to a disfavored policy outcome were significant. In the first two years after the BBA was implemented, an estimated 1.65 million beneficiaries were impacted through benefit reductions, cost increases, or the complete termination of plans.[71] Unsurprisingly, such disruptions in a valued and critical social program produced subsequent political consequences for those in government. Second, the policy and political consequences of these disruptions led policymakers to swift and repeated actions to pump money back into the program. In these episodes, policymakers quickly passed bipartisan legislation in 1999 and 2000 that increased plan payments and provided financial incentives for plans to reenter markets that had experienced exits and disruptions. When assessments of the development of private Medicare plans fail to adequately consider the intent of the BBA, while also overlooking the policy efforts between 1997 and the implementation of the 2003 MMA, the result is an incomplete picture of the power of insurers and the mechanisms through which that power is used.

As has been described above, policymakers responded to the benefit reductions and plan terminations that followed the BBA 1997 by passing the BBRA of 1999 and the BIPA of 2000. The intention of both the BBRA and BIPA was to stop the benefit disruptions, stem the loss of plans, and entice those plans that had left to reenter the Medicare market. To do so, both the BBRA and BIPA increased plan payments and included bonus payments to plans that entered previously underserved markets. The BBRA and BIPA's payment "givebacks" gave plans what Chris Jennings, a Clinton administration health policy advisor, described as a "twofer."[72] Plans were now receiving higher payments as a result of increased benchmark payments and as a result of increasing fee-for-service payments. BIPA, for example, increased the minimum plan payment from $415 to $525 in larger urban areas and to $475 in all other markets.[73] For markets where plan payments already exceeded these floor payments, the annual payment update was increased from 2 to 3 percent.[74] These policies pushed an estimated $20 billion back into private Medicare plans, helping to stop the bleeding and stabilize the program.[75]

The original policy intentions of the BBA 1997, as well as the subsequent rush to pass BBRA 1999 and BIPA 2000, demonstrate how the policy options faced by those in government were constrained by the disruptive power of MCOs. Rather than using this disruptive episode to highlight the inability of MCOs to deliver Medicare benefits without steep overpayments or to highlight the instability created by private plan participation, Democrats joined with Republicans to stabilize a program that fractured the original social insurance design of Medicare and required payments that surpassed the costs of the traditional Medicare program. In the American political and policy context, it is far easier to undermine a policy by blocking needed policy updates than it is to stabilize and resuscitate that same policy through the enactment of policy reforms and recalibrations.[76] It is, therefore, quite telling that instead of blocking the policy recalibrations offered in the BBRA and BIPA, thereby letting plans hemorrhage beneficiaries until the entire private Medicare program drifted into oblivion, Democrats joined with Republicans in repeated efforts to update and save the program. As DeParle argued in the years following the BBA, BBRA, and BIPA, the "most important" reason to save private Medicare plans was because they enrolled roughly seven million beneficiaries.[77] With this statement, DeParle was acknowledging that a policy imperative to support private plans was created by the size of the covered population and the scale of the disruptions that might result if the program should continue to stumble. It was unfair, DeParle continued, to take the added benefits offered by private plans away from those

[67]Robert A. Berenson and Bryan E. Dowd, "Medicare Advantage Plans at a Crossroads—Yet Again," *Health Affairs*, November 24, 2008, https://doi.org/10.1377/hlthaff.28.1.w29; Christensen, "Medicare+Choice Provisions in the Balanced Budget Act of 1997"; Rick Mayes, "Medicare and America's Healthcare System in Transition: From the Death of Managed Care to the Medicare Modernization Act of 2003 and Beyond," *Journal of Health Law* 38, no. 3 (July 1, 2005): 391–422.

[68]Starr, *Remedy and Reaction*, 142.

[69]Pear, "Beyond Medicare"; Marilyn Moon, "An Examination of Key Medicare Provisions in the Balanced Budget Act of 1997" (New York: Commonwealth Fund, September 1, 1997).

[70]Lori Achman and Marsha Gold, "Medicare+Choice 1999–2001: An Analysis of Managed Care Withdrawals and Trends in Benefits and Premiums" (New York: Commonwealth Fund, February 2002).

[71]DeParle, "As Good as It Gets?" 502. Larry Katzenstein, "Making Your Way through the Maze of Medicare Options," *New York Times*, February 16, 2000.

[72]Christopher Jennings, personal communication with author, April 30, 2013.

[73]Marsha Gold and Lori Achman, "Monitoring Medicare+Choice, Raising Payment Rates: Initial Effects of BIPA 2000" (New York: Commonwealth Fund, June 2001).

[74]Ibid.

[75]DeParle, "As Good as It Gets?" 503.

[76]Hacker, "Privatizing Risk"; Kelly, "Finding Stability and Sustainability in the Trump Era."

[77]DeParle, "As Good as It Gets?"

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fortunate enough to have them. It was, in DeParle's assessment, unfair to allow the health care disruptions caused by the BBA to continue. With twenty-six million enrollees in 2021, the rationale for protecting private Medicare plans described by DeParle in 2002 has only hardened.

5. The Power to Constrain the Conservative Policy Agenda: MCOs and the Fight Against Competition

"We got rolled politically."[78] This was the conclusion offered by Vladeck after the failed implementation of the Medicare Competitive Pricing Demonstration in 1997. This was not, however, the first or last time that policy efforts to introduce direct price competition into Medicare were defeated by private insurers and their allies in Congress. In the mid-1990s, HCFA began efforts to implement a series of demonstration projects that would test the effects of direct bidding and price competition within the Medicare HMO program. Demonstration projects offer policymakers an opportunity to implement policy reforms in miniature, in a select number of jurisdictions, and evaluate the outcomes as part of an effort to justify programwide adoption. Under the proposed competitive pricing demonstration projects, which would take place in a small number of Medicare markets, HCFA would no longer administratively set the payment rate for Medicare HMOs. Rather, insurers would submit bids based on their expected cost of providing care, and HCFA would then use those bids to set the payment rate for Medicare HMOs. This type of market-based reform had long been a policy goal associated with conservative policymakers and their efforts to transform Medicare into a more privatized and voucherized program.[79] Insurers, however, rightly feared that this type of direct competition and bidding would result in payment rates that were below their current, administratively set payment rates.[80] If this type of conservative policy goal was achieved, and Medicare moved further in the direction of voucherization, the associated payment reductions would lead to increased premiums, fewer additional benefits, and a relatively less attractive option compared to traditional Medicare. Ultimately, this type of conservative policy victory would likely lead to less revenue for private insurers.[81] In this way, the structural power of private insurers was used to defend against conservative efforts to more dramatically transform Medicare in the direction of direct competition.

Under its administratively set pricing structure, Medicare had become a "juicy target" for HMOs.[82] The administratively set payments allowed plans to offer generous additional benefits like prescription drug coverage, which enticed seniors to enroll in private plans and drove the enrollment booms. Plans were described as being "addicted" to the government's administratively set overpayments.[83] The irony that these market-based actors came to prefer the so-called "Soviet-style" pricing of HCFA was, as Representative James McDermott (D-WA) described it, "the moral of this story with no morals."[84] Speaking on the floor of the House of Representatives, McDermott quite accurately and explicitly identified the policy preferences of insurers, arguing that "unless [competition] is done in a way the industry want it to be done; where it protects their overpayments and protects their ability to "cherry pick" healthy beneficiaries and leave the sick to be treated by the government, would mean plans get less, not more, money." It was this reason, McDermott continued, that the insurance industry and their congressional allies were "fighting tooth and nail" to prevent the competitive pricing demonstrations from being implemented. McDermott was describing a broad, multivenue, and ultimately successful campaign by insurers and their largely Republican congressional allies against competition and against a long-held conservative policy goal. In successfully blocking efforts to more fully marketize and privatize Medicare, the ability of the insurance industry to also constrain the conservative policy agenda becomes clearly visible. McDermott and other Democrats were, in a way, daring Republicans to finally follow through on their own policy agenda of increasing competition and marketization in Medicare. But with the threat of disruptions so clearly leveled at particular districts and members of Congress, Republicans pulled back on their policy goals.

Using its own research and demonstration authority, in 1996, HCFA first attempted to implement a Medicare competitive pricing demonstration in Baltimore, Maryland. Opposition to the small-scale demonstration quickly mobilized. In the years immediately preceding the planned demonstration, enrollment in Medicare HMOs in Maryland had grown dramatically. In 1994, only 978 Medicare beneficiaries were enrolled in a private Medicare plan. By September 1996, on the eve of the planned demonstration, enrollment in Maryland had ballooned to more than 34,000 Medicare beneficiaries. Medicare plans were understandably keen to defend the policy status quo that produced such substantial year-over-year enrollment growth. In the Medicare competitive pricing demonstration, the Maryland Association of Health Maintenance Organizations (MAHMO) saw a "grave concern."[85] In voicing its opposition, MAHMO focused on the potential disruptions to care and the negative consequences that Medicare beneficiaries might experience. Martha C. Roach, the director of MAHMO, predicted that the demonstration would cause seniors to pay higher premiums for reduced benefits.[86] The result, Roach continued, would be the disruption of care as seniors were forced to leave those plans that began raising premiums or changing benefits. MAHMO also described how the demonstration would make Medicare HMOs less attractive to new enrollees and cause some of the participating HMOs to leave the Medicare program—creating an additional source of disruption.[87]

The political consequences of health care disruptions were made very clear. Roach warned that not only would many seniors be harmed by the demonstration's lower payments, but that those seniors would also waste little time contacting their elected officials.[88] During the summer of 1996, news of the proposed demonstration, its potential impact, and Roach's warnings were

[78]"Congress Nixes Competitive Bid Pilot," *Relias Media*, November 1, 1997.

[79]Hacker, "Privatizing Risk"; Marmor and Mashaw, "Understanding Social Insurance."

[80]Bryan Dowd, "More On Medicare Competitive Pricing," *Health Affairs* 20, no. 1 (January 1, 2001): 306–308, https://doi.org/10.1377/hlthaff.20.1.306.

[81]Bryan Dowd, Robert Coulam, and Roger Feldman, "A Tale of Four Cities: Medicare Reform and Competitive Pricing," *Health Affairs* 19, no. 5 (September 1, 2000): 9–29, https://doi.org/10.1377/hlthaff.19.5.9.

[82]Al Dobson, personal communication with author, November 11, 2013.

[83]Christopher Jennings, personal communication with author, April 30, 2013.

[84]*Congressional Record*, 106th Congress, 1st Sess., 1999, H3285.

[85]Diana K. Sugg, "Medicare Experiment Set for Baltimore," *The Baltimore Sun*, May 29, 1996.

[86]William M. Salganik, "HCFA Less Sure It'll Try Medicare Bids Here," *Baltimore Sun*, September 21, 1996.

[87]William M. Salganik, "Medicare Changes Could Spur HMO Competition," *The Baltimore Sun,* July 24, 1996.

[88]Alice A. Love, "Bounced in Maryland, Medicare HMO Competition Demo Again Rejected," *Daily Record*, April 29, 1997.

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given broad coverage in *The Baltimore Sun*. With the 1996 elections approaching, the threat of disruptions carried potentially even greater political and policy influence. Maryland's congressional delegation joined MAHMO in opposing the demonstration and pressuring HCFA to terminate the demonstration before it began. In voicing his opposition to the demonstration, Representative Ben Cardin (D-MD), a leading member of Maryland's congressional delegation and the Ways and Means Committee, expressed concern that the demonstration would reduce Medicare plan options for Maryland's seniors.[89] Cardin's statement was a direct expression of the policy and political fear created by Roach and MAHMO. With the dramatic growth of private plan enrollment in Maryland, the threat and potential for the demonstration to lower plan payments, produce an exodus of plans, and disrupt the health and health care of Maryland's seniors made this demonstration project a politically salient and consequential issue. So much so that this seemingly small demonstration became a main topic on the agenda of a Cardin campaign event in August 1996.[90] In a demonstration of how this type of structural power works to constrain policy, the opposition to the demonstration came from those elected officials whose constituencies would experience the largest disruptions and biggest potential political fallout.

As of July 1996, HCFA still fully intended to move forward with the competitive pricing demonstration in Baltimore. By September 1996, however, after consistent pressure from insurers and from Maryland's congressional delegation, the demonstration was cancelled. In her description of the policy environment surrounding the demonstration project, Barbara S. Cooper, the Deputy Associate Administrator for Policy at HCFA, perfectly captures the policy preferences of insurers and the related political concerns of elected officials. "For a lot of people, the status quo is just dandy, and when you try to make changes, people get nervous."[91] While private insurers were certainly happy with the status quo, their warnings about potential disruptions worked to create a political wariness among elected officials. In the end, it was the political nervousness and lobbying of elected officials that caused HCFA to cancel the demonstration in Baltimore. HCFA was not, however, ready to give up entirely. Instead, HCFA shifted its focus to Denver, Colorado. It was in Denver that HCFA, according to Vladeck, was politically rolled.

The opposition to the proposed demonstration in Denver mobilized quickly and broadly. The Colorado HMO Association was even more blunt in its assessment than its counterpart in Maryland. "It's not clear," said Steve O'Dell, president of the Colorado HMO Association, "what HCFA is trying to accomplish except to take money out of HMOs' pockets."[92] A bipartisan coalition quickly mobilized against the planned competitive pricing demonstration in Denver. Together with Colorado-based insurers, Democratic Governor Roy Romer and Republican Senator Ben Nighthorse Campbell pursued a multivenue course of opposition. The goal, as described by Karen Ignagni, the president of the American Association of Health Plans (AAHP), was to maintain the current policy structure and its administratively set prices.[93] To achieve this end, Governor Romer pressured HCFA to delay implementation of the demonstration, while AAHP joined with the Colorado HMO Association to challenge the demonstration in court. After an injunction was secured in court against the demonstration, Senator Ben Nighthorse Campbell successfully attached an amendment to an appropriations bill that would terminate the demonstration legislatively. In his remarks to the Senate, Nighthorse Campbell described the demonstration as "ill-conceived" with "the potential to disrupt and reduce benefits for over 100,000 Medicare beneficiaries."[94] As was also true in Baltimore, HMOs feared that the demonstration would reduce their revenue, while elected officials feared that such lost revenue would disrupt the health care of thousands of their constituents. Elected officials, therefore, went to great lengths to maintain the policy status quo of Medicare's private insurance program, thereby avoiding the potential for politically costly disruptions in their backyards. After experiencing another policy failure, Vladeck lamented that "most members of Congress only support competitive Medicare pricing until it's about to be instituted in their district."[95] Vladeck's characterization of the changing policy preferences of elected officials captures how the structural power of insurers shapes policy development. Vladeck was describing a political and policy environment in which members of Congress changed their policy preferences in response to the threat of disruptions to the health care of their constituents. As enrollment in private Medicare plans grew, private insurers increasingly had the ability to cause very concrete disruptions to specific constituencies across the United States, creating a kind of policy constraining, Medicare NIMBYism. In an effort to insulate future competitive pricing demonstrations against the influence and pressure that doomed them in Baltimore and Denver, the next attempt to implement competitive pricing demonstrations was statutorily required. Despite this added political protection, the next round of demonstrations was destined for the same fate as the Baltimore and Denver demonstrations.

The BBA of 1997 statutorily mandated the implementation of Medicare competitive pricing demonstrations. In statutorily requiring the demonstrations, Congress was attempting to tie itself and HCFA to the mast. Congress was also making a clear statement of its policy agenda and preferences in support of competitive pricing demonstrations. Policymakers learned in Baltimore and Denver, however, that their policy agenda and their policy preferences were vulnerable to the pressures of private insurers and the political anxiety of their colleagues. In an effort to place the demonstrations even further from the political influence and reach of insurers and their allies, the BBA also created the Competitive Pricing Advisory Committee (CPAC)—a committee of national experts that was given responsibility for designing and guiding the demonstrations through implementation. CPAC was meant to implement a minimum of four demonstrations and a maximum of seven. After considerable political pressure from insurers and members of Congress who represented the potentially affected markets, HCFA did not implement a single demonstration.

With its statutory power in hand, CPAC selected Phoenix and Kansas City as the next locations for the competitive pricing demonstration. With the Kansas City market straddling both Missouri and Kansas, this round brought direct opposition from the congressional delegations of three affected states: Arizona, Missouri,

[89]Diana K. Sugg, "Medicare Pilot Project Now in Doubt," *Baltimore Sun*, June 17, 1996.

[90]"Representative Cardin Is to Speak to Seniors at Vantage House," *Baltimore Sun*, August 6, 1996.

[91]Sugg, "Medicare Pilot Project Now in Doubt."

[92]Jonathan Gardner, "Medicare HMO Demo Project at Risk," *Modern Healthcare*, May 5, 1997.

[93]"Congress Nixes Competitive Bid Pilot."

[94]*Congressional Record*, 105th Congress, 1st Sess., 1997, 143, S5583.

[95]"Congress Nixes Competitive Bid Pilot."

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and Kansas. As was true in both Baltimore and Denver, the opposition centered around the threat of disruption caused by higher premiums, reduced benefits, and the exiting of plans from the Medicare market. The language of "disruption" was present in the statements and messaging of all involved stakeholders. Karen Ignagni, the president of the AAHP, traveled to Kansas City in the months before the demonstration was meant to begin, warning of the "disruptions" that the demonstration would cause with its higher costs to seniors, fewer benefits, and the broader deterioration of the Medicare marketplace.[96] "People need to think very carefully," said Ignagni, "about what the inadvertent consequences of this policy will be."[97] Members of the Area Advisory Committee (AAC), another committee established by the BBA 1997 to assist in the implementation of the demonstration, echoed Ignagni's message. Kathleen Sebelius, who was a member of the AAC and the Kansas Insurance Commissioner, voiced her concerns that beneficiaries would only see higher prices and fewer benefits. "That's 100 percent negative disruption," Sebelius stated, "and I'm not very comfortable with that. I think we're making a step back, not forward."[98] The AAC eventually voted to suspend the implementation of the demonstration. The suspension provided additional time to mobilize opposition against the demonstration.

In Arizona, the executive director of the Arizona Association of Health Plans described its Medicare customers as being "penalized" and used in an "experiment" to cut Medicare.[99] A letter from the Arizona congressional delegation to DeParle warned that the demonstration would "only disrupt the market."[100] Such threats and concerns about disruptions in these Medicare markets were made even more clear by the announcements by major insurers UnitedHealth, Cigna, and Humana that they each planned to leave the Medicare market in several counties in the Kansas City area and the Phoenix market.[101] UnitedHealth's decision, according to a company spokesperson, was a reaction to low reimbursement rates and to the prospect that the competitive pricing demonstration would result in even lower reimbursement rates in the affected markets.[102] The potential disruptions and the actions by UnitedHealth, Cigna, and Humana were all covered in local media markets, undoubtedly serving to increase the political salience of the demonstrations. In a joint statement issued the same day as UnitedHealth's announcement, Senators John Ashcroft (R-MO), Kit Bond (R-MO), Sam Brownback (R-KS), and Pat Roberts (R-KS) called for the demonstration to be terminated, stating that halting the demonstration was "necessary to protect the health care of senior citizens and to assure that Medicare beneficiaries continue to have access to excellent care at prices they can afford."[103] In a separate statement, Senator Ashcroft described the potential disruptions in a manner that reflected both the prior statements of HMOs and the elected officials in Baltimore and Denver. "The likely effects of the upcoming federal health care project in Kansas City," said Ashcroft, "are higher premiums for senior citizens and financial pressure to change health care plans, even if it means giving up their preferred physician."[104] In both Kansas City and Phoenix, Republican members of Congress, fearing health care disruptions, fought openly and successfully against the broader marketization and privatization of Medicare.

Through a combination of direct pressure applied to CPAC and HCFA, as well as various legislative efforts, the congressional delegations of Arizona, Missouri, and Kansas succeeded in killing this renewed effort at competitive pricing in Medicare. An amendment that passed as part of the Patient's Bill of Rights prohibited the secretary of Health and Human Services from implementing a competitive pricing demonstration in Kansas City, Missouri, Kansas City, Kansas, or anywhere in Arizona.[105] That the opposition and their eventual victory was so geographically specific is further evidence that the threat of disruptions was politically decisive. It was the elected officials from both parties, whose constituents would be harmed by the disruptions, who led the policy charge to defend the policy preferences of private insurers—a policy charge that went against the stated preferences of the "clear majority" of Congress who voted for the BBA 1997 and for the implementation of competitive pricing demonstrations.[106] As former senator and CPAC member, David Durenberger, concluded after the end of the Kansas City and Phoenix demonstrations, "there are powerful forces in health care that do not want to bid on price."[107] An important piece of that power, and one that was visible throughout this multiyear and multivenue policy battle, came from threat of disruptions and the structural power of private insurers.

Subsequent attempts to introduce direct competition met similar ends. In 2003, as part of the MMA, Congress again called for the implementation of four to six competitive pricing demonstrations, all set to begin in 2010. The demonstrations were continually pushed lower on the agenda and were ultimately never implemented. Similarly, the ACA again placed price competition on the agenda. In his effort to block the demonstration, Senator Orin Hatch (R-UT) warned of the "strong possibility that Medicare Advantage beneficiaries will lose benefits under competitive bidding."[108] Again, policymakers referenced the potential disruptions to beneficiaries' health care in arguing to remove a policy reform from the agenda. Undoubtedly, MCOs also used their steadily increasing instrumental power to influence reforms in a direction that was favorable to their business, but the growing power that MCOs gained as a result of their ability to disrupt the health care of millions of seniors worked to influence and constrain policy in a way that ran counter to the previous policy preferences of elected officials like Hatch.

6. The Affordable Care Act: Assessing Wins and Losses and the Power of MCOs

Managed care organizations are not politically invincible. Their power and influence may rise and fall with time and, in many instances, depends on lobbying and campaign contributions.

[96]Bonar Menninger, "Business Group Suspends Local Medicare Coverage Project," *Kansas City Business Journal*, May 16, 1999.
[97]Ibid.
[98]Ibid.
[99]Laurie McGinley, "Medicare Tests of Competitive Bidding Rile HMOs Fearing a Drop in Payments," *Wall Street Journal*, May 14, 1999.
[100]Ibid.
[101]Julius A. Karash, "Medicare Plan Called Harmful HMO Demonstration," *Kansas City Star*, July 2, 1999.
[102]Ibid.
[103]Ibid.
[104]Steve Everly, "HMO Study Faces Delay," *Kansas City Star*, July 17, 1999.
[105]*Congressional Record*, 106th Congress, 1st Sess., 1999, S8691.
[106]Len Nichols, "Lessons from the Competitive Pricing Advisory Committee Experience for the Medicare+Choice Program and Long Term Reform," Statement before the United States Senate Committee on Finance, April 3, 2001.
[107]Alan Bavley, "Medicare Project Is Delayed," *Kansas City Star*, July 23, 1999.
[108]Jeffrey Young, "Obama, Reid Take Dead Aim At Medicare HMOs," *The Hill*, January 14, 2009.

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Payments from the federal government to Medicare MCOs have, for example, fallen over the last decade. Following the enactment of the MMA, payment rates in some counties climbed as high as 124 percent of the cost of traditional Medicare. Yet, Congress has successfully clawed these rates back down to an average of roughly 103 percent of traditional Medicare. The ACA also reduced MA payment rates by $132 billion. In addition to its MA payment reductions, the languishing of the ACA's Medicaid expansion in many states and the multiyear effort to repeal the ACA represent a direct challenge to the power, policy preferences, and revenue of MCOs. None of these facts, however, require the structural power of MCOs to be discounted or disregarded. Yet, as Culpepper writes, similar evidence of business power rising and falling, the coexistence of instrumental power, or business not always winning has been used to challenge the idea or presence of business's structural power.[109] The case of MCOs and the ACA is no different. When examined in its entirety, however, the ACA provides additional examples of how MCOs use their structural power to help constrain both liberal efforts to roll back private Medicare plans and conservative efforts to retrench Medicaid and repeal the ACA.

In considering the potential political feedback effects that delegating responsibilities to MCOs might generate, Morgan and Campbell hypothesize that MCOs could gain power and maintain inflated payment rates precisely because of the growing dependence of seniors on MCOs.[110] In assessing this hypothesis, Morgan and Campbell provide evidence of elected officials who, in the face of potential disruptions to Medicare, made policy decisions that seemingly ran counter to their preferred policy positions. When Morgan and Campbell turn to the ACA, however, they reassess downward their assessment of the influence of MCO power.[111] In the ACA's successful reduction of MA payment rates, Morgan and Campbell see a loss of political clout for MCOs. In their assessment, the declining influence of MCOs is partly a product of Republican losses in Congress. In connecting the power of MCOs to the power and number of Republicans in Congress, Morgan and Campbell provide evidence in support of a more instrumental theory of MCO power, where the partisanship of a lobbying campaign's target is critical. More importantly, however, because MA enrollment rates are often lowest in Republican states, the argument that MCO power is dependent on Republican control of Congress would run counter to the idea that MCOs have more structural power when they cover more lives and could, therefore, be more disruptive.

When viewed in isolation, the payment cuts delivered to MA by the ACA do appear to offer evidence of waning political influence. A broader view of the ACA and the role of MCOs, one that includes the ACA's health insurance exchanges and Medicaid expansion, offers a less bearish account of MCO power. When considering this wider view of policy developments, the ACA can be viewed as delivering to MCOs millions of new customers and a larger and more secure business. The ACA has two primary mechanisms for expanding access to health care: the expansion of Medicaid to low-income populations and the provision of subsidies for the purchase of private health insurance in the ACA-created health insurance exchanges. Both of these mechanisms for expanding access rely heavily on MCO participation and have resulted in MCOs gaining millions of new publicly funded customers.

The majority of the eleven million people who became newly eligible for Medicaid under the ACA are enrolled in MCOs. In twenty-five of the thirty-two states that were first to expand Medicaid under the ACA, at least 80 percent of the newly eligible population are enrolled in Medicaid MCOs.[112] In seventeen of these states, over 90 percent of the newly eligible population are enrolled in Medicaid MCOs. In addition to the millions of new covered lives that MCOs gained as a result of the ACA's Medicaid expansion, nearly nine million people received federal subsidies in 2018 to help purchase private insurance.[113] Of these nine million, more than half also received financial assistance to help reduce the cost of coinsurance, copayments, and deductibles.[114] With the enactment of the ACA, the federal government, therefore, placed millions of additional public insurance beneficiaries under the responsibility of MCOs, while providing public funds for millions more to purchase individual or family insurance plans from MCOs. In one of the largest restructurings of the American health care system, MCOs not only secured the continued existence of a private market within both Medicare and Medicaid—markets that represent their biggest future growth areas—but also gained millions of new customers. In the ten years after the ACA's 2010 enactment, the stock value of a representative set of MCOs outpaced the major indices, climbing by as much as 500 to 900 percent.[115] Structural power alone did not produce this favorable policy environment, but by assessing the entirety of the ACA's impact on MCOs, it is difficult to conclude that the power of MCOs has waned or that the policy influence of MCOs is significantly dependent on the partisanship of officeholders. Indeed, even the $132 billion cut made by the ACA was later modified in favor of MCOs.

Medicare Advantage, according to President Obama, was a program that did not work.[116] Not surprisingly, it became a prime target in the search for money to pay for the ACA's insurance expansion. Speaking to George Stephanopoulos, President Obama described a strategy for paying for the ACA in which his administration would target programs that "don't work." MA was the only program listed during Obama's interview with Stephanopoulos. That the ACA did not eliminate MA is, itself, evidence of the continued power of MCOs.[117] But in addition to the continued existence of a program identified by the president for elimination, after the $132 billion in payment reductions was enacted with the ACA, the Obama administration took unprecedented steps to put billions of dollars back into MA.

[109]Culpepper, "Structural Power and Political Science in the Post-Crisis Era."
[110]Morgan and Campbell, *The Delegated Welfare State*, 183.
[111]Ibid.

[112]Julia Paradise, "Data Note: Medicaid Managed Care Growth and Implications of the Medicaid Expansion," *KFF* (blog), April 24, 2017, https://www.kff.org/medicaid/issue-brief/data-note-medicaid-managed-care-growth-and-implications-of-the-medicaid-expansion.
[113]"Total Marketplace Enrollment," *KFF* (blog), April 6, 2020, https://www.kff.org/health-reform/state-indicator/total-marketplace-enrollment/.
[114]The ACA required that insurance companies provide cost-sharing reductions (CSRs) to people between 100 and 250 percent of the federal poverty level. In 2018, the Trump administration stopped reimbursing insurance companies for the cost of CSRs. Despite the termination of CSR payments by the federal government, insurance companies are still required to offer CSRs. As a result, insurance companies have increased premiums, which has driven the premium subsidies higher.
[115]Between March 1, 2010 and March 1, 2020, the stock value of UnitedHealth increased by 758 percent; Centene, 889 percent; Molina, 733 percent; and Humana, 571 percent. These four MCOs are representative of the industry, with high exposure in Medicare Advantage, Medicaid, or both. Over this same period, the Nasdaq increased by 360 percent and the Dow Jones Industrial Average increased by 102 percent.
[116]Barack Obama, interview by George Stephanopoulos, *This Week With George Stephanopoulos*, ABC, September 20, 2009.
[117]Morgan and Campbell, *The Delegated Welfare State*, 188.

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Out of consideration for the potential disruption caused by the ACA's MA cuts, the Obama administration undertook a demonstration project that pumped an estimated $8.3 billion back into MA over three years. This policy reversal not only stood counter to the stated position of the administration but also proceeded over the objections of the Government Accountability Office and the Medicare Payment Advisory Commission. Despite conclusions that the demonstration could not achieve its evaluation goals until 2014, the demonstration gave back the largest amount of money to MA plans during 2012—an election year. The demonstration, as one former Medicare official described, was compelled by the "politics of unhappy bennies."[118] Fearing the disruptions that might be caused during an election year as a result of decisions made by MCOs facing payment cuts, the Obama administration took steps counter to its own policy interests and gave money back to a program it previously described as not working. In a critique of the Obama administration's effort to pump money back into MA and avoid election year disruptions, Senator Orin Hatch (R-UT) and Representative Dave Camp (R-MI) sarcastically applauded the Obama administration's "newfound support" for MA. The Obama administration is not, however, alone in having its ACA-related policy objectives constrained and thwarted by the private actors, including MCOs, operating within the ACA.

After taking control of the White House, Senate, and House of Representatives in 2017, repealing the ACA was near the top of the Republican policy agenda. Over the previous six years, Republicans had voted more than sixty times to repeal the ACA. With the veto of a Democratic president now gone, it seemed that Republicans would finally deliver on a long-promised policy goal. The ACA seemed particularly vulnerable to retrenchment because it had not yet generated a politically powerful constituency of beneficiaries capable of defending the program against attack.[119] What the ACA did generate, however, was a powerful, protective constituency of health industry interests. As the Trump Administration and congressional Republicans began their efforts to repeal the ACA, the health care industry was united in defense of the ACA. For-profit hospitals, safety-net hospitals, and the insurance industry were all outspoken defenders of the ACA. It was not, however, only the ACA that these private interests were defending. Contained within the American Health Care Act (AHCA)—the Republicans' initial legislative effort to repeal the ACA—was also a broader effort to block grant and retrench the entire Medicaid program—not just the ACA's Medicaid expansion. If successful, this legislation would have placed a per capita cap on Medicaid spending, thereby ending Medicaid's entitlement status and reducing funding and coverage.

In a letter to the Ways and Means and the Energy and Commerce Committees, Marilyn Tavenner, president of America's Health Insurance Plans (AHIP), raised concerns about the "unnecessary disruptions to the coverage and care of beneficiaries" that would result from the AHCA.[120] In a similar fashion to how her predecessors addressed the potential for unfavorable policy over the previous three decades, Tavenner reminded policymakers to "consider how long-term reforms impact consumers, health care providers, employers, and other stakeholders." Together with Scott Serota, president of the Blue Cross Blue Shield Association, Tavenner continued to lobby against the successive legislative efforts by Republicans to repeal the ACA. In a letter to Senators Mitch McConnell (R-KY) and Charles Schumer (D-NY), Tavenner and Serota warned that key provisions of the Better Care Reconciliation Act made it "unworkable in any form" and would "increase premiums and lead to widespread terminations of coverage for people currently enrolled in the individual market."[121] The insurance industry was not, however, acting alone in their campaign against repeal, but were joined in their opposition by an alliance of health industry sectors, including hospitals and provider groups, that are rarely seen to act in unison with insurers. Each group voiced their strong concerns about the health care and economic disruptions that repeal would produce. While not necessarily the determinative source of power in constraining and ultimately thwarting the conservative repeal agenda, the insurance industry's threats and warnings about the disruptions to the health and health care of millions of people across the United States remained a consistent part of the effort to defend the ACA and defend against disfavored policy developments.

Even before Senator McCain joined with Senators Collins and Murkowski in offering his dramatic "thumbs down" vote to defeat the Healthcare Freedom Act, also known as "skinny repeal," the Republican path to repeal was constrained by the fear of health care disruptions. Earlier versions of repeal legislation considered in 2017, including the Better Care Reconciliation Act (BCRA) and the Obamacare Repeal Reconciliation Act (ORRA), proposed larger and more transformative cuts to Medicaid.[122] These repeal efforts lost even more Republican support, failing on votes of 43–57 and 45–55, respectively. The vote on the ORRA, in particular, which included a dramatic retrenchment of Medicaid, shows most clearly the GOP concern over Medicaid disruptions. Six of the seven Republican "no" votes came from senators representing expansion sates, showing that what had previously appeared to be unified Republican support for repeal broke down primarily among senators whose constituents would face the largest disruptions from Medicaid retrenchment. Even during a period of hyperpartisanship, and even under extreme political pressure to deliver on a years-long promise to repeal the ACA, the potential for widespread disruptions acted to constrain the policy actions of Republican officials.

Eliminating the ACA's Medicaid expansion, for example, was largely taken off the table when Senators Lisa Murkowski (R-AK), Shelley Moore Capito (R-WV), Rob Portman (R-OH), and Cory Gardener (R-CO), all of whom represented expansion states, informed Majority Leader Mitch McConnell (R-KY) that they would not vote for any legislation that repealed the ACA's Medicaid expansion.[123] Like the senators from expansion states, many of the most outspoken Republican defenders of the ACA were the Republican governors of Medicaid expansion states

[118]Bruce Vladeck, personal communication with author, June 5, 2013. Vladeck used the abbreviation "bennies" to refer to Medicare Advantage beneficiaries.

[119]Jonathan Oberlander and R. Kent Weaver, "Unraveling from Within? The Affordable Care Act and Self-Undermining Policy Feedbacks," *The Forum* 13, no. 1 (April 2015): 37–62; Kelly, "Finding Stability and Sustainability in the Trump Era."

[120]Marilyn B. Tavenner, Letter to Kevin Brady and Greg Walden, March 8, 2017, https://www.bbhub.io/bgov/sites/12/2017/03/AHIP-LETTER.pdf.

[121]Marilyn B. Tavenner and Scott B. Serota, Letter to Mitch McConnell and Charles Schumer, July 14, 2017, https://www.ahip.org/documents/Joint-AHIP-BCBSA-Consumer-Freedom-Option-Letter-FINAL-071417.pdf.

[122]Daniel Beland, Philip B. Rocco, and Alex Waddan, "Policy Feedback and the Politics of the Affordable Care Act," *Policy Studies Journal* 47, no. 2 (May 2019): 395–422.

[123]Jessie Hellman, "Four GOP Senators Pledge to Vote against Rolling Back Medicaid Expansion," *The Hill*, March 6, 2017.

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such as Ohio, Michigan, and Nevada. Even prior to the inauguration of President Trump, Governors Kasich (R-OH), Snyder (R-MI), and Sandoval (R-NV) visited Washington, DC, to lobby congressional Republicans on protecting the ACA's Medicaid expansion. In joining their states' governors, Senators Portman (R-OH) and Heller (R-NV) shared concerns about the disruptions to Medicaid that would be caused by the various repeal efforts. Portman described his concern that the House-passed AHCA "does not do enough to protect Ohio's Medicaid expansion population, especially those who are receiving treatment for heroin and prescription drug abuse."[124] Heller, for his part, openly supported Governor Sandoval and shared his opposition to the AHCA and BCRA, acting as a decisive vote in the Senate against the BCRA.[125] Senator Capito (R-WV), who like Heller and Portman represented a Medicaid expansion state, voiced concerns about the "tragic consequences" that would follow the end of the ACA's Medicaid expansion.[126]

While the Americans for Prosperity, a group backed by the Koch brothers, held a "You Promised" rally in Washington, DC, urging Congress to repeal the ACA, health care industry groups pushed strongly and decisively in the other direction. The defeat of the Republicans' ACA repeal efforts was the result of much more than the structural power of the insurance industry. If the ACA was successful repealed, and no meaningful alternative was put in its place, the entire health care industry and the health care of millions of people across the United States would be severely disrupted. If the AHCA, for example, was enacted, the Congressional Budget Office estimated that twenty-four million fewer people would be insured in 2026.[127] Between 2013 and 2015, alone, the reduction in uncompensated care resulting from the ACA's Medicaid expansion saved hospitals more than six billion dollars.[128] In the absence of the ACA, much of the cost of uncompensated care would be shifted back onto state and local governments. There were, therefore, many interested parties working to constrain and defeat the repeal efforts. Despite the crowded field of opposition, the role of the insurance industry in defending against the retrenchment of public insurance programs is clearly visible. What is also clear in these episodes is both the insurance industry's repeated and consistent use of the threat of disruption to influence policy. The ability of these threats, together with similar threats by other sectors of the health care industry, also demonstrate how elected officials are highly sensitivity to the political cost of the disruptions that are possible with delegated policy systems.

7. Conclusion

"Washington cannot tax and cut Medicare Advantage this much and not expect seniors to be harmed."[129] This statement from Karen Ignagni, the former chief lobbyist for AHIP, lays bare the logic and mechanism of the structural power of MCOs. If policymakers enact policies that disfavor the private plans operating inside Medicare and Medicaid, those MCOs can respond by reducing benefits, increasing premiums, or terminating plans. When MCOs take such actions in response to disfavored policies, the result is the disruption of the health care of millions of public insurance beneficiaries across the United States. By creating or threatening to create disruptions to critical social benefits, for which elected officials are likely to be blamed, private insurers can deliver political punishment to those in government—particularly those elected officials who represent the affected markets. Since the late 1990s, we have seen instances of both Democratic and Republican policymakers constraining and changing their policy preferences and policy demands in response to this type of disruptive power. The fear of health care disruptions, therefore, acts as an additional constraint on the health care policy agendas of both political parties.

The ability of business to generate power through a credible threat to disrupt critical social programs is a type of power that is unique to delegated forms of policymaking. In the case of Medicare and Medicaid, federal and state governments delegate responsibility to private insures by contracting with private insurers to provide public health insurance benefits to nearly seventy-five million people across the United States. In 2019, this meant that nearly 70 percent of Medicaid beneficiaries and 34 percent of Medicare beneficiaries were enrolled in a managed care plan offered by a private insurer. It is estimated that by 2025, Medicare will join Medicaid in having the majority of its beneficiaries enrolled in a managed care plan, via MA.[130] At that time, a majority of all publicly insured individuals in the United States will receive their health insurance benefits through a private plan. It is also increasingly the case that most public insurance beneficiaries will be enrolled in health insurance plans operated by a small number of publicly traded, for-profit, Fortune 500 companies. In Medicaid, six firms account for 50 percent of all managed care enrollment.[131] In Medicare, enrollment is even more concentrated. In 2021, UnitedHealth and Humana accounted for 45 percent of all MA enrollees across the country.[132] Together, UnitedHealth, Humana, Centene, Aetna/CVS, and Anthem enroll more than thirty-four million publicly insured beneficiaries across Medicare and Medicaid. It is, therefore, the case that as private insurers gain power inside Medicare and Medicaid, that power is increasingly concentrated among a small number of major firms. It is this level of responsibility and the increasingly concentrated enrollment growth that creates the structural power that allows private insurers to constrain the reform agenda through warnings of harm and disruptions like that made by Ignagni.

In the absence of broad reforms to American health care policy, enrollment in both Medicare Advantage and Medicaid managed care plans will only continue to increase. The current policy

[124]Jack Torry, "Portman Pushing Gradual Medicaid Cut Instead of Elimination," *Dayton Daily News*, June 9, 2017.

[125]Caitlin MacNeal, "GOP Sen. Heller Says He Won't Vote for Obamacare Repeal Bill," *Talking Points Memo*, March 17, 2017, sec. M.

[126]Shelley Moore Capito, "Capito, Portman Announce Opposition to Current Senate Health Draft," news release, June 27, 2017, https://www.capito.senate.gov/news/press-releases/capito-portman-announce-opposition-to-current-senate-health-draft.

[127]Congressional Budget Office, "American Health Care Act: Budget Reconciliation Recommendations of the House Committees on Ways and Means and Energy and Commerce, March 9, 2017," March 13, 2017, https://www.cbo.gov/sites/default/files/115th-congress-2017-2018/costestimate/americanhealthcareact.pdf.

[128]David Dranove, Craig Garthwaite, and Christopher Ody, "Uncompensated Care Decreased at Hospitals in Medicaid Expansion States but Not at Hospitals in Nonexpansion States," *Health Affairs* 35, no. 8 (2016): 1471–79.

[129]Jon Kamp, "Health Insurers Tumble Amid Medicare Proposal," *The Wall Street Journal*, February 19, 2013, https://www.wsj.com/articles/SB10001424127887323495104578314322115844336.

[130]Gretchen A. Jacobson and David Blumenthal, "Medicare Advantage Enrollment Growth: Implications for the US Health Care System," *JAMA 327*, no. 24 (May 23, 2022): 2393–94.

[131]Elizabeth Hinton and Lina Stolyar, "10 Things to Know about Medicaid Managed Care," *KFF*, February 23, 2022.

[132]Meredith Freed et al., "Medicare Advantage in 2022: Enrollment Update and Key Trends" (KFF, August 25, 2022), https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2022-enrollment-update-and-key-trends/.

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status quo favors private insurers and promises to bestow upon them a larger role and a more privileged position within public insurance programs. From this privileged position inside public insurance programs, private insurers will develop an even broader base of power from which to defend their interests and influence policy. As highlighted above, enrollment in MA is projected to crack 50 percent of eligible beneficiaries in 2025. Medicaid, too, shows continued robust growth in managed care enrollment, with a number of states electing to transition even more populations from fee-for-service into their existing managed care programs. Other states are placing more beneficiaries under MCO responsibility. North Carolina, one of just eleven states in 2020 with no Medicaid managed care penetration, began a transition to Medicaid managed care in 2021. In June 2022, the North Carolina Senate passed legislation to finally enact the ACA's Medicaid expansion, signaling a new willingness to adopt this program. If the expansion passes the North Carolina House of Representatives, its implementation would likely place more individuals in Medicaid managed care. If North Carolina and other holdout states join the recent trend of Republican states adopting the ACA's Medicaid expansion, it would likely further boost Medicaid managed care enrollment, as most expansion states have placed the majority of their expansion population under managed care. To be sure, the trend toward increased access to health insurance in the United States is a positive trend, with significant health and economic benefits for individuals and states, but it is also necessary to recognize and understand the implications of expanding public health insurance benefits through private, mainly for-profit insurers. While private insurers can act as important defenders of public insurance programs, as we saw most prominently during the 2017 efforts to repeal the ACA, their interests are decidedly in favor of defending a particular form of public insurance—one that maintains their privileged position and continues to generate revenue for shareholders. In other reform episodes, like the recent efforts to add vision, dental, and hearing to traditional Medicare, the power of private insurers stood opposed to expansions of public health insurance. The intertwining of public and private authority and political and economic power in American health care policy continues to grow deeper and carries important implications for the trajectory of future health care reform, as well as for how federal and state governments respond to near-term health policy problems.

The COVID-19 pandemic represents an extreme example of a near-term policy challenge that confronted both federal and state governments. It is telling of the trajectory of the American health care system that, when faced with extreme pressure and an unprecedented policy problem, the federal and state responses to the public health emergency only expanded the role of private insurers within public insurance programs. Doing so did not require new policies aimed specifically at increasing managed care enrollment, but rather, the expanding enrollment during the pandemic reflects the default position and response of the current system to increase public coverage through private plans. Between March 2020 and December 2021, for example, overall Medicaid enrollment increased by roughly 23 percent. Enrollment growth during this period also followed the trend of concentrating enrollment in a small number of plans. The five largest Medicaid MCOs saw Medicaid enrollment during this period increase by more than 32 percent. The enrollment growth during the COVID-19 pandemic also saw revenues rise dramatically for participating MCOs. Over the first two years of the pandemic, three of the five largest Medicaid MCOs—Centene, UnitedHealth, and Molina—reported year-to-year increases in Medicaid revenues of 19–23 percent. When thrust into crisis, the intertwining and interconnection of public and private authority in American health care only increased.

Neither the enrollment growth nor the revenue increases are wholly attributable to the pandemic and its policy response, but the "organic" membership growth and associated revenue gains were largely the result of COVID-related disruptions creating a newly eligible population and the decision to suspend Medicaid eligibility redeterminations. The Families First Coronavirus Response Act provided a significant financial incentive for states to suspend eligibility redeterminations and maintain continuous Medicaid coverage during the public health emergency for any individual who was Medicaid eligible as of March 18, 2020. According to Anthem, its $5.8 billion year-to year revenue increase was "primarily driven by higher premium revenue due to mainly organic membership growth in our Medicaid business resulting primarily from the continued temporary suspension of eligibility recertification during the COVID-19 pandemic."[133] As the likely end of the public health emergency approaches, private insurers will also play an important role in limiting the disruptions to care that will result when states restart Medicaid eligibility redeterminations. As large numbers of individuals will become ineligible for Medicaid at the end of the public health emergency, private insurers will undertake efforts to help transition individuals who are no longer eligible for Medicaid coverage into plans offered through the ACA's health insurance exchanges. Again, private insurers will fill critical social and policy roles by developing advanced analytics and expanding outreach to help limit disruptions to care, but private insurers will likely focus such efforts on transitioning their own Medicaid customers into their own policies offered through the exchanges. While it is certainly beneficial to avoid unnecessary disruptions to care, it is likely that these private policy efforts will produce uneven policy outcomes across states and populations. The policy response to the COVID-19 pandemic demonstrate both the benefits of a post-ACA health policy environment in which the health care safety net is considerably stronger than it once was, but it also demonstrates the limitations of such heavy reliance on private actors and a glimpse into how the continued expansion of private plans may hinder broader reform goals.

For some, a potential silver lining of the COVID-19 pandemic is the potential opportunity for large-scale reforms to the American health care system. The pandemic exacerbated many of the disparities and inefficiencies of the America health care system, which helped raise the visibility and expectations for reforms like a public option or single payer—both of which pose serious threats to the interests of private insurers. Because the trajectory of enrollment growth in private plans that preceded and continued through the pandemic has only built them more strongly into the structure of public insurance programs, it is necessary to center the structural power of private insurers in our assessments of future reform opportunities and efforts. If, for example, we fail to consider how the prospects and path to a single-payer system in California are shaped by the continued growth of managed care enrollment in California's Medicaid program, we ignore both a major source of power, as well as the unique mechanisms by which that power is exerted. In addition to being home to a

[133] Andy Schneider and Allie Corcoran, *Medicaid Managed Care: The Big Five in PHE 19 (Q1 2022)*. (Georgetown University Health Policy Institute: Center for Children and Families, May 10, 2022).

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robust and vocal single-payer movement, California is also the largest Medicaid managed care market in the nation, with nearly twelve million Medicaid beneficiaries, or 80 percent of the Medicaid population, enrolled in private plans in 2021.[134] California's growth is indicative of the broader trends, with Medicaid managed care enrollment increasing by roughly 7.5 million between 2011 and 2021, and with the Big 5 insurers playing a large role in the program.[135] To be clear, California's success in expanding access to health insurance, broadening the populations served by Medicaid, and reducing the state's uninsured rate is worthy of strong praise, but that success has given more responsibility and power to private insurers. Even if California is eventually successful in developing a single-payer model, it may likely require a design that maintains an administrative role for the insurers who currently dominate health care policy in the state. For those actors and coalitions interested in broad, transformative change, failing to consider the structural power of private insurers would leave them unprepared for the political contests ahead—even when operating in the most politically hospitable environments.

The structural power that will continue to shape health care reform at the state and federal levels was generated as a result of the past thirty years of private plan expansion inside Medicare and Medicaid. This expanding role, which first began to accelerate in the mid-1990s, has only continued in the post-ACA health policy environment. Unlike previously described manifestations of the structural power of business, MCOs do not generate structural power only as a result of their ability to withhold investment or cause general economic disruption, but rather as a result of their ability to disrupt the provision of public benefits. What this demonstrates is that firms can develop structural power and an ability to influence future policy development as a result of how prior policies build those firms into the structure of public policies. The delegation of governing responsibility to private actors produces unique feedback effects and opens pathways of policy change that may not exist in more direct forms of policymaking.[136] By more clearly differentiating between the different types of power that such policies generate, it is possible to gain a more complete understanding of the mechanisms by which public-private policies can constrain future policymaking, as well as provide insights into the types of reforms that may rebalance policymaking power in the United States. If we are concerned about the power and policy influence that organized interests possess in the area of health policy, then we must be as concerned about the design of current health policies as we are about the lobbying activities and campaign contributions or private interests.

The argument that the structural power of private insurers acts as a powerful constraint on health care reform should not be taken to imply that other forms of power and influence are less important. The instrumental power displayed in the campaign contributions and lobbying activities of private insurers, as well as their more traditional form of structural power as major employers and sources of economic growth, remain important considerations in understanding the trajectory of past and future reform efforts. The argument offered here should also not be taken to imply an invincibility of private insurers in battles over health care reform. Indeed, prominent examples of elected officials pursuing policy goals that go directly against the interests of private insurers provide opportunities to further test and refine the theory offered here. The efforts to repeal the ACA, for example, while ultimately beaten back, show how the structural power of MCOs and the threat of health care disruptions was not strong enough to prevent a large number of Republican officials from undertaking a highly visible repeal effort. Even prior to the efforts to repeal the ACA, the refusal of many states to adopt the ACA's Medicaid expansion raises additional questions about how and when the power of MCOs is most effective.[137] It is possible that such episodes show that the structural power of MCOs is more effective when defending existing policies than in securing the expansion of benefits, the addition of new populations, or in the enactment of a more broadly transformative health care agenda. Such confounding episodes may also demonstrate a need to differentiate between the structural power generated by Medicare and that generated by Medicaid. If the structural power of MCOs is a product of the potential disruption they can deliver to a given population, then it is logical to believe that such power may vary with different covered populations. It is possible, then, that the disruptions delivered to Medicare beneficiaries would generate greater political punishment and, therefore, provide a greater policy constraint than the threat of disruption to Medicaid beneficiaries. It may also be possible that Medicaid contains better mechanisms to temper the potential disruption of plan terminations or exits, lessening the potential for negative political consequences, and potentially demonstrating mechanisms that can rebalance the power within public insurance programs. Future research on the structural power generated by delegated policymaking can fruitfully engage with the variation both across states and across time in Medicaid, as well with the potential differences between Medicare and Medicaid. Such future research is necessary to better understand the forces shaping future health reform efforts as well as the policy vulnerabilities within the American care system that may arise as a result of building private and largely for-profit actors so directly into the structure of public insurance programs.

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[134]"Total Medicaid MCO Enrollment."

[135]Ibid.

[136]Kelly, "Boutique to Booming"; Mettler, *The Submerged State*; Morgan and Campbell, *The Delegated Welfare State*.

[137]As of June 2022, there were twelve states that had still not expanded Medicaid under the ACA. On June 1, 2022, North Carolina, which is one of the twelve remaining holdout states, passed legislation in the Senate to expand Medicaid under the ACA. The legislation then moved to the North Carolina House, but voting has not yet occurred. Since 2018, seven states that had previously refused to expand Medicaid have since expanded Medicaid either through legislation or ballot measures.

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