I would like to thank Danny Schneider, Phil Rocco, Eric Schickler, and the UC Berkeley APD Workshop for their helpful feedback on an earlier draft. I would also like to thank Mark Kelly, Arnela Colic, and the archivist at the Bentley Historical Library and the Ronald Reagan Presidential Library for their research assistance on this project.
Introduction

In 2012, more seniors enrolled in Medicare than in any year since 1973. In this near-record year for Medicare enrollment, more than half of the enrolling seniors elected to join Medicare Advantage. In doing so, more seniors opted to receive their health coverage through a private insurer like Humana or United Health than chose to enroll in Medicare’s traditional Fee-For-Service (FFS) program. Medicare managed care, the once-boutique program that twenty-five years earlier enrolled just 3% of eligible beneficiaries and drew little attention from lawmakers, reached another major benchmark in 2014; the enrollment of its sixteen-millionth beneficiary. Nearly 30% of eligible beneficiaries are now enrolled in Medicare Advantage (figure 1). How did such a dramatic change occur within a policy that is popularly considered to be a quintessential case of policy stasis in a quintessentially change resistant environment?

The growth of MA represents both a shift in the universal characteristic of traditional FFS Medicare and an instance of welfare state expansion in a hostile environment. No longer operating only as a universal, indemnity insurance program, the capitated per member per month plans represent a paradigm shift in how the government purchases healthcare and how providers deliver services to America’s seniors. In shattering the universality of traditional FFS Medicare, MA enrollees pay different premiums, receive different benefits, and experience different cost sharing obligations from those beneficiaries enrolled in traditional FFS.\(^1\) These dramatic changes have not, however, led to a reduction in spending or an erosion of benefits. In fact, between 2004 and 2009, the Federal government spent an additional forty-four billion dollars over what it would have spent had all MA beneficiaries been enrolled in FFS.\(^2\) Prior to the 2003 Medicare Modernization Act, seniors without supplemental Medicare coverage were able to obtain prescription drug coverage only by enrolling in a Medicare HMO. By enrolling in MA, seniors have also gained additional benefits not included in FFS, including coverage for hearing, vision, and dental, as well as protections against Out-Of-Pocket (OOP) costs (figure 2). The added benefits, which often come with little or no added premium, have become an attractive way for seniors who do not qualify for Medicaid and do not have employer-sponsored retirement benefits to fill the gaps in FFS coverage.

---

\(^1\) Differences in premiums, benefits, cost sharing, and delivery types also exist among MA enrollees.

\(^2\) The forty-four billion dollars in extra payments between 2004-2009 represents an average of $830 in extra spending per MA enrollee, per year, with the high-water mark coming in 2009 at $1138 per enrollee, per year. There are questions as to how efficient or fair this expansion of Medicare spending has been, particularly regarding the portion of extra spending that goes to insurance companies as opposed to beneficiaries. See, e.g., Duggan et al., “Who Benefits when the Government Pays More? Pass-Through in the Medicare Advantage Program,” NBER Working Paper 19989, March 2014.
The spectacular growth of private plan enrollment over the last quarter century is puzzling not just because it occurred, but also because of how and when it occurred. When private plan enrollment first began to surge in the early 1990s, it had been more than a decade since the last piece of legislation relating to Medicare managed care was passed. This suggests that Medicare has become susceptible to non-legislative forces and processes of change, which raises questions as to whom or what controls the development of America’s second largest social program. When the program came to experience sustained double-digit annual growth rates, few would have predicted that it would have occurred in a political context in which Democrats controlled the White House and both houses of Congress. Furthermore, when new legislation was adopted in 1997, legislation that was expected to significantly increase MCO participation and beneficiary enrollment, it was passed on a remarkably bipartisan basis before being “enthusiastically” signed by President Clinton (DeParle 2002: 505). These developmental curiosities indicate that in the era of the “incredibly shrinking middle” a separate and more bipartisan Medicare politics emerged around, of all things, privatization (Binder 1996). What I will demonstrate is that these puzzles are linked. Through a combination of primary and secondary source research, including key informant interviews with former high ranking Medicare policy officials from the executive and legislative branches, I show that forces generated by broad structural changes in the commercial market – forces that were beyond the direct control of policymakers – interacted with an existing policy framework to produce a significant expansion of Medicare private plan activity. The initial policy changes that were caused by these market forces, I argue, subsequently re-made the politics of Medicare and altered Medicare’s developmental trajectory.

A Challenge to an Entrenched Understanding of Medicare

There are two broad approaches to Medicare Change. One views Medicare as highly change resistant, with opportunities for significant programmatic transformation arising only as a result of an exogenous shock (Marmor 2000; Hacker 2002, 2004; Oberlander 2003; 2007). Reflecting the broader literature on institutional and policy change, the second approach, which seeks to describe incremental processes of change, is a response to the inability of the earlier literature to address or explain instances of change in the absence of a “big bang” (Marmor and Mashaw 2006; Hacker 2002; Streeck and Thelen 2005; Mahoney and Thelen 2010). Generally, these literatures divide the

---

3 The HMO provisions of the BBA 1997, which renamed the program Medicare+Choice, passed out of the Senate Finance Committee 18-2, and out of the Ways and Means Committee on a vote of 36-3.
history of Medicare into two periods: one before and one after the 1994 elections. The 1965-1994 period is widely seen as highly stable and appropriately accounted for by the policy stasis literature. The theories of incremental change offer a corrective to these earlier theories, which both validates their accounts of the pre-1994 stability while also acknowledging that in the absence of a destabilizing shock to the program, smaller, aggregative instances of change have accompanied the rightward shift in Congress that began in 1994. Because the incremental approach builds from the earlier policy stasis framework, both approaches struggle in similar ways to address the transformation of Medicare managed care. First, both approaches inadequately address forces of policy change that do not originate from inside the typical bounds of politics, i.e. from the legislative and executive branches. Second, by establishing an artificial boundary within Medicare’s history, scholars often miss important empirical insights that can be gained only by considering Medicare’s entire history.

Medicare’s stability is primarily identified as a product of its initial structure. Funded by compulsory tax contributions and characterized by common risk pools, no means testing, a shared benefit structure, and universality among the 65 and over population, Medicare was designed for durability. Its quick implementation, provision of a strong benefit to an identifiable constituency, demonstrated effectiveness in meeting its goals, and minimal interference with how existing insurers and providers conducted their business, further enhanced Medicare’s stability. Medicare’s all-in-the-same-boat structure has also been described as producing participatory and attitudinal feedback effects that have served to strengthen the support constituency behind the program (Campbell 2003; Campbell 2012; Mettler and Stonecash 2008, Skocpol 1991). Medicare’s existence within the veto-player-laden American political environment only added to the portrait of stability. Scholars understandably became bullish about Medicare’s long-run stability.

Theory, it seems, has both clouded our view of Medicare’s empirical reality and restricted the provenance of change to the legislative or administrative arenas. Conclusions that Medicare was in a “holding pattern,” for example, persisted despite the sustained double-digit annual growth rates that characterized private plan enrollment in the 1990s (Hacker 2004: 253). The difficulty in recognizing such change is, in part, a product of the theoretical preclusion by the earliest accounts of Medicare of the possibility of program change without an exogenous shock. “Absent overwhelming congressional and presidential victories,” Marmor (2000: 174) has argued, “one should not be

---

4 Means testing was introduced into Medicare as part of the 2003 Medicare Modernization Act, and took effect in 2007.
surprised by the limits of major change in Medicare.” Theory dictated that if there were no shock, there would be no change.

When programmatic change is recognized, this theoretical lens has caused scholars to turn their focus too quickly and too intensely to a temporally appropriate event that could be categorized as an exogenous shock. Given that the mechanisms of policy reproduction are primarily seen to operate through elected officials and their fear of voter retribution, scholars have most often identified the 1994 elections and the Republican Revolution as unsettling Medicare policy and politics. Jonathan Oberlander (2003: 160), for example, has argued that, “it is not much of an exaggeration to say [the 1994 elections] changed everything about Medicare’s political world.” Private plan enrollment did, indeed, increase by 78% between 1994 and 1996, but taking such a snapshot obscures the longer running process of Medicare’s creeping privatization. As figure 3 depicts, after the flat growth of the late 1980s, enrollment rates accelerated rapidly prior to the 1994 elections and the seating of the 104th Congress in January 1995. Having a larger number of sympathetic voices in Congress surely aided private plan expansion, but the enrollment and participation data suggests that Medicare’s world began to change prior to 1994, and that the transformation was not directly caused by a rightward shift in the political environment.

The Medicare literature’s difficulty in identifying the initial source of private plan expansion is, in part, a product of its inadequate consideration of processes of change that do not emanate from or act through the legislative or executive arenas. Medicare scholarship, for example, has focused primarily on the structural and electoral impediments to legislative change. Such theories are not incorrect in describing the impediments to legislative change, and do in fact, shed considerable light on the Medicare’s developmental trajectory. Between 1982 and 1997, for example, not a single piece of legislation regarding Medicare private plans was passed, not even in the two years following the Republican Revolution. But, as figure 4 shows, we cannot equate legislative stability with programmatic stability. Between 1989 and 1997, the percentage of Medicare beneficiaries enrolled in private plans grew by more than 300%. The occurrence of programmatic changes in the absence of a proximate legislative change demonstrates that in focusing primarily on legislatively driven change, scholars have perhaps overestimated Medicare’s level of entrenchment. If, for example, a force or process of change comes from outside the executive or legislative branch, then the electoral constraints that have previously stabilized and strengthened Medicare will be minimized. In this way, Medicare is defended by a Maginot Line of beneficiaries: well positioned and capable of repelling an advance made from one direction, but ill-equipped to defend the
program if forces of change do not advance from the legislature or executive. Only by considering the wider policy context can we gain a full understanding of both the policy and political change in Medicare managed care.

The process of change that shifted Medicare in the direction of private plan participation began almost as soon as Medicare was enacted – decades earlier than is commonly argued. Partially a product of the longer period of examination undertaken herein, the incremental change I will elucidate is considerably more complex than the Republicans vs. Democrats, anti-statist vs. statist theories of covert or stealth change that have, to date, characterized similar investigations of Medicare. One such theory, offered by Marmor and Mashaw (2006: 132), has characterized MA as a Trojan horse strategy adopted by the program’s opponents in an effort to unleash warring bands of market mechanisms within the walls of Medicare in order to destroy the program from the inside out. This theory of covert change bypasses the bipartisanship of the BBA 1997, the early Democratic support of the Medicare Modernization Act, as well as the fact that critical first steps in the movement toward private plans began in the Carter administration. If Medicare HMOs are simply a Trojan horse, scholars would need to explain why the Trojans (the Democrats in this analogy) helped the Greeks (the Republicans) construct the entity that was to deceive them and destroy that which they defended most dearly. By truncating the examination of Medicare privatization and beginning with the George W. Bush administration, scholars forewent the opportunity to examine how the longer-running process of Medicare change, itself, forever altered the politics of Medicare and contributed to the puzzling bipartisanship that has characterized Medicare privatization since the late 1990s. Without an understanding of how the process of policy change altered the political context in which Medicare exists, we are ill-equipped to understand recent Medicare developments, as well as the likely trajectory of future change.

Of similar importance for understanding the direction of Medicare’s past and future change is the recognition that strategies of incremental change are imprecise, unpredictable, and often rely on more than one set of actors or forces to eventually produce change. The first true introduction of private plans was the 1982 passage of the Tax Equity and Fiscal Responsibility Act (TEFRA), yet policy expansion was inconsequential and enrollment remained flat through the late 1980s. To form a full explanation of this transformation we must again expand our consideration of the forces of change to those operating outside the normal bounds of politics and consider that the agents involved in this process, along with their motives and preferences, may change overtime. In broadening our examination to consider non-legislative and non-administrative avenues of change,
as well as widening our window of exploration to include the earliest days of Medicare policy, the
complexity of Medicare change quickly overwhelms existing theories. In doing so, however, we can
understand how existing policy structures interacted with a changing market environment to alter a
public policy long-believed to be highly entrenched. Not only will I show that this consequential
policy changed took place far from the direct control of policymakers, but that these policy changes
were then responsible for altering Medicare’s political context.

**Argument: The Effect of Uncoordinated Market Forces on Policy and Political Change**

The operation and output of the Medicare managed care program was significantly altered
by three separate but interrelated market forces: (1) rising healthcare costs; (2) increasing commercial
penetration and competition; and (3) changes in the organizational structure of Managed Care
Organizations (MCOs). While such market forces were necessary for the transformation of
Medicare, the presence and intensification of these forces alone did not cause the rapid acceleration
of private plan participation or the alteration of Medicare Politics. The 1982 TEFRA HMO
provisions made Medicare particularly susceptible to programmatic change resulting from market
forces. By partnering with private insurers and creating a policy space with great operational
discretion, the TEFRA provisions opened Medicare to the possibility of unpredictable change at the
hands of uncoordinated and lightly controlled private actors. While the shifting dynamics in the
commercial market would, indeed, have affected Medicare operations in the absence of TEFRA, the
TEFRA provisions tied the commercial and Medicare markets closer together, assuring that not only
would changes occurring in the private sphere of American health insurance be translated directly
into the Medicare market, but also that this process would unfold at a more efficient rate. In other
words, I argue that the TEFRA provisions provided a direct path for market forces to enter
Medicare while also providing the mechanisms through which these forces altered the policy and
politics of Medicare.

Because the TEFRA provisions only set the outer parameters of MCO participation, and did
not require or even moderately compel participation or enrollment, policy output and development
depended largely on the decisions of private actors. MCOs, for example, were not only given
discretion in regards to whether or not to participate, but also in regards to *how* to participate.\(^5\)
Would an MCO charge a zero premium? Would they provide prescription drug coverage? At what
level would the cap on Out-Of-Pocket costs be set? Would the provider network be heavily

---

\(^5\) MCOs could elect not to participate in Medicare or could participate only in select counties.
restricted? The answers to these questions, which largely determined the output and developmental trajectory of the program, would, themselves, be determined by the uncoordinated response of MCOs to broad changes in the healthcare market. The development of Medicare managed care, I argue, demonstrates how the imprecision and unpredictability of incremental processes of change are increased when the policy is constructed around public-private partnerships. The preferences, strategies, and operations of private actors, and with them the operations of the public policy, are subject to forces of change outside the direct control of policymakers. Because of this, and as this case will demonstrate, the mere *layering* of a new policy on top of an exiting framework is no guarantee that the process of change will be successfully carried out, and that the outcome will likely depend on the actions of multiple sets of actors with motivations and preferences that will change as a result of the process of change, itself.

The argument that to varying degrees all three of these forces operated outside the immediate reach of policymakers does not mean that policymakers were powerless to alter such developments. Their responses were, however, a reaction to an initial change they did not control or directly initiate. In addition, at the point at which policymakers responded, the environment had already changed significantly, closing off certain policy paths while making others more likely. This uncoordinated process unfolded through multiple and interrelated mechanisms. First, MCOs were able to translate higher payments into extended benefits, increased enrollment, and higher profits by employing utilization controls not available to FFS and by enrolling a favorably selected beneficiary pool. The value of the extra payments was pushed even higher, making the program more attractive to beneficiaries, by the second set of market forces: competition and market penetration (figure 5) (Newhouse 2002). Competition in the commercial market incentivized MCOs to enter the Medicare market in search of new sources of revenue. In an effort to attract beneficiaries and dominate the fledgling marketplace, MCOs offered increasingly rich benefit packages, even if it meant incurring short-run losses. The market penetration that fuelled this competition also drove the expansion of participation and enrollment through the production of market complementarities. Such complementarities between the commercial and the Medicare market both eased and encouraged entrance into the Medicare market by lowering the costs of network construction and increasing plan efficiencies (Abraham et al. 2000). Finally, competition also helped spur a structural change among MCOs that made expansion to new populations and markets easier and less expensive (Rossiter and Langwell 1989; Hadley and Langwell 1991). The structural changes, which were in the direction of developing less restrictive physicians’ networks, contributed further to the alteration of
the interests and strategies of the government’s MCO partners. This in turn changed beneficiary preferences, policy outputs, and the political environment of a seemingly entrenched public program.

The immediate effect of these changes was to alter the output of the program by increasing MCO participation and producing benefit packages of a previously unseen richness. This caused a surge in enrollments in what had previously been a policy afterthought in most Medicare conversations. In the long-run, Medicare’s policy trajectory was forever altered by the policy changes that created and then empowered two new constituencies. First, MCOs became a powerful stakeholder alongside beneficiaries, providers (physicians and hospitals), and the government. Not only did the rising revenues from Medicare make them more dependent upon the Medicare market, and therefore highly sensitive to policy change, but MCOs also came to occupy a privileged position at the policy table. As more and more beneficiaries became dependent on private insurers for their care, plans were able to leverage the potential disruptions that would result from plan pullouts and benefit reductions into significant influence over policy reform. Plans were also protective of their overpayments in an effort to avoid the blame that would result from benefit reductions associated with lower government payments. Policy delegation can be a blame avoidance strategy for elected officials, but the blame for policy reductions must fall somewhere, with plans similarly motivated to avoid generating beneficiary dissatisfaction and an exodus of customers. Beneficiaries have become highly protective of the comprehensive benefit packages they now receive as MA enrollees, and politicians, like MCOs, must avoid the growing penalty this constituency can inflict. While this constituency of MA beneficiaries remains a minority within the Medicare population, it is one with a voice and influence that grows stronger with every enrollment period. Insurers and MA enrollees do not maintain complete control over all Medicare policy, but the changes in Medicare managed care policy have produces some surprising politics that continue to be an influence in contemporary Medicare decisions. Before we examine these changing politics and their affect on current policy decisions, let us first look at how Medicare managed care first emerged.

**Medicare Managed Care: The Early Years**

There was little support within Congress or the bureaucracy during the 1970s for the introduction of capitation into Medicare. There was, in fact, little support for any payment or delivery reform. Even with Congress having formally validated managed care with the passage of the 1973 HMO Act, HMOs in Medicare were still a political non-starter (Ebeler 7/25/13).
Resistance stemmed from both the political concern of upsetting American seniors and a belief that it was not actually the job of the Social Security Administration (SSA), the Bureau of Health Insurance, or Congress to control costs or interfere with the delivery of care. In the bureaucracy especially, the culture was one that placed “getting the checks out” above all else (Schaeffer 1/29/14). This culture was transferred from Social Security to Medicare, and resulted, in essence, in giving hospitals and physicians a blank check. Congress and the SSA were not initially concerned with what exactly that check covered. The overriding concern was that efforts at cost containment would result in the erosion of both the quality and extent of benefits. As a result of congressional and bureaucratic resistance, both the Nixon and Carter administration saw little success in controlling cost through structural reforms along the lines of managed care. The regulations that were introduced, created such heavy disincentives as to make little impact on participation or enrollment.

Managed care plans were initially required to operate within Medicare on a “cost basis.” This meant that if managed care plans were going to operate within Medicare they had to do so in the same way that physicians and hospitals operated – on an indemnity model. MCOs, however, operated in a completely different financing and care delivery paradigm than the indemnity insurance model. In the indemnity model, a beneficiary sees any doctor who accepts Medicare and that doctor is reimbursed for the cost of whatever services were provided. It is this structure that gives traditional Medicare its common label of “fee-for-service.” Prepaid group plans, what we know today as managed care companies, were built around a per member per month prospective payment, which ideally creates an incentive to keep a beneficiary healthy and control utilization. To operate in Medicare on a costs basis required that prepaid group plans alter not just their administrative and payment systems, but also the manner in which they provided care and delivered their added value to the system. Operating in Medicare, while technically allowed, was virtually impossible for MCOs under these conditions.

The 1972 Social Security Amendments only slightly lowered the disincentives to participation in Medicare by prepaid plans. Well-established plans would be able to contract for Parts A and B on a risk-basis and be paid a capitated monthly payment by the government. Payments would, however, be retrospectively adjusted, with plans only allowed to keep savings up to

---

6 Initially, Medicare reimbursed at “reasonable cost,” which was determined by the provider and a fiscal intermediary such as Blue Cross. As a result, costs soared and eventually the federal government introduced a prospective payment system and a fee schedule for hospital and physician services, which established administratively set pricing for a service or set of services.
10% of the government payment level. All savings accrued beyond this point would go back to the government, while the plans would be responsible for all losses. For MCOs operating in a new and largely unknown market, the balance between financial risk and reward tilted toward not participating. In barely altering the Medicare status quo, the 1972 Social Security Amendments meshed well with the goals of Congress and the bureaucracy. Despite rising cost concerns, the resistance to payment and delivery innovations like managed care remained strong. The Medicare managed care “switch,” as Jack Ebeler (7/25/13), a former special assistant to the administrator of the Health Care Financing Administration and Commerce and Energy committee staffer, has described it, was set to “no” between 1965 and 1983. How, though, did the switch finally get thrown to “yes”?

The early spending concerns surrounding Medicare led Congress to establish what was called a “demonstration authority” within the BHI. One office within the bureaucracy was charged with carrying out experiments in the delivery and financing of Medicare. There was very little oversight of this demonstration authority from either the legislative or executive branch. Neither the OMB nor the White House, more generally, could control the budget of the demonstration projects or determine the projects that were carried out. The demonstration projects provided significant discretion to a small portion of the bureaucracy in influencing the direction of Medicare policy. Al Dobson, a former director of the Office of Research and Demonstration, described the enormous power and stunning authority that demonstrations bestowed upon Medicare administrators. With this power placed in their hands, the newly created HCFA undertook the Capitation Demonstration project in 1978. This was followed in 1982 by the Competition Demonstration. These demonstration projects gave the HCFA administrator and the Office of Demonstration and Research the authority to push a program they believed in and supported. The authority gave administrators the ability to run a program on a relatively small scale to see if they could get it up and running and allow support to develop.

The demonstrations provided the engines to make the program run. Without them, according to Dobson, it is likely that the full-blown national program would not have come online. Enrollment processes and payment systems were devised and tested, while both the government and private entities developed additional tools and the knowledge required to operate in this new market. The demonstrations not only allowed administrators to set the policy agenda, but they also worked to reduce skepticism and increase support for an alternative approach to traditional FFS Medicare

---

7 The budget for demonstration projects came from the Medicare Trust Fund.
The primary concern of introducing new financing and delivery innovations into Medicare was, after all, the fear that beneficiaries would be harmed – that benefits and quality would erode. When asked if the demonstrations served to allay concerns of previously skeptical congressmen, Dobson (11/19/13) responded simply, “It’s harder to say something doesn’t work when it does.” The success of the demonstrations also served to slowly transform the internal culture of HCFA. Cliff Gaus (1/29/14), another former director of the office of Research and Demonstrations, described the effect of the demonstrations by stating, “as things succeed or they’re shown that they can even be possible, people become a little more sympathetic to it.” Managed care plans might not have been saving money for the federal government, but neither were they reducing benefits, quality, or beneficiary satisfaction (Langwell and Hadley 1989). The first hurdle for risk-plans was not to demonstrate savings, but to demonstrate functionality. Dobson succinctly characterized the demonstrations’ return in the following way: “you had a way to get people in, you had a way to handle them when they got in, you had a way for the government to make the payments and risk adjust. All of those things came together to allow an actual program.”

Four years after the first managed care demonstration, Congress enacted a full-fledged, nationwide program as part of the 1982 Tax Equity and Fiscal Responsibility Act (TEFRA). The HMO provisions in TEFRA followed directly from the structure of the demonstration projects. TEFRA HMOs, as they were known, brought greater operational parity between the commercial and Medicare markets – reducing what had been the key disincentives to prepaid plans operating within Medicare. TEFRA HMOs were paid on a prospective basis, with no retrospective adjustments, at a level equal to 95% of the Adjusted Annual Per Capita Cost, which was basically the FFS cost of a given beneficiary. If the demonstrations were Medicare sticking its toe in the water of managed care, TEFRA is the legislative equivalent. Passed as one piece of a much larger omnibus bill on an up or down vote at the end of the session, TEFRA HMOs were not widely celebrated, but meekly accepted. “It wasn’t pretty,” said Bill Roper, “but it’s the way things get legislated most of the time.”

While the pyrotechnics of TEFRA were not around HMOs, it did serve the critical purpose of formally throwing the Medicare managed care switch from “no” to “yes.” The demonstrations pushed the door evermore slightly open, showing policymakers that there was a way to make HMOs in Medicare work, if there was a desire to do so. TEFRA then served to completely open the door to HMOs in Medicare. Despite the fact that the door was now open, entrance was still not assured. Growth over the next years was, in fact, almost imperceptible. From 1986 to 1987, enrollment rose...
from 900,000 to 1.1 million, and remained stuck at that enrollment level for the next three years. Growth remained relatively flat through the early 1990s, finally passing two million enrollees in 1994. In these early days, enthusiasm for Medicare HMOs ran cool among both beneficiaries and managed care companies, alike. The HMO structure was unknown to most beneficiaries and the Medicare market was just as unfamiliar to plans. Enthusiasm would, however, eventually rise along with participation and enrollment. The critical factor in the growth of Medicare managed care, it turns out, was not in the opening the door, but in how the door was opened.

**The Transformation of A Boutique Program**

There were as few fireworks in the first years following the enactment of TEFRA as there were at the time of enactment itself. Because the impactful policy drama played out years after enactment does not, however, mean that the TEFRA provisions were themselves of little importance. It is true that the mere layering of a new payment and delivery structure on top of the traditional Medicare framework did little to immediately alter the policy or politics of Medicare, but the new provisions created a considerably more direct connection between the commercial and Medicare markets – providing both a path into Medicare and the mechanisms by which the forces generated by changing commercial market dynamics would alter the policy and politics of Medicare. With enrollment hovering below 4% until 1992, Medicare HMOs remained an after thought until changing market forces interacted with the existing policy structure to trigger a policy transformation.

The passage of TEFRA removed the major disincentives to participation and enrollment. No longer were payments from the government to MCOs retrospectively adjusted. HMOs operating in Medicare were now paid a prospective, per member per month fee. Because Medicare, prior to TEFRA, allowed only cost-based reimbursements, HMOs were not eligible for reimbursement for benefits offered in addition to the basic FFS benefits. The TEFRA provisions lifted the cost-based reimbursement restrictions, allowing HMOs for the first time to offer benefits in addition to the basic FFS package. HMOs were also now able to charge variable premiums and offer protections against OOP costs. These policy changes were central factors in ending the all-in-the-same-boat structure of FFS Medicare, but they also allowed Medicare beneficiaries to select plans, where available, that offered hearing, vision, or prescription drug coverage, all as a part of a zero premium plan. Because the TEFRA provisions did not allow profits to be made in the Medicare market that were in excess of those earned in the commercial market, savings that
produced profits over this cap could either be returned to the government or given back to beneficiaries in the form of the now allowable extra benefits, lower premiums, and/or caps on OOP costs. This created a framework in which expansion could take place outside the direct control of policymakers. Even so, this initial framework and environment did not cause skeptical seniors to flock to HMOs or encourage HMOs to dive head first into an unknown market place with a government partner that was completely new to managed care.

Of critical importance to the eventual explosion of Medicare managed care was the fact that the TEFRA provisions tied Medicare HMO payments directly to FFS costs. It was believed that by setting payment levels at 95% of the AAPCC, the government was building in an automatic 5% savings. What this policy structure meant, however, was that if the AAPCC increased, that is, if Medicare costs increased, payments to HMOs would also increase. Because the TEFRA provisions allowed Medicare HMOs to offer benefits beyond the basic Medicare package, as well as offer lower premiums and caps on OOP costs, the extra payments to Medicare HMOs allowed them to offer the increasingly attractive benefit packages that began to attract beneficiaries to HMOs in large numbers (McBride 1998; Penrod et al. 2001:735; Vladeck, June 5, 2013).

Between 1994 and 1996, a period in which enrollment grew by nearly 80%, the value of the extra benefits offered by Medicare HMOs increased from $43 per member per month, to $83 per member per month (McGuire et al 2001: 300). At the end of this period of expanding enrollment, in counties where the AAPCC was above $500, 92% of beneficiaries were offered prescription drug coverage, filling what was considered by many to be the largest gap in traditional Medicare coverage (McBride 1998: 172). According to the former Clinton administration HCFA administrator, Nancy-Ann DeParle (2002), plans were spending, on average, 20% of the capitation payment on benefits that were not covered by Medicare. This demonstrates how the policy outputs were transformed despite stability in the policy’s structure. What was changing was the AAPCC (Figure 6). Because the AAPCC payments reflected both the rapidly increasing costs of health care services and vast utilization differences from one county to the next, managed care plans were able, in many cases, to negotiate lower prices and introduce utilization controls that were absent from FFS Medicare. When combined with favorable selection that allowed plans to create a beneficiary pool that was younger and healthier than the population from which the AAPCC is calculated, the lower costs and higher payments to managed care plans were translated into richer benefits, lower OOP costs, and higher enrollment. Medicare had become a rich juicy target for HMOs (Dobson, Nov. 19, 2013).
Bruce Vladeck, President Clinton’s former administrator of the Health Care Finance Administration (HCFA), described the rising AAPCC as the largest determinant of the expansion of Medicare managed care (Vladeck 6/5/2013). An environment was created in which to be a major player in the insurance world, you had to be in the Medicare market; and with the government paying fifteen cents over the dollar for beneficiaries enrolling in HMOs, it would have been criminal for HMOs not to jump into this market (Schaeffer; Dobson). As HMOs descended on this now lucrative and previously untapped market, HMOs began to aggressively market plans to Medicare beneficiaries (Vladeck 6/5/2013; Ebeler 7/25/2013; Rubin 10/31/13). These developments demonstrate how quickly the initial reluctance of plans to participate in the Medicare market evaporated when payments increased and new markets were needed. The higher payments that resulted from the interaction of the specific funding structure of the TEFRA provisions with rising system-wide healthcare costs altered the preferences and strategies of the government’s private partners. As plans offered richer benefit packages, the preferences of seniors towards Medicare HMOs were, themselves, altered. With the promise of extended benefits and protections against high OOP costs, seniors, for the first time, were enticed to leave traditional FFS for Medicare HMOs. A survey of beneficiaries from the earliest days of the program showed that lower OOP costs were the primary reason for switching to a TEFRA HMO from FFS. While 50% of respondents ranked lower OOP costs as the primary reason to enroll, another 20% identified expanded benefits as the driving force behind their enrollment (Rossiter and Langwell 1989: 122). Similarly, a survey of Medicare enrollees in the St. Paul/Minneapolis area found that attractive benefits and lower premiums were two of the top three reasons cited for applying to an HMO (Iversen and Polich 1985: 19). It did not, therefore, take a direct legislative act or even administrative changes to alter the output and effect of this critical piece of social policy. Absent of congressional legislation or changing bureaucratic regulations, the changing market dynamics operating within the existing policy framework led to an increasing role of managed care in Medicare.

The rising AAPCC rate was just one factor that both significantly altered the effect of Medicare’s managed care program and was out of the direct control of policymakers. The probability of participation by HMOs in the Medicare market, for example, increased significantly as HMO penetration in the commercial market also increased (Welch 1996). This means that an expanding presence of plans in the commercial, under-65 market had significant effects on the operation of the federal Medicare program. Welch (1996) has argued that commercial penetration
is, in fact, an even more important factor determining HMO participation than the AAPCC rate. Portland, Oregon, for example, had a below average AAPCC rate in the mid-1990s, but Portland HMOs had the third highest market share of Medicare beneficiaries among large metropolitan areas. Portland’s strong history of HMO participation in the commercial sector translated into above average participation in Medicare managed care plans. One mechanism by which commercial penetration translates into HMO participation in the Medicare market, it has been argued, comes in the form of cost complementarities (Abraham et al. 2000: 388). The growing presence in the commercial market can lower the costs and ease entry into the Medicare market. Asked if such complementarities existed between the commercial and Medicare market, Leonard Schaeffer, the former CEO of WellPoint and administrator of HCFA, stated quite directly, “Oh absolutely.” Improvements in utilization control and health management that resulted from operations in the commercial market, as well as the general efficiency gains and organizational knowledge that were also accrued, translated into the Medicare market. In a sense, the commercial market was where plans learned and developed techniques that enabled them to operate more effectively and efficiently in the Medicare program. A larger commercial presence in a given county also made it less expensive to create both a network of providers and a marketing campaign for the Medicare market for that same county. The benefits of increased commercial penetration are not limited only to those plans actually participating, but plans who were not yet participating in the Medicare market were shown to still benefit from the experience and knowledge gained by active HMOs. A GAO (1997a: 20) report from 1997 described how new firms entered the market when they judged that participating HMOs had demonstrated an effectiveness in managing the care of the Medicare population and an ability to produce a return on investment. As HMOs gain the ability to lower the costs to entrance and operation in the Medicare market, it allows them to offer more benefits, better care, and attract more beneficiaries. The discretion given to plans as to how to participate in Medicare, combined with the voluntaristic structure for beneficiary enrollment, created the possibility that changes relating to, for example, the efficiency and effectiveness of plan operations, would result in a significant transformation of policy outputs and operations.

Commercial penetration not only affects the preferences and decisions of insurers to participate in Medicare, but also the decision of beneficiaries to enroll in Medicare HMOs. Penrod et al. (2001), for example, have shown that in counties where the percent of commercial enrollment is one standard deviation above the mean, the probability of Medicare beneficiary enrollment increases almost threefold. The mechanisms connecting commercial penetration and Medicare
enrollment include increased consumer knowledge, acceptance, and trust in the HMO model. Again, the voluntaristic structure allows such changes in beneficiary preferences to shift policy operations without legislative or administrative input. A large commercial enrollment, it has been argued, can also provide a signal to Medicare beneficiaries that a particular HMO is well established and reputable (Abraham et al. 2000: 388). Such signals were important in the earliest days of Medicare HMOs because many potential enrollees had little initial knowledge or understanding of managed care. This further demonstrates how the changing effect of the Medicare manage care program resulted not from legislative or administrative changes, but from changes in the commercial insurance market. This also demonstrates that some developments in the commercial insurance market that shifted Medicare policy were even further from the control of policymakers than the AAPCC payment rates.

The effects of increasing commercial penetration on the Medicare managed care program were compounded by the impact that growing penetration rates had on competition among private insurers. As the number of managed care firms increased, the employer-sponsored market became saturated, prompting firms to look to the Medicare market for new avenues of growth and revenue streams. It was at this exact time of rising competition that the AAPCC payments began to shoot up. As competition spilled over into the Medicare market, it prompted insurers to offer even richer benefit packages and lower costs in order to win the market. This served to draw even more beneficiaries to private plans. The entrance of PacifiCare into the Boston market, for example, sparked off a two-year competition that saw Medicare HMO enrollment increase by 158%. According to the GAO (1997a), when PacifiCare entered the market offering a zero premium plan, existing HMOs dove more competitively into the market. When zero premium products were offered, according to HCFA and HMO officials, the Boston market saw even more competition and a dramatic increase in demand from beneficiaries for Medicare HMO plans (GAO 1997a). An additional GAO report (1997b) showed similar developments taking place in other major markets such as Los Angeles and South Florida. The result of increased competition in the South Florida Medicare market, like Boston, was the marketing of plans offering expanded benefits with zero additional premium. One plan offered a benefit-heavy, zero premium plan despite having been cleared by HCFA to charge a $94 a month premium. It was this type of competition that increased the value of the already rising AAPCC payments (Newhouse 2002). Republicans may have been more loudly promoting market-based reforms than in years past, but it was the richer benefits and
lower OOP costs that drove HMO enrollment to nearly 33% of eligible beneficiaries in Los Angeles (GAO 1997b).

Yet another factor that was far from the control of policymakers but that deeply impacted the operation and output of Medicare managed care was the changing organizational structure of HMOs. The changing organizational structure of HMOs was both a contributing cause and effect of the rising competition and commercial penetration of HMOs. In essence, what it was to be an HMO in 1982 when the Medicare Competition Demonstration began, had changed dramatically by the end of the decade. Nobody, according to Al Dobson, the former director of Research and Demonstrations at HCFA, envisioned anything like the radical alteration of the organizational character of the government’s partners in the provision of healthcare to the elderly (Dobson 11/19/2013). In many ways, the entities upon which the Medicare managed care program was based – the group and staff model HMOs of Kaiser, Group Health of Puget Sound, and Health Partners of Minnesota – were now the minority operators. In the staff or group model HMOs that predominated in the 1970s and early 1980s, physicians were employed directly by the HMO, worked in facilities owned by the HMO, and saw only patients that were enrolled in their HMO. Not only was the pre-1985 world of HMOs more populated with group and staff models, but these entities were also more likely to be not-for-profit and more likely to be federally qualified. Between 1980 and 1987, group and staff model HMOs went from controlling roughly 60% of the commercial market, to controlling roughly 20% of the market. What had replaced them, were the more flexible and dynamic Individual Practice Associations (IPAs) and the newly popular open-ended HMOs.

The growth of IPA and open-ended HMO models and the rise of for-profit entities had important repercussions for the Medicare program. The government’s private partners were now different animals from when the program began, and, as such, we would expect them to act differently. In their new form, HMOs and IPAs sought to, and succeeded in, expanding rapidly and drawing in more beneficiaries. The program outcomes were, therefore, changing as a result of the changing nature of the government’s private partners. First, in the group or staff model HMO, joining an HMO necessarily meant leaving your previous physician. In an IPA model, since physicians can operate across multiple networks, as well as in FFS and capitated payment structures, joining an HMO no longer necessarily meant changing physicians. It became the goal of HMOs operating in Medicare to demonstrate that a beneficiary’s doctor was in the network, which required the establishment of broader network (Schaeffer). As a result of the changes in the structure of HMOs operating in Medicare, it became possible for patients to obtain the added benefits and lower
out-of-pocket costs associated with Medicare managed care without having to change physicians. This organizational change removed a major hurdle to Medicare enrollment in an HMO. Second, Constructing or expanding a group or staff model HMO required heavy capital investment. In the group and staff model, the HMO owns and operates all necessary facilities, which means that in order to expand, an HMO of this type must construct or purchase new facilities. In addition, since a group model HMO is the sole employer of its physicians, the salary and recruitment costs are also high.

The shift away from this rigid style of managed care organization made HMOs more flexible and dramatically eased the costs and time required for expansion. Not only did new IPA models enter the market place at a higher rate, but older HMO models added IPA components to their operations, allowing them to expand their market presence without the capital investments that were previously required for such growth. These developments were both a response to, and a driver of, the competition that led MCOs to push into the Medicare market with rich benefit packages and low OOP costs (Gruber et al. 1988: 206). The policy structure of Medicare managed care remained stable throughout this period of expansion, but because of changes in the structure of the government’s private partners, the overall policy changed, altering policy outcomes and operations. Combined with increasing payments rates, the effects of competition and commercial expansion, and the resultant shifts in plan and beneficiary interests and preferences, the Medicare program underwent a dramatic transformation in the absence of legislation or major administrative changes. It was not, however, simply the immediate policy outputs that changed, but as we will see, the politics, and therefore, the long-run policy trajectory of Medicare was also forever altered.

**Policy Re-Making Politics**

In 2002, former Clinton health policy advisor and HCFA administrator, Nancy Ann DeParle (2002: 510), argued that the “first and most important” reason to save Medicare+Choice is that it has seven million enrollees. DeParle’s declaration captures what many health policy scholars and political scientists have missed: the extent to which the early growth of Medicare managed care re-made the politics of Medicare. This once-boutique program that had few friends in Congress, the bureaucracy, or society at large, has proven highly sustainable, boasting a strong bipartisan coalition of support in Congress and multiple sources of significant societal influence. This section describes

---

8 Medicare+Choice (M+C) was the name given to the Medicare managed care program prior to the enactment of the 2003 MMA, which changed the name to Medicare Advantage.
the mechanism by which the policy itself altered the politics of Medicare and established this new political environment. Through a series of empirical examples from the last two decades, I will show that in an era of ruthless partisanship, a separate politics of Medicare managed care emerged. I will show how a policy that was a “political non-starter” came to enjoy near unanimous bipartisan support in the 1997 effort to double enrollment. I will show further that when this policy effort stumbled, rather than seizing an opportunity to highlight the failure of market-based approaches to Medicare, Democrats joined Republicans in attempting to revive, stabilize, and return Medicare managed care to a positive growth trajectory. To conclude this section, I will detail two recent policy reversals that demonstrate the policy-induced mechanisms of political change at work. In detailing the Star-Rating Demonstration project and the MA implications of the so-called “doc fix,” both of which were advanced by the Obama administration, we see that even at this time of health policy flux, the size, generosity, and resultant constituencies provide a certain level of protection against MA retrenchment.

There are, I argue, three primary mechanisms by which early Medicare managed care policy re-made Medicare politics and re-shaped the Medicare political environment. First, the ever-rising payment rates and organizational changes within MCOs that drew seniors to MA helped create a new sub-constituency within Medicare that became determined to protect against any reductions or disruptions in private coverage. This produced a “politics of unhappy beneficiaries,” as elected officials sought to avoid the costs of reduced MA payments and benefits – a cost that increased with each new enrollee.9 Furthermore, the popularity of MA among low income and minority beneficiaries has provides proponents with a strong rhetorical position from which to champion MA’s continued ascent. This particular policy outcome has also drawn societal groups like the NAACCP and LULAC into the debate on the side of MA – if only temporarily (LULAC 2003; NAACP/Shelton 2007). A policy dynamic has resulted in which it has become unacceptable to take away what has become a healthcare subsidy for those beneficiaries fortunate to have it. As former Clinton health policy advisor, Chris Jennings (4/30/2013) stated, “once you give a benefit that, in essence, is an overpayment to a plan for additional benefits, its hard to extract that and return it to the genie’s bottle, if you will.” Despite only representing 30% of the Medicare population, this growing sub-constituency of Medicare serves as a strong political, and therefore a strong policy, constraint. Reflecting on the position he found himself in as the administrator of HCFA in the

---

9 The label “politics of unhappy bennies” came from an interview conducted by the author with Bruce Vladeck, June 5, 2013.
period after the initial enrollment spikes, Vladeck (6/5/2013) commented, “I’ll also say it made it politically much tougher for me to try to throttle [Medicare managed care] back because you’re cutting an existing entity and enterprise in certain markets more and more.” Vladeck’s statement captures the political reality of attempting to take away a benefit from America’s seniors, a group that Andrea Campbell (2003) has shown to be highly politically attentive, particularly in regards to Medicare policy. Furthermore, the political cost of taking away MA’s subsidy has not been lessened by a policy-induced fragmentation that some feared would accompany an expansion of MA (Morgan and Campbell 2011). Figure 7 shows that among “active choosers,” beneficiaries who neither qualify for Medicaid nor have access to retiree benefits, MA shows fairly stable penetration rates across income groups.

Second, as enrollment has expanded, the Medicare market has become a key determinant of financial success for leading MCOs. Humana, which is the third leading MCO in terms of overall revenue and fourth in profit, now receives 66% of its revenue and 58% of its profit from MA (Wayne 2013). United Health, which is the across-the-board industry leader, made 25% of its revenue from MA in 2012. The financial importance of the Medicare market has understandably given MCOs like Humana and United Health a significant vested interest in this policy. With even seemingly small policy decisions having an outsized effect on the financial performance and outlook of MCOs, the incentive and imperative to be politically engaged and to seek out influence has increased. Figure 8, which shows the large and immediate effect of a 2013 CMS payment determination on the stock price of the four leading MA companies, demonstrates just how strong an interest these companies have on maintaining payment levels. The figure shows the intra-day trading value for Humana, UnitedHealth, Cigna, and WellPoint – four of the top MCOs in the sector – for April 1, 2013. At approximately 3:45 on April 1, it became known that CMS would reverse an earlier proposal to cut MA payment rates for calendar year 2014 by 2.3%, and replace the cut with a 2.96% increase. Over a matter of minutes, the stock prices of the sector-leading MCOs jumped nearly 10%. For Humana and UnitedHealth, the two leading MCOs in regard to MA, figure 8 shows that the jump was, as would be expected, higher compared to Cigna and WellPoint, who have more modest MA exposure.

An estimate of the market capitalization increase that resulted from this policy reversal was placed at approximately $2.7 billion (Dugan et al. 2014). It became clear as early as the mid 1990s...
that not only had plans become “addicted” to their artificially high reimbursement rates, but that they also now possessed the influence in Congress to maintain them. In two instances in 1999 and 2000, MCOs successfully secured payment updates that reversed cuts that were enacted in 1997. The legislative victories produced what has been described as a “twofer.” The Balanced Budget Refinement Act (BBRA) and Benefits Improvement and Protection Act (BIPA) increased payments directly to plans and to FFS providers, and because plan payments are connected to FFS costs, the direct payments to plans were now being calculated against a higher baseline, which produced, in essence, two increases for one. It was this policy, according to Jennings (7/25/13), that reignited the migration of beneficiaries back to private plans. Also telling of the power of policy to remake politics is the fact that policy not only strengthened the lobbying influence of MCOs, but it also influenced what they lobbied for.

The BBA 1997 established a demonstration project that would test direct competition as the mechanism for setting the benchmark payment level for MA. Up to this point, payment levels were administratively set. It was this payment system that Newt Gingrinch (R-GA) railed against, invoking the idea of a Stalinist price setting system. It was not, however, competition that plans were lobbying for at this time. In fact, plans twice sued to stop the competition demonstrations (Dowd et al 2000). Plans instead focused at this time on the BBRA and BIPA and put their energy and lobbying into the efforts to keep the administrative pricing system, though with higher payment levels. What this process taught us, according to Jennings, was that the plans were addicted to the reimbursements in the current system and that they were more focused on increasing update rates and minimum benchmarks than in winning the introduction of competitive bidding (Jennings 4/30/13). The resistance of plans to competitive bidding was not, however, simply about protecting overpayments for their own sake, but having increasingly become an integral part of the operation of a major social policy and the provision of a public good, the plans recognized that they, too, would be blamed for any reduction in benefits or narrowing of networks that would result from payment cuts arising from the imposition of competitive bidding or some form of Medicare vouchers. It is this policy dynamic that kept plans from embracing the Bush administration’s initial and more aggressive privatization push in the MMA. The initial proposal pushed harder in the direction of premium support, but mainly as a result of AHIP lobbying, Congress watered down the Bush administration proposal and kept payments tied closer to the old AAPCC payment mechanism (Scully 6/19/25). Plan preferences for the current, administratively set pricing system was evident again in the cool reception given to the Ryan budget’s premium support proposals by the insurance
sector. “I don’t think you’ve seen them really rush to embrace that,” Jennings (4/30/13) stated. “[The plans] know that their reimbursement rates would be far less than what they have today,” Jennings continued, “and they worry that they won’t be able to provide the benefits and that they’ll be blamed, ultimately, for tighter constraints in their networks than a lot of seniors are used to.”

Rather than serving as a bridge between FFS and a voucher or premium support-style program, MA has itself become entrenched with the help of both the “happy beneficiaries” and “addicted” plans that the policy created.

The incentives for lobbying were clearly increasing over the last two decades, but so to were abilities and capabilities of the MCO sector to lobby. From 1998 to 2008, the number of lobbyists for the HMO/Health Services sector increased from 421 to 1058.11 In 1990, the sector was the 76th biggest sector in terms resources expended on lobbying. In 2014, the HMO/Health Services sector ranked 30th, spending $68 million on lobbying and showering Congress with roughly $7 million during the 2014 election cycle. Plans, as the former CMS administrator, Tom Scully described it, have been repeatedly successful in defending their turf (Scully 6/19/2013). After a legislative drafting error saw MA payment rates soar well beyond the already intended overpayments, plans “lobbied like crazy” to maintain these unintended payment levels, which in some places rose to as much as 170% of FFS (Scully 6/19/25). Despite the unintended nature of the payment rates, plans took the position that intended or unintended, these were now the MA payment rates, and anything below them represented a cut to Medicare. Heading into the midterm elections, in which senior citizens make up an even larger percentage of the electorate than in a Presidential year, the last thing a Congressman wanted was to be accused of cutting Medicare. “That’s just human nature,” Scully said in regards to the plans’ strategy, “that’s just what they’re going to do.” The policy – its intended and unintended outcomes – structured plan preferences and policy preferences. We have come along way from 1994 when John Iglehart (1994), in an article in the New England Journal of Medicine, described plans as winning the market arena, but struggling in the political arena. As we will see in greater detail below, it might now be difficult to determine in which arena plans are enjoying more success.

The structure of Medicare policy gives MCOs the responsibility for the direct provision of a public good that is, quite literally, a matter of life and death to American seniors. This provides

---

11 These statistics are drawn from information on the “HMO/Health Services,” which includes entities other than HMOs and other MCOs such as dialysis companies and prescription drug services, but the large majority of the lobbying and spending captured in this data is done by HMOs and MCOs.
MCOs with significant and increasing policy leverage. It is this leverage, which Vladeck described as the “defensive sway” of MCOs (Vladeck 6/5/13). It provides the third mechanism by which Medicare managed care policy remade the politics of Medicare. MCOs can withdrawal from participating in Medicare Advantage, they can withdraw from certain counties, they can charge higher premiums, or offer modified benefits to the millions of seniors enrolled in their plans. The potential effect of which is to throw a growing portion of the Medicare market into turmoil, forcing some beneficiaries to re-enroll in FFS, purchase Medigap, find new private plans, or potentially face larger costs. The extent of the potential disruption, and therefore the political cost, caused by plan withdrawals or reductions increases with each new enrollee.

The turmoil that would be caused by such withdrawals or reductions does not exist in the abstract, but was seen when the BBA 1997 unintentionally resulted in severe payment cuts. Between 1998 and 2000, the coverage of approximately 750,000 beneficiaries was disrupted by withdrawals or modifications, which provided a policy lesson that was well-learned by policymakers on both sides of the aisle (Katzenstein, NY Times, Feb. 16, 2000). It also led to the quick efforts by Democrats and Republicans to increase payments and raise the minimum benchmarks with the BBRA and the BIPA in 1999 and 2000, respectively. As enrollment has grown and MA has increasingly become a core part of Medicare, plans gained the ability to state convincingly, “don’t cut us because we’ll dis-enroll all of your happy beneficiaries.” This “defensive sway” provides plans with a unique and significant source of leverage, which is not only eagerly deployed, but also highly effective. In a letter from AHIP president, Karen Ignagni, to CMS after the CMS-proposed 2.3% rate reduction in February 2013, Ignagni wrote, “Unless significant changes are made by April 1, seniors and people with disabilities enrolled in Medicare Advantage will experience higher costs, reduced benefits, and fewer health care choices” (Ignani to Blum, March 1, 2013). Reading between the lines, the statement can perhaps be more accurately described as questioning whether the Obama administration really wanted to take on these political costs. The answer, as we will se, was no. The position of MCOs in the public-private structure of MA has made them, in essence, an additional veto-point in the Medicare political process.

Bipartisanship in the Reviving of Market-Based Reforms

Perhaps most notable in demonstrating the interesting political dynamics created by MA, are the efforts surrounding the bipartisan push to add provisions to the MMA to increase MA payment rates. Together with Sen. Rick Santorum (R-PA), Charles Schumer and John Kerry (D-MA)
sponsored the Medicare+Choice Equity and Access Act of 2003. Writing to the members of the MMA conference committee, a bipartisan group of Senators encouraged the conferees to preserve the House’s “stronger” managed care provisions as opposed to the “modest step” taken by the Senate version.12 This would, according to the bipartisan group, ensure a “meaningful increase” in Medicare managed care funding. “By providing funding now to stabilize existing private health plan options,” Kerry argued in the Senate on June 26, 2003, “we can help ensure that the proposed Medicare Advantage Program will be successful in the future.”13 A declared Democratic presidential candidate was fighting to “help ensure” the success of President Bush’s Medicare privatization efforts. While Kerry did not vote on the final passage of the MMA, he was in his own words, “enthusiastically” supporting efforts to ensure the success of one of the two integral policy changes enacted by the law. Kerry’s enthusiastic support for increasing payment rates to M+C arose from his concerns for his constituents who were enrolled in the program, as well as for the Massachusetts-based MCOs. Kerry spoke of the need to rectify the unfair and inadequate payments made to plans, as well as the need to improve care for the 170,000 Massachusetts Medicare beneficiaries enrolled in private plans. Congress, according to Kerry, had to “step up to the plate” to help the plans in their “time of need.” In making his case and describing his support for Medicare private plans, Kerry made direct reference to the additional benefits and comprehensive coverage that was not always available or affordable under FFS. Kerry also referenced the “millions of low income and minority” seniors whose difficulty in securing other forms of supplemental insurance caused them to be particularly affected by reduced payments, coverage, and availability of Medicare private plans. Medicare+Choice had become “a vital safety net” for many of the nation’s most vulnerable seniors, and Kerry urged his colleagues to remember this fact as the debate went forward. The expanded benefits, lower premiums, and reduced OOP costs that many seniors had grown dependent upon, and which Kerry was now fighting to maintain, were the result of accelerating payment rates and structural changes that occurred during the late 1980s and early 1990s. After years of program growth, we find ourselves in a political world in which the Democratic nominee for president in 2003 declared that supporting Medicare+Choice should, “be among our highest priorities in this year’s Medicare debate.”14

14 Ibid.
On January 11, 2009, in an interview with George Stephanopoulos, President Obama was asked how he would pay for his proposed health care reform. “Now what I’ve done,” the President replied, “is indicated to my team that we’ve got to eliminate programs that don’t work.” The only program on the President’s list that morning was Medicare Advantage. This sentiment was affirmed by Senate Majority Leader Harry Reid that same week, stating in an interview with The Hill, “Medicare Advantage is gone” (Young 2009). While the Affordable Care Act (ACA) did not eliminate MA altogether, in its effort to pay for itself, the legislation did cut $136 billion from program over ten years. Despite its rhetoric and the need to finance the ACA, once the ACA was passed and shortly after the Democrats incurred heavy losses in the 2010 midterms, the Obama administration took an extraordinary step in putting back a not insignificant portion of the MA cuts.

The ACA instituted a policy of quality-based bonus payments that were to be made to MA plans that receive a four or five star rating. This policy innovation was meant to reward plans that scored highly on various performance metrics by increasing their payment by 1.5% of the payment benchmark. The overall goal was to move the Medicare program more in the direction of paying for quality outcomes. In November 2010, the Obama administration announced the Quality Bonus Payment (QBP) demonstration project. The demonstration was designed to be a nation-wide demonstration that would not only extend bonus payments to 3 and 3.5-starred plans, but it would also increase the bonuses paid at each level. Under the ACA, bonus payments were to be made to plans covering 26% of MA beneficiaries. Under the QBP demonstration, it was estimated that 91% of MA beneficiaries would now be in plans that would receive a bonus payment. In addition, the bonuses were also increased. Under the ACA bonus policy, both four and five-star plans were set to receive a 1.5% bonus. Under the demonstration, however, the bonus payment jumped to 4% and 5%, respectively, while the 3 and 3.5-star plans, which were previously not receiving bonuses at all, are awarded a 3.5% and 3% bonus, respectively. In addition to extending and enlarging the bonuses, the demonstration changed the benchmark upon which the bonus would be calculated, substituting in a higher, blended benchmark. In 2012, the first year of the demonstration, plans were projected to receive $3.1 billion in bonus payments – only 4% of which was established under the ACA legislation. In fiscal year 2012, the demonstration gave back 71% of the MA cuts that were put in

place by the ACA (GAO 2012a). Over the course of the entire demonstration project, more than a third of the cuts made by the ACA for those years will be given back.

At an estimated cost of $8.3 billion, the QBP demonstration is the most expensive demonstration project undertaken by CMS since 1995. In fact, it is more than seven times costlier than the next most expensive demonstration, exceeding the cost of the combined total of every demonstration conducted between 1995 and 2012 (GAO 2012a). In short, the Obama administration took extraordinary steps to pump money into a program that by their own account did not work. Not only was the Obama administration reversing course on MA, they were also doing so over the objections of the Government Accountability Office (GAO) and the Medicare Payment Advisory Commission (MedPAC). The GAO (2012b), in a letter to Sen. Orin Hatch (R-UT), wrote that the design of the QBP demonstration “precludes a credible evaluation of its effectiveness in achieving CMS’s stated research goal.” Only in the final year of the demonstration, the GAO concluded, would the demonstration’s incentives to improve quality have a “full impact.” What this means, is that in the two years of the demonstration – 2012 and 2013 – in which the largest offsets against the ACA cuts will occur, the program would not be able to adequately meet its experimental goals. MedPAC, which is an independent Congressional agency and leading voice in Medicare policy, similarly urged CMS to reconsider its decision to undertake the QBP demonstration (MedPAC 2013: 288). Citing concerns regarding the cost and design of the program, the MedPAC chairman described the demonstration as reducing the incentive to achieve the highest levels of performance. The chairman also stated that the demonstration sent the wrong message regarding program priorities and how best to achieve quality (Hackbarth 2011). In other words, according MedPAC, the demonstration could not achieve its stated goals and was operating in contradiction to MedPAC’s long-standing recommendation that demonstrations only test innovations on a small scale – not a national one.

In what is likely a veiled critique of the Obama administration’s motives for the QBP demonstration, the chairman of MedPAC explicitly reiterated a 2006 admonition of the Bush administration from MedPAC: “Demonstrations should not be used as a mechanism to increase payments” (MedPAC 2006). The demonstration in question was a 2005 demonstration related to the reimbursement of physician-administered oncological drugs. The Quality-of-Life demonstration followed on the heels of the MMA’s cuts to oncology drugs – the fight over which, according to one of the MMA’s chief architects, Tom Scully, threatened to scuttle the entire MMA at several points. The 1-year demonstration, which would cost $300 million, was described in the Journal of Oncology
Practice as being designed to “mitigate the reimbursement reduction for Part B drugs under the Medicare Modernization Act of 2003” (*Journal of Oncology Practice* 2005). The demonstration, the article continued was to “make up” for reductions in a particular payment area that would have dropped from 32% in 2004 to 3% in 2005. The alterations to the reimbursement rate were clearly a political trouble spot, as the battle over them were considered to be the second most controversial part of the MMA – behind only the prescription drug benefit (Scully). What followed was a demonstration project for which MedPAC held “serious concerns.” The demonstration put in place no control mechanism for the type of cancer, it was implemented without any period of comment by clinicians or researchers, and had no uniform data collection process. It was, however, as MedPAC stated, “a way to provide additional funds to oncologists.”

The admonition of the Obama administration by MedPAC was recycled from this earlier instance in which a demonstration was employed improperly to increase Medicare payments after a controversial piece of legislation produced politically fraught cuts. By associating the two instances together, MedPAC is able to implicitly rebuke the Obama administration for using demonstrations for political purposes. The Obama administration did, however, take the use of demonstrations to a new level that was well beyond that of the 2006 demonstration. Whereas the 2006 demonstration cost $300 million, the QBP launched by the Obama White House cost $8.3 billion. While MedPAC made its displeasure known in this subtle manner, others were more direct.

The QBP demonstration was a “blank check” written by the Obama administration for the purpose of masking cuts made to MA by the ACA. This was the conclusion reached by the ranking member of the Senate Finance Committee, Sen. Orin Hatch (R-UT) (2012). In a letter to Secretary Sebelius, Hatch, along with the chairman of the House Ways and Mean Committee, Rep. Camp (R-MI), went on to describe the QBP demonstration as a “thinly veiled use of taxpayer dollars for political purposes” (Hatch and Camp 2011). Given the expected electoral repercussions of the ACA’s cuts to MA, it was argued, the Obama administration responded with a unprecedented maneuver to put a significant portion of money back into a program it had previously derided (Hatch 2012; Alonso-Zaldivar 2012). Supporting the argument that the demonstration was a purely political maneuver, one made necessary by the influence of the MA constituency and their clout at the ballot box, is the fact that the demonstration was heavily front-loaded. Not only would it spend an unprecedented amount of money, the QBP demonstration would produce 71% of its total ACA offsets in the 2012 election year (GAO 2012a). This spending schedule was put in place despite the

fact that the purported goal of incentivizing improved quality could not be fully achieved until the back end of the demonstration. Glen Hackbarth, the chairman of MedPAC, described the QBP demonstration as, “a fairly transparently (sic) way to give money to plans and that’s disappointing.”

In sarcastically stating their appreciation for the Administration’s “newfound support” of MA, Hatch and Camp’s final dig at the Obama Administration’s political use of its demonstration authority captures the power of MA to reshape American politics. The Obama Administration’s “newfound support” was compelled by the politics of Medicare Advantage, which saw CMS put in place a demonstration project of unprecedented expanse and expense, and did so over the objections and recommendations of both the GAO and MedPAC. The Obama administration’s support for MA also contradicted its own earlier policy declarations, opened itself up to deserved criticism from Republican and other critics, and gave back a significant source of early funding for its signature legislative achievement. The Obama administration was compelled by the “politics of unhappy bennies” to take this unprecedented step. This would not be the last unprecedented maneuver made by the Obama administration to favor MA.

_Folding Under the Influence of MA: CMS and the SGR Fix_

In another telling moment of the changed political landscape and strength of Medicare Advantage and its constituencies, in the spring of 2013 CMS took steps it had never taken before in an effort to boost MA payment rates. What CMS did in this instance, which was to assume a legislative fix to the Sustained Growth Rate (SGR) when setting MA rates, went against their long-standing procedures and best judgment. The SGR is used by Congress to control year-to-year spending on Medicare physician costs. As a result of the BBA 1997, there is a yearly dance in which Congress passes a last minute “doc fix” to prevent harsh cuts from befalling physician payments as a result of the SGR. Because MA payments are tied to FFS payments, a cut in payments to physicians will translate into cuts to MA rates. On February 15, 2013, in its advance notice for the 2014 MA rates, CMS announced a 2.3% reduction in payments – part of which was a result of the SGR. When the final notice for the 2014 rates was announced on April 1, the 2.3% reduction had become a 2.96% increase. The month-long comment period that began on February 15, featured strong lobbying and what was a rare instance of bipartisan fervor in the 113th Congress.

During a Senate hearing on February 28, 2013, Sen. Orin Hatch (R-UT) questioned CMS's Acting Principal Deputy Administrator and Director, Jonathan Blum, regarding what leeway CMS had in setting MA rate reductions or increases.\(^\text{18}\) While acknowledging that some of the cuts that resulted in the 2.3% reduction were statutory, Hatch enquired as to whether Blum believed CMS had the authority to assume that Congress would act to stem cuts coming from the SGR. It was CMS’s long-term policy, Blum stated, not to assume the cost of the SGR fix when setting MA rates. That is, CMS did not inflate MA rates based on the potential for future legislation to be passed, but rather based its rates on current law. Blum also acknowledged that CMS had received numerous comments asking them to take a “second look” – and take a second look they did. CMS’s final rate notice stated that the, “basis for the Growth Percentage for 2014 has been changed to incorporate an assumption that Congress will act to prevent the scheduled 25-percent reduction in Medicare physician payment rates from occurring.” This reversal produced roughly a five-percentage point swing in the 2014 rates from the first to the final notice from CMS.

Neither Sen. Hatch nor the Republicans were alone in this fight. Hatch, the ranking member on the Senate Finance Committee, was joined by Chairman Max Baucus (D-MT) in issuing a letter to CMS Acting Administrator Marilyn Tevenner, stating that, “We support the participation and growth of high quality private plans in Medicare and believe they should continue to offer a diverse set of options for beneficiaries in the country” (Baucus and Hatch 2013). In other words, do no cut the rates and reduce benefits and availability. Baucus and Hatch’s effort to reverse the proposed MA rate cut was joined by a bipartisan group of over 120 congressmen. In a separate letter to Tevenner that was signed by leading Democratic and Republican senators, including Charles Schumer (D-NY), Ron Wyden (D-OR), Richard Blumenthal (D-CT), John Cornyn (R-TX), Michael Enzi (R-MT), and Robert Portman (R-OH), the senators wrote that, “While we strongly support reforms to the Medicare Advantage program that provides seniors with high quality care, we are concerned that the proposals could result in reduced access for our constituents who are enrolled in Medicare Advantage” (Schumer et al. 2013). The result of such lobbying efforts was the reversal of both CMS’s long-held position not to assume the SGR fix and the proposed cuts. The CMS final rate notice included a statement describing how the Office of the Actuary had been directed by the Secretary to use the assumption that Congress would fix the SGR, but it also including the statement that, “the assumption conflicts with the Office’s professional judgment that, as in all past years, the

\(^{18}\) Hearing is available at: http://www.finance.senate.gov/newsroom/ranking/release/?id=5b4fee8c-3e8f-49d9-913b-71ce0f569904
determination should be based on current law, not an assumed alternative” (CMS Final Notice, April 1, 2013). This episode is just the latest to illustrate the altered political landscape and political strength of this once boutique program. As Jack Ebeler described it, the SGR incident illustrates how hard it is to squeeze the MA rates now that enrollment has increased so significantly. Pressure comes from both beneficiaries and insurers (Ebeler 7/25/13). The thinking might once have been that if you get enough people in MA, then MA becomes Medicare by default and rates can be squeezed. But the new reality, as Ebeler continued, is that once you get more beneficiaries enrolled in MA, it becomes harder to cut the rates.

The rapid growth of Medicare managed care, a growth that did not come from direct legislative action and a growth that caught many by surprise, not only created the new constituency of beneficiaries described by Ebeler, but also helped to politically empower the MCO industry. As insurance interests became politically and financially stronger as a result of the Medicare market, they simultaneously became more dependent on it. Managed care plans, as former Clinton health policy advisor, Chris Jennings, described it, are “pretty much addicted to their reimbursement rates under the program” (Jennings 4/30/13). DeParle’s (2002: 510) statement regarding the unacceptability of taking away the subsidy was, in the minds of many, equally applicable to the insurance industry as it was to beneficiaries. The above cited letter from the group of twenty-two US Senators to Tavenner regarding the 2013 MA rate reduction also included the following sentence: “Plans have informed us that they may exit certain markets as a result of CMS’ proposal” (Schumer et al. 2013). The fates of beneficiaries and health plans were tied directly together. This fact added to the strength and influence of private plans. The fear that once precluded the shift to managed care now precludes any retrenchment of it: the retribution of beneficiaries at the ballot box.

**Conclusion**

The reports of Medicare Advantage’s death have been both greatly exaggerated and frequently offered. The program was characterized in 2002 as having a dimmer future than it did in the mid-1990s, it was described in 2007 as being more impressive in theory than in reality, and in 2009, Senate Majority Leader, Harry Reid, straightforwardly declared, “Medicare Advantage is gone” (Hacker 2002: 331; Oberlander 2007: 201; Young 2009). The ability of MA and its predecessors to repeatedly defy the reasoned expectations and predictions of scholars and policymakers, alike, speaks volumes about the durability, resiliency, and strength that has come to characterize the program. It
also illustrates the cost of giving too little scholarly attention to the ability of policy to re-make politics. Seniors, for example, were once nearly universal in their reluctance to enroll in a relatively unknown insurance entity, while American society, more generally, was skeptical of HMOs. But once the policy output came to include prescription drugs, lower OOP costs, and a broader network, the policy preference of seniors changed. With this policy change came a dramatic political change. It was not, as we have seen, just beneficiaries that became a protective constituency behind MA, but the financial dependence of MCOs on the Medicare market has also further altered Medicare’s political environment.

It was not just the creeping political strength of MA that caught observers by surprise, but the initial enrollment and participation surge that began this re-making of politics also occurred outside both the control of policymakers and the view of scholars. The path for change was, indeed, opened by legislation, but the layering of the TEFRA provisions upon the traditional Medicare structure was not sufficient to produce meaningful change. It was not until broad structural changes in the wider healthcare system generated new and intensifying market forces that the policy output and operations began to significantly change. The changing policy dynamics that were first witnessed in the 1990s were most directly the result of the shifting strategies and organizational structures of the government’s private MCO partners, which in turn altered the policy and political preferences of a growing portion of the Medicare beneficiary population. This process of change also illustrates how the unpredictability and imprecision of incremental strategies of change can be heightened by the involvement and activity of private partners within the target policy or institution. Because of the central role played by private actors in the Medicare program, the policy was made more vulnerable and opened more widely to forces of change that operated outside the direct control of policymakers. As a result, dramatic change occurred within America’s second largest social program as a result of alterations in the preferences, strategies, and organizational structure of uncoordinated and lightly controlled private actors. As the American healthcare system and the public polices that structure it continue to draw private partners more deeply into its workings, whether through the Affordable Care Act’s embrace of Accountable Care Organizations or the private Medicaid option being explored by some states, we must recognize and be mindful of the unique possibility and processes of policy and political change that such a system creates. If we do not, we risk the chance of entering a policy and political environment that no one predicted or planned, and for which we will have difficulty leaving.
References

Archives
Bentley Historical Library, University of Michigan: Carolyne K. Davis Papers
Ronal Reagan Library: Edwin Meese Papers
Bill Roper Papers

Interviews
Al Dobson – Health Care Financing Administration, Director of Research, 11/19/2013
Jack Ebeler – House Committee on Energy and Commerce, staff; Health Care Financing
Administration, special assistant, 7/25/2013; 1/6/2014
Clifford Gaus – Health Care Financing Administration, Director Office of Research and
Demonstrations, 1/29/2014
Joan Hermann – WellPoint, President and CEO, Specialty, Senior and State Sponsored Business,
Chris Jennings – Clinton White House, chief healthcare policy advisor, 4/30/2013
Bob Rubin – Health and Human Services, Assistant Secretary for Planning and Evaluation, Reagan
White House, 10/31/2013
Leonard Schaeffer – Health Care Financing Administration, administrator 1978-1980, CEO Blue
Cross CA/WellPoint, 1/29/2014
Tom Scully – Centers for Medicare and Medicaid Services, Administrator 2001-2004, 6/19/2013
Bruce Vladeck – Health Care Financing Administration, Administrator 1993-1997, 6/5/2013

Campaign and Lobbying
Open Secrets, Health Services/HMOs (Last checked May 5, 2014:

Congressional Resources
Congressional Record


Figure 1.

Growth of Medicare Managed Care 1985-2013

Figure 2.

Extra Benefits in Medicare Advantage

Figure 3.

Pre-Republican Revolution Enrollment Growth Rates
(1988-1999)

1994 Election

Figure 5.

Figure 6.

Adjusted Annual Per Capita Cost
1990-1997

<table>
<thead>
<tr>
<th>Year</th>
<th>National Mean AAPCC</th>
<th>Urban Mean AAPCC</th>
</tr>
</thead>
<tbody>
<tr>
<td>1990</td>
<td>250</td>
<td>300</td>
</tr>
<tr>
<td>1992</td>
<td>275</td>
<td>325</td>
</tr>
<tr>
<td>1994</td>
<td>300</td>
<td>350</td>
</tr>
<tr>
<td>1995</td>
<td>325</td>
<td>375</td>
</tr>
<tr>
<td>1996</td>
<td>350</td>
<td>400</td>
</tr>
<tr>
<td>1997</td>
<td>375</td>
<td>425</td>
</tr>
</tbody>
</table>

Figure 7.

Income and Healthcare Choices
(2002)

Figure 8. Policy Sensitivity of MCOs
April 1, 2013 Intra-Day Trading

Source: Bloomberg