Consequences of Medicare Advantage for Beneficiaries and Politics: Revisiting *The Delegated Welfare State*

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Abstract

The Delegated Welfare State (Morgan and Campbell 2011) explored the causes and possible consequences of the 2003 Medicare reform boosting private managed care plans in the delivery of Medicare benefits. In this paper, we review scholarship on beneficiary experience (access, costs, outcomes) and political feedbacks arising from the delegated governance reform to evaluate whether predictions about consumer behavior and policy entrenchment have manifested. We find that beneficiary experiences and satisfaction do not differ significantly between Medicare Advantage and traditional Medicare, and MA plans' managed care techniques have cut per beneficiary spending. However, MA remains costlier to the federal government, per beneficiary, because of the outsized payments received by plan providers. Officials have failed to rectify these overpayments because of policy feedback effects – the empowerment of lobbying groups with a stake in the program and beneficiary support for it. Growing dependence on private plans to deliver health insurance for a large and politically influential constituency, senior citizens, has rendered government officials and elected politicians reluctant to imperil this market and the happiness of beneficiaries.

Keywords Medicare, Medicare Advantage, policy feedbacks, market model reforms, consumer choice reforms

In some ways, Medicare looks much as it did in 1965. Hospital and physician expenses are covered through Parts A and B, with private doctors and hospitals delivering the care. There is no coverage for hearing, dental or vision needs; no long-term care beyond short skilled nursing facility (SNF) stays after acute hospitalizations; limited access to home health services beyond the SNF period; and a variety of out-of-pocket expenses – such as premiums, deductibles, and co-insurance – with no annual cap on the total. The one major expansion of Medicare benefits came in the 2003 Medicare Modernization Act (MMA) that created Part D prescription drug coverage.

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Yet alongside this stability, Medicare has been fundamentally transformed by the addition of an alternative way for beneficiaries to receive coverage – Medicare Advantage (MA). MA is a system of private plans that receive public payments to provide coverage. To induce competition for beneficiaries, plans can use some of their revenues to provide more complete coverage than is offered by traditional Medicare and reduce cost-sharing. These plans have proved spectacularly popular with seniors, more than half of whom now choose MA.

MA is a quintessential example of what we call delegated governance, a phenomenon whereby the government delegates responsibility for social welfare provision to private actors who receive public funds. Delegated governance has taken varied forms in the Medicare program, but MA and Part D plans embody a consumer choice approach, in which the ability of beneficiaries to choose from a competing array of plans is supposed to bring efficiencies, higher quality, and cost control into the Medicare program. In our 2011 book, *The Delegated Welfare State: Medicare, Markets, and the Governance of Social Policy,* we explored the causes and possible consequences of the delegated governance programs instituted through the 2003 MMA. Although the main focus of the book was on the Part D drug benefit, our expectations about delegated governance can help make sense of the explosive growth of Medicare Advantage plans. Sixty years into Medicare's history, and twenty years into the Medicare Advantage experience, we assess the arguments in that book to examine both how seniors are faring in these private plans and the implications of MA for Medicare politics.

Our book explored how delegated governance affects access to healthcare provision and coverage, health outcomes, budgetary cost, and Medicare politics. We predicted that consumers would not be up to the task of shopping among plans effectively or imposing market discipline by leaving low-quality providers. We were especially concerned about the ability of older,

sicker, and less health-literate beneficiaries to behave as the effective consumers that market-model reforms presuppose. We also worried that government oversight would prove insufficient and that promised cost-savings would not materialize, as insurers used their political power to wrangle high payments. Many of these predictions have been borne out in the MA program.

We also speculated in the book about the policy feedback effects of delegating provision to market actors – that there would be interest group effects, via the empowerment of lobbying groups with a stake in the delegated programs, and mass attitudinal effects, as beneficiaries come to embrace this form of social provision. What has proven most important in entrenching the MA program is the growing dependence of the federal government on a private plan market for the delivery of health insurance to a large and politically influential constituency – senior citizens. Reluctant to do anything that would imperil this market and the happiness of beneficiaries, government officials have not taken action on payment policies and MA plan practices that make it significantly more expensive to cover beneficiaries in MA plans than in traditional Medicare (Berenson et al. 2022; Kelly 2016). Indeed, with more than half of Medicare beneficiaries enrolled in MA plans, MA enjoys bipartisan backing, especially from members of Congress, who pressure administrations and the Center for Medicare and Medicaid Services (CMS) to keep the dollars flowing.

Medicare's future depends in large part on how the MA market evolves. Advocates for bringing private plans into Medicare have hoped to transform the entire program along the lines of a premium support model, with all beneficiaries receiving subsidies to choose between competing private plans (Morgan and Campbell 2011, pp. 84-5; Oberlander 2014; Moffit 2023). Yet, there may be limits to how much MA can expand since some beneficiaries resist the restrictions on provider choice and utilization that come with managed care. Some healthcare

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providers also have pushed back against MA by refusing MA plans or threatening to do so (Appleby 2023). Given the large number of beneficiaries in MA, a hybrid of MA and traditional Medicare is likely to continue, but so will pressure on federal officials to sustain what may be the sagging profits of insurers if they are unable to expand their markets further. The political question going forward is the degree to which the federal government is willing, and able – given threats to the financial viability of Medicare – to keep providing oversized payments to support this market.

Delegated Governance and Medicare

Delegated governance is the delegation of responsibility for publicly-funded social welfare to non-state actors. While some might use the terms privatization or contracting out to capture a similar phenomenon, we use this concept to convey how public officials transfer their governing authority over a social program to private actors, empowering those actors to make consequential decisions about the welfare of beneficiaries. The dynamics of delegated programs reflect both the non-state actors involved and the terms of the delegated authority. The actors may be non-profit organizations or profit-making firms, and for the latter, they may operate under a conventional contracting relationship that guarantees a certain level of payment, or they could bear some risk for program management and costs with the aim of incentivizing efficiencies and improved delivery. There is also a consumer choice variant of delegated governance that gives beneficiaries some responsibility for making decisions about social welfare programs.

Medicare exemplifies these varied forms of delegated governance. From its inception in 1965, Medicare did not take on responsibility for the delivery of healthcare; this was instead delegated to private healthcare providers, with private accreditation organizations responsible for

overseeing the quality of this care. Moreover, even though Medicare is the public payer for these services, private insurance bodies have always been involved in the administration of these payments by serving as "fiscal intermediaries." These intermediaries processed claims and paid bills but were paid on a cost basis rather than tying their compensation to the ability to hold down health care spending. With so much responsibility for Medicare delegated to outside actors, a small federal bureaucracy was created to run the program – about 5,000 people, compared to the 60,000 public servants administering the Social Security program. Even as Medicare took on an increased role in setting prices for medical care, through the development of Diagnosis Related Groups (Oberlander 2003, pp. 120-21), the program continued to be overseen by a small cadre of public officials.

Medicare later developed the other forms of delegated governance – delegation to risk-bearing private providers and the consumer choice variant. The 1972 Social Security Act Amendments allowed HMOs to provide Medicare benefits, but they were paid on a cost basis. By the 1980s, concern about rising healthcare spending and a belief in the merit of injecting market forces into public programs led to the institution, in the 1982 Tax Equity and Fiscal Responsibility Act, of risk contracts for managed care providers in Medicare (Oberlander 1997). Receiving capitated per beneficiary payments, these firms bore some risk for beneficiary costs in the hope this would incentivize them to restrain utilization, coordinate care, and bring down spending. Moreover, by giving beneficiaries a choice in how to receive their benefits – through traditional Medicare, which encompassed Part A (hospital) and Part B (physician coverage), or through managed care plans that covered both Parts A and B – Medicare incorporated a consumer choice element. In 1997, Congress allowed more types of plans to enter the Medicare market by creating Medicare Part C (Medicare+Choice) for private plans to contract with

Medicare to provide coverage. Congress also cut payment rates to stimulate more competitive pressures on plans, although this inadvertently spurred many plans to leave the Medicare program entirely (McGuire et al. 2011, p. 310).

The 2003 Medicare Modernization Act aimed to resuscitate Part C while also creating a fully delegated set of benefits – Part D drug coverage (Morgan and Campbell 2011). To receive Part D benefits, Medicare enrollees have to choose from a marketplace of private plans competing for their business on the basis of the drugs they cover and the extent of cost-sharing. Medicare+Choice was renamed Medicare Advantage, and Congress raised payments to plans in order to lure them back into the Medicare market. Medicare Advantage took off, and has been a significant part of Medicare ever since.

How does delegated governance affect the workings of publicly-funded programs? What impact does it have on the politics of social provision? Although *The Delegated Welfare State* focused principally on the implementation of the Part D drug benefit, we can explore our claims through an examination of the Medicare Advantage program over the past few decades, with a focus on its impacts on beneficiaries and politics.

For beneficiaries, the question is what impact the consumer choice model, predominantly through private managed care plans, has on their care and costs. In *The Delegated Welfare State*, our survey of beneficiaries found that Part D/MA increased access to prescription drugs while lowering costs, leading to favorable evaluations of both. However, seniors also expressed lower satisfaction and more problems with Part D and MA plans than if they had other forms of insurance coverage, and people with low incomes or multiple chronic conditions reported more difficulties and doubts about their ability to pay for prescriptions (pp. 207-216). Although today we lack a survey like the one we conducted for our book, the longer timespan and major

expansion of MA enables us to ask whether the many hoped-for gains from managed care – including better coordination of care that can reduce hospitalizations and other unnecessary treatments – have materialized. As payments to the MA program require plans to use some of their excess revenues to provide coverage of care needs not covered by Medicare – such as dental, vision, or hearing insurance – as well as reduced cost-sharing, we would expect this to bolster the popularity of MA. Managed care could also impose limits on needed care, however, and could create particular problems for disadvantaged populations and/or those with expensive needs – post-acute care, dementia and behavioral health issues.

In our book, we argued that the positive impacts of Part D/MA resulted more from the heavy subsidies going to these plans than from market competition (pp. 159-161). The consumer choice model of delegated governance depends on informed decision-making and plan switching, with beneficiaries knowledgeable about their health needs, able to evaluate plan choices, and willing to switch to a better plan during open enrollment periods. Yet, in our study of Part D, we found little evidence of reasoned plan choice or switching (pp. 205-6), and others have noted similar limitations with regard to the ACA exchanges, with those who are sicker, poorer, or less health-literate being the least equipped to leave suboptimal plans (Hoffman 2020).

The effectiveness of consumer choice at providing market discipline becomes all the more important given that advocates of delegating authority to private plans often have assumed that, with market competition driving product improvements, there is less need for government oversight. As the HHS Inspector General described thinking among policymakers about how bringing private managed care plans into Medicare would result in *less* need for government regulation – "many believed that managed care would be less susceptible to the types of fraud, waste, and abuse that were pervasive in fee-for-service. With fixed, capitated payments, the

thinking went that plans would be appropriately incentivized to address fraud. Through risk-based payments, plans would take on the task of preventing fraud, along with managing costs and patient care to protect their bottom lines" (Grimm 2023). Yet, *The Delegated Welfare State* argued that an effective system of delegated governance requires *more*, not less, government capacity for oversight. We found that the same forces that propelled delegated governance – such as antipathy to government and lobbying by powerful interest groups – also rendered CMS a "small, hollow agency…charged with the task of overseeing a vast terrain of decentralized, largely-self-governing agents" that was "frequently outgunned" by private plans (p. 145). Our book provided early evidence of Part D and MA plans engaging in marketing abuses, manipulation, and fraud, driven by a scramble to take advantage of generous federal subsidies and scoop up market share (pp. 164-5). Our expectation for the MA program is that such practices have continued with little effective pushback from CMS.

As for the impact on politics, our book explored whether bringing private plans into Medicare could transform the politics of the program through feedback effects. One feedback channel is through the construction of a mass constituency in support of private plan delivery of Medicare benefits. Some early advocates of Part C and MA hoped that, as people became accustomed to these plans providing care, traditional Medicare would be entirely replaced by a system of premium support and competing private plans (Morgan and Campbell 2011, pp. 84-5). The panel survey in *The Delegated Welfare State* did not find that beneficiaries in MA or with Part D plans became any more supportive of market-based reform, but that the provision of satisfactory coverage reduced senior citizen political participation on this issue and helped push it off the political agenda (pp. 172-6, 190-198). As long as beneficiaries are happy with their MA coverage, we would expect MA to become increasingly entrenched as a pillar of Medicare.

A second feedback effect could come through the growing influence of organized interests, especially the insurance companies whose profits depend on participation in Medicare on terms that are most favorable to them. Thus, while officials may hope that stimulating competitive pressures on private providers will lower program costs, these gains may be swamped by the effect of firms engaging in rent-seeking and monopolistic behavior, seeking instead to limit competition and pad profits. *The Delegated Welfare State* found mixed evidence about the power of insurers, noting that some Democrats were willing to take on the industry and trim plan payments to help pay for the Affordable Care Act in 2010. On the other hand, we observed that MA insurers were gaining influence by dint of expanding coverage to minorities and people living in urban areas, which helped build bipartisan support (p. 186-7). We also speculated that insurers were gaining political power through "their crucial role in delivering a benefit…the Medicare Advantage program is much appreciated by millions of beneficiaries who enjoy coverage superior to that which regular beneficiaries receive, without having to pay any more for it." (p. 188) Only one-quarter of beneficiaries were covered by MA at the time our book was published, which perhaps accounts for our mixed findings about insurance industry power. That share has more than doubled in the meantime, providing an opportunity to see whether the industry has gained political heft as a result.

Medicare Advantage and the Beneficiary Experience

With Medicare Advantage plans gaining large enrollments, including sizable shares of economically and medically needy populations, one question concerns how beneficiaries are faring and whether the distinctive features of MA plans render these individuals better off than those in traditional Medicare.

MA plans perform well on many quality-of-care criteria, although not across all metrics or types of beneficiaries. Researchers' ability to compare MA and traditional Medicare performance is hindered both by gaps in MA data (Biniek et al. 2024a) and the lack of randomized control trials, which raises concerns about selection effects. Available studies indicate that health and other outcomes are not worse in MA plans, despite critics' worries about the spread of managed care to a population of older and medically needy beneficiaries. But they are not necessarily better either, despite the higher per enrollee spending (Biniek et al. 2024a). A 2021 overview of studies based on observational data, which may reflect favorable selection into MA, shows that MA performs better on some quality-of-care metrics (more preventive care, fewer preventable hospital admissions), but not better on beneficiary experience, racial/ethnic disparities, mortality, or readmission rates; MA plans are also associated with fewer hospital admissions and emergency department visits, which may or may not reflect higher quality (Agarwal et al. 2021). There is some concern about the quality of providers and facilities available to MA beneficiaries. MA enrollees are less likely to get care at the lowest-quality hospitals but also at the highest-quality hospitals, which are still accessible to traditional Medicare beneficiaries (Meyers et al. 2020). MA enrollees are also less likely to enter higher quality skilled nursing facilities (Meyers et al. 2018) and less likely to get care from high quality home health agencies (Schwartz et al. 2019).

MA plans have achieved lower medical costs than traditional Medicare, as promised by advocates, but the benefits have not necessarily redounded to enrollees or taxpayers. MA beneficiaries are more likely than traditional Medicare beneficiaries, especially those with supplemental coverage, to express concern over out-of-pocket costs (the small number of Medicare beneficiaries who are in the traditional program but lack supplemental coverage are the

most likely to report cost-related problems; Biniek et al. 2021). Cost savings for taxpayers have not materialized either, as we explain later, with supplementary benefits and insurer profits more than offsetting the lower medical costs: MA is more expensive per enrollee than traditional Medicare (MedPAC 2024). It appears the low average medical costs in MA plans result less from competition among plans and market discipline imposed by actively-shopping consumers than from the financial incentives MA plans have to maximize profit, as we predicted in *The Delegated Welfare State* and as the following discussion suggests.

Consumer choice was intended to help drive down costs, as Medicare beneficiaries first choose between traditional Medicare and MA, and if the latter, among MA plans. At first glance there appear to be many options for beneficiaries: in 2023, 184 insurers offered 5,635 plan options (MedPAC 2024, 357), and the average beneficiary had a choice from among 43 plans sponsored by an average of 8 organizations (MedPAC 2024, 358). At the same time, there is considerable concentration at the local and national levels, as 94% of MA enrollees live in counties with highly concentrated markets, and on average the top three insurance organizations have 81% enrollment in each county (MedPAC 2024, 389). Such concentration may undermine the competitive dynamic that is supposed to bring down costs.

Nor have beneficiaries proven to be the high-information, friction-free consumers upon which market-model insurance reforms are predicated. Many beneficiaries are poorly equipped to make the complex assessments optimal plan selection would require, and most do not review or switch from their initial choices. A 2022 survey of Medicare beneficiaries found that 69% did not compare Medicare coverage options during the 2021 open enrollment period, and more than four in ten MA enrollees did not review their plans for possible changes in premiums, other out-of-pocket costs, or coverage of services, treatments, or drugs (Ochieng et al. 2024). Reviewing

coverage annually is less common among men, the less educated, older beneficiaries, those who are dually eligible for Medicare and Medicaid, and those who have three or more limitations in activities of daily living (Park et al. 2022). Not only is comparison shopping uncommon, but also switching rates are low: between 2008 and 2020, the share of beneficiaries in MA plans with prescription drug coverage who switched plans during the open enrollment period never exceeded 12% (Biniek et al. 2022). Switching rates also decline with age, and decision making abilities vary with health literacy: enrolling in MA and reviewing coverage options each year is more common among patients with higher health literacy, who are also more likely to enroll in plans with high ratings and low monthly premiums (Biniek et al. 2022; Park et al. 2022).

Because these ill-considered and sticky consumer choices seem unlikely to drive low patient medical costs in MA plans, our attention turns to the financial incentives of MA insurers. While traditional Medicare pays a fixed rate per service, Medicare Advantage plans are paid a fixed rate per beneficiary, which is based on a base rate and a risk score (MedPAC 2024). To increase their profits, MA plans try to maximize payments and to minimize spending per beneficiary. Later we take up the issue of MA plan payments exceeding FFS spending. Here we note the four mechanisms through which MA plans have achieved low medical costs: favorable selection of enrollees; contracting with lower cost providers; less intensive resource use (lesser use of specialists, emergency departments, and elective procedures); and utilization management (see Politzer 2024 for citations).

Selection effects favor MA plans, as risk scores are unable to predict all the variation in patient costs (Garrett 2024). MA plans attract enrollees with costs lower than others with the same risk score through their benefit offerings, cost-sharing structures, utilization management practices, and provider networks (MedPAC 2024). Patients with complex needs or greater taste

for health care may be scared off by narrow provider networks or by prior authorization requirements that they perceive as barriers to care. Selection effects, ironically, are the one mechanism behind low costs that actually arise from consumer choice: because consumers choose plans, those plans can try to appear attractive to potential enrollees likely to be less costly.

The other three mechanisms behind low medical costs have more to do with plan strategies. Much of the cost savings associated with MA arises from contracting with lower cost providers (Politzer et al. 2024) and clinicians who achieve lower rates of avoidable hospital stays (Xu et al. 2023). On surveys, primary care physicians with mainly MA patients report higher rates of care coordination, which may also lower costs (Shah and Jacobson 2024). One consequence for MA beneficiaries is that plans can limit their choice of providers. MA network breadth and provider quality is better for MA beneficiaries in large metropolitan areas, whereas in micropolitan and rural areas, some beneficiaries must drive hundreds of miles to access specialists, and high-quality specialists are often excluded from MA networks because of high price demands arising from their monopolistic position (Haeder 2019). Another study finds that switching from MA back to traditional Medicare is more common in rural areas, especially among those with high needs, with dissatisfaction with provider access an important reason (Park et al. 2021).

Low medical costs also arise from lower resource use in MA plans compared to traditional Medicare. Much of the difference arises from lesser use of expensive in-patient services (Schwartz et al. 2021; Jung et al. 2023; Geng et al. 2023), and lower use of skilled nursing facilities and home health care (Li et al. 2018a; Marr et al. 2023; Prusynski et al. 2024; Skopec et al. 2020). Prior authorization, meant to ensure that health care services are medically

necessary, also lowers medical costs. Prior authorization is required for a limited number of conditions in traditional Medicare, such as durable medical equipment, whereas nearly all MA enrollees are in plans that require prior authorization for covered services, particularly, but not only, expensive services such as chemotherapy and skilled nursing home stays (Biniek et al. 2024b; U.S. Senate Permanent Subcommittee on Investigations 2024). Prior authorization has generated rising denial rates – denials rose from 5.7% in 2019 to 7.4 % in 2022 – and few denials are appealed – just 10% – even though more than 80% of appeals are successful; many beneficiaries apparently do not realize that denials can be appealed (Biniek et al. 2024b). Traditional Medicare also does not require referrals to specialists for the most part, while they are a common form of utilization management in MA plans. The impact of both of these practices are reflected in survey data: MA enrollees are more likely than traditional Medicare beneficiaries to report that their care was delayed because of needing pre-approval, 22 to 13% (Jacobson et al. 2024).

One question is whether minority populations now enrolling in MA plans in record numbers are better off than similar populations in traditional Medicare. Members of racial/ethnic minority groups are often attracted to MA by the supplemental benefits and predictable out-of-pocket expenses. Drawing conclusions about racial/ethnic group experiences across and within the two versions of Medicare is difficult because of the limited number of studies. Some findings indicate that minority enrollees are better off in MA plans: as a group, Black, Hispanic, Native American, and Asian/Pacific Islander beneficiaries are more likely to have a regular source of primary care and to receive preventive care in MA plans than their counterparts in traditional Medicare (Johnston et al. 2021).

A follow-on question is whether racial and ethnic minorities fare as well as whites within Medicare Advantage. The Johnston et al. (2021) study also found that minority enrollees fared worse than white enrollees in both traditional Medicare and MA plans. A wider review of extant studies found that within MA, the evidence on quality of care and beneficiary experiences for people of color compared to white beneficiaries is decidedly mixed, although differences between Black and Hispanic enrollees and whites are generally greater than differences between Asian enrollees and whites, where results are often inconclusive (Ochieng et al. 2023). A study on behavioral health in MA found lower quality care for Black, Hispanic, and (to a lesser extent), Asian/Native Hawaiian/other Pacific Islander groups compared to whites (Breslau et al. 2018). Black Medicare recipients are also more likely than their white counterparts to report cost-related problems across all coverage types (40% to 28% for those in traditional Medicare without supplemental coverage; 20% to 10% for those in traditional Medicare with supplemental coverage; and 32% to 16% for those in MA; Biniek et al. 2021). Note that Black recipients in MA were worse off than those in traditional Medicare with supplemental coverage; so were whites, but the gap is larger for Black beneficiaries.

For high-need populations, there is some evidence that the coordinated care promised by MA plans has come to fruition: disabled beneficiaries have better access and quality outcomes than disabled beneficiaries in traditional Medicare (Johnston et al. 2022), and patients with end-stage renal disease in special needs plans in MA had lower mortality and rates of utilization than in traditional Medicare (Powers et al. 2020). However, lower quality MA plans had higher costs for dialysis patients and more switching back to traditional Medicare (Li et al. 2018b), and Hispanic, Asian, and Native American enrollees with ESRD were more likely to be enrolled in narrow networks of dialysis facilities than white enrollees (Oh et al. 2023).

Two other groups of beneficiaries for which more pronounced differences exist between MA and traditional Medicare are those with dementia and those in need of treatment for mental health or behavioral health conditions, who have enrolled in MA in increasing numbers. MA beneficiaries with Alzheimer's disease and related dementias (ADRD) had lower utilization than similar patients in traditional Medicare, and the gap was larger than for beneficiaries without ADRD; nonetheless, care satisfaction scores were the same for ADRD beneficiaries in MA and traditional Medicare, which Park et al. (2020) interpret as meaning lower utilization is effective and satisfactory. Other researchers find, however, that the rate of exit from MA to traditional Medicare is higher for those with ADRD than for those without (James et al. 2023), suggesting that the lower utilization is unsatisfactory to patients. Psychiatrist networks are much narrower in MA than in Medicaid and ACA plans (Zhu et al. 2023). MA beneficiaries had more cost sharing for mental health services than those in traditional Medicare, and MA payments to mental health providers are lower (Pelech and Hayford 2019).

MA enrollees are generally happy with their coverage, although so are those in traditional Medicare. A 2024 Commonwealth Foundation survey found that 65% of people in MA and traditional Medicare alike felt their coverage had met their expectations, and rates of complaints were similar as well (Jacobson et al. 2024). One group that stands out are dual-eligible beneficiaries, 62% of whom said that their MA coverage had met their expectations, versus 45% of those in traditional Medicare. At the same time, a study of high-needs beneficiaries found satisfaction concerns for that population: high-needs enrollees in MA plans are younger and healthier than those in traditional Medicare, and as a result have much lower utilization of physician visits, hospital services, and home health care. Perhaps too low, as those in MA had greater concerns about affordability of care and less satisfaction with care (Levinson and Adler-

Milstein 2020). MA plans hold the promise of coordinated care for all, but incentives for MA plans to minimize the provision of expensive services such as post-acute care mean that concerns about the effects of managed care on some subpopulations persist.

In sum, MA plans appear to provide comparable care to traditional Medicare across many, although not all, categories of medical services (although cautions abound: metrics may not be comparable, and data availability and selection effects hinder comparison; Agarwal 2021). Enrollee satisfaction is similar. It is doubtful that the dynamics of consumer choice have much to do with that relative success, given the lack of meaningful switching between MA plans. Plans have been able to hold down their health care spending through managed care techniques, but this in turn has sparked concerns about access to care, particularly for more needy populations.

Feedback Effects on the Politics of Medicare

In addition to shaping how beneficiaries experience Medicare, the expansion of Medicare Advantage has generated strong policy feedback effects that have entrenched the program. MA plans cover a large, geographically dispersed, and socioeconomically diverse array of beneficiaries, thereby creating a vast constituency in support of the program. Not only has this fostered bipartisan support in Congress, but lobbying by managed care companies helps ensure generous payment policies that protect profits and encourage rapid expansion of the program (Kelly 2016). The lobbying heft of the industry stems from the meshing of a popular social program with a potentially unstable private marketplace of plans. If CMS policy is not to the liking of the insurance plans, plans can threaten exit or reduced benefits. As these plans increasingly come to depend on MA business for their bottom line, federal policymakers also have some leverage and they have at times tried to use it to redress marketing abuses, denials of

care, and over-diagnosing of medical conditions. Thus far, however, federal agencies have shown limited capacity for reining in overpayments or abusive and fraudulent practices.

Since the creation of MA, enrollment has grown continuously and now accounts for 54% of all Medicare beneficiaries (Figure 1). There are a number of forces driving higher enrollments (Neuman et al. 2024). One is that the federal government pays more to MA plans than it would cost to have these beneficiaries in traditional Medicare, and that plans then use these payments to offer supplemental benefits, lower cost-sharing, reduce out-of-pocket costs, and/or provide Part D drug coverage at no extra premium. Plans also have deployed intensive marketing campaigns to draw seniors into the program, incentivizing brokers with higher payments for signing up MA enrollees versus what they would receive for enrolling people in Part D or supplemental plans. Finally, a big source of MA growth in recent years has been employers shifting their retiree population into MA plans in an effort to contain their own costs.

[Figure 1 about here]

Enrollees in an MA plan may be locked into it by the fact that, if they switch back to traditional Medicare, they could have difficulty purchasing a Medigap policy. Because of limitations in traditional Medicare coverage, beneficiaries can purchase a private Medigap plan to help with high out-of-pocket costs. It is important to sign up for Medigap in the first six months of enrolling in traditional Medicare; after that period, plans can reject applicants or charge higher rates based on preexisting conditions (Freed et al. 2024a). For those enrolling in MA, many can switch back to traditional Medicare and a Medigap policy only during an initial 12-month Medicare Advantage trial period. After the trial period, if a MA beneficiary decides that their MA plan coverage is unsatisfactory, they may be deterred from shifting into traditional Medicare, given the potential difficulty of getting a Medigap plan.

The growth of Medicare Advantage has created a mass constituency for the program that crosses the partisan divide. Not only is the population of MA beneficiaries large and growing – reaching almost 33 million people in 2024 – but it is geographically dispersed and socioeconomically diverse. MA covers more than one-half of Medicare beneficiaries in 30 states, and is below 30 percent in only five states – Alaska, Maryland, North Dakota, South Dakota and Wyoming – all rural states except Maryland (Freed et al. 2024b). MA enrollment is over 50 percent in politically red states (Alabama, Florida, Georgia, Louisiana, Texas, among others) and blue ones (Connecticut, Oregon, New York, California, etc.; Freed et al. 2024b). And, as was noted earlier, MA enrollment has grown significantly among racial and ethnic minorities (Meyers et al. 2021) and low-income individuals who are eligible for both Medicaid and Medicare. The mass constituency for the program gives MA plans unique heft in the political process. "That is different from most other health care provider groups that lobby," according to Bruce Vladeck, a former Medicare administrator. "It's a political weapon that Medicare Advantage plans have not been at all reluctant to use" (Schulte and Hacker 2024).

With so many people reliant on Medicare Advantage, policymakers are cautious about actions that might disrupt the MA market and encourage a deterioration of plan offerings or large-scale plan exits beyond the expected minor churn arising in a marketplace with voluntary participation. The meshing of private insurance markets with a public program creates the risk of instability – that if insurance companies are concerned about profitability, they could simply drop their involvement in the market (Morgan and Reisenbichler 2022; Kelly 2023). This occurred when the 1997 Balanced Budget Act sought to rectify the fact that it was costing the government more to have people in private plans than if they were in fee-for-service Medicare. Cutting payments spurred plans to exit the program in droves, resulting in 2 million beneficiaries

losing their plans between 1999 and 2003 (McGuire et al. 2011, p. 310). The resulting political uproar, coupled with insurance industry lobbying, helped lead to the restoration of more generous payments in the 2003 Medicare Modernization Act, which made "no pretense of cost control" (Oberlander 2007, 204). The episode has served as a cautionary tale for federal policymakers ever since. Both the Obama and Biden administrations have attempted, at times, to tamp down on MA payments, but the industry has successfully pushed to soften the impact of these initiatives.

The MA industry also spends a great deal on lobbying, and they have significantly increased their spending since 2019 (Figure 2), more than most other industry sectors. In 2023, health services and HMOs spent $129 million on lobbying, the eighth highest sector (the pharmaceutical and health products sector spent the most, $383 million, according to opensecrets.com). One source of pressure is the Better Medicare Alliance (BMA), a group that presents itself as a grassroots membership organization of MA beneficiaries but is funded through donations by the big managed care companies that are MA plan providers (Alonso-Zalvidar and Lardner 2018). The group makes the case for MA plans through statements about the preferences of beneficiaries, while also emphasizing the diverse constituency of enrollees in MA plans. For instance, BMA's website presents MA as a "health equity" measure, offering data about the disproportionately high share of Latino and Black MA beneficiaries and how they spend less than in traditional Medicare. MA plan providers frequently couch their opposition to policy measures in terms of the threat posed to the well-being of beneficiaries, pressuring members of Congress – sensitive to voters in their states or districts – to intervene with CMS.

[Figure 2 about here]

These dynamics are evident in the lobbying frenzy that takes place around the annual CMS announcement of MA plan payments. Early each year, CMS releases the Advance Notice of Methodological Changes for Calendar Year (CY) 2025 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies, indicating the expected average net increase in payments to plans, compared to the previous calendar year. After the required comment period, CMS regularly adjusts plan payments upward (table 1), sometimes by a great deal. A key reason for this is that MA plan providers mobilize in response to the initial announcement, which can include pressuring members of Congress to advocate on their behalf for higher rates. In the words of one industry critic, "The health plans throw a temper tantrum and then CMS will back off" (Schulte and Hacker 2024).

In 2023, for instance, after CMS initially proposed a rate increase of 1%, the industry responded with a multi-million-dollar advertising campaign; one ad showed seniors at a bowling alley grousing about the threat to cut MA plans. "Cut Medicare Advantage…That's Nuts," said one senior, and the ad's voiceover continued, "For 30 million seniors, Medicare Advantage is Medicare. Call the White House. Tell them not to cut it."[1] Sixty-one Senators, from both parties, sent a letter to CMS that stated, "We are committed to our nearly 30 million constituents across the United States who rely on Medicare Advantage, and to maintaining access to the affordable, high-quality care they currently receive. We ask that the Administration provide a stable rate and policy environment for Medicare Advantage that will strengthen and ensure the long-term sustainability of the program—protecting access to its important benefits on which our constituents have come to rely."[2] CMS relented and offered a 3.3% increase in its final notice.

[1] https://www.ispot.tv/ad/2UHG/better-medicare-alliance-cutting-medicare-thats-nuts
[2] https://www.collins.senate.gov/imo/media/doc/senate_bipartisan_medicare_advantage_letter.pdf

The lobbying of the industry, and defense of it by politicians of both parties, has impeded payment reform to reduce the cost of the MA program. Despite bringing down spending on beneficiary care, payments to these plans have, on the whole, always been higher than if beneficiaries were in traditional Medicare for reasons that are treated further below. A 2024 MedPAC report projects that payments to MA plans in 2024 will be 122% of what payments would have been if beneficiaries were in traditional Medicare, totaling $83 billion in excess payments (MedPAC 2024). Some of these excess payments are used by plans to provide extra benefits and lower cost-sharing, but this is subsidized by those who remain in traditional Medicare and face higher Part B premiums: MedPAC estimates that premiums in 2024 will be $13 billion higher as a result of the overpayments to MA plans. Those paying these premiums are not eligible for the extra benefits unless they sign up for MA.

These high payments – well above the cost of coverage – have been a boon to the insurance industry. One estimate holds that firms reap twice as much gross profit from their MA plans than from their other insurance products (Ortaliza et al. 2024). In 2023, Humana announced that it would cease providing employer-sponsored health insurance to focus on Medicare Advantage, given the greater profitability of that sector. Other insurers, such as UnitedHealthGroup and CVS-Aetna, also made big bets on MA as critical to their revenue growth.

But as private insurers have become reliant on MA for their financial health, public officials have gained some leverage. For example, in 2024, despite industry protests, CMS maintained 2025 payment rates at the same level as that which was announced in the advance notice (table 1). The attentiveness of federal policymakers, and especially members of Congress, to beneficiaries' well-being also has spurred them to investigate complaints about MA plans.

[Table 1 about here]

Senator Ron Wyden (D-OR), for instance, has steered Senate Finance Committee investigations of fraud and abuse in the marketing of MA plans. In November 2022, the Committee's majority staff report assailed the MA industry for its aggressive marketing practices, use of false or misleading information – such as making marketing communications appear to come from Medicare, or telling seniors that an MA plan would cover their doctors when that was in fact not the case – and targeting of vulnerable populations, such as the cognitively impaired or dual-eligible beneficiaries (U.S. Senate 2022). In subsequent Senate committee hearings, Wyden castigated the use of middlemen to market MA plans to beneficiaries, denouncing them as "sleazy marketers" engaging in "money-grubbing" and "slimy practices" (U.S. Senate 2023b). In response to this and other criticism, CMS issued rules in 2023 and 2024 that attempt to regulate marketing practices and the use of third-party organizations to sign up beneficiaries.

Another set of investigations concerns MA plans denying care to enrollees or requiring prior authorization before allowing it. A 2022 report from the Office of the Inspector General in the U.S. Department of Health and Human Services found that 13% of the prior authorization requests that MA plans denied would have been approved under traditional Medicare (Grimm 2022). The chairman of the Senate Permanent Subcommittee on Investigations, Richard Blumenthal (D-CT), used a May 2023 hearing on these practices to criticize firms for reaping huge profits while denying people care to which they are entitled. As Blumenthal declared in the hearing, "I want to put these companies on notice. If you deny lifesaving coverage to seniors, we are watching. We will expose you. We will demand better. We will pass legislation if necessary, but action will be forthcoming" (U.S. Senate 2023a, p. 3). An April 2023 CMS rule requires

plans to use Medicare's coverage rules when determining what counts as "medically necessary" care (Hellmann 2023) while a 2024 rule seeks to streamline prior authorization processes. Providers also have expressed frustration with low payments, prior authorization requirements, and frequent claims denials, leading some to refuse to accept some MA plans (Appleby 2023).

The most consequential challenge to the MA industry has come in response to plans seeking to maximize payments through aggressive diagnostic practices. To combat the practice of some plans of targeting the healthiest beneficiaries, Congress instituted higher payments for people with more health conditions. This led plans to maximize the coding of enrollee conditions so as to increase payments. Some plans began bombarding beneficiaries with calls offering them a health assessment and sent nurses to their homes to conduct tests to find as many conditions as possible. Kaiser and UnitedHealth have pressured or incentivized their directly-employed physicians to engage in upcoding (Weaver et al. 2024). As one whistleblower from Kaiser Permanente declared about these practices, "the cash monster was insatiable" as plans coded conditions that, in some cases, never received any treatment (Abelson and Sanger-Katz 2022). A *Wall Street Journal* investigation found evidence of dubious diagnoses, such as coding over 66,000 MA beneficiaries for diabetic cataracts even though they previously had cataract surgery, something that one physician remarked would be "anatomically impossible. Once a lens is removed, the cataract never comes back" (Mollica 2024).

Executive branch agencies have taken on the MA industry for these practices. HHS Office of Inspector General (OIG) reports have revealed the pervasiveness of upcoding and the huge sums of money paid out to plans as a result. The OIG regularly audits MA coding practices and recommends that plans return some of the resulting overpayments. The Department of Justice has pursued cases and won settlements from MA firms for upcoding and other fraudulent

practices through The False Claims Act, which incentivizes whistle-blowers to come forward. MedPAC shows that coding intensity accounts for more than half of overpayments to plans in recent years (MedPAC 2024), and in January 2023 CMS issued a final rule to claw back over $4 billion in overpayments from plans over a period of 10 years (Hellman 2023). The rule prevailed even though, after the initial announcement, MA firms launched an intense lobbying campaign that sought to prevail on congressional lawmakers to intervene on their behalf. Notably, members of Congress did not openly or aggressively defend plans on these overpayments, but the Biden administration did decide to phase-in the clawback so as to soften the impact on firms (Sanger-Katz and Abelson 2023).

These congressional hearings and executive branch actions indicate that, while providing MA plans to Medicare beneficiaries has been good for the industry, at times the industry must tread carefully given the sensitivity of policymakers towards this large bloc of the voting public. What remains to be seen is how effective government regulators and congressional oversight can be when faced with a vast private market that is backed by the resources and political heft of the insurance industry. The fact that payments to private plans have never been brought down to the same level as, or below, the cost of beneficiaries in traditional Medicare is a sign that private plans have the upper hand.

Implications for the Future of Medicare

What are the implications of the above trends for the future of Medicare? One is that private plans are now an entrenched feature of Medicare, moving it further away from being a public social insurance program. As was noted earlier, Medicare program administration and health care provision were always delegated to private providers, but a government agency was the payer

responsible for determining prices and assuring a uniform package of benefits. With more than half of beneficiaries in MA plans, a consumer choice model has now firmly taken root and is unlikely to go away, given the powerful policy feedback effects of a mass constituency for MA plans and empowerment of insurance industry interests.

One consequence could be further weakening of the capacity of federal officials to provide oversight and hold down Medicare spending. The consumer choice model hinges on the ability of consumers to discipline providers by choosing cheaper and higher quality plans, but so far they have proven unable to do so. Another assumption was that fraud would be *less* likely in MA because capitation payments shift risk onto firms, incentivizing them to root out fraud. Yet, not only have plans failed to do any better against health care fraud (Grimm 2023), they have engaged in it themselves through the practice of diagnostic upcoding that MedPAC estimates to have added almost $200 billion to the cost of the program since 2014. Nonetheless, government attempts to regulate plans have been hobbled by industry lobbying and fears of destabilizing the market.

The ongoing transformation of Medicare into a consumer choice program has implications for the vision long espoused by some for a wider reform of U.S. health insurance along the lines of Medicare-for-all. This vision assumed people would get traditional Medicare – a public social insurance program in which healthcare is privately delivered but a federal payer shapes prices. What does Medicare-for-all mean when more than 50% of beneficiaries are in private plans (McIntyre et al. 2023)? Some have argued the aspiration should now be "Medicare Advantage for all" – a system in which all employer coverage would run through CMS, with firms paying taxes to the agency and insurance plans applying to be plan providers and receiving risk-adjusted, capitated premiums (Zahner et al. 2022). This could be a way to achieve universal

coverage without having to fight with private insurers, who would mobilize against a universal government payer system. Federal officials, though, would need to develop improved capacities for the oversight and regulation of private plan providers. While the HHS Inspector General has pursued legal action against MA insurers for fraud and other abuses, CMS remains a small agency charged with overseeing a vast and complex sector of healthcare providers and payers. Medicare is thus on the GAO's list of programs at high risk of waste, fraud, abuse, and mismanagement (GAO 2023). The revolving door between CMS and the private health care industry also fuels doubts about the agency's autonomy from the sector it oversees, as high percentages of CMS appointees land in industry jobs following their time at CMS (Kanter and Carpenter 2023).

A Medicare-Advantage-For-All approach also assumes most people would accept having care provided through plans imposing managed care techniques, such as limiting provider options or requiring pre-authorization. Some analysts believe there is a ceiling on MA enrollment because a significant proportion of Medicare beneficiaries are not interested in these plans. CBO estimates enrollment to reach 64% of beneficiaries by 2034, while Wall Street investors have voiced doubts about the continued ability of MA plans to expand their market share. As one financial analyst observed about the rapid growth of MA in Miami, Florida, once enrollment hit 75% it flattened out as wealthier seniors chose to stay in traditional Medicare because they are less concerned about out-of-pocket costs and value having free choice in their providers (Wainer 2023).

There have been a flurry of journalistic articles warning of the downsides of MA enrollment (Silvestrini 2022; Cattanach 2023). These articles highlight the tradeoffs between low premiums and supplementary benefits on the one hand and the disadvantages of narrow provider

networks on the other. Other program skeptics alert readers to the fact that MA enrollees feeling "buyer's remorse" may encounter barriers in switching back to traditional Medicare if they are unable to enroll in Medigap supplemental plans on favorable terms (Tribble 2024). The message of such accounts is that beneficiaries may be well served in avoiding MA plans and sticking with traditional Medicare, with its broad access, while leaving MA plans to those who lack retiree coverage from former employers or who cannot afford to purchase supplemental coverage. In short, the industry may soon start to hit limits to expanded enrollments, which means profits can only be sustained by cost-cutting measures and/or successfully lobbying campaigns for MA-friendly policies. During the 2024 campaign season, AHIP launched a 7-figure lobbying campaign to push back against recent regulatory scrutiny and tighter payments (Ciruzzo and Leonard 2024). Insurance executives have warned shareholders that the MA industry will be cutting benefits and dropping plans in unprofitable parts of the country (Vollers 2024).

A final question concerns whether the threat of Medicare trust fund insolvency could impel public officials to bring down the overpayments to plans. Currently, the expected year of depletion is 2036, but the federal government also faces perennial budgetary challenges tied in significant part to high health care spending. Government officials could try to hold the line, but plans may respond by making their offerings less attractive, inducing beneficiary and/or provider complaints. Bringing managed care into Medicare has not helped with resource shortages, but instead exacerbated them.

Delegated governance in Medicare has provided some benefits and welfare improvements – such as supplemental coverage for Medicare beneficiaries of modest means who wish to avoid Medigap premiums – but created a host of other problems for beneficiaries and taxpayers, including an aggressive claims denial regime, fraud and abuse, and outsized spending.

As we wrote in *The Delegated Welfare State*, government does not disappear in these delegated arrangements, but is transformed. Twenty years into one of the largest delegated governance initiatives in American history, we must ask whether the government role has transformed enough to protect the interests of the public from the aggressive rent-seeking behavior of insurers, who have turned the Medicare program into a profit center. Our analysis suggests that government regulators have been outmatched, and that in a fiscal war between senior beneficiaries and taxpayers, lawmakers are loath to cross the former.

■■■

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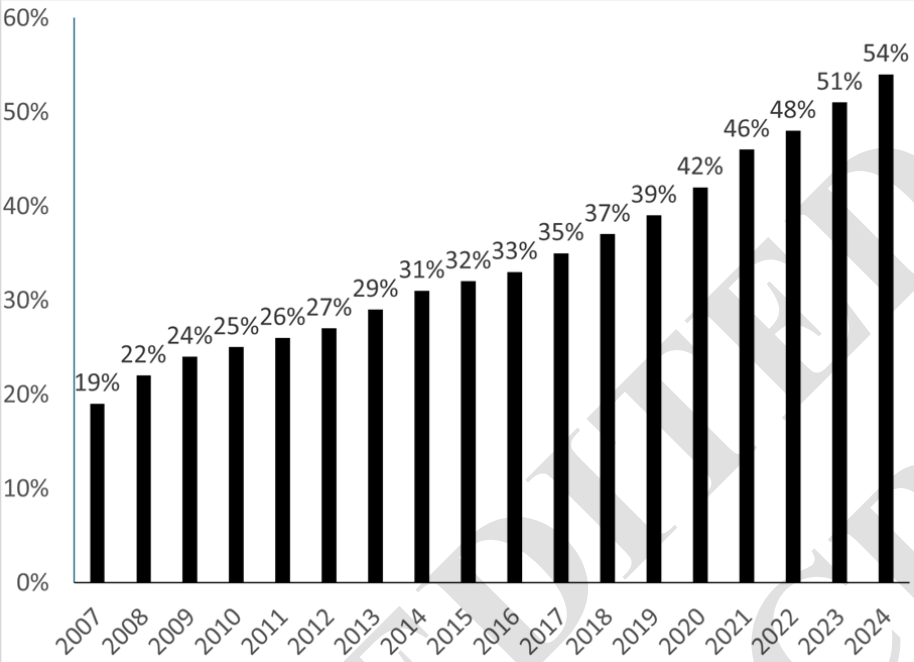
Table 1 Expected Change in Average Plan Revenues: Advance Notice and Final Rule

Calendar year	Advance notice	Final
2020	1.59%	2.53%
2021	0.93%	1.66%
2022	2.82%	4.08%
2023	7.98%	8.50%
2024	1.03%	3.32%
2025	3.70%	3.70%

Source: CMS.

Figure 1 Medicare beneficiaries in Medicare Advantage.

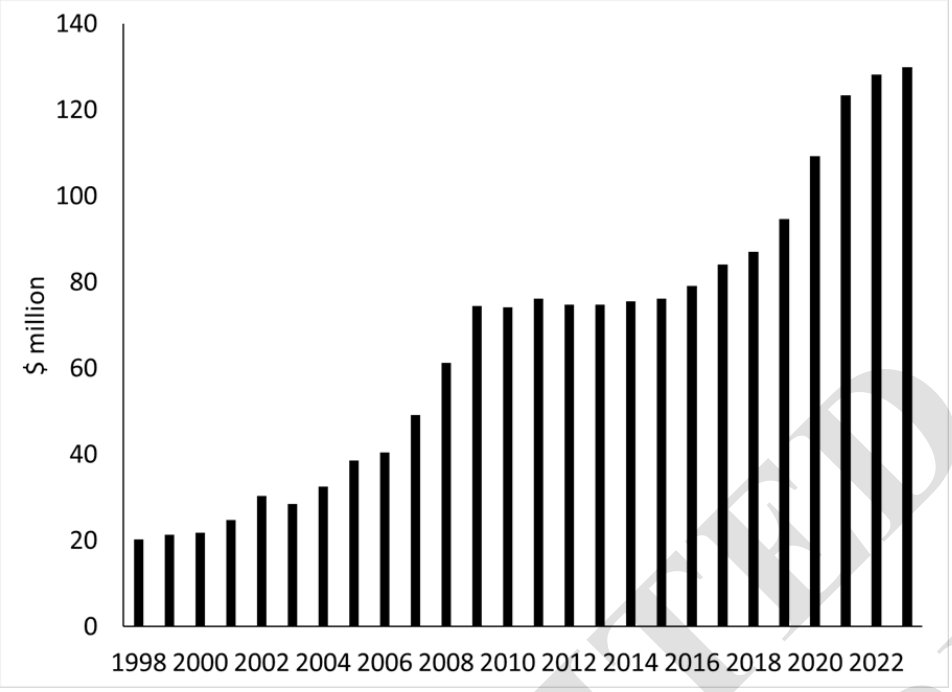


Source: KFF.

Figure 1 Alt Text:

Figure 1 is a bar graph showing the percentage of Medicare beneficiaries in Medicare Advantage by year, which rises from 19 percent in 2007 to 54 percent in 2024.

Figure 2 Annual expenditures on lobbying by firms in the Health Services and HMOs category.



Source: Open Secrets.

Figure 2 Alt Text:

Figure 2 is a bar graph showing annual expenditures on lobbying by firms in the Health Services and HMOs category by year, which rises from $20 million in 1998 to $129 million in 2023.