

**The Making of Entitled Consumers: A
Conceptualization of Social Citizenship in Medicare
Reforms**

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**I, Yifei Li, confirm that the work presented in this thesis is my own.
Where information has been derived from other sources, I confirm that
this has been indicated in the thesis.**

Abstract

This research examines how ideological and budgetary pressures have shaped Medicare reforms and how these reforms, in turn, have influenced types of social citizenship in the U.S. Tracing the evolving politics of health rights for the elderly, it investigates who gains access to what rights and under what circumstances. Medicare is among the few programs that is resilient against what Paul Pierson called “the welfare retrenchment” since the 1980s, and therefore is particularly valuable in studying varying forms of social citizenship in the US context. Tracing the program’s development, I provide a typology of social citizenship reflected in different periods: contributory, ordo-liberal, consumerist, and post-neoliberal.

Contributory social citizenship revolves around the idea of deservingness and involves a reciprocal relationship where citizens’ contributions are met with government obligations to provide access to essential needs. We shall see how Medicare institutionalized this form of social citizenship through its Social-Security-based financing mechanism and generous payment to hospitals. “Ordo-liberal” here describes the reactive way the government deals with social citizenship in the 1970s and 1980s. Consumerist is used to describe Medicare reforms around the turn of the century, but consumerist social citizenship means an “active citizen” mentality that regards seniors as knowledgeable consumers capable of making rational choices. At last, post-neoliberal social

revolves around social investment, which emphasizes preventive care and long-term care. Together, the elderly as a distinctive category sheds new light on the idea of social citizenship and contribute to its theoretical debate regarding “residual” programs.

Impact Statement

This research makes a significant contribution to academic scholarship, public policy, and societal discourse by exploring the evolution of social citizenship in the United States through the lens of health care rights, with a particular focus on Medicare. By analysing the complex interplay between government policy, advocacy, and citizen behaviour, this study offers new insights into how American social citizenship has evolved and distinguished itself from European welfare models.

Academic Contributions

The thesis introduces a four-phase typology of American social citizenship—contributory, ordoliberal, consumerist, and post-neoliberal—to challenge the traditional Marshallian model of collective social rights. By demonstrating how American social citizenship is embedded within market-driven values, it provides a fresh perspective on welfare state evolution. This nuanced analysis contributes to fields such as political science, welfare state studies, and American studies, offering a framework for comparative analysis between American and European welfare systems.

The study's multidisciplinary approach, combining political theory, historical analysis, and policy evaluation, also offers a comprehensive method for

understanding the dynamics between social rights, policy reforms, and demographic changes. This methodology serves as a valuable model for future research and broadens the theoretical understanding of how social citizenship evolves in the context of shifting political, economic, and social landscapes. By centring the discussion on seniors' health rights, the research also makes a contribution to gerontology and health policy studies by illustrating how seniors have both shaped and been shaped by evolving conceptions of citizenship.

Policy and Practical Implications

This research has important implications for public policy. It reveals that the transition from collective entitlement to an individualistic understanding of health rights has led to market-oriented health care policies, often at the expense of equitable access. These findings underscore the need for a balanced approach that prioritizes both cost-efficiency and the maintenance of health care rights, especially for vulnerable groups like the elderly.

Broader Societal Impact

This thesis contributes to public discourse by challenging the dominant narrative of health care as merely a market commodity, advocating instead for a more inclusive and rights-based approach that aligns with the principles of social citizenship and collective responsibility. The study encourages

policymakers, advocacy groups, and the general public to re-examine health care reform in the context of social justice, equity, and democratic engagement.

Future Implications and Reach

The research's typology and analysis offer a framework for understanding social citizenship beyond health care, making it relevant to policy areas such as housing, education, and employment. Its findings provide a foundation for ongoing dialogue about social citizenship, especially in the face of demographic shifts and increasing health care costs. The study's insights can inform advocacy efforts by organizations like AARP, helping articulate the needs and rights of seniors in an evolving policy landscape.

In essence, this research enriches our understanding of social citizenship, offers a comprehensive model for future studies, and provides actionable insights for policymakers and advocates, especially in the context of rising health care needs among an aging population.

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Introduction

Americans have an exceptionally vague sense of social rights. When citizens say they have a right to something, it is hardly clear whether they are claiming a collective entitlement or an individual moral property. The story we usually hear is that American social welfare is “laggard” and “residual” compared to its European counterparts.¹ Many countries began to weave a safety net for their citizens by addressing risks associated with illness, unemployment and aging around the turn of the twentieth century. Germany became the torchbearer in the 1880s, and many other countries like Sweden and the UK followed suit by 1920. Yet the United States did not enact contributory retirement insurance or old age and unemployment insurance until what was commonly known as the first “big bang” of the American welfare state—the New Deal of 1935. Nor did it adopt national health insurance in the 1940s or afterward. Medicare arrived in 1965 as the peak of the second big bang—the Great Society, but this partial substitute of universal health insurance in effect jinxed all subsequent efforts of health care expansion due to the inflation it caused.²

¹ Residual welfare states provide minimal support, acting as a safety net only when the market and family fail and emphasizing means-tested assistance and individual responsibility. For details, see Erdem Yörük, İbrahim Öker, and Gabriela Ramalho Tafoya, “The Four Global Worlds of Welfare Capitalism: Institutional, Neoliberal, Populist and Residual Welfare State Regimes,” *Journal of European social policy* 32, no. 2 (2022). For critics of this view, see Christopher Howard, “Is the American Welfare State Unusually Small?,” *Political Science and Politics* 36, no. 3 (2003); Irwin Garfinkel, Lee Rainwater, and Timothy Smeeding, *Wealth and Welfare States: Is America a Laggard or Leader?* (Oxford: Oxford University Press, 2010).

² Margaret Weir, Ann Shola Orloff, and Theda Skocpol, *The Politics of Social Policy in the United States*, Studies from the Project on the Federal Social Role, (Princeton, N.J.: Princeton University Press, 1988);

This is not the only way to tell the story. An often-neglected trend emerges when we focus on the elderly and the evolution of their rights claiming. At the start of the 20th century, there was a recognition that social policies were needed to address issues like elderly poverty. The focus was primarily on family welfare, with limited specific assistance for seniors. The Great Depression exposed the economic vulnerabilities of older Americans, and the New Deal responded to these economic struggles particularly by introducing the Social Security Act. The program was unique in that it was not an outright welfare program but instead relied on worker contributions through payroll taxes—a clear sign of the American value of self-reliance. Social Security later became so successful that it was expanded to cover additional groups such as self-employed and domestic workers in the 1950s, but fiscal conservatism tempered significant benefit increases, and health care for the elderly remained unaddressed. The Great Society initiatives under Lyndon B. Johnson responded to this critical gap with Medicare in 1965. Broadly speaking, the development of the American welfare state around the two “big bangs” of social programs saw a gradual expansion of support for the elderly, addressing both income and health care needs over time.

Notably, the New Deal introduced essential social supports (the unemployment insurance and old-age pensions), but Roosevelt’s Committee on Economic Security ultimately excluded health care due to intense opposition

Howard Christopher, *The Welfare State Nobody Knows: Debunking Myths about U.S. Social Policy* (Princeton University Press, 2021).

from the American Medical Association and strong free-market ideological influence. This omission not only set the U.S. apart from other welfare states by creating a system where health care remained largely privatized but also left the U.S. with a fragmented welfare state where healthcare access remains contested rather than an inherent social right.³ In this dissertation, I explore Medicare not merely as a service or entitlement program but as a central, albeit complex, part of the American welfare state entangled with contradictions and shifting values around citizens' rights to health care. This recontextualization addresses what the existing scholarship does not: how Medicare's structure, limitations, and reforms reflect changing expectations around what it means to be a citizen with inherent social rights. I critique Medicare's trajectory as not only a health care program but a reflection of America's changing social contract, particularly as new political, social, and economic dynamics continually reshape citizens' rights.

Scholars have explored with various approaches such questions as what

³ In his history of the U.S. welfare state, Edward Berkowitz emphasized the transformative role of the New Deal and the Social Security Act of 1935 in American social policy, though both notably excluded universal healthcare—a central feature of Britain's Beveridge Plan. The exclusion of health care from early social policy frameworks, Berkowitz suggests, entrenched a model that continues to shape the unique structure and political debates of American health care today. Edward D. Berkowitz, *America's Welfare State: From Roosevelt to Reagan* (Baltimore: Johns Hopkins University Press, 1991). Colin Gordon, *Dead on Arrival: The Politics of Health Care in Twentieth-Century America*, Course Book ed., Politics and society in twentieth-century America, (Princeton, NJ :: Princeton University Press, 2005). Jill Quadagno, *One Nation, Uninsured: Why the U.S. Has No National Health Insurance* (Oxford University Press, 2006); Alan Derickson, "Health Security for All? Social Unionism and Universal Health Insurance, 1935-1958," *Journal of American History* 80, no. 4 (1995).

prevents the United States from developing a welfare state comparable to that in Europe even during the high-water marks of Democratic Party power in the twentieth century, and why are social programs in the US developed in such a divided way (e.g., the often-demeaning Aid to Families with Dependent Children vs. Social Security and Medicare for the “deserving” people). They used system-level variables such as “state structures”, “interest group politics” and “the American values” to explain the ambiguity in social rights definition and the absence of national health insurance in the US, but they usually defended health rights and social rights more broadly as infungible, sustainable terms in the citizen-state relationship, despite that right being in itself an evolving concept.⁴ Structural-level variables, such as divided power among three branches of government, fall short when explaining historical variations in policy outcomes, nor can “path dependency” theory explain why one path is chosen over another; focusing on stakeholders easily confounds our understanding of legislation that clearly contradicts interests of some interest groups; and as Skocpol argues, “many scholars who talk about national values are vague

⁴ Political scientists usually attribute the absence of universal health care to American political institutions or broader forces of American political development (sometimes “path dependency” as well), see Jacob S. Hacker, “The Historical Logic of National Health Insurance: Structure and Sequence in the Development of British, Canadian, and U.S. Medical Policy,” *Studies in American Political Development* 12, no. 1 (1998); Sven Steinmo and Jon Watts, “It’s the Institutions, Stupid! Why U.S. Health Care Expenditure Is so Different from Canada’s,” *Journal of Economic Issues* 45, no. 1 (2011). Medical sociologists explain this from the lens of “countervailing powers” or stakeholders, see D. W. Light, “The Medical Profession and Organizational Change: From Professional Dominance to Countervailing Power,” in *Handbook of Medical Sociology*, ed. C. Bird, P. Conrad, and D. Fremont (New York: Prentice-Hall, 2000); Jill Quadagno, “Why the United States Has No National Health Insurance: Stakeholder Mobilization against the Welfare State, 1945-1996,” *Journal of health and social behavior* 45, no. extra issue (2004). For analysis on American values and universal health care, see Lawrence R. Jacobs, “Health Reform Impasse: The Politics of American Ambivalence toward Government,” *Journal of Health Politics, Policy and Law* 18, no. 3 (1993). For counter-argument, see Theda Skocpol, *Protecting Soldiers and Mothers: the Political Origins of Social Policy in the United States* (Cambridge: Harvard University Press, 1992), 16.

about the process through which they influence policymaking.” Ultimately, we must ask what does the American way of treating the deserving people, and especially the elderly, inform us about social citizenship and social rights as a whole? The answer to this question is important as it shows the developing patterns of health service distribution as well as the substance of social citizenship.

I draw on ideas of Alexis de Tocqueville, John Rawls and T.H. Marshall to address these conundrums. The resonance of Tocqueville’s work on American social citizenship is remarkable. For Tocqueville, individualism that is highly valued in the American society is balanced by a strong sense of mutualism—a form of informal social contract where individuals actively support one another at the community level through voluntary, private action. This mutualism tempered individualism and ensured that social citizenship in the U.S. emphasized active participation and engagement in community life rather than passive reliance on state provisions.⁵ Similarly, Rawls understands social justice based on equal liberty, meaning every individual had an equal right to basic liberties, such as freedom of speech, thought, and political participation, and in terms of social citizenship, Rawls advocates for a society where social structures were designed to improve the lives of the least advantaged, which

⁵ Tocqueville’s idea is evident in the American frontier experience, where community members come together to help each other without government intervention and form a society that values self-reliance and community interdependence. For an overview of Tocqueville’s ideas, see Daniel Bell, “Alexis de Toqueville at the Crossroads of History,” *The Tocqueville Review* 26, no. 1 (2005). On the American Frontier, see Stanley Elkins and Eric McKittrick, “A Meaning for Turner’s Frontier: Part I: Democracy in the Old Northwest,” *Political science quarterly* 69, no. 3 (1954).

expanded the concept of social citizenship by emphasizing not just the provision of rights but also the active participation of citizens in a society where every individual can thrive.⁶ Both Tocqueville and Rawls suggest the significance of “active citizens” in American social policies and acknowledge its role in shaping the way of rights claiming. This partly explains why American social programs have long been tied to concepts of work history and life stage even during the height of Democratic Party power.

In fact, Marshall’s understanding of citizenship also includes an exchange of entitlements and civil engagement between citizens and the state, and he does contend that social rights should be tied to duties. However, it is quite clear that Marshall’s focus is on societal structures and the frameworks of citizenship that shape them, rather than on individual behaviours of compliance or defiance.⁷ This made the Marshallian notion of social welfare particularly suitable for explaining the genesis of Social Security and Medicare parts A and B (hospital and medical insurance), which mainly benefit seniors who have earned their privilege through a lifetime; no social programs guarantee equal access and benefits to all citizens under the same terms. Yet at the same time, the Marshallian conception of social rights for the elderly has been institutionalized in the US to such a degree that the federal government is reluctant to significantly change patterns of social service provision, even when

⁶ J. Rawls, *A Theory of Justice* (Cambridge, MA: Harvard University Press 1971). For an in-depth analysis Rawls’ theory and social justice, see Robert S. Taylor, *Reconstructing Rawls: The Kantian Foundations of Justice as Fairness*, 1 ed. (University Park, PA: Pennsylvania State University Press, 2011).

⁷ T.H. Marshall, *Class, Citizenship and Social Development* (New York: Double-day, 1964).

there is strong evidence suggesting a necessity to reform (e.g., the surging cost of Medicare and inefficiencies in hospital management). On a more practical level, it is evident that symbolic disputes over social rights in the US have gone beyond federalism and partisan politics to directly involve citizens, who now express fervent responses under the banner of entitlements.⁸ The Marshallian framework on social citizenship, while particularly productive and useful in his own analyses and those of the twentieth-century social democratic welfare states in Esping-Anderson's typology, lacks the sophistication needed for social rights discussions in the twenty-first century United States.⁹

This makes necessary an examination of the evolution of social citizenship within both historical interpretations of entitlements and contemporary notions of differentiated identities in rights claiming. To this end, this thesis focuses on the right to health care to illustrate the changing nature of social citizenship in the U.S. By examining how "economic empowerment" in the 1990s substituted "political empowerment" that was traditionally granted by social rights, I provide a conceptual model on differentiated social citizenship while citizens began to assert their health care rights with new meaning. I argue that the American

⁸ It is evident that health care for the elderly as a social right, institutionalized during a period of abundance and political commitments to Keynesianism, is in clash with the vagaries of budgeting in periods of acute scarcity. For further argumentation on this, see Arthur Dyck, *Rethinking Rights and Responsibilities: The Moral Bonds of Community* (Cleveland: Pilgrim Press, 1994).

⁹ Gøsta Esping-Andersen's welfare state typology includes three models: the liberal (e.g., U.S., UK) model emphasizes limited state support, favouring market-based solutions with minimal, means-tested benefits for the neediest, resulting in higher inequality. The conservative/corporatist model (e.g., Germany, France) focuses on stability and employment-based benefits, which reinforces traditional family roles with moderate social support. The social democratic model (e.g., Sweden, Norway) prioritizes universal benefits, funded by high taxation, to promote equality and autonomy for all citizens, with extensive social protections. Each model reflects unique approaches to balancing market, state, and family roles in welfare provision. For details, see Gøsta Esping-Andersen, *The Three Worlds of Welfare Capitalism* (Cambridge: Polity Press, 1990).

approach is not necessarily inferior but represents a different set of values, where social support is seen as the responsibility of individuals within a community, and that American social citizenship is a distinctive model of social citizenship that is neither diminished nor deficient compared with European welfare states.

Debates concerning social citizenship and health care largely run parallel to each other, but their relationship is important in that debates on both issues reflect a change in the “bargaining” between citizens and the state regarding rights and responsibilities. Social citizenship involves an equation, with citizens’ rights and autonomy constituting one side of it and their duties and obligations being the other. Yet in the U.S. context, debates surrounding this equation—how burdensome should duties be in exchange for entitlements? What are the boundaries of government intervention in securing social rights? And how to define the substance of social citizenship? —underwent significant changes between the “big bang” of social programs in the 1960s and the “welfare retrenchment” in the 1990s. The collective claiming of social rights was encroached by a much more individualistic mentality since the 1980s, and the continuing “rolling back of the state” in an age of austerity gave rise to a vacuum regarding entitlements.¹⁰ The government was trying to transfer the burden of social services to the private sector, while citizens clung to social rights as their own property and made possessive, individualistic claims with a nostalgic

¹⁰ Anton Hemerijck, “Two or Three Waves of Welfare State Transformation?,” in *Towards a Social Investment Welfare state?*, ed. Nathalie Morel, Bruno Palier, and Joakim Palme (Bristol University Press, 2012).

longing for the “good old days.” The citizen-state exchange (or bargaining if you may) was simply unequal at the time. This changed the nature of social citizenship in a traditional sense as needs, obligations and entitlements were all tucked into the market framework.

Debates around health care saw a similar trend during the last decades of the twentieth century. In the early 1960s, the remarkable medical advancements in the U.S.—the first successful heart transplant, substantial improvements with the development and use of vaccines and medical imaging, as well as the rise of genetics and molecular biology, etc.—pushed health care availability to the forefront of the national policy agenda and raised questions concerning whether health care ought to be distributed as a public good.¹¹ The inception of Medicare revealed how Americans perceived rights with regard to health care: benefits were tied to individual merit, and those deemed “deserving” were individuals who met specific criteria, such as a solid employment history or contributions to social insurance. Up till the early 1980s, the right to health care remained a collective entitlement for American seniors and was perceived as central to their social citizenship. However, the late 1980s saw health care becoming increasingly individualist. The government used “client” and “consumer” framing to cushion the impact of Medicare privatization, making it sound as an empowerment to achieve quiescence in such potentially controversial reform efforts, but some seniors felt their rights had been violated

¹¹ Gordon, *Dead on Arrival: The Politics of Health Care in Twentieth-Century America*.

because they had paid for these rights through taxes, and now they had to purchase it from the private market again.¹² Thus as governments made health care a tool of budgeting, citizens resisted changes to what they perceived to be their social rights of citizenship. This tension between the government's changing expectation for citizens and citizens' persistent expectation for their earned rights characterized the dynamic of American health care.

Few socio-demographic groups felt this tension more strongly than seniors. They were largely marginalized in the private health insurance market before Medicare, but were later constructed as the most deserving, prestigious, and almost ideal group in American social citizenship with the passage of Medicare in 1965. In the 1990s they were again plunged back into the uncertainties of the market, making the 1960s almost an anomaly, but how could someone without substantial medical knowledge make fully rational choices simply because the government expected them to do so? How, further, could someone "discipline the market" through their purchasing power when their choices were very much circumscribed? These were common questions bewildering all Americans since the so called "neoliberal turn of American health care," but established approaches often overlook the value of seniors as a group demonstrating its most stark features.¹³ From another perspective, the ideal notion of citizenship was historically built around the image of a male worker, whose stable and

¹² T. Jost, *Health Care at Risk: A Critique of the Consumer-driven Movement* (Duke University Press, 2007).

¹³ For detailed accounts for this transformation, see Sean Petty, "The neoliberal restructuring of healthcare in the US " *International Socialist Review*, Features, no. 94 (2016), <https://isreview.org/issue/94/neoliberal-restructuring-healthcare-us/index.html>.

standardized full-time employment granted him social rights tied to the concept of “decommodification.” This meant securing the right to maintain a decent standard of living during such times as unemployment or illness, as well as economic protection from destitution in old age.¹⁴ Yet seniors were among the few groups who suffered no significant cut in their benefits during what Paul Pierson called “the welfare retrenchment” in “an era of permanent austerity” starting from the 1980s, and their rights were so well protected that politicians would rather circumvent the “rights talk” by cutting payments to hospitals than actually shrink down their medical service coverage.¹⁵ In this sense, seniors might well be seen as the ideal citizens in American health care. Taken together, this demographic group is useful in explaining both the resilience and the fungibility of American social citizenship, and for this reason I try to keep seniors, and both their group advocacy and individual economic power, very much at the centre of our explanatory attention.

The purpose of explaining the change in the substance of seniors’ health rights is not to lament the loss of the golden age of social welfare, which has long been a victim of the rhetorical power of consumerism. Quite the contrary, the goal is to look forward and chart the course of social citizenship development in the twenty-first century. Each of the major theories concerning this transformation—arguments about the New Public Management, arguments

¹⁴ Esping-Andersen, *The Three Worlds of Welfare Capitalism*; Gosta Esping-Andersen, *Social Foundations of Postindustrial Economies* (Oxford University Press, 1999).

¹⁵ Henry J. Aaron, Jeanne M. Lambrew, and Patrick F. Healy, *Reforming Medicare options, tradeoffs, and opportunities*, 1st ed. (Washington, D.C: Brookings Institution Press, 2008).

about the increasingly polarized political regime, and arguments about the power of interest groups—have all been loosely appropriated for discussions of contemporary American social welfare.¹⁶ Yet they seldom ask: what underlies the balance between being exposed to “privatized risks” and having particular rights, and how did social citizenship around differentiated identities play out in this context? To address these conundrums, this thesis retells Medicare history around two causal chains: how ideological and budgetary considerations facilitate Medicare reforms, and how Medicare reforms help forge certain types of social citizenship. I develop a typology of social citizenship—contributory, ordoliberal, consumerist, and post-neoliberal—to show the progression of rights claims over time through lens of seniors’ health rights, which at once adds fabric to the narrative of welfare retrenchment and enriches our understanding of social citizenship as a philosophical term. Besides, this research does not prioritize the demonstration of theoretical approaches at the expense of accurate storytelling and historical facts, nor does it seek to legitimize one specific citizenship theory across all sections of the research. Overall, considering three interrelated dimensions—moral, political and historical, this research provides a new model for rethinking social citizenship in a context of limited resources and rising needs of an aging population.

¹⁶ See, for example, Christopher Pollitt and Geert Bouckaert, *Public Management Reform : A Comparative Analysis : New Public Management, Governance, and the Neo-Weberian State*, 3rd ed. (Oxford: Oxford University Press, 2011); Hacker and Pierson., *Off Center: The Republican Revolution and the Erosion of American Democracy*, Michael T. Heaney, "Brokering Health Policy: Coalitions, Parties, and Interest Group Influence," *Journal of health politics, policy and law* 31, no. 5 (2006).

Development of Citizenship Studies

Scholarly discussion on citizenship could be traced back to the late 19th century, yet it is British sociologist T.H. Marshall who first theorized social rights (including the right to a guaranteed minimum of social welfare) as an essential part alongside civil (e.g., freedom of speech) and political rights (e.g., participation in the exercise of political power) that constitute modern citizenship. For Marshall, a just society relied on the equal acceptance of all citizens as full members of the political and social community so that social inequalities related to class could not be passed on to the next generation.¹⁷ However, it should be noted that Marshall was writing at a time when some kind of equilibrium was attained as the post-war British welfare state helped forge a “class compromise” between large capital and organized labour.¹⁸ In America, the Civil War pension system as well as those “maternalist” welfare policies for women and children had also constituted a “precocious social spending regime” since the progressive era.¹⁹ Especially since the famous 1960 book *The End of Ideology*,

¹⁷ T. H. Marshall, *Citizenship and Social Class and Other Essays* (Cambridge: Cambridge University Press, 1950).

¹⁸ Interestingly, Edgerton questioned whether the UK can be accurately described as social democratic after 1945 and argued that while there were significant transfers to the public sector and some social democratic elements in policies like the NHS, there was a lack of a distinctively social democratic governmentality or systematic effort to restrict the prerogatives of property. For Edgerton, the post-war consensus was more about pragmatic management rather than a true class compromise driven by social democratic ideals. For details, see David Edgerton, “What Came between New Liberalism and Neoliberalism? Rethinking Keynesianism, the Welfare State and Social Democracy,” in *The Neoliberal Age? Britain since the 1970s*, ed. Aled Davies, Ben Jackson, and Florence Sutcliffe-Braithwaite (UCL Press, 2021).

¹⁹ Skocpol, *Protecting Soldiers and Mothers : the Political Origins of Social Policy in the United States*.

the debate between laissez-faire capitalism and Marxist theories of class struggle—the two biggest ideological legacies of the nineteenth century—was largely rendered redundant because a welfare state was proved to be capable of reconciling divergent demands.²⁰ As a result, the 1960s saw few studies addressing social citizenship as well as the question of what it meant to be an American citizen in any systematic sense, despite some general analysis on the social contract asserting that the state has a moral obligation to secure a certain level of social rights for its citizens.

In the 1970s, economic stagnation called into question the solvency of almost all public programs and subsequently highlighted the tension between citizenship and capitalism: while social citizenship was a vision underpinned by equality, capitalism was characterized by de facto inequalities of income and wealth. Marshall recognized this tension in his later works and regarded social citizenship as a component of a “hyphenated society”. That is, a democratic–welfare-capitalism society where full citizenship status was achieved with all three elements in equilibrium.²¹ Along with Marshall’s synthesis there has also been a revival of interest in conditions for full citizenship, especially by political

²⁰ The author later provided a more sophisticated version of the idea, see Daniel Bell, *The end of ideology : on the exhaustion of political ideas*, Revised ed. (Free P; Collier-Macmillan, 1965). However, recent scholarship, particularly from historians like Elizabeth Tandy Shermer, Kim Phillips-Fein, and Bethany Moreton, has increasingly challenged this view, suggesting instead that the welfare state has not adequately reconciled these divergent demands and that class-based and economic inequalities remain deeply embedded within American society. See Elizabeth Tandy Shermer, *Sunbelt Capitalism: Phoenix and the Transformation of American Politics* (University of Pennsylvania Press, 2015); Kim Phillips-fein, *Invisible Hands: The Businessmen’s Crusade Against the New Deal* (W. W. Norton & Company, 2009); Bethany Moreton, *To Serve God and Wal-Mart: The Making of Christian Free Enterprise* (Harvard University Press, 2010).

²¹ T. H. Marshall, “Value Problems of Welfare Capitalism,” *Journal of Social Policy* 1 (1972); T. H. Marshall, *The Right to Welfare* (London: Heinemann Educational Books, 1981).

scientists and policy analysts on the Right who held that public programs had been encouraging welfare dependency and accordingly undermined citizens' moral character.²² At the same time scholars were re-evaluating the nature and aims of the welfare state. Robson, for example, emphasized that effective welfare states entailed a high degree of individual freedom, protection of citizens from abuses of power, as well as continuous improvement of social services.²³ In short, during this period the conception of social citizenship and social rights started to diverge from what was originally seen as the provision of welfare benefits.

Citizenship studies in the 1980s was a field significantly influenced by the New Right, which advocated for free market mechanisms in all spheres of public policy.²⁴ Lister examined the debate on citizenship in this period particularly regarding the New Right's opposition to the "dependency culture" and their support for an "enterprise culture", in which individuals were responsible for their own welfare.²⁵ New Right philosophers also challenged John Rawls's ideas on social justice, which have been very much influential in political philosophy.²⁶ However, on his argument that a just society should allow inequalities of wealth and power only if they have a positive impact on the well-

²² Mary Bryna Sanger, *Welfare of the Poor*, 1 ed. (San Diego: Elsevier Science & Technology, 1979); Ralph Segalman, "American Models of Social Welfare and the Developing Nations," *Studies in Comparative International Development* 9, no. 2 (1974).

²³ William A. Robson, *Welfare State and Welfare Society* (London: Allen&Unwin, 1976).

²⁴ Daniel Stedman Jones, "Introduction," in *Masters of the universe: Hayek, Friedman, and the birth of neoliberal politics* (Princeton University Press, 2012).

²⁵ Ruth Lister, *The exclusive society: citizenship and the poor* (London: Child Poverty Action Group, 1990).

²⁶ This was particularly related to his work: Rawls, *A Theory of Justice*.

being of the most disadvantaged group in society, Flew charged Rawls with distorting the very notion of justice, and Nozick accused him of disregarding the importance of property rights and of assuming that society had a ready supply of goods to distribute according to Rawlsian principles.²⁷ While neoliberalism—
—an important branch of the New Right—emerged in the 1930s, it was not until the 1980s that this rationality gained dominance in both political and philosophical debates.²⁸ Much literature drew on works by Hayek and Friedman to examine new ways of welfare provision and the changing boundaries of social citizenship.²⁹ Overall, the 1980s saw discussions on social citizenship focusing on the redirection of social structure, not only regarding the delusion of state interventionism but also about new ways to organize citizens' lives, seeking to enhance their social sense as members of this entrepreneurial community.

Around the turn of the century citizenship studies were largely divided. On the one hand, the New Right emphasized consumer empowerment in welfare state programs and replacement of state functions by deregulation and privatization. Some ideas were especially throughgoing: Barbalet doubted that social rights were citizenship rights at all, and Bourdieu called for an adjustment

²⁷ Anthony Flew, *The Politics of Procrustes: Contradictions of Enforced Equality* (London: Temple-Smith, 1981). For an in-depth analysis on Nozick's ideas, see Lester H. Hunt, *Anarchy, state, and utopia: an advanced guide*, 1st ed. (Chicester: Wiley, 2015).

²⁸ Gary Gerstle, *The Rise and Fall of the Neoliberal Order: America and the World in the Free Market Era* (OUP USA, 2022); Jennifer Burns, *Goddess of the Market: Ayn Rand and the American Right* (Oxford University Press, USA, 2011); David Harvey, *A Brief History of Neoliberalism* (Oxford University Press, 2005).

²⁹ See, for example, H. Johansson and B. Hvinden, "Welfare Governance and the Remaking of Citizenship," in *Remaking Governance: Peoples, Politics and the Public Sphere*, ed. J. Newman (Bristol: Policy Press, 2005).

of both the state and citizens to enable structural, generalized competition.³⁰ On the other hand, there has been a revival of the interest in social rights and duties as well as social inclusiveness, as it was increasingly acknowledged that more privatizations did not necessarily equate to more autonomy and freer choice.³¹ Marshall's original works were reexamined in this regard, but this time with a focus on the relations between welfare and workfare. "The incentive that responds to social rights is that of public duty," according to Marshall, "the citizen is urged to respond to the call of duty by allowing some scope for the motive of individual interest."³² Scholars then approach such conditional citizenship from various lenses, anchoring it within a broader analysis of social inclusion and inclusiveness.³³ Taken together, the seemingly competing ideas between the market dogma and social inclusion have compelled the government to derive new approaches to social rights, facilitating what was commonly known as "the Third Way" in the United States and Britain. This partly explained why we constantly saw welfare policies being featured by what Bode termed a "conceptual fragmentation," with universal rights still dominating some policy areas, while others followed a market-based approach; and a "procedural

³⁰ J. M. Barbalet, *Citizenship: Rights, Struggle and Class Inequality* (Milton Keynes: Open University Press, 1988); P. Bourdieu, "The Left Hand and the Right Hand of the State," *Variety* 32, Summer (2008).

³¹ For how and why this occurred, see David Green, *Reinventing Civil Society: The Rediscovery of Welfare Without Politics* (London, 1993).

³² T. H. Marshall and T. B. Bottomore, *Citizenship and Social Class* (London: Pluto Press, 1992), 43.

³³ E.g., Joel F. Handler, *Social Citizenship and Workfare in the United States and Western Europe: The Paradox of Inclusion*, 1 ed., Cambridge studies in law and society, (New York: Cambridge University Press, 2004); Stuart White, "Review Article: Social Rights and Social Contract—Political Theory and the New Welfare Politics," *British Journal of Political Science* 30, no. 3 (2000); H. Hecló, "The Search for Social Citizenship," in *Poverty, Inequality and the Future of Social Policy*, ed. K. McFate, R. Lawson, and W.J. Wilson (New York: Russell Sage Foundation, 1994).

fragmentation,” resulting from inconsistent outcomes in terms of coverage and quality due to marketization.³⁴

The neoliberal discourse was still prevailing after the early 2000s, but increasing attention was directed to the “social investment” perspective. Discussions on social investment could be dated back to the mid-1990s, when the ill-fated Clinton health plan generated much debates on long-term care and its costs, but its policy impacts were not systematically analyzed until well into the next century.³⁵ A “social investment state”, termed by Anthony Giddens in his 1998 work *The Third Way*, typically entailed an investment in social and human capital so that social citizenship could be reinforced within a post-industrial, knowledge-based economy.³⁶ In practice, it meant different patterns of social spending, increasing support for labour market participation as well as more efforts to ensure work would pay so that pension systems could stabilize in an aging society.³⁷ This suggested a shift of state expenditure from “passive spending” to preventive and proactive “investments”. Compared with neoliberalism, social investment prioritized social policy rather than implementing austerity measures. It promoted a more generous approach to

³⁴ Bode Ingo, “Social citizenship in post-liberal Britain and post-corporatist Germany: curtailed, fragmented, streamlined, but still on the agenda,” in *Social Policy Review 20: Analysis and Debate in Social Policy*, ed. T. Maltby, P. Kennett, and K. Rummery (Policy Press, 2008).

³⁵ It should be noted that most theoretical advancement in social investment is placed within the context of Britain and EU countries. For an overview see Adalbert Evers and Anne-Marie Guillemard, *Social Policy and Citizenship: The Changing Landscape* (Oxford: Oxford University Press, 2013). Yet little systematic review is found on social policies in the United States.

³⁶ Anthony Giddens, *The Third Way: The Renewal of Social Democracy* (Cambridge, UK: Polity Press, 1998).

³⁷ Jane Jenson, “Redesigning Citizenship Regimes After Neoliberalism: Moving Towards Social Investment,” in *Towards a social investment welfare state? Ideas, policies and challenges*, ed. Nathalie Morel, Bruno Palier, and Joakim Palme (Bristol University Press, 2012).

welfare reform but regarded the modern welfare state as an economic entity beyond a social necessity; it emphasized the importance of social protection but replaced citizenship rights with the notion of social policy as the vehicle of economic growth. However, to date social investment analysis is still in its early stages.³⁸ It has not been fully acknowledged as a dominant framework in welfare state analysis on a par with Keynesianism or neoliberalism, and its development trajectory was greatly contingent upon the precarious aftermath of the global financial crisis between 2007 and 2010.³⁹

In overview, each period of social citizenship study carries a distinct label in both field of studies: the 1960s with Keynesianism, the 1970s with a diversified definition of social citizenship, the 1980s with the New Right, the turn of the century with the Third Way, as well as the 2010s with social investment theories. Yet two aspects are particularly noteworthy here. First, citizenship studies have been navigating between the poles of a Keynesian welfare state and the neoliberal ideal of an entrepreneurial society. Second, citizenship studies developed much more quickly in Britain than in any other Western countries, and much literature we have reviewed were situated within British and European contexts since Marshall gave social citizenship its current persona. Marshall made little attempt to differentiate types of social citizenship,

³⁸ Christopher Deeming and Paul Smyth, "Social Investment after Neoliberalism: Policy Paradigms and Political Platforms," *Journal of social policy* 44, no. 2 (2015).

³⁹ Nathalie Morel, Bruno Palier, and Joakim Palme, "Beyond the welfare state as we knew it?," in *Towards a social investment welfare state?*, ed. Nathalie Morel, Bruno Palier, and Joakim Palme, Ideas, policies and challenges (Bristol University Press, 2012).

but it clearly assumed quite different forms in Europe and in America. In this thesis we shall see a more nuanced account of social citizenship in the US context. Focusing the elderly as a distinctive category sheds new light on the idea of social citizenship and contributes to its theoretical debate with regard to health rights.

A Brief History of Medicare

As discussed before, Medicare's delay from the 1930s to the 1960s reflects changing views on the role of government in guaranteeing citizens' welfare in terms of social rights. In the 1930s, while Social Security addressed old-age income as a basic social right, health care was not seen as a collective entitlement. Political resistance, especially from the American Medical Association, framed health care as a private, market-based good rather than a right that the state should guarantee, limiting the scope of social rights to economic security without addressing health security. By the 1960s, however, attitudes toward social rights had evolved. Rising health care costs, the growing elderly population, and the successes of other welfare programs led to the idea that access to health care for older Americans was essential to a dignified life in retirement, as much a social right as income security. The civil rights movement also expanded public awareness of social justice and equity, pushing health care access onto the social rights agenda. President Lyndon B.

Johnson's Great Society program, with its emphasis on expanding rights and protections for marginalized groups, framed Medicare as a moral and civic duty, enabling health care to be recognized as a core social right for the elderly. Thus, Medicare's enactment in 1965 marked an important shift, embedding health care within the framework of American social rights, where federal responsibility extended to include both financial and health security as essential to citizenship.⁴⁰

Medicare's evolution from the 1970s to the 2010s also reflected an ongoing struggle to balance seniors' entitlement to health care with financial constraints and market-driven reforms. In the 1970s, economic challenges pressured Medicare to implement cost-control measures like the Professional Standards Review Organizations (PSROs) and anti-fraud amendments, aiming to protect program integrity. Simultaneously, proposals like President Ford's catastrophic coverage in 1976 emphasized expanding Medicare's role in safeguarding seniors from extreme financial risk due to prolonged illness. This period reinforced Medicare's commitment to seniors' health rights despite economic limitations.⁴¹

In the 1980s, the Reagan administration introduced the Prospective

⁴⁰ Daniel Béland and Jacob S. Hacker, "Ideas, Private Institutions, and American Welfare State 'Exceptionalism': The Case of Health and Old-Age Insurance, 1915–1965.," *International Journal of Social Welfare* 13, no. 1 (2004).

⁴¹ For how presidents have influenced health policy as well as political motives, see David Blumenthal and James A. Morone, *The Heart of Power: Health and Politics in the Oval Office* (Berkeley, CA: University of California Press, 2010).

Payment System (PPS) and authorized Health Maintenance Organization (HMO) contracts through the Tax Equity and Fiscal Responsibility Act (TEFRA), marking a shift toward cost predictability and market involvement. Alongside cost-control efforts, discussions of catastrophic coverage resurfaced with the Medicare Catastrophic Coverage Act (MCCA) of 1989. It was quickly repealed as seniors were furious about the surtax to fund it—the anticipated benefits did not outweigh the costs for many seniors, but overall, the 1970s and 1980s both saw the government striving to reconcile seniors' health rights with limited resources.⁴²

The 1990s and early 2000s saw Medicare embrace a market-oriented model, with legislation like the Balanced Budget Act (BBA) and Medicare Modernization Act (MMA) emphasizing “managed competition.” This approach framed seniors as consumers in a health care marketplace and changed Medicare from a health care *program* to a health care *market*.⁴³ Nevertheless, even with the dominance of neoliberal thoughts—an entrepreneurial mentality—in policymaking and the supposed “crisis” of the welfare state, Medicare reforms did not completely dismantle its original architecture. Social inclusion and social rights were clearly articulated in the reforms, albeit in a way that

⁴² David Dranove, *The Economic Evolution of American Health Care: From Marcus Welby to Managed Care* (Princeton, NJ: Princeton University Press, 2000).

⁴³ Jonathan Oberlander, “The Politics Of Health Reform: Why Do Bad Things Happen To Good Plans?,” *Health Affairs* 22 (2003), <https://doi.org/10.1377/hlthaff.W3.391>.

differed sharply from those conceived in traditional welfare provisions.⁴⁴ Overall, while policymakers around the turn of the century were still enthusiastic about the role of market in reining Medicare costs and promoting its efficiency, they were combining this endeavour with a more sophisticated interpretation of individualism and citizenship rights, with incentive design and consumer empowerment being the key words of this narrative.

Medicare in the 2010s was underlined by a social investment principle. The Affordable Care Act (ACA) of 2010 was considered to be deeply rooted in the neoliberal tradition, but it also entailed a significant expansion of benefits by closing the so-called “donut hole” in the Part D prescription drug program and making more preventive services accessible to Medicare beneficiaries with no cost sharing.⁴⁵ In 2018, CMS also expanded the supplemental benefits available to beneficiaries with chronic conditions in the Medicare Advantage program, going beyond what was covered by traditional Medicare⁴⁶ By allocating more spending towards social services, it aimed at generating long-term dividends such as lower costs and better health outcomes. Except for these endeavors, there has been a recent push for “Medicare for All” as a single-payer program in Medicare research. The notion of Medicare as a base for universal health care was nothing new, but only at two moments has it

⁴⁴ For Medicare’s financing structure and political challenge during this period, see Marilyn Moon, *Medicare Now and in the Future* (Washington, D.C.: Urban Institute Press, 1996).

⁴⁵ Howard Waitzkin and Ida Hellander, “Obamacare: The Neoliberal Model Comes Home to Roost in the United States—If We Let It,” *Monthly review (New York. 1949)* 68, no. 1 (2016).

⁴⁶ William H. Shrank, Donna J. Keyser, and John G. Lovelace, “Redistributing Investment in Health and Social Services—The Evolving Role of Managed Care,” *JAMA* 320, no. 21 (2018).

forged large-scale debate—one in 2020, when Democrats made it a political issue, and one in 1965, almost immediately after ink was dry on LBJ's signature.⁴⁷ Sixty years after the inception of Medicare, discussions on the program seemed to hark back to an earlier appeal to health care as a universal public good.

Taken together, the development of Medicare featured three trends. First, its cost containment reforms primarily made cuts to hospital payments rather than benefits. In fact, benefits continued to expand over time. This is what I call the “inertia” of popular, large scale social programs with entrenched interests. Second, the program's generosity in payments declined as it developed, and there has been an increasing emphasis on its sustainability. While the late 1960s saw Medicare capitalize on the prevailing liberal momentum to robustly institutionalize health rights for seniors, the following decades were characterized by increasing demands, limited resources, and struggles of the government to reconcile the two. Third, Medicare has become an intricate maze navigable only by those knowledgeable and resourceful individuals who could make “rational” decisions as well-informed consumers, while many seniors fell through the cracks. However, this was not a linear story of decline from Medicare's inception—it was about a shift of priorities. My research thus

⁴⁷ For such debate in Medicare's early years, see Mark Schlesinger and Jacob S. Hacker, “Secret Weapon: The “New” Medicare as a Route to Health Security,” *Journal of health politics, policy and law* 32, no. 2 (2007), <https://doi.org/10.1215/03616878-2006-038>. For recent discussions, see Jonathan Oberlander, “Lessons From the Long and Winding Road to Medicare for All,” *American Journal of Public Health* 109, no. 11 (2019); Gail R. Wilensky, “Medicare for All,” *The Milbank Quarterly* 97, 2 (2019).

unfolds this narrative by providing a categorized analysis of American social citizenship oscillating between Keynesianism and neoliberalism. In doing so, I show a reflexive relation between Medicare and social citizenship American style: while citizenship conceptions shaped the political discourse around Medicare, Medicare's development over time also added new insights to the ideal of social citizenship.

Three Worlds of Medicare studies

Up to this point, we have learnt that social citizenship is in itself an evolving term and that it manifests different characteristics of citizens' and the government's perception on social rights over time. Yet to what extent are citizens' rights to health care justified or legitimized? If only a certain demographic group enjoys the privilege, how, or in what sense, does it serve as a meaningful philosophical or political counter to undesirable reforms within the health care system? As discussed before, the elderly become a distinctive group in the American welfare state largely after the second big bang of social programs, when Medicare addresses their health security in addition to income security. However, seldom has Medicare been approached from a lens of seniors' social rights as well as the changing definition across its political life. A historiography of the programme is helpful when understanding its complexity and the interests entrenched in this system. Built on such knowledge, we are

able to comprehend the void in Medicare research regarding rights talk as well as the necessity to bring new insights into this field.

Medicare research has proceeded along three fronts—political and economic, quality and access, as well as demographic and behavioural. Firstly, while political and economic studies have examined the influence of lobbying, interest groups, and market forces, these analyses frequently regard Medicare as a battleground for political interests rather than as a vehicle for social rights. Following the groundbreaking work *The Politics of Medicare* by Theodore Marmor, historians of American social policies have provided a wide array of insights regarding Medicare legislation as well as its impact on American seniors, medical professionals, and overall health care costs.⁴⁸ Prominent examples were Oberlander's *The Political Life of Medicare* and Béland & Waddan's *The Politics of Policy Change*. Both argued that Medicare's evolution was heavily influenced by political forces, interest group pressures, and partisan ideologies rather than merely technical and economic factors.⁴⁹ In particular, Béland and Waddan demonstrated how policies were shaped by a combination of motives as long-term efforts mixed with short-term partisan expediency and ideological principle. Yet this thesis brought a citizen

⁴⁸ Theodore Marmor, *The Politics of Medicare* (London: Routledge & Kegan Paul, 1970). See also Theodore Marmor, *The Politics of Medicare, 2nd ed* (Hawthorne, NY: Aldine de Gruyter, 2000); Oberlander, "The Politics Of Health Reform: Why Do Bad Things Happen To Good Plans?."; Aaron, Lambrew, and Healy, *Reforming Medicare options, tradeoffs, and opportunities*.

⁴⁹ Jonathan Oberlander, *The Political Life of Medicare* (Chicago: University of Chicago Press, 2003); Daniel Béland and Alex Waddan, *The Politics of Policy Change: Welfare, Medicare, and Social Security Reform in the United States*, American Governance and Public Policy series, (Washington: Georgetown University Press, 2012).

perspective into this narrative. Medicare's impact on health equity also accounted for a striking aspect of this set of scholarship. Scholars such as Butler and Rogné et. al highlighted Medicare's role in reallocating resources to promote social justice and portrayed Medicare's inception as a bold governmental effort to bring a unified national system into the fragmented old-age health insurance market into—an apt example of what Lowi called the “redistributive” policy.⁵⁰ Several prominent analyses, such as Campbell's *How Policies Make Citizens*, also emphasized the role of Medicare in fostering senior citizen activism, illustrating how the program empowered seniors to become more politically active and engaged.⁵¹ Together, these analyses highlighted Medicare as a cornerstone of American social policy and documented its development against a backdrop of both intense pressures for austerity and enduring popularity.

Substantial attention has also been paid to the role of market forces in Medicare, particularly through the influence of interest groups. Scholars like B. Ehrenreich and J. Ehrenreich have highlighted how entities within the “American health empire” (or a “medical industrial complex”) —including hospitals, nursing homes, pharmaceutical manufacturing companies and

⁵⁰ Stuart Butler, “American Values and Social Justice: Why Medicare Today Is in Conflict with Our Social Values,” *Generations (San Francisco, Calif.)* 29, no. 1 (2005); *Social Insurance and Social Justice: Social Security, Medicare and the Campaign Against Entitlements*, ed. Leah Rogné, Carroll Estes, and Brian Grossman (Springer Publishing; 1st edition, 2009); Theodore J. Lowi, “American Business, Public Policy, Case-Studies, and Political Theory,” *World Politics* 16, no. 4 (1964).

⁵¹ Andrea Campbell, *How Policies Make Citizens: Senior Citizen Activism and the American Welfare State* (Princeton, NJ: Princeton University Press, 2003); Frederick Lynch, *One Nation under AARP: The Fight over Medicare, Social Security, and America's Future*, 1st ed. (Berkeley, CA: University of California Press, 2011).

insurers—actively participate in the policy-making process to protect and advance their interests.⁵² This dynamic, where lobbying groups form a “third house” in the political arena, plays a crucial role in understanding the power structures that influence Medicare's implementation and evolution.⁵³ More broadly, in their book *The Delegated Welfare State*, Morgan and Louise examined how the interplay between market forces and delegated administration shaped the program's implementation and effectiveness.⁵⁴ Similarly, Hacker's *The Divided Welfare State* delved into the tension between public and private social benefits in the U.S. and positioned Medicare as a crucial battleground for these competing interests.⁵⁵ Given the flexibility of such a public-private partnership, Hacker also saw the existing structure of Medicare as a vehicle to achieve universal health care.⁵⁶ These discussions form the basis of our senior advocacy analysis.

The second body of research is concerned with quality of care for Medicare beneficiaries, their access to Medicare services, and the equilibrium between physicians' interests and patients' rights. Yet these issues are often framed in technical terms rather than in the broader context of citizens' rights and

⁵² Barbara Ehrenreich and John Ehrenreich, *The American Health Empire: Power, Profits, and Politics* (New York: Vintage Books, 1970).

⁵³ Alan Rosenthal, *The Third House: Lobbyists and Lobbying in the States* (Washington, DC: CQ Press, 2001).

⁵⁴ Kimberly J. Morgan and Andrea Louise Campbell, *The Delegated Welfare State : Medicare, Markets, and the Governance of Social Policy*, Oxford studies in postwar American political development, (New York ;: Oxford University Press, 2011).

⁵⁵ Jacob S. Hacker, *The Divided Welfare State: The Battle Over Public and Private Social Benefits in the United States* (West Nyack: Cambridge University Press, 2002).

⁵⁶ Jacob S. Hacker, "Medicare Expansion as a Path as well as a Destination: Achieving Universal Insurance through a New Politics of Medicare," *The Annals of the American Academy of Political and Social Science* 685, no. 1 (2019).

entitlements. The establishment of PSROs with an aim of identifying and sanctioning Medicare misconduct has generated much debate on professional autonomy and authority, and the introduction of HMOs has facilitated discussions on patients' choice and organizing structures of health care delivery.⁵⁷ These concerns were initially stated by sociologists like Paul Starr, who noted the intrusion by government regulatory agencies on physicians' sovereignty and the increase in economic and moral programs in medicine, and later by political scientists such as Lawrence Brown, in his work on HMOs during the transition from the "benefit and government expanding public philosophy in the 1960s" to the "cost and government containing spirit" since the 1970s.⁵⁸ On Medicare's attempt to introduce market forces, these discussions were also echoed by economists and health service researchers who traditionally favoured a separation of policy from politics—policy decisions should be insulated from partisan confrontations, bureaucratic pressures as well as interest group politics.⁵⁹ In this view the market was regarded as the paragon of efficiency, quality, and innovation, while government was viewed as inherently ineffective because its susceptibility to influence from interest groups

⁵⁷ On professional authority & autonomy, see R. A. Culbertson and P. R. Lee, "Medicare and physician autonomy," *Health care financing review* 18, no. 2 (1996); Bernard Barber, "Control and Responsibility in the Powerful Professions," *Political science quarterly* 93, no. 4 (1978), <https://doi.org/10.2307/2150105>. On impact of HMOs on patients' choice and health care delivery, see Richard McNeil and Robert E. Schlenker, "HMOs, Competition and Government," in *Politics in Health Care Milbank Reader*, ed. John B. McKinlay (Cambridge, Mass: MIT Press, 1981).

⁵⁸ Paul Starr, "Medicine and the Waning of Professional Sovereignty," *Daedalus (Cambridge, Mass.)* 107, no. 1 (1978); Lawrence Brown, *Politics and Health Care Organization: HMOs as Federal Policy* (Washington, DC: Brookings Institution, 1983).

⁵⁹ See, for example, Carlos Zarabozo, "Milestones in Medicare Managed Care," *Health Care Financing Review* 22, 1 (2000); James C. Robinson, *The Corporate Practice of Medicine: Competition and Innovation in Health Care* (Berkeley: University of California Press, 1999).

has significantly compromised the ability to regulate and administer programs in the public interest.

Bringing this view into sharper focus were studies on alternative payment models for Medicare. Alain Enthoven is a prominent scholar in this field. Pioneering the idea of managed competition, Enthoven proposed to integrate market mechanisms within Medicare and promote competition among health care providers to drive down costs while maintaining quality.⁶⁰ His 1984 book with Noll argued that the prospective payment system was not a long-term solution as it was itself a partial market model. A successful plan to bring Medicare cost under control, they argued, should take into account practices and problems in the entire health care financing and delivery system.⁶¹ Following Enthoven's lead, some scholars explored the cost-effectiveness of Medicare managed care as well as its "spill-over effect". For instance, Baicker et al argued that increased enrollment in Medicare Advantage, which was designed to boost healthcare efficiency through competition among private managed care plans, significantly reduced hospital costs and shortened hospital stays for both Medicare and commercially insured patients.⁶²

⁶⁰ Alain C. Enthoven, *Theory and practice of managed competition in health care finance* / Alain C. Enthoven, Professor Dr. F. De Vries lectures in economics ; 9, (Amsterdam :: North-Holland, 1988); Alain C. Enthoven, "Market Forces And Efficient Health Care Systems," *Health Affairs* 23, no. 2 (2004); Alain C. Enthoven, "Reforming Medicare by reforming incentives," *The New England journal of medicine* 364, no. 21 (2011).

⁶¹ Alain C. Enthoven and Roger G. Noll, *Prospective payment : will it solve Medicare's financial problem?* / Alain C. Enthoven and Roger G. Noll, Issues in science and technology ; v. 1, no. 1., (Washington, D.C: National Academy of Sciences, 1984).

⁶² Katherine Baicker, Michael E. Chernew, and Jacob A. Robbins, "The spillover effects of Medicare managed care: Medicare Advantage and hospital utilization," *Journal of health economics* 32, no. 6 (2013), <https://doi.org/10.1016/j.jhealeco.2013.09.005>. See also Katherine Baicker and Jacob A. Robbins, "Medicare Payments and System-Level Health-Care Use: The Spillover Effects of Medicare Managed Care," *American*

Additionally, there was a growing body of research investigating fraud and abuse within Medicare, identifying system vulnerabilities and examining their causes.⁶³ An often-seen conclusion of these studies was that the fragmented Medicare system left many loopholes for the interest groups to take advantage of, and waste and inefficiency in its operation posed a significant threat to access and quality of medical care.

The third world of Medicare research looked at its demographic and epidemiological aspects, i.e., characteristics of the Medicare population, including age, gender, race, and health status. However, they typically examine Medicare's outcomes rather than its underlying assumptions about social citizenship and the rights of individuals within the healthcare system. For instance, research by Salganicoff showed that women generally had longer lifespans and thus prolonged engagement with Medicare, while Groeneveld et al found that racial minorities often faced disparities in access to care and health outcomes.⁶⁴ There was also a growing body of literature on the behavioral and social determinants that affect Medicare beneficiaries' health and health care decisions. These studies covered a range of topics, such as health literacy,

journal of health economics 1, no. 4 (2015), https://doi.org/10.1162/AJHE_a_00024.

⁶³ E.g., Thomas H. Stanton, "Fraud-And-Abuse Enforcement In Medicare: Finding Middle Ground," *Health Affairs* 20, no. 4 (2001); David C. Chan and Michael J. Dickstein, "Industry Input in Policy Making: Evidence from Medicare," *The Quarterly journal of economics* 134, no. 3 (2019); Alberto Coustasse et al., "Upcoding Medicare: Is Healthcare Fraud and Abuse Increasing?," *Perspectives in health information management* 18, no. 4 (2021).

⁶⁴ Alina Salganicoff, "Women and Medicare: An Unfinished Agenda," *Generations (San Francisco, Calif.)* 39, no. 2 (2015); Peter W. Groeneveld, Sara B. Laufer, and Alan M. Garber, "Technology Diffusion, Hospital Variation, and Racial Disparities among Elderly Medicare Beneficiaries 1989-2000," *Medical care* 43, no. 4 (2005).

which impacted patients' understanding and management of their health conditions, and social determinants of health, including income, education, and social support.⁶⁵ Illustrative here, in their survey with 3260 Medicare beneficiaries as participants, Gazmararian et al found that 33.9% of English-speaking seniors and 53.9% Spanish-speaking ones had difficulties in reading medical information related to their health. The level of health literacy, Park and Stimpson argued, was closely related to the education and social background of Medicare beneficiaries.⁶⁶ Building on these findings, Jones and Dolsten identified major risks facing American seniors in the overburdened health care landscape and concluded that the supply crisis in Medicare could hardly manage the rising needs of the aging population.⁶⁷

In overview, all three worlds of Medicare research—political and economic studies, quality and access studies, and demographic and behavioral studies—addressed seniors' health rights to some extent. Yet the answer to the question of how health rights changed as Medicare shifted from its original architecture remained elusive. The relationship between Medicare and social citizenship was often cast in financial terms, and Medicare reformers often tackled the

⁶⁵ Yongkang Zhang et al., "Social determinants of health and geographic variation in Medicare per beneficiary spending," *JAMA network open* 4, no. 6 (2021); Melony E Sorbero et al., "Addressing Social Determinants of Health Needs of Dually Enrolled Beneficiaries in Medicare Advantage Plans," *Santa Monica, CA: RAND Corporation* (2018); Merton Lee et al., "Social Determinants Predict whether Medicare Beneficiaries are Offered a Comprehensive Medication Review," *Research in Social and Administrative Pharmacy* 19, no. 1 (2023).

⁶⁶ Sungchul Park and Jim P. Stimpson, "Unmet Need for Medical Care among Medicare Beneficiaries by Health Insurance Literacy and Disability," *Disability and health journal* 17, no. 2 (2024).

⁶⁷ Charles H. Jones and Mikael Dolsten, "Healthcare on the Brink: Navigating the Challenges of an Aging Society in the United States," *Npj Aging* 10, no. 1 (2024).

policy dilemma with either ineffective, piecemeal changes, or drastic, all-or-nothing reasoning.⁶⁸ Some scholars noted Medicare's ironic design from the start, as American physicians who appeared to lose the battle actually benefited the most from the new program, and prohibition of government interference in medical practices furnished a built-in inflationary impetus that threatened Medicare's solvency for the following decades. However, the overall message was not that "Medicare was flawed in ensuring social rights" but that these flaws resulted much less from bad policy design than the political context in which Medicare was created.⁶⁹ The next section retells Medicare history in social rights terms. The right to health care has been perceived and defended as an infungible concept since the program's inception, but we shall see the changing nature of social citizenship as the political rhetoric on rights contradicted citizens' expectation in a context of new social, political and economic dynamics.

Theorizing Citizenship Types

Measured with core elements of social welfare—broad-based social rights, government delivery of services, and direct public expenditure, this research divides citizenship evolution into four phases along with Medicare reforms: contributory (mid-twentieth century), ordo-liberal (the 1970s and the 1980s),

⁶⁸ Herman Somers and Anne Somers, *Medicare and the Hospitals: Issues and Prospects* (Washington, DC: Brookings Institution, 1967); Richard Harris, *A Sacred Trust* (New York: New American Library, 1966); Eugene Feingold, *Medicare: Policy and Politics* (San Francisco, CA: Chandler, 1966).

⁶⁹ Jonathan Oberlander, *Medicare and the American State* (Ph.D. diss. : Yale University, 1995).

consumerist (the 1990s and the early 2000s), and post-neoliberal social citizenship (the 2010s and beyond), respectively. In doing so, I provide a more nuanced account of the evolution of American social citizenship since World War Two.

Contributory

I use the term *contributory social citizenship* to capture the ideas underpinning Medicare's inception and its early years. First of all, contributory social citizenship is centered around the concept of deservingness. Skocpol has argued in her classic book *Protecting Soldiers and Mothers* that the notion of deservingness significantly influenced who received welfare benefits and how these benefits were justified.⁷⁰ An illustrative example was the Civil War pension system, which provided benefits to Union veterans and their families. Veterans were seen as deserving recipients due to their military service, legitimizing the extensive pension system. Similarly, during the Progressive Era, policies aimed at protecting mothers and children were framed around their deservingness as mothers, especially widows adhering to moral standards, were deemed worthy of support for their role in raising future citizens. I draw on Skocpol's analysis to argue that Medicare was shaped not just by economic need but also by social values and moral judgments about deservingness. Discussions connecting Medicare's inception with social rights and citizenship

⁷⁰ Skocpol, *Protecting Soldiers and Mothers: the Political Origins of Social Policy in the United States*.

also focused on the definition of deservingness and what was later known as “welfare contractualism,” that is, conditional welfare benefits based on citizens’ responsibilities and rights.⁷¹ The elderly, as life-time contributors to the country and good practitioners of such welfare contract, were then acknowledged to be better positioned than any other groups to claim such benefits.⁷²

This brings us to the second dimension of contributory social citizenship: conditional benefits. The term is usually discussed regarding work-tests in welfare, yet it also highlights the government’s obligation in ensuring certain needs. In his 1986 book *Beyond Entitlement*, Lawrence Mead emphasized both rights and responsibilities conferred by social citizenship, proposing to introduce contracts that require welfare beneficiaries to accept work, training, and/or other obligations in exchange for their benefits⁷³. However, Stuart White, in his analysis on welfare contractualism—a philosophy that regards welfare benefits as a contract instead of a charity, argues that fair reciprocity is achieved only when the society distributes the social product to recognize and institute a right of reasonable access to the resource package necessary to meet citizens’ basic needs, i.e., needs for food, clothing, housing, effective social participation as well as health care. Here reasonable access means one can get this

⁷¹ E. Richard Brown, “Medicare and Medicaid: The Process, Value, and Limits of Health Care Reforms,” *Journal of public health policy* 4, no. 3 (1983). On welfare contractualism, see White, “Review Article: Social Rights and Social Contract—Political Theory and the New Welfare Politics.”

⁷² On the political implications of deservingness, see Michael B. Katz, *The Undeserving Poor: America’s Enduring Confrontation with Poverty*, 2nd ed. (Oxford University Press, 2013); Gordon, *Dead on Arrival: The Politics of Health Care in Twentieth-Century America*.

⁷³ Lawrence Mead, *Beyond Entitlement: The Social Obligations of Citizenship* (New York: Free Press, 1986).

resource without unreasonable efforts.⁷⁴ Besides, fair reciprocity entails a protection of citizens from the dangers of market vulnerability and the risks of capital exploitation. Taken together, with deservingness being a prerequisite, the concept of contributory social citizenship involves two dimensions: in a contractual relationship where citizens are required to make contributions, the government is also bound by obligations to ensure reasonable access to certain needs.

Ordoliberal

The 1970s and the 1980s saw the government “talk right” while “legislating left” in addressing Medicare’s financing problems.⁷⁵ On the one hand, there was a decline in reciprocity—the obligation of distributing resources was partly shifted to private actors in forms of utilization review and cost control measures like the Professional Standards Review Organizations and Health Maintenance Organizations. On the other hand, Medicare benefits actually expanded when the 1972 amendments made disabled people eligible for the program. Individuals enrolled in the Old-Age, Survivors, and Disability Insurance (OASDI) program could qualify for Medicare after a two-year period, while those with end-stage renal disease (ESRD) were eligible immediately. Besides, President Ford called to introduce coverage for catastrophic illness under Medicare, and

⁷⁴ Stuart White, “Welfare Contractualism,” in *The Civic Minimum: On the Rights and Obligations of Economic Citizenship*, ed. Stuart White (Oxford: Oxford University Press, 2003).

⁷⁵ Oberlander, *The Political Life of Medicare*.

there were some Medicare-funded demonstration projects on end-of-life care.⁷⁶

I draw on German ordo-liberalism (which took its name from the German journal *Ordo*) to illustrate the essence of social citizenship reflected in this seemingly contradictory strategy. On a conceptual level, ordo-liberalism embraced a high degree of state intervention and regarded the role of the state as the very centre of designing public policy and building an ideal social order of capitalism.⁷⁷ At the same time, ordo-liberals also conceived of the need to theorize a framework on the relationship between the state, the economy, and society in general, and therefore came up with an early understanding of a socially embedded competitive order. To address what they framed as “the social question,” ordo-liberals attempted to resolve issues of social cohesion while at the same time limiting the welfare state. They managed to do so because of their readiness to cross disciplinary boundaries and successful formation of the sociocultural foundations required for a liberal economic order, that is, a regulatory order comprised not only of legal and state but also social institutions.⁷⁸

It is worth noting here that while almost all periods of American social welfare manifested a certain level of ordoliberal principles, the concept does

⁷⁶ For detailed account of these reforms, see Edward D. Berkowitz, *Something Happened: A Political and Cultural Overview of the Seventies* (New York: Columbia University Press, 2006); Jonathan Engel, *Unaffordable: American Healthcare from Johnson to Trump* (University of Wisconsin Press, 2018).

⁷⁷ David Gerber, "Ordoliberalism: A New Intellectual Framework for Competition Law," in *Law and Competition in Twentieth-Century Europe: Protecting Prometheus*, ed. David Gerber (Oxford University Press, 2001).

⁷⁸ Ralf Ptak, "Neoliberalism in Germany: Revisiting the Ordoliberal Foundations of the Social Market Economy," in *he Road From Mont Pèlerin: The Making of The Neoliberal Thought Collective*, ed. Philip Mirowski and Dieter Plehwe (Cambridge, MA and London, England: Harvard University Press, 2019).

not fully capture the American health care state due to differences in ideological roots, structure, and policy orientation. The New Deal (1930s) and Great Society (1960s) initiatives reflect an expansive vision of the welfare state that was more interventionist than ordoliberalism's concept of a socially embedded market. Besides, unlike ordoliberalism's model of state-supported competition and social order, American policy has focused more on individual agency and minimal interference especially after the 1980s. As we shall see in Chapter 5, American welfare since the 1990s increasingly emphasized privatization, deregulation, and individual choice, resulting in policies that pushed risk onto individuals and introduced private options into welfare services more extensively than ordoliberal social citizenship entails. The American model's marketization—such as private health insurance reliance and privatized retirement accounts—also diverges from the limited, regulatory stance under ordoliberal social citizenship. As will be explained in Chapter 4, ordo-liberal citizenship is an apt term capturing the government's efforts to strike a balance between state regulation and market principles during the 1970s and the 1980s. These reforms aimed to maintain social cohesion and protect the elderly while limiting the welfare state's expansion, reflecting ordo-liberal ideals of a socially embedded competitive order.

Consumerist

During the 1990s, Medicare was further opened to market forces with

redesigned economic incentives for both its beneficiaries and medical providers—an apt example for the making of “welfare consumers” in Baldock’s words and a period marked by what I call *consumerist social citizenship*. The term is largely two-sided. On the one hand, it takes roots in neoliberalism and therefore downplays democratic participation. It has been acknowledged that neoliberalism is detrimental to political-democratic dimension of citizenship, and there are voices that consumption contradicts social citizenship as its emphasis on personal choice has greatly eroded the once powerful idea of a collective citizenry. On the other hand, however, from another perspective consumerist citizenship can also help redefine the public values and goods—as Canclini articulates in his book *Consumer Citizens*, “when we select goods and appropriate them, we define what we consider public valuable, the ways we integrate and distinguish ourselves in society.”⁷⁹ As we shall see in Chapter 4 and 5, while Medicare beneficiaries make choices between different insurance plans with varying delivery mechanisms and co-payments/deductibles, they also reshape the patient-doctor relations and facilitate the development of certain insurance plans. In this sense, through consumption citizens are also participating in the transformation of welfare programs and can therefore be considered as co-authors of social citizenship.

Further to this point, consumerist citizenship entails a market-dominated society where the public sector is gradually assimilated into the market

⁷⁹ Nestor Canclini, *Consumer Citizens: Globalization and Multicultural Conflicts* (G. Yudice, Trans.) (Minneapolis: University of Minnesota Press, 2001), 20.

framework. This means consumerist citizenship is not an unconditional membership but a status contingent upon one's ability to contribute market value, with buying and selling being the central gauge of its worth. Contrary to the Marshallian ideal of social citizenship—universal and unconditional entitlement, consumerist citizenship fosters a depoliticized, knowledge-based, and elite-driven welfare state which justifies power asymmetries and prioritized economic logic over moral logic. Emphasizing “recognition” and “participation,” individuals under consumerist citizenship are conceived as “subjects” rather than “objects” in the welfare state.⁸⁰ In this narrative the passively entitled citizens are replaced by actively engaged citizen—the smart “health care consumer” —who claim a voice in their own health provision, challenging the supremacy of medical professionals and being responsible for their own health care choice. In a public statement on 20 September 2001, President George W. Bush also testified this notion by regarding citizens’ “participation and confidence in the American economy” as a symbol of their support for “the values of America.”⁸¹ In short, their participation is largely defined by their economic behaviours (earning and spending) rather than democratic engagement; citizens are expected to be politically passive but socially active.⁸²

⁸⁰ Ruth Lister, "Towards a Citizens' Welfare State: The 3 + 2 'R's of Welfare Reform," *Theory, Culture & Society* 18, 2-3 (2001).

⁸¹ Quoted from Whitney Gent, "'Expensive' People: Consumer Citizenship and the Limits of Choice in Neoliberal Publics," *Communication and the Public* 3, no. 3 (2018): 192.

⁸² Tony Fitzpatrick, "The Two Paradoxes of Welfare Democracy," *International Journal of Social Welfare* 11, no. 2 (2002): 162.

Post-neoliberal

With the ascendance of the new century, Medicare also started to adopt preventive measures to reduce the use of expensive medical services in the future. Examples include the “initial preventive physical examination” introduced by the MMA in 2003, the “end of life planning” program that prepared Medicare beneficiaries for future health care decisions in 2008, as well as the “annual wellness visits” —a comprehensive risk assessment and a “personalized prevention plan” —created by the ACA in 2010. Underpinning these measures is the theory of social investment, which represents a “social” version of neoliberalism with its emphasis on the role of social policy in supporting the development of markets.⁸³ Social investment theorists see neoliberalism as a “negative state theory” for its advocacy for the “minimalist state”. They challenge the neoliberal notion that social spending and government intervention are “in conflict with economic prosperity” and that social policy is a “wasteful cost” impeding economic growth, and regard social policy as a vehicle to reduce welfare dependency and boost social inclusion.⁸⁴ I therefore explore the philosophical tenants of social investment reflected in Medicare as *post-neoliberal social citizenship*. Notably, the “social investment spending” differs greatly from social spending that addresses “old social risks” such as pensions and financial aid that encourages dependency. In this narrative, the “passive” Medicare benefits that facilitates moral hazard are

⁸³ C. Crouch, “The Terms of the Neoliberal Consensus,” *The Political Quarterly* 68, no. 4 (1997): 358-9.

⁸⁴ Morel, Palier, and Palme, “Beyond the welfare state as we knew it?.”

replaced by “active” investments anticipating future returns.

Much literature on social investment focuses on its core features: investment in human capital and full labour market participation. However, a crucial point in such analysis, especially in relation to policies for older individuals, is the notion of “active aging.”⁸⁵ In this view, retiring from the labour market does not necessarily mean withdrawing from all forms of productive engagement. Quite the contrary, it calls for maximum autonomy and inclusion of the elderly.⁸⁶ For example, the MMA of 2003 opened up new channels for seniors’ participation in their health care decisions by creating the Office of Medicare Hearings and Appeals (OMHA), which oversaw Medicare appeals at the administrative law judge level and ensured Medicare beneficiaries’ right to a hearing in front of an Administrative Law Judge if they were unsatisfied with their initial benefits or eligibility decisions. In 2006, the World Health Organization (WHO) also improved seniors’ social inclusion initiated the global age-friendly movement. In the United States, hospitals and health care systems were redesigned to meet the specific needs of seniors, and support systems for physical and mental health were enhanced to build inviting and accessible communities for the elderly (Chapter 7).⁸⁷ In this sense, post-neoliberal social citizenship is “more to fight against social exclusion than for social equality,” in

⁸⁵ Silke van Dyk et al., “The Many Meanings of “Active Ageing”. Confronting Public Discourse with Older People’s Stories,” *Recherches sociologiques et anthropologiques : RS&A* 44, no. 1 (2013).

⁸⁶ Alan Walker, “A strategy for active ageing,” *International social security review (English edition)* 55, no. 1 (2002).

⁸⁷ Deb Hipp and Joseph Shega, “The Age-Friendly Movement And How It Supports Older Adults,” *Forbes Health*, Aug 31, 2023.

Jenson and Saint-Martin's words.⁸⁸ It goes beyond a protection from citizens from the market and emphasizes an inclusion of as many as individuals into the market.⁸⁹

Such inclusion, however, is not measured in a democratic sense. In the Keynesian era, the reconciliation between the economic and the social is largely considered as a political issue that necessitates social conflicts. However, in the post-neoliberal context the social concerns can only be addressed in a way that aligns with prevailing economic conditions. As a result, in welfare reforms democratic participation is largely rendered unnecessary, as welfare is understood as a mere response to changing socioeconomic circumstances. Additionally, post-neoliberal citizenship acknowledges the legitimacy of state intervention, but only "when it is behaving like a good business" that seeks to "increase the promise of future returns."⁹⁰ Importantly, it also restores the reconciliation of the social and economic elements, a central feature of Keynesianism that is diminished under the influence of neoliberalism. From the outset, just as with neoliberalism, the social investment theory conflicts with social citizenship and social justice due to its extension of economic rationale into social policy. However, under social investment the "social" and the "economic" are equally emphasized—the economy also needs to be reformed to satisfy social needs. Therefore, post-neoliberal social

⁸⁸ J. Jenson and D. Saint-Martin, "New Routes to Social Cohesion? Citizenship and the Social Investment State," *Canadian Journal of Sociology* 28, no. 1 (2003): 91.

⁸⁹ Anton Hemerijck, *Changing Welfare States* (Oxford: Oxford University Press, 2013), 143.

⁹⁰ Jenson, "Redesigning Citizenship Regimes After Neoliberalism: Moving Towards Social Investment," 66.

citizenship shares the neoliberal notion about a strong economic but weak democratic state—the state’s legitimacy is grounded largely in its economic performance, and the state is at once regulating the market and under the supervision of the market.⁹¹

Overview of Chapters

Chapter 1 outlines the post-war American health care system to contextualize the inception of Medicare and the formation of contributory social citizenship. Beginning with an analysis of the reason why seniors were disadvantaged in a health insurance market where major entities like Blue Cross and Blue Shield competed to diversify their offerings, this chapter emphasizes the inadequacy of seniors’ health security during this period. It then explores the politics from below, i.e., the role of the American Association of Retired Persons (AARP) in ensuring seniors’ health care rights. Together with politics from above—governmental health reforms such as President Truman’s push for national health insurance, the Taft-Hartley Act of 1947 as well as Eisenhower’s health plan, this chapter showed the post-WWII America was in urgent need of a “risk-pooling” system for seniors.

Chapter 2 explores how Medicare’s inception forged a particular type of social citizenship with a focus on the social construction of the elderly. With

⁹¹ Michel Foucault, *The Birth of Biopolitics: Lectures at the College de France, 1978-79* (New York: Palgrave Macmillan, 2008), 116.

detailed analysis on hearings held by the Senate Special Committee on Ageing and oral histories of key legislators such as Wilbur Cohen and Nelson Cruikshank, I argue that the American social citizenship in the 1960s was based on a contractual reciprocity, which followed a rationale of contract rather than charity. Such conditional citizenship had allowed American citizens to live at peace with the American liberal ideals while supporting systematically the elderly as a deserving but economically disadvantaged group at the same time.

Chapter 3 analyses ordoliberal social citizenship along with the interplay between the government and medical professionals in the 1970s. Policymakers by this time believed the loopholes in Medicare's initial legislation could be resolved through managerial and regulatory means, and therefore they focused on "supply side" reforms with regard to health service delivery and utilization review. Highlighting the irony that the government sought cost control measures while expanding Medicare benefits at the same time, this chapter shows two major features of ordoliberal social citizenship: reactive, instead of proactive, in coping with external pressures and resilient in its core principle that involved substantial government intervention and moral commitment. Chapter 4 explores the tension between budget constraints and the rhetoric of health security and social rights in Medicare reforms during the 1980s. It examines three major programs—Prospective Payment System (PPS), Medicare HMOs, and the Medicare Catastrophic Coverage Act (MCCA)—which reflected the era's "gilded" approach to policy, where the stated goals often masked

underlying budgetary motives. Overall, the chapter underscores the 1980s as a continuation of the 1970s in terms of Medicare management strategy and social citizenship type. Chapter 5 examined the debate around the BBA and the MMA and historical evidence of their effectiveness in ensuring health rights, with a focus on medical organizations, private health insurance lobby and the AARP. In doing so, I challenge the oversimplified theoretical assumptions about the consumer-driven health care (CDHC)—the moral hazard—and showed what consumerist citizenship means in practical terms and to what extent had the government’s vision about “active citizens” been compromised.

The last two chapters discuss social citizenship in a post-neoliberal era, when health care reforms in this period were largely characterized by an emphasis on patients’ behaviours and management strategies of health insurance. Chapter 6 analyses the ACA’s impact on Medicare through the lens of social investment in three major aspects: cost containment, quality assurance, and fraud and abuse prevention. Yet instead of policy details, this chapter focuses on the motivations and driving forces of certain articles of the legislation. I study discussions revolving around its increased costs for upper-income Medicare beneficiaries, and mine Congressional records from 2003 to 2010 for evidence supporting the goal of investing in Medicare’s future by helping the program get rid of payments for unnecessary services, even if they did not harm or are even marginally conducive to the beneficiaries. Chapter 7 further explores the post-neoliberal social citizenship by analysing health care

strategies of the Trump and Biden administrations. Divergent political and philosophical assumptions about the ‘Medicare for all’ and the “Medicare-like public option” are comparatively assessed. Finally, this chapter looks into the future of Medicare as both a prominent model that shaped the ongoing discussions surrounding health care and a precursor to potential shifts in US health policy.

In overview, the transformation of American social citizenship regarding health care during the past decades had been influenced by evolving notions of individualism, government responsibility, as well as market forces. Unlike European welfare states, where social rights were understood as collective entitlements, American social citizenship had always been an ambiguous one that blends notions of individual merit and collective entitlement. This ambiguity became especially apparent in the evolution of Medicare, which originally emphasized contributory social citizenship based on the idea that certain groups, like seniors, were “deserving” due to their lifetime contributions. However, starting in the 1980s, a more individualistic, market-oriented approach emerged, as the government shifted health care responsibilities onto private actors and framed citizens as consumers rather than beneficiaries of social rights. In the four phases of this transformation—contributory, ordoliberal, consumerist, and post-neoliberal—we shall see how Medicare changed from a program framed as a collective entitlement for seniors to one emphasizing “social investment” with an aim of integrating social needs with economic goals.

Therefore, my project challenges existing theories of social citizenship by demonstrating that the American experience is not merely a laggard version of European models but a unique trajectory shaped by market-oriented policies and cultural individualism. Practically, it underscored the need for policymakers to rethink social citizenship facing an aging population and contentious health care politics.

Chapter 1

Sumptuous Destitution: Health Insecurity for the Aged during the Early Post-war Years

This chapter explores the evolution of health security and social citizenship in the post-World War II United States with a focus on the complex path that ultimately led to the establishment of Medicare. By situating the Medicare debate within earlier New Deal reforms and unsuccessful proposals for public health insurance—especially the Social Security Act of 1935 and the Murray-Dingell bill—this chapter highlights the formative decisions that excluded health insurance from America’s social welfare foundation. These early legislative efforts reveal both the potential and limitations of social citizenship in the U.S. welfare state, where ideological, political, and economic forces coalesced to shape a health policy framework that prioritized private over public solutions. In particular, this chapter analyses how these exclusions from early welfare legislation not only reflected key features of American political culture but also reinforced a preference for privatized health solutions, setting a trajectory that marginalized vulnerable populations, particularly seniors, from comprehensive health coverage.

Social citizenship traditionally focused on income security. This was explicit

during the first three decades following the creation of New Deal. Yet, despite intensive debate, the Social Security Act of 1935 as a cornerstone of New Deal reforms excluded health insurance from its list of entitlements.¹ On one hand, opposition from the American Medical Association (AMA) and private insurers was fierce, driven by concerns that government-administered health care would interfere with physician autonomy and market control. On the other hand, policymakers believed that the public might view government involvement in health care as an overreach, especially in a society where self-reliance and limited government intervention were deeply valued. These dynamics created a welfare model focused on income security but left a significant gap in health coverage.

The Murray-Dingell bill, introduced during World War II by Senator James Murray and Representative John Dingell, sought to address this gap by proposing a national health insurance program that would offer comprehensive health coverage to all Americans. Building on New Deal ideals, the Murray-Dingell bill was an ambitious attempt to integrate health care into the social contract, advocating for a publicly funded system that would cover hospital stays, outpatient services, and doctor visits for all citizens. It aimed to make health care affordable and accessible and was therefore an implicit recognition that health security was essential to social citizenship (we will return to this point later in this chapter). Yet with the wartime economy already stretched thin and

¹ Edward D. Berkowitz; and Kim McQuaid, *Creating the Welfare State: The Political Economy of Twentieth-century Reform* (Praeger, 1988).

other priorities taking precedence, the Murray-Dingell bill failed to gain enough support.²

By the post-war years, the private health insurance market had rapidly expanded and filled the void left by these early legislative setbacks. The growth of employer-sponsored insurance, incentivized by tax breaks, fostered a health care landscape dominated by private insurers like Blue Cross and Blue Shield. By 1951, these plans covered over 37 million Americans, and over half of all hospital patients had some form of private insurance, a stark increase from only 9% in 1940.³ This dominance of private health insurance solidified a two-tiered system that limited access for the elderly, who often faced prohibitive costs due to their higher medical risks.

As for the unions, they received encouragement from government regulators to bargain for health care as part of the collective bargaining agreements they reached with employers.⁴ Besides, in craft trades, in which journeymen carpenters or electricians went from one job to another, unions were always allowed to organize their own health care.⁵ As a result, health care developed in a way that put the federal government at a disadvantage in the 1940s and 1950s. The absence of health insurance in the Social Security Act

² For a comprehensive account of the bill, see Leah Rogne, *Social Insurance and Social Justice: Social Security, Medicare, and the Campaign Against Entitlements* (New York, NY: Springer Publishing Company, 2009).

³ Edward D. Berkowitz, *America's welfare state : from Roosevelt to Reagan* (Baltimore: Johns Hopkins University Press, 1991), 158.

⁴ For a detailed account of how unions bargain for health, see Michael K. Brown, "Bargaining for Social Rights: Unions and the Reemergence of Welfare Capitalism, 1945-1952," *Political Science Quarterly* 112, no. 4 (1997).

⁵ For a comprehensive account of this issue, see Nelson Lichtenstein, *State of the Union: A Century of American Labor* (Princeton: Princeton University Press, 2002).

left a void that the private sector filled. A robust private market in health insurance developed, and employers and unions began to fund health insurance programs for their employees or members.⁶

In this context, social citizenship became a battleground of competing visions: while income security expanded through Social Security, health security remained fragmented and privatized. By analyzing these foundational legislative moments and the rise of private insurance, this chapter illuminates how the U.S. welfare state evolved with a clear divide between income and health security. In short, this chapter argues that the early decisions to exclude health care from social welfare programs and the subsequent development of a privatized health insurance market set the stage for Medicare as a targeted, age-specific program rather than a universal entitlement. This approach to social citizenship has had lasting consequences by shaping a U.S. health care model that combines elements of social provision with market-driven values, ultimately leaving questions of inclusivity and collective responsibility unresolved.

Health Insecurity of the Elderly

The post-war years saw three major types of insurance addressing health

⁶ Jennifer Klein, *For All These Rights: Business, Labor, and the Shaping of America's Public-Private Welfare State* (Princeton, NJ: Princeton University Press, 2010).

security: the Blue Cross and Blue Shield (BCBS) plans, commercial insurance plans, as well as prepaid group practice plans. Research by Weirnerman showed that nationwide, by 1962, around 50% of insured people were covered by commercial insurance plans, most of which were union plans negotiated under collective bargaining.⁷ Some 40% had BCBS plans. The last 10% or so were involved in various independent or local plans, among which prepaid group practice insurance took 4% of the population.⁸ These plans have sprouted up across local, regional, and national spheres of union organization with varied benefits. Some are constructed entirely or partially according to commercial policies, and others were based on non-profit entities, such as Blue Cross and Blue Shield plans and the Health Insurance Plan of Greater New York. Some employers, such as the Kaiser Co., even established their own insurance plans to furnish coverage for disability, hospitalization, and surgical requirements.⁹ The lack of homogeneity among these plans suggested post-war American health care financing was largely experimental.

Regarding health care for the aged, in the mid-1950s, big businesses in America also began to offer health coverage for both their current employees and retirees. Employers often paid a large share of premiums, and retired

⁷ Edwin Richard Weirnerman Papers, 1963 (undated), Transaction number: 389617, Box 58, Series 4. Addresses and Writings, 1939-1940, 1942, 1945-1946, 1948-1949, Archives at Yale. New Haven, Connecticut.

⁸ In California, 85% of workers were in some kind of health and welfare programs by the 1960s, with 90% of their premiums being paid by their employers. This, Weirnerman argued, was a result of local unions' collective bargaining abilities.

⁹ Edwin Richard Weirnerman Papers, 1963 (undated), Transaction number: 389617, Box 58, Series 4. Addresses and Writings, 1939-1940, 1942, 1945-1946, 1948-1949, Archives at Yale. New Haven, Connecticut.

workers were not charged extra because of higher sickness rates and higher medical costs. However, the measure was largely an unintended consequence of the 1942 Stabilization Act. Designed to curb post WWII inflation, the Act limited employers' freedom to raise wages and therefore incentivized employers to provide health insurance for their workers—companies had to attract workers and kept them loyal with perks, and health coverage was considered part of the compensation instead of taxable income.¹⁰ This trend began with the group policies the automobile industry negotiated with the United Auto Workers (UAW) in 1953 and soon became widespread across the country. By 1964, around 63 out of 100 major employers offered health benefits to retirees, according to a study by the Department of Labor.¹¹ Nevertheless, nearly half of the nation's elderly were still uninsured by 1964.¹²

BCBS companies once came closest to providing adequate health insurance for the elderly, but only for those who retired from labour unions. These plans were strongly favoured by the AFL-CIO national offices and of the headquarters of major unions and especially president of the Congress of Industrial Organization (CIO) Philip Murray and Walter Reuther of the United Auto Worker (UAW). However, beginning in the mid-1950s their subscribers were increasingly troubled by the reduced extent of protection, as many BCBS

¹⁰ David Blumenthal, "Employer-Sponsored Health Insurance in the United States — Origins and Implications," *The New England journal of medicine* 355, no. 1 (2006), <https://doi.org/10.1056/NEJMhpr060703>.

¹¹ Medical care for the aged, Part 2, (Washington, D.C.: U.S. Government Printing Office 1964).

¹² CMS.gov, Medicare 2000: 35 Years of Improving Americans' Health and Security, (<https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/TheChartSeries/downloads/35chartbk.pdf> July 2000).

plans started to adopt such measures as deductibles, coinsurance, and dollar limits on benefits under competitive and cost pressures.¹³ Following World War II, the health insurance market went through rapid expansion after the entry of commercial insurance companies into the health insurance sector. Commercial insurers, being better positioned to attract low-risk groups, gained a competitive advantage over BCBS plans and took over the market swiftly and sweepingly.

Central to this narrative is the concept of community rating and experience rating. Community rating charged the same per capita premiums to all companies in a state or region, resulting in companies with younger, healthier workers subsidizing those with older workers and retirees, while experience rating assessed their subscribers' previous healthcare utilization and set "merit-rated" premiums based on their average medical cost, lifestyle, and health habits. Non-profit BCBS plans, which commonly used community rating, were thus less attractive to companies and unions with low-risk staff and members than those provided by commercial insurance companies with lower experience-rated premiums. Besides, companies and unions with personnel in different regions saved plenty of administrative costs with for-profit, nationally uniform policies that seamlessly merged physician and hospital coverage, but BCBS plans often discouraged them with complicated policies whose benefits and administrative procedures varied from region to region.¹⁴ This at once

¹³ Christy Ford Chapin, "Chapter 5," in *Ensuring America's Health: The Public Creation of the Corporate Health Care System* (New York: Cambridge University Press, 2015).

¹⁴ Robert Cunningham and Robert M. Cunningham, *The blues: A history of the blue cross and blue shield system* (DeKalb, IL, 1997).

incentivized companies and unions with better risk rates to favour experience rating and compelled BCBS plans with a community-rated structure to increase premiums for those entities who were striving to cover their increasingly high-risk workforce.

Apart from these incentives, two other factors made it decisive for experience rating to succeed. First, the overall medical costs increased sharply in the 1950s and so did the insurance premiums, which meant that small differentials between experience rating and community rating could represent significant savings in a large group plan. Such a challenge strained the relationship between labour unions and BCBS companies in the late 1950s. Their alliance, starting from the 1930s, has been contingent on BCBS companies' pledge to provide workers with a non-profit and centrally organized administrative mechanism that ensured essential coverage, as compared to commercial insurance plans that charged employees the full rate for their health insurance while allowing employers to receive a "dividend" for each worker covered at the end of the year. However, as premiums increased, even unions in prosperous industries found it difficult to cover members and their dependents if they adhered to community rated plans. A 1963 correspondence of the United Auto Workers (UAW) showed that the collectively bargained, community-rated Blue Cross plans were taking too large a bite out of their members' benefit package.¹⁵ As a result, unions soon abandoned their

¹⁵ Rosner, David, and Gerald Markowitz. "The Struggle over Employee Benefits: The Role of Labor in Influencing Modern Health Policy." *The Milbank Quarterly*, vol. 81,1 (2003).

commitment to community rating and increasingly relied on experience rating as a means to achieve lower insurance rates for their members.

The other factor contributing to the development of experience rating was the growth in collectively bargained health plans. As health insurance programmes in the 1950s were generally (at least partially) employer-financed, a sophisticated insurance buyer was needed to deal with details of the plan. Unions were better organized and staffed than individuals and voluntary groups in this regard, and it was not uncommon for unions to negotiate plans with a premium rate that exactly covered medical costs incurred and an additional administrative cost that was the same as the average “load” based on the insurer’s own calculation. This means BCBS plans with community rating would have a quite slim profit margin with their largest group buyer. A survey on the development of the health-insurance market in the Bay Area in the 1950s showed that prevailing collective bargaining contracts played a pivotal role in making experience rating nearly ubiquitous in the Bay Area.¹⁶ These conditions together compelled BCBS plans to convert to experience rating, otherwise they would suffer from adverse selection because low-risk subscribers were disproportionately contracted with commercial insurers. By 1960, community-rating persisted, but it was mostly limited to small business employees and individual subscribers, especially in states like New York where Blue Cross could reimburse hospitals at much lower rates than commercial insurers.

¹⁶ Joseph W. Garbarino, *Health Plans and Collective Bargaining* (Berkeley and Los Angeles University of California Press, 1960).

However, this was not the true community rating of the original social insurance model. Many of the healthier, low-risk individuals had shifted to experience-rated plans, leaving behind a “community” that was largely made up of workers and their dependents, as well as the elderly, many of whom were battling chronic illnesses.¹⁷

A dire consequence of this shift was increased inequality between low-cost and high-cost groups. With unions and major employers securing cost-effective health plans for their low-cost workers, high-cost groups and the aged in particular faced sharply increased premiums as well as discrimination in the insurance market. Experience rating was supposed to be founded on objective scientific principles, but there is strong evidence that experience rating has been characterized by significant subjectivity over time, as professionally trained underwriters made subjective determinations in the application of this practice.¹⁸ Unions were so protective of the lower insurance premiums associated with an experience-rated system that they were hesitant to extend health-care coverage to retirees and even female members, as they were concerned about the potential increase in insurance premiums due to the disproportionate rate of medical claims by these high-cost groups relevant to middle-aged male workers. At the same time, the prevailing adoption of experience rating dealt a detrimental blow to the development of universal

¹⁷ Michael Morrissey, "History of Health Insurance in the United States," in *Health Insurance, 2nd edition* (AUPHA/HAP Book, 2013); J. F. Follmann, "Experience Rating vs. Community Rating," *The Journal of Risk and Insurance* 29, no. 3 (1962).

¹⁸ Duncan MacIntyre, *Voluntary Health Insurance and Rate Making* (Ithaca, N.Y.: Cornell University Press 1962).

health care. As union officials immersed themselves into the intricacies of the health care system, large amounts of resources, political energy, and time were diverted from the pursuit of national health insurance.

Importantly, the widespread commitment to experience rating has also solidified the principle of “actuarial fairness,” which means individuals should assume responsibility for their own medical risks. This was achieved through medical underwriters who assessed policyholders and price policies based on market-driven logic, and profoundly affected how Americans perceived health care. With higher-risk individuals being charged higher premiums for increased protection, Americans were shifting away from the belief in “mutual aid”, that is, collective risk-sharing in social welfare provision. Experience rating itself ran contrary to national health care, and the compromise non-profit insurers made national health insurance less feasible politically. “We fought tooth and nail. To the last gasp,” said William McNary, CEO of the Blue Cross of Michigan, “but then you get to the point where unions are pulling out because they know damn well their experience is better. We would have lost the telephone company. We would have lost the gas company. We would have lost—we did lose—the state employees, 30,000 of them, because we were not experience rating.”¹⁹ The implications are stark—either privatizing risk or being edged out. In terms of health care development, this is as much a matter of union power and insurers’ profits as a story about individualizing the risk and marginalizing disadvantaged

¹⁹ McNary, interview with Anderson, pp 8-9.

people in the health insurance marketplace.

In terms of retired workers and the aged more broadly, therefore, the inadequacies in health care were stark. Only about one-third of the collectively bargained health insurance contracts provided coverage for retired workers and fewer than one-fourth covered their dependents. Besides, comprehensive commercial health insurance policies are too expensive for most elderly individuals to afford, with policies costing between \$500 and \$600 per year in the 1960s, while the median income of aged couples in 1962 was only \$2,875.²⁰ Taking a broader view, only half of the elderly population in the US had healthcare at the end of 1962, and those who failed to acquire even the most inadequate insurance were the very ones who needed it most—the very old, those in poor health, the unemployed, and those with the lowest incomes. In fact, only one fourth of the elderly had adequate hospital insurance according to the way in which the American Hospital Association defined “adequacy”. Even those who were fortunate enough to secure adequate health insurance found themselves paying more for less, all of which coupled with rule changes of insurance plans that tended to price the aged out of the market.²¹

The reality was most likely to be bleaker. The health insurance industry claimed to have insured 10.3 million elderly people, but the number was actually inflated and misleading. A 1965 report by Senate Subcommittee on Aging

²⁰ I.S. Falk and Anita Pepper, "Health insurance through collective bargaining in an urban area " *American Journal of Public Health* 56, no. 12 (1966).

²¹ *Developments in Aging, 1963 and 1964* (U.S. Government Printing Office, Washington, D.C. 1965).

showed that the industry manipulated the data to create an impression that private health insurance had made great progress in extending coverage to the elderly. Yet the actual number of people covered by individual company mass enrolment programs was at most 750,000, not the several millions that was claimed. Besides, an overwhelming majority of all commercial hospital insurance plans paid only \$10 or less a day for hospital room-and-board services, yet the actual cost usually exceeded \$20 for seniors under such plans.²² Highlighting such inadequacy was the advancement of modern medicine in the early 1950s. The so-called “revolution in U.S. medicine” with breakthroughs such as penicillin, advanced antibiotics, radiation therapies, and pioneering surgeries made health care a more prominent issue. Fully covered Americans enjoyed easy access to these innovations through both family physicians and specialized hospitals, while people without insurance were marginalized in this system.

To sum up, private health insurance failed to provide adequate hospital protection at a reasonable premium cost for the aged, and many elderly individuals who held private health insurance found it difficult to maintain even an inadequate level of protection. In the early 1960s, policymakers reached a conclusion that the existing private health care insurance market was ill-equipped to meet the demand, as it appeared deeply flawed in its ability to provide widespread, affordable insurance with comprehensive benefits.

²² Developments in Aging, 1963 and 1964 Short.

National health care also remained unrealistic politically following World War II. Had universal health insurance been enacted in the late 1940s, policy makers would have had to deal with numerous difficulties regarding the organization, finances, and distribution of health care because they could hardly learn from the experience of the private insurance market. However, as awareness of health care inequality continued to grow, some grassroots forces also came to the fore. The next section thus shows how the AARP was created and how it strove to make health care accessible for seniors. As the organization became increasingly influential with an enormous membership base, it also brought old age health care to the national forefront and made it a pressing issue that required government involvement.

AARP: The Cradle of Active Social Citizenship

The story of AARP started with a remarkable woman. In 1944, Ethel Percy Andrus retired as California's first female urban high school principal at the age of 62 and began volunteering at the California Retired Teachers Association (CRTA). As the director of welfare for the Southern Section, she frequently visited retired teachers and was deeply moved when she learned that many retired teachers in America lived in poverty due to inadequate pensions and lack of healthcare. The defining moment came when a local grocer asked her to check on a retired teacher he had not seen in several months. Andrus

knocked on the door but no one answered. She then asked a neighbour passing by. "Oh, you must mean the old woman living out back," the neighbour said. The next moment Andrus saw the scene that changed her life and probably the entire American old age health care system in the following decades—the retired teacher was living in a chicken coop, as she was gravely ill and unable to afford medical care. It was not until then Andrus realized that the destitute living condition of retired teachers was a national issue.²³ As a result, in 1947 she founded the National Retired Teachers Association (NRTA), a precursor of the American Association of Retired Persons (AARP). For years to come, the AARP's televised commercial all began with one line, "A chicken coop—the unlikely birthplace of a fundamental idea."²⁴

Andrus's vision was clear: she wanted to organize retired teachers on a national level to give them a collective voice and to improve their living conditions. Thus, she spent years trying to convince insurance companies to provide group health insurance to NRTA members—the elderly were often deemed too risky in the health insurance market at that time. Her efforts finally paid off when Leonard Davis, an insurance agent, agreed to give it a try. Together they created a national health insurance program for retired teachers, which soon became popular. Recognizing the broader need for such coverage, Andrus expanded her vision and, with Davis's help, founded the AARP in 1958

²³ Craig Walker and Bret Bradigan, "The Age of Reformation: Dr. Ethel Percy Andrus and the Founding of the AARP," *Ojai History* Winter (2011): 123.

²⁴ AARP, *AARP History* (<http://www.aarp.org/about-aarp/company/info-2016/history.html>, May 10, 2010).

to serve the entire senior population, not just teachers—“What we do, we do for all.”²⁵ From the first day of its inception, Andrus made it clear that the AARP was built “to serve, not to be served”. Based in California, she passionately championed a vibrant and active view of aging through her speeches, interviews, and numerous visits to Washington, D.C. and state capitals. Andrus tirelessly fought against stereotypes that painted older adults as passive and dependent, and advocated for lifelong learning, self-fulfilment, and community service during retirement. “Creative energy is ageless,” she said.²⁶ Andrus’s relentless advocacy helped reshape society’s perception of aging and promoted a message that old age could be a time of continued growth, contribution, and joy. This positive image later turned out to be a major force uniting seniors in their advocacy for health rights.

The AARP grew quickly with Andrus’s groundwork. Initially, AARP operated under the NRTA umbrella, sharing administrative support and office space. Yet the organization’s landscape changed dramatically in 1959, when a direct-mail campaign advocating for the end of mandatory retirement struck a chord with the public and caused AARP’s membership to skyrocket to 150,000. The organization took pride in its rapid expansion, at one point welcoming 8,000 new members daily.²⁷ AARP’s reputation grew not just for its size but for its

²⁵ Christine L. Day, *AARP : America's largest interest group and its impact* (Santa Barbara, California: Praeger, 2017), 3.

²⁶ Ethel Percy Andrus, "The Aged and Retired," in *Who Is My Neighbor?*, ed. Esther Pike (Greenwich, CT: Seabury Press, 1960).

²⁷ David Van Tassel and Jimmie Elaine Wilkinson Meyer, *United States Aging Policy Interest Groups : Institutional Profiles* (Connecticut: Greenwood Publishing Group Inc., 1992), 16.

ability to track down nearly every American approaching the age of 50. The iconic invitation letter to join the AARP soon became a national symbol of turning 50. This success was rooted in a sophisticated database management process developed over decades. AARP meticulously purchased and mined lists from voter registrations, subscriptions, and product warranties to build an extensive network, and pioneered in using commercialized direct mail to reach them. This direct-mail prowess fuelled AARP's explosive growth and established a robust connection among older Americans nationwide.²⁸

Seniors liked the AARP largely because of its generosity. Beginning with health insurance, AARP soon broadened its offerings to attract members with a range of benefits. These included life, auto, and homeowners' insurance, affordable prescription drugs, hearing aids, and travel perks like low-cost European tours. Additionally, members could access mutual funds, annuities, tax assistance, the 55-Alive driving skills seminar (now known as the Driver Safety Program), a bimonthly newsletter called *The AARP Bulletin*, and a magazine titled *Modern Maturity*.²⁹ As the number of people enjoying these benefits grew exponentially, services on old age life became a profitable business. In 1963, five years after the organization's inception, its co-founder Leonard Davis started his own company Colonial Penn. Not only did it provide health insurance for AARP/NRTA members when no one else would do so, it

²⁸ Day, *AARP: America's largest interest group and its impact*, 16.

²⁹ *Ethel Andrus (1884-1967)*, (National Women History Museum, Archived from <http://www.nwhm.org/education-resources/biography/biographies/ethel-andrus/> on Jan. 23, 2012, 2012).

also introduced services tailored for seniors such as AARP's travel service, a temporary employment service, and even a trailer park for older adults.³⁰ Through these efforts, AARP not only delivered essential services to its members but also created a strong network that supported and enriched the lives of older Americans. This largely cemented its role as a powerful advocacy and service organization.

Besides these benefits, a significant contribution of the AARP to the senior population was restoring their dignity and value in society. In a 1961 report on a health reform bill, Dr. Larson from the AMA said what physicians had learned in the past few years was that the elderly “[were] oppressed with the feeling of not being wanted any longer, of not being useful, of not being important. They [felt] that they [had] been stripped of their value, and, hence, of their dignity as human beings.” In particular, Larson noted this was a sociological problem and “society [was] falling down on the job, not government.”³¹ The AARP largely filled this void. It encouraged continued employment beyond the traditional retirement age and encouraged seniors to actively participate in policy hearings. It also inspired them to get involved in helping others to foster a sense of purpose and community. Thus, in an era where seniors were largely seen as a vulnerable group to be “aided” or even “rescued,” it was the AARP that believed

³⁰ A telling fact here to illustrate how desperate seniors were in need of those services was that Colonial Penn was later rated by Forbes as the most profitable company—not just among insurance companies, but across all industries—in America. In his monograph on the AARP, historian Christine L. Day commented: “Arguably nobody benefited more than insurance entrepreneur Leonard Davis, who invested \$50,000 in startup funds and ended up on the Forbes magazine list of the 400 wealthiest Americans with an estimated fortune of \$230 million.” Day, *AARP: America's largest interest group and its impact*, 71.

³¹ “AMA Testifies King Bill Imperils Quality of Care,” *The AMA News* 4, no. 17 (Aug. 7, 1961).

in the power of older adults to contribute to society.³²

AARP's mission extended beyond advocacy; it was about enriching the lives of its members by promoting lifelong learning, self-fulfilment, and active participation in society. The organization aimed to educate its members on political, social, and personal issues, as outlined in their pamphlet "All About AARP."³³ In this sense, the AARP was a beacon of hope and opportunity for seniors in the late 1950s and early 1960s. Thus, through its advocacy and educational programs, AARP sought to empower its members to stay engaged as active contributors to society. It encouraged them not only to make informed decisions but to participate fully in civic and social life. This reflected a deeper meaning of social citizenship that extended beyond passive entitlements like health care or pensions and emphasized active involvement in social activities. As we shall see in the following chapters, in eras when Medicare became increasingly shaped by budgetary pressures rather than the preservation of genuine social rights, AARP's mission stood as a powerful reminder of the broader ideals of social citizenship. It highlighted that health and welfare policies should be about more than just economic pragmatism; they must also ensure that individuals—especially the elderly—were provided with opportunities for lifelong learning, meaningful engagement, and the ability to maintain their social roles. This reinforces the understanding that true social

³² Walker and Bradigan, "The Age of Reformation: Dr. Ethel Percy Andrus and the Founding of the AARP."

³³ Craig Walker, *Ethel Andrus: How One Woman Changed America* (A talk given to the Ojai Walley Museum: www.ojaihistory.com/ethel-percy-andrus-how-one-woman-changed-america/, May 1, 2011).

citizenship demanded policies that nurtured both material security and active societal participation, beyond the thin façade of fiscal austerity and rhetoric.

Also notable here is how AARP organized its members. Throughout its history, AARP prided itself on its nonpartisan and inclusive ethos—it is open to anyone aged 50 and above with a strong emphasis on voluntary service. Members could opt in by choice, and local engagement starts at the grassroots level, where community volunteers reach out to their neighbours. In the early 1960s, AARP's local chapters had a number of 3,700 groups across the country, all managed by a volunteer network through area offices. Each of the 50 states was represented by ten key representatives, ensuring comprehensive coverage and support. Four critical volunteer roles maintained the local organizational structure: Area Vice-President, Associate Area Vice-President, District Director, and Community Coordinator. These positions were essential for administrative management and fostering community involvement. One notable position was the Health Advocacy Services (HAS) volunteer, who interfaced with state coordinators to promote health care for the aged and collaborated with related agencies.³⁴ This structured approach allowed AARP to effectively support its members and address their needs through a well-organized and dedicated volunteer network.

Despite its strengths, AARP's early efforts to highlight the vitality and service contributions of its older members had an uneven effect on seniors in

³⁴ *AARP's Portfolio of Service: A profile of the community programs, services, and issues addressed by AARP*, (Washington, D.C.: AARP Programs Division, 1994).

different social strata. By harnessing the collective purchasing power of older people, AARP made health care and leisure activities more affordable, but these benefits were often out of reach for the very poor. AARP also focused on creating volunteer opportunities, which, while valuable, did not match the comprehensive support that government programs could provide for low-income seniors. This was why the most ardent advocates for AARP in its early years were white, middle-class families.³⁵ As we shall see in the next chapter, AARP's stance on Medicare was somewhat passive. There is no substantial evidence that AARP opposed the passage of Medicare, but it was not a fervent supporter either. In 1959, Ethel Andrus testified before Congress in 1959 advocating for a voluntary health care plan. This plan reflected her belief in freedom of choice as it was to be managed by a private board of trustees and funded through Social Security deductions. It also aligned with Colonial Penn's interests in selling health insurance policies.³⁶ In essence, this revealed the importance of autonomy and access to health care in seniors' health rights. In this sense, AARP's strategy of providing private-market solutions had a mixed impact. It brought valuable services to many seniors, enhancing their quality of life and enabling participation in activities that fostered community and service. However, it also highlighted the limitations of relying solely on private initiatives to address broader social issues. This necessitated government intervention to support the most vulnerable elderly populations, and it is the government's

³⁵ Day, *AARP: America's largest interest group and its impact*, 70.

³⁶ "A Retirement Force," *Sun Sentinel* (July 3, 1989).

measure to which we now turn.

Government Health Care for the Aged

In the early postwar period, old age health care did not garner significant attention, and the focus of post-war health care reforms and policies primarily revolved around broader public health concerns, the establishment of new medical institutions, and the expansion of access to medical care for the general population. Since President Truman introduced his health insurance ideas in 1949, many Democrats passionately urged for some variation of a national health insurance plan. The Wagner-Murray-Dingell bill, initially drafted in 1939 by Senator Robert Wagner, aimed to establish a national medical care and hospitalization fund. However, it faced fierce opposition and failed to gain traction, especially as President Roosevelt distanced himself from the proposal amidst economic concerns. The bill was revised in 1946, with Senators James Murray and Representative John Dingell joining Wagner to focus exclusively on healthcare. Yet again, it was denounced as socialized medicine and failed to pass.³⁷ President Truman made a third attempt on the bill after his re-election in 1948. The administration hailed it as “health security for all, regardless of residence, station, or race” and tried to sidestep accusations of communism by emphasizing pragmatic reasons such as high costs and inadequate benefits of

³⁷ "Federal Wagner-Murray-Dingell Bill," *Public Health Economics* 3, no. 8 (1946).

existing voluntary insurance. However, for a third time, the Wagner-Murray-Dingell bill lost traction in Congress as there was no significant grassroots activism to counterbalance powerful groups like the AMA.³⁸

The Taft-Hartley Act of 1947 was another significant development around the same time. Established after a wave of strikes, the Act required employers to contribute to a health fund for each hour worked by employees. This fund purchased health insurance for employees, retirees, and their dependents, and in some cases, directly covered certain medical services. Yet in fact, the Act helped build a multi-billion-dollar trust fund predominantly controlled by unions. By allowing employers to contribute to extensive benefit packages and avoid the administrative burdens of managing in-house programs, these funds became a significant source of private-sector health benefits for many workers and retirees. This close relationship and the large-scale trust funds strengthened ties between unions and private health care. This largely sidestepped the push for government-run health insurance.³⁹

Consequently, when President Eisenhower and his Republican administration took office, there were few prospects for comprehensive health insurance legislation. This explained why the Eisenhower Administration's

³⁸ For a detailed account of the drafting and legislative battle of the Act, see Monte M. Poen, *Harry S. Truman versus the Medical Lobby: The Genesis of Medicare* (Columbia: University of Missouri Press, 1979); J. Joseph Huthmacher, *Senator Robert F. Wagner and the Rise of Urban Liberalism*, [1st] ed. (New York: Atheneum, 1968); Brown, "Bargaining for Social Rights: Unions and the Reemergence of Welfare Capitalism, 1945-1952."

³⁹ NCCMP, Taft-Hartley, Multiemployer Health and Welfare Plans and National Health Care Reform, (Washington, D.C. 1949). For detailed account of union efforts on Taft-Hartley Act, see CIO, Congress of Industrial Organizations, Final Proceedings of the Eighth Constitutional Convention, (Washington, n.d. 1946).

health programs were quite modest and focused solely on allowing small insurance companies to pool resources to spread risk and instituting federal reinsurance to protect against excessive losses from extended medical insurance coverage (detailed in the next section).⁴⁰ The federal role was quite limited as well. In his 1955 special message to the Congress, Eisenhower simply recommended to authorize small Federal grants to match State and local expenditures in improving medical care for the aged, dependent children, the blind, and the permanently and totally disabled who were on public assistance programs.⁴¹ “It is unfortunately a fact that medical costs are rising and already impose severe hardships on many families,” said Eisenhower, “the Federal Government can do many helpful things and still carefully avoid the socialization of medicine.”⁴²

A critical turning point came when Representative Aime Forand introduced a bill providing health insurance coverage for persons already covered by the basic Old-Age, Survivors, and Disability Insurance (OASDI) programs in 1957.⁴³ This move stirred the waters of a dormant debate, and hearings were held on the bill in 1958. However, despite general acknowledgement of the

⁴⁰ Dwight D. Eisenhower, *Special Message to the Congress Recommending a Health Program.*, The American President Project, (UC Santa Barbara: <https://www.presidency.ucsb.edu/documents/special-message-the-congress-recommending-health-program>, 1955). See also: Alan Derickson, "Health Security for All? Social Unionism and Universal Health Insurance, 1935-1958," *Journal of American History* 80, no. 4 (1995).

⁴¹ Eisenhower, *Special Message to the Congress Recommending a Health Program.*

⁴² Dwight D Eisenhower, *State of the Union Message*, Primary Sources in U.S. Presidential History, (Washington, D.C.: Government Printing Office, Jan. 7, 1954).

⁴³ The OASDI program was introduced as part of the Social Security Act of 1935. It is not specifically a health care program, but rather a broader social insurance program designed to provide financial support to various groups of people, including retirees, survivors of deceased workers, and individuals with disabilities.

pressing need for old age health security, the House Ways and Means Committee ultimately rejected the proposal. They instead reported an omnibus social security bill that notably lacked any health insurance provisions, much to the dismay of advocates for expanded coverage. Forand did not give up. He reintroduced his hospital and surgical insurance legislation in 1959, labelled H.R. 4700. The Ways and Means Committee scheduled public hearings again to set the stage for a renewed battle over old age health insurance, but this time the focus was on its ideological implication. “Do you feel that this type of provision for the care of patients is socialized medicine?” Forand confronted Dr. Berger from the New York State Society of Internal Medicine—a major opponent of the bill representing the broader medical community nationwide. “I would say that this is a small degree of socialized medicine, yes,” Dr. Berger said, but it was not communism “because these people still have a considerable degree of free choice.”⁴⁴

Their debate continued, and Dr. Berger insisted the bill was problematic because its costs could not be managed economically by individuals alone, and the taxes to cover these costs would be shared by the entire population. Yet ironically, Dr. Berger also accepted payment for his services from local taxes in New York. He argued that local administration was more efficient and better suited to handle funds, yet he overlooked the fact that local taxes are also public

⁴⁴ *Hospital, Nursing Home, and Surgical Benefits for OASI Beneficiaries Hearings on H.R. 4700 before the House Ways and Means Committee*, (86th Cong. 1st Sess., Department of Health, Education and Welfare. Washington: Government Printing Office, 1959), 43-5.

funds, often supplemented by federal money. His willingness to accept local tax funding while condemning federal involvement thus suggested a bias against larger governmental structures rather than a coherent stance on public funding.⁴⁵ Forand clearly outperformed his opponent during the hearings, and their debate drew significant public attention to the bill's potential to address a critical gap in Social Security. However, the Eisenhower Administration remained firmly against the bill and argued that financing old age health care through federal funds was both unnecessary and potentially harmful to the foundational structure of the social security system. "We are convinced that making adequate medical care reasonably available to our aged population should, as far as possible, be achieved through reliance upon and encouragement of individual and organized voluntary action," Secretary of Health, Education, and Welfare Arthur Flemming stated on behalf of the Administration in a congressional hearing.⁴⁶

The Forand bill failed in Congress, but the controversies it generated remained. Sensing the political atmosphere, the Senate Labour and Public Welfare Committee established a subcommittee specifically tasked with studying the problems of the aged and aging. In 1959, the subcommittee scheduled hearings in six major cities across the country to capture various perspectives from local leaders of national organizations and elderly citizens.

⁴⁵ *Hospital, Nursing Home, and Surgical Benefits for OASI Beneficiaries Hearings on H.R. 4700 before the House Ways and Means Committee*, 43-5.

⁴⁶ *Hospital, Nursing Home, and Surgical Benefits for OASI Beneficiaries Hearings on H.R. 4700 before the House Ways and Means Committee*, 10.

They also consulted a panel of recognized authorities on elderly issues beforehand to inform the subcommittee's approach. In most hearings organization leaders reiterated the calls for better health care already voiced in Washington. For example, the AFL-CIO spokesman restated the organization's support for enhanced income maintenance programs and comprehensive health care in San Francisco.⁴⁷ Yet the subcommittee members did not really resonate with the issue until they opened the floor to elderly citizens in the audience. "The old folks lined up by the dozen everywhere we went," said a member of the subcommittee. "And they didn't talk much about housing or recreational centres or part-time work. They talked about medical care." The seniors shared heartfelt stories about the huge pressure of medical costs and the immense challenges they faced in getting adequate treatment. By mid-December 1959, the subcommittee had completed its hearings and returned to Washington with a wealth of testimony and data. The information later became major referencing sources of Eisenhower's health care plan based on the existing OASDI program.⁴⁸

Specifically, in May 1960, Eisenhower proposed a federal grants-in-aid plan for medical care for the aged. "I think we have got to develop a voluntary program," said Eisenhower, "...to get all the people that are interested—the insurance companies, the doctors, the older people...get them in and work out what should be the responsibility of the individual and the city and the State

⁴⁷ Robert Bocking, *Income Security* (New York: Chelsea House Publishers, 1970), 550-1.

⁴⁸ Bocking, *Income Security*, 550-1.

and, finally, the Federal Government.”⁴⁹ The first part was a state-administered program with a \$24 annual enrolment fee. States would have to cover 80% of certain medical services, but the federal government would cover an average of 50% of the overall medical costs, scaling up to 80% for poorer states. The second part involved subsidizing private medical insurance policies with federal and state funds paying up to 50% of the premiums for policies meeting state criteria. While the first part focused on direct state involvement and administration, the second one emphasized private sector involvement and subsidized individual premiums to make private insurance more affordable for the elderly. States were required to adopt both programs, but its scope was still limited—only seniors with a low-income were eligible.⁵⁰ The House Ways and Means Committee eventually rejected Eisenhower’s plan and embraced an omnibus social security bill instead. The bill included many significant changes but dropped all proposals for government-run health insurance; it even omitted plans on federal subsidy for medical services. Health care for the aged thus failed to gain momentum again.

In sum, the Truman administration largely focused on improving overall health care access but did not specifically address the unique needs of the elderly. The fear of communism and the desire to promote a free-market economy during this period also led to a preference for private health care

⁴⁹ Dwight D Eisenhower, "Presidential News Conference," *Public Papers of the President, Dwight D. Eisenhower, 1960-61* (1960): 67.

⁵⁰ *Social Security Act Amendments of 1960, House Report No. 1799, 86th Cong., 2d Sess.*, (Washington, D.C.: Government Printing Office, July 12, 1960).

solutions over government intervention. This ideological stance further marginalized discussions about comprehensive public health care programs for the elderly, as any form of socialized medicine was often met with suspicion and resistance. Old age health care gained much more attention during the Eisenhower years. A 1960 survey by University of Michigan revealed that around 60% Americans (and 65% among those aged 65 or above) preferred government involvement in old age health security, and a gallop poll showed that some two-thirds Americans supported the proposal to finance health care for the aged through Social Security.⁵¹ The failure of Eisenhower's health plan thus called for more inclusive and more comprehensive care for the aging population.

Other Health Insurance Plans for the Elderly

Apart from government proposals, health care for the aged during the 1940s and the 1950s was largely achieved through labour unions' collective bargaining for private-sector benefits. Though a 1948 survey by the 20th Century Foundation found that more than 50% of organized workers wanted a state-supported system of health insurance and old-age security, unions generally believed the possibility of creating government health program was

⁵¹ Wilbur J. Cohen, *Attitudes Toward Governmental Participation In Medical Care* (Ann Arbor: University of Michigan, 1960).

almost nil and soon tended to the private sector for solutions.⁵² The United Mine Workers (UMW) was a notable example in this regard. Led by John L. Lewis, the UMW diverted employee payroll deductions to a fund to provide medical services for its retirees, and later created a welfare and retirement fund supported by a fee imposed by local government on each ton of coal extracted (also known as a “royalty”). The goal was to create a privatized alternative to the “company doctor” system, in which mine workers made mandatory payroll deductions to pay salaries of those company doctors who cared for everything from common injuries to childbirth but had no right to select or supervise them. With this more participatory and worker-centric health care arrangement, the union restructured health care services in the Appalachian mining region by sponsoring group medical practice plans, creating new rehabilitation programs, and establishing ten general hospitals in rural areas through the Miners Memorial Hospital Association.⁵³

BCBS as non-profit insurers also played an important role in post-retirement health security. BCBS plans used to enroll those who were converted from employer group coverage. Yet in 1957, the National Association of Blue Shield Plans (NABSP) was pressing its members to accept those elderly who joined as individuals even if they were not previously employed.⁵⁴ By 1961, 51

⁵² Lichtenstein, Nelson, ‘Labor in the Truman Era: Origins of the “Private Welfare State”’, in *The Truman Presidency*, ed. by Michael James Lacey, Woodrow Wilson Center Press (Cambridge: Cambridge University Press, 1989), pp. 128–55

⁵³ Warren F. Draper, “Voluntary Health Insurance on the National Scene: The United Mine Workers Health Program,” *American Journal of Public Health* 40 (1950).

⁵⁴ It was largely because of the introduction of the Forand bill, which proposed to increase Social Security tax by 0.5% to add surgical and nursing home care to the benefit package. For details, see Frank D. Champion, *The AMA and U.S. Health Policy Since 1940* (Chicago: Chicago Review Press

among the 69 Blue Shield plans answered the call to allow nongroup coverage. Similarly, in 1962, the Blue Cross Organization also initiated a hospitalization and long-term care program with uniform rates nationwide for people aged 65 and above. Regarding the labour market, BCBS plans had been providing health coverage for both current employees and retirees of the federal government. The practice, testified by the chairman of the NABSP's board of directors Dr. Donald Stubbs, was acknowledged as a prominent case for the growing trend of employer contributions to health coverage after retirement in the early 1960s and one that the congressional committee was familiar with.⁵⁵ Over time, providing insurance for the aged gradually became a defining feature of BCBS plans.

Such a trend started even before 1957. In 1954, the Congress was planning to create a prepaid plan that allowed retirees to receive the same coverage at the same rates while they were working. Yet Eisenhower also made it clear during his 1954 State of the Union that seniors' health needs "[could] best be met by the initiative of private plans." To this end, he established a federal health reinsurance service to subsidize private health insurance organizations in offering broader benefits to their enrollees and called for private insurance entities to devise new plans catering to specific needs of the aged.⁵⁶ The American Hospital Association (AHA) and the Blue Cross Commission then

1984).

⁵⁵ Donald Stubbs, *Statement of the National Association of Blue Shield Plans on H.R. 4222, August 3* (Chicago BCBSA Archives, 1962).

⁵⁶ Eisenhower, *State of the Union Message*. (1954).

answered the call by establishing a group named the Joint Committee to Draft Legislation for the Aged, Indigent and Unemployed to conduct surveys among 14 BCBS plans. It was found that the cost of hospital care for people aged 65 or above was almost four times as high as that of people aged between 20 and 64.⁵⁷ Based on this information, the AHA and the Blue Cross Commission drafted a bill on creating a federal grant-in-aid program to subsidize health care for the aged, dependent children and the disabled. The bill later lost traction after it made its way into the Congress, but the relationship it reflected was particularly noteworthy here. The investigating and drafting process itself indicated the increasing relationship between the Blue Cross Commission and the congressional members as well as the Eisenhower administration at that time.⁵⁸ Such a collaboration, together with the Commission's growing knowledge about health care for the aged, paved the way for the BCBS companies' more nuanced approach to old age health security in the following years.

An apt example here was the Colorado health care program for the aged. In 1957, BCBS companies were chosen to administer the program when the state decided to amend its old age pension scheme to expand the provision for the elderly. The pension scheme, established in the 1930s, was originally designed to provide a monthly minimum income plan for people over 65 with

⁵⁷ BCC, *Report on Survey on Utilization by Age, October 1956*, Blue Cross Commission (Chicago: BCBSA Archives, 1956).

⁵⁸ Robert J. Myers, *Medicare* (Bryn Mawr, Pa: McCahan Foundation, 1970).

85 percent of the state's excise tax revenues. Meanwhile, its original legislation made it clear that the scheme's funds could not be used for other purposes, and any surplus in excise tax revenues should be disbursed to the beneficiaries in a year-end payment. The health care program was a result of this surplus, as the post-World War II economic boom had swollen the fund by a hundred percent. The Colorado plan also marked the first collaboration between BCBS plans and the state government in providing subsidized hospital and surgical care for the aged. "We are absolutely free of any criticism in our administration to date," said Thomas Tierney, head of the BCBS plans in Denver.⁵⁹

Beyond their collaboration with state governments, BCBS plans also made health care accessible and affordable for the elderly in many areas by following enrolment and rating policies that would not disadvantage older people. In Rhode Island, for example, BCBS plans were covering 84 percent of the elderly aged 65 or above within the state, excluding those beneficiaries of the OAA by 1959. Additionally, in the same year, the Blue Cross Commission and the AHA jointly approved an initiative to expand health care for the aged by providing more cost-effective extended care facilities and providing more fully funded care for the needy aged and other welfare recipients.⁶⁰ Such achievements in old age security not only led to BCBS plans being increasingly recognized as plans for the elderly, but provided a social laboratory that political conservatives

⁵⁹ BCA and AHA, *A Report on Health Care of the Aged* (Chicago: BCBSA Archives, 1961).

⁶⁰ James E. Stuart, *The Blue Cross Story: An Informal Biography of the Voluntary Nonprofit Prepayment Plan for Hospital Care* (Chicago BCBSA Archives, Photocopied transcript, 1966).

and the AMA favoured in their fight against universal health care. Important for our discussion about social citizenship, the fact that they ensured everyone—regardless of health status—paid the same insurance premiums aligned with social citizenship’s core values of equal access to social rights and reinforced the idea that healthcare was a right of all citizens, not just the healthy or wealthy. Community-rated BCBS plans also fostered solidarity and reduced inequality, a clear embodiment of the principles of shared responsibility central to social citizenship.

Another prominent approach addressing old age health security was a new organization form known as prepaid group practice (PGP). With prepayment, PGP plans organized and provided medical services directly and usually with its own groups of physicians and sometimes personnel from local medical centres.⁶¹ The organization of PGP was smart in its incentive design. In terms of cost control, the capitation payment provided each group member with a fixed income so that physicians were incentivised to reduce unnecessary care and use preventive methods to avoid costly care in the future, while a fee-for-service system did not involve such motivation. The way PGP ensured its quality was also kind of a check-and-balance. Each physician was responsible for the reputation of other physicians in the group, as all members within a PGP system were subject to the same malpractice insurance conditions. Given that patients of one physician might be seen by other physicians in the same group,

⁶¹ MacIntyre, *Voluntary Health Insurance and Rate Making*.

each physician had a professional and personal stake in selecting qualified colleagues and ensuring that they provide high-quality care to their patients. Further to this point, such arrangements also made it easy to establish accountability mechanisms and peer review of individual physicians' practice. This motivation of colleague interaction as well as the aforementioned cost control were nowhere to be found in fee-for-service systems, especially as private insurance plans were not subjected to systematic review .

With their integrated medical care across multiple specialities and fixed fees, PGP plans were regarded by their proponents as an effective way to provide quality medical services while constraining the expenses of health insurance for high-risk enrollees like the elderly. The PGP plans attracted officials in the US Public Health Service and gained government endorsement in the early 1960s and was soon regarded as a favourable pathway to old age health security and national health care more broadly. "The Department of HEW considers prepaid group medical practice as a promising route toward these goals."⁶² Though PGP plans only held a small market share in the 1950s and the Congress in 1959 acknowledged that prepaid health benefits were still in a state of experimentation, the concept was revisited by the Nixon administration and rebranded as "Health Maintenance Organizations."⁶³

However, PGP plans fell short in securing health care for the elderly as a

⁶² "HEW Endorses Group Practice," *Group Health & Welfare News* 1967.

⁶³ S. R. Falkson and V. N. Srinivasan, "Health Maintenance Organization," in *StatPearls* (Treasure Island (FL): StatPearls Publishing, Copyright © 2022, StatPearls Publishing LLC., 2022).

whole because most people enrolled in such plans through their occupational affiliations. The enrolment of large groups played a crucial role in the early development of PGP plans. For example, the success of the Health Insurance Plan of Greater New York (HIP) was attributed to the enrolment of New York City employees, and the Kaiser Foundation's expansion was initially driven by its relationship with the longshoremen's union. Similar cases could also be found in Detroit, where the United Auto Workers played a key role in stimulating the Community Health Association, and in Washington, D.C. where the Group Health Association was founded with a focus on providing healthcare coverage to federal employees.⁶⁴ Since the first PGP plan was introduced in 1929 by the Ross-Loos Clinic in Los Angeles to provide prepaid care to 2,000 employees and their dependents from the local Department of Water and Power, PGP plans remained relatively unfamiliar to most patients and doctors by the 1960s and continued to be a niche market. Most enrolment in PGP plans were achieved through collective bargaining, and enrollees tended to stay with the medical relationships they were familiar with. As PGP plans were still in development in the 1950s and early 1960s, it was often difficult for the general public to decipher their complicated and frequently changed rules.⁶⁵

In overview, labour union health plans and private-sector initiatives partly filled the gaps in the health insurance market at a time when government's

⁶⁴ Avedis Donabedian, "An Evaluation of Prepaid Group Practice," *Inquiry* 6, no. September (1969).

⁶⁵ Merwyn R. Greenlick, "The Impact of Prepaid Group Practice on American Medical Care: A Critical Evaluation," *The Annals of the American Academy of Political and Social Science* 399, no. 1 (1972), <https://doi.org/10.1177/000271627239900112>.

attempts to ensure old age health security largely failed, but the scope of coverage was still quite limited. By creating health funds from payroll deductions and local taxes to provide medical services for their retirees, unions largely cemented a worker-centric health care system where entitlement to health benefits was premised on employment. Non-profit BCBS plans were more generous in this regard. Not only did they provided health coverage for retirees, but they also made it available to non-group individuals aged 65 and above. Besides, BCBS's collaboration with state governments, exemplified by the Colorado health care program, marked a significant advancement in making health care more accessible and affordable for the elderly as a whole. Another innovative approach was the PGP plans. Despite their potential, PGP plans struggled to secure widespread adoption due to their niche market status and reliance on occupational affiliations. Ultimately, these efforts highlighted the experimental nature of post-war American health care financing and the challenges in providing adequate health security for the elderly. The period set the stage for the passage of Medicare and played an important role in making seniors' health rights a political issue.

Conclusion

This chapter has set to explain the post-war health care landscape that set the baseline for Medicare. While old age health care remained underdeveloped in

the 1940s and the 1950s, there was a consistent and structured pattern of interaction between major organizations and the government—a set of relations that went beyond purely pluralistic arrangements and fell into a framework that disadvantaged high-cost patients. The period saw diverse approaches to health security, with Blue Cross and Blue Shield plans, commercial insurance policies, and prepaid group practice plans each vying to diversify their coverage. Yet despite such rapid expansion of health insurance, the market failed to adequately serve the elderly. The AARP thus rose to address this issue particularly. From its humble beginnings addressing the basic health needs of retired teachers, AARP rapidly expanded to offer a wide array of services and benefits and became a powerful advocacy and service organization for seniors nationwide. While the AARP focused more on providing services than politics in its early years, its success in harnessing collective purchasing power, fighting against stereotypes of the elderly and fostering a sense of community and purpose among seniors also set the stage for future health care reforms and solidified AARP's role as a crucial player in advocating for the rights and well-being of older Americans.

However, while grassroots advocacy for old age health care was simmering, the government's efforts to address the issue were quite limited during the post-war years. Health reforms in the 1940s were largely concerned with broader public health concerns and expanding medical

infrastructure.⁶⁶ Despite persistent efforts by Democrats, including President Truman's advocacy for national health insurance, these proposals repeatedly faced strong opposition and failed to pass. The Taft-Hartley Act of 1947 further complicated the issue by strengthening private-sector health benefits through union-controlled funds and somewhat diverted public attention from government-run health insurance. As a result, the prospects for comprehensive health insurance legislation remained bleak during the Eisenhower years. Though the Forand Bill reignited the debate on old age health care, it ultimately failed in Congress due to concerns about federal overreach. Eisenhower's subsequent 1960 proposal suffered from a similar fate. The American political landscape was not ready for federal solutions for old age health care during the Eisenhower years.

Other private plans addressing health care for the aged in this period were largely centered on employment. Unions like the UMW led efforts to create privatized health care alternatives for their retirees, funded through payroll deductions and local government fees on coal extraction. Blue Cross and Blue Shield companies also played provided health coverage for retirees. They later allowed individual seniors to purchase the plan as well, but low-income seniors were still exposed to the risks of catastrophic health needs. Taking a broader view, there was no definitive winner in terms of health coverage by the late

⁶⁶ Beatrix Rebecca Hoffman, *Health Care for Some: Rights and Rationing in the United States since 1930* (Chicago, Ill: University of Chicago Press, 2012); Christy Ford Chapin, *Ensuring America's Health: The Public Creation of the Corporate Health Care System* (New York: Cambridge University Press, 2015); Derickson, "Health Security for All? Social Unionism and Universal Health Insurance, 1935-1958."

1950s, but a cross-class alliance of interests had developed to support the government's endeavour to take over the role of employer-sponsored, collectively bargained health coverage in protecting the financial well-being of the elderly and securing their equal opportunities in the insurance market. The next chapter thus examines how this story unfolds and how such advocacy amounted to important legislations and ultimately the passage of Medicare. In fact, it was not until the inception of Medicare in 1965 that health security, in addition to income security, was officially recognised as a part of social citizenship in the United States. The definition of old age health security and social citizenship more broadly in Medicare's early years is what concerns the next chapter.

Chapter 2

Contributory Social Citizenship: Medicare Inception and its Early Years

“No longer will older Americans be denied the healing miracle of modern medicine. No longer will illness crush and destroy the savings that they have so carefully put away over a lifetime so that they might enjoy dignity in their later years.... And no longer will this Nation refuse the hand of justice to those who have given a lifetime of service and wisdom and labour to the progress of this progressive country.”

—President Lyndon B. Johnson¹

The words of LBJ reflected a broader, optimistic vision of American citizenship

¹ Lyndon Baines Johnson, *Remarks With President Truman at the Signing in Independence Hall of the Medicare Bill*, Public Papers of the Presidents, Lyndon B. Johnson, (Washington: United States Government Printing Office, July 30, 1965).

by capturing the extravagant hopes attached not just to Medicare, but to the entire progressive framework aimed at eliminating poverty and racial injustice while improving the quality of life for all Americans. This optimism was shaped by several factors, including post-war economic growth and the belief in the perfectibility of American democracy. The Great Society, and specifically Medicare, reflected a commitment to an expansive vision of social rights, in contrast to the limited and reactive social policies of earlier periods like the New Deal. While the New Deal focused on economic recovery and creating a social safety net during the Great Depression, the Great Society aimed at going beyond mere survival to build a more equitable and just society. What made this moment unique was the progressive faith in the ability of the federal government to deliver large-scale social programs, addressing fundamental issues like health care. This optimism was also rooted in a belief that the American democratic system had the capacity to evolve and improve. The passage of Medicare, therefore, marked a high point in the belief that the state could and should take on an active role in securing citizens' welfare, an ideal that began to shift in subsequent decades as economic and political realities changed.

This chapter introduces a term “contributory social citizenship” to capture the LBJ administration’s attitude towards old age health security with detailed analysis on the political and health care landscape of the 1960s. Specifically, the 1960s saw the emergence of many health care programs, all of which were

ideologically framed as responses to the widespread public demand for increased accessibility to medical care. Yet different interests had different strategies to meet (and even conceive) that objective. By actively engaging in political debates, these major players strove to maximize their own interest and interacted in a way that highlighted the flaws of the insurance market. How the Johnson administration navigated through these competing interests thus warrants lengthy analysis. I argue that Medicare institutionalized a quite limited version of social citizenship that centred around individual contribution to balance these powerful interests. On the one hand, Medicare helped turn health care into a public good for seniors as the pooled funding helped mitigate financial barriers. It also elevated seniors' social status—the program's generosity in payments to hospitals and physicians, while potentially contributing to rising costs, also served to address the historically unmet needs of deserving elderly citizens. On the other hand, the program implicitly disadvantaged financially struggling seniors with its limitations—a hierarchy in health care and an undertreatment of chronic diseases.

As we shall see, social citizenship under Medicare was crystalized into a concept premised on employment and contribution. Lawrence Mead once suggested that policies enforcing work and civic duties in the United States best captured the essence of Marshall's vision and proves to be the most effective approach.² This was because Marshall's conception of citizenship was rooted

² Lawrence Mead, *Beyond Entitlement: The Social Obligations of Citizenship* (New York: Free Press,

in a delicate exchange between the individual and the state, where rights were earned through fulfilling corresponding responsibilities. Yet the deeper public debates ventured into matters of rights and responsibility, the more conspicuous it became that Americans have polarized into distinct camps with conflicting views about entitlements and social rights. On the one hand, employment-related, work-earned benefits remained a dominant theme in the public discourse, with health care being regarded as a *private benefit* by people holding conservative beliefs. On the other hand, liberals viewed health care as a *public right* guaranteeing universal coverage because it was at once integral to effective liberty and embedded in human dignity.³ As detailed below, while such moral considerations in liberal arguments resonated with the public in the 1960s, it was the political context and previous health legislations that defined the scope and content of social rights to health care.

A critical debate in the early sixties was about the public-private dichotomy. The balance between government support and individual agency in providing health security for the elderly has always been an ongoing dialogue. However, even within the voluntarist regime that held sway over health affairs in the middle of the twentieth century, there was an acknowledgment that certain social problems were beyond the reach of market solutions and required state intervention. This approach, referred to by Richard Titmuss as the “residual

1986).

³ Dan E. Beauchamp, *Health Care Reform and the Battle for the Body Politic* (Philadelphia: Temple University Press, 1996).

welfare model of social policy,” entailed governmental involvement as a final means for those being disadvantaged in the health care market. Yet the road to old age health security was still fraught with obstacles in the 1960s.⁴ Congressional conservatives used socialist medicine rhetoric and public scepticism towards government bureaucracy to divert public attention away from demands for a comprehensive, federally underwritten universal health care system. Just as journalist Godfrey Hodgson noted, Americans in the early 1960s had a strong desire for *change*, but were resistant to *be changed*.⁵ This was particularly true for health care. Americans welcomed advancements in equipment and medical services, but were not ready for changes in their lifestyle or institutions. As a result, health benefits in this period were related closely to social insurance but nothing like socialized medicine.⁶ This is particularly important for our understanding of the contributory social citizenship—deservingness centred around employment.

The analysis unfolds in four steps. First, I examine the factors facilitating health reform in the 1960s, including union efforts and grassroots mobilization. I then explore how the Kerr Mills Act and the King-Anderson bill pave way for the legislation of Medicare. As we delve into the driving forces that propelled health security into the national spotlight, it becomes evident that the lessons

⁴ Richard Titmuss, *Social Policy: An Introduction*, ed. Brian Abel-Smith and Kay Titmuss (New York: Pantheon Books, 1975).

⁵ Godfrey Hodgson, *America in Our Time* (New York: Doubleday, 1977).

⁶ Paul Starr, *The Social Transformation of American Medicine* (New York: Basic Books, 1982). See also Paul Starr, *Remedy and Reaction: The Peculiar American Struggle Over Health Care Reform*, Revised ed. (New Haven, CT: Yale University Press, 2013).

gleaned from the Kerr-Mills Act and the King-Anderson bill had a profound influence on shaping the trajectory of subsequent health care initiatives. The examination of these factors sheds further light on the evolving landscape of health security and the intricate interplay between policy, public sentiment, and social citizenship during this era. Thirdly, with detailed analysis on Medicare's benefits, I contend that health rights during the Johnson administration went beyond financial security; a part of Medicare funding was also directed to improve seniors' quality of life. The final step is to scrutinize the effects of Medicare. Under the framework of contributory social citizenship, the program helped shift health care from a private good to a public good with pooled funding and collective reimbursement. Overall, I argue that contributory social citizenship entailed a system where seniors were improved from a disadvantaged group in the health care market to an esteemed category of population.

Prelude: Health Politics from Below

Health insurance in the 1960s was much more attractive to policymakers than it had been in the 40s and 50s. The ranks of national office were increasingly filled by advocates of liberal values, and their advocacy for social welfare won the support from a growing number of seniors across the country. Senator Pat

McNamara, chairman of a newly formed Senate subcommittee specializing in aging and the aged, sensed the potential of this political atmosphere and in 1959 led the committee to hold nationwide hearings in which the elderly testified to their plight. “The old folks lined up by the dozen everywhere we went,” according to a member of the committee. “And they didn’t talk much about housing or recreational centres or part-time work. They talked about medical care.” Further boosting such public interest in health care was the extensive press coverage those hearings received and the proposals to make healthcare an additional part of Social Security around the same time. As congressmen received a greater volume of mail regarding health care compared to any other pending legislation in the months following the hearings, a news magazine even described the mounting pressure for the bill as “assuming the proportions of a crusade.”⁷ While previous opinion polls once suggested increased support for health care reform, the 1960s saw for the first time in decades a grassroots movement derived from the elderly push health care onto the national agenda .

Another force elevating old age health security to the forefront of the national conversation was organized labour. While unions never stopped bargaining for health coverage after the World War II wage stabilization policies, the 1960s saw a constellation of actions on health security by almost all unions. This largely resulted from two recurring pressures. First, medical costs were

⁷ James L. Sundquist, *Politics and Policy: The Eisenhower, Kennedy and Johnson Year* (Washington, D.C.: Brookings Institution, 1968).

rising continuously and at a rate faster than any item on the cost-of-living index, which drove up the premium rates of health insurance and made indemnity plans inadequate to ensure workers' health security. Second, questions remained if employers were willing to forego some wage increases and use that money to make an additional employer contribution. In this way, employees at once got more money to pay for the uncompensated portion of their medical bills and be exempted from some income tax.⁸ In 1960, the working members of the United Auto Workers assembled at the State Fair Grounds in Detroit to advocate for less costly and more comprehensive health insurance. More broadly, the AFL-CIO formed the National Council of Senior Citizens (NCSC) in 1961 using their preexisting organized and easily reachable retired members through union newspapers. In 1962, the NCSC launched a concerted effort to inundate Congress with letters and postcards in support of Medicare. They also conducted widespread mailings to seniors across the country, seeking their backing. In May 1962, the NCSC brought together the most prominent public event witnessed by the health reform movement.⁹

The third, and perhaps most evident, driving force was the civil rights movement. Though health care was not a priority of this struggle in American history, almost all movements during this period challenged discrimination and unjust rationing in health care to some extent, and mentioned directly and

⁸ R. Munts, *Bargaining for health : labor unions, health insurance and medical care* (Madison, Wis.: University of Wisconsin Press 1967).

⁹ Jill Quadagno, "Chapter 2," *One Nation, Uninsured: Why the U.S. Has No National Health Insurance* (Oxford University Press, 2006).

indirectly in their rights statement that medical inequality was a hinderance to full realization of social justice. Besides, while the social movement mobilizations, first by African Americans and then by other ethnic minorities, consumers, women, students and workers, together sparked equalitarianism as well as awareness of rights and changed the social relations in America, there has also been a growing concern for health care as a social right.¹⁰ At the same time, health and civil rights activists shifted the blame for poor health from vulnerable groups to institutional factors like racial segregation. Dr. Montague Cobb, president of the National Medical Association—a professional organization representing African American physicians—and a tireless advocate of racial justice, insisted that medical rights and civil rights were inextricably connected. “In a roll call of the recent Senate vote,” said Cobb, “the senators who opposed medical care for the elderly through Social Security were virtually those who traditionally opposed civil rights legislation.”¹¹

These factors together pushed health care to national prominence during the 1960 campaign and contributed to the burgeoning strength and diversity of the Medicare coalition as a political force to be reckoned with. By 1965, health care for the aged had gathered fervent and vocal support from various fronts:

¹⁰ James T. Patterson, *Grand expectations : the United States, 1945-1974* / James T. Patterson, Oxford history of the United States ; v. 10, (New York ;: Oxford University Press, 1996); Jenna M. Loyd, *Health rights are civil rights : peace and justice activism in Los Angeles, 1963-1978* / Jenna M. Loyd (Minneapolis, Minnesota: University of Minnesota Press, 2014); Hugh Davis Graham, "Legacies of the 1960s: The American "Rights Revolution" in an Era of Divided Governance," *Journal of policy history* 10, no. 3 (1998); John Dittmer, *The Good Doctors: The Medical Committee for Human Rights and the Struggle for Social Justice in Health Care* (University of Mississippi, 2017).

¹¹ Beatrix Rebecca Hoffman, *Health Care for Some: Rights and Rationing in the United States since 1930* (Chicago, Ill: University of Chicago Press, 2012), 123.

the President, labour unions, civil rights leaders, as well as senior citizens. A 1960 survey by University of Michigan revealed that around 60% Americans (and 65% among those aged 65 or above) preferred government involvement in old age health security¹², and a gallop poll showed that some two-thirds Americans supported the proposal to finance health care for the aged through Social Security.¹³ The following section looks into the intricacies of Medicare. I skip its legislative process because detailed analysis can be found elsewhere.¹⁴ Instead, I focus on the moral implications of Medicare that reflected the government's attitude towards social rights and how Medicare formalized contributory social citizenship in the American health care system.

Interlude: Kerr-Mills vs. King-Anderson

When considering the cornerstones of Medicare, two pieces of legislation were particularly relevant—the Kerr-Mills Act and the King-Anderson bill. Named after Oklahoma Senator Robert Kerr and Arkansas Congressman Wilbur Mills, the Kerr-Mills Act was introduced in 1960 empowering states to finance health care for the low-income elderly and the medically indigent through federal

¹² Wilbur J. Cohen, *Attitudes toward Governmental Participation in Medical Care* (Subcommittee on Income Maintenance and Social Security of the Coordinating Committee on Social Welfare Research 1960).

¹³ Medical Care for the Aged, 1961, Lydon B. Johnson Papers, Public Opinion New Service, LBJ Library; Cohen, *Attitudes toward Governmental Participation in Medical Care*.

¹⁴ See, for example, Christy Ford Chapin, *Ensuring America's Health: The Public Creation of the Corporate Health Care System* (New York: Cambridge University Press, 2015); Jonathan Oberlander, "The Political History of Medicare," *Generations* 39, no. 2 (2015).

matching funds. It also created a scheme called Medical Assistance to the Aged (MAA), wherein states were granted the authority to define eligibility criteria according to their own discretion. An important innovation of the Act was to provide health coverage for a new category named the medically indigent, a group aged 65 or above, who were not necessarily recipients of the old age assistance but were unable to pay for the costs of necessary medical services. It broke from past welfare policy to aid those in need instead of exclusively targeting recipients of public assistance, and entailed a means test requirement but allowed states to determine eligibility criteria and benefits as they saw fit.

Importantly, Kerr–Mills showed how early legislation of health care for the aged was implemented and how an open-ended commitment by the federal government in health care was made. It was an attempt to quell the demands for more expansive program while laying the groundwork for greater federal involvement in the health care market. The Act was born in a period during which southern Democrats had considerable influence due to their control over many committees and the seniority system. In general, southern Democrats were reluctant to expand government's role in the civic life and especially in health care, but both Congress and the presidency began to acknowledge a federal role in the flawed health insurance market. The Kerr-Mills Act thus emerged as a compromise that addressed a balance between those seeking federal health care assistance for the aged and southern Democrats cautious

about federal intervention.¹⁵ The AMA was the most ardent advocate of the Act. In a 1961 report, then AMA president Dr. Leonard Larson said Kerr-Mills was “a flexible plan which [kept] control and determination of need where it [belonged], at the local level.”¹⁶ Similarly, Dr. Donovan F. Ward, president of the AMA in 1965, contended later at the National Conference on Kerr-Mills in Chicago that the legislation demonstrated the Association’s basic positions that “all persons 65 years of age or older who need help in paying for health care should receive it; that maximum responsibility and authority for providing such help should be delegated to the states; and that voluntary health insurance and prepayment principles should be utilized whenever possible.”¹⁷

The AMA’s support did not lead to success of the Act. According to a 1963 report presented to the Special Committee on Aging in the United States Senate, the benefits were only extended to two million people, as compared to the 10 million beneficiaries projected by the program’s advocates.¹⁸ There were also stark disparities in terms of benefits and beneficiaries’ residence. A report by the Senate Special Committee on the Aged showed that the states’ monthly expenditure on medical assistance per capita varied greatly from \$318. 81 to \$18.40, and 60% of Kerr-Mills’ beneficiaries lived in New York, Massachusetts,

¹⁵ HEW Commissioner Robert M. Ball’s letter to Vice President Lyndon B. Johnson, Sept. 21, 1962, Lydon B. Johnson Papers LBJ Library.

¹⁶ “AMA Testifies King Bill Imperils Quality of Care,” *The AMA News* 4, no. 17 (Aug. 7, 1961).

¹⁷ “AMA Proposes Expanded Health Care Plan for Aging,” *Journal of American Medical Association* 191, no. 4 (Jan. 25th, 1965).

¹⁸ *Medical Assistance for the Aged: The Kerr-Mills Program 1960-1963*, 3 (Washington, DC: Government Printing Office 1963).

and California.¹⁹ For a long time after its introduction, the program was criticized as “uneven, unfair, and undignified.”²⁰ Overall, the Act failed to provide financial incentives for states to establish their own MAA programs because the funding for administration and staffing was surprisingly inadequate.²¹ However, it was insufficient to see the Act simply as a policy failure. Kerr–Mills in fact had a twin legacy for health care reform. As the commissioner of Social Security Robert Ball noted, the Kerr-Mills Act was not only a “precursor of Medicaid” but also a plan “designed to head-off a universal Medicare-type plan and substitute just a means-tested basic program.”²² In this sense, Kerr-Mills showed that increased federal involvement in health care was possible.

King-Anderson bill

The King-Anderson bill was proposed in this context. As a precursor to Medicare, the bill was proposed by Representative Cecil King (D-CA) and Senator Clinton Anderson (D-NM) in February 1961. Introduced in the 89th Congress as H.R 1 in the House and S. 1 in the Senate, the first bills in the hopper, the bill was still a moderate way to help senior citizens. As a staff of the

¹⁹ HEW Commissioner Robert M. Ball’s letter to Vice President Lyndon B. Johnson.

²⁰ Miriam Kerpen; and Beverly Liden, “Medical Assistance for the Aged ” *Management Record* 24, Mar. (1962): 26-35.

²¹ For a comprehensive account of Kerr-Mills, see Robert Stevens and Rosemary Stevens, *Welfare Medicine in America: A Case Study of Medicaid* (New York: Routledge, 2017).

²² Kevin Hillstrom, *U.S. Health Policy and Politics: A Documentary History* (Washington, DC: CQ Press 2011).

Department of Health, Education, and Welfare (HEW) noted, the King-Anderson's coverage "left a substantial place for private health insurance...[particularly] for physicians' services at the hospitals." The bill allowed private insurance companies to administer and audit payments and the hospitals to choose whom to contract with. In essence, King-Anderson was simply "hospital insurance for the aged through social security," and no more. It covered neither ordinary doctors' bills nor drugs, and only paid for 30 days of hospital-stay.²³ The HEW secretary Abraham Ribicoff once asserted that private insurance could not address "the cruelty of fear and insecurity" facing seniors because of its high costs and high risks. Neither was Kerr-Mills a solution because it people hesitated to apply for charity and the means test was degrading. "Social security is the only practical answer," Ribicoff testified. In this way, the bill not only kept intact the foundation of private insurance market but also served as a promising route towards universal health care because of its compulsory, non-means-tested benefits and the Social Security financing.²⁴

Despite its modest agenda, the bill's experimental nature generated ongoing debate. On the one hand, advocates of the King-Anderson bill were repeatedly accused of being a socialist or even a communist, but they continued to centre their efforts on a group depicted as frail and deserving to heighten the plan's appeal. "My accusers' rationale was that the King-Anderson

²³ Theodore Marmor, *The Politics of Medicare* (London: Routledge & Kegan Paul, 1970), 60.

²⁴ Lawrence S. Kubie and Robert E. Cooke, "King-Anderson Bill," *JAMA* 181, no. 7 (1962): 653-4, <https://doi.org/10.1001/jama.1962.03050330083023>, <https://doi.org/10.1001/jama.1962.03050330083023>.

bill would interfere with the doctor–patient relationship,” said Malcolm Watts, proponent of the bill and president of the San Francisco Medical Society, “I saw it quite differently: it was the lack of insurance that was interfering with that relationship and with continuity of care.”²⁵ On the other hand, the AMA fiercely opposed the bill on the grounds that “government intervention in medicine failed to explain how seniors could access affordable health care.”²⁶ The association also stated that the enactment of the King-Anderson bill was “an engraved invitation” to overuse hospitals; the subsequent overcrowding and long waits for admission would certainly affect the quality of in-patient care.²⁷ “Mr. Ribicoff claims that the King bill provides free choice of hospital and physician,” F. J. L. Blasingame, the executive vice president of the AMA, tried to set the record straight about the King Bill in his letter to the American Society of Newspaper Editors. “The fact is only hospitals signing contracts with the federal government would be available to patients. If the only hospital in a community was not approved by the secretary of HEW, patients in that community would be forced to seek hospitalization in some other city,” said Blasingame. Furthermore, if their regular doctor was not on staff at the new hospital, they would also lose their choice of physician. This clearly went against the bill’s promise of free choice.²⁸

²⁵ Philip R. Lee, “Battling for the Right Health Policy, Then and Now,” *Generations (San Francisco, Calif.)* 39, no. 2 (2015): 15-20, <https://go.exlibris.link/j4Ms3jcW>.

²⁶ Archie Fine, “King-Anderson Bill,” *JAMA* 183, no. 1 (1963), <https://doi.org/10.1001/jama.1963.03700010114026>, <https://doi.org/10.1001/jama.1963.03700010114026>.

²⁷ “AMA Testifies King Bill Imperils Quality of Care.”

²⁸ F. J. L. Blasingame, “A Letter to the Editors—Re: King Bill,” *The AMA News* 4, no. 11 (May 15, 1961).

The fact that the government only contracted with certain hospitals also caused concerns about medical professionals' autonomy. "If the HEW is specifically empowered to set 'conditions of participation' for all hospitals, facilities, or agencies," Blasingame continued, "it is ridiculous to claim that the department is not empowered to regiment our system of hospital medical practice from top to bottom, from patient to nurse to doctor."²⁹ Additionally, Blasingame referred to a quote from the King-Anderson Bill stating that it would not authorize federal supervision over medical practices or hospital staff. Yet in fact federal oversight or control over hospitals were permitted "except as otherwise specifically provided". For example, the bill mandated that hospitals have a "utilization committee" or agree to meet other requirements set by the Secretary to achieve similar purposes. Yet most hospitals in the early 1960s did not have such committees. "This loophole covers a multitude of sins," complained Blasingame, "the important thing is to see...the disruption of the doctor-patient relationship; the delays in admission to hospitals; the time wasted in the over-crowded offices of doctors; the regimentation of medical practice; the effect of the program on medical research; the availability of medical facilities and personnel—in other words, medicine in action on a government-run, assembly-line basis."³⁰ The AMA equalled infringement of doctors' autonomy with a collapse of hospital order.

²⁹ Blasingame, "A Letter to the Editors—Re: King Bill."

³⁰ Blasingame, "A Letter to the Editors—Re: King Bill."

It turned out that the AMA was not alone in its opposition. The American Hospital Association (AHA) joined the fray, and the AHA President Frank S. Groner painted a grim picture of the potential consequences such as unnecessary hospitalizations and skyrocketing costs. Leslie J. Dikovics of the Council of State Chambers of Commerce also contended that the King bill would fundamentally change the philosophy of the Social Security System by allowing Congress to dictate how a portion of each beneficiary's monthly benefit should be spent.³¹ In 1963, the AMA took a step forward and launched Operation Home Town, a vigorous campaign using an array of tactics, including telephone calls, radio and TV programs, and detailed propaganda kits to fight against the King-Anderson bill. These kits contained over fifty strategies for generating opposition, such as writing letters, placing ads, and contacting influential people. Doctors were also encouraged to use these kits themselves and distribute them to patients who shared the AMA's values.³² The King-Anderson bill was finally defeated in committee by a narrow majority (11 vs. 12) under such fierce attack. Some senior activists accused doctors of being hypocritical as "they apparently contend federal assistance for scientific research and medical school construction is okay but a program that would help the aged pay their own doctor bills is bad for their patients."³³ Yet the bill set a solid foundation for the upcoming debate around Medicare, and concerns

³¹ "AMA Testifies King Bill Imperils Quality of Care."

³² Cliff Carter, *Memo to Jack Valenti* (White House Central Files, Box 76, LBJ Library, 1964).

³³ "Operation Negative," *National Council of Senior Citizens for Health Care through Social Security News Letter* Box 29, Grahame Papers (1962).

around the boundaries between public and private health care continued unabated.

Kennedy's Medicare

The King-Anderson bill was later revised to appease fierce resistance from doctors and tamp down concerns about the solvency of the plan. Labelled as “Medicare” by the Kennedy administration, the bill turned out to be quite politically moderate because policymakers deleted the surgical benefits to exclude all physician services and limit coverage to hospital as well as nursing home care. The bill was quite popular at first. Polls showed that around 69 percent of the public supported the Kennedy version of Medicare. It also found enthusiastic support among unions and senior advocacy groups. One key figure in this movement was Aime Forand, who spearheaded the Forand bill—an ill-fated 1958 hospital insurance plan for the aged—and later established the National Council of Senior Citizens (NCSC) to champion the Medicare cause. By the end of 1961 the NCSC had swelled to over 500,000 members. The Council wasted no time in mobilizing its base. It organized massive rallies in cities like Miami and Detroit to drum up support for Kennedy's Medicare plan, and thousands of flyers and letters flooded into Congressional offices urging the passage of the bill. The NCSC also formed a powerful alliance with organized labour. At the 1962 National Council meeting, president of the United

Automobile Workers (UAW) Walter Reuther declared that “the American labour movement will work with you, stand with you, and fight shoulder-to-shoulder with you” in the NCSC’s fight for Medicare. In the following weeks, union members were encouraged to write to their congressmen pushing for the Medicare legislation to advance.³⁴

In the spring of 1962, as the King-Anderson bill reached a critical moment, the Kennedy administration decided it was time to take the battle to the public. President Kennedy addressed an excited crowd of 17,500 senior citizens at Madison Square Garden, and some 10 million people watched from home on television. Kennedy portrayed Medicare as the next step in fulfilling the New Deal and appealed to younger adults by promising they would not be “heavily burdened” by their parents’ medical expenses. On criticisms that the Medicare program would undermine personal responsibility, Kennedy responded, “I can’t imagine anything worse...to sap someone’s self-reliance than to be sick, alone, broke.”³⁵ However, despite the enthusiastic reception in the hall, the public relations campaign fell flat. This was largely because Kennedy’s speech came across poorly on television; he had not prepared adequately and improvised most of his statement. While the crowd at Madison Square Garden cheered, viewers at home found his tone harsh and unconvincing. “How could he have given such a terrible speech if he was really behind the bill?” Staffers from the

³⁴ "No Title in Original," *Newsweek* (June 4, 1962).

³⁵ *Address at a New York Rally in Support of the President's Program of Medical Care for the Aged*, Public Papers of the Presidents of the United States, John F. Kennedy, (Washington: United States Government Printing Office, May 20, 1962).

UAW watched the speech and concluded that Kennedy was not fully committed to the bill; their support for Medicare quickly softened thereafter. The Public Relations campaign that was initially planned to span twenty cities also got abruptly halted. Therefore, instead of rallying the nation, the campaign backfired and overall support for the bill visibly dwindled.³⁶

This misstep was not lost on the bills' opponents. Before the final vote in July 1962, the Kennedy administration had already secured 48 votes for Medicare. Only two senators remained undecided—West Virginia Democrat Jennings Randolph and Arizona Democrat Carl Hayden. With their support, Vice President Johnson could then break the 50:50 tie with his decisive vote in favour of the bill. However, this was never realized because Randolph voted against Medicare and Hayden followed him, resulting in a vote of 52 to 48 to table the bill. It was difficult to say why exactly Randolph did not lend his support, but existing records suggested a strong connection between West Virginia's indebtedness and senator Kerr's help in this regard—when Randolph faced an overwhelming debt on West Virginia's welfare programs in 1961, Kerr did him a favour to introduce a clause excusing the state's financial liabilities. The quid pro quo then turned out to be Randolph's vote against Medicare.³⁷

Had the Kennedy health plan passed, the US would have a much narrower and limited Medicare than what we have today. Though Kerr's manoeuvre killed

³⁶ Richard Harris, *A Sacred Trust* (New York: The New American Library, 1966), 142.

³⁷ "Senate Kills Social Security Health Plan," *Congressional Quarterly Weekly Report* July 20 (1962).

Medicare for 1962, there was growing bipartisan support for implementing some type of health insurance for the elderly in the early 1960s. While the composition of the Ways and Means Committee remained unfavourable to financing Medicare through Social Security (with the 10 Republicans and 3 out of the 15 Democrats in the Committee voting against it), the year 1964 saw two distinct insurance plans put forth by liberal Republicans. The first one, sponsored by Republican Jacob Javits, adhered closely to the recommendations by the Committee on Health Care for the Aged and featured a mechanism to foster the purchase of supplemental private insurance to cover expenses beyond the scope of Medicare. The second plan, championed by Republican Representative John Lindsay and built on an idea of Nelson Rockefeller, a prospective Republican candidate for the presidential race, offered the elderly population a choice between Medicare and cash benefits to help purchase private insurance.³⁸ The responsibility of administering the hospital insurance plan was assigned to Blue Cross to ensure that hospitals would be reimbursed up to 99 percent of their expenses. This not only committed Blue Cross to the program but also kept commercial insurance company from serving as the administering agent, which, according to Robert Ball of the SSA, was a promising strategy to appease concerns about the involvement of private commercial insurers in Medicare from HEW Secretary

³⁸ "Social Security Hospital Care," *Congressional Quarterly Weekly Report* 22, Jan. 31 (1964).

Celebrezze and labor representative Nelson Cruikshank.³⁹

In overview, examining the Kerr-Mills Act and the King-Anderson bill sheds light on the government's attitude towards old age health security during a period of ever-changing political dynamics and ideological confrontations. The Kerr-Mills Act, though initially falling short of its ambitious goals, served as a precursor to future health care reforms. The King-Anderson bill, with its innovative approach to health benefits, showed the complex interplay between public and private spheres regarding health security. Though it failed to pass, the bill's revisions and subsequent policy proposals underscored the growing consensus on the need for elderly health care coverage. This contributed to the groundwork for Medicare and the expansion of federal involvement in health care. In 1964, LBJ's landslide victory in the election—61 percent of the vote along with huge liberal Democratic majorities in the House (295–140) and Senate (68–32)—reset the clock for Medicare's passage. As we shall see in the next section, this powerful liberal build-up greatly enriched health rights for the elderly in the 1960s. This time, Medicare not only addressed health care costs but also catered to seniors' quality of life as a whole.

Climax: Health Rights Redefined in Medicare Legislation

³⁹ Edward Berkowitz, *Mr. Social Security: The Life of Wilbur F. Cohen* (Lawrence, Kans., 1995).

In spring 1965, just as Medicare regulations were about to be issued, LBJ invited the AMA leadership to the White House. In the stately Oval Office, under the watchful gaze of Franklin D. Roosevelt's portrait, the AMA officials sat on twin sofas, being poised to confront Johnson on Medicare. Yet to their surprise, Johnson settled into his rocking chair and began to talk about Vietnam. He emphasized the urgent need for physicians to serve the civilian population there. "Would the AMA help?" he asked, "could it get doctors to rotate in and out of Vietnam for a few months? Your country needs your help. Your President needs your help." "Of course," the AMA officials spoke in concert and promised to start a program immediately. Johnson was clearly satisfied with the answer. "Get the press in here," he told his press secretary Bill Moyers. The press poured into the room and quickly formed a semicircle to Johnson's left. The President then described the AMA's new Vietnam medical program and spoke highly of the humanitarian spirit of the doctors present. But the first question from the reporters was not about Vietnam—it was about Medicare. "Would the doctors support the Medicare program?" a reporter asked. LBJ appeared irritated. "These men are going to get doctors to go to Vietnam where they might be killed," he snapped. "Medicare is the law of the land. Of course they'll support the law of the land." "Tell him," Johnson turned abruptly to the head of the AMA leadership. "You tell him." "Of course, we will," the AMA official was clearly caught in surprise and had no choice but to affirm his words. With that, Johnson shook hands warmly with the delegation as the cameras clicked. The tension

in the room eased, and everyone breathed a little more easily.⁴⁰

This was LBJ's political manoeuvring in a snapshot, but getting a bill passed was never easy. In spring 1965, as the Johnson administration began its final actions on Medicare, Wilbur Mills—the powerful Chairman of the House Ways and Means Committee—dropped what Johnson would later call a “bombshell.” He proposed merging the King-Anderson bill with two alternative proposals meant to block it. The first, from House Republicans, suggested covering physician costs (what we now know as Medicare Part B). The second was the Kerr-Mills plan backed by the AMA, which later became Medicaid. This unexpected merger tripled the size of the original bill and added an estimated \$400–500 million to its annual costs. Wilbur Cohen rushed back to the White House to consult with President Johnson—the future Secretary of HEW was clearly surprised by Mills' bold move. To his astonishment, LBJ, ever the pragmatist, decided to roll with the punches. “Five hundred million. Is that all?” Johnson exclaimed, waving his hand dismissively. “Do it. Move that damn bill out now, before we lose it.”⁴¹ As a result, the legislation moved forward with LBJ's forceful push. Wilbur Cohen dutifully drafted the expanded bill, and Medicare and Medicaid were born. Reflecting on the dramatic turn of events, Johnson later marvelled at Mills' transformation from obstructionist to champion. “Chairman Wilbur Mills, so long the villain of the act, was now a hero to the old

⁴⁰ Joseph A. Califano, *Triumph and Tragedy of Lyndon Johnson : The White House Years* (Touchstone, 1992), 50-1.

⁴¹ Joseph A. Califano, *Governing America: An Insider's Report from the White House and the Cabinet* (New York: Simon and Schuster, 1981), 140.

folks,” he mused.⁴²

As has been widely documented, the final legislation of Medicare was a combination of three plans (commonly known as the “three-layer cake”) —the aforementioned King-Anderson bill and Kerr-Mills Act, as well as the Byrnes bill, a Republican proposal that called for voluntary enrolment and a system financed through premiums⁴³. While their intricacies have been well-researched, how these proposals were incorporated into Medicare deserves special attention. The King-Anderson bill was later modified to be Medicare Part A for hospital insurance, and the Byrnes bill to be part B for voluntary and contributory medical-surgical benefits without drug coverage. The Kerr-Mills Act, however, was excluded from Medicare and reintroduced as Medicaid, a means-tested program for added with little discussion almost as an afterthought.⁴⁴ Though all US citizens reaching 65 were eligible for Medicare regardless of their previous employment status, it is evident that Medicare had a strong emphasis on contribution.⁴⁵ Though it was centred on a social insurance system, where younger workers supported the elderly, Medicare was commonly seen as a program that ensures seniors receive a personal pay-out based on the Medicare taxes they have paid throughout their lives. In important ways, Medicare took over the role of employer-sponsored health coverage in

⁴² Lyndon Johnson, *The Vantage Point* (New York: Holt, Rinehart and Winston, 1971), 216.

⁴³ Theodore Marmor, *The Politics of Medicare, 2nd ed* (Hawthorne, NY: Aldine de Gruyter, 2000).

⁴⁴ David Smith, *Entitlement Politics: Medicare and Medicaid 1995-2001* (New York: Walter de Gruyter, 2002).

⁴⁵ Note that individuals (or their spouses) must have worked and paid Medicare taxes for at least 10 years (40 quarters) to qualify for premium-free Medicare Part A (hospital insurance). Those who haven't met this requirement can still enroll in Part A but must pay a premium.

protecting the financial well-being of the elderly and securing their equal opportunities in the insurance market for hospital and specialist services. Yet its primary focus on contribution largely defined the scope of social citizenship in this period.

Another important message the “three-layered cake” conveys was the dignified position of Medicare beneficiaries. Though LBJ did not mention rights in particular in his speech celebrating the passage of Medicare, he referred to FDR’s “freedom from fear” as the essence of this legislation: “For the Nation it will bring the necessary satisfaction of having fulfilled the obligations of justice to those who have given a lifetime of service and labour to their country.”⁴⁶ On top of this, the Special Committee on Aging in the Senate asserted that if “the objective of a public program designed to assist with the expenses accompanying illness is the preservation of the financial independence of older persons, then any program employing means tests...cannot achieve that goal. For such programs afford some help only after the older individual has depleted his irreplaceable assets to the point of semi-dependency or total dependency.”⁴⁷ In this sense, Medicare helped intertwine contribution and deservingness as defining narratives in the health care discourse.

While LBJ continued working on health care reforms that Kennedy had started, he was much more committed to the cause than his predecessor. In his

⁴⁶ *Statement of the President Following the Passage of the Medicare Bill by the Senate*, (July 9, CMS Speeches 1965).

⁴⁷ *Developments in Aging, 1963 and 1964* (U.S. Government Printing Office, Washington, D.C. 1965).

1965 State of the Union address LBJ announced that Medicare was one of his first priorities. “We are going to fight for medical care for the aged as long as we have breath in our bodies,” the president announced in his special health message to Capitol Hill.⁴⁸ Notably, in the often-bitter struggles on Medicare, the focus was almost entirely on access and seldom on cost. The federal government was quite generous about the payments—the program allowed hospitals to bill Medicare based on “reasonable costs” decided at their discretion. Apart from that, hospitals got a 2 percent bonus to cover other expenditures including administration, supplies, pharmaceuticals, depreciation of infrastructure and equipment, and even activities related to public relations. For-profit hospitals and nursing homes got an extra 7.5 percent from the government, which went straight into their profits.

In terms of Part B, physicians got an equally generous payment based on “prevailing” and “reasonable” charges for their medical services, with the reasonableness solely determined by physicians themselves. Much literature on Medicare’s original payment understood the generous payment as an outcome of interests group pressures or a strategy to get Medicare passed.⁴⁹ After all, the rules on hospital reimbursement under Part A were decided in secret talks involving the American Hospital Association, Blue Cross, and the

⁴⁸ Jr. Joseph A. Califano, *America’s Health Care Revolution: Who Lives? Who Dies? Who Pays?* (New York: Random House, 1986), 50.

⁴⁹ See, for example, Quadagno, *One Nation, Uninsured: Why the U.S. Has No National Health Insurance*; Monte M. Poen, *Harry S. Truman versus the Medical Lobby : The Genesis of Medicare* (Columbia: University of Missouri Press, 1979); Daniel Béland and Alex Waddan, *The Politics of Policy Change: Welfare, Medicare, and Social Security Reform in the United States*, American Governance and Public Policy series, (Washington: Georgetown University Press, 2012).

Social Security Administration, which explained why hospitals were so supportive of Medicare. Yet from a social citizenship perspective, the absence of cost regulation might well be seen as a bonus that accompanies “deservingness”, as doctors were spared from cost concerns when they bill a patient who found some services unaffordable. In fact, while people were surprised by a potentially 300% cost increase in doctors’ fees after Medicare launched, a significant part of Medicare payments were to compensate the doctors who served those underprivileged elderly who were unable to pay in the past—exactly the purpose of health reform.⁵⁰

Medicare’s reimbursement mechanism created a strong incentive for doctors to charge more, and led to a dramatic increase in hospital costs. With advancement in new technologies and treatments, as well as overall inflation, the national health expenditures grew from \$198 per capita in 1965 to \$336 by 1970. The cost of labour was rising at the same time. Medicare helped make the US medical profession the highest paid worldwide, and hospitals total assets rose from \$16.4 billion to \$47.3 billion within five years after the program launched.⁵¹ In fact, LBJ was keenly aware of the potential outcome of unregulated billing—in a meeting held a month before Medicare’s launch with leaders of the American Hospital Association, he emphasized that hospitals and doctors should “exercise intelligent self-restraint” to “prevent unreasonable

⁵⁰ Martin Tolchin, "Doctors' Fees Up as much as 300% under Medicare," *New York Times* 1966.

⁵¹ Rosemary Stevens, *In sickness and in wealth : American hospitals in the twentieth century* / Rosemary Stevens, ACLS Humanities E-Book., (New York: Basic Books, 1989).

costs for health services.”⁵² It was difficult to say whether the cost was left unregulated purely because of partisan or interest group politics, but the payment mechanism revealed how determined LBJ was to improve old age health security.

It is worth noting that the Johnson administration was also attentive to seniors’ quality of life, not just their medical costs. Shortly after Medicare’s inception, LBJ signed the “Older Americans Act” into law to create a new Administration on Aging within the HEW. Headed by a Commissioner on Aging, the new bureau was dedicated to coordinating federal programs for the elderly, including Medicare and Medicaid. It allocated \$14 million over the next two fiscal years for community planning, demonstration projects, and training specialized personnel. This funding also supported the establishment of centres focused on recreation and leisure activities for the elderly, though it would not fund the construction of facilities like nursing homes directly. On top of this, the legislation earmarked \$4.5 million over the next two years for research and training projects that aimed to explore and enhance how communities could best meet the needs of their elderly residents.⁵³

LBJ’s commitment to improving seniors’ living condition was also reflected in his nursing home reform. The drive to improve nursing homes stemmed from LBJ’s personal experience. In a sunny afternoon in 1967, a group of experts—

⁵² Louis Cassels, "LBJ Warns Hospitals on Bias in Medicare " *Daily Defender* 1966.

⁵³ "Washington News," *Journal of American Medical Association* 193, no. 5 (Aug. 2, 1965).

doctors, housing specialists, finance authorities, health professionals— assembled at the Fish Room next to the Oval Office. Seated at the head of the mahogany table, LBJ mentioned the filthy nursing homes he saw in person and said “good taxpayer dollars” in Medicare could not be “spent to keep people in ratholes.” His voice gradually grew louder and more passionate as he condemned the facilities as “fire traps, rat traps, a disgrace...no one of you would let your mother near one.” As he continued, his intensity shifted to a determined optimism. “I established this task force because of what I saw,” he declared, his eyes brightening. “Our elderly deserve nursing homes that are not only liveable but also joyful places where they can spend their twilight years with dignity.” He outlined his vision for facilities designed with care: flat floors and gentle slopes for wheelchair accessibility to ensure safety and preserve dignity for the elderly; he even detailed the bathroom layouts—“Don’t make people wrench their backs or dislocate a shoulder to get toilet paper,” and “place the rack alongside or in front so it’s easy to reach.”⁵⁴ The reform was funded by Medicare. In doing so, LBJ aimed to build a future where nursing homes would become sanctuaries of comfort for the nation’s aging population.⁵⁵

Another important measure affecting seniors’ medial experience in this period was Title VI of the Civil Rights Act. Title VI prohibited discrimination

⁵⁴ Califano, *Triumph and Tragedy of Lyndon Johnson : The White House Years*, 178-9.

⁵⁵ However, the actual effectiveness of such measure was later much questioned, and there were many significant unintended consequences regarding nursing home reforms. For details, see Gabriel Winant, “A Place to Die: Nursing Home Abuse and the Political Economy of the 1970s,” *The Journal of American History* (Bloomington, Ind.) 105, no. 1 (2018).

based on race, colour, or national origin in any institution receiving financial aid from the US government, Medicare included. In practice, it affected admission policies, the way of assigning patient rooms, availability of services and facilities, benefits of hospital employees, as well as staff training programs. Hospitals were required to treat all patients, visitors, professional staff, and trainees equally regardless of their race, colour, or national origin. The Public Health Service—a division of the United States Department of Health, Education and Welfare (HEW)—also issued guidelines to help hospitals meet these requirements, and physicians played a crucial role in ensuring their local hospitals complied with these new regulations. In the latter half of the 1960s, a dedicated field force of 300 professionals worked closely with hospital administrators to resolve any procedural issues potentially stymieing this transition.⁵⁶ The collaboration between physicians, hospital administrators, and federal officials thus greatly facilitated health equality in hospitals across the country. This movement not only improved health care access for minorities but also strengthened the moral and ethical foundation of medical practice in the United States.

A final action on seniors' experience in hospital was related to out-patient diagnostic services (e.g., x-ray and laboratory analysis). These services were not included in Medicare at first. In 1964, the AMA spared no efforts to lobby

⁵⁶ William H. Stewart, "Civil Rights and Medicare," *Journal of American Medical Association* 196, no. 11 (June 13, 1966).

against the inclusion of services provided by radiologists, anaesthesiologists, psychiatrists and pathologists within Medicare Part A. "They are professional medical services which do not belong in a program solely designed to offer hospital benefits," said Dr. Donovan F. Ward, the AMA president at the time. In fact, what the AMA worried the most was that including these services would subject them to excessive regulation by the Secretary of HEW and would undermine the autonomy of medical professionals due to budget constraints imposed by non-medical government employees.⁵⁷ Their lobbying was successful at last, but the result was a significant inequity in Medicare coverage for outpatient diagnostic services. Beneficiaries under Parts A and B were required to pay only a \$20 deductible (the amount patients were liable for before Medicare started to pay) for these services in hospital outpatient departments, whereas they must pay a \$50 deductible for the same services if provided by private radiologists and pathologists, plus a 20% coinsurance (the share patients needed to pay in addition to the deductible).⁵⁸ This largely created an imbalanced health care system by driving patients towards hospital-based specialists and putting private practitioners at a significant disadvantage, which not only undermined the financial viability of private specialists but also restricted patient choice.

The 1967 Social Security Amendments addressed this issue in particular.

⁵⁷ "Washington News."

⁵⁸ MD Leonard S. Ellenbogen, "Medicare Problems," *Journal of American Medical Association* 198, no. 1 (Oct. 3, 1966).

It allowed for full payment of reasonable charges for radiological and pathological services provided to hospital inpatients under Medicare Part B. This at once enhanced Medicare's protection for the elderly by eliminating the 20% coinsurance and the \$50 deductible and aligned Medicare more closely with standard hospital billing practices and private insurance methods, making it easier for hospitals and intermediaries to handle Medicare claims.⁵⁹ Additionally, experience with established health care plans like Blue Cross suggested that the overall cost was significantly lower when the specialist services were incorporated within comprehensive hospital care. It was estimated that a change in the calculating method from covered hospital services to individual fees would result in a \$55 million increase in Medicare expenditures, and nearly \$600 million if applied to all age groups. In this sense, including medical specialists' services into Medicare improved both financial security of the elderly and the quality of care because it made the hospital system less fragmented.⁶⁰

In overview, the "three-layer cake" approach of Medicare not only underscored the focus on contribution and deservingness but also intertwined social insurance principles with the aim of providing equitable health care access for seniors. Health rights were also redefined in this period as LBJ's commitment went beyond just medical costs; he also addressed the quality of

⁵⁹ "Washington News," *Journal of American Medical Association* 203, no. 1 (Jan. 1, 1968).

⁶⁰ *Congressional Record—Senate*, July 9, (Senate Special Committee on Aging, the 88th Congress, Medicare, NAID: 12093763: National Archives, Washington, D.C., 1965).

life and medical experience for the elderly by creating the Administration on Aging, reforming nursing homes, and implementing Title VI of the Civil Rights Act. Before Medicare's inception, president of the AMA Dr. Larson once noted a pressing sociological problem that the elderly "worry less about health and finances than they do about rejection. They are oppressed with the feeling of not being wanted any longer, of not being useful, of not being important. They feel that they have been stripped of their value, and, hence, of their dignity as human beings."⁶¹ LBJ explicitly took this into account in his vision for Medicare. These measures were pivotal in securing health security for America's aging population. The final section critically assesses Medicare's effects. In doing so, we are able to see how redefined health rights played out in Medicare's actual implementation, and how loopholes of the program and the intricate moral dimensions underpinning it planted a seed of the disjunction in the distribution of benefits and burdens of citizenship.

Epilogue: Immediate Effect of Medicare

It was widely acknowledged that Medicare was a huge success even with its high costs—LBJ was bathed with appreciation letters for the new benefits shortly after it launched. "We have brought medical care to older people who

⁶¹ "AMA Testifies King Bill Imperils Quality of Care."

were unable to afford it," LBJ declared in his 1967 state of union address, "three and one-half million Americans have already received treatment under Medicare since July."⁶² As the new legislative year began, President Johnson still had strong support from a broad coalition in Congress who were determined to protect and even expand the Great Society programs despite the challenges of war and inflation. The general public remained enthusiastic about the administration's domestic initiatives. On January 9, 1966, a Harris poll revealed that Congress was riding a wave of unprecedented public approval. More than 70 percent of voters gave Congress a favourable rating for its work in 1965. The pollsters attributed this surge in approval to the widespread and almost universal praise for the legislative achievements under LBJ's leadership, and Medicare was backed by 82 percent of the population.⁶³

There were some misleading messages in the program's early days. A study by the American Academy of General Practice revealed that since the introduction of Medicare, doctors had been earning more and working longer hours. In 1969, doctors across all categories experienced a net increase in income. This once caused panic among seniors that their medical costs would soar accordingly. However, this income boost was largely because Medicare compensated doctors for services they previously offered for free.⁶⁴ Dr.

⁶² Lyndon Baines Johnson, *Annual Message to Congress on the State of the Union* (Washington: United States Government Printing Office: Annual Message to Congress on the State of the Union, Jan. 10, 1967).

⁶³ Merle Miller, *Lyndon: An Oral Biography* (New York: G. P. Putnam's Sons, 1980), 453.

⁶⁴ "Summaries of compensation articles from business and professional periodicals," *Compensation & Benefits Review* 2, no. 4 (Oct. 1970).

Leonard Larson, then head of the AMA, noted that U.S. physicians in the early 1960s provided around \$658 million worth of free medical care each year.⁶⁵ Besides, a study examining physicians' prescribing habits before and after Medicare's introduction showed that physicians remained focused on providing the best care for their patients. Socioeconomic factors were secondary to the primary goal of effective medical treatment. Specifically, researchers conducted a statistical analysis and found no significant overall difference in prescribing habits between the pre-Medicare and post-Medicare groups. This went against the assumption that Medicare significantly changed health care costs and practices. Besides, the study noted that the rise in drug costs for patients with conditions like neoplastic diseases were not due to more prescriptions; it was largely a result of the use of cephalosporin antibiotics for treating infections.⁶⁶

A more disturbing trend was about hospital utilization. The increased use of hospital beds by the elderly was anticipated, but no one expected the actual rate of hospitalization for Medicare patients to skyrocket to 150% higher than predicted. Before Medicare, seniors made up fewer than 20% of patients in community hospitals. After its introduction, they accounted for more than 30%.⁶⁷ This unexpected surge put immense pressure on the administration to control medical costs. "I think doctors and the general public are taking advantage of Medicare for the least little illness," an elderly reader commented in *The*

⁶⁵ "AMA Testifies King Bill Imperils Quality of Care."

⁶⁶ Charles J. Nithman, Yale E. Parkhurst, and E. Blanche Sommers, "Physicians' Prescribing Habits: Effects of Medicare," *Journal of American Medical Association* 217, no. 5 (1971).

⁶⁷ "Medical Survey," *Geriatric Times* 2, no. 10 (Oct. 1968).

Geriatric Times, an authoritative journal providing medical information specifically for seniors, “and while I believe in helping those who need help, why pay for those who can afford to pay? The government is handing out too much. No wonder taxes are high.”⁶⁸ The White House anticipated the problem and devised a politically savvy strategy before Medicare’s passage: increase competition by multiplying the number of doctors, dentists, and health care facilities. The idea was simple yet bold—more providers would mean more competition, which, in the long run, would help keep fees reasonable. In 1963, Congress passed the Health Professions Education Assistance Act. The legislation authorized nearly \$800 million over four years for hospital construction and medical-dental education. The ambitious goal was to double the number of medical school enrollees from eight thousand to sixteen thousand. Still not completely satisfied, Johnson took further action in May 1966 by appointing the National Advisory Commission on Health Manpower. This commission was designed to investigate the rising health care costs and making additional recommendations.⁶⁹

Setting aside the mixed effects of increased hospital manpower, a significant factor threatening the elderly’s health rights was Medicare’s primary focus on the treatment of acute rather than chronic diseases, such as asthma, diabetes, congestive heart failure, back pain, etc. This was largely a result of

⁶⁸ "Medical Survey."

⁶⁹ Irwin Unger, *The best of intentions : the triumphs and failures of the Great Society under Kennedy, Johnson, and Nixon* (New York: Doubleday, 1996), 115-6.

the historical context. The period from the early 1900s to the late 1950s was aptly named “American medicine’s golden age” by historian John Burnham.⁷⁰ By the early 1960s, infectious diseases were on the verge of being conquered, and medical science held great promise. Antibiotics had significantly reduced the danger of infectious diseases such as pneumonia, and even seemingly insurmountable illnesses offered hope for a cure. Mental illnesses also appeared to be increasingly treatable, with the new psychotropic drugs being used to treat a range of conditions by the early 1960s.⁷¹ The US health care system during this period was also focused on curing acute conditions, and biomedical research and access to hospital and specialist care were seen as more important than primary care and long-term services. In fact, there was substantial evidence that many people with chronic conditions were treated in the same manner as acute diseases.⁷² The design of Medicare accorded with this trend. By taking the aggressive, technological, science-based, disease-focused, and interventionist style of American medicine as its primary basis, Medicare assumed the responsibility of curing acute, hospital-oriented illnesses and sought to affirm the social value of curative medicine.

Two factors contributed to this arrangement. Firstly, officials of the LBJ administration worried that they would have fewer supporters in the House

⁷⁰ John C. Burnham, "American Medicine's Golden Age: What Happened to it?," *Science (American Association for the Advancement of Science)* 215, no. 4539 (1982), <https://doi.org/10.1126/science.7038876>.

⁷¹ H.M. Somers and A.R. Somers, *Doctors, Patients and Health Insurance: The Organization and Financing of Medical Care* (Washington: The Brookings Institute 1961).

⁷² Developments in Aging, 1963 and 1964 Short.

Ways and Means Committee and in Congress as a whole if the cost of their plan appeared to be uncontrollable, and many of them fiercely opposed the proposal by Russell Long, chairman of the Senate Finance Committee, to add a “catastrophic or long-term illness system.”⁷³ Secondly, Medicare was largely modelled on the existing structure of the 1960s, a system where non-profit and for-profit insurance plans still competed on prices and benefits, and one with a financing mechanism designed for acute episodes of precisely diagnosable diseases instead of care for patients after they were discharged from hospitals. As a result, though the early 1960s already saw some changes in epidemiology from acute to chronic diseases, Medicare was premised on cure rather than care for long-term diseases and hardly fit the changing pattern.⁷⁴ In fact, care for chronic diseases has always been an under-addressed policy area in the United States, and neither the government nor the private insurers has proposed any plan more extensive than Medicare on chronic conditions: as many as 60 days of nursing home stays and 240 days of home care each year. This was largely a compromise the government made to appease interest groups conflicts, but it still fell short for those with long-term needs and multiple conditions.⁷⁵

There had been some complementary measures. For example,

⁷³ Jonathan Oberlander, "The Politics Of Health Reform: Why Do Bad Things Happen To Good Plans?," *Health Affairs* 22 (2003): 404, <https://doi.org/10.1377/hlthaff.W3.391>.

⁷⁴ R. Anderson and O.W. Anderson, *A Decade of Health Services Social Survey Trends in Use and Expenditure* (Chicago: University of Chicago 1967).

⁷⁵ Daniel Fox, *Power and illness : the failure and future of American health policy* (Berkeley: University of California Press, 1993).

supplemental coverage called “Medigap” plans were created as a response to such limitations. Branding them as “Medicare Booster Plans”, Blue Cross announced the approach was to “develop a structure of benefits that take over where Medicare leaves off”⁷⁶, i.e., co-pays after the 60-days hospital stay coverage, doctors’ bills that went beyond a deductible, as well as prescription drugs, medical equipment and appliances. Yet these supplementary measures did not come without challenges. It was acknowledged that seniors sometimes faced “high pressure sales tactics, fraudulent representation, false or misleading advertising, over-insurance, replacement of already adequate policies, inadequate coverage at excessive rates, intentional inadequate disclosure or misstatement of coverage.”⁷⁷ This also called for further oversight and regulations to safeguard seniors from unscrupulous practices and ensure that these supplementary plans actually proceeded as they planned.

Additionally, the American Hospital Association (AHA) came up with a Patients’ Bill of Rights to improve the quality of medical service. The bill was a significant achievement in health rights as it was applicable to both the well-off and the impoverished. At the same time, it granted maximum flexibility to hospitals and the adoption was entirely voluntary. The measures did little to regulate the way hospitals made profits or their financing mechanism, nor did they cede any control from hospitals and doctors to patients. Many articles in

⁷⁶ “Medicare Booster’ Plan Bows,” *Daily Defender* March 15 (1966).

⁷⁷ *Statement on the Marketing of Medicare Supplementary Policies*, (Folder 9-25, CNHI Collection, Reuther Library, 1970).

the Bill were also ambiguous. Article seven, for example, stipulated that “the patients have the right to expect that within its capacity a hospital must make reasonable response to the request of a patient for services,” yet neither such “capacity” or “reasonableness” was clearly defined.⁷⁸ While the Bill did not carry much weight at that time—eighteen months after it was launched, only one-third of the country’s 7,000 hospitals adopted the bill, it left an important mark on the restructuring of American health care system with its emphasis on patients’ rights.

A final immediate effect of Medicare, and perhaps the most important one for our argument, was the implicit hierarchy the Johnson administration helped create in the American health care system through the program. By pouring a huge number of efforts and resources into Medicare with an emphasis on lifetime contributions, Medicare elevated senior citizens from a marginalized group in the health insurance market to a privileged position, leaving behind those younger people who found health care unaffordable. It could also be seen that Medicare was not really designed to dismantle the class structure in health care. President Johnson’s Great Society speech only mentioned developing Medicare and increasing funding for health professional training in terms of health, neither of which were specifically targeted at the poor. As a result, the so-called war on poverty was on primarily concerned with community action

⁷⁸ David Barton Smith, *Health Care Divided: Race and Healing a Nation* (Ann Arbor University of Michigan Press 1999).

and education.

Despite frequent emphasis on the relationship between poor health and poverty in liberal narratives, health care was not a core issue in the antipoverty program.⁷⁹ In light of this, though Medicare proclaimed to help the most vulnerable groups in the health care market, it was never designed to address poverty per se. Quite the contrary, it has institutionalized a form of social citizenship that prioritized people who have made contributions through their payroll. In other words, it gave senior citizens an honourable entitlement and provided a kind of security that was nowhere to be found in American health care system, but did not eliminate the medical hierarchy as it was practised in the United States.

To sum up, Medicare granted entitlements to the elderly without imposing an obligation on medical providers to provide care to the enrolled patients. Compared with Medicaid, which made no pretence of conferring a right, Medicare gave its beneficiaries legitimate entitlement to health care. Before the King-Anderson bill, administrator of the AFL-CIO George Meany testified at a Congress hearing that despite advancements in medical equipment and hospital organization, there remained a significant *social* problem for the elderly.⁸⁰ Five years later, what was a “social problem” turned into a “social privilege” that set the tone for American health care for decades to come. As

⁷⁹ Starr, *The Social Transformation of American Medicine*.

⁸⁰ "AMA Testifies King Bill Imperils Quality of Care."

the landscape of health care continued to evolve, reforms with the imperative of maintaining efficiency, fairness, and integrity in their implementation would continue generate debates on right to health care and social citizenship more broadly.

Conclusion

This chapter has set to illustrate the implications of Medicare on social citizenship by contextualizing its original design. The 1960s saw a convergence of influential factors that propelled health insurance reform to the forefront of national attention. The era's political climate, characterized by growing support for liberal values and a responsive government, created a receptive environment for change. The efforts of organized labour amplified the demand for improved health security due to rising medical costs and the desire for comprehensive coverage. At the same time, the civil rights movement, despite its primary focus on racial justice, indirectly underscored the link between health rights and equality more broadly. LBJ thus skilfully used these forces to position Medicare in the context of rights-based advocacy. The emergence of a "rights revolution", therefore, signalled a shift towards health justice and measures to tackle risks and disparities. The culmination of these factors then marked a transformative period, where Medicare not only addressed elderly health care

needs but also crystallized a vision of social citizenship that intertwined the right to health care with the requirement of an individual contribution.

This particular form, which I call contributory social citizenship, might well be seen as the core of Medicare's moral principles. The "three-layered cake" formulation demonstrated its focus on contribution and deservingness. While Medicare extended health coverage to senior citizens, it simultaneously reinforced an implicit hierarchy by prioritizing lifetime contributions and leaving those who had not made sufficient contributions behind—a vivid demonstration of contributory social citizenship. The failed health programs preceding Medicare's establishment also offered crucial insights into the complex path toward old age health security in the United States. The Kerr-Mills Act and the King-Anderson bill, while falling short in their objectives, laid the foundation for federal involvement in health care and prompted discussions about social rights. This influenced subsequent health care initiatives and shaped the original design of Medicare. Taking a broader view, Medicare highlighted the dynamic interplay between individual rights, social responsibilities, and the role of government in providing essential resources like health care. In other words, Medicare's impact on health care access underscored the ongoing struggle to strike a balance between individual autonomy and collective health security.

The road to full-fledged social citizenship is fraught with obstacles. To some extent, the emphasis on shared responsibility and affordable health care indicated the LBJ administration's commitment to health equity and health

justice. However, Medicare's emphasis on acute rather than chronic conditions underscored the challenges of aligning entitlement to insurance with the broader concept of a right to care. Additionally, the premium-based enrolment for Part B and the presence of deductibles and co-payments, while providing a form of health security, created a financial barrier that disproportionately affected low-income seniors. Complementary measures like the Medigap plans and the Patients' Bill of Rights attempted to address these limitations. Yet challenges such as deceptive practices necessitated vigilant oversight and ongoing reforms. In the next chapter, we shall see how these loopholes of Medicare transformed into pressing problems for both the government and the elderly. The moral implications of Medicare kept evolving during an era of fiscal austerity, and social citizenship took on new characteristics as the government strove to balance limited budgets with legacies of the Great Society.

Chapter 3

Ordoliberal Social Citizenship: Medicare in the 1970s Revisited

“In the health community, you’re dealing with some of the most sophisticated people in our country...You have the philanthropist who sits on the hospital board, the doctors, the attorneys and even the nun who can roll her eyes to the heavens and say, ‘Oh God, what is government doing to us now?’”

—Rep. Dan Rostenkowski, Democrat of Illinois¹

Imagine yourself standing beside a swiftly flowing river seeing people struggling in the water and crying out for help. You keep pulling out one drowning person after another, but soon realize you cannot keep up. Exhausted, you notice the

¹ As we shall see, Medicare by the 1970s was no longer just a health insurance program for the elderly; it had become a symbol of social rights for seniors. Yet despite the need for cost control and reform, the entrenched interests of these powerful groups made it difficult to implement significant changes to Medicare. The quote suggests that these stakeholders were not just passive recipients but active players in shaping health care policy, often resistant to government intervention and changes to the established system. John K. Iglehart, "The Great Society Is Alive and Well at HEW," *National Journal* (Jan. 28, 1978).

number of people in the water is not decreasing at all. The immediate need to rescue those downstream leaves you no time to venture upstream to discover why so many are falling into the river. This is a well-known public health parable told by medical sociologist Irving Zola. Just like the protagonist in the story, Medicare in the 1970s was overwhelmed with addressing immediate needs—bringing the surging costs under control, making new medical advancements available for seniors, and reforming nursing homes as a cost-effective solution to long-term care. However, this focus on “downstream” activities means Medicare had little opportunity to address the “upstream” factors—the root causes contributing to its surging costs and limited health care access in the first place. The program’s “cost+2 percent” reimbursement model for services deemed “reasonable” by physicians furnished a built-in inflationary impetus from the beginning. There was also a significant increase in the number of for-profit medical service providers such as hospitals, clinics, and insurers. Along with significant medical advancements during this period, costs associated with health care began to increase more rapidly than ever before.

In this chapter we shall see the government becoming aware of the upstream problems of Medicare and so began to deal with the root causes of its surging costs. Yet the symbolic significance of Medicare and its importance for seniors’ health rights have become so deeply entrenched that they limited the government’s ability to make policy decisions. In an era of fiscal constraints and rapid medical advancements, defending health care solely as a social right

of citizenship was no longer an adequate response to the increasing demands for reform. I therefore use “ordoliberal social citizenship” to capture the guiding principles of Medicare reform in the 1970s. Rooted in an early 20th century German economic theory upholding the principles of maintaining a free-market economy while ensuring strong state oversight, ordoliberalism advocates for a competitive market system but emphasizes the need for government regulation to prevent monopolies and ensure fair competition. The theory also integrates social welfare concerns, promoting a balance between individual economic freedom and social justice, ensuring that the benefits of a market economy are widely shared.² In this chapter, ordoliberal social citizenship is positioned between our conceptualizations of “contributory social citizenship” and “consumerist social citizenship” within the spectrum of state intervention in health care. It is a more accurate term between the Great Society principle, which is a full-fledged strategy for expansive social welfare, and the neoliberal paradigm, which blurs the boundary between the civil society, the market, and the state by imposing economic rationality on almost all spheres of the society.

I argue that the surging cost of Medicare compelled the government to reform its financing mechanism, while various interests embedded in the program, such as medical professionals, hospitals, manufacturers of medical equipment as well as Medicare beneficiaries as a powerful constituency,

² Ralf Ptak, “Neoliberalism in Germany: Revisiting the Ordoliberal Foundations of the Social Market Economy,” in his *Road From Mont Pèlerin: The Making of The Neoliberal Thought Collective*, ed. Philip Mirowski and Dieter Plehwe (Cambridge, MA and London, England: Harvard University Press, 2019).

together insulated Medicare from institutional overhaul. After all, “the health industry evolved during a period of abundance. Now that resources have become more limited and some belt-tightening seems in order, every interest is closely protecting his or her piece of the pie,” said Rep. Dan Rostenkowski, chairman of the House Ways and Means Subcommittee on Health.³ These concerns have together contributed to a scenario where the government struggled to balance Medicare benefits with the program’s budget. Therefore, the analytical objective is to specify the impact of the government’s maneuvering in the 1970s on the essence of social citizenship in an experimental era of health reform.

This is the major argument in a nutshell. I will develop it by laying out the political and economic background of the 1970s and then explaining how it shaped the government’s strategy about health care. The first section starts with general cost control measures of Nixon, Ford and Carter. It then probes into reforms within hospital and particularly policy implementation of the Professional Standards Review Organizations (PSROs), an agency designed to review whether services and practices reimbursed through Medicare were necessary and provided in the most effective and economic manner. As policymakers were increasingly concerned with the solvency of Medicare due to well-publicized Medicare fraud and abuse, the tensions between patients’

³ Iglehart, "The Great Society Is Alive and Well at HEW."

interest and medical professionals' authority also became more pronounced.⁴ The second section explores proposals to expand Medicare benefits in the 1970s. It should also be noted that this chapter gives limited treatment to the political activism of the American Medical Association (AMA), as lobbying is beyond the scope of our discussion. Analyzing the ordoliberal social citizenship that emerged as a consequence of Medicare's development will help us consider more broadly what being an American citizen implies.

Before diving into historical details, it is necessary to note the political context of the 1970s. The period was a period marked by meandering policy strategies. During the Kennedy and Johnson administrations, Democrats regularly turned to liberal academic think tanks for expertise on issues ranging from nuclear strategy to poverty alleviation. However, when Richard Nixon took office in 1969, many intellectuals retreated into their studies and "the poor Republicans were left without anyone to talk to," said Richard Burrell, a former Nixon aide. In the second half of the 1970s. However, this dynamic changed again and a national move away from traditional liberalism towards conservative thought suddenly made conservative ideas more respectable.⁵ However, the dominance of the neoliberal rationality in political and economic domains was far from settled in the 1970s, and Democrats had by this time believed the foundering fortunes of Keynesianism could be reversed by

⁴ For details of medical authority, Thomas Haskell, "Introduction," in *The Authority of Experts*, ed. Thomas Haskell (Bloomington: Indiana University Press, 1984); B. H. Gray, *The Profit Motive and Patient Care* (Cambridge, Mass.: Harvard University Press, 1991).

⁵ Kenneth Woodward and William J. Cook, "Conservative Brain Trust," *Newsweek* (Jan. 12, 1976).

improving management and planning. The ideational support of this belief was Peter Drucker's argument that the issue with government is not necessarily its size, but its inefficiency. In his influential 1968 essay *The Sickness of Government*, Drucker advocated for a strong and active government that separates the tasks of governing and implementation—policymakers should focus on raising awareness, rallying public support, and making decisions, while leaving the actual administration of programs to non-state actors.⁶

An apt example is Nixon's vision about health care. On May 20, 1974, President Nixon declared in his radio address to the nation that neither universal health care nor keeping health care as it was appeared to be feasible in an era of austerity. The former "would diminish the quality of care available and destroy the incentive for excellence which motivates those who provide our health care," and the latter "would mean that fewer and fewer Americans would have access to the kind of care which we are capable of providing". "Sometimes the best way to measure what we can accomplish in the future is to look at what we have achieved in the past," Nixon said.⁷ The state in this regard had to curb the market's possible overreach into governance and its unjust intrusions into civic society. This necessitated an exertion of government authority as a countervailing force to the market and ensured a certain level of public goods.

⁶ Peter F. Drucker, "The Sickness of Government," *The Public Interest* 14, no. 14 (1969).

⁷ Richard M. Nixon, Radio Address About a Proposed Comprehensive Health Insurance Plan., (Public Papers of the Presidents of the United States, Richard Nixon, Containing the Public Messages, Speeches, and Statements of the President, 1974. (Washington: United States Government Printing Office, 1975). May 20, 1974).

Therefore, under ordoliberal social citizenship what neoliberal advocates termed as the “market fundamentalism” is considered harmful at once to people’s well-being and to the economy because it potentially leads to pronounced increases in inequality.⁸

Therefore, the government has played an active role in ensuring seniors’ health rights throughout the 1970s. As detailed below, though the government has “talked right”, it has “legislated left”. Since it was a daunting task to persuade the elderly to accept modifications to a program they favoured, the only feasible way was to promise more benefits. The quest for such an approach has led some conservative policymakers to abandon complete privatization and advocated for regulatory strategies instead to contain the cost of Medicare. Yet from another perspective, adjustments to the overall provisions for eligibility and the extent of coverage were minimal during this period—the most notable ones were the expansion of Medicare eligibility to the disabled in 1972 and the unsuccessful attempt to broaden Medicare benefits to cover catastrophic costs. Overall, social citizenship in this period was characterized by a decline of the government’s commitment to reciprocity and an ambiguity in policy makers’ conception of social programs—a clear dilution of health security. Ordoliberal social citizenship is therefore an apt term in capturing the wavering attitudes of the government.

⁸ For an in-depth analysis of market fundamentalism, see Fred Block and Margaret R. Somers, *The Power of Market Fundamentalism: Karl Polanyi’s Critique*, 1 ed. (Cambridge: Harvard University Press, 2014).

In what follows we shall see “negotiations about citizenship take place above and below the state” in the 1970s—during this period the surging expenditure of Medicare and the growing social antagonism towards medical providers not only brought a reform urge “from above,” but also mobilized a series of attempts “from below” to reshape American medicine.⁹ It was also a time when Medicare and the “medical empire” more broadly were typified as a closed system in which patient discourse played little role, and patients were sceptical of public institutions and health care policies because provision of medical services was largely dominated by self-referential professionals¹⁰. The driving forces—economic stagnation, a demand to dismantle medical monopoly, and an urge to contain health care expenditures—together facilitated a set of policy diagnoses and prescriptions to reshape American health care. It is against this backdrop that our discussion unfolds.

Diluted Commitments: Cost Control Measures in an Era of Austerity

On February 15, 1977, in his meeting with President Carter in the Oval Office,

⁹ E. F. Isin and B. S. Turner, "Citizenship Studies: An Introduction," in *Handbook of Citizenship Studies*, ed. E. F. Isin and B. S. Turner (London: Sage Publication, 2002). For other successful organizing pertained to consumer rights, gender equality and women's health care, and disability movement in assessments of the physician-patient relationships. See M. A. Rodwin, "Patient Accountability and Quality of Care: Lessons from Medical Consumerism and the Patients' Rights, Women's Health and Disability Rights Movement," *American Journal of Law & Medicine* 20 (1994); C.S. Weisman, *Women's Health Care: Activist Traditions and Institutional Change* (Baltimore: Johns Hopkins University Press, 1998).

¹⁰ S. Shortell, E. Morrison, and B. Friedman, *Strategic choices for America's hospitals* (New York: Jossey Bass, 1990).

HEW Secretary Joseph A. Califano Jr. suggested raising Medicare payments for rural doctors to equitize Medicare accessibility in urban and rural areas. “Let me make sure I understand,” Carter’ looked at him directly in the eye, “you will pay rural doctors more money than they are now making.” “Yes, Mr.President,” Califano continued, “by doing this we can help fulfill your campaign promise to get more health care to rural areas.” “I don’t like the program,” Carter almost stared at Califano. “I am opposed to any program that would pay any doctor any more money. Find another way to solve the problem.” Later in the year, in a speech delivered at the annual AMA convention in San Francisco, Califano noted the high costs and lack of competitiveness in the American health care system and called for a change. Yet the *Washington Post* amplified Califano’s comments into a eye-catching title “CALIFANO, AMA TRADE ACCUSATIONS: HEW SECRETARY SAYS SYSTEM NEEDS PROFOUND REFORMS” and the AMA executive director James Sammons reacted strongly afterward. “I thought I had gone too far,” Califano wrote in his memoir. Yet to his surprise, Carter later approached him in a Cabinet meeting and said, “I liked what you told the AMA. Keep it up... . Just keep giving ‘em hell. No one deserves it more than they do.”¹¹

Carter’s moral outrage about physicians was well-justified. During the 1970s, an apparent pushback against medical authority (and against

¹¹ Joseph A. Califano, *Governing America: An Insider's Report from the White House and the Cabinet* (New York: Simon and Schuster, 1981), 162-3.

professional authority in a broader sense) was already underway. “For the first time in a century,” Paul Starr testified, “American physicians faced a serious challenge simultaneously to their political influence, their economic power, and their cultural authority.”¹² As the spirit of social and political activism of the 60s became ripe, medical professionals were increasingly criticized for their high charges, lack of public accountability, ineffective peer review, as well as non-transparent decision-making processes.¹³ Such “crisis of legitimacy,” as Starr put it, has given rise to a trend of “de-professionalisation” where medical professions lost “their monopoly over knowledge, public belief in their service ethos, and expectations of work autonomy and authority over clients.”¹⁴ The trend was further amplified when a commission appointed by the Department of Health, Education, and Welfare issued a report on medical malpractice in 1974, and the State of New York formed its own special investigation panel in 1976 as a response to the growing concern over malpractice.¹⁵ A 1976 survey also revealed that a significant number of citizens expressed their willingness to question the authority of physicians and actively engage in the decision-making process.¹⁶

¹² Paul Starr, *The Social Transformation of American Medicine* (New York: Basic Books, 1982), 379, 85.

¹³ Bernard Barber, "Control and Responsibility in the Powerful Professions," *Political science quarterly* 93, no. 4 (1978), <https://doi.org/10.2307/2150105>.

¹⁴ Starr, *The Social Transformation of American Medicine*, 380. Marie R. Haug, "Deprofessionalization: An Alternate Hypothesis for the Future," *The Sociological review (Keele)* 20, no. 1 (1972): 197.

¹⁵ *Report of the Secretary's Commission on Medical Malpractice* U.S. Department of Health, Education, and Welfare (Washington, D.C.: U.S. Government Printing Office, 1973); *Report of the Special Advisory Panel on Medical Malpractice*, State of New York (Albany, N.Y., , 1976).

¹⁶ M.R. Haug and B. Lavin, "Practitioner or Patient: Who's in Charge?," *Journal of Health and Social Behaviour* 22 (1981). The criticism on health professionals is also a theme in Elizabeth Etheridge, *Sentinel for Health: A History of the Centres for Disease Control* (California University Press, 1992).

In addition, costs of Medicare shot up from 3 billion dollars in the first year of full operation to 17 billion in 1975.¹⁷ By 1978, the number had surged to \$26.1 billion, 19% percent higher than that of the previous year.¹⁸ This largely attributed to the original design of Medicare, which enabled doctors to set fees and policy almost at their sole discretion. Too often did physicians prescribe unnecessary and expensive treatments or hospitalizations because they were all covered by Medicare or private insurance. Big-city hospitals also increased their room rates to over \$100 per day, and previously underpaid hospital workers were securing substantial pay raises in the late 1970s.¹⁹ In fact, the debate over Medicare throughout the 1970s was about cost control. The Nixon Administration tried to control costs of the health industry in the spring of 1974, though Congress declined to extend the Economic Stabilization Act (84 Stat 799), the legislative framework necessary for such reform. In 1976, President Ford cut the government's funding to public programs such as food stamps, Social Security and Medicare by \$20 billion, making his total budget for the fiscal year of 1977 \$394.2 billion. "The American people know that promises that the federal government will do more for them every year have not been kept," Ford declared. "I make no such promises."²⁰

Similarly, in his first major legislative move of the campaign session in 1975,

¹⁷ "Crackdown on Welfare; White House Blueprint," *U.S. News & World Report* (Dec. 22, 1975).

¹⁸ Joel Havemann, "The Lame-Duck Budget That Probably Won't Last a Month," *National Journal* (Jan. 22, 1977).

¹⁹ "Keeping An Eye On The Doctors," *Forbes* (July 15, 1975).

²⁰ "\$394.2 Billion Budget Presented; Long-Term Growth Rate Cut in Half, Deficit Projected at \$43 Billion; Defense up, social programs down," *Facts on File World News Digest* (Jan. 31, 1976).

President Ford unveiled a sweeping \$28 billion tax cut proposal—even heftier than the previous year’s reduction of \$22.8 billion—to urge congressional action in reducing the size and scope of federal spending programs. Congress responded coolly to Ford’s proposal. House Ways and Means Committee chairman Al Ullman derided the program as a “mirage,” and cited the challenge of voting on budget reductions without formal submission from the President. Republicans were also frustrated; Senator Robert Griffin of Michigan complained that the proposed budget ceiling was potentially forcing Republicans to vote against popular entitlement programs like Medicare. Yet Ford remained steadfast in his stance. He insisted on pursuing both tax cuts and budgetary restraint and thought the ever-expanding federal government must be brought under control. Ford believed his anti-Big Government stance to be politically advantageous. “The President believes,” according to a White House aide, “that people have reached the point where, rather than look forward to eternally increasing taxes and inflation, they are now willing to put a stop to some of the benefits doled out by the government.”²¹

Carter had his own way of cost control. Instead of attempting to cap Medicare’s overall spending, he targeted the hospital industry to reform the program institutionally. On May 11 of 1977, the Carter administration formally launched its campaign by initiating the Hospital Cost Containment Act. Carter

²¹ Tom Mathews, Thomas M. DeFrank, and Henry W. Hubbard, “Ford’s First Plank,” *Newsweek* (Oct. 20, 1975).

and Califano strongly advocated for this plan and aggressively pushed it in HEW. "America simply cannot tolerate hospital costs that are rising at 2.5 times the rate of inflation," Califano said assertively.²² To resonate with Americans, he also likened hospitals to an "obese" and "overweight" person indulging himself in a whole chocolate cream pie. This relatable image was soon embraced by the media—cartoonists helped make the idea of hospital reform more palatable for the public and major newspapers demanded action on the rising costs.

However, Congress remained hesitant to support the legislation because they seldom heard from any constituents in favour. The complex Medicare reimbursement system where third parties cover over 90% of hospital bills made it hard to engage individual citizens. Many Americans were unaware of their direct financial contribution to hospitals, as they only paid a small portion of the total costs. Additionally, it was hard to promote the reform idea beyond big cities because many local news outlets, particularly those in small towns, took so much pride in their community hospitals that they simply could not accept the metaphor. The Act became largely invisible in the public domain as a result, but Carter's strategy of targeting structural inefficiencies in the hospital industry itself aligned with ordoliberal social citizenship principles as it did not mandate broader caps on Medicare spending but emphasized a regulated

²² John K. Iglehart, "Like It or Not, Congress Must Grapple with Hospital Cost Controls," *National Journal* (May 21, 1977).

market structure where the state intervenes selectively to uphold order, efficiency, and fairness.

Hospital administrators were furious about the reform, nevertheless. Tons of angry letters flooded Califano's office and those of other congressmen accusing it to be "too much" and "too soon". Many hospitals even introduced a "voluntary program" about cost control to counter the government's push for mandatory controls. In his memoir, Califano wrote about a personal encounter with the Act's impact. In November 1977, as he was about to be discharged from a Washington, D.C. hospital after his thumb operation, a hospital administrator went to his room and handed him the bill. "Just mail it to my office," said Califano. "Oh, no," the administrator was quite serious, "my boss wanted you to review it before you left." "I don't know why," she continued, "But when my boss found out you were coming here, he said, 'My God! Of all the hospitals in Washington, why does he have to pick this one.'" Soon every hospital worker in DC knew about this. Later when Califano's friend Edward Williams had a surgery at Georgetown University Hospital, so many doctors and administrators talked to him about Califano that William joked when Califano visited him, "for Joe to walk into a hospital to see me was the bravest deed one man ever performed for another."²³ It was a time when everyone working in a hospital believed a storm was about to come.

²³ Califano, *Governing America: An Insider's Report from the White House and the Cabinet*, 144-5.

The PSRO Program

The sharpest stick of Medicare reform in this period was the Professional Standards Review Organizations (PSROs). Originally introduced in 1972, PSROs aimed to address the escalating costs of health care and hold individual physicians accountable for their practices. With PSROs, physicians were required to review medical care in their respective regions and assess whether the care Medicare patients received were appropriate and of high quality, as well as reduce hospital stays. Hospital admissions had to be approved by PSROs, and standards for treatment and length of stay for government-financed patients were established. Hospitals would not get their Medicare payment if they violated the standards. In 1977, the Carter administration also created the Office of Inspector General (OIG) within the HEW to oversee all investigative operations in relation to Medicare and Medicaid and serve as the main liaison between HEW, the Department of Justice, and the FBI. As a first of its kind within the U.S. Government, the OIG was a crucial step towards setting up a framework for potential criminal prosecutions regarding medical malpractice.²⁴ The year 1977 also saw Congress enact the Medicare-Medicaid Anti-Fraud and Abuse Amendments to the Social Security Act. The legislation amplified the consequences for misconduct and necessitated more

²⁴ For a detailed account of the role of Inspector General in American government, see Nadia Hilliard, *The Accountability State: US Federal Inspectors General and the Pursuit of Democratic Integrity*, 1 ed., Studies in Government and Public Policy, (Kansas: University Press of Kansas, 2017).

comprehensive reporting to HEW by PSROs.

While the objectives of PSROs sound moderate from today's view—to identify and sanction Medicare misconduct, at the time it was acknowledged to be an extraordinary intrusion on their medical practice and even “one of the most far-reaching forays into regulation to be legislated by Congress,” as testified by Dr. Harris Cohen from the Department of Health, Education, and Welfare (HEW).²⁵ Dividing the nation into approximately 200 review areas, the PSRO program was expected to streamline health care practices, improve patient outcomes, and relieve the financial burden on the Medicare system. In addition, PSROs reinvigorated the historical debate over the scope and boundaries of medical authority and was seen as a “silent revolution” against the medical profession across the 1970s. “PSROs are going to affect type of care given, the provider, length of treatment and the setting in which it is rendered,” said Dr. Henry Simmons, head of HEW's PSRO program. “It's going to have a very substantial impact, probably more profound than anything we've ever done.”²⁶

The program soon made significant progress with full-fledged government support. In February of 1980, the American Association of PSROs released a report based on data from 30 out of 185 regional organizations showing that PSROs were able to reduce hospital admissions, improve the quality of care,

²⁵ Harris S. Cohen, "Regulatory Politics and American Medicine " *American Behavioral Scientist* 19, 1 (1975): 134.

²⁶ Linda E. Demkovich, "The Physicians' Peer Review Program -- Does It Cost More Than It Saves?," *National Journal* (May 3, 1980).

and change the pattern of health care delivery. Dr. Dale N. Schumacher, director of medical care studies at St. Agnes Hospital in Baltimore, emphasized the importance of physician advisers in identifying inappropriate treatments and implementing necessary corrections and described the changes PSROs brought to St. Agnes as “rather dramatic”. “Doctors are pushing more,” Schumacher said, “many extra days where patients used to sit are disappearing. And doctors have begun to set target dates for patient discharges.” Similarly, in Manhattan, a PSRO program known as the New York County Health Services Review Organization took credit for the closure of 12 out of 40 local hospitals and the elimination of 1,500 excess beds. Over a two-year period, the average length of stay for Medicare patients dropped from 17.7 days to 15.8 days, a change also attributed to the organization. Additionally, the organization played a crucial role in shutting down a substandard hospital in the county that was reported to be “endangering the lives of its patients.” This facility was permanently closed in February 1979 due to the organization’s intervention.²⁷

Officials in the Carter administration also spoke highly of the program. “I think if I were a doctor...I would work very hard to make that PSRO program work,” said Califano in a news conference on November 9th of 1977, “It’s one of the opportunities the doctors have to police their own overutilization of medical facilities, their own prescribing problems, their own hospitalization problems, their own overloading of laboratory tests...If the doctors can’t do it,

²⁷ Demkovich, "The Physicians' Peer Review Program -- Does It Cost More Than It Saves?."

then somebody else is going to do it...So we intend to work to try and make that program more effective than it's been." Norman A. Fuller, the executive director of the National Capital Medical Foundation Inc., a PSRO in Washington, D.C., also hailed the program as a groundbreaking initiative in American medicine and regarded it as essentially "a physician behavior modification program." In short, the PSRO program gave doctors the opportunity to demonstrate their will and muscle to discipline colleagues who were providing inappropriate medical services.²⁸

Despite these achievements, PSROs' financial impacts kept stirring debates. "There seem[ed] to be an impact on utilization," said analyst Daniel M. Koretz from the Congressional Budget Office (CBO), "but not enough to pay for the program." According to Koretz, PSROs caused hospitals to transfer expenses to private payers because hospitals could only directly manage around 40% of their costs, while the remaining 60% were largely fixed. Consequently, when hospitals received lower payments from sources like Medicare, they had to make up the difference by increasing charges to private insurers. Additionally, seldom could hospitals manage demand for their services because external factors like local shortages of nursing home beds often hindered their ability to transfer elderly patients out of acute-care beds. "If all of this is true," Koretz said, "utilization review—of any kind—may not be the

²⁸ John K. Iglehart, "Pushing Physician Review to Prove It's Worth the Price," *National Journal* (Jan. 14, 1978).

most effective way to cut back on overutilization, because it's not tapping the root of the problem." However, Koretz also acknowledged that such transfer of costs was inevitable in a later event. "Any successful utilization review will have that effect," said Koretz, "That doesn't make utilization review inappropriate. We are simply arguing that costs merely transferred to other parties must be distinguished from costs truly saved."²⁹

This called into question the actual cost-effectiveness of PSROs. The key debate was whether the program could generate significant tax savings and medical care improvements or simply transferred Medicare cost to private insurers and increased health care costs for the society as a whole. On one side of the argument were President Carter and the Office of Management and Budget (OMB), while on the other side were the Health, Education, and Welfare Department, key congressional staff, PSRO operators, and some private physicians supporting the program. HCFA and the CBO offered conflicting assessments of the Medicare hospital use review program's cost-effectiveness. The HCFA claimed PSRO saved Medicare by \$1.27 for every dollar spent, yet the CBO's estimate was 87 cents. This was largely attributed to the different measures they used to define the cost of care. The CBO assumed fewer additional services at the end of patient stays, while HCFA looked at the average daily costs. Second, they disagreed on how many PSRO programs were actually operating. HCFA focused on those active in 1978, while the CBO

²⁹ Demkovich, "The Physicians' Peer Review Program -- Does It Cost More Than It Saves?."

counted all programs; this would surely affect their cost-benefit analysis.³⁰

In addition to these controversies, a prominent issue that kept challenging PSROs' normal implementation was poor record-keeping, as there was no centralized national database for PSROs to go through the proceedings and derive a disciplinary action. Besides, there was no system in place for communication between different state medical licensing boards. This means even if a citizen sued a physician for his misconduct and led to his sanction, such a lack of coordination and communication would allow the physician to slip through the cracks by moving to another state. Furthermore, PSROs were one of those organizations that could easily become subject to regulatory capture, a situation in which regulators bias government decisions toward the regulated party's preferred policies.³¹ Under such circumstances government agencies often fall under the sway of the interests they are meant to oversee and end up *systematically* favouring regulated party's private interests over public interests.³² Although there is no direct evidence suggesting PSROs were captured on regulatory terms, after their creation the expenditure has

³⁰ Iglehart, "Pushing Physician Review to Prove It's Worth the Price."

³¹ Sam Peltzman, "Toward a More General Theory of Regulation " *Journal of Law and Economics* 19 (1976).

³² The term originates from Bernstein's view on the development pattern of regulatory agencies, which is equivalent to a man's life cycle: gestation, youth, maturity, and old age. The gestation phase finds fierce struggle among aggrieved interests demanding government redress, culminating in the creation of a regulatory agency. The agency then acts aggressively in its administration during its youth phase, yet this is quite short as the support for regulation is usually unmatched by the regulated party's cohesive efforts in making the agency its servant. The maturity phase, then, finds the agency frequently making concessions and ultimately being "captured" by the interests it is supposed to regulate. For further details, see Marver Bernstein, *Regulating Industry by Independent Commission* (Princeton: Princeton University Press 1955). For its critics and other arguments in this regard, see Peltzman, "Toward a More General Theory of Regulation ". And R. B. Horwitz, *The Irony of Regulatory Reform: The Deregulation of American Telecommunications* (New York Princeton University Press 1991).

been conspicuously high. There were claims that the cost of enhanced peer review was higher than the savings it generated. In general, the expenses associated with the PSRO program were even double the savings reported, according to a 1978 Congressional Budget Office report.³³

Therefore, though utilization review was employed to mitigate public doubt for the medical profession and the government, the unintended consequence was usually increased public dissatisfaction with the complex administrative structure it brought. In this sense, the failure of PSROs has initiated a self-sustaining loop where intentional administrative shortcomings and insufficient regulation yielded disappointing outcomes, which further intensified public distrust in the government. Illustrative here, in November 1976, the National Academy of Sciences' Institute of Medicine released a study titled "Assessing Quality in Health Care: An Evaluation," which examined eighteen separate quality assessment programs, including seven PSROs. Led by Dr. Robert J. Haggerty, a Harvard University professor of public health, the study revealed mixed results across the programs. It found that many programs lacked clearly defined goals, making it difficult to gauge their achievements. Moreover, even when deficiencies in patient care were identified, the programs struggled to address them effectively. "We believe that the widespread interest in...professional reexamination that occur as programs are initiated and

³³ *PSRO Program: Hearing Before the Subcommittee on Health of the House Committee on Ways and Means*, (96th Congress, 2nd Session, 1980).

standards for care are established should eventually improve the general quality of medical practice,” said members of the study, but “there is a need for less expensive methods to achieve better results.”³⁴

Many of these issues remained unresolved even well into the twenty-first century, but one thing was certain amidst the fervent debates surrounding the PSRO program: Medicare in the 1970s was in urgent need of such a program to keep its benefits untouched. “If we didn’t have PSRO, government would have to invent something else very much like it,” Jay B. Constantine from the Senate Finance Committee asserted during a PSRO briefing hosted by the National Health Council on December 15 of 1977.³⁵ By 1978, even the once-skeptical American Medical Association was celebrating PSRO as a triumph of cooperation between the government and medical practitioners, and advocated fervently for its continued financial support. Further illustrating the program’s robustness was President Carter’s sudden reversal of stance in his revised fiscal 1981 budget, which departed from his previous unfavorable evaluations of the program and requested a hefty \$48.5 million increase in PSRO funds. Congress ultimately allocated \$149.9 million in total, with a significant portion earmarked for broadening the scope of reviews into physician practices and usage patterns within acute-care hospitals.³⁶

A less relevant, though important, cost control measure in the 1970s was

³⁴ Iglehart, "Pushing Physician Review to Prove It's Worth the Price."

³⁵ Iglehart, "Pushing Physician Review to Prove It's Worth the Price."

³⁶ Demkovich, "The Physicians' Peer Review Program -- Does It Cost More Than It Saves?."

the Health Maintenance Organizations (HMOs). Introduced in 1973, HMOs were self-regulatory systems that combined capitated payment and group practice to improve quality and rein in costs while at the same time avoided undesirable trade-offs like the traditional fee-for-service system of indemnity insurance. They were not open to Medicare beneficiaries until 1982, and the federal funding allocated to HMOs in the 1970s was simply no match for the expectations and regulatory requirements. According to a report by the General Accounting Office, HEW had distributed only \$70 million to HMO development out of the \$250 million authorized amount as far into the year as 1977.³⁷ Consequently, of the 124 prepaid plans that were established before 1974, only forty were successfully organized during 1974 and 1978. Even though an apparent call for health care reform, as well as subsequent HEW-authorized small grants, facilitated HMO development in states where federal oversight was loose in the early 1970s, the 1973 HMO Act actually undermined such progress.³⁸

By 1976, fewer than half (17 out of 39) of the approved HMOs in rural areas still remained active, and forty-one of the 108 HMOs funded by HEW were closed, with the remaining sixty-seven either under feasibility check or in planning phases and no one being in actual operation.³⁹ Many HMOs were

³⁷ John K. Iglehart, "Health Report/Heralded HMO Programs Beset by Unexpected Problems" *National Journal* (1974).

³⁸ Richard McNeil and Robert E. Schlenker, "HMOs, Competition and Government," in *Politics in Health Care Milbank Reader*, ed. John B. McKinlay (Cambridge, Mass: MIT Press, 1981).

³⁹ George B. Strumpf, *Health Maintenance Organizations, 1971-1976: Issues and Answers* (1976). Talk given at the 104th American Public Health Association of Health Plans (formerly Group Health Association of America), Washington, D.C.

terminated because they could not recruit enough physicians to participate in the plans.⁴⁰ Despite these failures, HMOs developed quickly and became an industry after a period of consolidation in the 1980s. As we shall see in Chapter 4 and 6, HMOs in the 1970s in fact provided significant experience for the development of Medicare HMOs and served as forerunner of the Accountable Care Organizations (ACOs) created by the Affordable Care Act (ACA) of 2010. Its enrolment standards, numbers in operation as well as financing mechanism under Medicare all changed dramatically in recent decades, with each period featuring a particular principle of the government's vision about elderly care. In sum, both the HMOs and the PSROs demonstrated a desire to impose market discipline on a healthcare system plagued by inefficiencies, and a commitment to regulate medical practices without overextending state intervention, a core tenet of ordoliberal social citizenship. The tension between expanding healthcare access and maintaining economic stability also mirrored the ordoliberal focus on balancing social rights with economic restraint. Ordoliberal social citizenship within this process features dual aspects: a less ambitious plan for health coverage and an inertia that kept Medicare from diverting from its original principles. It is the second dimension of ordoliberal social citizenship that we now turn.

⁴⁰ George B. Strumpf and Marie A. Garramone, "Why Some HMOs Develop Slowly," *Public Health Reports* 91 (1976).

Adaptation instead of Reformation: More Benefits under a Tighter

Budget

In 1978, an article in the *National Journal* wrote “the Great Society [was] alive and well at HEW” based on the fact that between 1964 and 1979, the HEW budget ballooned eightfold and the department’s share of the federal budget pie swelled from 18 percent to 36 percent. The budget for 1979 reached an anticipated \$181.3 billion, almost four times than that of 1969. A significant portion of this growth went to programs deemed “uncontrollable” —Medicare was a prominent example here—which constituted a staggering 89 percent (\$161.2 billion) of HEW’s 1979 budget.⁴¹ It was quite ironic to see such rampant increase in public welfare budgets given the consistent emphasis placed on cost containment almost since the beginning of the decade. Yet from another perspective, it was also a clear indicator of the robustness of the order established during the Great Society, or in other words, how resilient these federal programs were against major reforms.⁴²

Ordoliberal social citizenship thus emerged as a paradigm that emphasized the critical role of the state in safeguarding the rights and well-being of its citizens. This framework highlighted the government’s commitment

⁴¹ Iglehart, "The Great Society Is Alive and Well at HEW."

⁴² For the enduring effect of the Great Society, see Mitchell Robertson, "The Afterlife of the Great Society : Richard Nixon Vs the Permanent Government, 1969-1974" (ProQuest Dissertations & Theses, 2020).

to upholding principles of solidarity, equality, and social rights. This meant ordoliberal social citizenship was essentially incompatible with complete marketization (or sometimes known as market fundamentalism) that was a central feature of neoliberal principles. Moreover, the notion of ordoliberal social citizenship underscored the imperative of proactive state intervention. In this sense it also stood as a testament to the delicate balance between government intervention and private sector participation, which called for a collaborative approach that prioritized welfare of the public over market-driven agendas.⁴³

The following part thus details attempts to expand Medicare benefits in the 1970s to show the government's determination to protect health security of the elderly. In doing so, it demonstrated that the legal and moral framework of social citizenship in this period retained a substantial part of what has been evisioned during the Great Society.

Proposal for catastrophic coverage

⁴³ In this sense, ordoliberal social citizenship also differs greatly from what is often referred to as "neoliberal citizenship". While ordoliberal citizenship is accompanied by the conversion of a substantial segment of civil society into an apparatus of the state, neoliberal citizenship entails a market-dominated society where the public sector is gradually assimilated into the market framework. This means neoliberal citizenship is not an unconditional membership but a status contingent upon one's ability to contribute market value, with buying and selling being the central gauge of its worth. Furthermore, neoliberal citizenship is essentially "sacrificial". According to Wendy Brown, as neoliberalism sets loose individuals to take care of themselves, it often demands potential self-sacrifice to the nation's wealth and economic growth because individuals are socially obligated to considered themselves as investment assets for economic development of the country. A distinct problem, therefore, is that the elderly have little to offer in this neoliberal regime. Their predicament is not merely the hardship of commodification, but rather their perceived low value that makes them undesirable for commodification. This is deeply corrosive of the essence of social citizenship. For details on neoliberal citizenship, see Wendy Brown, "Sacrificial Citizenship: Neoliberalism, Human Capital, and Austerity Politics," *Constellations (Oxford, England)* 23, no. 1 (2016), <https://doi.org/10.1111/1467-8675.12166>; Luca Mavelli, "Citizenship for Sale and the Neoliberal Political Economy of Belonging," *International studies quarterly* 62, no. 3 (2018), <https://doi.org/10.1093/isq/sqy004>.

The first major attempt to expand Medicare benefits in the 1970s was President Ford's call for catastrophic coverage. At that time, Medicare only provided partial coverage for hospitalization from the second day up to the 150th day and paid nothing for the first day of hospitalization and costs incurred after the 150th day. Beneficiaries also faced a \$60 deductible and a 20 percent co-payment for doctor's services. To tackle this issue, President Ford proposed in his 1976 state-of-union address to increase Medicare benefits for the elderly and outlined his plan about a "catastrophic" coverage for long-term care later in a message on seniors sent to Congress on February 9. The aim was "to address the haunting fear of our elderly that a prolonged, serious illness could cost them and their children everything they have," said Ford, "nobody after reaching age 65 [would] have to pay more than \$500 a year for covered hospital or nursing home care nor more than \$250 for one year's doctors' bills."⁴⁴ The government was responsible for any further expenses once these thresholds were reached. Medicare payment to hospitals and doctors for 1977 and 1978 would be limited to fund this plan, and seniors on Medicare would have to pay more—the portion they were responsible for in hospital bills would rise from \$92 to \$104 for the first 60 days of care, and from \$23 to \$26 per day for the following 30 days.⁴⁵ The anticipated expenditure for this coverage ranges from \$1.1 billion to \$1.4 billion for the upcoming fiscal year.⁴⁶

⁴⁴ Tom Nicholson and Rich Thomas, "Ford's Go-Slow Budget," *Newsweek* (Jan. 26, 1976).

⁴⁵ "Crackdown on Welfare; White House Blueprint."

⁴⁶ "Helping the Elderly: What Fight is About," *U.S. News & World Report* (Feb. 23, 1976).

Ford's proposal ran into a flurry of opposition. Leading Democrats were reluctant to endorse the plan as they thought the extent of assistance it offered was too limited. Only a million persons would benefit from the catastrophic coverage, but "almost every patient would pay more for shorter periods of hospitalization than he pays now," according to Representative Brock Adams (Dem.) of Washington, chairman of the House Budget Committee.⁴⁷ In an interview with *Newsweek's* Washington correspondent Mary Hager, Joseph Califano criticized the proposal and likened it to a misguided path that would exacerbate the system's tilt towards costly health care options. "It's the wrong way to go," said Califano. "The arguments against catastrophic coverage are, one that under any circumstances you encourage people to go to the most expensive end of the health-care system. Two, as a function of equity you should also take some of your resources and provide coverage for poor people not now covered. And three, you need more fundamental reforms in the system to increase prevention and control reimbursement systems." Califano also emphasized the importance of a balanced coverage approach considering at once catastrophic coverage and hospital-cost containment during his testimony before the Senate Finance Committee. Yet there was no serious efforts on such mixed method by then.⁴⁸

Ford's plan failed to gain traction in Congress. Yet as we shall see in

⁴⁷ "Helping the Elderly: What Fight is About."

⁴⁸ Mary Hager, "Califano Answers Back," *Newsweek* (May 28, 1979).

Chapter 4, around a decade later, the Medicare Catastrophic Coverage Act (MCCA) of 1988 was strikingly similar to what Ford had envisioned, especially regarding the proposed way to fund the program. Most changes made to Medicare in the 1980s also aligned with Ford's declaration about the government's role. On Jan. 19 of 1976, Ford said the nation should be ready "for a fundamentally different approach for a new realism that is true to the great principles upon which this nation was founded." He planned to cut taxes and federal spending, fortify the financial foundation of the Social Security system, and streamline federal education, health, and social services programs to allow for more flexible implementation by state and local governments. "And in all that we do," Ford stated in his State-of-Union address, "we must be more honest with the American people, promising them no more than we can deliver, and delivering all that we promise."⁴⁹ In addition, Ford flatly rejected the idea to shift Medicare financing from the Social Security trust fund to the general tax revenue fund of the Treasury Department. He said such change would deviate Medicare from the principle of compulsory payroll contributions by workers.⁵⁰ In this sense, the Ford administration had no intention to dismantle the architecture (the aim, principles and institutions) of Medicare, but rather adopted an ordoliberal approach regarding its commitment to social welfare under the great pressure of cost control.

⁴⁹ "State of the Union Message: President Ford Urges 'New Realism,' Calls for Spending and Tax Cuts;," *Facts on File World News Digest* (Jan. 24, 1976).

⁵⁰ "Action on Social Security deficits urged," *Facts on File World News Digest* (Mar. 15, 1975).

Reorganization of HEW

The second major attempt to ensure seniors' health security while reining in costs happened during the Carter administration. On March 8th, 1977, Joseph Califano reorganized the HEW to put Medicare and Medicaid under a single Health Care Financing Administration (HCFA), announcing it to be the most extensive overhaul in the department's 24-year history.⁵¹ "Medicare and Medicaid are not accomplishing what they were designed to do in 1965," the HCFA declared soon after its establishment. "Our priority is to redirect the Medicare and Medicaid programs toward their initial goals -- to provide access to needed care for low-income and elderly people. Our proposals encompass program eligibility and benefits, reimbursement reform, financing, program management and administration and delivery system reform."⁵² Califano also saw this reorganization as a way to "simplify and streamline" Medicare's operation as well as an opportunity to combat the rampant issues of fraud, abuse, and waste that kept plaguing the program. "A key to persuading Congress to provide additional health care benefits to the elderly was to demonstrate that Medicare could be operated efficiently," said Califano, "literally hundreds of millions of dollars can be saved through introduction of basic

⁵¹ "HEW Reorganized," *Facts on File World News Digest* (Mar. 12, 1977).

⁵² John K. Iglehart, "A New Strategy for Medicare and Medicaid?," *National Journal* 10, no. 12 (Mar. 25, 1978).

managerial techniques in this area.”⁵³

It is interesting to note that such an ambitious vision faced numerous hurdles in the HCFA's early days. Three months after the administration's creation, Robert A. Derzon, director of the hospitals and clinics at the University of California was appointed by Carter as the first director of the Health Care Financing Administration. New in Washington, Derzon faced significant personnel challenges as he was often compelled to prioritize civil service status over competence when filling key roles. At the same time, the management structure of Medicare appeared alarmingly fragile, while HCFA's ability to steer the program was hampered by legal constraints that delegated much administrative authority to individual states. Criticism of Derzon's leadership style thus grew quickly within HCFA and the Secretary's office, with concerns raised about the agency's lack of clarity about its future direction. Califano was then the most vocal critic of HCFA. "He beats on Derzon's head at every turn, demanding to know why HCFA cannot move faster to integrate Medicare and Medicaid than it has done until now," said one department staff member who refused to be quoted by name. Derzon could only reply by saying "yes, it can be done, but not without new legislative authority and benefits."⁵⁴ As internal tensions simmered and external pressures mounted, the reorganization had a bumpy start at first.

⁵³ Califano, *Governing America: An Insider's Report from the White House and the Cabinet*, 157.

⁵⁴ Iglehart, "A New Strategy for Medicare and Medicaid?."

The first achievement the HCFA made was about kidney dialysis. In the 1970s, the federal government allocated well over \$1 billion to provide this treatment for approximately 50,000 Americans, and Medicare reimbursement policies encouraged dialysis to be conducted in hospitals or standalone clinics. Yet there was a chance to save Medicare payments—up to 50 percent—by allowing patients to have kidney dialysis in their own homes. Not surprisingly, this proposition faced fierce opposition from hospitals and the clinic-based dialysis industry that feared losses in revenue. Their lobbying was always successful as their staunch ally in Congress, Senator Herman Talmadge, chaired the Senate Finance Committee’s Health Subcommittee; any proposed changes to reimbursement must be approved by the Subcommittee.⁵⁵

To address the problem, Califano invited Talmadge for breakfast in the Secretary’s private dining chamber at HEW on May 16, 1977. Interestingly, Talmadge mentioned a recent medical test he had before Califano raised the dialysis issue. It was a costly test and, “When the doctor finished, he told me that if the test had been done in a hospital, Medicare would have picked up the bill. Since it was done in his office, Medicare wouldn’t pay the bill. That’s not sensible,” said Talmadge. “It’s a lot less expensive in his office,” said Califano. “That’s the point, Joe,” the Senator agreed. This gave Califano a perfect opening of his idea. He drew a parallel between Talmadge’s experience and the

⁵⁵ *Institute of Medicine (US) Committee for the Study of the Medicare End-Stage Renal Disease Program.*, ed. Rettig RA and Levinsky NG, *Kidney Failure and the Federal Government*, (Washington (DC): National Academies Press (US), 1991).

challenge of home-based kidney dialysis and highlighted the potential for significant cost savings if the law were amended to fully reimburse for such treatments. “Let me see about that,” Talmadge seemed to recognize the need to change Medicare’s reimbursement policies. A few days later, Talmadge withdrew his objection to reimbursement change and the law was eventually amended on June 13, 1978.⁵⁶

With Talmadge’s support, Califano also proposed to allow direct reimbursement of nurse practitioners in rural areas and urban centers experiencing severe shortages of doctors through Medicare. Previously, Medicare coverage for nurse practitioners was insufficient as they were classified as primary care providers. Their profession faced limitations due to restrictions imposed by state laws and medical associations, which often define the “practice of medicine” broadly and reserve it for physicians. However, nurse practitioners were capable of delivering various healthcare services, including immunizations, physical examinations, and basic diagnoses and treatments at a lower cost compared to physicians. Incorporating them into Medicare thus encouraged many basic medical services to be performed by nursing practitioners, potentially saving federal funding. Congress eventually allowed the HCFA to carry out Califano’s plan in rural areas. Though the AMA then managed to change the locale to inner-city areas on the grounds that minorities had lower political influence than farmers and rural congressmen, this proposal was a

⁵⁶ Califano, *Governing America: An Insider's Report from the White House and the Cabinet*, 156-7.

clear indicator of the Carter administration's attitude towards Medicare: ensuring seniors' health rights while reining in costs in innovative ways.⁵⁷

End-of-life Care

A similar action in this regard was concerned with patients' dignity in their last days. By the 1970s, Medicare had become a thriving marketplace brimming with sophisticated equipment designed to prolong life. Billions of Medicare dollars flew into nursing homes to pay for those enormously expensive, excruciatingly painful, and often de-humanizing therapies for terminally ill patients. "Too often we use the drug technology of Librium and Valium and the federal funds that pay for institutional care to put our elderly and our sick out of sight, mind, and conscience," Califano bemoaned in his memoir.⁵⁸ Around the same time, however, an advocacy known as the "hospice movement" started to gain momentum within the elderly care industry. "Hospice" was a medieval notion of a resting place for travellers, yet in the 1970s the word was largely known as a compassionate philosophy of care for the terminally ill. Unlike conventional medical approaches that tethered patients to machines and subjected them to aggressive treatments, hospice prioritized humane care and pain relief and allowed individuals to embrace their final days with dignity. Ideally, hospice care was performed in patients' own homes where they were

⁵⁷ Califano, *Governing America: An Insider's Report from the White House and the Cabinet*, 156-7.

⁵⁸ Califano, *Governing America: An Insider's Report from the White House and the Cabinet*, 168.

surrounded by loved ones. Teams of nurses and physicians provided not only medical assistance but also emotional support and solace to the dying individual and their family members during their hospice care.⁵⁹ In addition to its compassionate ethos, hospice care offered a pragmatic advantage: cost-effectiveness. A case in point was the New Haven Hospice, where the average total cost of caring for a patient in the final three months of life amounted to a mere \$750, while hospital care usually cost \$5000.⁶⁰

Califano detailed his personal experience during a campaign tour on September 19, 1978. When he talked to Connecticut Governor Ella Grasso about the way seniors were treated in society, Grasso was surprised by the share of Medicare funding spent on senior patients' last days—most of that money was used to pay for the various tubes and equipment needed to keep patients alive for a little longer, often in a comatose state, that lasted days, weeks, or even months. She then mentioned the hospital movement and took Califano to a hospice in New Haven, which was funded by \$1 million from the HEW along with state and private contributions. "You've got to see this," said Grasso, "It allows the dying to stay with their families and die with some dignity." They also visited a terminally ill cancer patient in his home. The 68-year-old man was lying in a hospital-style bed with a hospice worker by his side. "His wife said that it was wonderful having him at home," Califano recalled, "that they

⁵⁹ Robert MacNeil and Charlayne Hunter-Gault, "No Headlines in Original," *PBS NewsHour* (Oct. 6, 1978).

⁶⁰ Kenneth L. Woodward et al., "Living with Dying," *Newsweek* (May 1, 1978).

could be together, talk, and watch television. It was so much better than being in a depressing hospital.” On their way back, Califano was so moved by the scene that he asked how could hospice workers cope when a patient they spent much time with died. “We give them a great deal of time off,” said Dr. Sylvia Lack who ran the New Haven hospice, “and we counsel them. Most are deeply religious people”. “They’d have to be,” Califano thought.⁶¹

Deeply impressed by this visit, Califano then orchestrated demonstration projects under the Medicare program and opened the doors for a select number of hospice demonstrations. The response was overwhelming—applications poured in from every corner of the nation, and ultimately twenty-six were handpicked in December of 1979 to embark on this pioneering journey.⁶² In fact, the first hospice was opened in New Haven in 1974, and by 1978, the fervor for hospice had spread like wildfire and the new caring form took root in 33 states.⁶³ “One of the strengths of the hospice movement was its genuine grass-roots inspiration,” Califano said.⁶⁴ Yet what made it special was that this “reform from below” had the government’s support this time. A total amount of \$2.5 million of federal funding was channelled into various hospice programs across the nation. The Carter Administration also convened a panel of officials from the the National Institute on Aging (NIA), National Cancer Institute (NCI),

⁶¹ Califano, *Governing America: An Insider's Report from the White House and the Cabinet*, 168-9.

⁶² Califano, *Governing America: An Insider's Report from the White House and the Cabinet*, 170.

⁶³ Woodward et al., "Living with Dying."; Linda E. Demkovich, "Hospice and HEW," *National Journal* 11, no. 30 (July 28, 1979).

⁶⁴ Califano, *Governing America: An Insider's Report from the White House and the Cabinet*, 170.

and other Federal agencies to discuss the nation's approach to end-of-life care. NIA director Dr. Robert Butler promised that the Institute would strive to ensure that dying patients were "in peace and dignity, with less pain."⁶⁵

In sum, the hospice movement signified a paradigm shift in end-of-life care for terminally ill patients. More importantly, initiating demonstration projects under Medicare meant the government was becoming attentive to patients' dignity in medical treatment. Medicare as a federal insurance program used to focus on what services should be covered and how much the program should pay, especially in the 1970s when economic stagflation called into question the solvency of almost all social welfare programs. Yet paradoxically, the seventies was also a time when people—at least some groups in the hospital industry—started to realize the considerable funding allocated to elder health care starkly contrasted with the often undignified treatment they receive. This was a pivotal moment in Medicare history because instead of simply subjecting patients to machines and tubes and wires, the program now took into account patients' psychological and emotional needs in addition to their financial ones.⁶⁶ This was closely tied to the social market aspect of ordoliberal social citizenship, which emphasized the integration of ethical concerns with social welfare policies. Enhancing the moral dimension of Medicare greatly enriched the program's commitment to seniors' health rights and social citizenship more

⁶⁵ Woodward et al., "Living with Dying."

⁶⁶ For a detailed account of the residential care's historical development, see Gabriel Winant, *The Next Shift : The Fall of Industry and the Rise of Health Care in Rust Belt America* (Cambridge, Massachusetts: Harvard University Press, 2021).

broadly.

Conclusion

This chapter has examined the cost control measures the government adopted in the 1970s under the pressure of economic downturn as well as the attempts to expand Medicare benefits with a tight budget. How policymakers struck a balance between reducing medical costs and retaining the principles of Medicare illustrated the essence of what I called the ordoliberal social citizenship. On the one hand, there has been an increased emphasis on regulation and market forces compared to that of the 1960s, with the complex interplay of political, economic, and social forces reshaping the very foundations of the health care landscape. All three Presidents in the 1970s—Nixon, Ford and Carter—emphasized the urgency to control Medicare costs and cut the government’s budget for social welfare; the Carter administration also changed the operation of Medicare institutionally by introducing utilization review to the system (the PSROs).

Specifically, the Hospital Cost Containment Act of 1977 represented a concerted effort to curb the excessive growth in hospital costs and rein in the unchecked autonomy of physicians in setting fees and policies. The personal encounters recounted by Califano vividly illustrated the contentious atmosphere

surrounding the Act, yet amidst the pushback and controversy, the Carter administration remained steadfast in its pursuit of a more sustainable Medicare. PSROs represented a significant milestone in such efforts. PSROs were effective in reducing hospital admissions and changing the pattern of health care delivery, but controversies about the cost of maintaining such organizations as well as the efficiency of its administration never ceased. Besides the PSROs, the government has another foot in the medical door via the HMOs, but their implementation was half-hearted at best. After all, HMOs were introduced during a recession period when business communities across the country called for more cost-effective health care, and its savings largely failed their expectation. In our Medicare pyramid framework, the experience of PSROs and HMOs also stood as a testament to the importance of collaboration between government agencies, medical professionals, and private insurers in promoting accountability and efficiency within the Medicare system.

On the other hand, Medicare in the 1970s did not depart from its original aim or embark on a totally different trajectory. Despite the failure of President Ford's ambitious proposal for catastrophic coverage in Medicare, this initiative aligned with his commitment to maintaining the integrity of Medicare and laid the groundwork for the Medicare Catastrophic Coverage Act of 1988 (though this also ended up a failure). While Ford's approach may have been diluted by the pressures of cost control, his efforts underscored the ongoing struggle to balance fiscal responsibility with the imperative to ensure seniors' health rights.

Another pivotal moment in this regard was the Carter administration's reform to bring Medicare and Medicaid under the Health Care Financing Administration (HCFA). Despite hurdles in the HCFA's early days, such as internal tensions within the administration and resistance from vested interests, Califano's leadership proved instrumental in achieving key milestones. One such achievement was the expansion of Medicare coverage to include home-based kidney dialysis, a move that promised substantial cost savings and improved patient outcomes.

Additionally, Califano's proposal to allow direct reimbursement of nurse practitioners in underserved areas demonstrated a commitment to innovative solutions for addressing health care disparities. Besides, hospice care not only prioritized pain relief and emotional support but also proved to be a cost-effective alternative to traditional hospital care. The grassroots inspiration behind the hospice movement, along with government support, not only propelled the rapid expansion of hospices across the country but also addressed the inadequacies of home health care system in the United States.⁶⁷ Exemplary here, there was one home health service for every 120 people in Sweden by the 1970s, but in the United States the ratio was only 1/5,000.⁶⁸ In navigating these challenges, the Carter administration also reaffirmed the government's role in safeguarding the health rights of seniors.⁶⁹

⁶⁷ Eileen Boris and Jennifer Klein, *Caring for America: Home Health Workers in the Shadow of the Welfare State* (New York: Oxford University Press, 2012).

⁶⁸ Califano, *Governing America: An Insider's Report from the White House and the Cabinet*, 168.

⁶⁹ Notably here, Carter was also determined to trim the federal government in public services, for

In overview, the 1970s' health care landscape left an indelible mark on the trajectory of citizenship development and served as a stark reminder of the delicate equilibrium between professional authority and government intervention. The experimental cost control measures have triggered a progressive watering down of the enclosed medical empire—first reduction in Medicare's payment to hospitals, second PSROs as tools to eliminate fraud and abuse in Medicare billing, and finally prepaid group health care such as HMOs. However, it may not have been the “controversial” nature of PSROs and HMOs that ultimately doomed them and accelerated the rise of a neo-liberal order. More significant factors likely included the overwhelming complexity of the health care system, a constrained fiscal and economic environment, and increasing public expectations for social protection. These forces created divergent pressures that complicated reform efforts, regardless of their design.

In this context, the 1970s can be understood less as a simple transition period and more as an experimental phase for the American health care system. Compared to neoliberal citizenship, which fundamentally challenged the concept of collective responsibility, ordoliberal social citizenship demonstrated a more inclusive approach that sought to integrate market efficiency with social protection.⁷⁰ Had reform efforts successfully navigated these complexities and

details, see Gary M Fink and Hugh Davis Graham, *The Carter Presidency: Policy Choices in the Post-New Deal Era* (Kansas: University of Kansas, 1998).

⁷⁰ Citizenship designates a protected status, but neoliberalism “diminishes all significant venues of active citizenship” by economizing the political and undermining the very idea of the social. For detailed analysis, see Brown, “Sacrificial Citizenship: Neoliberalism, Human Capital, and Austerity Politics,” 8. This inherent tension also illuminates a major feature of neoliberalism: it can hardly coexist with other schemes of value because of its remarkable ability to integrate them. “Neoliberalism,” to borrow

stronger momentum been maintained for expanding Medicare benefits, the ascendancy of the neoliberal order might have been delayed significantly. This growing complexity, characteristic of the American government at large during this time, also contributed to increasing public disillusionment with government, even as citizens demanded more from it.

Mavelli's words, "has no outside." Mavelli, "Citizenship for Sale and the Neoliberal Political Economy of Belonging."

Chapter 4

The Gilded Age: Framing Medicare as a Budget Policy Through Social Citizenship in the 1980s

“Medical costs are like shifting sands—they don’t disappear, they just move from one area to another.”¹

“Medicare is an impossible maze, defeating even the most educated consumers...Adding to this confusion, consumers must comprehend a variety of private policies marketed to the elderly.”²

There is a common assumption that the 1980s was a period marked by a wholesale shift to smaller government and reduced social welfare spending, along with an emerging belief in individualism and free markets as the embodiment of freedom. Yet for Medicare in the Reagan years this description appears to be over-simplified. In the early 80s, Congress brought about the

¹ Christine Woolsey, "Claims Systems Generate Savings in Work Comp Bills," *Business Insurance*, July 23 1990.

² *Catastrophic Health Insurance*, (Washington, D.C.: Government Printing Office 1987).

Health Maintenance Organization (HMO) demonstration program and the Prospective Payment System (PPS) to counter the high inflation across the medical industry. As cost containment appeared to be successful, the Prospective Payment System (PPS) was introduced in the late 80s in the name of Medicare benefits expansion. It sounds like a story of a government being attentive to seniors' needs again as soon as they were freed from budget shackles. After all, the PPS, the Medicare HMO as well as the Medicare Catastrophic Coverage Act (MCCA) all took protecting the seniors and improving quality of care as one of their principal goals.

However, a closer inspection of the three programs showed that they were similar to other social policies in this period—regulation light, ideologically conservative, and budget neutral. The Reagan administration claimed that Americans were now such informed and rational consumers that they no longer needed the protections against the private market—“Consumers are not as gullible as most regulators think they are.”³ Yet experiences with HMOs and Medigap plans suggested otherwise. I call this disjuncture between the outset (the stated goal) and essence (the actual impact) as “gilding”, and hence the 1980s as a “gilded age” for Medicare. The term “gilded” in this context refers to the 1980s being a period where Medicare policies were presented as enhancing social rights and health security for the elderly, but in reality, these

3 Similarly, the Reagan White House's consumer spokesperson Virginia Knauern said: “consumers are very sophisticated, and by making their own choices in the free marketplace, they become the regulators”. See Michael deCourcy Hinds, “The Rational Consumer May Be Just a Deregulator's Dream,” *New York Times*, November 1 1981.

reforms are driven primarily by budget constraints rather than genuine improvements in care. The "gilding" implies that while the surface rhetoric emphasized protection and social citizenship, the underlying policy goals are more focused on controlling costs.

With analysis of each program focusing on one party—the PPS (medical providers), Medicare HMOs (private insurers), and the MCCA (beneficiaries), respectively, I show that social citizenship in the Reagan years is compromised by budget constraints, and that advocacy for market forces have a narrow focus on changes in the financial incentives of medical providers and private insurers, with little attention to social rights and health justice of the elderly. Literature in health justice has argued that health reforms should be guided by three key principles: *autonomy*, which emphasizes self-governance, liberty, privacy, and free choice; *justice*, which involves treating similar cases equally; and *benevolence or non-maleficence*, which entails the moral duty of doctors to act for the benefit of their patients.⁴ However, each change made to Medicare violates one or two of the principles: the PPS sees doctors go against non-maleficence principles to discharge patients prematurely; HMOs' risk selection undermines justice in health care, and its unscrupulous marketing infringes upon autonomy of the elderly; and the MCCA encroaches seniors' autonomy by assuming their needs and makes them pay for it. As we shall see, these are

⁴ TL Beauchamp and JF Childress, *Principles of Biomedical Ethics* (Oxford: Oxford University Press, 2001), 12.12.

characteristics of the consumerist social citizenship—partially informed consumers facing the stormy waters of privatization.

The PPS: A Win-win-lose Situation

In 1983, the prospective payment system (PPS) was established as a tool to rein in Medicare costs. Contrary to the previous fee-for-service reimbursement mechanism, the PPS paid Medicare beneficiaries' health care costs based on a pre-determined price. To ensure that the price was set properly, the federal government also introduced Diagnosis-Related Groups (DRGs), a system to classify hospital cases into groups that reflected the resources used to treat patients with similar clinical diagnoses and treatments. However, the PPS's impact has been mixed. On the one hand, the Medicare PPS was thought to be a win-win situation for Congress and the hospital industry. By the late 1980s, it had both restrained Medicare's rate of cost increase and helped alleviate the Congress budget deficit, and the hospital industry was not financially harmed by the reimbursement changes—hospital profits under the PPS were \$5.1 billion in 1985, rising from \$4.6 billion in 1984.⁵ On the other hand, it has given hospitals more incentives to make profits with each medical service becoming

⁵ Each of the 4,912 hospitals participated in the survey has reported a \$1.04 million surplus in 1985, as compared to \$939,207 in the previous year. Tamara Henry, "New Medicare payment system yields big hospital profits," *United Press International* June 1, 1987.

a “product line” based on DRGs, as hospital administrators could identify which services were profitable and collaborate with cost-generating physicians to minimize losses and increase revenues.⁶ “The prospective system is causing a reaction from the hospitals dissimilar to anything that’s happened in 20 to 30 years,” said R. Allen Vaughan from the Arizona Hospital Association. “Hospitals now are faced with the same type of marketplace incentive that many other businesses have always faced.”⁷ Consequences included premature discharge of patients, delayed treatment as well as fewer lab tests—patients were on the losing side of this system. Understanding their causes required an inspection of both the program design and the inner dynamics of hospitals.

The AMA was once concerned that the PPS would create tensions between physicians and hospital administrators and undermined quality of care if administrators got in the way of the reimbursement process. In fact, a 1985 survey by the AMA showed that 42 percent of the physicians reported a deterioration in their relations with hospital administrators under the PPS.⁸ However, during times when hospital budgets were in balance, administrators highly esteemed physicians and recognized them as key professionals who not only provided medical care but also brought in patients and enhanced hospitals’ reputation. Even as financial constraints began to tighten, administrators

⁶ W. C. Hsiao et al., “Lessons of the New Jersey DRG payment system,” *Health Affairs* 5, no. 2 (1986), <https://doi.org/10.1377/hlthaff.5.2.32>.

⁷ Robert Pear, “Hospitals Worry over Fixed Rate Set for Medicare,” *New York Times*, August 28 1983.

⁸The report also showed that 30 percent reported no change and the remaining 28 percent said relations had in fact improved. For details, see William Kronholm, “Doctors Criticise New Medicare Payment System,” *The Associated Press* December 7, 1985.

preferred to seek reductions in other areas rather than confront physicians directly. Rather than attempting to change the treatment plans and practices of physicians, administrators often resorted to traditional cost-cutting measures such as reducing inventories, trimming administrative overheads, and stopping recruiting new staff. In this way, administrators navigated the complexities of budgetary constraints while maintaining a harmonious relationship with the physicians who played a pivotal role in the hospital's success.⁹ Therefore, the PPS's impact on physician-administrator relations was quite limited. This preliminary analysis casts doubt on the idea that physicians might have diverging interests from the hospitals.¹⁰

The PPS's impact was twofold. On physicians it was largely concerned with the DRG system. Under DRG, each Medicare patient was classified in one of 467 categories, ranging from serious diseases like heart attack and kidney transplant to less serious ones like ankle sprain. Reimbursements were made based on a code number assigned to a particular diagnosis rather than the severity of the disease or preventive health screening; each insurance claim must be filed with a specific code to be processed. In fact, DRGs have created a new language system where medical terminology was easier to be understood than plain English. "I'm learning 'double speak'," said a Connecticut physician Lee Sataline, "not outright lies...but telling the truth 'on the slant'."

⁹ Hsiao et al., "Lessons of the New Jersey DRG payment system."

¹⁰ This means we could treat them as a whole within our Medicare pyramid framework in the case of the PPS.

With DRGs, physicians often conflated a bad cold with bronchitis or diagnosed a severe menstrual pain as “a possible ectopic (tubal) pregnancy” to get reimbursed. Citing the case of a 61-year-old man with scarring in his lungs as an example, Sataline said previously, the patient’s file stating “Routine Annual Screen” were always reimbursed by the insurance company. Yet in the year DRGs went into effect, such payment was refused. After many phone calls and letters and all of the patients’ previous X-ray reports, Sataline finally changed the file title into “Routine Screen for Tuberculosis” in order to get the payment.¹¹

As physicians learned to game the system, hospitals were also making quick adjustments. The average length of stay for patients on Medicare declined dramatically. As reported by the Department of Health and Human Services (HHS), Medicare patients under the new payment system had an average hospital stay of 9.1 days, yet the number was around 10.3 days in 1982. Similarly, the American Hospital Association reported that the duration of hospital stays was declining more rapidly for Medicare patients than for younger groups. Under the PPS hospital occupancy rates have also decreased from 74% in 1983 to 68% in 1984, and 64% in 1985—a natural by-product of the increasing premature discharges and the decreasing admission rates.¹² “The evidence that quality of care...has suffered has become abundantly clear,”

¹¹ This happens both in Medicare and in private insurance, for details, see Lee Sataline, “Connecticut Opinion: A Physician Learns the ‘Double Speak’ of Insurance Forms,” *The New York Times*, September 14 1986.

¹² Paul C. Rettig et al., “Medicare’s Prospective Payment System: The Expectations and the Realities,” *Inquiry (Chicago)* 24, no. 2 (1987): 179.

lobbyist for the National Council of Senior Citizens Eric Shulman testified in a congressional hearing.¹³ Concerns kept growing, but leaders of the hospital industry refused to acknowledge that quality of care was compromised. “Some elderly patients may feel they were pushed out of the hospital a little sooner than they should have been,” said executive vice president of the American Hospital Association Jack W. Owen, “but I don’t think the quality of care has suffered so far, and I don’t think it will if the prices (i.e., government payment) remain fair”. When asked about the complaints about hospitals skimping on services, president of the Texas Medical Association George Alexander staunchly denied the issue was systemic—“The smoke hasn’t led to fire”. Additionally, Carolyne Davis, head of the Federal Health Care Financing Administration, said the quality of care might even have improved under the new system because “care [was] better planned and coordinated” by doctors and nurses.¹⁴

Yet such rhetoric contradicted Medicare patients’ actual experience. As consumer groups found an increasing number of Medicare beneficiaries were discharged from their hospital beds prematurely by the end of 1986, with most of them being transferred into nursing homes after their Medicare benefits ran out. While many hospitals started to acquire nursing homes or contract with nearby ones to secure a certain number of beds, the cost of long-term stays,

¹³ "Hearings On Bill To Keep Patients From Being Discharged Too Soon, Too Sick," *The Associated Press*, April 23 1986.

¹⁴ Robert Pear, "Medicare Limits Make Hospital Careful on Costs," *The New York Times*, August 26 1984, Late City Final Edition.

which was not covered by Medicare, kept burdening patients with lower incomes but were not entitled to Medicaid. As a result, the American Association of Retired Persons (AARP) and the People's Medical Society urged the Reagan administration to protect the legal rights of Medicare beneficiaries especially regarding negative effects of the PPS, but whether the administration was determined to address the issue remained hard to tell. Although Health and Human Services Secretary Otis Bowen assured that patients could appeal discharge decisions, a 1986 General Accounting Office report revealed many premature discharges went unreported.¹⁵

However, a 1986 study by the General Accounting Office showed that many cases of premature discharges were never reported to the government by the PROs.¹⁶ The case of *Wickline v. State of California* is exemplary here. As an oft-cited case in PPS administration analysis, it focused on the question of who should be held accountable for premature discharges: the hospital, the individual doctor, or the insurance company. In this case, physicians were subject to a prospective utilization review that required them to obtain approval from third-party insurers before performing certain medical services, and the utilization review was commonly used in Medicare to determine whether the services provided under the PPS were appropriate.

Ultimately, the court ruled that there was no liability for premature

¹⁵ William Kronholm, "Government Spells Out Medical Rights of the Aged," *The Associated Press*, February 24 1986.

¹⁶ Medicare: Physician Incentive Payments by Hospitals Could Lead to Abuse, (July 1986).

discharge, although physicians could be held liable if they negligently allowed cost containment pressures to dictate medical decisions.¹⁷ This means the rights of patients on Medicare could be potentially harmed due to compromised medical judgment and disrupted continuity of care, because under the PPS hospital discharge decisions were often swayed by cost-saving policies over medical necessity. Furthermore, under such circumstances patients' consent of discharge were usually not fully informed, and patients' autonomy to make informed choice were undermined accordingly. In short, the legal battle in *Wickline v. State of California* highlighted the perils that the PPS might pose to patient health.

Regarding access to care, the PPS also gave hospitals an incentive to turn away severely ill patients due to the "bottom-line financial mentality," as Robert Sillen, director of the Santa Clara Valley Medical Centre, put it. Similarly, general counsel of the Florida Hospital Association William Bell testified that said hospitals encouraged physicians to do more tests on an outpatient basis before admitting people to the hospital. While previously hospitals tried to prevent doctors from doing too many tests, under the PPS "there will be pressure on the doctors and the hospitals to do too few," said Bell.¹⁸ The sickest patients were not the only group being disadvantaged in a PPS. In 1984, the AMA encouraged physicians to freeze their fees for all patients to protect

¹⁷ *Wickline vs. State of California*, (Appendix 3d 1175, 228 California Reporter 661, petition for review granted, 727, 1986).

¹⁸ Pear, "Hospitals Worry over Fixed Rate Set for Medicare."

them from rising medical costs, and around 73 percent physicians answered the call. “I haven’t raised my fees in one and a half years anyway,” said Dr. Karl Franzon from New Jersey.¹⁹ Yet the PPS did not mandate that doctors must “accept Medicare patients on assignment” —a scenario where the physician agreed to accept the Medicare fee schedule as full payment for services provided to Medicare beneficiaries. Therefore, doctors could choose to “balance bill” patients and charge them more than the Medicare reimbursement rate, with the patients responsible for the difference. “So here we are trying to get doctors to do something voluntarily in the interest of their patients, and the Congress is providing the maximum disincentive for them to comply,” complained Joseph Boyle, president of the California Medical Association and previous chairman of the AMA’s board of trustees.²⁰

Another factor posing threat to Medicare beneficiaries’ access to care was the way bad debt and uncompensated care was handled under the PPS. Notably, the PPS drew heavily on the empirical evidence of New Jersey’s state-regulated payment system, but failed to incorporate the most effective strategies from that model—solving bad debt by distributing these costs across all healthcare payers. Under this approach, hospitals serving low-income communities were able to save themselves from constant deficits and achieve some surpluses. In practice, this equated to an extension of health care access

¹⁹ "AMA Asks Doctors to Freeze Fees," *United Press International* February 23, 1984.

²⁰ Linda E. Demkovich, "AMA President Says Patients Want Traditional Doctor-Patient Relationship," *National Journal* August 4, 1984.

because many hospitals were saved from bankruptcy and had no incentive to turn down low-income patients, and they did so without exerting excessive pressure on the government budget because the financial burden was dispersed more broadly. However, the PPS did not include any reimbursement for bad debt. Since the PPS only applied to Medicare, hospitals might try to make up for the shortfall in Medicare payments by charging more to other payers, like private insurers—known as “cost shifting”. As a result, the overall cost burden on the healthcare system was not necessarily reduced. Otherwise, if hospitals could not recover Medicare-related losses through cost shifting, they tended to avoid treating Medicare patients who were more likely to result in bad debt. In this sense, the PPS potentially undermined access to care because both scenarios led to reduced access to care for Medicare beneficiaries, particularly those who are low-income.

In conclusion, the PPS was a success as a cost-containment policy, but a major change it brought to the health care landscape was the shortened length of hospital stays and increasing deaths in nursing homes. Both hospitals and physicians managed to make quick adjustments to the system after its inception. Incentivized to maximize profits under the DRGs, hospitals tried to balance financial objectives with the delivery of patient care and reduced length of stays. Physicians, on the other hand, were compelled to navigate a new coding system that did not always align with clinical realities, sometimes resulting in the manipulation of diagnoses to get proper reimbursement. Physicians also

managed to maintain a good relationship with hospital administrators as both parties sought to preserve the viability of their practices and institutions within the constraints of the PPS. Yet patients could hardly find themselves a comfortable place in the new system as quickly as medical providers. The legal and ethical challenges highlighted by cases like *Wickline v. State of California* underscored the need for protection of patient rights and the integrity of medical decisions. Access to care under the PPS was also undermined, with hospitals having disincentives for treating severely ill patients and potentially encouraging the practice of “balance billing,” which left seniors financially vulnerable. Overall, the fundamental issue is not whether a federal defined-contribution system could be effective in Medicare as a traditionally defined-benefit program. The real issue goes beyond technical considerations. If the government kept creating cost containment measures in the name of protecting the elderly, the essence of social citizenship needs to be redefined. I will come back to this issue later in this chapter.

Medicare HMOs: The Disillusioned Market

In December 1987, phone calls flooded the lines of the United Seniors Health Cooperative—a consumer group advocating for the elderly—in a Maryland suburb of Washington. Seniors complained that with just three weeks’ notice, a

local HMO named M.D.-Individual Practice Association would triple its monthly premium from \$22 to \$62 and cut prescription drug benefits for 1,300 of its enrollees who were also on Medicare.²¹ At issue was Medicare's "risk contract" program. As part of the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982, the program paid HMOs a capitation fee and required HMOs to provide additional benefits if they operated at lower costs than fee-for-service Medicare in the same area. This means participating HMOs would provide at least the full range of Medicare benefits for a set fee for each enrollee and bear the loss should the costs of services exceed the payment. This was an approach aligning with what was conventionally known as managed care—a system that entrusted private third parties with the delivery of quality medical care at controlled costs. The senior citizens' lobby was initially drawn to the idea—director of the National Institute of Aging Dr. T. Franklin Williams said at a 1984 symposium that "HMOs have shown remarkable results in reducing hospitalization rates for the enrolled recipients...with resultant cost savings that can be converted into a wider range of benefits."²²

Policymakers also believed that HMOs were particularly well-suited for serving the elderly. First, HMOs were designed to coordinate health care across a variety of departments—the so-called "polypharmacy", and seniors often had multiple illnesses and chronic conditions that required the involvement of health

²¹ Julie Kosterlitz, "HMO 'Risk Contracting' Has Its Risks," *National Journal* January 16, 1988.

²² John K. Iglehart, "Second Thoughts About HMOs for Medicare Patients," *Health Policy Report* 316, no. 23 (1987).

professionals with different expertise. Second, the pre-paid financing mechanism provided HMOs with an incentive to promote the use of initial, more cost-effective, and less technologically advanced treatments (such as outpatient and preventative measures) over more costly and more invasive options (like acute care in hospitals or long-term care in nursing facilities).²³ However, by March 1987, only about 3 percent of Medicare beneficiaries—867,087 people—were enrolled in 151 HMOs.²⁴ Discussions have attributed the low enrolment rate to legislative and operational barriers discouraging HMOs from contracting with Medicare, such as the market-insensitive reimbursement rate and restrictions on the composition of the HMO benefit package, yet the social citizenship implications of the program were also among the major factors hindering its implementation.²⁵ As detailed below, it was soon proved that Medicare HMOs were a flawed idea especially in terms of its ability to ensure social rights. “I felt like the father of an errant child,” said the program’s leading legislator Senator John Heinz, “a program I claim as legislative progeny ... is flawed as currently operating.”²⁶

Risk selection

²³ Hearings Before the Subcommittee on Health of the Senate Committee on Finance, Medicare Reimbursement on Finance of HMOs, (97th Congress, 1st session 30 July 1981).

²⁴ John Heinz, "Medicare and HMOs: A First Look, With Disturbing Findings," *Caring* 6, no. 7 (1987).

²⁵ James Bautz Bonanno and Terrie Wetle, "HMO Enrollment of Medicare Recipients: An Analysis of Incentives and Barriers," *Journal of Health Politics, Policy and Law* 9, no. 1 (1984).

²⁶ Charles Stafford, "Report Finds Problems with HMOs under Medicare," *St. Petersburg Times (Florida)*, April 8, Wednesday April 8, 1987.

In fact, almost all studies conducted in this regard found biased selection to be true for Medicare HMOs, and the tendency was exacerbating in the 1980s.²⁷ First, the introduction of new screening techniques and DNA-related technologies (generic tests) enabled insurers to know one's medical risks in a more specific way, compared with previous methods relying almost solely on one's medical history. Second, while there had been some proposals to address the problems brought by risk selection by the Health Insurance Association of America (HIAA), their thrust was not to ban risk selection but to reinsure those who were considered by the private industry as uninsurable.²⁸ Overall, a total number of 14 states, including Alaska, California, Maine, New York, New Jersey, and Texas, introduced comprehensive measures addressing rating, benefits, reinsurance as well as underwriting by 1990, but there was no punishment for such underwriting practices or regulations that would threaten the profitability of the insurers.²⁹ Additionally, according to an economist at the University of California Medical School, Harold Luft, HMOs usually enrolled healthier patients because joining an HMO required the person to sign up a new physician, but people with serious medical conditions already had a physician they were familiar with. "Those more inclined to switch are those not using

²⁷ For example, P.W. Eggers, "Risk Differential between Medicare Beneficiaries Enrolled and not Enrolled in an HMO," *Health care Financing Review* 1 (1980); R. Brown, *Biased Selection in the Medicare Competition Demonstrations* (Princeton, NJ: Mathematica Policy Research, 1988); Frank W. Porell and Winston M. Turner, "Biased Selection under an Experimental Enrollment and Marketing Medicare HMO Broker," *Medical care* 28, no. 7 (1990).

²⁸ The HIAA recommended the government to establish state risk pools to guarantee the availability of health insurance to all Americans under age 65, and that the losses resulted from insuring high-risk individuals would be financed through state general revenue.

²⁹ Carl J. Schramm, "Government, Private Health Insurance, and the Goal of Universal Health Care Coverage," *Inquiry* 29, no. 2 (1992).

health services as much,” said Luft.³⁰ The next section examines a deeper issue compounding these flaws.

It is a curious irony that HMOs, despite their responsibility to expand health care access, sometimes created a barrier that impeded access. A researcher from the Health Care Financing Administration (HCFA) noted that in most test sites—seven out of eight—there was a tendency for HMOs to enrol those who were healthier than the average and turn down high-risk patients, a phenomenon commonly known as biased selection or favourable risk selection. While a Government Accounting Office survey suggested that the adjusted mortality rates for those in HMOs were roughly 25% less than those in the FFS groups, it was possible that the lower mortality rates in HMOs were not due to better quality care or superior access to healthcare services, but rather because these members were healthier to begin with.³¹ Interestingly, empirical studies found that instead of confronting the government’s urge to enrol Medicare beneficiaries, HMOs usually used techniques to subtly dissuade them. Cited were conducting medical assessments before enrolment; targeting their marketing efforts to attract lower-risk individuals; subtly influencing existing high-risk enrollees to underutilize services, refusing them care, or even persuading them to leave the plan; and discontinuing their services in regions

³⁰ Julie Kosterlitz, "The Government, Health Experts, Wall Street Pinning Their Hopes on HMOs," *National Journal* November 23, 1985.

³¹ Medicare Issues Raised by Florida Health Maintenance Organizations, Report to Congress, GAO/HRD-86-97, (Washington, DC: U.S. Government Printing Office 1986).

where high usage by enrollees leads to elevated costs.³² “Did the HMO manage care or just get lucky?” Rick Lee, vice president of the Washington Business Group on Health, questioned the optimistic estimate on HMOs’ prospect released in a 1985 government report and suggested that 200 of its members found HMOs only “moderately effective” in containing costs.³³

Administrative inefficiency

Ironically, the very agency designed to rein in costs was a major driving force of the cost increase. “We have created a Stone Age system to deal with the problems of modern-day health care,” said Representative Larry Smith. Illustrative here, a report by the General Accounting Office showed that in Florida, the error rate in Medicare HMOs billing stood at a significant 28 percent, which exceeded the acceptable rate by 26 percent. Additionally, Medicare issued \$700,000 in duplicate payments for HMOs in the year 1985 alone. The process to confirm whether beneficiaries were enrolled in an HMO was also sluggish. It usually took HMO administrators as long as 37 days to verify, a period during which beneficiaries were improperly billed. Furthermore, there was a lack of clarity regarding who—regular Medicare or HMOs—was responsible for settling bills during the transition period when a beneficiary either joins or exits an HMO, leading to frequent billing errors.³⁴ The Florida

³² Stafford, "Report Finds Problems with HMOs under Medicare."

³³ Kosterlitz, "The Government, Health Experts, Wall Street Pinning Their Hopes on HMOs."

³⁴ Robert Doherty, "Government Reports Criticizes Administration of HMO Program," *United Press*

case was not unique, nevertheless. There was substantial evidence that traditional Medicare was more administratively efficient than HMOs—while HMOs on average spent 11.9 percent of premiums on administration, in the fee-for-service system of Medicare the number was only 3.2 percent.³⁵ Taking a broader view, the administrative workforce of the health insurance industry in fact accounted for some 30 percent of premiums in the 1980s, and from 1983 to 1987, there has been a 37 percent increase in health administration expenditure.³⁶ In this sense, the U.S.'s efforts to achieve efficiency seem to have led to more inefficiency—every aspect of medical practice is meticulously examined, except for the bureaucratic system itself.

Marketing Problems

In 1987, the Senate Special Committee on Aging conducted a study in five states to see whether HMOs have made quality care accessible to Medicare beneficiaries. Based on information collected from Florida, California, Minnesota, Michigan and Massachusetts, the study concluded that unscrupulous marketing techniques constituted one of the most distinctive factors undermining senior citizens' health security.³⁷ In some cases, beneficiaries were even enrolled or dropped out of programs without their

International March 11, 1985.

³⁵ AMA Center for Health Policy Research. (1989). The Administrative Burden of Health Insurance on Physicians. *SMS Report*, 3(2): 2-4.

³⁶ S. Woolhandler and D. Himmelstein, "The Deteriorating Administrative Efficiency of the U.S. Health Care System," *New England Journal of Medicine* 324 (1991).

³⁷ Heinz, "Medicare and HMOs: A First Look, With Disturbing Findings."

consent, either infringing their consumer rights or putting them at risk of no care and huge out-of-pocket bills. “I did not sign anything. But I want to make clear that I don’t want to belong to any HMO. That is how they trick people into this,” a women said she was surprised to find herself subscribing to an HMO after a man dropped at her house unexpectedly, asked for her Social Security number and promised to send her information afterwards, according to an August 26, 1986 HHS memo on fraudulent enrolment of Medicare beneficiaries in Finlay HMO, a company in Miami.³⁸

It is worth noting here that the drop-out and switching rate showed that HMOs were not popular among the elderly. In areas where HMOs options were abundant, the rate of enrollees leaving their plan was as high as 38.86 percent, and only a quarter of those who disenrolled from their initial plan went on to join another HMO after leaving.³⁹ Senator Heinz of Pennsylvania summed it up well, stating that instead of offering Medicare beneficiaries a valuable choice, HMOs actually “functioned as an expensive gamble.”⁴⁰

The low enrolment and high drop-out rate later created a vicious cycle: the more seniors tried to avoid HMOs plans that were not as cost-effective as expected, the more sophisticated and deceptive HMOs’ selling tactics became. In the late 1980s, the Consumer Union—a prominent consumer advocacy group—claimed that the HMO marketing was so unprincipled that even those

³⁸ Jacquelyn Swearingen, “No Headline in Original,” *States News Service* 1987.

³⁹ Kathryn M. Langwell and James P. Hadley, “Insights From the Medicare HMO Demonstrations,” *Health Affairs* 9, no. 1 (1990), <https://doi.org/10.1377/hlthaff.9.1.74>.

⁴⁰ Heinz, “Medicare and HMOs: A First Look, With Disturbing Findings.”

members who were accustomed to insurance sales pitches found it surprising. The Union's official journal *Consumer Reports* found that none of the HMO sales representatives could provide accurate information about the doctors in their networks. Yet they did not hesitate to assign doctors to their potential client. The representative from Humana admitted to overstepping his boundaries by choosing a doctor for his clients and even offering to take them to visit the selected doctor's office. Meanwhile, the salesperson from Health Options—one of the largest Medigap plans—recommended a new doctor in the network, asserting that new doctors, being less busy and eager to please, were desirable. It was also surprising how poorly Medicare benefits were explained to consumers. Salespeople at AV-Med, with a business card showing "Medicare consultant", barely knew how Medicare worked. Similarly, when sales representatives at CareFlorida were asked about what Medicare meant by a skilled nursing facility, they had no idea except saying "it was licensed". If the consumer did not sign up on the spot, the salespeople often pressed him into buying. "I'm sorry you're not making up your mind," a salesman from Health Options said using a typical selling tactic, "you'll regret it. Don't get involved with anyone else". Similarly, another salesman said to his customer, "you make me look bad with the company."⁴¹

In overview, the Medicare HMO program was overshadowed by disincentives such as biased risk selection, administrative inefficiencies, and

⁴¹ "HMOs for the Elderly: Should Medicare Recipients Join?," *Consumer Reports* 57, no. 8 (1992).

unprincipled marketing strategies. Despite the legislative intent to offer the elderly a cost-effective health care option, the outcome was a system where the most vulnerable enrollees were disproportionately affected and social citizenship was deeply compromised by the pursuit of profit and the exploitation of legislative loopholes. James F. Doherty of the Group Health Association of America once defended the program by citing that most plans combined financial incentives to physician reviews to assure high-quality care; only 100,000 seniors were in plans without such quality control.⁴² Yet evidence explicitly showed that principal issues with HMOs stemmed not from physicians but rather their regulation. According to a report released in September 1987, the HCFA lacked both financial resources and determination to follow up complaints or to conduct thorough reviews of the quality of care, and had been relying too heavily on HMOs to monitor and regulate themselves. This fostered an environment where the Medicare beneficiaries were highly exposed to aggressive marketing and inconsistent gaps in their health insurance coverage.⁴³ In this sense, the bumpy road of Medicare HMOs was largely attributed to its flawed design that overlooked the commercial pattern of HMOs, and any program designed to enhance social citizenship failed easily without considering market rules and actual needs of the elderly. It is this correlation that the next section is concerned.

⁴² Irvin Molotsky, "Doctor Incentives on Costs Assailed," *The New York Times* December 16, 1988.

⁴³ Cathleen L. Yordi, *Interim Report to Congress: Evaluation of the Social/HMO Demonstration*, U.S. Health Care Financing Administration (1987).

Medigap and the MCCA: The Consumer Revolt

In 1989, Ethel Weinberg, a 72-year-old woman living in Massachusetts, joked about dropping her Medigap plan that cost \$500 a month and finding a faith healer.⁴⁴ The beginning of the story was the legislation of the Medicare Catastrophic Care Act (MCCA). Enacted in June 1988, the Act was designed to protect seniors from illness-related catastrophic financial losses. Yet as many seniors realized that the program's cost might outweighed its benefits, they flooded Congress with tons of letters and other protest materials that preluded an open revolt. The revolt climaxed when a group of outraged seniors surrounded the car of House Ways and Means Chairman Dan Rostenkowski, vigorously pounding on its windows and striking it with picket signs while shouting "Coward!" and "Impeach!"⁴⁵ Under such pressure, the MCCA was soon terminated by the Medicare Catastrophic Repeal Act on 30 November 1989, eleven months after it went into effect. It was unusual for Congress to repeal a legislation in such a short period of time, and its causal effect warrants lengthy analysis. As we shall see, the fraud and abuse in Medigap sales prompted Congress to develop a plan taking over catastrophic care, but deficiencies in the MCCA and its quick repeal resulted in further increase in

⁴⁴ David Conn, "Health Insurers Under Fire for Medigap Rate Increases," *Journal of Commerce* November 6, 1989.

⁴⁵ "The Elderly Duke it Out," *Newsweek* September 11, 1989.

Medigap premiums. Therefore, instead of bringing additional benefits, the MCCA in fact disturbed the insurance market and caused unnecessary harm to seniors financially.

Before the MCCA, seniors largely used Medigap to protect themselves against costs associated with acute hospital stays. About 70 percent of the nation's 35 million Medicare beneficiaries had Medigap policies with an average annual spend of \$705 in 1989.⁴⁶ A 1987 survey by Health Insurance Association also found high levels of satisfaction in general—some 80 percent of the 1500 participants said their claim was promptly and fairly paid. Another survey by Federal Trade Commission conducted around the same time, however, found that the loss ratio (the percentage of premiums paid out as claims) was surprisingly low given the high satisfaction rate, and that 70 percent of the elderly believed Medicare provided coverage for their long-term nursing home stays—a clear sign of seniors' misleading perception about Medicare because the program only covered acute care.⁴⁷ The fact was confusing enough, but the fraud and abuse in Medigap sales helped explain the contradiction. According to a congressional report, salespeople of Medigap continued inducing seniors to purchase duplicative and low-value plans and misrepresenting themselves as government agents or influential senior

⁴⁶ David Dahl, "More Increases Ahead in Price of Health Care," *St. Petersburg Times (Florida)* February 3, 1990.

⁴⁷ Charles Stafford, "Medigap: Savior of the Ill Elderly or Abuser of Them?," *St. Petersburg Times (Florida)* March 27, 1987.

organizations.⁴⁸ “I learned how to intimidate, force, manipulate and lie to the people,” said a salesman from Clearwater, one of the most profitable Medigap plan in Florida. “We were taught to lie about who we represented, what we represented, what the policies were and what the waiting periods were.”⁴⁹ This added even more fabric to our discussions of social citizenship—while citizenship was conventionally believed to involve an exchange between citizens and the state on their rights and responsibilities, private interests often confounded such exchange as well as citizens’ rights claiming.⁵⁰

It was in this context that the MCCA was introduced. Such deceptive tactics were even more prevailing in the late 1980s, despite the presence of the Social Security Act of 1980 that protected seniors from overpriced and substandard Medigap plans—commonly known as the Baucus Amendments. “Many [were] being ripped off and [were] being cheated out of their limited fixed incomes,” asserted Representative Ron Wyden in a hearing of a Senate subcommittee on finance. It was evident that Medigap policies were taking advantage of the seniors’ confusion about Medicare coverage. After all, “Medicare [was] an impossible maze defeating even the most educated consumers...Adding to this confusion, consumers must comprehend a variety of private policies marketed

⁴⁸ Catastrophic Health Insurance, Short, 95-96, pt. 3.

⁴⁹ Karl Vick, "Medigap Seller Tells of Being Taught to Lie," *St. Petersburg Times (Florida)* March 8, 1987.

⁵⁰ It is worth noting that private medical insurance has always been a significant part of the American social policy even since the 19th century, see Brian Balogh, *A Government Out of Sight: The Mystery of National Authority in 19th-Century America* (Cambridge: Cambridge University Press, 2009). Marie Gottschalk, *The Shadow Welfare State : Labor, Business, and the Politics of Health Care in the United States*, 1st ed. (Ithaca, NY: Cornell University Press, 2018).

to the elderly,” concluded Gail Shearer of the Consumers Union.⁵¹ As a response, Otis Bowen, then Secretary of Health and Human Services, devised a plan to shift the burden of financial catastrophic medical costs—most of which were covered by Medigap—from the private to the public sector. It was surprising to see that President Reagan, with his famous quote “Government is the problem”, allowed Bowen to develop such a liberal plan that explicitly countered his ideological commitment to free enterprise and government retrenchment. In this sense, health care had become so deeply entrenched in the political and social fabric that even governments with conservative leanings found themselves constrained in making significant changes. Despite their broader agenda, they were forced to compromise on this issue—a clear sign of the significance of health care as a social right and its central role in public expectations.⁵² As a bill passed under a President known for his conservative governance, the MCCA was even praised to be “a major step in a new direction for the administration...after six years of Reagan administration cutbacks in health care coverage for the elderly and poor.”⁵³

From the outset, the Act seemed to be an attempt to expand seniors’ social rights. Regarding Medicare Part A, it provided unlimited hospitalization for

⁵¹ Stafford, “Medigap: Savior of the Ill Elderly or Abuser of Them?.”

⁵² Quadagno once argued that the MCCA illustrated a broader pattern in American health policy: even modest expansions of public insurance face strong opposition when they entail additional taxes or redistribution of costs. The Act showed the inherent difficulty in establishing comprehensive health insurance in the U.S., where tax-based funding models often clash with public aversion to perceived government overreach and additional financial burdens. Jill Quadagno, *One Nation, Uninsured: Why the U.S. Has No National Health Insurance* (Oxford University Press, 2006).

⁵³ Bud Newman, “Bowen Unveils Medicare Catastrophic-illness Plan,” *United Press International* November 21, 1986.

approved medical services after the patient paid an annual deductible (approx. \$564 in 1989), skilled nursing facility care for 150 days each year, and other benefits including psychiatric hospital benefit and hospice care. For Part B, it added a limit (\$1370) to charges for all services and supplies per year, a new coverage for certain prescription drugs, as well as benefits for X-ray screening and home health aides.⁵⁴ However, it was its financing mechanism that revealed the MCCA's nature—another budget-neutral policy with light regulation and limited expansion of Medicare in an era characterized by welfare retrenchment. Conservatives in Congress encouraged the Medigap industry to dismantle the Bowen plan with a market-based alternative, which changed the regulation that prohibited Medigap plans from covering hospital stays beyond 365 days after Medicare benefits of the enrollee was exhausted. However, industry leaders soon balked as they found it too costly to be practical—Medigap could hardly make profits without a significant increase in premiums. Budget considerations outweighed social citizenship in this case.

Notably, seniors were initially split over the MCCA. On the one hand, the AARP, the largest senior citizen's lobby boasting 28 million members and an annual budget of \$145 million, supported the Act on the grounds that the progressive method of the MCCA's financing would benefit most seniors ("Otherwise the poor couldn't afford the benefits"). On the other hand, a number of smaller groups, with the National Committee to Preserve Medicare and

⁵⁴ Medicare Has Improved: Catastrophic Protection and Other New Benefits, (1988).

Social Security (NCPMS) being the most prominent, fiercely opposed the MCCA and condemned the premiums to be overpriced, the benefit inadequate, and the surtax unfair.⁵⁵ Consisting of 4.5 million members and led by James Roosevelt, son of President Franklin Roosevelt, the National Committee not only promoted its members to send nearly a million messages to members of Congress demanding repeal of the Act, but also handed out numerous flyers with eye-catching headlines. "A special tax on senior citizens! Have you ever heard of anything so outrageous in your life?" One missive screamed at its reader. The clarion call continued, "1989 INCOME TAXES FOR MILLIONS OF SENIORS WILL INCREASE BY UP TO \$1,600.000 (\$800.00 FOR SINGLES) —IT'S A TAX ON SENIORS ONLY AND IT MUST BE STOPPED!" The messages were strong enough to paint a picture of government injustice that was as vivid as it was terrifying.⁵⁶

It was interesting to see two camps, both declaring to protect the elderly and their social rights, setting out on entirely different paths regarding catastrophic care. While the Association's legislative director John Rother revealed "the financing mechanism was not our proposal," he acknowledged the plan was the best deal they could get as "there [were] compromises and negotiations."⁵⁷ With 150 trained volunteers in cities across the country, the association held open events and used its newsletter to spell out the MCCA's

⁵⁵ Desda Moss, "Seniors Groups at Odds over Catastrophic Care," *USA Today* March 29, 1989.

⁵⁶ Jacob Weisberg, "Cat Scam," *New Republic*, October 30 1989, 11.

⁵⁷ Martin Tolchin, "New Health Insurance Plan Provokes Outcry over Costs," *New York Times* November 2, 1988.

benefits. “We feel strongly,” said Rother, “that when people take a closer look they’ll see it helps the people who need help the most.”⁵⁸ The reality was not the case, nevertheless. The more they learned, the more obvious the fact that the MCCA was a zero-sum game where affluent seniors would be funding the benefits of low-income and middle-income beneficiaries. In 1988, a memorandum of the Congressional Budget Office (CBO) predicted that the most affluent 30 to 40 percent of the elderly would “face new premium costs in excess of their new expected benefits under the act.”⁵⁹ In a 1989 report, the CBO further substantiated the prediction by showing the “negative incremental effect” the MCCA would have on these beneficiaries.⁶⁰ Therefore, for the first time in the American health care history the affluent beneficiaries were on the losing end and getting back less than they have contributed. To defend the Act, policymakers kept saying “only the rich are complaining” and blamed those opponents for being selfish, but in fact anyone over 65 who paid income tax were classified as “rich” in this case—almost half of the Medicare beneficiaries.⁶¹

In this sense, the MCCA was by no means a redistributive policy in conventional terms; it was more of an outlier in American social provision. For social citizenship theorists, reciprocal policies that spread risks across the life

⁵⁸ Moss, “Seniors Groups at Odds over Catastrophic Care.”

⁵⁹ Subsidies Under Medicare and the Potential for Disenrollment Under a Voluntary Catastrophic Program, ix (Washington, D.C., Congressional Budget Office September, 1989).

⁶⁰ Impact of the Medicare Catastrophic Coverage Act on Enrollees with Employment-Based Insurance Coverage, 3 (Memorandum, December 12, 1988).

⁶¹ John A. Fisher, “Health Insurance Plan Needs Fresh Ideas,” *St. Petersburg Times (Florida)* September 21, 1989.

cycle (e.g., retirement and unemployment benefits) and inclusive policies that share the security between advantaged and disadvantaged groups (i.e., means-tested programs) constituted the essence of redistribution.⁶² Yet the MCCA did not fall into any of these categories.⁶³ This partly explains why its congressional advocates refused to label the Act as a redistributive policy, despite the blunt statement by Representative Gradison that “Elderly Americans with the ability to pay more should contribute more to sustain Medicare.”⁶⁴ Another element undermining the MCCA’s protection of the elderly was the requirement of paying premiums up-front but receiving benefits gradually over a five-year period. Initially, policymakers introduced such arrangement to provide the government with a safety net of financial reserves in case the Act’s cost exceeded its estimates. However, once the MCCA became effective the design turned out to be “a recipe for disaster.”⁶⁵ If the legislation’s financing mechanism led to the protest of those liable for the surtax, the deferred benefits left the remaining seniors with little reason to support the Act. In other words, the MCCA’s design left it with no chance to develop a wide constituency before it came under attack from the opponents.⁶⁶

Except for fiscal considerations, a major factor preventing the MCCA from

⁶² Peter Taylor-Gooby, "Social Citizenship Under Pressure," in *Reframing Social Citizenship* (Oxford: Oxford University Press, 2008), 8.

⁶³ Though the MCCA also entailed a risk share between the more affluent elderly and less advantaged ones, it could hardly be defined as an inclusive policy because the latter usually involves a limited risk and considerable distance between the groups on the giving and the receiving end. For detailed analysis, see Peter Dwyer, "Membership," in *Welfare rights and responsibilities*, Contesting social citizenship (Bristol University Press, 2000).

⁶⁴ Congressional Record, H6464, S15110 (July 22, October 23, 1987).

⁶⁵ Julie Kosterlitz, "Fiscal Catastrophe," *National Journal*, October 7 October 7, 1989, 2454.

⁶⁶ Weisberg, "Cat Scam," 12.

enhancing social citizenship was the omission of coverage for long-term care. Long-term care, as what Representative Dan Burton said, was “the No.1 health care concern for the elderly.”⁶⁷ Similarly, Representative Harris Fawell testified that long-term care was the “highest priority” among all medical provision. This was “a benefit all Americans, young and old alike want[ed],” said Fawell, “and the law [did] not even address it in the most minimal of ways.”⁶⁸ In a 1987 poll commissioned by the National Alliance of Senior Citizens Inc. (NASC), 40 percent of the 600 senior participants chose long-term nursing home care as the coverage they wanted most from a catastrophic bill, followed by home health care (24 percent) as their second choice. Yet these concerns were barely addressed in the MCCA. Regarding prescription drug coverage, the centerpiece of the legislation, only 8 percent participants listed it as their priority. “No one bothered to ask seniors what they wanted,” said NASC’s director Curt Clinkscales, “electing instead to make policy without attention to the concerns of those who are expected to benefit and who would be forced to pay the huge tax burden.”⁶⁹ In this sense, the MCCA was sending a negative message to all Americans—telling them the government could not be counted on should they need long-term care in their old age.⁷⁰

The MCCA’s coverage for out-patient care was half-hearted at best. It only

⁶⁷ U.S. Congress, *Congressional Record* (101st Congress, October 4, H6566-616, 1989), H6575.

⁶⁸ Congress, *Congressional Record*, H6570.

⁶⁹ “Poll Finds Elderly Oppose Medicare Catastrophic Bill,” *PR Newswire* November 2, 1987.

⁷⁰ The Claude Pepper Comprehensive Health Care Act of 1991 once established the federal long-term care trust fund from which federal subsidies for long-term care in states was made. Yet many of its intended reforms were not fully enacted. See <https://www.congress.gov/bill/102nd-congress/house-bill/8/all-info> for more details.

expanded skilled nursing facility care by eliminating the three-day prior hospitalization requirement, which means Medicare beneficiaries could be admitted directly from home without being hospitalized. Besides, current skilled nursing home residents could be reclassified as Medicare-eligible groups if they met certain medical eligibility criteria. However, skilled nursing facility care was largely acute care, differing sharply from the long-term custodial nursing home care desired by the senior population. The majority of nursing homes in the U.S. did not qualify for skilled nursing care, and many skilled nursing homes did not contract with Medicare.⁷¹ Initially, the AARP officials were excited about such extended coverage because it “got [them] half way there” toward a federally funded long-term care program.⁷² Yet they clearly underestimated the dominant reaction to the Act’s perceived fallacies, and hardly could they build on a policy so unpopular. Its financing mechanism and failure to address seniors’ major concern ran counter to President Reagan’s promise that the MCCA’s purpose would “remove a financial spectre facing our older Americans” so that they needed not to choose between bankruptcy and death.⁷³

By the late 1980s, most seniors, and not just those in organized groups, realized that the Act contradicted “the ‘spread the risk’ social-insurance principles upon which Medicare was founded,” in AARP’s words.⁷⁴ “We are

⁷¹ Medicare Has Improved: Catastrophic Protection and Other New Benefits, Short.

⁷² Richard Himelfarb, *Catastrophic Politics: The Rise and Fall of the Medicare Catastrophic Coverage Act of 1988* (Pennsylvania State University Press, 1995), 38.

⁷³ Medicare Has Improved: Catastrophic Protection and Other New Benefits, Short, 1.

⁷⁴ American Association of Retired Persons (AARP), “Millions of Americans Need Catastrophic Health Care. And a Better Way to Fund it,” *Washington Post* (September 1, 1989).

getting too much flak,” said House Minority Leader Robert Michel, “the only way to wash our hands, cleanse ourselves the whole thing, is outright repeal.”⁷⁵ The termination was not surprising, but the change it brought to the Medigap industry was considerable. “Congress [had] now ‘thrown out the baby with the bath water’ and our senior citizens [would] suffer from it,” Delaware Insurance Commissioner David Levinson cautioned Medicare beneficiaries to be prepared for the significant increase in Medigap premiums.⁷⁶ As the MCCA largely usurped an area covered by Medigap policies, companies that scaled back their Medigap programs due to the Act were busy adding back coverage it had cut after its repeal. Along with the increases in medical-care prices and utilization rates, there was a clear impetus for Medigap insurers to raise their premiums. There was also no sign of a decrease in fraud and abuse in Medigap marketing and sales. In a letter to Representative Ron Wyden, the Consumers Union said that it was appalled to find insurers seeking “freedom to write unnecessary coverage in the wake of excessive consumer confusion about catastrophic benefits.”⁷⁷

A good intention finally turned into a set of unintended consequences. While advocates for the MCCA promised the legislation would provide catastrophic care and subsequently reduce the cost of Medigap plans that many seniors would continue to purchase until the benefits were fully phased

⁷⁵ Julie Rovner, "Finance Weighs Benefit Cuts in Catastrophic-Costs Law," *Congressional Quarterly*, October 7 1989, 2397.

⁷⁶ "New Medicare Supplement Insurance Regulation," *PR Newswire*, January 22 1990.

⁷⁷ Martin Tolchin, "Filing Medicare Gaps: Debate Grows," *New York Times* 4 Dec. December 4, 1989.

in, the Act was more of a disturbance of the Medigap industry and a failed attempt to make health care more accessible to seniors. While According to a Blue Cross and Blue Shield Association (BCBSA) survey, 38 of its members revealed an average increase in monthly premium of 29 percent for 1990, but before the MCCA was repealed, the expected increase was only 9 percent.⁷⁸ Additionally, a survey by the Senate Committee on Aging showed that such premium increase varied greatly across states, ranging from 10 percent in states such as Massachusetts and Washington to as much as 120 percent in Mississippi and 133 percent in Arizona.⁷⁹ Facing numerous complaints about the increases, MCCA architects could only argue that costs could have soared by an additional 10-15% without the Act. Yet few seniors accepted the explanation; they were expecting actual premium reduction rather than just a decrease in the rate of its increase.⁸⁰ The main beneficiaries of the MCCA were in fact those who were not eligible for both Medicare and Medicaid because the Act changed some of the qualification rules, but for Medicare beneficiaries this was largely an expensive trip uncalled for.⁸¹

⁷⁸ Dahl, "More Increases Ahead in Price of Health Care."

⁷⁹ Conn, "Health Insurers Under Fire for Medigap Rate Increases."

⁸⁰ Tolchin, "New Health Insurance Plan Provokes Outcry over Costs."

⁸¹ The MCCA revised the upper income and asset thresholds needed to qualify for Medicaid under the spouse impoverishment provision, so that middle-income nursing home residents did not need to spend-down assets to meet the very strict Medicaid means test. For details, see P. Feldstein, *The Politics of Health Legislation* (Ann Arbor, MI: Health Administration Press, 1988), 223.

Conclusion

This chapter has detailed three major programs to show that Medicare was more of a budget policy in this period, but its reforms were all introduced with a banner of enhancing health security and social rights of the elderly. This made the 1980s a “gilded” age for Medicare with actual policy goals being covered by fancy rhetoric of protection and rights. From the PPS to the Medicare HMO to the MCCA, such gilded features became increasingly evident as the government’s emphasis on budget gradually shifted to benefits expansion, but their actual impacts remained the same. Empirical evidence made it abundantly clear that the ultimate goal of the PPS was to achieve long-term Medicare cost containment through fundamental changes in health care providers’ incentives regarding distributing and managing medical resources. Yet the PPS was very narrowly targeted. Its focus on the inpatient care implicitly encouraged hospitals to evade the financial constraints by moving medical services out of the hospital, and hence shortened hospital stays and increased nursing home use. However, long-term care was not in the benefit package of Medicare, the PPS thus potentially put Medicare beneficiaries at a financially vulnerable place.

In addition, the Medicare HMO program began with an ambitious initiative rooted in the principles of managed care and incentivized through the Medicare “risk contract” program. Yet the practical rollout of this policy highlighted significant flaws—ranging from risk selection to administrative inefficiencies and deceptive marketing practices—all of which compromised the intended

benefits. The low enrolment figures and high rates of disengagement from HMOs reflected a broader dissatisfaction among seniors, who found themselves navigating a complex and sometimes predatory landscape that often prioritized profitability over patient care. An important lesson drawn from the Medicare HMO program was that beneficiaries would not voluntarily switch to prepaid plans in substantial numbers unless such contractual arrangements with alternative health insurance options could not be lightly regulated and treated in a laissez faire manner according to President Reagan's vision for a small government. Close monitoring was essential to protect seniors from the rough edges of the market. When we talk about Medicare, we talk not only about its reimbursement but also how the government, its beneficiaries, and medical professionals reacted to varying and ever-changing incentives. The fiscal viability of HMOs was independent from the delivery of high-quality health care, as it was solely determined by the financial equation of premiums and claims. This is why we constantly saw a disjunction between social citizenship analysis and private health care.

At last, despite its well-intentioned design to shield seniors from the devastating financial impact of catastrophic illnesses, the MCCA ultimately faltered due to its own shortcomings. It not only misinterpreted the seniors' primary healthcare concerns, focusing on aspects like outpatient care and prescription coverage over the more pressing need for long-term care, but also implemented a financing mechanism that paradoxically penalized the very

group it aimed to benefit. The upheaval that led to its repeal was not just a protest against a single piece of legislation but a defence of social rights. The MCCA's repeal and the subsequent increase in Medigap premiums are testaments to the delicate balance needed in healthcare reform—one that assures protection without causing undue strain on those it seeks to protect. It underscores the need for a more nuanced and inclusive approach to policymaking, one that truly listens to and addresses the needs of its constituents. In overview, the surtax imposed on a significant portion of the senior population, lack of long-term care in a policy intended to shelter the elderly from catastrophic medical costs, and increase in Medigap premiums as a separate though related source of displeasure for seniors, together made the MCCA another “gilded” policy under the guise of benefits expansion.⁸² Overall, Medicare in the 1980s was marked by incentive change and limited protection of the elderly, but as long as Medicare remained as a federal program rather than a voucherized one, Congress would continue to prioritize rationing as they grappled with the reality that there would always be limited resources to meet the unlimited healthcare needs of citizens.

⁸² There were indeed some attempts by Congress to enhance long-term care, but it still remained points of contention in today's health care debates. For a comprehensive account of this issue, see Quadagno, *One Nation, Uninsured: Why the U.S. Has No National Health Insurance*.

Chapter 5

Consumerist Social Citizenship: Demand-side Reforms in the 1990s and the 2000s

Consider the case of John, a Medicare beneficiary who had been enrolled in an HMO since he first became eligible. He favoured the plan for its lower monthly premium and the convenience of having one plan instead of three (traditional Medicare plus a supplemental Medigap coverage and a separate prescription drug plan). One day, John had an accident and needed surgery. After researching online, he discovered that all the surgeons capable of treating his injury were out of his plan's network. Frustrated, John decided to disenroll from his HMO and switch to traditional Medicare during the next open enrolment period to gain more freedom in choosing his providers. However, John soon encountered unexpected challenges. Traditional fee-for-service Medicare did not have an annual out-of-pocket limit for outpatient or inpatient care. This meant that his potential medical expenses could be significantly higher. To manage these costs, John sought to obtain Medigap coverage, only to find that he was denied.

Unlike private markets, Medigap did not have the same consumer protections, such as an annual open enrolment period. This left John in a difficult position, facing high medical bills without the supplemental coverage he

needed.¹ John's story highlighted the complexities and potential pitfalls of navigating Medicare options in the late 1990s. While private insurance plans could offer lower premiums and simplified coverage, they might also limit provider choices. On the other hand, traditional Medicare provided greater freedom but could come with higher costs and fewer protections for those seeking supplemental coverage. Such dilemma facing seniors compelled us to investigate the nuances of Medicare changes during this period.

This chapter studies the Balanced Budget Act (BBA) of 1997 and the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 as two distinctive Medicare reforms during a period characterized by consumer sovereignty, removal of "unnecessary" state involvement in the economy, and extension of market logic to all spheres of policy making and implementation. Scholarship regarding Medicare privatization in this era emphasized two dominant, interdependent pathways. First, the period saw a revival of arguments by the intellectual father of neoliberalism, Milton Friedman, that the problem with health care was lack of competitive free markets and the unreasonably high standards for medical licensure that prevented a large number of insurers from selling their services.² Second, there had been a

¹ There is no direct source for John's story, I constructed him as a typical image based on two studies. Jeff Lemieux, Teresa Chovan, and Karen Heath, "Medigap Coverage And Medicare Spending: A Second Look," *Health Affairs* 27, no. 2 (2008); Peter D. Fox, Thomas Rice, and Lisa Alecxih, "Medigap Regulation: Lessons for Health Care Reform," *Journal of Health Politics, Policy and Law* 20, no. 1 (1995).

² M. Friedman, *Capitalism and Freedom* (Chicago: University of Chicago Press, 1962). See also Alain C. Enthoven, "Market Forces And Efficient Health Care Systems," *Health Affairs* 23, no. 2 (2004); C. Crouch, "The Terms of the Neoliberal Consensus," *The Political Quarterly* 68, no. 4 (1997); Kimberly J. Morgan and Andrea Louise Campbell, "The Rise of the Market Reform Movement," ed. Kimberly J. Morgan and Andrea Louise Campbell, *The Delegated Welfare State: Medicare, Markets, and the Governance of Social Policy* (Oxford University Press, 2011); Alain C. Enthoven, "Reforming Medicare

significant change in the cultural construction of citizenship, which could be characterized as a move from a more passive model of citizenship towards an active one, where individuals were expected to be autonomous, self-responsible, flexible, and highly mobile.³ However, changes in policy goals did not naturally amount to change in seniors' behaviours and worldview. To a great degree, seniors were unprepared when a dazzling array of options were made available to them in a short period of time. The nuances of real-world impact, and how this gave rise to a particular form of social citizenship that differed from the "active citizens" ideal, are what concerns this chapter.

Specifically, in the 1990s, social scientists have noted that contemporary welfare state policies increasingly emphasized active citizenship.⁴ The concept of the enabling state was often framed in terms of empowerment, privatization, and responsibility. In the U.S. context, this approach to social protection could be summarized by the phrase "public support for private responsibility."⁵ Particularly for those who were on public social programs, the shift from traditional social citizenship by Marshall to active social citizenship involved enabling citizens to take more active roles in managing risks and promoting their own welfare.⁶ Policies that encouraged citizens to participate in decisions

by reforming incentives," *The New England journal of medicine* 364, no. 21 (2011).

³ Karl Henrik Sivesind, Karl Henrik Sivesind, and Jo Saglie, *Promoting Active Citizenship: Markets and Choice in Scandinavian Welfare*, 1st 2017. ed. (Basingstoke: Springer Nature, 2017); Per H. Jensen and Birgit Pfau-Effinger, "'Active' citizenship: the new face of welfare," (Bristol, UK: Policy Press, 2005).

⁴ Jørgen Goul Andersen et al., *The Changing Face of Welfare: Consequences and Outcomes from a Citizenship Perspective*, 1 ed. (Bristol University Press, 2005); Janet Newman and Evelien Tonkens, *Participation, Responsibility and Choice: Summoning the Active Citizen in Western European Welfare States* (Amsterdam University Press, 2011).

⁵ Neil Gilbert and Barbara Gilbert, *The Enabling State: Modern Welfare Capitalism in America* (Oxford: Oxford University Press, 1989).

⁶ It was worth noting that people with private health insurance have always been active in managing

about their care provision aimed to empower them to become self-determined, active agents in their well-being and service arrangements.⁷ However, scholars also noted that when these policies were implemented in contexts where the welfare state provides minimal support for social security and services, individuals were largely forced into self-reliance, which further marginalized vulnerable groups.⁸

At the same time, advocates of neoliberalism acknowledged that market-oriented policies underpinned by the idea of consumer empowerment tended to distribute health care resources according to individual or family socioeconomic status, instead of providing these resources more equitably as a right of citizenship.⁹ This had greatly exacerbated the inequality in health care and left seniors exposed to potential risks of consumerisation. Second, the deepening of social inequalities facilitated by neoliberalism creates a context in which citizenship and the sense of collectivity are greatly weakened.¹⁰ Competition, as the American economist Enthoven and those after him realized,

their health decisions, intricacies of the private market and the changes in such public programs like Medicare largely run parallel to each other. For a conceptual discussion on active citizenship, see Håkan Johansson and Bjorn Hvinden, *Towards a Post-Marshallian Framework for the Analysis of Social Citizenship* (Oxford: Oxford University Press, 2013).

⁷ M. Barnes, "Users as Citizens: Collective Action and the Local Governance of Welfare," *Social Policy & Administration* 33, no. 1 (1999).

⁸ Patricia Frericks and Julia Höppner, "Self-Responsibility Readdressed: Shifts in Financial Responsibility for Social Security Between the Public Realm, the Individual, and the Family in Europe," *American Behavioral Scientist* 63, no. 1 (2019); Newman and Tonkens, *Participation, Responsibility and Choice: Summoning the Active Citizen in Western European Welfare States*; Andersen et al., *The Changing Face of Welfare: Consequences and Outcomes from a Citizenship Perspective*.

⁹ J. Jensen and D. Saint-Martin, "New Routes to Social Cohesion? Citizenship and the Social Investment State," *Canada Journal of Sociology* 28, no. 1 (2003); I. Kawachi and L.F. Berkman, "Social Cohesion, Social Capital, and Health," in *Social Epidemiology*, ed. L.F. Berkman and I. Kawachi (Oxford: Oxford University Press, 2000).

¹⁰ D. Coburn, "Income Inequality, Social Cohesion and the Health Status of Populations: The Role of Neo-liberalism," *Social Science Medicine* 51, no. 1 (Jul 2000).

was the opposite to solidarity.¹¹ Thus, as detailed below, the early stages of the neoliberal turn with regard to Medicare suffered significant setbacks, with the government temporarily intervening to assist private managed care plans through pseudo-Keynesian measures. However, this not only failed to challenge the neoliberal agenda but further entrenched market-disciplinary modes of governance. Most importantly, as well captured by Marmor and Oberlander, “danger is not just that the poor and sick would fare badly in a segmented insurance market; it is that the embrace of individualism would erode programmatic ideals of social community and collective responsibility for financing medical care, hence weakening Medicare’s political foundations.”¹²

This chapter builds on these two scholarly debates —around active citizenship and neoliberalism—to observe policy change from seniors’ perspective. Importantly, the BBA of 1997 and the MMA of 2003 marked a significant transition of Medicare reform from the “supply side” —hospitals and doctors—to the “demand side,” i.e., Medicare beneficiaries. Instead of, or in addition to, capping payments to medical providers, these two reforms changed seniors’ perception about health care from “getting coverage from the government” to “spending their own money.” This transition of target group in cost containment measures, I argue, was the watershed in Medicare politics regarding social rights and was critical to our notion of “consumerist social

¹¹ A.C. Enthoven and R. Kronick, “Universal Health Insurance Through Incentives Reform,” *Journal of the American Medical Association* 265, no. 19 (1991).

¹² Theodore Marmor and Jonathan Oberlander, “Rethinking Medicare Reform: Budgetary discipline, not vouchers, may be the solution to Medicare’s fiscal woes,” *Health Affairs* 17, no. 1 (1998).

citizenship.” Besides, I argue that there was an overt clash of priorities between seniors and the government when it came to privatization of Medicare. While policymakers expected seniors to “regulate the market” by making rational choices about their health plan and boost competition among private insurers, in most cases seniors just preferred an affordable and accessible plan that did not require advanced medical knowledge to understand. In most cases, more choices of health care plan just left seniors less able to manage their health needs as private insurers often took advantage of the plan’s complexity and misled seniors on their choices. This chapter therefore emphasizes a notable tension at the heart of neoliberal reforms—efforts to frame marketization as a pathway to improved socio-economic outcomes, especially as the MMA refused to make use of the government’s clout to bargain down drug prices, which could have increased the proportion of cost covered by beneficiaries themselves. Such incoherence of the so-called “neoliberal” project explains why we need a new concept to illustrate the intricacies of Medicare around the turn of the century.

The early 1990s was a peculiar time for Medicare. Clinton’s victory in 1992 brought promising prospects for major health care expansion, and the National Health Care Reform on which he campaigned heavily during the presidential election proposed to entitle all Americans to medical treatment and preventative services. However, what began as a bold attempt to redirect the health care system in a manner that might enhance Democratic advantage in social policy

actually had opposite effects. The ill-defined debate about the 1993 health care reform package and the disastrous framing of the issue as one unwarranted big-government interference forced Democrats to forfeit ownership of health care policy innovation, and made the administration realize it has bitten off more than it could chew.¹³ Thus, after the GOP took over Congress in the 1994 midterm elections, the newly ascendant Republican congressional majority was keen to launch what they saw as their mandate to downsize the “big government.”¹⁴ This was an overt ideological project, yet the aspiration to cut government spending was backed by the more objective urgency to reduce the deficit. Consequently, when official projections indicated that the Medicare Part A trust fund would be insolvent by 2001, the unique institutional structure of the trust fund led to Medicare being viewed as “bankrupt” in a way that did not apply to programs funded by general federal revenue.¹⁵ As a result, Medicare quickly became a top priority on the conservative agenda.

Importantly, this period saw Medicare take center stage in a much broader ideological transformation. By the early 1990s, the Public Management Committee of the OECD appeared to believe there was a common path along which most of the capitalist world was proceeding. Looking back, the emergence of social rights in the 1960s was largely a reflection of the sweeping

¹³ Jacob S. Hacker, *The Road to Nowhere: The Genesis of President Clinton's Plan for Health Security* (Princeton University Press, 1998).

¹⁴ Paul Starr, *The Logic of Health Care Reform: Why and How the President's Plan Will Work* (New York: Penguin Books, 1994).

¹⁵ *1994 Annual report of the Board of Trustees of the Federal Hospital Insurance Trust Fund*, (Federal Hospital Insurance (FHI) Board of Trustees, 1994).

economic currents of that era. Buoyed by Keynesian ideals and the framework of the Bretton Woods Agreement, the governments were able to invest heavily in social programs without being shackled by fiscal limitations. Yet by the 1970s, the winds had shifted and the once-feasible model began to wane. By the 1990s, the priority shifted again—balancing the budget took precedence after the collapse of the USSR and its satellites. The economic context that allowed social rights to flourish was very different from the one in the 1990s, where the focus was on defending those rights, particularly in the realm of health care. The direction involved introducing more competition to public programs, prioritizing consumer-orientation and quality, and strengthening the “devolution revolution” against the operational role of the center.¹⁶

In the U.S., the direction was labeled as “reinventing government” after two American consultants, David Osborne and Ted Gaebler, claimed that an “entrepreneurial government” was both a global trend and “inevitable.”¹⁷ They then became advisers to vice-president Al Gore on some major reform programmes, and their solution to Medicare was a closer public-private partnership with enhanced market force.¹⁸ Therefore, while emphasizing the impending shortfall in Medicare funds helped Republicans gain an upper hand in the budget battle, the larger issue has not been the benefits or entitlements,

¹⁶ OECD, *Managing with Market-type Mechanisms* (Paris: PUMA/OECD, 1993); OECD, *Public Management Developments: Survey 1993* (Paris: PUMA/OECD, 1994); OECD, *Governance in Transition: Public Management Reforms in OECD Countries* (Paris: PUMA/OECD, 1995).

¹⁷ David Osborne and Ted Gaebler, *Reinventing Government: How the Entrepreneurial Spirit is Transforming the Public Sector* (Reading, Mass.: Addison Wesley, 1992), 325-8.

¹⁸ Christopher Pollitt and Geert Bouckaert, *Public Management Reform: A Comparative Analysis: New Public Management, Governance, and the Neo-Weberian State*, 3rd ed. (Oxford: Oxford University Press, 2011).

but the boundaries of state governing and the balance between public and private responsibilities. In terms of social citizenship, this largely meant reduced state responsibility for health care and a greater emphasis on individuals to assume self-responsibility.¹⁹ As we shall see, while the BBA and the MMA called for smaller government, economic vitality, and self-sufficiency, they also risked exacerbating social inequalities if not accompanied by adequate state support. This nuanced understanding underscored the complexity of balancing seniors' autonomy with the government's responsibility in Medicare.

The BBA and the Bipartisan Support for Competition

Medicare was a central issue during the 1992 presidential campaign, and throughout the Clinton presidency the main agenda item after the legislation on deficit reduction—Omnibus Budget Reconciliation Act of 1993.²⁰ While Democrats had championed Medicare for nearly 30 years, by the mid-1990s they were on the defensive. In 1995, Republicans proposed a significant restructuring: capping Medicare spending and cutting \$270 billion (some 30% of Medicare spending by then) over seven years to promote managed care plans at the expense of traditional fee-for-service (FFS) Medicare.²¹ Democrats argued that such caps would jeopardize seniors' access to medical

¹⁹ A. Serrano-Pascual, "Reshaping Welfare States and Activation Regimes," in *Reshaping Welfare States and Activation Regimes in Europe*, ed. A. Serrano-Pascual and L. Magnusson (Brussels, Belgium: P.I.E. Peter Lang, 2007).

²⁰ Theodore Marmor, *The Politics of Medicare*, 2nd ed (Hawthorne, NY: Aldine de Gruyter, 2000), 30.

²¹ Jonathan Oberlander, *The Political Life of Medicare* (Chicago: University of Chicago Press, 2003).

care and harm providers working with FFS Medicare. In particular, they saw financial penalties for staying in FFS Medicare as a betrayal of the program's commitment. Additionally, Democrats opposed transforming Medicare into a defined-contribution program, namely a system where enrollees would receive a fixed amount of money to choose a health care plan and pay the difference themselves if they wanted a plan that costed more than the given amount.²² Yet paradoxically, given these disputes, the Balanced Budget Act (BBA) was passed in 1997 with bipartisan support. Nancy-Ann DeParle, then director of the Health Care Financing Administration (HCFA), noted that both the Clinton administration and members of Congress from both parties viewed the program as a universally acceptable Medicare reform.²³

Several factors contributed to this political turnaround. The bipartisanship stemmed from a shared vision for managed care's future. When Clinton vetoed substantial Medicare and Medicaid cuts in 1995, it marked the end of extreme Republican efforts to balance the budget through severe reductions.²⁴ The focus shifted to opposing the high cuts in Medicare spending and the structural changes to open Medicare to private insurers.²⁵ After Clinton's reelection, both parties found common ground in expanding managed care as a solution to Medicare's financial issues while maintaining a commitment to traditional FFS

²² H.J. Aaron and R.D. Reischauer, "The Medicare reform debate: What's the next step?," *Health Affairs (Winter)* (1995).

²³ N. DeParle, "As Good it Gets? The Future of Medicare + Choice," *Journal of Health politics, Policy and Law* 27, no. 3 (2002): 500.

²⁴ Quoted from Mary Hager, "Califano Answers Back," *Newsweek* (May 28, 1979).

²⁵ D. Beland and A. Waddan, "The Politics of Social Policy Change: Lessons of the Clinton and Bush Presidencies," *Policy & Politics* 38, no. 2 (2010).

Medicare.²⁶ Underpinning this agenda was a view that Medicare beneficiaries quite rationally exploited the generosity of the program because the system's built-in incentive structure encouraged beneficiaries to use Medicare whether they needed health care or not.²⁷ According to a Heritage Foundation report published in September 1995, the deductible for Part B services (the amount of money that beneficiaries have to pay out-of-pocket before Medicare pays their health costs) was only \$100. The figure "not only has nothing to do with economic reality, but it is also an incentive to increase demands on the system".²⁸ Medicare's financing crisis might be exaggerated, yet the built-in incentive for seniors to overspend was clearly a central theme of the Medicare discourse during this period.²⁹ This approach challenged traditional views that attributed Medicare's surging costs to hospitals and doctors, arguing that the real issues stemmed from the program's incentive design.³⁰

Also known as the "moral hazard" —people were not cost-conscious about their health care because their insurance plans covered all their claims, this idea promoted advocacy for a "consumer-driven health care" (CDHC) paradigm.³¹ The concept of CDHC dated back to the 1980s, when several

²⁶ Jonathan Oberlander, "The Politics Of Health Reform: Why Do Bad Things Happen To Good Plans?," *Health Affairs* 22 (2003), <https://doi.org/10.1377/hlthaff.W3.391>.

²⁷ David Dranove, *The Economic Evolution of American Health Care: From Marcus Welby to Managed Care* (Princeton, NJ: Princeton University Press, 2000).

²⁸ J. C. Liu and R.E. Moffit, *A Taxpayer's Guide to the Medicare Crisis*, 3 (The Heritage Foundation 1995).

²⁹ Some scholars claimed the mid-1990s saw a "phony economic crisis" being turned into a "genuine political crisis", as the reality was that the welfare state was remarkably successful in reducing inequality and poverty, and has been on a sound financing status. For detailed illustration on neoliberalism's false charges regarding the welfare state, see Palley, T. 2020. "Re-theorizing the welfare state and the political economy of neoliberalism's campaign against it." *Journal of Economic Issues* 54(3): 588-612.

³⁰ A. Burgin, *The Great Persuasion: Reinventing Free Markets Since the Depression* (Cambridge: Harvard University Press, 2012).

³¹ M Pauly, "Means-testing in Medicare," *Health Affairs* 23, no. 1 (2004).

neoliberal think tanks promoted the idea that a consumer-driven system would enhance competition and benefited both patients and insurers. Proponents of CDHC emphasized demand side reforms—“without active collective management on the demand side, the medical plans would be free to pursue profits or survival using numerous competitive strategies that would destroy equality and efficiency and that individual consumers would be powerless to counteract.”³² Under the banner of CDHC, the BBA mandated substantial cuts of Medicare expenditure of some \$116 billion over the period 1998-2002, and a total of approximately \$394 billion in ten years.³³ This would be achieved by reducing provider payments (including enhancing administrative efforts to root out inappropriate and fraudulent payments to providers), restructuring payment methods for nursing facilities, home health agencies, and rehabilitation hospitals, and shifting some Hospital Insurance (Part A) costs to Supplemental Medical Insurance (Part B) so that pressure on the payroll-tax-financed Part A were lessened and Part B premiums were forced to increase.³⁴ Yet health care costs would not just disappear. In practice, the significant payment cut simply meant getting seniors more financially involved in the Medicare system.

Under the BBA, the shift of risk from the supply side to the demand side was achieved through the Medical Savings Account (MSA). In general, MSAs

³² A.C. Enthoven, *Theory and Practice of Managed Competition in Health Care Finance* (Amsterdam: North Holland, 1988), 11.

³³ CBO (Congressional Budget Office), *Budgetary Implication of the Balanced Budget Act of 1997*, (Washington, D.C.: Government Printing Office, 1997).

³⁴ P. Rivers and K.L. Tsai, "The impact of the Balanced Budget Act of 1997 on Medicare in the USA: The fallout continues," *International Journal of Health Care Quality Assurance* 15, no. 6 (2002).

were tax-favored accounts that could be used to pay health care costs. Anyone who had no plans other than the catastrophic high-deductible health insurance plan could enjoy both tax-deductible contributions and tax-exempt interest.³⁵ Requiring MSAs to be attached to high-deductible health insurance plans could greatly advance the “consumerization” of health care. By letting people spend their own money, MSAs were established with an aim to induce price-sensitive behaviors so that overall health care expenditure could be held down in the long run.³⁶ “Many features of Medicare were developed before consumer-directed health plans became widely used to lower health care costs for millions of Americans,” said CMS Administrator Mark McClellan, “we are now providing some needed flexibility to make the increasingly popular consumer-directed plans available to Medicare beneficiaries, and we are going to provide support for our beneficiaries to make informed decisions about their health care spending.”³⁷

Essentially, MSAs were independent bank accounts that engaged consumers in their health care decisions and encouraged them to make more informed and cost-effective choices. The reasons for having MSAs were twofold: cost and control. Beneficiaries continued to pay their Part B premium but avoided additional monthly plan premiums. They received a pot of money for

³⁵ P. Fronstin, “The Potential Impact of Consumer Health Savings Accounts as a Market-Based Approach for Improving Quality and Reducing Costs,” *Wisconsin Family Impact Seminars* (2005), https://www.purdue.edu/hhs/hdfs/fii/wp-content/uploads/2015/07/s_wifis21c02.pdf.

³⁶ T. Jost, *Health Care at Risk: A Critique of the Consumer-driven Movement* (Duke University Press, 2007).

³⁷ “Centers for Medicare&Medicaid Services Announces Steps to Improve Access to Consumer-Directed Health Plans in Medicare,” *US Fed News* (July 10, 2006).

initial health care expenses, and once that was exhausted, they had excellent coverage compared to original Medicare. “Medicare MSAs offer an important choice for Medicare beneficiaries,” said Susan Rawlings from WellPoint, the largest health benefits company in the U.S. “They allow members to save for future health care needs and exercise direct control over how their health care dollars are spent.” Furthermore, Susan’s colleague Richard White added, “an MSA makes you think a little more about going to the doctor. If patients are responsible for the cost, they might ask themselves, ‘Do I go to the doctor, or do I wait a day or two to see if the symptoms get better?’ It encourages cost-effective treatment. For instance, if a doctor suggests an MRI, a patient might ask, ‘Can we try an x-ray first?’ You still get quality care but at a lower cost.”³⁸ In this sense, MSAs were designed to provide beneficiaries with a financial stake in their health care decisions, enabling them to make autonomous choices rather than depending on a heavily managed care approach.

Apart from incentive design, the BBA also aimed to make more health plans available to seniors by introducing Medicare Part C. As a central issue in the Commission’s major proposal (otherwise known as the Breaux-Thomas Plan due to the co-chairmanship of Democratic Senator John Breaux of Louisiana and Republican representative William Thomas of California), Part C relaxed previous restrictions to more formally integrated private plans into Medicare. The hallmark was a premium support system where beneficiaries are

³⁸ “WellPoint offers Medicare medical savings account,” *Managed Care Outlook* (Nov. 15, 2006).

provided with a choice between remaining in the traditional fee-for-service Medicare and enrolling in private health plans in which the premiums are jointly paid by beneficiaries and the government, namely a Medicare + Choice plan that further offered MSA, provider-sponsored organizations (PSO), and other indemnity fee-for-service options other than the existing health maintenance organizations (HMOs) and point of services (POS).³⁹ Although managed care plans as an alternative to traditional FFS Medicare had been available to beneficiaries since 1982, when the Tax Equity and Fiscal Responsibility Act (TEFRA) amended Medicare to allow enrollment in HMO plans, it was not until the establishment of Part C that Congress pushed hard on increasing the number of managed care plans participating in Medicare. The assumption was facilitating market competition would ultimately rein in costs, and that plans would be marketed fairly and beneficiaries be well informed.⁴⁰

These new options came with important consumer protections. All Medicare+Choice plans were required to provide medically necessary care. In addition, they encouraged providers to provide advising services for Medicare beneficiaries about their medical care. The BBA also introduced stringent anti-fraud measures. Under the “three strikes and you are out” rule, any provider caught defrauding a federal health program three times would face a lifetime ban from all federal health care programs, along with other severe criminal and

³⁹ J. B. Christianson, R. D. Feldman, and D. R. Wholey, "HMO mergers: estimating impact on premiums and costs," *Health Affairs* 16, no. 6 (1997).

⁴⁰ Marmor, *The Politics of Medicare*, 2nd ed, 107.

civil penalties.⁴¹ Importantly, the Medicare+Choice formula was to change beneficiaries' incentive by hanging its pitch primarily on the notion of consumer choice, i.e., Medicare beneficiaries would choose insurance plans according to their actual needs more reasonably if they were self-responsible consumers. That said, "choice" was also conflated with individual freedom and empowerment.⁴² This was another a significant step towards consumer-directed health care as citizens were expected to organise their medical needs themselves by using schemes provided by the market.

In sum, The BBA signaled two major shifts in the Medicare landscape: a change in incentive design and an enhancement of consumer choice. MSAs allowed beneficiaries to manage their healthcare spending more directly by providing tax-favored accounts for medical expenses, and Medicare Part C offered seniors a broader selection of plans, from traditional fee-for-service to various managed care plans. The underlying goal was to empower seniors with more choices, allowing them to select the best plans for their needs, thereby promoting active citizenship and self-responsibility in managing health care while "disciplining the market" through competition. Yet the reality was never that simple. A closer inspection of the BBA's impact suggests that seniors were neither freer nor more empowered after the Act. Quite the opposite: the BBA at once challenged physician autonomy and limited beneficiaries' choice despite

⁴¹ Stephen Horn, "Saving Medicare from Bankruptcy," *Congressional Press Releases* (Aug. 6, 1997).

⁴² J. B. Schor, "Towards a new politics of consumption," in *The Consumer Society Reader*, ed. J.B. Schor and D.B. Holt (New York: The New Press, 2000).

its commitment to devolution and deregulation. The introduction of numerous plan options often led to confusion and complexity for beneficiaries, who had to navigate a bewildering array of choices within a limited enrollment period. The next section discusses this irony in greater detail.

The BBA and Health Rights

In 1999, a group of Medicare beneficiaries from across the country gathered at Capitol Hill as deeper cuts to Medicare payments loomed. They came with a crucial mission: to urge Congress to save their Medicare choices. Among them was Pierre Henry from Florida, a member of AVMED Health Plans. "I can't imagine getting my health care anywhere else," said Henry, "I want choices at prices I can afford—that's why I chose a health plan." General Fred Flo who enrolled in PacifiCare Health Plans also shared his concerns. "Without the comprehensive benefits and lower out-of-pocket costs from my health plan, getting the medical care I need would be much harder. I doubt I could afford the old Medicare program," he said. Their complaints were largely concerned with the BBA. Three years after its enactment, the number of contracts under Part C dropped from 340 in 1998 to 180 in 2001.⁴³ Besides, while Medicare+Choice plans with no additional premium accounted for 62 percent in 1999, they were available in only 42 percent of contract segments in 2000. The availability of

⁴³ "Beneficiaries Meeting in Washington Fear Losing Affordable Options, Worry about Increases in Out-of-Pocket Costs," *PR Newswire* (Feb. 9, 1999).

some key benefits was also in decline. Prescription drug coverage was included in 73 percent of basic plans in 1999, yet in 2000 the number dropped to 68 percent. The number of basic plans with coverage for preventive dental benefits went down from 40 percent in 1999 to 30 percent in 2000, and chiropractic benefits, relatively limited in general, also decreased by 10 percent during this time.⁴⁴ As we shall see, the BBA introduced the Medicare Part C under the banner of providing more choices for seniors but did not make it sustainable enough to fulfil that promise.

In fact, the number of managed care plans participating in Medicare kept decreasing after the BBA. Although almost all managed care organizations (MCO) renewed at least one contract with Medicare over this period, many scaled back their benefits and reduced service areas.⁴⁵ This resulted not just from the payment cut; a variety of factors were associated with such massive plan withdrawals. The first is that some plans realized they were not competitive enough in certain areas, as they faced larger competitors or failed to establish sufficient provider networks. Notably, some plan representatives claimed that they were discouraged by administrative burdens associated with the BBA, such as the requirements to implement new and more comprehensive quality improvement programs, collect more information on such programs, and report such information as the number and type of services provided to enrollees.⁴⁶

⁴⁴ A. Cassidy and M. Gold, *Medicare+Choice in 2000: Will Enrollees Spend More and Receive Less?* (Mathematica Policy Research, Inc., 2000).

⁴⁵ GAO, *Medicare + Choice: Recent Payment Increases Had Little Effect on Benefits or Plan* (Washington, D.C., 2001). <https://www.gao.gov/assets/gao-02-202.pdf>.

⁴⁶ GAO, *Medicare Managed Care Plans: Many Factors Contribute to Recent Withdrawals; Plan Interest*

The “managed care lite”, as appeared in some policy analysis during this time, not only had the lowest levels of public confidence in social surveys but became a source of derision in movies, television series, and in late show comedy routines.⁴⁷ Since Robinson proclaimed the “end of managed care” in the *Journal of the American Medical Association*, the failure of the BBA has become a verdict widely shared within the health community.⁴⁸

Specifically, prior to the BBA, rates for managed care plans in Medicare were set on the basis of comparable fee-for-service expenditures in the area where the plan operated. Yet after the BBA the rates would be based more on the national cost expenditure instead of local experience. Congress also adjusted the benchmark against which the capitation fees of managed care plans were paid, so that regional disparities could be reduced with rates being adjusted upwards in areas where low reimbursement was inhibiting the participation of private plans and those where high reimbursement was turning managed care plans to a cash cow.⁴⁹ The immediate effect of this payment restructuring, nevertheless, was a high turnover rate that significantly undermined enrollees’ experience. “Plans exited and others continue to join,” said a Wall Street analyst in a roundtable on health care, “and some patients

Continues, (1999).

⁴⁷ R.J. Blendon and J.M. Benson, "Americans' Views on Health Policy: A Fifty Year Historical Perspective," *Health Affairs* 20 (2001).

⁴⁸ D. Mechanic, "The Rise and Fall of Managed Care," *Journal of Health and Social Behavior/ Extra Issue: Health and Health Care in the United States: Origins and Dynamics* 45 (2004); J.C. Robinson, "The End of Managed Care," *Journal of American Medical Association* 285, no. 20 (2001).

⁴⁹ *Medicare Reform: A Century Foundation Guide to the Issues*, ed. Century Foundation (New York: Century Foundation Press. , 2001), 34.

got disenrolled three times last year".⁵⁰ By this time, the HCFA had approved 10 new plans that were able to enroll beneficiaries from January 1999, and was reviewing 30 additional applications, some of which were for counties that previously had few or no managed care plans. Meanwhile, nevertheless, 45 private plans ended their contracts with Medicare and 54 others reduced the geographic areas in which they provided services shortly after the BBA came into force, affecting some 407,000 beneficiaries (7 percent of the managed care population) in total.⁵¹

Most notably, while beneficiaries were paying more, they were getting less. Since the enactment of the BBA, average monthly premiums nearly doubled, increasing from \$13.31 to \$25.73.⁵² The number of enrollees decreased from 6.4 million in 1999 (17 percent of Medicare beneficiaries) to 5.6 million (14 percent) in 2001 and to 4.6 million in 2003 (12 percent). By 2002, total Medicare managed care enrollment was even lower than it was in 1997.⁵³ The Balanced Budget Refinement Act of 1999 and the Benefits Improvement and Protection Act of 2000 addressed some of these grievances, but they focused more on attracting private plans and did little to improve the overall efficiency of the Medicare Part C.⁵⁴ This clearly contradicts the competitive market assumption,

⁵⁰ Center for Study Health System Change (CSHSC), *Wall Street Comes to Washington: Analysts' Perspectives on the Changing Health Care System*, (1999).

⁵¹ GAO, *Short Medicare Managed Care Plans: Many Factors Contribute to Recent Withdrawals; Plan Interest Continues*.

⁵² Cassidy and Gold, *Medicare+Choice in 2000: Will Enrollees Spend More and Receive Less?*

⁵³ R. Lagoe, D.L. Aspling, and G.P. Westert, "Current and Future Developments in Managed Care in the United States and Implications for Europe," *Health Research Policy and Systems* (May 17, 2005), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1079919/>.

⁵⁴ GAO, *Medicare + Choice: Recent Payment Increases Had Little Effect on Benefits or Plan*.

that a new orientation with mandatory competitive tendering and an emphasis on performance-based results would lead to a more cost-effective health care system. In fact, there has been an ongoing tension between significant budget cuts of the BBA and its aspiration to attract more for-profit insurers, because managed care, and its implicit challenge to the legitimacy of social insurance, was a product of privatization, powerful entrepreneurial networks, and a quest for larger profits.⁵⁵ It is thus impossible for the new formula to attract for-profit private plans with even lower profits than before, especially in a time when the tide was turning demonstrably against small entrepreneurs and localized cottage industries because big insurance companies had more financial resources at hand through merging and acquisition.⁵⁶ In this sense, the “choices” in Medicare were more of a rhetoric than an action. While the goal was to encourage private plans to compete for enrollees, the Act did not give them enough incentive to join the game in the first place.

Regarding the quality of care, the Act’s impact was also far from ideal. First and foremost, the Act’s budget cuts were too deep for hospitals to provide normal services. Historically, hospitals and physicians were only responsible for providing patients with services, capacity, and technology in pursuit of better clinical outcomes. Yet since the 1990s a variety of hospital systems, medical groups, and physician-hospital entities began to take the burden of managing

⁵⁵ R. H. Miller and H.S. Luft, "Managed Care Plan Performance since 1980: A Literature Analysis," *Journal of the American Medical Association* 271 (1994).

⁵⁶ Mechanic, "The Rise and Fall of Managed Care," 81.

costs as well.⁵⁷ The dual role of agent for society (managing costs) and for individual patients (managing quality) has made hospitals extremely vulnerable to significant financial cuts. In the first year of the BBA's implementation, hospitals not only faced a much lower profit margin (4.2%) compared with 1996 (6.9%), an actual \$71 billion cut compared with the predicted \$51 billion, but also a new policy of reimbursement, which meant that hospitals that transferred patients to an outpatient management setting (e.g., home health care) or to nursing facilities could no longer get the whole payment for the diagnosis-related-group (DRG) for that hospitalization.⁵⁸ Hospitals thus needed to strike a balance between achieving as short a stay as possible to lower the overall cost of treatment while completing the necessary care, and not to lose too much of their DRG payment due to early discharges. The net effect was that a growing number of patients were neither getting enough treatments nor able to be transferred to skilled nursing homes or home health care agencies.⁵⁹

Another factor undermining seniors' health rights was its ill-conceived risk adjustment strategy. Although the 1982 TEFRA created the Medicare Risk Contract Program in which HMOs were required to "accept beneficiaries in the order in which they apply up to the limits of its capacity", it left a giant loophole by stating "...unless to do so would lead to...an enrolled population

⁵⁷ J.C. Robinson, *The Corporate Practice of Medicine: Competition and Innovation in Health Care* (Berkeley: University of California Press, 1999).

⁵⁸ CHIA (Center for Health Information and Analysis), *The BBA and a Guide to Hospital Performance with National Analysis*, (Baltimore July 1999).

⁵⁹ Rivers and Tsai, "The impact of the Balanced Budget Act of 1997 on Medicare in the USA: The fallout continues."

unrepresentative of the population in the area served by the HMO”.⁶⁰ HMOs could thus define “unrepresentative” quite flexibly and reject people almost at their absolute discretion. By 1994 the risk selection had been so publicized that the Clinton administration called for adjustment measures in their health plan, yet not surprisingly, as the Clinton health care reform failed these pressures were also left unresolved. The situation persisted even after the BBA was introduced because its new measures to address risk selection still had limitations. Managed care plans were prohibited from denying enrollment based on a beneficiary’s medical history, use of medical care, insurance claims, or physical or mental illness. However, this prohibition did not apply “if they will result in enrollment substantially misrepresentative of the Medicare population in the service area”.⁶¹ This almost means managed care was available only to those who were private plans’ favorite clients, namely, healthy people. Even those who already enrolled in the plan could be forced to opt out by being refused to pay their claims or granting them referrals, as managed care plans were forbidden to disenroll them directly on the basis of their health status and medical conditions.

To sum up, the BBA significantly exacerbated a number of existing problems of the health care industry. First, physicians faced more workloads, less professional autonomy, and lower incomes as hospitals encountered their

⁶⁰ J. C. O’Sullivan et al., *Medicare Provisions in the Balanced Budget Act of 1997 (BBA 97, P.L. 105-33)* (Congressional Research Service (CRS) Report for Congress, Washington, D.C.: CRS, Aug. 18, 1997), 48.

⁶¹ O’Sullivan et al., *Medicare Provisions in the Balanced Budget Act of 1997 (BBA 97, P.L. 105-33)*, 51.

lowest profit margin in a decade. In other words, the BBA's budget cuts removed much of the "fat" in health care system on which medical providers and insurers (including managed care organizations) lived. As a number of health care management and delivery organizations suffered from bankruptcy or near-bankruptcy, seniors were left with fewer choices, higher premiums and fewer benefits.⁶² Additionally, managed care organizations needed to cope at once with their "profitability crisis" during this time and the legislative assault on the industry resulting from consumer and physician backlashes against them, since the general public blamed commercial managed care for "turning doctors into entrepreneurs who maximize profits by minimizing care", and thus Republicans and Democrats at the state level competed with one another to attack HMOs.⁶³ The net result was that the managed care revolution of Medicare, which aimed at boosting seniors' medical choices while rationalizing health care costs, stalled and eventually ceased.

The MMA: Structural Change Under Consumer-directed Health Care

By the early 2000s, the BBA's significant Medicare cuts had given rise to another health care crisis in the U.S. A number of medical providers

⁶² KFF & Harvard University School of Public Health, *The Medicare Drug Benefit: Beneficiary Perspectives Just Before Implementation*, (Online 2005); M. Romano, "'It's like Enron': FPA, Other Physician Practice Management Companies near the Death Knell," *Modern Healthcare* (Feb. 18, 2012).

⁶³ Deborah Stone, "Health Equity in a Trump Administration," *Journal of Health Politics, Policy and Law* 42, no. 5 (2017): 42.

consolidated into larger networks as a response to the payment cuts, which greatly improved their bargaining leverage. With their consistent lobbying, medical providers managed to receive sizable payment increases, and many constraints on their professional autonomy were legislated or litigated out of existence over time. The private plans followed suit and quickly restored their profitability by increasing premiums and enrolling members that were less costly to cover.⁶⁴ For seniors, this meant the cost of private health care insurance soared again and they were getting less while paying more. “We are now back to runaway health care inflation, with annual premium increases of 15 to 20 percent or more in some areas,” Enthoven’s words aptly captured the scenario.⁶⁵ It was in the midst of these alarming trends that the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 was passed. Marking the biggest expansion of Medicare since its creation in 1965, the MMA introduced a \$724 billion prescription drug benefit into the program.⁶⁶ Unlike the BBA, the legislation made no pretense of containing costs. In March 2004, four months after George W. Bush signed the MMA into law, it was disclosed that Medicare’s chief actuary originally estimated the cost of the plan to be nearly \$500 billion over 10 years, instead of the \$400 billion figure during the Act’s initial deliberations.⁶⁷

⁶⁴ R. Mayes, “Medicare and America’s health care system in transition: From the death of managed care to the Medicare Modernization Act of 2003 and beyond,” *Journal of Health Law* 38, no. 3 (2005).

⁶⁵ A. C. Enthoven, “Employment-based Health Insurance is Failing: Now What?,” *Health Affairs (Web exclusive: 28 May)* (2003): W3240.

⁶⁶ B. Vladeck, “The Struggle for the Soul of Medicare,” *Journal of Law, Medicine, and Ethics* 32 (2004).

⁶⁷ J.K. Iglehart, “The New Medicare Prescription Drug Benefit—A Pure Power Play,” *New England Journal of Medicine* 350 (2004).

Narrative of the MMA revolved around privatization and mirrored the priorities of the private sector and special interest groups.⁶⁸ Illustrative here, Oberlander described the MMA as part and parcel of “the new politics of Medicare” as it took the market-oriented reform to a new level.⁶⁹ Indeed, for the first time in Medicare history, a benefit was provided solely by private insurers; beneficiaries could get prescription drug benefits either through stand-alone plans or as part of the Medicare Part C (later known as Medicare Advantage after the inception of the MMA). Even in areas with no such plans, Medicare could not offer prescription drug benefits directly to beneficiaries; it had to be administered by private insurers with Medicare assuming the risk by paying the government’s share of cost.⁷⁰ Medicare had always been a public-private mixture since its inception, but the MMA ceded a whole area of program benefits to market-oriented private plans that developed at the expense of traditional Medicare. Besides, although the MMA did not herald a switch to a defined-contribution approach as an earlier presidential speech implied it mandated a demonstration project in six metropolitan areas, whereby beneficiaries would be given vouchers to buy either FFS Medicare or private plans.⁷¹ The Act also banned the government from negotiating with drug

⁶⁸ E.g., S. A. Bass, "Medicare Reform--A Wolf in Sheep's Clothing," *Journal of Aging and Social Policy* 17, no. 3 (2005); L. Polivka, "Medicare and the Future of Retirement Security," *Gerontologist* 47 (2007).

⁶⁹ Oberlander, *The Political Life of Medicare*, 160.

⁷⁰ J. O'Sullivan et al., *CRS report for Congress: Overview of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003* (Washington, D.C.: Congressional Research Service, 2003).

⁷¹ In a speech to an organization called Coalition for Medicare Choice, Bush 43 emphasized the advantage of private plans to provide benefits that were not available in traditional FFS Medicare, and stated “The defined benefit plan in Medicare limits the capacity of seniors to meet their needs, and that doesn’t seem right to me”. G.W. Bush, "Speech," (May 17, 2002), <http://www.whitehouse.gov/news/releases/2002/05/20020517-8.html>. For general discussion on this

companies for lower prescription drug costs, despite the sizable bargaining unit Medicare could bring to the table.

For seniors, such grand trends simply meant more choices. The MMA brought more private insurance plans by rebranding Medicare+Choice as Medicare Advantage (MA) and increasing payments to health maintenance organizations (HMOs), preferred provider organizations (PPOs), and private fee-for-service (PFFS) plans to cover Medicare beneficiaries. For example, the MMA paid PPOs an additional \$60 million over 10 years to encourage these plans to serve regions (especially rural areas) that had been ignored by private insurance companies with the new regulations and payment incentives it legislated. The extra payment included a regional plan stabilization fund, a blended payment rate adjusted according to plans' actual bids in the regions, as well as a network adequacy fund to cover payments of regional hospitals outside of the plan's network.⁷² Policy makers hoped that private plans could offer better services and more benefits than traditional Medicare with these over-payments, and their decision to delay the enactment of risk adjustment measures to make private plans be "held harmless" from financial losses further shifted Medicare politics to the private sector's advantage.

The MMA's substantial subsidies also boosted enrollment in private fee-

issue, see T. Rice and K.A. Desmond, "Distributional Consequences of Premium Support," *Journal of Health Politics, Policy and Law* 29, no. 6 (2004).

⁷² KFF, "The Medicare Part D Prescription Drug Benefit Fact Sheet," *Kaiser Family Foundation: Medicare* September (2014), <https://files.kff.org/attachment/medicare-prescription-drug-benefit-fact-sheet>; CBO, "A Detailed Description of CBO's Cost Estimate for the Medicare Prescription Drug Benefit," *Congressional Budget Office* (2004), <https://www.cbo.gov/publication/15841>.

for-service (PFFS) plans contracting with Medicare as an alternative to traditional Medicare for those beneficiaries in areas with fewer private plan options. The number of beneficiaries in PFFS grew from 20,000 in 2003 to 800,000 in 2006, accounting for about half of the recent growth in Medicare Advantage plan enrollment.⁷³ With such promising prospects of enrollment and profits (they were paid an 11 percent subsidy on average for each enrollee with the MMA), PFFS plans then moved from the margins of Medicare sub-programs to a prominent stage.⁷⁴ Regarding MA more broadly, beneficiaries could enjoy “one-stop shopping” that included both drug benefits and health care insurance coverage after the 2003 bill went into force, while beneficiaries who stayed in traditional Medicare but sought comprehensive coverage had to purchase Medigap or stand-alone prescription drug plans—another facilitator of privatization.⁷⁵ Just as the BBA, the MMA spared no efforts to bring more choices (and more competition as well) into Medicare.

Yet while the BBA emphasized payment cuts to Medicare, the MMA expanded Medicare benefits by providing coverage for prescription drugs (known as Medicare Part D). This dual approach underscored a central tension in Bush-era reform between the stimulation of market forces and the expansion

⁷³ The PFFS is one of the most common type of Medicare Advantage Plans, the other three are: Health Maintenance Organization (HMO) Plans, Preferred Provider Organization (PPO) Plans, and Special Needs Plans (SNPs). For detailed explanation, see J. Zhang and V. Fuhrmans, "Seniors flock to private fee-for-service Medicare plans," *Wall Street Journal* (Aug. 29, 2006). See also <https://www.medicare.gov/sign-up-change-plans/types-of-medicare-health-plans/medicare-advantage-plans>

⁷⁴ M. Freudenheim, "Luring Customers from Medicare: Fee-for-service Health Plans Flourish with Government Help," *New York Times* (Sep. 22, 2006).

⁷⁵ R. Berenson, "Medicare Disadvantaged and the Search for the Elusive “Level Playing Field,” *Health Affairs (Web exclusive, Dec. 15)* (2004).

of federal programs. The MMA reflected a complex interplay of ideological and political motivations. On one hand, it could be seen as a neoliberal policy, introducing market mechanisms like private plan competition and reliance on market-driven solutions. On the other hand, the expansion of benefits, particularly for vulnerable populations, suggested a break from the broader narrative of diminished citizenship under neoliberal hegemony. This apparent contradiction raised a key question: how did this reconcile with the Bush administration's broader ideological commitments? One explanation lied in the politics of Medicare itself—an area where seniors are a powerful voting bloc, and expansions of benefits have historically been politically advantageous, regardless of ideological commitments. The MMA might thus represent a pragmatic convergence of neoliberal and electoral considerations that blended market-oriented reforms with the political necessity of maintaining public support for a flagship program.

The program included several key details. Seniors would pay a monthly premium of around \$35 and receive an annual benefit starting at \$250. After meeting this initial amount, Medicare would cover 75% of prescription drug costs, leaving seniors to pay 25%, up to \$2,250 in total expenses. For those with significant drug costs, once out-of-pocket expenses reached \$3,600, Medicare would cover 95% of any additional costs. This was the “catastrophic coverage” part of the MMA. Additionally, the prescription drug plan provided the most assistance to those with the greatest need. Single seniors with annual

incomes below \$12,920 and couples earning less than \$17,321 would not have to pay deductibles or monthly premiums, and their co-payments would be minimal. Seniors with slightly higher incomes would benefit from reduced deductibles, premiums, and co-payments.⁷⁶ Starting in 2006, seniors would receive drug coverage through a prescription drug plan while remaining in traditional fee-for-service Medicare or opt for a Medicare private fee-for-service plan. In both scenarios, Medicare would cover approximately 75% of the beneficiary's premium and leverage market competition to offer the best access to necessary medications at the lowest possible cost. Beneficiaries with employer-sponsored plans could also continue with their existing coverage if they preferred.⁷⁷

In essence, such prescription drug benefits were another demand-side reform to lower in-hospital costs of Medicare. "Hospital stays cost more than medications," testified Congresswoman Brown-Waite. "We want to make sure seniors stay out of the hospital." In 2003, seniors spent an average of \$1,400 annually on medications. Yet the pre-MMA demonstration project could save seniors some 10 to 25 percent on most drugs with a Medicare-approved discount card to be used at pharmacies. This card was a temporary measure that provided savings until the full drug benefit rolled out in 2006. By 2006,

⁷⁶ This approach aligns with the broader trend in Medicare politics of providing targeted support to seniors. This particular case demonstrated more continuity than a significant ideological shift akin to the Bush-era tax cuts. "Special Community Meetings Event to Help Seniors Learn about New Medicare Prescription Drug Benefit," *US Fed News* (Dec. 15th, 2005).

⁷⁷ L. Bakk, "Medicare Prescription Drug, Improvement, and Modernization Act of 2003: Implications for the Future of Health Care," *Health & Social Work* 34, no. 1 (2009).

seniors without coverage could join a Medicare-approved plan, cutting their yearly drug costs roughly in half for a \$35 monthly premium. Additionally, low-income seniors received extra support with a \$600 annual subsidy added to their drug discount card. “The lower-income people can’t wait,” said Jeff Johnson from the American Association of Retired Persons. “It’s a good first step, and something is better than nothing.” The new legislation also introduced other benefits, such as physical exams for new Medicare enrollees and health screenings for diabetes and cardiovascular disease. This was another preventive measure to enhance pre-hospital care while providing financial relief to doctors, ensuring they continued to accept Medicare patients despite previously low reimbursements.⁷⁸

A final change the MMA mandated was means-testing premiums and insurance benefits. Previously, all beneficiaries paid the same Part B premiums. Yet from 2007 onward premiums would vary according to beneficiaries’ ability to pay and need for help. Specifically, Part B premiums for better-off seniors with an annual gross income above \$80,000 (single) and \$160,000 (household) would be set at a higher rate than the previous approximately 25 percent benchmark, and Part D drug benefits would be more generous for beneficiaries with incomes below 135 percent of the federal poverty level, with the premium being completely subsidized and cost sharing limited to less than 5% per prescription.⁷⁹ The arrangement generated much debate initially. While Sen.

⁷⁸ “Seniors Discuss New Medicare,” *The Tampa Tribune (Florida)* (Jan. 27th, 2004).

⁷⁹ Pauly, “Means-testing in Medicare.”

John Kerry (D-MA) favorably discussed the idea of making the wealthy pay more during his 2004 presidential campaign, opponents regarded it as fiscally misleading and politically inappropriate. First, premiums for Part B paid for only one fourth of the program's cost, and the number of wealthy elderly was too small to make a difference in Medicare's fiscal future.⁸⁰ More importantly, proportional or progressive contributions were applicable to mandatory social insurance programs because they provided income protection that reflected government responsibility regardless of specific characteristics, risks, and circumstances of the individual.⁸¹ For voluntary plans, however, introducing a steep income-related mechanism might very likely prompt the wealthier and healthier to opt out of Part B. This, in turn, would "undermine the diversified risk pool and widespread popular support that have sustained Medicare since its inception," to use Marmor and Hacker's words.⁸²

Additionally, opponents of means-testing premiums feared it would transform Medicare from a social insurance program into a welfare system, and wealthy seniors might be lured away by private insurance, leaving Medicare with the poorest and sickest. Phasing in higher premiums for retirees with incomes above \$100,000 annually could alienate a unified constituency, and premium hikes would need to be kept low enough to prevent wealthier seniors

⁸⁰ H.J. Aaron, "The Grand Delusion," *Century Issues* Oct. 15 (2003).

⁸¹ T.R. Marmor, Marshall J.L., and P.L. Harvey, *America's Misunderstood Welfare State: Persistent Myths, Enduring Realities* (Basic Books: Reprint edition, 1992).

⁸² T.R. Marmor and J.S. Hacker, "Medicare Reform and Social Insurance: The Clashes of 2003 and Their Potential Fallout," *Yale Journal of Health Policy, Law and Ethics* 5, Jan. (2005): 484.

from abandoning the system altogether.⁸³ This was an overt departure from Medicare's original architecture both in terms of financing and values. Some scholars such as Jonathan Oberlander even viewed the MMA as introducing "the politics of differentiation" into Medicare.⁸⁴ However, the means-testing in Medicare was also limited in scope. Had policymakers really wanted substantial subsidies to save low-income beneficiaries from potential bankruptcy, Medicare would include income-related premiums for its mandatory part A. In fact, by alleviating the burden of rising costs, means testing was largely a cost control measure crucial for Medicare's sustainability. Just as Robert Bixby of the Concord Coalition said, "You can't save Medicare by means testing alone. However, it is and should be part of a cost savings strategy."⁸⁵

To sum up, building on the BBA, the MMA enhanced the private insurance market by rebranding Medicare + Choice as Medicare Advantage, potentially delayed seniors' admission to hospital by introducing prescription drug coverage, and improved the quality of medical services by increasing payments to various health plans, including HMOs, PPOs, and private fee-for-service plans. These changes together highlighted a significant shift in social citizenship in the sense that the increased emphasis on consumer choice aimed to empower beneficiaries with more options and autonomy in their health care

⁸³ Olga Pierce, "Analysis: Is Medicare means testing fair?," *United Press International (UPI)* (Sep. 8, 2006).

⁸⁴ Jonathan Oberlander, "Through the Looking Glass: The Politics of the Medicare Prescription Drug, Improvement, and Modernization Act," *Journal of health politics, policy and law* 32, no. 2 (2007): 209.

⁸⁵ The Concord Coalition is a prominent advocacy group promoting responsible fiscal policy and addressing the federal budget deficit. Ellen Beck, "Analysis: Medicare Means Testing Unlikely," *United Press International (UPI)* (July 8, 2003).

decisions. In addition to offering health care benefits, the MMA represented a set of welfare policies aiming to strengthen the self-responsibility of the seniors regarding their needs for health security while forging a competitive and vibrant private insurance market. However, though competition was intended to increase efficiency and hold private insurers accountable to a market-driven health care model, widespread privatization could lead to numerous private schemes and potentially cause service disruptions and rising costs. Were seniors truly empowered, or were they finding themselves lost in the whirlpools of swift and sweeping marketization of health care? This is the question that concerns the next section.

Unkept Promises of Choice and Coverage

When selling the prescription drug benefit in 2003, the Bush administration hung its pitch primarily on the principle of individual choice. “For the seniors of America more choices and more control will mean better health care,” Bush showed his complete faith in the market to yield optimal outcomes in his December 2003 statement, “we are putting individuals in charge of their health care decisions, and as we move to modernize and reform other programs of this government, we will always trust individuals and their decisions and put personal choice at the heart of our efforts.”⁸⁶ “Choice” in this context was

⁸⁶ CNN, “President Bush Signs Landmark Medicare Bill into Law,” *CNN Live Event/Special* (2003).

conflated with rights, freedom, and consumer empowerment. However, as the consumer frame dominated the public discourse, there were surprisingly few appeals to social rights and citizenship even from those who positioned themselves as liberal health care reformers. Ironically, as seniors being empowered with more options, an increasing number of beneficiaries found their benefits even lower than that of their traditional FFS plans.

The most general explanation is, as researchers in American health care know all too well, that more choice does not guarantee better outcomes. For example, in 2006, seniors in Oklahoma could choose their prescription drug plans from 57 stand-alone options, up from 42 in the previous year. Similarly, beneficiaries in North Carolina enjoyed a selection-pool of 51, compared to 38 in 2005. States like New York, Ohio, Pennsylvania, and West Virginia each offered more than 60 plans. In addition, beneficiaries could choose from a wide range of Medicare Advantage plans that provided coverage for additional medical expenses such as doctor visits. “They don’t want dozens of choices” said Deanne Beebe, spokeswoman for the Medicare Rights Center. “They want one affordable drug benefit they can count on when it comes time to fill their prescription.” Nevertheless, competition was the central point of the MMA and largely the reason that kept premiums stable over years. “Competition brings down prices,” said Congressman Bill Thomas (R-Calif.), “and ensures seniors save money on their prescription drug costs throughout their lifetimes.”⁸⁷ There

⁸⁷ Kevin Freking, "Seniors to Get More Medicare Choices," *Associated Press Online* (Sep. 30, 2006).

was thus a clear conflict of priorities between seniors and the government. While policymakers emphasized the solvency of Medicare and the program's guiding principle, seniors were concerned with the easiest way to navigate through such policy changes. The tension between grand financing strategy and individual medical choices was a constant theme in our notion of consumerist social citizenship.

Another example of such tension was concerned with the distinctiveness of seniors as a demographic group. While Medicare beneficiaries were expected to be well-informed "rational consumers" who could always choose the option that had optimal benefits, the choices provided by the MMA seemed to escape this consumer logic.⁸⁸ The discount card for prescription drugs as a transitional program before the MMA drug plan took effect in 2006 was both complicated and confusing. While seniors' limited ability to figure out their actual needs and options should be taken into consideration, there is strong evidence that both seniors and their caregivers found the researching process complex and time-consuming. In 2003, Families USA, a nonprofit and nonpartisan health advocacy organization, held a traveling expo and recorded a video to provide guidance for seniors about what benefits were included and which discount card to use, yet the effect was still quite limited because seniors faced a major obstacle when clarifying what their medical problems were to determine which card could best meet their needs.⁸⁹ Consequently, although it was speculated

⁸⁸ Schor, "Towards a new politics of consumption."

⁸⁹ K. Lind, "Medicare Drug Discount Card Program: How Much Does Card Choice Affect Price Paid?,"

that beneficiaries would enrol in private plans due to additional benefits, the complicated directions often confounded seniors. By 2004, critics argued that the program was becoming increasingly complicated rather than simpler. “The complexity arises from the growing number of available plans, each differing from the others, coupled with a much shorter decision-making period for seniors,” explained Ron Pollack, executive director of Families USA. Initially, seniors had half of a year to decide which plan to enroll, but in late 2004, seniors only had about two months to make their decision.⁹⁰

Ironically, as the MMA pushed seniors to decide, available information about their drug plans was unreasonably insufficient and confusing. Approximately 78 percent of seniors participating in a 1998 Princeton Survey Research Associates poll supported the law that required managed care companies to “provide people with more information about their health plan.”⁹¹ In 2005, just before the MMA’s implementation, the Kaiser Foundation also reported that around 46 percent of seniors responding to their survey chose “I don’t know enough about it”, and 37% chose “it’s too complicated” when asked about the reason they did not enrol in a Medicare drug plan.⁹² This had allowed private plans substantial room to manoeuvre when appealing to enrollees. In most cases, private insurers claimed that their plans provided the “same”

AARP Bulletin Online (Nov. 1, 2004).

⁹⁰ Freking, "Seniors to Get More Medicare Choices."

⁹¹ KFF (Kaiser Family Foundation) & Harvard University School of Public Health, Survey of Americans' Views on the Consumer Protection Debate, (Storrs, CT: Roper Center, Sep. 17, 1998).

⁹² KFF & Harvard University School of Public Health, Short The Medicare Drug Benefit: Beneficiary Perspectives Just Before Implementation.

coverage as traditional Medicare, especially as many seniors were still reluctant to abandon their FFS plans without such assurances. Yet the fact was that private plans only provided “actuarially equivalent” coverage (i.e., equal out-of-pocket costs) to the public system. This means that private insurers could change the type of benefits or structure cost-sharing quite flexibly to cover different groups of beneficiaries. For instance, including benefits like discounted fitness club memberships could attract healthier beneficiaries who were less costly to cover.⁹³

In addition to misleading seniors on their benefits, private insurance companies also lied about the reason beneficiaries would have extra benefits or lower premiums.⁹⁴ Emphasizing their aim to encourage members to have regular physical exams so that some diseases could be found at early stage (i.e., to be treated at relatively low costs), private plans claimed that extra benefits were made possible by lower overall costs.⁹⁵ Yet in fact, these extra benefits insurance companies had promised were “overwhelmingly...not financed out of plan efficiency, but rather by the Medicare program and other beneficiaries” noted Glenn Hackbarth, chairman of Medicare Payment Advisory

⁹³ MedPAC, “Medicare Advantage Payment Areas and Risk Adjustment,” in *Report to the Congress: Issues in a Modernized Medicare Program* (Medicare Payment Advisory Commission: 2005).

⁹⁴ Notably, while there were complexities in choosing Medigap or supplemental insurance before the MMA, the pre-MMA landscape was less focused on a competitive private marketplace for prescription drug coverage. Traditional Medicare provided standardized benefits, so seniors were not required to navigate the array of private plans with varying cost structures and benefits as they did post-MMA. The introduction of Part D under the MMA created a completely new and complex marketplace. Seniors were now expected to compare a wide range of private prescription drug plans, each with unique formularies, cost-sharing requirements, and premiums. This was a significant shift from the simpler decision-making process of choosing between standardized Medicare and supplemental coverage pre-reform.

⁹⁵ Monique Morrissey, *Medicare Privatization: A Cautionary Tale* (Economic Policy Institute, 2009). <https://www.epi.org/publication/pm142/>.

Commission.⁹⁶ This means that some beneficiaries were getting more benefits at the expense of others, and that private plans had been taking advantage of the flat fee paid by the government regardless of beneficiaries' actual health care costs. Further contributing to this argument, there is strong evidence that insurance companies had been exaggerating the health problems of their enrollees by "upcoding" them, i.e., assigning diagnosis codes for more serious diseases to beneficiaries, so that government's payments to these companies could be inflated.⁹⁷ In this sense, the "choice promotion strategy" had diverted way from its original expectation—the goal to rein in costs through competition and diversify plan offerings to meet seniors' various needs had given way to unscrupulous selling tactics and risk selection of the market.

Adding to the misleading concept of choice, some scholars believed efforts to move beneficiaries out of traditional Medicare had been relying more on carrots than sticks, but this was only partly true.⁹⁸ Advocates of the "choice" strategy believed that inducement was favoured over compulsion as a political strategy to privatize more of Medicare when explaining the bill.⁹⁹ "The strategy of the MMA is to make Medicare Advantage plans so attractive that most beneficiaries will voluntarily switch out of traditional Medicare," testified Joseph

⁹⁶ G.M. Hackbarth, "Report to the Congress: Medicare Payment Policy," *MedPAC* (Mar. 17th, 2009): 18.

⁹⁷ M. Miller, *Private Fee-for-service Plans in Medicare Advantage* (Written testimony of MedPAC Executive Director Mark E. Miller before the Health Subcommittee of the House Ways and Means Committee, May 22, 2007).

⁹⁸ Oberlander, "Through the Looking Glass: The Politics of the Medicare Prescription Drug, Improvement, and Modernization Act," 207.

⁹⁹ R. Pear and R. Toner, "Bush Medicare Proposal Urges Switch to Private Insurers," *New York Times* (Mar. 4th, 2003).

Antos of the American Enterprise Institute, a prominent neoliberal think tank.¹⁰⁰ Nevertheless, in practice seniors were often compelled (ironically with the rhetoric of choice) to desert the traditional program. First, the enrolment rule of the prescription drug coverage was a significant departure from conservatives' rhetoric about "voluntary switch", because beneficiaries had to enrol in a private plan if they were to get this benefit.¹⁰¹ Besides, prior to the MMA, most Medicare beneficiaries had been using Medigap or other types of subsidies like retiree coverage to pay for services that FFS Medicare did not cover. Yet after 2003 these supplemental coverages had rarely kept pace with medical advancements—another implicit compulsion.¹⁰²

Additionally, most MA plans restricted beneficiaries to a small network of hospitals and doctors. Some plans allowed members to use providers outside of the network but required them to pay extra to do so. This was hardly an expansion of choice compared with Medicare in the past, as less-advantaged patients would simply give up their free choice if the cost was too high. Under the new rules, seniors were not entitled to an out-of-pocket limit if they chose to stay in traditional Medicare. Even if beneficiaries had the opportunity to switch back to traditional Medicare from MA plans during an open enrolment season, it was hard for them to protect themselves from unexpected costs by

¹⁰⁰ Joseph R. Antos, "Ensuring access to affordable drug coverage in Medicare," *Health care financing review* 27, no. 2 (2005).

¹⁰¹ R. Berenson, "Doctoring health care, II.," *The American Prospect* Jan/Feb (2007): 13.

¹⁰² J. Lambrew and K. Davenport, Has Medicare been Privatized? Implications of the Medicare Modernization Act, beyond the Drug Benefit, (2006).

purchasing supplemental coverage if they had medical problems.¹⁰³ This was because the MMA allowed private providers to adjust drug prices and formulas on a weekly basis, but beneficiaries were only permitted to change benefit provider once a year. This was a time painfully long for those who were suddenly caught by serious disease, especially as in managed care plans they also needed a referral from a primary care doctor to consult a specialist (in traditional Medicare that was not required). In this sense, the MMA particularly limited the choice of beneficiaries who wanted financial protection yet favoured traditional Medicare due to greater flexibility of choosing medical providers.

Regarding access to health care, the impact of the MMA was quite complicated. The guaranteed ability for all seniors to enrol in the newly ascendant Medicare Part D was certainly helpful to some, given the government subsidies for 75 percent of the cost of a benefit which would, in turn, cover nearly 50% of prescription drug costs. Yet since the drug benefit did not entail full reimbursement, how much it improved the situation for seniors varied greatly from one beneficiary to another based on their income and secondary insurance coverage. On the one hand, three groups of beneficiaries would significantly benefit from the new plan: 1) those who had no private supplemental coverage and thus had high drug costs, 2) Medigap enrollees, because Medicare Part D provided better coverage than Medigap premiums (50% vs. 37% on average), and 3) beneficiaries whose income was too high for

¹⁰³ Tricia Neuman, "Traditional Medicare Disadvantaged?," *KFF Perspectives* (2016), <https://www.kff.org/medicare/perspective/traditional-medicare-disadvantaged/>.

Medicaid but low enough for low-income subsidies established by the MMA, as in many state Medicaid plans were limited to people with incomes below 74 percent of the federal poverty level, while the MMA's low-income subsidies were for those with incomes up to 150 percent of the poverty level.¹⁰⁴

On the other hand, however, "sicker" people or those with chronic disease were particularly disadvantaged by the new arrangements. This was because some plans either charged fees not required of beneficiaries with FFS Medicare or Medigap or excluded coverage for certain medical treatments.¹⁰⁵ Thus seniors in poor health usually had much greater out-of-pocket costs than they would have in traditional Medicare. For example, enrollees in a plan in Florida were required to pay \$325 per day as part of co-payments for hospital stays, which was up to a \$3,350 deductible, yet in traditional Medicare they needed to pay only a flat \$1068 deductible for stays up to 60 days.¹⁰⁶ Besides, beneficiaries who enjoyed generous supplemental retiree coverage prior to the MMA had seen a significant reduction of their private drug benefits. It is hard to tell whether such changes resulted from the MMA or the long-standing trend of private retiree plans, because employer-sponsored retiree insurance has been declining since the early 1990s. What is certain, however, is that the number of seniors who completely lost their retiree benefits had increased sharply after

¹⁰⁴ D. Jaenicke and A. Waddan, "President Bush and Social Policy: The Strange Case of the Medicare Prescription Drug Benefit," *Political Science Quarterly* 121, no. 2 (2006).

¹⁰⁵ KFF, "Costs under Private Medicare Advantage Plans Higher than Traditional Medicare for Some Beneficiaries, GAO Report Finds," *Kaiser Daily Health Policy Report* (Feb. 28, 2008).

¹⁰⁶ B. Biles et al., "Medicare Beneficiary Out-of-Pocket Costs: Are Medicare Advantage Plans a Better Deal?," *Issue Brief (Common Fund)* May (19) (2006).

the bill.¹⁰⁷

Another major group who was not better-off under the MMA was those known as the dually eligible, i.e., Medicare beneficiaries who received prescription drug coverage through Medicaid before the 2003 bill. Under the MMA, this group were required to switch from Medicaid to Medicare Part D plans so that their prescription drug benefits would not be interrupted, but many faced decreased benefits and higher payments under the new plan. This is because the MMA explicitly prohibited states from using federal matching payments to supplement Part D coverage for this group of people. The net result, therefore, was a higher co-payment of the new plan than what many Medicaid programs required them to pay, as well as a significant increase in out-of-pocket drug costs for some 3.9 million dually eligible beneficiaries.¹⁰⁸ Taken together, seniors of different social status had different experience about the MMA. As policymakers loaded the dice heavily in favour of private plans, all parts of Medicare were subjected to the market logic, leaving no beneficiary unaffected by its unexpected consequences.

In overview, market-driven solutions entailed significant disparities for Medicare beneficiaries. The increased number of plan options, coupled with insufficient information and shorter decision-making periods, left many seniors struggling to navigate their choices effectively. The practical outcomes were

¹⁰⁷ J. Gabel, H. Whitmore, and J. Pickreign, "Retiree Health Benefits After Medicare Part D: A Snapshot of Prescription Drug Coverage," *The Commonwealth Fund: Issue Brief* 46 (2008).

¹⁰⁸ As of 2005, 11 states did not charge co-payments, and 13 states have co-payments lower than the established Part D levels. For details, see J. Angeles and M. Moon, "The Medicare Prescription Drug Law: Implications for Access to Care," *AMA Journal of Ethics* 7, no. 7 (2005).

also mixed regarding prescription drug benefits. While some beneficiaries benefited from the new options and subsidies, others, particularly those with chronic conditions or lower incomes, faced higher out-of-pocket costs and reduced access to necessary services. Regarding its guiding principle, choice and competition, the MMA was misleading as well. Obviously, the MMA was paying private plans for doing more, whether or not more meant appropriate. From a patient experience perspective, beneficiaries' "free choices" were not free at all. A potential explanation was that restraining members to a small network of providers can make beneficiaries more "cost conscious" because it allowed plans to bargain for better rates *beforehand*, yet it was hard to say whether such "extensive governing" had improved consumers' cost consciousness or sent more money to private insurers. In this vein, the MMA's impact on fuelling competition was ambiguous as well, as private plans were only competitive because they played on a tilted ground.

Conclusion

When reviewing implementation of Medicare reforms in the late 1990s and the early 2000s, it was tempting to conclude that this era was marked by a shift towards active citizenship given the consumer empowerment rhetoric in the BBA and the MMA. For proponents of active citizenship, Medicare in this period had been able to support seniors in their agency and activities rather than

merely providing benefits and services. Yet in this context, claiming responsibility for one's own health and well-being was not merely an option; to a large extent, it also represented an obligation. Our notion of consumerist social citizenship thus adds a richer layer to the unfolding chronicle of privatization. When seniors were considered as self-reliant consumers who were then expected to manage their own medical needs, they were also burdened with risks of privatization. This transfer of responsibility had exacerbated inequalities and left vulnerable populations without adequate support. The shift toward consumerist citizenship therefore carried both promise and peril. In particular, there was a clash of interest when seniors preferred some simple and straightforward solution to their health needs while the government clung to the notion that more insurance options meant more health security. This disjuncture between seniors' and the government's goals about "choice" characterized social citizenship around the turn of the century.

The initial goal of the BBA to provide seniors with greater flexibility and access to managed care plans was undermined by significant budget cuts and administrative burdens. Specifically, the Act's restructuring of payment rates based on national rather than local expenditures, alongside adjustments to capitation fees, turned out to be an ill-conceived strategy for attracting for-profit private plans and therefore resulted in high turnover rates and disenrollment issues for beneficiaries. In this way, the BBA fell short of its promises as the decrease in available plans and benefits left many beneficiaries facing higher

premiums and reduced services. Moreover, the quality of care suffered as hospitals and physicians struggled with lower profit margins and increased financial pressures. The dual role of managing costs and providing quality care became increasingly difficult to balance, leading to inadequate treatment and transfer options for patients. The flawed risk adjustment strategy further compounded these issues by allowing managed care plans to selectively enrol healthier individuals, thereby undermining the equity of care. From a social citizenship perspective, the BBA's legacy was marked by a notable change in incentive design of Medicare. If the Prospective Payment System of 1983 changed providers' incentive to overtreat patients, the BBA changed patients' incentive to overspend under the banner of "moral hazards." The change of focus from the supply side to the demand side was another major feature of consumerist social citizenship.

The MMA attempted to address problems of the BBA by creating prescription drug coverage and rebranding Medicare+Choice as Medicare Advantage. However, the fundamental challenges of balancing cost control, quality care, and equitable access within a privatized framework remained unresolved. Some beneficiaries did enjoy lower premiums and better medical services under the MMA, while others found their choices limited, the overall efficiency of the system unimproved, and their benefits inadequate and even fewer than that of their traditional FFS Medicare. At last, and most importantly, while the role of government in health care had been a recurring theme in

Medicare history, the MMA significantly challenged the imagined boundaries between being a citizen and being a consumer. The seemingly contradictory fact that the MMA at once emphasized consumer choice and entailed a variety of limitations illustrated two distinctive aspects of consumerist social citizenship. The first was that Medicare beneficiaries had a right to be well informed when purchasing their medical services and complain when the services did not fulfil their expectation, but they could no longer count on the government to give them particular rights, especially with regard to welfare.

The second was a change of focus from collectivist social rights to individual responsibilities, and inequality and social risk were no longer regarded as systematic pathology but rather as a result of unwise decisions by individuals. To be sure, individualism had long been critical to Americans' perception towards social welfare, and the tendency to assign individual responsibility for economic outcomes at the expense of structural explanations long predated this period. The notable change was the increasingly sporadic rights claiming. As the government continued to exercise fiscal restraint, disjuncture also emerged between citizens' expectation for their rights and burdens of social citizenship. In health care, personal responsibility was accompanied by personal consequences regarding health, service quality, access, as well as costs. There was little remedy for poor choices because neither insurers nor the government was to provide a safety net. Notably, the notion of a consumer-directed health care and a consumerist Medicare system

had been performed on the premise of not bringing significant disruptions to Medicare benefits, and had been built through policy layering which led to programme reconstruction. However, the experience of the MMA has already showed that private plans alone could not sustain the huge and diversified system of Medicare, and for those who think that a well-functioning health care system without a public plan would be a workable compromise, the issue of seniors' capability and navigate through the market risks must be considered.

Chapter 6

Spending to Save: The Affordable Care Act as a Post-neoliberal Policy

“When Medicare sneezes, health care catches cold.”¹

“Medicare is looking like a big fat piggy bank for health care overhaul.”²

This chapter investigates the Affordable Care Act (ACA) as a sweeping and swift reform with a scale not seen in years in the American health care system from the lens of post-neoliberal social citizenship. The major contention is that the ACA demonstrated the core feature of post-neoliberal social citizenship, i.e., a shift of focus from cost control to value-based health care, which means investing in preventive care, introducing regulations to improve quality of care, and downplaying the role of the private market. While the debates on preventive care and healthier lifestyle had been raging since the 1970s and well into the 1990s, I show that the ACA marked a new level of government intervention in promoting preventive health. In particular, I discuss how the ACA demonstrated

¹ HCN, "Medicare Cut 'When Medicare Sneezes, The State's Health Care System Catches A Cold'," *Healthcare News* (Online) 2003, <https://healthcarenews.com/mss-raps-4-5-medicare-cut-when-medicare-sneezes-the-states-health-care-system-catches-a-cold/>.

² Ricardo Alonso-Zaldivar, "When Medicare Is the Piggy Bank, Most Seniors Willing to Help Younger Generations.," *Associated Press* (Sep. 28th, 2009).

a major dilemma in American health care: at first glance, the government was obligated to uphold social rights and ensure equity, regardless of financial pressures. Yet ironically, these same commitments could also hinder essential reforms.

For example, despite growing demand for extended prescription drug coverage, the majority of funding continued to flow towards traditional physician services and hospitals. When efforts were made to redirect resources—cutting funding to primary care physicians or reducing hospital readmissions—public backlash quickly followed. As a result, while political rhetoric emphasized progressive ideals such as “investing in the future” and innovative health models, actual policy remained stagnant. In this sense, the right to health care was both a symbolic stabiliser (that tied the government to its commitment) and a constraint, which accounted for a degree of “path dependency” in Medicare reforms. As we shall see, the ACA also became a watershed moment in senior advocacy as the organization reportedly lost three million members after its passage, with around 300,000 directly attributing their departure to the AARP’s role in supporting the legislation. This mass exodus highlights a critical shift in senior advocacy: seniors, once a united force in demanding health rights and expansion of welfare benefits, increasingly felt disconnected from the very organizations that claimed to represent them. In this environment, the AARP’s actions underlined a disjuncture between seniors’ rights claims and the advocacy power they once wielded. This divergence undermined the

foundation of social citizenship for seniors by suggesting that their needs were secondary in interest group negotiations.

When the ACA was passed in 2010, many people applauded for its reorganization of Medicare and Medicaid, the new regulation that prohibited price discrimination against higher-risk patients. It was also praised for its creation of so-called health exchanges, in which uninsured individuals could buy government-subsidized insurances. These efforts significantly reduced the spending growth of public programs and helped roughly 35 million Americans be covered by 2021.³ They also built expectations about providing health care as a matter of right that accompanied citizenship. However, a 2010 survey by the Kaiser Family Foundation showed that only 50% of seniors were aware that the new law aimed to gradually eliminate Medicare's "doughnut hole."⁴ Additionally, just 14% knew that the ACA would extend the lifespan of the Medicare Trust Fund, while nearly half (45%) mistakenly believed that the reform weakened the program's financial health. Furthermore, many seniors held misconceptions about the law's impact: 50% thought it would cut Medicare benefits, and 36% feared it would establish a government panel to make end-of-life care decisions.⁵ The following part examines these issues to clarify the

³ HHS.gov, *New Reports Show Record 35 Million People Enrolled in Coverage Related to the Affordable Care Act, with Historic 21 Million People Enrolled in Medicaid Expansion Coverage*, U.S. Department of Health & Human Services (2022), <https://www.hhs.gov/about/news/2022/04/29/new-reports-show-record-35-million-people-enrolled-in-coverage-related-to-the-affordable-care-act.html>.

⁴ The "doughnut hole" in Medicare Part D was a coverage gap where beneficiaries paid full out-of-pocket costs for drugs after reaching a spending limit, until qualifying for catastrophic coverage.

⁵ Andrea Louise Campbell, *How Policies Make Citizens: Senior Political Activism and the American Welfare State*, 1 ed. (Princeton: Princeton University Press, 2011).

(mis)conceptions. As we shall see, what is new, what is old, what has been tested, and what the ACA leaves entirely undone all fit neatly into the “social investment” framework—investing in social programs for future gains—and set in motion a post-neoliberal initiative in American health care.

This chapter does not intend to provide a comprehensive political history of the ACA’s passage and implementation because such accounts are available elsewhere.⁶ Rather, it illustrates how the ACA invests in Medicare’s future to redefine health rights and social citizenship more broadly—a transition to value-based health care. This is done through analysis of two aspects of the ACA’s implementation. The first section details how the legislation expands Medicare benefits by extending benefits to preventive care, mandating regulations to reduce hospital readmissions, and establishing the Accountable Care Organizations (ACOs). The other section then explores the negative side of the ACA. The Obama administration has to make concessions to get support from powerful interest groups, while Medicare beneficiaries had little part in the negotiation process. Moreover, the cuts in Medicare funding greatly narrowed provider networks and caused discontinuation of plans under Medicare Advantage, leaving many seniors grappling with reduced healthcare access

⁶ Tom Daschle and David Nather, *Getting it done: How Obama and Congress Finally Broke The Stalemate to Make Way for Health Care Reform* (New York: Thomas Dunne Books, 2010); Jacob S. Hacker, "Why Reform Happened," *Journal of health politics, policy and law* 36, no. 3 (2011), <https://doi.org/10.1215/03616878-1271063>; Richard Kirsch, *Fighting for Our Health: The Epic Battle to Make Health Care a Right in the United States* (New York: Rockefeller Institute Press, 2011); Richard Kirsch, "The politics of Obamacare: health care, money, and ideology," *Fordham law review* 81, no. 4 (2013); Paul Starr, *Remedy and Reaction: The Peculiar American Struggle Over Health Care Reform*, Revised ed. (New Haven, CT: Yale University Press, 2013); Jonathan Oberlander, "Long Time Coming: Why Health Reform Finally Passed," *Health Affairs* 29, no. 6 (2010), <https://doi.org/10.1377/hlthaff.2010.0447>.

and choice. As detailed below, the Act did not make reducing costs its primary goal. In fact, it came with a price tag of some \$1 trillion in federal spending during the acute reality of the post-2008 global slump, whose recovery required what McNally called “a decade of pain” in the form of fiscal austerity.⁷ Specifically on Medicare, the ACA is less of a neoliberal policy than a post-neoliberal one with “spending to save” being its central tenant.

Investing in Quality: A Shift Towards Value-based Care

When Obama declared his plan for Medicare, he also mentioned a possible “surtax” imposed on seniors to fund the reform. Under this plan, retirees earning \$85,000 or more, and married couples making \$170,000 or more, would see their monthly Medicare premiums increase. Over the next 20 years, the top 25% of earners among Medicare recipients would gradually begin paying higher, income-adjusted premiums. Specifically, premiums for higher-income beneficiaries would rise by 15%.⁸ This made the ACA look much like the Medicare Catastrophic Coverage Act (MCCA), which planned to control Medicare costs by charging better-off seniors more in their health insurance plans to fund greater catastrophic illnesses coverage for the elderly as a whole

⁷ David McNally, *Global Slump : The Economics and Politics of Crisis and Resistance* (PM Press, 2014), 2.

⁸ Ricardo Alonso-Zaldivar, "Obama Medicare plan: No voucher but maybe a bill," *Associated Press Online* (Sep. 24th, 2012).

(detailed in Chapter 4). However, the ACA's vision for Medicare centred on quality rather than costs. The legislation broke away from neoliberal paradigms—which leveraged market-forces to contain public programs' spending and improve its efficiency—and encapsulated a transformative shift that emphasized quality and access in Medicare. This was more proactive, long-term investment into Medicare's future than a reactive response to its solvency.

Preventive Care

On a sunny Wednesday in July 2010, First Lady Michelle Obama announced at George Washington University Hospital that new federal guidelines required all private health insurance plans to cover preventive health care services, ranging from early detection services for conditions such as high blood pressure and colon cancer to obesity counseling. “These essential services,” she emphasized, “would come without a deductible, co-pay or coinsurance.” The statement related to a new set of benefits the ACA aimed to feature. For seniors, the ACA mandated protective services such as medical treatment facilities oversight and background checks for employees at nursing homes and other long-term care facilities. The legislation also covered part of training costs for nurses and social workers to prepare them for medical emergencies and challenges in patients' everyday needs, with preventive services that could

keep patients from common hazards being provided free of charge to Medicare beneficiaries.⁹ Joined by Second Lady Dr. Jill Biden—we shall see President Biden’s investment in preventive care in Chapter 7—and Health and Human Services (HHS) Secretary Kathleen Sebelius, Michelle Obama declared prevention to be a critical factor in the administration’s health care reform. “Because we know that the best way to keep our families healthy and cut health care costs is to keep people from getting sick in the first place,” her words aptly captured the Obama administration’s commitment to invest in preventive care.¹⁰

An HHS report showed that chronic diseases that were often preventable, including heart disease, cancer, and diabetes, accounted for 70% of annual deaths in the U.S. and constituted 75% of the country’s health care expenditure. Moreover, health care expenses for individuals who were overweight were 39% higher than the average. Early detection of chronic conditions through preventive care could play a significant role in reducing these costs.¹¹ “Our challenge is to remove the obstacles between patients getting the preventive services that they need to stay healthy,” according to a statement released by the White House, “If we fail in this challenge, we all pay the price. If we succeed, we are on our way to a healthier nation.”¹² The strategy on prevention was not

⁹ Lawrence R. Jacobs and Theda Skocpol, *Health care reform and American politics: What everyone needs to know* Rev. and updated ed., What everyone needs to know, (New York: Oxford University Press, 2012), 124-5.Pp. 124-5.

¹⁰ Kendra Marr, "New Rules: Free Preventive Care," *Politico.com* (July 15th, 2010).

¹¹ Marr, "New Rules: Free Preventive Care."

¹² "Prevention is a Priority-Now is a Reality," *CQ Federal Department and Agency Documents* (July 14th, 2010).

just about getting more tests; it also attended to in-hospital scenarios. A federal report released in December 2014 suggested that since the enactment of the ACA, efforts to protect patients from hospital-acquired conditions have prevented 50,000 deaths and led to savings of \$12 billion. This included the prevention of entirely avoidable complications such as surgical infections, pressure sores, ventilator-associated pneumonia, and catheter-related bloodstream infections, all of which could cause severe harm or death.¹³ “Getting access to early care and screenings will go a long way in preventing chronic illnesses that consume up to three-fourths of the nation’s health care spending,” President Obama thought preventive care a wise investment in cost control and quality improvement.¹⁴

The strategy did secure great achievements. In the first year of the ACA’s implementation, 32.5 million people received one or more preventive benefits without charge under traditional Medicare.¹⁵ The following year, 2012, saw 34.1 million seniors reaping the benefits of Medicare’s coverage of over 20 preventive services without any cost-sharing. In the first quarter of that year, 8.9 million beneficiaries of traditional Medicare used at least one preventive service at no personal expense. This included more than 560,000 who utilized the new Annual Wellness Visit.¹⁶ By 2014, the number of beneficiaries accessing

¹³ Robert Kraig and Kevin Kane, "Crusade Against Health Reform is Threat to Life; Opinion & Commentary," *The Capital Times (Madison, Wisconsin)* (Dec 17th, 2014).

¹⁴ "New Regulations Ban Cost Sharing for Preventive Services in Some Health Plans," *Congressional Quarterly HealthBeat* (July 14th, 2010).

¹⁵ "Affordable Care Act Saved People on Medicare Over \$3.4 Billion on Prescription Drugs," *Targeted News Service* (April 30th, 2012).

¹⁶ "What will Obamacare do to my Medicare?," *The Independent (Edgewood, New Mexico)* (July 3,

preventive care had surged to 39 million.¹⁷ The trend continued upward as the Centres for Medicare & Medicaid Services reported in 2015; nearly 5.9 million (18%) Part B beneficiaries took advantage of their free annual wellness visit in 2015, a noticeable increase from the nearly 4.8 million in 2014, and 73% of the 36 million Part B enrollees used at least one free preventive service. “Medicare consumers are now more engaged and empowered in their own health thanks to the Affordable Care Act,” said CMS administrator Andy Slavitt. “Millions are now able to access more affordable prescription medicine for their chronic conditions and millions more are staying healthier by accessing preventive services, especially vital for people living with disabilities or growing older.”¹⁸

On specific treatments, a study published in *Cancer* revealed a notable increase in mammography—a cancer diagnostic screening—usage among older Americans following the implementation of the ACA. “Even if the program itself is dismantled, that would be a worthy benefit to keep, said the leading scholar Dr. Gregory Cooper of University Hospitals Cleveland Medical Centre and the Case Comprehensive Cancer Centre. By analysing Medicare claims data for beneficiaries aged 70 and older, Cooper and his team highlighted how Obama’s investment in preventive care encouraged more women across various income and education backgrounds to undergo this vital cancer

2013).

¹⁷ “Obamacare saves Arkansas seniors millions in drug costs, preventive health care,” *Arkansas Times* (Feb 25th, 2015).

¹⁸ Richard Franki, “Medicare Part B Wellness Visits up 1 Million in 2015,” *Frontline Medical News* (Feb 24th, 2016).

screening test. David H. Howard from Emory University and Lauren Hersch Nicholas from Johns Hopkins School of Public Health echoed the study's findings. "In terms of bang for the buck, it [mammography] is one of the most valuable cancer screening services," said Howard and Nicholas, but "It is known that when people have to pay more for medical care, they get less of it." In particular, their studies noted the importance of keeping preventive services accessible to mitigate health care inequalities and improve public health outcomes.¹⁹ Being attentive to preventive care revealed an explicit change in defining what was best for seniors in health management and potentially enriched their social rights. We now turn to the quality improvement aspect of this transition.

Hospital readmissions

In 2012, the ACA established the Hospital Readmissions Reduction Program (HRRP) to impose penalties on hospitals that have an excessive number of patients being readmitted soon after discharge. Hospitals faced financial penalties or rewards based not only on their performance against established care standards but also on patient satisfaction ratings. The stakes were high, as the penalty rate was slated to escalate from 2 percent of regular Medicare payments in October 2013 to 3 percent the following year. In the first year of

¹⁹ Susan Scutti, "More Women Got Mammograms When Obamacare Paid for Them," *CNN.com* (Jan 6th, 2017).

the program's implementation—2012, the penalties amounted to \$280 million, representing a mere 0.3 percent of total Medicare payments to hospitals.²⁰ In a Monday blog post on the Office of Management and Budget's website, White House Budget Director Peter R. Orszag highlighted hospital readmissions as a key component of President Obama's "aggressive" strategy to "change the game" in health care.²¹ As we shall see, this was part of a multipronged effort by the Obama administration to redefine health rights and social citizenship more broadly.

In 2010, nearly 2 million Medicare beneficiaries found themselves readmitted to hospitals within just 30 days of their initial discharge, incurring an additional \$17.5 billion in hospital charges for Medicare. Despite efforts by numerous hospitals to reduce this figure, the national readmission rate stubbornly hovered around 19 percent. In fact, the prevailing structure offered hospitals scant financial motivation to ensure the continued care of patients post-discharge, and hospitals stood to gain from the revolving door because they got another payment from Medicare each time a patient was readmitted, regardless of the length of stay.²² The situation was complicated further by the economic realities faced by doctors, who counted on multiple patient hospitalizations to secure income. "It's OK if you have enough patients in the

²⁰ Jordan Rau, "Medicare To Penalize 2,217 Hospitals For Excess Readmissions," *KFF Health News* (Aug. 13th, 2012).

²¹ John Reichard, "CMS Pilot Sweats the Details of Cutting Hospital Readmissions," *Congressional Quarterly HealthBeat* (Apr. 14th, 2009).

²² Rau, "Medicare To Penalize 2,217 Hospitals For Excess Readmissions."

hospital,” said Dr. Sandeep Jauhar, a cardiologist at a Long Island hospital, “but if you don’t, you sometimes have to drag out the stay. I don’t like to do it, but sometimes you have to.”²³ Compounding the issue, a study published in the *New England Journal of Medicine* revealed a startling gap in care continuity: about half of the patients readmitted within 30 days had not had any documented outpatient visits between their discharge and subsequent readmission. This lack of follow-up care exemplified the systemic failures contributing to the cycle of readmissions.²⁴

This high rate of readmissions highlighted two critical flaws in the American health system: it was both exorbitantly costly and fundamentally uncoordinated. “Medical evidence shows that the patient’s success after discharge is a function of how well the entire care team communicates and engages the patient,” said CMS spokesman Peter Ashkenaz, “This can include a home health agency, a nursing home, a primary care physician, a pharmacist, or anyone else in the community.” Recognizing frequent readmissions as a problem of the entire community of providers rather than just the acute care hospital marked a pivotal moment in the quest for quality improvement—and not just cost control—in Medicare. “I’m not sure penalties alone are going to move the needle, but they have raised awareness and moved many hospitals to action,” Dr. Eric Coleman, an expert on hospital readmissions from the University of Colorado School of

²³ Dan Bowman, "Docs, Hospitals Should Share Responsibility for Readmissions," *FierceHealthcare* (Dec. 1st, 2009).

²⁴ Reichard, "CMS Pilot Sweats the Details of Cutting Hospital Readmissions."

Medicine, noted the significance of the initiative after observing a significant shift in the mindset of hospital executives due to the impending penalties. By ensuring smooth transitions from hospitals to skilled nursing care or home health care, the goal was to “yield sustainable and replicable strategies that achieve high-value health care for Medicare beneficiaries,” according to CMS Acting Administrator Charlene Frizzera.²⁵

The penalties were calculated on the readmission rates of Medicare patients suffering from heart failure, heart attacks, and pneumonia within 30 days from July 2008 to June 2011. When assessing these rates, Medicare considered the severity of patient conditions but did not factor in their racial or socio-economic statuses. Starting October 1, 2012, these penalties were applied by reducing the reimbursement for each claim a hospital submits. For instance, under the maximum penalty of one percent, a hospital billing \$20,000 for a stay would only receive \$19,800 from Medicare. To mitigate this issue, the CMS has also provided grants to help hospitals and community organizations with patient care coordination post-discharge. Across the country, over 2,000 hospitals, some of which are nationally acclaimed, faced penalties due to high rates of patient readmissions shortly after discharge.²⁶ “This combination of incentives and penalties should lead to better care after a hospital stay and result in fewer readmissions,” said the Obama budget proposal, “saving roughly

²⁵ “Medicare Announces Sites for Pilot Program to Improve Quality as Patients Move Across Care Settings,” *US Fed News* (Apr. 14th, 2009).

²⁶ Rau, “Medicare To Penalize 2,217 Hospitals For Excess Readmissions.”

\$36 billions of wasted money over ten years.”²⁷

The HRRP did see significant progress. In 2016, a study by the Schroeder Center for Health Policy showed that repeat visits for Medicare patients in Virginia were on the decline. Prof. Jennifer Mellor and her team examined the readmission rates of Medicare patients treated for certain conditions and found that after the HRRP went into effect, those treated for acute myocardial infarctions, or heart attacks, were 2.5 to 2.8 percentage points less likely to return to the hospital within 30 days following treatment.²⁸ Similar research published in the journal *Annals of Internal Medicine* and the *New England Journal of Medicine* also showed that the HRRP went well.²⁹ Furthermore, research from the University of Florida suggested that while the HRRP has effectively lowered readmission rates, it has not necessarily reduced mortality rates. Besides, larger hospitals saw more significant drops in readmissions compared to smaller ones, and areas with higher percentages of Hispanic and African-American populations noted larger decreases in readmission rates.³⁰ “Paying hospitals for how well they do, and not how much they do, [was] one of few elements [of the ACA] that [could] carry bipartisan support,” said Dr. Robert Yeh from the Beth Israel Deaconess Medical Centre.³¹

²⁷ Reichard, "CMS Pilot Sweats the Details of Cutting Hospital Readmissions."

²⁸ "Study Finds Decrease in Medicare Hospital Readmissions a Result of Affordable Care Act Penalties," *Medical Xpress* (Nov. 4th, 2016).

²⁹ Rachael B. Zuckerman et al., "Readmissions, Observation, and the Hospital Readmissions Reduction Program," *New England Journal of Medicine* 374, no. 16 (2016); Steve Sternberg, "Hospitals Reduce Readmissions in Face of Obamacare Penalties," *USNEWS.com* (Dec. 27, 2016).

³⁰ "New Insurance Data Have Been Reported by Researchers at University of Florida (Impact of the Hospital Readmission Reduction Program On Hospital Readmission and Mortality: an Economic Analysis)," *Health Policy and Law Daily* (May 30th, 2022).

³¹ Sternberg, "Hospitals Reduce Readmissions in Face of Obamacare Penalties."

Nevertheless, a distinct unintended consequence of the HRRP was that safety-net hospitals serving low-income communities—and often facing higher readmission rates—were hit particularly hard under the program. Addressing the post-discharge healthcare needs of the underserved, 80% of these hospitals saw of their Medicare funding cut due to penalties, highlighting a sharp contrast with the 67% of hospitals with fewer low-income patients penalized. The crux of the issue lay in how Medicare enforced its penalties; hospitals complained that Medicare was applying the rules more stringently than Congress intended and criticized its lack of consideration for the root causes of readmissions—disadvantaged groups tended to leave hospitals early to evade costly bills. Atul Grover, chief public policy officer for the Association of American Medical Colleges, regarded the HRRP as “a total disregard for underserved patients and the hospitals that care for them.” “It’s our mission, it’s good, it’s what we want to do, but to be penalized because we care for those folks doesn’t seem right,” said Dr. John Lynch, chief medical officer at Barnes-Jewish Hospital in St. Louis, which received the maximum penalty. “It’s really ironic that you penalize the hospitals that need the funds to manage a particularly difficult population,” said Blair Childs from the Premier healthcare alliance of hospitals.³² In this sense, through disproportionately affecting hospitals serving low-income patients the HRRP potentially undermined health equity for Medicare beneficiaries.

³² Rau, "Medicare To Penalize 2,217 Hospitals For Excess Readmissions."

In addition, 307 hospitals across the nation faced the stiffest penalty allowed by the HRRP, losing 1 percent of their Medicare payments. Among these penalized institutions were some of the country's leading hospitals, such as New Jersey's Hackensack University Medical Centre and Boston's Beth Israel Deaconess Medical Centre affiliated with Harvard Medical School. Interestingly, while these hospitals had a high rate of readmissions, they also boasted notably low patient mortality rates. According to Dr. Kenneth Sands from Beth Israel, the paradox was that only by readmitting and treating critical patients promptly could these hospitals excel in preventing potential fatalities.³³ This meant high readmission rates might not solely signify negative outcomes but could also reflect effective life-saving interventions. Yet overall, the ACA's penalty scheme provided hospitals with an appropriate financial incentive to prevent avoidable readmissions and accordingly shielded Medicare patients from premature discharge. Compared with neoliberal policies that redesigned medical providers' incentive as a tool of budgeting, the ACA demonstrated the core element of post-neoliberal citizenship—changing providers' incentive to achieve quality care, a clear shift of priorities. The next section also deals with incentive of medical providers. Yet compared with program to reduce hospital readmissions, the establishment of ACOs institutionalized such incentive change and marked a serious effort of the Obama administration to achieve long-term quality control of health care.

³³ Rau, "Medicare To Penalize 2,217 Hospitals For Excess Readmissions."

ACOs

James Conway, a 73-year-old Massachusetts resident who struggled with a set of health issues like high blood pressure, recurring urinary tract infections, and a condition causing fluid accumulation at his skull's base, was admitted in hospital four times in just one year. However, one day he found his pharmacists began to make house calls. They reviewed his long list of medications, reducing the number from eighteen to thirteen, and clearly explained the reason for each of the drugs he continued to take. They also gave him a spreadsheet to simplify and track his medication schedule. Additionally, a nurse started to coordinate his care to ensure each health professional and service operated in harmony. The nurse also facilitated the regular replacement of his catheter by an aide, which greatly reduced his risk of infection. This improvement in Conway's health care came about when his primary care doctor joined the Pioneer ACO, an initiative of the Boston-based Steward Health Care System. Consisting of 11 hospitals and a team of 2,900 doctors, the network tried to keep their 47,000 Medicare patients healthy and out of the hospital.³⁴

Conway's experience was part of a broader initiative to promoting health rather than just treating illness. The ACA introduced Accountable Care Organizations (ACOs) to bring together a group of hospitals, clinicians, and

³⁴ Ilene MacDonald, "Medicare ACOs growing faster than non-Medicare ACOs," *FierceHealthcare* (Aug. 21st, 2013).

other health care providers and let them coordinate and deliver high-quality care for their assigned Medicare patients while assuming clinical accountability and financial responsibility for the care delivered.³⁵ The word “coordinated” here means a formal legal structure that links providers along the care continuum (i.e., primary care, specialist, inpatient, post-acute, and outpatient care), and a highly integrated system where all stakeholders share a common point of reference for each patient to keep transactional costs to a minimum.³⁶ “ACOs were created to fill a void in the Medicare program,” said a report by the American Enterprise Institute. Traditional fee-for-service Medicare had no incentive to save costs; Medicare Advantage plans with capitated payments encouraged cost savings but sometimes at the expense of necessary care, yet “many hospital systems and physician groups believe[d] they [were] in a better position than insurers to manage the clinical process on behalf of patients. Medicare ACOs provide[d] them with the opportunity to form their own managed care arrangements separate and apart from the MA program.”³⁷ In its ideal form, ACOs would marry cost control with quality improvement in a way that was more aligned with patient and physician preferences—they allowed patients free choice of providers, set quality benchmarks and implemented protective

³⁵ They can take form of integrated delivery systems, multispecialty group practice, physician-hospital organizations, independent practice associations, and virtual physician organizations. For details on their differences, see “5 Types of Accountable Care Organizaitons (ACOs)”, accessed 12/10/2022, 2022. Andrew J. Barnes et al., “Accountable care organizations in the USA: Types, developments and challenges,” *Health Policy* 118, no. 1 (2014/10/01/ 2014).

³⁶ S. M. Shortell and L. P. Casalino, “Implementing qualifications criteria and technical assistance for accountable care organizations,” *Jama* 303, no. 17 (May 5 2010).

³⁷ “It’s time to revamp Medicare ACOs,” *US Official News* (Dec. 13th, 2017).

measures against the reduction of necessary care.

A typical ACO served 5000 Medicare beneficiaries and got payment from the Medicare Shared Savings Program (MSSP)—the program through which the ACO initiative operated.³⁸ Compared with the fee-for-service model, the MSSP calculates an initial benchmark cost based on Medicare expenditure on each beneficiary (i.e., the capitated payment) averaged three years prior to the ACO's establishment. The "shared savings" is achieved if the amount calculated is less than the national benchmark.³⁹ In fact, the capitation payment model has been a central part of managed care since the Health Maintenance Organization (HMO) Act of 1973. Yet HMOs are essentially insurance groups that contract with clinicians, while ACOs are clinician groups that contract with insurers.⁴⁰ This means HMOs prioritize cost control because they cannot make profits if the capitation fee is higher than the annual premium, but ACOs prioritize quality improvement because provider groups have a direct interest in improving performance, and can get rewards from patients as well as the MSSP program.⁴¹ HMOs combine the insuring of patients with

³⁸ There are three models for ACOs: the Pioneer ACO Model, the Advanced Payment Model, and the Medicare Shared Savings Program (MSSP)—the largest one. For details of different types and comparisons, see C. L. Schur and J. P. Sutton, "Physicians In Medicare ACOs Offer Mixed Views Of Model For Health Care Cost And Quality," *Health Affairs* 36, no. 4 (Apr 1 2017).

³⁹ Elliott S. Fisher and Stephen M. Shortell, "Accountable Care Organizations: Accountable for What, to Whom, and How," *JAMA : the journal of the American Medical Association* 304, no. 15 (2010).

⁴⁰ Managed care refers to a health care delivery system designed to manage health care cost and quality. On detailed analysis of its organization and types, see Chapter 3. R. G. Stefanacci and S. Guerin, "Calling something an ACO does not really make it so," *Managed Care* 22, no. 3 (Mar 2013).

⁴¹ Providers get financial rewards from patients due to market logic (people will always choose the provider with better service). For how MSSP rewards ACOs for quality improvement, see "ACO Narrative Measures," accessed 13/10/2022, 2022, <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/ACO-NarrativeMeasure-Specs.pdf>.

management of their health care, but ACOs do not provide insurance plans.⁴²

If an HMO is a company, an ACO is a labour union.

Such organization makes ACOs a central part of Obamacare to invest in quality care. ACOs bear less financial risk and are therefore less incentivized to reduce utilization of medical services to increase profits. This is because an overwhelming majority of ACOs (99.2% by 2015) have a “one-sided contract” with the MSSP, which means they will not be punished if the costs exceed the national benchmark but will get a bonus for cost control⁴³. ACOs also have more refined quality measurements. Each ACO’s integration is achieved through sharing of electronic records and syncing of operations, so that patients get more timely and targeted care while undergoing fewer duplicate checks and less tedious paperwork⁴⁴. “We all feel like we’re pioneering an effort to convert our health care system from purely volume-based to a more value-based approach,” said Jim Hinton, CEO of one of the Pioneer ACOs.⁴⁵ Five years after Obamacare went into effect, 480 ACOs had joined the MSSP, reaching one third of the beneficiaries in traditional Medicare, and by January 2024,

⁴² Elliott S. Fisher et al., “Creating Accountable Care Organizations: The Extended Hospital Medical Staff,” *Health Affairs* 26, no. 1 (2007).

⁴³ There is an alternative payment model known as “the two-sided ACO model”, in which providers also enjoy a shared savings but are required to refund the payer for a portion of the losses if the cost goes beyond the financial benchmark. Up till 2018 (the latest data available), among the 506 ACOs across the country, 460 ACOs have one-sided contract, and only 46 have two-sided contract. For details, see Medpac.gov, *Medicare accountable care organization models: Recent performance and long-term issues*, The Medicare Payment Advisory Commission (2018). For comparisons between one-sided and two-sided model, see Vicki Harter, “How ACOs can better manage two-sided risk,” *Health Management Technology* (Report), 2016 November-December, 2016, Gale.

⁴⁴ Jean Phillip Shami, “A promise realized? A critical review of accountable care organizations since the enactment of the Affordable Care Act,” *University of Miami law review* 71, no. 1 (2016).

⁴⁵ Julie Bird, “Pioneer ACOs Threaten to Walk,” *FierceHealthcare* (Mar. 7th, 2013).

nearly half of traditional Medicare beneficiaries (13.7 million) were in ACOs.⁴⁶ The data is an indicator of the program's viability in ensuring seniors' health rights.

However, controversy arose surrounding ACOs' rule for enrolling patients. The method is known as retrospective attribution, where patients are assigned to ACOs based on the primary care physician who has provided the majority of their primary care services. This means ACOs will not be aware of their specific patient responsibilities until six months into each annual cycle of a three-year contract. This does not affect patients' experience because CMS provides ACOs with data on their medical history, but the crux of the controversy lies in its reliance on compulsory participation rather than voluntary enrolment. Medicare beneficiaries are automatically assigned to ACOs based on their historical interactions with Medicare, particularly through claims made when visiting physicians who are ACO members. "These ACOs are transforming the way healthcare is delivered but many of the estimated 27 million people in ACOs aren't even aware they are in one," a report by U.S. News & World asserts.⁴⁷ Many seniors may wonder why their physicians and other care providers are suddenly more attentive to their needs. This time, being informed is not a prerequisite to claim health benefits.

Also controversial is ACOs' overlooking of surgical care. Despite the critical

⁴⁶ Medicare shared savings program fast facts, (Baltimore: Centers for Medicare and Medicaid Services, Jan. 2018). "About Half of Traditional Medicare Beneficiaries Are in ACOs, Says CMS," *Managed Healthcare Executive* (Jan. 2024).

⁴⁷ MacDonald, "Medicare ACOs growing faster than non-Medicare ACOs."

role surgeons play in patient care, a study published in *Health Affairs* finds that these organizations predominantly concentrate on managing chronic conditions, reducing hospital readmissions as well as cutting emergency department visits, while neglecting the strategic inclusion of surgical care. “Surgery was clearly not part of the strategic plans of any of the case study sites,” noted James M. Dupree, the lead author of the study and a former health policy fellow at the American College of Surgeons, “[t]ellingly, not a single interviewee could say-- or would even guess--how much of their ACO’s total expenditures were attributable to surgery.” Among the 59 Medicare-approved ACOs surveyed and interviewed by the researchers, 88% of respondents said they “didn’t know” about their ACOs’ expenditure on surgery, and 86% considered the reduction of unnecessary surgery a low or medium priority. Only a small fraction, 10%, viewed it as a high or very high priority.⁴⁸ Thus, contrary to Medicare’s historical emphasis on acute disease, ACOs placed their focus on chronic diseases.

This arrangement would undoubtedly be expensive. As a result, opposing voices soon appeared. In December 2017, an American Enterprise Institute released a report stating that ACOs failed to produce any savings for the federal government, and they “would become more efficient and innovative if they were forced to compete with the other options beneficiaries have for getting their Medicare-covered benefits”. The report highlighted that in 2016, after

⁴⁸ Ilene MacDonald, "Surgeons and Surgery are Missing Components in Medicare ACOs," *FierceHealthcare* (June 6th, 2014).

accounting for bonus payments for those ACOs with significant cost savings, the net increase in Medicare costs was \$39 million, continuing a trend seen in 2015 where ACOs increased Medicare expenses by \$216 million.⁴⁹ However, the fact is that with ACOs, Medicare's expenditure increased but did not increase as much as originally projected. In 2020, ACOs achieved gross savings of \$4.5 billion for Medicare, and net savings of \$2 billion after deducting the shared savings payments. This was remarkable because the savings came amidst the financial difficulties of the COVID-19 pandemic. "ACOs were proactive in their outreach to high-risk patients to keep them healthy, quickly established telehealth and remote monitoring capabilities to continue to provide care, and effectively managed home visits and post-acute care to reduce COVID transmission," according to the National Association for ACOs. The program managed to provide quality care during a time when public health was called into question.⁵⁰

Besides, it is worth noting that the American Enterprise Institute is a neoliberal think tank embracing only market-oriented options for health care.⁵¹ Their ideological bias easily explained their opposition to Obamacare, but the Obama administration explicitly demonstrated their commitment to keep ACOs as value-based provider networks. "Our team is dedicated to shifting how medicine is practiced in our community from reactive to preventive medicine,"

⁴⁹ "It's time to revamp Medicare ACOs."

⁵⁰ "CMS: ACOs saved Medicare \$1.6B overall in 2021 as big changes on the horizon," *Indian Health care news* (Sep. 2, 2022).

⁵¹ A brief history of health savings accounts, (National Centre for Policy Analysis (NCPA). 2013).

said Dr. Monzer Yazji from South Texas Clinical Partners ACO.⁵² The administration has also proved that ACOs were able to generate costs while providing quality care. In August 2017, the HHS Office of Inspector General reported that Medicare ACOs reduced spending by almost \$1 billion in the initial three years, achieving a cost reduction of \$673 per beneficiary for crucial Medicare services without compromising care quality.⁵³ Since the ACO program's inception in 2013, it has led to \$8.6 billion in savings for Medicare.⁵⁴ "Accountable Care Organizations are a true Affordable Care Act success story, and it is inspiring to see the results year after year," said CMS Administrator Chiquita Brooks-LaSure in a statement.⁵⁵

Overall, ACOs were by nature a quality improvement measure that dealt with the supply side of health care. Providers were encouraged to streamline payment for hospital care, primary care and other services to reduce administrative costs, build their health IT infrastructure, optimize post-acute care, and implement other cost management strategies. The 2014 quality and financial performance results by the CMS showed that ACOs managed to provide quality care for Medicare beneficiaries while generating financial savings, and the number of seniors enrolled in ACOs continued to grow. "These results show that accountable care organizations as a group are on the path

⁵² "Universal Health Services Accountable Care Organizations (ACOs) Saved Medicare \$79.6 million in 2022," *Contify Life Science News* (Sep. 19th, 2023).

⁵³ John Wilkerson, "HHS OIG: ACOs Saved Medicare Nearly \$1B In First Three Years," *Inside Health Policy* (Aug. 30th, 2017).

⁵⁴ "Universal Health Services Accountable Care Organizations (ACOs) Saved Medicare \$79.6 million in 2022."

⁵⁵ "CMS: ACOs saved Medicare \$1.6B overall in 2021 as big changes on the horizon."

towards transforming how care is provided,” said CMS Administrator Andy Slavitt. “Many of these ACOs are demonstrating that they can deliver a higher level of coordinated care that leads to healthier people and smarter spending.”⁵⁶ However, [a problem with ACOs was that individual, small-scale providers were put at a decided disadvantage. With its bundled payments determined by the average costs per capita, medical providers were incentivised to avoid sicker patients, provide fewer services to their patients, cut services that do not relate directly to measurable health outcomes; larger ACOs were more resourceful in coping with such risk.⁵⁷ No policy operates in a vacuum; it is to the compromises the ACA made that we now turn.

The Medicare Cut and Trade-offs of the ACA

In a 2009 interview with the American Broadcasting Company (ABC), Obama acknowledged that one-third of the ACA’s funding (\$716 billion) was derived from Medicare cuts. To finance a large number of subsidies associated with coverage expansion, the ACA not only reduced payments to many health care providers contracted with Medicare, including hospitals, nursing facilities and homecare providers in general, but also reduced Medicare Advantage (MA)

⁵⁶ "Medicare ACOs Continue to Improve Quality of Care, Generate Shared Savings," *States News Service* (Aug. 25th, 2015).

⁵⁷ Sean Petty, "The neoliberal restructuring of healthcare in the US " *International Socialist Review*, Features, no. 94 (2016), <https://isreview.org/issue/94/neoliberal-restructuring-healthcare-us/index.html>.

payment rates. “President Obama has a long history of launching shameful political attacks on Medicare—but he’s the only person in the race who has actually cut Medicare,” Republican Ryan Williams argued, viewing the \$ 716 billion cut as an infringement on seniors’ benefits.⁵⁸ Yet the Congressional Budget Office reported that such cuts added eight years on the life of Medicare.⁵⁹ The Obama administration also touted it as an achievement. “I’ve proposed reforms that will save Medicare money by getting rid of wasteful spending in the health care system,” said Obama, “Reforms that will not touch your Medicare benefits, not by a dime.”⁶⁰ This section explores the constraints of social citizenship. As detailed below, the ACA’s cut in Medicare has an undeniably negative impact on primary care and MA plans and potentially increased the Medigap premiums through benefiting the American Association of Retired Persons (AARP). Yet the legislation also “danced in chains” while expanding benefits for prescription drugs and simultaneously maintaining the pharmaceutical industry intact. It is such mixed effect of the ACA on seniors’ health rights that concerns this section.

Health rights and funding cuts

⁵⁸ "The Truth: President Obama Cut Medicare for Seniors," *States News Service* (Aug. 15, 2012).

⁵⁹ Brooks Jackson, ""The Promise That 'Benefits Will Remain The Same' Is Just As Fictional As The Town Of Mayberry," *FactCheck.org* (July 31st, 2010).

⁶⁰ "The Truth: President Obama Cut Medicare for Seniors."

When promoting the ACA, President Obama claimed “If you like your doctor, you can keep your doctor.” However, the fact was that the cuts to Medicare led to primary care payments plummeting to just 3.5% of total Medicare spending. As a result, the number of primary care doctors opting out of Medicare surged, from 130 in 2010 to an astonishing 7,400 by 2016 according to the Centre for Medicare Services. It was a stark revelation, especially given the established link between robust primary care funding and improved patient outcomes, higher quality of care, and reduced costs. Further illuminating this trend was research by the Rand Corporation, which scrutinized 16 million Medicare primary care visits across the country and found that primary care spending by Medicare oscillated between 2.12% and 4.88% of total medical and prescription expenditures. According to the study’s lead researcher, Dr. Rachel O. Reid, while there was no agreed-upon ideal percentage of medical spending for primary care, the allocation was significantly lower than what was previously estimated before the ACA. Paradoxically, the Obama administration tried to compensate for the loss by granting a 10% annual bonus for Medicare primary care doctors from 2011 to 2015, but private insurance companies such as Wellpoint were actually offering up to a 50% extra reward for managing patient care via “non-visits” —consultations over the phone rather than face-to-face interactions.⁶¹ In this sense, the incentives and dis-incentives in providing primary care both increased under the ACA, but Obama’s assurance that

⁶¹ "Obamacare Robs Medicare," *iOTW Report* (April 22th, 2019).

patients could keep their doctors seemed to ring hollow.

Another important change to seniors' health benefits was the Medicare Advantage (MA) plans. At the heart of ACA's strategy was a phased reduction—around \$200 million in ten years—in MA payments, which aimed to equalize government spending per beneficiary across MA and traditional Medicare. The law also put a mandatory cap on out-of-pocket expenses for members and prohibitions on charging more than Original Medicare for certain services. It mandated that plans allocate at least 85% of premiums to benefits, limiting the amount spent on marketing, administrative costs, and profits.⁶² Such changes generated fierce criticism because MA programs used to offer Medicare beneficiaries extra benefits to receive higher reimbursement rates than the traditional fee-for-service Medicare. These generous payments have been incentivising private insurers to provide a variety of plan options for Medicare beneficiaries. The cut led insurance companies to reduce the number of plans available for the 13 million seniors in the MA program, some 27% of all Medicare beneficiaries.⁶³ Besides, though the ACA offered bonus payments to plans that achieved high star ratings (4 out of 5) in their service quality, many plans hovering around a 3 to 3.5-star rating found it hard to endure long enough to

⁶² Danielle Kunkle, "Medicare Advantage after PPACA," *BenefitsPro* (2015).

⁶³ According to a MedPac report in 2010, the MA payment rates were almost 13 percent higher than the traditional FFS Medicare on estimated spending for comparable individuals, see Medicare Payment Advisory Commission MPAC, "Report to the Congress: Medicare Payment Policy," *MedPac* Washington, D.C. (2010).for more details. For the divergence between the general FFS Medicare payments and MA payment rates in different counties, see B. Biles, J. Pozen, and S. Guterman, "The Continuing Cost of Privatization: Extra Payments to Medicare Advantage Plans Jump to \$11.4 Billion in 2009," (2009).New York: The Commonwealth Fund.

attain the 4 to 5-star rating required for such a bonus.⁶⁴ Thus, despite Obama's statement that it was a cut to health care providers, not to Medicare beneficiaries, there has been a notable reduction in health care access.

Other evidence for such access decrease includes the Kaiser Family Foundation (KFF)'s report that some 500,000 beneficiaries had to seek new plans for 2014 due to their previous ones being discontinued. Although some believed that having too many plan options was confusing for beneficiaries and thought fewer choices might be better, those impacted actually faced challenges in finding new, suitable plans. Moreover, one MA plan leaving the market meant up to 15 percent of its in-network physicians would stop seeing Medicare beneficiaries. As a result, many MA plans chose to narrow their networks as a way to absorb funding cuts without drastically changing their benefit package. In this selective process, doctors who demonstrated cost-effective care practices were retained, while others were let go.⁶⁵ While the Secretary of Health and Human Services (HHS) Kathleen Sebelius funnelled \$8.3 billion into a "Medicare Advantage Quality Demonstration Project" shortly after the ACA took effect to give MA plans a soft landing and keep benefits changes to a minimum, the project only lasted for three years.⁶⁶ Over the long run, according to the Congressional Budget Office, the \$200 billion cuts would result in three million fewer enrollees in MA plans. "[The demonstration project]

⁶⁴ Kunkle, "Medicare Advantage after PPACA."

⁶⁵ Kunkle, "Medicare Advantage after PPACA."

⁶⁶ "ObamaCare's Hidden Medicare Advantage Cuts," *Congressional Documents and Publications* (Oct. 18, 2012).

is a gimmick that tries to cover up how the president's law devastates seniors' ability to get the care they need from the doctor they want at a cost they can afford," the remarks from Senator John Barrasso (Republican-Wyoming) were somewhat true for Obamacare's overall impact on health care access.⁶⁷

Interestingly, the largest beneficiary of Obama's strategy to "cut the waste in Medicare" was not seniors, but the AARP. The association was supposed to represent seniors, but in fact it made great profits by taking advantage of seniors' insurance gap.⁶⁸ The cut in MA plans drove millions of seniors towards Medigap supplemental insurance plans, a market where AARP held a significant 34% share. A 2011 report by the House Ways and Means Committee showed that based on low, mid and high-range estimates, AARP was expected to make an extra \$55 million to \$166 million in 2014 because of new members signing up for Medigap insurance after cuts to Medicare Advantage. Under the mid-range estimate, the AARP was positioned to earn over \$1 billion in the decade following Obamacare's implementation.⁶⁹ Despite calls by House Republicans urging the government to look into whether AARP's actions were more driven by political agendas or financial gains rather than the interests of

⁶⁷ The irony lies in how different ideological groups frame their arguments depending on the political climate. Barrasso as a Republican who traditionally advocate for smaller government and free-market solutions paradoxically positioned himself as defender of Medicare—a government-run program—when criticizing reforms like Obamacare. Similarly, the Tea Party's demand to "keep government out of my Medicare" reflected a misunderstanding of Medicare's structure as a government program. In this sense, The incongruity here suggested broad labels like "neo-liberal" or "conservative" to policy debates were often shaped by pragmatic and political considerations rather than consistent ideological principles. "Obamacare Devastates Medicare Advantage," *US Fed News* (Apr. 25th, 2012).

⁶⁸ Ted Abram, "AARP and Obamacare Prey on Seniors," *States News Service* (Sep. 29th, 2012).

⁶⁹ "AARP Profits from Obamacare at the Expense of American Seniors, New Report Shows," *States News Service* (Mar. 30th, 2011).

its members, there has been no public action on this issue.⁷⁰ “The AARP has become less advocacy group and more insurance company in modern times,” a politics-focused newspaper called *Say Anything* wrote, aptly capturing the consequences of mixing advocacy with financial interests.⁷¹

In this sense, the AARP’s ability to improve seniors’ health rights weakened as it became financially invested in private insurance markets. This turned out to be a major obstacle to the broader social investment project because the organization’s social responsibility and commitment to equitable access has largely been compromised. Moreover, this has reshaped social citizenship around individual financial contributions rather than collective health investment. Further to this point, there was substantial evidence that the AARP has made a “deal” with the Obama administration on the ACA. In November 2009, the Wall Street Journal exposed a series of emails between AARP officials and the White House, suggesting that AARP was acting more like a champion for Obamacare than an advocate for seniors. Among all interest groups, the AARP stood out as possibly the most passionate advocate for Obamacare. It dedicated \$121 million to supportive advertising campaigns and additional millions to lobbying for the legislation. In return, the Department of Health and Human Services (HHS) exempted Medigap providers from the rate review rules introduced in May 2011.

⁷⁰ Ryan Ekvall, "Conservatives flee AARP after Obamacare," *Newstex Blogs&Say Anything (North Dakota)* (Nov. 22nd, 2013).

⁷¹ "Lets Be Clear About Why The AARP Is Supporting Obamacare: Its About The Money," *Say Anything* (Nov. 25th, 2009).

The AARP as the nation's largest seller of Medigap plans was then shielded from the rigorous oversight that would now govern other insurance providers' rate increases, but other insurers lacking such exemptions must publicly detail and explain any increases in payment rates.⁷² In addition, there has been an apparent disproportionate allocation of Obamacare waivers to businesses in House Minority Leader Nancy Pelosi's district. This not only deepened suspicions of partisanship but led Obamacare critics to view the exemption from rate review rules as a sign of political favouritism.⁷³ Yet for seniors, this was simply another political manoeuvre exposing them to higher Medigap premiums and potentially harming their health rights.

Taking a broader view, the AARP's action was an explicit violation of seniors' social rights and social citizenship more broadly. The organization used to represent seniors, but in the case of Obamacare it at once posed a threat to their health rights and overlooked their democratic rights to voice their opinion on the legislation. For social citizenship, this meant a disjuncture between seniors' rights claiming and the power of a senior advocacy group. "AARP's membership had written to them on a repeated basis...[but] their mail still comes and it goes right into the trash barrel," said Phillip Owens, a veteran who served in both the U.S. Army and Navy. Shortly after the passage of Obamacare, he cancelled his 20-year AARP membership and became a state delegate for

⁷² "AARP: Obamacare For Thee, But Not For Me," *States News Service* (May 20th, 2011).

⁷³ Rob Port, "Shocker: AARP Gets An Obamacare Waiver," *Say Anything* (May 20, 2011).

the Association of Mature American Citizens (AMAC), which claimed over 1 million members by late 2013. Owens noted that AMAC was rapidly growing and attracting about 60,000 new members each month. “People are searching for alternatives,” said Owens. As reported by the Washington Business Journal, the organization lost three million members following the enactment of Obamacare in 2011. Out of these, an estimated 300,000 departures were directly attributed to the organization’s role in passing Obamacare. The Obamacare was therefore a watershed in senior advocacy, as it highlighted the disillusion of seniors’ rights claims through collective power—once seen as key to expanding welfare programs—in today’s complex political, budgetary, and medical environments. In this context, seniors’ actual needs and expectation for continued health care development has little traction in interest group negotiations and evolving policy priorities.

Another senior advocacy group called the American Seniors Association (ASA) also capitalized on such sentiment and attracted some 1.5 million members within two years after the passage of Obamacare. “We made an offer to anyone who cut their AARP card in half that we’d give them a year’s free membership,” said Randy Lewis, spokesman of the ASA, “We had to stop it early. I had too many 55-gallon trash bags full of AARP cards cut in half”. For seniors, conservative or liberal, the AARP changed from an independent entity to the seniors’ department of the Democratic Party. The backlash from AARP members was so strong that it prompted former executive vice president John

Rather to write a letter to a White House official, “Ann, I think we will try to keep a little space between us and the White House on the [Obamacare] issue. Our polling shows we are more influential when we are seen as independent, so we want to reinforce that positioning.”⁷⁴ Notably, the AARP was not the only association making deals with Congress; the pharmaceutical industry also participated in this game. To get the ACA passed, the Obama administration had to make concessions to the industry and win their support. This story was not just about Medicare reform—it was a tale of influence, economics, and the unforeseen consequences of intertwining the long-term protection of social citizenship with short-term financial gain.

Prescription Drugs

While Obamacare challenged many industries’ rules of the game, one player escaped that upheaval. The drug industry saw no structural reform disrupting its product pricing and profitability and was able to keep the most treasured prize it won in 2003—the non-interference clause in the Medicare Modernization Act (MMA), which prohibited the government from negotiating the prices of Medicare-covered prescription drugs with pharmaceutical companies. “Medicare sets prices for hospitals, doctors, for all kinds of services,” said Levitt, executive vice president of the Kaiser Family Foundation (KFF), “but

⁷⁴ Ekvall, “Conservatives flee AARP after Obamacare.”

drugs are the anomaly in Medicare.”⁷⁵ Lobbyists from Big Pharma, one of the largest lobbies in Washington, D.C., held that negotiating drug prices would ultimately harm patients by defunding the research and development of new drugs. Such sentiment has not only got them a promise to preserve the non-interference clause, but also a further protection about prohibiting the U.S. Department of Health and Human Services (HHS) from taking cost-effectiveness analysis as a basis for determining reimbursement and coverage. In terms of new proposals that could have harmed their profitability, such as importing medicine from other countries where they were sold at lower prices, the industry managed to kill them as well.⁷⁶ It was estimated that if Medicare negotiated the same drug prices as paid in Canada and Denmark, the federal government would save \$230 billion and \$541 billion, with beneficiaries saving \$48 billion and \$112 billion, respectively.⁷⁷ In a political system permeated by corporate interests, this surely demonstrates the sadly impoverished range of possibilities in health care reform.

Obama himself also had concerns about high drug prices, but the powerful pharmaceutical industry compromised his idealism. The sporadic attempts of President Nixon in the 1970s and Clinton’s failed attempt to introduce some government regulation of the drug prices in 1993-94 both demonstrated the

⁷⁵ Dan Diamond; Amy Goldstein, "A bitter pill: Biden suffers familiar defeat on prescription drug prices " *The Washington Post* (online) 2021, <https://www.washingtonpost.com/health/2021/10/29/biden-medicare-drug-negotiation/>.

⁷⁶ Starr, *Remedy and Reaction: The Peculiar American Struggle Over Health Care Reform*, 204.P. 204.

⁷⁷ Dean Baker, *Reducing Waste with an Efficient Medicare Prescription Drug Benefit*, Center for Economic and Policy Research (CEPR) (2013), <https://cepr.net/documents/publications/medicare-drug-2012-12.pdf>.

pharmaceutical industry's ability to dismantle a proposal. This was something Democrats in Obama and his fledging administration were acutely aware of and keen to avoid. They then worked out a deal with the pharmaceutical industry in the early stage of ACA design, promising not to initiate systemic change in drug regulations in exchange for an industry agreement to help the ACA get passed and support the individual market.⁷⁸ This was a mutually beneficial deal, for sure. For the Obama administration, the drug industry proved to be a powerful ally. It spent millions lobbying for the ACA's passage and sunk another \$150 million into an advertisement blitz promoting it: few players in the legislative process could amass so many resources promptly.⁷⁹ For drug companies, the ACA extended health insurance to nearly 50 million uninsured people and brought a huge new pool of potential customers, and it was claimed that high drug prices provided much of the funding and incentive to drug development and innovation. In fact, a golden decade for new drugs followed the passage of the ACA, as approvals by the Federal Drug Administration (FDA) rose from 21 in 2010 to 50 in 2021.⁸⁰ "The drug companies were first in line [during the negotiations]" said John McDonough, a top health policy advisor to the late Senator Ted Kennedy (D-Mass), "[...]they got a good deal they could live with

⁷⁸ Orestis A. Panagiotou et al., "Hospital Readmission Rates in Medicare Advantage and Traditional Medicare: A Retrospective Population-Based Analysis," *Annals of internal medicine* 171, no. 2 (2019), <https://doi.org/10.7326/M18-1795>.

⁷⁹ KHN, "Drug Industry To Spend \$150 Million To Support Obama In Health Overhaul Efforts," *Kaiser Health News*, Sunday, Aug 9 2009, <https://khn.org/morning-breakout/drug-industry-backs-obama/>.

⁸⁰ PharmaExcipients, "2021 FDA Approvals " (2021). <https://www.pharmaexcipients.com/news/2021-fda-approvals/>.

and stuck to it.”⁸¹

Still, the Obama administration managed to include a limited benefit in their health plan. The ACA greatly narrowed the so-called “doughnut hole” between \$2700 and \$6154—a coverage gap where patients had no reimbursement to pay their drug bills—by offering discounts on the cost for any brand-name medication and generics. The law has progressively provided more support for those who fall into the donut hole. In 2010, individuals who reached this coverage gap received a one-time rebate of \$250. The following year, the ACA introduced a 50 percent discount on covered brand-name drugs and covered 7 percent of the cost of generic drugs for those in the gap. By 2012, coverage for generic drugs in the donut hole increased to 14 percent. This support was slated to grow each year until 2020 when the coverage gap would be completely eliminated, and patients would just pay for 25% of their drug costs and get access to much cheaper medicine.⁸²

By March 2012, Medicare beneficiaries had saved \$3.4 billion in total on their prescription drugs. The Centres for Medicare & Medicaid Services (CMS) announced that just in the first quarter of 2012, over 220,000 beneficiaries saved an average of \$837 each after reaching the “donut hole.” This amounted to \$184.5 million in savings during those three months alone. These figures added to the momentum of the previous two years, where over 5.1 million

⁸¹ Brett Norman; Sarah Karlin-Smith, "The one that got away: Obamacare and the drug industry," *POLITICO* (online) 2016, <https://www.politico.com/story/2016/07/obamacare-prescription-drugs-pharma-225444>.

⁸² "Affordable Care Act Saved People on Medicare Over \$3.4 Billion on Prescription Drugs."

Medicare recipients saved more than \$3.2 billion on their medications.⁸³ By 2015, the total savings of seniors' spending on prescription drugs amounted to \$15 billion. In specific areas, 40,505 Medicare recipients in Arkansas enjoyed savings totalling \$31 million—an average of \$778 per beneficiary—in 2014.⁸⁴ In New Jersey, Medicare beneficiaries enjoyed nearly \$70 million in savings on their prescription medications in the first year of Obamacare, averaging about \$700 per individual. "I am incredibly encouraged to see seniors already reaping the benefits of health reform," said Senator Robert Menendez, "[t]hese numbers show seniors are getting real cost savings which is exactly what health reform was intended to do."⁸⁵ The achievements in Medicare drugs not only demonstrated the Obama administration's commitment to enhance seniors' health rights but set in motion a long-term plan generating savings for Medicare beneficiaries.

In sum, the Obama administration has been "dancing in chains" while expanding Medicare benefits. As president of the Kaiser Family Foundation, Drew Altman, stated in a commentary in the *Wall Street Journal*, "Attention is focused on Obamacare, but, like our political system generally, it is hard to move the health system dramatically left or right. If you cut through the political debate, there are ideas at play in the health system that liberals, moderates and conservatives should each like."⁸⁶ The concessions the Obama

⁸³ "Affordable Care Act Saved People on Medicare Over \$3.4 Billion on Prescription Drugs."

⁸⁴ "Obamacare saves Arkansas seniors millions in drug costs, preventive health care."

⁸⁵ "New Jersey Seniors with Medicare Saved \$70 Million This Year," *US Fed News* (Dec. 7th, 2011).

⁸⁶ Drew Altman, "What's trending in health care? Conservative ideas.," *Wall Street Journal*, July 14th

administration made to the AARP and the drug industry highlighted the ongoing challenge of balancing health reform goals with what was achievable in an era foreshadowed by neoliberal principles. Going back to our analysis on the \$716 billion cuts, the projected reduction in payment to MA plans meant that Obama has no intention to make the ACA a market-oriented policy—he stuck to this plan despite warnings from his actuary team that such cuts could lead to providers opting out of Medicare.⁸⁷ This largely made the ACA a post-neoliberal legislation in which value-based health care came to the fore. These negative impacts—decrease in the amount of primary care doctors and MA plans available on the market, as well as potential increase in Medigap premiums and the untouched ban on negotiating Medicare drug prices—were simply the trade-offs of leaping towards post-neoliberal paradigms in a neoliberal era.⁸⁸

Conclusion

2014.

⁸⁷ David Limbaugh, "Obama's Medicare Fear Mongering Will Drown in the Facts," *Creators Syndicate* (Aug. 15th, 2012).

⁸⁸ It is worth noting here that the growing polarization since the 1990s often overrode substantive policy considerations. The Republican Party has been persistent in their efforts to repeal the ACA regardless of any evidence or incentives that might align it with conservative principles, such as market-based solutions or state-level flexibility. The ACA in this sense showed how deeply entrenched opposition can persist despite demonstrable benefits or alignment with aspects of conservative ideology, such as promoting private-sector involvement in healthcare. On discussion over whether meaningful bipartisan cooperation is feasible even on issues where shared goals might exist, see Jacob Hacker and Paul Pierson., *Off Center: The Republican Revolution and the Erosion of American Democracy* (New Haven, Conn.: Yale University Press, 2005).

This chapter has tried to illustrate changes in the essence of social citizenship reflected in Obamacare. Social citizenship used to be demonstrated in *reactive* treatment of acute disease for Medicare beneficiaries, but Obamacare expanded preventive health care services to spotlight *proactive* investment into the future. By removing financial barriers to essential screenings and preventive measures, the ACA played a pivotal role in mitigating seniors' burden of chronic diseases and reducing Medicare costs. The substantial increase in the utilization of preventive services such as mammography screenings also enhanced health equity and seniors' health rights as a whole. The regulation on hospital re-admission rates was another measure of the Obama administration in this regard. Through financially incentivizing hospitals to reduce preventable readmissions, the HRRP promoted a shift towards higher quality, coordinated care, and patient satisfaction. This initiative also underscored the complexity of the Medicare system, where economic, social, and medical dynamics intersected. Additionally, the program's impact extended beyond the financial penalties and rewards and fostered a culture of accountability and continuous improvement among health care providers. It has prompted hospitals to invest in better discharge planning, patient education, and follow-up care, thereby reducing readmissions for conditions like heart attacks and pneumonia.

The ACO program further testified the transition of Medicare from a volume-driven model to one that values patient outcomes and cost-effectiveness. Despite issues such as automatic patient enrolment and

perceived neglect of surgical care, ACOs succeeded in streamlining medication management and improving care coordination while making significant savings. This success not only refuted criticism from sceptics but also solidified the role of ACOs in promoting a more integrated, patient-centred Medicare system. However, trade-offs of such a transition were also distinctive. Reductions in the number of MA plans available in the market and primary care doctor shortages starkly contrasted with Obama's promises of unchanged doctor-patient relationships and improved access to care. These policy shifts have inadvertently fuelled a significant migration of seniors towards Medigap plans, notably benefitting organizations like the AARP at the expense of broader, more equitable health care advancements for seniors. In this sense, the ACA somewhat set the most established senior advocacy group against American seniors by giving them an incentive to exploit the population they represent.

The strategic alliance between the Obama administration and drug companies was another trade-off in this regard. The ACA left the powerful pharmaceutical industry's pricing mechanisms largely untouched to get their support for the legislation in exchange. Yet the ACA managed to deliver tangible benefits within this constrained framework, notably narrowing the "doughnut hole" in Medicare Part D, and offered immediate relief to countless individuals struggling with high medication costs. Therefore, while the ACA's engagement with the pharmaceutical industry reflected the limitations of health care reform in the face of powerful corporate interests, it also demonstrated the

administration's adept navigation of political realities to secure key victories for American citizens. In this sense, President Obama is a pragmatist who managed to navigate through the complex landscape of post-financial-crisis health care system. The ACA actually appealed to all constituencies: seniors got more Medicare benefits, the AARP got many new customers, and hospitals got fewer uninsured patients, amongst other winners. As a plan that catered to a variety of interests, the ACA provided a political blueprint for expanding health coverage without generating fierce backlash.

In the end, the ACA neither voucherized Medicare altogether as conservatives wanted nor turned the American health care into a single-payer system according to liberal preferences. Instead, it aimed at giving major players in health care (hospitals, pharmaceutical companies and private insurance corporations) enough incentives to control costs, improve quality, and expand coverage. By doing so it also enriched the definition of health rights and social citizenship. The past decades have seen an emphasis on redistribution giving way to stark inequalities in income and wealth, and labour unions losing power to amplified corporate dominance of the political system.⁸⁹ It would be surprising if there has not been a shift in the way which health care is conceived as well. The crucial question is how to interpret the intent of health reforms while neoliberalism is on the wane. The next chapter illustrates this issue in greater

⁸⁹ Jacob S. Hacker, Suzanne Mettler, and Joe Soss, *Remaking America: Democracy and Public Policy in and Age of Inequality* (New York: Russell Sage Foundation, 2007).

detail. We will see that President Biden, then vice president in the Obama administration, largely adhered to President Obama's vision about a post-neoliberal Medicare system and continued investing in its organization and payment mechanism to enhance its effectiveness and affordability.

Chapter 7

Medicare Now and in the Future: Investing in Health in a Post-neoliberal Era

Barely hours into his presidency, Donald Trump enacted an executive order that set in motion his long-held vow to dismantle the Affordable Care Act (ACA).¹ The *New York Times* framed such action as a deliberate scaling back of his predecessor's signature legislation, and the *Washington Post* warned it might gut the ACA's crucial individual mandate and pose a threat to American citizens' health security, especially as the order's new agenda included measures to "waive, defer, grant exemptions from, or delay the implementation of any provision" in an effort to cut down on the costs and regulatory demands placed upon states, private insurers, and individuals. However, the executive order's language spoke to a deeper vision: a rollback of the government's reach with "a free and open market in...healthcare services and health insurance" but not necessarily a reduction in health care provision.² Many people believed President Trump deliberately drew a line between his strategy and that of Obama, especially as his signature legislative success, which slashed taxes for corporations and the affluent by a trillion dollars, brought about a budget hole

¹ Executive order minimizing the economic burden of the Patient Protection and Affordable Care Act pending repeal. , (Washington, DC: The White House January 20, 2017).

² Timothy Stoltzfus Jost and Simon J.D. Lazarus, "Trump's Executive Order on Health Care — Can It Undermine the ACA if Congress Fails to Act?," *New England Journal of Medicine* 376, no. 13 (2017).

ready to be used to justify healthcare cutbacks.³ However, Trump did vow— atypically for a Republican—to defend Medicare and to confront the pharmaceutical industry’s unpopular price hikes. As we shall see, despite his scorn for the ACA, he positioned himself as a Medicare populist.⁴ Just as prominent consumer advocate Ron Pollack concluded, the executive order was more theatrical than practical—a tempest in a political teapot.⁵

On January 20, 2021, Democrat Joe Biden was inaugurated as the 46th President of the United States on the very steps of the US Capitol engulfed by a violent insurrection just two weeks before. In a closely fought contest, his party also narrowly secured control of the US Senate and maintained a majority in the House of Representatives. However, even triple political victories could not guarantee smooth sailing for Biden’s health care agenda. The first year of his presidency saw no significant legislative progress to lower Medicare eligibility to 60 years or to introduce a public option that would offer an alternative to private insurance. The Build Back Better Act (BBBA), which passed the House with ambitious health policy reforms such as extended subsidies, improved Medicare coverage, and measures to curtail prescription drug costs, also hit a wall in the Senate.⁶ However, it was Biden who elevated

³ Deborah Stone, "Health Equity in a Trump Administration," *Journal of Health Politics, Policy and Law* 42, no. 5 (2017).

⁴ Steffie Woolhandler et al., "Public policy and health in the Trump era," *The Lancet (British edition)* 397, no. 10275 (2021), [https://doi.org/10.1016/S0140-6736\(20\)32545-9](https://doi.org/10.1016/S0140-6736(20)32545-9).

⁵ Jost and Lazarus, "Trump's Executive Order on Health Care — Can It Undermine the ACA if Congress Fails to Act?."

⁶ Jonathan Cohn, "What Biden's Record On Health Care Says About His Potential Presidency," *The Huffington Post* (May 31, 2019).

chronic disease to the centre stage of health reform, confronted the ban on Medicare to negotiate drug prices, and saw it through to the end. “He’s made it very clear that he wants to do things quite differently from his predecessor”, said Lanhee Chen, a public policy fellow at the Stanford University’s Hoover Institution.⁷ As the latter half of this chapter details, Biden might handle health care with caution, but his agenda in fact demonstrated an ambitious goal to shift American health care from treatment to prevention.

This chapter compares the health agenda of President Trump and President Biden to show two distinct features of post-neoliberal social citizenship: 1) a preference for incremental change and focused adjustment over radical transformation, and 2) a paradigm shift from neoliberalism as a “negative state theory” that advocates for the “minimalist state” to social investment that assigns the state a positive role and sees social welfare as an investment—not a cost—to future economic growth and social equality.⁸ Firstly, I show that despite their completely different approaches, Trump and Biden both fought against Medicare for All, a proposal by Senator Bernie Sanders on a national single-payer system based on traditional Medicare, and placed their bet on modest reform. Feasibility and expandability were always at odds, but in the 2010s this became crystal clear in Medicare. Some scholars called the

⁷ Tommy Christopher, "CNN'S Jess McIntosh Warns Biden 'Sounds Suspiciously Like Trump' on Medicare for All," *Mediaite* (July 16, 2019).

⁸ Nathalie Morel, Bruno Palier, and Joakim Palme, "Beyond the welfare state as we knew it?," in *Towards a social investment welfare state?*, ed. Nathalie Morel, Bruno Palier, and Joakim Palme, Ideas, policies and challenges (Bristol University Press, 2012); J. Jenson and D. Saint-Martin, "New Routes to Social Cohesion? Citizenship and the Social Investment State," *Canadian Journal of Sociology* 28, no. 1 (2003).

Trump and Biden years a period of “post-neoliberalism,” a time when “improved social equity goes hand in hand with economic efficiency.”⁹ Within our social citizenship framework, this marked a “post-cost-control” era where the focus shifted from emergency and acute care to a growing emphasis on preventive and palliative medicine. This shift in priorities became the central theme in health reform discussions, replacing budgetary concerns as the dominant discourse. The purpose of this chapter is to unpack this argument, subject it to scrutiny, and unravel its implications.

I then examine Trump’s reforms on Medicare regulation and Biden’s preventive measures for chronic disease, in particular Alzheimer’s disease that affected millions of seniors. These measures were their “investment” into Medicare that promised a more effective and efficient system with lower costs and more accessible health care. For sure, health care was not a domain where Biden had significant expertise, and during the first year of his presidency the administration was busy with the economic stimulus package called the Recovery Act. Additionally, Trump was often thought to be unpredictable in his decisions and statement. “He has no ideology,” Sanders contended, once joking that even though Trump had always been an ardent opponent against Medicare for All, we would see him championing the plan on Fox News the next

⁹ See, for example, Anton Hemerijck, “Two or three waves of welfare state transformation?,” in *Towards a social investment welfare state?*, ed. Nathalie Morel, Bruno Palier, and Joakim Palme, Ideas, policies and challenges (Bristol University Press, 2012); Jane Jenson, “Redesigning Citizenship Regimes After Neoliberalism: Moving Towards Social Investment,” in *Towards a social investment welfare state? Ideas, policies and challenges*, ed. Nathalie Morel, Bruno Palier, and Joakim Palme (Bristol University Press, 2012).

morning if he thought it would “get five more votes out of it.”¹⁰ However, this chapter draws out their commonalities in Medicare reform and discerns a pattern. This chapter thus goes beyond the concerns of seniors and addresses the interests of all Americans. The way individuals perceive and support the idea of Medicare for All is indicative of the way they view health rights and social citizenship more broadly.

Post-neoliberal Medicare: Adjustments Outweighed Sweeping Reform

This section details the attitudes of the Trump and Biden administration towards Medicare for All—a prominent proposal to establish universal health care based on traditional Medicare—and their own vision improving medical services for the elderly. The idea of complete government takeover in health care has been simmering for decades, but in the late 2010s it recaptured the nation’s attention. As citizens across the country found themselves facing increasingly burdensome medical costs even after the ACA took effect, Senator Bernie Sanders’s plan to create a single-payer system quickly found its receptive audience in the public and especially among the majority of Democrats. It was also endorsed by powerful interest groups such as the largest nurses’ union across the country and the American College of Physicians, a body

¹⁰ Leia Idliby, "Bernie Sanders Says Trump Would Support Medicare for All if He Thought He Could Get 'Five More Votes' Out of It," *Newstex Blogs* Oct. 16, 2020.

representing over 163,000 members.¹¹ At the heart of Sanders' plan was a simple yet revolutionary idea: a "Universal Medicare" card for every American that signified the end of an era for privately managed Medicare Advantage and military healthcare program TRICARE. "The country would end up with one health system," noted Donald Berwick, former president of the Institute for Healthcare Improvement. Such a transformative initiative would certainly be costly. According to a 2019 government report, it called for an increase in federal spending by \$20.5 to \$39 trillion over ten years, a sum to be raised through a combination of taxes: a 4 percent income-based premium paid by employees, a 7.5 percent income-based premium paid by employers, and progressive taxation measures that included higher taxes on the "extreme" wealthy—those making more than \$10 million a year.¹²

From another perspective, the appeal of Medicare for All lay in its promise to streamline the complex financing of health care. Should Medicare for All be implemented, there would be a staggering amount of savings—\$626 billion per year—simply by reducing the expenditures tied to medical billing and administration. The data was not something Democrats fabricated to trick people into voting for the bill; it was supported by several studies including 20 out of 22 economic reports, a policy piece in *The Lancet*, and estimates from the Congressional Budget Office. A common conclusion of these studies was

¹¹ Gail R. Wilensky, "Medicare for All," *The Milbank Quarterly* 97, 2 (2019).

¹² "Medicare For All: Everything You Need To Know," *Newstex Blogs: Medical Daily* Nov. 22, 2019.

that enacting a single-payer system could shrink overall health care costs while simultaneously extending coverage to every American—a dual achievement that had long eluded the health care system. Notably, a CBO report said Medicare for All would also “reverse the harmful shift toward the commercialisation of care that began in earnest in the 1980s” and “inaugurate a new era of respect for the human right to health and health care.”¹³ In a word, it promised to herald a new era—one where the right to health care was respected and safeguarded for every citizen.

The following part thus examines how Medicare for All was received during the Trump and Biden years. Medical professionals were not major players in this narrative because their viewpoint was never homogenous and coherent. This was evident from a Medscape poll which surveyed 1,306 healthcare professionals on their stance towards Medicare-for-All. The results showed doctors were often more supportive of the program than other health care providers. Still, the health care community as a whole remained closely split on the prospect of trading in private health insurance for a government-administered healthcare system—49% of physicians supported the idea, with nurses and advanced practice registered nurses slightly behind at 47%. Those involved in health administration and pharmacists were even more split, showing support at 41% and 40%, respectively.¹⁴

¹³ Woolhandler et al., "Public policy and health in the Trump era," 728.

¹⁴ Joanne Finnegan, "Poll Finds 49% of Doctors Support 'Medicare for All'," *Fierce Healthcare* May 30, 2019.

This lack of uniformity in opinion is further reflected in the position of the American Medical Association (AMA). Initially, the association adopted a firm public stance advocating for a blend of private and public insurance rather than Medicare for All. “We remain opposed to Medicare for All, and policies that reduce patient choice and competition, and are built on flawed financing policies,” said James L. Madara, AMA CEO and executive vice president. However, only two months after this statement the AMA dropped out of the Partnership for America’s Health Care Future, a coalition formed to fight against Medicare for All. The internal discord within the AMA became apparent during their annual meeting, where a group of doctors, nurses, medical students, and community activists organized a protest urging the AMA to support Medicare for All.¹⁵ In short, the AMA’s strategy for Medicare for All was characterized by ever-shifting positions and a lack of consensus between organization leaders and its members. We now turn to the government’s attitudes towards the proposal.

Trump and Medicare Advantage

Amidst a term often driven by bold decisions, Trump was particularly circumspect in his handling of Medicare reform. Yet he had ample reasons to tread carefully. Given the program’s resounding popularity—90% of seniors

¹⁵ Joanne Finnegan, "Opposition to 'Medicare for All' remains, but the AMA drops out of coalition fighting single-payer system," *Fierce Healthcare* Aug. 16, 2019.

praised their Medicare coverage - few politicians would risk irritating such a significant constituency. While politicians often criticized big health insurance companies for their deceptive marketing and the push for socialized medicine, Medicare remained lauded as a legislative masterpiece.¹⁶ Previous attempts by GOP leaders, such as Newt Gingrich and Paul Ryan, to scale back Medicare not only met with substantial public disapproval but also allowed Democrats to cast themselves as the defenders of the program. Additionally, for most part of his presidency Trump faced a notoriously divided Congress, with health care being predominantly associated with the Democratic Party. Therefore, while Republicans aimed to capitalize on the shortcomings of current health care system, they confronted the potential obstacle of being held responsible for any failures related to it.¹⁷ As a result, the strategy Trump adopted was to frame his plan on Medicare as the opposite of Medicare-for-All, embracing a neoliberal approach in a post-neoliberal era and going to great length to promote Medicare Advantage plans. By doing so, he aimed to thread the needle—appealing to a base that valued market-based solutions while avoiding the backlash that might come from directly confronting a system cherished by many.

This was Trump's signature style—painting policies with bold strokes regardless of their focus and framing them as a series of stark dichotomies: merits of the private market against socialized medicine, extremists against

¹⁶ Flaviu Simihaian, "Private Insurers Are Afraid of Medicare for All. They Should Be Excited," *Fortune* June 6, 2019.

¹⁷ Jonathan Oberlander, "Collision course? Donald Trump, Paul Ryan, and the fate of Medicare," *Journal of Aging & Social Policy* 30, no. 3-4 (2018).

citizens, international allies and associates against the United States, and of course, adversaries against himself.¹⁸ On Medicare, Trump envisioned health rights as something built on the effectiveness of the private market and fostered a perception of collective health security and support for any government takeover of health care as misguided and detrimental. The sentiments were so profound that his followers were deeply convinced that defying Medicare-for-All was not just urgent, but a moral obligation. “Medicare is under threat like never before,” said Trump at a 2019 rally in The Villages, Florida, a retirement community near Orlando. “These people on the other side are totally crazy, they want to take it away and give you lousy health care...it will definitely raid Medicare to fund socialism...[and] totally obliterate Medicare.”¹⁹ He invited Charles McLaughlin, a 71-year-old Marine veteran of the Vietnam War, to the stage and encouraged him to recall how useful his Medicare Advantage plan was when he was fighting another battle of his life—this one against cancer. “I know a lot about Medicare and the supplement, my family, financially, would have been destroyed without Medicare,” said the veteran, “The politicians on the left are pushing Medicare for All. I say, the result would be no Medicare at all. It will collapse under the load of the system...The lines would be incredible”. The rally then culminated with the issuance of an executive order with a proactive title “Protecting Medicare from Socialist Destruction.”²⁰ True to form,

¹⁸ Stone, "Health Equity in a Trump Administration."

¹⁹ Nicholas Sakelaris, "Trump Details Medicare Reform Plan, Says System 'Under Siege'," *UPI* Oct.3, 2019.

²⁰ "Democrats' Health Care Plan Would 'Totally Obliterate Medicare,' Trump Says," *Western Free Press (Arizona)* Oct. 3, 2019.

Trump was trying to equate support for Medicare for All with being morally irresponsible.

Importantly, Trump's vision for Medicare was surprisingly coherent across his tenure, especially as his personality often "trumped" his ideology.²¹ The goal was to gradually weaken traditional Medicare and shift toward more privatized options for seniors. On April 1st 2019, the Trump administration issued a new directive called "2020 Medicare Advantage and Part D Rate Announcement and Final Call Letter Fact Sheet" to enable MA plans to extend enrolment incentives, a privilege that was not afforded to traditional Medicare. Additionally, it approved a notable increase in the payment rates for MA plans by 5.62%, which was 1.02% higher than the previously calculated rate increase. This policy decision was consistent with earlier actions taken during the Trump administration—similar increases were also sanctioned in the years 2017 and 2018. Later in 2019, on October 3, Trump signed an executive order named "Protecting and Improving Medicare for our Nation's Seniors" to authorize MA plans to offer beneficiaries cash rebates, ensuring a level playing field between traditional Medicare and MA plans, and to ease the network adequacy requirements for MA plans and challenging state laws that limit hospital expansion. The order also called for removing unnecessary restrictions on private contracts between Medicare beneficiaries and healthcare providers,

²¹ Joshua Hart and Nathaniel Stekler, "Does personality 'Trump' ideology? narcissism predicts support for Trump via ideological tendencies," *The Journal of social psychology* 162, no. 3 (2022), <https://doi.org/10.1080/00224545.2021.1944035>.

broadening the use of Medical Savings Accounts and implementing market-based pricing for services in traditional Medicare.²² In other words, the Trump administration sought to accelerate the privatization of Medicare by bolstering MA plans.

Another goal of Trump in his health care blueprint was to use MA as a preventive measure. “We are making your Medicare even better,” said Trump at the aforementioned rally in Florida, “and Medicare Advantage should certainly be a model for health care reform.”²³ The statement explicitly suggested an attack against big-government health care and aligned with his aim to prevent greater costs in the future by investing in current Medicare system—the private part only. As a matter of fact, research from America’s Health Insurance Plans (AHIP)—a national trade association representing the health insurance industry—showed that MA plans were more effective at facilitating access to preventive healthcare services and played a significant role in reducing the likelihood of diseases and enables the timely identification of health issues. While AHIP’s research was somewhat biased due to its mission of advocating for the interests of insurance companies, there was still evidence that patients enrolled in MA programs made greater use of the medical services covered under these plans. CMS data spanning from 2016 to 2019 revealed that a larger proportion of individuals enrolled in Medicare

²² Woolhandler et al., “Public policy and health in the Trump era.”

²³ “Democrats’ Health Care Plan Would ‘Totally Obliterate Medicare,’ Trump Says.”

Advantage underwent preventive screenings for critical conditions such as breast cancer (73.3%) and colorectal cancer (38.9%), compared to those with traditional Medicare. Additionally, diabetes patients within the MA plans were more diligent in managing their condition, with higher rates of HbA1c testing and statin therapy adherence (83.4%) than their counterparts in traditional Medicare. This was largely because patients were more cost-aware in these plans.²⁴

With strong belief in MA's efficacy, Trump presided over a significant expansion in the MA sector and introduced 1,200 additional plans in the latter half of his term. He declared that this period was marked by a dramatic downturn in premiums, which fell by 28%, a figure unseen in over ten years and starkly contrasted the average premium increase of 54% for MA plans since 2014.²⁵ The data was testified by the federal Centre for Medicare and Medicaid Services. While the decrease rate slowed down after 2016, the Centre still found MA plans were 6% cheaper compared with their price in 2018 with increased benefits simultaneously.²⁶ "The president wants to build on the success they have had managing Medicare Advantage," said Robert Moffitt of The Heritage Foundation, "they have used the administrative authority to increase the plans for chronically ill people, such as people with congestive

²⁴ Briana Contreras, "Medicare Advantage Trumps Medicare in 2023," *Managed Healthcare Executive* (December 2023).

²⁵ "Why Trump's Medicare Reforms Offer Superior Alternative to 'Medicare for All'," *Western Free Press (Arizona)* Oct. 5, 2019.

²⁶ "Why Trump's Medicare Reforms Offer Superior Alternative to 'Medicare for All'."

heart failure or diabetes”. Moreover, Trump strengthened the use of telehealth options such as consultations via telephone or internet-based platforms. The intent was to alleviate the burden on emergency services by offering an alternative, cost-efficient solution for handling minor health issues and thereby saving costs of emergency treatment.²⁷

It was clear that Trump had put his bet on MA plans to contain costs and improve quality of health care, but the strategy was a hard sell. President of Social Security Works—an advocacy group dedicated to protecting Medicare and Social Security—Nancy Altman denounced MA as a vehicle for enriching for-profit entities at the public’s expense and a deliberate strategy to wean seniors off traditional fee-for-service Medicare. “Medicare Advantage is a hustle designed to allow for-profit corporations to suck up public dollars,” said Altman. Republicans have been shovelling money into MA programs and allowing them more flexibility in offering benefits that traditional Medicare was forbidden from covering since the 1980s, but “under the Trump administration, the thumb on the scale has turned into an entire arm,” in Altman’s words. In particular, Altman pinned her critique of MA plans on their narrow range of options and tried to make their efforts sound like desperate attempts to boost conservative ideology. “They [The Trump executive staff]’ve been flooding seniors’ inboxes with advertisements for Medicare Advantage...What these emails don’t mention is that Medicare Advantage plans often have narrow networks, restricting which

²⁷ "Democrats' Health Care Plan Would 'Totally Obliterate Medicare,' Trump Says."

doctors and hospitals patients are allowed to use". Her viewpoint was also supported by a 2019 government report that demonstrated MA plans often unjustly denied care in order to increase their profit margin. This tactic, she asserted, disproportionately harmed the frailest of seniors and compelled those who were most in need of comprehensive care to drop out of their MA coverage. These unintended consequences later turned out to be major obstacles promoting MA plans under the Trump administration.²⁸

Such attacks even went beyond the Trump's tenure and culminated when Representatives Pramila Jayapal (WA), Rosa DeLauro (CT), and Jan Schakowsky (IL), along with 60 other lawmakers, urged the Centres for Medicare and Medicaid Services (CMS) to implement crucial changes to Medicare Advantage (MA) plans in February 2024. The effort was also endorsed by advocacy groups including Social Security Works, People's Action, and National Union of Healthcare Workers, etc. "As a physician, and especially as a gynecologic oncologist, I have personally seen...narrow networks and onerous prior authorization requirements lead to needless patient suffering and damaging delays in treatment," said Dr. Diljeet Singh, vice president of Physicians for a National Health Program (PNHP), "These practices exemplify the damage corporate-controlled Medicare Advantage plans can cause to patient care, all in the pursuit of increasing profits for insurance companies."²⁹

²⁸ "Social Security Works Issues Statement Critical of Trump Medicare Advantage Executive Order," *Targeted News Service* Oct. 4, 2019.

²⁹ "Jayapal, DeLauro, Schakowsky Lead Effort to Protect Enrollees on Medicare Advantage," *Congressional Documents and Publications* Deb. 29, 2024.

However, it is worth noting that what these organizations advocated for—Medicare for All as a system based largely on traditional Medicare—also had distinctive shortfalls. There was substantial evidence that the financial strain on Medicare was largely attributable to Medicare Part A (for hospital services). Last year, this segment of Medicare suffered a \$3 billion shortfall, and forecasts suggested the hospital insurance trust fund would run dry by 2028. In contrast, a Milliman study showed that MA plans actually offered a better return on every dollar spent by the government compared to traditional Medicare. Milliman has calculated that the combination of lower out-of-pocket costs and supplementary benefits equated to an additional value of \$123 per enrollee each month, with \$48 attributable to decreased cost sharing for covered services, and \$76 due to benefits not included in traditional Medicare. Overall, MA plans contributed an extra \$32.5 billion in value to both the federal government and their beneficiaries.³⁰ Yet this also struck at the core of social citizenship. To maximize financial returns, a risk management approach often entailed denying care to those who require the most medical services. Conversely, ensuring positive health outcomes necessitated significant expenditure without concern for cost efficiency, or selectively prioritizing certain services based on political or social considerations (as was often the case with emergency care or eldercare, such as in the UK). These two models—one focused on cost control and the other on broad health equity—are inherently at odds, making it difficult

³⁰ "Medicare Advantage Report Ignores Benefits of Competition in Program," *States News Service* Feb. 7, 2024.

to reconcile them through the concept of “value for money.” Ultimately, one group was invariably disadvantaged under either approach. Making MA plans the selling pitch thus called into question the issue of equity in health rights.

Additionally, a commentary in the *Fortune* magazine suggested that broadening Medicare could in effect enlarge the MA program at the same time. If Medicare’s reach were extended from 60 million to all 327 million Americans, the Advantage market would see an unprecedented nearly sixfold increase. Such an expansion would immensely benefit private insurers like UnitedHealth, Humana, and CVS Health, which offered Advantage plans. When Sanders first proposed his Medicare for All plan, most Democrats in the White House showed some support largely because they saw it as an expansion of current Medicare. Other, similar proposed plans also somewhat indicated this trend. Amy Klobuchar aimed to broaden Medicare but keep private insurers, and Elizabeth Warren envisioned a Medicare for All with a temporary role for private insurance. Joe Biden’s proposal allowed a Medicare-like option for all (detailed in the next section). Implementing these expansion plans would likely not just preserve but significantly bolster the Medicare Advantage sector.³¹ Therefore, the irony here is that Medicare for All as a policy designed to increase government-provided health care could actually lead to a further privatization of Medicare.

In this sense, while Trump spared no efforts in promoting MA plans as a vehicle for his vision of “a more personal, affordable and patient-centric

³¹ Simihaian, "Private Insurers Are Afraid of Medicare for All. They Should Be Excited."

Medicare,” people on the opposing side kept emphasizing the limited choices on hospitals and doctors, a trade-off of the “one-stop shopping” provided by MA plans.³² Both camps were cherry-picking facts to win people over, and both claimed their plan to be the only way to bring seniors actual benefits and ensure their health rights. Health rights in this period were thus largely a baby-doll dressed at the whim of others; it was redefined with different focal points each time politicians and organization leaders tried to sway the populace to their side. Overall, during the tenure of the Trump Administration, the subtle bias favouring Medicare Advantage became overtly aggressive. Warning that Medicare for all would mean “massive rationing of health care” and “long waits for appointments and procedures”, Trump chose a path that sought to balance innovation with preservation.³³ His advocacy for Medicare Advantage plans and telehealth services, coupled with his vocal opposition to Medicare-for-All, underscored his strategy to modernize and privatize aspects of the system without dismantling a program integral to the well-being of millions of Americans. It is Biden’s reaction to such strategy with which the next part is concerned.

Biden and the Public Option

In a Thanksgiving weekend of 2023, Trump blindsided his own aides—and

³² "Trump sells Medicare changes in red, white, gray GOP stronghold," *The Breeze: James Madison University* Oct.4, 2019.

³³ Jonathan Cohn, "Donald Trump Attacks 'Medicare-For-All' With Rambling, Dishonest Rant," *The Huffington Post* Oct. 10, 2018.

much of the Republican establishment—by announcing his plan to get rid of the ACA. While many Republicans refused to comment, Trump reiterated his stance in Iowa and allowed Florida Governor Ron DeSantis to promise on a “Meet the Press” event held by the National Broadcasting Company (NBC) that the administration would “replace and supersede” the ACA with a “better plan” that would be unveiled next year. This unexpected move of Trump caught the Biden administration off guard and prompted them to accelerate their timeline on health care reform, which was supposed to feature in Biden’s 2023 State of the Union address. “We’ve learned a lot in the last couple of years about how important health care is and lowering health care costs are to the American people,” said a senior adviser to Biden, “And this is an area of deep resonance and frankly a deep contrast between us and really extreme Republicans who...have voted against these [health care] provisions.” The Biden administration was planning to use Trump’s bold statement as a chance to distinguish their stance. However, despite their emphasis on health rights, neither Biden nor his re-election campaign has laid out concrete proposals for a second term by the decidedly late date of December 2023. Instead, they kept the focus on attacking Trump and planned to tout Biden’s achievements on social provision to “attack Trump all at once,” said an official in Biden’s team.³⁴

This was just a snapshot of the contest between Democrats and

³⁴ “Biden’s Prescription for 2024 Turnaround will Include Major Health Care Focus,” *CNN Wire* Dec. 4, 2023.

Republicans on health care. As detailed below, social citizenship in the post-neoliberal era was often framed in a flexible way that served the purpose of different parties' current endeavour. While both camps used the "Medicare" approach to take advantage of senior people's fear that they would face higher costs and less generous benefits of Medicare, they referred to it with completely different focal points. The Trump administration kept emphasizing the flexibility and efficiency of private plans, while the Biden administration emphasized the significance of having a government-run option to enhance people's choice. Some interest groups also joined this debate. David Wichmann, CEO of the United Health Group, a company with an insured customer base nearly as large as Medicare's, contended that Medicare for All would "surely jeopardize the relationship people have with their doctors, destabilize the nation's health system, and limit the ability of clinicians to practice medicine at their best."³⁵ Tailoring to individual patients' needs rather than adhering to a one-size-fits-all approach was also emphasised in the 2010s. Yet the common ground of these ideas was targeted reform instead of complete overhaul of the current system.

Before probing into Biden's specific strategy on Medicare, it is useful to see competing views on the best way to serve American citizens in this era. An apt example was the advocacy for a third option in addition to expanding the private market and complete government takeover. In the closing months of 2019, the

³⁵ "Speaker Gingrich Announces Support for Job Creators Network Foundation's 'Healthcare for You' Reform Framework," *Targeted News Service* Nov. 8, 2019.

Culinary Union—a powerful force in the Nevada Democratic caucuses—declared their opposition against Medicare for All on the grounds that it would sever the sacred bond between doctor and patient, a bond defined by trust and personalized care. “It would be a health care disaster for American workers and their families,” Alfredo Ortiz, President and CEO the Job Creators Network, shared the Union’s view. Notably, the Job Creators Network as a leading advocate for small businesses had been confronting socialist health care through their innovative plan, “Healthcare for You” since 2018, which was “personalized healthcare that [gave] patients maximum choice and control and protect[ed] the all-important doctor-patient relationship for themselves and their families—the opposite of Medicare for All,” in Ortiz’s words.³⁶ The plan also won support from Newt Gingrich, the ex-House Speaker known for his pivotal role in solidifying the Republican party in the 1990s through strategies like opposing the Clinton health plan.³⁷ Evidently this period saw the resurgence of the health care debate, with competing parties armed with statistics and reform proposals, each claiming that only their plan could steer the American health care system in the right direction.

This was also a time when the future of American health care became very much elusive for the public. A 2019 survey by the Kaiser Family Foundation

³⁶ This format was not new, for sure, unions had been having collectively bargained deal since the 1940s. In this case it was simply another alternative to Medicare-for-All. "Job Creators Network Affirms Culinary Union's Strong Opposition to Medicare for All," *Targeted News Service* Feb. 20, 2020.

³⁷ "Speaker Gingrich Announces Support for Job Creators Network Foundation's 'Healthcare for You' Reform Framework."

revealed that while 56 percent of Americans initially supported Medicare-for-all, public opinion was highly responsive to the details of the proposal. Approval increased to 71 percent when the survey narrative positioned Medicare-for-all as a vehicle to enshrine health insurance as a universal human right. Similarly, the prospect of reducing premiums and out-of-pocket costs got 67 percent approval. However, the endorsement saw a precipitous drop to a scant 26 percent when people were informed that a government-run system might lead to delayed healthcare services, and to 37 percent if the plan meant higher taxes. “The issue that will really be fundamental would be the tax issue,” said Robert Blendon, a professor at the Harvard T.H. Chan School of Public Health. Yet taking a broader view, the major ebbs and flows in public opinion showed that the debate over how the country’s health care would develop was far from settled, especially as the outbreak of Covid-19 led many people to favour government intervention in health care. “You immediately see that opinion is not set in stone on this issue,” said director of the Kaiser poll Mollyann Brodie, “It’s a key issue for Democrats going into the 2020 presidential election...Any public debate about ‘Medicare-for-all’ will be a divisive issue for the country at large.”³⁸

It was within this context of fluctuating approval ratings that Biden’s careful positioning became evident. During the 2020 presidential campaign, three out of four candidates in the top tier publicly demonstrated their support for

³⁸ "Poll: Support for 'Medicare-for-all' fluctuates with details," *Medical Xpress* Jan. 23, 2019.

Medicare for All. Apart from the program’s architect Senator Sanders, Senator Elizabeth Warren of Massachusetts also advocated for the complete abolition of the private health insurance industry and specified her vision for Medicare for All. Senator Kamala Harris of California joined Sanders and Warren on the frontlines during the first Democratic debate, though with a more fluid and less defined position compared to her colleagues. Only then former Vice President Joe Biden stood firmly against the idea of government-run health care. “I don’t know why we’d get rid of what in fact was working and move to something totally new,” Biden recalled the effectiveness of the ACA in a 2019 gathering in New Hampshire.³⁹ In fact, Biden “sound[ed] suspiciously like Trump” on Medicare for All when he proclaimed “Medicare goes away as you know it. All the Medicare you have is gone,” as noted by former Hillary Clinton senior adviser Jess McIntosh.⁴⁰ Therefore, around the same time when Trump was whipping up seniors’ anxiety about Medicare for All, Biden was also “fearmongering” in order to promote his own vision for the American health care system.

Specifically, Biden proposed a public option that was based somewhat loosely on Medicare, to compete with private health plans in the exchanges—new marketplaces where people could go and select their own health plans, a gentle yet firm nudge against the private insurance market. Financial relief was a cornerstone of this plan—governmental financial aids would be channelled

³⁹ Chris Cillizza, "The danger for Democrats in 'Medicare for All'," *CNN.com* July 22, 2019.

⁴⁰ Christopher, "CNN'S Jess McIntosh Warns Biden 'Sounds Suspiciously Like Trump' on Medicare for All."

into ACA exchanges and swollen with subsidies that would lower premiums and expand coverage. Biden's plan also included a part known as "Medicare for More", which gave near-seniors, those aged 55-65 navigating the precarious waters between private insurance and senior care, a green light to claim Medicare benefits earlier than ever before. In terms of social citizenship, Biden has made "choice" his selling pitch, a tactic usually employed by Republicans when they tried to promote the private sector. "If the insurance company isn't doing the right thing for you, you should have another choice," Biden said in his first major address as a 2020 presidential candidate in April 2019.⁴¹ Such a plan was justified on the grounds of its dual effect. "The choice people make between private plans and a public one is likely to function as a check on both," said Robert Reich, labor secretary under Bill Clinton, in a *Wall Street Journal* piece, "Such competition will encourage private plans to ... [offer] more value at less cost ... [and] encourage the public plan to be as flexible as possible."⁴²

Compared with Medicare for All that entailed a transformative change, Biden's plan was only a supplement to the current system. The proposal by Warren and Sanders promised a health care Utopia—free at the point of service, enriched with comprehensive care, and financially backed by the government coffers. "Medicare for All is about the same price as our current path—and cheaper over time," Warren pledged to generate \$20.5 trillion in

⁴¹ "2020 Candidate Joe Biden Backs Medicare Public Option: 'You All Should Have a Choice'," *Newsweek* Apr. 29th, 2019.

⁴² Jacob Fridman, "A Better Consensus: Let's do a public option instead - The Tufts Daily," *Tufts Daily: Tufts University* Nov. 17, 2021.

revenue over a decade without levying a single penny of additional tax on the middle class.⁴³ By contrast, according to Jacob Hacker, architect of the idea of public option, Biden's plan was in fact characterised by "three Bs": a Medicare-like plan that would back up the failure of private plans; a benchmark for its counterparts in the insurance market; and a backstop to enhance cost containment in the long run.⁴⁴ This aligned with Biden's statement in a 2019 presidential forum held by the AARP: "The transition of dropping 300 million people on a new plan—totally new—is, I think, kind of a little risky at this point."⁴⁵ Just as Hacker commented, "US social policies have often started small and grown bigger over time, there was good reason to think that a public option would expand and become more robust."⁴⁶ In this sense, with a single-payer system on the one end and a much narrower measure relying on the private market—the aforementioned strategy of Trump—on the other, the public option stood anywhere in between the poles.

Setting partisan conflicts aside, the public option might well be seen as a part of the post-neoliberal health reform agenda—one without radical changes so commonly promised by neoliberal agendas. "He definitely believes it's a moral imperative [to have universal health care]," said one official who worked

⁴³ "Elizabeth Warren reveals long-awaited plan to fund Medicare for All," *Salon.com* Nov. 1, 2019.

⁴⁴ Jacob S. Hacker, "Between the Waves: Building Power for a Public Option," *Journal of health politics, policy and law* 46, no. 4 (2021), <https://doi.org/10.1215/03616878-8970739>.

⁴⁵ "President Trump Doubles Down On Racist Politics; Biden And Sanders Battle Over Health Care; Missing Camper Found Alive. Aired 5:30-6a ET," *CNN Early Start* July 16, 2019.

⁴⁶ S. Hacker Jacob, "The Original – And Still the Best?: The Health Insurance Public Option and the Politics of Social Reform," in *Politics, Policy, and Public Options*, ed. Ganesh Sitaraman and Anne Alstott (Cambridge University Press, 2021), 85.

closely with Biden previously in the Obama administration, “But he’s also somebody who doesn’t like to over-promise. He doesn’t want to say chicken-in-every-pot on health care because he doesn’t think he can deliver”⁴⁷. Biden’s plan was clearly a pragmatic one. “It’s fair to say that Biden did not have a comprehensive health reform plan like Obama and Clinton,” Larry Levitt, senior vice president of the Kaiser Family Foundation, said Biden’s plan was “more like a collection of incremental measures.”⁴⁸ This also explains why Biden refused sweeping renovation of the current medical system, even though his way of talking people out of Medicare for All was almost the same as that of Trump. “The Democratic Party’s so-called Medicare for All would really be Medicare for None,” a classic Republican tactic straight out of 2008 Republican vice-presidential nominee Sarah Palin’s heinous “death panels” playbook. Throughout his presidential campaign, Biden had been using variations of this line at public events and during press interviews to foment discontent among older Americans that anyone else’s gains come at their expense.⁴⁹ Interestingly, two Presidents from the opposing side of the political spectrum both wielded not a sword of radical reform like Sanders’ Medicare for All, but rather a shield to protect the familiar.

To conclude, both Trump and Biden based their vision for health care on

⁴⁷ Cohn, "What Biden's Record On Health Care Says About His Potential Presidency."

⁴⁸ Jonathan Cohn, "Ex-White House Official: Joe Biden Launched a 'Tirade' Against Obamacare," *The Huffington Post* (May 31, 2019).

⁴⁹ Christopher, "CNN'S Jess McIntosh Warns Biden 'Sounds Suspiciously Like Trump' on Medicare for All."

the current health care system and rejected transformative changes. Biden's public option promised minimal disruption compared to Sanders' plan, which expected a wholesale transition to a government-run health care system within four years—a formidable task by any measure. The public option provided Americans with another choice, enabling them to select between private insurance or a novel government-run plan. The idea was proved to be attractive. In March of 2019, Morning Consult polling showed that more than two-thirds of all voters backed a public option, and over half supported Medicare for All. Even a slight majority of Republican voters supported a public option, compared to less than 30% approval for Medicare for All. However, just as reporter Sarah Kliff said in an interview on Biden's health plan, "things that are the advantage are the exact same things that are the disadvantage."⁵⁰ While the public option sought to enhance citizens' health rights at controllable costs, it also perpetuated a system that itself prevented it from achieving these goals. Additionally, the plan failed to exert comprehensive regulation over healthcare costs and accordingly failed to address the pervasive issue of unexpected medical billing, an issue frequently lamented by consumers. The next section thus shows how Biden navigated his plan's drawbacks by providing targeted reform on Medicare drugs.

⁵⁰ "Examining Biden's Health Care Pitch," *Weekend Edition Sunday* (Jul. 21, 2019).

Investing in Medicare: Prevention against Short-termism

In a pivotal forum held by the Kaiser Family Foundation during his 2008 presidential campaign, then Senator Biden defended his health care strategy that was anchored in a proactive, prevention-focused approach. Specifically, it suggested a paradigm shift from reactive treatment to proactive prevention with a rationale that while preventive care might incur upfront costs, it could potentially reduce the more significant expenses associated with managing chronic diseases in their advanced stages. “The problem with the mentality of American insurance company is that they always think about the next quarter,” Biden championed a long-term view amidst skepticism from economists (“a dollar spent on prevention today could be more than a dollar spent on treatment tomorrow”). “Very seldom does anybody think about the next year, the next 5 years, the next 7 years. And if we can get these costs under control, it seems to me that you got to be investing now.”⁵¹ Thirteen years later, President Biden did keep his promise by investing in medical research, capping the price of some Medicare drugs and improving care for Alzheimer’s disease. In fact, as detailed below, President Trump also enacted regulations that prevented future increase in Medicare drug prices and invested in the current system to improve its efficiency. Since 2017, Medicare has seen constant changes in its coverage

⁵¹ KFF, “2008 Presidential Candidate: Joe Biden (Youtube video),” (<https://www.youtube.com/watch?v=XAOOv4wvT7Y&app=desktop>, 7 Sept. 2011).

and operation guidelines; all promised improvements in health security of the elderly in the long term.

Trump's strategy on social investment was largely characterized by institutional change. In September 2019, Trump signed an executive order targeting the excessive regulatory and bureaucratic workload in Medicare that drew a doctor's attention away from their patients. "Right now, clinicians recording office visits to bill Medicare have to wrestle with guidelines from the 90s," Seema Verma, administrator of the Centre for Medicare and Medicaid Services, wrote in a tweet. Medicare's billing manual had seen no substantial revision since 1997; its outdated billing practices were not only incompatible with the efficiencies of modern digital tools but also imposed a burden on clinicians who were compelled to comply with procedures created in an era of pen-and-paper record-keeping. During the Trump years, physicians often found themselves dedicating twice the amount of time to computer-based tasks as compared to direct patient care. Add to such imbalance was additional clerical duties that often spilled into the time beyond regular working hours.⁵² "CMS is bringing their lives into this century by proposing to adopt coding guidelines up to date with today's medicine," Verma said, emphasizing that the administration had taken into account not only the billing procedures but also the clinical workflow, and therefore introduced a well-rounded set of directives aimed at reducing the regulatory demands imposed on clinics and easing the

⁵² "Why Trump's Medicare Reforms Offer Superior Alternative to 'Medicare for All'."

administrative load on healthcare providers.⁵³ In practice, this means a more functional Medicare system with less paperwork and accordingly less expenditure in administration—a high-yield investment in the long term.

Another notable action of Trump's "investment" in Medicare was about prescription drug prices. On July 24, 2020, Trump signed four orders asking the Secretary of Health and Human Services to ensure that American patients would benefit from lower costs on essential medications, such as insulin and epinephrine, and that drug prices in the United States would be competitively priced, matching the lowest prices found in other economically similar OECD countries. In particular, one order targeted the shadowy rebate system where middlemen thrived on backroom deals and kickbacks while patients fell prey to high out-of-pocket expenses at the pharmacy counter. According to a government report, these rebates even amounted to \$30 billion in 2018 and translated into discounts of 26 to 30 percent for consumers.⁵⁴ The new measure was clearly set to redirect these substantial savings directly to American seniors through Medicare Part D plans and provided them with much-needed relief in their healthcare costs. Thus, instead of funding prescription drugs directly, Trump invested in a way that changed how the system works. Both reforms addressed critical concerns that have long plagued Medicare and promised lower costs and higher financial stability of the program.

⁵³ "Why Trump's Medicare Reforms Offer Superior Alternative to 'Medicare for All'."

⁵⁴ "Trump Administration Announces Historic Action to Lower Drug Prices for Americans," *States News Service* (2020).

Biden also campaigned on drug price reform, but his resolve was clearly more palpable than his predecessor's. Trump once proposed to allow more negotiations in Medicare—a stark departure from the established policies since the creation of Medicare Part D in 2003, which had prohibited such negotiations. Yet these efforts did not materialize into policy change. Biden triumphed where Trump had stumbled. Only a few months into his presidency, Biden passed a significant reform that changed the way that the government paid for prescription drugs and made negotiating Medicare drug prices the lynchpin of his ambitious health care agenda.⁵⁵ The impact of this reform was also expected to extend beyond lower drug prices. Anticipated savings were projected to fund dental coverage for seniors and reduced premiums under Obamacare.⁵⁶ Two years later, in August 2023, Biden did achieve his goal and confirmed government officials would start price negotiations for ten high-cost drugs under Medicare.⁵⁷ “There is no reason why Americans should be forced to pay more than any developed nation for lifesaving prescriptions just to pad Big Pharma’s pockets,” said Biden.⁵⁸ Similar words were once heard from Trump, but he often tempered his enthusiasm when confronting powerful interests from the medical industry. From a social investment perspective,

⁵⁵ CBS News, "Where Biden and Trump Stand on Health Care Policy (Youtube video)," (<https://www.youtube.com/watch?v=PjC5lkha5F0>, 12 Mar. 2024).

⁵⁶ Ricardo Alonso-Zaldivar, "Ban on negotiating Medicare drug prices under pressure," *AP News* Oct. 7, 2021.

⁵⁷ "US Department of Health and Human Services. HHS selects the first drugs for Medicare drug price negotiation.," Aug 2023.

⁵⁸ "Statement from President Biden on historic action to lower prescription drug costs. ," *WhiteHouse.gov* (<https://www.whitehouse.gov/briefing-room/statements-releases/2023/08/29/statement-from-president-joe-biden-on-historic-action-to-lower-prescription-drug-costs.>) Aug 2023.

Biden opted for a more radical approach and spared no efforts to get it to the finish line.

Another testament to this point was his regulation of particular drugs. In March 2023, the Biden administration made a bold move by putting a cap on the skyrocketing cost of insulin. This historic intervention slashed the monthly expense of insulin to a mere \$35 for patients on Medicare and provided much-needed financial relief for patients struggling with steep diabetes treatment expenses. Importantly, the enactment of this ceiling on insulin prices not only aligned with the administration's commitment to dismantling the barriers to indispensable health care services but served as a signal for the government's action on chronic disease. According to the U.S. Department of Health and Human Services, had this provision been in effect back in 2020, an estimated 1.5 million Medicare beneficiaries would have collectively saved an astounding \$761 million—an average saving of \$500 per person.⁵⁹ This echoed Biden's statement back in the 2008 forum mentioned at the beginning of this section. "I've not seen any evidence or convincing studies saying that moving to deal with chronic disease at the front end is going to exponentially increase the cost." Biden cited studies by the Federation of American Hospitals and the RAND Corporation when one forum panellist questioned the cost of managing chronic disease. These studies did not promise instant net savings, but they revealed

⁵⁹ Khaliq Siddiq, "A deep dive into the intersection between primary and culturally competent care," *Medical Economics* (January 2024).

a profound insight—the cost curve would flatten as investment in preventive measures increased.⁶⁰

Central to Biden’s strategy to manage chronic disease was dementia treatment. In the United States, Alzheimer’s disease affects over 11% of those aged 65 and above. It ranks within the top ten most fatal illnesses in the country and is the sixth leading cause of death for American adults. As of 2021, the disease has affected more than 6 million Americans, and the number was predicted to be 14 million by 2060. There are also more than 11 million unpaid caregivers looking after patients with Alzheimer’s disease or other forms of dementia.⁶¹ Importantly, as a disease disproportionately affected seniors, Alzheimer-related reforms significantly impacted Medicare expenditure. In December 2021, Senator Sanders made a direct appeal to the Oval Office urging Biden to halt what he described as an “outrageous increase” in Medicare premiums, a surge pinned on the cost of the Alzheimer’s medication Aduhelm produced by a biological company named Biogen. “Biogen’s \$56,000 price of Aduhelm is the poster child for how dysfunctional our prescription drug pricing system has become,” Sanders’ message was pointed. “The notion that one pharmaceutical company can raise the price of one drug so much that it could negatively impact 57 million senior citizens and the future of Medicare is beyond absurd. With Democrats in control of the White House, the House and the

⁶⁰ KFF, “2008 Presidential Candidate: Joe Biden (Youtube video).”

⁶¹ “Klobuchar Statement on Annual Update of Biden Administration’s National Plan to Address Alzheimer’s Disease,” *Congressional Documents and Publications* (2021).

Senate we cannot let that happen.”⁶²

Biden initially held back on enacting coverage for the drug. Should he answer Sanders’ call, the expected rise in Medicare’s Part B premium for outpatient care set for January 2022—a jump of \$21.60 per month—would be more than halved, bringing it down to about \$10. This adjustment would place the monthly premium for 2022 closer to \$159, rather than the looming \$170.10—an unprecedented increase in absolute dollar terms.⁶³ Partly because of this decision to refrain from covering Aduhelm, Biden announced in a September 2022 event that for the first time in a decade, premiums for Medicare Part B—which covered essential medical services such as doctor visits, hospital stays, and related drug treatments—were set to decrease, translating to savings of over \$60 per beneficiary each year.⁶⁴ Therefore, by the time he boasted of this achievement, the administration’s support for Alzheimer’s disease was very much limited. Only a bipartisan bill called Alzheimer’s Caregiver Support Act got passed in May 2021. Introduced by Senators Klobuchar and Collins, the Act offered grants for caregivers training and at-home services for Alzheimer’s and dementia patients, thereby postponing their admission into long-term care facilities.⁶⁵

⁶² Ayumi Davis, "Bernie Sanders Asks Biden to Prevent Medicare Premium Hike Tied to Pricy Alzheimer's Drug," *Newsweek.com* (Dec. 3, 2021).

⁶³ Davis, "Bernie Sanders Asks Biden to Prevent Medicare Premium Hike Tied to Pricy Alzheimer's Drug."

⁶⁴ "Biden Medicare Costs Victory Due Mostly To Alzheimer's Drug Change," *Newstex Blog: International Business Times News* (Sep. 27, 2022).

⁶⁵ "Klobuchar Statement on Annual Update of Biden Administration's National Plan to Address Alzheimer's Disease."

Such a deceptive decrease in Medicare costs then stirred calls for a more inclusive approach. On April 26th of 2023, Attorney General Miyares along with 25 other attorneys general reached out to the Centres for Medicare & Medicaid Services (CMS) with a plea. They wrote to urge CMS to maintain their long-standing tradition of providing unlimited access to FDA-approved prescription drugs for Medicare beneficiaries—this time, for Alzheimer’s treatments.⁶⁶ Thus, as the issue gained prominence, Biden was again tasked with finding a delicate equilibrium between managing limited resources and the need to make cutting-edge medical treatments accessible to the elderly. In the wake of this renewed dialogue, the Biden Administration demonstrated its commitment to social investment with tangible strides forward. On August 1st, 2023, the U.S. Department of Health and Human Services (HHS) announced its Guiding an Improved Dementia Experience (GUIDE) Model to enhance the quality of life for those living with dementia, alleviate the burdens on unpaid caregivers, and enable individuals to continue living within their own homes and communities. “We are proud to take these steps to deliver on the President’s promise to increase care coordination and improve access to services and supports for our families,” said HHS Secretary Xavier Becerra. Compared with Trump who largely opted for talk over action regarding Medicare drugs, Biden has been

⁶⁶ "Okla. A.G. Drummond Urges Biden Administration to Provide Medicare Coverage for Alzheimer's Drug," *Targeted News Service* (May 2, 2023); "Idaho A.G. Labrador Sends Letter Urging Biden Administration to Provide Medicare Coverage for Alzheimer's Treatment," *Targeted News Service* (May 3, 2023); "Va. A.G. Miyares Urges Biden Administration to Provide Medicare Coverage for Alzheimer's Treatment," *Targeted News Service* (May 2, 2023); "Attorney General Moody Urges Biden Administration to Provide Medicare Coverage for Alzheimer's Treatments," *US Fed News* (May 2, 2023).

consistent with his vision for chronic disease management.

At the heart of the GUIDE Model was a comprehensive set of services: meticulous care coordination and management, educational resources and support for caregivers, and respite services to provide temporary relief. This model marked a concrete fulfilment of President Biden's April 2023 Executive Order on Increasing Access to High-Quality Care and Supporting Caregivers. It also aligned with the ambitious objectives set forth in the National Plan to Address Alzheimer's Disease. Importantly, through GUIDE the Centre for Medicare and Medicaid Innovation would test an alternative payment structure for participating service providers who delivered essential supportive services to dementia patients. This included thorough, individualized assessments and care plans, seamless care coordination, as well as 24/7 access to a support hotline. Patients with dementia and their caregivers would be granted access to a dedicated care navigator—a cornerstone of the model—entrusted with the task of guiding them through a maze of available services and supports. This included not only clinical care but also vital non-clinical services such as meal deliveries and transportation, facilitated by community-based organizations. In this sense, the GUIDE Model has changed the landscape of dementia care and caregiver support into a more integrated, patient-centred experience.

A less relevant, but still important, fact here was Biden's emphasis on scientific research. Since 2013, HHS and its partner institutions have been investing in research and services on evidence-backed support systems for

dementia caregivers and the enhancement of community providers' capacity to serve dementia patients.⁶⁷ Yet it was during the Biden years that medical research became elevated to the centre of the health reform agenda. In his first major address to Congress on April 28, 2021, Biden proposed to establish a new biomedical research agency within the National Institutes of Health (NIH). This agency would spearhead the fight against diseases that have long plagued Americans and especially senior citizens—Alzheimer's, diabetes, and cancer—with an ambitious promise to “end cancer as we know it,” in Biden's words.⁶⁸ “Right now when Americans overpay for prescription drugs, too many pharmaceutical companies don't use the profit nearly enough to innovate or research.” He reminded his audience that pharmaceutical giants spent \$577 billion on buybacks and dividends between 2016-2020, overshadowing their research and development expenditure by \$56 billion. “I'm not criticizing companies that aren't prepared to spend billions of dollars on certain projects to research,” Biden said, “I get it. But if they're not, we should, to make sure that Americans are covered.”⁶⁹ The Agency was thus expected to counter this trend and invest in medical innovation that promise future savings in chronic disease.

In overview, both Trump and Biden valued the significance of investing in

⁶⁷ "Centers for Medicare & Medicaid: Biden-Harris Administration Announces Medicare Dementia Care Model," *Targeted News Service* (August 1, 2023).

⁶⁸ Elizabeth Gourd, "Biden determined to “end cancer as we know it”," *The lancet oncology* 22, no. 6 (2021), [https://doi.org/10.1016/S1470-2045\(21\)00282-5](https://doi.org/10.1016/S1470-2045(21)00282-5).

⁶⁹ Michael Gibney, "Cost of Care: Biden seeks price controls amid Alzheimer's drug debate," *The SNL Insurance Daily* (2021).

Medicare as a way to reduce future costs, with each administration leaving its distinct mark on the system. Trump focused on streamlining Medicare's administrative processes and addressing the long-standing issue of escalating prescription drug costs, and his tenure saw the initiation of several reforms aimed at curbing these costs. Biden picked up what his predecessor left unfinished and brought concrete achievements to the field by allowing Medicare to negotiate drug prices and implementing price caps on particular Medicare drugs. Importantly, Biden's strategy in chronic disease management underscored his belief in a more proactive and prevention-oriented healthcare system. The GUIDE Model's strategic intent was not only to enhance patient outcomes but also to reduce the financial strain on Medicare over time. By addressing the needs of a population segment that is particularly vulnerable to the shortcomings of health care provision—the elderly with chronic conditions—the model had the potential to transform the way in which Medicare supports its beneficiaries. Therefore, despite their different approaches, the strategy of the Trump and Biden administrations on Medicare reflect a shared underlying objective: the adaptation of the Medicare system to enhance health rights of seniors as well as health equity for people vulnerable to chronic disease.

Conclusion

The tug-of-war over Medicare between the Trump and Biden administrations was like two different chefs trying to spice up the same dish in their own way. Trump favoured bold, market-driven flavours, adding a dash of private sector zest to Medicare Advantage plans and being wary of anything that smelled too much like a socialist stew. Biden, on the other hand, was a chef who appreciated some of the ingredients from the “Medicare for All” kitchen but knew he could not just throw out the existing menu. His team mixed in progressive ideas carefully, trying not to turn off those diners who liked things just the way they were. Yet both presidents wanted to give everyone a seat at the table without cooking up a whole new health care feast from scratch. Trump was all about choice and efficiency, while Biden’s plan, even though some saw it as just a patch-up job, tried to strike a balance—something new but not too radical. It was more of a limited and targeted reform of Medicare than what had been seen in the years of hard-driving neoliberal reforms.

In the end, Biden’s narrative in American health care was a tale not of revolution, but of evolution. Biden’s proposal also entailed an increased role of the government in health care, as it would create a public option to rival private insurers and provide substantial financial aid for people purchasing from the ACA health insurance exchanges, in addition to new insurance programs for children and extending health care for federal employees to outsiders. His plan for Medicare specifically was to lower the eligibility standard, allowing near-seniors (people aged 55-65) to buy into Medicare. In this sense, the public

option showed a clear inclination toward maintaining a mix of private and public insurance sectors. It was somewhat unconventional for a Democratic president to reject universal health care, but Biden's support for sweeping reform was moderated by his sharp awareness of what was not achievable in American health care.⁷⁰

Biden and Trump have both made investment in Medicare to enhance cost control and efficiency of the system. Trump's tenure was marked by significant regulatory reforms aimed at reducing the bureaucratic burden on healthcare providers and introducing competitive drug pricing measures. In the same vein, Biden's early call for a prevention-focused health care paradigm during his first presidential campaign in 2008 has been reflected in his administration's efforts to cap drug prices, especially for chronic conditions such as diabetes and Alzheimer's disease. The introduction of the GUIDE Model for dementia care further exemplified the Biden administration's commitment to reshaping healthcare by addressing the needs of patients and caregivers in a holistic manner, ensuring that the long-term sustainability of Medicare goes hand in hand with the provision of high-quality, patient-centred care. In other words,

⁷⁰ Like Biden, Carter as a Democratic president opted against pursuing universal health care and focused instead on more limited reforms such as hospital cost containment. Both Biden's and Carter's pragmatism illustrated the boundaries of social citizenship within the American welfare state, but both before and after the "permanent age of austerity" as Pierson called it, American health care remained conditional and limited fraught with a persistent compromise between public health needs and private sector interests. Paul Pierson, "Coping with Permanent Austerity: Welfare State Restructuring in Affluent Democracies," *Revue française de sociologie* 43, no. 2 (2002). Iwan Morgan, *The Age of Deficits: Presidents and Unbalanced Budgets from Jimmy Carter to George W. Bush* (University Press of Kansas, 2009).

Biden's strategy was a challenge to the short-termism that pervaded the business and insurance sectors and a call to change the paradigm of American healthcare from within. The efforts of both administrations underscored not only a continuing trajectory towards a health care system that balances immediate needs with strategic long-term investments, but also a moment when the conversation shifted from the cost of illness to the value of health.

The battle over healthcare was just the tip of the iceberg, a snapshot of the larger ideological war over how much the government should step in to serve the aging population and help its citizens stay healthy while keep costs of medical care under control. In terms of reforming Medicare's drug prices, lifting its administrative burden and dealing with chronic disease, social investment represents a "social" version of neoliberal doctrines. It means a nuanced equilibrium between the Keynesian vision of state-operated health care and the neoliberal idea to open all parts of Medicare to the private market; from another perspective it might well be seen as an expedient measure before universal health care is possible. In essence, the struggle to fix American healthcare reflected a grappling with larger questions: what kind of country do Americans want to live in, and how much should the government do to make sure everyone gets a fair shot at staying healthy? Especially when viewed through the lens of social citizenship, social investment is a viable strategy to reconcile economic efficiency with the imperative to meet the health needs of the populace, thereby contributing to the foundational principles of what constitutes health justice.

Conclusion

Medicare politics evolved amid strong political demands for austerity, on the one hand, and persistent public support, on the other. Historians of American health care painted a picture of heroic reformers endeavouring to save seniors from being marginalized in the private insurance market and protecting their health security.¹ Yet as its reform agenda became increasingly populated by proposals to enhance competition, promote managed care, and develop private plans, one also sees deep loss of what Putnam called “social capital”, namely a sense of trust and duty, norms of reciprocity that arise from connections among individuals, and a bond that ensures solidarity in the face of adversity.² This compels us to investigate the implications in Medicare’s changing ideals. How did the reorganized system present a threat to the ideals, values, and capacities of the American health care system? How, further, did such a transition reconfigure the notion and breadth of social citizenship, and what role did the government play in the process? This thesis has considered the ways in which Medicare reinforces a sense of social citizenship and how efforts toward privatization undermine this sense, shifting from a community-oriented

¹ See, for example, Colleen M. Grogan, *Grow and Hide: The History of America's Health Care State* (Oxford University Press, 2023). Monte M. Poen, *Harry S. Truman versus the Medical Lobby: The Genesis of Medicare* (Columbia: University of Missouri Press, 1979). See also Rosemary A. Stevens, "History and Health Policy in the United States: The Making of a Health Care Industry, 1948–2008," *Social History of Medicine* 21, no. 3 (2008); Michael Morrissey, "History of Health Insurance in the United States," in *Health Insurance, 2nd edition* (AUPHA/HAP Book, 2013).

² Julia Häuberer, "Introducing the Civic Perspective on Social Capital – Robert D. Putnam's Concept of Social Capital," in *Social Capital Theory: Towards a Methodological Foundation*, ed. Julia Häuberer (Wiesbaden: VS Verlag für Sozialwissenschaften, 2011). For other interpretations of social capital, see Bourdieu (1986) and Coleman (1988). For a comprehensive literature review of this concept, see Portes (1998).

ethic to one centered on individualism, and substituting the assurances provided by the State with the unpredictability of the “free” market.

Citizenship traditionally serves to draw the boundaries between those who are recognized as members of a community, deserving of respect, protection, and rights, and those who are excluded and thus not granted such recognition and entitlements.³ It functions as a relational concept, where the individual and the state engage in an asymmetrical, yet consensual relationship. In this dynamic, the individual is obligated to fulfil certain duties to the state, while the state is responsible for guaranteeing specific rights to the individual. This relationship is particularly crucial in the US context. As Turner notes, “any theory of citizenship must also produce a discussion of the state”, so our analysis of Medicare and social citizenship explores the evolving boundaries of state intervention in health care and the government’s role in defining health security for the elderly.⁴ Besides, across the four dimensions—discourses, rights and obligations, participation, and citizens’ perceptions of their roles—it is evident that social citizenship has undergone significant changes as policymakers emphasize consumer-driven Medicare. This marked the beginning of a new blend of individual duties and collective entitlement, and took its root in evolving values about social welfare and understandings about how to best serve American seniors.

³ Evelyn Nakano Glenn, “Constructing Citizenship: Exclusion, Subordination, and Resistance,” *American Sociological Review* 76, no. 1 (2011).

⁴ Bryan S. Turner, “Outline of a Theory of Citizenship,” *Sociology (Oxford)* 24, no. 2 (1990): 193.

The traditional concept of citizenship was anchored in a particular understanding of the welfare state's relationship with its citizens and the nature of citizenship itself in the context of industrial society. The citizen was typically envisioned as a male worker whose entitlement to social rights was linked to a stable, full-time employment history. As discussed in the Introduction and Chapter 1, federal welfare provisions before the New Deal were minimal and often targeted specific groups (like Civil War veterans) rather than the general population. The mother's pensions of the 1920s were a notable exception but were limited in scope and unevenly implemented across states. The New Deal formalized the idea of the welfare state in the U.S. through programs that anchored social rights in the workplace, primarily benefiting full-time, long-term employment. Illustrative here, the Old-age security that focused on retirement benefits recognized the need for security in old age but was still heavily employment-based. This model of social citizenship thus reinforced a particular vision of who "deserved" welfare benefits, largely excluding women, minorities, and workers in informal sectors. It created a system where social citizenship was defined by labor market participation, reinforcing both gender and class divisions in welfare access.

However, seldom is social citizenship for seniors discussed as a particular category of citizenship. In important ways, seniors are at once a politically powerful constituency making life-long contributions through decades of hard work and a demographic group particularly vulnerable to social risks.

Considering seniors' health security along the core elements of the welfare state—broad-based social rights, government delivery of services, and direct public expenditure—allows us to understand central tendencies in the American ideal of social welfare.

In this dissertation, I argued that Medicare was not only presented as a crucial component of social citizenship specifically tailored to meet the needs of older Americans but an embodiment of the “contributory-contractual principle” that ushered in a new era of family benefits under this framework.⁵ The notion of a “contract” here was more ideological than legal. It indicated that these benefits were not mere acts of state generosity, vulnerable to the caprices of government, but rights earned and due to the individuals. This is why we employed “contributory social citizenship” to analyse the implication of Medicare's inception. An important feature of contributory social citizenship was the mitigation of social risks, particularly as traditional welfare states grappled with the challenge of addressing needs unmet by market incomes. Chapter 1 and 2 have shown that T.H. Marshall's ideas, while not directly designed for health care in the American context, shaped subsequent debates on social rights in the U.S., including health care as a critical component of social citizenship. As the concept of citizenship evolved, so did expectations regarding the role of the state in safeguarding social welfare, adapting to new economic

⁵ Edward D. Berkowitz; and Kim McQuaid, *Creating the Welfare State: The Political Economy of Twentieth-century Reform* (Praeger, 1988), 126.

and social realities.

Most importantly, our notion of contributory social citizenship entailed a strong sense of social solidarity. In the classic welfare state model, policymaking focused on designing and implementing programs to fill the gaps left by the market, often through horizontal transfers across an individual's life cycle and some vertical transfers to assist poorer minorities. This system relied heavily on intergenerational solidarity—an implicit understanding that today's workers would support today's retirees, with the expectation that they, too, would be supported in their old age. During the “golden age” of welfare states, redistribution was relatively uncontroversial because economic growth softened the blow of rising taxes and social insurance contributions. The idea of a “generational contract” or “risk-pooling” underpinned these policies, with the state stepping in to provide cradle-to-grave care and ensuring that everyone had access to essential services like pensions and health care. The broad public consensus recognized the legitimacy of these programs, as most people understood that they might one day need these services themselves.

In the 1970s, Medicare faced mounting challenges as medical authority was questioned, costs spiraled, and the broader social contract underlying the welfare state was increasingly scrutinized. The decrease in political deference and the government's dwindling economic authority made citizens more demanding and questioning than before. These factors collectively contributed to the transition of risk management strategies in health care from open-ended

government funding to capitated payment that shifted risks to private actors, compelling them to improve quality and efficiency by putting their profits at stake. However, decentralizing of health care management and devolution of authority do not necessarily mean dissemination of social citizenship. Compared with neoliberalism that shifts risk onto individuals and strips them of the protection against economic insecurity—“the great risk shift” in Jacob Hacker’s words—delegated governance conceives social citizenship in an intact administrative system, albeit with a longer chain of power with the presence of more intermediaries.⁶

I therefore used “ordoliberal social citizenship” to capture the tensions inherent in balancing the ideals of social insurance with the practicalities of managing a complex, expensive, and often inefficient health care system. The first feature of ordoliberal social citizenship is a strong commitment to social welfare despite the tight budget. The 1970s marked a crucial period in the evolution of Medicare, characterized by a growing tension between the program’s expanding scope and the federal government’s increasing focus on cost containment and deregulation. The tension reflected the broader ideological shift of the time, as policymakers grappled with balancing the needs of an aging population against the pressures of economic stagnation and rising public skepticism about the efficiency of government programs.

⁶ Jacob Hacker, “The Great Risk Shift,” in *Inequality in the 21st Century*, ed. Jacob Hacker, Jasmine Hill, and David B. Grusky (Routledge, 2018).

Second, under ordoliberal social citizenship the boundaries of social rights are very much restrained. The initial optimism that Medicare would be the first step to health security for all Americans was quickly dashed as rising health care costs became the focus of policy interventions of the late 1970s and the 1980s. In contrast to the era of expanding the boundaries of citizenship in U.S. social insurance programs described in the previous section, this second era (1980s to the present) could be characterized by active attempts to constrain the boundaries of citizenship in U.S. social insurance programs.

The final feature of ordoliberal social citizenship is an advocacy for the state's role in establishing and maintaining the rules of the market, preventing monopolistic practices, and ensuring that the market serves the broader social good. Medicare HMOs represented an attempt to inject market mechanisms into the provision of health care for the elderly, and in terms of ordoliberal social citizenship, Medicare HMOs represented an effort to leverage market competition to improve efficiency in health care delivery. Similar to the HMOs, the PPS tied payments to diagnosis-related groups and sought to create a system where hospitals would be financially motivated to provide only the necessary level of care, thus controlling costs and improving efficiency. This aligned with the ordoliberal emphasis on using market mechanisms to drive efficiency while still requiring state oversight to set the rules of the game.

Chapter 5 analysed three interrelated ideas underlying Medicare marketization reform: active citizenship, the ownership society, as well as the

consumer-directed health care (CDHC), on which our notion of consumerist social citizenship was based. Firstly, there has been a lack of research concerning the ways in which the policy concept of active citizenship is culturally embedded in the American context, but our discussion clarified the change of the cultural ideal of social citizen during the 1990s as the notion of active citizenship—often assumed to be rooted in neoliberal thought—prevailed in welfare reforms. Secondly, in Medicare, the ownership society emerged as a political and economic vision steeped in individual responsibility, personal control, and the privatization of social services. Privatization and market-based solutions were the lifeblood of the ownership society. This philosophy promoted private insurance options and managed care plans as superior alternatives to traditional government-provided services. Thirdly, Consumer-Directed Health Care in Medicare represented a fundamental shift in how people finance their health care consumption and granted people greater control over how their dollars were spent. This shift resulted in increased out-of-pocket expenses for beneficiaries, with higher premiums and co-pays encouraging cost-conscious health care choices.

Together, these three sets of ideas—active citizenship, ownership society, and CDHC—formed the basis of our notion of consumerist social citizenship. Historically, Medicare has been focusing on the “supply side” to reform the organization of hospitals and incentives of doctors. Yet the Balanced Budget Act of 1997 shifted the focus to the “demand side” and made Medicare

beneficiaries the central players. The first feature of consumerist social citizenship was thus getting seniors more financially involved in their health care decisions and moving their perception about Medicare from “getting coverage from the government” to “spending their own money.” Health Savings Accounts (HSAs) and Medical Savings Accounts (MSAs) exemplified this approach.

The second feature of our consumerist notion is increased autonomy as consumers. The Medicare Modernization Act (MMA) of 2003 enhanced this trend by rebranding Medicare+Choice plan as Medicare Advantage (MA). Broadly speaking, construction of the notion of the citizen as a consumer was embedded in the commodification of old age through an individually based approach to service provision, driven by the multitrillion-dollar for-profit medical industrial complex and aging enterprise.⁷ This complex system of service provision had actively promoted the role of older citizens as consumers. In this model, seniors were encouraged to view their health care and related services as commodities to be purchased and managed rather than entitlements provided by the state. Yet we also saw the road towards “real choice” and “efficiency” in private insurance and medical markets as fraught with obstacles in the case of the BBA and the MMA. Under consumerist social citizenship the original idea about competition and efficiency has in fact created a marketplace riddled with disparities instead. While the intention was to broaden access and

⁷ Carroll Estes, *The Aging Enterprise* (Jossey-Bass, 1979). See also Carroll Estes, “The Future of Aging Services in a Neoliberal Political Economy,” *Generations* (San Francisco, Calif.) 38, no. 2 (2014).

improve care, the result has often been confusion, higher out-of-pocket expenses, and a fragmented system that failed to address the core needs of many seniors.

Chapter 6 and 7 built our notion of post-neoliberal social citizenship upon the shift in the management strategy of Medicare towards value-based care as the federal government emphasized quality, coordination, and efficiency over mere cost containment. Importantly, this period was characterized by a transition from merely protecting against income loss to preventing reduction in earnings altogether—a critical feature of post-neoliberal social citizenship.⁸ This partly explained why health policy since the 2010s had increasingly focused on preventing illness through public health measures rather than solely treating illnesses after they occurred.⁹ Preventive health measures, such as vaccination programs, health education, and early intervention strategies, aimed to reduce the incidence of chronic diseases and improve overall

⁸ G. Bonoli, "The Politics of the New Social Policies: Providing Coverage against New Social Risks in Mature Welfare States," *Policy and Politics* 33, no. 3 (2005).

⁹ Notably, during the Reagan administration "health promotion" emerged as a key concept highlighting a preventive approach that emphasized lifestyle choices, personal health practices, and self-management. It encouraged citizens to take personal responsibility for avoiding illness, advocating for healthy behaviors to reduce long-term health care costs. With an emphasis on cutting back social spending, Reagan's policies promoted health education and preventive care as cost-effective alternatives to expanding federal welfare provisions. The administration's strategy was partly pragmatic, as it sought to alleviate pressure on federal budgets by reducing public reliance on welfare benefits, yet the concept was not as firmly established as it became in the 2010s. For details, see Edward D. Berkowitz, *America's Welfare State: From Roosevelt to Reagan* (Baltimore: Johns Hopkins University Press, 1991); A. O'Connor, *Poverty Knowledge: Social Science, Social Policy, and the Poor in Twentieth-Century U.S. History* (Princeton University Press, 2001).

population health.¹⁰

Social investment as another major feature of post-neoliberal social citizenship highlighted the importance of viewing health not only as an outcome of health care and welfare policies but also as an input for active social policies. While social investment had not been extensively analysed in relation to health—most studies had focused on labour market policies and early childhood education, with less emphasis on health - the social investment framework aligned closely with our analysis of the broader shift from passive to active health policy.¹¹

Finally, under post-neoliberal social citizenship there was a declined commitment to Medicare's generosity and increased emphasis on its efficiency, affordability, and most importantly, sustainability. The notion of post-neoliberal citizenship might be an ambiguous one, and the new politics of Medicare might even have a Janus face. This was perhaps one of the main reasons why interpretations of Medicare's current guiding principle were so difficult to rationalise, especially as it grew from several pages as part of a Social Security Amendment in 1965 to a legislative tome nowadays. Yet Medicare would continue to reflect an enduring commitment to improving the health and well-being of the nation's elderly and chronically ill, and we shall see how this tension

¹⁰ Fran Baum and Matthew Fisher, "Why Behavioural Health Promotion Endures despite its Failure to Reduce Health Inequities," *Sociology of Health & Illness* 36, no. 2 (2014).

¹¹ Thomas Leoni, "Social investment: A guiding principle for welfare state adjustment after the crisis?," *Empirica* 43 (2016); Nathalie Morel, Bruno Palier, and Joakim Palme, "Beyond the welfare state as we knew it?," in *Towards a social investment welfare state?*, ed. Nathalie Morel, Bruno Palier, and Joakim Palme, Ideas, policies and challenges (Bristol University Press, 2012).

unfolds in a new battlefield while previous ideals of social citizenship fail to explain the novel institutional criteria.

Throughout our discussion three significant trends in Medicare development stand out. First, there has been a noticeable decline in the generosity of Medicare payments over time, accompanied by a growing emphasis on sustainability. This trend has been especially evident during the Trump and Biden administrations, where health reform efforts focused on “investing in the future” to ensure long-term viability (though at the expense of immediate payment generosity). Second, Medicare’s core benefits have largely remained intact, and reductions have primarily targeted payments to health care providers rather than cutting benefits directly. This strategy became prominent in the 1970s and 1980s, when proposals for expanded services, such as nursing home care and catastrophic care, gained traction as necessary adjustments to meet the increasing demands of senior care within a constrained budget under intense budgetary pressure.

Third, change in political rhetoric did not necessarily mean change in seniors’ worldview. Since the late 1990s, seniors were increasingly characterized as “consumers” or “active citizens” who could make rational decisions and be responsible for their own choices. Yet hardly could seniors be truly rational about their medical decisions unless they were highly knowledgeable and resourceful. In this sense, more choices in Medicare did not mean better care, and seniors’ options became an obligation. The notion of

seniors as rational actors often overlooked the challenges they faced in managing their health care in a market-driven system, where the promise of choice might lead to greater obligations rather than enhanced care.

Political theorist Kathryn Dean once discussed the fraught relationship between individual responsibility and capitalist social relations by portraying a society where social citizenship and the collective bonds of democracy, rooted in inclusivity and mutual support, clashed with the exclusionary nature of capitalism, which bestowed privileges based on property and wealth. This view was at the heart of what Dean termed the “impossible partnership” between capitalism and social citizenship. Citizenship thrived on the inclusion and participation of all societal members, while capitalism inherently created exclusion through wealth and property.¹² This tension became especially visible in the realm of Medicare since the late 1980s. As Medicare shifted toward privatization, the ideal of a shared social contract—where everyone contributed and benefits collectively—was undermined as well. Instead, the system increasingly mirrored the capitalist ethos of individualism and market competition. Individual autonomy had been institutionalized as a key policy focus as governments increasingly sought to reduce the scope of the welfare state.

In this context, policies and practices were deliberately structured to

¹² Kathryn Dean, *Capitalism and Democracy: The Impossible Partnership* (London: Routledge, 2003).

encourage individuals to take personal responsibility for their own health choices. Autonomy, in this framework, was understood as individualism—where each person was motivated by self-interest and interacts with others and with society in a detached, external manner. Beneficiaries were expected to navigate a complex array of private plans; this effectively turned health care into a marketplace where self-interest prevailed. This broad context and the evolving notion of social citizenship, despite some similarities in discourse and procedures, covers highly contradictory and divergent tendencies. Even today, Medicare remains a crucial battleground for balancing individual autonomy with collective responsibility while the government strives to ensure that the program meets the needs of an aging population while maintaining the principles of equity and access that underpin social citizenship.

The typology provided in this research serves as a tool to assess such large-scale, highly visible social policies. Conventional concepts of social citizenship—civil, political, and social rights as well as duties and responsibilities—have been particularly useful and productive in broadly-brushed, philosophical comparison of different welfare states, but our typology offers a basis for grasping the right to health care and recognizing the need to evolve beyond the current stage of social rights in policy and citizenship in more specific policy implementing contexts. The problems particular to Medicare are also endemic to a robust conceptualization of social citizenship more broadly. While there is no conclusive approach for balancing cost containment in health

care with the protection of entitlements, the examination here helps us understand the arrival of a new blend of duties and collective entitlements for American citizens in an age of permanent austerity.

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