Entrenching Incumbent Power: Medicare Advantage, Part D, and the Politics of Health Reform

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Introduction: Health Policy, Power, and the Biden Administration

During each of the past three Democratic presidential administrations, health policy has been a key domestic priority. President Clinton unsuccessfully sought to pass comprehensive health reform, before settling for important incremental expansions of health insurance coverage during his second term. President Obama successfully pushed the Affordable Care Act to enactment, though perhaps at the cost of losing Congress decisively in his first midterm election. And President Biden both dealt with the health-policy consequences of the COVID emergency and enacted a major reform of the Medicare prescription drug program, including the first-ever provision for the government to negotiate prices, in the Inflation Reduction Act.[1]

In each of these administrations, the crafters of health policy have focused on identifying tools that can ensure the broadest possible insurance coverage, while delivering high quality care at affordable cost for both consumers and the system as a whole. That focus is understandable—and, indeed, entirely salutary. The goal of health policy should be to ensure that everyone can live longer, better lives, and to do so in a sustainable way for our society. The successive reforms of the Clinton, Obama, and Biden Administrations have moved us closer to that goal—though we have a ways to go before everyone has the coverage they need.

But the heavy focus on technocratic policy levers risks disregarding the prior question about how we can enable good policies to get enacted—and to survive the inevitable political attacks that health reforms occasion. That is fundamentally a question about power: Can those who wish to pursue health reforms muster enough power to overcome the entrenched power of those who benefit from the status quo?

And the power of those within the system to advance or thwart reform often depends not just on factors outside of health policy but on the effects of health policy decisions themselves. Thanks in part to the key work of Suzanne Mettler, Jacob Hacker, and others, it is now a commonplace to note that our health care system has developed in a highly path-dependent fashion—below-the-radar decisions to subsidize private, employer-based health insurance have made it difficult for policymakers to shift to a broader, and more overtly public, health care system for working-aged individuals and their families.[2]

For each of the three most recent Democratic presidents, this path dependence has presented a major constraint to the health reform agenda. Any effort to make significant changes to the existing health care system threatens some incumbent player whose power has been bolstered by prior policy decisions. President Clinton was unable to overcome the power of

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[1] Pub. L. No. 117-169, title I, subtitle B, 136 Stat. 1818, 1833-1905 (Aug. 16, 2022).

[2] *See, e.g.,* SUZANNE METTLER, THE SUBMERGED STATE: HOW INVISIBLE GOVERNMENT POLICIES UNDERMINE AMERICAN DEMOCRACY (2011); JACOB HACKER, THE DIVIDED WELFARE STATE: THE BATTLE OVER PUBLIC AND PRIVATE SOCIAL BENEFITS IN THE UNITED STATES (2012).

these incumbent players in his efforts to adopt comprehensive health reform.[3] President Obama was able to pass the Affordable Care Act only by making major concessions that essentially bought off key incumbents in the insurance industry.[4]

As I argue in this paper, the entrenched power of incumbent players in the health care system also presented significant problems for President Biden's health care reforms. The Inflation Reduction Act's Medicare drug pricing provisions directly challenged the power of big pharmaceutical companies in a way that the federal government had never done before. By enacting and implementing those provisions, President Biden was able to gain the upper hand on one of the key players in the health care sector.

But his efforts to take on the power of insurance companies in the Medicare program had less success. The Medicare Modernization Act of 2003 had given private insurers the central role in administering the new Medicare prescription drug program (Medicare Part D). It had also expanded the privatized "Medicare Advantage" program, under which Medicare beneficiaries could choose to receive their benefits from private insurance companies rather than the federal government. By relying heavily on privatization and consumer choice, the Medicare Modernization Act implemented the conservative ideology of then-President George W. Bush.

By the time President Biden took office, it was apparent that the costs of this privatized structure outweighed any supposed benefits. Both Medicare Part D and Medicare Advantage imposed very substantial costs on the Treasury—costs that went beyond what the government would likely pay if it were covering Medicare beneficiaries directly.[5] And consumer choice was illusory. As Kenneth Arrow argued long ago, patients' uncertainties about their future illnesses and the likely effects of particular treatments, combined with persistent information asymmetries in the health care system and the need for (and effects of) insurance, make health care markets a particularly poor context for unfettered consumer choice.[6] In the context of Medicare Part D and Medicare Advantage particularly, beneficiaries found themselves overwhelmed with choices and unable as a practical matter to assess which plans, from which insurers, were best for them.[7]

The Biden Administration attempted to address these problems. The Inflation Reduction Act included major provisions redesigning the Part D benefit to put more of the risk on insurance companies and thus relieve the federal Treasury of significant cost burdens. And the administration initially sought to use its regulatory tools to crack down on abuses by Medicare Advantage plans. But it ultimately backed off on these policy efforts. It did so, I will argue, because of the entrenched power of health insurers—power that the Medicare Modernization Act had played a significant role in affording them.

By backing down in this way, the Biden Administration missed clear opportunities to address the troubling trend of consolidation in health care. This trend is occurring across the

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[3] *See* JACOB HACKER, THE ROAD TO NOWHERE: THE GENESIS OF PRESIDENT CLINTON'S PLAN FOR HEALTH SECURITY (1997); THEDA SKOCPOL, BOOMERANG: HEALTH CARE REFORM AND THE TURN AGAINST GOVERNMENT (1996).

[4] *See* PAUL STARR, REMEDY AND REACTION: THE PECULIAR AMERICAN STRUGGLE OVER HEALTH CARE REFORM (2011); Jonathan Oberlander, *Implementing the Affordable Care Act: The Promise and Limits of Health Care Reform*, 41 J. HEALTH POL. POL'Y & L. 803 (2016).

[5] *See infra* text accompanying notes 87-100.

[6] *See* Kenneth J. Arrow, *Uncertainty and the Welfare Economics of Medical Care*, 53 AM. ECON. REV. 941 (1963).

[7] *See infra* text accompanying notes 77-86.

system: Physicians are increasingly working for hospitals, while hospitals are merging; insurance companies are buying up provider groups and merging themselves; providers and insurers are joining with health technology companies; and private equity firms are increasingly rolling up an array of market participants. The result is higher prices and more profits—and often reduced services for key populations (notably including people who live in rural areas) and lower wages for nurses and other health care workers.

Multiple studies have detailed the extent of the problem and its harms. Hospital acquisition of physician practices is growing: A September 2025 GAO report found that "at least 47 percent of physicians were employed by or affiliated with hospital systems in 2024, up from less than 30 percent in 2012."[8] So is acquisition of physician practices by insurance companies: A 2025 study by a group of leading health economists found that "[p]ayer-operated practices accounted for 4.2% of Medicare primary care services in 2023, up from 0.78% in 2016"—and that "Optum, the largest payer-affiliated entity" (which is a subsidiary of the massive insurer UnitedHealth) by itself "controlled 2.71% of the national primary care market by service volume in 2023."[9] KFF reports that Optum "now employs or is affiliated with about 10% of all practicing physicians."[10]

And private equity is making a big entrance into the field. "According to a nationally representative survey of physicians conducted by the American Medical Association, about 6.5 percent of physicians worked in private equity owned practices in 2024, up from 4.5 percent in 2022."[11] Although that number remains small, it is growing quickly—and private equity has taken an outsized role in certain specialties. The Biden Administration's Department of Health and Human Services reported some key data:

> PE firms have invested heavily in nursing homes, hospitals, and emergency departments. Some estimates suggest that more than 40% of the country's emergency rooms are "overseen by for-profit health care staffing companies owned by private equity firms." Up to a quarter of mental health and substance use facilities in some states are owned by PE.[12]

According to the GAO, "One study found that roughly 1.5 percent of primary care physicians were part of private equity-backed practices in 2022, while another study found 29 percent of retina specialists worked at private equity backed practices in the same year."[13] And "[a]nother study found that private equity firms invested in practices employing 6 percent of radiologists in 2021, up from about 1 percent in 2012; and in practices employing 11 percent of dermatologists in 2021, up from roughly 2 percent in 2012."[14] Private equity has taken a particularly outsized role in certain regions of the country. According to one study, "[i]n 120 of 384 MSAs, in 2021,

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[8] GAO, HEALTH CARE CONSOLIDATION: PUBLISHED ESTIMATES OF THE EXTENT AND EFFECTS OF PHYSICIAN CONSOLIDATION 16-17 (Sept. 2025), https://www.gao.gov/assets/gao-25-107450.pdf.
[9] Loren Adler *et al.*, *The Changing Landscape of Primary Care: An Analysis of Payer-Primary Care Integration*, HEALTH AFF. SCHOLAR, vol. 3, iss. 7, qxaf120 at 6.
[10] KFF, *Ten Things to Know About Consolidation in Health Care Provider Markets* (Apr. 19, 2024), https://www.kff.org/health-costs/ten-things-to-know-about-consolidation-in-health-care-provider-markets/.
[11] GAO, *supra* note 8, at 22.
[12] U.S. Dep't of Health & Human Servs., HHS Consolidation in Health Care Markets RFI Response 6 (Jan. 2025), https://www.hhs.gov/sites/default/files/hhs-consolidation-health-care-markets-rfi-response-report.pdf.
[13] GAO, *supra* note 8, at 22.
[14] *Id.*

PE firms collectively held a greater than 30 percent market share in at least one specialty, including forty-two in gastroenterology, thirty-one in dermatology, and twenty-one in obstetrics gynecology. In 60 of those 120 MSAs, PE firms collectively held a greater than 50 percent market share in at least one specialty, including nineteen MSAs in gastroenterology, fifteen in dermatology, and eight each in orthopedics and oncology"[15] The American Hospital Association has "estimated that private equity accounted for the majority of physician practice acquisitions from 2019 through 2023—representing 65 percent of physicians whose practices were acquired by any type of entity."[16]

As for hospitals, the Biden Administration's HHS made the following findings:

> Consolidation has been most pronounced in the hospital sector. In 1990, 65% of Metropolitan Statistical Areas (MSAs) in the country were considered highly concentrated for hospital services; by 2006, the share had increased to 77%, and by 2016, it was 90%. Consolidation trends have continued to this day. A study of 183 MSAs found that between 2017 and 2021, hospital system concentration rose in nearly 70% of MSAs and prices rose in 98%.[17]

The harmful effects on the health care system are well documented. "Numerous studies have shown that hospital consolidation within markets leads to price increases without consistent increases in quality, and that hospital systems that have vertically integrated with physicians are associated with higher hospital prices and spending."[18] And "evidence is emerging that cross-market hospital mergers lead to higher prices, with the most recent study finding that higher prices did not lead to a commensurate increase in quality."[19]

But the harmful effects go beyond the health system. As analysts in the Neo-Brandeisian school have argued, industry concentration gives dominant players not just market power but political power.[20] That dynamic has certainly played out in a health industry marked by increasing consolidation. As players like UnitedHealth have become dominant economically, they have used their power to resist regulation and bolster their own market power.

As the quotes above suggest, the Biden Administration recognized that consolidation is a major and increasing problem in the health industry. Yet its Medicare policies both missed clear opportunities to take on health care consolidation and in some cases actually further entrenched the market power of dominant players. Biden health policy officials undertook these policies for understandable reasons. To a large extent they acted out of legitimate fear that dominant industry players would stoke a political backlash if the Administration attempted to regulate more aggressively—thus bowing to the political power that consolidation itself gave those dominant players. But their decisions had the effect of bolstering the power of those who would oppose further gains in health care access, coverage, and efficiency.

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[15] Ola Abdelhadi *et al.*, *Private Equity–Acquired Physician Practices And Market Penetration Increased Substantially, 2012–21*, 43 HEALTH AFF. 354, 357 (2024).
[16] GAO, *supra* note 8, at 23.
[17] U.S. Dep't of Health & Human Servs., *supra* note 12, at 4.
[18] Katherine J. Gudiksen *et al.*, *Hospital Consolidation Across Geographic Markets: Insights from Market Participants on Mechanisms for Price Increases*, 50 J. HEALTH POL., POL'Y & L. 681, 682 (2025).
[19] *Id.*
[20] *See, e.g.*, TIM WU, THE CURSE OF BIGNESS: ANTITRUST IN THE NEW GILDED AGE (2018).

I examine these Biden Administration actions as missed opportunities to shift power in the health sector. Health care is necessary for individuals to live long and to flourish during their lives. It is also extremely significant economically—accounting for more than a sixth of GDP—and fiscally—accounting for more than a quarter of federal expenditures. At a moment when affordability was becoming perhaps the central domestic political issue, and fast-rising health care costs were increasingly placing heavy burdens on individuals, families, businesses, and governments, the failure to take on the large players in the health care industry was especially inopportune. I examine the decisions the Biden Administration made, why it made them, and how an administration that seeks to shift power can do better.

An Overview of Medicare Advantage and Medicare Part D

Medicare is the flagship government health insurance program in the United States—so much so that politicians who favor a public single-payer universal health care system refer to it as "Medicare for All."[21] Yet more than half of Medicare beneficiaries receive their hospital and physician coverage by contracting directly with private insurance companies through the "Medicare Advantage" program.[22] And *all* Medicare beneficiaries who have coverage for prescription drugs receive it by contracting directly with private insurance companies under Medicare Part D.[23] Those beneficiaries who participate in Medicare Advantage receive their Part D drug coverage from the private insurance plans from which they receive the rest of their Medicare coverage. The rest (about 40% of Part D beneficiaries as of this writing) receive their Part D coverage from private insurance companies with which they contract specifically for the prescription drug benefit.[24] Although Medicare Advantage and Medicare Part D plans carry the name "Medicare," and are financed by the Medicare program, beneficiaries receive their coverage from—and deal directly with—private insurance companies.

Congress created both Medicare Part D and the current iteration of Medicare Advantage in the Medicare Modernization Act of 2003.[25] As Kimberly Morgan and Andrea Campbell explain, a Republican-dominated Congress and the George W. Bush Administration adopted these provisions as part of an effort to expand the scope of public insurance programs—particularly to provide a prescription drug benefit, which had not previously existed, in Medicare—while at the same time delegating to the private sector increased responsibility for administering those programs.[26]

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[21] *See, e.g.,* Jonathan Oberlander, *Lessons from the Long and Winding Road to Medicare for All*, 109 AM. J. PUB. HEALTH 1497 (2019); Akilah Johnson, *Medicare-for-All Is Not Medicare, and Not Really for All. So What Does It Actually Mean?*, PROPUBLICA, Sept. 6, 2019, https://www.propublica.org/article/medicare-for-all-is-not-medicare-and-not-really-for-all-so-what-does-it-actually-mean.

[22] *See* Jeannie Fuglesten Biniek, Meredith Freed, Nancy Ochieng &Tricia Neuman, *Medicare Advantage Enrollment Grew by About 1 Million People, Mainly Due to Special Needs Plans*, KFF, Feb. 23. 2026, https://www.kff.org/medicare/medicare-advantage-enrollment-grew-by-about-1-million-people-mainly-due-to-special-needs-plans/.

[23] *See* Juliette Cubanski, *A Current Snapshot of the Medicare Part D Prescription Drug Benefit*, KFF, Oct. 9, 2024, https://www.kff.org/medicare/issue-brief/a-current-snapshot-of-the-medicare-part-d-prescription-drug-benefit/.

[24] For a good overview of Medicare Part D, see CONG. RESEARCH SERVICE, MEDICARE PART D PRESCRIPTION DRUG BENEFIT (Nov. 14, 2023).

[25] Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. 108-73, 117 Stat. 2066 (2003).

[26] *See* KIMBERLY J. MORGAN & ANDREA LOUISE CAMPBELL, THE DELEGATED WELFARE STATE: MEDICARE, MARKETS, AND THE GOVERNANCE OF SOCIAL POLICY 6 (2011).

Although the Bush Administration and congressional Republicans were wary of expanding Medicare, they felt compelled to respond to strong public pressure for a Medicare drug benefit. But they sought to place a conservative stamp on the policy by requiring it to be implemented through largely privatized means. Morgan and Campbell thus offer the Medicare Modernization Act as their prime example of what they call "the delegated welfare state."[27]

Because they both reflect this Republican agenda of privatization, Medicare Advantage and Medicare Part D share a key structural feature: They "purport[] to shift risk onto both private firms—putting their profits at stake in the hope of generating improved efficiency and quality—and onto individual beneficiaries, who [a]re tasked with purchasing their benefits or services in social welfare marketplaces."[28] But there are some important differences between the two programs.

Medicare Advantage

As amended by the Medicare Modernization Act, the Social Security Act provides that any beneficiary who is eligible for Medicare Part A (hospital coverage) and enrolled in Medicare Part B (physician coverage) may choose to receive traditional fee-for-service Medicare under Parts A and B or instead may choose to participate in Medicare Advantage (technically, Medicare Part C).[29] The operations of Medicare Advantage are complex, but here is how the program works in a nutshell. Beneficiaries may opt into Medicare Advantage when they first become eligible for Medicare, or during an open enrollment period each year.[30] They may also change Medicare Advantage plans during that open enrollment period—or even leave Medicare Advantage altogether to return to traditional Medicare.[31]

The plans that are available in any given geographic area depend on an intricate "bidding" process.[32] Each insurance company submits bids to CMS for each plan it intends to offer in that area. Medicare Advantage plans must provide the basic Part A and B benefits received by beneficiaries of traditional Medicare.[33] For the overwhelming majority of Medicare Advantage recipients (close to 90%), the plans also cover Part D benefits.[34] In addition, Medicare Advantage plans may offer services that are not covered by traditional Medicare. For

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[27] *Id.* at 4-6.
[28] MORGAN & CAMPBELL, *supra* note 26, at 6.
[29] 42 U.S.C. § 1395w–21.
[30] Alex Cottrill, Jeannie Fuglesten Biniek, Tricia Neuman & Juliette Cubanski, *What to Know about the Medicare Open Enrollment Period and Medicare Coverage Options*, KFF, Sept. 26, 2024, https://www.kff.org/medicare/issue-brief/what-to-know-about-the-medicare-open-enrollment-period-and-medicare-coverage-options/.
[31] Although beneficiaries may legally return from Medicare Advantage to traditional Medicare, they may find it practically impossible to do so. Traditional Medicare imposes substantial out-of-pocket costs, which beneficiaries typically cover by purchasing a private "Medigap" plan. "But unless you sign up for Medigap soon after you're first eligible, insurers can often deny coverage or charge steeper premiums based on preexisting conditions." Sarah Jane Tribble, *Medicare Advantage is Popular, But Some Beneficiaries Feel Buyer's Remorse*, WASH. POST, Jan. 23, 2024, https://www.washingtonpost.com/politics/2024/01/23/medicare-advantage-is-popular-some-beneficiaries-feel-buyers-remorse/. Individuals who try to opt out of Medicare Advantage thus often find themselves unable to obtain Medigap coverage, and thus unable to afford returning to traditional Medicare.
[32] The regulations governing this process appear at 42 C.F.R. § 422.250 *et seq.*
[33] *See* Christina Ramsay, Gretchen Jacobson, Steven Findlay & Aimee Cicchiello, *Medicare Advantage: A Policy Primer*, COMMONWEALTH FUND (Jan. 31, 2024), https://www.commonwealthfund.org/publications/explainer/2024/jan/medicare-advantage-policy-primer.
[34] *See* Biniek *et al.*, *supra* note 22.

example, "[m]ost plans offer additional benefits such as eyeglasses, hearing aids, and some coverage of dental care, such as cleanings."[35] The coverage of these additional benefits has made Medicare Advantage especially attractive to many beneficiaries.[36]

Unlike traditional Medicare, Medicare Advantage plans are required to cap beneficiary out-of-pocket expenses.[37] And although participants in traditional Medicare must pay a monthly premium to participate in Part B physician coverage—and in Part D prescription drug coverage in many cases—Medicare Advantage plans may effectively reduce or (in the case of Part D) waive those premiums; indeed, the vast majority waive the Part D premium entirely.[38] These limits on out out-of-pocket expenses also make Medicare Advantage plans attractive to beneficiaries—particularly in a time when "[p]remiums for Part D stand-alone prescription drug plans" are "rising rapidly."[39]

But these additional benefits come at a cost to beneficiaries. Although Medicare Advantage plans must cover the benefits covered by traditional Medicare, they may restrict access to those benefits in ways traditional Medicare does not—by reimbursing covered services only in limited provider networks, or by imposing prior authorization or other medical management requirements for particular treatments, for example.[40]

Indeed, it is these cost-cutting tools of managed care that enable Medicare Advantage plans to provide the services that traditional fee-for-service Medicare does not, and to limit beneficiaries' out-of-pocket charges. The structure for compensating these plans makes this point clear. Plans receive a capitation payment—a set amount for each beneficiary they serve. Because they assume the risk that the costs for a given beneficiary will exceed the capitation payment, they have an incentive to design their benefits to keep those costs down.[41]

The bidding process amplifies that incentive. When Medicare Advantage plans submit bids to CMS, they do so against a benchmark set based on the cost of serving a beneficiary under traditional fee-for-service Medicare in the geographic area they wish to serve.[42] To avoid giving plans an incentive just to serve the healthiest individuals, the bids are "risk-adjusted"—plans will receive higher payments for beneficiaries with more or more serious conditions, and lower payments for those with fewer or less serious conditions.[43] The bids are also adjusted based on

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[35] *Id.*
[36] *See* Tricia Neuman, Meredith Freed & Jeannie Fuglesten Biniek, *10 Reasons Why Medicare Advantage Enrollment is Growing and Why It Matters*, KFF, Jan. 30, 2024, https://www.kff.org/medicare/issue-brief/10-reasons-why-medicare-advantage-enrollment-is-growing-and-why-it-matters/.
[37] *See* Ramsay, *et al.*, *supra* note 33.
[38] *Id.*
[39] Neuman, *et al.*, *supra* note 36. This year, that trend reversed so that average Part D premiums have gone down. *See* Juliette Cubanski, *Few Plans Are Increasing Premiums by $50, the Maximum Allowed Under the PDP Premium Stabilization Demonstration*, KFF, Oct. 7, 2025, https://www.kff.org/medicare/medicare-part-d-premiums-are-decreasing-for-many-stand-alone-drug-plans-in-a-number-of-states-in-2026/.
[40] *See* Ramsay, *et al.*, *supra* note 33.
[41] *See id.*
[42] *See id.* "For counties with relatively low spending, benchmarks are set higher than average spending for traditional Medicare (for example, 115%); for counties with relatively high spending, benchmarks are set lower than average traditional Medicare spending (for example, 95%)." *Id.*
[43] *See id.*

quality measures, so that those plans that receive higher "star ratings" from CMS will bid against a higher benchmark.[44]

Plans may not submit bids above the (risk- and quality-adjusted) benchmark for the area they seek to serve.[45] But if a plan's bid comes in below that benchmark, the plan is entitled to a "rebate" of a portion of the difference. "Plans are required to use the rebate to lower patient cost sharing, lower premiums, or provide some coverage for benefits not included in traditional Medicare. Rebate dollars also can be used to pay for administrative expenses and profits associated with providing additional benefits."[46] Private insurers participating in Medicare Advantage thus have a particular incentive to use managed-care techniques to reduce their expenditures so they can cover the additional services that play such a powerful role in inducing beneficiaries to sign up with them.

Medicare Part D

As I noted above, most Medicare beneficiaries who receive prescription drug coverage do so through Medicare Advantage plans. But a large minority receive that coverage through stand-alone Part D plans. As with Medicare Advantage, a beneficiary can sign up for a Part D plan either when initially enrolling in Medicare or during an open-enrollment period; beneficiaries may also change to a different Part D plan during open enrollment.[47] As under Medicare Advantage, insurance companies design plans and compete with each other to sign up beneficiaries. Part D plans "must offer at least a minimum package of benefits," which "may include either a standard package of prescription drug coverage established under law (the standard benefit) or an alternative package that is actuarially equivalent."[48] "Plans may also offer enhanced coverage that exceeds the value of standard coverage."[49] In exchange, beneficiaries must pay "(1) a monthly premium, (2) a capped, annual deductible, and (3) copayments or coinsurance for drug purchases."[50] Plans with enhanced benefits typically charge higher premiums.[51] Pursuant to a provision in the Inflation Reduction Act, beneficiary deductibles and copayments or coinsurance are capped at $2,000 per year beginning in 2025.[52]

Part D plans set their premiums through their own bidding process, one that involves a complex set of calculations and subsidies by CMS. Premiums depend on drug costs generally, as well as on each plan's decisions regarding what drugs to cover and how generous that coverage should be.

Part D plans may establish a formulary defining which drugs they will cover. That formulary "must be developed and reviewed by a pharmacy and therapeutic committee" dominated by practicing physicians and pharmacists who rely on "scientific evidence and standards of practice."[53] Each plan must generally cover at least two drugs "within each

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[44] *See id.*
[45] *See id.*
[46] *See id.*
[47] CONG. RESEARCH SERVICE, MEDICARE PART D PRESCRIPTION DRUG BENEFIT 7-8 (Nov. 14, 2023).
[48] *Id.* at 14.
[49] *Id.*
[50] *Id.* at 13.
[51] *See id.* at 14.
[52] *See* 42 U.S.C. § §1395w–102(b)(4)(B)(VII).
[53] 42 C.F.R. § 423.120(b)(1); *see* 42 U.S.C. § 42 U.S.C. 1395w-104(b)(3).

therapeutic category and class,"[54] though plans must generally cover all drugs within six "protected classes": anticonvulsants, antidepressants, antineoplastics, antipsychotics, antiretrovirals, and immunosuppressants for the treatment of transplant rejection.[55] Plans must employ a "cost-effective drug utilization management program,"[56] which may include prior authorization and step therapy requirements.[57] Plans also generally engage in "tiered cost-sharing,"[58] in which they "assign formulary drugs to tiers that correspond to different levels of cost sharing."[59] This practice typically "encourages use of generic medications by placing these medicines on the plan tier with the lowest out-of-pocket costs, and discourages the use of more expensive or less effective drugs by putting them on tiers that require higher out-of-pocket spending."[60]

A Part D plan's premiums will typically depend significantly on these formulary decisions, as well as on the insurance company's dealings with pharmaceutical manufacturers regarding the prices the manufacturers will charge for their drugs. The company that sponsors the Part D plan (often acting through a pharmacy benefits manager) will negotiate with a manufacturer to place a drug on a lower tier (one that requires less out-of-pocket spending by the beneficiary) in exchange for a rebate off of the manufacturer's list price.[61] For the drugs for which CMS negotiates a price directly with the manufacturer under the Inflation Reduction Act, that price—the "maximum fair price"[62]—is the starting point for each insurance company's negotiation for the price that will be charged its plan.

For 2025, the average Medicare beneficiary had "a choice of 48 Medicare plans with Part D drug coverage."[63] That number included 14 stand-alone Part D plans and 34 Medicare Advantage plans that included drug coverage.[64]

How Medicare Advantage and Medicare Part D Harm Consumers and the Public Fisc

I discuss the Medicare prescription drug program (Part D) and the Medicare Advantage program together, because each took their current form in the same legislation (the Medicare Modernization Act of 2003), and most people who receive Part D benefits do so through Medicare Advantage plans.[65] Each policy rests on the same premise—that competition among

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[54] 42 C.F.R. § 423.120(b)(2).
[55] 42 U.S.C. § 1395w–104(b)(3)(G)(iv).
[56] 42 U.S.C. § 1395w–104(c)(1)(A).
[57] *See generally* Geoffrey Joyce, Barbara Blaylock, Jiafan Chen &Karen Van Nuys*, Medicare Part D Plans Greatly Increased Utilization Restrictions On Prescription Drugs, 2011–20*, 43 HEALTH AFF. 391 (2024). CMS regulations bar Part D plans from imposing these requirements on antiretroviral prescriptions; for the other five protected classes, Part D plans may impose these requirements only "for enrollees that are not on existing therapy on the protected class Part D drug." 42 C.F.R. § 423.120(b)(2)(vi)(C).
[58] 42 C.F.R. § 423.4.
[59] CONG. RESEARCH SERVICE, MEDICARE PART D PRESCRIPTION DRUG BENEFIT 36 (Nov. 14, 2023).
[60] *Id.*
[61] *See id.* at 42, 57-59.
[62] 42 U.S.C. § 1320f-2(a)(1).
[63] Juliette Cubanski & Anthony Damico, *Medicare Part D in 2025: A First Look at Prescription Drug Plan Availability, Premiums, and Cost Sharing*, KFF, Nov. 22, 2024, https://www.kff.org/medicare/issue-brief/medicare-part-d-in-2025-a-first-look-at-prescription-drug-plan-availability-premiums-and-cost-sharing/.
[64] *Id.*
[65] *See* MEDICARE PAYMENT ADVISORY COMM'N, REPORT TO CONGRESS: MEDICARE PAYMENT POL'Y xxix (March 2026) ("With the ongoing enrollment shift from PDPs to MA–PDs, PDPs now account for less than 42 percent of all

private insurers will lead to more cost-effective coverage, as consumers have an incentive to choose the plans that meet their needs at the lowest cost, and insurers have an incentive to provide those plans.[66]

Yet there is ample reason to doubt that the premise holds in practice. For one thing, these programs have been associated with substantial consolidation in the insurance market—consolidation that will ultimately deprive consumers of choices among insurers. A recent study found that "[n]ationally, the large national carriers (Cigna, CVS, Elevance, Humana, and UnitedHealthcare) increased their market share" in Medicare Advantage "from less than 50 percent in 2012 to almost 66 percent in 2023."[67] This trend "was closely related to the decline in regional carriers, which were the primary targets of acquisitions by some national carriers."[68] (In the past year, some of the largest insurers have begun to reduce their Medicare Advantage enrollments, which has slightly reduced market concentration; but other large insurers have increased their enrollments at the same time.[69])

The same trends are evident in Part D plans. KFF reported in 2025 that "Part D enrollment is concentrated in a handful of top plan sponsors, with 5 firms covering 73.5% of all Part D enrollees in 2025, or 40.2 million out of 54.8 million enrollees."[70] About 23% of beneficiaries were "in Part D plans sponsored by UnitedHealth," with "CVS, Humana, and Centene each hav[ing] around 15% of the Part D market," and Cigna having just under 7%.[71] UnitedHealth, in particular, has been called "a modern-day Standard Oil, exerting unmatched dominance over health care in the United States."[72]

In addition to horizontal consolidation among insurers, Part D is experiencing growing vertical integration as well. The program is "increasingly concentrated among the largest sponsors that own (or are owned by) a PBM [pharmaceutical benefits manager] and pharmacies."[73] UnitedHealth (an insurer) owns OptumRx (a PBM); CVS Health owns Aetna (an insurer) and Caremark (a PBM), as well as CVS pharmacies; and Cigna (an insurer) owns Express Scripts (a PBM). All told, 77% of Part D beneficiaries receive coverage from an insurance company that is affiliated with a PBM.[74] An analysis of 2023 data found that 33.4% of

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Part D enrollees, down from 53 percent in 2020. The number of PDPs has declined, especially among enhanced plans, while the number of SNPs—a type of MA plan—has grown.").

[66] *See* MORGAN & CAMPBELL, *supra* note 26, at 6, 18-19.

[67] Joseph G. P. Hnath, J. Michael McWilliams & Michael E. Chernew, Medicare Advantage: *National Carriers Expand Market Share While Regional Carriers Without Affiliation Decline, 2012–23*, 43 HEALTH AFF. 1647, 1652 (2024).

[68] *Id.*

[69] *See* Biniek *et al.*, *supra* note 22.

[70] KFF, *Key Facts About Medicare Part D Enrollment, Premiums, and Cost Sharing in 2025* (July 16, 2025), https://www.kff.org/medicare/key-facts-about-medicare-part-d-enrollment-premiums-and-cost-sharing-in-2025/.

[71] *Id.*

[72] Bob Herman, *et al.*, *How UnitedHealth Harnesses its Physician Empire to Squeeze Profits out of Patients*, STAT, July 25, 2024, https://www.statnews.com/2024/07/25/united-health-group-medicare-advantage-strategy-doctor-clinic-acquisitions/.

[73] MedPAC, *Report to the Congress: Medicare and the Health Care Delivery System* 70 (June 2023), https://www.medpac.gov/wp-content/uploads/2023/06/Jun23_Ch2_MedPAC_Report_To_Congress_SEC.pdf.

[74] Amer. Med. Ass'n, *Competition in PBM Markets and Vertical Integration of Insurers with PBMs: 2024 Update* (2024), https://www.ama-assn.org/system/files/prp-pbm-shares-hhi-2024.pdf.

Part D prescriptions were filled through Caremark, 27.7% through OptumRx, and 15.4% through Express Scripts.[75]

What is true at the national level is also true at the local level. A recent KFF analysis found that: "[m]ost (89%) Medicare Advantage enrollees were in highly concentrated markets, with another 4% of Medicare Advantage enrollees in very highly concentrated markets"; "[n]ine in ten (90%) Medicare beneficiaries lived in a county where at least half of all Medicare Advantage enrollees were in plans sponsored by one or two insurers in 2024"; and "[i]n more than four in ten counties (44%), comprising 22% of all Medicare Advantage enrollment, a single Medicare Advantage insurer had at least 50% of enrollment in 2024, including 22% of counties where UnitedHealthcare had at least 50% of enrollment and 10% of counties where Humana had at least 50% of enrollment."[76]

Even in the presence of industry consolidation—and a reduction in the number of plans available in the past year[77]—many beneficiaries find themselves overwhelmed by plan options and unable to make an informed choice among them.[78] This is a common problem in health insurance markets.[79] As the Medicare Payment Advisory Commission has observed, Medicare Advantage "[p]lan benefit packages vary, and research has found that beneficiaries have difficulty comparing plans and deciding which one best meets their needs when they have many choices."[80] Indeed, there is substantial evidence that most Medicare Advantage and Medicare Part D beneficiaries do not even compare their existing plans with available alternatives during the open enrollment period.[81] That can be a particular problem because "[c]overage and costs vary widely among both Medicare Advantage plans and Part D prescription drug plans and can

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[75] *See* Dima M Qato, Yugen Chen & Karen Van Nuys, *Pharmacy Benefit Manager Market Concentration for Prescriptions Filled at US Retail Pharmacies*, 332 J. AM. MED. ASSN. 1298 (2024).
[76] KFF, *Most Medicare Advantage Markets are Dominated by One or Two Insurers* (July 14, 2025), https://www.kff.org/medicare/most-medicare-advantage-markets-are-dominated-by-one-or-two-insurers/.
[77] *See* Meredith Freed, Jeannie Fuglesten Biniek, Nancy Ochieng & Tricia Neuman, *Medicare Advantage 2026 Spotlight: A First Look at Plan Offerings*, KFF (Oct. 2025), https://www.kff.org/medicare/medicare-advantage-2026-spotlight-a-first-look-at-plan-offerings/ (average beneficiary can choose from 32 MA plans in 2026, down from 43 in 2025, and from 15 stand-alone Part D plans in 2026, down from 21 in 2025).
[78] *See* MORGAN & CAMPBELL, *supra* note 26, at 203-206; *see also* Christina Ramsay, Gretchen Jacobson, Steven Findlay & Aimee Cicchiello, *Medicare Advantage: A Policy Primer*, COMMONWEALTH FUND (Jan. 31, 2024), https://www.commonwealthfund.org/publications/explainer/2024/jan/medicare-advantage-policy-primer ("For Medicare beneficiaries, the choice between traditional Medicare and a Medicare Advantage plan, or between individual Medicare Advantage plans, can be frustrating, complex, and confusing.").
[79] *See* Saurabh Bhargava, George Loewenstein & Justin Sydnor, *Choose to Lose: Health Plan Choices from a Menu with Dominated Options*, 132 Q. J. ECON. 1319 (2017); Katherine Baicker, William J. Congdon & Sendhil Mullainathan, *Health Insurance Coverage and Take-Up: Lessons from Behavioral Economics*, 90 MILBANK Q. 107 (2012).
[80] MEDICARE PAYMENT ADVISORY COMM'N, REPORT TO THE CONGRESS: MEDICARE AND THE HEALTH CARE DELIVERY SYSTEM 109 (June 2023).
[81] *See, e.g.,* Wändi Bruine de Bruin, Nathan Hodson, Lila Rabinovich, Daniel Czarnowske, Florian Heiss, Joachim Winter, Amelie Wuppermann & Daniel McFadden, *Medicare Part D Beneficiaries' Self-Reported Barriers to Switching Plans and Making Plan Comparisons at All*, 2 HEALTH AFF. SCHOLAR qxae141 (2024); Florian Heiss, Daniel McFadden, Joachim Winter, Amelie Wuppermann & Bo Zhou, *Inattention and Switching Costs as Sources of Inertia in Medicare Part D*, 111 AM. ECON. REV. 2737 (2021); Nancy Ochieng, Juliette Cubanski, Meredith Freed & Tricia Neuman, *Nearly 7 in 10 Medicare Beneficiaries Did Not Compare Plans During Medicare's Open Enrollment Period*, KFF, Sept. 26, 2024, https://www.kff.org/medicare/issue-brief/nearly-7-in-10-medicare-beneficiaries-did-not-compare-plans-during-medicares-open-enrollment-period/.

change from one year to the next, which could lead to unexpected and avoidable costs and disruptions in care for beneficiaries who do not review their options annually."[82]

Many beneficiaries simply find the number of choices overwhelming, the differences among them difficult to process, and the utility of particular benefits difficult to predict. But absent a true opportunity for consumers to compare plans, the market mechanism on which the statute is premised cannot be expected to work. Even when they do make comparisons, beneficiaries primarily focus on the premium they are paying; they thus miss the prior-authorization requirements, narrow provider networks, and other practices under which the private insurers carrying out these programs deny care to their enrollees.[83] As Pamela Herd summarizes the problem, "Beneficiaries must now confront a dizzying array of choices that mostly generate confusion and frustration, which can lead to costly consequences, both in terms of older adult[s'] finances and their health when they inevitably make mistakes choosing."[84]

The result is that consumers are likely paying too much, and receiving too little, under these programs.[85] And the insurers are the ones who profit. The problem is not just financial. "Failure to switch to a financially optimal prescription drug plan can have health consequences, because beneficiaries may try to manage their costs by limiting their use of prescribed medications."[86]

But the problems go beyond insurers profiting off of drug plans that poorly serve their beneficiaries. Medicare Advantage in particular has become a major engine of government

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[82] Nancy Ochieng, Juliette Cubanski, Meredith Freed & Tricia Neuman, *Nearly 7 in 10 Medicare Beneficiaries Did Not Compare Plans During Medicare's Open Enrollment Period*, KFF, Sept. 26, 2024, https://www.kff.org/medicare/issue-brief/nearly-7-in-10-medicare-beneficiaries-did-not-compare-plans-during-medicares-open-enrollment-period/.

[83] *See* OFF. OF INSPECTOR GEN., DEP'T OF HEALTH & HUMAN SERVICES, SOME MEDICARE ADVANTAGE ORGANIZATION DENIALS OF PRIOR AUTHORIZATION REQUESTS RAISE CONCERNS ABOUT BENEFICIARY ACCESS TO MEDICALLY NECESSARY CARE (April 2022), https://oig.hhs.gov/documents/evaluation/3150/OEI-09-18-00260-Complete%20Report.pdf; U.S. Sen. Perm. Subcomm. on Investigations, *Refusal of Recovery: How Medicare Advantage Insurers Have Denied Patients Access to Post-Acute Care* (Maj. Staff Rep., Oct. 17, 2024), https://www.hsgac.senate.gov/wp-content/uploads/2024.10.17-PSI-Majority-Staff-Report-on-Medicare-Advantage.pdf; Robert King, *'It Was Stunning': Bipartisan Anger Aimed at Medicare Advantage Care Denials*, POLITICO, Nov. 24, 2023, https://www.politico.com/news/2023/11/24/medicare-advantage-plans-congress-00128353.

[84] Pamela Herd, *Making Medicare Complicated: How Privatizing Medicare is Increasing Administrative Burden for Beneficiaries*, 31 PUB. POL'Y & AGING REP. 133, 133 (2021).

[85] *See* Wändi Bruine de Bruin, Nathan Hodson, Lila Rabinovich, Daniel Czarnowske, Florian Heiss, Joachim Winter, Amelie Wuppermann & Daniel McFadden, *Medicare Part D Beneficiaries' Self-Reported Barriers to Switching Plans and Making Plan Comparisons at All*, 2 HEALTH AFF. SCHOLAR qxae141 (2024) ("If all beneficiaries chose the financially optimal plan, it would save the government an estimated $1.3 billion every 3 years."); Florian Heiss, Daniel McFadden, Joachim Winter, Amelie Wuppermann & Bo Zhou, *Inattention and Switching Costs as Sources of Inertia in Medicare Part D*, 111 AM. ECON. REV. 2737 (2021); Florian Heiss, Adam Leive, Daniel McFadden & Joachim Winter, *Plan Selection in Medicare Part D: Evidence from Administrative Data*, 32 J. HEALTH ECON. 1325 (2013) (concluding that "fewer than 25 percent of individuals enroll in plans that are ex ante as good as the least cost plan specified by the CMS Plan Finder benchmark" under Part D, and that compared to that "benchmark, enrollees lost on average about $300 per year"); Allison K. Hoffman, *Health Care's Market Bureaucracy*, 66 UCLA L. REV. 1926, 1955 (2019) ("Despite some early evidence suggesting that people might get better at making decisions in the Medicare Part D program over time, these poor choices have persisted in the decade since the program began and have in fact grown worse, suggesting that people are not becoming better consumers.") (footnotes omitted); *id.* at 1956 (describing similar findings for Medicare Advantage).

[86] de Bruin, *supra* note 81.

waste. A recent report from the Medicare Payment Advisory Commission estimates that "In 2026, we estimate that Medicare will spend 14 percent—a projected $76 billion—more for [Medicare Advantage] enrollees than it would spend if those beneficiaries were enrolled in [fee-for service] Medicare."[87] And the "two largest factors responsible," the Commission found, "are favorable selection and coding intensity."[88]

To understand how favorable selection and coding intensity work, recall that Medicare Advantage plans are paid on a capitated basis: They receive a fixed sum each month for each patient, a sum that is based on the average cost of insuring a beneficiary of Medicare's traditional fee-for-service program in the area served by the plan.[89] Capitation is designed to give the insurer an incentive to hold down costs by ensuring that care is delivered most efficiently; the insurer bears the risk if a beneficiary's care costs more than the capitation payment, and it profits if the care costs less than that payment. "The prospective, lump-sum payment approach has the potential to curb costly and unnecessary overtreatment that the fee-for-service approach tends to encourage, and it favors preventative care and other health-protective measures, enabling cost efficiencies that can elude a fee-for-service system."[90]

But of course the insurer could hold down costs a different way—by covering only those individuals who, because of their medical history, are likely to use less expensive services than the average fee-for-service beneficiary. That is "favorable selection"—favorable, to be clear, for the insurer but not to the program as a whole. The insurer profits without achieving any particular efficiencies for the system, but simply by covering patients who can be expected to have below-average costs—all while shifting the costs of more expensive patients onto other insurers or traditional Medicare.

Congress dealt with favorable selection through two key provisions. First, it barred Medicare Advantage plans from discriminating based on health status in their coverage decisions.[91] That provision addresses the most blatant acts of favorable selection. Second, Congress adopted a "risk adjustment" to the capitation payment. Rather than simply setting the capitation amount at the average cost of insuring a fee-for-service beneficiary, Congress required CMS to adjust that amount up or down based on "such risk factors as age, disability status, gender, institutional status, and such other factors as the Secretary determines to be appropriate, including adjustment for health status," all in an effort "to ensure actuarial equivalence."[92] In other words, if an individual's risk factors make it likely *ex ante* that serving that individual will be more costly than serving the average fee-for-service beneficiary, CMS will increase the capitation payment accordingly. And if an individual's risk factors cut the other way, CMS will decrease the capitation payment.

In theory, these two provisions should eliminate insurers' incentive to engage in favorable selection. But they do not. As the Medicare Payment Advisory Commission has found, Medicare Advantage plans still engage in favorable selection. This is because the risk factors identified by CMS are not comprehensive. Insurers have an incentive to enroll beneficiaries

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[87] MEDICARE PAYMENT ADVISORY COMM'N, *supra* note 65, at xxvi.
[88] *Id.* at xxvii.
[89] *See* 42 U.S.C. § 1395w-23.
[90] UnitedHealthcare Ins. Co. v. Becerra, 16 F.4th 867, 873 (D.C. Cir. 2021).
[91] 42 U.S.C. § 1395w-22(b)(1).
[92] 42 U.S.C. § 1395w-23(a)(1)(C)(i).

whom CMS erroneously treats as high-risk. If Medicare Advantage plans can identify the individuals for whom CMS is overstating the risk, those plans can profit by pocketing the risk adjustment. Although the law prohibits these plans from engaging in formal discrimination against enrollees based on their health conditions or risks, they have ways of more subtly ensuring that they cover a less risky pool of beneficiaries.[93] And that appears to be exactly what those plans are doing.[94]

So much for "favorable selection." What is "coding intensity"? The term refers to a practice under which Medicare Advantage plans themselves can inflate the risk scores for their beneficiaries. The risk adjustment the government provides an insurer "varies according to demographic characteristics and diagnoses that CMS has determined, based on its past experience in traditional Medicare, to be predictive of healthcare costs."[95] Under traditional Medicare, providers do not have an incentive to report every condition a patient might have. Because they get paid only for the particular services they provide, they will report to CMS only those diagnoses that led them to provide a particular treatment. But because Medicare Advantage plans get more money with each additional diagnosis, they have an incentive to report every condition with which one of their beneficiaries is diagnosed—even if it would never lead to treatment.

Sometimes, this incentive can lead to outright fraud.[96] But even when the diagnoses are valid, the program's incentives create, in the words of former CMS official Sean Cavanaugh, "a nonproductive industry where there are businesses that collect diagnoses on Medicare Advantage solely for the purpose of getting paid—not to improve the care that these folks receive, but to improve the payment that the plans receive."[97]

The problem is well known. "Federal watchdogs and whistleblowers have warned government regulators for more than 15 years that health insurers have been abusing risk adjustment in Medicare Advantage, such as by exaggerating or fabricating someone's illnesses."[98] The result is to increase Medicare premiums—for both MA and traditional Medicare recipients. In 2026, Congress's Joint Economic Committee found that "[Medicare Advantage] overpayments increased Part B premiums by $212 per enrollee in 2025, totaling

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[93] *See, e.g.,* Lindsay F. Wiley, *Privatized Public Health Insurance and the Goals of Progressive Health Reform*, 54 U.C. DAVIS L. REV. 2149, 2184 (2021) ("The privatized plans are prohibited from imposing eligibility criteria and must take all comers, but commentators note that privatized plans may seek to 'skim the cream' of the public program risk pool by attracting healthier enrollees with enhanced convenience and wellness services and discouraging less healthy enrollees by imposing onerous requirements on those who use a lot of treatment services.") (footnotes omitted).

[94] *See* MEDICARE PAYMENT ADVISORY COMM'N, REPORT TO CONGRESS: MEDICARE PAYMENT POL'Y 343-346 (March 2025).

[95] *UnitedHealthcare*, 16 F.4th at 869–70.

[96] *See id.* (upholding a CMS effort to counteract such fraud and noting that "[p]ayments to the Medicare Advantage program depend on participating insurers accurately reporting to CMS their beneficiaries' salient demographic information and medically documented diagnosis codes").

[97] Bob Herman, *Former Top Medicare Official Says Medicare Advantage's Coding Industry Offers 'No Benefit to Society,'* STAT, May 18, 2022, https://www.statnews.com/2022/05/18/medicare-advantage-coding-no-benefit/.

[98] Bob Herman, *Unitedhealth Has Turned Medicare Advantage Coding Into 'Profit-Centered Strategy,' Senate Report Finds*, STAT, Jan. 12, 2026, https://www.statnews.com/2026/01/12/unitedhealth-medicare-advantage-coding-profit-strategy-grassley-senate-report/.

$13.4 billion in higher premiums."[99] And "[traditional Medicare] beneficiaries, who are not enrolled in MA, bore roughly $6 billion of that burden."[100]

How Medicare Advantage and Medicare Part D Promote Consolidation

The opportunity to make money off of upcoding Medicare Advantage beneficiaries has encouraged industry consolidation, as insurers who run MA plans purchase medical practices, steer their enrollees to those practices, and direct the doctors at those practices to code as many diagnoses as possible.[101] When insurers own medical practices, they can "embed technology, workflows, and compensation structures that maximize coding."[102] And when insurers own information technology providers—as UnitedHealthcare does since its acquisition of Change Healthcare, a company that provides billing services and financial analytics to health systems across the country—they "can leverage their data across lines of business to target practices with profitable patients" for acquisition.[103] As a recent analysis explains, the large insurers that participate in Medicare Advantage "are acquiring physician practices and care-delivery companies in order to execute a two-pronged strategy that involves maximizing capitated payments and reducing costs by means of utilization controls and 'intercompany transfers' (*i.e.*, paying their provider-side subsidiaries)."[104] Not surprisingly, empirical evidence suggests that "coding intensity increases with vertical integration."[105]

The Medicare Advantage "star rating" system promotes vertical integration as well. In the words of a recent analysis from the American Economic Liberties project, "vertical conglomerates can inflate quality scores with greater control of clinicians":

> They can, for example, game medication adherence quality measures by pushing providers to put their patients on 90-day refills, mail-order prescriptions, and automatic refills, even if patients never take the medications. Similarly, they can discourage or

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[99] Joint Econ Comm., *The Part B Premium Pass Through: Medicare Advantage Overpayments Inflate Premiums for All*, Mar. 10, 2026, https://www.jec.senate.gov/public/vendor/_accounts/JEC-R/issue-briefs/The%20Part%20B%20Premium%20Pass-Through.pdf.

[100] *Id.*

[101] *See* Christopher Weaver, Anna Wilde Mathews & Tom McGinty, *UnitedHealth's Army of Doctors Helped It Collect Billions More from Medicare*, WALL ST. J., Dec. 29, 2024, https://www.wsj.com/health/healthcare/unitedhealth-medicare-payments-doctors-c2a343db?&mod=article_inline; *see also* Herman, *et al.*, *supra* note 72 ("Central to these tactics is UnitedHealth's unrivaled leverage over physicians, whose diagnoses help determine how much private insurers get paid for covering older adults. Dozens of former doctors and employees at UnitedHealth medical practices told STAT how they became enmeshed in UnitedHealth's strategy to make their patients seem as sick as possible. Doctors said the company had a fixation with medical coding to generate more revenue — encouraging clinicians through bonuses and performance reviews to identify more health problems in patients, even if those conditions seemed dubious."); *see generally* MEDICARE PAYMENT ADVISORY COMM'N, REPORT TO CONGRESS: MEDICARE PAYMENT POL'Y 368 (March 2025) (noting that "MA payment policy—though not the only factor influencing firms' decisions to integrate—likely promotes such arrangements by," among other things, "rewarding plans that record diagnoses more thoroughly").

[102] Amer. Econ. Liberties Proj., *Medicare Advantage and Vertical Consolidation in Health Care* 25 (Apr. 2024), https://www.economicliberties.us/wp-content/uploads/2024/04/Medicare-Advantage-AELP.pdf; *see also id.* at 26 ("The centrality of data in diagnosis coding puts vertical conglomerates in the driver's seat.").

[103] *Id.* at 31.

[104] Hayden Rooke-Ley, Soleil Shah & Erin C. Fuse Brown, *Medicare Advantage and Consolidation's New Frontier*, 391 NEW ENG. J. MED. 97, 98 (2024).

[105] Michael Geruso & Timothy Layton, *Upcoding: Evidence from Medicare on Squishy Risk Adjustment*, 12 J. POL. ECON. 984 (2020).

prohibit clinicians from giving samples to patients and allowing them to use lower-cost alternatives.[106]

The star rating system also "require[s] significant administrative efforts, placing small practices at a disadvantage," and creating opportunities for the large insurers to acquire those practices.[107]

For many of the same reasons that Medicare Advantage promotes vertical integration, it promotes horizontal consolidation among insurers. A large customer base is what provides insurers with the capital to purchase providers; to the extent that the structure of MA favors vertically integrated enterprises, it necessarily also favors insurers with a large enough market share to be able to integrate vertically.

As for Part D, vertically integrated Medicare prescription drug plans seem to be using their relationships with PBMs to draw higher payments from the government than insurers without those relationships can.[108] The structure of Part D also enables "vertical conglomerates that own PBMs" to "devise formularies and copays that funnel patients to their own pharmacies"—thus increasing their own profits and "squeezing independent pharmacies."[109]

Most significantly, the number of stand-alone Part D plans has dropped precipitously in recent years, a development that has pushed beneficiaries into Medicare Advantage if they wish to obtain prescription drug coverage. In 2026, "a total of 360 PDPs will be offered by 17 different parent organizations across the 34 PDP regions."[110] That's "a 22% decrease in PDPs from 2025 (and nearly half as many as in 2024) and 2 fewer parent organizations."[111] This dramatic shift seems to result from two factors: (1) the opportunity for Medicare Advantage plans to use their rebates to cross-subsidize prescription drug coverage, and thus draw customers away from Part D plans; and (2) the greater ability of Medicare Advantage plans to game risk scores and thus receive greater federal reimbursements than stand-alone Part D plans.[112] This development further exacerbates the consolidation problems caused by Medicare Advantage itself.

The Biden Administration's Failure to Mount an Effective Response

Medicare Advantage

Biden Administration officials understood that insurers had manipulated the Medicare Advantage risk adjustment system, to the detriment of the Medicare Trust Fund. And they proposed policies that would have helped address, even if they wouldn't have fully solved, the problem. But at crucial moments the administration backed down. In 2023, it finalized a regulation creating a more aggressive policy for auditing MA plans' coding decisions—but it "watered down" a key piece of that policy "by giving insurers seven years of immunity from having the samples of their diagnosis coding errors extrapolated to their broader Medicare

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[106] Amer. Econ. Liberties Proj., *supra* note 102, at 27.
[107] *Id.*
[108] *See* MedPAC, *Report to Congress: Medicare and the Health Delivery System* 98 (May 2023), https://www.medpac.gov/wp-content/uploads/2023/06/Jun23_Ch2_MedPAC_Report_To_Congress_SEC.pdf.
[109] Amer. Econ. Liberties Proj., *supra* note 102, at 29.
[110] KFF, *A Current Snapshot of the Medicare Part D Prescription Drug Benefit* (Oct. 7, 2025), https://www.kff.org/medicare/a-current-snapshot-of-the-medicare-part-d-prescription-drug-benefit/.
[111] *Id.*
[112] *See* MEDICARE PAYMENT ADVISORY COMM'N, *supra* note 94, at 411.

Advantage membership."[113] Shortly thereafter, the administration finalized a new risk-adjustment model designed to address some abuses, but it gave insurers three years to come into compliance, and it coupled the new model with an increase in reimbursement rates that was more than triple the amount it originally proposed.[114] And although the Medicare Payment Advisory Commission had for years recommended that CMS raise its "coding intensity adjustment" (which would have reduced payments to Medicare Advantage plans to account for abusive coding practices), the Biden Administration kept the adjustment at its statutory minimum.[115] Although the Biden Administration proposed tougher measures after the 2024 election, when it was on its way out the door, by then it was too late for the administration to be in a position to finalize those measures.[116]

The Biden Administration backed off from its most significant reforms in the face of an advertising and lobbying campaign for which industry spent over $15 million.[117] The campaign portrayed the administration's proposals as cuts to Medicare itself—rather than as efforts to crack down on abusive billing practices by private insurance companies. Precisely because Medicare Advantage has taken such a dominant position in Medicare, the private insurers who profit from the system can succeed in fending off reform by portraying any effort to cut their profits as a cut to Medicare itself.[118] And of course they can use those profits to influence policymakers to back down. Medicare Advantage organizations have "managed to deflate or deflect financial penalties and steadily gain clout in Washington through political contributions; television advertising, including a 2023 Super Bowl feature; and other activities, including mobilizing seniors. There's also a revolving door, in which senior CMS personnel have cycled out of government to take jobs tied to the Medicare Advantage industry and then returned to the agency."[119]

The Medicare Advantage program thus created a vicious cycle: Its own rules encouraged vertical and horizontal industry consolidation, giving massive profits to a small number of large businesses. And those businesses were able to use those profits—and the hold-up power they

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[113] Bob Herman & Tara Bannow, *Medicare Advantage Insurers to Repay Billions Under Final Federal Audit Rule*, STAT, Jan. 30, 2023, https://www.statnews.com/2023/01/30/medicare-advantage-insurers-to-repay-billions/. Even the weakened rule was too much for right-wing federal district judge Reed O'Connor. In September 2025, O'Connor vacated the rule based on the conclusion that the Department of Health and Human Services violated the Administrative Procedure Act in issuing it. *See* Humana Inc. v. Becerra, No. 4:23-CV-00909-O, 2025 WL 2734234 (N.D. Tex. Sept. 25, 2025).

[114] David Dayen, *Insurance Lobbyists Force Government to Heel on Medicare Advantage*, AM. PROSPECT, Apr. 11, 2023, https://prospect.org/health/2023-04-11-insurance-lobbyists-medicare-advantage/; John Wilkerson, *Biden Administration Goes Easy on Medicare Advantage Insurers After Intense Industry Lobbying*, STAT, Mar. 31, 2023, https://www.statnews.com/2023/03/31/medicare-advantage-rule/.

[115] *See* MEDICARE PAYMENT ADVISORY COMM'N, *supra* note 94, at 355-356.

[116] *See* Kelly Hooper, *Biden Admin Takes Last Shot at Reining in Medicare Advantage*, POLITICO PRO, Nov. 26, 2024, https://subscriber.politicopro.com/article/2024/11/biden-admin-takes-last-shot-at-reining-in-medicare-advantage-00191659.

[117] *See* Dayen, *supra* note 114 ("Better Medicare Alliance spent over $13.5 million on its ad campaign, while the American Action Network, a dark-money group backed by pharma money, piled on with $2 million in ads of its own. The groups unleashed thousands of comments to regulators and members of Congress, often with identical language taken from a form letter.").

[118] *See* Jake Johnson, *Medicare Advantage Industry 'Scare Tactics' and Lobbying Intensify Over Efforts to Curb Fraud*, COMMON DREAMS, Mar. 23, 2023, https://www.commondreams.org/news/medicare-advantage-lobbying-fraud.

[119] *See* Fred Schulte & Holly K. Hacker, *The Medicare Advantage Influence Machine*, KFF HEALTH NEWS, Sept. 30, 2024, https://kffhealthnews.org/news/article/medicare-advantage-cms-overcharges-lobbying-unitedhealth-lawsuit/.

had as the gateway to health care for around half of Medicare beneficiaries—to fight off efforts to regulate the abusive practices that enable them to keep gobbling up other businesses and market share. Just as in the classic example of protesters yelling "keep your government hands off my Medicare," Medicare Advantage organizations exploited the confusions and ambiguities inherent in a system that pays private entities to form public functions.[120] As Morgan and Campbell predicted, "the same hostility toward government that dr[ove] the decision to delegate governance in the first place also impede[d] the growth of an effective oversight body"[121]—though, interestingly, it did so by empowering profit-making entities to serve their own ends while nominally opposing cuts to government programs.

Medicare Part D

The Biden Administration *did* make significant changes to the Medicare Part D program through its signature legislation, the Inflation Reduction Act.[122] As is well known, the IRA empowered HHS for the first time ever to negotiate with pharmaceutical companies over the price Medicare will pay for certain high-cost drugs. But the statute's changes to Part D went well beyond drug price negotiation. Most pertinent here, the law imposed a cap on the out-of-pocket costs that Part D plans could require beneficiaries to pay ($2,000 per year, beginning in 2025), and it placed on plans the lion's share of the burden to pay the drug costs of beneficiaries who reach the "catastrophic phase."[123] Before the IRA, the federal government paid 80% of the costs during that phase, while the insurance plans paid 15% and the beneficiaries paid 5%; post-IRA, Medicare's share decreased "from 80% to 20% for brand-name drugs and from 80% to 40% for generic drugs," while the plans' contribution increased "from 15% to 60% for both brands and generics above the cap."[124] This change shifted from the federal government to the private insurers a large amount of the risk that a beneficiary would incur very high drug costs. Congress made the change to address "the substantial increase in Medicare's reinsurance payments to Part D plans over time, which accounted for close to half (48%) of total Part D spending in 2022, up from 14% in 2006."[125]

As it began to implement the IRA's reforms, however, the Biden Administration came to understand that Part D plans would respond to their new risk burden by raising premiums. That response would lead some seniors to switch to Medicare Advantage plans and others to abandon drug coverage altogether.[126] And it would have been hard to ignore the electoral calendar: The first set of Part D plan premiums reflecting the IRA's reforms would be announced just weeks before the 2024 elections.[127]

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[120] Suzanne Mettler uses the "keep your government hands off my Medicare" rallying cry as the motivating example in METTLER, *supra* note 2; *see also* HACKER, *supra* note 2, at 52-57.
[121] MORGAN & CAMPBELL, *supra* note 26, at 15.
[122] Pub. L. No. 117-169, title I, subtitle B, 136 Stat. 1818, 1833-1905 (Aug. 16, 2022).
[123] For a good explanation, see KFF, *Changes to Medicare Part D in 2024 and 2025 Under the Inflation Reduction Act and How Enrollees Will Benefit* (Apr. 20, 2023), https://www.kff.org/medicare/changes-to-medicare-part-d-in-2024-and-2025-under-the-inflation-reduction-act-and-how-enrollees-will-benefit/.
[124] *Id.*
[125] *Id.*
[126] *See* GAO, *Department of Health and Human Services—Medicare Part D Premium Stabilization Demonstration* 9-10 (May 27, 2025), https://www.gao.gov/assets/880/878023.pdf.
[127] *See* Tony Pugh, *Medicare Draws Ire for Plan to Hold Down Drug Premium Increases*, BLOOMBERG L., Aug. 30, 2024 ("The demonstration has also raised eyebrows because it could diffuse what could be a thorny political issue

To avert premium increases, in July 2024 CMS announced a "Premium Stabilization Demonstration." Invoking its authority to test whether different "methods of payment or reimbursement" in Medicare would "increas[e] the efficiency and economy" of the program,[128] the agency offered Part D plans the opportunity to voluntarily participate in a demonstration project that had three essential components: (1) all participating plans would reduce their premiums by $15 (which CMS would reimburse through its subsidies to the plans); (2) all participating plans would limit year-over-year premium increases to $35 (the cost of which CMS would also defray through its subsidies); and (3) the agency would shift more of the costs of large plan losses to the federal government.[129] All told, the demonstration was expected to "cost about $5 billion if all plan sponsors participate," or "about 3% of the $162 billion total Part D spending expected in 2025."[130]

And, indeed, "virtually all" sponsors did participate.[131] The Medicare Payment Advisory Commission concluded that without the demonstration "premiums likely would have grown dramatically."[132] But these results came at a large cost—"these policies are expected to increase Medicare's subsidy by about 12 percent."[133]

A crucial point of the IRA's reforms to the Part D program was to *reduce* the amount of money the Medicare program was paying to insurers that run prescription drug plans. But when those insurers responded by increasing their premiums on the eve of an election, the Biden Administration decided to send new subsidies their way. In the long run, that decision may lead the insurers who run Part D plans to set their premiums *higher* in the expectation that CMS will again subsidize them to keep those premiums in check.[134] Although the Government Accountability Office concluded (properly in my view) that the Premium Stabilization Demonstration was a valid exercise of CMS's demonstration authority,[135] conservative analysts had a point when they described it as "effectively a $5 billion bailout" that paid "insurers to prevent them from raising premiums on seniors in an election year."[136]

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for Democrats: a wave of seniors fuming about higher Medicare premiums weeks before the November 2024 elections. Premiums for 2025 Part D plans will be released in September, followed by open enrollment from Oct. 15 to Dec. 7."), https://www.bloomberglaw.com/bloomberglawnews/health-law-and-business/XFTG0R40000000#jcite.

[128] 42 U.S.C. § 1395b-1(a)(1)(A).

[129] *See* Memorandum from Meena Seshamani, Director, Center for Medicare, to All Medicare Advantage Organizations and Medicare Prescription Drug Plan Sponsors (July 29, 2024), https://www.cms.gov/files/document/july-29-2024-parts-c-d-announcement.pdf.

[130] Pugh, *supra* note 127.

[131] MEDICARE PAYMENT ADVISORY COMM'N, *supra* note 94, at 418.

[132] *Id.* at 425.

[133] *Id.*

[134] CBO, *A Call for New Research in the Area of Spending on Medicare Part D* (Nov. 21, 2025) ("[I]f insurers expect administrative actions to shield enrollees from the full impact of increased premiums, they may be less constrained in submitting bids with higher costs. Those effects may persist over time if insurers expect the subsidies to recur."), https://www.cbo.gov/publication/61824.

[135] *See* GAO, *supra* note 126.

[136] Jackson Hammond, *"Free" Is Never Free: Restoring Market Reality to Part D* (Paragon Health Inst., Oct. 15, 2025), https://paragoninstitute.org/medicare/free-is-never-free-restoring-market-reality-to-part-d/.

The goal of such conservative analysts is to adopt an even more privatized approach to Medicare prescription drug coverage.[137] From a progressive perspective, though, one might see the problem as one of too much privatization. By handing over Medicare prescription drug coverage to private insurers, the Part D program puts those profit-making businesses in a hold-up position: They can threaten to raise premiums on seniors if they don't receive large subsidies. After Congress enacted the IRA in an effort to reduce the amount of money the federal government sends to Part D plans, the insurance companies were able to exploit their hold-up position to blunt those reforms. By adopting the Premium Stabilization Demonstration, the Biden Administration gave in to the power of the insurance industry—and ended up bolstering that power by raising expectations that the government would give in to future industry threats.

Looking Ahead

It's easy enough to say that the Biden Administration should have done more to take on the increasingly consolidated and vertically integrated insurance industry in the Medicare Advantage and Medicare Part D programs. But the administration faced a genuinely difficult problem. The 2003 Medicare Modernization Act, which created these programs, gave private insurers the responsibility for running them—and, in so doing, shifted massive political power to those private insurers. The insurance industry has consistently used its favorable political position to resist change—and it effectively deployed its power against the Biden Administration's efforts.

Distilling the Power Dynamics

It is helpful to tease out at least three different types of power that insurance companies were able to exert as they blocked some of the Biden Administration's significant efforts to reform Medicare Advantage and Medicare Part D. As I've shown. the Medicare Modernization Act gave insurance companies ***hold-up power***—the power to cause great harm to Medicare and its beneficiaries by withholding their services. Insurers used this power to great effect in their response to the Inflation Reduction Act's redesign of Part D—tacitly threatening to dramatically increase premiums or leave the program entirely if the Administration did not resume major subsidies. The MMA also gave the insurers significant ***financial power***—massive profits that could be transformed into political power through lobbying and electoral spending. Finally, the opacity of the health care system, and particularly of the peculiar public-private hybrid created by the Medicare Modernization Act, gave the companies a fair amount of ***narrative power***—the power to convince the public that reforms designed to prevent corporate abuses were instead "cuts to Medicare."

As Biden Administration policymakers faced these pressures, they did not confront any organized pressure from the other side. Although reforms to Medicare Advantage and Part D would likely have led to better results for Medicare beneficiaries, and would almost certainly have protected the public fisc, these benefits accrued to diffuse, unorganized people. Neither the administration, nor outside groups, had made a meaningful effort to organize Medicare

[137] *See id.* (arguing for "a broader set of market-based changes to Part D that empower beneficiaries with more choices from less government micromanagement regarding benefit structure, as well as limit current and future taxpayers' payments to ensure greater competition within a capitated amount that drives efficiency").

beneficiaries to fight the abuses of insurance companies. So it was hardly surprising that the companies got a lot of what they wanted.

How to Do Better

It should be clear that taking on the insurance-company power entrenched by the Medicare Modernization Act was easier said than done. Political scientists have long argued that the dynamics of path dependence make it hard to effectuate major changes in our health care system, as earlier laws give particular incumbent entities large stakes in existing arrangements, with both the incentive and the power to fight off significant reforms.[138] And the Biden Administration was already mounting a major challenge to one of the key players with entrenched power in the health care system—the pharmaceutical industry. Occupied by its herculean and successful effort to adopt and implement the first-ever Medicare drug price negotiation program, the administration can perhaps be forgiven for shrinking from opening a second front against the insurance industry.

Nonetheless, perhaps the Biden Administration should have been bolder. Recent events, including some of the public responses to the horrific killing of UnitedHealthcare CEO Brian Thompson, demonstrate great anger at the health insurance industry.[139] People are upset when they cannot get health insurance, to be sure. But in some ways those who do have insurance are even more upset, as they find that insurance companies limit the providers they can see, delay and deny authorization for medications and specialty care, hit them with surprise bills, and refer them to collection agencies when they can't afford to pay.

And the Trump Administration has made a show of going after Medicare Advantage plan abuses. It has, for example, announced that it would "audit all eligible MA contracts for each payment year in all newly initiated audits and invest additional resources to expedite the completion of audits for payment years 2018 through 2024."[140] Trump's Justice Department also filed a lawsuit alleging "that insurers Aetna, Elevance Health (formerly Anthem), and Humana paid 'hundreds of millions of dollars in kickbacks' to large insurance brokerages" in an effort to "steer" healthy patients into their MA plans "while also discouraging enrollment of potentially more costly disabled beneficiaries."[141] In recent congressional hearings, leading lawmakers from both parties have been highly critical of Medicare Advantage organizations.[142] And the Trump

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[138] *See* METTLER, *supra* note 2; HACKER, *supra* note 2; *see also* Harold Pollack, *Medicare for All—If It Were Politically Possible—Would Necessarily Replicate the Defects of Our Current System*, 40 J. HEALTH POLITICS POL'Y & L. 923, 928 (2015) ("Medicare for All cannot offer itself as the replacement of our depressing health politics. It would have to arise as another product of that very same process, passing through the very same legislative choke points, constrained by the very same path dependencies that bedevil the ACA.").

[139] *See* Dylan Scott, *The Deep Roots of Americans' Hatred of Their Health Care System*, VOX, Dec. 6, 2024, https://www.vox.com/future-perfect/390111/united-healthcare-ceo-shot-insurance-hospitals-doctors.

[140] *CMS Rolls Out Aggressive Strategy to Enhance and Accelerate Medicare Advantage Audits* (May 21, 2025), https://www.cms.gov/newsroom/press-releases/cms-rolls-out-aggressive-strategy-enhance-and-accelerate-medicare-advantage-audits.

[141] Julie Appleby, *Trump's DOJ Accuses Medicare Advantage Insurers of Paying 'Kickbacks' for Primo Customers*, KFF HEALTH NEWS, May 19, 2025, https://kffhealthnews.org/news/article/justice-department-accuses-medicare-advantage-insurers-kickbacks-top-customers/.

[142] *See* Richard Payerchin, *Medicare Advantage or Disadvantage? Lawmakers Hear About the Good, the Bad, and the Prior Authorizations*, MED. ECON., July 24, 2025, https://www.medicaleconomics.com/view/medicare-advantage-or-disadvantage-lawmakers-hear-about-the-good-the-bad-and-the-prior-authorizations.

Administration's proposed 2027 Medicare Advantage regulations would have both held reimbursement rates flat and impose new restrictions on certain coding practices.[143]

To be sure, there is reason to doubt the sincerity of the Trump Administration's commitment here. As one leading journalist who follows the area put it, "almost every major decision Trump officials have made since reclaiming the White House has benefitted insurers and their bottom lines."[144] Most notably, the administration's final 2027 regulations actually *increased* reimbursement rates and also "scrapped a proposal that would have used more updated data in the payment process, ensuring that Medicare Advantage insurers retain billions of dollars."[145] The administration also altered the MA star rating system to "slashing the number of quality and care measures that Medicare Advantage plans will be graded on, a move that will funnel an extra $18.6 billion toward health insurers over the next decade."[146]

These actions follow similar steps the Trump Administration took during its first year. In April 2025 the administration finalized "the largest rate increase in the past decade" for MA plans—an action one industry publication called "a massive gift" to the insurers.[147] The administration took that action just after it finalized the rule the Biden Administration had proposed on its way out the door—though Trump's appointees stripped out key consumer protections such as "commonsense initiatives to increase transparency, limit prior authorization, and rein in marketing."[148]

At a minimum, though, it seems clear that Trump and his appointees see an advantage in being *perceived* to attack health insurance companies. Recently, in their efforts to fight off extension of the expanded subsidies for Affordable Care Act marketplace plans, they have doubled down on their attacks on the health insurance industry.[149] Trump and his appointees are probably reading public opinion correctly. A 2025 Pew poll, for example, found that "a solid majority of U.S. adults (69%) say health insurance companies have too much influence on public debates about health policy."[150] Even if Trump's efforts to appeal to this anti-insurance-industry

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[143] *See* Fred Schulte, *Medicare Advantage Insurers Face New Curbs on Overcharges in Trump Plan That Reins in Payments*, KFF HEALTH NEWS, Jan. 29, 2026, https://kffhealthnews.org/news/article/medicare-advantage-overcharging-chart-reviews-trump-federal-rate-hike/.

[144] Bob Herman, *Trump Promised to Clamp Down on Health Insurers. His Policies Are Enriching Them*, STAT, Apr. 9, 2026, https://www.statnews.com/2026/04/09/medicare-advantage-rates-latest-trump-policy-helps-health-insurers/.

[145] Bob Herman, *Health Insurers Score Major Win With Higher 2027 Medicare Advantage Rates*, STAT, Apr. 6, 2026, https://www.statnews.com/2026/04/06/medicare-advantage-rates-2027-unitedhealth-humana-cvs-health-stocks-climb/.

[146] Bob Herman, *Medicare Advantage Plans Win Extra $18.6 Billion as Feds Cut Star Ratings Measures*, STAT, Apr. 2, 2026, https://www.statnews.com/2026/04/02/medicare-advantage-star-ratings-changes-18-billion-windfall-health-insurers/.

[147] Rebecca Pifer, *Trump's CMS Dramatically Raises Payments to Medicare Advantage Plans*, HEALTHCARE DIVE, Apr. 8, 2025, https://www.healthcaredive.com/news/medicare-advantage-2026-payment-rates-trump-humana-unitedhealth/744682/.

[148] Julie Carter, *Troubling Signs from Administration's Weak Medicare Advantage Oversight* (Medicare Rts. Ctr., Apr. 10, 2025), https://www.medicarerights.org/medicare-watch/2025/04/10/troubling-signs-from-administrations-weak-medicare-advantage-oversight.

[149] *See, e.g., Trump Says Money Should Go to People, Not Health Insurers*, REUTERS, Dec. 8, 2025, https://www.reuters.com/world/trump-says-money-should-go-people-not-health-insurers-2025-12-08/.

[150] Giancarlo Pasquini & Eileen Yam, *Americans' Views on Who Influences Health Policy and Which Health Issues to Prioritize* (Pew Res. Ctr., July 10, 2025), https://www.pewresearch.org/science/2025/07/10/americans-views-on-who-influences-health-policy-and-which-health-issues-to-prioritize/.

sentiment have been in bad faith, poll results like these suggest there is political space for an administration to take on the industry in a more aggressive way than the Biden Administration did.

Moreover, there are policy steps the Biden Administration could have taken to undermine the power of private insurers in Medicare, particularly in Part D. In particular, the administration might have proposed to use its demonstration authority—the same authority it used to subsidize private plans in 2024—instead to create a form of public option for Medicare Part D. It could, for example, have facilitated state and local governments in creating their own Part D plans that would compete with private plans in their regions. It could also have had CMS create its own Part D plan that would compete with private plans in particular regions or nationwide. Such an approach would be aggressive, because it would directly challenge the privatized structure set up by the Medicare Modernization Act. It would no doubt draw a legal challenge. But there would be adequate grounds to defend a public option demonstration as testing whether a "change[] in methods of payment or reimbursement" from that purely privatized system "would have the effect of increasing the efficiency and economy of health services" under Part D "without adversely affecting the quality of such services."[151] And there would be good arguments that such a demonstration complies with Part D's "noninterference clause," which prohibits CMS from "interfer[ing] with the negotiations between drug manufacturers and pharmacies and PDP sponsors" or "requir[ing]" them to adopt "a particular formulary" or "price structure."[152] A public option demonstration would not require CMS to insert itself into private plans' negotiations or internal operations at all; it would simply provide Medicare beneficiaries with an alternative to receiving drug coverage from private plans.

A Part D public option demonstration, if successful, would have drawn customers away from both stand-alone Part D plans and the Medicare Advantage plans from which most beneficiaries in fact get their drug coverage. It would thus have directly challenged the source of economic and political power that enabled large, vertically integrated insurance companies to abuse the existing system for profit and fight off reforms. But such a demonstration was never seriously considered by the Biden Administration; instead, in the wake of the IRA the administration implemented a demonstration that further enriched the large insurers.

Conclusion

In this paper, I have described the Biden Administration's missed opportunities to take on the power of the large, vertically integrated insurance companies that profit handsomely off of Medicare. But perhaps the opportunities will recur in the future. Cracks are increasingly appearing in the edifice erected by the Medicare Modernization Act. Insurers have dramatically cut back the number of standalone Part D plans they offer, and increased health care costs are putting pressure on Medicare Advantage organizations. The time may soon be ripe for more major reform of the system. By focusing on limiting the power of private insurance companies within Medicare—and limiting the degree to which Medicare itself enhances their economic and political power—a future administration could open the way to making our largest public health insurance program truly public again.

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[151] 42 U.S.C. § 1395b–1(a)(1)(A).
[152] 42 U.S.C. 1395w-111(i).

One might also draw lessons for other federal programs from the Medicare Modernization Act experience. Privatization of government programs has often been criticized for displacing public values with the profit motive, and for insulating those programs from democratic and legal accountability. But the Medicare Advantage and Part D programs highlight a distinct problem with privatization in the context of a highly concentrated industry—a description that characterizes much government contracting in defense, transportation, and other arenas. In that context, privatization can put the government at the mercy of a small number of private, profit-making firms, who can threaten to walk away or make life difficult for program beneficiaries if the government regulates them too closely. The result is to amplify the political power of those firms, and to give them a tool to prevent reforms that may be necessary to serve the public interest. All of which suggests that policymakers should be wary before granting such hold-up power in the first place.