AUSTERITY IS NOT ENOUGH:
US MEDICAID, ADAPTIVE ACCUMULATION, AND REPUBLICAN RULES OF REPRODUCTION

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Neoliberal reform in healthcare has become global a fact of life, with widely varying healthcare policies regularly placed under the pressure of both austerity and market reform. Nowhere is this more evident than in the United States, where healthcare reform consistently telescopes America's most divisive social antagonisms along class, racial, and ideological lines. US health reform is surely unique, mostly aimed at overcoming shortfalls of market-based healthcare. In contrast, reform in other health systems is primarily concerned with the degree to which market actors are *allowed* entry to *already existing* publicly oriented plans. That said, the peculiar nature of the US system, as well as its now entrenched conservative shift, may offer valuable insights into future healthcare pressures across a global environment besieged by similar rightward political trajectories.

One major pillar of US reform is Medicaid expansion, part of the now decade-plus battle around the implementation of the *Affordable Care Act* (*ACA*) (Oberlander 2020). Medicaid expansion has the energetic support of the business community, precisely because the program has become a highly lucrative field of largely market-administered healthcare delivery. This article suggests, as part of a two-pronged argument, that Medicaid now falls squarely within what I have previously highlighted as 'adaptive accumulation' – the pursuit by corporate actors of quasi-public roles in which stable and socially-legitimised profit streams can be secured

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(Loeppky 2019, 2022). It presents another policy case in which the neoliberal image of increasingly minimalist government should be modified, as corporate players and state actors alike seek a business-friendly enlargement of the healthcare domain.

At the same time, that business support also makes it harder to explain why there is such a vociferous (and successful) right-wing backlash against Medicaid expansion. There has been strong resistance among Republicans to the expansion of Medicaid, and it is oddly positioned *contra* commercial interests and state economic development – conventionally cherished by Republicans. To understand this surprising outcome, we need to account for horizontal class relations and the 'rules of reproduction' under which the Republican right is currently operating. These have scrambled US politics, accentuating a malevolence within policy approaches on the right, making Medicaid expansion a vulnerable target on a state-to-state basis.

To animate this argument, the article first lays out the terrain of Medicaid and Medicaid expansion, demonstrating both its uneven variability across state jurisdictions, as well as its not-so-public form of implementation. The concept of adaptive accumulation is used to highlight the heavy inclusion of market actors in both the purchasing and provision of care. The article goes on to explain intensifying Republican dissatisfaction with even market-conducive Medicaid policies, by exploring the importance of horizontal class relations (Comninel 1987). It focuses especially on the 'rules of reproduction' for social actors (Knafo and Teschke 2020), which are affecting both the shape of day-to-day politics and, ultimately, the party's historical disposition to bipartisanship, social inclusion, and social policy. With this in mind, the final section returns to Medicaid, pointing to performative horizontal battles at both the federal and state level that surround (and often block) program expansion. This sheds light on policy positions that, while often seemingly nonsensical and detrimental to many, align with the altered rules of reproduction for Republican political actors.

Medicaid expansion, adaptive accumulation, and confounding resistance

The advent of Medicaid occurred with the *Social Security Amendments* of 1965, creating a Federally funded but state-administered healthcare program for the impoverished and disabled. At the time, Medicaid was viewed as temporary, necessary only until the long-term objective of a

unified Federal healthcare system – modelled on the single-payer US Medicare program for senior citizens – was fulfilled (Thompson 2011). Against this, the American Medical Association saw Medicaid a means-tested program and a more reliable way to *avoid* the possibility of generalised single-payer system (Patashnik and Oberlander 2018: 666). In this sense, Medicaid experienced immediate political resistance from the political right, industry, and professional classes, who feared encroaching government intervention and potential regulation. Indeed, already by 1967, with fear of expanding eligibility for the program in New York State, the US Congress linked Medicaid requirements to Assistance to Families with Dependent Children (AFDC), limiting access and cementing its position as 'welfare medicine'.

Despite this ideological resistance, two factors would drive Medicaid's expanding role in US healthcare: growing societal inequality and the reality of federalism, whereby state politicians have typically been loath to reject federal funding, even when it does not align with their ideological designs. The program grew even through the 1980s and 1990s, surviving both the Reagan Revolution and House Speaker Newt Gingrich's mid-1990s 'Contract with America', dovetailing with Republican objectives of limited, means-tested coverage and local state control. Thus, historically, despite their frequently outsized rhetorical position, Republicans have not questioned the program's necessity as much as the form and size it takes. By 2008, as the Republican Party began its more pronounced turn to the right, almost 50 million people were already enrolled in Medicaid, and by 2019, the number had rapidly climbed above 75 million.

While Medicaid growth is continuously decried as government handout, it is crucial to account for its increasingly not-so-public characteristics. Indeed, the somewhat confusing patchwork of Medicaid across US states is largely viewed by business actors as opportunity, in keeping with what I have elsewhere called adaptive accumulation, where private actors encourage public intervention as a means to profit (Loeppky 2022). Adaptive accumulation complicates the neoliberal archetype of the lean American state that consistently recedes from the public arena. Rather, public institutions provide platforms for corporate agents to expand new avenues of accumulation, operationalising lucrative public programs through private means. The advantages – in the health sector and elsewhere – include, first, stepped-up opportunities for private revenue, rooted in stable, predictable government issued payments. To the extent that corporate actors within the US health sector have experienced

profitability pressures (Kelly 2016), adaptive accumulation offers an obvious (counter-tendential) release valve. Second, private actors appear to 'selflessly' fulfill societal needs, ensuring market demand but also crafting social legitimacy. Finally, and especially germane to Medicaid, adaptive accumulation taps into a strain of American political culture that disparages the role of the state, taxation, and those 'undeserving' of public care. It both captures a neoliberal ethic and directs blame at 'lazy' sections of society, reinvigorating a call to 'save' the republic through moral discipline and efficiency of market imperatives (Loeppky 2023).

In concrete terms, platforms for adaptive accumulation utilise sections 1932(a) and 1915(b) of the *Social Security Act*, which allow states to change Medicaid delivery models. Since the mid-1990s, when Republican pressures on redistributive social programs intensified, most US states have altered delivery formats and population eligibility, with visible and widespread consequences (Grogan *et al.* 2017: 249). The stringency of state budgeting and the corporate designs of the health industry have ensured that most purchasing of care is now farmed out to private actors. Overall state and federal spending on Medicaid amounted to $662 billion in 2020, constituting a very lucrative market for these corporate actors. The central vehicle for their entry has been the managed care organisation (MCO), which utilises networks of primary and acute care providers to administer Medicaid plans on behalf of the state. MCO arrangements have been taken up by all states, with some 90 percent of Medicaid enrollees in some form of managed care, and 70 percent enrolled in a comprehensive health package (governing all services) through an MCO (KFF 2021). As with most public policy in US federalism, the variation by state is extensive, from 5 percent in Arkansas to 100 percent in Tennessee.

MCO operations also vary, as there are 282 for- and non-profit organisations operating across the Medicaid landscape. This mix, however, should not obscure either the business-friendly nature of this policy sphere or the concentrated nature of its industrial sector. There are 16 'parent firms' operating across state lines, 7 of which are for-profit entities. Of these, 6 firms (Centene, Molina, Anthem, UnitedHealth, Molina, and Aetna/CVS) have MCOs across 12 or more states and control over half of all Medicaid enrollment (Hinton and Stolyar 2022). The profit levels in this industry are, indeed, difficult to tease out, as Medicaid plans are intermingled with employer and health exchange plans on the private market. Companies involved do not always break down their Medicaid returns as a component of overall revenues, but it is certainly clear that the

program is not hurting their bottom line. Among the five largest corporations involved in Medicaid, market share continues to increase, and revenues have been on a steady increase over the last decade. Of those who report Medicaid revenues, 2021 saw a 12.5 percent increase for Centene, 16.1 percent for UnitedHealth, and 43.4 percent for Molina (Schneider and Corcoran 2022).

As such, Medicaid represents a stable stream of revenues, and rising needs based on growing inequality ensure this stability going forward. While the program restricts payment levels to providers, this is compensated by the overall volume of the largest government-funded health program in the country. Little wonder that program expansion has been greeted with a positive reception by large corporations, business associations, and chambers of commerce (Hertel-Fernandez *et al.* 2016). States' positive inclination towards the managed care sector, as well as the associated use of capitation payments, speak to their obvious need for budgetary constraint. However, the very uneven medical-loss-ratios (MLRs) across the country (and from plan to plan) also make clear that payouts to this sector vary wildly.[1] Add to this the fact that cash reserves among many MCOs remain suspiciously high, potentially allowing them to bolster their MLR artificially, because reserves can, for accounting purposes, be viewed as healthcare expenses (actuarial risk funds). This might be diverting the eyes of state regulators who ask for minimum MLR thresholds, potentially allowing the use these funds in merger acquisitions or other investment returns (Goldsmith *et al.* 2018). Ultimately, Medicaid funds are absorbed by the financial 'black box' internal to MCOs, rendering the accountability process for these public dollars a mostly speculative endeavour.

Importantly, Medicaid's significant market contours were already in place before the emergence of the *ACA* and Medicaid expansion. Indeed, by 2009, 41 percent of enrollees were in publicly-traded, for-profit plans (Grogan 2020). The *ACA's* Medicaid design surely had admirable goals: to capture larger segments of the uninsured population (particularly low-income adults without children), by expanding eligibility to those earning up to 138 percent of the federal poverty line (FPL). But it did not challenge existing Medicaid delivery programs or offload excessive costs onto state

[1] The medical-loss-ratio is the 'share of total health care premiums spent on medical claims and efforts to improve the quality of care. The remainder is the share spent on administration costs and fees, as well as profits earned' (NAIC 2021).

budgets. Under the *Act*, the federal government absorbed 100 percent of expansion costs until 2014, after which matching rates would begin to decline incrementally to 90 percent. The fiscal incentives, in other words, were/are high for states to participate. And recently, the *America Rescue Plan Act* of 2021 incentivized program adoption, by offering an additional two-year, 5 percent increase in federal funds to all existing traditional Medicaid programs in non-expansion states.[2] The federal government has gone far to encourage uptake of the *ACA* mandate, and this included negotiations for terms more favourable to these non-expansion states' political and economic environments.

However, as is well known, the *ACA* was born into a world of political hostility, and Medicaid expansion has remained a central target. Republicans have resisted at both the federal and state level, and numerous court challenges, culminating in *NFIB v. Sebelius*, undercut its federal enforcement. Writing for the majority opinion in *Sebelius*, Chief Justice John Roberts asserted that Medicaid expansion would not be 'a program to care for the neediest among us, but rather an element of a comprehensive national plan to provide universal health insurance coverage' (*National Federation of Independent Business v. Sebelius* 2012). This decision, while not precluding the federal government from *offering* incentives to expand Medicaid, did preclude it from withdrawing the states' existing Medicaid funding in order to *compel* expansion. States, in other words, would retain the right to decline such funds, and Medicaid expansion would remain a choice. At the time, only 30 states (plus D.C.) took on expansion and, to date, 12 states remain outside of the program. In these states, the average income requirement for Medicaid eligibility is an astounding 41 percent of FPL, and adults without children largely remain ineligible (Garfield *et al.* 2021). This translates into a potential loss of access for somewhere between 2.2 and 4 million adult citizens.

The ideological basis for this outcome was not entirely predictable, and it is difficult to see the downsides to expansion for conservative states. Meta studies suggest accumulating evidence on the positive effects of expansion across indicators that are conducive to both the political left and right. For instance, one project compiled the results from 77 discrete studies, in order

[2] Since the bulk of state Medicaid costs is for non-expansion populations, this 5 percent add-on effectively means that new matching funds would continue to cover 100 percent of expansion costs for two years.

to assess whether Medicaid expansion had achieved the goals laid out for it by *ACA* advocates (Mazurenko *et al.* 2018). The authors found that: 'Medicaid expansion following the *ACA* was associated with increases in access, quality and Medicaid spending' and 'very little evidence that [...] expansion resulted in negative consequences' (2018: 948). Another rolling meta-study, under the auspices of the Kaiser Family Foundation, found positive outcomes across health and non-health indicators. Specifically, the report listed encouraging results in relation to overall and disease-related mortality; cancer, chronic disease, and disabilities; sexual and reproductive health; behavioural health; economic impacts on states and providers; racial, ethnic, and socioeconomic disparities; and social determinants of health (Guth and Ammula, 2021). One might expect Republican-dominated states to be particularly drawn to these economic benefits, the low budget impact, and projected cost offsets (for instance, morbidity-related improvements may offset or go beyond expansion costs entirely).

Indeed, there are indications that many business-friendly conservatives support state program expansion, as such funds are readily diverted into private profit streams, simultaneously undergirding a discourse that sees market mechanisms 'fixing' the ostensibly dysfunctional government apparatus. Both Ashley Tallevi (2018) and Colleen Grogan (2020) have utilised Susan Mettler's (2010) notion of the 'submerged state' to demonstrate the degree to which health delivery in general and Medicaid in particular have already entirely meshed the worlds of government and industry. Americans, for instance, who advocate for private insurance and employer-driven healthcare do not easily recognise the significance of the '$437 billion in tax-exempt subsidies for employer-based health insurance,' or that, '[in] reality, the [...] system reflects a complete interdependence between private and public sectors' (Grogan 2020: 627). At the same time, Medicaid programs are being projected in ways that obscure their public origins, associating them to place names or intermingling them with private insurance plans. This translates into a 'decreased awareness of program use and increased difficulty in connecting [the] experience back to government' (Tallevi 2018: 163). Again, all of this should find resonance within Republican circles, as government sponsorship is obscured, market actors are validated, and 'individual responsibility' can be attached to program design in powerful ways.

Nonetheless, dogged resistance to Medicaid expansion continues in a manner that exacerbates healthcare inequality and population vulnerability. Whether one sees Medicaid as part of a submerged state or adaptive accumulation, it seems that neither concept adequately explains the intensity of this resistance. Indeed, in Tennessee, where Republican Governor Bill Haslam proposed a deeply conservative version of Medicaid expansion, the proposal was summarily dismissed by his own Republican House as insufficient (Hertel-Fernandez et al., 2016: 273–274). Repeated across Republican-dominated states, such scenarios usually involve fervent activity from numerous state-based affiliates of conservative organisations like the State Policy Network (SPN) or Americans for Prosperity (AfP). This desire on the right to knock down policy proposals containing conservative-friendly principles demands explanation.

Assessing the Right: Horizontal class relations and the rules of reproduction

If political economy (via adaptive accumulation) helps unpack the expansive role of government in a market-based healthcare system, it should also be the first stop for understanding the peculiar ideological resistance to such a system. Political Marxism, with its emphasis on the historical specificity of class relations in a given time and place, can be explored as a means to understand distinct political dynamics. Two significant methodological insights are of particular interest here: the underexplored importance of *horizontal* class relations and the conditioning effects of the *rules of reproduction*. These may help us unpack the reasons for the emergence of such counterintuitive behaviours – behaviours neither wholly explained by the past nor easily undone in the future.

At the centre of this school of thought lies the work of Robert Brenner, who has explored a variety of class-driven political and economic transformations, from the mid-millennial agricultural revolution in England to the post-world war II political-economic trajectories of the US, Germany, and Japan (Brenner 1982, 2006). Overall, he re-asserts the centrality of social property (class) relations in the organisation of production and the political structures that sustain it. It is, in this sense, a detailed historical re-assertion of Marx's (1981: 927) theoretical-historical claim that '[i]t is always the direct relationship of the owners of production

to the direct producers […] which reveals the innermost secret, the hidden basis of the entire social structure, and with it the political form of the relation of sovereignty and dependence, in short, the corresponding specific form of the state.' Brenner (1982) emphasises the fact that, along with these exploitative vertical relationships, relations between members (or factions) of the ruling class have conditioning effects on how historical development proceeds. In other words, the existence of exploitative capitalist property relations does not determine the precise manner in which they will be institutionally manifested, the ways in which they will be regulated, or how their range of effects will be mitigated.

George Comninel (1987) captures this most effectively, by arguing that intra-class *competition* among those with power also needs to be understood as a significant mover in relation to the specific political, historical, and institutional forms which accompany capitalist (or any other) societies. In relation to postwar capitalism, he argues that the association of ruling class competition to the state has identifiable and varying historical effects in each society, even if the basic (vertical) property relations remain the same. In this way, historical development:

> is not reducible to the 'logic of capital' in the abstract – although its implications are central – but must include the heritage of political activism (or apathy), the form and extent of democracy, the legacy of trade unionism, the national 'logic' of state intervention, the history of international relations, the potential for implementing welfare reforms, *etc* (1987: 171).

Each of these is worked out through ongoing political struggle, where, in the case of Medicaid, social redistribution remains a central point of contention. The degree of redistribution, as well as the overall societal willingness to 'de-commodify' elements of citizens' lives, is undoubtedly linked to the strength of working classes and social movements *vis-à-vis* business power or governing classes (Coburn 2006; Esping-Andersen 1990; Hoffman 2003). But significant pitched battles can also occur on an intra-class basis, whereby the way forward can become the subject of heated political contestation *between* those with decision-making capacity. The deep divides across the right in relation to the *ACA*, immigration, and financial regulation make this abundantly clear.

The difficulty lies in the fact that historical outcomes – as Brenner long ago pointed out – cannot simply be read off of the identification of social property relations. Rather, understanding these relations requires a further determination of the governing 'rules of reproduction' – the prevailing

guidelines for social agents, as they seek to preserve or enhance their status or circumstance. Class agents largely operate with these rules in mind and rarely act in ways that *intentionally* bring about transformative change. In this sense, whether we are talking about a 'bourgeois revolution' or a 'Trumpian revolution', such terminology does little to capture the reasons for most class agents' actions. Mostly, social actors seek not to transform the conditions of their existence, but rather to satisfy the conditions that allow their existence to continue or expand. The rules for this are,

> maintained or reproduced collectively, beyond the control of any individual, by *political communities* which are constituted for this very purpose […] [They] constitute and maintain social property relations collectively and by force […] [and] individual economic actors cannot as a rule alter them, but must take them as given, as their framework of choice (Brenner 2007: 58).

Critically, this in no way means that outcomes are always predictable according to socio-political rules, only that societal *transformation* is usually not the intended outcome. Indeed, particular constellations can lead to unexpected change, precisely as a product of their historical specificity and even novelty. Class agents, in the face of rules, find creative and innovative ways to ensure their reproduction, at a minimum, or enhance their position, at a maximum. While they may not be consciously seeking transformation, they are no doubt contributing to an evolving political community, with potential aggregate effects to the rules of reproduction, however subtle those changes may be (Knafo and Teschke 2020). In this sense, taking the rules of reproduction seriously requires that we thread the needle between historical contingency and the conditioning effects of existing social structure.

How, then, might we understand the specificity of class relations and rules of reproduction in the current US political climate, where turmoil driven on the right and eyebrow-raising political events are the order of the day? At their core, US class relations have continued as before, with steeply unequal property relations, deeply interconnected racial tensions, and left-right contention over how to address these issues. There has, however, been a marked shift on the right, where intra-class competition affects the terms by which political actors govern or operate publicly. The origins for this are open to debate, but the election of Barack Obama and the forceful arrival of Tea Party politics marked significant inflection points. Prior to this, one prevailing rule would have been the ever-present necessity to seek bipartisanship, or at least create the impression that bipartisanship is the

goal. But, in the face of soaring 'Obamamania', bipartisanship almost certainly appeared for Republicans to be ceding political ground completely to the Democrats. Viewing this popularity as an existential threat, creative (but well-funded) 'grassroots' Tea Party protests would blossom into loud anti-Obamacare rhetoric; the formation of the Freedom Caucus in Congress; and palpable political pressure on party leadership to stand firm *against* Democrats (Dimaggio 2011; Skocpol and Williamson 2012). These innovative acts were matched by similarly creative moves on the part of the Leadership. House Speaker John Boehner, for instance, used the adamancy of Freedom Caucus members tactically in his budget and debt ceiling negotiations with the White House, claiming a powerlessness to act without their approval. Similarly, when Minority Leader Mitch McConnell publicly stated that his top priority was to make Obama a one-term President, he was (perhaps inadvertently) signaling a strategy that would become indicative of Republican politics over the next decade (Barr 2010). Leadership's tactical engagement with conservative demands also conferred legitimacy upon the hostile approach to Democrats, attracting further adherents with each electoral round. It is difficult to identify a singular moment of transition, but then-Senate Majority Leader McConnell's successful refusal to undertake confirmation hearings for Obama's legitimately selected Supreme Court nominee marked the most robust endorsement of this rule. Since then, political hostility toward Democrats has become the Republican norm, and even conventionally bipartisan matters, such as the debt ceiling votes, defense policy, or low-level executive appointments, result in increasingly ugly contestations.

This *inter*-party hostility has been derivative of a growing *intra*-party struggle *between* Republicans. Here, the rules of reproduction have been altered with a performative element, necessitating the public espousal of policy positions which are often practically and/or ethically at odds with conservative actors' own political convictions (or even sometimes with reality). Republican actors' hold on power in congressional, executive, or administrative positions demands not only obstructionism *vis-à-vis* Democratic opponents, but willingness to pursue extreme conservative convictions. Social values have always created friction within Republican circles, as they are always not easily aligned with the reassertion of individualism and economic imperatives resident in neoliberalism. While these issues (family values, abortion, religious 'rights', *etc.*) found an ideological home, they took a subordinate position to the Party's ever-reliable support for corporate America and national security issues. But, as

Tea Party fiscal rectitude evolved into Freedom Caucus hostility, a growing number of Congressional members prioritised strong right-wing values as platforms in their own districts, while not relying on corporate campaign donations. With the Trump administration amplifying these values over conventional Republican concerns, political actors have been increasingly cajoled into an intra-Republican competition to demonstrate their superior conservative credentials. Performative displays of conservative 'authenticity' – accompanied by racist, xenophobic, and patriarchal discourse – have been progressively prioritised over the Party's conventional economic pursuits. As this rule has generalised, fear of coming under public attack or direct electoral challenge for being insufficiently conservative drives a continuing re-assertion of these views. As such, the course for political survival among Republicans is fealty to Trump's erratic messaging and/or a manufactured display of deep hostility to even the most modest forms of social progressivism.

These are the evolving, now performative rules of reproduction on the political right in the US, epitomised by the antics of House Representatives Marjorie Taylor Green, Matt Gaetz, and Jim Jordan. Much of this conditioned behavior aligns with Eric Fromm's rise of the 'authoritarian character' and a societal punitiveness (Cheliotis 2013), and it is precisely this form of punitiveness and revenge politics that has become the subject of display. In practical political terms, this means that fiscal conservatism is no longer an adequate expression of one's Republican qualifications. Instead, sentiments of routing out the 'undeserving'; 'taking back' one's country; and revenge against transgressors of the conservative worldview have taken on widespread popular and professional political appeal. Active displays of righteousness, punitive harshness (in policy), and intolerance now seem to be integral to political success on the right. While such sentiments may go against the bulk of majority public opinion, there is undoubtedly a fear among political actors that failure to perform these rituals will result in the loss of core popular support. This is as true for individual actors as it is for the Republican party as a whole, with the latter sensing its own growing demographic disadvantages. It may not be, ultimately, a winning political strategy, but it is here where the rules of reproduction evolve and take hold, precisely as a result of individual agency and unintended outcome. In other words:

The true hallmark of an account which makes social conflict, rather than a structural logic, the motor of history is its ability to separate agency from intentions and to move away from more-functionalist readings of history

where social developments are explained in terms of systemic needs or the intentions of powerful actors. In reality, things rarely pan out the way in which people plan them, even when it turns out much worse/better than expected for some (Knafo and Teschke 2020: 21).

The intentions of individual actors on the right, such as Florida Governor Ron DeSantis in Florida or Senator Ron Johnson in Congress, may be short-sighted, self-serving, cynical, and disingenuous. But they also reach new heights in creativity and right-wing innovation – witness DeSantis' almost inconceivable fight with Disney over its public position on the *Parental Rights in Education Act* (the 'don't say gay' law) (Luscombe 2022). The cumulative effect of their permissive speech acts, targeted battles with often illusory enemies, and relentless push for intolerant public policies all add up to an unintended social agency in shifting the rules of reproduction for the right in general.

Back to Medicaid – Austerity is not enough

How do we interpret the politics of Medicaid in the light of these new rules of reproduction? The overall dynamic is characterised by unrelenting budgetary containment, whittling down of health benefits, and/or harnessing program requirements for ulterior ideological objectives. On a federal level, this has been orchestrated *via* the long saga of *ACA* obstructionism, whereby Medicaid expansion has been particularly targeted. Congressional attempts to change Medicaid's federal fiscal payment structure amount to a Republican recognition that such public programs are generally more efficient; bring palpable politico-economic benefits to enrollees; and constitute a political threat to the right. This has rendered attacks on 'entitlement' and the pursuit of controlled spending caps, such as during the Trump-driven attempts at *ACA* dismantlement, where Medicaid expansion was specifically in Republican crosshairs. The holy grail of these efforts was the potential reversal of Medicaid expansion, withdrawing funding for the adult low-income population, along with the general instantiation of block grants to states for a residual, *per capita* funded program. Operating under the umbrella of 'repeal and replace' legislation, a consistent theme shines through: Medicaid is a waste of public money; produces weak quality and inconsistent care; and does nothing to incentivize beneficiaries towards individual responsibility. Indeed, 'individual responsibility' is a theme that permeates all reform

attempts, whereby poverty simply reflects an individual's unwillingness to work. After all, 'the magic of casting aspersions on the poor tends to work well in an era in which the politics of resentment are ascendant' (Rosenbaum 2018: 595).

The difficulty with such highly visible assaults on Medicaid is that it remains a valuable and effective state-based public policy. As Rosenbaum (2018) has correctly pointed out, Medicaid is large but it is nimble, delivering relatively low-cost care to the largest segment of healthcare beneficiaries in America. It represents a majority share of public policy budgets for states, and dismissing its significance runs contrary to public opinion. In blunt economic terms, 'Medicaid remains the low-cost alternative to private insurance coverage, with annual per capita spending 25 percent below the cost of comparable private insurance, chiefly because provider payment rates are lower' (Rosenbaum 2018: 583). Moreover, Medicaid expansion has obvious societal effects that offset any perceived fiscal burden. Besides the large influx of federal dollars into state economies, Medicaid expansion brings people out of poverty. Zewde and Wimer (2019) found that expansion coverage alone lifted 1 percent of the US population out of poverty – approximately 690,000 adults. The authors found evidence that this effect accelerates over time, which 'would imply that future expansions or retractions of Medicaid could produce poverty effects that are larger in magnitude than those observed under the *ACA*' (2019: 136). This tracks with other studies suggesting a correlation between acquired Medicaid coverage and decreases in personal debt, payday loans, and, most significantly, housing evictions (Allen *et al.* 2019). Because poverty and homelessness have resounding effects for state budgets, any assertion that Medicaid wastes federal dollars amounts to ideological dogma rather than an evidence-derived claim.

Largely discarding such evidence, Republican lawmakers continue to ramp up their performative acts to adhere to the new rules of reproduction. Particularly at the state level, degrading Medicaid is a significant part of demonstrating Republican 'authenticity'. While the acceptance of federal dollars by state officials may appear a political 'no-brainer', state officials feel compelled to show that such funds will not result in unmerited 'handouts'. Medicaid, as a redistributive program, has always been subject to such attacks, but many state officials now approach this with a discernible pre-emptive 'meanness' in program design. The primary mechanism for this has involved section 1115 waivers (from the *Social Security Act*), negotiated with the Federal Government's Centers for

Medicare and Medicaid Services (CMS), and applied largely to low income adults, without children, made eligible by the *ACA*. These waivers are used to demonstrate that funds go only to the 'deserving' among new beneficiaries. Indeed, as expansion has been negotiated in states where conservatives dominate, Grogan *et al.* (2017: 249) find a 'chronological pattern developing where each grouping of conservative states pushed for reforms further to the right of their predecessors […] questioning the deservingness of the newly eligible, and seeking to return Medicaid to its original intent of only serving the truly needy.' Austerity, in this sense, now makes up only one element of conservative virtue signaling on Medicaid. Alongside austerity, waiver agreements have rapidly become the norm, and they are used to impose strict program features intended to outline and enforce the responsibilities of beneficiaries. Importantly, this phenomenon is not limited to Republican-led states: while driven primarily by the right, political calculations in all states now require that such conservative sentiment is somehow addressed.

To varying degrees, Medicaid expansion has become about obscuring its reality *as Medicaid* – characterising it as a program with more 'responsible' objectives and not really part of the *ACA* or, worse, with little or no link to the federal government. Making this characterisation operational is precisely where 'rules of reproduction' are most visible, beginning with the imperative to *ensure that any expansion program is not made up of beneficiaries or citizens, but rather responsible consumers*. Part of this relates to the use of MCOs, where programs are mixed in with either existing employer-based managed care plans, or the possibility of a 'private option' is offered. The latter incentivizes recipients to purchase their healthcare with state funds on individual marketplace exchanges, ironically set up under the *ACA*. Either way, administrations seek to project Medicaid as 'not Medicaid', such as in Arkansas, where 'the administration strategically eliminated the term *Medicaid* from public statements, and only focused on the *private option*' (Grogan *et al.* 2017: 261). This is repeated across a range of states, to the point that it is legitimately difficult to discern who is or is not a recipient of government funding. As Tallevi (2018: 627) has pointed out, 'this encourages Medicaid participants to think of themselves outside of the Medicaid population and to underestimate the role that government plays in the provision of their health insurance.' One cannot help but note that lowering citizens' perception of their own participation in government programs has an added benefit for Republicans: it interrupts a documented correlation

between Medicaid and political participation, including electoral registration, likely to help Democrats (Clinton and Sances 2018).

Instilling a consumer mentality – with its associated responsibilities – is augmented by cost-sharing and health savings accounts (HSAs). The former is not new in healthcare, but its imposition on those who are greatest in need (and with the least ability to pay) is particularly harsh. Tennessee's 2015 waiver application to CMS for Medicaid expansion included a monthly premium (2 percent of household income) for all enrollees and co-payments for services (KFF 2015a). After already having adopted Medicaid expansion, a new Republican Governor in Ohio sought (but was denied by CMS) to add on premiums and copayments for service (KFF 2016). Such attempts have been successful in 8 waiver-negotiated expansions, usually with an eye to satisfying state legislatures. An increasingly popular mechanisms to augment this payment structure is the HSA, requiring individual contributions and ostensible accounting of individual health spending. Indiana's Medicaid expansion, under then-Governor Mike Pence and Seema Verma (who was later put in charge of CMS), created Personal Wellness and Responsibility (POWER) HSAs that require monthly contributions, for use with copayments and/or deductibles. HSAs – also in Georgia, Michigan, and Arizona – are used to ensure that premiums are associated to an individual's personal account and consumption in the marketplace. This bolsters an environment in which 'states hypothesize [the] benefits of premiums for beneficiaries, including improving health outcomes and health literacy, increasing personal responsibility, and preparing enrollees to transition off Medicaid by aligning the program more closely with commercial coverage' (Guth *et al.* 2021).

Beyond setting beneficiaries as responsible consumers in the marketplace, a second imperative requires that policymakers show that *expansion funds are utilised only for those who are qualitatively 'deserving'*. The publicisation of program design focuses on (and valorises) the working poor, while the seemingly ever-present (but difficult to identify) 'lazy poor' are intentionally excluded. There is a strong undertow of racism built into these design features, where black and Hispanic communities are, however subtly, characterised as unproductive abusers of government largesse. In this, 'symbolic racism portrays racial minorities as 'demanding', and 'undeserving' individuals with a 'lack of work ethic and responsibility', especially in association with social welfare programs' (Grogan and Park 2017: 543-4). Waivers build in behavior requirements

and/or incentives, some of which are attached to premium reduction: 8 states have incorporated healthy behaviour incentives (more programs are pending). However, the more controversial waivers include work requirements. Historically, these have been strictly rejected at the federal level by CMS, but they rather suddenly found encouragement under the Trump administration. From 2017 onward, at the invitation of Verma's CMS, mostly Republican (and mostly non-expansion) states applied for waivers to implement work requirements in their Medicaid programs. 13 states received federal approval, and 9 remained pending at the point of the 2020 election. With the obvious complication of COVID-19, only Arkansas had moved to implement the program, with consequences for failure to comply (Guth and Musumeci, 2022). These waivers, some of which were struck down by courts at the District and Appeals level, varied from state to state, but they all disregard the readily available evidence that 'poor health is associated with increased risk of job loss, while access to affordable health insurance has a positive effect on people's ability to obtain and maintain employment' (Antonisse and Garfield, 2018).

Actual health and well-being outcomes, however, were hardly the point. Rather, the spurious claim that working harder both merits healthcare access and leads to better health amounts to little more than a performative display of harshness, aligning with both retributive conservative and neoliberal values. Even when Governors, both Democratic and Republican, try to appease these values, by emphasising that it is *mostly* working Americans who require Medicaid expansion, they are met with deep Republican (often legislative) skepticism. New Hampshire legislative Representative Neil Kurk (R) captured this sentiment, when he polemically asked whether 'simply because you are alive and poor you receive this health care and you don't have to do any work if you don't wish to?' (Grogan *et al.* 2017: 269). In the end, the Biden administration has undertaken to revoke work requirement waivers, across the board, but the likelihood that they can and will be revived under the next right-leaning administration remains high.

While full-blown work requirements have not yet materialised, penalty programs have been put in place. Indeed, a third imperative under these performative politics urges *the demonstration of consequences for non-adherence to Medicaid requirements*. To date, this has centered around financial cost-sharing; and HSAs have again proven a fruitful mechanism to demonstrate intolerance for so-called non-contributory Medicaid recipients. Federal rules do not allow premiums for Medicaid recipients

below 150 FPL, because they typically create a barrier to care. However, eight states (Arizona, Arkansas, Georgia, Indiana, Iowa, Michigan, Montana, Wisconsin) have received a waiver to charge such premiums, including punitive measures for non-payment. Such measures can include disenrollment from coverage, a 'lockout' period, a plan downgrade, or any combination of these actions (Guth *et al.* 2021). In Indiana, Medicaid recipients between 100 and 138 percent FPL who fail to make a premium payment are disenrolled and locked out for 6 months. Those below 100 percent FPL who fail to do so are both downgraded to a 'basic' plan and subjected to co-payments (KFF 2015b). Such punitive measures now form the 'basics' of Republican efforts to either change existing Medicaid expansion programs (*eg*. Ohio, Kentucky) or propose new ones (*eg*. Utah, Tennessee). Not only do these impose draconian sanctions on states' most vulnerable populations, they further a *de facto* work requirement (as premiums are difficult to cover without income). Paradoxically, the *ACA's* strongest Republican resistance decried the intrusive nature of the individual mandate, punitive governmental measures (in the form of taxation), or any potential cancellation of their existing health insurance. The irony here would be rich, if it were not so tragic. Clearly, when it comes to poor, racialised, and disadvantaged populations, punitive governmental measures aimed at individuals are viewed as entirely acceptable, even socially advantageous.

All in all, the performative rules for reproduction demand that Republican political actors not only cloak Medicaid expansion in a 'not-Medicaid' aura, but they should strive to limit government help only to those who can help themselves. As such, even Republican officials in states that initially accepted Medicaid expansion, such as Kentucky and Ohio, have sought to modify these programs with far stricter terms, proving that they are not, in the end, RINOs. Along the way, a particularly harsh form of individual responsibility and accountability has been brought to bear, reserved especially for the impoverished and working poor of America. This harsh turn on the right affects the whole political spectrum, where Democrats have proven, 'willing to compromise and support waiver proposals under the logic that even restrictive coverage is better than no coverage' (Grogan *et al.* 2017: 278). In this environment, it is unlikely that Republican policymakers will reverse the trajectory of their policy efforts, as they seek to outperform each other and demonstrate an authentic devotion to the conservative cause.

Conclusion

Navigating Medicaid policy across the US is a tricky affair, involving not only complicated federal-state relationships, but also a highly varying field of Medicaid delivery programs across states. While cast as public healthcare for those in need, the system exhibits the 'Mildred Paradox':

> Mildred was the mother-in-law of political scientist Don Kettl. In the last few years of her life, a combination of Medicaid and Medicare paid for Mildred's extensive health care needs, including her $85,000-per-year nursing home. Despite the numerous government-funded health services she received, Mildred never encountered a government employee (Tallevi 2018: 139).

Indeed, Medicaid is noteworthy precisely for its intensive utilisation of the market, both in the purchasing and provision of this government-based healthcare. Within this adaptive accumulation, Medicaid expansion should assuage Republican principles (market-based consumption, revenue neutral budgeting). But, whereas Medicare (for seniors) – organised around the same principles – has met with broad acceptance among Republicans, Medicaid expansion faces ongoing hostility from the right. Horizontal class relations and the rules of reproduction explain this somewhat peculiar and counter-intuitive reaction, whereby Medicaid expansion is integral to a decade-long struggle within the Republican political environment. The acquisition of political power – or even the survival of those holding it – increasingly requires the recurring expression of strong, often punitive, right-wing values. Not unlike other policy spheres, such as gun control and women's reproductive rights, policymakers are willing to push far outside majority sentiment, in order to demonstrate their Republican *bona fides*. Thus, even as the Biden administration attempts to undo the damage done to federal Medicaid standards (particularly through Seema Verma's 2017 'invitation to waiver'), Republican state policymakers will step up their demands, minimising program eligibility; tying eligibility to work requirements and behavior modification; and enhancing retributive punishment against those who fall short. In the meantime, Democrats have limited their fight to arguing for the 'working poor' of America, which 'plays into a larger Republican frame of returning Medicaid to its original intent' (Grogan *et al.* 2017: 279). While the grossly unequal access across the American states renders a rather cruel healthcare terrain for the poor, without some unforeseen development or external interruption, the Republican rules of

reproduction will exhibit undue influence over this landscape for some time to come. To the extent that policymakers in other national jurisdictions face reform pressure, this mounting conservative harshness – along with its demonstrable electoral appeal – should be of concern for even the most well entrenched healthcare systems.

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