

## **The Medicare Modernization Act and the New Politics of Medicare**

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On December 8, 2003, President Bush signed into law the Medicare Modernization Act (MMA), creating a new prescription drug benefit for Medicare and enacting other important changes in the program. He did so despite strong criticism of the measure by his party's conservative base, fierce Democratic opposition, and a lack of enthusiasm among the general public for the law as written. That Republicans would enact the largest Medicare expansion in the history of the program is puzzling. Previously, most major extensions of the American welfare state took place during periods of Democratic political control. Moreover, since the 1990s, many Republicans have championed reform of entitlement programs that would cut benefits while increasing the role of private markets in providing for old-age security. Although the MMA augments the influence of private actors in the program, it fails to achieve the main objective of many Republicans: the transformation of Medicare into a premium-support program in which beneficiaries would receive subsidies but would choose their own insurance provider.

Why did Congress pass the Medicare Modernization Act (MMA) and why did the legislation take the form it did? This paper explores the origins and development of the MMA, seeking to place this legislation in the larger context of Medicare politics. For years, the Medicare program failed to expand, with the benefits package remaining virtually the same since the creation of the program and covering only half of beneficiaries' expenses. According to one influential account (Oberlander 2003a), a tacit bipartisan consensus on the program placed fiscal considerations above all else and prevented policy-makers from engaging in the kind of benefits bidding war that one might have expected. This kept Medicare outside of the political spotlight, and program politics were characterized more by backroom negotiation than by electoral

grandstanding. Agreement on the need to contain program costs also helped policy-makers hold firm against provider groups, diminishing the influence of organized interests over the program.

The passage of the MMA directly contravenes this picture of Medicare politics. Since the late 1990s, deficiencies in the Medicare benefit became part of the national political debate, and in 2000, for the first time since the program's creation, Medicare became a significant issue in a presidential campaign. Then, in 2003, legislators jettisoned fiscal caution and added an expensive new benefit to the Medicare program, one that many knew at the time would be much costlier than officials' projections claimed. In addition, the development of the MMA was shaped by the active lobbying of organized interests, including the pharmaceutical industry but also hospitals, HMOs, employers, and a host of smaller provider groups. These groups got much of what they wanted, and this added significantly to the cost of the legislation.

To make sense of these new political dynamics around Medicare, we trace the roots of this reform to the move by Republicans in the mid-1990s to break with the bipartisan consensus that had governed Medicare politics for decades. Knowing the difficulties of challenging a popular entitlement, the conservative Republicans who came to power in that period engaged in a full-scale partisan mobilization on behalf of market-based reform. In so doing, they elevated Medicare to the national political stage and provoked a fierce response by Democrats. In the ensuing fights over the program Democrats and Republicans staked out opposing views, with Democrats pushing benefits improvements while Republicans sought market-based reform. This renewed political competition helped propel the prescription drug issue onto the national political stage. With both sides believing there were electoral gains to be had by credit claiming on this issue, political competition drove continued attention to the problem of seniors' access to prescription drugs.

The mobilization strategy of Republicans, and opening of the door to a major expansion of Medicare, also increased the activism and influence of organized interests. The collapse of bipartisan support for government cost controls in Medicare, coupled with the emergence of a budget surplus, eroded legislators' discipline with regard to provider reimbursements. In addition, the determination of Republicans to enact a reform that relied heavily on private actors created an opening for those groups to extract benefits for themselves. For example, managed care companies could argue that they would not participate as insurance providers if reimbursement levels were not high enough, and employers could demand subsidies to assure their continued willingness to provide retiree drug benefits. All of this added to the cost of the bill. More generally, gaining the support of powerful interest groups was essential in passing a reform that was likely to garner little Democratic support and was viewed skeptically by more conservative Republicans.

Thus, while the MMA began as an effort to transform Medicare into a premium support program, the bill was crucially shaped by both interest groups and wider electoral imperatives that thwarted those pushing for a more radical reform of the Medicare program. The chain of events began when President Clinton put the prescription drug issue on the political agenda, making it difficult for lawmakers to ignore the glaring omission of prescription drug coverage from Medicare, particularly in the face of seniors' increasing need and diminishing alternatives for coverage. Budget surplus projections also made a new entitlement for this large and crucial political constituency seem affordable. Even after the surplus had disappeared, however, Republicans were under pressure from Democrats and the public to do something about seniors' prescription drug costs, and they saw potential political gain in passing a drug reform law for which they could claim credit.

To satisfy more conservative elements in the party, Republican leaders sought to wrap the new benefit together with a structural overhaul of Medicare that would inject more market competition into the program. However, moderate and rural state Republicans blocked two of these market-supporting measures as they opposed limiting drug benefits to those in managed care plans as well as the drive to create direct competition between traditional Medicare and private plans. At the same time, under pressure from business interests, Republicans refused to allow drug price controls or importation from abroad and also had to promise subsidies to nearly every private entity involved in elder health: to private health plans to induce them to readopt the (unprofitable) senior clients they had been dropping; to insurance companies to create drug-only policies; to employers to continue retiree health coverage; to rural hospitals and doctors; and so on. Thus, electoral and organized interest pressures forced Republicans to adopt expensive legislation that both failed to meet their ideological goal of further privatizing Medicare and is likely to produce exactly the outcome they most feared: a huge and growing new entitlement, on the cusp of baby boomer retirement no less.

### **The Breakdown of the Medicare Consensus and the Rise of the Prescription Drug Issue**

Medicare is a fee-for-service insurance program in which the federal government serves as an insurance agent for the nation's retired population (Oberlander 2003a). Medicare Part A, financed through payroll tax contributions, covers hospital care for seniors. Medicare Part B is a voluntary program that pays for doctors' visits and outpatient services; nearly 98 percent of those eligible take up this benefit, and currently monthly premiums on seniors cover 25 percent of costs, with general revenues paying the rest. Complex cost-sharing arrangements characterize the program, with annual deductibles and co-payments for hospital and doctors' visits on top of

the monthly premiums for Part B. There is no cap on out-of-pocket expenses for beneficiaries, and all together, beneficiaries are liable for about half the cost of acute care (Moon 2001). Also, Medicare was not designed to cover all needs, as most long-term care and prescription drugs were originally excluded from coverage.<sup>1</sup>

The enactment of Medicare in 1965 represented the culmination of several decades' work to include some form of national health insurance in the American welfare state. After many failed attempts to insure all Americans, or all workers, under a government program, proponents seized on the strategy of insuring seniors first and then trying to extend coverage to other groups later on. Older Americans were a sympathetic group that had difficulty purchasing health insurance on their own. In addition, both commercial insurance companies and unions favored government coverage for this group – insurance companies because seniors were a difficult group to insure, and unions because retiree benefits distracted from other goals to be attained through collective bargaining (Quadagno 2005, 56-7, 61, 72). What made possible the creation of Medicare was the Democratic electoral victory in 1964, giving Democrats control of the House, Senate, and Presidency and thus the ability to circumvent opposition. This led Republicans and conservative Democrats to also jump on board so that all could claim credit for the creation of a popular new entitlement program (Marmor 2000).

This bipartisan agreement on Medicare would endure for several decades but did not promote further expansion of the program. Instead, rapidly rising medical inflation produced what Oberlander calls a “negative consensus” on the need to contain program costs. That Medicare spending rose rapidly with the implementation of the program can be traced to features of program design. Seeking to mollify often hostile provider groups like doctors, Medicare's

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<sup>1</sup> Limited nursing home care is available after hospital stays, while prescription drugs dispensed through physician offices also have been covered.

creators promised them the full reimbursement of all “reasonable charges” and no government interference in setting prices or clinical decision-making. This produced a rapid increase in program costs and led policy-makers to prioritize spending restraint over any expansion of benefits (Marmor 2000, 96; Oberlander 2003a, chp. 3). Thus, after adding End Stage Renal Disease coverage to the program in 1972, the Medicare package remained essentially the same, covering a lower proportion of expenses than most private insurance plans. Provider groups such as doctors and hospitals would also be affected by federal fiscal austerity. The creation of a prospective payment system (DRGs) in 1983 contained hospital spending and was followed by a fee schedule for physician reimbursements (the RBRVS).

This evolution of the program has led some analysts to emphasize the relative autonomy of Medicare decision-makers from either electoral pressures or organized interests (Oberlander 2003a, chp. 6). According to Oberlander, bipartisan agreement on the basic contours of the program and the need to restrain spending precluded partisan jousting over the benefits package. One surprising result was that since the creation of the program, no Democrat made improving the coverage of Medicare a major priority during the campaign (Vladeck 2004, 67), and Medicare decision-making largely took place behind closed doors – well away from the electoral limelight (Marmor 2000, 175-6). Such back-room decision-making hardly worked to the benefit of organized interests either, as policy-makers had clamped down on provider reimbursements by the 1980s (Oberlander 2003, chp. 5). Within this negative consensus on fiscal restraint, policy change took place at a fairly incremental pace (Smith 2002).

All of this changed in the mid-1990s, when Republicans broke with the tacit bipartisan consensus on the basic contours and principles of the Medicare program (Oberlander 2003a; Vladeck 2004). Many of the conservative Republicans who came to power in 1994 viewed their

electoral victory as a referendum on the Clinton health reform effort and vindication of their anti-government campaign programs. In the view of Newt Gingrich and many of his allies, the door was open for a bold agenda that would include fundamental reform of entitlement programs such as Medicare and Medicaid (Peterson 1998, 197-8). One goal of the conservative movement was to try to break the Democrats' political advantage on entitlement policy by offering an alternative vision of how to "modernize" the social safety net through market-based reforms. An additional motivation was to try to reduce the size of Medicare and Social Security before the retirement of the baby boom generation rendered these programs costlier to the federal government and made a huge segment of the population dependent on public spending (and thus politically beholden to these programs' Democratic defenders). As Gingrich told the Atlanta Constitution in 1995, "If we solve Medicare, I think we will govern for a generation" (quoted in Smith 2002, 71).

In addition to making an ideological break from past patterns of Medicare policy, Congressional Republicans adopted a strategy of political mobilization so as to tackle federal entitlements head-on. Rejecting the incrementalism and consensus-building style of Medicare politics in the past, Republican leaders treated reform of the Medicare program like a military campaign, one that required a mobilization of public and interest group support (Smith 2002; Peterson 1998, 203). What conservative leaders perhaps failed to see was that re-injecting partisan politics into the Medicare program would provoke a high partisan response, unleashing electoral competition over who could best assure the future of Medicare. The Democrats would then emphasize the need for expanded benefits to shore up the public program – a potentially popular message that had long been kept out of the public discourse.

So began the first "high-profile, partisan, and ideological debate over first principles" since the creation of the Medicare program (Oberlander 2003a, 160). In 1995, Republicans

sought not only to cut the Medicare budget but also to expand the role of HMOs in the program and make traditional Medicare and private plans compete (Smith 2002, 93). This sparked a strong Democratic response that cast Republicans as Grinch-like attackers of a popular government program. Ultimately, President Clinton vetoed the reconciliation bill containing these measures and during the resulting government shut down, Clinton successfully pinned the obstructionist label on Republicans while also publicizing and politicizing their cuts in Medicare (Peterson 1998, 207). After Clinton was re-elected, Republicans became somewhat more cautious on the Medicare issue, and in 1997, Republicans and Democrats took Medicare back out of the spotlight and agreed on a softer version of the 1995 reform, temporarily restoring the bipartisan consensus around the program (Oberlander 2003b, 1124). The 1997 Balanced Budget Act (BBA) not only made spending cuts but also created the Medicare+Choice program that expanded the role of private, managed care companies in providing coverage to beneficiaries.

Debates continued about the future of the program, however, in which sharply opposing visions were put forth by liberals and conservatives. The larger context was one of intensifying partisan competition over health policy. Since the defeat of the Clinton reform plan, Democrats had been pushing less ambitious reforms that could gradually achieve universal coverage. Incremental expansions in Medicare were one way to achieve this, such as allowing early retirees to buy into the program. Republicans sought to counter these proposals with tax breaks and market-based reforms of Medicare and Medicaid (Smith 2002, 344-6). According to Smith (2002, 346), the stakes were particularly high for Republicans because Medicare's many gaps in coverage could be exploited by Democrats to justify program expansions. Such popular ideas could only benefit Democrats while further obstructing Republican efforts to reform the

program. By mid-1998, for example, President Clinton began pushing the idea of adding a prescription drug benefit to the Medicare program.

A similar idea emerged during the debates in the National Bipartisan Commission on the Future of Medicare that was created by the 1997 BBA. In the words of Vladeck (2004), the Commission “became the cockpit of Medicare conflict” in the late 1990s as it sought to change Medicare into a premium support program that would give beneficiaries subsidies and allow them substantial choice in who would actually provide insurance coverage. Medicare+Choice was the first step in this transformation, and the hope of many on the commission was to further augment the role of HMOs and other forms of managed care in providing services, thereby creating competition with the traditional, fee-for-service program. One potential sweetener was to add a prescription drug benefit to Medicare in exchange for this larger reform. Ultimately, however, the Commission failed to reach the required supermajority among commissioners for a proposal to institute both premium support in Medicare and a prescription drug benefit.

By this point, there were a number of developments that helped nudge the issue of prescription drugs onto the political stage. Many policy analysts agreed that Medicare’s lack of prescription drug coverage had become an illogical gap in coverage that deprived some people of needed drugs or threatened their financial well-being. There also were significant increases in prescription drug spending throughout the 1990s, particularly for elders who lacked prescription drug coverage (Laschober et al. 2002). The average number of prescriptions and refills per elderly person climbed from 19.6 in 1992 to 28.5 per year in 2000, according to Families USA (Pear and Toner 2001). A June 2000 study by a pharmacy benefit manager, Express Scripts, found that prescription drug spending increased 17 percent in 1999, with the elderly facing the largest increases. As of 1999, 80 percent of Medicare beneficiaries regularly took prescription

drugs, but a third had no coverage to help pay the costs of their drugs (Pear 1999a; Toner 2002c)<sup>2</sup>.

At the same time, efforts to get senior citizens to join Medicare HMOs with prescription drug coverage had largely failed. While the 1997 Balanced Budget Act (BBA) encouraged seniors to join HMOs, by 1998, HMOs were already pulling out of many markets or cutting back on benefits for elderly retirees, especially drug coverage (Brenner 1999; Gold 2001). Indeed, 1999 was the peak year for Medicare beneficiary enrollment in HMOs, at 6.7 million, a figure that dropped each year through 2003 (see figure one). The plans complained that their federal payments, set by the BBA at 95 percent of the average amount spent for traditional Medicare beneficiaries, were too low to sustain benefits at the current levels. By 2000, no HMOs were offering free drug coverage (Pear 1999i). In addition, the proportion of large employers (200 or more employees) offering retiree health benefits fell throughout this period, from 66 percent in 1988 to 36 percent in 2004 (Kaiser Family Foundation 2004a, v). Among the dwindling number that still offered retiree health benefits, many were cutting back on drug benefits or increasing co-payments. The price of Medigap premiums also was rising, as Medigap plans with drug coverage were so expensive that only 10 to 15 percent of Medigap purchasers selected them (Freudenheim 1999).<sup>3</sup>

In these problems, Democrats spied an opportunity to put forth an alternative vision of Medicare policy, yet a triggering event was needed to transform these objective conditions into a problem requiring, in the public's eyes, government action (Kingdon 1995). The spark came from President Clinton's January 1999 State of the Union speech, in which he proposed using part of the projected budget surpluses over the next 10 years to bolster the Medicare program's

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<sup>2</sup> At the time, about 12 million Medicare beneficiaries had drug coverage through former employers, 4 million through Medicaid, and just over a half million through privately purchased Medigap plans (Freudenheim 2001).

<sup>3</sup> Medigap is supplemental insurance that seniors can buy to cover gaps in Medicare coverage.

trust fund and add a new drug benefit. Smith argues that Clinton chose this moment to unveil these ideas in an effort to preempt the report of the Bipartisan Commission. As Congress was supposed to vote on whatever proposal they put forth, Clinton sought to influence the course of these debates in a Democratic direction. Later, in June, Clinton unveiled the specifics of his plan, which sought to offer first dollar coverage to all seniors and then some assistance with catastrophic drug costs, but not full coverage for them (Pear 1999e).<sup>4</sup> The goal of the plan was to provide drug coverage for less than what comparable Medigap policies cost and to make the coverage as attractive as possible since it would be voluntary.<sup>5</sup>

This agenda-setting moment had two crucial effects. First, there was increased media attention to declines in HMO and employer coverage for prescription drugs, which gave credence to Clinton Administration claims that while two-thirds of seniors might have drug coverage of some sort, it was imperiled (Pear 1999j). Second, public attention was now focused on the issue. Before Clinton's announcement, there was no apparent groundswell of public opinion in favor of expanding coverage. In Kaiser Family Foundation surveys asking Americans what they thought was the "most important problem in health or health care for the government to address," concerns about the costs of health care and insurance and the lack of coverage for the uninsured dominated the polls in 1997 and 1998 (figure two); neither the price of prescriptions in general nor need for prescription coverage for the elderly appeared in these polls

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<sup>4</sup> The premiums would be \$24 per month in the beginning, rising to \$44 in a few years. The plan would pay for half the cost of prescription drugs, with the maximum federal payment rising from \$1000 per year initially to \$2500 when the program was fully implemented (Pear 1999e).

<sup>5</sup> The Clinton plan also contained features that became central to the policy debate for the next three years: the program would be voluntary (premiums were intentionally set low to maximize enrollment); would include all seniors rather than low-income or those without supplemental coverage; would use pharmacy benefit managers, private firms that government would hire to manage the new benefit; would not include catastrophic coverage (the maximum federal payment would remain \$2500 no matter what the beneficiaries total expenditures); contained no explicit price controls; introduced price competition among HMO's (but not traditional Medicare); and subsidized employers to continue retiree health benefits including drug coverage at least as generous as the proposed program. The poor (incomes under \$17,000 for a couple) would have no out-of-pocket costs (Pear 1999g).

at all. Indeed, other Kaiser Family Foundation polls showed that, when prompted, seniors favored adding a prescription drug benefit to Medicare, but few volunteered prescription drug coverage as a priority when asked about major policy issues. After Clinton's speech, concerns about the prices of prescription drugs and the need for senior coverage began appearing in the most-important-health-problem surveys (the darker lines near the bottom of figure two), although these concerns continued to be eclipsed by the long-standing concerns about health care and insurance cost and availability.<sup>6</sup>

Once the possibility of a prescription drug benefit for seniors was raised, lawmakers could not stuff the cat back into the bag. While the majority of the elderly had coverage for prescription drugs already, the idea of a new benefit was enticing. Toner noted that while drug coverage had been mentioned before – most recently in the Clinton health care reform effort of 1993-94 – “many Democrats say they have been stunned at the power of the issue in recent months” (Toner 1999b). Moreover, desire for drug coverage spread well beyond the target population. A September 2000 New York Times/CBS News Poll found that 65 percent of respondents – and 71 percent of women – said reducing the costs of prescription drugs for the elderly mattered to them “a lot” (Toner 2000e). And the call for a new policy was apparent across political lines: a January 2002 New York Times/CBS News polls showed that 59 percent of Republicans, 76 percent of Democrats, and 67 percent of Independents said making prescription drugs more affordable for the elderly matter to them “a lot.”

### **Political Competition over Prescription Drugs**

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<sup>6</sup> Note that when prescription drugs for seniors was first mentioned in responses to the surveys' open-ended questions, the responses were coded together with general Medicare, April 2000 to August 2000. But starting in August 2000, prescription drugs for seniors was coded as a separate issue. In neither case was concern over these issues greater than more long-standing issues like health care costs and general insurance costs/availability.

With the prescription drug benefit for Medicare now on the political agenda, partisan competition developed around the issue and propelled expansions in the proposed benefit. Initially, Republicans were cautious in reacting to Clinton's proposal, as many sought to use more of the budget surplus for a tax cut. When the Congressional Budget office declared that the Clinton plan would cost 42 percent more than first estimated – \$168 billion over ten years rather than \$118 billion – Republicans seized the opportunity to promote a more limited Medicare drug benefit (Pear 1999j). Legislative efforts largely stalled in 1999, however, and in his 2000 State of the Union address, Clinton reiterated his call for a new prescription drug benefit. The White House also announced that his proposal would indeed cost \$160 billion over ten years rather than \$118 billion, an increase similar to that first suggested the previous summer by the Congressional Budget Office.

Republicans continued to criticize the president's plan, especially its universal coverage, which they thought unnecessarily expensive and inefficient. However, their tardiness in coming up with an alternative became increasingly problematic during the election year. Citizens aged 65 and over are a large and growing proportion of the electorate, and although they only make up 17 percent of the voting age population, they have constituted 25 percent of the electorate in recent presidential elections and 30 percent in midterm congressional elections. They also comprise about 30 percent of all campaign contributors in both types of elections (Campbell 2003). Moreover, the prescription drug benefit was emerging as a significant issue to the elderly middle class, not just the poor. Of the 16 million Medicare beneficiaries who did not have drug coverage in 2000, 40 percent had incomes above 200 percent of the poverty line (Pear 1999f). One of the AARP's arguments for universal drug coverage, rather than a program targeted at the

poor, was that seniors at any income level could have high out-of-pocket drug costs (Pear 1999m).

Perhaps most importantly, senior citizens have become a swing group that is in play for both political parties. Over time, an earlier cohort of senior citizens – dependable Democrats socialized to politics during the New Deal – are being replaced by a younger group that was socialized under Eisenhower and in the work force during the Reagan era (Binstock 2005). In addition, as political gerontologist Susan MacManus notes, these younger seniors are “more affluent, more educated, more mobile, healthier, wealthier, and . . . more positively disposed to the private sector” (quoted in Toner 1999a). As the AARP’s John Rother puts it, noting seniors turning 65 in 2003 were born in 1938:

If you were born in '38, you barely remember the Second World War. You are basically an Eisenhower kid. You are more likely to have grown up in the suburbs. You are less likely to have been a union member. You are much more likely than your parents to have been white collar. Your attachment to FDR is much less than your parents’ generation. So it’s all trending in a Republican direction (quoted in Stolberg 2003).

The partisan consequence of these shifts is apparent in voting patterns in congressional elections. These younger seniors are more likely to vote for and identify with the Republican Party, so that the traditional Democratic dominance of the senior vote has now been replaced by party competition for the senior vote. From 1980 through 1992, exit poll data show that except for 1984, Democrats won the 60+ vote in House races, but Republicans won the senior vote in the House races of 1994, 1996, and 1998 (Toner 1999a). That Republicans lost the two-party vote among seniors for both the House and the Presidency by a small margin in 2000 no doubt whet their appetite to continue reaching out to seniors.

Expansions in the Medicare program also seemed all the more possible when the federal budget was projected to be in surplus. Even in summer 2001, when a shaky economy cast the size of the surplus into doubt, the Congressional Budget Office (CBO) still declared Republican (\$176 billion over ten years) and Democratic (\$318 billion) proposals for prescription drugs affordable under the budget Congress adopted earlier in the year. Moreover, Medicare spending in 1998 increased by the smallest amount in program history – 1.5 percent – and actually decreased by 1 percent in 1999, after having risen 10 percent a year on average from 1990 to 1997 (Pear 1999b; Pear 1999n). Thus, adding a large new benefit gave fewer lawmakers pause than might otherwise be the case.

For all of these reasons, Republicans decided to jump onto the prescription drug issue and try to compete for the votes of senior citizens – or at least blunt the impact of Democratic attacks. In April 2000, House Republicans put forth a plan in which drug coverage would be provided through private insurers. In May, congressional Democrats countered with their own plan that was similar to Clinton’s but more generous and expensive, including a cap on out-of-pocket expenses (Pear 2000f). Then, in a major change in approach, House Republicans amended their drug proposal in June 2000 to state that in locations where private insurers failed to enter the market, the government would be the “insurer of last resort.” This change of heart came in response to criticism from Democrats, advocates for the elderly, and the insurers’ industry group, the Health Insurance Association of America (HIAA), which did not want to shoulder the financial risk of providing seniors with drug coverage. Republicans did maintain a large “doughnut hole” in coverage, whereas Clinton’s proposal would provide first dollar benefits – a considerably more attractive set of benefits for seniors.<sup>7</sup>

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<sup>7</sup> In the Republican version, variation in plans would be allowed, and plans could include a donut in which there was no coverage – specifically, beneficiaries would pay a monthly premium of \$35 to \$40 per month, the first \$200 to

Although the House passed this measure on June 28, 2000, largely on party lines, the legislation died in the Senate. Interestingly, Senator William Roth Jr., a Republican from Delaware, proposed a Democratic-type bill that would provide a drug benefit through traditional Medicare with similar benefits nationwide, but required that those who accepted the benefit pay more for other services like home health care. The reason for his proposal was that he was locked in a tight reelection race and needed to appeal to the elderly voters of his state. This proposal went nowhere with his fellow Republicans, however, because it did not include private plans (Pear 2000o).

By mid-summer 2000, however, the prescription drug issue was fully wrapped up in election year politics as both Bush and Gore offered Medicare reform plans. Gore's plan – for prescriptions only – would cost \$253 billion over ten years, charge seniors monthly premiums on a sliding scale, and cover half their drug costs up to \$5000. They would then pay all of the next \$1500 out of pocket, after which the government would pay all additional costs (Stolberg 2000b). The Bush plan, to cost \$158 billion over ten years, altered the Medicare program entirely in line with conservative visions. The government would subsidize seniors' purchase of private insurance for all their health care needs, including prescription drugs, or else allow them to remain in traditional Medicare and have the option of buying a subsidized plan for prescriptions. The government would pay the entire cost for low-income elderly while subsidizing costs for the near-poor. Out-of-pocket health care spending would be capped at \$6000 per year (Mitchell 2000b). The Gore plan was seen as more generous, spending more than twice as much on prescriptions alone than Bush would spend on both prescriptions and overhauling the larger program (the CBO said Gore's plan would cost \$338 billion over ten years

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\$250 in drug expenses, and then half of the next \$2000 in expenses with their plan paying the other half. Then there would be no coverage at all until several thousand dollars later, when coverage would kick in again, with out-of-pocket expenses capped at \$5000 or \$6000 per year (Pear 2000i).

(Toner 2000e)). The Gore plan also had no deductible, provided benefits at lower levels of annual drug usage, included a lower catastrophic cap, subsidized lower income seniors more generously, and provided uniform benefits nationwide.

Democrats also sought to exploit the high cost of prescription drugs as an electoral issue in both House and Senate races. Several senators, members of Congress, and challengers took groups of senior citizens to Canada or Mexico to highlight the fact that the same pharmaceutical often cost a fraction of what seniors spent for them in the United States. These actions garnered much media attention and were reinforced by political ads making the same claims (Cook 2000). For Democrats, demonizing pharmaceutical companies was good politics, given senior hostility toward drug companies. Thus, Gore alleged that drug companies had actually written the Republican bill passed by the House in June (Mitchell 2000a). Democratic pollster Celinda Lake maintained that people “just laugh” when asked in focus groups whether they prefer a government benefit or subsidies to purchase private insurance – their anger at drug companies trumps any fears of government (Toner 2000c). Polling by the Pharmaceutical Research and Manufacturers of America (PhRMA) showed that many Americans were ambivalent about drug companies and many wanted price controls (Toner 2002b). Democrats easily tapped this anger and frustration about the high cost of pharmaceutical and made it into a potent electoral issue.

At the same time that Medicare was emerging as a “first order issue” in national politics (Oberlander 2003b), there were another set of pressures on lawmakers – the growing power of interest groups with a strong stake in Medicare reform.

### **The Renewed Power of Organized Interests**

While partisan jousting over Medicare gave momentum to expanded benefits, it also created openings for organized interests to push their own agendas for the reform. Previously, there had been a fairly strong, bipartisan consensus around the use of prospective payments and fee schedules to contain Medicare spending. Since the early 1990s, however, more Republicans had been elected to Congress that were actively hostile to any form of government price controls. HCFA, the agency that runs Medicare (since renamed the Centers for Medicare and Medicaid, or CMS), came under particular criticism, and one motive behind market-based reforms was to try to shift power from government regulators to private actors such as managed care companies. While lacking empirical proof at this time, we suspect that this made Republicans more sympathetic to provider complaints of their ill-treatment at the hands of HCFA. This did not spare these groups from budget cuts in 1995 and 1997, when Republicans were determined to reduce the size of government through cuts in the Medicare program. By the next major Medicare reform of 2003, however, many Republicans had become sympathetic to provider complaints about low reimbursement levels. Thus, even before there was agreement on adding a prescription drug benefit to the Medicare program, it appeared very likely that the Republican majority would give providers a significant increase in reimbursements (Carey 2003b).

In addition, for provider groups such as doctors or hospitals, their lobbying efforts were facilitated by the budget surplus, which helped undercut the previous bipartisan consensus on the need to restrain Medicare costs. As Oberlander (2003) has argued, high budget deficits during the 1980s helped bring about tacit agreement on the need to restrain program spending. The growth of a budget surplus eliminated a powerful argument for such restraint, enabling groups such as rural providers to argue they needed higher rates of reimbursement for Medicare services.

Finally, by the 1990s, two powerful new interest groups had developed around health care – pharmaceuticals and managed care companies – that would play a significant role in the debates over the MMA. The rapid growth of the pharmaceutical industry since the 1980s was shaped, in part, by favorable government legislation and legal decisions (Angell 2005, 6-7, 9). This spurred the industry to become actively involved in politics through campaign donations and lobbying by its main interest group, Pharmaceutical Research and Manufacturers of America (PhRMA). In recent years, congressional staffers have ranked PhRMA as the most influential interest group in the health care field (Heaney 2003). Between 1998-2005, the Pharmaceutical industry spent more on lobbying, by far, than any other health-related industry (figure three) and, since 1990, pharmaceutical manufacturers spent over \$87 million in campaign donations, \$40 million of which went to congressional candidates.

Managed care companies also emerged as an important actor in health policy debates by the 1980s, reflecting their growing importance in the health care economy (Quadagno 2005). Represented by the American Association of Health Plans (which later merged with the HIAA to become one entity: the American Association of Health Plans), the managed care industry been a significant source of campaign funding and active lobbying presence in Washington DC. The positive reception they have received by many policy decision-makers also reflects a hope that they can hold down health costs. Thus, by the 1990s, growing reliance on managed care in Medicare and Medicaid was perceived by many legislators and analysts as the linchpin of a market-based strategy of cost controls (Smith 2002).

This fact points to the difficulties of untangling the independent influence of interest groups on legislation such as the 2003 Medicare reform. The interests of pharmaceutical companies and managed care firms are congruent with the free market values espoused by many

Republicans and conservative Democrats. For example, would Republicans oppose price controls on pharmaceuticals because of the lobbying of PhRMA, or was this driven by their own ideological predispositions? We have reached no conclusion on this point, but can make at least one observation about the influence of pharmaceuticals and managed care firms on the Medicare reform debates. Once Republicans determined to proceed with a reform that would add a drug benefit and increase the role of managed care in Medicare, they would become dependent on the good will of these industries, which in turn gave leverage to these groups. In the case of managed care, the industry threatened that it would “exit” from the Medicare program if reimbursements were not high enough – a repeat of the post-BBA performance when HMOs dropped their Medicare beneficiaries. Maintaining the support of PhRMA also was essential to help keep skeptical Republicans on board. If PhRMA had strongly opposed the legislation, it would have been harder to convince conservative Republicans that the bill would not do harm to the health care marketplace.

In short, much like during the creation of the Medicare program in 1965, expanding the Medicare benefit entailed the mobilization of constituencies for reform, including a range of provider groups. This led to concessions that could either maintain the support of these groups or undercut their active opposition. In 1965, legislators tried to keep doctors and hospitals happy by promising not to interfere in prices or clinical decision-making. Doctors even threatened a boycott on the Medicare program and had to be mollified (Quadagno 2005). Similarly, in 2003, subsidies would flow to the private actors that were essential to the success of the reform: the pharmaceutical and managed care industries as well as health care providers.

### **Forging a New Entitlement, 2000-2003**

The MMA was forged in this context of partisan and interest group mobilization. Following Bush's electoral victory in 2000, he repeatedly called for a prescription drug bill as part of a larger Medicare reform, reinforcing competitive dynamics in Congress over the issue. The ensuing Congressional debates led to continual expansions in the generosity and cost of the legislation, and undercut the plans of conservative Republicans to achieve their primary aim – injecting market competition into the Medicare program. At the same time, interest group pressure shaped key features of the legislation and diverted resources that could otherwise have been used to improve the generosity of the benefit. Out of this tug-of-war between ideological aims, interest group pressures, and electoral imperatives, Congress would create a bill that failed to satisfy either conservatives or the mass public, but would deliver much of what organized interests had wanted.

From the start, plans to use the prescription drug reform to bring about fundamental reform of Medicare met with opposition by the moderate Republicans and conservative Democrats who were essential to pass this reform. In 2001, Bush called for a drug benefit as part of a large-scale reform of the Medicare program but the idea met with a cool reception in the Senate. Senate Finance chairman, Charles Grassley (R-IA) said that his committee would only take up a new drug benefit, and not a more fundamental restructuring of Medicare, because Republicans lacked the votes to pass a bill making traditional Medicare compete with private plans. The senior Democrat on the committee, Max Baucus of Montana, said that price competition – where Medicare would compete against private plans and risk having its premiums raised if it cost more than the private plans – should be tested in demonstration projects before being implemented on a wholesale basis (Pear 2001c). More generally, lawmakers on both sides of the aisle had reservations about the Medicare plan Bush had put forth during the campaign.

The size of the new benefit also quickly expanded. Bush initially proposed allocating \$156 billion over 10 years for reform of Medicare. In February, the Congressional Budget Office increased its estimate of prescription drug spending by the elderly for the decade from 2002 to 2011, from \$1.1 trillion to \$1.5 trillion. This meant that the prescription drug program of \$156 billion over ten years included in Bush's proposed budget would cover only 10 percent of elders' expected drug expenditures. In response, Senate Republicans urged \$200 billion instead (Pear 2001e), while Senate Democrats said \$330 billion would be needed, and the National Council on the Aging proposed \$400 billion (Pear 2001f). Former CBO director Robert Reischauer said that even at \$350 billion, the benefit would not be as generous as that in most employer-provided plans for current workers (Pear 2001f).

Given the defection of Senator James Jeffords (VT) from the Republican Party in May, and the uneasiness toward the Bush plan among both Democratic and moderate Republican senators, fundamental reform of Medicare looked unlikely for 2001. By the end of the summer, economic slowdown and the \$1.35 trillion tax cut that passed in June led to a rapidly diminishing surplus (Stevenson 2001c). Instead, Bush urged a much more modest effort of supplying seniors with drug discount cards issued by manufacturers in the interim.<sup>8</sup> The President also continued to lay out principles for Medicare reform, which included giving the private sector a greater role in the Medicare program. While the government would subsidize beneficiaries in the purchase of prescription drug plans and there would be an upper limit on costs (catastrophic coverage), beneficiaries would have to choose from a menu of private plan options. Bush also called for subsidies to employers who continue providing drug coverage for retired employees, as well as increased subsidies to HMOs to prevent them from dropping elderly beneficiaries or failing to provide drug coverage (Pear 2001k).

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<sup>8</sup> By the end of the year, a federal judge had said Bush lacked the authority to initiate such a program.

Although the terrorist attacks of September 11 pushed many domestic initiatives off the agenda, the Bush administration called once again for Medicare reform in January 2002. The renewed push for prescription drug and Medicare reform came despite the evaporation of budget surpluses. In January, Bush proposed spending \$190 billion over the decade to overhaul Medicare and provide a drug benefit. Coverage for low-income seniors would begin immediately, with the federal government paying 90 percent and the states paying 10 percent and determining eligibility (Pear and Toner 2002). Key congressional leaders soon asserted that the Bush proposal was too minimal. Republican House Speaker Dennis Hastert announced that he wanted \$300 billion for prescription drug reform and in May 2002, House Republicans and Senate Democrats put forth competing prescription drug plans.

The Congressional reaction reflected the power of this issue during an election year. With the Senate under the control of the Democrats, it was clear that Majority Leader Daschle was going to push for votes on the prescription drug issue as a way to undermine Republican candidates (Nather 2002). Throughout the year, Democrats would pound on Republicans about their failings on this issue, encouraged by Democratic strategists who showed that Democrats had a wide lead in public opinion on this issue (Rich 2002; Carey 2002). In addition, it was becoming clear that senior citizens had certain expectations about what a prescription drug bill would look like, and the stingy versions proffered thus far were disappointing. As of July 2001, for example, the main Senate Democrat plan had included monthly premiums of \$53, which lawmakers hoped to reduce to \$35. At the same time, many seniors, who already paid \$50 per month in Medicare premiums, thought an additional drug premium should be more like \$10 per month. Indeed, Kaiser Family Foundation focus groups found that both older Americans and younger people were shocked by how expensive yet meager the proposed benefits were. They

expected plans more similar to those for workers – no additional premiums and a co-payment of \$10 or \$15 for each prescription (Pear and Toner 2001).

Thus, by 2002, the Democratic plan had expanded to \$400-\$500 billion over ten years, had no deductible, required a monthly premium of \$25, and contained a catastrophic limit above which the government would pay all drug costs of \$4000. The Republican plan would cost \$350 billion, and had a \$250 deductible, a \$35 to \$40 monthly premium, a \$5000 catastrophic limit, and a complex benefit that included a doughnut hole – Medicare would pay 75 percent of drug costs from \$250 to \$1000, 50 percent from \$1001 to \$2000, nothing from \$2000 to \$5000, and then 100 percent over \$5000 (Pear 2002d).<sup>9</sup>

On June 28, 2002, exactly two years after first passing a prescription drug bill, the House passed a bill again, on a largely party-line vote, 221 to 208.<sup>10</sup> This bill was essentially the Republican plan noted above, with some modifications, and was slated to cost \$350 billion over ten years.<sup>11</sup> House Democrats wanted to spend more, but they were not allowed to offer their version because it didn't conform to the \$350 billion limit adopted in the budget earlier in 2002 (Pear 2002i). In July the Senate devoted two entire weeks to the prescription drug issue – an extraordinary amount of time to devote to a single issue – before finally killing prescription drug legislation. They rejected four different proposals, unable to agree on how much to spend or who to cover. The chamber did pass legislation to speed the approval of generic drugs (Pear 2002k).

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<sup>9</sup> In addition, private plans only need provide actuarially equivalent plans, not this precise plan; private entities would bear the financial risk of providing the insurance; and the federal government is prohibited from setting drug process or establishing a formulary.

<sup>10</sup> Eight Democrats voting for bill, eight Republicans against.

<sup>11</sup> Premiums of \$33, \$250 annual deductible; Medicare pays 80% from \$250 to \$1000, 50% from \$1001 to \$2000, nothing from \$2001 to \$3700, and 100% above that; pays subsidies to private insurance companies to get them to offer drug-only policies.

With the November 2002 elections, Republicans regained control of Senate and, one might expect, a free hand for Medicare reform. Bush and some congressional Republicans apparently saw the mid-term elections as providing a mandate for fundamental reform of Medicare that would increase the role of market forces in the program (Adams 2003). In his 2003 State of the Union address, Bush promised \$400 billion over ten years to overhaul the program, and although a new prescription drug benefit was part of the package, much of the focus was on structural reform (Nather 2003a). As Bush traveled across the country pushing for the items contained in his State of the Union address, his administration revealed that the Medicare plan under current consideration would limit a new prescription drug benefit to seniors in HMOs or PPOs (preferred provider organizations) and that there would be no benefit for those remaining in traditional Medicare.<sup>12</sup>

Lawmakers of both parties immediately objected to the proposal, reflecting concerns about the unpopularity of managed care. One “political truth” that had emerged from Clinton’s failed health reform effort is that “any hint of coercing people into health maintenance organizations – using the carrot of drug benefits to entice them – is guaranteed to create an uproar” (Toner 2003a). That so many HMOs were cutting back on drug coverage or pulling out of Medicare completely in the period that drug legislation was under consideration reinforced seniors’ suspicions. As the Republican Congressman Billy Tauzin remarked, “You couldn’t move my mother out of Medicare with a bulldozer. She trusts it, believes in it. It’s served her well” (Pear and Toner 2003a). By mid-February 2003, even House Speaker Dennis Hastert (R-II) said he did not think requiring Medicare recipients to join a private health plan in order to get drug benefits could be done either “humanely” or “politically” (Toner 2003b).

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<sup>12</sup> Also notable is the fact that Bush made this pledge on that very same day that the director of the White House Office of Management and Budget announced the federal budget deficit would be the highest ever, \$300 billion, that year (Andrews 2003).

In addition, moderate lawmakers, some of whom came from rural states, embraced the new drug benefit but opposed many of the market-based ideas their conservative counterparts were advocating. A particular point of contention was limiting drug benefits to beneficiaries in private plans. A number of Republican members of Congress hailed from rural areas where HMOs were either not available or had pulled out over time because the costs of doing business – often higher in rural areas because there are fewer patients – exceeded Medicare payment levels (Adams CQ 3/1/2003). Senators Charles Grassley (R-IA) and Olympia Snowe (R-Me), both members of the Senate Finance Committee, said that drug coverage must be available to all seniors, as did Representatives Tauzin (R-La, Chair, House Energy Commerce Committee) and Jim Nussel (R-IA, Chair, House Budget Committee). That two-thirds of the Senate Finance Committee members were from heavily rural states was crucial in tipping the balance (Toner 2003a).

By late February, the Bush Administration changed its tactics, saying that a drug benefit would be available to those in fee-for-service Medicare, but that people who join HMOs or PPOs would get a more generous benefit (Pear 2003c). More generally, the administration decided to let Congress work out the details of the reform. Democrats and some Republicans continued to say the drug benefit should be the same for all, and Democratic proposals ranged from \$600 to \$900 billion. The Congressional Budget Office (CBO) projected that total elderly drug spending would hit \$1.8 trillion over the next ten years (Pear 2003d). Still, the \$400 billion figure that Bush first proposed, and that was enshrined in that year's budget agreement, became the ceiling that no drug reform bill could exceed, forcing legislators to find a way to provide coverage to all while limiting the extent of that coverage. One reason for this was that conservatives, already

highly skeptical about adding a prescription drug benefit to Medicare, were vigilantly watching to make sure the bill did not cost any more than planned.

Republican lawmakers also had limited room for budgetary maneuvering due to the lobbying of organized interests for their share of increased Medicare funding. For one thing, an increase in provider payments had been in the works since 2002 and one such increase already had been approved by both the House and Senate in February 2003, before the drug benefit had even been drafted. The 2003 Omnibus Appropriations bill gave providers as much as \$54 billion in additional payments over 10 years, but many legislators felt that providers, particularly those in rural areas, deserved further increases. As the Medicare law aimed to increase the role of HMOs in the program, they also would need higher payments to lure them back into the program. Throughout 2002 and 2003, the AAHP had been lobbying for these higher payments, frequently arguing that without more money managed care companies would refuse to participate in the program.

Employer made similar demands for public subsidies to continue providing drug benefits to retirees, and this also worked against improved generosity of the benefit. Legislators were determined not to replace the existing system of employer-provided drug benefits, however tattered that safety net had become. Threatening to drop retiree coverage, employers argued consistently, and successfully, for public subsidies that would help them preserve this coverage. In addition, if the government benefit were more generous than that provided by private employers, the latter would disappear as retirees signed up for the government benefit. As AEI policy analyst Douglas Besharov said at the time, “If you don’t want crowd-out, you sure as heck better not have a government program that is as good as a private program” (Carey 2003a).

These concerns created a counter-weight against the more generous drug benefit that Democrats were demanding, and that clearly resonated with the mass public.

Faced with these constraints, legislators sought ways to limit the cost of the new bill, with some proposing a means-tested benefit. This deeply unpopular idea was soon jettisoned, and legislators instead created a benefit with a large gap during which beneficiaries would have to pay the full cost of their drugs until reaching a certain threshold. By creating a doughnut hole with no coverage, legislators could keep overall costs down while still promising at least some benefit to all retirees. Low-income beneficiaries would be subsidized, and there would also be new subsidies to both HMOs and employers who pay drug costs for retired employees. To provide something in the short-term, drug discounts would be available before the new benefit was fully in place.

While this formed the basic outline for the final legislation, there would be much conflict over various aspects of the bill until the final moment of passage. One issue concerned the size and structure of the doughnut hole in coverage. There also were disputes about whether the new law should incorporate elements of income-testing, charging higher premiums to wealthier beneficiaries or providing less coverage to them. The former was finally included. The more fundamental problem facing Republicans was that jettisoning the larger project of Medicare reform would antagonize conservatives in the party. For these conservatives, the prescription drug benefit was acceptable only as part of a larger reform that put more market mechanisms into the Medicare program. While the House bill, which passed on party lines (216-to-215), contained measures requiring the Medicare program to directly compete with private alternatives starting in 2010, the Senate bill did not include such a measure, and passed with much bipartisan support (76-to-21). Given the smaller margin of Republican control over the Senate, and the

ever-present threat of a filibuster, it would be difficult to achieve a prescription drug bill that ran counter to the wishes of the many Democrats who had voted for this bill.

These issues were left for resolution by the conference committee that met in the summer and fall of 2003. By this time, interest groups had ramped up their activity around the legislation (Carey and Adams 2003). One of the big issues was whether to allow re-importation of prescription drugs. During passage of the MMA in the House in June, Republican leaders promised a vote on this to intransigent Republicans whose vote they badly needed. Much to their surprise, this highly popular measure passed in the House, despite the mobilization of pharmaceutical companies to block it. As figure four shows, both Republican and Democratic supporters of PhRMA's position (those voting yes) had received significantly higher contributions than had those voting against. PhRMA led a fierce fight against including this measure in the final MMA and prevailed in the final legislation.

The issue that had the potential to destroy the MMA was that of how much competition to introduce into the Medicare program. Here, conservatives were intransigent. As Stephen Moore of the influential Club for Growth asserted, "We don't see any room for negotiations on that, because that's the key reform. I don't see how anybody in good fiscal conscience could vote for something without it" (Adams CQ 7/12/2003). At several times during the conference negotiations, groups of conservative Republicans announced that they would not support a bill that did not require Medicare to compete with private plans for the business of beneficiaries. They had an important champion in the figure of Bill Thomas, chairman of the House Ways and Means Committee and a determined advocate of private competition in the program (Carey 2003c). At the same time, moderate Democrats such as Max Baucus, who also was on the committee, signaled that including this provision would mean it would never pass the Senate.

The determination of both sides on this point created a deadlock on the conference committee. As the negotiations wore on through September and October, many began to fear that the MMA would fail.

Ultimately, the Republican leadership decided to overrule Thomas, placing electoral motivations above ideological ones. The crucial moment came when Hastert, DeLay, and Frist took control of the conference committee from its leaders, Thomas and Grassley, and worked out a compromise agreement with moderate Senate Democrats, Breaux and Baucus. The agreement turned the premium support measure into a demonstration project rather than requiring Medicare to go head-to-head with private plans. Such direct involvement of the political leadership on a conference committee was highly unusual, and Thomas was furious to find he had been outmaneuvered. Ultimately, he swallowed his anger and agreed to vote for the bill. Thus, on November 15, the conference committee announced a deal on drug legislation (Carey 2003d).

What was the role of President Bush in getting the MMA to the finish line? Repeatedly throughout the summer and the fall, Bush exhorted the conference committee to reach some kind of compromise that could enable passage of the bill. It appears that the Bush team saw this reform as a central aspect of their re-election strategy, as they were hoping to at least neutralize the Democratic advantage on these issues, if not actively gain the support of senior citizens (Cook 2003; Iglehart 2003). How much this influenced the course of the negotiations is difficult to say at this stage of our research. In the fall of 2003, some pundits believed that tensions between Bush and the Republican Congress had diminished his influence on the hill (Nather 2003b). Conservative activists and organizations were livid about the legislation and could not be persuaded by White House officials that the seeds of a larger, structural reform of Medicare were being planted in the bill (Medvetz 2006). It does appear, however, that the Republican

leadership shared Bush's view of the political merits of the reform, and was determined to pass the bill. This created a rift with conservative activists and would make it difficult to sustain a Republican majority around the bill.

Once the compromise had been reached in the conference committee, the fight was on to get the agreement passed in the House and Senate. The crucial development at this juncture was that on November 17 the AARP decided to back the plan. Earlier, the AARP was forceful in challenging various aspects of the proposed legislation. In a July 2003 letter to Congress, for example, the organization outlined its concerns and threatened to withhold its support unless the listed shortcomings were addressed (Welch 2003). In particular the group objected to price competition between traditional Medicare and private plans, and preferred the Senate version of the bill in which the government would provide drug coverage in markets private insurers did not enter. With its main objections addressed, the organization decided to endorse the legislation, despite the bill's meager benefits and other limitations. This last minute endorsement of the legislation gave political cover to lawmakers and helped push the bill over the top. The organization claimed to have achieved several concessions, including greater subsidies for low-income beneficiaries and larger subsidies to employers to preserve retiree drug benefits (Barry 2003).

Critics alleged that the AARP held its commercial interests above those of its membership, as private entities selling medigap products are well situated to begin offering drug insurance products in 2006, when the legislation will be implemented. However, there are other, more likely reasons the AARP decided to endorse the legislation. The organization felt that the \$400 billion on the table, inadequate as it was, was unlikely to be there much longer in an era of growing budget deficits of historic proportion. Also, long regarded by Republicans as a "wholly

owned subsidiary of the Democrat party” (Oliver, Lee, and Lipton 2004, 319), the AARP decided that it needed to work with the party in power for the foreseeable future, the Republicans. In addition, the group felt that the younger portion of its membership was the key to maintaining the organization in the long run. A new focus on the younger half was the reason the group both adopted its acronym as its official name, downplaying the “Retired” aspect of its identity, and changed the name of its flagship publication from *Modern Maturity* to *AARP: The Magazine*. This younger membership was more accustomed to private health plans, and surveys showed that while seniors preferred to get their health insurance through traditional Medicare over private plans by 63 to 19 percent, those aged 50 to 64 preferred private plans to the traditional program 44 to 41 percent (Kaiser Family Foundation 2003).

Having endorsed the legislation, AARP proceeded to run a \$7 million advertising campaign to promote it. Ironically, just a couple of months later, the organization published in its newsletter a list of changes it now demanded in the legislation it had just helped pass, primarily narrowing the doughnut hole and allowing the purchase of private supplemental insurance to cover gaps in the law’s drug coverage (Barry 2004). Some 45,000 AARP members are reported to have resigned from the organization in protest, something executive director William Novelli said he regretted, but that this could hardly affect an organization of 35 million.

Republicans also included subsidies for a wide range of organized interests in an effort to improve the chances of passage. The final legislation subsidizes employers who continue to offer drug benefits to retirees, although employers who simply drop such coverage will save an average of \$1000 per employee (Harris 2003). Private health plans were also big winners in the MMA, as the final law subsidizes private plans at levels even higher than traditional Medicare. There also were generous subsidies to a wide range of health care providers and related interest

groups. As Judith Feder, Dean of the Georgetown School of Public Policy remarked, “There’s a tremendous amount of money floating in this bill. While we think it’s about prescription drugs, the promoters of this bill put money into every interest group – physicians, hospitals, rural providers, cancer doctors...the pharmaceutical and insurance industries, and it’s tough to fight all those bucks” (Iglehart 2004).

Even so, the final vote on the bill was grueling, particularly in the House. In the Senate, many Democrats changed their mind and opposed the final law, although it still passed 55 to 44, with 11 Democrats voting for and nine Democrats voting against. In the House, by contrast, the Republican leadership could count on only a handful of Democratic supporters, and thus had to hold onto as many Republicans as they could. At one point, Democrats had an absolute majority of votes against the bill, but the House leadership kept the vote open for several more hours while they and the Bush administration tried to persuade enough Republicans to switch their nay vote to a yea. This was the longest electronic vote tally – two hours and 53 minutes – since the use of electronic voting, and Republican leaders almost literally had to twist arms to get enough Republicans to support the bill (Martinez 2003). One Republican congresswoman hid behind a banister on the Democratic side of the House, hoping not to be found, while others turned off their cell phones or stood in a large group that could fend off attempts by the leadership to pick off vulnerable individuals (Koszczuk and Allen 2003). At 5:51 in the morning, the MMA passed, 220-215, with 25 Republicans voting against, and 16 Democrats voting in favor.

### **Concluding Thoughts**

The passage and nature of the Medicare Modernization Act raises questions about the forces driving the politics of old-age entitlements today. Previously, several analysts of Medicare

politics argued that policy-makers often have acted in a relatively autonomous manner to achieve their own political or policy goals in the program. This is congruent with the fact that, since the mid-1990s, the Republican Party has intensified its push for marketization, or even privatization, of federal entitlements despite public opinion studies that show considerable skepticism among retirees about market-based health care, and several political setbacks (Kaiser Family Foundation/Harvard School of Public Health 2003; Peterson 1998). Our analysis shows that, although these motivations were an important driving force behind the legislation and shaped some features of the final bill, conservative politicians were ultimately unable to achieve the kind of market-oriented reform they wanted. Efforts to increase market competition in the Medicare program were continually thwarted by powerful legislators from rural states, and from a more general perception that forcing seniors into managed care or providing them too many choices would prove highly unpopular. Ultimately, the fact that Republicans lacked a larger majority in the Senate forced compromise on this issue. What we cannot know is whether having a larger Republican majority in the Senate would have enabled conservatives to prevail in these debates. Given the skepticism of moderate Republicans toward the marketization of Medicare, it appears unlikely.

Thus, our account supports, to some degree, an alternative view that the MMA was driven by wider electoral considerations. Classic accounts of American politics assert that politicians seek to appeal to the median voter to maximize vote shares, thereby drawing them toward the center on many issues. Yet, many authors have challenged median voter theory, showing that politicians listen disproportionately to the wealthy (Bartels 2002; Gilens 2004; Hacker and Pierson 2005), to the well-organized, such as the elderly (Campbell 2003), or to the strong partisans that are more likely to contribute to campaigns and vote (Fiorina 2005; Layman

et al. 2005). Yet, while one could not argue that the MMA was tailored to fit the preferences of the mass public, features of the bill seem designed to alienate these more select groups of people. With its complexity and lack of complete drug coverage for non-poor seniors, the legislation contains many elements likely to alienate older Americans. The MMA should hardly appeal to the wealthy either because it charges them higher Part B premiums, could produce a decline in the employer-provided drug benefits that many of them have, but bars beneficiaries from purchasing supplemental drug coverage. Moreover, if the legislation was intended to appeal to strong partisans in the Republican party, such as conservatives, it did so in a strange way – by introducing new benefits that increase the size of government.

We believe that electoral competition drove Republican leaders to create the MMA and push it through the legislative process. This competition was unleashed by the decision by Republicans to attack the Medicare program head on, which spurred a fierce response by Democrats. The resulting fight over the legislation would in many ways work to the advantage of Democrats by allowing them to push an expensive addition to the Medicare program. We believe that the stakes were raised for both sides by perceptions that this law would generate positive “political feedbacks” for those who could claim credit for its passage. For example, many Republicans are convinced that the New Deal and Great Society programs fashioned a unified, pro-Democratic constituency that is dependent on these public programs (Peterson 1998, 200). Some Republican strategists thus believe that market-based reforms of Social Security and Medicare are essential for courting these voters and blunting the Democrats’ advantage on social policy issues. As Republican pollster Bill McInturff put it, “This is the equivalent of what welfare reform did for Clinton. Having a Republican president deliver on the largest expansion

of Medicare in two generations is an enormous advantage going into the 2004 election” (Bumiller 2003). The MMA appears to have been swept up in this current of beliefs.

Ultimately, the form of the bill antagonized those Republicans who believed that the key to capturing the votes of future retirees was to wean them off of government programs and make them more dependent on markets – the Republicans’ strength (Butler and Moffit 2003; Bandow 2003). Instead, the dominant goal became getting a Medicare law at any cost so as to undercut the Democrats on this issue. What we find intriguing is how a belief in policy feedbacks helped hold together a diverse group of Republicans through much of the reform process, and that electoral calculations helped guide this bill through the legislative gantlet.

A final question concerns the influence of organized interests in shaping the drafting and passage of this law. The MMA did have the support of many health care interest groups, including PhRMA, the American Medical Association, American Hospital Association, and the American Association of Health Plans (Oliver et al., 319), and critics lambasted the MMA as a boondoggle for the pharmaceutical and managed care industries (Iglehart 2004). Some also note that, by caving into pharmaceutical companies’ insistence that price controls not be adopted, the MMA’s costs will explode in the future.<sup>13</sup>

Overall, we lack sufficient evidence to say how influential these interests were and whether they will continue to hold this kind of influence. As Oberlander (2003c) has pointed out, the initial Medicare program also was highly conciliatory towards organized interests, but that fiscal shortfalls led decision-makers to close ranks against the pleas of provider groups. The same could happen with pharmaceutical and managed care interests. At certain points,

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<sup>13</sup> Other successful models for controlling drug costs, like the Veterans Administration, were ignored. The VA uses efficacy reports to determine a strict drug formulary. With negotiation power, the VA has been better at keeping drug costs down even than private prescription benefit managers, who sometimes have an incentive to encourage the use of expensive drugs since they reap a percentage of total drug costs (Pear and Bogdanich 2003).

legislators appeared to be adding goodies to the MMA not only to appease the interest groups that fund their campaigns, but also in the hope that these interest groups would then pressure intransigent members of Congress to support the bill. Thus, interest groups were not necessarily calling the shots, but were pawns in a larger strategy developed by Republican leaders to stitch together a pro-MMA coalition in Congress.

While we believe that electoral calculations were critical in the construction and passage of the MMA, we are still left with one of the largest ironies of all: that the MMA was, at least at first, highly unpopular with the general public. In the immediate months following passage, a GOP poll found that 44 percent of people surveyed thought the MMA benefited pharmaceutical companies, and 29 percent said it favored insurance companies. Only 13 percent said the benefit was designed to actually help seniors (Carey 2004). In a December 2004 Kaiser Family Foundation poll, just 15 percent of seniors said the new law would be very helpful for themselves personally; half said it would help only a little or not at all. Early implementation of the prescription drug plans was quite rocky, and the percentage of seniors with an unfavorable impression of the new Medicare drug benefit in Kaiser Family Foundation tracking polls reached 50 percent in December 2005, nearly achieving the peak of 55 percent reached just after MMA passage in February 2004 (Kaiser Family Foundation 2006a).

However, by six months into implementation, senior ire had subsided considerably.<sup>14</sup> The percentage of seniors with an unfavorable impression fell to 30 percent by June 2006 (although the “favorable” proportion has never exceeded one-third, and is just 26 percent among those not enrolled in a Part D plan). Eighty-one percent of those enrolled say they are somewhat

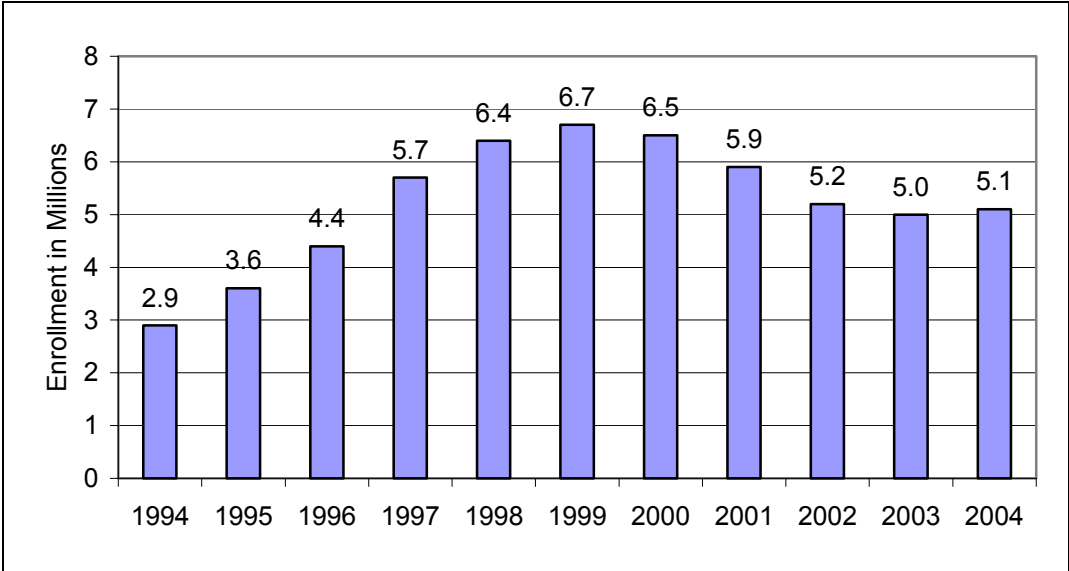
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<sup>14</sup> As of June 2006, 22.5 million beneficiaries were enrolled in Part D, including 5.5 million in Medicare HMOs, 6.6 million dual eligibles who were assigned to a Part D plan, and 10.4 million beneficiaries who enrolled in stand-alone drug plans. Another 15.8 million Medicare beneficiaries have comparable or better coverage (termed “creditable coverage”) from former employers, unions, the Veterans Administration, or other entity. Four or five million people, about 10 percent of the Medicare population, remain uncovered (Kaiser Family Foundation 2006b).

or very satisfied with their drug plan (Kaiser Family Foundation 2006a). Moreover, if seniors had reservations about the MMA, they do not appear to have punished President Bush electorally in 2004: seniors are the age group in which Bush made his largest gains over 2000, posting a 7-point increase in vote share among the 60+ group and 5 points among the 65+ group, according to the national exit polls (52 percent of seniors 65 and over voted for Bush in 2004, compared to 51 percent among all voters).

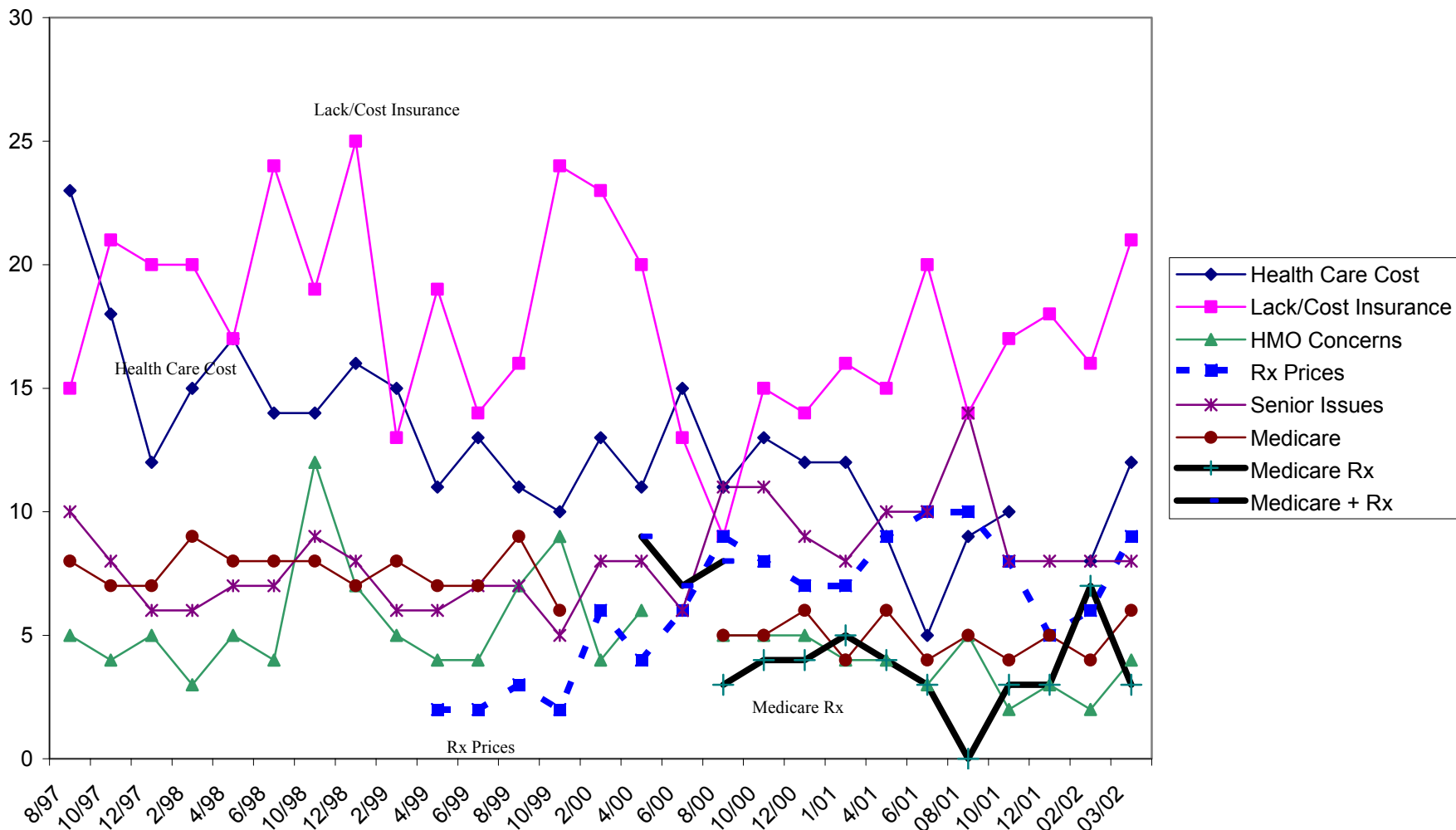
Thus, in the name of undercutting the Democrats on their own turf, Republicans passed a huge new program, destined to grow rapidly in the future, that initially garnered only little public support. Does this represent a massive miscalculation on the part of Republican leaders? Or are they already reaping electoral awards (or at least avoiding blame?) And did they believe that, in the long-run, Republicans would benefit by moving more seniors into managed care programs, and thus reducing their dependence on the government programs championed by Democrats. We already know that seniors in Medicare HMOs no longer feel that they are in a government program (Bernstein and Stevens 1999), and that, compared to clients of traditional Medicare, seniors in Medicare HMOs exhibit lower levels of group consciousness, are less likely to support strategies of collective action, and are more likely to see health care as an individual rather than a societal responsibility (Schlesinger and Hutchings 2003). There could be a long-term strategy at work, one that hews strongly to particular beliefs about the political consequences of public policy. These are the kinds of questions we will explore in our continuing study of the Medicare Modernization Act of 2003.

**Figure one. Medicare Recipients Enrolled in HMOs, 1994 – 2004**



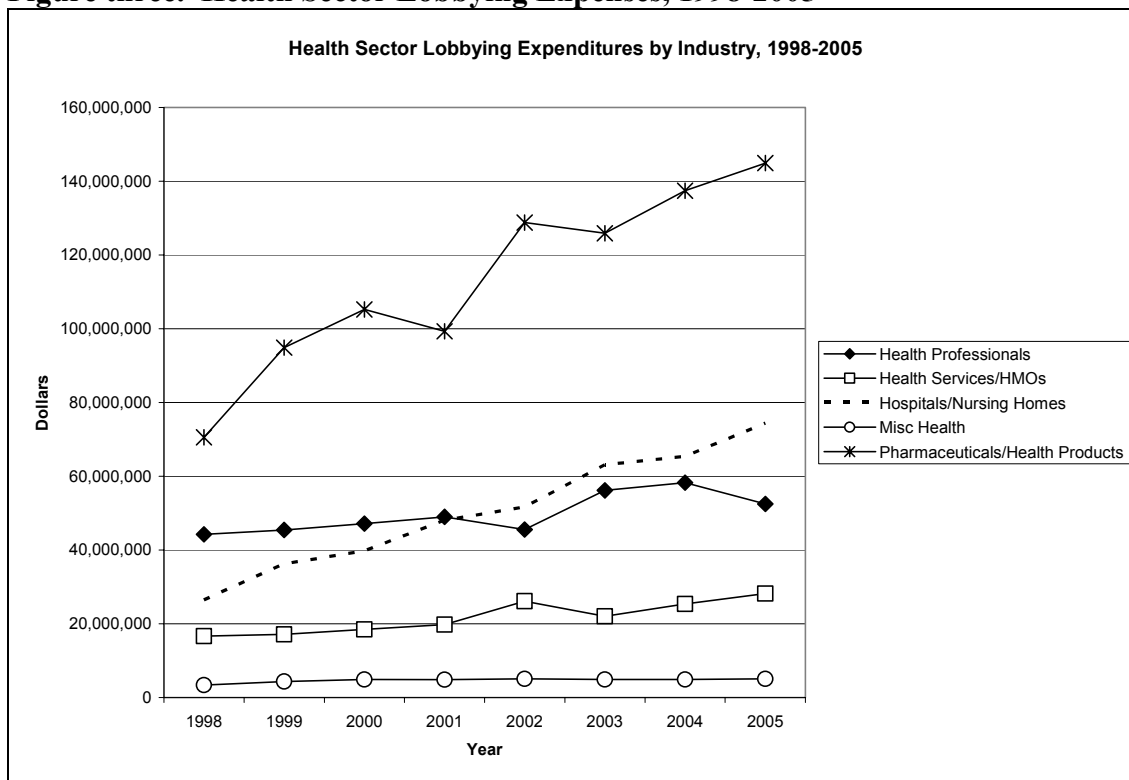
Source: Centers for Medicare & Medicaid Services, Office of Research, Development, and Information, InterStudy, 1991- 2004.

Figure two. Most Important Health Problem, August 1997 – March 2002



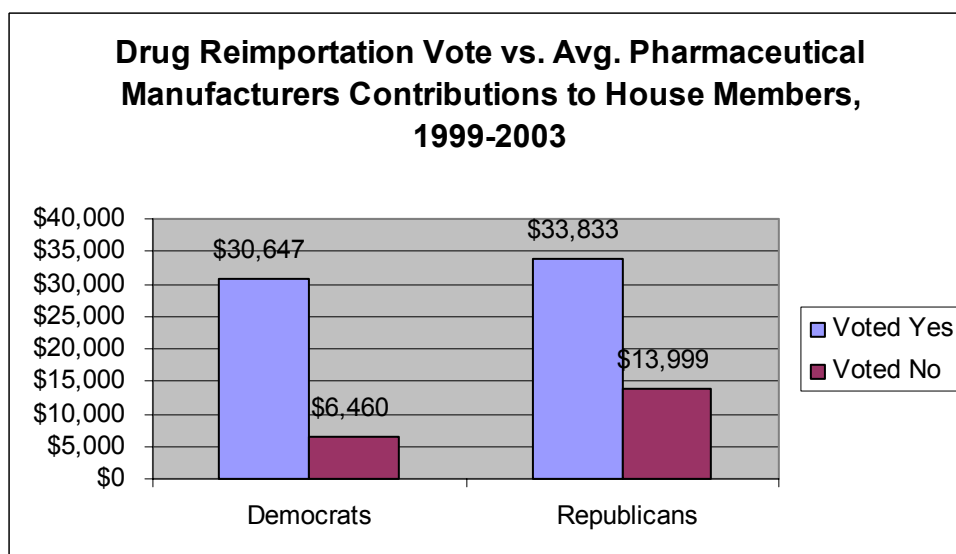
Source: Kaiser Family Foundation/Harvard School of Public Health, Health Interest Index Polls.

**Figure three. Health Sector Lobbying Expenses, 1998-2005**



Source: [www.opensecrets.org](http://www.opensecrets.org)

**Figure four. Vote for the MMA compared to average Pharmaceutical contributions to House Members between 1999-2003.**



A “yes” vote is one that favors the Pharmaceutical industry and prevents drug reimportation.

Source: [www.opensecrets.org](http://www.opensecrets.org)

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