

**The Shifting Line between Public and Private: The Politics of the 2003 Medicare  
Modernization Act and Prescription Drug Reform**

Andrea Louise Campbell  
Department of Political Science  
Massachusetts Institute of Technology  
acampbel@MIT.edu

Kimberly Morgan  
Department of Political Science  
George Washington University  
kjmorgan@gwu.edu

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On December 8, 2003, President Bush signed into law the largest Medicare expansion in the history of the program, creating a new prescription drug benefit and enacting other important changes in the nature of 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. However, some argued that the stakes around this law were far higher than simply adding a prescription drug benefit to Medicare. As the reform sought to further the reliance of seniors on private, managed care plans, Republicans hoped – and Democrats feared – that the law also would undermine the constituency behind this popular, federally-funded entitlement. In this view, the Medicare Prescription Drug, Improvement and Modernization Act of 2003 was part of an on-going political battle for the hearts and minds of current and future retirees.

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 understand the place of this legislation in the contemporary politics of old-age entitlements. Since the 1990s, many Republicans have increasingly championed a reform of entitlement programs that would effectively cut benefits and services while increasing the role of private markets in providing for old-age security. The ascent of George W. Bush to the presidency in 2001, matched by the Republican majority in the House and Senate, opened up a window of opportunity for these visions to be enacted. Moreover, many observers have argued that this administration has pursued a course of action that deviates from the preferences of the median voter, following ideological imperatives at the expense of ordinary citizens.

While the MMA bears the fingerprints of free-market ideologues, 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. Thus, electoral competition over this issue helped keep it on the agenda and spurred repeated expansions in both cost and coverage.

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.

### **Medicare and the Problem of Prescription Drugs**

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 2003). 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 visits 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 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. Indeed, with the enactment of Medicare, seniors went overnight from

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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.

being the age group least likely to have health insurance to being the age group most likely to be covered (Aday, Andersen and Fleming 1980; Anderson, Feldman 1956).

That prescription drugs were not included among Medicare's benefits in 1965 was more an oversight than an intentional omission (in contrast with long-term care, which was excluded on purpose because of its budget-busting potential (Vladeck 1980, 49). Pharmaceuticals were a less important part of health care at the time, as drugs were fewer in number then and much less clinically effective. Over time, however, pharmaceutical drugs became more important, especially for older patients who finally had effective treatments for a variety of acute and chronic ailments. Moreover, the goal of Medicare had always been to approximate private health insurance in its coverage, and prescription drugs were covered under nearly all private insurance. That senior citizens were the last people without drug coverage, the last people 'still paying retail,' became increasingly untenable.

Despite this fact, several efforts to add prescription drug coverage to Medicare failed because they were part of larger, controversial reform efforts. The 1988 Medicare Catastrophic Coverage Act (MCCA) was the first major expansion of Medicare benefits since the program's inception, and it aimed to cap out-of-pocket expenses for beneficiaries. To get the support of the AARP (then known as the American Association of Retired Persons), the MCCA also contained a prescription drug benefit (Oliver, Lee and Lipton, 2004, 298-99). Just seventeen months after passage, however, Congress repealed the MCCA in the face of vehement protests by seniors against the higher premiums they would have to pay for the bill (see Himelfarb 1995 for details). Clinton's health reform effort of 1993-94 also included prescription drug coverage, and the federal government was supposed to use its power as the dominant purchaser to control drug

prices. While this would have been highly controversial, the HSA failed before this issue could come to the fore (Oliver, Lee and Lipton, 2004, 302).

In the aftermath of the Clinton health reform debacle, a prescription drug benefit seemed an unlikely candidate for legislative action. By the late 1990s, however, it began gaining steam through the efforts of both Democrats and Republicans. Following the collapse of the Clinton reform effort, Democrats sought more incremental health insurance measures that could address the situation of sympathetic groups in society, such as children and the elderly. For Republicans, the key issue was how to contain Medicare costs, and some began pushing to increase the role of managed care in the program. This would create competition between insurance plans and hopefully reduce costs. Thus, the Balanced Budget Act of 1997 created a Medicare+Choice program that encouraged seniors to join Health Maintenance Organizations (HMOs), some of which offered more extensive coverage (like prescription drugs). In these debates, some began to see prescription drug coverage as a potential sweetener that could help push through a larger, market-oriented reform – especially if drug coverage was made available only to those who join HMOs.

Prescription drug coverage was finally achieved in the 2003 MMA, which created a voluntary Part D program for Medicare beneficiaries. While the new bill continued elements of the conservative Republican vision that was emerging by the late 1990s, it violated their ideals in several ways. The first was the cost of the program, which was projected to be \$409 billion over 10 years when the law passed – already a staggering amount at a time when budget deficits were projected to be high for years to come. Then, less than two months after President Bush signed the law, the Office of Management and Budget (OMB) revealed a new estimate of \$534 billion over ten years (and as of February 2005, the estimated ten-year cost had risen to \$724 billion

[Pear 2005]). In addition, the law contains a large gap in coverage that many believed would create strong political pressures for continued expansions of the program. The new program would charge seniors a \$35/month premium and a \$250 deductible, after which 75 percent of their costs would be covered up to \$2250. There would then be a gap in coverage until drug costs reached \$5100, after which the program would pay 95 percent of drug costs. This unpopular “doughnut” hole in coverage would potentially leave beneficiaries with high drug costs responsible for \$4020 of the first \$5100 – 79 percent of their costs. While this doughnut hole was a mechanism that helped keep the law under a fixed budgetary target, many at the time believed it would ultimately generate political pressures to make coverage more generous.

While the MMA included measures to inject more market competition into Medicare program, these were substantially less than what many conservatives wanted. The Medicare+Choice program of managed care plans received a new name, Medicare Advantage, and substantially greater funds. These plans could offer complete health care coverage to seniors, including prescription drugs, and would be subsidized to do so. What conservatives most wanted, however, was to convert the Medicare program into a premium support system that would pay vouchers to seniors and let them choose from a host of private insurance alternatives (Cohen 2004). Instead, the final MMA authorized experiments with a premium support system in at most six cities after 2010. Given the unpopularity of Medicare HMOs among seniors in the past, and the limited nature of these experiments, it appears likely that the Medicare program will continue in its current fee-for-service guise, with a potentially explosive new benefit added on that will make the program even more expensive.

The existence and nature of the prescription drug reform raise a number of intriguing questions. Why was this expensive new entitlement adopted in an era of GOP control and rising

budget deficits? And why did it stray so far from the Republican's vision of entitlement reform? To answer these questions, we first look at how prescription drugs came onto the agenda in the first place, followed by an analysis of how political competition spurred the continued expansion of the benefit while undermining the push to put more market competition in the Medicare program.

### **1999: The Agenda-Setting Moment**

The drive for prescription drug reform began in the late 1990s, when the issue first came on the political agenda. Before then, prescription drug coverage for seniors was not a highly salient issue. Spending by people over 65 on prescription and non-prescription drugs amounted to just over three percent of their household spending in the late 1990s. In fact, total spending on prescription drugs is about the same as a proportion of national spending today as it was in the early 1960s (Fan, Sharpe, and Hong 2003; Oliver et al. 2004, 291). Arguably, the larger gap in the Medicare program is the coverage of long-term care costs. A 2002 study by Knickman and Snell (2002) estimated that the uncovered lifetime costs for a current 65-year old are \$12,000 for prescription drugs and \$44,000 for long-term care. While prescription drugs are clearly a burden, they do not threaten the long-term economic well-being of most seniors the way chronic care needs do.

In addition, most drug expenditures of the non-elderly are covered by private insurance. The rise of managed care organizations meant that over time an increasing proportion of total drug costs in the United States were covered by private insurance – from 8 percent in 1970 to 20 percent in 1980 and 34 percent in 1990. In 2000, three-quarters of non-elderly Americans had public or private health insurance, and 99 percent of them had some drug coverage. Thus even

as per capita spending on prescription drugs increased from \$26 in 1970 to more than \$300 in 2000, out-of-pocket spending for prescription medicines actually decreased in real terms (Rosenbaum 2000).

Perhaps for these reasons, 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 1). Neither the price of prescriptions in general nor need for prescription coverage for the elderly appeared in these polls 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. In fact, a government survey of Medicare recipients in 2002 that asked how much of a problem it was to get needed prescription medicines found that 86.4 percent said it was not a problem, 9.4 percent said it was a small problem, and 4.2 percent said that getting access to prescription drugs was a big problem (Cohen 2004, 47). Instead of growing out of grass-roots sentiment, the push for prescription drug reform came first from elites.

There were a number of objective reasons why the prescription drug issue might appear on the political stage. By the 1990s, 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 suffering the largest increases. Between 1998 and 2000 alone, overall prescription spending rose 40 percent. Moreover, 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, 45 percent among those over 80 (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) offered seniors the option to join HMOs, by 1998 HMO's 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, the entire period during which a new prescription drug benefit was debated (see Figure 2). 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 (Pear 1999h).<sup>3</sup> Moreover, a Kaiser Family Foundation study found that HMO's varied tremendously in their prescription drug coverage, with one in six offering no coverage, one in four unlimited coverage, and most in between. The average annual drug benefit limit was \$1100, but an increasing number of plans were capping the benefits at \$500 or below (Toner 1999c). By 2000, no HMO's were offering free drug coverage (Pear 1999l).

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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> This is true even though many studies showed that Medicare beneficiaries in HMO's are on average healthier than those who remain in traditional Medicare.

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). And 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>4</sup> In New York State, the largest medigap insurer announced in 2001 that premiums for plans with drug coverage would rise 31 percent. At the same time, an increasing number of participants were hitting the upper limit on drug coverage in their plans (Freudenheim 2001). Moreover, the marginal cost of purchasing medigap policies to cover drugs often nearly equaled the benefits provided, especially for older seniors. For example, two of the ten available medigap policies cover up to \$1250 in drug expenses, but those aged 75 and over had to pay \$1200 extra to get that coverage (Pear 2000c).

As is often the case, a triggering event was needed to transform these objective conditions into a problem, and one 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 trust fund and add a new drug benefit. 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>5</sup> The goal of the plan was to provide drug coverage for less than what comparable medigap policies cost,

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<sup>4</sup> Medigap is supplemental insurance that seniors can buy to cover gaps in Medicare coverage.

<sup>5</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).

approximately \$70 to \$90 per month (Toner 1999b), and to make the coverage as attractive as possible since it would be voluntary.<sup>6</sup>

This agenda-setting moment had two crucial effects. First, there was increased media attention to the declines in HMO and employer coverage described above, 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 focused on the issue. 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 1).<sup>7</sup>

These concerns continued to be eclipsed by the long-standing concerns about health care and insurance cost and availability, but once the possibility of a federal program to offset the costs of prescription drugs 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 prospects for a new benefit were far too enticing, especially since many among the elderly apparently thought the new government benefit would resemble the drug coverage many workers enjoy – no annual deductibles and co-payments of \$10 or \$15 for each prescription (Pear and Toner 2001). The very tangibility of the issue no doubt helped. As one White House advisor noted, while much of Medicare is complex and confusing, drug coverage is “a very digestible concept”

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<sup>6</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).

<sup>7</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.

(Toner 1999b) and far more immediately relevant to seniors than future expenses like long-term care. Robin Toner notes 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.”

While prescription drug coverage had not been an issue before Clinton’s speech, once the issue was put on the agenda, policymakers could hardly ignore it, particularly since objective events during the period when the issue was under legislative consideration only reinforced the desire for the new benefit. This set the stage for heated partisan competition on the issue.

### **Political Competition in an Era of Budget Surpluses**

Once President Clinton raised the idea of a Medicare prescription drug benefit, political competition developed around the issue and propelled expansions in the proposed benefit. Initially, Republican reaction to Clinton’s proposal was cautious, as some feared the long-term costs of the new entitlement and preferred focusing benefits on those without current coverage. Moreover, some Republicans sought to use more of the surplus for a tax cut, although moderate Republicans like Senators William Roth, Jr., (R-Del.) and Pete Domenici (R-NM) wished to strengthen Medicare and provide a modest prescription drug benefit as well (Stevenson 1999).

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 have been a large and growing proportion of the electorate. 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, prescription drugs are 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 are 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). Or 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 consequences 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, a huge Republican year, 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 and reignite the pro-Republican trend.

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, while Clinton’s proposal would provide first dollar benefits – a considerably more attractive set of benefits for seniors.<sup>8</sup>

While 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

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<sup>8</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 \$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).

would 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. 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 (Toner 2000e)). Also the Gore plan 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.

### **Forging a New Entitlement**

Following Bush’s electoral victory in 2000, he continued to push for prescription drug reform rather than trying to let the issue fade off the political agenda. Instead, President Bush 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. By the time Congress was done forging the MMA, these goals would be substantially weakened while the cost of the bill would be far greater than what many conservatives had envisioned.

Initially, forecasted budget surpluses improved the prospects for large-scale reform of Medicare. As of January 2001, the budget surplus was estimated at \$5.6 trillion over the next decade, including \$3.1 billion of non-Social Security money. President Bush asserted that his proposed tax cut of \$1.6 trillion was affordable, while leaving additional funds for new measures like a prescription drug benefit (Stevenson 2001b). Bush pushed for a drug benefit as part of a large-scale reform of the Medicare program, allocating \$156 billion over 10 years for the program.

This 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 the idea of 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 proposed during the campaign.

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 elder's 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).

However, 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. Several manufacturers said they would cooperate with the administration to set up such cards, although Democrats criticized the program as far too little to solve the real problem (by the end of the year, a federal judge had said Bush lacked the authority to initiate such a program).

Bush also laid out some principles for Medicare reform that reflected conservative priorities for the program. Bush called for giving private sector actors a greater role in the Medicare program, with private pharmacy managers helping to provide the new drug benefit and HMOs competing with the traditional Medicare program for beneficiaries. 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).

While 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 did not meet their expectations. 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 pay \$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).

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 appear to have seen the mid-term elections as providing a mandate for a fundamental reform of

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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.

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 Medicare, and while a new prescription drug benefit was part of the package, much of the focus was on structural reform (Nather 2003). 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 PPO's (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 HMO’s 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).

In addition, while some Republicans were urging market solutions, believing in Newt Gingrich’s pithy formulation that “choice creates competition, and competition drives down price” (Pear 2003j), seniors found choice confusing. As the Brookings Institution’s Henry Aaron

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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).

has asserted, most seniors were satisfied with Medicare as run and liked the choice of doctors and hospitals the fee-for-service program affords, rather than a choice among health plans (Brock 2003). Bruce Vladeck, who headed the administration that runs Medicare during the Clinton Administration, said that “If you listen to beneficiaries, it’s not ‘choice’ they’re asking for – they want additional benefits” (Toner 2001a).

Finally, 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 HMO’s 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 (Toner 2003a). Senators Charles Grassley (R-IA) and Olympia Snowe (R-Me), 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). Senator John D. Rockefeller IV (D-WV), a Senate Finance Committee member, said, “[Bush] says choice and who’s going to argue with that? It’s a great American word. [But] there won’t be any choice in West Virginia” because only one private plan is available for Medicare beneficiaries in the state (Toner 2003a). 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). 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.

Republican lawmakers also had limited room for budgetary maneuvering due to the strong lobbying of pharmaceutical companies against any form of price controls. Indeed, the pharmaceutical industry successfully defeated two of the most popular policy options among the general public – government controls of drug prices, and allowing the importation of pharmaceutical drugs from other countries – both of which were supported by three-quarters of adult Americans (Kaiser Family Foundation 2003; *NewsHour* et al. 2000).<sup>13</sup> While the pharmaceutical industry came to accept the reality of a Medicare benefit early on, they fought to make sure the bill was to their liking. PhRMA, the drug industry's chief organization, increased its lobbying budget 23 percent, to \$150 million, and increased the size of its federal affairs staff from 5 to 20 between 1999 and 2003 (Pear 2003f). In the 2002 campaign, the pharmaceutical and health products industries gave \$20 million to House and Senate campaigns and political parties, about three-quarters to Republicans. They also spent close to \$500 million on lobbying between 1996 and 2002, and employed 600 lobbyists (Pear and Oppel 2002). They funded ads in close Congressional races, praising Republican members for their work in supporting prescription drug legislation. Democrats contended that the ads were aimed at providing cover

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<sup>13</sup>Indeed, 91 percent of adult Americans favored government negotiation power. Even after hearing arguments against their position – that lower prices might lead drug companies to do less research and development, support remained at 54 percent (Kaiser Family Foundation 2003). Similarly, support for drug importation was 50 percent after counter arguments about reduced research and development (*NewsHour* et al. 2000).

for lawmakers who voted for a Republican version that closely adhered to drug industry preferences (Toner 2002d).

Faced with these constraints, the compromise that began developing in the House and Senate committees offered drug benefits to all – and not just those in managed care plans – yet did not promise full coverage. 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 just how large the doughnut hole would be and how it would be structured. 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 more fundamental problem facing Republicans was that jettisoning the larger project of Medicare reform would enrage 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. Thus, 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 fall of 2003. The committee might have failed in the task had it not been for the constant pressure by the White House in favor of a prescription drug bill. Clearly, the Bush team saw this reform as a central aspect of their re-election strategy (Cook 2003; Iglehart 2003). Hoping to at least neutralize the Democratic advantage on these issues, if not actively gain the support of senior citizens, raised the stakes for this bill and helped hold together the House and Senate leadership in favor of a compromise measure. Not surprisingly, Democrats announced that allowing competition between Medicare and private plans would kill any deal (Pear 2003w). Given their intransigence, the proposal ultimately was scaled back to a set of demonstration projects. Thus, on November 15, the conference committee announced a deal on drug legislation.

Whether this law could actually pass both the House and the Senate remained to be seen. 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. We are at the beginning of a larger research project that aims to understand both the factors shaping this policy, and the lasting influence it will have on the politics of the Medicare program. While we have not yet conducted interviews that would enable us to assess the motives of policy-makers involved in this bill, we can use our narrative reconstruction of the MMA's passage to provisionally address some larger debates about the contemporary politics of Medicare.

One possibility is that, in the development and passage of the MMA, politicians were acting in a relatively autonomous manner to achieve their own political or policy goals. Oberlander (2003) argues that Medicare policy often has contravened the preferences of organized interests and the mass public, while Jacobs and Shapiro (2000) show that politicians increasingly act according to their own beliefs rather than "pander" to public opinion. Since the mid-1990s, the Republican party has intensified its push for marketization, or even privatization, of federal entitlements. In fact, they have pursued this course on Medicare 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). These efforts reflect a larger ideological commitment to introducing more competitive elements into the health care system (Marmor 2000, 157-68).

Our analysis shows that these motivations were an important driving force behind the legislation, and that they shaped some features of the final bill, yet that 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). The MMA offers some mixed evidence. With its complexity and lack of complete drug coverage for non-poor seniors, the legislation contains many elements likely to alienate older Americans. Yet, 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.

Instead, we suspect that much of what drove the Medicare bill to the finish line was a set of shared perceptions among politicians that this law would generate positive “political feedbacks” for those who could claim credit for its passage. While scholars have long argued that public policies can generate enduring political effects, politicians appear to believe in a similar notion of policy-feedback effects. For example, many Republicans are convinced that the New Deal and Great Society programs fashioned a pro-Democratic constituency that is dependent on these public programs. 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. Some have argued that Medicare policy-makers are relatively autonomous from the pressures of organized interests (Oberlander 2003), while other analysts believe health care providers play a central role in the politics of the program, all fighting for their piece of the “Medicare-Industrial-Complex” (Vladeck 1999). 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>14</sup>

Overall, we lack sufficient evidence to say how influential these interests were. At certain points, 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, and remains, 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

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<sup>14</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).

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.

Seniors have good reason to be skeptical. The bill threatens to crowd out existing, more generous drug coverage, as low-income seniors lose their more extensive Medicaid drug coverage and medigap plans covering prescription drugs will no longer be allowed. The CBO estimates that at least one-third of retirees will lose their employer-provided drug coverage (Holtz-Eakin 2003). And because of adverse selection, those who do take up the new Part D benefit may in the future face spiraling premium increases.<sup>15</sup>

In short, it appears that Republicans reaped little immediate political support from the legislation, and subsequent polls show a low level of support for the legislation. On the other hand, after narrowly losing both the House and Presidential votes of seniors to the Democrats in 2000, Republicans made significant gains in 2004, after the passage of the MMA. Exit poll data show that Bush earned 54 percent of the 60+ vote (seven points over his 2000 performance) and 52 percent of the 65+ vote (five points over 2000). Republican House candidates won 53 percent of the 60+ vote, 52 percent of the 65+ vote.

That said, the vote is a blunt instrument, and there is no way to know how much of the Republicans' increase in vote share was driven by the MMA or other issues like the war on terrorism (exit poll questions for example are notoriously imprecise – in 2004, the national exit poll asked about the importance of “health care” in respondents' vote choice, but not about the MMA). Before the 2004 election, 28 percent of Medicare beneficiaries said in a Kaiser Family

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<sup>15</sup> Adverse selection is a particular problem in insuring prescription drugs for the elderly. Many suffer from chronic conditions and so their drug needs are predictable enough for them to make rational decisions about whether to enroll (that is, they know whether their annual drug costs place them above or below the break-even point of the new benefit). Healthier seniors will have little incentive to join, and the Part D plans be may left with sicker and smaller pools of persons, necessitating increasing premiums (Altman 2003).

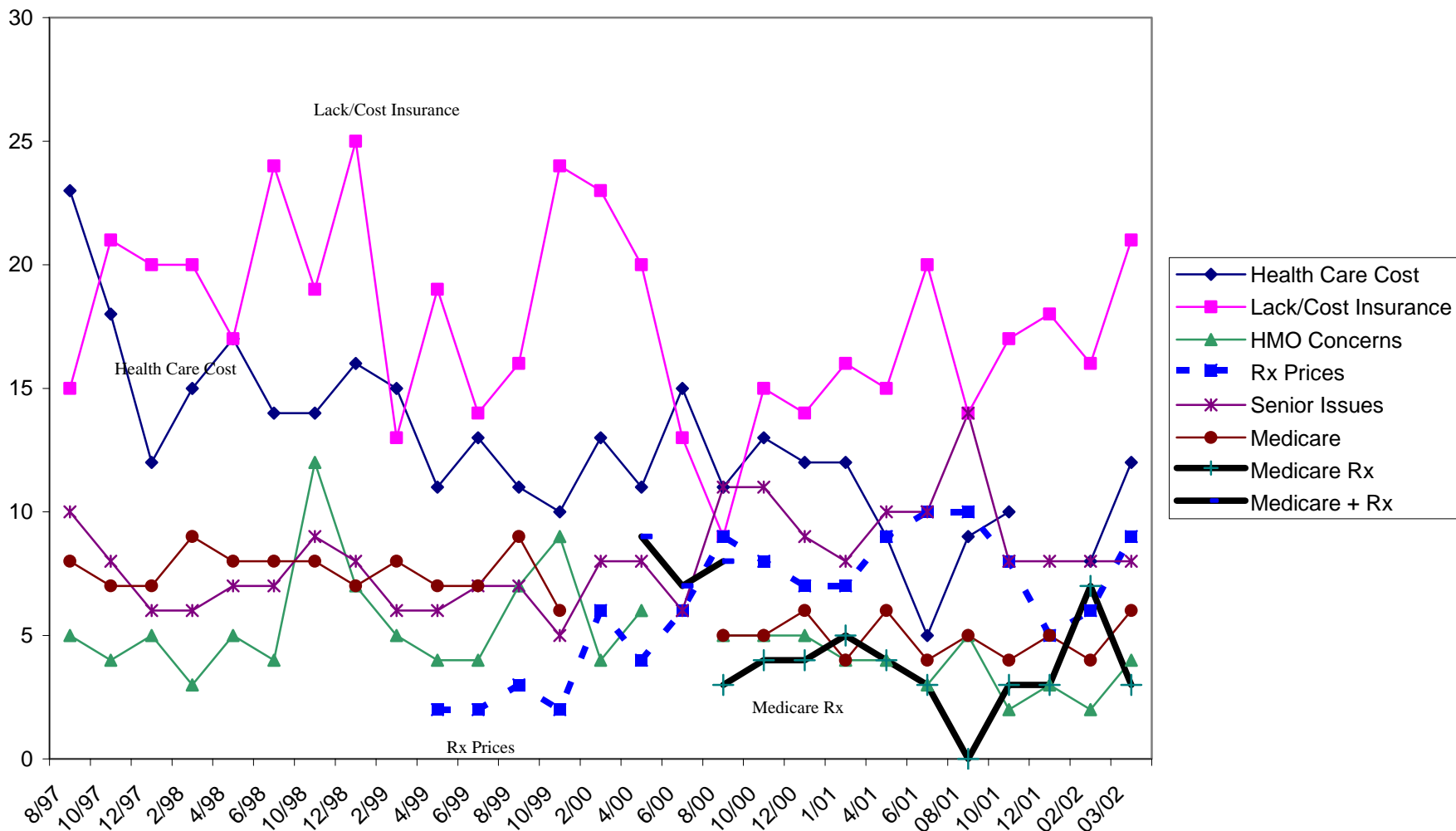
Foundation poll that the new law would affect their presidential vote. Among that slice of the senior electorate, 44 percent said it would make them more likely to vote for Kerry and only 18 percent said it would make them more likely to vote for Bush (Kaiser 2004b).

No advantage seems to have redounded to either Bush or congressional Republicans specifically for having passed a prescription drug bill. More Americans approved than disapproved Bush's handling of prescription drugs for older Americans between July 2001 and April 2003. But beginning in September 2003 and continuing through June 2004, six months after Bush signed the MMA into law, disapproval outweighed approval (Figure 3). Nor did the Republican party appear to have overcome the Democrats' advantage on elderly entitlements. From December 1999 through March 2005 more Americans said they trusted the Democrats in Congress to do a better job on prescription drug benefits for the elderly than either the Republicans in Congress or, later on, President Bush (Figure 4). Moreover, the law has not yet been implemented. As seniors begin to sign up for the new benefits during the initial November 2005 – May 2006 enrollment period, the many shortcomings of the legislation may become more visible, and anger could be directed at Republicans who forced through the bill.

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 garnered only little public support. Does this represent a massive miscalculation on the part of Republican leaders? Or 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 HMO's 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

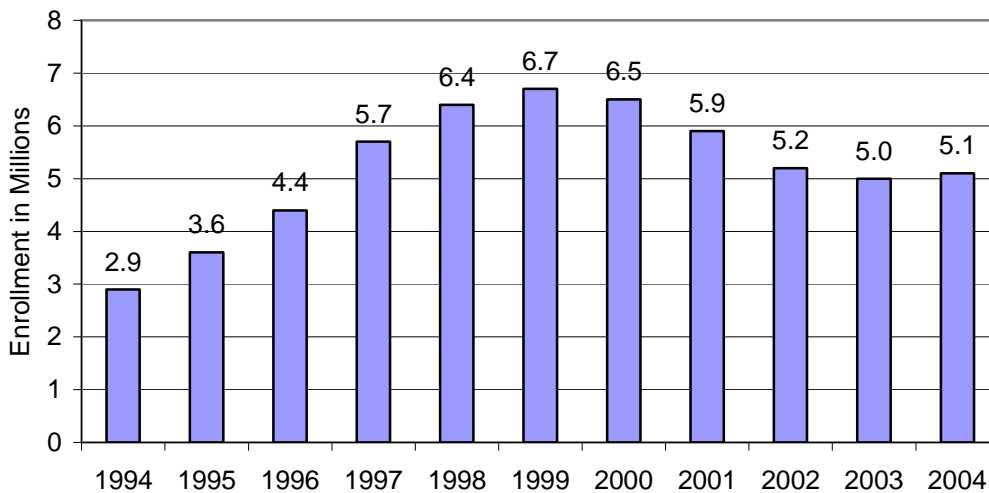
to support strategies of collective action, and are more likely to see health care as an individual rather than a societal responsibility (Schlesinger and Hutchings 2003). There could be a long-term strategy at work, one that hews strongly to particular beliefs about the political consequences of public policy. These are the kinds of questions we will explore in our continuing study of the Medicare Modernization Act of 2003.

**Figure 1. Most Important Health Problem, August 1997 – March 2002**



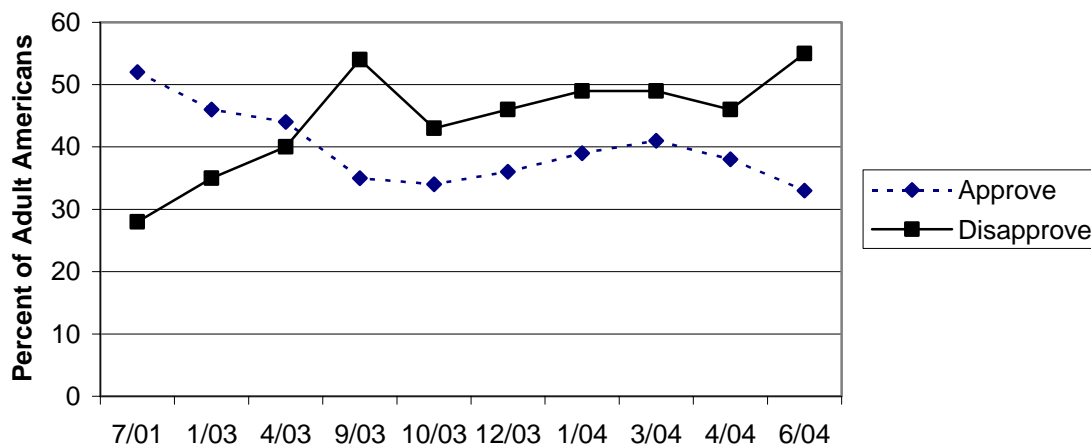
Source: Kaiser Family Foundation/Harvard School of Public Health, Health Interest Index Polls.

**Figure 2. Medicare Recipients Enrolled in HMOs, 1994 – 2004**



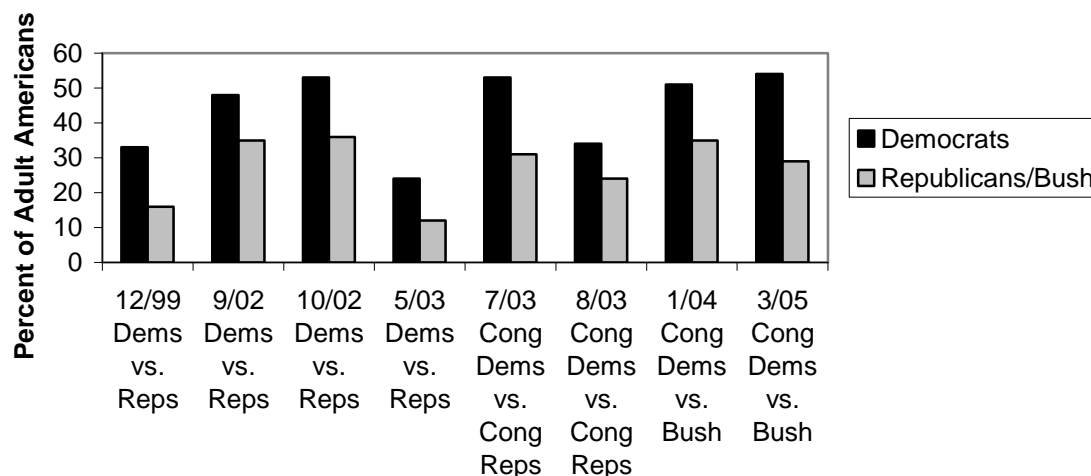
Source: Centers for Medicare & Medicaid Services, Office of Research, Development, and Information, InterStudy, 1991- 2004.

**Figure 3. Approve-Disapprove the Way George Bush is Handling Prescription Drugs for Older Americans?**



Source: Gallup, Kaiser and other polls from Roper Center for Public Opinion Research, University of Connecticut.

**Figure 4. Which Political Party Do You Trust To Do a Better Job Handling Prescription Drug Benefits for the Elderly?**



Note: In the December 1999 through May 2003 surveys, the questions compared the Democratic and Republican parties; in the July and August 2003 surveys, Congressional Democrats vs. Congressional Republicans; and in the 2004 and 2005 surveys, Congressional Democrats vs. Bush. The overall responses are lower for surveys where explicit “both” or “neither” options were allowed, such as the 12/99 and 5/03 surveys. Source: Gallup, Kaiser and other polls from Roper Center for Public Opinion Research, University of Connecticut.

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