



Fall 9-1-2003

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Jonathan Oberlander

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Recommended Citation

Jonathan Oberlander, *The Politics of Medicare Reform*, 60 Wash. & Lee L. Rev. 1095 (2003).
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The Politics of Medicare Reform

Jonathan Oberlander*

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I. Introduction

Medicare politics has been remarkably turbulent in recent years. The current debate over Medicare prescription drug coverage is only the latest episode in a decade-long political drama. In 1995, the Republican congressional leadership, led by Speaker of the House Newt Gingrich, proposed sweeping changes in the program. A rancorous debate with President Bill Clinton and congressional Democrats ensued. It was, in fact, the most high-profile, acrimonious, and sustained debate over Medicare since the fight that preceded the program's enactment in 1965. Still, Republican congressional majorities passed their Medicare reform bill in 1995, only to have

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President Clinton veto the bill. After all of the political tumult and calls for program restructuring, Medicare reform deadlocked.

Only two years later, the direction of Medicare politics reversed: with scant public attention or political theater, Congress and the Clinton administration agreed to a major overhaul of Medicare as part of the 1997 Balanced Budget Act (BBA). Many policymakers and analysts viewed passage of the BBA as a milestone in Medicare politics. Managed care was ascendant in the private sector, as growing numbers of Americans enrolled (or were enrolled by their employers) in Health Maintenance Organizations, Preferred Provider Organizations, and a host of new plans that promised to control health spending. Medicare, whose basic structure had remained largely intact since its adoption in 1965, appeared to a growing number of observers to be out of step and badly in need of modernization. The BBA, they believed, would at long last usher in a historic transformation of Medicare by introducing competition, choice, and market dynamics into the program.

Yet by 2003, the expected transformation still had not materialized. Indeed, many effects of the 1997 Medicare reforms were exactly the opposite of what observers had anticipated: managed care plans abandoned Medicare or raised premiums while cutting covered benefits; beneficiary enrollment in Medicare HMOs stalled; and the expected diverse menu of private insurance options for Medicare beneficiaries never developed.¹ The reality of Medicare reform thus bore little resemblance to the rhetoric of market transformation. Judged against some of its central aims, today Medicare+Choice appears to have been a classic case of public policy failure.

After a decade of largely failed reform efforts, then, the future of Medicare is unclear. Medicare's exposure to the political spotlight, however, is hardly a thing of the past. In recent years, the political momentum to add outpatient prescription drug coverage to Medicare has intensified and finally culminated in adding a prescription drug benefit to Medicare in December 2003. President Bush declared in his January 28, 2003 State of the Union address that "health care reform must begin with Medicare."² The benefit links an ambitious and politically divisive vision of program reform seeking to expand the role of

1. See Marsha Gold, *Can Managed Care and Competition Control Medicare Costs?*, HEALTH AFF. WEB EXCLUSIVE W3-176-88 (Apr. 2, 2003) (reporting declining enrollment, fewer available plans, and reduced benefits available in Medicare+Choice programs during last few years, but noting that enrollment remains higher than before Balanced Budget Act of 1997), at <http://www.healthaffairs.org/WebExclusives.php> (on file with the Washington and Lee Law Review).

2. George W. Bush, State of the Union Address (Jan. 28, 2003), available at <http://www.whitehouse.gov/news/releases/2003/>.

private insurers in Medicare.³ Under the original Bush plan, Medicare beneficiaries receive broader coverage for prescription drugs only by joining a private managed care plan; Medicare enrollees not enrolling in "enhanced Medicare" but remaining in traditional Medicare would have received a more limited prescription drug benefit.⁴

The Bush administration's failure to recommend a significant Medicare drug benefit for all beneficiaries and its decision to load the dice against traditional Medicare immediately drew criticism from Democrats⁵ and some Republicans.⁶ Representative Billy Tauzin (R-La.) quipped that "you couldn't move my mother out of Medicare with a bulldozer."⁷ The administration produced only a framework for legislation, leaving the crucial details to Congress.⁸ In June of 2003, though, there was an unexpected breakthrough in the Senate, leading to enactment of a Medicare drug bill with bipartisan support; the House of Representatives followed by passing their own bill. Yet euphoria over the prospect of finally adding drug coverage to Medicare faded as the vast differences between the House and Senate bills became clear in conference committee. In particular, the House bill would have transformed Medicare from a defined benefit to a defined contribution system and forced the traditional Medicare program to compete with private insurers on the basis of price, while the Senate bill envisioned only incremental changes to Medicare's existing structure. The differences in the House and Senate bills tapped into a broader debate on Medicare reform and the role of markets and government in health care, making their resolution difficult. It is clear, however, that given the impending retirement of the baby boom generation and the program's

3. See Mike Allen, *Bush to Seek New Medicare Drug Plan*, WASH. POST, Mar. 4, 2003, at A1 (noting that under President Bush's new Medicare plan, patients who sign up with private insurers would receive "much more extensive benefits").

4. See Press Release, White House, Framework to Modernize and Improve Medicare Fact Sheet (Mar. 4, 2003) (comparing percentage discount on prescription drugs that remains in traditional Medicare to President Bush's plan for comprehensive coverage under privatized "Enhanced Medicare" plan), available at <http://www.whitehouse.gov/news/releases/2003/03/20030304-1.html>.

5. See Allen, *supra* note 3 (reporting vocal opposition from several key Democrats).

6. See Amy Goldstein, *On Medicare, Bush Left Details to Congress*, WASH. POST, Apr. 20, 2003, at A4 ("Reaction [to President Bush's Medicare proposal] from key Republicans has been relatively tepid . . .").

7. Allen, *supra* note 3.

8. See Goldstein, *supra* note 6 (describing Bush administration's decision to provide a guideline for Medicare reform, while allowing Congress "ample room" to design its own plan).

growing claim on the federal budget, the issue of Medicare reform will remain at the center of American politics and health policy throughout the next two decades.

This Article places recent developments in Medicare politics in context by offering a political history of Medicare reform. Are the politics of Medicare heading in a fundamentally new direction or simply repeating past patterns? What explains the decade of apparent failure in Medicare reform and what model of reform will likely emerge? What political forces will determine the future course of Medicare policy? This Article aims to describe the central themes of Medicare's political history, with a focus on the last decade of program policy, in order to address those questions and illuminate the significance of contemporary debates over Medicare reform.

I argue that one can understand Medicare's political development from 1966 to 1994 as predominantly one of consensus.⁹ That is, during this period a *de facto* consensus over program philosophy, structure, and operations represented the defining element in Medicare politics, which was often both bipartisan and quiescent. The tumult in Medicare since 1995 signals the unraveling of that consensus and the emergence—or more precisely, the re-emergence—of a competing vision for organizing the program.¹⁰ At its core, this vision seeks to transform Medicare from a health insurance *program* into a health insurance *market*.¹¹ Consequently, the debate over federal health insurance for the aged that ended with Medicare's enactment in 1965 has, I contend, been reopened.¹²

Part II of this Article describes the origins of Medicare and the character of the consensus that governed program politics for three decades. Next, Part III explains why that consensus unraveled in the context of a changing political environment and health care system. Part IV examines the 1997 Medicare reforms and their aftermath. Finally, Part V describes the debate over prescription drug coverage and the implications for the present and future politics of Medicare. In Part VI, this Article concludes that the long debate over Medicare politics has come full circle back to its origins in the 1960s.

9. JONATHAN OBERLANDER, *THE POLITICAL LIFE OF MEDICARE* 5 (2003).

10. *See id.* at 179 (noting movement to transform Medicare into "competitive market, a managed competition system that embraced managed care").

11. *Id.*

12. *See id.* at 6 (describing shift in Medicare politics from consensus to controversy).

II. Medicare's Origins and the Politics of Consensus, 1966–1994

The early history of Medicare was anything but consensual. Social Security administrators, frustrated by the failure of the Truman administration's national health insurance legislation, proposed federal hospital insurance for the aged in 1952 as a more incremental and politically feasible option. They believed that sympathy for the elderly, as well as appeals to the popularity of Social Security and a restricted benefit package that omitted coverage for physician services, would enable Medicare legislation to successfully navigate the gauntlet of opposition.¹³ This opposition coalesced around the influence of the American Medical Association (AMA), the power of the conservative coalition of Republicans and Southern Democrats (which constituted a working majority in Congress), and the Cold War stigma of "socialized medicine" that had stopped the Truman NHI plan.¹⁴

Despite strategic concessions, however, Medicare reproduced the same political cleavages and controversies that had marked earlier disputes over national health insurance. During the 1950s and early 1960s, Medicare was a polarizing issue in American politics. On one side, liberals, unions, and union-sponsored elderly advocacy groups mobilized for passage of the program; in opposition stood organized medicine, business, and conservatives.¹⁵ The AMA was unimpressed with the narrowed benefits. The group warned that sixty days of hospital insurance for the elderly still amounted to socialized medicine and threatened an unacceptable slippery slope toward national health insurance. As a consequence, from 1958 to 1964 a high-profile, ideological, and highly partisan political contest existed over Medicare legislation. The liberal landslide in the 1964 elections finally settled that contest, leading to Medicare's enactment the following year with a much broader scope and a more generous benefit package than even program advocates had thought possible. (The legislation also established Medicaid and provided elderly beneficiaries with coverage, under Medicare Part B, for physician services and hospitalization).¹⁶

13. See THEODORE R. MARMOR, *THE POLITICS OF MEDICARE* 10–11 (2d ed. 2000) (explaining that Truman's Social Security advisors shifted their focus toward providing government health insurance for aged Americans, rather than general population, because of such program's political feasibility).

14. See *id.* at 17–21 (describing how Republicans and Southern Democrats characterized Medicare as "entering wedge of the Socialized State," and discussing American Medical Association's role in furthering that perception).

15. See *id.* (discussing alignment of various interest groups in years prior to Medicare's enactment).

16. See *id.* at 45–47 (describing Democrats' substantial victory in 1964 election, which led to easy passage of strengthened Medicare bill).

Yet, the controversial origins of Medicare receded once the program began operation. Medicare became a cherished institution in American political life, broadly popular with the public as one of the few acknowledged successes of the welfare state.¹⁷ The popularity of Medicare was due in large part to the substantial number of American families it helped, and it continues to have a broad impact. For instance, the Centers for Medicare and Medicaid Services projected that in 2003, Medicare would provide health insurance to thirty-five million elderly and six million disabled persons.¹⁸

The reach of Medicare, however, extends far beyond elderly and disabled beneficiaries. The program also spares children and grandchildren the burdens of paying for much of their parents' or grandparents' medical care. Moreover, unlike other government programs serving only the poor, such as the now-defunct Aid for Families with Dependent Children (AFDC), Medicare's constituency has retained a middle-class identity because all retirees are eligible for the program regardless of their income.

As noted above, the controversy surrounding Medicare's enactment disappeared once the program began operation. Political opponents who otherwise disliked the program learned, at least, to accommodate its political popularity. Members of Congress, as well as presidential administrations, vied to be seen as friends of the program. More crucially, they wanted to avoid being seen as a threat to Medicare, lest they pay a heavy price at election time. The policy world similarly accommodated Medicare's popularity. Most health care analysts focused on incremental proposals to make Medicare's existing structure more efficient and equitable, rather than on creating a new program structure.¹⁹ The status quo appeared so powerful that one analyst questioned

17. See FAY LOMAX COOK ET AL., SUPPORT FOR THE AMERICAN WELFARE STATE: VIEWS OF CONGRESS AND THE PUBLIC 62 (1992) (reporting that, in random nationwide 1986 survey, 67.6% of respondents believed that government should increase Medicare benefits; this result was 10% higher than poll results for any other social welfare program).

18. CTRS. FOR MEDICARE & MEDICAID SERVS., MEDICARE ENROLLEES SELECTED YEARS, in 2002 DATA COMPENDIUM, <http://www.cms.gov/researchers/pubs/datacompendium/2002/> (Sept. 2002) (on file with the Washington and Lee Law Review).

19. See KAREN DAVIS & DIANE ROWLAND, MEDICARE POLICY: NEW DIRECTIONS FOR HEALTH AND LONG-TERM CARE 72 (1986) ("Major steps need to be taken to improve, rather than dismantle, programs that have brought many gains and achieved notable successes."); MARILYN MOON, MEDICARE: NOW AND IN THE FUTURE 219-37 (2d ed. 1993) (discussing various potential improvements to existing Medicare system, such as containing provider costs, expanding managed care options, revising cost sharing, and increasing direct costs for beneficiaries). See generally RENEWING THE PROMISE: MEDICARE AND ITS REFORM (David Blumenthal et al. eds., 1988); Thomas Rice & Jill Bernstein, *Volume Performance Standards: Can They Control Growth in Medicare Services?*, 68 MILBANK Q. 295 (1990) (discussing volume performance standards, an incremental modification to Medicare payment protocol intended to control costs).

whether his own proposal for Medicare restructuring through vouchers amounted to "the impossible dream."²⁰

Medicare's popularity meant that the essence of the program adopted in 1965—its philosophy, structure, and goals—became institutionalized. The programmatic boundaries of Medicare marked a political boundary that opponents rarely dared to cross. A de facto, implicit consensus consequently developed around Medicare. The consensus was, at root, liberal because in several crucial respects Medicare was a liberal program. Medicare's architects, who previously worked for the Social Security Administration, were committed advocates of social insurance and government activism to redress social problems.²¹ The programmatic structure of Medicare reflected their liberal vision; it was government health insurance, a public program that the federal government organized and operated on the social insurance model.

In the contemporary parlance of health policy, Medicare is a single-payor health insurance program. Medicare's embrace of single-payor insurance has been a well-kept secret in a nation where many ironically consider single-payor insurance to be politically infeasible and culturally taboo.²² Yet, failure to acknowledge that Medicare represents a form of single-payor insurance does not change the fact that the program shares the main properties of the single-payor model: universality for its population, government-operated insurance, and centralized cost control.

The Medicare consensus was so strong, and challenges to it so rare, that policymakers and analysts have often forgotten that the form of health insurance that Medicare represented in 1965—*public* insurance—was not the only option available to cover the elderly. One alternative would have been for the federal government to provide the elderly with subsidies or vouchers to purchase *private* health insurance from commercial insurers. Under such a system, the federal government would not have operated its own public

20. See Robert Bovbjerg, *Vouchers for Medicare: The Impossible Dream*, in LESSONS FROM THE FIRST TWENTY YEARS OF MEDICARE 25, 25 (Mark Pauly et al. eds., 1988) (posing question whether Medicare vouchers are impossible dream and suggesting that only experience can provide answer).

21. See MARMOR, *supra* note 13, at 10–11 (discussing Social Security Administration's desire to broach idea of national health insurance by providing health insurance for aged persons); Robert Ball, *What Medicare's Architects Had In Mind*, HEALTH AFF., Winter 1995, at 62, 63–65 (same); ERIC R. KINGSON & EDWARD D. BERKOWITZ, SOCIAL SECURITY AND MEDICARE: A POLICY PRIMER 45 (1993) ("Social Security officials persisted in their argument that a social insurance approach would both protect the dignity of America's older people and avoid burdening the general taxpayer with the cost of their health care.").

22. See Alain Enthoven, Letter to the Editor, 5 THE AM. PROSPECT 20, 20–22 (1991) (arguing that Canadian health care system is politically unfeasible in United States).

insurance program, but rather, it would have supervised Medicare as an actor in the private insurance market. This was, in fact, the preferred approach of Medicare opponents when the electoral results of 1964 made Medicare's enactment inevitable, forcing them to formulate their own plans.²³

Why, then, did Medicare emerge in 1965 as a public insurance program, rather than a system of subsidized private insurance? Perhaps the most important reason was that the preferences of the social insurance advocates who designed Medicare largely determined its character.²⁴ They assumed that public insurance was the most appropriate, efficient, and just model of medical care delivery.²⁵ The glaring inability of the private insurance market at the time to cover retirees appeared to confirm their preferences. The most compelling argument in favor of public medical insurance for the elderly was that the market had failed to meet their needs.

In the aftermath of the 1964 elections, the programmatic structure of Medicare reflected the dominant political current of liberalism. The structure of any health insurance program carries with it a corresponding set of values, social commitments, and political dynamics. In 1965, the properties of public health insurance matched the values and social commitments favored by the liberal majority: universalism, government responsibility for social welfare provision, and public accountability. At a different time, under different ideological and electoral circumstances, Medicare could have become a very different program.

The Medicare consensus, then, was the idea that Medicare should remain a government-operated insurance program and that public insurance was the proper vehicle to guarantee access to medical care for the elderly. The consensual character of Medicare politics, however, extended beyond acceptance of these broad principles and reached various areas of policy development. Absent a debate over ideology or programmatic first-principles, a striking degree of bipartisanship characterized Medicare policymaking during the program's first three decades, bipartisanship reinforced by the divided government that was the norm in American politics for much of this era. Certainly during this era in Medicare politics, Democrats and Republicans

23. See EUGENE FEINGOLD, *MEDICARE: POLICY AND POLITICS* 140 (1966) (noting that American Medical Association advocated "Eldercare," under which government would supervise private market for health insurance, after 1964 Democrat landslide made clear that Congress would pass some form of Medicare).

24. See Ball, *supra* note 21, at 63 (explaining preference of Medicare's architects for public social insurance model).

25. See MARMOR, *supra* note 13, at 7 (discussing strong belief of Truman and his supporters that all Americans should have access to public health insurance, regardless of their financial means).

disagreed on important issues. For instance, they disagreed over whom should bear the financial burden of rising Medicare costs. Further, some conservatives continued to oppose Medicare as social insurance.²⁶ But partisan differences were ultimately far less impressive than the similarities between the two parties' positions on Medicare. Medicare's congressional enemies were few in number, and their political impact was negligible.

The consensual, bipartisan character of Medicare politics was evident in three major areas of program policy: benefits, financing, and regulation. With respect to expanding benefits, the consensus was primarily negative. For two decades Medicare benefits for the elderly remained essentially the same as they had been in the 1965 legislation. The stability in benefits occurred despite the presumed existence of strong forces for expansion, including the reputed political power of the elderly and the quite limited protection against medical care costs that the original Medicare program provided. However, cost overruns in Medicare's first years of operation produced fiscal concerns that defused pressures to expand program benefits.²⁷ Medicare quickly acquired a reputation, as chairman of the Senate Finance Committee Russell Long put it in 1969, as being a "runaway program" and, consequently, fiscal constraints drove both Democratic and Republican positions on Medicare policy.²⁸

While Medicare's popularity forced conservative Republicans to accept its existence, it similarly forced liberal Democrats to accept the program's existing benefit package, limitations and all. Democrats, after all, controlled both houses of Congress from the program's enactment in 1964 until 1981. Yet Democratic congressional majorities enacted no substantial expansions of program benefits for the elderly during this period. Congress designed the addition of ESRD and disability as conditions for Medicare eligibility in 1972 to make new populations eligible for Medicare, rather than to enhance benefits for elderly beneficiaries.²⁹ Nor did the Democratic Party frequently raise Medicare benefit expansion as a first-order electoral issue between 1966 and 1994.

26. See MAX J. SKIDMORE, *SOCIAL SECURITY AND ITS ENEMIES* 87 (1999) (describing Ronald Reagan's long campaign against social insurance programs such as Social Security and Medicare).

27. See OBERLANDER, *supra* note 9, at 47 (suggesting that Medicare benefits did not expand during program's first two decades because of its reputation as "uncontrollable burden on the federal government").

28. Mark Schlesinger et al., *Medicare's Coverage of Health Services*, in *RENEWING THE PROMISE: MEDICARE AND ITS REFORM* 58, 69 (David Blumenthal et al. eds., 1988) (arguing that conservatives intended early on to cap Medicare benefits).

29. See OBERLANDER, *supra* note 9, at 40-43 (discussing reasons why Congress did not expand Medicare benefits during program's first two decades).

The politics of Medicare benefits remained bipartisan even when the negative consensus briefly gave way to momentum for benefits expansion in 1988, when Congress passed the ill-fated catastrophic health insurance program. Conservative Republican President Ronald Reagan sponsored the largest expansion of benefits in Medicare history³⁰ and Congress eventually enacted this expansion with bipartisan support.³¹ When Congress repealed the catastrophic insurance legislation only sixteen months after its adoption, it did so again with bipartisan support.³²

Financing policy demonstrated a similar pattern of consensus. Medicare's drafters largely copied its financing arrangements from Social Security, including a payroll tax-based trust fund for hospitalization insurance and reliance on long-term actuarial forecasting. However, spending on medical care proved much more volatile and therefore more difficult to project than spending on pensions. The trust fund system in Social Security had produced programmatic stability and frequent surpluses during the program's first three decades.³³ The same system applied to Medicare created the potential for frequent shortfalls and intermittent trust fund crises.³⁴

It is a sign of the strength of consensual politics in Medicare that the first two shortfalls, in the early 1970s and again in the early 1980s, generated relatively little controversy. Trust fund shortfalls provided policymakers with extraordinary opportunities to reshape public programs. Invoking the rhetoric of bankruptcy emphasized an urgency of immediate action to save the program from crisis. Such rhetoric had the power to weaken the usual barriers, such as interest group opposition, that normally frustrate program change. So it has been with Medicare—each of three periods of trust fund shortfalls preceded substantial reforms of program policy. It is all the more striking, then, that during the first two of these periods (roughly 1970 to 1972 and 1981 to 1983), the policy response was largely bipartisan even though the two crises were

30. See RICHARD HIMMELFARB, *CATASTROPHIC POLITICS* 17 (1995) (discussing President Reagan's 1983 proposal to expand Medicare coverage to encompass catastrophic health expenses).

31. See *id.* at 43 (referring to substantial margins by which Medicare Catastrophic Coverage Act of 1988 passed in House and Senate).

32. See *id.* at 93 (noting that House voted 352 to 63 and Senate voted unanimously to repeal Medicare Catastrophic Coverage Act).

33. See MARTHA DERTHICK, *POLICYMAKING FOR SOCIAL SECURITY* 244 (1979) (explaining that prior to its enactment of Medicare, Congress kept payroll tax rates that financed social security sufficiently high to cover expenditures and enlarge trust fund).

34. See OBERLANDER, *supra* note 9, at 75 (contending that Social Security model of trust fund and payroll tax financing has created Medicare system that is inherently vulnerable to cycles of bankruptcy).

addressed by very different solutions (professional self-regulation in 1972 and centralized price administration in 1983).³⁵ These two shortfalls had a relatively low volume of crisis language. "Bankruptcy" rhetoric appeared much less frequently to describe Medicare's fiscal condition situation in these years than during the Social Security crisis of 1981 or the Medicare crisis of 1995. Throughout the 1980s, Medicare trust fund shortfalls were, in a crucial sense, *consensual crises*.

Finally, the politics of Medicare reform regarding regulation of medical providers has also been largely consensual. In the case of the Prospective Payment System for hospitals in 1983 and the Medicare Fee Schedule for physicians in 1989, conservative Republican presidents joined congressional Democrats in adopting strong regulation of federal payments for medical care in order to slow the rate of growth in program expenditures.³⁶ Fiscal pressures from the budget deficit catalyzed this support: conservatives paradoxically supported expanding the scope of government authority in order to reduce the size of government spending. This bipartisanship was, in the case of Diagnosis Related Groups (DRGs), nourished by an important political attribute: the capacity to appeal simultaneously to multiple, and indeed seemingly incompatible, political constituencies. DRGs promised to regulate hospitals and control Medicare spending, but to do so by promoting competition and rewarding efficiency. They consequently held political appeal for both liberals and conservatives, creating a bipartisan foundation of support.

Along with the Medicare Fee Schedule, the introduction of the Prospective Payment System reversed Medicare's original payment policy, borrowed from private insurance, of paying hospitals and physicians retrospectively, generously, and with no questions asked. This system was, in effect, a blank check that medical providers were only too happy to cash during the program's first two decades. When the federal deficit rose sharply in the 1980s, however, Medicare's accommodation of hospitals and physicians became untenable. The result was a quiet revolution in Medicare policy, as Congress adopted groundbreaking reforms with little controversy, relative speed, and substantial agreement between the parties.

35. *See id.* at 106 (noting that, during Medicare financing crises of 1962–1972 and 1982–1984, both political parties remarkably agreed on how to manage financing problems).

36. *See* DAVID SMITH, *PAYING FOR MEDICARE: THE POLITICS OF REFORM* 47 (1992) (stating that "almost everyone in Congress wanted a prospective payment system," and noting extraordinarily rapid progression of proposal through Congress); James Morone et al., *Slouching to National Health Insurance*, 2 *YALE J. ON REG.* 263, 263–64 (1985) (discussing Diagnosis Related Groups as attempt by government to cut Medicare costs). *See generally* Lawrence D. Brown et al., *Technocratic Corporatism and Administrative Reform in American Medicine*, *J. HEALTH POL., POL'Y & L.* 579 (1985).

The 1980s regulatory reforms brought Medicare closer to the "international standard" in health care insurance.³⁷ Stripped of their technocratic language, scientific veneers, and appeal to market efficiency, DRGs and RBRVS³⁸ were essentially blunt instruments of prospective budgeting and price regulation. The health economist Uwe Reinhardt noted that postwar health policy in OECD nations can generally be divided into two eras: the expenditure-driven policies of 1945 to 1970, during which governments regarded increasing health expenditures as a public policy achievement, and therefore did little to control the open-ended costs of medical care; and the 1970s to present period, when in the face of stagnating economies and fiscal pressures, governments turned to budget-driven health policies to contain rising costs.³⁹ Since the mid-1970s, Canada and Western European nations have been increasingly aggressive in controlling spending in their national health care systems, generally moving from lenient expenditure targets to caps that set harder limits (with penalties for excess costs) on sectoral expenditures. The trend has been toward global budgets that prospectively limit governments' annual health care bill.

Medicare, albeit with less force, moved in the same direction of budget-driven health policymaking during the 1980s. As the decade proceeded, the scope of the Medicare program subject to prospective payment and budgeting expanded.⁴⁰ However, in contrast to health programs in countries such as Canada, Medicare never adopted a global budget that limited spending for the whole program; such controls would have been difficult to impose since Medicare controlled only a portion of the U.S. health marketplace and was regarded by supporters as incompatible with universal entitlement (for instance, tightening payments to medical providers too much might erode the access of

37. See, e.g., JOSEPH WHITE, *COMPETING SOLUTIONS: AMERICAN HEALTH CARE PROPOSALS AND INTERNATIONAL EXPERIENCE* 128–62 (1995) (discussing standards of quality and access in international health care).

38. DRGs (Diagnostic-Related Groups) are a system of classifying hospital admissions by a patient's diagnosis. Medicare pays a set fee, prospectively determined, for each DRG regardless of the actual resources spent on an individual patient's care. The RBRVS (Resource-Based Relative Value Scale) is a fee schedule for physician services based on the time and complexity of services and physician practice expenses. As with DRGs, the RBRVS provides the basis for a prospective fee schedule for Medicare payments to physicians. Both DRGs and RBRVS were promoted as instruments of rationality and science that would provide more accurate prices for medical care services, while encouraging efficiency.

39. See generally Uwe Reinhardt, *Global Budgeting in German Health Care*, *DOMESTIC AFF.*, Winter 1993, at 159 (describing gradual shift of health care policy in industrialized world from expenditure-driven financing to budget-driven delivery).

40. See MOON, *supra* note 19, at 52–77 (describing implementation of Prospective Payment System and its expansive impact).

Medicare enrollees to physicians).⁴¹ But, the regulatory mechanisms that Medicare adopted for physician and hospital payments were unquestionably similar in motivation and effect to those used abroad, though American political culture seemed to require their justification in technocratic terms.⁴²

Over time, Medicare looked more and more like single-payor insurance. Medicare reform through the program's first three decades largely meant federal regulation of payments to providers. It mirrored the strategies of administered pricing that other national health systems used. Moreover, the program's new regulatory regime was modestly successful in restraining Medicare spending from 1984 to 1991.⁴³ While Medicare's cost savings may not have been impressive on an international scale, compared to the inflationary American private insurance market they were downright remarkable. Further, the American private sector copied Medicare's payment innovations such as the Relative Value Units used to pay physicians. Not surprisingly, as universal health insurance returned to the agenda in the early 1990s, some analysts and politicians, including Congressman Pete Stark (D-Cal.), began to tout Medicare as a model for national health insurance.⁴⁴ A reinvigorated and more efficient Medicare appeared to be a promising model for private sector reform in the United States.

In sum, Medicare politics from 1966 to 1994 was consensual in two respects that shaped program reform. First, a *de facto* political consensus existed that the federal government should operate Medicare as a public insurance program. Second, the character of Medicare politics was largely bipartisan, with both parties generally supporting the same course of action, or, in the case of benefit expansion, inaction, often in response to fiscal constraints and pressures. This bipartisan character, in turn, made Medicare politics mostly quiescent, because conflicts over programmatic philosophy were rare.

41. See TIMOTHY STOLTZFUS JOST, *DISSENTLEMENT?: THE THREATS FACING OUR PUBLIC HEALTH-CARE PROGRAMS AND A RIGHTS-BASED RESPONSE* 268–79 (2003) (comparing Medicare to public health systems in other countries that cover their whole population instead of only indigent persons and thus are able to impose universal budgets and ration supply).

42. In fact, the Medicare RBRVS fee schedule resembled payment schemes used in Canadian provinces, though the Canadian schedules were derived by negotiation, without the scientific and technocratic aspiration claimed in the United States.

43. See MOON, *supra* note 19, at 43 (describing effect of Medicare cost-containment efforts in early 1980s).

44. See Alissa J. Rubin, *Stark's Bill Modeled on Medicare*, 52 CONG. Q. 609, 609 (1994) (describing Representative Pete Stark's plan to use Medicare as model for universal government-run health insurance program).

III. *The Unraveling of Consensus, 1995–1997*

In 1995, for the first time in over three decades, a high-profile, partisan, and ideologically divisive debate over first-principles took place in Medicare. All of the elements that had sustained the consensus in Medicare politics abruptly unraveled. By returning to the central issue of what form of health insurance the federal government should provide to the elderly, the 1995 debate represented a reopening of the Medicare debate of the 1950s and 1960s. Given the relative stability that characterized Medicare for three decades, it is worth exploring how and why the Medicare consensus unraveled when it did. The following section analyzes the combination of long-term forces, short-term pressures, and contingencies that led to the transformation of Medicare politics.

A. *Political Environment*

The most obvious, as well as important, precipitating factor in Medicare's political upheaval was the 1994 congressional elections.⁴⁵ Medicare, after all, had never operated under a Republican Congress during its first three decades of existence.⁴⁶ The Republican Party had last held majorities in both the House of Representatives and the Senate in 1954, a decade before the program's enactment. Congressional stewardship of Medicare consequently meant Democratic Party stewardship, notwithstanding an interregnum of Republican control of the Senate from 1980 to 1986.

The 1994 elections, which brought Republican majorities to both houses of Congress, produced a radically new political environment for Medicare. The House of Representatives majority, led by Speaker Newt Gingrich, was committed to an agenda of assertive conservatism.⁴⁷ While Ronald Reagan had helped to redirect political discourse toward conservatism, the new Republican leadership was not satisfied with rhetorical accomplishments. Instead, it sought to dramatically change the scope of the federal government by redefining the terms of federalism and federal budgeting, and by reshaping (and often dismantling) regulatory and social welfare policies.⁴⁸

45. See LINDA KILLIAN, *THE FRESHMEN* 161 (1998) (describing newly elected Republican Congress's effort to reform Medicare).

46. OBERLANDER, *supra* note 9, at 139.

47. See KILLIAN, *supra* note 45, at 415–16 (discussing conservative agenda pursued by Republican congressional majority).

48. See *id.* at 6 (stating elements of Republican agenda).

The political world arising from the 1994 elections stood in stark contrast to the world in which Medicare grew up. Medicare was a programmatic child of the "Great Society."⁴⁹ It represented liberalism, federal government activism, social insurance, and by the early 1990s, aggressive government regulation of private actors. The 1994 Republican revolution promised conservatism, decentralization of federal power to the states, the unleashing of market forces, and deregulation.⁵⁰ The gap between Medicare's programmatic character and the prevailing political order after the 1994 elections could hardly have been greater.

Given the ideological mismatch between the program and the Republican agenda, it was not surprising that the Republican leadership sought to restructure Medicare. The decision to pursue Medicare reform was, nonetheless, a controversial and politically risky one. Republican Party Chairman Haley Barbour, fearing the political fallout from program reform, unsuccessfully beseeched Speaker Gingrich to delay plans for Medicare reform until after the 1996 elections.⁵¹ However, filled with bravado after early legislative victories in 1995, Gingrich rejected Barbour's advice despite the recent example of the Clinton Administration's bitter experience with health care reform.⁵² Medicare was simply too critical ideologically and fiscally (given the Republican agenda of cutting taxes while balancing the budget) to ignore, despite the political risks.

B. Fiscal Environment

If Medicare grew up in a political world different from 1994 America, the fiscal world it faced was equally unfamiliar. Congress enacted Medicare in 1965 during a period of prosperity and economic growth when the federal government did not carry sizable deficits.⁵³ Broad acceptance of payroll taxes

49. See DAVID MARANISS & MICHAEL WEISSKOPF, *TELL NEWT TO SHUT UP 128* (1996) (noting that federal government implemented Medicare as part of Lyndon Johnson's "Great Society" program).

50. See KILLIAN, *supra* note 45, at 5 (listing principles of Republican agenda).

51. See MARANISS & WEISSKOPF, *supra* note 49, at 131 ("Don't touch Medicare for two years, Barbour urged the congressional leaders.").

52. See *id.* at 131 (stating that Republican congressional leaders rejected Barbour's advice to postpone Medicare reform until after the 1996 elections).

53. See CONG. BUDGET OFFICE, *THE BUDGET AND ECONOMIC OUTLOOK: FISCAL YEARS 2004–2013* app. F, table 1 (Jan. 2003) (describing revenues, outlays, surpluses, deficits, and debt from 1962 to 2002), available at <http://www.cbo.gov/showdoc.cfm?index=1821&sequence=0>.

to finance federal programs existed in American politics. Though some congressional leaders on Social Security, such as Ways and Means Committee Chairman Wilbur Mills, voiced concern that payroll taxes not become too burdensome, such opposition had little influence as social insurance benefits consistently expanded during the 1960s and early 1970s.⁵⁴ During Medicare's first financing shortfall both parties supported raising the program's hospitalization insurance tax to help redress the shortfall.⁵⁵

Medicare's fiscal environment began to change with "stagflation" in the 1970s and the rise of the federal deficit as an issue in the 1980s. Preoccupation with balancing the federal budget fundamentally changed Medicare's political position. High rates of growth in program spending, which had been overlooked in fatter financial times, were no longer easily tolerated. Medicare was now viewed as a chief culprit in the federal budget deficit, its expenditures a prime target for deficit reduction. Cuts in program spending, as well as enactment of regulatory reforms, became a regular feature of the budget process.

At the same time, the politics of the payroll tax had also changed. Deficit politics accompanied a parallel rise in antitax sentiment. The Republican Party made opposition to new taxes a political mantra, one that the Democratic Party only weakly challenged. The conservative Republican majorities of 1995, still seething over George Bush's 1990 betrayal of his "no new taxes" pledge and advancing a tax cut agenda of their own, had no appetite for raising payroll taxes. For Medicare, the consequence was that if a trust fund shortfall appeared, it would not be redressed, as it had in the past, by tax increases and therefore would require radical reform options that promised large savings.

This antitax sentiment, though, did not clearly reflect public opinion; there was, in fact, reason to believe that the public would have accepted increases in Medicare payroll taxes.⁵⁶ It is certainly difficult to imagine that a payroll tax increase for one of the nation's most popular public programs supported by both political parties would not have been accepted by a majority of the public.

But that support was not forthcoming. The Republicans were ideologically opposed to tax increases and the Democrats, still trying to escape the stigmatizing "tax and spend" label, were politically unwilling to challenge them. The resulting political cap on Medicare payroll taxes put the program in

54. See JULIAN E. ZELIZER, *TAXING AMERICA: WILBUR D. MILLS, CONGRESS, AND THE STATE, 1945-1975*, at 324 (1998) (noting legislative enactments between 1969 and 1971 which increased Social Security benefits).

55. OBERLANDER, *supra* note 9, at 96.

56. See *id.* at 143 (discussing evidence indicating that public would tolerate higher taxes to support Medicare).

a financial box. Without additional tax revenue, a shortfall in program finances was inevitable through cuts or restructuring. Fiscally, Medicare's environment was conducive to programmatic upheaval and the Republican leadership's agenda of tax cuts and a balanced budget, to be funded in no small part through cuts in Medicare spending, made that upheaval a certainty in 1995.

C. Intergenerational Equity

Nowhere was Medicare's changed political environment more apparent than in the transformation of the elderly's public image. During the 1960s, the elderly were the country's sympathetic social group nonpareil. The public perceived the elderly as poorer, less well insured, and sicker than younger Americans.⁵⁷ And, they were.⁵⁸ Indeed, their ability to command public sympathy was the reason that Medicare's architects chose to start national health insurance with a program for the aged.

Three decades later the political appeal of the elderly had eroded. Public support for programs directed at the aged remained high.⁵⁹ However, this support coexisted with a rising discourse of intergenerational equity concerns that reinvented the elderly as a "scapegoat" in American politics.⁶⁰ The success of federal programs had reduced elderly poverty rates to levels below that of the general population, though many elders lived just above the poverty line.⁶¹ Yet, resentment at the share of the federal budget devoted to the elderly helped feed a new stereotype: that of the "greedy geezer" who was, depending on the story, either spending younger taxpayers' dollars on an extravagant retirement, or on expensive high-tech medicine in the final days of life, or perhaps on both, thus taking potential funds away from public spending on children and needy Americans.⁶² Many viewed the "greedy geezer," in contrast to his or her 1960s

57. See MARMOR, *supra* note 13, at 11 (noting public perception during the 1960s of elderly persons as having more financial and health problems than most Americans).

58. See *id.* (citing statistical data supporting 1960s perception of elderly persons).

59. See COOK ET AL., *supra* note 17, at 63 (noting public opinion poll weighing support for social welfare programs aiding elderly persons).

60. See Robert H. Binstock, *The Aged as Scapegoat*, 23 THE GERONTOLOGIST 136 (1983) (stating that society perceives elderly persons as social and political burdens).

61. See MARILYN MOON & JANEMARIE MULVEY, ENTITLEMENTS AND THE ELDERLY 14-19 (1996) (discussing decline in poverty rates among some elderly Americans).

62. See generally Samuel Preston, *Children and the Elderly: Divergent Paths for America's Dependents*, 21 DEMOGRAPHY 435 (1984) (offering thesis that increases in life expectancy of elderly population combined with declining birth rates will, due to America's social program priorities, result in increased child poverty); see also DANIEL CALLAHAN,

elderly cousin, as wealthier and better insured than other Americans, and as media images of active elders suggested, increasingly healthy as well. The repeal of catastrophic health insurance in 1989 also fueled this stereotype as the media zeroed in on stories of more affluent elders selfishly leading the charge against a program that would benefit poorer Medicare beneficiaries (though the actual story of the demise of catastrophic insurance was much more complex).

Meanwhile, the coming retirement of the baby boomers in the twenty-first century increasingly became an object of anxiety in public discourse. Critics such as former Secretary of Commerce Peter Peterson, founding president of the Concord Coalition, alleged that Social Security and Medicare would soon represent an unsustainable burden on the federal budget, leaving future generations to cope with enormous public deficits and economic disaster.⁶³ Medical ethicist Daniel Callahan argued that norms of justice dictated that society should ration health care for the aged by setting age limits on eligibility for expensive medical treatments.⁶⁴ Political commentators warned that the graying of the population would make the already powerful elderly lobby, symbolized by the persistently vilified American Association of Retired Persons (AARP), even more powerful, institutionalizing an imbalanced political system that favored the needs of the elderly over other constituencies.⁶⁵ And finally, critics wondered why, in the face of declining poverty rates among the elderly, taxes of working families should finance public health and pension benefits for well-off elders.⁶⁶

There are, to be sure, significant problems with the intergenerational equity story and the dire warnings about the baby boomers.⁶⁷ Comparative

SETTING LIMITS: MEDICAL GOALS IN AN AGING SOCIETY 115–16 (1987) (noting that growing social and economic costs of health care for elderly citizens places economic pressures and burdens on government and society).

63. See PETER PETERSON, *WILL AMERICA GROW UP BEFORE IT GROWS OLD?* 11–14 (1996) (stating that failure to reform Social Security and Medicare will result in "a political, financial, and moral crisis").

64. See CALLAHAN, *supra* note 62, at 116–20 (proposing standard for rationing health care based on age limits).

65. See KEN DYCHTWARD, *AGE POWER: HOW THE 21ST CENTURY WILL BE RULED BY THE NEW OLD* 1 (1999) (predicting that "the epicenter of economic and political power will shift from the young to the old").

66. See PETERSON, *supra* note 63, at 123 (describing reluctance of middle-class Americans to contribute to government programs that support retirees who might be financially well-off).

67. See Jerry L. Mashaw & Theodore R. Marmor, *The Great Social Security Scare*, in *THE AMERICAN PROSPECT*, Nov./Dec. 1996, at 31 (noting pessimistic outlook of media sources regarding future of Social Security); Theodore R. Marmor & Jonathan B. Oberlander, *Rethinking Medicare Reform*, *HEALTH AFF.*, Jan./Feb. 1998, at 52, 53 (discussing instability of Medicare and possible solutions); Jill Quadagno, *Generational Equity and the Politics of the*

experience in demography, medical care costs, and pensions suggests a less fearsome outcome of the aging of America than the apocalyptic scenarios that some analysts predict. But the intergenerational story need not be accurate in order to be politically influential. Although public opinion studies find mass support for Medicare and Social Security to be consistently high over time, these same studies also find that support for government programs for the aged is noticeably weaker among members of Congress than among the public.⁶⁸ Among many policymakers, sympathy for the elderly has eroded over the past three decades. Intergenerational equity concerns and worries over the fiscal and economic impact of the soon retiring baby-boomers have predisposed policymakers to cut Medicare spending, impose costs on program beneficiaries, and restructure existing programmatic arrangements. In 1995 and beyond, politicians were more prepared than ever before to do something *to* the elderly rather than *for* them and were more willing to consider proposals that departed from the strict universalist ethos of Medicare that provides all beneficiaries the same benefit package regardless of income.

D. Changing Health Care System

The promise of Medicare was to bring the elderly into the mainstream of American medicine. In 1965, that meant the traditional health insurance model (along the lines of Blue Cross/Blue Shield) that commanded an overwhelming share of the private insurance market. Alternative delivery systems, such as prepaid group practices (what we now call HMOs) were rare, geographically limited in market presence, and organized medicine strongly opposed their inclusion in Medicare. Medicare's adoption of the prevailing model of insurance thereby not only assured retirees continuity in medical care, as well as broad access to mainstream hospitals and doctors, but it also reassured the medical profession that the federal government would not disrupt conditions in the private medical market—conditions that clearly favored the profession.⁶⁹

Welfare State, 17 POL. & SOC'Y 353, 353–55 (1989) (discussing intergenerational equity and impact of Americans for Generational Equity (AGE)); JOHN A. PALMER & ISABEL V. SAWHILL, THE VULNERABLE 420–24 (1988) (discussing social policy concerns regarding support of elderly persons); Carroll Estes, *Social Security: The Social Construction of a Crisis*, 61 MILBANK MEMORIAL FUND Q. 441, 446 (1983) (describing social perception of elderly persons as blameworthy for economic problems).

68. See COOK ET AL., *supra* note 17, at 89–91 (analyzing statistical data comparing public support for Medicare with congressional support for Medicare).

69. Those conditions included retrospective, fee-for-service reimbursement with few controls over fees; unquestioned physician autonomy in clinical decision-making; the absence of closed panels of medical providers; and the absence of any countervailing power, public or

This structure of federal health insurance for the aged essentially remained stable for three decades. The same cannot be said for private health insurance. By 1995, the private health insurance market was in the midst of a dramatic transformation as "managed care" plans and practices became the dominant form of insurance in the United States.⁷⁰ The diversity of health plans, payment practices, and organizational features grouped under the managed care rubric made the term virtually impossible to define. In practice, managed care referred to a staggering number of insurance models and policies that departed from traditional American insurance arrangements. Managed care plans, including Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs), and hybrid Point of Service (POS) plans grew rapidly during the 1990s. In 1992, HMOs' enrollment stood at forty million and PPOs at fifty million; only three years later HMOs covered sixty million Americans and PPOs another ninety million.⁷¹ At the same time, the number of physicians subject to capitation (flat payment per enrollee) and utilization review of clinical decision-making rose substantially.⁷² Surely the most striking symbol of change, however, was the steep decline of enrollment in America's traditional health plan, conventional indemnity insurance, from covering 49% of the employee market in 1992 to only 27% in 1995.⁷³

In fact, by the middle of the 1990s, only one significant bastion of unmanaged care remained in the United States: Medicare.⁷⁴ During the program's first two decades, efforts existed to expand the role of HMOs in Medicare. The 1972 Social Security Amendments authorized federal payments to federally qualified HMOs enrolling program beneficiaries.⁷⁵ But HMOs

private, that actively challenged physicians' hold over the medical marketplace. See PAUL STAR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE* 375 (1982) (discussing physicians' dominance of medical marketplace).

70. See WALTER A. ZELMAN & ROBERT A. BERENSON, *THE MANAGED CARE BLUES AND HOW TO CURE THEM* 53-63 (1998) (describing rise of HMOs and PPOs as price competitive alternatives in high cost environment and their effects on health care practices).

71. Mark A. Peterson, *Health Care into the Next Century*, 22 J. HEALTH POL., POL'Y & L. 291, 297 (1997).

72. *Id.*

73. See Gail Jensen et al., *The New Dominance of Managed Care: Insurance Trends in the 1990s*, HEALTH AFF., Jan./Feb. 1997, at 125, 126 (discussing growth of workers enrolled in various types of health care plans).

74. In the 1990s, Medicaid, adopted at the same time as Medicare and along the same insurance model, was moving aggressively towards managed care, as more and more states in search of cost savings mandated that program recipients join HMOs and other managed care arrangements. See MICHAEL S. SPARER, *MEDICAID AND THE LIMITS OF STATE HEALTH REFORM* 152-81 (1996) (laying out history of how Medicaid clients were moved into managed care).

75. See Jonathan B. Oberlander, *Managed Care and Medicare Reform*, 22 J. HEALTH

regarded the administrative and financial requirements for participation in Medicare as so onerous that, by 1979, only one prepaid plan had enrolled in the program. In 1982, policymakers revisited Medicare HMOs and, under the Tax Equity and Fiscal Responsibility Act (TEFRA), adopted provisions intended to encourage Medicare HMO enrollment. Managed care enrollment in Medicare subsequently grew, yet in 1993 it stood at only 5% of program beneficiaries.⁷⁶

As a consequence, by 1995, Medicare's managed care enrollment lagged far behind that in the private sector. Medicare had promised to bring the elderly into the mainstream of American medicine and health insurance but that mainstream had undergone substantial changes while Medicare had not. The widening gap between the private sector and federal health insurance was not lost on conservative reformers, who increasingly regarded Medicare as Chairman of the House Ways and Means Health Subcommittee Bill Thomas bluntly put it, a "dinosaur" that was becoming obsolete because of market innovations.⁷⁷

The divergence in insurance structure between Medicare and the private sector created a number of pressures on the program. Medicare is in a unique position internationally. In other nations, government-sponsored health programs commonly operate alongside a small private health sector that acts as a safety valve for more affluent citizens seeking shorter queues or greater amenities. In systems such as the British National Health Service (NHS), the size of the private sector is a matter of political dispute, but even after some growth, the public NHS remains the dominant institution in medical care delivery.⁷⁸

Medicare's position vis-à-vis the private insurance market is rather different. Because the United States has never enacted national health insurance, Medicare operates as a minority insurer alongside a dominant system of private insurance. This arrangement, directly opposite from the international

POL., POL'Y & L. 595, 598 (1997) (describing 1972 Social Security amendments that authorized Medicare to contract with certain older, established HMOs "on a capitated or 'risk' basis").

76. See HEALTH CARE FINANCING ADMINISTRATION, A PROFILE OF MEDICARE: CHARTBOOK 1998, at 64, fig. 42 (1998) (showing increased enrollment in Medicare HMOs from 1985 to 1997) (on file with Washington and Lee Law Review); see also Oberlander, *supra* note 75, at 598 (noting increase in number of Medicare beneficiaries enrolled in managed care plans following passage of TEFRA risk program).

77. See Robin Toner, *G.O.P. Moves Health Debate to Medicare*, N.Y. TIMES, Feb. 12, 1995, at A26 (recounting Chairman of House Ways and Means Subcommittee on Health Bill Thomas's description of Medicare as "dinosaur").

78. See RUDOLF KLEIN, THE POLITICS OF THE NATIONAL HEALTH SERVICE 145-58 (1989) (discussing size and scope of British National Health Services in relation to private health care providers).

standard, creates a set of potential pressures on Medicare when it diverges from the dominant private model of medical insurance. As managed care advanced in the 1990s, those pressures were fully unleashed.

The first pressure is that of performance. If the private insurance model is viewed as outperforming Medicare, for example in controlling costs, pressures will urge Medicare to follow the private sector lead in health care organization and payment practices. As the next section explains, performance pressures were particularly salient in the mid-1990s as managed care provided conservative reformers with an alternative to traditional Medicare. The second pressure is that of consistency. As the mainstream of medical care moves, pressures may urge Medicare to maintain the continuity between employee and retiree coverage. Concerns may also develop about the administrative costs of maintaining Medicare as a different health insurance system and about potential resentment from the public due to intergenerational equity concerns. For instance, Brookings Institution economists Henry Aaron and Robert Reischauer have written that Medicare must emulate the private sector's move toward managed care because if it does not, "public support may begin to erode for a system of coverage for the aged and disabled that is substantially different from and, therefore, more costly, than the health plans that cover the average taxpayer's family."⁷⁹

Finally, Medicare may be subject to the pressures of expansion. As insurers exhaust options for growth in the private sector, they may look to the public sector to expand their market share. In this context, Medicare represented "the last frontier" for managed care companies, and as such, they fought to expand their enrollment of program beneficiaries, which meant lobbying for reforms that would open up Medicare more widely to private insurers. In all of these dimensions, the development of managed care in the private sector brought about enormous political pressures on Medicare.

E. Trust Fund Crisis

Past trust fund shortfalls in Medicare proved to be largely noncontroversial, low-profile, and bipartisan. The trust fund crisis of 1995 produced very different politics. This crisis was contested, the first in program history, and it shattered the consensus that had defined Medicare politics for three decades.

79. Henry J. Aaron & Robert D. Reischauer, *Rethinking Medicare Reform Needs Rethinking*, HEALTH AFF., Jan./Feb. 1998, at 69, 69.

The 1995 trust fund crisis was, in part, happenstance. The Republican leadership was searching for ways to sell its Medicare reform package. Coming on the heels of the demise of President Clinton's health plan, the political risk in taking on Medicare should have been abundantly clear. But fiscally, the Republican Party needed Medicare savings to accomplish its goals of balancing the budget and cutting taxes. Ideologically, Medicare reform was central to Republican efforts to remake the welfare state. The question remained: how could the Republican Party convince the country that its vision of Medicare reform would help, not hurt, the program?

As party pollsters tested various Medicare marketing messages, Republican Party Chairman Haley Barbour thought he had found the answer in a report which showed that, in the absence of corrective action, the Medicare hospitalization insurance trust fund would run a deficit beginning in 2002.⁸⁰ Politically, the Republican leadership saw the report as a godsend; they could now advance Republican reforms as necessary to "saving Medicare" from "bankruptcy."⁸¹ The trust fund shortfall offered, in other words, a convenient problem to which Republican lawmakers could attach the solution that they already had in mind.

Focusing attention on Medicare's trust fund problems also had the potential to change the dynamics of the Medicare reform debate. Medicare's cost control performance, as previously noted, was fairly strong in the 1980s. However, the world of actuaries is one of long-term projections. Federal actuaries compute Medicare financing over periods of twenty-five and seventy-five years. These long-term estimates offer very little policy value given the enormous uncertainty about future rates of medical costs, medical practice and technology, health of the population, and the impact of program reforms. But, for the Republican leadership, these limitations would have been of no concern because the actuarial estimates offered an important political advantage: the longer the projection went, the worse Medicare's financial problems looked, in part because such estimates assumed no increases in payroll tax rates or adoption of reforms, and in part because no public program is fully funded seven decades ahead of time.⁸² The outlook on Medicare's trust fund for 2002 may have appeared bleak, but the outlook for 2032 seemed downright

80. See MARANISS & WEISSKOPF, *supra* note 49, at 133 (stating that Barbour regarded 1995 Medicare report as "manna from heaven").

81. See *id.* at 132–33 (describing Republican reaction to contents of "[t]he 1995 Annual Report of the Board of Trustees of the Federal Supplementary Medical Insurance Trust Fund").

82. See JOSEPH WHITE, FALSE ALARM: WHY THE GREATEST THREAT TO SOCIAL SECURITY AND MEDICARE IS THE CAMPAIGN TO "SAVE" THEM 10–12 (2001) (describing long-term assumptions used in Medicare budget projections).

catastrophic. Moreover, the projections picked up the retirement of the baby boomers, allowing Republican (and some Democratic) policymakers to connect Medicare reform to anxiety about the aging of the country and the affordability of entitlements. Suddenly, the concern was not just that the Medicare trust fund would soon go bankrupt, but also that Medicare would soon bankrupt the government. Actuarial projections provided an indictment of Medicare on the basis of its future performance and thereby changed the focus of public discourse. The argument was that Medicare reform would be necessary to save the program (and the federal budget) from an inadequate performance in cost control that had not yet occurred.

If the timing of the trust fund shortfall was convenient for Republican lawmakers, its coincidence with a rise in Medicare spending rates relative to the private sector was pure political manna. The adoption of regulatory reforms during the 1980s had left Medicare with stricter payment policies than private insurers. From 1984 to 1991, Medicare costs rose at rates slower than those in the private sector.⁸³ As the 1990s wore on, the pattern reversed and suddenly it was Medicare that appeared to be the weaker agent of cost control. The spread of managed care arrangements and newly aggressive competition in the health insurance market had lowered, temporarily as it turned out, the rate of increase in private sector health costs.⁸⁴ Meanwhile, Medicare costs resumed a higher rate of growth, driven by substantial increases in spending for postacute care and unexpected increases in spending for hospital services.⁸⁵

Medicare became financially vulnerable at precisely the same moment that it became politically vulnerable. Republican lawmakers pointed to the private sector's lower rates of growth as evidence that Medicare was inefficient, especially in comparison to innovative managed care and competitive contracting strategies. They argued that Medicare's regulatory framework of "price controls," as it was derogatorily known, had failed, and that the program should instead adopt successful "market-based" strategies.⁸⁶

83. See MOON, *supra* note 19, at 43 (discussing rate of growth of Medicare costs).

84. See CENTER FOR STUDYING HEALTH SYSTEM CHANGE, DATA BULLETIN NO. 13: DESPITE FEARS, COSTS RISE ONLY MODESTLY IN 1998 (Fall 1998) (showing data on growth in private sector health premiums during early 1990s), available at <http://www.hschange.com/CONTENT/84/#graph1>.

85. MEDICARE PAYMENT ADVISORY COMMISSION, NATIONAL HEALTH CARE AND MEDICARE SPENDING DATA BOOK § 5, chart 5-5 (2003) (comparing average cost increase per enrollee in Medicare versus private sector), at <http://www.medpac.gov/publications/>.

86. Of course, the "inefficient" Medicare "price controls" denounced in the 1990s (DRGs and RBRVS) were the same policies that were promoted in the 1980s as fostering competition and efficiency in the medical care market.

In large part, however, the resurgence of Medicare spending was due, not to the failure of regulation, but to the failure to implement a full-scale regulatory scheme. The reforms of the 1980s were sectoral, targeting hospital and physician spending. Other sectors, such as home health care, were left essentially unregulated. As providers figured out how to shift services (and thus profits) into unregulated areas of the program, an increasing share of program spending was uncontrollable, not subject to prospective budgeting. Moreover, the 1980s regulatory reforms did not impose a prospective limit on total Medicare spending, such as through a global budget of the sort used in Canada.⁸⁷ Without a global budget, Medicare was inevitably susceptible to unforeseen increases in spending. When a high rate of growth existed in any one program sector, no hard cap existed to compensate for it by limiting overall program spending. And, because it only covered a portion of the American population, Medicare lacked a crucial cost containment tool used in other national health systems: limits on the diffusion of medical technology. As a consequence of its half-way regulatory reforms, Medicare had, in a sense, the worst of both worlds: enough regulation to serve as a political scapegoat, but not enough to ensure successful cost control.

The Republican attempt to use the trust fund shortfall in 1995 to push through program reforms was nothing new. During the early 1970s and 1980s, policymakers had pursued the same strategy. What was new, however, was the scope of the Republican-sponsored reforms and their expected impact on beneficiaries' medical care. The proposed cuts in the rate of growth in Medicare spending (\$270 billion over seven years, a 30% reduction) were substantial.⁸⁸ The Republican legislation also proposed a transformation of Medicare's budgetary entitlement status by introducing a hard cap on annual expenditures. The plan also called for a restructuring of Medicare insurance by opening the program up to a host of private insurance plans that lawmakers hoped would increase the elderly's enrollment in managed care at the expense of public Medicare.⁸⁹ Taken together, these reforms had the potential to impact program beneficiaries profoundly, a considerable departure from previous trust fund remedies that had raised taxes and targeted medical care providers.

87. See WHITE, *supra* note 37, at 66–70 (describing Canadian practice of making lump-sum allocations to hospitals and subsequently requiring hospitals to adhere to budget controls).

88. See Colette Fraley, *Republicans Outline Medicare Plan . . . To Hit \$270 Billion Budget Target*, 53 CONG. Q. 2780, 2780 (1995) (discussing Republican plan to reduce Medicare spending by \$270 billion).

89. See *id.* at 2780–81 (describing Republican plan to give beneficiaries option to leave Medicare and opt for managed care).

As a result, the Republicans overreached in their reform effort, miscalculating that the rhetoric of trust fund crisis would inoculate them from political damage. As Clinton's health plan had done only two years earlier, the Republican Medicare plan became a political "boomerang."⁹⁰ President Clinton, who had been searching for relevance after the humbling 1994 elections, seized on the issue, vowing he would veto the bill and that he would "not let [the Republican Party] destroy Medicare."⁹¹ Congressional Democrats similarly found a unified opposition voice in decrying the Republican Medicare proposal as turning back, in the words of House Minority Whip David Bonior, "30 years of trust and 30 years of hope that our parents and our grandparents will always have the health care they need."⁹²

Despite the controversy, Republican congressional leaders succeeded in passing a Medicare reform bill.⁹³ But, the Democrats' so-called "Mediscare" campaign took a toll, and the issue played no small part in rehabilitating President Clinton's political standing and in cementing the Republican Congress's image as too extreme. When the President vetoed the Medicare bill with the same pen that Lyndon Johnson had used to sign Medicare into law in 1965, program reform appeared dead. The 1996 Clinton campaign's successful use of the Medicare issue against Republican nominee Robert Dole (who had voted against the original Medicare legislation) did nothing to persuade otherwise.

IV. The Rise of the Market Model: Medicare and the 1997 Balanced Budget Act

The defeat of the 1995 Republican Medicare reform bill obscured the powerful long-term and short-term forces that were undermining the old program consensus. Electoral outcomes had placed ideological opponents of Medicare's liberal model into positions of influence in Congress. The rise of

90. See THEDA SKOCPOL, *BOOMERANG: THE RISE AND RESOUNDING DEMISE OF THE CLINTON HEALTH PLAN* 178 (1996) (using "political boomerang" metaphor to describe failure of President Clinton's Health Security proposal).

91. See Colette Fraley, *Historic House Medicare Vote Affirms GOP Determination*, 53 CONG. Q. 3206, 3206 (1995) (noting President Clinton's reaction to Republican Medicare reform bill).

92. See *id.* at 3210 (discussing Democrats' criticism of Republican Medicare reform efforts).

93. See David E. Rosenbaum, *Battle over the Budget: The Details*, N.Y. TIMES, Dec. 29, 1995, at A1 (describing government "shutdown" controversy and passage of Republican balanced budget bill that would limit Medicare spending).

managed care created a powerful constituency in the private sector for ceding Medicare's public insurance function to the market. Medicare remained a prime fiscal target as momentum for balancing the federal budget increased.

How much the liberal consensus had unraveled became apparent in the aftermath of the 1996 elections. In August of the following year, Congress and the President agreed on the Balanced Budget Act of 1997 (BBA). The 1997 BBA mandated a wide variety of key policy changes, including a balanced federal budget by 2002.⁹⁴ The BBA also kept alive the practice, which had been prominent in the previous decade, of adopting Medicare reform as a part of large-scale fiscal legislation. Among the BBA provisions was a series of Medicare reforms and substantial cuts in the rate of growth in Medicare spending over the next decade.⁹⁵ The legislation also established the "Bipartisan Commission on the Future of Medicare" to consider the program's future (which would, in 1999, fail to produce the super-majority necessary to officially forward its recommendations to Congress).⁹⁶ But, the centerpiece of the reforms was the creation of a new Medicare+Choice option that opened Medicare up to a variety of new private insurance plans, including Medical Savings Accounts, commercial Fee-for-Service plans, Provider-Sponsored Organizations, and the full gamut of managed care plans.⁹⁷

The changes in Medicare attracted, in comparison to the high-profile Medicare debate of 1995, relatively little public attention or press scrutiny.⁹⁸ Indeed, most of the coverage of the 1997 reforms focused on controversial measures that ultimately did not pass Congress. These included provisions to raise Medicare's retirement age and income-related beneficiary premiums.⁹⁹

The dearth of attention to what did pass in 1997 was largely a function of the bipartisan agreement on these changes. There simply was no echo of the deeply partisan and highly charged 1995 atmosphere in deliberations over the Medicare+Choice arrangements. In June 1997, in a telling show of bipartisanship, the House Ways and Means Committee approved the Republican-sponsored Medicare reforms 36-3, while the Senate Finance

94. CONG. BUDGET OFFICE, BUDGETARY IMPLICATIONS OF THE BALANCED BUDGET ACT OF 1997, at 1 (1997).

95. *Id.* at 17.

96. *Id.*

97. *See id.* at 16 (describing options available to Medicare beneficiaries under Medicare+Choice plans).

98. *See* Lynn Etheredge, *The Medicare Reforms of 1997: Headlines You Didn't Read*, 23 J. HEALTH POL., POL'Y & L. 573, 574 (1998) (stating that Medicare reform process "mostly took place outside the media spotlight").

99. The fact that Congress openly considered these measures was a significant development in Medicare politics in and of itself.

Committee voted for them 20–0, a far cry from the polarizing partisanship and party-line voting on Medicare reform in 1995.¹⁰⁰ The final conference report containing the Medicare legislation similarly cleared the House of Representatives 346–85 and the Senate 85–15.¹⁰¹ One prominent participant declared that, after the ill will of the 1995 Medicare debate, enactment of the BBA was "a bipartisan miracle."¹⁰²

Yet, for all the apparent bipartisanship, the stakes were still high. Taken together, the 1997 Medicare reforms arguably represented the most important changes in the program since its inception. The scope of agreement on these reforms, and the consequent absence of public debate, was remarkable because the Medicare BBA provisions resembled, in key respects, the Republican plan that had died amidst all the controversy just the year before.

Why the abrupt political turnabout? First, the 1997 BBA omitted or altered several key provisions that had been the focus of Democratic Party objections, including a hard cap on Medicare spending that would have transformed the program's budgetary entitlement status and a fail-safe provision that would have triggered automatic spending cuts in the program. Democrats widely viewed such a cap as threatening the ability of seniors to access quality medical care, and as incompatible with Medicare's social contract and American conceptions of entitlement. Moreover, they believed (with good reason, given stated Republican aims and the probable impact of the proposed reforms) that the program cap and fail-safe provision would starve traditional Medicare of beneficiaries and providers, who would both have financial incentives to move into managed care plans. Managed care organizations, in turn, would be guaranteed a larger piece of program spending. In short, traditional Medicare would potentially be devastated by the spending cap. Without its omission, broad Democratic support for the legislation simply would not have been forthcoming in 1997. In addition, the spending cuts adopted in 1997 were less than those initially sought by the Republican leadership, making them more palatable to Democratic members of Congress and the President, who viewed the 1995 cuts as unrealistically high. The 1997 BBA was consequently not as ambitious as the 1995 Republican Medicare reform proposals. Still, by embracing Medicare+Choice, Republicans saw the

100. See Charles N. Kahn III & Hanns Kuttner, *Budget Bills and Medicare Policy: The Politics of the BBA*, HEALTH AFF., Jan./Feb. 1999, at 37, 43 ("[C]onsensus characterized the 1997 BBA as much as conflict had the 1995 BBA.").

101. Jerry Gray, *The Budget Deal: The Overview*, N.Y. TIMES, Aug. 1, 1997, at A22.

102. Kahn & Kuttner, *supra* note 100, at 37.

BBA as "moving the ball a great deal down the field towards their goal of a competitive Medicare market."¹⁰³

Second, as the electoral glare of 1996 receded, the extent to which President Clinton and the Republican Congress shared common ground on crucial elements of health reform became clear. The President's opposition to the 1995 legislation focused on the size of spending cuts, not the proposed structural changes in Medicare insurance that opened the program up to private insurers. The Republican Medicare proposals ironically followed an approach similar to the managed competition blueprint for health care reform that the Clinton health plan proposed. Managed competition seeks to control health care costs by having patients pay the costs of choosing more expensive health plans that compete in a regulated private market. In the end, President Clinton was hard-pressed to oppose a plan for Medicare reform that reflected his own preferred model of health care reform. And, as managed care arrangements advanced in the private sector and appeared to outperform Medicare, a growing number of congressional Democrats supported the goal of expanding managed care in the program as a remedy to the program's financing problems and benefit limitations.¹⁰⁴ The fact that the 1997 reforms retained the commitment to a Fee-for-Services (FFS) option made it easier for the Clinton Administration and liberal Democrats in Congress to support this version of competition.¹⁰⁵ This option meant that beneficiaries would not suffer undue pressures, including financial penalties, for staying in traditional Medicare rather than enrolling in managed care.

Crucially, the 1997 reforms represented something of a legislative wishing well: different interests and political factions saw in the legislation what they wanted to see. But, their visions were quite different. For Republicans, conservative Democrats, and the managed care industry, the 1997 Medicare reforms represented an important move toward transforming Medicare into a competitive market—a managed competition system that embraced managed care. Some liberals saw it differently. For example, Pete Stark, who was a key Democratic figure on Medicare policy, predicted that the legislative provisions intended to accelerate managed care and introduce competition into Medicare

103. Telephone Interview with Charles Kahn, former Staff Director, House Comm. on Ways and Means; President, Health Association of America (Feb. 13, 2002) [hereinafter Kahn Interview].

104. Telephone Interview with Bill Vaughan, former Staffmember, House Comm. on Ways and Means (Feb. 11, 2002) [hereinafter Vaughan Interview].

105. Telephone Interview with Chris Jennings, former Deputy Assistant to President Clinton, Health Care Policy (Feb. 29, 2002).

"wouldn't amount to a hill of beans."¹⁰⁶ Stark and other Democrats were therefore willing to vote for legislation that they did not believe would work as Republicans intended. The BBA thus had broad political appeal because its impact was sufficiently uncertain to ensure that multiple and even conflicting political interests could find it acceptable.

Third, and perhaps most critically, deficit pressures continued to shape Medicare politics. President Clinton's acquiescence in adopting a balanced budget was a major turning point. While the President regarded the proposed Republican cuts as excessive, Medicare spending reductions were still essential to balancing the budget. The President and congressional Democrats may have had a different vision than Republicans on how to end the federal deficit, but reducing Medicare spending remained crucial to that vision.

Fourth, by avoiding the block granting of Medicaid, the 1997 BBA omitted any proposals to limit federal contributions to health insurance for the poor. The 1995 Medicare reform bill had also targeted Medicaid, and the President strongly opposed Republican efforts to block grant the program and loosen government regulations on nursing homes. Immediately after his 1996 re-election, President Clinton was politically stronger than at any point since 1993, and congressional Republicans were forced to compromise with him on the legislation.

Finally, without the controversies over spending cuts and the budgetary cap, it was difficult to oppose the rhetorical appeal of the 1997 reforms. After all, the legislation's managed competition-like provisions proposed to offer Medicare beneficiaries more choice while at the same time generating budgetary savings and more competition among insurers. The reforms thus combined the assurance of fiscal control with the symbolism of individual empowerment and market efficiency, a powerful appeal in the confines of American political culture that legislators commonly find difficult to resist.

In short, the 1997 BBA represented at least a temporary reinstatement of political consensus in Medicare. It also offered a programmatic direction for Medicare that promised a radical departure from the old program consensus. The 1997 legislation appeared to mark both the unraveling of Medicare as single-payor insurance and the transformation of Medicare from a health insurance *program* into a health insurance *market*. This change was a profound one in Medicare's operations. Writing about the significance of the 1997 reforms, health policy analyst Lynn Etheredge declared the transformation of Medicare into a "consumer-choice" model similar to the Federal Employees Health Benefits Program (long a favorite of managed competition advocates), a

106. Vaughan Interview, *supra* note 104.

"watershed" in federal health policy that "ratified the Market Paradigm as National Policy."¹⁰⁷ Etheredge summarized the conventional wisdom among many supporters of the legislation:

The Medicare legislation brings the nation's largest purchaser of health care into the new mainstream of managed care plans and competitive markets. Through a national political process it ratifies market-oriented approaches as the new national health policy for dealing with health care costs. This was a political recognition of just how well the market-oriented approach has been working.¹⁰⁸

By opening Medicare up to a host of new private insurance options, the BBA had the potential to fundamentally alter Medicare's character as a public, federally-operated insurance program. Public Medicare was now to take its place among dozens of private plans competing for beneficiaries in a new Medicare insurance market.¹⁰⁹ Over time, experts expected a substantial number of program beneficiaries to leave traditional Medicare and enroll in managed care organizations and other private plans offered under Medicare+Choice.¹¹⁰ The Congressional Budget Office (CBO) forecasted that by 2002, the BBA would result in 27% of all Medicare beneficiaries being enrolled in managed care plans, a number projected to increase to 35% by 2005.¹¹¹ Beneficiary movement out of traditional Medicare was to be facilitated by: (1) the annual coordinated open-enrollment period; (2) raising payments to managed care plans in rural counties that had little success in attracting Medicare beneficiaries; (3) reducing geographic variation in payments; and (4) loosening some regulations on health plans.¹¹² If the legislation worked as planned, then the philosophy underlying Medicare as well as program operations would be transformed. Medicare would shift from a single-payor government insurance program to a federal subsidy program for private insurance. Over time, many expected that the majority of beneficiaries would no longer enroll in public Medicare.

107. See Etheredge, *supra* note 98, at 574–76 (describing fundamental changes in Medicare program stemming from 1997 Medicare reform legislation).

108. *Id.* at 576.

109. See *id.* at 575 (discussing new health insurance market created by 1997 Medicare reform legislation).

110. See CONG. BUDGET OFFICE, *supra* note 94, at 28 (describing Congressional Budget Office projections regarding increase in Medicare+Choice plan enrollment by Medicare beneficiaries).

111. See *id.* (estimating percentage of all Medicare beneficiaries that will be enrolled in capitated plans of Medicare+Choice by 2002 and thereafter).

112. CONG. RESEARCH SERV., MEDICARE PROVISIONS IN THE BALANCED BUDGET ACT OF 1997.

This vision of Medicare strongly resembled what opponents of Medicare had proposed in 1965, a plan in which the role of government would be to subsidize beneficiary purchases of private insurance, rather than to operate a government insurance plan. Medicare had, in essence, returned full circle to the original debate over its enactment, but with a realignment of political forces that favored market advocates. The features of the new Medicare market as envisioned by the BBA, with competing private insurance plans, a regulated marketplace, and an organized shopping period for enrollees, embodied the principles of managed competition that economist Alain Enthoven had first articulated.¹¹³ Yet, while managed competition had a strong impact on Medicare, in one crucial respect the Medicare reforms diverged from traditional managed competition. Consequently, the ascendance of a new program consensus did not completely supplant the old Medicare consensus.

The 1997 BBA did not legislate what the Republican leadership had originally wanted: to convert Medicare into a defined-contribution system. Under such a system, the federal government would give Medicare enrollees a fixed dollar amount to choose a health plan; if they chose a plan that cost more than the value of the government voucher, they would have to pay the difference themselves. A defined-contribution, or voucher, is a core element of managed competition because, according to the theory, it generates savings, allows budgetary certainty, promotes innovation, and creates incentives for people to choose low-cost (and presumably more efficient) health plans.¹¹⁴ In the case of Medicare, managed competition advocates anticipated that the impact of a defined-contribution incentive would be to hasten the departure of enrollees from public Medicare to lower-cost managed care plans.¹¹⁵

By the mid-1990s, in addition to a wide range of health policy makers and analysts, the Congressional Budget Office and the American Medical Association endorsed the introduction of a defined-contribution system into Medicare.¹¹⁶ The idea enjoyed considerable support among Republican

113. See generally ALAIN ENTHOVEN, HEALTH PLAN: THE ONLY PRACTICAL SOLUTION TO THE SOARING COST OF MEDICAL CARE (1980).

114. *Id.*

115. Kahn Interview, *supra* note 103.

116. See, e.g., CONG. BUDGET OFFICE, REDUCING THE DEFICIT: SPENDING AND REVENUE OPTIONS 423 (1996) (advocating conversion of entire Medicare program to defined-contribution system as means of reducing spending on program); Henry J. Aaron & Robert D. Reischauer, *The Medicare Reform Debate: What is the Next Step?*, HEALTH AFF., Winter 1995, at 8, 20–22 (calling for conversion of Medicare system from "service reimbursement system" to "premium support system," whereby "Medicare would pay a defined sum toward the purchase of an insurance policy that provided a defined set of services"); Stuart M. Butler & Robert E. Moffitt, *The FEHBP as a Model for a New Medicare Program*, HEALTH AFF., Winter 1995, at 47, 51–59

congressional majorities and some Democratic conservatives. But, the political stigma of "voucherizing" Medicare was still sufficiently strong in 1997 that sponsors left defined-contributions out of the reform package. The omission had two key consequences. The first was that it lessened the financial pressure on beneficiaries to leave public Medicare.¹¹⁷ This decrease in financial pressure ensured the continuation of large enrollments in the public sector of the program during the short-term, meaning that traditional Medicare would remain predominant in the new Medicare market. The second consequence was that, without defined-contributions, the BBA lacked the key cost control mechanism of managed competition. Even though the BBA contained much of the essential managed competition infrastructure, without imposing defined-contributions and cost consciousness on Medicare beneficiaries, the competitive dynamics of the system were not fully realized.

Yet, as noted above, the BBA mandated substantial cuts in the rate of growth in Medicare spending over the next decade.¹¹⁸ From where, in the absence of a competitive dynamic, would the projected savings come? This question was the ultimate paradox of the 1997 legislation: while the BBA represented a historic milestone in introducing managed competition to Medicare, it simultaneously continued the recent process of moving Medicare closer to the single-payor model. The 1997 legislation substantially increased the scope of Medicare subject to prospective budgeting by reining in payments for home health care and skilled nursing facilities.¹¹⁹ With the addition of these two sectors of prospective payment, public Medicare came closer than ever to having a global budget by default. The legislation also linked the growth in payments for physician services to changes in the gross domestic product, a potentially stronger brake on program expenditures that resembled cost control instruments used in other industrial democracies.

While reducing payments to providers under previously established regulations, these new regulatory reforms generated savings in program spending, but they did not do so as a result of any procompetitive elements of the legislation.¹²⁰ In this sense, the BBA's enactment resembled the enactment

(suggesting that legislators could remedy many problems with Medicare in its current form by transforming program into defined-contribution system).

117. See Kahn Interview, *supra* note 103 (explaining that inclusion of defined-contribution element would cause many to view Medicare as more expensive than managed care insurance plans).

118. See *supra* notes 94–97 and accompanying text (describing Balanced Budget Act of 1997).

119. See *supra* notes 94–112 and accompanying text (describing policy changes in Balanced Budget Act of 1997 and their influence in aiming to make Medicare more efficient).

120. CONG. RESEARCH SERV., *supra* note 112.

of the Prospective Payment System in the 1980s. In 1997, as in 1983, the rhetoric was all about markets and competition. But, the reality was that the savings all came from regulation: once again, Medicare talked "right" but moved "left." The secret of the BBA was that the move to competition was not projected to save Medicare any money. Given budgetary pressures for Medicare savings, Republicans and Democrats once again embraced more regulation and lower payments to providers as the best way to achieve short-term savings.

In the short-term, Medicare consequently assumed a dual personality, moving in two directions at once. It embraced the market while continuing the development of its traditional component into a full-scale single-payor program. The new coalition in Medicare politics was not sufficiently strong to displace the old liberal consensus, so it had to build market arrangements on top of the old regime. Market and regulatory instruments began to share an uneasy co-existence within the program. Consequently, the future shape of Medicare as a public program was by no means clear. Would the program's original status as government-operated social insurance endure, or would Medicare transform into a full-fledged market of private insurers?

V. The Politics of Prescription Drug Coverage, 2000–2003

The debate over Medicare's future entered electoral politics in 2000, commanding more attention in a presidential election than at any time since 1964. In a contest between incumbent Democratic Vice-President Al Gore and Republican Texas Governor George W. Bush that lacked (until election night) both excitement and compelling candidates, Medicare emerged as a first-order issue. As the 2000 campaign season got underway, the fiscal environment of Medicare had fundamentally changed and with it, Medicare's place in American politics had also changed. In 1998, for the first time in three decades, the CBO announced a federal budget surplus,¹²¹ forecasting a surplus of \$131 billion for 2000 and \$381 billion by 2009.¹²² The surplus arrived as a result of the unprecedented period of economic growth in the late 1990s that filled federal tax coffers and also as a result of the budgetary policies pursued by President Clinton and Congress. It also heralded a new (albeit very short-lived) era in Medicare politics, in which the deficit pressures and the zero-sum

121. See CONG. BUDGET OFFICE, LONG-TERM BUDGETARY PRESSURES AND POLICY OPTIONS, at xv–xvii (1998) (discussing projected federal budgetary surplus).

122. CONG. BUDGET OFFICE, THE ECONOMIC AND BUDGET OUTLOOK: FISCAL YEARS 2000–2009, at 33 tbl.2-1 (1999).

politics of the 1980s and 1990s gave way to the friendlier and costlier dynamics of surplus politics. The trust fund outlook for Medicare was also improving. In 1996, Medicare's Hospitalization Insurance trust fund was predicted to go insolvent in 2001.¹²³ By 2000, its estimated date of insolvency had been pushed back to 2023, the best fiscal situation in which Medicare had been since 1974.¹²⁴ The improved finances of the program were due to surging revenues from the growing economy and the greater than anticipated successes of the 1997 regulatory reforms in slowing down Medicare spending. In 1998, Medicare spending grew by only 1.5% and in 1999 it actually declined for the first time in program history. The idea that Medicare faced a trust fund crisis, which had driven program politics since 1995, started to seem far-fetched and far off in the future.

Two of the most important pressures for fiscal restraint in Medicare, federal deficits and trust fund shortfalls, were not evident in 2000. As a consequence, the politics of Medicare in that year's election revolved around something that had rarely happened in the program's history: a bidding war to expand benefits. The potential benefit that became the subject of Al Gore and George W. Bush's attention was prescription drug coverage. Surplus politics made the rise of prescription drug coverage possible as an issue in Medicare politics, but that was not its only impetus. The long-standing gap between Medicare's lack of outpatient coverage and the standard of coverage in the private sector was growing. Medicare HMOs, an important source of drug coverage for about 15% of program beneficiaries, were increasingly adopting tight restrictions on such coverage, for instance, by instituting low ceilings on the maximum amount that could be covered, or by dropping drug coverage altogether.¹²⁵ Similarly, Medigap and supplemental insurance plans that covered prescription drugs were raising premiums to levels many beneficiaries could no longer afford. Employer-sponsored drug coverage for seniors promised to follow a similar trajectory. The erosion of prescription drug coverage for seniors was largely due to an explosion in drug costs. Though small as a percentage of overall health care spending in the U.S., spending on prescription medications rose by 15% from 1997 to 1998, making pharmaceuticals one of the fastest growing components of national health

123. See Robert Pear, *Outlook Better for Social Security and Medicare*, N.Y. TIMES, Mar. 31, 2000, at A18 ("The Medicare fund has gained 22 years of life since 1996, when the administration predicted that it would run out of money in 2001.").

124. See *id.* (quoting Health and Human Services Secretary Donna E. Shalala as saying that Medicare trust fund would not be depleted until 2023).

125. See Gold, *supra* note 1, at W3-176-80 (noting decline in range of coverage and attractiveness of Medicare HMO plans, including reduction in service areas like drug coverage).

spending.¹²⁶ The increasing costs made Medicare's omission of coverage for outpatient medications all the more glaring.

Beyond the financial pressures underlying the widening gap between Medicare and the private standard, the medical implications of that gap seemed to grow as well, with the promise of a new generation of drugs, reinforced by an avalanche of advertisements and celebratory media stories about the latest medical discoveries that made access to these "miracle" drugs seem like a basic human right. The promised benefits of drugs soon to be generated by research on the genome only upped the ante, as some observers boldly, and undoubtedly precipitously, imagined sizable gains in average life expectancy and even "life without disease."¹²⁷ William Schwartz, a prominent health policy analyst and physician, declared the U.S. on the threshold of a "medical utopia," arguing that:

[O]ur exploding knowledge of the genetic mechanisms of disease begins to make plausible the once impossible dream of a largely disease-free existence . . . the possibility of a broad-based victory over disease and a dramatic increase in the human lifespan in the not too remote future must now be taken seriously.¹²⁸

Thus, the prospects of a genetic revolution on the horizon made it imperative to extend drug coverage to Medicare. The data was overwhelming: in 1996, 80% of seniors took medications and seniors filled an average of twenty prescriptions per year. In a 2000 survey by the Kaiser Family Foundation, 76% of the public supported "guaranteeing prescription drug coverage to everyone on Medicare, even if it means more government spending to pay for it."¹²⁹ Modernizing Medicare had begun to entail benefit expansion as an integral part of program restructuring.

By 2000, Medicare's promise to bring the elderly into mainstream medicine appeared to require adding a drug benefit to the program. What form the benefit would take was an entirely different matter. While both presidential candidates had joined the "expand Medicare benefits" bandwagon—Bush more reluctantly than Gore—they offered contrasting plans. Gore proposed a drug

126. KAISER FAMILY FOUNDATION, *PRESCRIPTION DRUG TRENDS: A CHART BOOK 2* (2000) (describing dramatic increase in spending on prescription drugs as component of total personal health care spending during period from 1990 to 2000).

127. See WILLIAM B. SCHWARTZ, M.D., *LIFE WITHOUT DISEASE: THE PURSUIT OF MEDICAL UTOPIA I* (1998) (hypothesizing that medical breakthroughs may eventually lead to disease-free existence for humans).

128. *Id.*

129. THE NEWSHOUR WITH JIM LEHRER & KAISER FAMILY FOUNDATION, *NATIONAL SURVEY ON PRESCRIPTION DRUGS 4* (2000).

benefit (resembling a plan that the Clinton Administration had proposed earlier in 2000) that was voluntary, universally available to all Medicare beneficiaries, and would add coverage to the traditional Medicare program, all at an estimated cost of \$338 billion over ten years.¹³⁰ Early in the campaign, Bush had suffered politically because he lacked a prescription drug proposal. Thus, he eventually countered with a plan that would initially provide block grants to the states to assist low-income Medicare beneficiaries with drug costs and enrollees with "catastrophic" costs that totaled more than \$6,000 annually; in subsequent years, coverage would become available through private insurers participating in Medicare, all at an estimated cost of \$158 billion over ten years.¹³¹ The cost difference was due to the fact that the benefits in the Bush plan were not as generous and the eligibility not as comprehensive as that envisioned in the Gore plan. But in reality, the insurance protection offered by both plans was likely to disappoint seniors because it left beneficiaries responsible for considerable costs and paled in comparison to standard benefits in the employer-sponsored market. In addition, candidate Bush tied his prescription drug plan to a commitment to comprehensively reform Medicare along the lines recommended by the 1999 Bipartisan Commission, which had endorsed a version of managed competition known as "premium support."¹³² Gore alternatively proposed to strengthen Medicare's trust fund by devoting a share of the federal budget surplus to a much discussed "lockbox."

Once again the philosophical divide over Medicare's direction was exposed. Gore's proposal harkened back to Medicare's roots, with a commitment to universalism, government-provided benefits, and social insurance. Significantly, however, the Gore proposal called for voluntary enrollment rather than the mandatory enrollment conventionally associated with social insurance arrangements.¹³³ From a strictly policy perspective, the logic of insurance pools and adverse selection suggested that mandatory enrollment for a prescription drug benefit was a sensible course. The political logic,

130. See KAISER FAMILY FOUNDATION, HEALTH ISSUES IN THE 2000 PRESIDENTIAL ELECTION 9 (OCT. 2, 2000) (describing Al Gore's prescription drug plan during 2000 presidential election), available at <http://search.kaiserfamilyfoundation.org/kffpubs/index.html?qk=a>.

131. See *id.* (describing George W. Bush's prescription drug plan during 2000 presidential election).

132. See NATIONAL BIPARTISAN COMMISSION ON THE FUTURE OF MEDICARE, FINAL BREAUX-THOMAS MEDICARE REFORM PROPOSAL: BUILDING A BETTER MEDICARE FOR TODAY AND TOMORROW, at <http://medicare.commission.gov/medicare/bbmtt31599.html> (March 16, 1999) (describing premium support system to provide comprehensive coverage) (on file with the Washington and Lee Law Review).

133. See KAISER FAMILY FOUNDATION, *supra* note 130, at 7 (noting that Gore proposal for Medicare reform would add voluntary drug benefit).

however, argued for voluntarism due to the fact that roughly two-thirds of seniors already had some form of drug coverage and because of the potential stigma of a "coercive" government plan. Thus, Gore chose the more convenient route of modified universalism. In contrast, the Bush plan relied on market forces and the private sector for benefit expansion, rejecting the notion that the federal government should directly provide the benefit through public Medicare.¹³⁴

Prescription drug coverage thus became another front in the war over the future of Medicare between the old Medicare consensus and the new vision of a Medicare market. The current debate over Medicare prescription drug coverage is not really about prescription drugs. Rather, at stake in this debate is what kind of program Medicare will be and what kind of public philosophy will guide its future.

VI. Conclusion

In sum, 1995 marked the end of the liberal consensus that had governed Medicare politics since 1965. The ensuing debate over the transformation of Medicare from a public, single-payor program into one increasingly comprised of private insurance plans is filled with historical significance. In particular, it appears that the losing option in 1965—subsidizing the elderly to purchase private health insurance—has re-emerged three decades later as a critical influence on program policy. As the 2003 debate over Medicare prescription drug coverage legislation makes clear, the Medicare debate of four decades ago, with its polarizing politics and intense ideological cleavages, has indeed reopened in American politics. But in the context of a changed health care system and political environment, the tide of the debate over the appropriate federal role in health insurance for the elderly has now turned toward proponents of the market. As the 1997 BBA and troubles in the Medicare+Choice program signified, however, it is unclear how far market proponents can push their agenda and how successful it will be. There will be no easy resolution to this conflict. After nearly four decades of operation, Medicare politics is back where it started.

134. See *id.* at 9 (explaining that Bush plan would allow choice between Medicare-approved private health plan and government-sponsored plan).

ADDENDUM

The enactment of Medicare prescription drug legislation in November 2003 was a milestone in Medicare politics. Medicare's political history has long been a contest between two competing visions:¹ the liberal vision of Medicare as a single-payor social insurance program operated by the federal government, and the conservative vision of Medicare as a competitive market in which the federal government subsidizes beneficiaries to purchase private insurance. At Medicare's enactment in 1965, in the context of the Great Society and wide Democratic congressional majorities, the liberal vision prevailed. And, during the program's first three decades, a de facto consensus governed Medicare largely according to these liberal programmatic properties and principles.

What is so striking about the 2003 Medicare prescription drug legislation is that it is, in crucial respects, a political reversal from 1965 and from the main principles historically associated with Medicare. The new drug benefit will be offered through private insurers, rather than as part of traditional Medicare, and the legislation promotes the enrollment of Medicare beneficiaries in private managed care plans.² It also allows benefits and premiums to vary across the country by insurer, rather than guaranteeing a single level of coverage for the entire nation. In 2010, a demonstration project in "premium support" will be launched—potentially involving as many as six metropolitan areas—that will introduce managed competition into the program. Finally, the law requires that, for the first time, higher-income beneficiaries must pay higher premiums for Medicare coverage.

All of this is, at least at first glance, a spectacular political victory for the Bush Administration (as well as for the pharmaceutical industry, which escaped price controls and re-importation). The legislation achieved more in terms of reforming Medicare in a conservative direction than I believed possible given

1. See generally JONATHAN OBERLANDER, *THE POLITICAL LIFE OF MEDICARE* (2003) (discussing history of political conflict over Medicare).

2. For a good analysis of the details of the Medicare bill, see Jeanne Lambrew, *Lost in the Fine Print: Ten Overlooked Policies that Harm Medicare and its Beneficiaries*, Center for American Progress [hereinafter Lambrew, *Lost in Print*], at [http://www.americanprogress.org/site/pp.asp?c=biJRJ8\)VF&b=13275](http://www.americanprogress.org/site/pp.asp?c=biJRJ8)VF&b=13275) (Dec. 4, 2003) (on file with the Washington and Lee Law Review) and Jeanne Lambrew, *Medicare Legislation: Think Twice*, Center for American Progress [hereinafter Lambrew, *Think Twice*], at http://www.americanprogress.org/site/pp.asp?cid={E9245FE4-9A2B-43C7-A521-5D6FF2E06E03}&bin_id={45E5F769-11E2-4D4C-8CA0-B954FD9247CC} (Nov. 14, 2003) (on file with the Washington and Lee Law Review).

the slim Republican majorities in Congress. At the outset, President Bush sought to link adoption of a prescription drug benefit to broader changes in Medicare. While his initial efforts to do so floundered, ultimately this linkage was largely achieved. To be sure, conservatives did not get the full-fledged transformation of Medicare into a premium support system that House Republicans supported. The Administration also made key concessions: Program beneficiaries can stay in traditional Medicare and obtain the full drug benefit, and the benefit will be available to all Medicare enrollees.

But the legislation contains several important provisions that promote private insurance, managed care, and ultimately, privatization. As previously noted, the benefit itself will be delivered by private insurers, either through plans that offer only prescription drug coverage or as part of Medicare coverage by managed care plans. Moreover, the federal government will be legally prohibited from directly negotiating with pharmaceutical companies over prices, a provision that will ensure the maintenance of drug company profit margins, at a high cost to Medicare.

Perhaps most crucially, the bill creates a \$10 billion fund to encourage the participation of private plans in Medicare and that changes the program's payment formula for private plans in a way that will substantially boost payments.³ This latter change, buried in the technical minutiae of the 678-page bill, could have a profound impact on the program by enabling Medicare HMOs to offer very generous drug benefits. After the new payment methodology goes into effect, HMOs will be paid an estimated 25% more than it would cost the traditional Medicare program to serve the same beneficiaries.⁴ This means that Medicare beneficiaries will have to join HMOs to obtain comprehensive drug coverage (the law prohibits beneficiaries from purchasing separate Medigap plans to fill in the holes in the benefit). Over time, that inducement could hasten the departure of Medicare beneficiaries from the traditional program, as they join private insurance plans that can, thanks to increasing federal subsidies, offer them a better deal as a result of federal overpayments. In the name of competition, Medicare in coming years will have to compete in a one-sided system that favors private insurers.

Nevertheless, the final impact of the 2003 Medicare legislation, both in political and policy terms, is far from clear. The experience with Medicare+Choice, which also promised to move Medicare towards the market and private insurance, but failed in practice to reach those goals, provides a

3. See Lambrew, *Lost in Print*, *supra* note 2 (describing \$10 billion "stabilization fund" to promote potentially costly regional and national private plans).

4. See *id.* (estimating that costs will be 25% higher under HMOs by 2006).

cautionary lesson about the limits of anticipating the performance of market-based health reforms. Such reforms are highly dependent on how private institutions and individuals respond to government incentives, and there is no assurance that these responses will take the predicted form. Much about the Medicare drug legislation is uncertain, as journalist Robert Pear notes:

Will elderly people sign up for the new drug benefit? Can insurers secure big discounts in negotiations with drug manufacturers? Will increased federal payments lure private health plans into the Medicare market? Will competition among health plans save money for Medicare? Or will private plans cost more than traditional Medicare? Will employers scale back health benefits for retirees, knowing they can get a basic drug benefit from Medicare?⁵

In addition, it is not clear what, if anything, will become of the planned demonstration in premium support.

Perhaps the most crucial—and least predictable—variable is the political sustainability of this legislation. The new Medicare drug plan is not (with the notable exception of lower-income beneficiaries, who receive more generous coverage) a very good benefit. The plan has a confusing structure and more limited coverage than what younger Americans are accustomed to receiving from their employers or what older Americans want and expect from Medicare. The much-discussed "donut hole" means that Medicare beneficiaries have no coverage in between \$2,250 and \$3,600 of spending on prescription drugs (a budgetary savings gimmick to keep the program within its projected ten-year, \$400 billion price tag). In addition, Medicare beneficiaries must pay 25% of drug costs (after a \$420 annual premium) before they reach the \$2,250 threshold.

How seniors react to the benefit once it goes into full effect in 2006—beneficiaries will be offered a prescription drug discount card in the interim, beginning in 2004—is the great unknown. It is possible that displeasure with the benefit will lead to a political revolt among the elderly against the legislation, such as occurred during the catastrophic health insurance debacle of 1989. And while the AARP's endorsement of the bill may have enabled its enactment by giving cover to members of Congress, it is worth recalling that the AARP also endorsed the catastrophic health insurance bill that was later repealed. At the same time, the voluntary nature of the 2003 benefit may deter a political backlash. Even if full-scale repeal of the 2003 bill is unlikely, there

5. Robert Pear, *Medicare Law's Costs and Benefits are Elusive*, N.Y. TIMES, Dec. 9, 2003, at A1.

are likely to be mounting political pressures to expand the benefit to fill in its coverage gaps.

All of this volatility will play out against the polarized background of Medicare politics. That polarization was evident in the heated rhetoric over the Medicare drug law and in the close votes in Congress, with the legislation passing 54–44 in the Senate and 220–215 in a dramatic vote in the House of Representatives that was held open after Democrats initially appeared to have enough votes to defeat the legislation; it was the longest recorded roll call vote in House history.⁶ The ideological and partisan divisions over the Medicare drug benefit can be expected to carry over into battles over Medicare reform in the coming years. For the moment, President Bush and the Republican Party have succeeded in weakening the Democrats' political advantage on Medicare, a key political goal akin to President Clinton's signing of welfare reform. But Democrats will not surrender Medicare so easily, and in 2004 and beyond they will try to counteract Republicans' taking credit for expanding the program by catalyzing opposition to the legislation.

The politics of Medicare reform are thus far from over. The prescription drug legislation has not conclusively settled the battle over Medicare's philosophy and program structure. With the baby boomers on the horizon, over the next two decades partisan divisions will intensify and the stakes will grow higher. A change in the definition of Medicare's fiscal solvency that was attached to the Medicare drug legislation, triggering action if general revenues comprise more than 45% of program spending,⁷ also promises to move up the date of political reckoning.

6. See David Broder, *Time Was GOP's Ally On the Vote*, WASH. POST, Nov. 23, 2003, at A1 (discussing House passage of Medicare bill).

7. See Lambrew, *Think Twice*, *supra* note 2 (criticizing "cost containment" provisions that put off "hard decisions about Medicare's cost and financing to the next generation of policymakers").