A Political History of Medicare and Prescription Drug Coverage

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This article examines the history of efforts to add prescription drug coverage to the Medicare program. It identifies several important patterns in policymaking over four decades. First, prescription drug coverage has usually been tied to the fate of broader proposals for Medicare reform. Second, action has been hampered by divided government, federal budget deficits, and ideological conflict between those seeking to expand the traditional Medicare program and those preferring a greater role for private health care companies. Third, the provisions of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 reflect earlier missed opportunities. Policymakers concluded from past episodes that participation in the new program should be voluntary, with Medicare beneficiaries and taxpayers sharing the costs. They ignored lessons from past episodes, however, about the need to match expanded benefits with adequate mechanisms for cost containment. Based on several new circumstances in 2003, the article demonstrates why there was a historic opportunity to add a Medicare prescription drug benefit and identify challenges to implementing an effective policy.

On December 8, 2003, President George W. Bush (R) signed the Medicare Prescription Drug, Improvement, and Modernization Act (P.L. 108–173), which authorizes Medicare coverage of outpatient prescription drugs as well as a host of other changes to the program. The new drug assistance represents a major new

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federal entitlement for Medicare beneficiaries, who now spend an average of $2,322 per year on prescription drugs (Kaiser Family Foundation 2003c). The drug assistance and other provisions of the new law are projected to cost taxpayers at least $395 billion, and possibly as much as $534 billion, over the next decade (CBO 2004a, 13; CBO 2004b; Pear 2004a). Senate Majority Leader Bill Frist (R-Tenn.), one of the initiative's chief negotiators and political investors, hailed its passage: "Today is a historic day and a momentous day. Seniors have waited 38 years for this prescription drug benefit to be added to the Medicare program. Today they are just moments away from the drug coverage they desperately need and deserve" (Pear and Hulse 2003).

In fact, for many Medicare beneficiaries, the benefits of the new law are not so immediate or valuable. By mid-2004, the federal government will authorize cards that can be used to obtain price discounts on prescription drug purchases and will offer a $600 credit to about 4.7 million low-income beneficiaries. In 2006 the full-fledged program is scheduled to begin. At that time, more than 40 million beneficiaries will have the following options: (1) they may keep any private prescription drug coverage they currently have; (2) they may enroll in a new, free-standing prescription drug plan; or (3) they may obtain drug coverage by enrolling in a Medicare managed care plan. Medicare will subsidize the cost of coverage for about 14 million low-income beneficiaries. Other beneficiaries will face significant gaps in coverage and, as a result, will still be liable for up to $3,600 or more in annual expenses.

In the wake of this political breakthrough, public opinion on the final product was remarkably negative:

> After years of fierce campaigning, lobbying, and legislating over the issue, a landmark agreement finally emerged in Congress this week to provide Medicare prescription drug benefits. Among the key stakeholders in the legislation, there were definite winners and losers. But the group that should have come out on top—America's seniors—was reeling and confused at the prospect of limited help, while watching industry groups count their booty. In fact, members of Congress from both parties contended that some seniors struggling to pay for prescription drugs may actually end up worse off than they are now. (Serafini 2003)

In a poll taken in the week that President Bush signed the new Medicare law, 47 percent of senior citizens opposed the changes, and only 26 percent voiced their approval. Among people of all ages who

said they were closely following the Medicare debate, 56 percent said they disapproved of the legislation, and 39 percent supported it (ABC News/*Washington Post* Poll 2003). Their disappointment reflected high expectations as well as the upside-down politics that produced the new reforms:

> Even before Bush's ink on the bill was dry, the two political parties prepared to make the issue a focus of the 2004 elections. Bush, who defied conservatives in the Republican Party by backing a massive increase in a federal program long championed by Democrats, heralded the act as a strengthening of "compassionate government." And Democrats, calling the legislation inadequate and harmful to many seniors, drafted substantially more generous prescription drug coverage and vowed to "take back our Medicare." (Milbank and Deane 2003)

When observers look back at 2003, they will wonder why it took 38 years to authorize Medicare coverage for such a critical component of modern medicine. Why did political leaders finally agree to address this gap in coverage at this time, and why was that agreement so fraught with controversy? Why did the new outpatient drug benefits under Medicare take the form they did? What issues remain for policymakers to confront in the future? This article attempts to answer each of these questions, as well as to provide a concise history and analysis of the role of prescription drugs in the evolution of Medicare policy. Our intent is to clarify both the contemporary debate over ways to "modernize" Medicare and the factors leading to or inhibiting changes in the program.

First, we review the key episodes related to Medicare and prescription drug coverage. We begin by examining the omission of outpatient prescription drugs from the initial package of Medicare benefits. This incomplete package prompted the development of other sources of coverage—employer retirement programs, privately purchased supplemental benefits ("Medigap"), Medicaid, and managed care plans—which generally deterred subsequent efforts to add prescription drugs to Medicare. We recount the subsequent history of initiatives to introduce Medicare prescription drug benefits, including administrative actions by the Johnson and Nixon administrations, the enactment and repeal of the 1988 Medicare Catastrophic Coverage Act, President Bill Clinton's proposals for national health care reform, the deliberations of the National Bipartisan Commission on the Future of Medicare, proposals before and after the 2000 presidential election, and the adoption of prescription drug coverage and other reforms in late 2003 (see Table 1).

TABLE 1
Comparison of Prescription Drug Benefits in Major Medicare Reform Proposals, 1988–2003

Proposal	Participation	Monthly Premium	Deductible	Coinsurance	Drug Discount Card	Low-Income Assistance	Administration	Estimated Cost of Drug Benefits
Medicare Catastrophic Coverage Act (enacted as P.L. 100–360 in 1988, repealed in 1989)	Drug benefit added to Medicare Part B	$4 per month added to Part B premium Supplemental premium for high-income beneficiaries	$600	Beneficiary pays 20% over $600, maximum tied to general catastrophic coverage limit			Federal Medicare program and Part B carriers	
Health Security Act (proposed 1993, defeated 1994)	Drug benefit added to Medicare Part B	$11	$250	Beneficiary pays 20% over $250, maximum of $1,000			Federal Medicare program and Part B carriers	
Clinton proposal (1999)	Voluntary enrollment in new Medicare Part D	$24 in 2002, increasing to $44 in 2008	None	Beneficiary pays 50%, maximum of $2,500		Full premiums, deductibles, and coinsurance below 135% of poverty Subsidies for 135% to 150% of poverty	Private regional pharmacy benefit manager selected through competitive bidding	$118 billion over ten years for drug benefits
House Republican Bill (passed in 2002)	Voluntary enrollment in new Medicare Part D	$35 to $40	$250	Beneficiary pays 25% between $250 and $1,000, 50% between $1,000 and $2,000, $100% between $2,000 and $5,000, nothing over $5,000				$350 billion over ten years, including drug benefits

House Democratic proposal (2002)	Voluntary enrollment in new Medicare Part D	$25	$100	Beneficiary pays 20% over $100, maximum of $2,000		Full premiums, deductibles, and coinsurance below 150% of poverty Subsidies for 150% to 175% of poverty	Private pharmacy benefit managers (with federal assistance in price negotiation)	
Bush administration proposal (2003)	Drug benefits included for enrollees in restructured Part C managed care plans	Unspecified	Unspecified	Stop-loss protection for all beneficiaries (estimated at $5,500 or higher)	Yes	Credit of $600 for low-income beneficiaries in discount card program		$400 billion over ten years, including drug benefits
H.R. 1 (passed House in June 2003)	Voluntary enrollment in new Medicare Part D	Estimated $35.50 in 2006 (indexed, estimated at $56 in 2013)	$250 in 2006 (indexed)	Beneficiary pays 20% between $250 and $2,000, maximum of $3,500 Stop-loss higher for income above $60,000 for individuals and $120,000 for couples	Yes	Interim credit for low-income beneficiaries in discount card program Full premiums, deductibles, and coinsurance below 135% of poverty and meeting asset test Sliding scale premiums between 135% and 150% of poverty	Part C managed care plans or private drug plans Private fallback plan with federal financial risk if no qualified coverage available in region	$415 billion over ten years for drug benefits
S. 1 (passed Senate in June 2003)	Voluntary enrollment in new Medicare Part D	Estimated $34 in 2006 (indexed, estimated at $62 in 2013)	$275 in 2006 (indexed)	Beneficiary pays 50% between $275 and $4,500, 10% over $4,500, maximum of $3,700	Yes	Interim credit for low-income beneficiaries in discount card program	Part C managed care plans or private drug plans with government-administered fallback plan if no qualified coverage available in region	$422 billion over ten years for drug benefits

TABLE 1–*Continued*

Proposal	Participation	Monthly Premium	Deductible	Coinsurance	Drug Discount Card	Low-Income Assistance	Administration	Estimated Cost of Drug Benefits
						Full premiums, deductibles, and coinsurance below 135% of poverty Sliding scale premiums between 135% and 160% of poverty		
Medicare Prescription Drug, Improvement, and Modernization Act (enacted in November 2003, signed into law as P.L. 108–173)	Voluntary enrollment in new Medicare Part D Part D enrollees prohibited from buying private supplemental drug coverage Financial penalty for late enrollment	Estimated $35 in 2006 (indexed, estimated at $58 in 2013) Could vary based on enrollee's choice of plan	$250 in 2006 (indexed, estimated at $445 in 2013)	Beneficiary pays 25% between $251 and $2,250, 100% between $2,250 and $5,100, 5% over $5,100, no maximum	Yes	Full premiums, deductibles, and coinsurance below 135% of poverty and meeting asset test Sliding scale premiums and reduced deductible and coinsurance between 135% and 150% of poverty and meeting asset test Beneficiaries must make small copayments for each prescription	Part C managed care plans or private drug plans Private fallback plan with federal financial risk if no qualified coverage available in region	$409 billion over ten years for drug benefits (OMB estimates $534 billion over ten years)

Sources: CBO 2004a and b; Health Policy Alternatives 2003b and c; Health Security 1993; Himelfarb 1995; National Economic Council 1999; Pear 2002.

This history reveals that from the late 1960s to the late 1990s, prescription drug coverage for Medicare beneficiaries was always linked to the fate of other proposals for health care reform and that only at the end of the Clinton administration did the issue take on a life of its own.

In the second part of this article, we draw on theories of the policy process to identify additional patterns in the history of efforts to improve prescription drug coverage in Medicare. Based on the work of John Kingdon (1995), we describe how and why opportunities for policy change arose and explain why there was an extraordinary political window of opportunity in 2003. Our analysis confirms that political and economic forces outside Medicare have as much or more influence on policies as do conditions inside the Medicare program itself. Shifts in control of the presidency and the Congress create or close down opportunities for reform and, in addition, dictate what kinds of Medicare reform are possible. Another important contextual factor is the nearly perennial federal budget deficit, which grew dramatically after President Ronald Reagan's tax cuts in the early 1980s and had a dominant influence on Medicare policies until the short-lived budget surpluses of the late 1990s.

We build on the work of Paul Sabatier and Hank Jenkins-Smith (1993) to explain how ideological conflict over the role of government created nearly insurmountable barriers to Medicare reform over the past decade. The ideological shift in the Republican Party, which was first manifested in the 1970s and became more dramatic after the 1994 congressional elections, has transformed much of Medicare policymaking from a deliberative, bipartisan process into a highly polarized, deadlocked debate. Despite the clear opportunity for policy change in 2003, it took all the resources and tactical maneuvering of the president and other Republican leaders, as well as favors for key constituencies, to overcome ideological misgivings and secure political agreement for a complex package of reforms.

Today's problems and policy options are in part "legacies" of earlier decisions and non-decisions. Based on the work of Mark Peterson (1997), we demonstrate how the reform proposals of 2003 reflected not only the primary problems facing beneficiaries today but also the lessons learned from earlier episodes by beneficiaries, interest groups, and government officials. The chief legacies reflected in the design of the new program are that participation is voluntary and that the costs will be shared by the Medicare beneficiaries and taxpayers, rather than borne entirely by the beneficiaries themselves. In addition, policymakers went to great lengths

to ensure that the new prescription drug benefits will be administered principally by private companies and not by the federal government. Since the history of Medicare demonstrates that expansion of the federal regulatory role is nearly inevitable, the pharmaceutical industry has long anticipated similar controls in any Medicare prescription drug program and strongly resisted a benefit that would be centrally administered by the federal government.

Missed Opportunities for a Prescription Drug Benefit

The Enactment of Medicare in 1965

The limited scope of the original Medicare benefits reflects the beating that President Harry Truman (D) took at the hands of the American Medical Association (AMA) after he introduced proposals for national health insurance between 1945 and 1948 and again after his election in 1948. The AMA launched a very well-funded and bitter attack on "socialized medicine" to defeat Truman and his congressional allies even after the Democrats regained control of the House of Representatives and the Senate in 1949 (Marmor 2000, 6–15; Starr 1982, 280–9).

In 1951 the idea of a health insurance program for the elderly was initially proposed by Oscar Ewing, head of the Federal Security Administration. Between 1958 and 1965, the House Ways and Means Committee and the Senate Finance Committee held annual hearings on proposals to offer hospital insurance for the elderly. The hearings provided a battleground for pressure groups with deeply differing ideological views of the role of the federal government in any aspect of medical care (Marmor 2000, 17). When the 1964 election produced a landslide victory for President Lyndon Johnson (D) and the largest Democratic majorities in both houses of Congress since the 1936 election, the enactment of new medical assistance for the aged was no longer in doubt. This major shift in legislative power and President Johnson's activist social policy agenda led to the prompt enactment of Medicare in the spring of 1965.

The main Democratic proposal supported by the Johnson administration, the King-Anderson bill, was intended only to cover many of the costs of hospitalization through a universal social insurance mechanism. The counterproposal offered by Republicans, the Byrnes bill, called for voluntary enrollment in a health insurance program financed by

premiums paid by the beneficiaries and subsidized by general revenues. It had more benefits, including physician services and prescription drugs. In addition, the AMA proposed a state-based, means-tested program of comprehensive benefits to expand the Kerr-Mills program for impoverished seniors first enacted in 1960.

Representative Wilbur Mills (D-Ark.), chairman of the House Ways and Means Committee, made the surprise suggestion that the Democratic and Republican proposals essentially be combined into Title XVIII of the Social Security Act, a new Medicare program with two parts, A (hospital insurance) and B (supplementary medical insurance). President Johnson supported this proposal. As the Ways and Means Committee marked up the combined bill in March 1965 (and also added what would become Medicaid), the outpatient prescription drug benefit for Part B was dropped "on the grounds of unpredictable and potentially high costs" (Marmor 2000, 49).

Thus, despite the overwhelming Democratic majorities in both the House of Representatives and the Senate, as well as nominal Republican support for such a benefit, the first of many opportunities to cover Medicare beneficiaries for the costs of outpatient prescription drugs ended in failure. The Medicaid program, enacted as Title XIX of the Social Security Act, ended up providing far more comprehensive coverage for the indigent elderly, blind, disabled, and families with dependent children. It included outpatient prescription drug coverage as an optional benefit, which all the states elected to offer when they set up their Medicaid programs.

It would be wrong to conclude that an outpatient drug benefit was omitted because the cost of prescription drugs in 1965 was negligible. In fact, prescription drugs accounted for nearly the same proportion of national health spending in the early 1960s (10 percent) as they do today (11 percent), even with the recent rapid increases in prices and utilization (Cowan et al. 1999, 190; Levit et al. 2004, 155). It was hospital costs that were far less predictable and potentially devastating to the individual retiree, and for that reason, they were the priority for the architects of Medicare from the outset. Thus, while outpatient prescription drug coverage was a limited feature of many private health insurance plans, it was never incorporated into the main Democratic proposals during Medicare's long gestation.

From the outset, Medicare did cover those prescription drugs that were dispensed in the physician's office and not self-administered by

the patient. This limited benefit was designed to keep physicians from hospitalizing a patient just for a needed drug. The expansion of Medicare coverage to patients with end-stage renal disease in 1972 led to high costs associated with the erythropoetin used to treat the anemia common in these patients. Later, more drugs that could be administered in a physician's office were added, including immunosuppressive drugs to treat cancer and to prevent the rejection of transplanted organs. In the 1990s Congress authorized coverage for orally administered drugs for cancer (MedPac 2003). Members of Congress routinely added amendments mandating Medicare coverage for specific drugs on behalf of pharmaceutical, medical device, and biotechnology companies in their districts (Pear 1999). By 2001, Medicare covered approximately 454 physician-dispensed prescription drugs at a cost of $6.5 billion per year, up from just $700 million in 1992 (Dummit 2002).

The explosive growth in the costs of these drugs caught the attention of policymakers. The inspector general of the U.S. Department of Health and Human Services (HHS) found that Medicare paid between two and ten times more than the price advertised to doctors by drug companies (U.S. DHHS 2001c). As Thomas Scully, administrator of the Centers for Medicare & Medicaid Services, testified, "It is clear that Medicare's payment system for those covered drugs, based on average wholesale price, is seriously flawed" (Scully 2002). Congress gave Medicare statutory authority to set payments based on "inherent reasonableness" in 1997 but then, presumably in response to pressure from the pharmaceutical industry and physicians, suspended regulatory development in 1999. When it came time to add outpatient prescription drug benefits to Medicare in 2003, however, Congress instituted new payment methods for physician-administered drugs even while it assiduously avoided price controls for the broader benefit package.

The Task Force on Prescription Drugs

Soon after Medicare was implemented, unexpected increases in the program's spending on hospital and physician services drew the attention of officials in the U.S. Department of Health, Education and Welfare (HEW; later renamed Health and Human Services) and the White House. The particular policies that contributed to the early and rapid rise of Medicare expenditures were the cost-based reimbursement of hospitals and the payment of physicians based on "customary, prevailing, and reasonable charges" (Oliver 1993, 116; PPRC 1987, 4). When President

Johnson was faced with proposals to expand Medicare—precisely what its original supporters had anticipated—it seems likely that he did not want to add even more to the program's rapidly rising costs. In the fall of 1967, for example, he would not agree to support a proposal, called KiddyCare, from HEW to provide Medicare coverage for pregnant women and children (Gordon 2003, 29).

By calling for a careful assessment, the president could lessen the immediate political pressure to add a prescription drug benefit. In May 1967 HEW Secretary John Gardner established the Task Force on Prescription Drugs in response to a directive from President Johnson "to undertake immediately a comprehensive study of the problems of including the cost of prescription drugs under Medicare" (Gardner 1967). Congress also weighed in on the issue. Section 405(a) of the 1967 amendments to the Social Security Act included the following provision: "The Secretary of Health, Education, and Welfare is authorized and directed to study . . . quality and cost standards for drugs for which payments are made under the Social Security Act, and . . . the coverage of drugs under Part B of Title XVIII of such Act" (Cohen 1968). The task force was required to submit its findings and conclusions by January 1, 1969. It functioned for 20 months and studied all who would be affected by the policy, including drug users, drug makers, drug distributors, and drug prescribers.

The task force found that all out-of-hospital prescription drug use, prices, and expenditures had risen rapidly between 1950 and 1965. The number of prescriptions had climbed from 363 million in 1950 to 833 million in 1965 to 930 million in 1967. The number of prescriptions per capita had almost doubled from 2.40 to 4.75, and expenditures had risen from $736 million in 1950 to $3.25 billion in 1967. Moreover, the burden of prescription drug use fell disproportionately on the elderly, who incurred 47 percent of the total costs (U.S. DHEW 1968b, 15–29).

Information about insurance coverage was difficult to obtain, but it appeared that only a small percentage of Medicare beneficiaries had any coverage of prescription drugs outside the hospital. The task force noted that although most large and small insurance companies offered out-of-hospital prescription drug benefits under the heading of general medical expenses, "this type of protection is so limited by restrictions—including coinsurance regulations, maximum amounts payable, and deductibles of $100, $250 or even $500—that its impact appears to be minimal. In addition, many such policies are restricted to those under the age of 65" (U.S. DHEW 1968a, 116).

The prospect of extending Medicare prescription drug coverage to patients outside the hospital raised several issues, including how to control the costs of such a program. In striking a balance between a comprehensive benefit and economic viability, policymakers struggled with many issues that are as salient today as they were in 1967. These included (1) drug prices, (2) formularies, (3) drug utilization review (to ensure the appropriateness of prescriptions for the patient's condition, to reduce unnecessary care, and to promote cost-effectiveness), (4) consumer cost sharing, and (5) reimbursement of pharmacists (U.S. DHEW 1969b).

The final report of the Task Force on Prescription Drugs was submitted on February 7, 1969, to Robert Finch, the secretary of HEW newly appointed by President Richard Nixon (R). Perhaps its most significant finding was that "a drug insurance program under Medicare is needed by the elderly, and would be both economically and medically feasible." The task force recommended that such a program be instituted and, in addition, that "consideration should be given to providing coverage at the outset mainly for those drugs which are most likely to be essential in the treatment of seniors' illnesses" (U.S. DHEW 1969b, 57). These recommendations were not adopted, however, and Medicare coverage of prescription drugs was not considered again as an independent issue until 1999, 30 years later.

Prescription Drug Policies in the Nixon Administration

Following submission of the task force's report, Secretary Finch appointed a review committee headed by John Dunlop of Harvard University, the former chair of President Nixon's health transition team who had been appointed secretary of labor. The committee convened in April and submitted its report on July 23, 1969. With only one dissenting voice from a representative of the pharmaceutical manufacturers, the committee endorsed a number of the task force's recommendations. In particular, "the Secretary of Health, Education, and Welfare should recommend an Administration decision for an out-of-hospital drug insurance program under Medicare" (U.S. DHEW 1969a, 4).

Secretary Finch acted on a number of the review committee's recommendations, but the Nixon administration did not endorse an outpatient prescription drug benefit for the Medicare program. Even though measures to provide an outpatient prescription drug benefit were proposed in Congress, none was enacted. In January 1971 President Nixon

introduced his first proposal for national health insurance. When the proposal was finalized at a meeting of the president, HEW secretary Eliot Richardson, and Assistant Secretary for Planning and Evaluation Lewis Butler, the issue of prescription drug coverage in Medicare was raised at the request of Commissioner of Social Security Robert Ball. President Nixon stated, "We have done as much as we need to do," and that was the end of the discussion (Butler 2002). In lieu of expanding benefits, in 1972 Congress extended eligibility for Medicare to the permanently disabled and to individuals with end-stage renal disease.

In 1973 actions initiated by another HEW secretary, Caspar Weinberger, set in motion political forces that would make it more difficult to establish a prescription drug benefit in Medicare. On December 19 of that year, Secretary Weinberger praised the work of the Task Force on Prescription Drugs before the Senate Health Subcommittee chaired by Senator Edward Kennedy (D-Mass.). He described the task force's operations as "landmarks in the consideration of prescription drug issues." Weinberger outlined the steps taken by HEW to implement many of the task force's recommendations and then dropped what a trade publication called "a bombshell." Specifically, Weinberger proposed regulations to limit drug reimbursement under existing federal programs—the largest of which was Medicaid—to "the lowest cost at which the drug is generally available unless there is a demonstrated difference in therapeutic effect" (Silverman and Lee 1974, 168).

The proposed regulations were very similar to those recommended by the task force in 1969. Such a policy stemming from a Republican administration came as a surprise, however, and illustrated how concerned policymakers were about rising medical costs. Weinberger's announcement touched the pharmaceutical industry's most sensitive nerves, endorsing generic substitutes for brand-name products and limits on reimbursement. Despite vigorous industry opposition, state laws were already changing to allow pharmacists to substitute cheaper, generic drugs for brand-name products. Now the federal government was adopting similar methods.

Although it had only a limited effect on the aggregate expenditures for drugs, the new policy nevertheless aroused a vehement response from both the drug industry and pharmacists. The pharmacists' opposition was particularly strong because it was more profitable to dispense brand-name drugs than generics. In the end, lawsuits and bitter disputes about HEW's methods for setting reimbursement levels slowed and later limited implementation of the program. After many delays, the

regulations were revised in 1983, replacing complicated procedures for determining the "maximum allowable cost" and simply setting upper limits on prescription drug expenditures in state Medicaid programs.

In addition to its efforts to control federal spending on prescription drugs, the Nixon administration imposed general wage and price controls and maintained them for health services well after easing them in other industries. It pursued these regulatory policies even as it also proposed federal investment in health maintenance organizations and national health insurance based on "structured competition" (Brown 1983; Falkson 1980; Fleming 1973). This combination of initiatives illustrates two persistent themes in federal health care policy. First, concern over rising costs has been a major driver of policy, and Republicans often subordinate their market-oriented ideology when regulatory interventions can achieve more predictable cost control. Second, federal officials from both political parties give the highest priority to containing the budgets of existing programs, not to rationalizing the broader U.S. health care system (Marmor 2000, 116–7; Oberlander 2003, 123; Oliver 1991, 473; Oliver 1993, 132). The pharmaceutical industry was not yet a powerful political force, but it drew from this episode the lesson that price controls would likely accompany any federal sponsorship of prescription drug coverage. The industry's resistance to price controls would become a formidable barrier when subsequent opportunities to add drug benefits to Medicare arose.

The Long Wait for New Benefits

More than a decade passed before there was another major effort to introduce prescription drug coverage under Medicare. Even though the Democrats controlled both the legislative and executive branches of government in the wake of the Watergate scandal and the election of President Jimmy Carter (D) in 1976, the energy crisis, a weak economy, and rising inflation precluded costly new initiatives (Starr 1982, 411). Inflation and growing unemployment were threatening the solvency of Social Security, and Congress responded by raising payroll taxes in 1977. Richard Himelfarb observed that

> the economic troubles of this period transformed the politics of federal programs serving the elderly. Whereas the 1960s and early 1970s had been marked by significant expansion of federal aid to the aged, the late 1970s and 1980s constituted an era of scarcity in which public

> officials struggled to maintain the gains of an earlier era. In short, from the Carter years onward, legislators would face no more "easy votes" on programs affecting the elderly. (1995, 5)

Although President Carter had promised to pursue national health insurance, during his first year in office he turned his attention instead to containing soaring hospital costs (Starr 1982, 411–4). His proposals in 1977 and 1979 died in Congress amid criticism that they were excessively complex and regulatory, but the issue continued to dominate federal health policy until Congress accepted the Reagan administration's proposals in 1982 and 1983 to establish a new prospective payment system for Medicare hospital services (Oliver 1991). Throughout the rest of the 1980s Congress devoted considerable energy to reforming Medicare's payment system for physicians (Oliver 1993; Smith 1992).

The reason for the lack of a focus on prescription drug coverage, therefore, was the more pressing financial problems inside and outside health care. Even though prescription drug prices were increasing rapidly during this period, spending on other health services was growing even more rapidly. As a result, prescription drug costs as a share of total health spending declined from 10 percent in 1960 to 4.7 percent in 1982. Between 1982 and 1993, their share of total health spending increased only from 4.7 to 5.6 percent (Cowan et al. 1999, 190). It was not until after 1993 that drug prices and utilization quickly accelerated and became a focal issue for policymakers. So even when an opportunity to add drug coverage to Medicare arose in the latter part of the Reagan administration, the primary goal once again was to protect beneficiaries from the even higher costs of hospital and physician services.

The Medicare Catastrophic Coverage Act of 1988

The Medicare Catastrophic Coverage Act of 1988 (MCCA) began with the 1984 report of the Social Security Advisory Council chaired by Otis Bowen, a physician and former Republican governor of Indiana. The council's report did not focus on prescription drugs but on the limited hospital coverage provided by Medicare and the out-of-pocket expenses for both hospital and physician services. After Bowen was appointed as secretary of HHS by President Ronald Reagan (R) in November 1985, he urged the White House to support the council's reform proposals

and successfully lobbied for an initial proposal in the 1986 State of the Union address. The combination of Bowen's interest and changes in the political climate—the Iran/*contra* scandal in the White House and Democrats' regain of control of the Senate after the 1986 election, along with their continuing control of the House of Representatives—soon created the opportunity for new Medicare benefits, among them prescription drug coverage (Fuchs and Hoadley 1987; Himelfarb 1995; Moon 1993; Rovner 1995).

The initial version of the MCCA capped beneficiaries' total out-of-pocket expenses and modestly expanded Medicare's Part B coverage of physician and other outpatient services. As the legislation was being crafted in 1987–88, members of Congress added provisions for hospice care, home health care, mammography screening, state payments of Medicare deductibles and premiums for elderly with incomes below the poverty line, and protection against spousal impoverishment from nursing home expenses. The benefits were included in order to gain the support of Claude Pepper (D-Fla.), the chairman of the House Rules Committee and a champion of senior citizens, who wanted to fill as many of Medicare's coverage gaps as possible, including long-term care (Himelfarb 1995, 27; Rovner 1995, 157).

Despite considerable uncertainty over the costs, Representative Henry Waxman (D-Cal.) succeeded in adding outpatient prescription drug coverage at the urging of House Speaker Jim Wright (D-Tex.), who saw it as "a way to put a Democratic stamp on what had been a Reagan initiative" (Himelfarb 1995, 29). The prescription drug benefit emerged as the pivotal proposal for the MCCA. The 28-million-member American Association of Retired Persons (AARP) would endorse the legislation only if it included a drug benefit. Conversely, senior officials in the Reagan administration, including Secretary Bowen, threatened a veto if prescription drugs were included. In addition, in mid-1987 the Pharmaceutical Manufacturers Association spent $3 million on a campaign to derail the proposal (Rovner 1995, 160).

In the spring of 1988 the chairman of the Senate Finance Committee, Lloyd Bentsen (D-Tex.), proved to be the final arbiter when he accepted a drug benefit "scaled back to catastrophic coverage and not a routine benefit." Medicare would cover 80 percent of drug costs once the beneficiary met a $600 deductible. The administration, weakened by scandal, did not have the will to fight over prescription drugs, and it ultimately supported the final package (Himelfarb 1995, 29–31).

In June 1988 the Senate and the House of Representatives resolved the differences in their bills, with coverage for prescription drugs incorporated into the MCCA. With the AARP's cooperation and enthusiastic support, the new law passed both houses of Congress with large, bipartisan majorities (328 to 72 in the House and 86 to 11 in the Senate), and the president signed it into law as P.L. 100–360. It was the first major expansion of benefits since the creation of Medicare in 1965.

President Reagan had agreed to support the legislation if it added nothing to the deficit. He added a further condition that the benefits would have to be self-financed, paid entirely by Medicare beneficiaries (Rovner 1995, 154). Democratic leaders in Congress accepted the concept of "user fees" because they were reluctant to raise general taxes heading into the 1988 presidential election (Himelfarb 1995, 34). But this position had profound consequences for the ensuing design of the MCCA and its poor political reception. The prescription drug benefits led to a dramatic increase in the cost of the program and were thus a major source of the ensuing problems.

To pay for the new benefits, legislators increased, after much debate, the monthly Part B premium (about $28 at the time) for all Medicare beneficiaries by $4.00. In addition, all beneficiaries who paid more than $150 in federal income taxes would pay a "supplemental premium" of 15 percent on the amount of tax they owed, capped at $800 for individuals and $1,600 for couples. This was done for pragmatic reasons, to help cover the costs of the new benefits and to keep the program "budget neutral," and also because many policymakers accepted the principle that financial contributions should be based on a person's ability to pay and should not unduly burden low-income seniors (Himelfarb 1995, 34–7).

The progressive financing proved to be the Achilles' heel of the MCCA, however. It meant that one-third of the elderly population—those with higher incomes—would be paying for more than two-thirds of the cost of the new benefits. Many upper-income elderly already had outpatient prescription drug coverage—through employer retirement programs and, to a lesser extent, through Medigap policies—but because the new coverage was mandatory, they had no choice but to participate (Newhouse 2002, 943). In the eyes of many beneficiaries and advocacy groups, furthermore, the income-related premium violated the original social contract, under which individuals earned benefits during

their working years and so would not have to pay for added benefits during their retirement; and all seniors would have the same set of benefits from and financial obligations to the Medicare program. They feared that this method of financing might become a "back door" precedent to more general forms of means testing in social insurance programs (Himelfarb 1995, 36).

The large majority of beneficiaries who would gain from the MCCA—the low- and middle-income elderly—did not rally to support it despite favorable opinion polls before its enactment and the prominent endorsement by the AARP. Instead, the negative reaction to the legislation was broad based: The AARP found opposition to the MCCA among all income groups (Himelfarb 1995, 72; Rice, Desmond, and Gabel 1990). One reason was that the new program still failed to pay for long-term custodial nursing home care. As Julie Rovner noted, "In 1988 Medicare paid less than two percent of the nation's nursing home bill. And as both supporters and opponents of the Catastrophic Coverage Act were quick to point out, long term care was by far the leading cause of catastrophic medical expense for elderly people" (Rovner 1995, 149). More important, seniors were unaware of or were misled about how limited the impact of the supplemental premium would be. The maximum payment would take effect at an annual income of $45,000 for individuals and $75,000 for couples. The Congressional Budget Office (CBO) estimated that only 36 percent of beneficiaries would pay any supplemental premium at the start of the program and that only 5 percent would pay the maximum amount (Himelfarb 1995, 40).

A public campaign for repeal of the MCCA was led by the National Committee to Preserve Social Security and Medicare, joined by a 40-group coalition of unions and other groups and several grassroots organizations (Himelfarb 1995, 73–81; Rovner 1995, 167). Defenders of the MCCA alleged, but never proved conclusively, that the pharmaceutical industry helped organize and fund the campaign for repeal (Moon 1993; Rovner 1995, 168). The campaign illustrated the power of "new breed lobbying," which, Hedrick Smith found, "borrows heavily from the techniques of political campaigns with their slick P.R., television advertising, orchestrated coalitions, targeted mass mailings, and their crowds of activists" (Smith 1988, 236). The same approach was used by other interest groups to defeat the Clinton health security plan in 1994.

Supporters of the legislation were even less inclined to resist the calls for repeal when the Congressional Budget Office released new projections

showing that the costs of the MCCA—and thus the beneficiaries' costs if the program were to remain self-financing—were now expected to be far higher than the projections made before its enactment (Himelfarb 1995, 89; Moon 1993, 125). After weighing several proposals to modify the scope of benefits or elderly-only financing, Congress repealed most of the MCCA's major provisions in November 1989, including the prescription drug benefit. The entire episode left a powerful impression on chastened policymakers and on the AARP, which could no longer be counted on as a unified voice for Medicare beneficiaries.

Prescription Drug Coverage in the Health Security Act

The next opportunity to add an outpatient prescription drug benefit in the Medicare program came in 1993 as part of the health security act proposed by President Bill Clinton (D). Adding a Medicare drug benefit was good policy and good politics: It would be extraordinarily difficult to guarantee comprehensive health benefits, including drugs, to all Americans under age 65 and not to do the same for senior citizens and the disabled, whose needs were generally higher. A new drug benefit might also rally the support of Medicare beneficiaries for the Clinton plan, or at least neutralize potential opposition, given that the plan called for savings in other parts of Medicare as a way to help pay for coverage of uninsured persons under age 65.

The proposed expansion of the Medicare program would include an outpatient prescription drug and biologics benefit as well as a guaranteed national benefits package for those under the age of 65. The Medicare drug benefit would become part of Part B, adding $11 per month to the premium. Beneficiaries would pay a $250 annual deductible and 20 percent of the cost of each prescription up to an annual maximum of $1,000. Low-income beneficiaries would receive assistance with cost sharing.

In the report describing the health security act, the Clinton administration made clear its strategy to contain the cost of the prescription drug benefit:

> Under reform, with the addition of prescription drug coverage, Medicare will become the world's largest purchaser of drugs. And, the Medicare program will use its negotiating power to get discounts from the pharmaceutical companies. In addition, with competing health plans

> trying to become more efficient, more and more buyers will use the same successful negotiating techniques. (Health Security 1993, 55)

The administration proposed that as a condition of participation in Medicare and Medicaid, drug manufacturers had to sign rebate agreements with the secretary of HHS, to be paid on a quarterly basis. For brand-name products, Medicare would receive rebates from manufacturers of at least 17 percent of average retail prices. The government could negotiate rebates for new drugs considered to be overpriced, or it could exclude them from coverage (Ford et al. 1994, 75–6). An additional rebate would be required if a manufacturer increased its prices at a rate higher than inflation. The Clinton plan also provided incentives to encourage the use of generic drugs. The benefit would cover only generic drugs unless the physician indicated that a brand-name prescription drug was required. These provisions reflected the policymakers' judgment that it was necessary to use a regulatory approach to control prescription drug expenditures even when the broader approach to containing costs in the proposed health security act emphasized "managed competition."

The Clinton plan and other major proposals for health reform died in September 1994, losing public support under a withering attack from conservatives and interest groups, who claimed that it was too complex, would ration health care, and represented too much "government bureaucracy" (Hacker 1997; Johnson and Broder 1996; Skocpol 1996). Although the defeat of President Clinton's proposed reforms was not directly related to the prescription drug coverage, the provisions exacerbated concerns among pharmaceutical firms that new drug benefits would be accompanied by price controls and other regulation of industry practices (Newhouse 2002, 943).

National Bipartisan Commission on the Future of Medicare

Following the failure of President Clinton's health care reform proposal in 1994, Republicans captured majorities in both houses of Congress. In 1995 the main policy issue regarding Medicare was not how to improve benefits but how to restructure the program and limit the federal government's financial liability for existing coverage. The Medicare Preservation Act, which Congress passed as part of the Balanced Budget Act of 1995 but President Clinton vetoed, included major reforms and

reductions in spending in Medicare and other government programs as well as substantial tax cuts. Republican strategists miscalculated both the president's willingness to accept the legislation and the public's reaction (Peterson 1998). Nonetheless, reducing the budget deficit remained a high political priority, and two years later, the Balanced Budget Act of 1997 (Balanced Budget Act) cut projected Medicare spending by $115 billion over five years and by $385 billion over ten years (Etheredge 1998; Oberlander 2003, 177–83).

The Balanced Budget Act created a new Medicare+Choice (Part C) program, which encouraged beneficiaries to choose among the traditional fee-for-service Medicare, HMOs, and preferred-provider organizations. It also created Medicare medical savings accounts, changed payment policies and formulas for providers and health plans, strengthened efforts to prevent and prosecute fraud and abuse by Medicare providers, and created the National Bipartisan Commission on the Future of Medicare.

According to David Smith, the bipartisan commission was included in the Balanced Budget Act, "primarily as a concession to members in both houses who were concerned that not enough had been done to assure the long-term solvency of the Medicare program, especially with the enormous drain that would be created by the retirement of the baby boom generation, rising medical expenditures, and a declining ratio of contributors to beneficiaries" (Smith 2002, 350). One brief sentence directed the commission to "make recommendations regarding a comprehensive approach to preserve the program." The expectations were low, since there was little more than a year to hire staff, establish an agenda, write reports, and make recommendations.

The commission met from 1998 to 1999 and included members of Congress and current or former executive branch officials. As the commission concluded its work in March 1999, it considered recommendations in three major areas: (1) establishing a system of "premium support," under which the government would contribute a fixed amount of money toward each beneficiary's coverage in either a private health plan or the traditional fee-for-service Medicare program and would no longer cover specific benefits regardless of cost; private plans would have to offer a "high option" with a benefits package at least equal to the fee-for-service program but otherwise could vary benefits, copayments, and deductibles subject to approval by a new Medicare governing board; (2) improving the current Medicare program, including a prescription drug benefit

for beneficiaries with incomes below 135 percent of poverty; and (3) changing eligibility and financing to improve the program's long-term solvency (National Bipartisan Commission 1999; Smith 2002, 351).

The commission had 17 members from both Congress and the private sector, representing a wide ideological spectrum. Under the legislative mandate that the Clinton White House insisted on, 11 affirmative votes were required to make any recommendations to Congress. Ten members (eight Republicans and two Democrats) supported a range of recommendations, including moving to a system of premium support, raising the age for Medicare eligibility from 65 to 67, and expanding copayments to help contain costs (Oberlander 2003, 188; Smith 2002, 351; Vladeck 1999a). In trying to attract one more vote, the majority added a prescription drug benefit to their plan. The benefit was extremely limited, however: It would be required only for "high option" fee-for-service and managed care plans and would not include price controls or limits on cost sharing other than a catastrophic limit. Most important, it did not offer a general subsidy for beneficiaries with incomes above 135 percent of the poverty level, and the cost of the drug benefit was to be absorbed by higher premiums or savings elsewhere in the benefits package (Smith 2002, 352). Other proposals were introduced into the bargaining, but in the end, the commissioners regarded as potential swing votes held back, sensing that the final plan failed to strike a fair balance among beneficiaries, providers, and health plans. None of the recommendations received the required 11 votes, and the commission was unable to submit a formal report to Congress (Oberlander 2003, 189).

While the structural reform proposed by the commission's cochairmen, Senator John Breaux (D-La.) and Representative Bill Thomas (R-Cal.), languished, the commission debate revived the idea of filling Medicare's gaps and indirectly encouraged a flurry of proposals by members of Congress, President Clinton, and later President George W. Bush to add an outpatient prescription drug benefit to the Medicare program. This paradoxical outcome—that structural reform would falter and proposals for adding prescription drug coverage would take on a life of their own—was the product of several new conditions inside and outside Medicare. First, the payment reforms of the Balanced Budget Act and an accompanying crackdown on fraud led to an unprecedented slowdown in the growth of Medicare spending. Indeed, in 1999, Medicare spending actually declined for the first time in the program's history (CBO 2004a, 137). Second, economic prosperity and the booming stock market erased the annual federal budget deficits and produced sizable

budget surpluses for the first time in decades. From fiscal year (FY) 1998 through FY2001, annual surpluses ranged from $69 billion to $236 billion (CBO 2004a, 129). These two developments extended the projected life of the Part A hospital trust fund from 2001 to 2029 and greatly reduced the pressure to seek further efficiencies in Medicare. Third, each year brought double-digit increases in the cost of prescription drugs, adding to the financial burden of beneficiaries and prompting many employers to cut back or eliminate coverage for their retirees (Kaiser Family Foundation and Hewitt Associates 2002; Strunk and Ginsburg 2003; Stuart et al. 2003). Finally, in the 1990s several million Medicare beneficiaries joined managed care plans. The growth of Medicare HMOs was due in part to a requirement that those plans whose per capita costs were significantly below the fee-for-service program (because of either greater efficiency or favorable risk selection) had to add benefits or return a portion of their capitation payments to Medicare. Accordingly, many plans reduced or eliminated cost sharing for their enrollees and added prescription drugs and other popular new benefits. The beneficiaries, in turn, cited lower costs or better benefits as their primary reasons for enrolling in a Medicare HMO (CMS 2002, 8).

The growing availability of coverage in managed care plans, coupled with the projected budget surpluses, made it more necessary to answer why the government could not help cover prescription drug costs for all beneficiaries. The political pressure to expand coverage only grew as many private insurers started to withdraw from the Medicare+Choice program in 1999, leaving millions of beneficiaries to shop elsewhere for prescription drug benefits—if they could afford them (Laschober et al. 2002). In addition, those plans that remained in the Medicare program dramatically cut back their prescription drug coverage as the price of medications continued to escalate. Between 1999 and 2003 the percentage of Medicare+Choice plans offering more than $750 in drug benefits (only one-third of the average costs per beneficiary) fell from 79 percent to 39 percent (Achman and Gold 2003).

The new proposals also reflected a change in the political environment. The AARP's chief lobbyist, John Rother, noted: "The public is already strongly supportive. Majorities of younger as well as older Americans support expanding Medicare to include prescription drugs, even given higher total costs for Medicare" (Rother 1999, 21). In contrast to past episodes, by 1999 the Pharmaceutical Research and Manufacturers of America (PhRMA) was not unalterably opposed to prescription drug benefits under Medicare. Instead, the industry group

publicly advocated a prescription drug benefit "as part of a Medicare program that is modernized to allow beneficiaries to choose among qualified private-sector health plans" (Holmer 1999, 24). While PhRMA's support appeared to be contingent on the transformation of Medicare into a premium support program, industry leaders probably recognized that if some drug benefits were on the horizon, it would be better to help craft those benefits than to oppose them outright.

The Impasse before and after the 2000 Presidential Election

In the wake of the bipartisan commission's deliberations, Senator Breaux and Representative Thomas joined Senator Bill Frist (R-Tenn.) on a series of proposals to include a prescription drug benefit as essentially an inducement for beneficiaries to shift from the traditional fee-for-service program to a private health plan. More liberal and moderate members of Congress introduced proposals for an independent outpatient prescription drug benefit in the Medicare program.

In addition, in his 1999 State of the Union address, President Clinton proposed his own plan for a voluntary outpatient prescription drug benefit available to all Medicare beneficiaries. A new Part D drug benefit premium would be established, providing subsidies for low-income beneficiaries with incomes below 150 percent of poverty. This plan introduced the idea of combining modest benefits for most if not all beneficiaries with "stop-loss" protection for the relatively few enrollees with catastrophic costs. Medicare would cover 50 percent of an enrollee's first $5,000 in annual drug spending and 100 percent of any additional expenses (National Economic Council 1999, 39).

The most significant difference between the 1999 Clinton proposal and the one considered in 1993–94 as part of the health security act was that participants would receive prescription drug benefits through existing health plans or through a regional pharmacy benefit manager operated by retail drug chains, health insurers, states, or other qualified entities and selected by Medicare through competitive bidding. By 1999, pharmacy benefit managers served about half of the insured population in the United States and performed the following functions: (1) claims processing and adjudication, (2) pharmacy network management, (3) formulary development and management, and (4) rebate negotiations and contracting with drug manufacturers (Copeland 1999;

Lipton et al. 1999). Unlike the earlier Clinton proposal, this one relied on the private sector's management and competition to control costs, not direct governmental regulation.

The issue of a Medicare drug benefit became a prominent issue in the 2000 presidential campaign, as all the major candidates proposed some version of a new benefit. Vice President Al Gore, the Democratic candidate, proposed a new voluntary benefit within Medicare to protect chronically ill or low-income beneficiaries against catastrophic expenses. Texas governor George W. Bush, the Republican candidate, advocated a new federal subsidy to help low-income beneficiaries purchase drug coverage through private insurers.

It is noteworthy that all the proposals in 1999–2000 were made in the context of a projected federal budget surplus and assumed that funds would be committed to bolster the long-range solvency of Social Security and Medicare. But this quickly changed with the economic downturn in 2001 and the trillion-dollar tax cut promoted by President Bush and enacted by the Republican-controlled Congress in 2001.

In his initial budget for FY2002 submitted to Congress in February 2001, President Bush proposed that $153 billion be allocated over ten years for "Medicare modernization," including prescription drug assistance (to put this in perspective, Medicare spent a total of $238 billion in FY2001 with no outpatient drug coverage). The president proposed creating a block grant to the states to help provide drug coverage for Medicare beneficiaries with incomes up to 175 percent of the poverty level and to provide catastrophic coverage to limit annual out-of-pocket spending to $6,000 for beneficiaries at all income levels. In July 2001, the Bush administration added a plan for Medicare beneficiaries to buy prescription drugs at discounted prices through private pharmacy benefit managers (U.S. DHHS 2001a). The firms endorsed by the Medicare program would negotiate prices with manufacturers and pass along the savings to their cardholders. The administration argued that the program "will help seniors immediately while a Medicare drug benefit is designed" (U.S. DHHS 2001b). It claimed that the program could be implemented without congressional action and be fully operational by January 2002. It did not announce estimates of expected savings from the program.

The initiatives stalled when the courts found that the administration had no legal authority for the drug discount program and Congress failed to endorse any form of drug assistance (Pear and Bumiller 2003).

Legislators in both parties opposed the concept of block grants, wary that Medicare beneficiaries would resent means testing, state-by-state variation in benefits, and especially the need for beneficiaries to go through welfare agencies to enroll in state Medicaid programs. Focus groups conducted by Republican and Democratic polling firms confirmed that regardless of party affiliation, most Medicare beneficiaries preferred that prescription drug coverage be administered by the federal Medicare program rather than by private health plans or state programs (Public Opinion Strategies 2001).

Another reason for the deadlock was that the amount proposed in the president's budget was only one-tenth of what the Congressional Budget Office projected that the Medicare population would spend on prescription drugs during that period. Heading into the 2002 election, Democrats reasoned that no benefit was better than an inadequate benefit.

A final reason for the deadlock was that once the Bush tax cuts were enacted in mid-2001, Democrats briefly gained majority control of the Senate when James Jeffords of Vermont left the Republican Party to become an independent. Thus, Senate Democrats were able to stop Republican leaders in Congress from working out a plan with the White House and claiming victory before the 2002 election. But the switch in the Senate only increased the partisan tensions that remained from the controversial election of President Bush and the subsequent shift of his administration from moderate to conservative rhetoric and policies.

In May 2002 Republicans in the House of Representatives and Democrats in the Senate announced competing proposals to add an outpatient prescription drug benefit to the Medicare program (Pear 2002). The estimated ten-year cost of the Republicans' plan was $350 billion, the same amount settled upon in the FY2002 budget resolution. In contrast, the cost of the Senate Democrats' final proposal was close to $600 billion. All the congressional proposals were considerably more generous than President Bush's 2002 proposal for a Medicare prescription drug benefit.

Because the Senate had not passed a budget resolution for FY2003, members were held to the $350 billion limit for Medicare reform from the previous year's budget resolution, when the chamber was controlled by the Republicans. Any proposal to spend more than that could be challenged on a point of order by any member. It would take 60 votes to suspend the budget rules and permit a vote on the Democratic plan. In

the end, the House passed its $350 billion plan by a narrow margin of 221 to 208, but the Senate voted down three separate proposals (Goldstein and Dewar 2002; Goldstein and Eilperin 2002).

The End of the Political Deadlock

The congressional elections in November 2002 produced a political alignment not seen since the 1950s: Republicans were now in charge of the White House, the House of Representatives, and the Senate. In addition, two of the Republicans most interested in Medicare reform—the new Senate Majority Leader, Bill Frist (the Senate's only member who is a physician), and the House Ways and Means Committee chair, Bill Thomas—were in a position to give the issue priority and exert considerable control over the legislative process. It became increasingly likely, therefore, that Congress and President Bush would agree to add outpatient prescription drug benefits to Medicare and that Republican leaders would make every effort to link those benefits to broader restructuring of the Medicare program (Lee, Oliver, and Lipton 2003).

In February 2003 President Bush made a "major shift in strategy" and decided not to propose detailed legislation but instead to offer only the general structure of a Medicare reform, incorporating prescription drug coverage in an effort to increase Medicare's reliance on private health plans. In doing so, Bush followed the advice of his congressional liaisons and Republican legislators who said they wanted to draft their own reform plan (California Healthline 2003a, b, c; Goldstein 2003d).

The following month the president announced his new "Framework to Modernize and Improve Medicare." Overlooking his previously stated concerns about expanding the federal budget deficit, he offered $400 billion in new spending over ten years, though not all of it devoted to prescription drug assistance. Low-income beneficiaries would be eligible for a $600 credit toward their drug expenses. All beneficiaries would receive a drug discount card, and those enrolled in the traditional fee-for-service Medicare program would receive "catastrophic" coverage for annual prescription drug costs above an unspecified amount, most likely between $5,500 and $7,000. The president's proposal openly encouraged Medicare beneficiaries to leave the traditional fee-for-service program, in which 89 percent are currently enrolled, by offering additional prescription drug coverage to those who joined private, Medicare-approved health plans (California Healthline 2003e; White House 2003).

Accordingly, beneficiaries' coverage would vary considerably, and access to the benefits would depend on the availability of a private plan in a beneficiary's locale.

With the distraction created by the war against Iraq in the spring of 2003, many observers believed that Medicare reform would once again be caught up in partisan politics and, without a significant investment of political capital by the president, would languish as it had in prior years (Toner 2003a). In June 2003, however, the Senate Finance Committee came forward with a "bipartisan" agreement that helped break the four-year-old deadlock over Medicare prescription drug coverage. The committee chair, Charles Grassley (R-Iowa), and the ranking minority member, Max Baucus (D-Mont.), announced the agreement with great fanfare and hoped to move the legislation to the Senate floor with little delay. With increasing encouragement from outsiders—including the White House and the leading Democratic voice on health issues, Senator Kennedy of Massachusetts—it took only seven days to progress from the announcement of a skeleton, two-page agreement to markup and committee approval of the 90-plus pages of S. 1, the Prescription Drug and Medicare Improvement Act. The bill passed out of committee on June 13 by a margin of 16 to 5, with substantial support from members of both parties (Pear and Toner 2003a).

The finance committee's approach deviated considerably from the Bush administration's proposal and from legislation previously passed in the House. Medicare beneficiaries would be offered two basic options, starting in 2006: They could join new single-state or multistate preferred-provider organizations, which would offer not only enhanced prescription drug benefits but also specialized disease management services for individuals with chronic conditions, or they could remain in the traditional Medicare program and, if they elected, receive comparable prescription drug benefits offered by private plans. Significantly, the Senate provided that if multiple private plans were not available in a geographic region, the Centers for Medicare & Medicaid Services would provide coverage under a "fallback" plan.

As in President Bush's proposal, the Senate package would limit the total outlay to $400 billion over ten years, and as a result, there would be similar gaps in coverage. Medicare would authorize the use of privately sponsored drug discount cards for all beneficiaries starting in 2004, two years before the new benefits would be implemented in January 2006. In that interim period, some low-income beneficiaries would be eligible for

a $600 credit toward the purchase of prescription drugs (Kaiser Family Foundation 2003a).

On June 27, 2003, the full Senate passed S. 1 by a margin of 76 to 21. The final package closely resembled the initial agreement by the finance committee. It required the new preferred-provider organizations to offer both catastrophic coverage and preventive services in addition to standard Medicare benefits and new prescription drug coverage (Kaiser Family Foundation 2003d; Toner and Pear 2003). The bill passed with substantial bipartisan support, as key Democrats such as Kennedy and Senate Minority Leader Tom Daschle (D-S.D.) felt it was best to accept the new $400 billion commitment as "money in the bank" toward a more comprehensive program (Toner and Pear 2003).

The week after senators unveiled their tentative plan, House Republicans in the two committees with jurisdiction over Medicare—the Ways and Means Committee and the Energy and Commerce Committee—announced an agreement on H.R. 1, their version of a drug benefit and other elements of Medicare "modernization." They, too, rejected the Bush administration's proposal to provide significant benefits only to beneficiaries who enrolled in private health plans. Billy Tauzin (R-La.), chairman of the House Energy and Commerce Committee, had earlier observed, "You couldn't move my mother out of [fee-for-service] Medicare with a bulldozer. She trusts in it, believes in it. It's served her well." He predicted that his colleagues "almost certainly will want a strong and adequate prescription drug benefit within fee-for-service Medicare" (Pear and Toner 2003a).

Like the Senate bill, the House bill introduced substantial new subsidies for low-income beneficiaries but made them subject to income and asset tests. A crucial difference from the Senate bill was that the "catastrophic" coverage limit—the annual amount of out-of-pocket spending above which the government would cover all remaining costs—would be higher for beneficiaries with incomes above $60,000. These provisions reintroduced the type of income-related financing that proved so controversial in the MCCA (Goldstein and Dewar 2003a; Kaiser Family Foundation 2003d). An even more controversial provision injected a modified form of "premium support" into the overall Medicare program, which linked future increases in beneficiaries' premiums to cost increases in whichever part of Medicare they were enrolled, thereby forcing private health plans and the traditional fee-for-service program to compete.

On June 17 the House Ways and Means Committee approved, by a margin of 25 to 15, its Medicare reform proposal, which prompted "an impassioned partisan debate over the proper roles of government and private industry in delivering health care to the elderly. . . . [House Republicans] insisted that private insurers and health plans should have a larger role in Medicare, to avoid any possibility that the government might set drug prices" (Pear and Toner 2003f). Despite partisan rancor and strong resistance from Democrats and some Republicans, the full House narrowly passed H.R. 1 by 216 to 215 votes on the same day as the Senate did, June 27, but only after an abnormally long roll-call vote.

The "cliff-hanger" vote came despite intense lobbying by the White House in support of the bill and a visit by Vice President Dick Cheney (R) to the House floor (Angle 2003; Goldstein and Dewar 2003b). House leaders had to persuade several GOP representatives to switch their votes at the last moment to save the measure. Many conservatives were reluctant to commit such large sums to a new federal entitlement, and they also felt that the bill did not go far enough in creating incentives for beneficiaries to switch from the traditional fee-for-service program to private health plans. To hold on to some conservative votes, House leaders attached a provision to expand the tax-exempt health savings accounts for uninsured or self-insured individuals and families, a move that was projected to add $174 billion more to the federal deficit over ten years (CBO 2003, 5; Toner and Pear 2003).

Republicans had a strong motivation to reconcile the differences in the cost-sharing and delivery systems and to pass a bill for President Bush to sign into law in advance of the 2004 election campaign. House and Senate leaders convened a conference committee in August 2003 and initially planned to complete their work by the end of the summer. The conference committee was heavily stacked in favor of Republican priorities. The chair, Thomas, allowed only two Democratic senators to participate in the day-to-day discussions—Baucus, who was working side by side with Finance Committee Chair Grassley, and Breaux, who had long supported market-oriented reforms with Frist and Thomas. Minority Leader Daschle, who had voted for the original Senate bill, was excluded entirely from the discussions. The three Democratic conferees from the House were also excluded, which reduced their participation to signing or not signing the conference committee report (Carey 2003a; Pear and Toner 2003e).

This "hardball" approach did not ensure a smooth process, however, and it took four months of negotiations to craft a package that might attract enough votes to get a bill to the president's desk. The chief negotiators, Thomas for the House and Grassley for the Senate, clashed over personalities and substance, not all related to drug coverage. At one point, Grassley's staff boycotted the meetings when he felt that there was insufficient commitment to increasing Medicare payments to hospitals and physicians in rural areas—a side issue but nonetheless one of the Iowa senator's priorities for the overall legislative package (Pear 2003a). As the conference committee was attempting to reach closure on its most difficult issues in late October, Thomas distributed a proposal that was written without outside consultation and disregarded weeks of bargaining among members. By mid-November, Speaker of the House Dennis Hastert (R-Ill.) interceded and directly negotiated a plan with Frist, believing that Thomas could not produce a bill that enough Democrats would support (Cohen, Victor, and Baumann 2004; Goldstein 2003b).

The leaders of the conference committee faced a number of problems: The first was to design a benefit that a majority of members could be persuaded to back. To do that, it had to satisfy members from rural states and districts—particularly those in the Senate (Toner 2003b). It could not rely heavily on managed care, since many rural states currently had no Medicare+Choice options and, furthermore, policymakers and beneficiaries were distrustful of private health plans after many pulled out of the program. Practically speaking, the drug benefit for beneficiaries in traditional Medicare needed to be equal or nearly equal to that given to beneficiaries who enrolled in managed care plans.

In addition, both bills depended on the emergence of drug-only insurance plans to serve the vast majority of beneficiaries who were in the traditional fee-for-service program. This was a significant departure from the logic of risk pooling and integrated benefits: From 1965 to 1994, all proposals to add prescription drug benefits contemplated a straightforward expansion of the Medicare Part B program. Since the Clinton administration proposal in 1999, however, a separate drug benefit administered by private organizations had been the dominant approach. Under the Clinton proposal, the federal government would have been the insurer under a new Medicare Part D, whereas under the legislative proposals in 2003 the economic risk fell primarily on private plans.

In the past, the insurance industry had opposed this approach. In 2000 Charles Kahn III, then the president of the Health Insurance Association of America, argued that no insurer would provide drug-only coverage because "it would be like providing insurance for haircuts": only those seniors with high out-of-pocket costs would be motivated to join the new plans. If insurers were not free to set premiums, they could easily lose money on such plans (Morgan 2000; Pear 2000, 2003e). Given the real possibility that private drug plans would not materialize or would prove unsustainable in some areas, policymakers needed a way to ensure universal availability of the drug benefits. Nonetheless, conservatives fiercely resisted the Senate's requirement for the federal government itself to provide "fallback" drug coverage.

The second problem was how to meet beneficiaries' expectations and needs under emerging budgetary constraints. Just as government estimates in 1999 and 2000 of large budget surpluses improved the feasibility of adopting a new benefit, the financial picture in 2003 appeared to diminish the capacity for significant prescription drug subsidies. After his inauguration in January 2001, President Bush gave first priority to a tax cut that, along with the sluggish economy, eliminated the surplus revenues that could have funded new Medicare benefits. The federal government faced record budget deficits of $375 billion for FY2003 and $477 billion for FY2004, exacerbated by the invasion and occupation of Iraq and the hundreds of billions of dollars in additional tax cuts (CBO 2004a, 1, 129; Weisman 2003). Many conservative Republicans were growing anxious about even more commitments for mandatory federal spending (Grier 2003). Before the war and a second round of tax cuts, the congressional budget resolution for FY2004 set aside $400 billion in future spending for augmenting Medicare; so if Congress did not act now, it would become difficult to set aside anything close to that amount in future budgets (Carey 2003b).

The $400 billion devoted to prescription drug coverage would cover scarcely one-fifth of the estimated $1.85 trillion that Medicare beneficiaries were expected to spend on drugs over the next decade. According to the Congressional Budget Office, prescription drug spending for the Medicare population would grow from $95 billion in FY2004 to $284 billion in FY2013. The new benefits, therefore, would be costly to the government but only of marginal value to many beneficiaries who did not qualify for additional low-income subsidies. For example, a beneficiary with $1,000 in annual drug costs would pay $826 in premiums,

deductible, and coinsurance under the House plan and $1,046 under the Senate plan. A beneficiary who required $5,000 worth of medicine would still have out-of-pocket costs of $3,926 under the House plan and $3,296 under the Senate plan (CBO 2003, 11).

This calculation led many experts to predict that seniors would experience "sticker shock" and realize that "after so many promises, the proposed drug benefit will look nothing like what they expected" (Pear and Toner 2003d; Stolberg 2003b). Under these circumstances, many beneficiaries would want to keep their current supplemental insurance coverage. In fact, 56 percent of the seniors polled in August 2003 agreed with the view that "Congress should vote against this bill and work to pass one that provides more help to seniors, even if it might take years to get done and cost the government more." Only 33 percent of seniors agreed with the argument that "something is better than nothing. Congress should pass this bill now, even though it would leave many seniors paying a substantial share of their drug costs, and work to improve benefits in the future" (Kaiser Family Foundation and Harvard School of Public Health 2003, 7).

The third problem was how to maneuver this highly visible, and highly controversial, legislation through congressional procedures. If the conference committee reached agreement on a reform package, the capacity of House leaders to push through a bill was already in doubt, given the one-vote margin on H.R. 1 in June. To move closer to the Senate version, which was necessary to maintain critical bipartisan support there, would likely alienate the more conservative House Republicans. Senate approval was likely to be even more difficult, despite the fact that S. 1 passed with a large majority in June. If "sweeteners" were added in the conference committee negotiations to assuage particular constituencies and gain votes, the cost of the overall package might exceed the $400 billion ceiling, and the legislation could be ruled out of order.

Passage was also more difficult because Republican leaders chose not to pursue an omnibus budget reconciliation bill in 2003. Usually, budget legislation is the preferred vehicle for making changes in Medicare (Oliver and Lee 2000, 49–53). Budget reconciliation has an important advantage in the Senate: It cannot be filibustered and requires only a simple majority to pass. That both houses proceeded with independent legislation suggests that even though Republicans may have had the power to enact Medicare reforms of their choosing, they feared that a near-straight party-line vote would leave them and President Bush

vulnerable to a voter backlash in 2004 if beneficiaries were disappointed with the financial value, the workability, or the timing of the new prescription drug benefits, which would not go into effect until 2006.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003

At several points, participants close to the conference committee negotiations believed that another opportunity for reform would be missed. On November 15, however, the conferees reached agreement on a new version of H.R. 1, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. The 678-page conference report included many of the features that had come to be widely accepted in earlier proposals, such as the discount card, additional assistance for low-income beneficiaries, a substantial gap in benefits for individuals with high drug costs (the "doughnut hole"), and the use of private pharmacy benefit managers in lieu of direct governmental regulation. Yet the bill reflected "concession" more than "compromise," with the final provisions on some of the most controversial issues watered down so as to become almost meaningless to their proponents. This deepened rather than resolved cleavages that pitted Democrats against Republicans and, at times, Republicans against Republicans (Goldstein 2003c; Rapp 2003).

The final product included the following major provisions (CBO 2004a, 12–3; Health Policy Alternatives 2003c; Kaiser Family Foundation 2004):

- It offered to Medicare beneficiaries relatively immediate, if modest, financial relief in the form of drug discount cards sponsored by private firms with federal approval. The voluntary interim program would begin in mid-2004. Medicare would pay the $30 enrollment fee and provide a $600 credit for those beneficiaries with a household income below 135 percent of poverty (in 2003, $12,123 for an individual and $16,362 for a couple) who do not qualify for Medicaid or have other coverage. Beneficiaries would be allowed to enroll in only one discount program.
- It required most beneficiaries to choose between maintaining any existing prescription drug coverage or joining a new Medicare Part D program, beginning in January 2006. The Part D drug benefits would be offered through stand-alone drug plans or through

comprehensive plans under Part C, renamed the Medicare Advantage program. The standard Part D benefits would have an estimated initial premium of $35 per month and a $250 annual deductible. Medicare would pay 75 percent of annual expenses between $250 and $2,250 for approved prescription drugs, nothing for expenses between $2,250 and $5,100, and 95 percent of expenses above $5,100. Including $420 in premiums, beneficiaries would have to spend $1,590 out of pocket to reach an initial breakeven point, and they would be responsible for $4,020 of the first $5,100 (79 percent) in annual drug expenses. Private plans could adjust their specific benefits as long as they remained actuarially equivalent to the standard benefits.

- It mandated that all individuals eligible for both Medicare and Medicaid would now be required to receive their drug coverage through Medicare. The government would cover the premiums, deductible, and coinsurance for beneficiaries eligible for Medicaid or who have an income below 135 percent of poverty and meet an asset test of $6,000 per individual or $9,000 per couple. Beneficiaries who have an income under 150 percent of poverty and who meet an asset test of $10,000 per individual or $20,000 per couple would be eligible for sliding-scale premiums, a $50 deductible, and 15 percent coinsurance. All beneficiaries would be required to make small copayments for each prescription. The states would be required to pass back to the federal government $88 billion of the estimated $115 billion they would save on Medicaid drug coverage.
- It prohibited beneficiaries who enrolled in Part D from buying supplemental benefits to insure against prescription drug expenses not covered by the program. Thus, they would not be able to enroll in Part D and convert existing retiree benefits or Medigap policies into "wraparound" coverage to pay the Part D premiums, deductible, and coinsurance. Also, a late enrollment penalty would raise Part D premiums by at least 1 percent for each month of delayed enrollment (for beneficiaries who switched out of preexisting coverage or failed to enroll in Part D when they first became eligible).
- It required that at least two options for Part D benefits from different entities be available to beneficiaries. Medicare could assume financial risk and contract with private entities to establish regional "fallback" plans where necessary, but it could not establish a national fallback plan.

- It provided more than $86 billion in subsidies for employers and unions to encourage them to maintain their prescription drug coverage for retirees. This addressed one of the AARP's principal concerns and earlier estimates (2003) by the Congressional Budget Office that approximately one-quarter of Medicare beneficiaries with current employer-sponsored drug coverage would lose it once the benefit was enacted.
- It allowed new Part D prescription drug plans to use formularies approved by the government and to negotiate independently with drug manufacturers, but it prohibited the government from negotiating prices directly.
- It maintained the current ban on reimporting prescription drugs from other countries but authorized the Food and Drug Administration to study the potential effects of reimportation from Canada.
- It abandoned the House plan to allow price competition between the traditional fee-for-service program and the managed care program and replaced it with a demonstration project in up to six metropolitan areas, not to begin until 2010.
- It significantly scaled back the scope and expected use of health savings accounts, reducing the estimated cost from $174 billion to $6 billion in lost tax revenue.
- It committed $14 billion to boost payments to managed care plans in the Medicare Advantage program. At least temporarily, managed care plans would, for the first time, be paid more per enrollee than the average cost in the traditional fee-for-service program.
- It provided $21 billion to increase Medicare fee-for-service payments to health care providers in rural areas.

The most direct benefits of the legislation would go to low-income Medicare beneficiaries who have no supplemental source of insurance coverage through retiree benefits, Medigap plans, or Medicaid. But there were other clear winners as well: Pharmaceutical manufacturers could now expect a higher demand from their best customers, and they prevailed on all three of their priority issues: no direct administration of benefits by the federal government, no explicit cost control measures, and no legalization of drug reimportation (Connolly 2003; Harris 2003). Employers, managed care plans, rural health care providers, and teaching hospitals would receive more than $125 billion in short-term subsidies (Goldstein 2003c). In the eyes of one analyst, it was "a classic

election-year giveaway, a year early" (Abelson and Freudenheim 2003). Another was even more critical:

> Here's another bit of insanity: The bill pays private insurance companies to take elderly patients. You know how one of the tenets of conservative philosophy is that private companies can always deliver a product better and cheaper? So why does the Medicare bill offer billions in subsidies to private insurers to induce them into the market? That's not competition; that's corporate welfare. (Tucker 2003)

Bruce Vladeck, a former administrator of the Medicare program, observed that "distributive politics"—providing favors for important industries and geographic constituencies—is an integral feature of Medicare policymaking, along with regulation and economic redistribution across age and income groups (Vladeck 1999b). Each of the major and minor subsidies inserted into the final version of H.R. 1 might well help achieve a given policy objective, but they could also help attract the votes of legislators who would otherwise oppose the bill for partisan or ideological reasons (Abelson 2003; Lee 2003; Samuelson 2003). These subsidies also helped gain support from a number of major interest groups, including the American Association of Health Plans, American Medical Association, American Hospital Association, U.S. Chamber of Commerce, General Motors, and, of course, PhRMA (Goldstein 2003c; Pear and Toner 2003e).

The prospects for reform increased dramatically when, on November 17, 2003, the AARP appeared to go against the tide of public opinion and announced its support: "The endorsement provides a seal of approval from an organization with 35 million members. Republicans also hope it provides political cover against charges by some Democrats that the bill would undermine the federal insurance program for the elderly and disabled" (Pear and Toner 2003g). The AARP committed $7 million to a weeklong newspaper and television advertising campaign aimed at Medicare beneficiaries and wavering members of Congress who were about to vote on the bill. It was a coup for Republicans, some of whom had previously referred to the AARP as a "wholly owned subsidiary" of the Democratic Party. In turn, the AARP's endorsement infuriated its usual allies in the Democratic leadership and labor and consumer groups, and in protest, 60,000 members either resigned or chose not to renew their membership (Broder 2004; Broder and

Goldstein 2003; Carey 2003b; Pear and Toner 2003g; Stolberg 2003a; Vaida 2004).

Despite the AARP's "defection," the outcome was still very much in doubt as congressional leaders planned for the final debate and votes on the reform package. Liberal opponents such as the AFL-CIO; Association of Federal, State, County and Municipal Employees; Consumers Union; Families USA; and American Nurses' Association criticized the inadequacy of the drug benefits, the threat to retiree benefit programs, its boost to private health plans, and the lack of any meaningful price controls. Key Democrats who had supported the original Senate bill, particularly Daschle and Kennedy, came out strongly against H.R. 1 when it increased Part B's premiums for high-income beneficiaries and did not allow the government itself to offer drug benefits directly when private options were unavailable (Dionne 2003; Pear and Toner 2003c, e). A few Republicans planned to vote against the bill because it failed to include provisions allowing seniors and other Americans to buy lower-priced drugs from other countries, a proposal that the general public supported by a margin of three to one (Kaiser Family Foundation and Harvard School of Public Health 2003). At least one Republican, Senator John McCain of Arizona, found it "outrageous" that H.R. 1 prohibited the federal government from using its purchasing power to negotiate better prices for Medicare beneficiaries (Pear and Hulse 2003).

Conservative groups such as the Heritage Foundation and the National Taxpayers Union attacked the new benefits as a burden to taxpayers and the economy. They criticized what they regarded as an inevitable replacement of employer-sponsored retiree coverage with a massive new public prescription drug program (notwithstanding its administration by private contractors). They also opposed any Medicare legislation that did not establish direct price competition between the managed care and fee-for-service programs (Agan 2003; Butler, Moffit, and Riedl 2003; Chen 2003). Conservative Republicans in the House had earlier warned the leadership that they would vote against the final bill if it eliminated or scaled back the main market-oriented reforms, premium support, and health savings accounts (Goldstein 2003b).

Trying to quell a rebellion in his own party, House Speaker Hastert recognized that the upcoming vote was uncertain. But he went ahead because the members were anxious to break for the Thanksgiving holiday and the bill could not realistically be revived during the upcoming

presidential election campaign (Koszczuk and Allen 2003). The House vote on the conference report came at 3:00 A.M. on Saturday, November 22. The reforms appeared to be dead when, at the end of the normal 15 minutes allowed for voting, the bill was losing by 15 votes. At that point, Hastert and the rest of the Republican leadership went into action and eventually faced a razor-edge margin of 216 to 218. It stuck there while HHS secretary Tommy Thompson, defying House custom, moved onto the floor and the leaders roused President Bush to make another half-dozen calls to convince a handful of their colleagues to change their votes. A Republican who is retiring in 2004 claimed he was offered $100,000 to help his son run for his seat on the condition that he switch his vote (Schuler and Carey 2004). After holding open the vote for nearly three hours—by far the longest known roll-call vote in the history of the House—H.R. 1 passed by a margin of 220 to 215. The vote closely followed party lines: only 16 Democrats supported the final package, while 25 Republicans opposed it (Broder 2003; Carey 2003b; Koszczuk and Allen 2003).

On November 25 the Senate leadership brought up H.R. 1 for final action, and again for many hours the outcome was far from certain. A vote to close off debate prevailed by a wide margin, but it appeared that opponents would succeed in blocking the legislation on a budgetary point of order. The Congressional Budget Office officially projected a net cost of $395 billion for the reform package. Democrats, however, contended that the budgetary impact of the tax-free health savings accounts had not been fully accounted for and that if it were, the cost of the full package would exceed the $400 billion limit allowed by the Senate budget resolution several months earlier. After colleagues beseeched him to support the president and his party, former Senate Majority Leader Trent Lott (R-Miss.) gave in and cast the deciding vote to waive the budget rules and proceed to an up-or-down vote on the Medicare bill itself. He then voted against the bill along with eight other Republican senators, but 11 Democrats and one independent (Jeffords) voted in favor of the reforms, and the final version of H.R. 1 was approved by a margin of 54 to 44 (Carey 2003a; Koszczuk and Allen 2003).

An editorial in the *Washington Post* summarized this chaotic conclusion to the debate on H.R. 1:

> For sheer political drama, it would be hard to beat the past few days on Capitol Hill. Between the normally apolitical hours of 3 and 6 on

> Saturday morning, the House voted, by the tiniest of margins, to pass a hugely controversial Medicare bill. During the vote, which was of unprecedented length, the House Republican leadership cajoled, berated and twisted arms, barely controlling a conservative revolt, while President Bush, jet-lagged from his trip to Europe, called up recalcitrant members one by one. On Monday it was the Senate's turn. Opponents of the bill used a bag of parliamentary tricks in an attempt to defeat what Sen. Edward Kennedy (D-Mass.) has called an "attack on Medicare as we know it." Nevertheless, two attempts to waylay the bill were defeated by some of the bribes and threats that won the day in the House, along with the fears of some Democratic senators of blocking a big new entitlement bill so soon before an election. (The Grand Finale 2003)

Senator Daschle and House Minority Leader Nancy Pelosi (D-Cal.) protested the Republican majority's extraordinary moves to pass the new law. They predicted that this was not the end of the process and promised to introduce legislation to repeal parts of it (Bettelheim 2003; Carey 2003a; Pear 2004a). Several controversies over Medicare and prescription drug coverage continued as the policy process moved from enactment to implementation in 2004.

One issue was the affordability of drugs: "Critics argue that the Republicans were so sensitive to the drug industry's fear of price controls that they left the elderly exposed to a future of soaring drug costs" (Toner 2004). The head of a prominent consumer group, Families USA, argued that the price of drugs was the "No. 1, 2, and 3 concern" of beneficiaries and warned that the provision barring the federal government from directly negotiating prices for Medicare was a "lightning rod" in the new law (Toner 2004). Another was the failure to legalize the reimportation of drugs. Many states and local governments already have drawn up plans to buy directly or enable their residents to buy prescription drugs from Canadian companies, directly challenging the federal ban on such practices (Belluck 2003; Dealing Drugs 2004).

Congress revived the issue of drug reimportation when President Bush nominated Mark McClellan, the commissioner of the Food and Drug Administration and a former White House health adviser, to become the new administrator of the Centers for Medicare & Medicaid Services. During the debate over Medicare reform in 2003, McClellan argued that the government was incapable of ensuring the safety of drugs from other countries and that therefore the existing ban should be kept in place. In his confirmation hearings in March 2004, however, McClellan

stated that he was "absolutely committed" to helping Americans safely import lower-cost medicines and that he would work with Congress on legislation to allow drugs to be imported from Canada (Pear 2004b).

Another controversy arose when the president's Office of Management and Budget announced in January 2004 that it projected the new law would cost the federal government $534 billion over ten years—35 percent higher than the estimate of $395 billion that lawmakers had relied on when they voted on the final package just a few weeks earlier (CBO 2004b; Pear 2004a). The discrepancy stemmed from different assumptions about how many Medicare beneficiaries would join private health plans, how many would sign up for the new Medicare Part D drug coverage, how rapidly Medicaid drug spending would rise, and many other "moving parts" in the legislation (Antos 2004; CBO 2004b). But the issue of technical assumptions was soon overwhelmed by the issue of political accountability. In March 2004 the chief actuary of the Centers for Medicare & Medicaid Services revealed that as early as the previous summer, his office had estimated much higher costs for the proposed reforms than congressional budget analysts had. His superiors in the Bush administration, however, ordered him to withhold the estimates from members of Congress and warned him that "the consequences for insubordination [would be] extremely severe" (Goldstein 2004; Stolberg 2004). The revelation forced Secretary Thompson to ask HHS's inspector general to launch an investigation into whether the administration improperly withheld information from legislators.

The concealment of budget estimates reflects the usual tug-of-war between the executive and legislative branches of government, yet it has had very real consequences. Members of both parties have acknowledged that if the administration's estimates had been known to legislators and the public, significant changes would likely have been required in the final provisions of H.R. 1. Otherwise, it would have faced even stronger opposition from conservatives in the House, and opponents in the Senate may well have succeeded in blocking the bill on a budgetary point of order (Contempt for Congress 2004; Schuler and Carey 2004; Stolberg and Pear 2004). In that event, policymakers would have missed yet another major opportunity to establish Medicare drug benefits, and new initiatives would not come until 2005 at the earliest. As things stand now, observers see the new Medicare law "devolving from a signature policy achievement into a growing political liability" for Republicans in the middle of an election year (Schuler and Carey 2004).

Patterns in Policymaking and Their Consequences for Medicare Prescription Drug Coverage

Next we look at how, over time, policymakers have handled the issue of improving prescription drug coverage in Medicare. We draw on theories of the policy process to analyze when and how opportunities for policy change arise, what options for drug benefits are favored, and what factors lead to the success or failure of initiatives. We also examine how the current handling of this issue is influenced by many "legacies" of earlier decisions. These patterns, we argue, are critical to understanding the conditions that finally allowed the establishment of a Medicare drug benefit in 2003.

Major Policy Change Requires Political Opportunities and Leadership

The need to cover outpatient prescription drugs was evident soon after Medicare was implemented. It was not inevitable that nearly four decades later, beneficiaries would still lack adequate coverage for this crucial component of modern medical care. Rather, the history we outlined earlier includes a number of missed opportunities for creating a Medicare drug benefit. That history illustrates how policy changes depend on shifts in political priorities, leadership, fiscal conditions, and the element of chance. It also demonstrates that Medicare prescription drug coverage has seldom been debated as an independent issue; rather, in nearly every debate, its fate has rested on the success or failure of other proposed changes to Medicare or the broader health insurance system.

John Kingdon (1995) argued that issues rise to the top of the policy agenda when two conditions are met. First, an abrupt shift in how a problem is perceived or in who controls the levers of governmental power opens a "window of opportunity" for policy innovation. Second, three relatively independent "streams" in the policy process—problems, policies, and politics—must converge. If advocates are able to couple their preferred policy alternative with the prevailing definition of the problem and the priorities of political leaders, organized interests, and public opinion, then the resulting alternative is likely to rise on the policy agenda and may lead to significant action within a short period of time.

The first major opportunity for improving Medicare coverage came in 1967 when President Johnson appointed HEW's Task Force on Prescription Drugs. In its final report in 1969, the task force recommended adding such coverage to Medicare. The timing of the report could not have been worse, however. Amid social unrest and political battering over the Vietnam War and his Great Society programs, President Johnson unexpectedly chose not to run for reelection in 1968.

When Vice President Hubert Humphrey (D) narrowly lost the presidential election to Richard Nixon, it became much more difficult to sustain the Johnson administration's initiatives. A review of the task force's recommendations for the incoming Nixon administration endorsed prescription drug coverage for Medicare, but neither HEW secretary Finch nor any of his successors drew up a formal proposal. A major window of opportunity thus closed with the change of administration. Over the next few years, rising costs in Medicare and Medicaid diverted what might have been the natural course of action, to expand eligibility and benefits, and cost containment became the chief priority for President Nixon and every succeeding president.

A combination of circumstances—the Reagan administration's desire to turn attention away from the Iran/*contra* scandal, the Democrats' desire for action on domestic issues after recapturing control of the Senate in 1986, and the unusual personal interest of HHS secretary Bowen in strengthening financial protection of Medicare beneficiaries—enabled the development of the MCCA and its universal but limited prescription drug benefit. Like many innovations in public policy, the MCCA required an extended period of what Kingdon calls "softening up," during which policy entrepreneurs develop the basic idea for reform and test the feasibility of different approaches (Kingdon 1995, 127–31). For the MCCA, this began with the 1984 report of the Social Security Advisory Council. President Reagan solicited action on catastrophic coverage for Medicare in his 1986 State of the Union address, which opened a political window of opportunity for legislative initiatives.

From 1986 to mid-1988, congressional committees wrestled with different versions of the catastrophic coverage bill, driven by the first opportunity in a generation to "improve" Medicare by adding a variety of new benefits but constrained by Reagan's insistence that the bill not add to the federal budget deficit. Budget neutrality was the key factor in undermining the MCCA, since it forced seniors to shoulder the

entire cost of the new coverage and effectively required well-off Medicare beneficiaries to subsidize lower-income beneficiaries.

Another window of opportunity opened in 1993 when the Clinton administration presented its plan for comprehensive health care reform. Given the guarantee of comprehensive benefits for the population under age 65, it was appropriate and politically necessary to add prescription drugs and other benefits to make the scope of Medicare benefits comparable. When the Clinton plan failed, enrollment in managed care rose rapidly throughout the U.S. health care system, including Medicare. Many plans offered additional benefits such as prescription drugs and also significantly reduced or eliminated most out-of-pocket costs. This may have helped convince many policymakers that moving most or all beneficiaries into managed care plans would be politically feasible and that universal prescription drug coverage would emerge automatically as a result of the private sector's practices, thereby eliminating the need for governmental mandates and explicit sources of financing. As the first step in that direction, Congress created the Medicare+Choice program in the Balanced Budget Act of 1997.

Not surprisingly, then, when Congress created the National Bipartisan Commission on the Future of Medicare, there was no mention of prescription drug coverage in its charge. The main proposals in 1999 called for the broad restructuring and privatization of the program, thus building on the Medicare+Choice approach. Only when several members expressed serious reservations about the commission's final proposals did the idea of adding drug benefits surface as a "sweetener" to win the number of votes needed to recommend a reform package to Congress.

The other significant development was the unexpected emergence of federal budget surpluses beginning in 1998, which enabled policymakers to come forward with proposals to add a prescription drug benefit to Medicare independent of the program's broad restructuring. As Kingdon explained, "A proposal must be shown to have a tolerable cost, at least a tolerable cost to the federal budget" (Kingdon 1995, 138). The combination of sizable budget surpluses along with unexpectedly low growth in spending for the rest of the Medicare program made it much easier to advocate an expensive new prescription drug program.

After 1999, the combination of rising costs, unequal access to coverage, a sharp decline in the stock market and retirement funds, and partisan politics forced policymakers to reexamine the options for a Medicare drug benefit. When the Balanced Budget Act trimmed

capitation payments to Medicare HMOs, many responded by reducing or eliminating coverage for prescription drugs and other supplemental benefits. Employer-sponsored coverage for retirees also was eroding. Nearly a quarter of Medicare beneficiaries had no prescription drug assistance, and existing sources of assistance were becoming less and less adequate with each passing year. In addition, the rising cost of prescription drugs had become an issue for all Americans (Freudenheim 2003b). Per capita spending on prescription drugs rose at an annual rate of 13 percent or more each year from 1998 to 2002, several times the general inflation rate or rate of growth in the nation's gross domestic product (Strunk and Ginsburg 2003). Both Kingdon (1995, 95–9) and Jack Walker (1981, 88) observed that indicators like these help define problems or "performance gaps" that create the demand for governmental action.

By 2002–03, the inadequacy of coverage for Medicare beneficiaries joined other issues such as automatic patent extensions and the reimportation of drugs from other countries. In clear violation of existing law, states and communities created programs to buy prescription drugs from Canada (Belluck 2003) and senior citizens were crossing the borders with Canada and Mexico to buy lower-cost medicine (Flaherty and Paul 2003). These controversies were mutually reinforcing and put the pharmaceutical industry on the defensive. The pressure for reform was now probably higher than ever before.

For several reasons, the time for a Medicare prescription drug program finally arrived in 2003. What favored governmental action was that as in Kingdon's conceptual model, the three "streams" in the agenda-setting process—problems, policies, and politics—converged at a moment when a "window of opportunity" for reform was open. As noted earlier, the problem of rising drug costs and the resulting decline in the ability of Medicare beneficiaries to secure and maintain supplemental coverage was serious and growing worse. In fact, this was the first time since 1969 that prescription drug coverage was the primary issue on the policy agenda and that its fate was not strongly bound to broader proposals for health care reform.

Even though the Bush administration and Republican congressional leaders tried to use the enhanced drug benefits as a way to induce beneficiaries to join private managed care plans, members of both parties in Congress bowed to political realities and public dissatisfaction with managed care and developed what is primarily a package of new subsidies for prescription drug assistance. Kingdon contended that in the

"primeval soup" of the policy stream, "creative activity usually involves recombination of old elements more than fresh invention of new ones" (Kingdon 1995, 124). From 1999 onward, all the major issues in designing a Medicare prescription drug benefit had been identified, and all the major components had been examined by officials and experts alike (e.g., CBO 2002). Thus the task for House and Senate leaders was to fit a variety of components into a $400 billion package that would pass muster with their colleagues and key constituencies. The income-related financing, the "doughnut hole" in coverage, the discount cards, and the reliance on pharmacy benefit managers were all adapted from recent proposals. The option of having the private sector manage the pharmacy benefits was especially important, as it allowed Republicans and their allies in the drug industry to support new benefits without appearing to support an expansion of governmental authority and bureaucracy.

Finally, there was sufficient political capacity and will to address this problem. A new, extraordinary window of opportunity opened when Republicans regained majority control of the Senate and maintained control of the House after the 2002 elections. At that point, President Bush made Medicare reform one of his administration's highest domestic priorities. Two of his party's most powerful legislators, Senate Majority Leader Frist and House Ways and Means Chairman Thomas, considered Medicare reform to be a high priority and were in a position to shepherd it through the Congress. Republican leaders concluded that they could claim credit for a prescription drug benefit but also that since they controlled both the legislative and executive branches of government, they could face negative consequences at the polls in 2004 if they failed to deliver on President Bush's pledge in the 2000 campaign. In their view, Medicare reform could take a major issue away from the Democrats and help ensure President Bush's reelection and the Republicans' domination of national politics. The chairman of the Senate Republican Conference, Rick Santorum (R-Pa.), pointed out that "if we can't pass it, that is a big problem for us. There's no question the responsibility falls on a Republican president and Senate and House Republicans, and that's why it won't fail" (Dewar 2003).

The president and other Republican leaders made numerous concessions by greatly increasing the amount of subsidies over those of previous proposals and by agreeing that beneficiaries could get generally equivalent benefits even if they remained in the fee-for-service program. The fact that President Bush and many conservatives in Congress were still

willing to commit $400 billion to get legislation enacted in 2003, despite the mounting costs of the war in Iraq and an unprecedented budget deficit, testifies to the eagerness of Republicans to co-opt an issue that has traditionally favored Democrats. Sensing that the limited bipartisan cooperation in the Senate prevented a filibuster, President Bush invested his political capital to win over skeptical allies and enact legislation as soon as possible (California Healthline 2003d; Goldstein 2003a).

Political support was also easier to obtain now than in the past because the "pay-as-you-go" requirements of the Budget Enforcement Act of 1990 expired in 2002. As a result, policymakers were not forced to create a costly prescription drug benefit within a zero-sum financial game, which would force them to pay for the new coverage by imposing the higher costs on seniors themselves, increasing taxes, or making cuts in other parts of Medicare or other domestic programs. The willingness to spend new federal revenues made it far less likely that policymakers would see a repeat of the revolt that led to repeal of the Medicare Catastrophic Coverage Act and its drug benefit in 1989. Nonetheless, the concerns held by both liberals and conservatives about specific provisions in the final conference report kept its fate uncertain until the very end.

Ultimately, it was the "sheer force" of the Republican leadership—House Speaker Hastert and Senate Majority Leader Frist, in concert with President Bush and HHS secretary Thompson—and perhaps the suppression of the administration's cost estimates, that maintained sufficient party discipline to nudge the reform package over the finish line in 2003 (Goldstein 2003b; Koszczuk and Allen 2003; Schuler and Carey 2004). This particular episode, as well as those that preceded it, illustrate what political scholars regard as an inherent unpredictability in the policy process, in which ideas, individual leaders, and the context for debate are often as influential as conventional political interests in determining the scope and substance of the agenda and the translation of proposals into policy (Baumgartner and Jones 1993; Jones 1989; Kingdon 1995; Oliver 1996; Polsby 1984; Walker 1981).

The Core Values of Competing Advocacy Coalitions Can Produce Policy Deadlock

Whereas Kingdon highlights the potential instability of politics and policymaking, other analysts focus on the reasons why certain policies

are so resistant to change. We explain next how the ideological conflict between those seeking to expand the traditional Medicare program and those preferring a greater role for private health care companies prevented political agreement on adding prescription drug coverage over the last decade and what forces narrowly broke the deadlock in 2003.

According to Paul Sabatier and Hank Jenkins-Smith (1993), long-term policy change depends on the competition among two or more "advocacy coalitions" whose members monitor and actively try to influence specific policy issues. Like Kingdon, Sabatier and Jenkins-Smith do acknowledge some degree of punctuated equilibrium in policy development. In their view, most policy changes are the product of shifts in large-scale social, economic, or political conditions. These shifts roughly correspond to what Kingdon calls "windows of opportunity" in the policy process. As the history of Medicare and prescription drug coverage demonstrates, however, even with a major shift in political power or other external circumstances, it is often difficult for government to respond to even serious problems because an effective response would violate the core values of an advocacy coalition.

Sabatier and Jenkins-Smith argue that on many, if not most, policy issues, the competing coalitions are not temporary alliances—"strange bedfellows"—but, rather, individuals and organizations with the same values and beliefs concerning what constitutes appropriate and effective public policy. They hold "deep-core" normative beliefs and "near-core" policy beliefs that are highly resistant to change. In addition, they hold a variety of "secondary" beliefs that are more tactical than strategic and are more subject to change over time. Building on these beliefs, they develop long-standing relationships with other members of the advocacy coalition and exhibit a high degree of coordination on political strategy.

In the absence of changes in broader, contextual conditions, Sabatier and Jenkins-Smith believe that policy still can change if partisan positions are modified through a process of "policy learning." Policy learning is a fairly subtle and gradual process. The members of an advocacy coalition almost never change their deep-core values and beliefs, which dictate their basic orientation to an issue and the role of government. But they may change their "near-core" policy-oriented beliefs and a variety of "secondary" beliefs when new information overcomes their claims about the nature of a problem or the effectiveness of a solution. Given a new understanding of the problem and potential remedies, current policies

may become indefensible, and a coalition may accept new methods of government intervention.

For most of Medicare's history, the principal advocacy coalitions were organized around the interests of providers, beneficiaries, and government officials (Oliver 1993, 128–30). The core values centered on professional autonomy (and economic interest) for providers, the preservation of meaningful entitlements for beneficiaries, and the protection of the public purse for government officials. Within the government coalition there was considerable bipartisanship, which was useful when countering beneficiaries' and providers' shared interests in expanding services and when instituting regulatory regimes for cost containment (Oberlander 2003, 106, 133; Oliver 1993, 132–41).

The politics of the Clinton health plan drastically changed the politics of Medicare in the mid-1990s. Although President Clinton had seized on "managed competition" as a synthesis of liberal goals and conservative methods (Hacker 1997; Starr 1992), the health insurance industry, small business groups, pharmaceutical companies, and other opponents successfully attacked the reforms on the grounds that they represented heavy-handed intrusion into individual choice and created sizable new bureaucracies to manage the system and constrain costs if competition failed to do so (Johnson and Broder 1996; Skocpol 1996).

Republicans helped kill the "big government" Clinton plan and then moved to dismantle many existing government programs once they captured control of Congress in 1995. As Haynes Johnson and David Broder pointed out, "It was not consensus politics being practiced in Washington or even conservative politics as previously defined. This was ideological warfare, a battle to destroy the remnants of the liberal, progressive brand of politics that had governed America through most of the twentieth century" (Johnson and Broder 1996, 569). Since the mid-1990s, the advocacy coalitions regarding Medicare policy have fractured, dividing providers and government officials in particular. The new coalitions are much more aligned with the Democratic and Republican parties, and as a result, the debates over adding prescription drugs and other strategies to "modernize" Medicare are highly polarized.

In contemporary politics, conservative Republicans and liberal Democrats often hold fundamentally different deep-core beliefs about individual responsibility, the role of government, and the capacity of the private sector to meet social needs. They also have very different

near-core beliefs that shape their policy preferences. Democrats tend to favor a government-financed system of national health insurance. They consider Medicare, along with Social Security, as the central components of a social insurance system that provides universal protection to all of the nation's senior citizens. Where health care is purchased privately, Democrats still favor a strong hand for federal and state regulation of providers, health plans, and the rest of the health care industry.

In contrast, Republicans advocate individual, not collective, responsibility for securing most goods and services. They accept a minimal role for the government in Medicaid, welfare, and other safety net programs for the poor and oppose the expansion of universal entitlements. Republicans stress the superiority of markets over government in the allocation of resources and thus want to preserve a major role for private business and health systems in the provision of health care services. Jacob Hacker and Theda Skocpol (1997) described what they perceived to be the threefold strategy adopted by the Republicans: (1) Reduce spending on existing programs and cut taxes to prevent future spending; (2) transfer authority for federal-state programs to the states (e.g., welfare, Medicaid); and (3) replace public services with the public purchase of privately delivered services.

These distinct approaches are deeply entrenched, and the series of proposals that have emerged over the past decade indicate that they are unlikely to be modified by more research and analysis. Robin Toner noted how closely intertwined politics has become with policy prescriptions:

> In fact, the divisions over health care—specifically, how much to trust private markets, how much to rely on government—are among the most profound in politics today. Republicans and their allies say turning Medicare into more of a private health care market place, in which numerous health plans compete for the elderly's business, will give the program's beneficiaries more choices and modernize its bureaucratic structure before the baby boom generation hits. . . . Democrats and their allies say Medicare was created because the private health insurance market failed to meet the needs of the elderly. They charge that what some Republicans are ultimately aiming for is replacing the guaranteed benefits of Medicare with a voucher. (2003a)

Ultimately, the different approaches of Republicans and Democrats depend on whether one views medical care as a market good or as a medically determined need. According to Sherry Glied, there are sharp

contrasts between "marketist" and "medicalist" advocates of health care reform. "Marketists" see health care as just another good or service (Glied 1997, 26). They object to the government's financing of health care because it distorts the market (despite abundant evidence that the market does not function properly in health care). For "medicalists," allocation should depend on a person's needs as determined by expert providers, whose diagnosis and treatment should be guided entirely by medical science and not cost (despite abundant evidence that practice patterns of health care providers often are unscientific and excessively expensive). Glied argued that ideological differences contribute to political deadlock and undermine even incremental reform, since "every such change increases the likelihood that either the marketist or medicalist view of health care will ultimately prevail" (Glied 1997, 34–5).

Between 1999 and 2003, initiatives to add prescription drug coverage to Medicare reached an impasse—even when it appeared that the coverage could easily be funded by federal budget surpluses—because of divided government and ideological conflict between the dominant advocacy coalitions in Medicare policy. More than anything else, the impasse was due to the seemingly irreconcilable core beliefs guiding public policy in general and Medicare in particular. Even when Republican leaders accepted the need for government subsidies of prescription drug costs, they almost exclusively favored the marketist approach to policy design, rejecting standard benefits and central administration. This was especially true for Representative Thomas and his colleagues in the House of Representatives. Most Democratic leaders strongly favored the medicalist approach (albeit with a heavy dose of government oversight). Similarly, the AARP focused on adequate benefits for all beneficiaries—ruling out a strictly marketist approach—and PhRMA vetoed any steps that could easily lead to price controls in what was by far its most lucrative market.

What happened to break the ideological and political impasse in 2003? The policies hammered out in the conference report did little to resolve the most controversial issues:

> Negotiators were never able to bridge the gap between free-market Republicans, on one side, who are hellbent on bringing the private market into the senior health care business; and New Deal Democrats on the other, who hold dearly to the belief that Medicare is a cornerstone of the federal government's social contract with senior citizens.

> How do you reach a compromise between those two intractable positions? In fact, there is more concession than compromise in this conference report. What it provides is a way to let each side think it has gotten a "foot in the door," and thus an inroad to its larger objectives. (Rapp 2003)

The critical changes were external to the ongoing legislative battles. First, the contextual conditions shifted when the Republicans took control of both houses of Congress and the White House and when President Bush decided to invest heavily in reaching a prescription drug program in order to take that issue away from Democrats in his 2004 reelection campaign. The president and the Republican leadership in Congress intensely lobbied legislators and the pharmaceutical industry to concede some of their market-oriented agenda on Medicare in order to strengthen their broader political agenda.

Second, a broadly constructed set of evidence and arguments emerged to challenge the practices of the pharmaceutical industry. Drug manufacturers were accused of charging Medicare beneficiaries prices that were many times higher than the prices for the identical drug in other countries, obtaining unwarranted extensions of patents to pad profits and delay the introduction of generic competitors, and investing millions of dollars in me-too drugs and direct-to-consumer advertising. Criticism of those practices, combined with the spectacular rise in drug spending per beneficiary and the consequent erosion of supplemental coverage through employers and Medicare+Choice, led Republicans to take responsibility for moving legislation that previously would never have been a high priority for them.

Third, the decision by the AARP to endorse H.R. 1 broke up the longstanding alignment of the competing coalitions and gave lawmakers political cover to vote for the reform package and, if necessary, disregard their ideological convictions. The unprecedented momentum for action forced members of both advocacy coalitions into concessions in policy design that challenged their core values. Conservatives won a heavy role for the private sector in providing drug coverage. But they were unable to dramatically strengthen the overall role of private health plans in Medicare and agreed to give those beneficiaries who choose to remain in the fee-for-service program benefits comparable to those for people enrolled in managed care. Many liberals supported the Senate bill, and a critical few ended up voting for the final version of H.R. 1, even though it introduced means testing of benefits and income-related premiums for the

first time in Medicare's history. They may believe that helping the neediest beneficiaries—those with low incomes and those with extraordinary drug expenses—is their core priority. If so, it is preferable to waiting for a more favorable political climate in which to adopt a more universal and generous program. They may also believe that once the government is providing some prescription drug assistance, if that assistance proves inadequate for large numbers of beneficiaries, then policymakers will be forced to improve the program rather than neglect it.

Policy Legacies and Learning Heavily Influence the Evolution of Medicare

As the advocacy coalition model suggests, many shifts in Medicare policy are based on longitudinal analysis and action, what Richard Rose (1993) called "learning across time." Simply put, there are several significant ways in which today's problems and possibilities are affected by actions in the past. Similarly, policy changes today will quite possibly have a significant impact on conditions, perceptions, and policy alternatives in the future. Mark Peterson warned of analysis that assumes that

> specific policy-making events could be well understood without reference to anything beyond the immediate political, institutional, and interpersonal contexts in which they transpired. Identify the players in the game, their vantage points and institutional resources, as well as the vectors of interest-group influence and general electoral incentives, and one had a sufficient explanation of the process of policy deliberation and choice. (1997, 1079–80)

Peterson's model of social learning builds on the work of Paul Pierson (1993), who found that a change in public policy creates "feedbacks" or "legacies" in two ways. First, by altering existing institutions or creating new ones, it can have "structural effects" on the resources and incentives of participants in the policy process: social groups, governmental elites, or the mass public. Second, policy change can produce "learning effects" that alter the distribution of information and interpretation of social conditions and government actions.

The evolution of Medicare has produced a number of structural effects that influence the contemporary debate over prescription drug coverage. Perhaps the most powerful one is the incentive of Medicare beneficiaries to mobilize politically to defend their existing benefits in a program that, despite its defects, gives them greater access to care and greater overall

satisfaction than nonelderly adults have with private insurance (Kaiser Family Foundation and Commonwealth Fund 1997). The skepticism of senior citizens about recent proposals to add prescription drug benefits, which were generally linked to proposals for restructuring other program benefits, proved to be a brake on reform efforts until the AARP made its dramatic endorsement of H.R. 1 as it came to a final vote in November 2003.

This policy legacy is tied closely to another one, namely, the problem of making a transition from separate Part A and Part B benefits to a more integrated set of benefits and program administration. The limited enrollment in Part C, the Medicare+Choice program (now Medicare Advantage), meant that policymakers were essentially forced to incorporate prescription drug benefits into Part B or create yet another administrative structure, an independent Part D.

Finally, Medicare's limited benefits—restrictions on institutional stays, no catastrophic coverage, no outpatient prescription drugs—created their own legacy. Part of the reason for creating Medicare was the lack of interest by private insurance companies in offering coverage to retirees. Not only was the coverage expensive, but it also was not regarded as classic insurance, since many seniors had chronic health conditions and a need for services. Yet Medicare beneficiaries demonstrated early on that they wanted comprehensive coverage and protection against catastrophic expenses, and when Medicare did not provide them, they found other sources of supplemental coverage. Today, 87 percent of all Medicare beneficiaries have supplemental coverage beyond Parts A and B, and 78 percent have some form of prescription drug coverage, whether bought by former employers or Medicaid or paid for out of their own pockets (Kaiser Family Foundation 2003b). It can be argued that over time, the expansion of supplemental coverage has stalled the development of broader benefits within the Medicare program proper (Oberlander 2003, 48–50). In particular, the repeal of the MCCA was in part a legacy of the incomplete benefits accepted by the architects of Medicare in 1965. Beneficiaries who found affordable drug coverage elsewhere were not inclined to support mandatory conversion to a new program (and perhaps pay more for the privilege), and private insurers who sold Medigap or employee retirement benefits were not inclined to give up those customers.

The history of Medicare also illustrates a number of learning effects on the current handling of the issue of prescription drug coverage. Peterson

makes the important distinction between "substantive learning" about the need for new policies and the relative effectiveness of policy options, and "situational learning" about the political and social consequences of policies (Peterson 1997, 1085–95). Substantive learning tends to be dominated by experts, whereas situational learning tends to be dominated by politicians and organized interests. Substantive learning tends to promote reform, as evidence and arguments mount to support new policies. Conversely, situational learning can either promote or inhibit reform, depending on the lessons that participants learn from past policy initiatives. The evolution of Medicare has numerous examples of each form of policy learning.

The most obvious examples of substantive learning in Medicare are the development in the 1980s and 1990s of prospective payment systems for hospitals, physician services, home health, and other services. Each change in policy followed a prolonged period of what policymakers regarded as unacceptable growth in that area of Medicare spending, as well as research on and analysis of methods to control costs without jeopardizing access to services for beneficiaries (e.g., Oliver 1993; Smith 1992). The rapid increase in prescription drug costs relative to those for other health services over the past decade has led both public and private health plans to negotiate lower prices, restrict utilization, and promote generic substitution. Such regulation will almost inevitably become part of any new prescription drug coverage for Medicare beneficiaries—if not immediately, then soon after its implementation (Oberlander and Jaffe 2003).

The repeal of the MCCA in 1989 is an enduring event in the minds of almost all experts in Medicare policy and a prominent source of situational learning. As Peter Hall (1993, 278, 293) and Peterson (1997, 1090) stated, nothing about either substantive or situational learning requires that the lessons learned by policymakers, interest groups, or the public be accurate; rather, it is the political effect on future policy choices that matters. Rovner argued precisely this point:

> The conventional wisdom on the ill-fated Medicare Catastrophic Coverage Act is that it was all a big mistake. . . . [F]inancially secure senior citizens rebelled when they realized they would have to pay for expanded benefits they felt they did not need. The real story of the rise and fall of the Medicare Catastrophic Coverage Act sends several ominous messages about the state of Congress

> and our political system, but the power of the senior citizens' lobby is not one of them. Those who lived through this nightmare instead learned a lot more about the power of direct mail, the ease of manipulating the public with information that is simply wrong, the resistance recipients of federal entitlement programs feel toward change, and the lack of knowledge Americans have about programs that so directly affect their lives. (1995, 145–6)

There is an additional and, in our view, critical lesson: The MCCA threatened the social contract established in 1965 in two ways, by advancing the concepts that Medicare benefits were no longer universally "earned" during one's working years and that the program would no longer treat all beneficiaries in a strictly equal manner. Thus, both the policy and process were important to sealing the fate of the MCCA.

The proposals advanced in 2003 reflected situational learning based on what Rovner called the "conventional wisdom" from the demise of the MCCA, whether accurate or not. Most significantly, none of the bills imposed the full costs of the new benefits on seniors themselves, as happened in 1988. Instead, the costs of the program were to be paid out of general revenues, enrollees' premiums, and out-of-pocket expenses. Another lesson was that participation in the new prescription drug coverage had to be voluntary (Dallek 2003). In particular, it was crucial to avoid requiring Medicare beneficiaries to switch out of supplemental coverage that was heavily subsidized and with which they were satisfied (e.g., employee retirement programs). Policymakers also created upfront benefits in the form of a discount card and a lower deductible, whereas the benefits under the MCCA were scheduled to take effect after beneficiaries had begun paying premiums to build up financial reserves for the program (Himelfarb 1995, 86).

Many provisions in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, however, were not consistent with the lessons learned from the demise of the MCCA. The incompleteness and complexity of the Part D benefits ensured that beneficiaries will be confused and that many of them will not see any improvement in their coverage (Bettelheim 2003; Pear 2003b; Stolberg 2003b). Indeed, many beneficiaries will be worse off if a large number of employers drop the prescription drug benefits that they currently offer to retirees. Beneficiaries may also react negatively when they learn that neither they nor their former employers may buy supplemental coverage for costs not

covered by the new Part D program (Pear 2003d). Finally, the new law reintroduced the income-related premiums so detested in the MCCA as well as direct means testing for low-income subsidies. The law requires Medicare and private insurers to obtain information about beneficiaries' income from the Internal Revenue Service or another source, something sure to raise concerns in many quarters (Bettelheim 2003). These are the logical outcomes of a process in which the price tag of reform is decided before the appropriate method of reform is settled on. Even if some of these outcomes are expected or easily explained, they may prove politically damaging for the proponents of this approach.

The proposals in 2003 also reflected the situational learning of the pharmaceutical manufacturers. Since the Nixon administration altered Medicaid's drug-purchasing practices, the industry has opposed most proposals to add prescription drug benefits to Medicare. The proposed rebates under the health security act only reinforced the industry's concerns. In recent years, the industry toned down its strident opposition and offered conditional support for adding Medicare drug benefits; yet it still vehemently resisted a centrally administered drug benefit. The influence of the pharmaceutical industry is one reason that most proposals called for a stand-alone drug benefit administered by pharmacy benefit managers or for formally integrating drug coverage into Medicare managed care plans.

From 1965 to 1999, proposals to expand Medicare benefits always included prescription drugs with the rest of ambulatory medical services in the Part B program. The idea of a stand-alone drug benefit first surfaced in President Clinton's 1999 proposal and is an integral part of the legislation passed in 2003. In some ways, this form of administrative intermediary is no different from the original Medicare program in contracting out claims payments and other functions to private insurers for both Part A and Part B. The idea then, as now, was to make transactions between health care providers and the Medicare program mirror the transactions with private health plans or, more bluntly, to create a buffer between health care providers and the regulatory reach of the government (NASI 2002, 24; Oberlander 2003, 111–6). Even if pharmacy benefits managers use cost-saving mechanisms like formularies, volume discounts, and utilization review, they still are viewed as part of the "market" and are not as threatening to the pharmaceutical industry as a central governmental agency employing the same techniques would be. The industry believes it will have stronger negotiating power vis-à-vis

private organizations and less regulatory oversight than it would if it had to deal directly with the federal government.

This sort of administrative fragmentation through benefit "carve-outs" has a short history, however: Pharmacy benefits managers appeared only in the past decade as employer-sponsored health plans struggled to contain the spiraling costs of prescription drugs for their beneficiaries. Without this institutional development, policymakers ideologically inclined to rely on the private sector's administration would not have had any experience on which to judge the viability of this approach. As it is, there are few examples of stand-alone drug plans that bear financial risk (CBO 2002), great uncertainty that insurers will actually participate in a Medicare drug benefit program (Goldstein 2003a, d; Health Policy Alternatives 2003a), and little evidence to date that they can control the costs of a major new Medicare benefit (Lipton et al. 1999; Lipton et al. 2000). When serving as administrator of the Centers for Medicare & Medicaid Services, Thomas Scully contended in congressional testimony that stand-alone drug coverage "does not exist in nature" and would probably not work in practice (Pear 2003e). Hence, the use of private pharmacy benefits programs is based more on situational learning than on substantive learning from experience. Given the uncertainty, the conditions for offering a fallback prescription drug program to Medicare's fee-for-service enrollees were among the most contentious provisions of the new law.

A final, powerful example of situational learning is based on the "managed care backlash" that began with rejection of the Clinton health plan in 1994 and culminated in the troubled experience of the Medicare+ Choice program. Not only did the enrollment of Medicare beneficiaries in managed care plans drop from 6.3 million to 5.0 million between 2000 and 2002, but the reduction of prescription drug coverage in the remaining managed care plans added to the pressure for an explicit Medicare drug benefit program. Thus, despite Republican control across the federal government, both the House and Senate produced bills with relatively equivalent benefits available to Medicare beneficiaries, regardless of whether they enrolled in a managed care plan or remained in the government-administered fee-for-service program.

The withdrawals of Medicare+Choice plans from the Medicare program since 1998 persuaded policymakers that they could not rely on comprehensive private plans completely, especially in rural regions of the country, and that beneficiaries would strongly oppose efforts to make drug benefits contingent on joining a health plan that might limit their

choice of providers or access to specialists. "Where is the line between financial incentives and economic coercion? Republicans are keenly aware that one of the most devastating accusations against President Bill Clinton's plan for universal health insurance was that it would force Americans into HMOs" (Pear and Toner 2003a). The heavy representation of rural states on the Senate Finance Committee ensured that it would adopt comparable benefits for the managed care and the fee-for-service programs (Toner 2003b), but in the end the House also agreed to adopt this approach in H.R. 1 to make the new program attractive to as many beneficiaries as possible.

Challenges Still Ahead

A general perception is that senior citizens are the preeminent political force in contemporary American politics. But the history of Medicare and prescription drug coverage teaches a different lesson. The elderly, like other interests, may be powerful defenders of their existing entitlements and benefits. But because of the politics of the federal budget and the command of key offices by conservative Republicans, the elderly alone do not have the capacity to gain improvements in the program. As we have shown, the history of Medicare from its inception in 1965 through the 2002 election campaign is littered with missed opportunities to add prescription drug coverage for beneficiaries.

In 2003 policymakers seized a historic opportunity to integrate prescription drug benefits into a program that 41 million older and disabled Americans admire and rely on. Despite this opportunity, the effort to establish a Medicare drug benefit was boxed in by current sources of coverage, by ideological insistence on market "solutions" for a massive social problem, by arbitrary budgetary constraints, and by the failure of managed care in rural America. The resulting program design may make it more difficult for Medicare administrators and private organizations to implement the policy successfully, satisfy the expectations of millions of Medicare beneficiaries, and protect the public purse. In our view, several challenges remain for those trying to implement the new law.

First, the coverage itself will prove inadequate for large numbers of beneficiaries, particularly those who currently have no supplemental drug coverage. Although the new law promises immediate relief through a discount card program, those companies offering the cards are not required to achieve a minimum level of savings. Medicare officials

estimate that only 7.3 million beneficiaries will sign up for the program (Pear 2003c). With more than 28 companies receiving federal approval to offer discount cards, it is not clear how beneficiaries will obtain information to choose the one that will save them the most on their individual prescription needs (Antos 2004; Freudenheim 2004; Pear 2004c).

The vast majority of the elderly have limited financial resources: 40 percent have household incomes below 200 percent of poverty, and 40 percent have assets under $12,000 (Kaiser Family Foundation 2004). Yet the new law requires them to pay hundreds or thousands of dollars in shared costs, except for those beneficiaries with very low incomes, and even they will still need to make out-of-pocket copayments for each prescription. This problem will be exacerbated if, as the Congressional Budget Office and other analysts expect, large numbers of employers who currently provide retiree benefits try to drop them once the Medicare benefits become available (CBO 2003, 22; Freudenheim 2003a). Any effort to improve the benefits, however, will almost certainly be stymied in the short run by fiscal concerns. Already, the White House Office of Management and Budget estimates the ten-year costs of the drug benefits to be $534 billion, or 30 percent higher than the estimates that legislators received from the Congressional Budget Office before casting their votes on H.R. 1 (CBO 2004b; Pear 2004a). Legislators who believe that the true costs of the new program were concealed are not likely to expand it further in the short term, particularly in the midst of record federal budget deficits.

Second, the new law takes only small steps to affect the quality and economy of physicians' prescribing practices. It established the Medication Therapy Management Service (MTMS) provided by pharmacists or case managers, which was designed to ensure that the drugs covered are used appropriately to optimize therapeutic outcomes and reduce the risk of adverse reactions. The inclusion of MTMS is important because it recognizes the pharmacists' contributions to reducing costs and improving outcomes. But the law does not clarify the scope of MTMS activities or guarantee that Medicare beneficiaries will have access to such services. Nor does it confer provider status on pharmacists and make sure that they will be adequately reimbursed by the new prescription drug plans. These and other critical details will need to be worked out in the regulatory process.

Third, the legislation does not deal comprehensively with the need to control the cost of prescription drugs. There are no direct incentives

to prescribe cost-effective drugs, only a provision that requires pharmacists to notify beneficiaries of the difference in price between a brand-name drug and a therapeutically equivalent generic drug. Both Republicans and Democrats share the hope that pharmacy benefit management companies or insurance companies will monitor prescribing patterns and encourage the use of lower-cost medicines, but there are no compelling data to demonstrate savings from the use of pharmacy benefit management in either managed care or fee-for-service programs (Lipton et al. 1999; Lipton et al. 2000). In fact, some pharmacy benefit managers have profited from their intermediary position but have not passed on these savings to the purchasers or beneficiaries (Martinez 2003). Many policymakers are ready to reconsider price controls if the savings promised under drug discount cards do not materialize. For the time being, the Centers for Medicare & Medicaid Services is planning to monitor prescription drug prices to ensure that prices do not rise inordinately as the discount program takes effect (Pear 2003c).

If the past patterns of policymaking hold true, the action that Congress and President Bush began in 2003 will be only the first step in a serial process of reform. Nearly every episode of Medicare reform—whether adding new benefits, controlling costs, or creating new delivery systems—requires several years of legislation and regulatory development before those elements become routine parts of the program (Oliver and Lee 2000, 54–9). Much work remains, therefore, before political leaders can claim to have solved the problems that pushed this issue to the top of the nation's domestic agenda.

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