

**THE POLITICS
OF MEDICARE**

Second Edition

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Contents

Preface to the Second Edition	<i>xi</i>
Acknowledgments	<i>xv</i>
Preface to the First Edition	<i>xix</i>
Introduction	<i>xxiii</i>
PART I THE ORIGINS AND ENACTMENTS	1
1 The Origins of the Medicare Strategy	3
Twentieth-Century Medicine:	
The Paradoxes of Progress	3
Origins of the Government Health Insurance Issue	4
Universal Health Insurance Proposals in the Fair Deal	6
The Politics of Incrementalism:	
Turning toward the Aged	10
The Appeal of Focusing on the Aged	11
Focusing on Social Security Contributors	15
Pressure Groups and Medicare:	
The Lobbying of Millions	17
2 The Politics of Legislative Impossibility	23
Medicare under a Republican President	23
The Forand Bill versus the Welfare Approach	25
Kerr-Mills Bill of 1960	27
3 The Politics of Legislative Possibility	31
Medicare, 1961	31

The Obstacle Course in Congress:	
First Try with Ways and Means	32
The Southern Democrats	35
The Kennedy Administration versus the AMA	38
Medicare's Near Miss, 1964	41
4	The Politics of Legislative Certainty
	45
The Impact of the Election of 1964	45
The Administration's Proposal: H.R. 1 and S. 1	46
The Ways and Means Committee and the House	
Take Action: January-April	47
H.R. 6675 Passes the Senate: April July	53
Medicare Comes out of the Conference Committee:	
July 26, 1965	55
The Outcome of 1965: Explanation and Issues	56
5	Medicare and the Analysis of Social Policy in American Politics
	63
Case Studies and Cumulative Knowledge	63
Conceptual Models and the Medicare Case	64
The Origins of Medicare:	
The Rational Actor Model	64
The Responses of Medicare, 1952-64:	
The Organizational Process Model	67
The 1965 Legislation:	
The Bureaucratic Politics Model	69
Processes and Policy in American Politics:	
The Case of Medicare	71
Medicare and the Character of American Social Policy	80
6	Legislation to Operation
	87
PART II	THE POLITICS OF MEDICARE: 1966-99
	93
7	Medicare's Politics: 1966-90
	95
The Origins of Medicare Revisited	95

	The Politics of Accommodation: Medicare's Implementation and Subsequent Evolution from 1966 to 1970	96
	The 1970s: Ineffectual Reforms and Intermittent Progress	99
	The 1980s: The Challenge of the Reagan Era	107
	Conclusion	115
8	The Politics of Medicare Reform in the 1990s: Budget Struggles, National Health Reform, and Shifting Conflicts	123
	Introduction: The Changing Context of Medicare's Politics in the 1990s	123
	Medicare and the 1992 Elections: The Reawakening of Concerns	124
	A Negative Consensus on Health Reform	126
	The 1995 Trustees' Report and Claims of Insolvency	135
	From Legislative Impasse 1995-96 to Medicare "Reform" in 1997	137
	The Medicare Reforms of 1997: Understanding the Politics of Balancing Budgets	141
	Medicare Flip-Flop	147
9	The Ideological Context of Medicare's Politics: The Presumptions of Medicare's Founders versus the Rise of Procompetitive Ideas in Medical Care	151
	Introduction	151
	Medicare's Philosophical Roots: Social Insurance and the Presumption of Expansion	152
	The Rise of Procompetitive Ideas about Medical Care	157
10	Reflections on Medicare's Politics: Puzzles and Patterns	171
	Introduction	171
	Understanding Medicare's Politics: Patterns, Puzzles, and Explanatory Approaches	171
	Puzzle One: Structural Explanations and Medicare's Limited Evolution	173
	Puzzle Two: Insider Politics, Medicare's Price Controls, and the Puzzles, of the Reagan/Bush Era	175

<i>Contents</i>	<i>x</i>
Puzzle Three: Medicare 1995-99-Macro Politics and the Emergence of Unexpected Remedies	176
Conclusion	179
Medicare Scholarship: A Selective Review Essay	183
Glossary	193
References to Part I	207
References to Part II	213
Index	221

CHAPTER 10

REFLECTIONS ON MEDICARE'S POLITICS: PUZZLES AND PATTERNS

Introduction

This chapter sets out analytically what has been suggested – sometimes explicitly, sometimes implicitly – in the preceding chapters. This effort, parallel to what was done in chapter 5 of Part I, addresses the patterns of Medicare, the puzzles its politics pose, and the types of approaches one needs to make sense of those puzzles. The story of Medicare's operational development since 1966 is marked by both irony and turbulence. The social insurance philosophy that ensured its original appeal as a proposal used the trust fund terminology for Part A to suggest a sense of financial pre-commitment and thus political stability to Medicare. But, over time, forecasts of the trust fund accounting – and projections of 'insolvency' – have partly undermined the very sense of security the trust fund was supposed to engender. The administrative compromises deemed necessary for Medicare's passage in 1965 nonetheless contributed to the subsequent and worrisome inflation in medical care. That development in turn produced effects quite inimical to the expansionist intentions of Medicare's original sponsors. The understanding of these discrepancies, surprises and disappointments lies not so much in the Byzantine subtleties of legislative bargaining and the idiosyncrasies of political personalities as in the political forces that framed this bargaining and shaped program operations after 1965.

Understanding Medicare's Politics: Patterns, Puzzles, and Explanatory

Approaches

The preceding chapters on Medicare post-enactment describe a politics dominated by administrative and fiscal issues. Those politics paid relatively little attention to disputes over the medical needs of the elderly and whether the program was adequately addressing them. Medicare's first five years, from 1966 – 71, were years of “accommodation” to American medicine in Larry Brown's appropriate phrase. But the smooth and efficient implementation of the program was purchased at the cost of built-in inflationary pressures. In the 1970s, in contrast, there were substantive changes in benefits (for example, to cover dialysis and the disabled). But much more political attention was given to nationwide medical reform. The first puzzle this chapter discusses is not what happened in the 1970s, but whether it might have been different. So for example, is the explanation for Medicare's limited expansion one of the situational politics of the period? Or are the limits of expansion the result of more powerful, structural factors in the American political that not only determined the constraints on Medicare but shaped the fate of universal health insurance proposals more generally?

Medicare has always been the subject of intense interest-group politics. But concerns about spiraling medical costs and the growing federal deficit increasingly came to the public's attention and shaped political debate over Medicare in the 1980s and 1990s. Indeed, the politics of the federal deficit, it is not too much to claim, dominated Medicare policy debates from 1980 to the enactment of the Medicare reforms of 1997. The second puzzle analyzed in this chapter, then, is what explains this evident pattern of fiscal politics and the recurrent “crises” we have already described. And how can the

regulatory programs that emerged – from administered prices in the hospital industry to tightened fee schedules for physicians – be reconciled with the pro-competitive ideology of the Reagan-Bush administrations?

The struggles over Medicare in the 1990s, as Chapter 8 noted, were shaped by a variety of factors. The Clinton administration’s effort to implement national health insurance, the shift in partisan control of the Congress in 1994, the Presidential election of 1996, and growing fears that the impending retirement of baby boomers would leave Medicare “bankrupt” – all were components of the narrative account. Within that history, however, is a puzzle that calls for explicit analytical attention. Why did the reform ideas associated with the failed Clinton health insurance proposal of 1992-94 reappear as a plausible policy answer for Medicare in the period 1995-99? Why was there a flip-flop – particularly by Republican congressional leaders -- over “managed competition” when the topic changed from universal health insurance to the “re-form” of Medicare”?

These, then are the puzzles on which I want to reflect, each of which calls forth in my view a quite different type of explanation. A summary of Medicare’s politics in the three decades after enactment, however understandable, cannot substitute for a causal account. Put another way, the narrative of what happened cannot answer why those patterns emerged. To do so requires integrating three factors largely implicit in chapters 7 and 8. One has to do with contemporary interpretations about the state of the economy and political order at any one time and their impact of those beliefs on the definition of Medicare’s “problems” and the range of plausible “remedies”. Medicare’s standard operating procedures – and the accepted organizational ideas they reflected – constitute

the second category of causally important factors. And, thirdly, there are the changing distributions of political power within the formal institutions of government, especially shifts in the party affiliation within the Congress and between the Congress and the Administration. All three of these causal factors are important: the first to define the problems that were on the political agenda, the second to specify the range of options that were operationally available, and the third to account for what choices were made among the options available to deal with the problems identified. Just as with the explanation for Medicare's enactment, the scholarly explanation for Medicare's political history requires attention to these quite distinguishable levels of analysis.¹

Puzzle One. Structural Explanations and Medicare's Limited Evolution:

A striking feature of Medicare's evolution since 1965 has been continuity – in basic financing sources, range of benefits, types of regulation, and, less obviously, beneficiaries. Put another way, for a program understood by reform advocates as the first step to universal health insurance, the puzzle is why there has been no dramatic expansion of who is covered or for what medical costs. (By contrast, for example, the politics of expansion in Canada proceeded in two large national steps: universal hospital insurance legislation and implementation 1957-61 and then physician coverage 1968-71.) The absence of fundamental expansion does not, of course, mean no change in policy, program operation, or coverage, as Medicare's inclusion in the early 1970s of the disabled and victims of renal failure illustrates. Nonetheless, the limits on expansion require explanation just as does the expansion beyond previous limits.

One approach to why Medicare has been constrained in expansion – and universal health insurance stalemated for most of the twentieth century – is what we have termed a “structural” account of political change. (Marmor and Mashaw, 1996, p. 68 ff.)

Structural explanations begin with the constitutional allocation of political authority, which means in the United States the fragmentation of institutional power expressed formally as separation of powers and federalism. This constitutional fragmentation means that large-scale policy change is less likely in the United States, other things equal, than in regimes with more unified political authority. Indeed, something close to super-majorities are required to overcome the legislative gauntlet civics books describe as “how a bill becomes a law.” A second structural constraint on political action is the distribution of fundamental beliefs about what government should and should not do. By that I mean not the slogans of particular parties or political contestants, but the underlying, deeper ideological commitments those slogans are meant to engage.

Viewed through this analytical lens, the structure of American politics is one of hobbled majoritarianism. Even where mass preferences appear clear – as with majority support for universal health insurance over most of the decades since the 1930s – the dispersion of authority provides ample opportunity for derailing reform plans. In addition, the underlying ideology of the American public is at best ambivalent about the positive role of government in domestic life. An “enduring unease regarding state interference awkwardly coexists with an acceptance of state involvement in specific social welfare programs.” (Jacobs, 1993, in Marmor & Mashaw, 1996, p.650)

The implication of this structural account should by now be reasonably clear. Medicare’s enactment emerged under extraordinary circumstances, a super-majority in

the aftermath of the Kennedy assassination and the overwhelming Democratic victories in the presidential and congressional races of 1964. Absent such majorities, one should not be surprised at limits on major change in Medicare – or continued stalemate over universal health insurance coverage either.

There is one counterfactual that might well arise in connection with this structural approach. If super-majorities are both rare in American politics and crucial to explaining major change, did Medicare reformers make a huge mistake in 1965 in limiting their aspirations to what had been on the agenda in less propitious times? Were they, to use the vernacular, “stupid” not to demand more? Should they have tried to make Medicare an instrument to reform American medicine then rather than an adaptation to it? To answer such questions requires attention to the understandings of the participants in the negotiations over Medicare’s enactment, details presented in the narrative, but analytically highlighted by what the first edition identified as Allison’s model of “bureaucratic politics.” The more one understands those parties, the less “stupid” their choices seem. But, equally, the risk-averse decisions of the 1960s, however comprehensible, were consequential. They rested on presumptions about Medicare’s incremental expansion that simply did not turn out to be the case, as Chapter 9 emphasizes.

Puzzle Two. Insider Politics, Medicare’s Price Controls, and the Puzzles of the Reagan/Bush Era

How can one explain the seemingly puzzling fact that in the 1980s presidential administrations committed to a free-market ideology agreed to impose administered prices on American hospitals and physicians? It is certainly not the case that the

structural constraints of American constitutional design entailed anything like diagnosis-related group payment for Medicare's hospital bills. Nor are there grounds for believing this was largely circumstantial, a seeming accident of a special, momentary configuration of setting, participants, and interests. Rather, the regulatory pattern of the 1980s emerged over years and has been sustained. Here, the most promising explanatory approach is a hybrid, something in between the constraints of fundamental structures and the momentary alignment of political forces. This is the explanatory approach Chapter 5 characterizes as "organizational"—paying attention to "stable, institutional rules and relationships, the inertial weight of existing arrangements, and ideological commitments that are malleable, but not in the short run." (Graetz and Mashaw, ms. Ch.15 –375)

The existing rules and relationships for Medicare policymaking in the 1980s were those we can call "insider politics." The relevant participants were the congressional committees with jurisdiction, the interest groups most affected by Medicare's payment policies, and the administrative officials in HCFA – all of whom dealt with each other regularly. To the extent the Reagan Administration wanted constraints on Medicare's hospital outlays, the range of relevant options – absent a super-majority of Republican legislators – were those acceptable to congressional Democrats in leadership positions, to managers in HCFA, and to significant sectors of the hospital community. The congressional Democrats presumed reliance on Medicare's history of regulating hospital prices. The interest groups had some familiarity with DRGs from experiments in New Jersey. HCFA officials had fostered and indeed financed the experiments that made DRGs an operational option. Without such understanding, Medicare's expansion of prospective reimbursement and tighter fee schedules during the Reagan-Bush era of the

1980s would be truly anomalous. Whether we call this micro-politics or insider politics, the puzzles it resolves are very different from those changes whose explanation demands attention to large-scale changes in the external political environment.

Puzzle Three. Medicare 1995-99: Macro Politics and the Emergence of Unexpected Remedies

A visitor from Canada who observed the fight over the Clinton health reform proposal in the early 1990s would, had she returned in 1995, been surprised by the advocacy of Republican legislative leaders for a system of vouchers in Medicare. Had the visitor stayed on to observe the struggle over the terms of the Balanced Budget Amendments of 1997 and the subsequent deliberations of the National Bipartisan Commission on the Future of Medicare, the puzzle would have deepened. Indeed, the key question might well have been the one raised at the close of chapter 8: how to explain the flip-flop of previous critics of “managed competition” when the object of reform changed from universal health insurance to Medicare.

My approach to that puzzle is to emphasize the impact of large-scale shifts in the balance of political power within the government. These electoral shifts, in turn, determine what problems are highlighted or subordinated, and what range of remedies are considered feasible or infeasible. Most simply put, the unexpected shift to Republican control of the Congress in 1994, combined with the constraints imposed by the balanced budget politics of 1997, made this flip-flop plausible where it once would have been extraordinary.

There are a number of explanations for the flip-flop that are simply wrong. It was not the case, for example, that public opinion shifted sharply and politicians were feeling

pressure to make managed care dominant within Medicare (Aaron and Reischauer, 1995, 1998). If anything, the appeal of managed care within the broader American public had dropped precipitously in the 1995-98 period. (Harris Poll, 1999)ⁱⁱ. Note, in addition, that since enactment public opinion has never been a major innovative force in Medicare policymaking. To the extent public opinion has been influential, it has set limits on efforts to transform Medicare, particularly serving to constrain program cutbacks. (Oberlander, 1995, 249-54). In so far as voucher proposals were an attempt to cut back public benefits indirectly, there was no demand for them from the public. (Public opinion may doom voucher reforms; it did not produce them).

Nor did electoral shifts in 1998 -- or changes in the announced positions of the Democratic or Republican parties -- play a major role in the demands for a major transformation of Medicare in 1998-99. The other sources of traditional political science explanations offer some limited help here. Interest groups within the medical care industry surely had a role in popularizing both managed care and competitive models of cost control throughout the decade. But that was close to a constant throughout the 1990s; a constant cannot itself explain the unexpected prominence of vouchers in 1998-99.

What can is a complicated (and unplanned) combination of elements, none of which alone would have produced the resultant outcome. Chapter 8 noted the conversion of Republican leaders to a managed competition plan for Medicare, with vouchers renamed "premium support", and the influence exerted by the AMA and the Federation of American Health Systems. To understand this conversion experience requires distinguishing Republican distaste for "big government" initiative (like the Clinton health reform plan) from Republican pragmatism about how to control existing government

programs (like Medicare). Vouchers appeal generally to Republicans and, in the case of Medicare, they seemed an acceptable way to reduce federal expenditures in the future and thus to secure the balanced budget that fiscal policy conservatives had long sought. (White, APSA 1998 paper) The use of "premium support" as a synonym for vouchers illustrated the search for euphemisms that excited less controversy. Voucher proposals had been notoriously conflictual in the world of public education and the notion of supporting premiums seemed a more neutral expression. The policy idea, nonetheless, was obvious, even if linguistically masked. The theory held that with a fixed sum Medicare beneficiaries would shop for the insurance plan they wanted, with competition among the plans holding down inflation. Relying on that reasoning, advocates projected considerable savings from what Medicare otherwise was projected to spend in the decades after 1998. Then the game shifted to expanding benefits, including most prominently prescription drugs. With cost control predicted, benefits expanded, competition at work, and choice to be enhanced, the conventional claim by the late 1990s was that Medicare would finally be ready for the 21st century.

The work during 1998-99 of the 17-member Bipartisan Commission illustrated the rise to prominence of this perspective. The Commission, as noted, disbanded without a formal recommendation. But, within little more than a month, two developments took place. First, the Medicare trustees reported that the hospital account was in much better condition than anyone had predicted just a year before. Medicare's expenses generally rose by only 1.5 percent in 1997-98 and the Part A trust fund would have enough funds to pay its bills until 2015. This was hardly the crisis requiring immediate reform of

Medicare and called into question the presumption of unaffordability that had dominated Medicare debates from 1997 to early 1999.

The headlines prior to the Commission report's release captured the direction of proposed reform; the Boston Globe claimed that "sweeping Medicare overhaul is planned," and that a "free market solution [was] touted to cut costs." (February 28, 1999) The Breaux-Thomas proposal in 1999 that Medicare be transformed into a quite different program conflicts simply with both what public opinion experts would have predicted and commentators within Washington would have thought imaginable in 1993-94. But the suggestion that Medicare requires fundamental alteration is precisely what a substantial proportion of the elite political community contemplated in 1998-99.

What is striking upon reflection is how unsubstantiated were the premises from which the reform proposal proceeded. Medicare was, according to this view, not sustainable in its traditional form. So expensive that it was sure to "run out of money" in time, Medicare was labeled as archaic according to [self-identified] "health care specialists". Seen as "out of touch with modern medical realities", Medicare, for the Commission's majority, ought to "harness the power of market competition to lower cost and improve quality of care." (Boston Globe, February 28, 1999)

And yet each of these premises conflicted with facts known in 1999 by most Medicare scholars. Medicare was hardly unsustainable in its present form; in 1997-98 its outlays had increased by a mere 1.5% and for most of its history its costs had increased no more than the private health insurance plans with which it was being compared. Further, the question of "running out of money" represented an intellectual confusion. As discussed in chapter 8, it involves the substitution of the thermometer of the trust fund for

the causes of genuinely unaffordable outlays. (No one would warn that the Defense Department would become insolvent in discussions of military financing; the notion of insolvency was an artifact of accounting procedures, not an unavoidable feature of the real economy.) Finally, the claim that Medicare was 'archaic' represented sheer perversity. The developments in American medicine during the 1990s had made so-called 'managed care' a butt of jokes among ordinary Americans, not a model to be followed. In addition, the claim that managed care could save substantial expenditures was intellectually undermined by the very surge in private insurance outlays in 1998-99. The appeal to the supposed virtues of 'managed care' in 1999 was more a function of interest group rhetoric and elite presumptions about interest group power than popular consultation or defensible analysis.

Yet, the conventional competitive strategy for Medicare reform did not constitute an inexplicable anomaly. It was an outcome no one would have expected at the beginning of the decade, but whose lineage is clear with hindsight. Once the Clinton Administration embraced 'competition' as the right answer to America's medical woes in 1993, the President could not easily reject that "solution" for Medicare when Republican and conservative Democratic legislators embraced it again in 1999. To do so would be to discredit his New Democrat conviction that big government was no longer required and market devices were generally the most effective instruments of public policy. Republican control of Congress after 1994 meant, moreover that their leaders could be counted on to advance such market solutions.

Just as with the birth of Medicare, the changing partisan composition of the Congress made the crucial difference. Had President Clinton returned for a second term

with a Democratic Congress, he would not have been impeached and the Medicare Commission's radical reforms might well have been rejected out of hand. The question for Medicare's future in 1999 would have been whether liberal Democrats could persuade the President to reject the reform proposal his own rhetoric had helped to generate. That outcome, at this writing (May 1999) was unknowable. But what can be claimed with certainty is that the framework for debating Medicare's future had been substantially altered once again by the partisan composition of American politics. (Peterson, 1999)

The question for futurologists is not so much to project Medicare's expenditures or the obvious demographic pressures but to anticipate the varying political responses that different coalitions will make in the first decades of the 21st century.

Conclusion

Part I examined the politics of Medicare's enactment and answers one particular set of questions. How could the American political system yield a policy that simultaneously appeased widely held anti-government biases and yet used the federal government to provide a major social insurance entitlement? How was one particularly strong interest group - the AMA - overcome legislatively and yet placated enough to participate in Medicare? Most of all, how did the Medicare law emerge so enlarged from the earlier proposals that themselves had occasioned such controversy? The chapters of Part I explain the rather curious progression by which the primary and strategically narrow aim of "initially" providing federal hospital insurance for the elderly (Part A) was at the last minute substantially expanded, with the approval of former opponents. That 1965 legislative expansion included the separate contributory insurance program for physicians' fees (Medicare Part B) as well as state-administered Medicaid,

thereby producing what was commonly referred to as an unexpected "three-layer cake." These puzzles of Medicare -- the movement from idea to legislation, the surprisingly comprehensive result, and the attendant explanations -- belonged to a particular time and a distinctive way of viewing Medicare's enactment politics that chapter 5 discusses in detail.

The story of Part II is quite different. Its subject is the changing politics of Medicare since 1966, the politics of administration. This raises a new set of questions about Medicare for a different set of actors, both new and old. Medicare became over time a key part of the extraordinarily complicated political and economic world of American medicine. Through most of these years, for example, medical inflation rose far past everyone's worst fears (the 1998 estimates of fourteen percent of gross national product consumed by expenditures for medical care represented a more than two-fold increase in three decades). Cost control -- in the form of a variety of federal, state private initiatives that first appeared a few years after Medicare -- regularly disappointed budget officials. National health insurance largely disappeared from the nation's political agenda between 1979 and 1989. Throughout the whole period of 1966-1999, Medicare's political fate was shaped as much by broader forces in the environment as by developments within its narrower medical care domain.

The hopes and expectations engendered by Medicare's passage gave way over time to doubts about the effectiveness of American government and ideological confusion about what Medicare's performance really signified. This was clear by the late 1990s, when Medicare returned to public prominence. What emerged was a largely unapologetic, dynamic, market-oriented medical and political environment -- an

environment that partly reflected Medicare's disappointments. It was (and is) a medical environment in which too many patients came to be turned away from emergency rooms and sent to beleaguered public hospitals; in which pressures on hospitals encouraged too many doctors to discharge their patients prematurely. It is as well a context in which benefit exclusions, deductibles, and co-insurance have eroded the comprehensiveness of the protection to which Medicare originally aspired and one in which broader questions of patient rights have become prominent. The question in the spring of 1999 was not "when will national health insurance be enacted?". Rather, for traditional supporters of Medicare, it was "can the program retain (or improve on) the gains made in access, security, and equity for the old and, especially, can prescription drugs be added to Medicare's benefits?". And, for the critics, the issue was "how to reform an archaic, unsustainable, Medicare program out of touch with the realities of American medicine?" (Boston Globe, Feb.28, 1999).

It should come as no surprise to the reader that at the end of the twentieth century there remain deep ideological divisions over the purposes, structure, and future of the Medicare program. As the first edition of this book showed, the critics of Medicare's original formulation were defeated, not converted. The enactment of Medicare came in the wake of a seismic shift in the electorate and a transformation of the congressional balance of partisan power. The puzzles of this final chapter illustrate the interplay of causal influences outside of Medicare and those more closely related to the program's organization and immediate constituencies.

So, for example, there is no way to understand the frustrated expansionist ambitions of Medicare's architects without taking into account the impact of the Vietnam war controversies and the stagflation of the 1970s on the evaluation of the Great Society's reforms and the political fate of national health insurance in that period. The Reagan era brought with it not only divided government but also the creation of a fiscal politics that would powerfully (re)shape the overall public policy environment. And, finally, as this chapter has emphasized, understanding Medicare's fate in the 1990s requires attention to the context in which the Clinton administration experienced humiliating defeat over health reform in 1993-94. That context changed substantially through the rest of the decade. With Republican control of the Congress, Democratic control of the White House, and the fiscal orthodoxy of a balanced budget in place by 1997, the options for Medicare's future and their political prospects were bound to alter.

Nonetheless, the options for Medicare's future are not simply a matter of reading the bills introduced in recent Congresses. Nor are they simple extrapolations of trends in progress. Rather, as with Medicare's origins, efforts to change the program reflect presumptions about the role of government in American life and the purposes of social insurance in paying for medical care. Medicare's fate will soon be intertwined once again with proposals to expand insurance coverage for the nation. That much was plain by the fall of 1999 from developments in the presidential campaign. It was equally obvious that controversies about "managed care" and whether Medicare should embrace or reject its expansion were squarely on the agenda of American politics. The agenda's range, however, is subject to transformation by both electoral and economic shifts, and no one

can claim with certainty what the political and economic environment will be like a few years, let alone decades, ahead.

What can be concluded, however, is that the politics of Medicare will consist of two types of policy disputes: first, relatively narrow but intense policy conflicts where the ideological cleavages in the broader public are largely irrelevant and, second, those relatively rare but more fundamental controversies where the deepest divides in the American polity are crucially relevant. That is what the politics of Medicare reveals, both in its origins and in its programmatic history.

End Notes

ⁱ It is also useful to analyze Medicare's politics by the program's substantive features. Jon Oberlander has done precisely that, and I have relied in Chapter 8 on his generalizations. Oberlander found three patterns in Medicare policy disputes: struggles over benefits (with a pattern of non-distributive politics), over financing (where the pattern has been one of crisis politics) and over federal payments (where the politics have centered on the budget). Benefits policy means what Medicare does and does not pay for – including longstanding issues of whether prescription drugs and long term care should be included in the services insured by Parts A and B. Oberlander describes the “pattern” in this area as “non-distributive politics”. By that, he means simply that Medicare's development since 1966 has not been one of expansion of benefits, “despite the existence of political incentives that [according to scholars like James Q. Wilson (Wilson, 1973, Pol.Org.ch.16,) in Oberlander, p5] might have generated the politics of distribution.” To be sure, Medicare came in the 1970s to insure new beneficiaries -- victims of renal failure and the disabled under Social Security. But the generalization still holds. Medicare has not experienced persistent expansion of its health insurance benefits even though those who stand to gain from the program – both insured and providers -- have been well-organized to demand expansion.

Secondly, the “core feature of Medicare financing policy has been *crisis politics*.” (5) What Oberlander means here is that the structure of Medicare's financing arrangements – the sources of funds ranging from payroll taxes to general revenues to beneficiary contributions – has “created recurrent bankruptcy crises,” as chapters 7 and 8 emphasized, prominent, “focusing” events in the program's politics. (5).

The third category is Medicare's regulatory politics, the program's policies affecting “payment to medical providers ...and the medical practices of these providers.” The main pattern here, according to Oberlander (5), “has been budgetary politics” in which the regulation of hospital and physician payments has largely responded to fiscal pressures and become intimately “intertwined with the federal budgetary process.” The key generalization is that “crises in Medicare financing explain the timing and political viability of [most] of Medicare's regulatory reforms.” This characterization was crucial to Part II's account and highlighted in the reflections of the final chapter.

ⁱⁱ In fact, the public was voicing increasing unhappiness with managed care in the private sector at precisely the same time that Washington began to talk seriously about applying the managed care concept to Medicare. (Harris Poll, 1999)