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Political Economy, Moral Economy and the Medicare Modernization Act of 2003

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Through the lens of political and moral economy, I examined the dominant values and actors in the legislative process of the Medicare Modernization Act of 2003. In my content analysis of federal hearings, I found that witnesses from government agencies, Congress and think tanks had almost equal presence at the hearings. Witnesses who were invited by Congress to testify at the hearings expressed twice as much support for private interests than for the general Medicare population or low-income beneficiaries. Few expressed concern for the uninsured population. Witnesses offered almost four times as many expressions of support for market rationalism than social insurance and three times as many than for improving Medicare's solvency/sustainability. The 2008 presidential candidates are split between support for social insurance and support for the private market. Medicare advocates will need to devote extraordinary efforts to significantly counterweigh the strength and influence of market rationalists.

Keywords: Political economy, Moral economy, Medicare Modernization Act of 2003, Medicare, Privatization, Market rationalism, Social insurance

Who decides, in the federal legislative process, who wins and who loses? Is it the public through their Congressional representatives? Is it the state, through the president and his
administration? Or, does policy reflect the economics and politics of market rationalism and the power of corporate capital (Estes, 2001)? The political economy model elucidates how social policy reflects the structural arrangements of society and the distribution of resources within it. Political elections disguise the reality that private property and capital determine the availability of public expenditures. Estes notes that the state is funded through and dependent on the resources generated by private profit and wealth, creating state interest in facilitating the growth of private property. Thus the state provides business with incentives to maximize profits and imparts limited resources to sustain the health and welfare of its citizens. Health care services, transformed into commodities, are viewed as economic products rather than social goods.

The moral economy model provides a conceptual lens to examine the composition of normative practices and reciprocal arrangements contextualized within shared beliefs and values about what is socially just (Hendricks, 2005). Market rationalists believe the market is the best social mechanism for exchanging goods and services, assuming that competition and profit-seeking will create fair exchange for consumers and higher rates of return for capital (Johnson, 2000). As part of their repertoire, market rationalists promote privatization, a transfer of public services provided at various levels of governments to the private sector (“Privatization,” 2007). Market rationalism, which reinforces the ideals of “individualism, self-reliance, independence, and gainful productivity as a measure of worth” (Hendricks, 2005, p. 515), is privileged in today’s political economy. In policies informed by productivity and economic priorities, the health and well-being of individuals and groups are cast as commodities as hegemonic interests exert their influence on the moral codes accepted by society. This study examines the actors and values that influenced the Medicare Modernization Act of 2003 (MMA) and analyzes the results within the context of public opinion on the legislation.

After a brief review of Medicare’s history in section one, including the actors involved and amendments to the program, section two outlines the study methodology. In section three, the research results are detailed, noting the predominance of support for market rationalism and private interests over concern for Medicare and its beneficiaries. Section four
Political and Moral Economy of the MMA

summarizes the views of providers and beneficiaries as reported in surveys and opinion polls. The paper concludes with a discussion about the influence of the pharmaceutical industry on the MMA legislation, the 2008 presidential candidates' platforms on health care, and a final note on the political status of Medicare.

**Medicare’s History**

Until the passage of Medicare in 1965, the American Medical Association (AMA) had successfully framed any form of national health insurance as a "first step" toward socialism (Oberlander, 2003; Quadagno, 2005; Smith, 2002). Because of resistance from the conservative coalition that included southern Democrats, the AMA, employer groups, insurance companies, and some trade-unions, presidents from Franklin D. Roosevelt to John F. Kennedy were unable to garner the congressional majority necessary to enact such legislation. Bipartisan controversy split along ideological lines in favor of market rationalism until three events happened: 1) the Democratic president in office had a definitive social vision (the Great Society) and powerful influence over Congress, 2) the Democrats gained control of Congress, and 3) trade union leaders defected from the conservative coalition. President Lyndon B. Johnson signed the Medicare legislation into law on July 30 as part of the Social Security amendments of 1965. The Medicare program was modeled after private health insurance plans and, despite their misgivings, medical providers profited from Medicare. Hospitals were reimbursed at cost plus 2% and physicians were compensated for whatever costs the market would bear. Health care expenditures rose dramatically. The increasing fees along with the lack of accountability and controls in Medicare's reimbursement process prompted administrative concern over the program's costs and its portion of the federal budget. Yet, attempts by the federal government to contain health care costs via freezing price increases, utilization review boards, and professional standards review organizations were ineffectual.

Alternative payment systems were encouraged through the Social Security Act (SSA) of 1972 and the Health Maintenance Organization (HMO) Act of 1973. The 1972 SSA legislation made provisions for research and demonstration projects, waivers (dispensations from Medicare regulations) for
experiments, and Medicare Health Maintenance Organizations. The 1973 HMO legislation utilized the private sector approach of payment capitation within HMOs to contain health care costs. Capitation systems pay the provider a flat fee per enrollee over a specified time period, frequently per member per month. Pro-market idealists favor capitation because it encourages competition and cost-saving mechanisms among providers.

The ideological debate on controlling health care costs formed around pro-competition (e.g. capitation) and pro-regulation (e.g. fee schedules) methods (Smith, 2002). In 1982, President Ronald Reagan signed into law the 1982 Tax Equity and Fiscal Responsibility Act (TEFRA). In addition to introducing new cost containment methods for hospitals and physicians, TEFRA provided incentives for HMOs to enroll Medicare beneficiaries. TEFRA was followed by the Prospective Payment System of 1983, which based reimbursement on diagnosis-related groups, and the Medicare Fee Schedule (part of the Omnibus Budget Reconciliation Act of 1989), which based reimbursement on resources used and work accomplished. Until the 1990s, all major reforms except those pertaining to Medicare HMOs followed fee scheduling and price regulation.

A major shift in program philosophy would have occurred in 1986 with the Catastrophic Coverage Act (CCA), which would have required beneficiaries to pay for additional benefits through self financing (Oberlander, 2003). However, the CCA was repealed the next year due to a public misunderstanding of and ensuing opposition to the Medicare benefits and supplemental insurance. The ideological shift from social insurance to market rationalism did take place a decade later when the Republicans gained control of Congress. After a debate over Medicare’s first principles, Congress created the 1997 Balanced Budget Act (BBA). The BBA created Medicare + Choice, a new structure for private insurance plans within Medicare that included HMOs and Medical Savings Accounts, tax-privileged savings accounts that can be used to pay for health care. When the private market failed to produce savings, HMOs exited Medicare + Choice leaving beneficiaries scrambling to find replacement plans. Subsequent research showed that over the three decades from 1970 through 2000, Medicare was more successful than private insurance in controlling costs.
per enrollee (Boccuti & Moon, 2003). The Medicare capitation system currently provides payments to private plans under a diagnosis-based risk adjustment model (for more detail see Pope et al., 2004).

Since 1995, Congress has continually increased payments to Medicare + Choice (renamed Medicare Advantage in the Medicare Modernization Act of 2003). The siphoning off of funds from traditional Medicare to Medicare + Choice plans has had the effect of reducing the Medicare Trust Funds and destabilizing the program’s financing (Marmor & Mashaw, 2006). The Medicare Modernization Act of 2003 was a big step taken by market rationalists to erode Medicare’s social insurance structure. Social insurance entails government responsibility for its citizens through spreading risk across a large population—rich and poor, healthy and sick—in order to reduce financial risk to individuals. The MMA provides prescription drug coverage to beneficiaries under Medicare (Medicare Part D), either through stand-alone drug insurance plans for individuals wishing to remain in the traditional fee-for-service program or through new private managed care networks (CQ Weekly, 2003). The legislation was crafted in isolation from Democratic opposition and passed in 2003 with support of AARP, Pharmaceutical Research and Manufacturers of America (PhRMA), and insurance companies. In the name of improving competition and incentives to remain in the market, subsidies are being provided to private insurance companies and employers, and Medicare is prohibited from using its leverage to negotiate lower drug costs. Additionally, wealthier beneficiaries are being charged additional premiums for Medicare Part B; Health Savings Accounts (formerly Medical Savings Accounts) are being promoted through tax incentives to those buying individual rather than group insurance; and an alert procedure is established for the President to notify Congress to take action when the percentage of Medicare reimbursement from general funds reaches 45%. The alert is sure to recur, as traditional Medicare loses more funding through payments to private plans and incurs greater costs by being prohibited from using its negotiating power to achieve lower drug prices.

The crafters of the MMA, hypothetically to maintain beneficiaries' sensitivity to prescription drug costs, created a gap (referred to as the "doughnut hole") in the Medicare Part D
coverage. Through the doughnut hole, which begins once they reach an initial limit of total drug expenses ($2,400 in 2007) and ends when they reach a "catastrophic" threshold of drug expenses for the year ($5,451 in 2007), beneficiaries receive no prescription drug coverage. Medicare Part D beneficiaries must continue to pay their monthly premiums through the coverage gap even though they are not receiving the drug benefit. In 2007, the number of beneficiaries without meaningful coverage through the gap is almost 7 million (Steinberg, 2006). Individuals with plans that do provide meaningful coverage through the gap will experience substantial increases in their monthly premiums at a national median of about 87%.

Estes (2005) has noted that prior to 1997, private plans were promoted to reduce costs; in 1997 the BBA promoted private plans to provide choice; and from 2003 forward, private plans have been promoted as the only way to update and expand Medicare benefits, giving greater payments and flexibility for private plans compared to traditional Medicare.

Methodology

Scholars contend that legislative hearing testimonies are used as a key method to influence legislation and that such testimonies are reflected in policy options, which can be conceptualized as "sets of value priorities and causal assumptions" (Baumgartner & Leech, 1998; Knoke, 2001; Sabatier & Jenkins-Smith, 1993, p. 16). Via a content analysis of federal hearings on the Medicare Modernization Act of 2003, this study identified: a) the actors who were invited by Congress to provide testimonies; and b) the recurring values that the actors expressed in their testimonies.

Sample

Testimonies are the unit of analysis in this study. The study analyzed the distribution of testimonies available through the Lexis-Nexis Congressional Information System electronic hearing database. All testimonies available in the database were collected using the following criteria: a) they occurred between January 1, 1999 and December 31, 2003, the date when the legislation was enacted; b) they were listed under the
subject heading search term “Medicare Modernization Act”; and c) the hearing specifically addressed Medicare reform. Witnesses were identified over the entire study period January 1, 1999 through December 13, 2003. The testimonies selected for coding were presented to Congress in 2000 and 2001, the years that contained the greatest frequency of testimonies. The coded sample comprised half (n=90) of the total number of testimonies (n=180).

**Data Analysis**

Atlas.ti, a content analysis software package, was used to measure values by outright expression or times mentioned by witnesses in their testimonies. The testimonies were examined based on their thematic cohesion within two ideological categories, market rationalism and social insurance. The market rationalism category comprised values that included: a) relief from government regulations, b) control of national health care by private interests, c) individual choice, control, and self-responsibility/assumption of risk, d) generational equity, and e) market solutions [e.g. competition, means testing and reducing entitlement benefits], and f) the use of managed care, pharmacy benefit managers and formularies to reduce costs. The social insurance category comprised values such as such as: a) support for traditional Medicare; b) citizen entitlement to the earned benefit; c) benefit adequacy and accessibility; d) intergenerational interdependence; e) shared responsibility/risk pooling, and f) government solutions [e.g. use of government leverage, administration, regulation and oversight to reduce costs].

**Results**

The study involved: a) identifying and classifying the witnesses who testified in the years 1999 through 2003; b) identifying and classifying the population sub-groups who received the witnesses’ expressed support; and c) coding the value domains that were consistently expressed by witnesses in their testimonies in the years 2000 and 2001. The witnesses were categorized into four major affiliation groups: 1) government agencies (n=38); 2) US Congress (n=38); 3) think tanks/interest groups [hereinafter think tanks for brevity] (n=36); and 4)
assorted private interests (n=50) [comprised of witnesses from health insurance (n=15), healthcare providers (n=10), business (n=10), pharmaceuticals (n=8), and pharmacy/pharmacists (n=7)]. The remaining seven witnesses were from state government (n=3) or did not indicate affiliation with any organization (n=4).

As depicted in Figure 1, witnesses expressed support for three major population groups in their 2000 and 2001 testimonies: 1) private plans (n=64) [in general (n=31), or by type (n=33) which included pharmaceuticals (n=10), healthcare providers (n=9), pharmacies or pharmacists (n=7), and insurers (n=7)]; 2) the entire Medicare population (n=29); and 3) low-income Medicare beneficiaries (n=29). Just under half (46%) of the witnesses expressed support for market solutions; 27% expressed support for regulatory relief/flexibility; a quarter (24%) expressed support for individual control/choice. Twenty-eight percent supported government solutions and just over a third (34%) expressed a desire to improve Medicare’s solvency/sustainability. Few supported complete private control over the drug benefit.

Figure 1: Number of MMA witnesses (n=90) expressing support for selected population sub-groups

Of the witnesses at the 2000 and 2001 hearings, those associated with government agencies expressed the greatest support for market solutions (65%); over half (53%) of whom also expressed concern for Medicare’s solvency/sustainability.
(see Figure 2). More than half (n=54%) of the witnesses from think tanks expressed support for market solutions. Of the congressional witnesses, close to half (45%) expressed concern for program solvency/sustainability, a third (33%) supported market solutions, and over a quarter (28%) expressed support for individual control/choice, regulatory relief/flexibility or government solutions. Six of the 10 witnesses associated with health insurance expressed support for regulatory relief/flexibility and half (50%) supported individual control/choice in their health plans. Witnesses associated with health insurance expressed no support for government solutions. Two-thirds (66%) of the witnesses representing healthcare providers expressed support for market solutions, and half (50%) supported private control and regulatory relief/flexibility. A majority of academic witnesses expressed support for government solutions (50%). All of the witnesses from pharmaceutical companies expressed support for market solutions, and most (80%) supported regulatory relief/flexibility as well as individual control/choice. Close to two-thirds (60%) of the witnesses who were associated with pharmacies expressed support for government solutions. Witnesses from businesses expressed some support for three values: 20% each for regulatory relief/flexibility, market solutions, or government solutions.

Public Opinion

Public opinion on the MMA through 2004 has been mixed (Shaw & Mysiewicz, 2004). Initially (1999-2001), most respondents from multiple surveys expressed high support (between 70% and 74%) for a prescription drug benefit, even if it meant additional premiums. Opinion was split on whether the benefit should be provided by government or through individuals paying private plan premiums. After the MMA passed (2003/2004), about one-half of respondents stated they felt the MMA would help drug companies more than Medicare beneficiaries. From one-half to two-thirds felt the program did not go far enough and from one-quarter to one-third stated they felt the MMA would help beneficiaries.

The Kaiser Family Foundation surveyed respondents’ perceived effects of the MMA on beneficiaries (Kaiser Family Foundation, 2007a; Kaiser Family Foundation & Harvard
School of Public Health, 2006). Physicians and pharmacists who were surveyed stated that the MMA helped beneficiaries save money, especially individuals with low incomes. Yet they also said the plan was too complicated and that it benefits health plans and drug companies too much. Pharmacists said the plan works well at getting beneficiaries access to prescription drugs they need, however, almost a quarter said “most” and about half said “some” of their clients had problems filling prescriptions. As of November, 2006 most Medicare beneficiaries who signed up for the prescription plans were pleased. Ninety percent of seniors favored allowing the government to negotiate with drug companies for lower prices. Sixty-five percent favored spending more federal money to get rid of the existing coverage gap. Adults ages 18 and older agreed that improving coverage for the uninsured and reducing health care costs should top the health care agenda for Congress and the President in 2007.

In summary, during the 1999 through 2003 MMA
hearing, witnesses from government agencies, Congress and think tanks had almost equal presence. Overall, witnesses expressed twice as much support for private interests than for the general Medicare population or low-income beneficiaries. Few expressed concern for the uninsured population. Witnesses offered almost four times as many expressions of support for market rationalism than for social insurance and three times as many than they did for improving Medicare’s solvency/sustainability. Because of their greater frequency in providing testimonies at the hearings, witnesses from Congress, government agencies and think tanks provided most of the expressions of support for market rationalism. Witnesses from health insurance companies also expressed overwhelming support for market rationalism and almost no support for social insurance and, although their number was small, witnesses from pharmaceuticals gave eight times as many expressions of support for market rationalism than for social insurance. Across various polls and surveys, the public and their providers appeared mostly to be pleased with the MMA, although they felt the prescription benefit provided too much to the drug companies. Almost all seniors favored allowing the government to negotiate with drug companies for lower prices and most favored spending more federal money to close the existing coverage gap. Adults of all ages felt Congress and the President should prioritize helping the uninsured gain coverage as well as lowering health care costs.

Discussion

Economic, social and historical events affected Medicare’s inception and subsequent reforms. Wars, demographics, changes in private industry, and public misunderstanding of the program affected the legislative processes. Yet, dominant political and economic interests through the vehicles of government agencies and congressional majorities have had the greatest influence. The ideological shifts of those involved in Medicare’s legislation impacted the policy options that were proposed and implemented. Invited by Congress to testify at hearings, private interests (including health insurance, healthcare providers, business, pharmaceuticals, and pharmacies) were the largest group of witnesses at the MMA hearings. The
next largest group, outside the federal government, was comprised of witnesses from think tanks. It is not surprising, then, that the witnesses expressed the greatest support, by far, for private interests and market rationalism. Future research might clarify the existence and memberships of advocacy coalitions in the Medicare policy domain. A cluster analysis of the total number of witnesses identified in the MMA hearings (n=180), based on the values they expressed in their testimonies, would be helpful in determining members of the advocacy coalitions for social insurance and market rationalism. Further, a media analysis of the terminology framing the need for Medicare reform (e.g. “crisis,” “socialized medicine,” individual choice and control, personal responsibility, big government) could signal ideological alignments.

A question arose from the study as to why the results indicated that few witnesses from PhRMA testified before Congress on the MMA, a topic of great importance to it. Research by Michael Heaney (2006) provided an explanation. Heaney interviewed 95 congressional members, including Republicans and Democrats from the House and Senate as well as senior, junior, committee and personal congressional staff (49 Republicans and 46 Democrats; 62 House and 33 Senate; 45 senior staff and 50 junior staff; 18 committee staff and 77 personal staff). Heaney’s respondents stated that PhRMA topped the list of the most influential groups in Congress (followed by the AMA, AARP, and the American Hospital Association). One of his principal findings was that although influence over health-care policy is widely dispersed among many groups, size and money make a big difference. No other industry has spent more money to sway public policy over the past seven years than PhRMA (Ismail, 2005). In 2003, the year that the MMA was passed, PhRMA spent $116 million lobbying government. Moreover, 52% of the lobbyists were former federal officials. PhRMA’s efforts have resulted in favorable tax laws, price containment, and industry-friendly regulatory policy at the FDA. Indeed, the U.S. government contributes more money to developing new drugs in the form of tax breaks and subsidies, than any other government.

The cost of prescription drugs is rising rapidly for consumers. Over the seven years 2000 through 2006, the manufacturers’ list prices of 153 widely used name brand drugs increased an
average of almost 54% annually; a cost increase of $368.00 over the seven-year period (Gross, Gross Purvis, & Schondelmeyer, 2007a). In 2006, the list prices increased an average of 6.2%, almost twice the rate of inflation. On the other hand, manufacturer’s list prices for 75 widely used generic drugs increased a cumulative 28% from 2001 through 2003 compared to a cumulative inflation rate of about 7% and decreased a cumulative 4% during the years 2004 through 2006 compared to a cumulative inflation rate of about 9% (Gross, Gross Purvis, & Schondelmeyer, 2007b). Nevertheless, any trend in savings on generic drugs is likely to be offset, either by out-of-pocket costs paid through the Medicare Part D coverage gap, or by increases in the premiums paid for meaningful coverage through the gap.

Drug prices are pushed by utilization (influenced by direct to consumer advertising), price (reflective of manufacturer pricing of new drugs, changes in pricing for existing drugs, and profit margins), and changes in types of drugs used (newer more costly drugs and fewer FDA approvals than a decade ago) [Kaiser Family Foundation, 2007b]. Proponents of the MMA say costs will be offset by increased availability of prescription drugs in general, increased use of generics, more people covered under tiered co-pay plans, and a shift to over-the-counter status. Alternately, opponents say that costs will continue to increase because the MMA promotes a dynamic of risk segmentation, not risk pooling (Marmor & Mashaw, 2006).

In the health insurance industry, plans compete on price and coverage for healthy beneficiaries. The MMA legislation shifted expenses from the private sector and Medicaid to Medicare, increasing the cost of the program to the federal government and thus taxpayers. As healthy individuals are siphoned off into private plans, the pool of insured people remaining in the traditional program increasingly will become more risky and more costly. Funds paid for plans to participate in the private market will be unavailable to support the traditional program. As a result, traditional Medicare will look more costly and financially unstable because individuals who are high risk have been separated from those who are low risk.

Providing health insurance and slowing health care costs are top issues in the 2008 presidential campaign (Davis & Collins, 2007). Democratic candidates Clinton, Edwards
and Obama envision expanding health insurance coverage by spreading risk over large groups, generating efficiencies through employer-based plans, and building on the success of public programs. In contrast, Republican candidates Romney and Giuliani foresee tax incentives to persuade individuals to purchase personal health insurance coverage, eliminating state regulation of private insurance, and expanding coverage without increasing the federal budget. Romney proposes a "federalist" approach that would encourage states to develop their own market-based reforms. To improve the efficiency and quality of the health system, the three Democratic candidates foresee utilizing pay-for-performance strategies, soliciting comparative effectiveness research, and promoting models that improve the chronic disease management as well as addressing health disparities. Candidates on both sides anticipate pursuing preventative health care, promoting transparency in health information technology, and disseminating information on plans and providers.

As long as market rationalists have the greatest influence over Medicare legislation, there is little likelihood that maintaining Medicare's social insurance structure and principles will counterbalance politically impelled economic concerns. Increasing health and prescription drug costs are reflected not only in Medicare but in private plans as well. Medicare's relative success in controlling costs makes it apparent that rhetoric about the efficiency of the private market is ideologically motivated. The values underlying the MMA, such as competition, individual choice and control, personal responsibility, and incentives for private plans, primes the Medicare program for massive reform in the form of privatization. Already the Bush administration is proposing to means test the prescription drug benefit through higher premiums and deductibles on individuals with upper-incomes, which would hasten the reduction of Medicare's traditional risk pool (Weisman, 2007). To be significant counterweights to market rationalists, supporters of traditional Medicare will need to be smart organizers and savvy framers of social insurance ideals as well as to continue building and strengthening their advocacy coalitions. In the media, all sides extol their concern for Medicare beneficiaries, rarely mentioning their own financial and political self-interests (Espo, 2007). Democratic presidential
candidates can facilitate the repeal or modification of the MMA and encourage legislation toward universal health care by embracing social insurance ideals and bringing them to the forefront in their 2008 debates.

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