Poor Coverage: Examining the Switch in Prescription Drug Insurance for Dual Eligibles from Medicaid to Medicare Part D

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**Chapter 1: Introduction**

After years of deficits and painful cuts to social programs, the federal government faced a budget surplus at the end of Clinton’s presidency. The budget surplus opened a policy window that enabled legislators to finally address pressing social issues confronting Americans. President Clinton believed the budget surplus provided a promising opportunity to reform Medicare. In his final “State of the Union Address” in 2000, President Clinton urged legislators to dedicate a sizable portion of the nation’s budget surplus to providing senior citizens with prescription drug coverage through Medicare reform (Clinton 2000). Clinton stated, “No one creating a Medicare program today would even think of excluding coverage for prescription drugs. Yet more than three in five of our seniors now lack the dependable drug coverage which can lengthen and enrich their lives” (Clinton 2000). Clinton set the agenda for including prescription drug coverage as part of Medicare reform, and he framed the issue as a moral duty to the nation’s aged citizens.

When legislators established Medicare in 1965, prescription drug coverage was not a pressing issue to the American people. At the time, prescription drugs were much fewer in number, less effective, and far less expensive than drugs today (Morgan and Campbell 2005). In the late 1990s, the exponential rise in prescription drug costs caused Medicare HMOs to adopt tighter restrictions on drug coverage (Oberlander 2003). Medigap and other supplemental insurance plans that covered prescription drugs for the elderly increased their premiums to levels many could not afford (Oberlander 2003). Employers, who for years had offered generous retirement benefits, began to decrease...
drug coverage or increase copayments (Morgan and Campbell 2005). Clinton’s address brought the prescription drug coverage issue to the fore of public discussion.

In the 2000 presidential election, prescription drugs became a focal point for both Al Gore’s and George W. Bush’s campaigns (Morgan and Campbell 2005). Both Gore and Bush supported adding a prescription drug benefit to Medicare that would provide coverage for all Medicare beneficiaries, including dual eligibles (“The Rx Campaign” 2000; “Bush on Health Care” 2000). According to Gore’s campaign proposal, Medicare would cover half the cost of prescriptions up to $5,000, and then, Medicare would provide full coverage of all prescription drug costs after an individual has paid $4,000 out of pocket during one year (“The Rx Campaign” 2000). Individuals that make less than $12,000 per year or couples with annual incomes below $14,000 would pay no premiums or copayments (“The Rx Campaign” 2000). According to Bush’s plan, Medicare would cover 25 percent of drug costs, and then, Medicare would provide full coverage of all drug costs after a senior has paid $6,000 out of pocket during one year (“Bush on Health Care” 2000). Individuals that make less than $11,300 per year or couples with annual incomes below $15,200 would pay no premiums or copayments (“Bush on Health Care” 2000). Additionally, individuals with incomes between $11,300 and $14,600 or couples with incomes between $15,200 and $19,700 would receive a partial subsidy to help pay premiums (“Bush on Health Care” 2000).

After lengthy deliberations within political parties and Congress, President Bush signed Public Law 108-173, also known as the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), on December 8, 2003 (Morgan and Campbell 2005). The centerpiece of this act, Medicare Part D, provides prescription
drug coverage for all Medicare beneficiaries (“Drug Benefit Fact Sheet” 2013). By signing the MMA into law, President Bush hoped to employ additional market mechanisms in Medicare in order to expand social welfare policy, limit the growth in the size of the federal government, control skyrocketing drug costs, and increase efficiency (Oberlander 2003).

While Part D expanded health insurance for millions of seniors by covering prescription drugs, the law contained a provision that actually undermined many of its goals. The MMA actually weakened coverage for 6.4 million dual eligibles, who are individuals who qualify for both Medicare and Medicaid (Nemore 2005). Prior to the MMA, dual eligibles received prescription drug coverage under state-run Medicaid plans (Nemore 2005). Although Medicaid coverage varied by state, dual eligibles experienced expansive drug formularies that enabled enrollees to obtain prescriptions affordably and without hassle (Nemore 2005). The switch in coverage caused a number of issues for dual eligibles - most notably enrolling in a drug plan, either by choice or automatically by the government - that prevented many dual eligibles from obtaining necessary prescriptions affordably (Nemore et al. 2006).

In addition to reducing coverage for dual eligibles, several other aspects of the bill are particularly interesting. First, the absence of price controls under Part D enabled drug manufacturers to charge high prices and profit immensely at the expense of the federal government (Oliver, Lee, and Lipton 2004). In contrast, states negotiated with pharmaceutical companies to ensure that states paid the lowest possible price for drugs covered by Medicaid (Drotleff 2006). Thus, Medicare paid more than Medicaid for drugs supplied to dual eligibles (Drotleff 2006). This fact contradicts the fiscally
conservative doctrine of limiting excessive expenditures promoted by the majority of Republicans during a time when the Republicans controlled the presidency and both houses of Congress.

Second, dual eligibles comprise of our nation’s poorest, sickest, and most vulnerable population. The MMA is an example of government sacrificing the interests of a vulnerable minority in order to satisfy majority demands and interests. In doing so, the government provided a universal prescription drug benefit for all Medicare beneficiaries and fiscal relief to states experiencing a severe budget crisis.

Third, politicians, particularly conservatives, value devolution, which enables the size of the federal government to seemingly shrink while also providing an additional benefit to the people. Devolution also enables states to experiment to find the most efficient implementation strategies. The switch in coverage for dual eligibles removed power from the states and returned it to the federal government (Morgan and Campbell 2011). This switch in power had occurred rarely in the past several decades, especially considering states sufficiently implemented the government program.

Finally, the Senate and House originally proposed bills with complete opposite solutions on how to best provide drug coverage for dual eligibles. While the Senate originally voted to maintain coverage for dual eligibles under Medicaid, the House bill supported switching their coverage to Medicare (Nathanson, Park, and Greenstein 2003). More interesting, although President Bush campaigned on providing a universal benefit, he supported the Senate approach and strongly opposed the House stance that ultimately emerged victorious (Blum 2006). In fact, President Bush telephoned Senate Majority Leader Bill Frist (R-TN) during conference committee negotiations to warn that he
opposed providing Medicare drug benefits to dual eligibles (Goldstein 2003). Thus, if Medicaid had been providing sufficient drug coverage for dual eligibles, why did the House bill, which ultimately harmed the nation’s sickest and poorest population, prevail?

My research suggests a combination of lobbying by the National Governors Association (NGA) and party politics determined the outcome of this bill. The NGA utilized its united stance and severe state fiscal crisis to set the agenda and influence Congressional discourse. As the legislative process progressed, party politics caused a drastic shift in stated support, forcing many who opposed the switch in coverage to support the switch and vice versa. This thesis will examine the role of each of these forces in determining the outcome of a policy with severe implications for dual eligibles.
Chapter 2: The Impact of the Coverage Switch on Dual Eligibles

Dual Eligibles

Before examining the passage of the MMA, it is useful to understand the characteristics of dual eligibles that differentiate them from other Medicare beneficiaries. Dual eligibles are individuals that qualify for both Medicare and Medicaid (Nemore 2005). Dual eligibles qualify for Medicare by being at least 65 years of age or having a disability, and qualify for Medicaid by earning an income at or below the Federal Poverty Level (Buchsbaum et al. 2007). As of 2006, nearly 75 percent of dual eligibles earned $10,000 or less annually, and less than half had graduated from high school (“Dual Eligibles’ Transition” 2006). Typically, dual eligibles have multiple chronic health conditions (Hayes 2011), which require the use of several expensive prescription drugs. Classified as the poorest, sickest, and most expensive health care consumers, dual eligibles require more services and drugs than other Americans (Nemore 2005). On average, dual eligibles use ten more prescription medications than non-dual eligible Medicare beneficiaries (Nemore 2005), making them very expensive to cover with prescription drug insurance. Dual eligibles are also more likely to suffer from cognitive impairments than other Medicare beneficiaries. Over 40 percent of dual eligibles have a cognitive or mental impairment compared to only nine percent for non-dual eligible Medicare beneficiaries (J. Ryan and Super 2003). Dual eligibles are twice as likely as non-dual eligibles to have Alzheimer’s disease (Nemore 2005). As I will explain, the prevalence of cognitive impairments impedes dual eligibles from making adequate decisions on their own when choosing a Part D plan.
When President Bush signed the MMA in 2003, dual eligibles consisted of 6.4 million people (Drotleff 2006). In 2008, that number had risen to about 9.2 million people (Hayes 2011). As the baby boomer generation continues to age and reach 65, the number of dual eligibles will increase and contribute to the rising trend in health costs.

**Automatic Enrollment**

The coverage switch caused two main problems for dual eligibles: the market-based design was ill suited for dual eligibles and drug formularies did not meet their coverage needs. Prior to Part D, dual eligibles only had one choice for drug coverage, which consisted of the package that state Medicaid officials believed best covered the Medicaid population. The MMA market-based welfare reform, however, emphasized choice as a way to promote efficiency and create competition between private plans vying for customers. Although other Medicare beneficiaries can voluntarily enroll in Part D, enrollment is mandatory for dual eligibles (“Drug Benefit Fact Sheet” 2013). During the transition from Medicaid to Part D drug coverage, dual eligibles could enroll in a drug plan they believed best suited their needs (Nemore 2005). If dual eligibles fail to enroll in a Part D plan, the Center for Medicare and Medicaid Services (CMS) automatically places dual eligibles in a plan that covers individuals in their geographic region (Nemore 2005). In order to ensure that dual eligibles can afford the coverage, CMS enrolls dual eligibles into plans with premiums at or below the regional average (Nemore 2005).

This automatic enrollment process, however, occurs randomly with no effort to match individuals with plans that best serve dual eligibles (Nemore 2005). In fact, the government designed automatic enrollment as a means to ensure that drug plans have an
equal number of enrollees (“Challenges in Enrolling Beneficiaries” 2007). Policymakers decided to implement random automatic enrollment because they claimed that an individual’s prescription needs change over time, and that past prescription drug use does not necessarily indicate that the individual will take the same drugs in the future (Thaler and Sunstein 2008). This rationale makes little sense because very few individuals change prescription drugs from a year-to-year basis, especially if the drugs they have been taking have produced positive outcomes (Thaler and Sunstein 2008). This is especially true for dual eligibles, many of whom have chronic conditions that continue throughout their lifetime, and as a result, need the same drug or the same type of drug year after year (Thaler and Sunstein 2008).

In comparison to Medicaid’s coverage, automatic enrollment has resulted in a decrease in prescription drug coverage and an increase in financial hardships for dual eligibles. CMS automatically assigned some dual eligibles to plans that inadequately covered their required medications (Nemore 2005), forcing individuals to pay out-of-pocket or forego filling a prescription. In 2006, only 18 percent of dual eligibles were enrolled in plans that covered all 178 of the most commonly prescribed drugs (Nemore et al. 2006). In some cases, pharmacy networks included in the prescription drug plans excluded a dual eligibles’ local pharmacy, forcing these individuals to travel long distances, often using public transportation, in order to obtain important medications (Nemore 2005). During the time in which state-run Medicaid coverage was in effect, dual eligibles had little problem obtaining necessary drugs from their local pharmacy.
The Problem of Choice

In order to function properly, market-based welfare reform depends on appropriate choices made by rational actors. Unfortunately, many dual eligibles lack the capacity to make well-informed, timely decisions. MMA law enables dual eligibles to change plans on a monthly basis, while all other Medicare beneficiaries can only change their plan yearly (Nemore et al. 2006). Legislators included this aspect of the law in order to offset potential weak coverage from random automatic enrollment. In order to switch plans, however, most dual eligibles require assistance (Buchsbaum et al. 2007).

In 2013, a Medicare beneficiary could choose from 23 to 38 plans to enroll depending on where the beneficiary lived (“Drug Benefit Fact Sheet” 2013). In order to choose the best plan for the individual, a dual eligible must compare covered drugs, pharmacy networks, and other features. The Center for Medicare and Medicaid Services (CMS) and other organizations have created comparative websites to facilitate the drug plan selection process by equipping Medicare beneficiaries with the necessary information to become rational actors (Nemore et al. 2006). During the initial enrollment period, however, only 15 percent of dual eligibles used the Internet (Nemore et al. 2006). This low percentage reflects both their lack of education and limited access to Internet due to cost constraints. As a result, dual eligibles must rely on either incomplete information sent by CMS through the mail or assistance from family, friends, or organizations designed to provide such help (Nemore et al. 2006). Letters mailed by CMS are only in English, and can be confusing due to the complexity of Part D (Buchsbaum et al. 2007). A poorly educated dual eligible could be easily overwhelmed by the offerings of each complex and distinct plan. Due to the nature of implementing
legislation utilizing private plans and markets, each plan has its own design, covers different drugs, and has a different appeals process (Nemore et al. 2006). In essence, in contrast to the uniform approach within each state as part of Medicaid drug coverage, the market-centered approach of the MMA encourages differences that overwhelm dual eligibles.

Certainly, choosing an appropriate plan overwhelms dual eligibles suffering from cognitive impairment. Although nine percent of non-dually eligible Medicare beneficiaries have a cognitive or mental impairment, over 40 percent of dual eligibles have a cognitive impairment (J. Ryan and Super 2003). In addition, dual eligibles are twice as likely to have Alzheimer’s disease as non-dually eligible Medicare beneficiaries (Nemore 2005). Having a cognitive impairment prevents an individual from making well-informed decisions when choosing an appropriate drug insurance plan. These individuals lack the cognitive capacity to make adequate decisions regarding drug insurance without additional assistance from friends and family. In some cases, however, these dual eligibles may not have a family member to assist them (Nemore 2005). Due to the complexity and confusing nature of the Part D plan selection process, even family members and friends without cognitive impairments can find the process overwhelming.

Not surprisingly, these obstacles for dual eligibles that prevented them from rationally selecting an appropriate drug plan encouraged the majority of dual eligibles to opt for automatic enrollment. By November 2006, which was 11 months after implementation of the MMA, only 29.8 percent of dual eligibles enrolled in a plan of their own choosing (“Challenges in Enrolling Beneficiaries” 2007). Thus, in contrast to
the predictions of market-based welfare reform supporters, dual eligibles did not take full advantage of the prescription drug plan market established by the MMA.

**Drug Plan Formularies**

Since Medicare Part D formularies did not include all of the medications covered by Medicaid, many dual eligibles experienced a reduction in drug coverage. Medicare Part D works best for beneficiaries with simple drug regimens (Buchsbaum et al. 2007). Individuals who take many different drugs may have a hard time finding a plan that covers all their needs without paying additional expenses (Nemore 2005). Dual eligibles tend to have complex health issues that require numerous, expensive medicines, some of which may only be covered by the highest copayment tier of their plan’s formulary (Nemore 2005). Under Medicare Part D, the basic insurance package fully subsidized by the federal government generally does not cover the most expensive medicines (Nemore et al. 2006). More generous packages often require an additional annual premium unaffordable to impoverished dual eligible beneficiaries. Private drug plans provide different levels of coverage with varying premiums, deductibles, and copayments depending on how much coverage an individual wishes to purchase. In contrast, state-run Medicaid provides only one, uniform plan for all Medicaid beneficiaries in each state.

If a doctor prescribes a drug not covered by a drug plan’s formulary, the dual eligible must pay for the prescription out-of-pocket, forcing many to borrow money that will most likely result in perpetual debt due to their meager incomes (Buchsbaum et al. 2007). Instead of borrowing, other dual eligibles may have to decide whether to go without medication, food, or some other basic necessity (Buchsbaum et al. 2007). The
most vulnerable and sick population in the United States should not have to make these
difficult choices.

Depending on the state in which a dual eligible resides, Medicaid may cover
drugs not listed on the formulary of an average benchmark plan (Nemore et al. 2006).
The extent to which states engage in this “wrap-around” coverage varies. For example,
while Florida does not help pay copayments or cover additional drugs, Connecticut has
complete wrap-around coverage, providing its residents with drugs not covered by Part D
formularies and eliminating copayments (Buchsbaum et al. 2007). The variations in state
wrap-around coverage reproduce the inequalities that universal coverage was intended to
erase.

Both state-run Medicaid and private drug plans require copayments for some
drugs in order to offset costs. In some states, dual eligible Medicaid beneficiaries did not
have copayments (Nemore 2005). In other states, Medicaid drug coverage copayments
ranged from $0.50 to $3 (Hearne 2008). States that required a copayment for dual
eligibles, however, could not deny a beneficiary access to a drug if they could not afford
to pay the copayment (Nemore 2005). In contrast, Part D required dual eligibles not
residing in long-term care facilities to pay $1 for generics and $3 for brand name drugs
(149:169 CR H11998). These prices would also increase in the future to adjust for
inflation (149:169 CR H11998). If an individual cannot pay the copayment, pharmacies
can refuse to fill the prescription (Nemore 2005). Although $3 may not seem like a lot of
money, a dual eligible struggling to find enough money to purchase food may not be able
to make this copayment, especially if the dual eligible has to make that same copayment
for the ten other drugs he is prescribed. For example, a $3 copayment for ten

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prescriptions filled in one month amounts to $30 per month spent on prescription drugs, which represents a sizable portion of an individual’s budget who earns $830 per month.

A survey of health care providers, pharmacy providers, and state agencies determined that copayments affected access to drugs (Buchsbaum et al. 2007). All survey respondents knew of dual eligibles not taking or rationing their medications because they could not afford the copayments (Buchsbaum et al. 2007). Other respondents knew of dual eligibles not paying bills or going without food or other necessities (Buchsbaum et al. 2007). Thus, although legislators worried that excluding dual eligibles by adding a means-tested Medicare benefit would undermine the universality of Medicare and discriminate against dual eligibles based on income, the new benefit created several new problems for dual eligibles.
Chapter 3: Literature Review

How should we understand this switch in coverage for dual eligibles? Research in American political science provides a foundation to understanding this development. This case draws on research in several areas including the future trajectory of health care reform, the lobbying debate between elitism and pluralism, agenda setting, and framing. The structure, particularly the market aspect, of the MMA caused the majority of the problems for dual eligibles. Some scholars argue, however, that a health insurance program implemented through both the public and private sector has the best chance of creating a universal health plan in the United States due to the prevalence of corporate interest groups and the public’s desire for a small federal government. Scholars have pointed out, however, that public benefits implemented in the private sector generally fails to protect beneficiaries from all forms of risk. The story of the MMA strengthens these theories as the federal government expanded health insurance using the private sector and scaled back insurance coverage for dual eligibles. My hypotheses, which I will explain in the next chapter, suggest that the National Governors Association (NGA), an elitist interest group, lobbied Congress to assume coverage and fiscal responsibilities for dual eligibles. In order to achieve this goal, the NGA helped set the agenda by elevating the importance of the dual eligible issue, and utilized frames to establish arguments adopted by members of Congress in order to generate support for the NGA’s initiative.
The Future Trajectory of Health Welfare Policy

The passage of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) marked a breakthrough in health care reform by taking another step toward universal health care coverage. The addition of a prescription drug benefit to Medicare fulfilled a pressing need for many Medicare beneficiaries. The market-based approach enabled compromise between liberals who supported the expansion of social welfare benefits and conservatives that argued federal programs were inefficient and opposed expanding the size of government. The market-based reforms of the MMA established a precedent for future welfare expansion programs. Scholars have attempted to explain and understand the role of market solutions to welfare expansion.

Many scholars have tried to explain why the U.S. is the only western industrialized nation that does not provide basic universal health insurance to its citizens (Quadagno 2004). Jill Quadagno has conducted research on the role of interest groups and health care reform. Quadagno argues that powerful health care interest groups have been able to defeat efforts to nationalize health insurance “because they had superior resources and an organizational structure that closely mirrored the federated arrangements of the American state” (Quadagno 2004). The organizations have successfully lobbied against health care reform in order to preserve their profits at the expense of the American public (Quadagno 2004). Congressmen depend on these interest groups to help fund their campaigns, and thus, feel obligated to appeal to their desires (Quadagno 2004). The result is a welfare benefit implemented through the private sector.
Quadagno explains other factors contributing to our unique health insurance system. The antistatist argument suggests that American skepticism of powerful government, which is inefficient and limits our liberty, has impeded public demand for national health insurance (Quadagno 2004). Political institutions unique to the United States have also prevented the nationalization of health insurance. For example, power diffusion between the three branches and within Congress as well as particular rules in Congress have delayed or blocked legislation to expand health insurance coverage (Quadagno 2004). Unlike other industrialized nations, the United States has not experienced a labor-based political party or a strong working class movement that demanded guaranteed health insurance (Quadagno 2004). Quadagno also explains that health care legislation has been difficult to revise after its passage and implementation (Quadagno 2004). Thus, path dependency has played a significant role in limiting the expansion of health insurance.

Despite these barriers, scholars look at possible arenas for expansion. Daniel Carpenter argues that health politics is distinctive in ways that should help facilitate the expansion of the health care welfare state (Carpenter 2012). Carpenter highlights four distinctive characteristics that shape the debate of health care reform. First, although people tolerate inequalities in other policy areas, particularly in economic realms, people generally believe that everyone should have access to health services (Carpenter 2012). Thus, people demand to reduce health care access inequalities (Carpenter 2012). Second, Carpenter claims that health is related to human identity and is essential to the human experience (Carpenter 2012). Our health shapes our mood, enables us to move around, affects reproduction, and can impact those around us emotionally (Carpenter 2012).
Third, anyone, regardless of economic status, can have good or poor health, and the quality of one’s health is often outside one’s control (Carpenter 2012). Finally, the prominent role of technology and professional expertise in health care differentiates health policy from other policy areas (Carpenter 2012). Carpenter is hopeful that these distinctions may help propel the expansion of the health welfare state in the future (Carpenter 2012). Despite these characteristics, however, efforts to expand have repeatedly failed.

Like Carpenter, Mark Schlesinger and Jacob Hacker are also hopeful that the U.S. can expand health care coverage. They argue that a health insurance program utilizing both private and public sectors provides the best chance of establishing universal health care in the United States (Schlesinger and Hacker 2007). The MMA is an example of Medicare’s transformation from a single-payer insurer into a hybrid plan utilizing both the public and private sectors. Schlesinger and Hacker explain that Congress will create these hybrid policies in the future because both liberals and conservatives find aspects of hybrid plans attractive (Schlesinger and Hacker 2007). While liberals are willing to implement a benefit in the private sector as long as it expands the welfare program, conservatives are willing to accept the program expansion as long as it utilizes markets to increase efficiency, stimulate the economy by benefitting businesses, and provide choice to beneficiaries. The public also supports policy that utilizes markets. According to Schlesinger and Hacker, the public values choice and has little faith in the government to efficiently implement policy (Schlesinger and Hacker 2007). Although outcomes of hybrid plans tend to be suboptimal, they provide the best hope of reforming health care.
In another article, Hacker argues that although social policy appears to have expanded, policymakers have deliberately drafted policies that fail to provide protection against some forms of risk (Hacker 2004). As a result, some reforms create barriers that have actually resulted in minor retrenchment (Hacker 2004). Thus, social policies in the United States have recently been unable to achieve their desired goals (Hacker 2004). According to Hacker, these policies that fail to provide complete protection and undermine their goals erode social protection in the United States (Hacker 2004). The emergence of public-private hybrid policies place vulnerable populations in the hands of private corporations, whose corporate goals can radically transform the way in which a policy is implemented often at the expense of consumers (Hacker 2004). The shift in coverage for dual eligibles from Medicaid to Medicare provides a perfect example that illustrates Hacker’s theory. Although the switch appears to have been based on good intentions, providing coverage for dual eligibles through a federally regulated market system left them more vulnerable to new risks due to their inability to obtain necessary medications.

Other scholars point to “new federalism” as a way to make health care reform more palatable. Scott L. Greer and Peter D. Jacobson examine whether the state or federal government should implement health care reform (Greer and Jacobson 2010). The MMA’s treatment of dual eligibles enabled the federal government to lead and implement the drug insurance program rather than the states. Although states may be able to enact health care reforms more easily than the federal government, Greer and Jacobson argue that the federal government should lead in expansive health reform initiatives (Greer and Jacobson 2010). They claim the federal government has stronger
resources, both monetary and administrative, that are nonexistent at the state level and enable the federal government to more adequately implement major health insurance programs (Greer and Jacobson 2010). As a result, if states led health insurance expansion, states would remain dependent on federal oversight and federal grants that could undermine the program’s implementation (Greer and Jacobson 2010). Even though some states, such as Massachusetts, have experienced successful health care reform programs, Greer and Jacobson claim that the success of these states is atypical and not replicable (Greer and Jacobson 2010).

Thus, according to these scholars, the future trajectory of health care reform is to expand coverage by means of crafting public-private health plans administered by the federal government. These scholars suggest, however, that expansion in this form will produce suboptimal outcomes that may reduce the quality of the benefit. Still, these scholars are hopeful that further health care reform will occur in the United States.

*Elitism vs. Pluralism*

This thesis also contributes to the vast literature devoted to determining whose interests prevail when lobbying Congress. Interest groups devoted a tremendous amount of resources to lobby the parent legislation of the MMA. Scholars and members of Congress agree that corporate interests prevailed while formulating the MMA (Oliver, Lee, and Lipton 2004; Oberlander 2003; Oberlander 2007; Morgan and Campbell 2005). The pharmaceutical industry, for example, successfully lobbied all three of their major demands: implementation of the benefit through the private sector; a ban on the reimportation of drugs from other countries; and no price controls on prescription drugs.
All of these victories enabled pharmaceutical companies to reap immense profits as a result of the legislation. Similarly, insurance companies wrote key provisions of the legislation (Oberlander 2007). Insurance companies successfully lobbied Congress in order to obtain large government subsidies in order to create insurance programs that only cover prescription drugs and incentivize insurance companies to provide coverage for expensive seniors, such as dual eligibles (Morgan and Campbell 2005). Some members of Congress called out legislators for conceding too much to pharmaceutical and insurance companies. For example, Senator Jack Reed (D-RI) referred to the legislation as “a big sloppy kiss to the pharmaceutical and insurance industries” (149:171 CR S15539). Although elite interests prevail for the overall MMA legislation, the treatment of dual eligibles cannot be explained by corporate lobbying. Instead, this thesis will test whether targeted lobbying by the NGA influenced the inclusion of dual eligibles in the reform.

One of the most active and oldest debates in political science tackles this exact issue of elite bias in American politics. C. Wright Mills defines the power elite as the “political, economic, and military circles which as an intricate set of overlapping cliques share decisions having at least national consequences” (Mills 1956). Business and government have gradually aligned interests, enabling them to become more involved with each other than ever before (Mills 1956). Although these men have the most power in society, they do not have the same interests as the rest of society, and thus, do not represent the interests of the general population (Mills 1956). Ordinary people are powerless, and cannot influence changes proposed by the power elite that impact and shape their daily lives (Mills 1956).
E.E. Schattschneider built on Mills theory of elite bias to examine the existence of a pluralist pressure system in which organized special interest groups jockey for favorable legislative policies (Schattschneider 1960). These special interest groups represent the interests shared by only a small percentage of the entire U.S. population (Schattschneider 1960). According to Schattschneider, business groups dominate the pressure system, creating an upper class bias (Schattschneider 1960). Thus, Schattschneider claims, “the flaw in the pluralist heaven is that the heavenly chorus sings with a strong upper class accent” (Schattschneider 1960). In essence, the pressure system breaks down the pluralist nature of politics in favor of a lobbying system biased by elite interests.

Since Mills and Schattschneider, many scholars sought to extend and explore elite bias. Kay Lehman Schlozman reassessed the relevance of Schattschneider’s theory in 1984. By examining data of 7,000 interest groups active in Washington listed in the *Washington Representatives – 1981* directory, Schlozman concludes that the pressure system still heavily favors business interests, and thus, Schattschneider’s theory still has relevance (Schlozman 1984). Business interests are overrepresented in terms of their sheer number of organized groups and structure of interest representation (Schlozman 1984). The overrepresentation of business interests occurs at the expense of interest groups representing the general public and the poor (Schlozman 1984). In fact, Schlozman claims that business influence has increased since Schattschneider’s publication in 1960 (Schlozman 1984).

In 1998, Darrell M. West and Burdett A. Loomis also reevaluated Schattschneider’s elitist theory. According to West and Loomis, “Schattschneider’s
heavenly chorus sings with more of an upper class accent than ever before” (West and Loomis 1998). West and Loomis emphasize that money dominates the policymaking process (West and Loomis 1998). As a result, large, well-funded business interests crowd out the interests of consumer groups, public interest groups, political parties, and social movements because corporations tend to have more financial resources (West and Loomis 1998). Voters, political parties, social movements, journalists, and government officials can’t effectively check the power of well-funded, well-organized groups (West and Loomis 1998). While corporations gain power and resources over time, voters have lost the power to protect their own interests (West and Loomis 1998). The high cost of information and the lags in information flow to the general public prevent voters from organizing effectively and influencing policy (West and Loomis 1998). Public interest groups that occasionally organize to combat a visible problem can have an initial impact, but have difficulty lasting long-term (West and Loomis 1998). Often, their agenda is specific to a particular problem, and once that problem has been resolved, membership and fundraising slows (West and Loomis 1998). West and Loomis conclude that the imbalance of financial resources threaten democracy by empowering a few interests at the expense of public (West and Loomis 1998).

Claims of elite bias have been challenged by scholars, such as Robert A. Dahl, who argues that, while the elite prevail on key issues, the pluralist system allows for other interests to prevail elsewhere. Dahl claims that political scientists have inadequately gathered support for elite bias in American politics (Dahl 1958). He acknowledges that political equality does not exist, but argues that this fact does not prove the existence of the ruling elite (Dahl 1958). Scholars confuse the ruling elite with a group that has a high
potential to control American politics or a group of people with more influence than others (Dahl 1958). As Dahl explains, potential for control is not the same as commanding actual control (Dahl 1958). In addition, a group with influence over one aspect of politics may not have the same amount of influence in another area (Dahl 1958). Thus, scholars cannot generalize the power of ruling elites based on one or a couple of cases (Dahl 1958).

Peter Bachrach and Morton S. Baratz offer additional criticism of methodology employed by both elitist and pluralist scholars. The questions pluralists and elitists ask make assumptions and predetermine their conclusions (Bachrach and Baratz 1962). While the elitists determine who rules, the pluralists examine if anyone has power (Bachrach and Baratz 1962). Instead, Bachrach and Baratz argue that pluralist and elitist scholars should investigate the mobilization of bias (Bachrach and Baratz 1962). Then, they need establish the winners and losers of this existing bias (Bachrach and Baratz 1962). Scholars must determine what barriers exist to limit decision making to safe issues (Bachrach and Baratz 1962). After this information has been established, scholars should analyze participation in the decision making of concrete issues in order to determine either the existence of a ruling elite or simply relative power (Bachrach and Baratz 1962).

Heinz, Laumann, Nelson, and Salisbury are skeptical of elite bias due to what they describe as the “hollow core:” the absence of central actors who stand in the middle of the political system and establish winning coalitions (Heinz et al. 1993). As Heinz et al. explain, interest groups affect decisions, but rarely control them (Heinz et al. 1993). As a result, the public should not credit or blame interest groups for the government’s
actions (Heinz et al. 1993). These scholars identify a paradox. Although there has been an increase in the number of organizations representing a wide variety of issues in politics and the intensity of their efforts, there is not a clear relation between results and effort (Heinz et al. 1993). Heinz et al.’s findings explain that no category of interest groups, including business, from 1978-1982 was more successful than others in winning policy demands (Heinz et al. 1993). They conclude that considerable uncertainty still exists as to who emerges as winners and losers when debating and drafting policy (Heinz et al. 1993). These results support the pluralist school of thought. Overall, Heinz et al. acknowledge an upper class bias, but disagree that interest groups representing upper class interests wield as much power as the other theorists claim (Heinz et al. 1993).

**Agenda Setting**

Elitists have two tools that they can use to expand their influence: agenda setting and framing. The unprecedented budget surplus at the end of Clinton’s presidency and rising prescription drug costs presented policymakers and activists with a rare opportunity to reform Medicare to include a prescription drug benefit. During the 2000 presidential campaign, Bush and Gore made clear that adding a prescription drug benefit would be a priority. As the 2001 recession hit, however, states began having trouble balancing their budgets. The severe state budget crisis provided leverage for the NGA’s lobbying effort to ensure that dual eligibles would be included in the Medicare reform. The NGA’s lobbying efforts elevated the dual eligible issue on Congress’s agenda by drawing additional attention to the severity of the state fiscal crisis and the potential
consequences of continuing to provide Medicaid prescription drug coverage for dual eligibles.

John W. Kingdon defines agenda as “the list of subjects or problems to which governmental officials, and people outside of government closely associated with those officials, are paying some serious attention at any given time” (Kingdon 2011). Agenda setting “narrows this set of conceivable subjects to the set that actually becomes the focus of attention” (Kingdon 2011). According to Kingdon, interest groups play an important role in setting the agenda (Kingdon 2011). Lobbying activities get government officials to pay attention to the issues being lobbied (Kingdon 2011). Kingdon explains, however, that assigning direct responsibility to interest groups for the emergence of a particular agenda item is challenging because many other factors can play a role depending on the issue at hand (Kingdon 2011). Additionally, when interest groups raise an issue and get it on the agenda, they do not necessarily control the debate (Kingdon 2011).

Frank R. Baumgartner and Bryan D. Jones also examine the influence of interest groups in setting the agenda. They claim that interest groups develop questions, affect public opinion, and help define the terms of debate (Baumgartner and Jones 1993). An interest group’s ability to affect public opinion and raise public awareness of an issue pressures Congress to place the issue high on its agenda (Baumgartner and Jones 1993). According to Baumgartner and Jones, interest groups have a greater chance of influencing the agenda today than in the past because people are more aware of the issues interest groups address and publicize (Baumgartner and Jones 1993). By increasing its coverage of interest group activity, the media provides a vehicle through which interest
groups can publicize their concerns and pressure members of Congress (Baumgartner and Jones 1993).

Highly publicized dramatic events or crises, such as natural disasters or industrial accidents, can change the priority of items on a given agenda in order to take timely legislative action to prevent a similar crisis in the future (Birkland 1998). Thomas R. Birkland refers to these kinds of events as focusing events, which he defines as sudden, uncommon events known by policymakers and the public to have produced harm or have the potential to produce future harm (Birkland 1998). According to Birkland, these events provide an opportunity for “politically disadvantaged groups to champion messages previously suppressed by dominant groups” (Birkland 1998). These messages often are the identification of new or existing problems that deserve greater attention (Birkland 1998). Thus, during focusing events, specialized, pluralist interest groups get to influence the priorities on Congress’s agenda (Birkland 1998).

Deborah Stone discusses in detail exactly how these interest groups would influence the agenda after a focusing event. Stone researches how problems move onto the policy agenda. According to Stone, a problem must first be defined and attributed to human action rather than to fate or an accident (Stone 1989). Problem definition involves the competition of political actors who utilize frames to manipulate the extent or importance of the problem (Stone 1989). The frames can be a “call for redistribution of power by demanding that causal agents cease producing harm and by suggesting the types of people who should be entrusted with reform” (Stone 1989).

Kingdon would explain that focusing events open policy windows, which he defines as “an opportunity for advocates to push their pet solutions or to push attention to
their special problems” (Kingdon 2011). Policy windows open either due to the emergence of a new problem demanding immediate attention or for political reasons, such as turnover of elected officials, a swing in public opinion, or vigorous interest group lobbying (Kingdon 2011). Since policy windows are scarce and open for short periods, legislators must take advantage of the situation immediately or they may have to wait a long time for another window to open (Kingdon 2011).

The fiscal crisis confronting state budgets provided a policy window for the NGA to lobby for the federal assumption of prescription drug costs associated with Medicaid’s most expensive consumers, dual eligibles. Kingdon explains that budgetary considerations can force certain items higher on an agenda (Kingdon 2011). For example, the government could place cost controls for medical expenses high on the agenda because these costs may be rapidly rising (Kingdon 2011). The exponentially increasing costs for dual eligibles applied incredible pressure on state budgets and created a focusing event that helped the issue reach the forefront of political deliberations. In general, budget policy changes with the state of the economy (Kingdon 2011). As the economy worsens, the budget worsens and expensive programs may stay low on the agenda (Kingdon 2011). Although the majority of deliberations on the MMA occurred during the aftermath of an economic recession, the issue of providing Medicare prescription drug insurance to beneficiaries reached the agenda while the economy and federal budgets remained strong.

The simultaneous occurrence of a severe fiscal budget crisis and a congressional initiative to create a prescription drug program provided an open policy window for states to lobby the federal government to claim financial responsibility for dual eligibles. If the
NGA failed to act or was unsuccessful, the next opportunity for fiscal assistance could have been long on the horizon. The state budget situation could have improved, limiting the states argument for fiscal assistance. Thus, the NGA, recognizing this policy window, aggressively lobbied Congress to provide Medicare prescription drug coverage for dual eligibles.

**Framing**

As soon as the NGA succeeded in placing the dual eligible issue toward the top of the agenda, the NGA shifted their focus toward creating frames that would convince members of Congress to adopt their perspective. Members of Congress adopted several of the arguments framed by NGA leaders in order to convince other legislators the importance of providing a Medicare drug benefit for dual eligibles. Dennis Chong and James N. Druckman define framing as “the process by which people develop a particular conceptualization of an issue or reorient their thinking about an issue” (Chong and Druckman 2007a). Scholars debate how framing shapes opinions, which in turn affects policy debates and outcomes.

Thomas E. Nelson and Zoe M. Oxley argue that frames affect attitudes by influencing the importance individuals attach to beliefs relevant to the issue (Nelson and Oxley 1999). Individuals utilize frames to clarify the reasons behind a policy dispute and to influence the way in which other people perceive a particular issue (Nelson and Oxley 1999). Nelson and Oxley test the persuasiveness of frames by examining how individuals respond to frames about a land development dispute and welfare reform
(Nelson and Oxley 1999). They conclude that framing affects belief content and belief importance, which can affect an individual’s perspective (Nelson and Oxley 1999).

Donald R. Kinder and Thomas E. Nelson explain the relation between framing and elite opinions (Kinder and Nelson 2005). Kinder and Nelson consider frames as “weapons” created by political elites to advance their opinions (Kinder and Nelson 2005). Since public opinion depends on how elites frame issues in democratic debate, elites can manipulate public opinion to gather support (Kinder and Nelson 2005). Yet, frames also supply a common vocabulary that enables elites and citizens to debate the same issue in the same conversation (Kinder and Nelson 2005). Citizens depend on elites to provide frames in order to aid their understanding of an issue (Kinder and Nelson 2005). When elites fail to provide these frames, citizens may lack the ability to form a logical argument in support of one side or the other (Kinder and Nelson 2005). Kinder and Nelson argue that framing can influence the opinions of both well-informed and less knowledgeable citizens (Kinder and Nelson 2005). Overall, Kinder and Nelson claim that frames help “citizens find their political voice” (Kinder and Nelson 2005).

Dennis Chong and James N. Druckman study the effects of competition between frames (Chong and Druckman 2007b). Chong and Druckman distinguish weak frames from strong frames. While strong frames are considered compelling, weak frames are generally viewed as unpersuasive (Chong and Druckman 2007b). As predicted, strong frames were much more likely to alter opinion than weak frames (Chong and Druckman 2007b). When not competing with a strong frame, however, weak frames can persuade less knowledgeable people (Chong and Druckman 2007b). Competition between strong frames caused individuals to take an intermediate position on the issue (Chong and
Druckman 2007b). Surprisingly, repeating a frame has little impact on changing opinions (Chong and Druckman 2007b). Chong and Druckman caution that their results suggest that those interest groups or politicians with the most resources to establish highly persuasive frames and disseminate those frames to a wide audience might cause the public to adopt an opinion that contradicts the public’s best interest (Chong and Druckman 2007b). Thus, Chong and Druckman echo Nelson and Kinder’s concern about elites utilizing frames to manipulate public opinion.

Druckman and Kjersten R. Nelson noticed that people base their opinions on frames from elites and their conversations with other people (Druckman and Nelson 2003). They examine how conversations impact elite framing effects by providing study participants with an elite frame about campaign finance reform and then dividing the participants into groups to discuss the issue (Druckman and Nelson 2003). A control group simply completed a questionnaire and left without receiving a frame or conversing with others (Druckman and Nelson 2003). Druckman and Nelson discovered that conversations with people that had the same viewpoints had no effect on elite framing (Druckman and Nelson 2003). In contrast, conversations with individuals that had conflicting opinions eliminated the elite framing effects, causing people to return to their original position or take an intermediary position (Druckman and Nelson 2003). In addition, Druckman and Nelson noticed that elite framing effects disappeared after 10 days (Druckman and Nelson 2003). Thus, Druckman and Nelson conclude that elite frames have less of an impact than often thought by political scientists (Druckman and Nelson 2003).
Several other scholars have commented on the limits of the effectiveness of framing. Among them, Charlotte Ryan and William A. Gamson acknowledge that frames are necessary, but not sufficient on their own to generate support (C. Ryan and Gamson 2009). According to Ryan and Gamson, successful frames must be utilized in the context of movement building (Ryan and Gamson 2009). Communicators and elites utilizing frames must build relationships with journalists, politicians, etc. to amplify the message and repeat it many times (Ryan and Gamson 2009). In contrast to Chong and Druckman, Ryan and Gamson argue that repetitive frames help alter opinion and encourage mobilization (Ryan and Gamson 2009). Ryan and Gamson suggest that narrowly focused frames limit what audiences resonate with the ideas or values presented (Ryan and Gamson 2009). Similarly, Jennifer Jerit argues that engagement strategies in addition to framing can be more effective than utilizing just framing techniques when generating support (Jerit 2008). Jerit argues that President Clinton’s focus on framing with little attention to engagement offer one explanation for failing to gather public support for health care reform (Jerit 2008). These scholars suggest that framing alone has limits toward impacting public opinion. Utilizing framing along with other strategies, however, makes framing a more powerful resource.
Chapter 4: Methods

The provision of the MMA that included dual eligibles in the benefit undermined three of the law’s goals, and thus, presents us with a puzzle. First, the general purpose of the MMA was to provide adequate prescription drug coverage that covered the needs of all beneficiaries. Some dual eligibles, however, experienced less expansive drug formularies under Part D than under Medicaid, and thus, were unable to access necessary drugs to treat or manage their health conditions (Nemore 2005). Second, policymakers, particularly conservatives, believed that utilizing markets to implement the benefit would drive down the costs of prescription drugs (Morgan and Campbell 2011). The inability of the government to negotiate Medicare prices, however, meant that Medicare paid more for the same drugs than Medicaid (Oliver, Lee, and Lipton 2004). In essence, the government paid more to provide drugs to dual eligibles under Part D. Third, policymakers believed the MMA expanded welfare policy, but also limited the size of the federal government by utilizing markets and private insurance companies (Morgan and Campbell 2011). In this particular case, however, the switch in coverage for dual eligibles seized power from the states, which had been providing the benefit, and returned the power to the federal government.

I propose two hypotheses that might provide a potential explanation for the puzzling outcome of this legislation.

Hypothesis 1: The NGA effectively lobbied Congress to place the dual eligible and state finances issues at the front of the policy debate, and their efforts influenced the outcome of the legislation.

As I will further develop in the next section, in the early 2000s, states experienced the worst state fiscal crisis in the least half century (Lav and Johnson 2002). The
Congressional Budget Office (CBO) projected Medicaid expenditures, which already comprised 21.4 percent of all state spending in 2003 (Samuels et al. 2003), to grow 8.5 percent annually from 2003 to 2010 (Boyd 2003b). The National Association of State Budget Officers (NASBO), however, projected Medicaid expenditures on prescription drugs to increase at a rate of 12.7 percent through 2011 (Samuels and Pattison 2002). Since dual eligibles consumed more prescription drugs than any other Medicaid population, much of these increases in spending would go toward covering the needs of dual eligibles. The combination of a state budget crisis coinciding with national prescription drug insurance reform provided states with a policy window to help set the agenda and provide fiscal relief to the states. This hypothesis states that state fiscal issues made the switch in coverage palatable to legislators, despite undermining several goals of the legislation.

In this hypothesis, while my independent variables are NGA lobbying and the fiscal conditions of state budgets, my dependent variable is the switch in drug coverage for dual eligibles. In order to gather evidence of lobbying, I examined the NGA’s website for archived documents, including letters, hearing testimony, and public statements. Letters addressed specifically to congressional leaders and members of the Bush Administration, such as Secretary of the Department of Health and Human Services Tommy Thompson, provide evidence of direct lobbying. When examining hearing testimony, I noted arguments and concerns addressed by the governors. I utilized this information to compare governors’ statements to congressional discourse. Frames employed by congressmen that match those created by NGA leaders would provide a strong indicator of NGA lobbying influence. I also examined newspaper articles in order
to see if the press covered the NGA’s lobbying efforts or reported any statements from NGA leaders regarding dual eligibles.

I examined legislative proposals to assess the influence of lobbying activity. One measure of lobbying success is to examine the demands of the lobbyist and compare those demands with the final legislation. NGA demands that appear in the final legislation are another strong indicator of NGA lobbying influence.

I recorded direct quotes from NGA leaders in letters, hearings, or public statements urging action on the dual eligible issue as well as direct attempts to persuade a congressman. Congressmen specifically targeted by NGA leaders who express concern for state budgets would suggest the influence of NGA lobbying.

In order to further determine the effectiveness of NGA lobbying influence, I examined congressional records from February 2003 through November 2003 relating to the debate of dual eligibles in the House and Senate. These dates mark the beginning and end of deliberation on the dual eligible provision of the MMA. I particularly looked for arguments adopted by congressmen from NGA representatives. I investigated if congressmen expressing similar arguments to the NGA represented states with NGA leaders, such as a chairman or Medicaid Reform Task Force member. Other indicators of NGA lobbying influence include citing a governor when presenting an argument to support their opinion, submitting letters written by governors individually or the NGA, and emphasizing the importance of providing fiscal relief to the states or how much a state will benefit from the legislation.

In addition to evaluating the influence of the NGA, I needed to be attuned to other potential influences. Changes in discourse and voting could signal the existence of an
additional, stronger influence, such as ideological or political party influences. Thus, I tracked voting patterns and discourse of every senator and representative that addressed the dual eligible issue as recorded in the congressional record. Other influences could arise from interest groups challenging the NGA or notable events during the legislative process that anger one of the political parties.

How much of a role did state budgets play in determining the outcome of the MMA? States with the most severe budgetary issues have the most incentive to support federal assumption of costs associated with providing coverage for dual eligibles. Using criteria explained in the remainder of this section, I have identified six states with the most severe budget issues as a result of Medicaid expenditures: Maine, Mississippi, Missouri, New Hampshire, New York, and Pennsylvania. These states have the most to gain from providing a Medicare drug benefit to dual eligibles, and thus, have the most incentive to support the provision.

Providing Medicare drug coverage for dual eligibles would save states millions, and in some cases billions, of dollars. States would no longer have to make difficult decisions about which important programs to reduce funding. In contrast, states with balanced budgets or mild budgetary concerns have little incentive to support the switch because these states gain little benefit from the federalization of prescription drug costs for dual eligibles. These states are least likely to cut future benefits to dual eligibles, and thus, can continue to provide expansive prescription drug coverage. In my second hypothesis, my goal is to distinguish between framing rhetoric and genuine state interest by senators.
Hypothesis 2: Congressmen representing states with severe Medicaid budgetary fiscal crises were more likely than congressmen representing states with balanced budgets or mild Medicaid budgetary crises to vocalize arguments in support of providing Medicare coverage for dual eligibles during debates.

Hypothesis 2a: Congressmen representing states experiencing severe Medicaid budgetary fiscal crises were more likely than congressmen representing states with balanced budgets or mild budgetary fiscal crises to vote in support of providing Medicare coverage for dual eligibles.

In my second hypothesis, while the independent variable is the severity of a state’s Medicaid budgetary crisis, the dependent variable is a congressman’s vocalized support or opposition of a Medicare drug benefit for dual eligibles. In hypothesis 2a, the independent variable is also the severity of a state’s Medicaid budgetary crisis, but the dependent variable is the outcome of a member of Congress’s vote. I distinguish between vocal and voting support in order to differentiate active and passive supporters or opponents. Vocalizing support during floor debates requires members of Congress to speak in front of his peers, and thus, requires active participation in debate. Congressmen speak during debate because they want to express their strong opinions, draw attention to an important point they believe other Congressmen are overlooking, and to make a statement recorded in the public records. Those who vocalize their support tend to have stronger opinions on the issue or have greater stake in the issue being debated than those who simply vote. Party leaders and other high profile figures such as Hillary Clinton, however, are the exception. The public and Congress expect these leaders to formally provide a reasoned argument in support or opposition of the issue. Since not everyone publicly expresses their opinions, tracking votes enables me to fill in the gaps where a congressman’s support or opposition could be in doubt.
In order to prove or reject my hypotheses, I classified states by the severity of their budget situation. In order to do so, I analyzed the data depicted in Table 1, which displays five categories of state-level expenditure data on Medicaid and dual eligibles. The United States data indicate the mean of all 50 states. Shaded boxes indicate instances where a state’s expenditures exceed the national average. In each instance where the state exceeded the national average, I assigned the state one point. States could receive up to five points for exceeding the national average of these expenditure categories. I also assigned one point to states with a projected budget deficit as of February 2003. Thus, point totals ranged from zero to six.

Table 4.1: State Medicaid Spending on Dual Eligibles

<table>
<thead>
<tr>
<th>State</th>
<th>Dual Eligibles as a Percentage of Total Medicaid Enrollees 2003</th>
<th>Spending on Dual Eligibles as a Percentage of Total Medicaid Expenditures for Drugs 2003</th>
<th>Percentage of Dual Eligible Spending for Drugs 2003</th>
<th>Medicaid Expenditures as a Percentage of Total Expenditures 2003</th>
<th>Percentage Change in Medicaid Expenditures from 2002 – 2003</th>
<th>Projected 2003 Budget Gap (Dollars in Millions)</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>United States</td>
<td>14%</td>
<td>40%</td>
<td>14%</td>
<td>21.40%</td>
<td>8%</td>
<td>N/A</td>
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<td>Alabama</td>
<td>21%</td>
<td>39%</td>
<td>14%</td>
<td>22.30%</td>
<td>11.20%</td>
<td>$0</td>
<td>3</td>
</tr>
<tr>
<td>Alaska</td>
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<td>17%</td>
<td>12.1%</td>
<td>16.8%</td>
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<tr>
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<td>38%</td>
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<td>9%</td>
<td>25.30%</td>
<td>7.40%</td>
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<td>31%</td>
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<td>Washington</td>
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<tr>
<td>Wisconsin</td>
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<td>Wyoming</td>
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Table 4.2 summarizes how many points a state must obtain to have a mild, moderate, or severe Medicaid budget fiscal crisis. As indicated by the table, I classified
states accumulating zero to two points as having mild Medicaid budgetary issues.

Similarly, states with moderate budgetary issues had either three or four points, and states with severe Medicaid budget crises accumulated five or six points.

**Table 4.3: States Listed by Budget Issue Classification**

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<tr>
<th>Severe</th>
<th>Moderate</th>
<th>Mild</th>
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<tr>
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<tr>
<td>Wisconsin</td>
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Table 4.3 displays which states I have classified as severe, moderate, or mild.

While Mississippi and Pennsylvania accumulated six points, Delaware received zero
points. Based on this categorization, I would expect that states with severe Medicaid fiscal crises would be more likely to vocalize support for and vote for providing Medicare drug coverage for dual eligibles than states classified with mild budgetary issues. While state budgets categorized as severe have the most to gain from providing Medicare drug coverage for dual eligibles, states classified as mild will receive the least benefit to their budgets.

When analyzing the impact of state budgets on vocal and voting support, I concentrate on senators. While the Senate devoted substantial time to floor debate on how to cover dual eligibles throughout the entire legislative process, the House of Representatives devoted little time to debate on the issue, especially prior to conference committee. From the start, the House wanted to provide dual eligibles with a Medicare drug benefit. No representatives proposed an amendment to either include or exclude dual eligibles from the benefit. Due to the lack of sample size for House discourse, I decided to focus my analysis on the Senate. Due to the nature of their position, senators also tend to represent their states’ interests more than representatives who tend to focus on the interests of their localized constituency.

In order to track vocal support or opposition on the issue, I read floor debates published in the Congressional Record. A senator expressed vocal support or opposition for the issue if the senator commented at least once on the issue during debate. In order to identify party behaviors that may have influenced decisions and opinions after conference committee, I provided two separate analyses: vocal and voting support prior to conference committee and vocal and voting support after conference committee. Changes in vocal or voting support by the majority of senators after conference
committee may suggest the influence of political parties. Since some senators may value party interests over state interests, the existence of partisanship could reduce the correlation between state budgets and support for providing Medicare drug coverage for dual eligibles. Finally, I calculated the percentage of states with severe, moderate, and mild budgetary issues with senators expressing vocal support or opposition to providing Medicare drug coverage for dual eligibles.

Similarly, I tracked voting behavior among senators. I analyzed votes on Senator Rockefeller’s Senate amendment, and I analyzed votes on the conference report, which became the law. If passed in June 2003, Senator Rockefeller’s amendment would have added to the Senate proposal a provision that included dual eligibles in the Medicare drug benefit (149:96 CR S8647). This amendment provoked the first officially recorded Senate vote on how to insure prescription drugs purchased by dual eligibles. I then calculated the percentage of senators from states with severe, moderate, and mild Medicaid budget crises who voted in support of or opposition to the Rockefeller amendment and the conference report.

Finally, I examined conference report voting patterns of House party defectors. Sixteen Democratic representatives and twenty-five Republican representatives defected from their party when voting on the conference report. I wanted to see if possibly state budgets provided an explanation why these representatives defected from their party. I separated these representatives by whether they represented a district within a state experiencing a severe, moderate, or mild budget crisis. Then, I tallied how many Democrats voted for and how many Republicans voted against the conference report. If there exists a relation between state budgets and House party defecting votes, then I
would expect to see more Democratic representatives from severe states to vote in favor of the conference report than Republicans from severe states that vote against the conference report. Similarly, more Republicans from states with mild budget issues should vote against the conference report than the number of Democrats from states with mild budget issues that vote against the conference report.

In the next chapter, I will explain the severity of fiscal budgets experienced by states in the year leading up to the MMA’s passage. In chapter six, I will examine the influence of NGA lobbying on congressional discourse surrounding the issue. In chapter seven, I will explore the impact of state budgets on congressional discourse and voting patterns. Finally, I will conclude by discussing the implications of my findings on the future of health care reform.
Chapter 5: The State of State Budgets Fiscal Year 2003

In the same year Congress passed the MMA, states experienced one of the worst fiscal crises in our nation’s history (Boyd 2003b). States desperately needed a solution that would curb their exponentially rising Medicaid costs (Samuels and Pattison 2002). The MMA provided an opportunity for the federal government to relieve state budgets by assuming financial responsibility for dual eligibles. Since the MMA saved states billions of dollars (J. Ryan and Super 2003), states emerged as one of the primary winners of the new legislation. Thus, it is logical to assume that state budgets influenced the decision to provide Medicare drug coverage for dual eligibles. This chapter discusses in detail the state budget context during which the MMA was debated and enacted into law.

During the fiscal boom in the late 1990s, state tax revenues exceeded state projections, enabling states to decrease taxes and increase spending for programs such as health care and education. Between 1990 and 2000, state tax revenues increased 26 percent per-capita after adjusting for inflation (Boyd 2003). During this decade, the federal government provided additional funding to state governments in order to help subsidize the costs for new and existing state programs. Overall, the increase in funds available for state spending from both tax revenue and federal sources increased 32% per-capita during this decade after adjusting for inflation (Boyd 2003b). This additional increase in cash enabled states to increase spending 26 percent per-capita after adjusting for inflation and population growth (Boyd 2003b). These spending increases occurred in all states except Alaska (Boyd 2003b).

Since the percentage of revenues from income taxes increased faster than increases in federal aid, states became more reliant on income taxes to fund their budget
(Boyd 2003b). The economic factors causing this surge in tax revenue, however, suggested that states would not be able to rely on rising tax revenue over the long-term. The stock market boom enabled people to earn more assets that could be taxed by the government (Boyd 2003a). This form of tax revenue, however, is volatile and unsustainable. At the height of the boom, the unemployment rate reached historic lows, enabling people to make more money and creep into higher tax brackets (Boyd 2003a). As people enter higher tax brackets, they pay higher taxes, and the states collect more in tax revenue. From 1995-2000, the number of people with incomes greater than $200,000 increased 117 percent (Boyd 2003b). As a result, states became more reliant on a small proportion of taxpayers (Boyd 2003b). As soon as the economy entered a recession, these individuals would likely return to their previous tax brackets, resulting in a dramatic decrease in state tax revenue. Overall, tax revenue grew faster than the economy, suggesting the existence of unsustainable revenue (Boyd 2003b). In addition, due to the strong economy, fewer people qualified for Medicaid. As soon as the economy entered a recession, Medicaid enrollees increased. Unfortunately, states did not adequately plan to pay for a sudden rise in medical expenditures as a result of this increased enrollment. Thus, states made fiscally irresponsible decisions to dramatically increase spending while also cutting taxes during the economic expansion.

The 2001 recession coincided with a huge stock market crash and a rise in the unemployment rate as manufacturing jobs disappeared (Boyd 2003). State revenue plummeted as previous sources of tax revenue from the decade before vanished (Boyd 2003). As corporations eliminated low-income jobs, Medicaid enrollment increased. Unfortunately, the recession coincided with exponential increases in spending on health
care, especially on prescription drugs (Iglehart 2003). States no longer had the revenue required to support recently expanded programs. In addition, increasing state taxes in order to fund these programs would have caused hardships for Americans already struggling to pay their own bills.

In Fiscal Year 2003 (July 1, 2002 – June 30, 2003), states experienced the worst state fiscal crisis in the last half century (Lav and Johnson 2002). At the start of the fiscal year, almost every state faced a projected budget gap (Boyd 2003b). Despite tempering their expectations, however, states still collected six percent less tax revenue than budgeted (Samuels and Von Behren 2003). Due to the unexpected shortfall in revenue and spending overruns, 36 states reopened their budget gaps as the year progressed (Boyd 2003b). As a result, an unprecedented 40 states made various program cuts in 2003 amounting to $11.8 billion (Samuels and Von Behren 2003).

States focused much of their attention on controlling the costs associated with Medicaid, which comprised of 21.4 percent of all state spending in 2003 (Samuels et al. 2003). State Medicaid spending had grown faster than any other classification of expenditures. According to the National Association of State Budget Officers (NASBO), Medicaid spending increased by eight percent from Fiscal Year 2002 to Fiscal Year 2003 (Samuels et al. 2003). All other state expenditures combined grew at a rate of 2.7 percent over the same time period ("Health Expenditure Report" 2005). As a result, health care spending consumed a larger percentage of states’ budgets each year. The Congressional Budget Office (CBO) projected that Medicaid spending would increase by 8.5 percent annually from 2003 to 2010, suggesting that Medicaid costs would continue to crowd out spending for other programs (Boyd 2003b). This projected annual increase also outpaced
projected state revenue increases over this same period, indicating that states would only be able to pay for Medicaid if they increased taxes or cut spending for other programs ("Health Expenditure Report" 2005). NASBO projected in 2002 that Medicaid spending on prescription drugs would increase 12.7 percent annually through 2011 (Samuels and Pattison 2002). As a result, prescription drugs, in particular, provided considerable fiscal stress on state budgets.

States spend a disproportionate share of their Medicaid expenses on individuals who qualify for both Medicare and Medicaid known as dual eligibles. Although dual eligibles comprised of only 14 percent of Medicaid beneficiaries in 2003, states spent 40 percent of their Medicaid expenses on costs associated with providing health care to dual eligibles (Wilhide 2005). While states spent the majority of their expenditures for dual eligibles on long-term care, prescription drugs accounted for 14 percent of state spending on dual eligibles in 2003 (Wilhide 2005).

In 2003, states faced a poor prognosis for state revenue growth, and as a result, were projected to face budget gaps for several more years (Boyd 2003b). Three factors contributed to this poor prognosis. First, private sector employment had been slow to increase jobs, indicating that the U.S. would be faced with high unemployment for at least a few more years (Boyd 2003b). Second, income from capital gains had to more than double to reach pre-recession capital gains returns, an unlikely occurrence for several more years (Boyd 2003b). Finally, economists projected low levels of consumption for the immediate years following the recession, which would keep sales tax revenue low (Boyd 2003b).
States have much stricter balanced budget requirements than the federal government, and governors in 45 states must submit balanced budgets (Samuels et al. 2003). In order to balance their budgets, states utilized a number of strategies. States can often decrease deficits in emergencies by using up rainy day funds or reserves, which states build up during strong economic years (Lav 2002). By the end of 2002, however, state governments had depleted almost all of these resources (Lav 2002). States also employed other strategies, such as postponing expenses, freezing hiring, forced early retirement for state workers, cutting government administrative expenses, administering bonds to finance projects, and cutting state programs (Lav 2002). Thus, states were desperate for fiscal relief. Remaining budget balance strategies included either additional cuts in essential programs, such as education and health care, or the always unpopular option of increasing taxes (Lav 2002).

Fortunately for states, this state budget crisis occurred at the same time Congress debated a new prescription drug benefit for Medicare beneficiaries. In order to avoid raising taxes or cutting important programs, state governors rallied to convince the federal government to assume all costs associated with providing prescription drugs to dual eligibles. A successful lobbying effort was projected to provide an estimated $44 billion of relief to the states between 2004 – 2013 (J. Ryan and Super 2003).
Chapter 6: NGA Lobbying and Influence

Prior to the MMA, the House and Senate proposed several bills that would have established a Medicare prescription drug benefit (“Health Bills” 2014). All of these bills died shortly after being proposed or after passage through one of the chambers of Congress (“Health Bills” 2014). The first of these bills, the Medicare Rx 2000 Act, passed the House, and then died before reaching the Senate (“H.R. 4680 (106th): Medicare Rx 2000 Act” 2000). This bill called for a gradual federal assumption of prescription drug costs associated with dual eligibles, indicating that the House wanted to include dual eligibles in the benefit from the start (“H.R. 4680 (106th): Medicare Rx 2000 Act” 2000). Although the NGA did not explicitly lobby this bill, NGA leaders did testify before the Senate Finance Committee to warn Congress about the exponential rise in Medicaid prescription drug costs associated with dual eligibles (Cellucci 1999; Sheppach 1999). Testimonies by Governor Paul Cellucci (R-MA) and NGA Executive Director Raymond Sheppach were primarily informative rather than persuasive (Cellucci 1999; Sheppach 1999). Sheppach, however, argued, “Any consideration of adding a prescription drug benefit to the Medicare program must recognize that state budgets have shouldered these costs for years, and that these costs should be borne by the Medicare program” (Sheppach 1999). This sentence marks the first lobbying effort by the NGA to encourage Congress to claim fiscal responsibility for providing a drug benefit to dual eligibles. As debate became more serious in 2003 and state budgets worsened, the NGA capitalized on a policy window and vigorously lobbied Congress to shoulder the fiscal burden of dual eligibles.
As I will explain in this section, the NGA’s lobbying efforts heightened the importance of and increased the amount of attention devoted to the proper drug insurance coverage for dual eligibles. As the NGA gave testimony at congressional hearings, wrote letters, and lobbied individual members of Congress, senators and representatives began to adopt the arguments presented by the NGA. These members of Congress reinforced frames established by the NGA in order to convince other members of Congress to adopt the NGA’s position. During conference committee, however, Republicans excluded several Democratic representatives and senators. As a result, Democrats began attacking several provisions supported by Republicans, including providing Medicare drug coverage for dual eligibles. This situation complicates evaluating the extent to which the NGA’s lobbying impacted the outcome of the MMA. I find evidence, however, that suggests the NGA helped set the agenda, shaped congressional discourse, and received an outcome that reduced the burden of Medicaid on state budgets.

**NGA Lobbying Before Conference Committee**

The NGA applied three main lobbying tactics in order to convince Congress of their position. First, in the beginning, representatives of the NGA provided Congress with as much information as possible through hearing testimony in order to convey the extent of the problem, potential consequences if the federal government did not provide financial assistance to the states, and viable solutions. Second, the NGA sent letters to Tommy Thompson, Secretary of Health and Human Services, and relevant committee leaders in both the House and Senate in order to express approval or disapproval of the
position taken by each chamber during policy formation. Third, the NGA Medicaid Reform Task Force created a proposal explaining how to best cover dual eligibles under the new Medicare prescription drug benefit.

Prior to the MMA, states paid 100 percent of prescription drug costs for dual eligibles (149:169 CR H11997). The NGA called for a gradual federal assumption of drug expenditures for dual eligibles over ten years (Patton et al. 2003). The NGA provided four main arguments. First, rising Medicaid costs during the severe state budget crisis will force states to reduce Medicaid coverage and other state programs, such as education. I will refer to this argument as the reduced future benefits argument. Second, benefits provided by Medicare have always been available to all Medicare beneficiaries, regardless of income. I will refer to this argument as the universality argument. Third, the balanced budget argument states that the federal government is in a better position to pay for a drug benefit for dual eligibles because the federal government has more flexible balanced budget requirements than states. Fourth, the accountability argument explains that overlapping responsibilities between the state and federal government reduce the performance and accountability of government.

All 50 governors plus the governor of Guam unanimously supported the switch in coverage for dual eligibles as indicated by a letter signed on July 31, 2003 by every governor and addressed to Representative William M. Thomas (R-CA), Chairman of the House Ways and Means Committee (Patton and Kempthorne 2003c). The letter explicitly states, “We strongly support the specific provision in the House bill that gives elderly and disabled Medicaid beneficiaries full access to the new Medicare prescription drug benefit” (Patton and Kempthorne 2003c). The letter suggested that the issue was
bipartisan among governors and symbolically reiterated the importance of this issue to governors from all states. The unanimous support suggested a widespread concern about state budgets and future Medicaid benefits that required the attention of Congress. This unusual situation provided substantial leverage to the NGA when lobbying in Congress.

On February 23, 2003, President Bush indicated his interest in working together with the NGA on Medicare reform at the NGA’s Winter Meeting Plenary Session (G. W. Bush 2003). Within three weeks of this speech, the NGA formed the bipartisan NGA Medicaid Reform Task Force to work with both the Bush Administration and Congress to draft legislation that would alleviate states’ strained budgets (Patton and Kempthorne 2003a). Over the next few months, the NGA informed Congress of the situation plaguing states. In doing so, the NGA shaped the discourse of members of Congress during debates on the MMA. In fact, many of the arguments the NGA employed to sway members of Congress were then argued by those policymakers to persuade other legislators.

In order to convince policymakers that the federal government should assume these prescription drug costs, leaders of the NGA testified to Congress about the fiscal stress Medicaid prescription drug expenses imposed on state budgets. On March 21, 2002, then-Vice Chairman Governor Paul Patton (D-KY) testified at a hearing to the Senate Special Committee on Aging (Patton 2002). Patton explained, “A crisis is at hand, that it must be confronted, and that [Medicaid] must be changed if we are to serve the needs of our families” (2002). In order to pay for the exponentially rising costs associated with providing Medicaid coverage, Patton argued that states would either have to reduce benefits from important programs or increase taxes (Patton 2002). Since Patton
strongly opposed increasing taxes, he emphasized the reduced future benefits argument and conveyed to the special committee that Medicaid benefits would be reduced or other programs, such as education, would lose a portion of their funding. Halfway through his testimony, Patton stated, “Governors believe that a Medicare drug benefit should be covered by and administered by Medicare” (Patton 2002).

On March 12, 2003, three governors on the NGA Medicaid Reform Task Force, including Jeb Bush (R-FL), John G. Rowland (R-CT), and Bill Richardson (D-NM), testified at a hearing held by the House Energy and Commerce Committee (J. Bush 2003; Richardson 2003; Rowland 2003). All three governors testified that states faced unsustainable growth in Medicaid costs particularly due to the rapidly rising prices of prescription drugs (J. Bush 2003; Richardson 2003; Rowland 2003). They argued the balanced budget requirement argument (J. Bush 2003; Richardson 2003; Rowland 2003), claiming that the federal government was not contributing its “fair share of the responsibility” (Richardson 2003). Governor Richardson reasoned that since the federal government has more flexible balanced budget requirements than states, the federal government was in a better position to absorb the costs (Richardson 2003).

The governors echoed a common trade-off expressed by Governor Patton a year before that states would need to reduce Medicaid benefits if they did not receive assistance from the federal government. This argument, which I have identified as the reduced future benefits argument, suggested that dual eligibles could be worse off by maintaining their Medicaid prescription drug coverage (J. Bush 2003; Richardson 2003; Rowland 2003). Overall, switching prescription drug coverage to Medicare would
provide a stronger safety net for dual eligibles (J. Bush 2003; Richardson 2003; Rowland 2003).

In a letter dated June 5, 2003 to Senate Finance Committee leaders Senator Charles Grassley (R-IA) and Senator Max Baucus (D-MT), Governor Patton and Governor Dirk Kempthorne (R-ID), Chairman and Vice Chairman of the NGA, outlined the NGA’s argument why the Senate should support the switch in prescription drug coverage for dual eligibles (Patton and Kempthorne 2003b). Patton and Kempthorne sent this letter right before Senate markup. They reiterated the reduced future benefits argument by explaining that states could no longer adequately fund both education and health care (Patton and Kempthorne 2003b). As a result, states would need to cut optional benefits that helped mostly women and children, which still are important investments for our nation’s future (Patton and Kempthorne 2003b). Thus, unless states received additional financial support, the quality of Medicaid coverage would be reduced, leaving our nation’s most vulnerable population more vulnerable.

Patton and Kempthorne also crafted the universality argument. They explained that the federal government has accepted responsibility for individuals over 65 years of age in the past (Patton and Kempthorne 2003b). For example, Social Security and Medicare, which are programs entirely funded and administered by the federal government, provide important services to people over 65 years old (Patton and Kempthorne 2003b). Never before had a Medicare benefit been denied to an individual who qualifies for Medicare. Failing to provide prescription drug benefit for dual eligibles would set a new historical precedent that could drastically alter our nation’s perceptions of universal benefit programs. Patton and Kempthorne also introduced the accountability
argument by claiming that overlapping and conflicting responsibilities between the state and federal governments reduced performance and accountability of government (Patton and Kempthorne 2003b). This argument suggested that failing to provide a Medicare drug benefit to dual eligibles would result in worse quality of care.

The following week, the NGA publicly released its proposal. Democratic governors on the NGA Medicaid Reform Task Force released a joint statement that proposed a gradual federal assumption of all drug expenditures for dual eligibles over the next ten years (Patton et al. 2003). These expenditures included copayments, premiums, deductibles, and other miscellaneous costs associated with providing prescription drugs for dual eligibles (Patton et al. 2003). Republican governors on the NGA Medicaid Reform Task Force sent a letter to Secretary of Health and Human Services Tommy Thompson expressing the same desires, suggesting a bipartisan agreement among our nation’s governors (Kempthorne et al. 2003).

**Senate Discourse Before Conference Committee**

An analysis of early Congressional discourse suggests that NGA lobbying mobilized senators to address their concerns. Senators, primarily Democrats, emphasized the importance of helping states balance their budgets while debating new legislation. Senate Democrats adopted NGA frames to convince Senate Republicans of the pressing need to extend the Medicare drug benefit to include dual eligibles. Senator Jeff Bingaman (D-NM), who represented the same state as NGA Medicaid Reform Task Force member Governor Bill Richardson, sympathized with state concerns. Senator
Bingaman attended an NGA subcommittee meeting on human resources and Medicaid (149:32 CR S2883). Bingaman stated:

It is clear that [states] are under severe stress at this point fiscally… it is important for the federal government to respond to that… The federal government needs to fundamentally reassess its own role in providing health care and reassess its relationship to the states. (149:32 CR S2883)

Bingaman echoed the demand of the NGA and called for the federal government to claim responsibility for the costs associated with providing drug coverage for dual eligibles (149:32 CR S2884). The senator viewed this responsibility as a federal obligation, and proposed the Strengthening our States Act, which provided minor Medicaid reform and fiscal relief to the states (149:67 CR S5862). When presenting this legislation, Bingaman frequently cited the concerns of governors and the importance of the federal government to fulfill the demands of the NGA by supplying budgetary assistance (149:67 CR S5863). Similarly, Senator Hillary Clinton (D-NY) acknowledged New York’s budget struggles and claimed that the federal government’s failure to assume the drug costs for dual eligibles “continues to leave New York, which is in a precarious State budget situation, to subsidize the federal government's lack of adequate investment” (149:97 CR S8856).

In a couple of instances, senators referenced letters from governors during debate, suggesting that governors utilized congressmen as champions in order to lobby their preferences directly on the Senate floor. In a letter read by Senator Clinton, Governor George Pataki (R-NY) wrote:

We have always believed that these costs should be borne by the federal government and strongly support efforts to federalize prescription drug costs for the dual eligible population… We urge you to work with us to ensure that our seniors get the prescription drug coverage they deserve, and that the federal government assumes its rightful role in supporting services for our dual-eligible population. (149:92 CR S8271)
This quotation from Pataki’s letter emphasized that the government had a responsibility to both the states and dual eligibles to cover the prescription drug costs of America’s sickest and most vulnerable population. This important theme frequently permeated the discourse of governors and official statements from the NGA. Senator Jay Rockefeller (D-WV) cited a June 11, 2003 letter to Senator Grassley and Senator Baucus signed by the Chairmen of the NGA arguing that referenced both the reduced future benefits and the universality arguments:

The nation’s governors oppose [the Senate’s] approach. It is not good health policy. It is not good precedent… If the dual eligible populations continue to be a joint responsibility, states will be forced to cut the optional (Medicaid) benefits and populations - mostly women and children - which are a key investment in the future. (149:93 CR S8324)

During floor debates of the MMA in June, senators frequently adopted arguments crafted by NGA leaders in order to convince fellow senators to support Medicare prescription drug coverage for dual eligibles. Several senators articulated the reduced future benefit argument. For example, Senator Edward “Ted” Kennedy (D-MA) claimed, “The poorest of the poor can no longer count on protection… With the states now facing very sizable deficits, they are cutting back on Medicaid” (149:89 CR S7966). Senator Rockefeller supplied an additional dimension to Senator Kennedy’s argument by explaining that “prescription drugs are… an optional benefit under Medicaid” (149:93 CR S8324). In doing so, Rockefeller implied that the optional nature of these benefits suggested that they would be one of the first to be cut by state governments. Rockefeller argued, “It is not fair for [dual eligibles] to be at the mercy of state coverage decisions” (149:93 CR S8324).
Senator Rockefeller also presented the balanced budget requirement argument originally argued by Governor Bill Richardson at a hearing held by the House Energy and Commerce committee. According to this argument, the federal government was in a better position to pay for the costs associated with providing drug coverage for dual eligibles than states because unlike the federal government, states must balance their budgets. For example, Rockefeller stated:

> It needs to be clearly understood by my colleagues that Medicaid in the hands of governors, which I had the honor of being at one point, is subject to whatever their whims might be. [Medicaid] is subject to budget pressures. Remember, they have to balance the budget. We don't; they do. (149:93 CR S8324)

Democratic senators also adopted the universality argument first argued by Governor Patton and Governor Kempthorne of the NGA. According to this argument, since Medicare covers all eligible beneficiaries for its other insurance policies, prescription drugs should not constitute an exception by denying the poorest of the poor Medicare prescription drug coverage. The universality argument conveys the idea that providing coverage for everyone regardless of income reduces the stigma associated with receiving insurance coverage through Medicare. In contrast, the public perceives Medicaid as welfare and its recipients as the undeserving poor (Katz 1990). Thus, the public negatively stigmatizes Medicaid beneficiaries. Failure to include dual eligibles in the Medicare benefit would send the message that they are too poor and unworthy of this federally funded benefit.

On June 23, 2003, Senator Rockefeller proposed amendment Number 975 to the Senate that would provide coverage for dual eligibles, arguing that Congress must preserve the universality of Medicare (149:93 CR S8324). I will refer to this amendment
as the “Rockefeller amendment.” When presenting this amendment to the Senate floor, Rockefeller emphasized the universality argument:

[ Medicare ] was the promise that society made to our seniors: That if you work, if you make your payroll contributions, then you, at the proper time, qualify for Medicare regardless of where you live, regardless of how old you might be, or your income. (149:93 CR S8324)

According to Rockefeller, failing to extend the drug benefit to dual eligibles would break our nation’s promise to the elderly. Rockefeller argued that it was “unfair” for dual eligibles to have spent their whole lives contributing to Medicare, expecting to receive all of its benefits when turning 65 years of age (149:93 CR S8324). Ultimately, Senator Rockefeller worried that excluding poor seniors would set a bad precedent for future Medicare policy (149:93 CR S8324).

Senator Clinton agreed with Senator Rockefeller and expressed the universality theme:

Never in the history of the Medicare program has a Medicare beneficiary been denied access to a covered benefit. I am just so troubled that we are excluding our lowest income seniors. I don’t know how we justify that. (149:92 CR S8271)

Similarly, Senator Kennedy expanded on the universality argument and explained that Medicare must provide coverage for dual eligibles because precedent suggested that Medicare was the primary insurer while Medicaid provided supplemental coverage:

The fact that Medicaid provides extra assistance for the poor does not reduce Medicare’s obligation to provide equal treatment for all. Medicare always has primary payment responsibilities for the services it covers. Medicaid is always supplementary. (149:94 CR S8393)

When debating Rockefeller’s amendment in June 2003, primarily Senate Republicans countered the arguments crafted by the NGA and adopted by Senate Democrats. Senate Republicans articulated three arguments. First, the better coverage
argument explains that Medicaid would provide better drug coverage for dual eligibles than Medicare. Second, the familiarity argument states that due to their poor education background, poor health status, and cognitive disabilities, dual eligibles should receive drug coverage in a plan that is familiar and easy to navigate. Third, the resources argument asserts that the federal government does not have enough money to provide adequate drug coverage for dual eligibles and the rest of the Medicare population, and as a result, the federal government should devote its resources to providing care for those without drug coverage.

Senator Grassley (R-IA) and Senator Craig Thomas (R-WY) disagreed with Rockefeller, Clinton, and Kennedy that dual eligibles would be treated as second-class citizens because they already received a generous drug plan that provided more expansive coverage than the coverage private plans would provide other beneficiaries in Medicare (149:93 CR S8326; 149:92 CR S8273). Senator Grassley also called out Senator Rockefeller directly by claiming the purpose of his amendment was primarily to provide fiscal relief to the states, rather than protect the interests of dual eligibles:

Is the purpose of the prescription drug bill before us to grant fiscal relief to the States, which would be what the amendment of the senator from West Virginia would do? I do not believe that is what we should be doing. (149:93 CR S8327)

In doing so, Grassley established a potential link between NGA lobbying pressures and Senator Rockefeller’s amendment.

During Senate debate on the Rockefeller amendment, Senator Thomas indicated his opposition to the switch by emphasizing both the better coverage and familiarity arguments. He explained that Medicaid “will provide high quality, accessible care through a system that is familiar to seniors and easy to navigate” (149:92 CR S8273). In
his statement, Thomas alluded to the downside of market-based insurance for dual eligibles, which can be confusing for the poor, uneducated elderly, especially if these individuals have cognitive disabilities. He further emphasized the better coverage argument by claiming “the Medicaid program is considered by most advocates and beneficiaries to be quite generous and far superior to the current Medicare program” (149:92 CR S8273).

Senator Grassley agreed with Senator Thomas’ familiarity argument, arguing that since dual eligibles were satisfied and comfortable with their drug plan, they should not be required to switch their coverage (149:93 CR S8327). Republicans downplayed the potential stigma of receiving coverage through Medicaid, and argued that having coverage dual eligibles knew and understood was most important (149:93 CR S8327). Senator Grassley asserted that dual eligibles deserved the best drug coverage, which could be provided for them through Medicaid (149:96 CR S8640). In contrast, however, Senator Rockefeller argued that dual eligibles would receive better coverage under Medicare even if Medicaid did not scale back its benefits in the future (149:93 CR S8324). Shifting dual eligible drug coverage to Medicare would provide better coordinated care, reduce conflicting policy coverage between Medicare and Medicaid, and result in better health outcomes (149:93 CR S8324).

Senate Republicans emphasized the resources argument when combating Rockefeller’s amendment. Republicans claimed that the new legislation must prioritize providing drug coverage for those who do not already have coverage. These senators did not believe the $400 billion budget provided enough money to adequately cover both dual eligibles and other Medicare beneficiaries without drug coverage. According to
Senator Grassley, “the purpose of the prescription drug bill is to provide prescription drugs to seniors who do not currently have access to drugs or otherwise would be paying extremely high drug costs” (149:93 CR S8327). Dual eligibles did not fit in this group of seniors. Senator Grassley calculated that Medicare coverage for dual eligibles would cost about 30 percent of the federal budget, which would greatly reduce the type of benefit package Medicare could offer those without drug insurance (149:93 CR S8328). Senator Don Nickles (R-OK) disagreed that the federal government would stay within its budget of $400 billion if it decided to cover dual eligibles, and thus, did not believe the federal government could afford to pay for this population (149:172 CR S15607). Senator Thomas developed a slightly alternative solution. While he strongly believed the government should not divert scarce resources to cover the already insured, he supported increasing federal contributions to states to pay for expected Medicaid drug cost increases (149:92 CR S8273).

Ultimately, Senator Rockefeller’s amendment to include dual eligibles in the new Medicare drug benefit failed to garner enough support. Senators voted mostly along party lines with 42 Democrats and 5 Republicans voting “Yea” and 46 Republicans, 4 Democrats, and 1 Independent voting “Nay” (Roll Call #257 47-51 CR S8648). Most notably, Democratic Senator Baucus, ranking member of the Senate Finance Committee, which had jurisdiction over the bill, voted against the amendment (149:96 CR S8648). NGA lobbyists frequently targeted Senator Baucus through letters in order to obtain his support for the NGA’s initiative. Thus, the failure of the NGA to persuade Senate opponents of the switch provides evidence in opposition to my hypothesis that the NGA effectively lobbied Congress and influenced the outcome of the legislation.
House Discourse Before Conference Committee

In contrast to the Senate, pre-conference committee debate in the House on covering dual eligibles was limited to sporadic statements. The majority of debate in the Senate occurred in response to Senator Rockefeller’s proposed amendment to include dual eligibles in the Senate bill. Unlike the Senate, no representative proposed an amendment to either include or exclude dual eligibles from receiving the Medicare benefit, which indicates that the House bill covered dual eligibles from the start of deliberation. This fact might explain the limited discourse surrounding the issue in the House. In addition, the limited debate complicates establishing a link between NGA lobbying efforts and the outcome of the House bill.

Some representatives, however, publicly spoke on the issue, and those that did expressed strong support for providing Medicare drug coverage for dual eligibles. Almost all representatives who spoke about the issue prior to conference committee stressed the importance of providing fiscal relief to state budgets. For example, Representative Gwen Moore (D-WI) explained that a Medicare drug benefit for dual eligibles would provide “relief to state Medicaid plans by making Medicare the primary payer for all individuals eligible for Medicare and Medicaid” (149:96 CR H6119). Similarly, Representative Joe Knollenberg (R-MI) argued that including dual eligibles in the benefit created a win-win situation in which dual eligibles would receive better drug coverage while also saving states an estimated $6.8 billion each year (149:96 CR H6119). Knollenberg’s support for including dual eligibles in the new drug benefit bolsters the claim that bipartisan support backed the House’s decision to cover dual eligibles under
Medicare. Representative Frank Pallone (D-NJ) adopted the reduced future benefits argument from the NGA:

The money that states are putting out now, if they are already providing some kind of prescription drugs, they will have saved, because they will not have to put out that money. In my state, which is hurting right now, we have cut back on the CHIP program… Why we have had to cut back is because we want to continue to pay for a low-income prescription drug program which we now have, state financed… There is a significant savings to the states at a time when they are hard hit to pay for Medicaid, CHIP, and all of these other programs, that they will save that money and will not have to cut back on health insurance for children and other people who really cannot afford it. (149:34 CR H1503-1504)

Similarly, Representative Sheila Jackson-Lee (D-TX) criticized the Senate Republican plan that excluded dual eligibles, arguing “this misguided policy endangers coverage for millions of seniors” (149:89 CR H5451). While House Democrats vocalized their support for including dual eligibles in the benefit more than Republicans, Senator Grassley indicated that House Republicans supported the measure as well (149:174 CR S15884). For example, Representative William Thomas (R-CA), Chairman of the MMA conference committee, was one of the strongest supporters from either party of including dual eligibles in the Medicare drug benefit, and he utilized his power as Chairman of the conference committee to ensure their inclusion.

On June 27, 2003, the House and Senate passed bills that provided opposite solutions to the dilemma of how to best cover dual eligibles (“H.R. 1 All Congressional Actions” 2003). In the Senate bill, dual eligibles maintained their state-run Medicaid coverage and were excluded from participating in the Medicare prescription drug benefit (Blum 2006). The outcome of the bill implied the NGA ineffectively lobbied senators. Tracing Senate discourse suggests that the NGA failed to persuade opponents to adopt the NGA’s position. Senate Democrats that supported the switch, however, adopted
NGA frames and arguments, suggesting that the NGA effectively mobilized supporters. To this point, NGA influence in the Senate was limited to agenda setting and congressional discourse.

In contrast, the House bill reflected the NGA’s demands by including dual eligibles in the new Medicare benefit and calling for a phased-in federal assumption of their prescription drug costs (149:169 CR H12008). By 2020, fourteen years after the planned full implementation in 2006, the federal government would assume 100 percent of what would otherwise be state costs (149:169 CR H12008). As stated earlier, the NGA Medicaid Reform Task Force proposed the same plan, except they requested a gradual federal assumption of drug related expenses reaching 100 percent in ten years instead of fourteen years (Patton et al. 2003; Kempthorne et al. 2003). Although little proof exists in congressional records regarding the impact of NGA lobbying on the House bill, the fact that the House bill and the Task Force’s propose a similar solution to the dual eligible issue suggests the potential of lobbying influence. I was unable to find evidence, however, to disprove the possibility that the House bill may have reflected a preexisting preference independent of the NGA’s lobbying efforts.

**Congressional Discourse During Conference Committee**

In an effort to help propel the House stance to victory, all state governors and the governor of Guam signed a letter to conference committee Chairman Representative William M. Thomas stating:

As you begin your negotiations, the nation’s governors urge you to give special attention to the impact of this legislation on populations dually eligible for both Medicare and Medicaid… We strongly support the specific provision in the House bill that gives elderly and disabled
Medicaid beneficiaries full access to the new Medicare prescription drug benefit. (Patton and Kemphorne 2003c)

According to Senator Grassley, one of the conferees, “providing drugs for dual eligibles through Medicare was a cornerstone issue for House conferees” (149:171 CR S15583). This statement suggests active mobilization efforts from Representative Thomas to appease the NGA.

Conference committee negotiations began on September 9, 2003 and concluded with the conference report released on November 21, 2003. Since the Senate is more vulnerable to party turnover than the House, conference committee deliberation outcomes generally favor the Senate’s position on a given issue (Ortega and McQuillan 1996). In essence, House and Senate party leaders collude in Congress to preserve Senate majority party seats at the expense of House majority party seats (Ortega and McQuillan 1996). In this particular situation, however, the House bill prevailed, despite some compromises to Senate conferees. At first glance, this provides support for a successful NGA lobbying campaign. The Senate, however, negotiated several compromises that drastically reduced how much the states would benefit from the new bill.

With the exception of two Senate Democrats, Senator Rockefeller and Senator Tom Daschle (D-SD), who Republican Representative Thomas excluded from deliberation due to their refusal to compromise on other aspects of the bill (Vlaicu 2004), all Senate conferees opposed providing Medicare prescription drug coverage for dual eligibles. I will expand upon Democratic Party exclusion from conference committee deliberations in the next section. The senators that participated, however, agreed to several compromises regarding dual eligibles in an attempt to appeal to members of the House of Representatives and Senate Democrats (149:174 CR S15884). As previously
mentioned during discussion of the resources argument, Republican senators opposed extending the Medicare benefit to dual eligibles primarily because they did not believe the budget provided enough money to adequately cover both dual eligibles and Medicare beneficiaries without prescription drug insurance (149:93 CR S8328).

In order to include dual eligibles without exceeding the government’s $400 billion budget, senators negotiated the “clawback,” which required states to contribute 90 percent of the costs associated with providing coverage for dual eligibles in 2006 (Schneider 2004). By 2015, the percentage states contribute phases down to 75 percent of related costs (Schneider 2004). The clawback single-handedly allowed the federal government to cover dual eligibles, provide some relief to state budgets over the long-term, and limit the amount of money from the federal budget devoted to dual eligibles. As a result, the federal government could devote adequate resources to covering those without prescription drug insurance. The clawback drastically reduced, however, how much states saved compared to the original House proposal. Figure 6.1 below depicts CBO estimates of how much states were projected to pay the federal government each year as part of the clawback. Although the states contribute a smaller percentage of the associated costs each year, the total amount states contributed increases due to projected increases in prescription drug prices, the number of dual eligibles as baby boomers age, and adjustments for inflation.
Similarly, copayments would also help slightly offset the costs to provide coverage for dual eligibles. In the Rockefeller amendment, dual eligibles were not required to pay copayments. The House proposal, however, required dual eligibles to pay $2 for generic drugs and up to $5 for a brand name drug (149:169 CR H11997). These payments would increase to adjust for inflation (149:169 CR H11997). Senators, however, thought these copayments were unaffordable for dual eligibles. They negotiated a compromise that eliminated copayments for dual eligibles in long-term care facilities, but required other dual eligibles to pay $1 for generics and $3 for brand name drugs (149:169 CR H11998). These prices would also increase in the future to adjust for inflation (149:169 CR H11998).

Thus, the NGA emerged partially victorious after conference committee negotiations concluded. Although the conference report required states to pay the clawback, states did receive some financial savings from the new bill. In addition, the NGA successfully lobbied the federal government to provide Medicare coverage for dual eligibles. Ultimately, the House bill, despite the clawback, won in negotiations. Due to

Figure 6.1: Projected State Clawback Payments

Source: The “Clawback:” State Financing of Medicare Drug Coverage June 2004
the clawback, however, states will save billions of dollars less than if the House bill provision had emerged unchanged.

**Congressional Discourse After Conference Committee**

While the NGA had modest lobbying success during conference committee, the deliberations after conference committee suggest a greater role for party politics than NGA lobbying. On November 21, 2003, at the conclusion of conference committee negotiations, the conferees released a conference report detailing the compromises negotiated between the House and Senate. Debate on the conference report occurred immediately in both chambers until the conference report passed the House and Senate on November 25, 2003.

In general, supporters of the conference report, mostly House and Senate Republicans, emphasized the fiscal relief the bill provided state budgets. I will refer to this argument as the state relief argument. According to this argument, the conference report is sound policy because it saves states hundreds of millions and, in some cases, billions of dollars during a state fiscal crisis. In contrast, opponents of the resolution, primarily House and Senate Democrats, stressed unaffordable copayments and potential drug formulary issues that would prevent dual eligibles from obtaining necessary prescriptions. I will refer to these arguments as the unaffordable copayment argument and the restrictive formulary argument. According to the unaffordable copayment argument, the conference report harms dual eligibles by requiring them to pay too much out-of-pocket for prescriptions, forcing them to choose between basic necessities, such as food, and their prescriptions. As a result, many dual eligibles will not fill their
prescriptions, and thus, will not be able to adequately manage their health conditions. According to the restrictive formulary argument, the health of dual eligibles will be further compromised by enrolling in a drug plan with a formulary that may exclude prescribed drugs previously covered by Medicaid. Representatives and senators of the same party employed the same arguments in order to support their opinions, suggesting party unification on the dual eligible issue.

Democrats, who previously supported providing Medicare coverage for dual eligibles prior to conference committee, generally opposed the switch in coverage when debating the conference report. Democrats argued dual eligibles received worse coverage as a result of the conference report than the insurance they received from Medicaid. For example, Senator Rockefeller pointed out that according to the conference report, states that provide wrap-around coverage would not receive federal matching dollars, establishing an unprecedented relationship between the state and federal governments (149:173 CR S15747). States provide wrap-around coverage by covering costs, such as copayments, for drugs not covered by Medicare. Senator Rockefeller worried this policy would discourage states from providing wrap-around coverage, and as a result, dual eligibles would go without necessary prescriptions (149:173 CR S15747).

Democratic representatives echoed these concerns expressed in the Senate by expressing the restrictive formulary argument. For example, Representative Spratt (D-SC) worried about the possibility of a dual eligible failing to receive coverage for a drug he took while receiving coverage from Medicaid:

This bill largely eliminates Medicaid's supplemental or "wrap-around" coverage under the new Medicare drug benefit. As a result, substantial numbers of poor elderly and disabled people would be forced to pay more for their prescriptions than they now do. In addition, in cases where
Medicaid covers a prescription drug but the private plan that administers the Medicare drug benefit in the local area does not provide that particular drug under Medicare, poor, elderly and disabled beneficiaries who now receive the drug through Medicaid could lose access to it. (149:170 CR H12268)

Senator Kennedy predicted that switching from expansive Medicaid formularies to more restrictive Medicare formularies would increase the number of hospitalizations, injuries, and deaths among dual eligibles due to their inability to affordably obtain their medications (149:173 CR S15767).

In order to express their opposition to the required copayments, Democrats articulated the unaffordable copayment argument. Medicaid copayments were optional, and beneficiaries could not be denied a prescription drug if they did not pay the copayment (Nemore 2005). Democrats argued that the required Medicare copayments forced dual eligibles to pay more money out of pocket than when they received Medicaid coverage. Senator Barbara Boxer (D-CA) argued that these copayments were unaffordable to dual eligibles:

A dollar may sound like zero, nothing, to people. But if you are an inch away from owning nothing, every dollar counts… Remember, most of these people don't make any money. When you get hit with inflation and you are on a fixed income, that bites. That takes food off the table. (149:171 CR S15577)

Similarly, Senator Debbie Stabenow (D-MI) explained that forcing dual eligibles to pay a copayment of just a few dollars “makes the difference between eating, paying their electric bill, or having a roof over their head” (149:171 CR S15546). Democratic representatives also presented the unaffordable copayment argument. For example, Representative Carolyn Kilpatrick (D-MI) mentioned, “Low-income seniors who get
additional assistance from Medicaid will pay more for their prescriptions because they will lose their Medicaid benefit” (149:170 CR H12234).

Senator Rockefeller did not propose copayments when he presented his amendment to provide Medicare coverage for dual eligibles. Democrats rallied around the amendment in part because dual eligibles did not have to pay more money out of pocket as part of the switch in insurance, which might provide an ideological explanation for why Democrats opposed the conference report. Since the NGA never mentioned copayments as part of their lobbying agenda, the NGA’s efforts had no impact in persuading opinion on the copayment provision in the bill. In addition, prior to conference committee, House Democrats raised no objections to the copayments in the House bill, which were more expensive than the copayments in the conference report. This sudden opposition to copayments provides further evidence of party influence. Thus, support and opposition for copayments depended on party politics rather than effective NGA lobbying.

The legislative process enraged Democrats more than individual provisions in the conference report. Congress appointed seven Democratic senators and representatives as conferees, but Chairman Representative William Thomas only allowed two Democrats to participate in discussions (Oliver, Lee, and Lipton 2004). Representative Thomas invited two fiscally conservative Democrats: Senator Baucus, because he had worked closely with Senator Grassley, and Senator John Breaux (D-LA), because he supported market-based welfare reforms (Oliver, Lee, and Lipton 2004). In general, Democrats are not fiscally conservative, and they prefer welfare implemented directly by the government instead of through market means. As a result, the conferees most representative of the
Democratic Party were excluded from negotiations, essentially eliminating the Democratic perspective from the conference report. The inclusion of Senator Baucus and Senator Breaux, however, enabled Republicans to consider the agreement as bipartisan.

Senator Tom Daschle (D-SD), the Senate minority leader, and Senator Rockefeller, who had proposed the dual eligible amendment, were most notably excluded from conference committee deliberations (149:173 CR S15719). Representative Thomas justified excluding important Democratic leaders by arguing they were unwilling to compromise with Republicans (Vlaicu 2004). In addition, Representative Thomas explained Congressional rules required only the majority of conferees to sign the conference report (Vlaicu 2004). Thus, Republicans did not need the votes of the excluded nominated Democratic conferees in order to reach an agreement (Vlaicu 2004).

Democrats likely opposed much of the conference report in order to display disapproval of the process utilized by Republicans to reach an agreement. As a result, party politics played in increasingly important role in post-conference debates and may have been a more important factor than NGA lobbying in influencing support for or opposition to the legislation.

Senator Baucus defected from his party because he believed the bill reflected the needs of Medicare recipients without burdening the federal budget (149:173 CR S15756). Senator Baucus emphasized the state relief argument when explaining his reasons to support the bill. He explained that states would save $17 billion by 2013 if the bill passed as written (149:173 CR S15756). Although he acknowledged that states would spend more than they save in the first year due to administrative costs and other provisions, Baucus argued, “In the long run, this bill will strengthen state budgets and
take some pressure off of strained Medicaid programs” (149:173 CR S15756). No evidence exists, however, to directly link Senator Baucus’ shift in opinion to the influence of NGA lobbying. Most likely, however, conference committee Chairman Representative Thomas successfully convinced Senator Baucus to adopt this perspective. Since the NGA lobbied Representative Thomas directly during conference committee negotiations, perhaps the NGA indirectly played a role by encouraging Representative Thomas to actively mobilize and convince other legislators to adopt the NGA’s position.

Republican representatives and senators also articulated the state relief argument by emphasizing the benefits the bill would bring to state budgets when voicing their support for the bill as a whole. For example, Representative Jennifer Dunn (R-WA) explained the legislation’s benefits to Washington:

To help every state, the federal government will assume the drug costs for people eligible for both Medicare and Medicaid. This is hugely important. It will help 82,000 beneficiaries who qualify for both programs in my state with their drug costs, but this bill will also save my state $500 million, half a billion dollars over the next 8 years on drug coverage for its Medicaid population. (149:170 CR H12249)

Similarly, Representative Mike Ferguson (R-NJ) mentioned that New Jersey would save $872 million (149:170 CR H12262), and Representative Thomas Reynolds (R-NY) explained that New York would save $3 billion over eight years due to the MMA (149:170 CR H12242).

Republican senators, who previously downplayed the importance of providing fiscal relief to state budgets, began citing the state relief argument as an important reason to pass the MMA. This unified, drastic, and sudden shift in opinion suggests party politics influenced their perspectives more than NGA lobbying. For example, Senator Hutchison (R-TX), who previously voted against the Rockefeller amendment, exclaimed
that the MMA would save his state $1.7 billion over an eight-year period (149:173 CR S15689). Similarly, Senator Chambliss (R-GA), another opponent of the Rockefeller amendment, mentioned that Georgia would save $469 million over eight years (149:173 CR S15749). Senator Grassley, a strong and vocal opponent of providing federal aid to state budgets in the MMA during pre-conference debates, referenced Iowa savings of $175 million over eight years as part of his speech in support of the legislation (149:171 CR S15581).

By reducing the amount of money states save, the clawback caused a split in opinion among NGA members. The Democratic Governors Association (DGA) supported further negotiations in order to provide more relief to state budgets. In contrast, the Republican Governors Association (RGA) was generally satisfied with the state savings included in the bill. Thus, while Democratic governors viewed the legislation as a failed lobbying effort, Republican governors perceived their efforts as successful. Republican governors encouraged Republican congressmen to vote in favor of the bill.

The DGA sent Senator Bingaman a letter to read on the Senate floor urging senators to delay the vote on the conference report in order to allow the governors enough time to calculate how much the clawback would save states (149:172 CR S15665). In general, Democratic senators and representatives disapproved of the clawback. Democrats argued that the clawback did not help states resolve their budgetary problems. Senator Akaka (D-HI) worried that the clawback would still lead to future reductions in Medicaid benefits:

The financial burden that the conference report places on states may lead to a reduction in other Medicaid services that states will no longer be able
to afford, because of the substantial share of prescription drug costs that states will have to pay the federal government for seniors who are eligible for Medicare and Medicaid. (149:173 CR S15678)

Senator Akaka implies a smaller state contribution may be necessary to avoid future cuts in benefits. Similarly, Representative Rodney Davis (D-IL) also referenced the reduced future benefit argument by claiming that states have too much debt and too many decisions on what to cut next to have to contribute 90 percent of the costs to provide drugs for dual eligibles (149:170 CR H12287).

Other Democrats insisted that Medicaid should not have to pay for a benefit that they have no control over. For example, Senator Boxer believed that either Medicaid should provide the benefit and pay for it or allow Medicare to administer the benefit and let the states keep their money:

Clawback. That is a new word for you. That expresses what happens if you are a state and you have helped our poorest people pay for their Medicaid. You no longer can help them, but you can’t keep the money. You have to send it to Uncle Sam. (149:171 CR S15578)

As Senator Jack Reed (D-RI) pointed out, states can't do anything to reduce the price of drugs, and thus, they will be paying more per drug than they had been under Medicaid (149:171 CR S15542). Medicare, unlike Medicaid, cannot negotiate the price of drugs with the pharmaceutical industry (149:171 CR S15542). As a result, drug prices will rise and states will experience even less savings (149:171 CR S15542). Overall, Democrats still support providing Medicare drug coverage for dual eligibles, but they oppose some of the specific aspects of the MMA that deal with the switch.

In contrast to the DGA, the RGA wrote letters to Republicans praising the legislation and emphasizing the benefit the MMA would provide for state budgets.
Florida Governor Jeb Bush wrote a letter to Representative Clay Shaw (R-FL) indicating that he supports the MMA because the bill would save taxpayers in Florida over $3 billion during the first 10 years (149:170 CR H12243). In the letter, Governor Bush encourages Representative Shaw to support the legislation (149:170 CR H12243). Shaw voted in favor of the MMA conference report during the roll call (Roll Call #669 220-215).

Representative Shaw also submitted to record a letter from the RGA addressed to Speaker Dennis Hastert (R-IL), House Minority Leader Nancy Pelosi (D-CA), Senate Majority Leader Bill Frist (R-TN), and Senate Minority Leader Tom Daschle (D-SD). The RGA wrote, “As governors, we urge the U.S. Congress to pass the bipartisan Medicare conference agreement” (149:170 CR H12243). The letter emphasized the state relief argument by highlighting the assistance states received from the federal government with costs related to providing prescriptions to dual eligibles (149:170 CR H12243). Senator Grassley cited the same exact letter from the RGA to back up his opinion in support of the legislation (149:171 CR S15587).

Thus, in contrast to other points during Congressional debate on the MMA, discussions after conference committee suggest a greater influence of party politics rather than NGA lobbying in determining the outcome of the bill. The split among the NGA along party lines likely hindered their lobbying power, particular among Democrats that wanted to eliminate the clawback or reduce state clawback payments. The NGA wielded significant influence in other stages of the legislative process primarily because they displayed unprecedented unity on the dual eligible issue.
Interestingly, the reduced future benefits, universality, and balanced budget requirement arguments almost entirely disappeared after conference committee. While no members of Congress referenced the universality or balanced budget requirement arguments, only Senator Akaka and Representative Davis argued the reduced future benefits argument. In contrast to other times during the legislative process in which members of Congress adopted NGA frames, discourse after conference committee contained primarily original frames not utilized by the NGA. These original frames correspond with either the Democratic or Republican Party and suggest the emerging influence of party politics.

The RGA, the Republican wing of the NGA, mentioned the state relief argument once in a letter dated November 21, 2003, the same day Republican representatives began articulating the state relief argument (149:170 CR H12243). Thus, it is impossible to tell for sure whether members of Congress independently crafted the frame or adopted it from the RGA. Prior to this point, although the NGA had advocated for state relief, the NGA never utilized projected state relief as a frame to generate support and wield influence. Instead, the NGA framed their need for relief in such a way that emphasized a high likelihood that states would reduce future Medicaid benefits unless the federal government provided fiscal assistance. The lack of frame adoption in the final stage of congressional debate provides evidence that disproves my hypothesis that the NGA influenced the outcome of the bill. Ultimately, the MMA conference report passed in both the House and Senate and became law.
Chapter 7: The Impact of State Budgets

As I have already established, Congress formulated the MMA during a severe state budget crisis, which provided a policy window to shift the expense of dual eligibles from the states to the federal government. Since Medicare drug coverage for dual eligibles delivered hundreds of millions and, in some cases, billions of dollars in fiscal relief to individual states, it would be logical to assume the condition of state budgets influenced the result of the MMA. In order to prove this influence, I need to establish a relationship between vocal support from a senator and the severity of his state’s budget crisis. Recall that I classified states as severe, moderate, or mild based on the severity of their Medicaid budget fiscal crisis. While state budgets categorized as severe have the most to gain from providing Medicare drug coverage for dual eligibles, states classified as mild will receive the least benefit to their budgets. I expected that states with severe Medicaid fiscal crises would be more likely to vocalize support for and vote for Medicare drug coverage for dual eligibles than states classified with mild budgetary issues.

Table 7.3 presents data on the number of states with at least one senator vocalizing support for the Rockefeller amendment broken down by the severity of the budget crisis in the state the senator represents. Recall that the Rockefeller amendment would have provided prescription drug coverage for dual eligibles in the Senate bill. Similarly, Table 7.4 displays data on the number of states with at least one senator vocalizing opposition to the Rockefeller amendment broken down by the severity of the budget crisis in the state the senator represents.
Table 7.3: Percentage of States with a Senator Vocalizing Support of Rockefeller’s Amendment

<table>
<thead>
<tr>
<th>Budget Status</th>
<th>Number of States</th>
<th>Total States</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Severe</td>
<td>2</td>
<td>6</td>
<td>33.3</td>
</tr>
<tr>
<td>Moderate</td>
<td>4</td>
<td>28</td>
<td>14.3</td>
</tr>
<tr>
<td>Mild</td>
<td>2</td>
<td>16</td>
<td>12.5</td>
</tr>
</tbody>
</table>

Table 7.4: Percentage of States with a Senator Vocalizing Opposition to Rockefeller’s Amendment

<table>
<thead>
<tr>
<th>Budget Status</th>
<th>Number of States</th>
<th>Total States</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Severe</td>
<td>1</td>
<td>6</td>
<td>16.7</td>
</tr>
<tr>
<td>Moderate</td>
<td>1</td>
<td>28</td>
<td>3.6</td>
</tr>
<tr>
<td>Mild</td>
<td>2</td>
<td>16</td>
<td>12.5</td>
</tr>
</tbody>
</table>

Unfortunately, the sample size of this data is too small to establish a relationship between state budget condition and vocal support for the Rockefeller amendment. Among vocal senators in debate, however, support for the Rockefeller amendment increased as the fiscal situation of states worsened. A senator representing a state in a severe fiscal crisis was more likely to vocally express his support for the amendment than a senator representing a state with a moderate or mild fiscal crisis. Contrary to expectation, senators from states with mild Medicaid budget issues were not more likely than senators from states with severe budget issues to vocally oppose the amendment. As expected, however, senators from states with severe or moderate budget issues were more likely to vocalize their support for rather than opposition to the amendment. More senator spoke out in favor than against the Rockefeller amendment. While mostly Democratic senators
vocalized support for the Rockefeller amendment, two Republicans also spoke in favor of the amendment. Interestingly, these Republican senators represented Maine, a state that I have classified as experiencing a severe Medicaid fiscal crisis.

The number of states with senators providing any kind of statement on the amendment is low because senators who often voiced their opinions spoke more than once. Senator Grassley and Senator Rockefeller participated the most in debate. While Senator Grassley spoke five times in opposition of the amendment, Senator Rockefeller expressed his support six times. Interestingly, both Grassley and Rockefeller were senators from states experiencing mild Medicaid budgetary crises.

Table 7.5: Percentage of States with a Senator Vocalizing Support of Conference Report

<table>
<thead>
<tr>
<th>Budget Status</th>
<th>Number of States</th>
<th>Total States</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Severe</td>
<td>3</td>
<td>6</td>
<td>50</td>
</tr>
<tr>
<td>Moderate</td>
<td>7</td>
<td>28</td>
<td>25</td>
</tr>
<tr>
<td>Mild</td>
<td>5</td>
<td>16</td>
<td>31.3</td>
</tr>
</tbody>
</table>

Table 7.6: Percentage of States with a Senator Vocalizing Opposition to Conference Report

<table>
<thead>
<tr>
<th>Budget Status</th>
<th>Number of States</th>
<th>Total States</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Severe</td>
<td>1</td>
<td>6</td>
<td>16.7</td>
</tr>
<tr>
<td>Moderate</td>
<td>11</td>
<td>28</td>
<td>39.3</td>
</tr>
<tr>
<td>Mild</td>
<td>7</td>
<td>16</td>
<td>43.8</td>
</tr>
</tbody>
</table>

Tables 7.5 and 7.6 display the relation between states with a senator vocalizing support for or opposition to the provision of the conference report providing Medicare drug coverage for dual eligibles and the severity of the budget
issues plaguing the state the senator represents. Keep in mind that debates on the conference report occurred after conference committee. As my last section suggests, this data could be influenced by partisan factors. According to the results, vocal opposition increases as the state’s degree of Medicaid fiscal crisis becomes less severe. Fifty percent of states classified as having severe budget issues had at least one senator who vocally supported the conference report. Senators from Mississippi, however, failed to comment despite the state’s six points indicating the severest of severe budget problems. Thus, some states with the most incentive to vocalize their support failed to do so.

There is limited evidence that fiscal stress influenced support. For example, both senators from Maine, despite being Republican, vocalized their support of both Rockefeller’s amendment and the conference report. Maine senators were party defectors when vocalizing support for the Rockefeller amendment, suggesting that Maine’s senators prioritized saving money over partisan ideology. Thus, state budget pressures may have strongly influenced the opinions of Maine’s senators.

One senator debated in favor of and one senator debated in opposition to the dual eligible issue in both Arkansas and Vermont, which were states with moderate budget issues. This lack of unity suggests state budgets were not a major factor in determining their vote. New York, the only state with Democratic senators with severe budget problems strongly opposed the conference report, providing evidence of the influence of party politics. Several Democratic senators, including Clinton (D-NY), Kennedy (D-MA), Rockefeller (D-WV), Bingaman (D-NM), among others, publicly expressed support for Rockefeller’s amendment to include dual
eligibles in the Medicare drug benefit, and then, expressed opposition to the conference report’s provision to include dual eligibles. Similarly, several Republicans, including Grassley (R-IA), Hatch (R-UT), Thomas (R-WY), among others, switched their opinion in debate about how best to cover dual eligibles. These patterns suggest influences outside of the budget, such as party politics, played a strong role in influencing vocal support for or opposition to the conference report.

Evaluating voting patterns should help fill in the gaps that remained after analyzing vocal support or opposition. If state budgets had a strong influence on votes, then the data should show higher percentages of support among senators representing states with severe budget crises and lower levels of support among senators with mild budget issues. Table 7.7 displays how senators representing states from each budget status voted on the Rockefeller amendment. Senator Joe Lieberman (D-CT) and Senator John Kerry (D-MA), both of whom represent states with moderate budget problems, abstained from voting on the amendment and were not counted during analysis (Roll Call #257 47-51 CR S8648).

**Table 7.7: Senator Voting Results on Rockefeller’s Amendment**

<table>
<thead>
<tr>
<th>Budget Status</th>
<th>Total Yea Votes</th>
<th>Democrat Yea Votes</th>
<th>Republican Yea Votes</th>
<th>Total Nay Votes</th>
<th>Democrat Nay Votes</th>
<th>Republican Nay Votes</th>
<th>Percentage of Supportive Senators (%)</th>
<th>Percentage of Opposed Senators (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Severe</td>
<td>5</td>
<td>2</td>
<td>3</td>
<td>7</td>
<td>0</td>
<td>7</td>
<td>41.7</td>
<td>58.3</td>
</tr>
<tr>
<td>Moderate</td>
<td>24</td>
<td>22</td>
<td>2</td>
<td>30</td>
<td>2</td>
<td>28</td>
<td>44.4</td>
<td>55.6</td>
</tr>
<tr>
<td>Mild</td>
<td>18</td>
<td>18</td>
<td>0</td>
<td>14</td>
<td>2</td>
<td>12</td>
<td>56.3</td>
<td>43.7</td>
</tr>
</tbody>
</table>
According to the results, votes were roughly split in each category with slightly higher support from senators representing states with mild budgetary crises, which runs counter to my expectations. Senators from states that would benefit the most from the federal assumption of prescription drug costs associated with dual eligibles were the most likely to vote against the amendment. Senators from states that would benefit the least were more likely to support the switch in coverage.

There is one explanation for these results. Democrats, led by Senator Rockefeller, spearheaded the amendment and provided by far the most vocal support during debate. States with severe budget classifications elected primarily Republicans to the Senate. New York was the only state with a severe budget status that elected at least one Democratic senator. In contrast, states with mild budget issues elected primarily Democrats to the Senate. Perhaps party politics played a larger role than state budgets before conference committee in influencing support for providing coverage for dual eligibles. Interestingly, however, all five Republican defectors represented states with severe or moderate budget crises. In addition, of the four Democrat party defectors voting against the amendment, two came from states with moderate budget crises and two came from states with mild budget crises. This information suggests a possible relation between state budget status and party defection.
Table 7.8: Senator Voting Results on Conference Report

<table>
<thead>
<tr>
<th>Budget Status</th>
<th>Total Yea Votes</th>
<th>Democrat Yea Votes</th>
<th>Republican Yea Votes</th>
<th>Total Nay Votes</th>
<th>Democrat Nay Votes</th>
<th>Republican Nay Votes</th>
<th>Percentage of Supportive Senators (%)</th>
<th>Percentage of Opposed Senators (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Severe</td>
<td>7</td>
<td>0</td>
<td>7</td>
<td>5</td>
<td>2</td>
<td>3</td>
<td>58.3</td>
<td>41.7</td>
</tr>
<tr>
<td>Moderate</td>
<td>32*</td>
<td>6</td>
<td>25</td>
<td>22</td>
<td>18</td>
<td>4</td>
<td>59.3</td>
<td>40.7</td>
</tr>
<tr>
<td>Mild</td>
<td>15</td>
<td>5</td>
<td>10</td>
<td>17</td>
<td>15</td>
<td>2</td>
<td>46.9</td>
<td>53.1</td>
</tr>
</tbody>
</table>

* 1 Independent Yea Vote

Table 7.8 presents how senators representing states from each budget status voted on the conference report. Senator Lieberman and Senator Kerry also abstained from voting on the conference report (Roll Call #459 54-44). For each budget status category, support is roughly even with slightly more support from senators representing states with severe or moderate budget crises. Despite comprising about one-third of all senators, almost half of all Democratic Party defectors represented states with mild budget issues. Most likely, these senators supported the conference report because they believed strongly in the expansion of the welfare state and this opportunity for expansion may not occur in the near future. New Hampshire is an outlier in both the Rockefeller amendment and conference report votes. New Hampshire received five points, indicating that New Hampshire experienced a severe Medicaid budget crisis. Despite this fact, both of New Hampshire’s senators, Senator Judd Gregg (R-NH) and Senator John Sununu (R-NH), defected from the Republican party and voted against the amendment and conference report (Roll Call #459 54-44). Their defection from the Republican
endorsed conference report suggests the status of New Hampshire’s budget had no impact on the senators’ votes.

Table 7.9: Conference Report Voting Patterns of House Party Defectors

<table>
<thead>
<tr>
<th>Budget Status</th>
<th>Democrats Voting Yea</th>
<th>Republicans Voting Nay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Severe</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Moderate</td>
<td>11</td>
<td>18</td>
</tr>
<tr>
<td>Mild</td>
<td>5</td>
<td>4</td>
</tr>
</tbody>
</table>

Table 7.9 breaks down House party defector voting patterns by the severity of the budget situation in the state where the representative resides. In general, representatives represent the localized interests of their constituents in their district. Thus, I would not expect state budgets to influence the voting behavior of representatives as much as senators, who tend to represent the interests of the state more broadly. Table 9 demonstrates no relationship between party defectors and state budgets. A relationship would have been demonstrated through more Democrats from states with severe budget problems voting in favor of the conference report than Republicans from severe states voting against the bill. Similarly, I would have expected more Republicans from states with mild budget issues to vote against the conference report than the number of Democrats voting for the conference report from states with mild budget concerns. Neither of these two patterns occurred.

Overall, while analyzing vocal support depicted mixed results, voting patterns show little influence of state budgets. Evidence suggests that senators from Maine vocalized support for and voted in favor of providing Medicare coverage
for dual eligibles because of the benefits the switch in coverage would provide for the state. Debate and voting patterns from senators in other states, such as New Hampshire, imply that the state fiscal benefits of the legislation were not an important factor in determining their stance on the issue. Overall, the state budget crisis had little direct impact on outcome of the legislation. Evidence does exist, however, suggesting that the state budget crisis shaped the debate and may have persuaded moderate Republicans, such as Senator Olympia Snowe (R-ME).
Chapter 8: Conclusion

My research provides an explanation for why Congress included dual eligibles in the Medicare drug benefit even though their inclusion meant that the sickest, poorest, and most expensive health care consumers would receive less expansive coverage than under Medicaid. I expected to find evidence suggesting that a combination of NGA lobbying and the state fiscal crisis directly influenced the outcome of the legislation. My research, however, presents a slightly different story.

At the beginning of debate on the MMA, the NGA exploited the open policy window made possible by the concurrence of a severe state fiscal crisis, rapidly rising drug costs, and Congress’s determination to expand Medicare to include a drug benefit. The NGA’s aggressive lobbying effort convinced members of Congress to place the dual eligible issue toward the top of their agenda. The NGA crafted several frames, including the reduced future benefit, the universality, and the balanced budget requirement arguments, which were adopted by members of Congress to convince their fellow legislators to support the NGA’s opinion. Thus, the NGA effectively mobilized supporters. The NGA’s influence, however, was limited to agenda setting and shaping congressional discourse. After conference committee, Senate supporters of providing a Medicare drug benefit to dual eligibles suddenly switched their opinions and opposed their inclusion. Similarly, Republican senators that had previously opposed including dual eligibles suddenly were strong proponents of extending the drug benefit to dual eligibles. I was unable to find evidence that suggested the NGA had any role in this drastic shift in opinion. As congressional debate continued, members of Congress stopped
employing the NGA’s frames, which suggested that other factors might have contributed to congressional shifts in opinion. I propose that one important factor influencing congressional opinion was party politics, which was likely triggered by the exclusion of Democrats from conference committee deliberations. Thus, although the NGA impacted congressional discourse, little evidence exists to suggest the NGA’s efforts directly translated into providing a Medicare drug benefit for dual eligibles.

I also conclude that the state budget crisis had little direct impact on the outcome of the MMA, but the crisis certainly shaped the debate and may have persuaded moderate Republicans to support the switch in coverage. The state budget crisis influenced support for the legislation on a state-by-state basis. For example, my research suggests that the severe budget crisis in Maine likely contributed to both its senators supporting the switch from the start of deliberations, despite having to defect from their party base when supporting the Rockefeller amendment. In contrast, the severe budget crisis in New Hampshire had no influence on the opinions of its senators. Both Republican senators from New Hampshire voted against the Rockefeller amendment and defected from their party by opposing the conference report.

Bringing the policy forward, the Affordable Care Act (ACA) has a few provisions that mitigate the impact of some of the troubles experienced by dual eligibles. As of January 1, 2012, dual eligibles receiving Medicaid home and community based services no longer have to pay copayments (“Information for Advocates” 2012). As a result, the ACA relieved the financial strain of paying copayments for some dual
eligibles. Prior to the ACA, only dual eligibles living in skilled nursing facilities were exempt from copayments (“Information for Advocates” 2012). The ACA also enabled dual eligibles to enroll in a Part D plan with a premium and deductible slightly higher than the benchmark established by the Center for Medicare and Medicaid Services (“Affordable Care Act” 2011). In doing so, the ACA has provided dual eligibles with a financial cushion, allowing them to pick a plan that covers more of their medications without paying additional out-of-pocket costs. In addition, the Inspector General of the Department of Health and Human Services now submits annual reports to Congress explaining the extent to which Part D plan formularies meet the needs of dual eligibles (“Affordable Care Act” 2011). These reports include medicines commonly used by dual eligibles in order to ensure the most commonly used medications exist on the formularies of benchmark prescription drug plans (“Affordable Care Act” 2011). Hopefully, these reports will reduce the likelihood that a dual eligible will enroll in a private prescription drug plan that does not cover all necessary medications. Finally, the expansion of Medicaid under the ACA has increased the number of dual eligibles in the United States. As a result, more people are now eligible for the low-income subsidies to purchase prescription drug insurance from Part D private drug plans. These amendments suggest that policymakers learn from their legislative mistakes and can carry out revisions to better the lives of welfare beneficiaries.

This thesis has several implications for American politics. My research suggests that the political environment can influence the extent to which C. Wright Mills’ power elite can influence policy outcomes. Without the emergence of party politics surrounding the dual eligible issue, the NGA may have been able to exert
more influence in the policymaking process and obtain more fiscal relief for the states. This research also provides support for Heinz et al.’s theory of the hollow core. Although the NGA received some fiscal assistance as a result of the legislation, the NGA failed to establish winning coalitions that would have overturned or reduced clawback payments. Ultimately, not enough evidence exists to establish a clear relationship between lobbying efforts and results.

Interestingly, although elite interests, such as the insurance and pharmaceutical industries, won huge concessions on the parent legislation of the MMA, the NGA could not wield enough power to win their primary demand. This result suggests that perhaps corporate interest groups wield more power than other elite interest groups. Perhaps this result also indicates that corporate interests prevail in major legislation, but other influences may prevail on underlying issues within that major legislation.

The MMA also has several implications for Schlesinger and Hacker’s prediction that public-private hybrid insurance plans provide the best chance of obtaining universal health coverage in the future. The MMA set the precedent in health care politics for the utilization of private sector markets when delivering public health care benefits. The expansion of health care coverage using private health care exchanges in the ACA further supports Schlesinger and Hacker’s theory. Through the debates of both the MMA and the ACA, Republicans have made it known that they will only support the expansion of health care benefits if they are implemented through the private sector. Once politicians realize that Schlesinger and Hacker are correct, policymakers must shift their attention to more pressing
needs. Instead of debating whether the government should implement a benefit through the public or private sector, we should focus our attention on ways to reduce the skyrocketing health care costs that are plaguing our nation, bankrupting the uninsured, and depleting our government's budget.
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