

ABSTRACT

PROMOTE THE GENERAL WELFARE:

A POLITICAL ECONOMY ANALYSIS OF MEDICARE & MEDICAID

By Sara Stephanie Rosomoff

Medicare and Medicaid are U.S. Federal health insurance programs established in 1965 as an amendment to the Social Security Act of 1935. They provide coverage to the aged population (65+), low-income individuals, and to other subsets of the U.S. population. After reviewing the foundations of Medicare/Medicaid, I analyze the political economy of Members' of Congress vote choices on the original 1965 Medicare/Medicaid law. I find evidence that the number of doctors per 100,000 individuals in a state is a strong predictor of vote choice and there is statistically significant interaction between percentage of Black Americans and the South. Moreover, there is evidence to suggest that party alignment of constituencies and geographic region played roles in persuading Republicans in party-contested states to defect. The behavior of these defectors is dependent on their party alignment and the party alignment of the majority in Congress. To assess the strength of the model across time and legislation, I run a fully interacted, pooled OLS regression on both the 1965 legislation, and the Medicare Modernization Act of 2003. I find the effects of hospitals do not hold across time. However, I find evidence target populations remain insignificant in both datasets, suggesting they are not strong influencers of vote choice.

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A POLITICAL ECONOMY ANALYSIS OF MEDICARE & MEDICAID

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Sara Stephanie Rosomoff

Miami University

Oxford, Ohio

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Advisor: Dr. Melissa Thomasson

Reader: Dr. Gregory Niemesh

Reader: Dr. Deborah Fletcher

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by Sara Stephanie Rosomoff

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The Farmer School of Business
and
The Department of Economics

Dr. Melissa Thomasson

Dr. Gregory Niemesh

Dr. Deborah Fletcher

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1 Introduction

In an era where social welfare programs are taken as a given in society, it is difficult to imagine that only a century ago their very existence was born. From the Supplemental Nutritional Assistance Program (SNAP) to Temporary Assistance for Needy Families (TANF), there are a variety of programs that span the spectrum of social need in the U.S., including health care. However, some people today are questioning the necessity of supporting social welfare, with some calling for such programs to be dismantled. Others claim that the U.S. has failed its citizens, and that society has not done enough for those on its fringes. On the national stage, the debate surrounding health care, health insurance, and health coverage continues to ebb and flow. But like most discussions surrounding social policy, health care has become a contentious and controversial topic on the Hill and at the dinner table. We are then left to wonder how we ever managed to institute social welfare programs in the first place. How did we go from a society that did not demand nor have health insurance to one that did? To one that instituted government-fulfilled health care in 1965 known today as Medicare & Medicaid?

Prior to the adoption of the Affordable Care Act in 2010, the original 1965 law establishing Medicare and Medicaid was the single largest change to the health care system in the history of the U.S. Previous historians and scholars have noted the uniqueness of their adoption, chronicling past failed attempts to institute government-provided health care in the U.S. Despite decades of opposition from interest groups such as the American Medical Association (AMA), advocates were able to successfully persuade Members of Congress to pass legislation to create not just one, but two government programs to provide health care insurance and coverage. Now, some lawmakers and would-be politicians are currently looking to expand the Medicare/Medicaid programs while others are seeking to dismantle reforms. 2020 presidential hopefuls Kamala Harris, Bernie Sanders, and Elizabeth Warren have all made calls for Medicare-for-All, essentially a single-payer national health program. There is seemingly a real possibility emerging for government-provided health care in the near future for America. Consequently, the enhanced spotlight on Medicare/Medicaid in the 21st century and the placement of the federal health insurance debate onto the national stage draws corollaries between the failed attempts and arguments of the past. The cries of “socialized medicine” and “physicians will lose their income” contrast sharply with “health care is a human right” and “the market is broken,” but these echo the sentiments of previous arguments for and against government-provided health insurance.

Debate has occurred over the years as to what made the 1965 act so different from others, but the focus has been mainly on qualitative analyses of the political environment and historical factors. Paul Starr, in his 1982 book, The Social Transformation of Medicine, attributes the failure of previous programs to the immense resources of the opposition, both in terms of material/capital wealth and social foundation (p.287-289). Essentially, proponents of government-provided health care were structurally handicapped, leaving them with little ammunition to fight back. Additionally, Starr (1982) argues public opinion and ideology enabled the opposition to grow even deeper roots, tugging at core American values to stand against the forces of socialism, considered to be a construct of Nazis and oppression (p. 287-289). Marmor

(1973) contrasts this idea in his work, The Politics of Medicare, suggesting that, the power of the opposition had little to do with resources or ideology (p. 79-81). Rather, it was the make-up of Congress that enabled the opposition to control the debate for so many years and only once that make-up was shattered were supporters able to make headway (Marmor, 1973, p. 80). Little empirical analysis has been conducted to bolster the qualitative conclusions drawn by these scholars, leaving us to wonder whose theory is most supported by the data.

I seek to reconcile the empirical gap in the literature and perform a political economy analysis (PEA) on the original 1965 legislation to truly understand how individual Congressmen passed the bill and why. A political economy analysis (PEA) is “concerned with the interaction of political and economic processes in a society: the distribution of power and wealth between different groups and individuals, and the processes that create, sustain and transform these relationships over time,” according to The Organization for Economic Cooperation and Development (OECD). Thus, this paper seeks to combine the qualitative analysis of the past literature with an empirical political economy analysis of the legislation to determine the true factors that led to the successful passage of the bill. I utilize both political theory and econometric analysis to dive deeper into the story of Medicare/Medicaid, to remedy the arguments which suggest a variety of differing factors led to Congressmen voting “yea” or “nay” on the 1965 original legislation.

Additionally, I will compare the enactment of the 1965 legislation to the 2003 Medicare Modernization Act, which created a new branch of Medicare: Part D (a prescription drug benefit). I analyze both datasets to detect structural differences in a pooled OLS regression model with interaction terms and find that several critical factors persist over time.

2 Background

Both Medicare and Medicaid continue to substantially influence the U.S. population 54 years after their establishment. Although they are sister programs, they are quite different in structure and coverage. Medicare is a voluntary U.S. federal health insurance program that provides coverage for the aged population (age 65 or older) as well as citizens with certain disabilities and diseases. In its initial adoption, the program only consisted of two parts: Parts A and B. Part A covers hospital insurance (inpatient care) and Part B covers medical insurance (physician services). Part D which covers outpatient prescription drugs was instituted in 2003. To gain an understanding of its size, Medicare alone is one of the largest health care programs in the world. As of 2018, it covers about 1/6th of the U.S. population or about 56.8 million (47.8 million of whom are age 65 or older), with an average benefit per enrollee of \$12,289.

Our other program of interest, Medicaid, is a voluntary U.S. health insurance program funded jointly by states and the federal government that provides coverage for certain citizens with low-income. As of 2014 under the Affordable Care Act, Medicaid can deliver coverage for those under the age of 65 with incomes below 138 percent of the Federal Poverty Level (FPL).¹

¹ The Patient Protection and Affordable Care Act (ACA) of 2010 expanded Medicaid including increasing eligibility for adults to up to 138% of the FPL (Medicaid and CHIP Payment and Access Commission). However, the outcome

Nearly 66 million citizens are covered under Medicaid, which is about 9.1 million more than Medicare, and represents 1/5th of the current U.S. population. Unlike Medicare, each state has its own Medicaid program and is given the authority to administer as it sees fit, given the federal standards are met. Consequently, there is wide coverage variation across the U.S. For instance, all programs are federally required to cover inpatient and outpatient services, but prescription drugs, dental services, glasses, and physical therapy are all optional benefits, provided at the jurisdiction of the state.

Together, Medicare and Medicaid cover 36.5 percent of the U.S. population.² The vastness of their coverage leads to an equally high price tag; as of 2017, federal/state governments spent a combined \$1.3 trillion on both programs—equivalent to about 37 percent of total U.S. health care expenditures³. Majority of the funding for Medicare comes from the 1.45 percent tax on each Social Security enrollee’s paycheck as part of the FICA tax.⁴ Most citizens do not pay a premium for Part A unless they do not meet the Social Security tax-paying requirements.⁵ Conversely, citizens pay a standard \$135.50 for Part B (unless they have higher incomes) and varying premiums for Part D. Medicaid is funded primarily through government initiatives. Premiums are determined at a state-by-state basis under federal restrictions and guidelines.

3 Origins of U.S. Government-Provided Health Insurance

As the 1800s drew to a close in the U.S., the very idea of social welfare was in its infancy. With a highly decentralized federal government, the private sector primarily managed the delivery of health care with very little interference from state and local governments. As opposed to Europe which was struggling under intense political upheaval, by the turn of the century, the U.S. experienced little political instability, resulting in a tightly knit political system with no vacuum for the kind of political change Europe was experiencing. Consequently, the U.S. diverged from Europe’s trajectory towards a prominent social welfare system. Germany and the United Kingdom adopted a compulsory healthcare program by 1883 and 1911 respectively (Blanpain, 1994). Rather than building a robust state with a focus on government-provided benefits, the U.S. lay dormant for a little while longer.

of SCOTUS’ ruling on National Federation of Independent Business v. Sebelius in 2012 deemed the expansion optional for states (Medicaid and CHIP Payment and Access Commission). According to the Medicaid and CHIP Payment and Access Commission, over 50 percent of states have adopted the expansion.

² 2017 statistics

³ 2018 statistics

⁴ Federal Insurance Contributions Act (FICA) created a group of taxes taken out of every paycheck for Social Security and Medicare

⁵ If you pay less than 30 quarters of Medicare taxes, you will pay a \$437 premium each month. 30-39 quarters has a standard premium of \$240.

As the U.S. entered the first World War, the tides of change began to stir as economic reorganization gave rise to new economic demands. Who holds responsibility for medical costs? How do they effect families, individuals, and society itself? How can we alleviate these pressures? These burgeoning questions gave birth to fledgling reform groups that sought to change the way America structured society and the government. The American Association for Labor Legislation (AALL), one such group founded in 1906, sought to reform the current labor system and bring greater welfare to its members. In 1913, the AALL founded the first committee on social insurance in the history of the U.S., dedicated to studying and understanding social welfare. Two years later it had drafted legislation modeled after Europe, demanding medical benefits for workers and their dependents as well as “assistance to low-income workers and cash compensation” (Johnson, 2009, p. 337). Their argument, one that would be recycled in years to come, was that it was to society’s benefit to have health insurance. It would assist in alleviating poverty and work to decrease its effect as a negative externality on society through ameliorating the significant medical costs on households and individuals, as well as creating efficiencies within health care itself. It was an argument that broad coalitions could support and addressed the heart of the issues facing the American people.

Other interest groups, such as the American Medical Association (AMA), consisting of U.S. physicians, were initially eager to get on board with the AALL’s proposals. Its own social insurance committee threw its support behind nationalized health insurance. However, member support was divided, and the opposition began to grow. There was a great deal of concern that health insurance, regardless of voluntary or involuntary, would encourage “group practice” and change physician pay structures from fee-for-service to a “per patient per year” model (Starr, 1982). Most doctors could not abide by these changes, fearing that these would damage their independence and lower their incomes. As a result, the AMA began what would become a decades-long campaign against health insurance and publicly denounced its existence:

“The American Medical Association declares its opposition to the institution of any plan embodying the system of compulsory contributory insurance against illness, or any other plan of compulsory insurance which provides for medical service to be rendered to contributors or their dependents, provided, controlled, or regulated by any state or federal government” (Johnson, 2009, p. 338).

By 1917, the AMA and other health insurance opponents were given the perfect propaganda to shut the lid on the debate for the next decade: WWI and the swelling tide of socialism in Europe. One pamphlet, created by an independent group of doctors, read: “What is Compulsory Social Health Insurance? It is a dangerous device, invented in Germany, announced by the German emperor from the throne the same year he started plotting and preparing to conquer the world” (Starr, 1982, p. 253). With such a compelling narrative, opponents were able to shift focus away from social reforms and redirect attention to the opulence of the 1920s.

Fast forward to 1935, the U.S. found itself demanding more from its government amid the Great Depression. Progressives found a champion in President Franklin D. Roosevelt and his New Deal which would establish some of the most controversial social programs in American history. However, health insurance took a backseat in this period as Congress found increasing

support for labor and employment reform. Proponents later found hope in what would eventually become the Social Security Act of 1935, as legislators discussed studying health insurance further and adding it to the bill's text. Fearing for the bill's passage amid strong opposition by the AMA, legislators eventually opted to leave out any mention of health insurance, shutting down another avenue for reform.

Yet President Roosevelt remained unsatisfied with the current progress on health insurance, calling for a National Health Conference to discuss a "national health program" in 1938 (Starr, 1982, p. 276). The public was receptive to the proposal, polling at 75 percent approval of government-provided medical subsidies and payments. Alarmed, the AMA offered support for all other recommendations made at the conference as long as compulsory health insurance was taken off the table. In their favor, the President's support for reform petered out as the midterm elections approached and WWII was on the horizon. Health insurance reform was seemingly a flame that burned brightly and diminished as quickly as it was ignited.

During this period, another set of powerful associations came into being; ones that would help shape the future of health insurance and provide significant support: Blue Cross/Blue Shield. Gaining their origins in Dallas, Texas, early hospital insurance plans developed under the Blue Cross name. The American Hospital Association, the AHA, guided their construction. Their requirements were simple: non-profit plans which covered only hospital costs that allowed free choice of physician. According to Starr (1982), in a few short years, 25 "states had passed special enabling acts for hospital service plans" like Blue Cross. The AMA caught wind of the popularity of these plans and issued its own guiding set of principles. They demanded private physicians have total autonomy regarding medical institutions and the medical market. By 1939, 26 states passed laws that established these principles in the legislature. In another three years, Blue Cross held 75 percent of the market and 26 million subscribers.

The AMA remained unsatisfied with the direction of health insurance. Cognizant that what might be voluntary insurance today might become compulsory in the future, the organization formed medical service plans run by physicians which would become the sister to Blue Cross—Blue Shield. Although they were, on the surface, intended to provide service coverage, their creation also provided a bulwark against the development of government-run insurance and care. The AMA and physicians were not subtle about their ideological stances on nationalized health care. Blue Cross, under the AHA's guidance, did not adopt the same point of view and "presented themselves as progressive organizations" (Starr, 1982, p. 308). Despite differences in ideology, the existence of Blue Cross/Blue Shield appeased opponents of compulsory health insurance.

In the aftermath of WWII, President Harry Truman, backed by a Democratic majority in Congress, pressed health insurance reform to the forefront of politics. Truman, like Roosevelt, felt strongly that that a national health program would not be a socialist endeavor and was in the best interests of the country:

"We must spare no effort to raise the general level of health in this country. In a nation as rich as ours, it is a shocking fact that tens of millions lack adequate medical care. We

are short of doctors, hospitals, nurses. We must remedy these shortages. Moreover, we need—and we must have without further delay—a system of prepaid medical insurance which will enable every American to afford good medical care” (Johnson, 2009, p. 341).

Consequently, he put forth a program that expanded upon the 1938 Roosevelt plan. Truman called for increasing the number of hospitals and supporting public health, maternal, and child health services. He also recommended providing federal aid for medical research and education. The most important difference between plans was the recommendation for a “single health insurance system” that provided coverage for all, not just for those covered by Social Security (Starr, 1982). It was a program that echoed today’s support for nationalized health insurance. And like its predecessors, it would encounter heavy obstacles on its way to becoming a law.

For a third time, health insurance reform failed to pass. The opposition, led by the AMA, had grown as the Red Scare of the late 40s gained traction, and buzz words like “socialism” and “communism” became increasingly taboo. The mainstream media, the American Hospital Association (AHA), as well as the American Bar Association, the Chamber of Commerce, and the National Grange all threw their support behind the AMA. By 1949, the AMA had hired a public relations firm, Whitaker and Baker, to launch a national opposition campaign to the tune of \$1.5 million. According to Starr (1982), it was, at the time, the most expensive lobbying effort in American history. Pandering to the outright fear that socialism would swallow the U.S. whole, Whitaker and Baker successfully branded the Truman plan as socialist, drowning the press and private organizations with 40-50 million pieces of literature propaganda “linking socialism to health insurance” (Starr, 1982). Consequently, some 8,000 non-medical organizations gave their endorsement against compulsory national insurance. Republicans picked up the narrative and soon even Congress accused Truman of forcing socialized medicine on society. In the span of several months, support for the plan dropped by 22 points to a meager 36 percent in the public opinion polls. Riding the wake of their success, the AMA spent another \$2.25 million in 1950 and garnered another \$2 million from corporate sponsorships. In 2018 dollars, this would be a whopping \$23.4 million and \$20.8 million respectively (Williamson, 2019). For further perspective, the total \$5.75 million spent by the AMA is equivalent to one-third of the DNC’s 2018 election cycle fundraising (The Center for Responsive Politics).

In the background of Truman’s failure, Congress began to expand Social Security and hospital funding, continuing to build upon the support for better social welfare as a whole. In 1946, Congress passed the Hill-Burton Act, which provided significant funding to hospitals and hospital projects (about \$3.7 billion over 24 years, \$9.1 billion of which came from state/local matching funds) (Starr 1982, p. 350). Scholars suggest a causal effect of the act in raising the supply of low-income state hospital beds to match the supply of high-income state hospital beds (Clark, Field, Koontz, and Koontz 1980; Starr 1982, p. 350). The act also required those hospitals receiving federal funding by its provisions would make available “a reasonable volume of hospital services to persons unable to pay” (Starr, 1982, p. 350). It was one of the first steps towards federally funded medical care for low-income citizens. During this same time period, under Old-Age and Survivor’s insurance, Congress passed the Social Security Amendments of

1950. These created “vendor payments” which provided federal matching funds to be distributed by states to doctors & hospitals for welfare recipients (Starr 1982, 286).

As the U.S. entered the 1950s, economic prosperity in the post-war period blossomed. Rather than focus on concern for acute needs, the U.S. now had the capacity to worry about overall quality of life and long-term goals. Starr (1982) points out that there was greater concern for “cancer, heart disease, and those conditions, such as obesity and neurosis, on which only an affluent society can afford to dwell” (p. 336). However, there was also great concern for the skyrocketing costs of medical care in the face of this new demand. Hillstrom (2012) comments commercial insurers and Blue Cross/BlueShield were unable to support this growing wave of demand as the cost of care nearly doubled over the course of the 1950s (p. 359). From the massive wave of new drugs to the leaps in medical technological innovation, insurance could not cover or design plans fast enough for these new expensive treatments and technology.

As time progressed, it was clear that certain groups of Americans were being left behind under the current health care system. Starr (1982) notes that by 1958, only about two-thirds of the population “had some coverage for hospital costs” (334). Those more likely to be covered tended to be employed, came from high income families, and/or lived in an urban area (Starr, 1982, p. 334). Starr (1982) explains these groups gained greater coverage on average because of the regressive structure of the pre-federal healthcare system (p. 333). It benefited those that had employment and gave “favorable tax treatment” to private insurance, essentially the higher income population (Starr, 1982, p. 333). Thomasson (2003) finds the tax subsidy of employer contributions to employee health insurance plans increased the amount of coverage purchased by 9.5 percent (p. 1382). Those left behind were the aged and low-income populations without access to employer-provided health insurance. Marmor (1973) estimates that 53.9 percent of the non-institutionalized elderly were without hospital insurance as of 1959 and three-fifths of those 65 and over “had less than \$1,000 in money income” (p. 33). Similarly, President Eisenhower states in a 1954 address that for families with under \$3000 in income, “about 6 percent spend almost a fifth of their gross income for medical and dental care” (As cited in Hillstrom 2012, p. 344).

Rising health care costs put a spotlight on the aged population. As a group, senior citizens were painted by politicians, scholars, and the like as “sicker, poorer, and less insured” than any other demographic (Marmor 1973, p. 18). Cohen (1960) notes “approximately 25 percent of low-income persons in the nation are aged” in 1960 and of those insured, “only 1/14 of their total costs of illness [were] met through insurance” (As cited in Marmor 1973, p. 18). Moreover, those 65+ were two times more likely to be chronically ill and hospitalized longer than those under the age of 65 (Marmor 1973, p. 18).

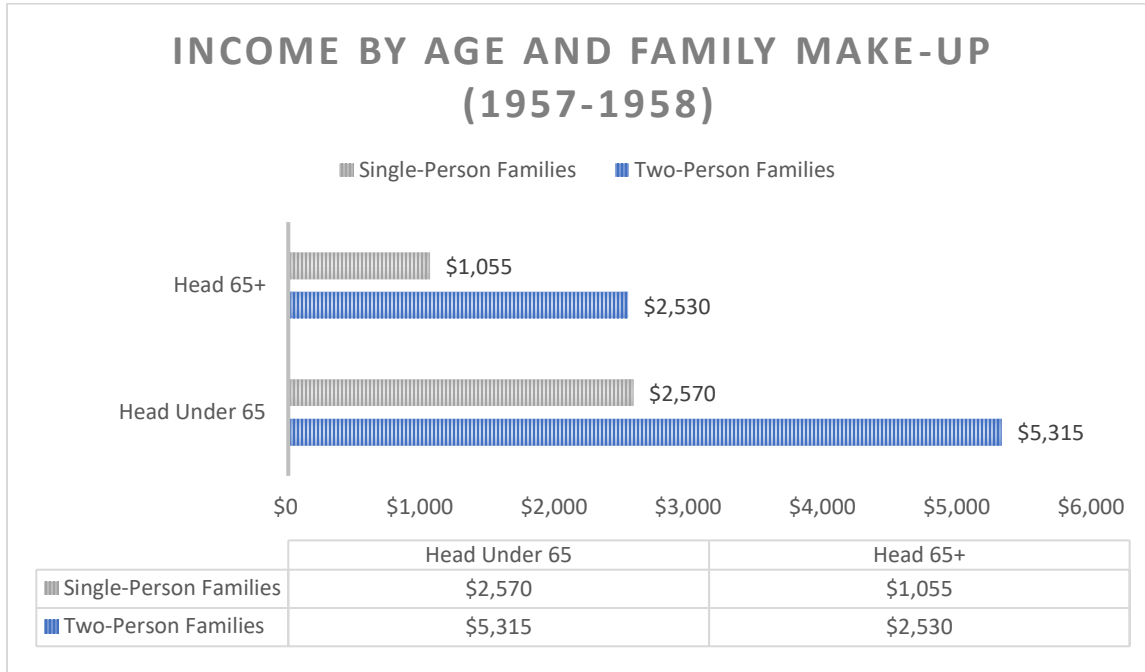
Table A. Percent of Aged Population with Health Care Coverage by Income & Marital Status

Marital Status	Low Income	Middle Income	High Income
Married Couples	42	66	81
Non-Married Men	16	31	64
Non-Married Women	31	43	66

Source: Marmor 1973, p. 18

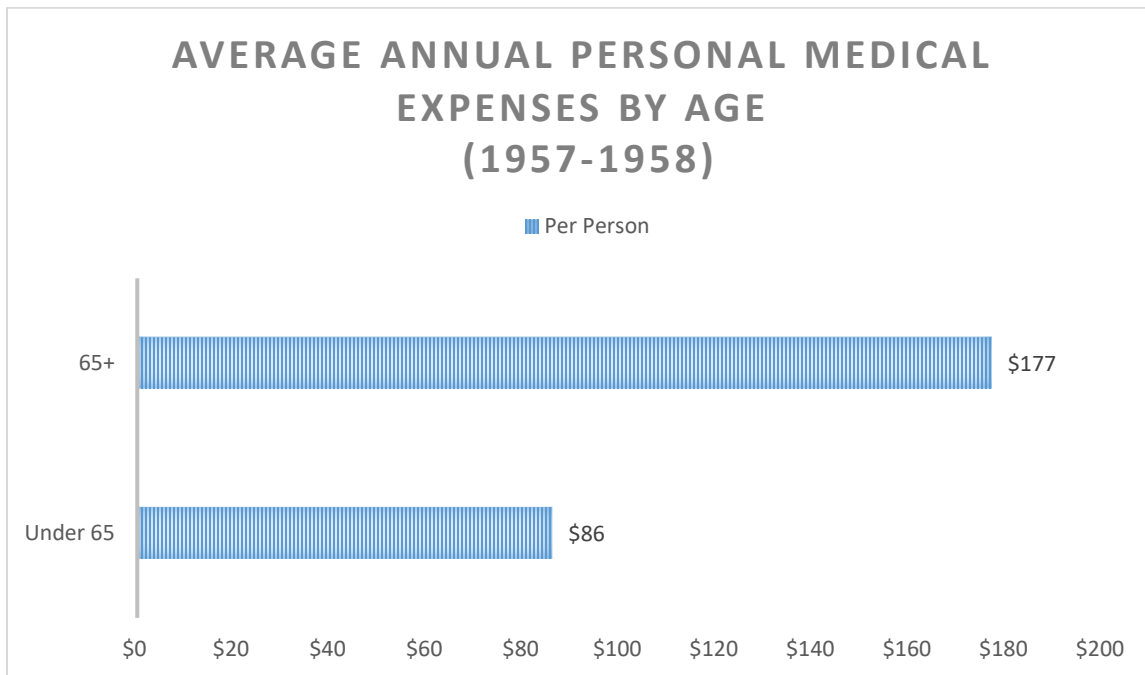
With clearly reduced income capacity and high medical expenses (Figures 3 and 4), senior citizens were seen by the public as “both needy and deserving” of assistance. Advocates of federal health insurance formulated a hypothesis that if a bill were to focus solely on the aged population, then perhaps the popularity and sympathy for senior citizens would be enough to carry the bill.

Figure 1. Income by Age and Family Make-up (1957-1958)



Source: Adapted from “The Politics of Medicare” by T. Marmor, 1973, p. 19

Figure 2. Average Annual Personal Medical Expenses By Age (1957-1958)



Source: Adapted from “The Politics of Medicare” by T. Marmor, 1973, p. 19

By 1958, Representative Aime Forand of Rhode Island drafted the first iteration of Medicare: health insurance for the aged population. Intended by advocates to reignite the debate for federal health insurance once again, there was little hope that the bill would survive committee (Marmor 1973, p. 31). True to these expectations, the bill did not survive, coming to a halt after a vote of 17-8 in the Ways and Means Committee. However, this early defeat of Medicare, as Marmor (1973) argues, signaled that “future demands for Medicare legislation would be forthcoming...the question was how would the Congress deal with those future demands” (p. 31).

President Kennedy was also of this mindset; one of his earliest speeches called for a bill that would provide health insurance and coverage for the elderly. A few short days later, the King-Anderson bill was developed, expanding Social Security to cover Old Age Security Income (OASI) beneficiaries’ “hospital and nursing home costs.” (Hillstrom 2012, p. 360). Hoping to appease opponents, legislators “excluded physicians’ fees from coverage” (Hillstrom 2012, p. 360). However, after years of fighting against federal health insurance, the opposition was not to be mollified by a simple nod to doctors. The AMA rolled out Operation Coffee Cup which featured future President and current Hollywood actor, Ronald Reagan. The campaign centered around doctor’s wives holding “coffee meetings” in their communities to rally against the bill, playing a recording of a speech given by Reagan:

“Now what reason could the other people have for backing a bill which says we insist on compulsory health insurance for senior citizens on a basis of age alone regardless of

whether they are worth millions of dollars, whether they have an income, whether they're protected by their own insurance, whether they have savings. I think we could be excused for believing that...this was simply an excuse to bring about what they wanted all the time: Socialized medicine..." (As cited in Hillstrom 2012, p. 375).

Subsequently, the bill died in committee, but was later resurrected after a rousing rebuttal by Kennedy in 1962, this time asking to put the tried and true socialism argument to rest:

"All these arguments were made against Social Security at the time of Franklin Roosevelt...This bill serves the public interest. It involves the Government because it involves the public welfare. The Constitution of the United States did not make the President or the Congress powerless. It gave them definite responsibilities to advance the general welfare—and that is what we're attempting to do" (As cited in Hillstrom, 2012, p. 379).

However, the bill came to a defeat for the second time as election season went into full swing, causing would-be party defectors to firmly align themselves with their party.

The following year, President Kennedy was assassinated, ending the era of the New Frontier and beginning the Great Society era of the newly elected President Lyndon B. Johnson. Under Johnson's direction, the first bills introduced in the 89th Congress were the House and Senate versions of Medicare (Marmor, 1973, p. 61). Realizing the inevitability of insurance for the elderly, the AMA rolled out its own plan known as Eldercare which expanded "voluntary insurance... [and provided] the aged broader benefits, including physicians' services" (Starr, 1982, p. 369). The AMA argued the Medicare bills had "inadequate benefits, would be too costly, and made no distinction between the poor and the wealthy among the aged" (Marmor, 1973, p. 61). Moreover, they claimed,

"Eldercare, implemented by the states would provide...physicians' care, surgical and drug costs, nursing home charges, diagnostic services, x-ray and laboratory fees and other services. Medicare's benefits would be far more limited, covering about one-quarter of the total yearly health care costs of the average person...Medicare would not cover physicians' services or surgical charges. Neither would it cover drugs outside of the hospital or nursing home, or x-ray or other laboratory services not connected with hospitalization" (As cited by Marmor 1973, p. 61).

It is interesting to note here that, for the first time, socialism was not the primary driver of the opposition's movement. Facing an entirely Democratic Congress, "Republicans, the insurance industry, and the AMA, all of whom recognized that Johnson was on a mission... gave tacit admission that simple obstructionism to Medicare would no longer suffice" (Hillstrom, 2012, p. 362). That is, old tactics which assumed the possibility of defeat (i.e. the socialism propaganda) weren't useful anymore. Rather than try to stop the outcome, the opposition sought to shape the way it was formed instead.

Over the course of eight months, the bill was dissected, discussed, and debated. The revised and final version of the bill became known as a "three-layer cake" (Starr, 1982, p. 369).

Combining the ideas of both the Democrats and Republicans, the “three-layer cake” bill by U.S. Representative Mills contained three parts. Part A outlined the original health insurance program for those 65 and older. Anticipating backlash from the AHA, legislators crafted the program to be managed by Blue Cross, a trusted friend and intermediary of hospitals. Consequently, hospitals were given “needed protection” and in return, gave their cooperation, according to Hillstrom (2012) (p. 363). Part B structured the “government-subsidized voluntary insurance to cover physicians’ bills” (Starr, 1982, p. 369). Hillstrom (2012) notes Part B was originally a concept generated by the AMA, added purposefully to “muffle” any forthcoming criticism about doctor autonomy and earnings.⁷ Furthermore, commercial insurers were reassured that a private market for supplemental insurance would exist given Medicare’s limited coverage, enabling them to still support the elderly insurance market. Additionally, demand by the aged with severe conditions for private insurance would be lessened, boosting commercial insurer’s profits.

Finally, the last layer created a federal program to provide increased state funding for low-income citizens, otherwise known as Medicaid. The program “authorized comprehensive coverage for all those, regardless of age, who qualified for public assistance and for those whose medical expenses threatened to produce future indigency” (Marmor, 1973, p. 79). Primarily, it covered single mothers and their dependent children as well those with blindness and other permanent disabilities (Hillstrom, 2012, p. 363). States would be the “primary administrators” with the majority of funding provided by the federal government (Hillstrom, 2012, p. 363). A remarkably large endeavor, Medicaid was hurriedly developed and slapped onto the final Medicare within a few short weeks of the final vote (Hillstrom, 2012, p. 363). Marmor (1973) notes “in the eyes of Wilbur Mills, it was yet another means of ‘building a fence’ around Medicare, by undercutting future demands to expand the social security insurance program to cover all income groups” (p. 79).⁹ Despite its significance, the Medicaid addendum to the bill escaped most of the criticism by lawmakers, interest groups, and the public. Health scholar John Cohn comments:

“It was a remarkably ambitious reach made possible by one key political ingredient: stealth...Medicare itself was still attracting most of the attention, allowing Medicaid to escape the intense scrutiny of officials and interest groups that might have seen fit to tinker with it” (as cited by Hillstrom, 2012, p. 363).

With a Democrat-controlled Congress and eight months of debate, the bill passed with flying colors. In the House, it passed 313-115 (5 abstaining) on April 8th, 1965 and in the Senate, it passed 68-21 (11 abstaining) on July 9th, 1965. A conference committee reconciled the differences between the bills to formally rework the bill in the weeks following. Final vote counts were 307-116 (10 abstaining) and 70-24 (6 abstaining) in the House and Senate, respectively.

⁷ The AMA suggested “using government-subsidized private insurance to cover doctors’ ‘customary’ and ‘reasonable’ fees into the Medicare legislation” (Hillstrom, 2012, p. 363).

⁹ Wilbur Mills, Chairman of the Ways and Means Committee of the 89th Congress

The nation had, after 50 years of obstacles, a form of federally provided health insurance. As President Johnson remarked at the signing of the bill,

“No longer will older Americans be denied the healing miracle of modern medicine. No longer will illness crush and destroy the savings that they have so carefully put away over a lifetime so that they might enjoy dignity in their later years. No longer will young families see their own incomes, and their own hopes, eaten away simply because they are carrying out their deep moral obligations to their parents, and to their uncles, and their aunts.

And no longer will this nation refuse the hand of justice to those who have given a lifetime of service and wisdom and labor to the progress of this progressive country” (“President Johnson, AMA and Republican Leaders Submit Bills,” 1966).

In October of 1965, the AMA formally adopted a resolution that stated it would not officially sponsor nor recognize any boycott of the new law, instead “permanently leaving it to each individual physician to determine whether he, personally, would participate in the Medicare program” (“President Johnson, AMA and Republican Leaders Submit Bills,” 1966). Legislators fears for mass non-cooperation by doctors were assuaged.

There would not be another piece of health care legislation passed in the U.S. of this size and magnitude for another 38 years, until the Medicare Modernization Act in 2003.

The question remains, how did Medicare/Medicaid survive the gauntlet? What made this bill special? Health insurance reform had been defeated three times prior with similar characteristics and arguments made on its behalf. Why was this time any different? What factors led to its success and can they be telling of future legislation’s survival?

In subsequent analysis, there will be a further exploration into the underpinnings of the Medicare/Medicaid bill passage. I will examine effects of both the states and the Congressmen in a series of linear probability models on the vote of “yea” on the legislation.

4 Empirical Strategies

4.1 Data

The data used are from various national surveys, health care source books, census data, and statistical abstracts. The dataset represents a cross-section of state effects and individual effects of Members of Congress (MOCs) for the year 1965. I elected to utilize state-level data for all socioeconomic and demographic factors.¹⁰ It is important to note not all data is from 1965. Specifically, IPUMS’ 1 percent survey on state population characteristics and the ICPSR survey

¹⁰ Ideally, I would have rather utilized Congressional district-level data for the U.S. House of Representatives models and state-level data for the U.S. Senate level models to increase precision. However, district-level data is difficult to aggregate and consequently, in future iterations of this paper I will focus on gathering this district-level dataset for the U.S. House models.

for county electoral data are representative of 1960. As the volatility of demographics is low in the short run, it is not unreasonable to assume 1960 census data is similar to state population characteristics in 1965. Data collected on hospitals and accompanying variables is sourced from the 1965 August issue of the American Hospital Association (AHA) Journal collected by Finkelstein (2007).¹¹ Lastly, all variables on Blue Cross and health insurance companies are from the 1964 U.S. Senate report on Blue Cross & Private Health Insurance and the 1965 Sourcebook of Health Insurance Data.

Individual characteristics (e.g. party alignment) of Members of Congress (MOC) are from Congressional Historical Statistics archives for the year 1965 and MOCs of the 89th Congress. Congressmen who abstained from voting are removed from the dataset (11 in the Senate, 5 in the House) whereas paired Congressmen are retained. “Pairing” during a Congressional voting is simply when an a MOC is absent at the time of the vote and elects prior to their absence to “pair” with MOC on the opposing side to record what their vote would have been had they been present (Davis, 2015). They have effectively voted despite their absence and therefore, the paired votes are included in the dataset. Lastly, due to the volatile nature of their states, Congressmen from Alaska and Hawaii are also removed.¹²

Preliminary summary statistics for the U.S. Senate by party reveals socioeconomically the Democratic states have a higher median population on welfare and a greater proportion of the population is Black. However, across other measures such as doctors for every 100,000 persons and hospitals for every 100,000 persons, these states are constant.

Table B. Summary Statistics for U.S. Senate States

Variable	Obs	Mean	Std. Dev.	-----Quantiles-----		
				.25	.50	.75
<u>Republican States</u>						
Insurance companies	29	2.66	0.70	2.18	2.57	3.22
Median family income in 1959 (\$)	29	5505.17	857.98	5050	5350	6050
Proportion of population 65+ in 1960	29	0.10	0.02	0.09	0.10	0.89
Proportion of Black Americans in 1960	29	0.05	0.07	0.00	0.02	0.7
Public assistance recipients in 1964 (000s)	29	3200	4900	38.24	1300	3100
Doctors per 100k people	29	64.28	21.69	48.96	59.67	81.76
Hospitals per 100k people	29	3.01	1.20	2.30	2.68	3.58
<u>Democratic States</u>						
Insurance companies	58	2.67	0.66	2.31	2.66	3.13
Median family income in 1959 (\$)	60	5318.33	1092.42	4650	5500	6150
Proportion of population 65+ in 1960	60	0.09	0.02	0.07	0.09	0.10
Proportion of Black Americans in 1960	60	0.11	0.11	0.02	0.07	0.17
Public assistance recipients in 1964 (000s)	60	2800	2400	1100	2100	4000
Doctors per 100k people	60	59.09	17.42	47.59	56.19	71.85
Hospitals per 100k people	60	2.44	1.05	1.68	2.29	2.88

¹¹ Huge thank you to Dr. Finkelstein for providing her cleaned dataset for my use.

¹² Alaska and Hawaii gained statehood in 1959, thereby having very scarce and volatile data at this point in time.

For the U.S. House of Representatives by party, the summary statistics reveal a different story. U.S. House Democrats have a lower median of welfare recipients than Republicans and a similar proportion of Black Americans, contrasting the Senate. Republicans also have a higher median of doctors for every 100,000 persons, but a slightly lower median of hospitals for every 100,000 persons.

Table D. Summary Statistics for U.S. House States

Variable	Obs	Mean	Std. Dev.	-----Quantiles-----		
				.25	.50	.75
<u>Republican States</u>						
Insurance companies	136	3.01	0.66	2.54	3.09	3.43
Median family income in 1959 (\$)	138	5847.83	859.85	5450	6150	6350
Proportion of population 65+ in 1960	138	0.10	0.01	0.09	0.10	0.10
Proportion of Black Americans in 1960	138	0.08	0.07	0.04	0.08	0.09
Public assistance recipients in 1964 (000s)	138	650	530	210	490	880
Doctors per 100k people	138	68.11	18.25	54.33	66.60	81.76
Hospitals per 100k people	138	2.14	0.93	1.50	1.74	2.33
<u>Democratic States</u>						
Insurance companies	276	3.10	0.79	2.47	3.11	3.43
Median family income in 1959 (\$)	280	5548.93	1046.02	4850	5800	6350
Proportion of population 65+ in 1960	280	0.09	0.01	0.08	0.09	0.10
Proportion of Black Americans in 1960	280	0.11	0.09	0.06	0.08	0.10
Public assistance recipients in 1964 (000s)	280	600	480	270	410	760
Doctors per 100k people	280	65.73	19.01	52.23	59.24	81.76
Hospitals per 100k people	280	2.06	0.65	1.50	1.88	2.45

4.2 Econometric Model

In order to examine the outcome of the bill, I estimate linear probability models on the likelihood of a MOC voting “yea” on state-level and individual-level characteristics. I run three separate models: one for each chamber and a combined model to analyze if there are significant differences in model specifications across chambers. Additionally, the combined model has a higher observation count allowing for a better analysis of the model’s goodness of fit. The key parameters are the Democratic party dummy variable for the MOC, percentage of citizens 65+, log of median family income, doctors per 100,000 citizens, and hospitals per 100,000 citizens.

As I highlighted in earlier analysis, history suggests the political environment, the party control of Congress, and the specific population of the bill’s focus may be key factors in determining the bill’s passage.

The basic estimating equation is:

$$\begin{aligned}
 P(\text{Vote}_{\text{yea}} = 1|x) \\
 = \beta_0 + \beta_1 \text{democrat}_i + \beta_2 \text{doctors100k} + \beta_3 \text{aged} + \beta_4 \text{hosp100k} \\
 + \beta_5 \text{logfaminc} + \alpha + \varepsilon
 \end{aligned}$$

Specifically, interest groups were significant bellwethers of the political environment and financed large campaigns to influence the vote. The ideal data to examine would be Congressional district-level and state-level special interest group campaign expenditures and membership numbers. However, these data are unavailable to the public. In order to examine the effect of the AMA, I instead control for the number of doctors per 100,000 individuals in a state. I hypothesize states with greater AMA/doctor presence are more likely to have increased opposition to Medicare/ Medicaid and reduce probability of a “yea” vote.

On the contrary, it is expected that states with larger hospitals on average will have an increased American Hospital Association (AHA) presence, known allies and managers of Blue Cross plans. Therefore, we would expect states with greater AHA presence to have increased advocacy for Medicare/Medicaid and to increase the probability of “yea” vote by their MOC.

Additionally, the model contains demographic effects by state. Key variables are median family income as well as percentage of the 1960 population that is age 65 and older. The Medicare program is targeted towards the aged population (age 65 and older) and its sister program, Medicaid, is targeted towards the low-income population. Therefore, I find it is logical to presume a higher percentage of the target population would lead to an increased probability of support for the 1965 bill. Additional state effects are added to control for omitted variable bias, including various subsets of the population, count of insurance companies, regional dummy variables, and state expenditures on public assistance.

It is important to note here limitations of the empirical model. One limitation is the support attributed to Medicare has the possibility to be confounded with the support for Medicaid. As Hillstrom (2012) has noted, Medicaid was an afterthought added to increase the bill’s chances of passage by appealing to hospitals who felt the burdens of providing “free charity care to impoverished patients” (p. 363). Therefore, it is difficult to empirically attribute the weight we should give for Medicaid because of the lack of forethought into its development. Moreover, the linear probability model itself warrants concern. Probabilities at the extremes of the model have the capacity to break outside of the mathematical bounds of [0,1]. However, the fit of this model does not experience these extremes and produces results similar to its counterpart models (i.e. probit and logit).

5 Determinants of “Yea” Vote on Original 1965 Medicare/Medicaid Legislation

5.1 Empirical Results

Table F outlines the results for the three specifications (i.e. House, Senate, Congress) side by side. Due to the low number of observations in the Senate specification, the model suffers from little to no statistical significance at any accepted confidence level (90 percent, 95 percent, 99 percent). Conversely, the Congress and House specifications have higher observation counts and do not suffer from this issue. I will focus on the results of the Congress Model which combines the two chamber specifications and will provide an overall discussion on the key takeaways.

Table F. Determinants of “Yea” Vote on Original 1965 Medicare/Medicaid Legislation

Variables	Congress Model Vote Yea dummy variable	House Model Vote Yea dummy variable	Senate Model Vote Yea dummy variable
Democrat party dummy variable	0.409*** (0.0404)	0.382*** (0.0450)	0.508*** (0.0951)
Log of median family income (\$\$\$\$)	0.104 (0.209)	0.0803 (0.257)	0.0287 (0.424)
Proportion of citizens 65+ in 1960	1.439 (2.0245)	1.633 (2.402)	-0.828 (3.753)
Proportion of Black Americans in 1960	0.0776 (1.122)	-0.453 (1.432)	1.945 (2.0112)
# of doctors per 100k people	-0.00240* (0.0361)	-0.00162 (0.00193)	-0.00385 (0.00256)
# of hospitals per 100k people	-0.0442 (0.0361)	-0.0657 (0.0509)	-0.000792 (0.0498)
Black * South	-2.186** (1.0865)	-1.805 (1.357)	-4.113** (2.0669)
Democrat*South	-0.123 (0.0998)	-0.158 (0.112)	0.0129 (0.235)
Constant	1.012*** (0.273)	0.970*** (0.324)	1.202** (0.546)
Observations	499	412	87
R-squared	0.360	0.353	.475

Robust standard errors in parentheses

*** p<0.01, ** p<0.05, * p<0.1

Notes: Includes region fixed effects. See Appendix A for full results.

The analysis of the Congress Model in Table F reveals that most, but not all key parameters were ultimately influential in the construction of the specification.¹⁶ Members of the Democrat party, as hypothesized, were on average 40.9 percentage points more likely than the Republican party to vote “yea” ($p < .01$ in all specifications). Similarly, the number of doctors per 100,000 citizens is consistent with the prior qualitative analysis that the AMA would be highly influential in reducing support for the 1965 bill. Every additional doctor per 100,000 citizens decreases probability of a “yea” vote by 0.24 percent. However, we expect the elderly population and low-income families to have positive effects. I find the estimated coefficient on the variables controlling for the percentage of citizens 65+ variable and the log of median family income to be positive, but not statistically significant.

Furthermore, in my original analysis, an additional 1 percent increase of the Black American population in the state decreased probability of voting “yea” by several percentage points with statistical significance. This result was surprising, given initial hypotheses indicated its impact would be positive, as we would expect larger target populations to increase support for the legislation.

However, upon further research of voting patterns, this result becomes unsurprising, given the remaining strength of the “Solid South.” The Solid South characterized the one-party mentality of the South in which white men dominated the region through the Democratic party at each governmental level (Black, 2004, p. 1007). Their main priorities of this voting bloc included “preserving white power” through resource concentration and “voter elimination” of Black Americans; a technique which removed Black Americans from the electorate by systemic restriction of opportunities and racial segregation (Black, 2004, p. 1007). According to Black (2004), although 25% of the South was comprised of Black Americans, they comprised only 5% of voters (p. 1007). The Solid South began to weaken towards the end of the 1960s as support for the Civil Rights Movement grew, but it still retained a great deal of strength between 1960-1965.

With this context in mind, I added a variable in my final analysis that interacts South with percentage of Black Americans to determine if this highly significant negative effect is due to the presence of the Solid South and Southern Democratic voting patterns. I find the effect of percentage of Black Americans becomes insignificant and the interaction effect becomes significant, decreasing probability of a “yea” vote by 2.19 percent and capturing the effect of the Solid South. Similarly, I added a variable that interacts South with Democrat party status, but I find this interaction to be insignificant.

All other parameters are not statistically significant.

5.2 *Discussion of Empirical Estimates*

Across the three models, one variable remains extraordinarily strong in magnitude and significance: the democrat party dummy variable, which is equal to one if the MOC is a member of the Democrat party. The variable represents an estimate of the MOC’s own ideology, party

¹⁶ Results reported in Appendix. Final models exclude Blue Cross/BlueShield/MedSocial plans and their corresponding enrollment variable. Found little effect on model (coefficients to zero) and statistical insignificance, therefore they were removed.

alignment, and historical voting record. I hypothesize party would be a strong influence on the model, given the Democratic control of Congress in 1965 after a sweep in the 1964 election cycle and the results are consistent with this prediction. Democrats, on average, were 40.9 percentage points higher than Republicans to vote “yea” ($p < .01$ in all specifications).

As stated previously, doctors are a crucial aspect of estimating the indirect effects of the American Medical Association. The AMA represents doctors, residents, and medical students, so a greater number of doctors in the state may lead to a larger AMA presence, and thus, greater local opposition for the MOC. We do see a decrease in the “yea” probability, but the magnitude of the effect is smaller than anticipated, not reaching a full 1 percent. It is possible that doctors are not a sufficient measure of the AMA’s power and strength and the true extent to which the AMA affected MOCs is underestimated.

However, Marmor (1973) notes that although the AMA has long dictated the terms of the health insurance debate, their concerns about doctor autonomy and income were folded into the final 1965 legislation (p. 80). Doctors were to be paid their usual and customary fees and be free to charge their patients directly (Marmor 1973, p. 80). This enabled doctors to charge more than the government could cover and avoid any type of fee schedule as long as their fees were “reasonable” (Marmor 1973, p. 81). Marmor (1973) thereby suggests doctors’ fears were assuaged in the final bill, resulting in less opposition. Per our empirical results, a smaller effect is thus in line with Marmor’s (1973) conclusions.

In contrast, larger hospitals increased the probability of a positive vote only in the House model. Starr (1982) notes the growing need for hospital expansion in the early 1940s caused the AHA to become more involved. By 1942, the AHA rounded up a national commission to generate support for a national hospital program, leading to increased assistance with the Hill-Burton Act of 1946.¹⁷ However, the hospital expansion of Hill-Burton ultimately created a new problem: with more beds available, physicians started to fill them with non-traditional patients (i.e. those who would’ve been recommended outpatient care in the past). The supply of these non-traditional patients was far larger than anticipated by physicians, and by the 1960s, led to an increasing need for expanding the bed supply and a shortage of doctors, despite the enormous funding provided previously by the Hill-Burton Act (Starr 1982, p. 364). Roemer & Shain (1959) suggest:

“A half century ago, only the most desperately ill were hospitalized... Today not only are these cases hospitalized, but so are cases of multiple-tooth extractions, psychoneurosis, epilepsy, diabetes for insulin stabilization, or any obscure condition for diagnosis. All this is made possible by an increase in the relative supply of beds, and reciprocally it creates pressure for continual expansion of the bed supply” (Roemer & Shain, 1959 as cited by Starr, 1982, p. 364).

Consequently, states had a demonstrable need for more funding for hospital expansion, leading organizations like the AHA to lobby on behalf of its hospitals to extract as much funding

¹⁷ Provided the federal government with authorization to give extensive funding to states to aid in hospital construction based on state population and per capita income (Starr 1982, p. 349).

from the government for its capital shortage as possible. Therefore, it is expected that larger hospitals, as shown in the House model, would increase support for the for 1965 bill due to growing resource scarcity.

Furthermore, the final version of the 1965 bill included a provision that would give Blue Cross administrative powers over Medicare.¹⁸ A strong criticism made by doctors and hospitals alike was that federal healthcare programs took away their independence to provide medical services as they saw fit. In placing the implementation of Medicare in the hands of Blue Cross, hospitals, allies and managers of Blue Cross plans, were therefore given some authority and autonomy within the program's administration. After the early stages of implementation, Blue Cross plans represented 90% of beds as intermediaries in participating hospitals (Cunningham, 1997, p. 147). Consequently, we find more evidence that an increased presence of hospitals would indicate greater support for the 1965 bill (10.7 percent increase in probability for every additional 100 beds).

We see opposite effects of the hypothesized estimates for both log of median family income and the aged population. In terms of the aged population, I identified this parameter in my initial hypothesis as critical to the model, specifically because it is the original target population of the legislation. We would assume a larger target population would garner more support for its corresponding bill, but this is not the case here. Not only do I find the variable to be statistically insignificant, but its coefficient is negative, suggesting decreased probability for a "yea" vote with a greater aged population. This result is disheartening in an idealistic sense. In a perfect world, we would expect politicians to represent the interests of their constituents and to make decisions based upon them. Yet, here I find evidence that perhaps those who are most affected by a politician's decision are not necessarily key influencers, which may lead us to believe it is these other structural barriers and gateways that have more power ultimately.

However, the strength of the party's control does not tell the entire story of this bill's passage and a more interesting tale lies in further looking at the Republican defectors.

Upon examination of the legislation's vote breakdown, the final vote on the 1965 bill to create the Medicare & Medicaid programs passed by a strong margin. From my adjusted vote counts, the House passed 295-117, and the Senate passed 64-23.¹⁹ Consider Tables G & H. With 136 Republicans in the House and 29 in the Senate, it is clear that some must have defected from the party opposition and voted for the bill. Out of 498 MOCs, 13 Republican Senators and 70 Republican Representatives chose to defect. I define defection as MOCs who chose to not vote with their party's majority. In this case, I am focusing on the Republican defectors.

¹⁸ After the passage of the Medicare Modernization Act in 2003, the federal government replaced Part A fiscal intermediaries such as Blue Cross with Medicare Administrative Contractors (MACs) to process Part A & Part B claims (U.S. Centers for Medicare & Medicaid Services, 2017). Current MACs today are Noridian Healthcare Solutions, CGS Administrators, and National Government Services among others (CMS, 2017).

¹⁹ MOCs who did not vote are not included. MOCs from Alaska and Hawaii are not included.

Table G. U.S. Senate Vote Distribution by Party

Vote Yea dummy variable	Republican	Democrat	Total
Nay	16	7	23
Yea	13	51	64
Total	29	58	87

Table H. U.S. House of Representatives Vote Distribution by Party

Vote Yea dummy variable	Republican	Democrat	Total
Nay	66	51	117
Yea	70	225	295
Total	136	282	412

Summary statistics reveal that the majority of both groups of defectors have the similar state characteristics. Tables I & J highlight most defectors represent richer states with a greater number of doctors and public assistance recipients and fewer hospitals and insurance companies in the Northeast. Furthermore, these states had a consistent proportion of the population voting Democrat in comparison to states represented by non-defectors.

Table I. Summary Statistics for U.S. Senate Republicans

Variable	Obs	Mean	Std. Dev.	-----Quantiles-----		
				.25	.50	.75
<u>Defectors</u>						
Insurance companies	13	2.36	0.65	1.85	2.17	2.74
Median family income in 1959 (\$)	13	5734.62	847.39	5050	5750	6450
Proportion of population 65+ in 1960	13	0.10	0.01	0.08	0.10	0.11
Proportion of Black Americans in 1960	13	0.04	0.04	0.00	0.04	0.14
Public assistance recipients in 1964 (000s)	13	400	560	28.79	410	760
Doctors per 100k people	13	65.76	25.40	49.43	76.95	81.76
Hospitals per 100k people	13	2.73	1.02	2.13	2.58	3.58
Proportion of population that voted Democrat in 1960 Congressional election	13	0.49	0.06	0.43	0.48	0.52
<u>Non-Defectors</u>						
Insurance companies	16	2.91	0.66	2.38	2.74	3.29
Median family income in 1959 (\$)	16	5318.75	846.73	4750	5250	5950
Proportion of population 65+ in 1960	16	0.09	0.02	0.08	0.09	0.11
Proportion of Black Americans in 1960	16	0.06	0.09	0.01	0.02	0.06
Public assistance recipients in 1964 (000s)	16	250	430	49.96	140	190
Doctors per 100k people	16	63.08	18.93	48.96	59.23	83.64
Hospitals per 100k people	16	3.24	1.32	2.45	2.68	3.90
Proportion of population that voted Democrat in 1960 Congressional election	16	0.53	0.15	0.46	0.49	0.52

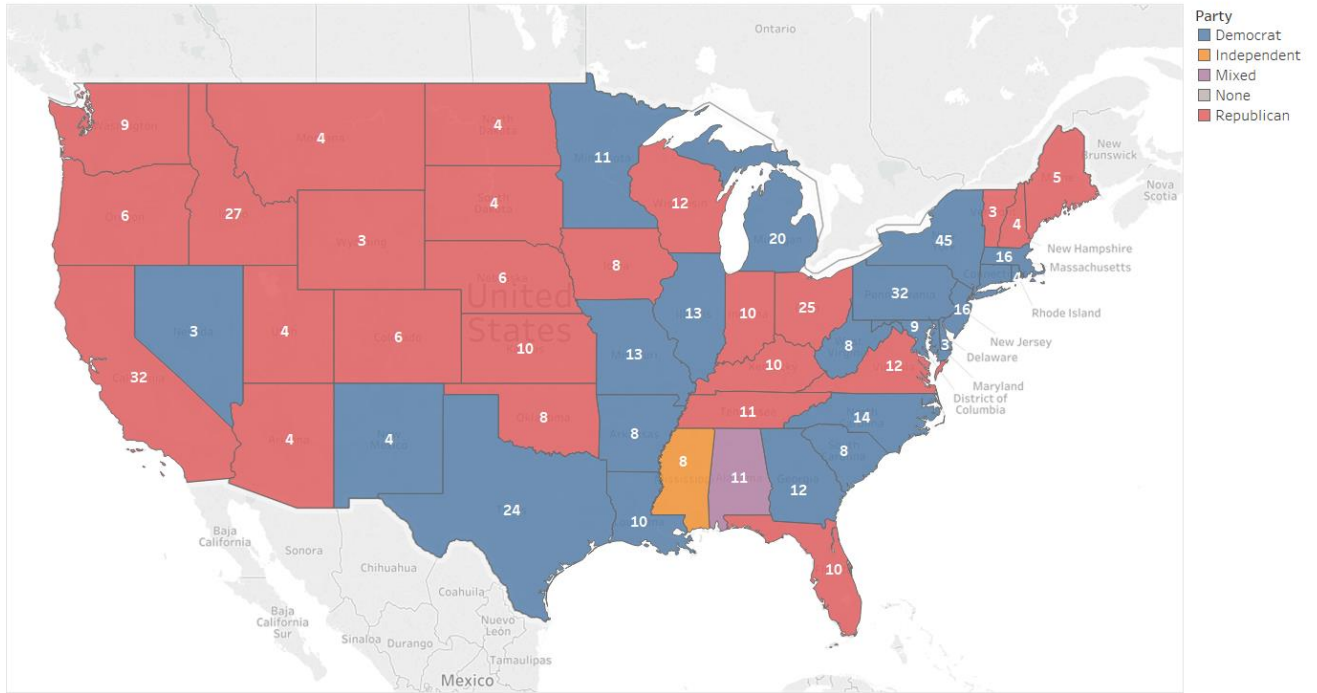
Table J. Summary Statistics for U.S. House Republicans

Variable	Obs	Mean	Std. Dev.	-----Quantiles-----		
				.25	.50	.75
<u>Defectors</u>						
Insurance companies	72	2.85	0.69	2.10	3.06	3.43
Median family income in 1959 (\$)	72	6022.22	655.04	5750	6250	6350
Proportion of population 65+ in 1960	72	0.10	0.01	0.09	0.10	0.10
Proportion of Black Americans in 1960	72	0.07	0.05	0.05	0.08	0.08
Public assistance recipients in 1964 (000s)	72	760	540	310	610	1300
Doctors per 100k people	72	74.15	17.84	59.01	80.83	88.37
Hospitals per 100k people	72	2.01	0.87	1.50	1.68	2.14
Proportion of population that voted Democrat in 1960 Congressional election	72	0.52	0.09	0.48	0.51	0.96
<u>Non-Defectors</u>						
Insurance companies	66	3.19	0.58	2.73	3.23	3.43
Median family income in 1959 (\$)	66	5657.58	1009.54	5050	5950	6650
Proportion of population 65+ in 1960	66	0.09	0.01	0.09	0.10	0.10
Proportion of Black Americans in 1960	66	0.10	0.09	0.04	0.08	0.10
Public assistance recipients in 1964 (000s)	66	540	490	180	440	760
Doctors per 100k people	66	61.52	16.43	49.34	59.24	76.38
Hospitals per 100k people	66	2.27	0.97	1.65	2.13	2.58
Proportion of population that voted Democrat in 1960 Congressional election	66	0.55	0.13	0.48	0.51	0.52

Additionally, most defectors' states went blue in the 1964 Presidential election (See Figures 3 & 4). Specifically, six states flipped from red to blue from the 1960 to the 1964 Presidential Election (i.e. Illinois, Maine, New Hampshire, Ohio, Tennessee, Vermont). Only three flipped from blue to red with only one representative defecting from each state (i.e. Alabama, Arizona, Mississippi). Here we see evidence that Republican defectors may have been persuaded by their Democratic constituency to vote "yea" on the bill. Overall, defectors are consistent with empirical findings that Northeastern Republicans were about 20 points higher than other regional Republicans to vote "yea."

Figure 3.

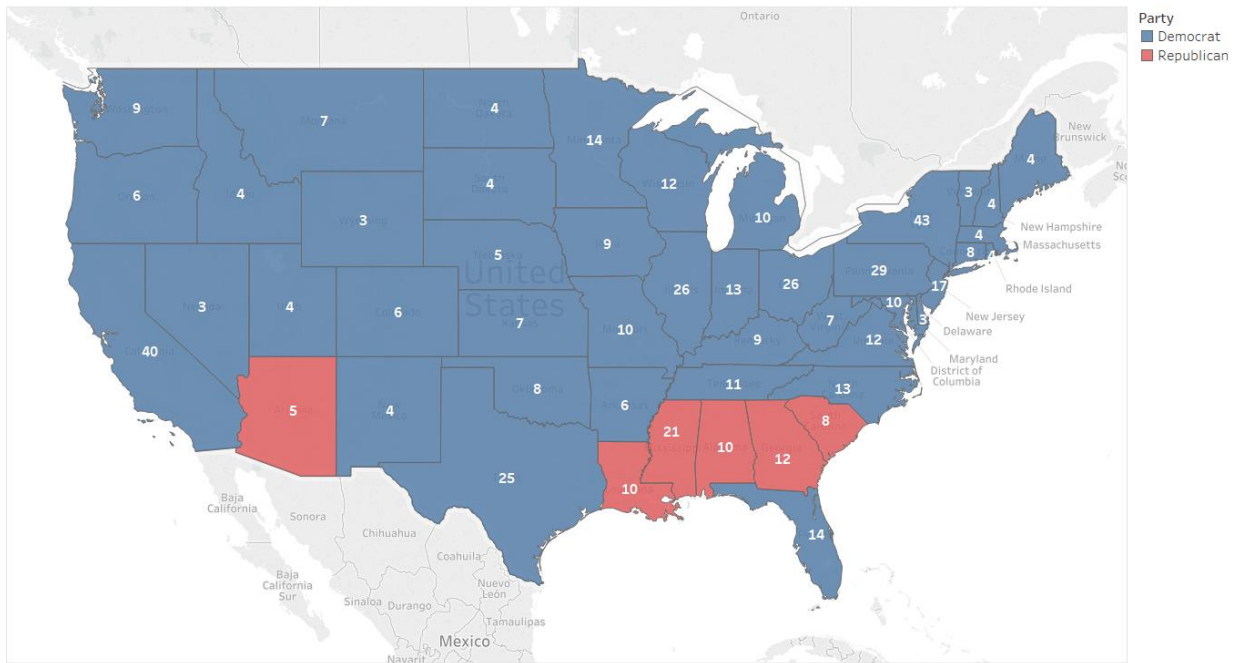
1960 Presidential Election Results



Map based on Longitude (generated) and Latitude (generated). Color shows details about Party. The marks are labeled by sum of Electoral Votes. Details are shown for State. The view is filtered on Exclusions (Party,State), sum of Electoral Votes and Party. The Exclusions (Party,State) filter keeps 49 members. The sum of Electoral Votes filter keeps no members. The Party filter keeps Democrat, Independent, Mixed, None and Republican.

Figure 4.

1964 Presidential Election Results



Map based on Longitude (generated) and Latitude (generated). Color shows details about Party. The marks are labeled by sum of Electoral Votes. Details are shown for State. The view is filtered on State, which excludes Alaska and Hawaii.

To analyze these findings further, I run a linear probability model on the probability of defection to see if these differences between defectors and non-defectors are statistically significant, specifically looking at Republican party status (see full Table I in Appendix A). The results indicate Republicans were close to 40 percentage points more likely to defect than their Democrat counterparts on the bill, given that the Democrats had full control of Congress in 1965. This suggests that Republicans are likely to defect in times of opposing party control.

Table I. Determinants of Defection on Original 1965 Medicare/Medicaid Legislation

Variables	Congress Model Defection dummy variable
Republican party dummy variable	0.397*** (0.0438)
Log of median family income (\$\$\$\$)	0.021 (0.216)
Proportion of citizens 65+ in 1960	-2.635 (2.0248)
# of public assistance recipients 1964 (10,000s)	0.000832* (0.000508)
# of doctors per 100k people	-0.00393** (0.00164)
South regional dummy variable	-0.295*** (0.110)
Midwest regional dummy variable	-0.366*** (0.0689)
West regional dummy variable	-0.311*** (0.0786)
Constant	0.644** (0.278)
Observations	499
R-squared	0.393

Robust standard errors in parentheses

*** p<0.01, ** p<0.05, * p<0.1

Notes: Includes region fixed effects. See Appendix A for full results.

6 Medicare Modernization Act (MMA) of 2003

In the previous section, I provide evidence that number of doctors and party alignment are strong predictors of vote choice for the original 1965 legislation that amended Social Security to establish the Medicare & Medicaid programs. Consequently, I find empirical evidence that interest groups have a tangible influence on the votes of MOCs. Additionally, I suggest that Republican defectors were persuaded to defect based on the party alignment of their constituencies (i.e. highly contested states) and the characteristics of their geographic region (e.g. urban concentration).

Further research is needed to examine how the model holds up over time and across similar pieces of legislation. To this end, I will analyze the previously outlined model's effects on the Medicare Modernization Act (MMA) of 2003 and run a fully interacted pooled OLS regression on both bills to assess differences in the datasets.

6.1 Background

The MMA established Medicare Part D, a new prescription drug benefit for those already enrolled in Part A or Part B (Megellas 2006). Private insurers and managed care organizations compete on formularies and cost to provide the benefit and meet the following initial requirements (Megellas 2006). The beneficiary has an annual deductible of \$250 and CMS has tentatively set the monthly premium at \$37 per month (or \$448 annually). Additionally, federal subsidies are given to those who cannot afford the new Part D benefit. For instance, those who are 135% or below the Federal Poverty level pay no premiums annually (Megellas, 2006) (See Tables A & B in Appendix B for further detail).

Furthermore, drug reimbursements for physicians now have a second competitive option: the competitive acquisition program (CAP) (Megellas 2006). The program enables physicians to purchase drugs from “third-party vendors who have contracted with Medicare on a competitive basis” as opposed to the prior reimbursement standard of 106 percent of the drug's average sales price (ASP) (Megellas 2006). Legislators hoped the program would enable physicians to save time and paperwork and ultimately, lower future drug costs (CMS, 2005). Lastly, Medicare +Choice is rebranded as Medicare Advantage with new enhancements including greater “payments to the plans and a regional preferred provider organization option” (Megellas 2006). The Bush White House stated the MMA allowed for “the biggest improvements in senior health care in nearly 40 years” (The White House and Office of the Press Secretary 2003).

6.2 Origins

Over the decades following the enactment of the 1965 legislature that established the Medicare and Medicaid programs, two major issues became the focus for reform: long-term solvency and prescription drug benefits. Medicare and Medicaid originally did not include a benefit for prescription drugs nor was the long-term costs associated with the programs ever fully addressed. In 1988, both issues entered the spotlight as President Reagan's administration pushed for the Medicare Catastrophic Coverage Act (MCCA) of 1988 (Hillstrom 2012, 450). The bill sought to contain beneficiaries' large medical bills, placing a \$2000 cap on “out-of-pocket

payments...for hospital (Part A) and physician (Part B) expenses” (Hillstrom 2012, 450). Provisions were later added for “hospice care, home health care, mammography screening, state payments of Medicare deductibles and premiums for elderly with incomes below the poverty line, and protection against spousal impoverishment from nursing home expenses” (Oliver, Lee, & Lipton 2004, p. 298).

Much to the consternation of Congressional Republicans, Representative Henry Waxman (D-Cal) successfully included catastrophic prescription drug coverage in the bill with the support of House Speaker Jim Wright (D-Tex) (Oliver et al. 2004, p. 298). Although a source of great contention, the drug benefit gained the support of many outside groups, not limited to the “AARP, AHA, AMA, generic drug makers, and large corporations that would get long-sought relief from retiree health costs with the passage of MCCA” (Hillstrom 2012, 451). Those against the bill included the Pharmaceuticals Manufacturers Association that spent \$3 million in opposition, the insurance companies who stood to “lose some Medigap policies” (Hillstrom 2012, 451), and senior officials in the Reagan administration who “threatened a veto if prescription drugs were included” (Oliver et al. 2004, p. 298). Essentially, the divide between the support and opposition came down to those who were seeking relief from rising drug costs for themselves or their membership and those who found such relief to be too costly.

Despite the opposition, the bill passed in the House (328-72) and Senate (86-11). Upon signing the bill, President Reagan stated:

“Since these [benefits] have never been covered by Medicare, we have no real way of knowing how much these services will cost. So, if future administrations and Congresses aren’t diligent, these new benefits could contribute to a program we can’t afford. This could be more than a budget problem; it could be a tragedy” (Reagan as cited by Hillstrom 2012, 505).

President Reagan’s statement proved to be omniscient once the bill was enacted into law. Seniors found themselves facing a \$4 increase in their monthly Part B premiums, raising it from \$28 to \$32 a month (Oliver et al. 2004, p. 299). For those “who paid more than \$150 in federal income taxes, they...[paid] a ‘supplemental premium’ of 15 percent on the amount of tax they owed, capped at \$800 for individuals and \$1,600 for couples” (Oliver et al. 2004, p. 299). Moreover, due to the progressive financing structure of the law, two-thirds of the elderly population’s costs fell upon the richer third of the elderly population to pay for (Oliver et al. 2004). In response to these steep costs, seniors “demanded repeal of the MCCA” (Hillstrom 2012, 451), angry and upset that the benefits they had been promised were more expensive than had been expected. Norman B. Ture of the Institute for Research on the Economics of Taxation called it “a tax-transfer scheme, requiring virtually all not-poor persons who are 65 or older to pay for the covered medical expenses of a small group of older persons who are not quite poor enough to qualify for Medicaid” (Ture as cited in Hillstrom 2012, 451).

By late 1989, the MCCA program was repealed after intense backlash.

A second attempt to push for prescription drug benefits came during the Clinton administration. With health care a major part of his campaign, Clinton took office and

immediately established a task force “to develop a healthcare plan” (Lavanty 2018). The task force’s ultimate proposal, dubbed informally as the Clinton Health Reform Plan and formally as the Health Security Act, included many sweeping changes to the health care system. In terms of Medicare, beneficiaries would receive “an outpatient prescription drug and biologics benefit as well as a guaranteed national benefits package for those under the age of 65” (Oliver et al. 2004, p. 301). The added benefits would be funded by an additional \$11 per month on the Part B premium with a \$250 annual deductible (Oliver et al. 2004, p. 301). Beneficiaries would pay up to 20 percent “of the cost of each prescription up to an annual maximum of \$1,000”; those with low incomes would receive further subsidization (Oliver et al. 2004, p. 301).

However, the proposal, as large and grand as it was, was crippled from the start. The task force itself did not include major players of past health care debates, such as the AHA, AMA, the Health Insurance Association, MOCs, and other national interest groups, causing waves of discontent within the health care policy community (Lavanty 2018). Consequently, when the task force submitted its health care reform proposal to Congress, it experienced enormous opposition, even from the President’s own party (Lavanty 2018). Senator Bob Dole (R-KS) lambasted the proposal, remarking “More cost, less choice, more taxes, less quality, more government control and less control for you and your family—that’s what the President’s Government-run plan is likely to give you” (Dole as cited by Hillstrom 2012, 558). The Health Security Act, amid the strong opposition, never came to a vote.

Following the failed Clinton plan, the Republicans took control of both chambers in 1994. Capitalizing on the fears for Medicare & Medicaid’s insolvency, they passed the Balanced Budget Act of 1997 which “cut projected Medicare spending by \$115 billion over five years and by \$385 billion over ten years” (Oliver et al. 2004, p. 303).²² Furthermore, it established the Medicare +Choice program (later known as Medicare Advantage and Part C), Medicare medical savings accounts, and the National Bipartisan Commission on the Future of Medicare, among other changes to payment plans and fraud/abuse protections (Oliver et al. 2004, p. 303). However, it did not include benefits packages for prescription drugs which were still deemed to be too costly from a Republican point-of-view.

Pressure from external forces soon began to push Republicans and Congress to determine a solution to the lack of government-funded prescription drug coverage. Rising drug costs caused more and more plans to reduce benefits and more and more private insurers to opt out of the Medicare +Choice program, leaving millions without drug coverage (Oliver et al., 2004, p. 305). According to Mayes (2005), the number of plans participating in Medicare +Choice fell from 346 in 1998 to 156 in 2002 (p. 409). Oliver et al. (2004) notes “between 1999 and 2003 the percentage of Medicare +Choice plans offering more than \$750 in drug benefits...fell from 79 percent to 39 percent” (p. 305).

²² It is to be noted here that later revisions of the BBA of 1997 (i.e. The 1999 Balanced Budget Refinement Act and the 2000 Benefits Improvement and Protection Act) altered the projected cuts, restoring about \$21 billion of hospital payment savings between 1998-2004 (Bazzoli, Lindrooth, Hasnian-Wynia, & Needleman 2004, p. 402). Despite these changes, the CBO estimates a total of \$112 billion resulted from the total Medicare program savings between 1998-2002 (Bazzoli et al., 2004, p. 402).

As a result, the issue of prescription drugs became a central focus in the 2000 Presidential and Congressional races. Representative Martin Frost (D-Tex) noted “It may be the single most potent issue we have back home. People really do care about this and the Republicans are clearly not going to do anything of consequence” (Frost as cited by Toner 2000). All major candidates took stances as the races progressed, hoping to capture the senior vote. Governor George Bush of Texas (R) emphasized federal subsidies for prescription drug coverage to low-income Medicare enrollees whereas Vice President Al Gore (D) supported voluntary catastrophic coverage for chronically ill or low-income Medicare enrollees (Oliver et al. 2004, p. 307).

Following Bush’s defeat of Gore in 2000, the Bush administration called for a modernization of Medicare and increased federal funding for the new reforms. Democrats were skeptical of Bush’s efforts, commenting on the difficulty of overhauling such a massive program and doing it well. Some went so far to say that “the proposal...[is] a backdoor effort to privatize a popular government program and throw millions of elderly Americans” onto the mercy of the HMOs (Toner 2001). Health Insurance Association of America President Chip Kahn issued a statement, remarking:

“The pressures of ever-increasing drug costs, the predictability of drug expenses and the likelihood that the people most likely to purchase this coverage will be the people anticipating the highest drug claims would make drug-only coverage virtually impossible for insurers to offer at an affordable premium” (Carey 2000).

Moreover, Bruce Vladek, former Administrator of the Health Care Financing Administration, said, “If you listen to beneficiaries, it's not 'choice' they're asking for -- they want additional benefits” (Vladek as cited by Toner 2001). But Republicans were confident in their President, stating that this time things were different and Bush’s proposals would not be met with the same backlash as Clinton’s: “The thing that's changed, and why what's happening today is totally different, and we can predict success, is twofold -- presidential leadership that has made this a priority, and secondly, the driving force is prescription drugs” (Frist as cited by Toner 2001).

Following a resounding victory during the 2002 midterms, Republicans, for the first time in years, had control of Congress and the presidency. The political environment had never been better for Republicans to push forth some intense legislation. Bush’s plan took on the form of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003. The Senate version of the bill limited total funding to \$400 billion over 10 years and required new preferred-provider organizations to give standard Medicare benefits, prescription drug coverage, as well as offer catastrophic coverage and preventive services (Oliver et al. 2004, p. 309). Passing by 76-21 in the Senate, the House offered its own version of the bill. Differing from the Senate bill, the House proposed a higher catastrophic limit for those beneficiaries making \$60,000 or more and forced private plans to compete with the traditional fee-for-service program by linking premiums to cost increases by program (Oliver et al., 2004, p. 311). The controversial income and asset tests that had sunk the MCCA were once again injected into the drug debate, splitting the House into those who advocated for traditional Medicare and those who wanted more aggressive,

market-based reform. As Karl Rove, Bush's chief political advisor, put it, this bill was a prime example of conservative ideology:

“Under the new law, seniors will be able to choose between traditional Medicare and plans administered by private companies... We're going to use the market, choice, innovation, and empowerment of the individual and incentives for savings and for taking personal responsibility to try to achieve [quality senior health care]” (Rove as cited by Hillstrom 2012, 604).

For many Republicans, this was direct pathway to bring Medicare into the 21st century. Representative Michael Castle (R-DE) stated on House floor, “every year we postpone this debate and fail to compromise on a Medicare and prescription drug bill, while the burden of drug costs on seniors continues to increase” (“Should the House Approve H.R. 1, the Medicare Prescription Drug, Improvement, and Modernization Act? Pro.”, 2004, p. 58). The bill passed 216-215 in the House with “intense lobbying by the White House... and a visit by Vice President Dick Cheney to the floor” (Oliver et al., 2004, p. 312).

Now, the conference committee was tasked with reconciling the two bills. Three main issues were at hand. The first, how to administer the new insurance plans? Decades of precedent had suggested an expansion of Part B, but Clinton had argued the federal government should be the new insurer and now Republicans opted for private sponsorship (Oliver et al. 2004, p. 313). It was unclear who would bear the weight of the responsibility and how would it sustainable in the future with a sky-high price tag (an expected \$1.85 trillion over the next decade) (Oliver et al. 2004, p. 314). The second issue was meeting beneficiaries' expectations for benefits while constrained by the enormous cost of the program (Oliver et al. 2004, p. 314). For those not covered by low-income federal subsidies, the new benefits as proposed by the House and Senate bills would be of only “marginal value” (Oliver et al. 2004, p. 314). An August 2003 poll showed that 56 percent of the aged population agreed that “Congress should vote against this bill and work to pass one that provides more help to seniors, even if it might take years to get done and cost the government more” (Oliver et al. 2004, p. 315). The last issue was how to maneuver the bill through Congress despite its contentious nature. The slim margin in the House during its initial passage did not bode well for the bill's future and lawmakers were skeptical it would truly pass.

However, the conference committee rallied and put forth a final version of the bill. In summary, it provided prescription drug coverage through private insurers, an enhanced version of Medicare +Choice (Medicare Advantage), and newly created tax-exempt health savings accounts (HSAs) “for the non-Medicare population” (Hillstrom 2012, 604). Most important, it established subsidies over the next 10 years for “employers, managed care plans, rural health care providers, and teaching hospitals” to the tune of \$125 billion (Oliver et al. 2004, p. 318). The expansiveness and controversy of the bill split support and opposition down party lines, opening the door for interest groups to push their chosen side. The battle for the bill's passage became a tug of war between special interests not unlike the 1965 fight for the establishment of Medicare and Medicaid.

With increased funding from the federal government for Medicare beneficiaries, industries and employers now felt more empowered to support the program than they had previously. It garnered support from several powerful organizations including the American Association of Health Plans (AAHP). Karen Ignagni, president and CEO of AAHP, “said that since her members provide prescription drug coverage to millions of seniors, it is critical for Congress to give managed-care plans more money” (Carey 2000). The most critical player was the AARP, comprised of 35 million seniors. By November, it had given its endorsement and launched a \$7 million campaign to persuade wayward Republicans and Medicare enrollees (Oliver et al. 2004, p. 319). The group maintained that:

“Without drug coverage... millions of elderly Americans will continue the dangerous practices they now use to stretch their medicine budgets: skipping doses, splitting pills and sharing medications with friends...Seniors often pay the highest retail prices for their prescriptions” (K. Epstein, 2002).

Doctors were generally supportive of the 2003 act after intense negotiations. Prior to 2003, the AMA had spent months over the course of 2002, lobbying against a 4.4 percent pay cut for Medicare providers (Carey 2003). Not only were they successful in lobbying against the cut, but they were able to argue for a 1.6 percent increase in their payments instead (Carey, 2003).²³ This would give \$54 billion to doctors over the course of 10 years (Adams, 2003). However, after the payment increase was implemented, the CMS discovered flaws (i.e. higher than anticipated spending by doctors and lower economic growth) in the calculation of the payments and sought to revise them which might jeopardize the new increase in payments. Angry at this unexpected change, doctors threatened to leave the Medicare system, arguing that since hospital payments are not tied to GDP, their payments should not be either (Adams, 2003).

Drug companies were also eager for the bill’s passage, employing some 1000 pharmaceutical lobbyists to push the pharma agenda in Congress (Singer & Kroft, 2007). Representative John Dingell (D-MI) remarked “the bill would not have passed without the efforts of the drug lobby” (Singer & Kroft, 2007). They advocated for prohibitions on the federal government’s ability to negotiate lower prices with drug companies (Singer & Kroft, 2007). This ensured that these companies could have the freedom to charge high prices for Medicare and continue to increase them as they saw fit (Singer & Kroft, 2007). Representative Dan Burton (R-IN) commented, “They wanted to make as much as money as possible. And if there’s negotiation, like there is in other countries around the world, then they’re gonna have their profit margin reduced” (Burton as cited by Singer & Kroft 2007). In other words, the absence of a price ceiling for drugs was highly profitable for the pharmaceutical industry and cultivated goodwill between Congress and pharma. As an example, Singer & Kroft (2007) note, after these

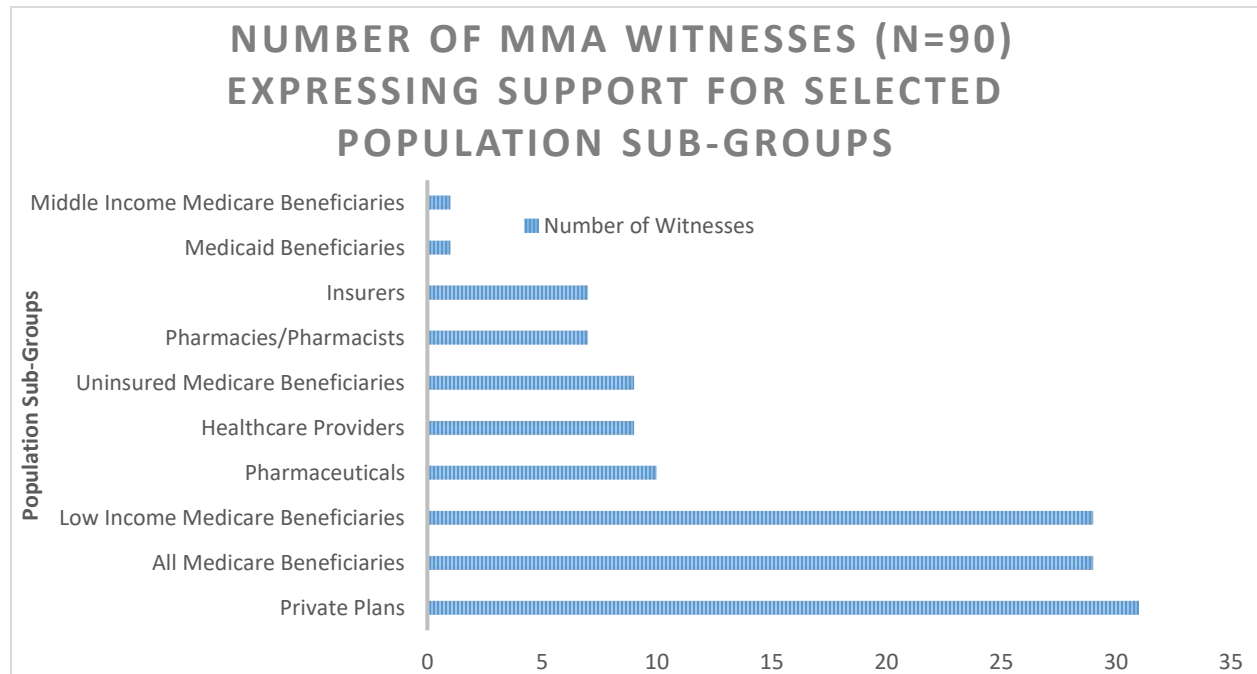
²³ It is important to note that despite the payment increase, Medicare reimbursements were reduced from 2004-2007. Additionally, payments would be “flat in fiscal 2008 and begin to rise again from fiscal 2009 through 2012” (Carey 2003). Although this appears to be a negative outcome for lobbyists, according to Carey (2003), “it not only stops this year’s cut, but reduces future cuts, which will cost less because Congress has already agreed to more money over the next decade.”

future restrictions became law, “the best Medicare price [for Zocor] is \$1,485 for a year’s supply. The same drug only costs \$127 a year under the VA’s plan.”²⁵

Furthermore, with that goodwill between pharma and Congress, MOCs could leverage prestigious employment opportunities in the pharmaceutical industry if their reelections fell through or they decided to retire (Singer & Kroft, 2007). Representative Billy Tauzin (R-LA) would go on to become the president of the Pharmaceutical Research and Manufacturers of America (PhRMA), “the industry’s most powerful trade group in Washington” (Hillstrom, 2012, p. 605). Consequently, the restrictions on drug price negotiations were a win-win for both the drug industry and Congress, leading to donations of more than \$14.6 million in the 2002 election cycle by pharmaceutical and health product companies, with 77 percent going to Republican candidates (Carey, 2002).

In line with this thinking, Svihula (2008) finds that the witnesses testifying during Congressional hearings for the MMA overwhelmingly represented private interests (p. 164). She finds “under half (46 percent) of the witnesses expressed support for market solutions; 27 percent expressed support for regulatory relief/flexibility; a quarter (24 percent) expressed support for individual control/choice,” with only 28 percent supporting government solutions and 34 percent supporting improvement in Medicare’s insolvency/sustainability (Svihula, 2008, p. 164). In other words, “witnesses expressed twice as much support for private interests than for the general Medicare population or low-income beneficiaries” (Svihula, 2008, p. 167).

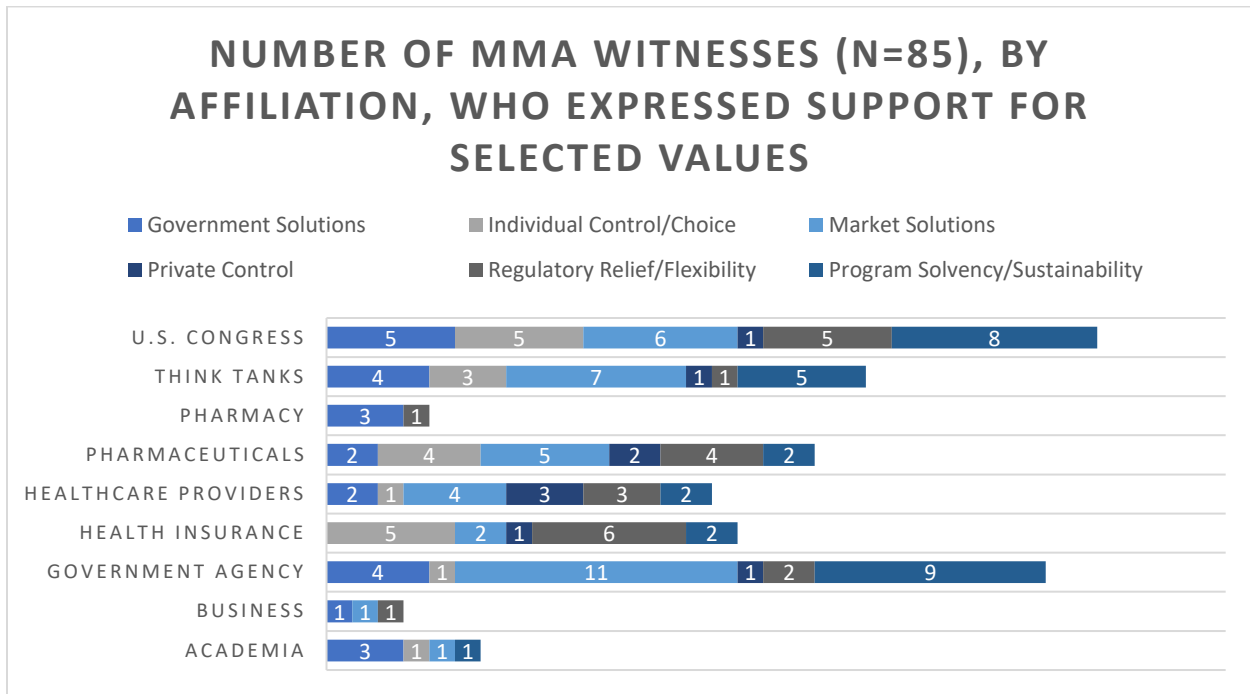
Figure 1.



Source: Svihula, 2008, p. 164

²⁵ Zocor is a statin drug which reduces levels of bad cholesterol and triglycerides and increases levels of good cholesterol (Sinhai, 2019).

Figure 2.



Source: Svihula, 2008, p. 166

Notes: Nonaffiliated (n=3) and state government (n=2) excluded.

Despite the resounding approval of many organizations, Democrats still fought decidedly against the final bill. Taking on a traditionally Republican argument, the Democrats claimed the bill to be “fiscally irresponsible,” and harped that the Bush presidency was on track to generate “the largest deficit in U.S. history to that point” (Hillstrom, 2012, 604). In the eyes of Representative Benjamin Cardin (D-MY), the conference report “contains an inadequate mechanism to lower the price of drugs” that prohibits the federal government from negotiating lower drug prices and instead, relies on private pharmaceutical benefits managers to do so. (“Should the House Approve H.R. 1, the Medicare Prescription Drug, Improvement, and Modernization Act?”, 2004, p. 51). Conservative think-tanks such as the Heritage Foundation and the National Taxpayers Union agreed on this point, painting “the new benefits as a burden to taxpayers and the economy” (Oliver et al., 2004). Republicans, in their eyes, were simply trying to win elderly support for the 2004 election cycle by pushing for the prescription drug benefit (Hillstrom, 2012, 604). Additionally, other Democratic opponents came out publicly to denounce the bill including the “AFL-CIO; Association of Federal, State, County and Municipal Employees; Consumers Union; Families USA; and American Nurses’ Association” (Oliver et al. 2004, p. 320). They saw the bill as a threat to existing benefit programs for the elderly as well as inadequately addressing current needs for prescription drugs and lacking price controls (Oliver et al., 2004, p. 320).

At 3:00am on November 22nd, the bill was put to a vote in the House. Facing a slim margin, the vote was held open for another three hours, allowing the bill to pass 220-215. In the chaos of those three hours, one Republican claimed he even offered his son \$100,000 to help him

win his seat after he retired in 2004, if only he would switch his vote (Oliver et al., 2004, p. 321). Representative Walter Jones (R-NC) called it “the ugliest night I have ever seen in 22 years [of politics]” (Jones as cited by Hillstrom, 2012, 605). Despite the razor-thin margin in the House, the bill passed the Senate 54-44 three days later (Oliver et al. 2004, p. 321). The week the bill was signed into law by President Bush, a public poll demonstrated nearly 50 percent of senior citizens opposed the new legislation and only 26 percent were in support (Mayes, 2005, p. 415).

The following tables from Appendix B outline the vote distribution for each chamber by party:

Table C. U.S. Senate Vote Distribution by Party

Vote Yea dummy variable	Republican	Democrat	Total
Nay	9	31	40
Yea	40*	13	53
Total	49	44	93

* includes 1 people who were independent

Table D. U.S. House of Representatives Vote Distribution by Party

Vote Yea dummy variable	Republican	Democrat	Total
Nay	26*	181	207
Yea	200	16	216
Total	226	197	423

* includes 1 people who were independent

President Bush signed the bill into law on December 8th (Hillstrom 2012, 605). Upon implementation of the new drug benefit three years later, he remarked:

“We had a problem in Medicare. It wasn’t working the way it should. It wasn’t modern. It wasn’t answering the needs of our seniors. And by coming together, we have done our job here in Washington. And as a result of working together, we have changed Medicare for the better. Medicare is now modern, reformed, and compassionate. And I urge all seniors—all seniors and those folks here in America who want to help seniors, look into this new prescription drug benefit; it will make your life better” (Bush as cited by Hillstrom 2012, 642).

In a similar fashion to the 1965 legislation that established Medicare and Medicaid, the MMA was the culmination of years of negotiations, debates, and failed attempts to reform and modernize Medicare. Although a less revolutionary piece of legislation, the MMA shared analogous obstacles to the 1965 bill. It experienced comparable support and opposition by interest groups, party control of Congress, and demand from target populations. Therefore, in subsequent analysis, I will assess the validity of the 1965 model across time and legislation upon comparison with the 2003 MMA.

7 Comparative Discussion

7.1 Data and Empirical Strategies

State level data are compiled primarily from a variety of national surveys and reports. I utilize data from the 2000 American Community Survey (located in the IPUMS USA database) and the 2003 Statistical Abstract to gather data on median family income and number of doctors by state. Additional data on hospitals and hospital beds for the year 2003 by state are collected from the 1999-1997 AHA Annual Survey, courtesy of the Henry J. Kaiser Family Foundation. Note, this comprises only 85 percent of all U.S. hospitals (i.e. community hospitals); it excludes federal hospitals, long term care hospitals, psychiatric hospitals, institutions for the intellectually disabled, and alcoholism and other chemical dependency hospitals. State expenditures on public assistance data are found in the 2002 State Expenditure Report by NASBO for the year 2003. Insurance company data for 2005 are collected from the National Association of Insurance Commissioners' 2005 report. Keeping with the same logic as used previously, demographic data has low volatility year to year and therefore, it is not a concern to utilize data from years prior to and after 2003. The states of Hawaii, Washington, and Alaska once again will not be used as well to maintain consistency.

Individual level data consist of party alignment and vote choice for each MOC. Members of Congress who abstained from voting will be removed from the model. There are no paired MOCs for the 108th Congress. Roll call votes and party alignment for both chambers for H.R.1 are collected from the Voteview: Congressional Roll Call Votes Database.²⁷

A preliminary look at the summary statistics for the U.S. House of Representatives reveals higher average median family incomes and greater average number of insurance companies and doctors per 100,000 individuals in states represented by Democratic MOCs.

²⁷ H.R.1. is the House version of the MMA. This designation is still used even after the conference committee puts forth its amended version. The bill formally states: an act to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes.

Table E. Summary Statistics for U.S. House States

Variable	Obs	Mean	Std. Dev.	-----Quantiles-----		
				.25	.50	.75
<u>Republican States</u>						
Insurance companies	226	238.72	171.97	96.00	186.00	380.00
Median family income in 2000 (\$\$\$)	229	47.23	5.76	43.00	46.50	50.60
Proportion of population 65+ in 2000	229	0.13	0.02	0.11	0.12	0.13
Proportion of Black Americans in 2000	229	0.12	0.08	0.07	0.11	0.15
Proportion of state expenditures on public assistance	229	0.02	0.02	0.01	0.01	0.02
Doctors per 100k people	229	239.86	49.11	205.00	235.00	248.00
Hospitals per 100k people	229	1.84	0.94	1.25	1.55	2.03
<u>Democratic States</u>						
Insurance companies	197	243.62	173.75	92.00	186.00	390.00
Median family income in 2000 (\$\$\$)	203	48.88	6.09	46.00	50.40	51.00
Proportion of population 65+ in 2000	203	0.12	0.02	0.11	0.12	0.13
Proportion of Black Americans in 2000	203	0.12	0.08	0.07	0.12	0.16
Proportion of state expenditures on public assistance	203	0.02	0.02	0.01	0.01	0.04
Doctors per 100k people	203	261.32	72.62	230.00	248.00	290.00
Hospitals per 100k people	203	1.62	0.72	1.09	1.44	1.99

Similarly, in the U.S. Senate, states represented by Democratic MOCs have greater average number of insurance companies and doctors per 100,000 individuals and a higher average median family income.

Table F. Summary Statistics for U.S. Senate States

Variable	Obs	Mean	Std. Dev.	-----Quantiles-----		
				.25	.50	.75
<u>Republican States</u>						
Insurance companies	49	128.86	124.89	44.00	67.00	185.00
Median family income in 2000 (\$\$\$)	49	45.27	5.27	41.90	44.08	48.00
Proportion of population 65+ in 2000	49	0.12	0.02	0.12	0.12	0.13
Proportion of Black Americans in 2000	49	0.10	0.10	0.02	0.07	0.12
Proportion of state expenditures on public assistance	49	0.01	0.01	0.01	0.01	0.01
Doctors per 100k people	49	213.59	45.43	195.00	213.00	244.00
Hospitals per 100k people	49	2.46	1.18	1.58	2.13	3.01
<u>Democratic States</u>						
Insurance companies	44	174.30	163.39	74.50	120.50	185.50
Median family income in 2000 (\$\$\$)	46	47.58	8.20	41.51	48.75	51.90
Proportion of population 65+ in 2000	46	0.13	0.02	0.12	0.13	0.14
Proportion of Black Americans in 2000	46	0.11	0.09	0.03	0.08	0.16
Proportion of state expenditures on public assistance	46	0.02	0.02	0.01	0.01	0.02
Doctors per 100k people	46	255.93	74.47	216.00	235.00	303.00
Hospitals per 100k people	46	2.29	1.69	1.09	1.48	2.48

The 1965 estimating equation and breakdown of the three models is outlined previously and will be directly applied to the data to assess the model with this new piece of legislation.

Additionally, I will run a fully interacted, pooled OLS regression for only the combined chamber model to determine statistically significant differences in the data and their associated marginal effects. Each variable will be interacted with a dummy variable for the 2003 legislation. These interactions will give the marginal effect of differences across time should they be significant. A significant difference would suggest a statistically significant change in the data for 2003 in relation to 1965.

7.2 Empirical Results

Table E located in Appendix B provides the full detailed results for all three models for the 2003 dataset. If the 1965 model were to hold true with the 2003 dataset, we would expect to see the following. First, the Democrat effect would be strong and significant. Based on the nature of the MMA, we would expect to see a negative effect from the Democrat party dummy in this iteration as opposed to the positive effect we experienced with the 1965 legislation. The bill was Republican-sponsored and passed with slim margins; therefore, the Democrats should be unlikely to vote for bill. Second, we would expect a strong, significant positive effect from larger hospitals. I estimated hospital size (beds/hospital) with the 2003 dataset. Consistent with the 1965 legislation, the MMA was also supported by the AHA and therefore, it is logical to predict a positive effect from hospitals. Lastly, we would expect strong, negative effects from greater Black American populations and doctor populations based on the 1965 model. In terms of the 2003 data, the AMA endorsed the MMA and therefore, we would expect a positive effect from doctors. With my prior analysis and discussion surrounding target populations, it would not be surprising to find evidence of negative and/or non-significant effects from these demographics (i.e. the aged, Black Americans, and low-income families).

Table E. Determinants of “Yea” Vote on the Medicare Modernization Act (MMA) of 2003

	Congress Model	House Model	Senate Model
Variables	Vote Yea dummy variable	Vote Yea dummy variable	Vote Yea dummy variable
Democrat party dummy variable	-0.749*** (0.0303)	-0.804*** (0.0303)	-0.506*** (0.112)
Log of median family income (\$\$\$)	0.125 (0.186)	0.107 (0.214)	-0.0208 (0.497)
Proportion of citizens 65+ in 2000	0.379 (1.0476)	0.0420 (1.154)	-2.268 (3.484)
Proportion of Black Americans in 2000	0.362 (0.338)	0.260 (0.327)	0.584 (0.998)
# of doctors per 100k people	0.0000568 (0.00047)	-0.000212 (0.000451)	0.000149 (0.00138)
# of hospitals per 100k people	0.0687** (0.0274)	0.0469 (0.0357)	0.0834* (0.0456)
Constant	0.387 (0.403)	0.630 (0.491)	0.642 (1.145)
Observations	514	422	92
R-squared	0.584	0.659	0.432

Robust standard errors in parentheses
*** p<0.01, ** p<0.05, * p<0.1
Notes: Includes region fixed effects. See Appendix B for full results.

Overall, the key parameters of the model were not statistically significant for the 2003 dataset. I find evidence that the Democrat party alignment does indeed have a negative effect on the probability of a “yea” vote. They were 74.9 percentage points lower than Republicans to vote on the 2003 bill ($p < .01$ across specifications). Additionally, hospitals per 100,000 individuals increased the probability of a “yea” vote by 6.9 percent meeting expectations given the AHA’s support of the 2003 bill. However, all other parameters in the model (across specifications) are not statistically significant, including the effect of doctors per 100,000 individuals. While I did find evidence that doctors have a strong negative effect in the 1965 model, there is not a strong positive effect in the 2003 data. As stated previously, it is expected that there are no significant effects for target populations and results are consistent with this hypothesis.

Upon analysis of the fully interacted pooled OLS model, I find that there are significant differences across both the 1965 and 2003 samples for all geographic regions, number of hospitals, percent of Black Americans, and percent of the aged population. Specifically, there is a significant negative 15.5 percent, 26.7 percent, and 15.7 percent change in probability of a “yea” vote in the West, South, and Midwest respectively for 2003 in comparison to 1965. Hospitals per 100,000 individuals increased by 13.9 percent and percentage of the Black American population increased by about 2.1 percent. The aged population, median family income, number of insurance companies, and doctors per 100,000 individuals all had statistically insignificant differences across the datasets, suggesting these variables held relatively constant over time.

Table F. Fully Interacted Pooled OLS Regression for Congress Model

Variables	Vote Yea dummy variable
MMA	-0.864* (0.482)
MMA * insurs	0.0359 (0.0282)
MMA * hosp	0.139*** (0.0425)
MMA * docs	0.00195 (0.00148)
MMA * logfaminc	-0.0943 (0.282)
MMA * dems	-1.124*** (0.0482)
MMA * pctblk	2.0586*** (0.521)
MMA * pctaged	-1.263 (2.207)
Constant	1.157*** (0.256)
Observations	

Robust standard errors in parentheses

*** p<0.01, ** p<0.05, * p<0.1

Note: Regression includes all parameters from Table E. See Appendix B for full results.

The key takeaways for the 2003 dataset are that doctors no longer have an impact on the vote and Democrats are less likely to vote yes. These effects are structurally different from the 1965 dataset which suggested doctors have a negative impact on the vote and Democrats have positive impact on the vote. It is clear there are significant differences between the two pieces of legislation, despite impacting the same population of individuals via the same program, Medicare.

7.3. Comparison Between 1965 & 2003 Legislation

At their core, the 1965 Medicare legislation and the 2003 Medicare legislation were born in very different political climates, although structurally there appear to be distinct similarities. It is important to note that the two bills faced similar internal circumstances in terms of party control. In both eras, they were crafted and passed under full party control of the presidency and Congress. This gave the controlling party a huge advantage over the other in terms of getting the bill through the gauntlet. On the surface, we would expect similar outcomes due to this structural similarity. However, we see differing vote margins and effects, particularly as a result of the external political environment. The 1965 bill was enveloped into a wave of social reforms under President Johnson with his vision of the Great Society and riding the coattails of President Kennedy's Great Frontier. These visions helped prioritize the need to include social welfare in the public policy debate and emphasized health care as a main focus. Although partisanship played a direct role in the passage of the bill, it was the Republican defectors, those who believed in the Medicare & Medicaid programs, which ultimately allowed victory. In contrast, the 2003 MMA was founded less on vision and more on partisan politics. While it was characterized as seeking to fulfill a gap in the original Medicare legislation, it was utilized as a means to advance the narrative that Republicans could find market solutions to social issues, and that the Republican party did care about the disadvantaged populations. Consequently, there was less of a unifying vision in the political environment in 2003 than there had been in 1965. This led to more under the table political dealings and bargains among MOCs as well as strong party loyalty for the MMA. As a result, it is not a surprise to see a 40.9 percentage point difference between Democrats and Republicans for the 1965 bill versus 74.9 for the 2003 bill. Moreover, the vote margin for both chambers is much slimmer in 2003 (House: 220-215 vs. 307-116; Senate: 54-44 vs. 70-24).

In terms of state effects of the model, it does not hold up to expectations for 2003 overall. I find evidence that target populations are ineffectual across both pieces of legislation. Again, we would expect that the aged population and low-income populations would benefit from prescription drug coverage and should therefore influence the bill's vote. (Particularly since the AARP was a huge endorser of the MMA). However, we find empirically insignificant influences. This appears to confirm my earlier conclusion that target populations are of little consideration during the legislative process, despite being the focus of such legislation. Moreover, I find evidence that hospitals and doctors do not have a significant effect on the probability of a "yea" vote which is inconsistent with my previous hypothesis that the AHA and AMA would be strong influencers of vote choice. Region also had an insignificant effect on vote choice. I suggest the insignificance of the predicted influencers of vote choice characterize the

MMA of 2003 as a partisan piece of legislation and unlike the 1965 bill, it was passed strictly on party lines.

To examine this conclusion more concretely, I analyze the characteristics of the Democrat defectors. I find that they are similar to the Republican defectors of the 1965 votes in that they are, on average, from highly contested states and have fewer hospitals. However, in contrast, they have a lower average median family income as well as fewer insurance companies and doctors per 100,000 individuals than 2003 Democrat Non-Defectors.

Table I. Summary Statistics for 2003 U.S. Senate Democrats

Variable	Obs	Mean	Std. Dev.	-----Quantiles-----		
				.25	.50	.75
<u>Defectors</u>						
Insurance companies	13	103.62	46.36	70.00	109.00	132.00
Median family income in 2000 (\$\$\$)	13	45.22	8.08	39.40	41.90	50.40
Proportion of population 65+ in 2000	13	0.13	0.02	0.12	0.13	0.14
Proportion of Black Americans in 2000	13	0.12	0.12	0.02	0.07	0.19
Proportion of state expenditures on public assistance	13	0.02	0.02	0.01	0.01	0.02
Doctors per 100k people	13	236.54	88.25	210.00	226.00	254.00
Hospitals per 100k people	13	3.07	2.08	1.24	2.84	4.97
Proportion of population that voted Democrat in 2002 Congressional election	13	0.47	0.13	0.43	0.48	0.52
<u>Non-Defectors</u>						
Insurance companies	16	203.94	185.29	79.00	133.00	380.00
Median family income in 2000 (\$\$\$)	16	48.52	8.18	42.10	50.40	51.90
Proportion of population 65+ in 2000	16	0.13	0.02	0.12	0.13	0.14
Proportion of Black Americans in 2000	16	0.11	0.08	0.03	0.08	0.15
Proportion of state expenditures on public assistance	16	0.02	0.02	0.01	0.01	0.02
Doctors per 100k people	16	263.58	68.30	219.00	235.00	303.00
Hospitals per 100k people	16	3.24	1.32	2.45	2.68	3.90
Proportion of population that voted Democrat in 2002 Congressional election	16	0.53	0.15	0.46	0.49	0.52

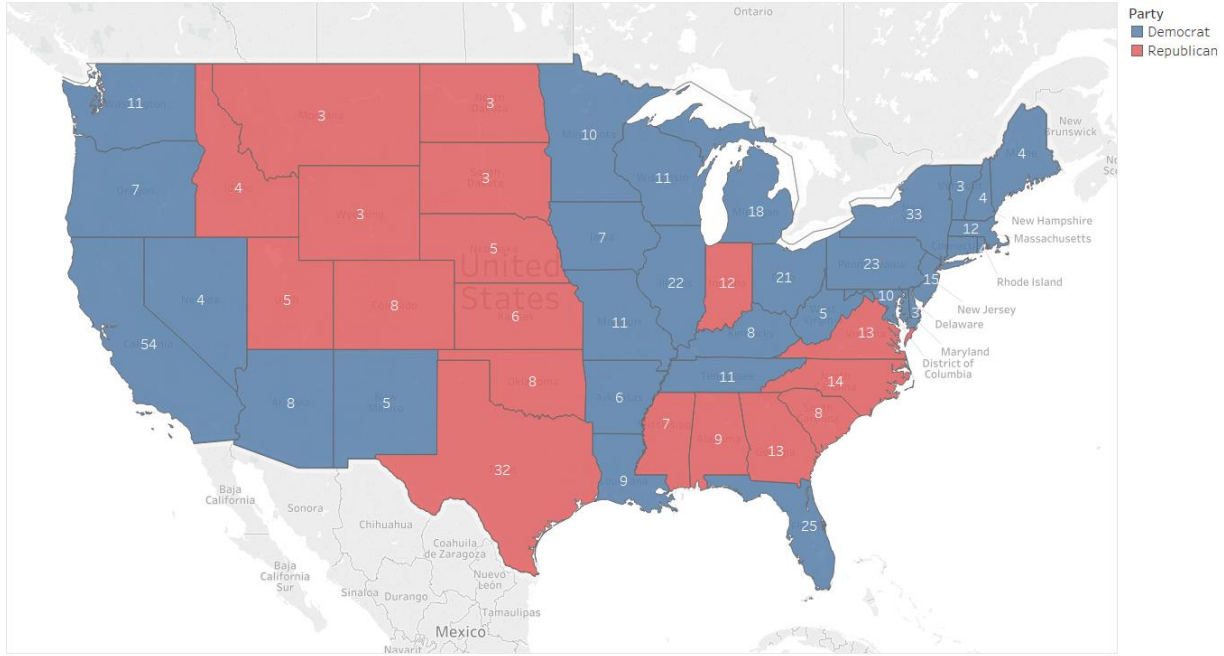
Table I. Summary Statistics for 2003 U.S. House of Representatives Democrats

Variable	Obs	Mean	Std. Dev.	-----Quantiles-----		
				.25	.50	.75
<u>Defectors</u>						
Insurance companies	16	182.13	165.62	71.50	130.00	181.50
Median family income in 2000 (\$\$\$)	16	44.88	5.21	40.00	44.91	49.20
Proportion of population 65+ in 2000	16	0.12	0.02	0.10	0.12	0.13
Proportion of Black Americans in 2000	16	0.15	0.12	0.05	0.13	0.27
Proportion of state expenditures on public assistance	16	0.01	0.01	0.01	0.01	0.01
Doctors per 100k people	16	211.06	54.49	201.50	212.50	248.00
Hospitals per 100k people	16	2.31	1.21	1.74	1.99	2.75
Proportion of population that voted Democrat in 2002 Congressional election	16	0.48	0.10	0.41	0.47	0.52
<u>Non-Defectors</u>						
Insurance companies	16	249.06	173.84	96.00	186.00	390.00
Median family income in 2000 (\$\$\$)	16	49.23	6.05	46.00	50.40	51.00
Proportion of population 65+ in 2000	16	0.12	0.02	0.11	0.12	0.13
Proportion of Black Americans in 2000	16	0.12	0.07	0.07	0.11	0.16
Proportion of state expenditures on public assistance	16	0.02	0.02	0.01	0.02	0.04
Doctors per 100k people	16	265.62	72.47	230.00	248.00	290.00
Hospitals per 100k people	16	1.56	0.64	1.09	1.40	1.84
Proportion of population that voted Democrat in 2002 Congressional election	16	0.53	0.15	0.46	0.49	0.52

Furthermore, 11 states flipped from Democrat to Republican between the 1996 Presidential Election (Democratic Candidate Clinton won) and the 2000 Presidential Election (Republican Candidate Bush won). The 11 states were Nevada, Arizona, Missouri, Louisiana, Arkansas, Kentucky, Tennessee, Florida, Ohio, West Virginia, and New Hampshire (see Appendix B, figures 1 & 2 for vote maps). Most of which are Southern states. Out of the 13 Senate Democrat Defectors, four came from a flipped Southern state. Similarly, out of the 16 House Democrat Defectors, six came from a flipped Southern state.

Figure 3.

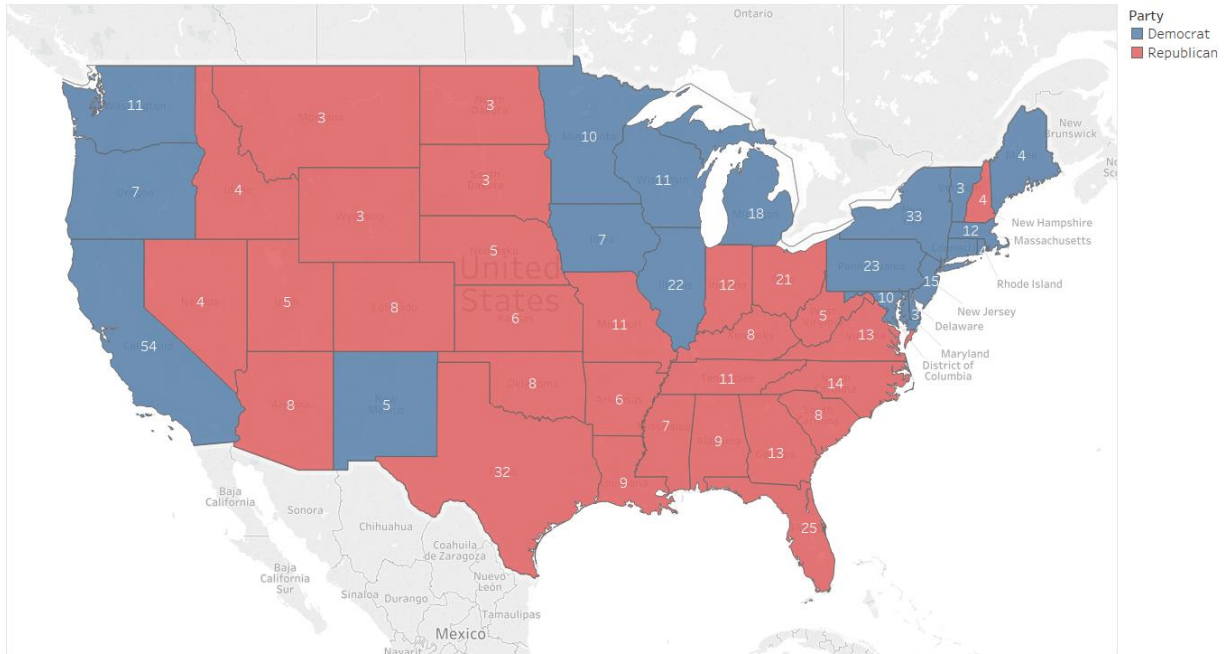
1996 Presidential Election Results



Map based on Longitude (generated) and Latitude (generated). Color shows details about Party as an attribute. The marks are labeled by sum of Electoral Votes. Details are shown for State. The view is filtered on State, which excludes Alaska and Hawaii.

Figure 4.

2000 Presidential Elections Results



Map based on Longitude (generated) and Latitude (generated). Color shows details about Party as an attribute. The marks are labeled by sum of Electoral Votes. Details are shown for State. The view is filtered on State, which excludes Alaska and Hawaii.

Therefore, in fashion similar to the Republican Defectors in 1965, these Democrats likely received pressure from their constituencies to support Republican measures. Consequently, I would argue the party alignment of their states and constituency make-up indirectly affected the influence of partisanship on probability of a “yea” vote.

Furthermore, as I had done previously for the 1965 bill, I ran a linear probability model (Table I) on the probability of defection with the same regressors as the Congress specification²⁸. In direct contrast to the 1965 defectors, I find Republicans in essence voted on party lines (only a 2.4% impact on the likelihood of defection), given they had full control of Congress in 2003.

Table I. Determinants of Defection on the Medicare Modernization Act (MMA) of 2003

Variables	Congress Model Defection dummy variable
Republican party dummy variable	0.0239 (0.0298)
Log of median family income (\$\$\$\$)	-0.144 (0.184)
Proportion of citizens 65+ in 2000	-0.177 (1.0424)
Proportion of Black Americans in 2000	-0.268 (0.332)
# of doctors per 100k people	0.000594 (0.000449)
# of hospitals per 100k people	-0.0511* (0.0277)
Proportion of state expenditures spent on public assistance in 2003	1.406 (1.214)
# of insurance companies (100s)	0.00915 (0.00846)
Constant	1.019** (0.398)
Observations	514
R-squared	0.324
Robust standard errors in parentheses	
*** p<0.01, ** p<0.05, * p<0.1	
Notes: Includes region fixed effects. See Appendix B for full results.	

²⁸ In this model, I employed a Republican dummy variable in place of the Democrat dummy variable used previously.

Overall, I would thus suggest that motivators directly tied to monetary compensation or political award are the key influencers of Congressional votes, but partisanship will always remain supreme. Interest groups, lobbying firms, and other powerful organizations saturate the political environment with money, leading to persuasion of the hearts and minds of the general public and Congress. Typically, they choose tactics which result in monetary benefits for themselves, but additionally benefit the MOCs individually if they are connected with the group. We see the indirect effects of these deals and campaigns in the size of the presence of their membership across the country which appear as influential variables in the model.

Lastly, the persuadable MOCs are highly influential in the outcome of the vote choice, prone to making decisions that enable their reelection and reflect their constituency. Therefore, they are more likely to defect from their chosen party than their counterparts and become embroiled in political bargains to sway their vote. Comparing the 1965 bill to the 2003 bill, the defection models suggest Republicans are more likely to defect when not in power and likely to vote on party lines when they are in power. With the understanding the 1965 vote was passed under full Democrat control, I argue the 1965 vote hinged on the Republican defectors who had greater likelihood to defect. In contrast, I argue the 2003 vote was overall based on party lines, given Republicans were in power and Democrats tend to vote on party lines when not in control.²⁹

8 Conclusion

In summary, I find that the key parameters predicting an individual MOC's vote of "yea" on the 1965 Medicare/Medicaid are, on the whole, consistent with my qualitative analysis of federal health insurance's political history and past literature. These key parameters include state effects of number of doctors, hospitals, and public assistance recipients as well as percentage of Black Americans. Furthermore, I find evidence that interest groups, such as the AMA, the AHA, and Blue Cross had significant influences on the individual votes of MOC on the bill, but that the effects of different demographics are inconclusive. Target populations were not found to be significant in the model. However, there is evidence to suggest party alignment of constituencies and geographic region played a role in persuading Republicans in party-contested states to defect. The behavior of these defectors is dependent on their party alignment, the party alignment of the majority in Congress, and the party alignment of the Presidency.

Upon comparison of the model in its application to the 2003 Medicare Modernization Act, interest groups play a lesser role in the outcome of the vote. This is in direct contrast to the 1965 bill in which the AMA and the AHA were strong predictors of outcome. However, target populations were consistently insignificant in the empirics across both bills and provide even greater evidence that they are not strong predictors of vote choice. I reason these deviations from expectation are the result of structural differences in the datasets. To accurately ascertain the strongest predictors of vote choice for the MMA, I suggest greater precision and identification of

²⁹ I ran an additional LPM with Democrat as the indicator variable instead of Republican. The results showed the opposite effects compared to the Republican indicator variable. Essentially, Democrats are less likely to defect when their party is in power and vote party lines when not in power.

possible vote factors would benefit the model. Furthermore, Congressional district-level data for the House model for both bills would greatly increase accuracy of the results.

I conclude that while interest groups can have a strong effect on certain bills, they are not consistent across time and legislation. They are reflections of the current political environment during a bill's development and passage and may give key insights into the other external factors and narratives influencing Congress. Nevertheless, at the end of the day, party alignment of MOCs tells us more about the predictability of a vote over all other parameters, and in certain climates, is the only one that truly matters. Thus, I suggest individual bills are unique in their character and aside from party, are difficult to predict with a general model. It is thereby necessary to take into account these unique characteristics to accurately forecast vote choice.

As it stands, the current research furthers the discussion on how and why individual MOCs vote on major bills and paves the way for better understanding and development of predictive models in the political economy analysis of federal legislation.

9 Appendix A

Table F. Determinants of “Yea” Vote on Original 1965 Medicare/Medicaid Legislation

	Congress Model	House Model	Senate Model
Variables	Vote Yea dummy variable	Vote Yea dummy variable	Vote Yea dummy variable
Democrat party dummy variable	0.409*** (0.0404)	0.382*** (0.0450)	0.508*** (0.0951)
Log of median family income (\$\$\$)	0.104 (0.209)	0.0803 (0.257)	0.0287 (0.424)
Percent of citizens 65+ in 1960	1.439 (2.0245)	1.633 (2.402)	-0.828 (3.753)
# of insurance companies (100s)	-0.0532** (0.0270)	-0.0387 (0.0288)	-0.0883 (0.0689)
Percent of Black Americans in 1960	0.0776 (1.122)	-0.453 (1.432)	1.945 (2.0112)
# of public assistance recipients 1964 (10,000s)	0.0000322 (0.0000503)	0.0000158 (0.0000586)	00000896 (0.000193)
# of doctors per 100k people	-0.00240* (0.0361)	-0.00162 (0.00193)	-0.00385 (0.00256)
# of hospitals per 100k people	-0.0442 (0.0361)	-0.0657 (0.0509)	-0.000792 (0.0498)
Black * South	-2.186** (1.0865)	-1.805 (1.357)	-4.113** (2.0669)
Democrat*South	-0.123 (0.0998)	-0.158 (0.112)	0.0129 (0.235)
South regional dummy variable	0.0666 (0.136)	0.103 (0.155)	-0.0255 (0.300)
Midwest regional dummy variable	-0.276*** (0.0636)	-0.265*** (0.0797)	-0.349*** (0.132)
West regional dummy variable	-0.146* (0.0766)	-0.107 (0.0889)	-0.311** (0.150)

Constant	1.012*** (0.273)	0.970*** (0.324)	1.202** (0.546)
Observations	499	412	87
R-squared	0.360	0.353	.475

Robust standard errors in parentheses
 *** p<0.01, ** p<0.05, * p<0.1
 Notes: Includes region fixed effects.

Table I. Determinants of Defection on Original 1965 Medicare/Medicaid Legislation

Variables	Congress Model Defection dummy variable
Republican party dummy variable	0.397*** (0.0438)
Log of median family income (\$\$\$)	0.021 (0.216)
Proportion of citizens 65+ in 1960	-2.635 (2.0248)
# of insurance companies (100s)	0.0428 (0.0294)
Proportion of Black Americans in 1960	-0.225 (1.136)
# of Public assistance recipients in 1964 (10,000s)	0.000832* (0.000508)
# of doctors per 100k people	-0.00393** (0.00164)
# of hospitals per 100k people	0.0151 (0.0364)
Black * South	1.293 (1.0977)
South regional dummy variable	-0.295*** (0.110)
Midwest regional dummy variable	-0.366*** (0.0689)
West regional dummy variable	-0.311*** (0.0786)
Constant	0.644** (0.278)

Observations	499
R-squared	0.393
<hr/>	
Robust standard errors in parentheses	
*** p<0.01, ** p<0.05, * p<0.1	
Notes: Includes region fixed effects.	
<hr/>	

10 Appendix B

Table A. Medicare Part D Coverage.

Drug Costs	Medicare	The Plan	Beneficiary
\$251-\$2250	75% (shared)	75% (shared)	25%
\$2251-\$5100	0%	0%	100%
>\$5100	80%	15%	5%

Table B. Federal Subsidies based on the Federal Poverty Level

Federal Poverty Level	Premium	Deductible	Prescription Copayment	Coverage Gap
0 %-100%	\$0.00	\$0.00	\$1.00-\$3.00	\$0.00
100%-135%	\$0.00	\$0.00	\$2.00-\$5.00	\$0.00
135%-150%	Sliding scale	\$50.00	15%	\$0.00

Table E. Determinants of “Yea” Vote on the Medicare Modernization Act (MMA) of 2003

	Congress Model	House Model	Senate Model
Variables	Vote Yea dummy variable	Vote Yea dummy variable	Vote Yea dummy variable
Democrat party dummy variable	-0.749*** (0.0303)	-0.804*** (0.0303)	-0.506*** (0.112)
Log of median family income (\$\$\$\$)	0.125 (0.186)	0.107 (0.214)	-0.0208 (0.497)
Proportion of citizens 65+ in 2000	0.379 (1.0476)	0.0420 (1.154)	-2.268 (3.484)
Proportion of Black Americans in 2000	0.362 (0.338)	0.260 (0.327)	0.584 (0.998)
# of doctors per 100k people	0.0000568 (0.00047)	-0.000212 (0.000451)	0.000149 (0.00138)
# of hospitals per 100k people	0.0687** (0.0274)	0.0469 (0.0357)	0.0834* (0.0456)
Proportion of state expenditures spent on public assistance in 2003	0.612 (1.192)	0.652 (1.341)	5.203 (5.778)
# of insurance companies (100s)	0.00405 (0.00838)	0.00370 (0.00855)	0.00423 (0.0254)
West regional dummy variable	0.0915 (0.0799)	0.0180 (0.0831)	0.213 (0.247)
Midwest regional dummy variable	-0.0134 (0.0574)	-0.0564 (0.0534)	0.0998 (0.195)
South regional dummy variable	0.0679 (0.0636)	0.0316 (0.0621)	0.120 (0.221)
Constant	0.387 (0.403)	0.630 (0.491)	0.642 (1.145)
Observations	514	422	92
R-squared	0.584	0.659	0.432

Robust standard errors in parentheses
*** p<0.01, ** p<0.05, * p<0.1
Notes: Includes region fixed effects

Table F. Fully Interacted Pooled OLS Regression for Congress Model

Variables	Vote Yea dummy variable
MMA	-0.864* (0.482)
MMA * insurs	0.0359 (0.0282)
MMA * hosp	0.139*** (0.0425)
MMA * SO	0.237** (0.104)
MMA * MW	0.263*** (0.0839)
MMA * WE	0.276*** (0.100)
MMA * docs	0.00195 (0.00148)
MMA * logfaminc	-0.0943 (0.282)
MMA * dems	-1.124*** (0.0482)
MMA * pctblk	2.0586*** (0.521)
MMA * pctaged	-1.263 (2.207)
Constant	1.157*** (0.256)
Observations	

Robust standard errors in parentheses
*** p<0.01, ** p<0.05, * p<0.1
Note: Regression includes all parameters from Table E

Table I. Determinants of Defection on the Medicare Modernization Act (MMA) of 2003

	Congress Model
Variables	Defection dummy variable
Republican party dummy variable	0.0239 (0.0298)
Log of median family income (\$\$\$\$)	-0.144 (0.184)
Proportion of citizens 65+ in 2000	-0.177 (1.0424)
Proportion of Black Americans in 2000	-0.268 (0.332)
# of doctors per 100k people	0.000594 (0.000449)
# of beds per hospital (100s)	-0.0511* (0.0277)
Proportion of state expenditures spent on public assistance in 2003	1.406 (1.214)
West regional dummy variable	-0.000495 (0.0828)
Midwest regional dummy variable	0.06404 (0.0558)
South regional dummy variable	0.0314 (0.0610)
# of insurance companies (100s)	0.00915 (0.00846)
Constant	1.019** (0.398)
Observations	514
R-squared	0.324

Robust standard errors in parentheses
*** p<0.01, ** p<0.05, * p<0.1
Notes: Includes region fixed effects.

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