

Prospects for Reform: Exploring Effective Health Policymaking in Congress

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Abstract

Health policymaking in Congress is mired in political gridlock. Reforms are far more likely to fail than to succeed, and the path forward is unclear. To reach such conclusions, scholars of health politics tend to analyze major reform proposals one by one to determine why they succeeded or failed and what lessons could be drawn for the future. Taking a different approach, we examine *all* health policies proposed in the U.S. House of Representatives between 1973 and 2002. We analyze these bills' fates and the effectiveness of their sponsors in guiding their proposals through Congress. Set against a baseline of policy advancements in other policy areas, we demonstrate that health policymaking is indeed far more gridlocked than policymaking in most other areas. We then isolate some of the causes of this gridlock, as well as the more promising paths forward to health policy reform.

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With the most recent round of proposals for a significant overhaul of the American health care system reaching a fever pitch, scholars and practitioners alike have been drawing lessons from the past in order to make predictions about the future. Focusing mainly on the politics of congressional policymaking, these authors have noted the similarities and differences between the current proposals and past successes or failures of national health policy reforms. The most common storyline that has emerged is a narrative of why the Clinton health plan of the early 1990s failed and why the proposals of today are likely to meet the same fate (or, alternatively, overcome earlier obstacles).

That interested observers and participants draw lessons from the past in this manner is not surprising. The substantive importance of health policy and what health politics illustrates about the dynamics of congressional policymaking has long motivated scholars to assess key health policy proposals, and their fates, in great detail. The politics of the Clinton health plan, for example, have been examined in perhaps every conceivable manner (e.g., Hacker 1997, Johnson and Broder 1996, Skocpol 1996, among a massive number of others), possibly receiving such attention due to the scope of the plan and its ultimate demise. Other health policy reforms, however, have likewise been analyzed in similar detail, such as the 1974 national health insurance proposals (e.g., Wainess 1999) or the 2003 prescription drug expansion of Medicare (e.g., Oberlander 2007; Oliver, Lee, and Lipton 2004).¹

While such narratives are valuable and may lead to a better understanding of health politics, Hacker (2001) reminds scholars to be cautious in drawing lessons from a limited set of political events. Indeed, depending on whether one focuses on the early Clinton years or the early Bush years, the advice for President Obama may be to act in a more bipartisan manner or to

play hardball partisan politics. Yet, we argue that such lessons are bound to be too narrowly drawn, and as a result, they do not produce a much-needed, broad, and evidence-based understanding of the congressional politics surrounding health policymaking.

In particular, we note that beyond the handful of proposals that have received all of the popular media and scholarly attention in recent years, there have been *thousands* of health policy bills introduced in Congress across recent decades. Moreover, hundreds of these bills have called for very significant reforms. By examining the fate of *all* such bills introduced in the U.S. House of Representatives between 1973 and 2002, and why their main sponsors differed in how well they navigated the lawmaking labyrinth, we are able to construct a broader understanding of whether and when health policy reform can be accomplished within Congress.

For example, a common claim that emerges from the in-depth case based analyses of past legislative successes and failures is that health policy is all-too-often mired in political gridlock. Yet, scholars of the U.S. Congress would respond to these arguments by wondering what is unique about health policy that would facilitate such legislative inaction. Is there reason to believe, for instance, that health policy proposals, perhaps due to their complexity or to the polarizing nature of the issue, are more likely to die in committee or to fail to pass through both houses of Congress than are proposals from other policy areas? That is, should the lessons we draw from the examinations of health politics and policymaking be distinct from the lessons drawn in other policy areas?

To address these and other questions about the politics of health policy, we explore the fate of all 9,740 health policy bills introduced in the 93rd through 107th House of Representatives, and compare them to the other 109,300 bills introduced in this time period not dealing with health. In so doing, we are uniquely positioned to explore whether health policymaking in

¹ For a helpful recent overview of the politics of health policy in general, see Oliver (2006).

Congress is plagued by legislative gridlock, whether such gridlock is more pronounced in the area of health politics than elsewhere, what the potential causes of health policy gridlock are, and how such gridlock was overcome in the many successful health policy reforms that were signed into law over the past four decades.

We begin this study by drawing on numerous accounts of congressional attempts at health policy reform in order to generate a series of hypotheses regarding health policy gridlock, its causes, and how it might be overcome. We then examine these hypotheses based on a quantitative examination of congressional bills and their fates. We conclude with a broader portrait of the keys to effective health policymaking in Congress.

Before taking these steps, however, it is worth noting the limits of our investigation. Just as any qualitative examination of a single policy proposal may well lead to incorrect conclusions regarding the nature of congressional politics, so too does our quantitative analysis paint an incomplete picture. In gathering details on thousands of bills and their sponsors, we must forego an examination of the richer institutional considerations of backroom dealings, coalition formation, interest group involvement, and the like – all of which is crucial to a fuller understanding of the fate of any single proposal. Scholars have demonstrated, for example, that budgetary considerations (e.g., Brady and Volden 1998, Fuchs and Hoadley 1987, White 1995) and interest group involvement (e.g., Johnson and Broder 1996; West, Heith, and Goodwin 1996) are important in understanding health policymaking. These and other considerations can best be included in case-by-case bill examinations, which we neglect in looking for more aggregate patterns.² We, therefore, are not claiming to offer a complete characterization of congressional health politics. Rather, we suggest that the aggregate findings uncovered here

should not be neglected in setting the stage for more detailed examinations of individual proposals.

Theoretical Considerations

As scholars and practitioners discuss national health policymaking, they either implicitly or explicitly rely on theories of congressional politics. In this section, we document a series of hypotheses that can be found in the recent literature on health policymaking, which together lay out the theoretical landscape for a broader understanding of health politics. The hypotheses that we consider are by no means exhaustive. Rather, they are claims that arise from a broad reading of the health politics literature, and specifically from work that has analyzed the fate of health policy proposals before Congress; and they are included here because we believe that our aggregate analysis can be used to assess (at least to some extent) their veracity.

The first such hypothesis addresses the concept of “policy gridlock.” Scholars use this term to capture the idea that many proposals, even those that may be supported by a majority of the American public as well as a majority of members in Congress, do not find their way toward passage. Perhaps it would be unsurprising if proposals with little support fail. But the claims of many observers of congressional health policymaking suggest that the failure of health reforms stretches even further. More specifically, they claim that, despite significant cries for reform, Congress is incapable of acting on anything approaching a significant overhaul of the American health care system. Health politics may not be unique in facing this dilemma. Binder (2003) and Brady and Volden (1998) are among numerous political scientists who offer theories of gridlock in Congress. And yet, health policy scholars seem to be suggesting that such gridlock is

² Similarly, due to the level of effort necessary to capture all of these bills and their fates in the House of Representatives, we do not offer an equivalent analysis of all Senate bills over a comparable time period. We think

particularly profound in areas of public health (e.g., Steinmo and Watts 1995). Along those lines, we offer our first hypothesis:

Health Policy Gridlock Hypothesis: *Health policy proposals are less likely than other proposals to pass through Congress and become law.*

Whether this hypothesis finds support or whether health care is simply as gridlocked as any other policy area, serious questions remain about *why* such gridlock exists and how it might be *overcome* on occasion. Although many different explanations of gridlock exist, even to explain a single failure (e.g., Brady and Buckley 1995, Hacker 1997, Johnson and Broder 1996, and Skocpol 1996), one of the more compelling theoretical accounts of health policy gridlock is offered by Steinmo and Watts (1995), who suggest that the checks and balances built into the U.S. separation of powers system, coupled with diverse preferences over complex issues, ensures that programs like comprehensive national health insurance will always fail in America. As they succinctly argue: “It’s the Institutions, Stupid!” While many such institutions change in form or importance over time (e.g., Peterson 1993), a brief examination of how a bill becomes a law demonstrates that most bills die in committee, and even those that pass the House may have difficulty gaining approval in the Senate or avoiding a presidential veto. Thus we seek to explore the following hypothesis:

Institutional Gridlock Hypothesis: *Congressional institutions, such as committee structures and bicameralism, lead to policy gridlock, especially in the area of health policymaking.*

Despite providing the potential for gridlock, these institutional impediments could easily be overcome if all policymakers and the American public shared a common view of problems and their ideal solutions. The reason that these institutions matter, however, is that preferences

that such an analysis in the future would also be immensely valuable.

of the American people, and thus of their elected politicians, differ substantially from one to the next. This theme of preference conflict has emerged in numerous analyses of health policy reforms. Brady and Buckley (1995), for example, examine the preference of U.S. Senators for health care reform in the 103rd Congress and demonstrate that there was no possible coalition for change that could overcome the 60-vote threshold needed to end a Senate filibuster. Bristol (2006, p. 2043) extends these arguments to more recent Congresses, noting that health politics today is driven by “age-old ideological differences” and “irreconcilable positions.” Hacker and Skocpol (1997) emphasize that these divisions are even more pronounced following the congressional realignment of preferences following the 1994 Republican takeover of Congress. Ruger (2007) argues that fundamental differences in the high-level principles that average Americans hold allow opponents of policy reform to use wedges to break apart proposed coalitions for change. And Gottschalk (2007) notes that such fissures even extend to different camps within organized labor.

All of these arguments tend to suggest that either there is no middle ground for health policy reform, or that reform proposals are instead coming from the more extreme and divisive actors in American politics. To the extent that one side firmly believes in increased governmental involvement in health care while the other side is set in its view of expanding and enabling the free market, their proposals will continue to divide and polarize health politics. Although we are not able to examine every element of these claims, our data allow us to investigate the following hypothesis regarding competing polarized proposals and lack of middle ground:

Polarized Politics Hypothesis: *Health policy proposals are more likely than other proposals to be raised by extremists rather than centrists.*

The above three hypotheses, and indeed much of the literature on health policymaking in Congress, paints a bleak picture of the prospects for policy change. And yet, as alluded to above, both major and minor policy reforms have been adopted over the last several decades. Even after the Clinton health reform plan was set aside, proposals soon emerged to address the portability of health insurance, to insure poor children whose families did not qualify for Medicaid, and to add a prescription drug benefit to the Medicare program. All of these proposals passed in one form or another; thus, in the next several hypotheses, we consider the conditions that enhance the prospects for reform.

A common element in health policy narratives is the emergence of a “policy entrepreneur” to break legislative gridlock. Such entrepreneurs have long been the subject of examination in political science and public policy (e.g., Walker 1974, Kingdon 1984, Baumgartner and Jones 1993); and in health policymaking these entrepreneurs are considered to be especially crucial due to the complexity of health policy and due to the contentiousness of reform proposals (e.g., Oliver 2004). Such entrepreneurs might be members of Congress who act through their formal institutional positions (e.g., Wainess’s 1999 description of Wilbur D. Mills) or their informal connections (e.g., Burgin’s 2003 examination of members of the Diabetes Caucus). Alternatively, health policy entrepreneurs can emerge from outside of Congress, such as interest groups that serve as policy brokers (Heaney 2006). Regardless of form, the pervasive argument in the literature is that significant health policy reforms will founder without effective policy entrepreneurs.

Policy Entrepreneur Hypothesis: *Health policy proposals need substantial involvement from policy entrepreneurs to achieve legislative success.*

Building on this point, institutionally ensconced party and committee leaders may be well positioned to serve the role of policy entrepreneur, yet there has been much debate in the health politics literature regarding whether majority party influence is more effective than bipartisan coalition building in achieving policy movement through Congress. Many political scientists have argued that party and committee leaders can (at least at times) help advance the party's agenda and stop opponents' bills (e.g., Aldrich 1995, Cox and McCubbins 2005, Rohde 1991); and consistent with these arguments, health policy scholars have often claimed that party leaders are instrumental in influencing changes in health policy. Marmor and Oberlander (2004, pp. 226-227), for example, suggest that successful reforms must start with the majority party attempting to build up to a winning coalition after securing its base, rather than initially trying to be bipartisan. Hacker (2009, p. 3) reaffirms this stance, referring to the inevitable failure that follows from relying upon "wistfully recalled images of the bipartisan politics of old." And Oliver, Lee, and Lipton (2004) recount the Republican arm-twisting needed to secure passage of the Medicare prescription drug benefit in 2003. These views of party influence motivate the following hypothesis:

Partisan Leadership Hypothesis: *Health policy proposals need strong majority party and committee leadership support to achieve legislative success.*

This partisan perspective, however, is far from universally held, as positive political theorists have for half a century touted the "median voter theorem" (e.g., Black 1958, Downs 1957). Applied to the congressional setting, this theorem suggest that proposals at or near the middle of the ideological spectrum have the greatest chance of legislative success. Attempts to modify such proposals away from a median position would not gain sufficient support from the right or left halves of the legislature, thus ensuring failure. Faced with such moderate proposals,

party leaders may have little ability to sway members away from the positions that are supported by their constituents (e.g., Krehbiel 1993). And, absent such moderate proposals preferred over the existing status quo health policies, failure is inevitable (e.g., Brady and Buckley 1995). While such moderate reform proposals may still lead to fairly partisan voting patterns, they might also serve as the basis for bipartisan coalition building, as advocated in health politics by Ferguson, Fowler, and Nichols (2008). Thus, in many ways contrary to the Partisan Leadership Hypothesis, we also explore the following hypothesis:

Moderate Proposals Hypothesis: *Moderate and bipartisan health policy proposals are more likely to achieve legislative success than are extreme or partisan proposals.*

One reason why leadership and legislative strategy are ostensibly so crucial in health policymaking is the inherent complexity of the issues surrounding health. Health care spending is a major and rapidly growing component of the U.S. economy, and each significant policy change has had unforeseen consequences requiring further policy modifications. Hence, the role of policy experts is often the focus of scholarly accounts of successful and failed health policy reforms (e.g., Hacker 1997, Johnson and Broder 1996, Skocpol 1996, regarding the Clinton health reform proposal). Participants both within and outside of Congress can, over time, acquire the necessary expertise to anticipate and avoid obstacles to both political and policy success. Bills formulated by experts are thus thought to be more likely to find their way through the legislative process, which motivates the following hypothesis:

Expertise Hypothesis: *Health policy proposals backed up by extensive expertise are more likely to achieve legislative success.*

While expertise, perhaps supported by congressional seniority and committee involvement, may help bring about policy change, the flip-side of such an argument is that health policymaking demands new ideas, rather than just the same old proposals coming from long-time participants in health policy debates. Perhaps the most exciting aspect of American federalism is the idea that the states can serve as policy laboratories, in which they try new ideas, abandoning failures while keeping and exporting successes. Scholars of health policymaking constantly claim that if the federal government is mired in policy gridlock, the states will take the lead in developing new programs (e.g., Gray, Lowery, and Godwin 2007; Mashaw 1993; Stream 1999). A related argument, denoted by political scientists as “vertical policy diffusion,” is that successful state experiments rise to national prominence and possibly to federal adoption. However, such diffusion has received mixed or conditional empirical support (e.g., Boeckelman 1992, Shipan and Volden 2006). Although there are likewise similar limitations on vertical policy diffusion specific to health policymaking (e.g., Hanson 1993, Weissert and Scheller 2008), there remain compelling accounts of specific state experiences being crucial to the development of national health policies (e.g., Mayes 2007). We therefore suggest that the following hypothesis be subject to further empirical scrutiny:

Federalism Hypothesis: *Health policy proposals arising from state experiences are more likely to achieve legislative success.*

Taken together, these hypotheses lay out the following theoretical understanding of congressional politics surrounding health policymaking. Due to significant institutional constraints and diverse preferences, health policymaking is generally stuck in gridlock. While reform is possible, policy change requires such factors as the emergence of strong policy entrepreneurs, the engagement of partisan leadership, and the development of moderate

proposals, built upon new ideas and refined by experts. While formidable, this vision of reform seems to have certain grains of truth of it, at least as judged by the anecdotal evidence examined to date. In what follows, we explore this theoretical narrative with a different approach, to see which hypotheses receive support across both small and large policy reforms advocated in Congress over the past four decades.

Empirical Approach

There may be many ways to assess the veracity of the hypotheses developed above. We here build upon the approach of Volden and Wiseman (2009), who examine every bill introduced in the U.S. House of Representatives over the past 35 years, with an eye toward determining which members of Congress are most effective at advancing their sponsored bills through the legislative process. In that work, we develop Legislative Effectiveness Scores (LESs) for each member in each Congress, based on how many bills they sponsor, how far each bill proceeds through the legislative process, and the degree to which the legislative proposal is substantively significant. We demonstrate, among other things, that members' scores predict whether they retire, stay in Congress, or seek higher office; that the scores can be used to illustrate the internal workings of such congressional institutions as committees, parties, and leadership positions; and that such analyses highlight the importance of individual members' political strategies within Congress and in relations with their districts.

Here we argue that a similar approach can be used not merely for all bills examined together but also to explore the subset of bills introduced in Congress dealing with health-related issues. By analyzing the progression of these bills, relative to those in all policy areas, we can assess the extent of policy gridlock in health and take steps toward determining the causes of

such gridlock. By examining which members have been most successful in navigating the legislative process to advance their health bills, we can assess claims regarding what factors enhance prospects for reform.

In undertaking this analysis, we will step through the above theoretical hypotheses one by one, first using aggregate data regarding the fates of all health policy bills and then generating Health Interest and Legislative Effectiveness Scores (Health ILESs) for each member to assess who can most effectively run the gauntlet of health policy reform and why.

Aggregate Patterns

Between the 93rd Congress (1973-74) and the 107th Congress (2001-02), members of the House of Representatives introduced 119,040 public bills (assigned an H.R. number).³ Of those, 9,740 (or 8.2%) dealt mainly with issues of health, as opposed to other policy areas. Clearly, the vast majority of these policy proposals were not the major reforms that receive discussion in academic papers and journalistic accounts. Indeed, Volden and Wiseman (2009) divide these bills into three categories: commemorative bills (7,540 bills overall, but only 7 dealing with health) that involved naming buildings, commemorating dates and events, and the like; substantive bills (105,480 overall, of which 9,295 dealt with health) that confronted public policy problems; and substantively significant bills (6,020 overall, with 438 focused on health policy issues) that not only dealt with substantive policy changes but also merited a write-up in the end-of-the-year *Congressional Quarterly Almanac*.⁴

³ We begin with the 93rd Congress as this is the earliest Congress for which bill details are listed on the Library of Congress THOMAS website. We end with the 107th Congress as this is the last Congress for which the bills are coded by issue area according to Scott Adler and John Wilkerson's Congressional Bills Project, relying on issue coding from the Policy Agendas Project at the University of Texas.

⁴ See Volden and Wiseman (2009, pp. 11-12) for more on the coding scheme used and the nature of the data gathering.

The Health Policy Gridlock Hypothesis raised above posits that almost all of these bills will fail to become law, and that such failures should be particularly profound in the area of health policymaking. Indeed, this is the case. Of the 119,040 bills introduced across these Congresses, only 4,910 became law, for a conversion rate of 4.1% (or a gridlock rate of 95.9%). It is clearly difficult for a bill to become a law; but given this low overall conversion rate, one wonders whether there is something particularly difficult about advancing health policy? The answer to this question is unambiguous: health policy is mired in gridlock at a level that far exceeds that in other policy areas. Of the 9,740 health bills introduced, only 154 became law, for a conversion rate of 1.6%, less than half of that for other policy areas.⁵

[Insert Figure 1 about here]

Figure 1 illustrates these conversion rates by Congress. Two aspects of the figure are worth noting in particular. First, health bills always have a lower conversion rate, often less than half of that for all bills. But, second, there seems to be an upward trend, at least through the 1970s and early 1980s, indicating that Congress may have grown in its capacity to manage its massive workload.

[Insert Figure 2 about here]

Although this overall portrait is interesting, health policy scholars are typically less interested in the most minor health policy changes, and rather pay much more attention to major reforms. Given our coding scheme, we can likewise narrow our focus down to the bills of substantive significance, as defined above. In focusing solely on substantively significant bills, policy gridlock emerges, although at nowhere near the levels found for the minor and commemorative bills that Congress routinely just dismisses out of hand. Of the full 6,020

⁵ A difference in means test allows us to reject the null hypothesis that health and non-health bills have the same conversion rates with greater than 99.9% confidence ($p < 0.001$).

substantive significant bills introduced between 1973 and 2002, 1,931 became law, for a conversion rate of 32.1% (meaning that more than two-thirds fell victim to gridlock, despite being important or controversial enough to be discussed in the *Congressional Quarterly Almanac*). Of the 438 substantively significant health bills, 99 became law, for a 22.6% conversion rate.⁶ Although the difference between health and non-health bills is not as stark for these important bills as it was for all bills, these findings indicate that major health reforms face a greater degree of gridlock than do other bills, all else equal. These conversion rates are illustrated over time in Figure 2.

As shown in the figure, with the exception of the 98th and 102nd Congresses, health bills were always gridlocked at a greater rate than were other bills.⁷ The other interesting feature of note in the figure is that both health and non-health conversion rates decline toward gridlock over time, at least in more recent Congresses. This trend stands in contrast to the findings in Figure 1 and seems to indicate that, while Congress may be increasing its passage rate for commemorative and minor substantive bills, the rate of passage of major reforms has not increased over time. Consistent with the Health Policy Gridlock Hypothesis, then, there remains a significant degree of legislative gridlock, especially on health policy proposals.

We cannot adjudicate whether health reforms fail more frequently due to the relative complexity of the health policy area or due to other health-specific reasons, as comparing all other policy areas and exploring their relative gridlock rates more systematically is beyond the scope of this paper. We can, however, start to investigate some of the causes of these high rates

⁶ These differences are also statistically significant ($p < 0.001$).

⁷ In addition to the Medicare reforms under the Social Security Act Amendments, the 98th Congress saw passage of amendments to the Federal Physicians Comparability Allowance Act and the Public Health Service Act and revisions of the Veterans' Administration's health care programs, among other actions. The 102nd Congress featured the enactment of such health reforms as extending greater regulatory discretion to the Secretary of Health and Human Services and to the Secretary of Veterans Affairs, further amendments to the Public Health Service Act, and multiple policies focused on preventive care.

of gridlock and explain what sponsors must do to enhance their prospects for successful reforms. One suggested cause of this gridlock, as articulated in the Institutional Gridlock Hypothesis, is the simple existence of particular congressional institutions, such as committees (which might engage in de facto gatekeeping) and bicameralism. To test this hypothesis, we isolated the course of a bill's progress into different stages from introduction to ultimate enactment.

[Insert Figure 3 about here]

First, consider whether bills that were introduced died in committee or found their way to the floor. Of the 119,040 bills introduced during our time period, all but 11,224 died in committee (for a 9.4% rate of bills reaching the House floor). For health bills, the likelihood of surviving the committee process was less than half as great, at 4.6% (451 of the 9740 health bills found their way to the House floor).⁸ Figure 3 illustrates these rates of committee survival over time. As with overall conversion into law rates, health bills consistently die in committee at a greater rate in all Congresses. Interestingly, the chance of reaching the floor increased fairly steadily from 1973 through 1984 for both health bills and all bills, yet after 1984, the rate of committee survival reached a plateau for all bills, but fell for health bills. Thus the institution of congressional committees seems to go a long way toward explaining the enhanced gridlock of health policymaking. Although such aggregate analyses cannot offer explanations for *why* health bills, in particular, die in committee, these results should point students of health politics to pay greater attention to the fate of proposals at the committee stage. These differences between health policy proposals and all bills within committee also extend (although not as dramatically) to the subset of substantively significant bills. Specifically, while 79.6% of all substantively significant bills reach the floor of the House, that rate for health bills is 66.7%.⁹

⁸ This difference between health and non-health bills is statistically significant ($p < 0.001$).

⁹ This difference is also statistically significant ($p < 0.001$).

[Insert Figure 4 about here]

Turning to bicameralism and separation of powers, we are next able to assess the fates of bills that pass the House but do not gain acceptance in the Senate or support from the president. Of the 9,207 bills that pass the House over our time period, only 4,910 find their way through the Senate and gain the president's approval.¹⁰ Thus 46.7% of all House-passed bills fall victim to bicameralism and separation of powers institutions. For health bills, 349 passed the House and 154 became law, indicating that 55.9% died due to House-Senate differences or the presidential veto.¹¹ The rate of conversion from House-passed bills into law is shown for each Congress in Figure 4. As is clear from that figure, much of the difference in the importance of bicameralism and veto powers between health and non-health bills arises from the first five Congresses in our dataset. From the early 1980s on, there are few discernable differences between health policies and all other policies, the exception being the greater amount of variance in this measure due to the smaller number of health bills. That said, for all bills, the institutional considerations of bicameralism and the presidential veto reduced the likelihood of bill enactment upon passing the House from about 60% in the 1970s and early 1980s to about 50% thereafter. Thus these institutions have become a greater source of policy gridlock across the time period of our study. Finally, for substantively significant bills alone, the conversion rate from House-passed bills into law is 48.6% for all bills and 40.7% in the area of health policy, once again indicating the institutional basis for a difference in success rates for health policy reforms.¹²

¹⁰ We do not separate out presidential vetoes in this analysis. While definitely an important institution, the numbers of vetoes are very small relative to all bills reaching his desk, and thus do not substantively affect our findings here. We believe that the power of the presidential veto is less important in these sorts of aggregate numbers than his ability to alter the content of bills based on veto threats.

¹¹ Once again, this is statistically significant difference for health policymaking ($p < 0.001$).

¹² The health vs. non-health difference in such success rates is statistically significant ($p < 0.01$).

Taken together, these results provide strong support for the Institutional Gridlock Hypothesis. Health bills clearly die in committee and fail to achieve bicameral support at a greater level than do bills in other policy areas.

Beyond these institutional considerations, the Polarized Politics Hypothesis suggests a further reason for policy gridlock – specifically that health proposals, in particular, are polarizing and that they are perhaps raised by strong conservatives with a free market vision and strong liberals with a pro-government agenda. Hence, while proposals in other policy areas might be based on finding more middle ground, health policy proposals tend to be raised by extremists and thus unlikely to pass. If this argument is correct, two clear patterns should emerge in the data on who introduces health policy bills. First, the number of people raising reforms should be quite small. And, second, most reforms should come from the more extreme members of Congress rather than the centrists.

[Insert Figure 5 about here]

Figure 5 presents the percentage of members of Congress who introduce at least one bill on health policy.¹³ On average, 47.4% of members advance an idea for health reform, which may seem high or low, depending on one's perspective. On the one hand, certainly not all members of Congress are health policy experts, and they must focus their attention on a vast array of policy topics in any Congress. On the other hand, all members' constituents are affected by health policy, and thus members have an interest in appearing responsive to constituent concerns by introducing at least one bill on their behalf. What can be said with greater confidence, however, is that these participation rates declined notably between the early 1970s and the 1980s to less than one-third of members making health proposals, but have risen back up

¹³ We do not include a comparable line for all bills, as all but a handful of members introduce at least one bill in each Congress.

to about half of all members making health proposals in more recent Congresses. Thus it would be incorrect to conclude that a very few members set the agenda for health policy reform.

[Insert Figure 6 about here]

Moreover, we can assess the ideological bent of the members who are making the bulk of reform proposals. Specifically, we divide members ideologically into quartiles, based on the well-accepted DW-NOMINATE scores advanced by Poole and Rosenthal (1997), and examine what percentage of all bills introduced come from the most conservative quartile and most liberal quartile versus the more moderate two quartiles. If the Polarized Politics Hypothesis is correct, significantly more than 50% of all health policy proposals should come from the extremists. Figure 6 shows the results of this analysis by Congress and demonstrates that on average, for all bills introduced, 51.0% are introduced by these two extremist quartiles. For health bills, this rate is 53.7%. These statistically significant differences ($p < 0.001$) are notable in Figure 6, where, except in the 93rd and 107th Congress, extremists introduce at least as great a percent of health bills as they do for all other bills. One additional worthwhile feature to mention about this figure is that both lines tend to be declining over time toward about 50% by the end of the time period. This trend contradicts the argument that, at least in terms of proposals, there is a greater degree of polarization today than in the past.¹⁴ Moreover, the differences between the extremist introduction rates on health bills compared to other bills are substantively small. Even if all extremists' bills were dead on arrival into the House (which is far from true in fact), these differences would account for only a small fraction of the gridlock differences between health policy proposals and those in other issue areas. Finally, in considering only the most important or "substantively significant" bills, 53.2% of substantively significant health bills were

introduced by the extremist quartiles, as compared to 48.8% extremist introductions for all substantively significant bills. Again, this is a small but statistically distinct difference ($p \approx 0.04$).

Together, Figures 5 and 6 illustrate that health policy proposals are not limited to those of a few highly polarized members of Congress. Nevertheless, there is some support for the Polarized Politics Hypothesis, in that fewer than half of all members make health policy proposals, and those proposals do come a bit more from those on the more liberal and more conservative ends of the ideological spectrum.

Health Interest and Legislative Effectiveness Scores

Thus far, we have concentrated our attention on aggregate statistics, examining raw numbers of bill introductions and the path of those bills through committee, across the floor of the House, and perhaps into law. To explore exactly which members' bills succeed, which fail, and why, we need to refine our approach to examine each member of Congress and to determine why his or her sponsored bills are more likely to be the proposals that become the basis for changes in American national health policy.

To do so, we follow the method of Volden and Wiseman (2009) in constructing member-by-member Legislative Effectiveness Scores. In our earlier work, we are concerned with which members are effective at moving bills through the legislative process and why. Here we argue that this approach can also be used constructively to explore when and how health policy proposals succeed. In both cases, member specific scores are constructed relying on the member's share of all bills introduced in the Congress (or all bills introduced on health policy),

¹⁴ Of course, the members in these outer quartiles may be more extreme liberals and more extreme conservatives today than they were in earlier Congresses. We are here merely exploring whether those with more extreme

as well as their share of bills that advance through each major stage of the legislative process, all weighted by whether the bills are commemorative, substantive, or substantively significant, as defined above. The following formula is used in constructing a Legislative Effectiveness Score (LES), for each member i in each Congress t :

$$LES_{it} = \left[\begin{aligned} & \left(\frac{\alpha BILL_{it}^C + \beta BILL_{it}^S + \gamma BILL_{it}^{SS}}{\alpha \sum_{j=1}^N BILL_{jt}^C + \beta \sum_{j=1}^N BILL_{jt}^S + \gamma \sum_{j=1}^N BILL_{jt}^{SS}} \right) \\ & + \left(\frac{\alpha AIC_{it}^C + \beta AIC_{it}^S + \gamma AIC_{it}^{SS}}{\alpha \sum_{j=1}^N AIC_{jt}^C + \beta \sum_{j=1}^N AIC_{jt}^S + \gamma \sum_{j=1}^N AIC_{jt}^{SS}} \right) \\ & + \left(\frac{\alpha ABC_{it}^C + \beta ABC_{it}^S + \gamma ABC_{it}^{SS}}{\alpha \sum_{j=1}^N ABC_{jt}^C + \beta \sum_{j=1}^N ABC_{jt}^S + \gamma \sum_{j=1}^N ABC_{jt}^{SS}} \right) \\ & + \left(\frac{\alpha PASS_{it}^C + \beta PASS_{it}^S + \gamma PASS_{it}^{SS}}{\alpha \sum_{j=1}^N PASS_{jt}^C + \beta \sum_{j=1}^N PASS_{jt}^S + \gamma \sum_{j=1}^N PASS_{jt}^{SS}} \right) \\ & + \left(\frac{\alpha LAW_{it}^C + \beta LAW_{it}^S + \gamma LAW_{it}^{SS}}{\alpha \sum_{j=1}^N LAW_{jt}^C + \beta \sum_{j=1}^N LAW_{jt}^S + \gamma \sum_{j=1}^N LAW_{jt}^{SS}} \right) \end{aligned} \right] \left[\frac{N}{5} \right],$$

where the five large terms represent the member's fraction of bills: (1) introduced (BILL), (2) receiving action in committee like hearings (AIC), (3) receiving action beyond committee like a floor vote (ABC), (4) passing the House (PASS), and (5) becoming law (LAW), relative to all N legislators.¹⁵ Within each of these five terms, commemorative bills (C superscript) are weighted by α , substantive bills (S superscript) by β , and substantively significant (SS superscript) by γ . The overall weighting of $N/5$ normalizes the average LES to take a value of 1 in each Congress. Following Volden and Wiseman (2009), we use a weighting of $\alpha = 1$, $\beta = 5$, and $\gamma = 10$, to

preferences dominate the policy debates, at least in terms of introducing bills in Congress.

¹⁵ See Volden and Wiseman (2009) for more on how these particular stages are defined.

capture the increasing difficulty in moving more substantive and more significant bills through the legislative process. As noted below, we also explore the robustness of our results to variations in this weighting assumption.

In addition to creating an LES for each member in each Congress based on all bills introduced, we use the same formula on only the subset of health policy bills. In so doing, we create what we term a Health Interest and Legislative Effectiveness Score (Health ILES) for each member in each Congress. We refer to this score both in terms of “Interest” and “Effectiveness” because, as was seen above, not all members are interested in affecting health policy through their bill sponsorship. Indeed, many members who do not introduce any health bills may nevertheless be quite capable of being effective policymakers in this area, were their personal or district preferences to predispose them to advance health policy proposals.

Before turning to our analysis of the Health ILES scores, a couple of points regarding their construction and use are worth noting. First, the measure that we construct is based on the advancement of legislation, and hence, we are thus setting aside the skills required to block the legislative initiatives of others. As a result, our operationalization necessarily focuses on the effectiveness at moving legislation through Congress, rather than engaging in counteractive tactics to squelch a legislative program. Related to this point, our method also does not account for legislators who do not sponsor many successful bills, but rather “work behind the scenes” to bring legislation to its fruition (or those who serve as effective obstacles to bill progress). While we believe that such legislators definitely exist and play an important role in lawmaking (and in health politics, in particular), they comprise a relatively small minority of all members of Congress, and their actions are exceedingly difficult to assess in an objective manner. While in-depth qualitative analyzes can offer valuable insights on the tactics of these members, which

helps to understand the various components of the health policy network, we also believe that valuable insight can be gleaned by considering large sample empirical analyses that seek to provide us with generalizable principles about the causes and consequences of legislative effectiveness in health policy. To this end, the scores that we develop are particularly well-suited for the analyses that we undertake to explore the numerous hypotheses that naturally emerge from existing health politics scholarship.

These caveats aside, given our formulation, the Health ILES is set to take an average score of one; and hence, we can examine variance in this measure to determine the characteristics of members who were particularly influential in formulating health policies in the House of Representatives since the early 1970s. Such examinations are useful in testing the remaining hypotheses raised above.

The Policy Entrepreneur Hypothesis states that policy entrepreneurs are critical to the success of health policies. As it relates to Health ILESs, these scores should reveal who took up such an entrepreneurial role or whether policymaking was much more open and egalitarian, in that all members achieved about the same scores. In looking over these scores, two members immediately jump out. Paul G. Rogers (D-FL) received a score above 150 for each of the 93rd, 94th, and 95th Congresses, after which he retired. His mantle of health policy entrepreneur was then passed on to Henry Waxman (D-CA), who subsequently scored above 100 in each Congress until the Republican ascendancy in the 1994 elections, as illustrated in Figure 7. Given that the average score is set at 1.0, these members are clearly special when it comes to sponsoring health policy reforms. No other legislator has come close to these levels, or this degree of consistency in his or her Health ILES. Interestingly, when the Republicans took control in the 104th Congress, the highest performers were a much more diversified lot, with the top members all

averaging under a score of 25 across the 104th through 107th Congresses (thus accomplishing less during those 8 years than Rogers or Waxman accomplished in any given Congress).

[Insert Figure 7 about here]

That these two members are health policy entrepreneurs should be surprising to very few scholars of health politics. Rogers was dubbed “Mr. Health” by his colleagues, and across his career either sponsored or played a major role in the passage of the National Cancer Act, the Health Maintenance Organization Act, the Health Manpower Training Act, the Medical Device Amendments, the Emergency Medical Service Act, the Medicare-Medicaid Anti-Fraud and Abuse Amendments, and the Radiation Control for Health and Safety Act. Both Rogers and Waxman chaired the Subcommittee of Health within the Energy and Commerce Committee. Upon attaining that position, Waxman sponsored or help ensure passage of the Safe Medical Devices Act, the Patent Term Restoration and Drug Competition Act, the Safe Drinking Water Act Amendments, and the Orphan Drug Act, among many others. Furthermore, following the 2008 elections, Waxman ousted John Dingell (D-MI) to become Chair of the Energy and Commerce Committee, from which he has been serving a central role in working out a compromise to advance national health care reform in the current 111th Congress.

Beyond supporting the Policy Entrepreneur Hypothesis, the above discussions seem to indicate support for the Partisan Leadership Hypothesis, as both of these entrepreneurs were chairs of key subcommittees, and as Waxman’s influence significantly waned when Democrats became the minority party in the 104th Congress. To further explore this and the remaining hypotheses, we now turn away from individual level anecdotes to conduct regression analyses that explain which members’ Health ILESs were substantially larger than others and why.

Following Volden and Wiseman (2009), we run a series of regressions on members' scores, looking to explain their variance based on a variety of individual and institutional characteristics. Specifically, to test the remaining hypotheses and to control for factors that are relevant to the innate abilities, acquired skills, and institutional positions that lead to greater legislative effectiveness, we incorporate the following independent variables. A *Lagged Effectiveness Score* is incorporated to control for the fact that members are expected to have consistent interest and innate abilities from one Congress to the next. *Seniority* and its squared value measure the number of terms that the member has served in Congress, which helps to capture both the institutional power that might come to more senior members, and the expertise that is potentially necessary to bring about health policy change. The squared value allows the seniority effect to taper off over time. *State Legislative Experience* is a dummy variable capturing whether a member served in the state legislature prior to entering Congress, which captures both the member's legislative experience, and a potential conduit through which effective state health policy ideas might find their way up to the federal level. Because state legislatures vary significantly in how often they meet, whether and how much they pay legislators, the size of their staffs, and so on, the experiences of all state legislators are not equivalent. Therefore we also interact State Legislative Experience with an updated version of Squire's (1992) *Legislative Professionalism* measure to account for the possibility that members who served in more professional state legislatures will be more effective in Congress.

Majority Party is a dummy variable for whether a member in the majority party, which is thought to be important for politics generally and for health policymaking in particular. *Majority Party Leadership* accounts for whether a member is among the leadership (majority party leader, deputy leader, whips, and so on), with a similar variable included also for *Minority Party*

Leadership. Speaker is a dummy variable for the Speaker of the House. *Committee Chair* captures whether a member is a chair of a standing committee.¹⁶ *Power Committee* captures whether a member serves on the very important Rules, Appropriations, or Ways and Means committees, to explore whether these members receive additional deference. *Distance from Median* captures the absolute distance between the member and the chamber median on the DW-NOMINATE ideological scale discussed above. This variable helps us explore whether more centrist members offer proposals that are more likely to find their way into law.

Members' personal characteristics, including *Female*, *African American*, and *Latino* are incorporated because they have been shown to be important in earlier studies of effectiveness and also because health is often thought of as a "women's issue" (e.g., Barnello and Bratton 2007, Carroll 2001, Swers 2005). *Size of Congressional Delegation* within the member's state captures the possibility of natural coalitions among members who share the same state constituencies. *Vote Share* and its square are included to allow for the possibility that members from safe seats can dedicate greater time and effort to internal legislative effectiveness rather than external electioneering, and to allow this effect to be nonlinear. All independent variables, their sources, and summary statistics, are detailed in the Appendix.

[Insert Table 1 about here]

Taken together, this set of independent variables allows us to explain why some members more than others are able to successfully advance health policy reforms, as captured in the Health Interest and Legislative Effectiveness Scores. The simplest analysis of these scores is offered in Table 1, which shows the results of an Ordinary Least Squares regression (with robust standard errors clustered by members to account for potential non-independence of their scores

¹⁶ In future drafts we will specifically isolate the chairs (and perhaps also membership) of key committees and subcommittees dealing specifically with health issues. Investigatory analyses, including the policy entrepreneurship

over time). Specifically, Model 1 shows the results for the LES from all issue areas, while Model 2 focuses solely on the Health ILES. Model 1 thus sets a baseline for examining the results as they pertain to health.

Model 1 illustrates that members' effectiveness at successfully advancing their sponsored legislation through Congress is strongly related to their previous effectiveness, that senior members are more effective, as are majority party members, committee chairs, women, and those with safer seats electorally. Less effective are majority party leaders, who tend to focus their efforts beyond their own sponsorship, members of power committees, who exert their influence procedurally or on a handful of crucial (appropriations and taxation) measures, and African Americans and Latinos, who both introduce fewer bills and have more trouble advancing their proposals through congressional institutions. Other considerations, like state legislative experience, ideological position relative to the floor median, and size of congressional delegation are suggestive, but do not attain conventional levels of statistical significance.

Relative to these results for all bills combined, the health policy results in Model 2 look quite similar. The standard errors for these coefficients are quite a bit larger, due to the much higher variance in members' Health ILESs than their overall LESs, thus causing some variables to be less statistically significant in Model 2 than in Model 1 despite having larger substantive effects. Rather than recount all of these results one-by-one, we use the findings in Table 1 to discuss whether the hypotheses from the above theoretical developments section receive strong support.

The Partisan Leadership Hypothesis suggests that the majority party and its main leaders and committee chairs are the most likely sources of legislative reforms. Model 2 suggests conditional support for this hypothesis. Similar to other policy areas, majority party members

discussion, illustrate the importance of these positions.

are much more effective lawmakers than the average member in health politics. The very significant coefficient of 0.665 on the Majority Party variable implies that the average majority party member has a Health ILES of just over 1.3, while minority party members average just under 0.7, yielding an overall mean of 1.0. Put another way, according to our measure, majority party members are about twice as effective as minority party members. Further analysis (not offered here in detail due to space considerations) shows that much of this influence is due to the bills of majority party members having a much better chance of being considered in committee and then finding their way to the House floor. Beyond this general finding, there is strong support for the argument that committee chairs are generally more effective than rank and file members. This finding is undoubtedly partially due to the fact that committee chairs advance legislation on behalf of their committee (and especially the majority party's position in the committee). This finding is also mainly driven by the effectiveness of a few committee chairs, to whose committees most health legislation is referred. Finally, the insignificant coefficients on Majority Party Leaders and on Speaker might be seen initially as lessening support for the Partisan Leadership Hypothesis. But considering the role of these leaders as advancing party goals, rather than their own particular bills, these findings are not surprising. Furthermore, the coefficients on both of these variables tilt more positively than for all policy proposals in Model 1.

The Moderate Proposals Hypothesis suggests that proposals near the House median position ideologically are more likely to succeed. Assuming members advance policy proposals near their own preferred positions, we should therefore expect moderates to have higher Health ILESs. The key variable here is Distance from Median, which we would expect to take a negative value, as more extreme members' bills die in committee or on the floor. Instead, the

coefficient on this variable takes a positive, although statistically insignificant coefficient.¹⁷

Thus, there is no evidence in support of the Moderate Proposals Hypothesis. Moreover, as was seen in Figure 6, slightly more proposals tend to come from the conservative and liberal ends of the ideological spectrum than from centrists. That those proposals are not immediately dismissed is further evidence against success being limited to moderate proposals.

The Expertise Hypothesis suggests that due to the complexity of public health issues, policymakers need to acquire greater expertise in order to achieve legislative success. Although we cannot isolate who has gained the greatest level of health policy expertise in Congress, we can be confident that more senior lawmakers have at least had the opportunity to gain expertise with respect to health issues and health policymaking. As seen in Model 2, however, the more senior members are not statistically distinct from junior members in their effectiveness at advancing health policy reforms. Compared to Model 1, the coefficients on both Seniority and its squared term tend in a more negative direction. Thus we find no support here for the idea that more senior members have been likely to light the way forward to health care reform.

Finally, the Federalism Hypothesis suggests that good ideas will bubble up from state experiments to the national government. While this may be true, there does not appear to be strong evidence that the conduit for such vertical policy diffusion lies with members of Congress who draw upon their experiences in the state legislatures. While the coefficients on State Legislative Experience and its interaction with Legislative Professionalism are both positive, as would be expected, neither attains statistical significance.

[Insert Table 2 about here]

¹⁷ Substituting distance from the majority party median instead of distance from floor median also shows no ideologically based party effect.

The findings described here are fairly robust to alternative model specifications, as reported in Table 2. Model 3 creates a logged version of the Health ILES by taking the natural log of each member's Health ILES + 1 (to yield a minimum value of zero once again). This method reduces the role of high-scoring outliers in influencing the results reported in Model 2. Model 4 instead once again creates a version of the Health ILES, but this time assigns different weights to the substantive health bills. Recall that such bills deal with substantive health issues, but unlike substantively significant bills, they are not major enough to receive a write-up in *Congressional Quarterly Almanac*. Also, nearly all such bills die in committee. Because members may be getting a significant boost in their effectiveness score just for introducing a large number of such doomed (and perhaps symbolically introduced) bills we reduce the weight of these bills in Model 4 from 5 (or half that of the major bills) to 1 (making them much less impactful on a legislator's score). According to the formula given above, this change does not affect the average score, which is still normalized to a mean of one.

These alternative models still show support for the key role of the majority party and no support for policy effectiveness based on state legislative experience. Now, however, even less support for the success of moderate proposals emerges, as Distance from Median is not only positive but also statistically significant in Model 3. And there now emerges some support for the Expertise Hypothesis, as Seniority has a statistically significant coefficient in both models of Table 2. Substantively, according to Model 4, compared to a legislator in her first term, a member of Congress in her fifth term averages 0.25 points higher on her Health ILES, amounting to about 25% greater effectiveness than the freshman member. The negative coefficient on Seniority squared, however, indicates that this added effectiveness does not

continue to increase dramatically with more experience but actually starts to taper off across a member's career.

[Insert Table 3 about here]

Table 3 offers one final set of analyses of the Health ILESs as constructed for Model 2. Here, we take more seriously the idea that these scores capture not only effectiveness but also interest. Given that more than half of all members have scores of zero (due to not introducing any health policy bills in a given Congress), an ordinary least square regression might not be the most desirable approach. A tobit analysis accounts for the data being “left-censored” at zero, with results displayed in Model 5. Model 6 instead conducts a simple logit analysis where the dependent variable indicates whether or not a member chooses to introduce health bills. Finally, Model 7 reports the same analysis as was presented in Model 2, but now only considering those members who actually demonstrated an interest in health policymaking, as illustrated by their introduction of at least one health policy bill.

These models shed further light on the hypotheses regarding prospects for health reform. As before, majority party members perform well, as we see that their enhanced effectiveness is partly due to a 20-percent greater likelihood of introducing bills (Model 6) and an even more significant effectiveness boost among those who introduce at least one bill (Model 7). The earlier findings with respect to Majority Party Leaders and the Speaker also becomes more clear, as these individuals are indeed less likely to sponsor their own bills (Model 6); but when they do advance their own proposals, majority leaders (and especially the Speaker) have a greatly enhanced level of policy effectiveness (Model 7). The Moderate Proposals and Federalism Hypotheses continue to receive scant support. However, some further evidence emerges in favor of policy expertise, at least as captured by Seniority. More senior members are much more likely

to introduce health policy bills (Model 6), although upon doing so their bills do not seem to fare all that much better than those of their more junior colleagues (Model 7).

Conclusion

The existing literature on congressional health policymaking paints a fairly gloomy picture of the prospects of health care reform. Health policies are mired in excessive legislative gridlock, which arises from institutions that are biased against policy change and rife with contentious polarized politics. Although many scholars and practitioners offer their own prescriptions for how to bring about change, there is little consensus, with proposals ranging from strong majority party leadership to bipartisanship, from building upon the expertise of more senior members and policy entrepreneurs to bringing in new ideas from the states. In this paper we argue that such perspectives could benefit from analysis of the fates of a broader set of health policy proposals in Congress and from comparing health policy gridlock to the typical levels of gridlock faced by all proposals before Congress.

We therefore analyze the progress of all health bills introduced into the House of Representatives between 1973 and 2002. We account for some of these bills being more significant than others and for the fact that some bills move further through the legislative process than do others before being abandoned or finally enacted into law. We then create scores for each member of Congress based on their bill introductions and their ability to move such sponsored legislation through the congressional policymaking process. We use these scores as a lens through which to analyze how members have achieved legislative success on health policy proposals across recent decades.

In many ways, the picture that emerges here reinforces commonly held views. Indeed there is legislative gridlock in the health policy area. Perhaps surprisingly, health policy proposals were significantly more likely to fail overall, to die in committee, and to not succeed in resolving House-Senate differences than were other policy proposals before Congress. Although health policymaking does appear to be somewhat more polarized than other areas, with more proposals coming from the ends of the ideological spectrum, this does not seem to be the cause of health policy gridlock. Indeed proposals by moderate members do not fare any better, nor do those by members who build on their experiences back in their home state legislatures.

If a clear path forward for health policy reforms emerges here, it follows from what seems to have worked in the past. Key policy entrepreneurs have been crucial and highly effective – most notably Henry Waxman, now chair of the key Energy and Commerce Committee. Key subcommittee chairs, majority party leaders, the Speaker of the House, and rank-and-file majority party members have all played significant roles in advancing health policy proposals through Congress. Thus proposals that build coalitions with a strong majority party base and then engage in limited, but sufficient, compromise with supportive minority party members have been, and likely will continue to be, the most successful path to health policy reform in Congress. Yet, as the high degree of gridlock in health policymaking indicates, even the most effective legislative strategies end in failure far more often than not.

Appendix: Data sources, definitions, and descriptive statistics

Independent Variables	Description	Mean	Std. Dev.
Seniority ^a	Number of terms served by member in Congress	5.039	3.927
State Legislative Experience ^a	Equals “1” if member served in state legislature	0.479	0.500
State Legislative Professionalism ^b	Squire’s index of state professionalism relative to Congress	0.290	0.145
Majority Party ^a	Equals “1” if member is in majority party	0.577	0.494
Majority Party Leadership ^a	Equals “1” if member is in majority party leadership	0.009	0.095
Minority Party Leadership ^a	Equals “1” if member is in minority party leadership	0.008	0.090
Speaker ^a	Equals “1” if member is Speaker of the House	0.002	0.041
Committee Chair ^c	Equals “1” if member is a committee chair	0.050	0.219
Power Committee ^c	Equals “1” if member serves on Rules, Appropriations, or Ways and Means	0.247	0.431
Distance from Median ^d	Member <i>i</i> ’s DW-NOMINATE score – Median member’s DW-NOMINATE score	0.332	0.204
Female ^a	Equals “1” if member is female	0.074	0.262
African-American ^a	Equals “1” if member is African-American	0.057	0.231
Latino ^a	Equals “1” if member is Latino/Latina	0.022	0.145
Size of Congressional Delegation ^e	Number of districts in state congressional delegation	18.23	13.70
Vote Share ^a	Percentage of vote received in previous election	68.42	14.03

Data sources:

^aConstructed by authors based on *Almanac of American Politics*, various years.

^bConstructed by authors based on updates to Squire (1992).

^cConstructed by authors based on Nelson (1992) and Stewart and Woon (2005).

^dConstructed by authors from DW-NOMINATE scores provided by Keith Poole.

^eConstructed by authors.

References

- Aldrich, John H. 1995. *Why Parties? The Origin and Transformation of Political Parties in America*. Chicago: University of Chicago Press.
- Barnello, Michelle, and Kathleen Bratton. 2007. Bridging the Gender Gap in Bill Sponsorship. *Legislative Studies Quarterly* 32(3): 449-474.
- Baumgartner, Frank R., and Bryan D. Jones. 1993. *Agendas and Instability in American Politics*. Chicago: University of Chicago Press.
- Binder, Sarah A. 2003. *Stalemate: Causes and Consequences of Legislative Gridlock*. Washington, DC: Brookings Institution Press.
- Black, Duncan. 1958. *The Theory of Committees and Elections*. Cambridge: Cambridge University Press.
- Boeckelman, Keith. 1992. The Influence of States on Federal Policy Adoptions. *Policy Studies Journal* 20(3): 365-375.
- Brady, David W., and Kara Buckley. 1995. Health Care Reform in the 103rd Congress: A Predictable Failure. *Journal of Health Politics, Policy, and Law* 20(2): 447-454.
- Brady, David W., and Craig Volden. 1998. *Revolving Gridlock: Politics and Policy from Carter to Clinton*. Boulder, CO: Westview Press.
- Bristol, Nellie. 2006. Democratic Victory Could Fire Up U.S. Health Policy Debates. *The Lancet* 368: 2043-2044.
- Burgin, Eileen. 2003. Congress, Health Care, and Congressional Caucuses: An Examination of the Diabetes Caucus. *Journal of Health Politics, Policy, and Law* 28(5): 789-820.
- Carroll, Susan J. 2001. Representing Women: Women State Legislators as Agents of Policy-Related Change. In *The Impact of Women In Public Office*, ed. Susan Carroll. Bloomington, IN: Indiana University Press.
- Cox, Gary W., and Mathew D. McCubbins. 2005. *Setting the Agenda: Responsible Party Government in the U.S. House of Representatives*. New York: Cambridge University Press.
- Downs, Anthony. 1957. *An Economic Theory of Democracy*. New York: Harper and Row.
- Ferguson, Christine C., Elizabeth J. Fowler, and Len M. Nichols. 2008. The Long Road to Health Reform Requires Bipartisan Leadership. *Health Affairs* 27(3): 711-717.
- Fuchs, Beth C., and John F. Hoadley. 1987. Reflections from Inside the Beltway: How Congress and the President Grapple with Health Policy. *PS* 20(2): 212-220.

- Gottschalk, Marie. 2007. Back to the Future? Health Benefits, Organized Labor, and Universal Health Care. *Journal of Health Politics, Policy, and Law* 32(6): 923-970.
- Gray, Virginia, David Lowery, and Erik K. Godwin. 2007. Public Preferences and Organized Interests in Health Policy: State Pharmacy Assistance Programs as Innovations. *Journal of Health Politics, Policy, and Law* 32(1): 89-129.
- Hacker, Jacob S. 1997. *The Road to Nowhere: The Genesis of President Clinton's Plan for Health Security*. Princeton, NJ: Princeton University Press.
- Hacker, Jacob S. 2001. Learning from Defeat? Political Analysis and the Failure of Health Care Reform in the United States. *British Journal of Political Science* 31(1): 61-94.
- Hacker, Jacob S. 2009. Yes We Can? The New Push for American Health Security. *Politics and Society* 37(1): 3-32.
- Hacker, Jacob S., and Theda Skocpol. 1997. The New Politics of U.S. Health Policy. *Journal of Health Politics, Policy, and Law* 22(2): 315-338.
- Hanson, Russell L. 1993. Defining a Role for the States in a Federal Health Care System. *American Behavioral Scientist* 36(6): 760-781.
- Heaney, Michael T. 2006. Brokering Health Policy: Coalitions, Parties, and Interest Group Influence. *Journal of Health Politics, Policy, and Law* 31(5): 887-944.
- Johnson, Haynes, and David S. Broder. 1996. *The System: The American Way of Politics at the Breaking Point*. Boston: Little, Brown and Company.
- Kingdon, John. 1984. *Agendas, Alternatives, and Public Policies*. Boston: Little, Brown and Company.
- Krehbiel, Keith. 1993. Where's the Party? *British Journal of Political Science* 23(2): 235-266.
- Marmor, Theodore R., and Jonathan Oberlander. 2004. Paths to Universal Health Insurance: Progressive Lessons from the Past for the Future. *University of Illinois Law Review* 205-230.
- Mashaw, Jerry L. 1993. The Case for State-Led Reform. *Domestic Affairs* 2(1): 1-22.
- Mayes, Rick. 2007. The Origins, Development, and Passage of Medicare's Revolutionary Prospective Payment System. *Journal of the History of Medicine* 62(1): 21-55.
- Oberlander, Jonathan. 2007. Through the Looking Glass: The Politics of the Medicare Prescription Drug, Improvement, and Modernization Act. *Journal of Health Politics, Policy, and Law* 32(2): 187-219.

- Oliver, Thomas R. 2004. Policy Entrepreneurship in the Social Transformation of American Medicine: The Rise of Managed Care and Managed Competition. *Journal of Health Politics, Policy, and Law* 29(4-5): 701-733.
- Oliver, Thomas R. 2006. The Politics of Public Health Policy. *Annual Review of Public Health* 27: 195-233.
- Oliver, Thomas R., Philip R. Lee, and Helene L. Lipton. 2004. A Political History of Medicare and Prescription Drug Coverage. *The Milbank Quarterly* 82(2): 283-354.
- Peterson, Mark A. 1993. Institutional Change and the Health Politics of the 1990s. *American Behavioral Scientist* 36(6): 782-801.
- Poole, Keith T., and Howard Rosenthal. 1997. *Congress: A Political-Economic History of Roll Call Voting*. Oxford: Oxford University Press.
- Rohde, David W. 1991. *Parties and Leaders in the Postreform House*. Chicago: University of Chicago Press.
- Ruger, Jennifer Prah. 2007. Health, Health Care, and Incompletely Theorized Agreements: A Normative Theory of Health Policy Decision Making. *Journal of Health Politics, Policy, and Law* 32(1): 51-87.
- Shipan, Charles R., and Craig Volden. 2006. Bottom-Up Federalism: The Diffusion of Antismoking Policies from U.S. Cities to States. *American Journal of Political Science* 50(4): 825-843.
- Skocpol, Theda. 1996. *Boomerang: Clinton's Health Security Effort and the Turn Against Government in U.S. Politics*. New York: Norton.
- Squire, Peverill. 1992. Legislative Professionalism and Membership Diversity in State Legislatures. *Legislative Studies Quarterly* 17(1): 69-79.
- Steinmo, Sven, and Jon Watts. 1995. It's the Institutions, Stupid! Why Comprehensive National Health Insurance Always Fails in America. *Journal of Health Politics, Policy, and Law* 20(2): 329-372.
- Stream, Christopher. 1999. Health Reform in the States: A Model of State Small Group Health Insurance Market Reforms. *Political Research Quarterly* 52(3): 499-525.
- Swers, Michelle L. 2005. Connecting Descriptive and Substantive Representation: An Analysis of Sex Differences in Cosponsorship Activity. *Legislative Studies Quarterly* 30(3): 407-433.
- Volden, Craig, and Alan E. Wiseman. 2009. Legislative Effectiveness in Congress. Manuscript, The Ohio State University.

- Wainess, Flint J. 1999. The Ways and Means of National Health Care Reform, 1974 and Beyond. *Journal of Health Politics, Policy, and Law* 24(2): 305-333.
- Walker, Jack L. 1974. Performance Gaps, Policy Research, and Political Entrepreneurs. *Policy Studies Journal* 3(1): 112-116.
- Weissert, Carol S., and Daniel Scheller. 2008. Learning from the States? Federalism and National Health Policy. *Public Administration Review* 68(S): S162-S174.
- West, Darrell M., Diane Heith, and Chris Goodwin. 1996. Harry and Louise Go to Washington: Political Advertising and Health Care Reform. *Journal of Health Politics, Policy, and Law* 21(1): 35-68.
- White, Joseph. 1995. Budgeting and Health Policymaking. In *Intensive Care: How Congress Shapes Health Policy*, eds. Thomas E. Mann and Norman J. Ornstein. Washington, DC: American Enterprise Institute and Brookings Institution.

Table 1: Determinants of Legislative Effectiveness

	Model 1: Overall LES	Model 2: Health ILES
Lagged Effectiveness Score	0.521*** (0.033)	0.755*** (0.078)
Seniority	0.091*** (0.015)	0.075 (0.052)
Seniority ²	-0.004*** (0.001)	-0.006** (0.003)
State Legislative Experience	-0.049 (0.067)	0.088 (0.293)
State Legislative Experience × Legislative Prof.	0.284 (0.205)	0.523 (1.023)
Majority Party	0.601*** (0.049)	0.665*** (0.230)
Majority Party Leadership	-0.278* (0.150)	-0.093 (0.367)
Minority Party Leadership	-0.109 (0.090)	0.181 (0.247)
Speaker	-0.129 (0.176)	1.884 (1.953)
Committee Chair	1.713*** (0.193)	0.783* (0.458)
Power Committee	-0.215*** (0.040)	-0.232** (0.097)
Distance from Median	0.015 (0.103)	0.301 (0.421)
Female	0.108** (0.047)	0.223 (0.154)
African-American	-0.329*** (0.070)	-0.594*** (0.188)
Latino	-0.116** (0.054)	-0.563*** (0.150)
Size of Congressional Delegation	-0.0002 (0.0016)	-0.003 (0.004)
Vote Share	0.022* (0.012)	0.003 (0.053)
Vote Share ²	-0.00014* (0.00008)	0.00003 (0.00037)
Constant	-0.965** (0.449)	-0.760 (1.878)
N	5026	5026
Adjusted-R ²	0.55	0.52

Robust standard errors in parentheses, observations clustered by member.
* p < 0.1 (two-tailed), ** p < 0.05 (two-tailed), *** p < 0.01 (two-tailed).

Table 2: Robustness Checks of Regression Results

	Model 3: Logged ILES	Model 4: Modified Weights
Lagged Dependent Variable	0.504*** (0.053)	0.734*** (0.097)
Seniority	0.012* (0.007)	0.111* (0.062)
Seniority ²	-0.0007 (0.0004)	-0.008** (0.003)
State Legislative Experience	-0.023 (0.030)	0.135 (0.341)
State Legislative Experience × Legislative Prof. Majority Party	0.079 (0.098)	0.601 (1.168)
Majority Party Leadership	0.104*** (0.020)	0.708*** (0.262)
Minority Party Leadership	-0.036 (0.078)	-0.229 (0.317)
Speaker	-0.025 (0.057)	0.211 (0.304)
Committee Chair	0.364 (0.402)	3.382 (3.043)
Power Committee	0.135** (0.061)	0.895 (0.558)
Distance from Median	-0.015 (0.017)	-0.310*** (0.117)
Female	0.105** (0.052)	0.210 (0.502)
African-American	0.138*** (0.034)	0.124 (0.168)
Latino	-0.112*** (0.028)	-0.641*** (0.220)
Size of Congressional Delegation	-0.124*** (0.022)	-0.617*** (0.181)
Vote Share	0.0005 (0.0006)	0.004 (0.004)
Vote Share ²	0.011** (0.005)	-0.006 (0.068)
Constant	-0.00006* (0.00004)	0.0001 (0.0005)
	-0.465** (0.184)	-0.520 (2.382)
N	5026	5026
Adjusted-R ²	0.26	0.47

Robust standard errors in parentheses, observations clustered by member.

* p < 0.1 (two-tailed), ** p < 0.05 (two-tailed), *** p < 0.01 (two-tailed).

Table 3: Determinants of Health Interest and Effectiveness

	Model 5: Tobit	Model 6: Logit	Model 7: Positive ILES
Lagged Effectiveness Score	0.810*** (0.067)	---	0.774*** (0.069)
Seniority	0.369*** (0.133)	0.158*** (0.031)	0.070 (0.110)
Seniority ²	-0.022** (0.009)	-0.008*** (0.002)	-0.006 (0.006)
State Legislative Experience	-0.329 (0.691)	-0.110 (0.166)	0.375 (0.641)
State Legislative Experience × Legislative Prof.	1.673 (2.064)	0.170 (0.485)	0.785 (2.050)
Majority Party	1.497* (0.506)	0.192* (0.098)	1.412*** (0.475)
Majority Party Leadership	-2.151 (1.562)	-0.830** (0.371)	1.228 (1.626)
Minority Party Leadership	-1.529 (1.490)	-0.702* (0.399)	0.793* (0.439)
Speaker	1.336 (5.314)	-0.662 (0.978)	9.826*** (1.647)
Committee Chair	1.188 (0.823)	0.046 (0.192)	1.699** (0.845)
Power Committee	0.248 (0.311)	-0.189* (0.099)	-0.561*** (0.213)
Distance from Median	2.159** (1.049)	0.456* (0.255)	0.113 (0.786)
Female	2.535*** (0.507)	0.821*** (0.152)	0.187 (0.236)
African-American	-1.976** (0.785)	-0.512** (0.235)	-1.088** (0.427)
Latino	-2.436** (1.142)	-0.748** (0.330)	-1.196*** (0.326)
Size of Congressional Delegation	0.018 (0.012)	0.006* (0.003)	0.003 (0.007)
Vote Share	0.019 (0.105)	0.019 (0.021)	-0.027 (0.108)
Vote Share ²	0.00001 (0.00072)	-0.00009 (0.00014)	0.0003 (0.0008)
Constant	-8.672** (3.970)	-1.894** (0.760)	0.150 (3.828)
N	5026	6367	2380
F(18, 5008)	13.91***		
$\chi^2(17)$		112.5***	
Adjusted-R ²			0.54

Robust standard errors in parentheses, observations clustered by member.
* p < 0.1 (two-tailed), ** p < 0.05 (two-tailed), *** p < 0.01 (two-tailed).

Figure 1: Percent of Bills Introduced that Become Law

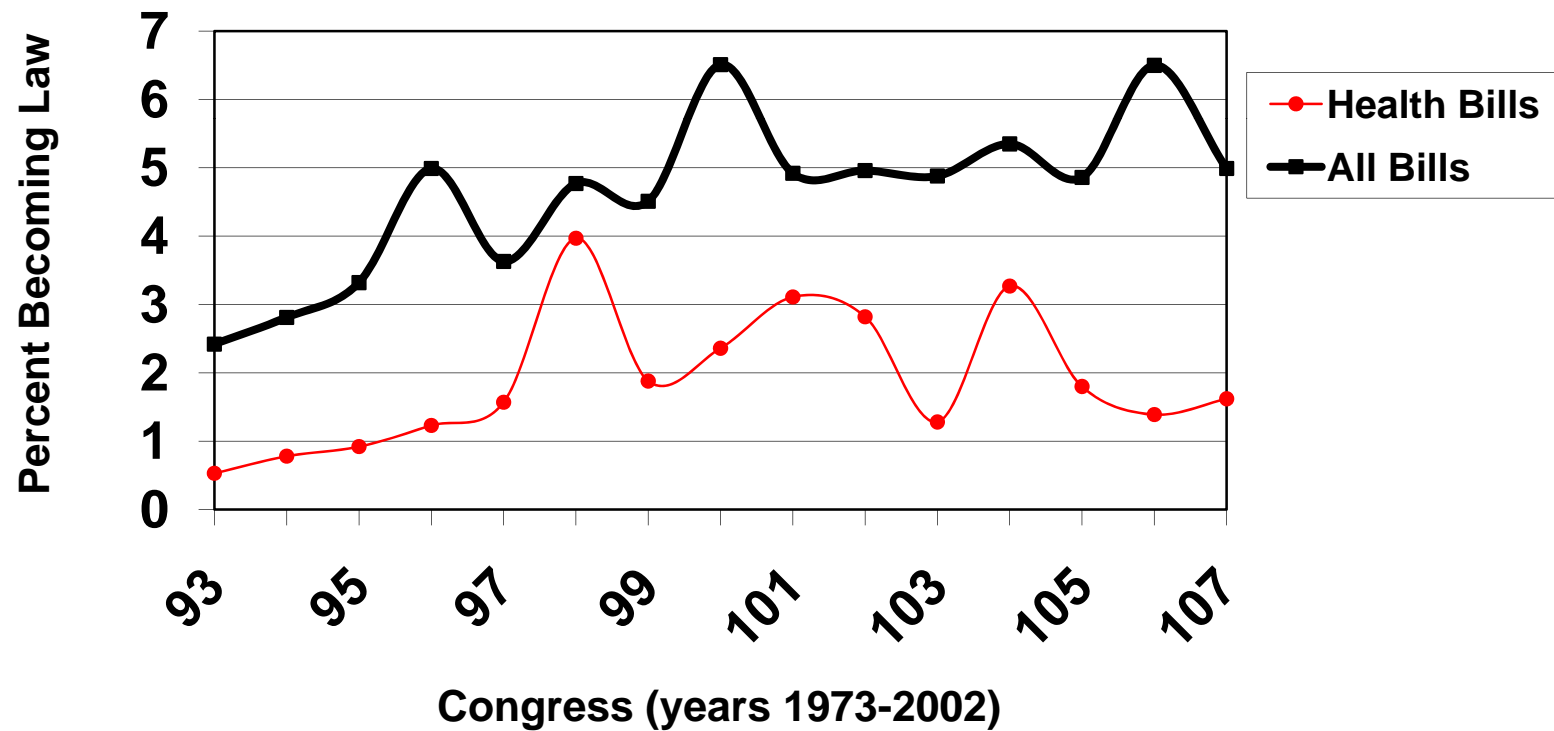


Figure 2: Percent of Substantively Significant Bills that Become Law

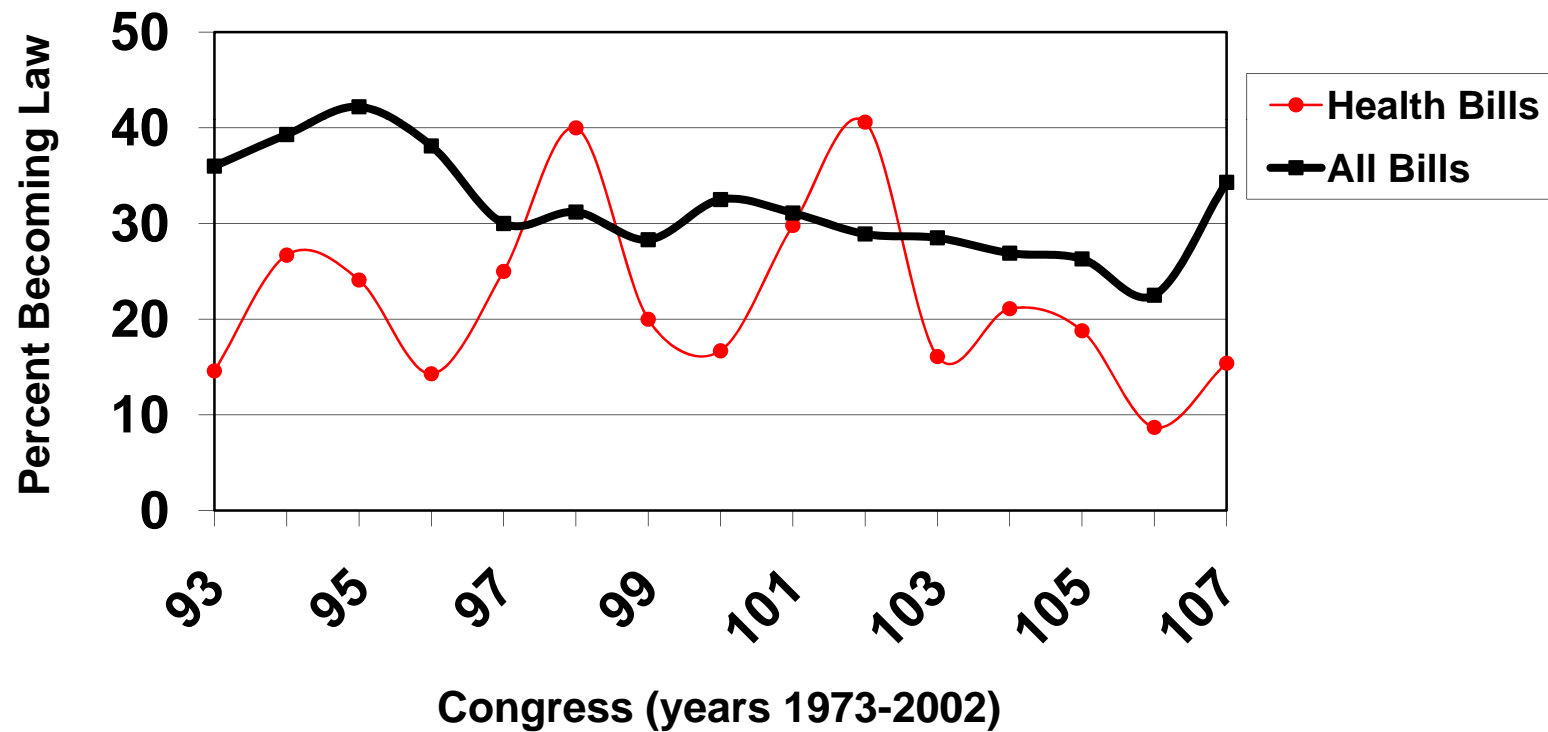


Figure 3: Percent of Bills Introduced that Reach House Floor

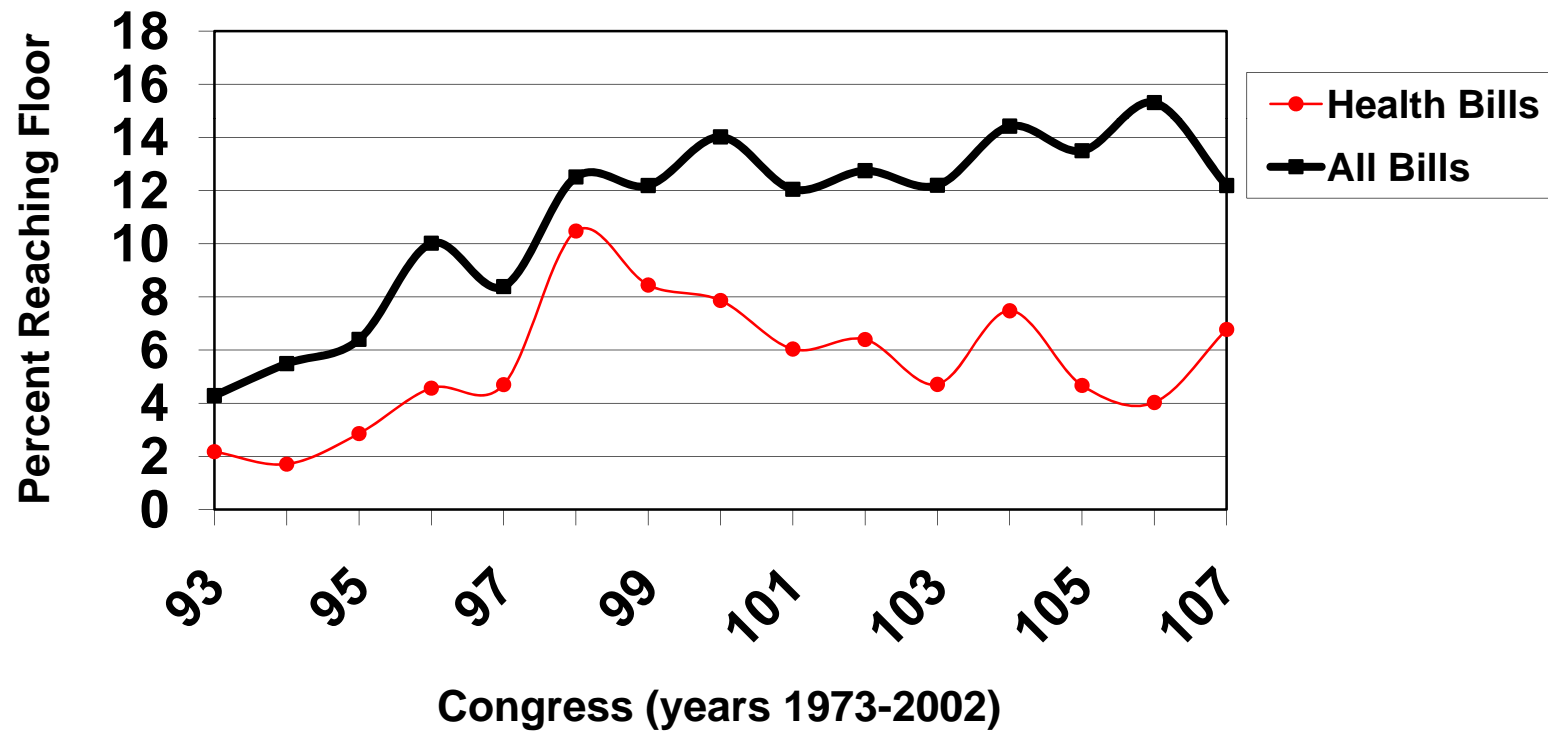


Figure 4: Percent of House-Passed Bills that Become Law

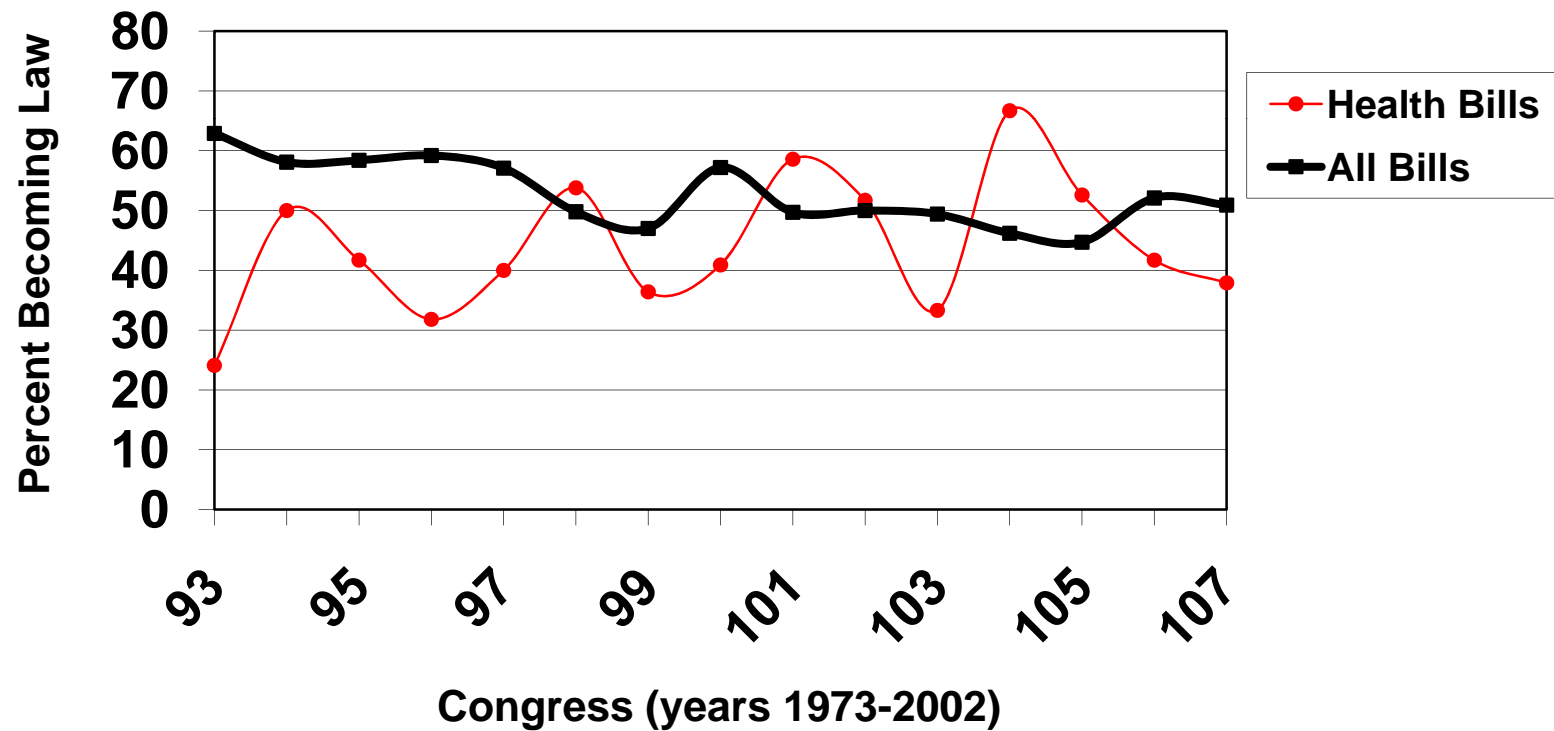


Figure 5: Percent of Members Proposing Health Policy Bills

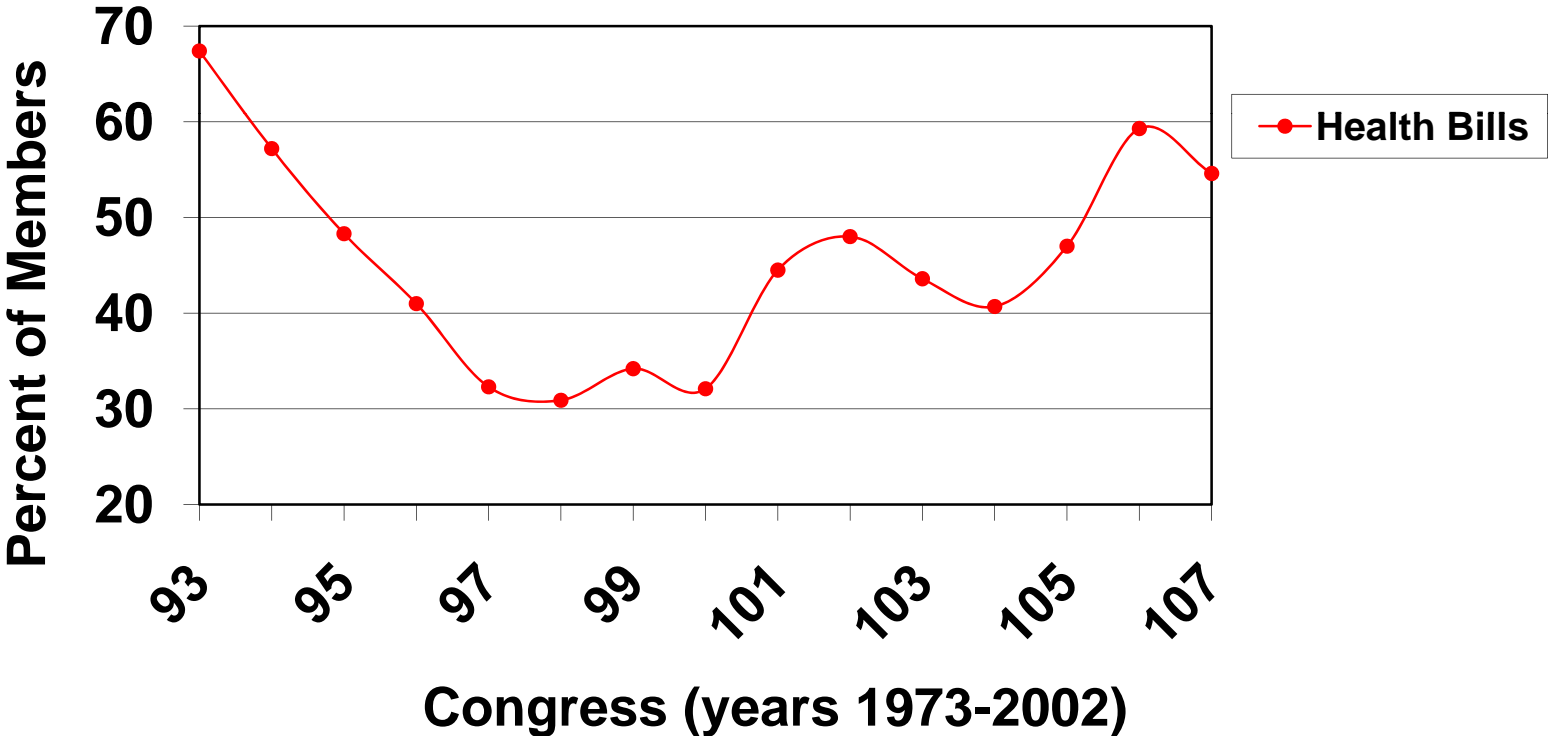


Figure 6: Percent of Bills Introduced by Extremist Quartiles

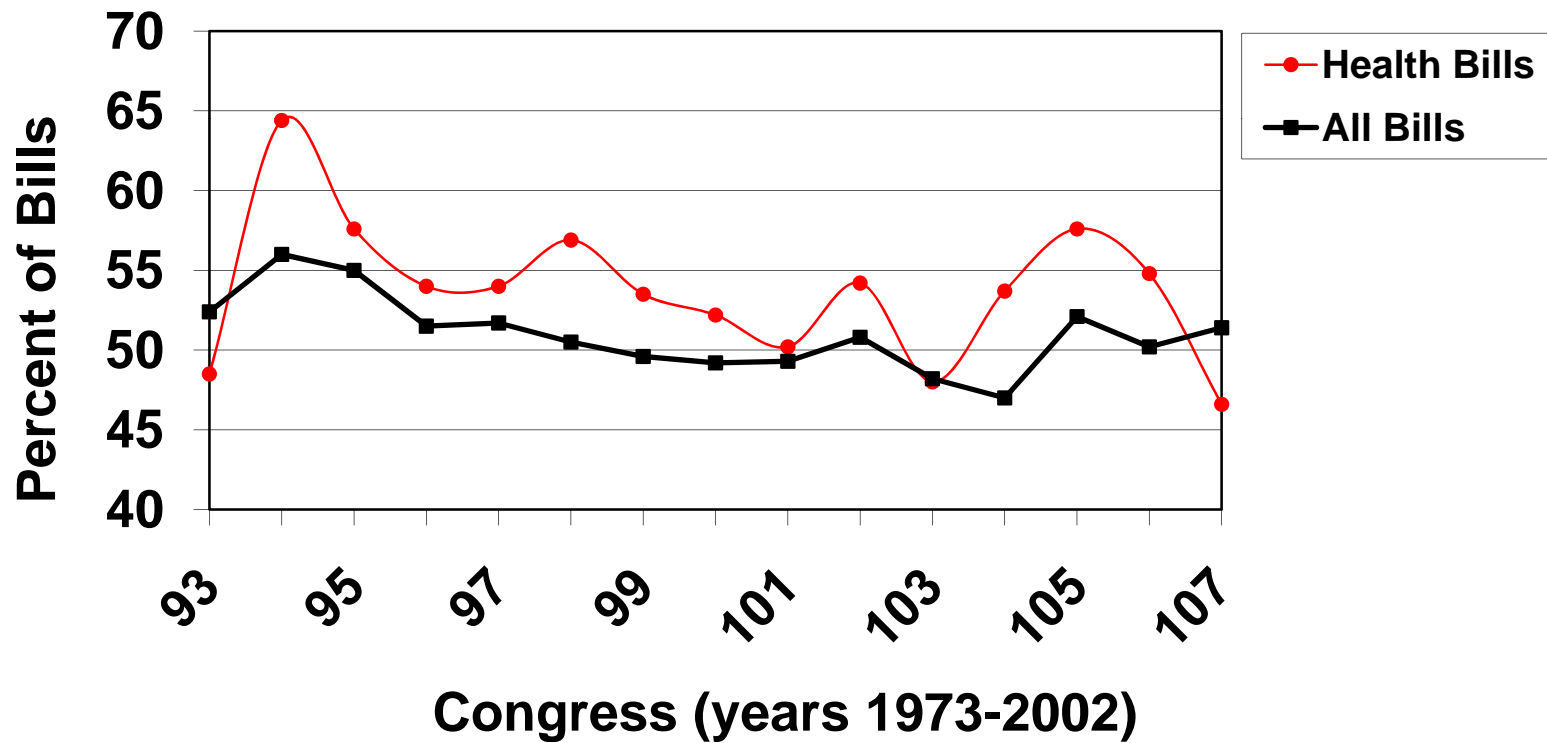


Figure 7: Two Policy Entrepreneurs

