

# Breaking Gridlock: The Determinants of Health Policy Change in Congress

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**Abstract** Prior to the 2010 health care reforms, scholars often commented that health policy making in Congress was mired in political gridlock, that reforms were far more likely to fail than to succeed, and that the path forward was unclear. In light of recent events, new narratives are being advanced. In formulating these assessments, scholars of health politics tend to analyze individual major reform proposals 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 these proposals through Congress. Setting these proposed policies against a baseline of policy advancements in other areas, we demonstrate that health policy making has indeed been far more gridlocked than policy making in most other areas. We then isolate some of the causes of this gridlock, as well as some of the conditions that have helped to bring about health policy change.

The early days of the Barack Obama administration brought a vibrant debate regarding the prospects for health care reform. In trying to understand the dimensions of the debate, scholars and practitioners alike found themselves drawing lessons from the past in order to make predictions

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about the future. Focusing mainly on the politics of congressional policy making, these authors noted the similarities and differences between the current proposals and past successes or failures of national health policy reforms. The most common story line that emerged was a narrative of why the Clinton health plan of the early 1990s failed and why various contemporary proposals were likely to meet the same fate (or, somehow, overcome earlier obstacles). Upon passage of the Patient Protection and Affordable Care Act (Pub. L. 111-148) and the subsequent Health Care and Education Reconciliation Act (Pub. L. 111-152) in March 2010, commentators turned quickly to assign credit to President Obama, Speaker of the House Nancy Pelosi (D-CA), and others, while striking comparisons to earlier failures at achieving reform on the same scale.

That interested observers and participants in the health care debate would draw lessons from the past in this manner is not surprising. The substantive importance of health policy and the illustrative nature of health politics for understanding congressional policy making have 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 by a wide range of scholars (e.g., Hacker 1997; Johnson and Broder 1996; and Skocpol 1996, among many others). Two possible reasons this plan has received such attention are its scope and its ultimate demise. Other health policy reforms, however, have likewise been analyzed in significant detail, such as the 1974 national health insurance proposals (e.g., Wainess 1999) and the 2003 prescription drug expansion of Medicare (e.g., Oberlander 2007; Oliver, Lee, and Lipton 2004).<sup>1</sup> A wave of scholarly assessments of the 2010 reforms is surely on its way.

While such narratives are valuable and may lead to a better understanding of health politics, Hacker (2001) reminds scholars to be cautious in taking lessons from a limited set of political events, as any such lessons are bound to be narrowly drawn. Building on this point, we argue that such narratives alone cannot produce a much-needed, broad, and evidence-based understanding of the congressional politics surrounding health policy making. In particular, we note that, beyond the handful of proposals that have received all 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

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

introduced in the U.S. House of Representatives between 1973 and 2002, and the variance in how well the bills' sponsors navigated the lawmaking labyrinth, we are able to contribute to 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 noting that legislative inaction is common in all policy areas, not just over issues of public health (e.g., Brady and Volden 1998). Is there reason to believe 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 policy making 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 not dealing with health that were introduced in the same time period. This approach makes us uniquely positioned to explore whether health policy making in 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 has been 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 bringing about change in health policy 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 forgo 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 policy making. These and other considerations may be best studied in case-by-case bill examinations, which we neglect in looking for more aggregate patterns.<sup>2</sup> We are therefore in no way 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 policy making, 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 policy making, 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.

The first such hypothesis addresses the concept of “policy gridlock,” which ostensibly occurs when (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. Many observers of congressional health policy making suggest 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, as Binder (2003), Brady and Volden (1998), and numerous other political scientists have offered theories of gridlock in Congress. Yet health policy scholars seem to be suggesting that such gridlock is particularly profound in areas of public

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, although we think such an analysis would also be immensely valuable. Throughout the article, therefore, we use the term *Congress* to refer to the institution over each two-year period and to its activities related to bills originated in the U.S. House of Representatives, rather than looking at each session of Congress separately (one-year period) or at the Senate specifically (beyond the fate of House bills that reach the Senate). As such, we are adopting the meaning of *Congress* frequently used in legislative studies.

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 sometimes be *overcome*. 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; 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, ensure that programs like comprehensive national health insurance will always fail in America.<sup>3</sup> Thus we seek to explore the next hypothesis.

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

Despite providing the potential for gridlock, these institutional impediments could easily be overcome if all policy makers and the American public shared a common view of problems and their ideal solutions. The reason these institutions matter, however, is that the preferences 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,<sup>4</sup> which suggests either that there is no middle ground for health policy reform or that reform pro-

3. As Steinmo and Watts (1995) succinctly argue, "It's the Institutions, Stupid!" Brady and Kessler (2010) offer a somewhat similar set of arguments in comparing the Clinton and Obama health care reform strategies.

4. Brady and Buckley (1995), for example, examine the preferences 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 sixty-vote threshold needed to end a Senate filibuster. Bristol (2006: 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 have been even more pronounced since 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 extend not only across political parties but also to different camps within organized labor.

posals are instead coming from the more extreme and divisive actors in American 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 policy making in Congress, paint a bleak picture of the prospects for policy change. Yet as we suggested 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. And mere moments after the historic Patient Protection and Affordable Care Act was finally passed in March 2010, the House of Representatives voted to modify its policies in the Health Care and Education Reconciliation Act. All of these subsequent proposals, whether following the failure or the success of major health care overhauls, passed in one form or another. In the next several hypotheses, we consider the conditions that enhance the prospects for both major and minor policy change.

First, 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 the making of health policy these entrepreneurs are considered to be especially crucial because health policy is so complex and reform proposals tend to be quite contentious (e.g., Oliver 2004), which motivates the next hypothesis.<sup>5</sup>

*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,

5. Such entrepreneurs might be members of Congress who act through their formal institutional positions (e.g., Wilbur D. Mills, as described in Wainess 1999) or their informal connections (e.g., the members of the Diabetes Caucus, as examined in Burgin 2003). Alternatively, health policy entrepreneurs can emerge from outside Congress, such as interest groups that serve as policy brokers (Heaney 2006).

yet in the health politics literature there has been much debate about whether majority party influence is more effective than bipartisan coalition building in achieving policy change. Such debates occurred openly throughout 2009 and into 2010 as analysts discussed the recent reforms. Many political scientists have argued that party and committee leaders can (at least sometimes) 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 (e.g., Marmor and Oberlander 2004; Hacker 2009; Oliver, Lee, and Lipton 2004) have often claimed that party leaders are instrumental in influencing changes in health policy, motivating the next hypothesis.<sup>6</sup>

*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), which suggests that proposals at or near the middle of the ideological spectrum have the greatest chance of legislative success because attempts to modify such proposals would not gain sufficient support from the right or left halves of the legislature to pass. 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 unless such moderate proposals both exist and are preferred over the existing status quo health policies, failure is inevitable (e.g., Brady and Buckley 1995).<sup>7</sup> Thus we also explore the following hypothesis, which in many ways is contrary to the partisan leadership hypothesis:

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

6. More specifically, Marmor and Oberlander (2004: 226–227) 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: 3) reaffirms this stance, referring to the inevitable failure that follows from relying on “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.

7. Ferguson, Fowler, and Nichols (2008) suggest that while such moderate reform proposals may still lead to fairly partisan voting patterns, they might also serve as the basis for bipartisan coalition building.

One reason that leadership and legislative strategy are ostensibly so crucial in health policy making 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; and Skocpol 1996, all 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, which motivates the next 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 policy making demands new ideas, rather than just the same old proposals coming from longtime participants in health policy debates. Scholars of health policy making 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 will rise to national prominence and possibly to federal adoption, which leads to the following hypothesis.<sup>8</sup>

*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 policy making. Due to significant institutional constraints and diverse preferences, health policy making 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 develop-

8. Such diffusion has received mixed or conditional empirical support (e.g., Boeckelman 1992; Shipan and Volden 2006), and while there are similar limitations on vertical policy diffusion specific to health policy making (e.g., Hanson 1993; Weissert and Scheller 2008), there remain compelling accounts of specific state experiences that have been crucial to the development of national health policies (e.g., Mayes 2007).



ment of moderate proposals built on new ideas and refined by experts. While formidable, this vision of reform seems to contain certain grains of truth, 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 that have been advocated in Congress over the past four decades.

### **Empirical Approach**

There may be many ways to assess the veracity of the hypotheses developed above. Here we build on the approach outlined in Volden and Wiseman (2009), in which we examine every bill introduced in the U.S. House of Representatives over the past thirty-five 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 he or she sponsors, 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 only to examine all congressional bills together but also to explore the subset of bills 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 gridlock in health policy 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 policy change.

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.

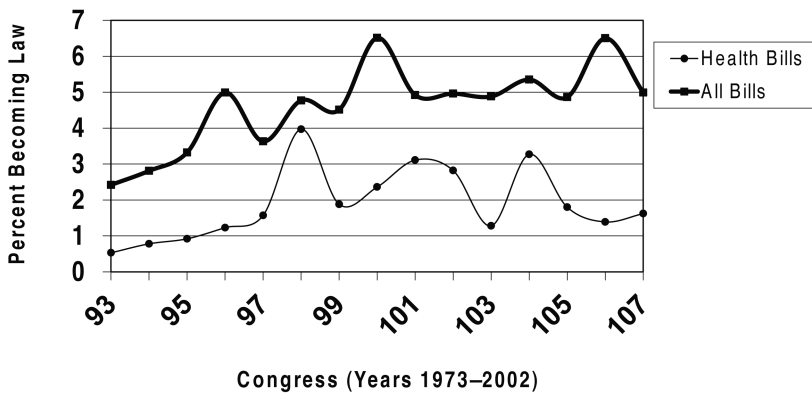
## Aggregate Patterns

Between the 93rd Congress (1973–1974) and the 107th Congress (2001–2002), members of the House of Representatives introduced 119,040 public bills (assigned an H.R. number). Of those, 9,740 (or 8.2 percent) dealt mainly with issues of health, as opposed to other policy areas. A bill is deemed a “health bill” if it is identified as being in the health policy area in Scott Adler and John Wilkerson’s Congressional Bills Project, a database that codes all congressional legislation according to substantive focus.<sup>9</sup> 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*.<sup>10</sup>

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 policy making. 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 percent (or a gridlock rate of 95.9 percent). It is clearly difficult for a bill to become a law; but given this low overall conversion rate, one wonders whether there is something

9. We begin with the 93rd Congress because this is the earliest Congress for which bill details are listed on the Library of Congress’s THOMAS Web site. We end with the 107th Congress because this is the last Congress for which the bills are coded by issue area according to Adler and Wilkerson’s Congressional Bills Project, relying on issue coding from Frank Baumgartner and Bryan Jones’s Policy Agendas Project, which categorizes legislation into one of 19 major topics and 225 subtopics.

10. It is possible that the *Congressional Quarterly Almanac* may exclude substantively significant legislation that is unlikely to advance through the legislative process or may include politically interesting legislative battles on bills that would not bring about major policy changes. However, this coding scheme likely strikes a useful middle ground between focusing on too few pieces of legislation (e.g., the Mayhew 1991 list of important laws includes only those bills that were signed into law and were later deemed historically important), or too many items of legislation (e.g., all noncommemorative bills). By employing the *Congressional Quarterly Almanac* list, we can identify a range of substantively important bills that did not achieve legal passage (thereby expanding the scope of bills beyond the types considered by Mayhew), while still providing for some meaningful discrimination among noncommemorative legislation. See Volden and Wiseman (2009) for more on the coding scheme used and the nature of the data-gathering process.



**Figure 1** Percent of Bills Introduced That Become Law

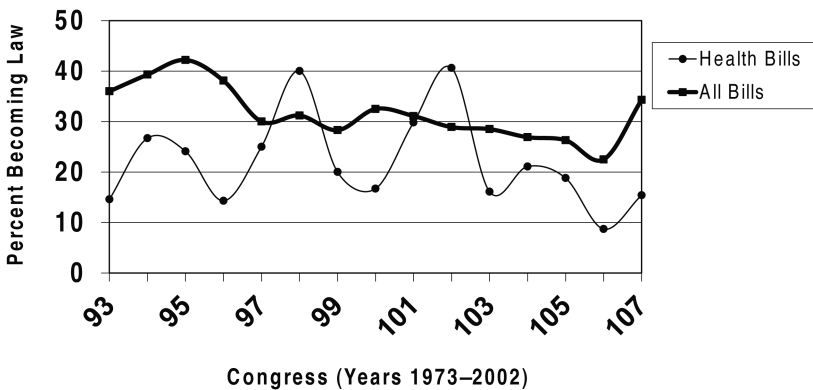
*Source:* Values calculated by authors (Library of Congress)

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 percent, less than half the rate for other policy areas.<sup>11</sup>

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. Second, there seems to be an upward trend, at least through the 1970s and early 1980s, indicating that the legislature's ability to manage its massive workload may have improved.

Although this overall portrait is interesting, health policy scholars are typically less interested in the most minor health policy changes; rather, they pay much more attention to major reforms. Given our coding scheme, we can likewise narrow our focus to the bills of substantive significance, as defined above. When we focus solely on substantively significant bills, policy gridlock again emerges, although at nowhere near the levels found for the minor and commemorative bills that Congress routinely just dismisses. Of the full 6,020 substantively significant bills introduced between 1973 and 2002, 1,931 became law, for a conversion rate of 32.1 percent (meaning that more than two-thirds fell victim to gridlock even

11. 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 percent confidence ( $p < 0.001$ ).



**Figure 2** Percent of Substantively Significant Bills That Become Law

Source: Values calculated by authors (Library of Congress)

though they were 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 percent conversion rate.<sup>12</sup> Although the difference between health and nonhealth 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 other bills, all else being equal. These conversion rates are illustrated over time in figure 2.

As shown in figure 2, with the exception of the 98th and 102nd Congresses, health bills were always gridlocked at a greater rate than other bills.<sup>13</sup> The other interesting feature in this figure is that both health and

12. These differences are also statistically significant ( $p < 0.001$ ). A quick perusal of the fifty-five nonsubstantively significant bills that became law reveals that they are substantively similar in focus to many of the bills that received attention in the *Congressional Quarterly Almanac*, the differences being that many of these fifty-five bills provided for either geographically targeted benefits (such as H.R. 2018 in the 105th Congress [1997–1998], a bill “to waive temporarily the Medicaid enrollment composition rule for the Better Health Plan of Amherst, New York”), the temporary extension of existing appropriations, or administrative deadlines (such as H.R. 2156 in the 97th Congress [1981–1982], which extended the amount of time for which previously appropriated funds for medical schools could be extended, or H.R. 3323 in the 107th Congress [2001–2002], which extended deadlines for health care providers to comply with various aspects of the Social Security Act), or other relatively noncontroversial measures (such as, in the 104th Congress, H.R. 2508, the Animal Drug Availability Act of 1996).

13. 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.

**Table 1** Gridlock by Issue Area (93rd–107th Congresses)

Issue Area	Bills Introduced	Laws Enacted	Success Rate (%)
Agriculture	4,062	126	3.10
Banking and commerce	7,665	230	3.00
Civil rights and liberties	2,715	51	1.88
Defense	7,446	331	4.45
Education	4,200	98	2.33
Energy	5,125	129	2.52
Environment	5,262	197	3.74
Foreign trade	5,354	124	2.32
Government operations	13,658	952	6.97
Health	9,740	154	1.58
Housing and community development	2,800	49	1.75
International affairs	2,739	177	6.46
Labor, employment, and immigration	6,987	131	1.87
Law, crime, and family	7,185	186	2.59
Macroeconomics	5,295	102	1.93
Public lands	8,693	905	10.41
Science and technology	2,126	93	4.37
Social welfare	6,305	84	1.33
Transportation	5,746	224	3.90

*Source:* Values calculated by authors (Library of Congress)

nonhealth conversion rates decline toward gridlock over time, at least in more recent congressional sessions. 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.

Tables 1 and 2 show these aggregate bill success rates across all sessions of Congress, relative to other issue areas, and broken down by subcategories within the health issue area.<sup>14</sup> As can be seen in table 1, not only is health policy making subject to gridlock at a rate exceeding that for all bills on average, but only social welfare policy proposals have a lower chance of passage than health proposals. Table 2 lists the various types of

14. We rely once again on the coding of Adler and Wilkerson's Congressional Bills Project.

**Table 2** Gridlock by Health Subcategories (93rd–107th Congresses)

Health Issue Area	Bills	Laws	Success
	Introduced	Enacted	Rate (%)
Insurance reform, availability, and cost	1,145	14	1.22
Facilities	960	10	1.04
Long-term care	847	6	0.71
Multiple benefits and procedures	842	6	0.71
Regulation of drugs, devices, and labs	805	18	2.24
Comprehensive health care reform	645	19	2.95
Provider payment and regulation	567	10	1.76
Research and development	542	10	1.85
Infants and children	446	8	1.79
Prevention and communicable diseases	437	4	0.92
Manpower and training	415	11	2.65
Tobacco abuse, treatment, and education	327	6	1.83
Mental health and retardation	242	2	0.83
Prescription drug coverage and cost	237	0	0.00
General health issues	232	8	3.45
Medical liability, fraud, and abuse	223	6	2.69
Controlled and illegal drugs	130	5	3.85
Alcohol abuse and treatment	109	0	0.00
Substance abuse treatment	45	1	2.22

*Source:* Values calculated by authors (Library of Congress)

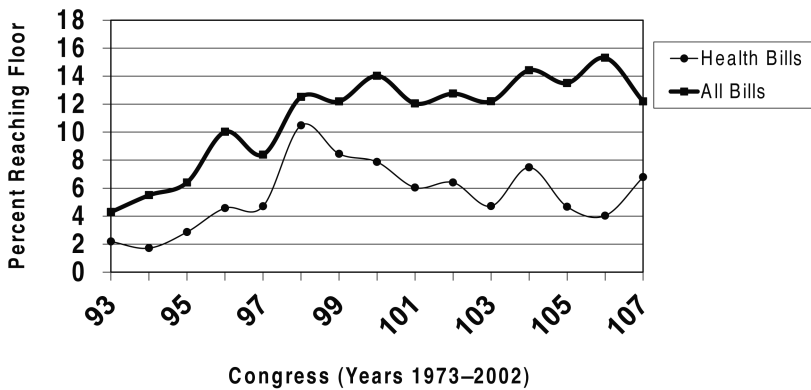
health legislation proposed in Congress, organized from most bills introduced to least.<sup>15</sup> While there is clearly some variance in success rates across these categories, it is noteworthy that *none* of the subcategories of health bills have a greater success rate than that of the average nonhealth bill introduced in the House.<sup>16</sup>

One suggested cause of gridlock in the area of health policy, 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 explore this hypothesis, we isolated the course of each bill's progress into different stages from introduction to ultimate enactment.

First, consider whether bills that were introduced died in committee or

15. The total numbers in these subcategories differ from the overall health issue bills and laws, as a small number of bills were not coded in any of these nineteen health subcategories.

16. In subcategories where no successful enactments are listed ("prescription drug coverage and cost" and "alcohol abuse and treatment"), policy change may still have come about through bills in broader categories such as "comprehensive health care reform."



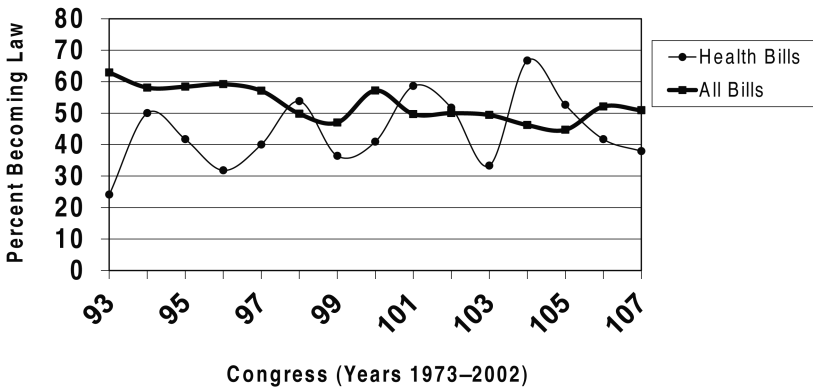
**Figure 3** Percent of Bills Introduced That Reach the House Floor

Source: Values calculated by authors (Library of Congress)

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 percent 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 percent (451 of the 9,740 health bills found their way to the House floor).<sup>17</sup> 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 both for health bills and for 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 increased gridlock of health policy making. Although such aggregate analyses cannot offer explanations for *why* health bills are particularly likely to die in committee, these results should encourage students of health politics to pay more 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 percent of all substantively significant bills reach the floor of the House, that rate for health bills is 66.7 percent.<sup>18</sup>

17. This difference between health and nonhealth bills is statistically significant ( $p < 0.001$ ).

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



**Figure 4** Percent of House-Passed Bills That Become Law

*Source:* Values calculated by authors (Library of Congress)

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 passed the House over our time period, only 4,910 found their way through the Senate and gained the president's approval.<sup>19</sup> Thus 46.7 percent of all House-passed bills fall victim to bicameralism and separation-of-powers institutions. Of the health bills, 349 passed the House and 154 became law, indicating that 55.9 percent died due to House-Senate differences or the presidential veto.<sup>20</sup> The rate of conversion from House-passed bills into law is shown for 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 nonhealth bills arises from the first five Congresses in our dataset. From the early 1980s on, there are few discernible 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

19. We do not separate out presidential vetoes in this analysis. While the veto is an important institution, the number of vetoes is very small relative to the total number of bills reaching the president's desk and thus does 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 the president's ability to alter the content of bills based on veto threats and other forms of persuasion.

20. Once again, this is a statistically significant difference for health policy making ( $p < 0.001$ ).



enactment on passing the House from about 60 percent in the 1970s and early 1980s to about 50 percent 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 percent for all bills and 40.7 percent in the area of health policy, once again indicating the institutional basis for a difference in success rates for health policy reforms.<sup>21</sup>

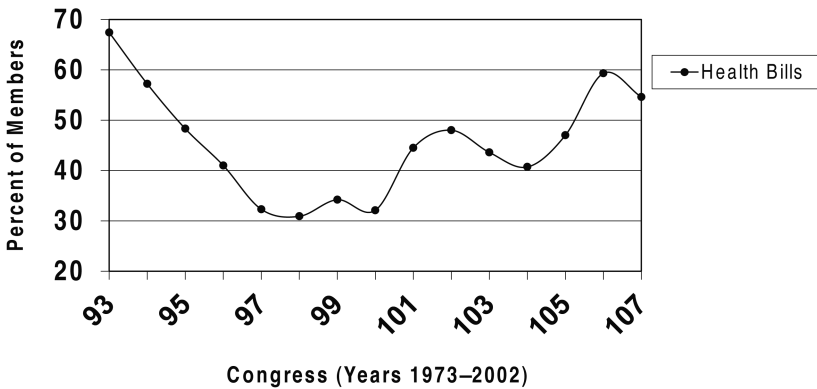
Taken together, these results are highly consistent with the institutional gridlock hypothesis. Health bills clearly die in committee and fail to achieve bicameral support at a greater level than do bills in other policy areas.

Beyond these institutional considerations, the polarized politics hypothesis suggests a further reason for policy gridlock—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 progovernment 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 are 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.

Figure 5 presents the percentage of members of Congress who introduce at least one bill on health policy.<sup>22</sup> On average, 47.4 percent 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, therefore 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 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 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 health policy agenda.

21. The health v. nonhealth difference in such success rates is statistically significant ( $p < 0.01$ ).

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



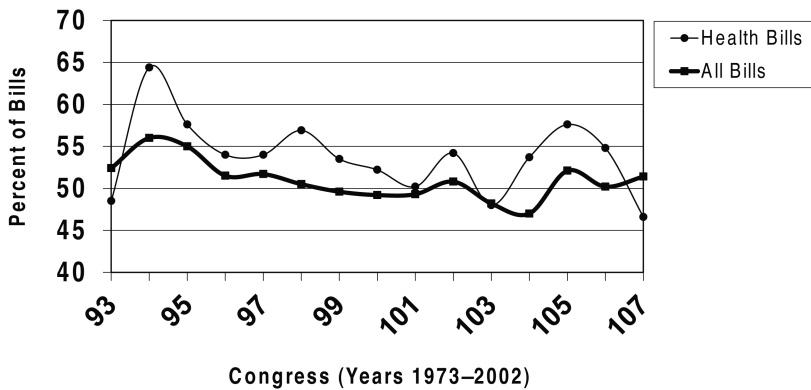
**Figure 5** Percent of Members Proposing Health Policy Bills

*Source:* Values calculated by authors (Library of Congress)

Moreover, we can assess the ideological bent of the members who are making the bulk of the 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 and most liberal quartiles versus the two more moderate quartiles. If the polarized politics hypothesis is correct, significantly more than 50 percent 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 percent are introduced by these two extremist quartiles. For health bills, this rate is 53.7 percent. These statistically significant differences ( $p < 0.001$ ) are visible in figure 6, where, except in the 93rd and 107th Congress, extremists introduce at least as great a percentage of health bills as they do for all other bills. For example, in the 106th Congress, 55 percent of all health bills were introduced by extremists, whereas extremists introduced 50 percent of the bills in all other policy areas.

Also worth mentioning is that both lines tend to be declining over time; they reach about 50 percent 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.<sup>23</sup> Moreover, the differences between the extremist introduction rates on health bills compared to other

23. Of course, the members in these outer quartiles may be more extreme liberals and more extreme conservatives today than they were in earlier Congresses. Here we are merely exploring whether those with more extreme preferences dominate the policy debates, at least in terms of introducing bills in Congress.



**Figure 6** Percent of Bills Introduced by Extremist Quartiles

*Source:* See source list in appendix

bills are substantively small. Even if all extremists' bills were dead on arrival into the House (which is far from true), 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 percent of substantively significant health bills, but only 48.8 percent of all substantively significant bills, were introduced by the extremist quartiles. 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 made only by a few highly polarized members of Congress. Nevertheless, some evidence does support the polarized politics hypothesis: fewer than half of all members make health policy proposals, and those proposals do come in slightly greater numbers 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 or less likely to become the basis for changes in American national health policy.

To do so, we follow the method we used in constructing member-by-member LESs (Volden and Wiseman 2009). In that work, we looked at 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 based on the member's share of all bills introduced in the Congress (or all bills introduced on health policy), as well as his or her 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 an LES for each member  $i$  in 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*, such as hearings (*AIC*), (3) receiving *action beyond committee*, such as a floor vote (*ABC*), (4) passing the House (*PASS*), and (5) becoming law (*LAW*), relative to all  $N$  legislators.<sup>24</sup> Within each of these five terms, commemorative bills (C superscript) are weighted by  $\alpha$ , substantive bills (S superscript) by  $\beta$ , and substantively significant bills (SS superscript) by  $\gamma$ . The overall weighting of  $N/5$  normalizes the average LES to take a value of 1 in each Congress. Following the method used in Volden and Wiseman (2009), we use a

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

weighting of  $\alpha = 1$ ,  $\beta = 5$ , and  $\gamma = 10$  to capture the 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.

Given the multiple stages of policy making included and the weighting scheme based on how far a bill advances, merely introducing a bill has a far lower impact on a member's LES than introducing a bill that advances through each stage necessary to become law. Because fewer and fewer bills advance to each subsequent stage, the member's share of total activity at each stage increases as his or her bill moves closer to becoming law. Thus, while the LES construction may pick up a degree of mere position taking by means of bill proposals, which has little to do with being an effective lawmaker, a member who introduces bills but does not put in the effort necessary to advance his or her agenda items will score quite low on the LES measure.

In addition to creating an LES for each member in Congress based on all bills introduced, we use the same formula on only the subset of health policy bills. In so doing, we create Health ILESs for each member in Congress. We refer to this score in terms of both interest and effectiveness because, as we noted above, not all members are interested in affecting health policy through their bill sponsorship. Indeed, many members who do not introduce any health bills might nevertheless be quite capable of being effective policy makers 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 ILESs, a couple of points regarding their construction and use are worth noting. First, the measure we have constructed is based on the advancement of legislation; hence, we are 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. Second, 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. While we believe that such legislators definitely exist and play an important role in lawmaking (and particularly in health politics), they comprise a relatively small minority of all members of Congress, and their actions are exceedingly difficult to assess in an objective manner.<sup>25</sup> While

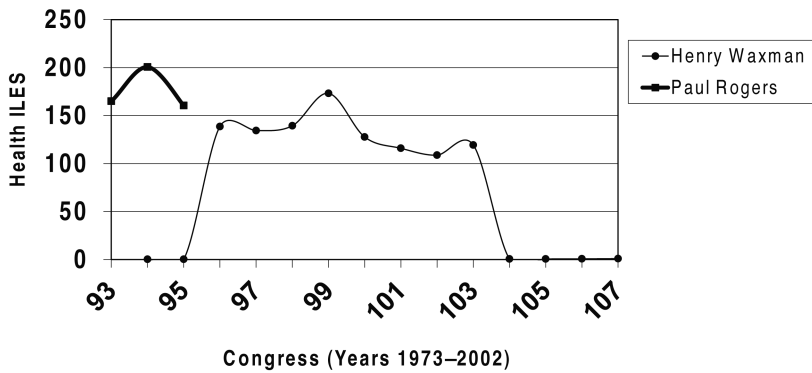
25. A more complex method that also accounts for which bills are amended and which legislators offer successful amendments yields substantively similar findings to those we report below.

in-depth qualitative analyses can offer valuable insights on the tactics of these members, we also believe that much can be gleaned by considering large-sample empirical analyses that can offer generalizable knowledge 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 through which we explore the numerous hypotheses that emerge from existing health politics scholarship.

These caveats aside, given our formulation, the Health ILES captures each member's relative share of bills progressing through each stage of the legislative process. Examining variance in this measure helps 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 exploring the remaining hypotheses raised above.

The policy entrepreneur hypothesis states that policy entrepreneurs are critical to the success of health policies. The Health ILESs should reveal whether some members of Congress took up such an entrepreneurial role or whether policy making 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 both the House and the Senate 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 became 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 eight years than Rogers or Waxman accomplished in any given Congress).

That these two members emerge from our data as 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 he 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 Amend-



**Figure 7** Two Policy Entrepreneurs

*Source:* See source list in appendix

ments, and the Radiation Control for Health and Safety Act. Both Rogers and Waxman chaired the Subcommittee of Health within the Energy and Commerce Committee. On attaining that position, Waxman sponsored or helped 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 served a central role in brokering several of the compromises needed to advance national health care reform in the 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 the approach used in Volden and Wiseman (2009), we run a series of regressions on members' scores, looking to explain their variance based on a range of individual and institutional characteristics. Specifically, to examine the remaining hypotheses and to control for factors 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 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 might be 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 is in the majority party, which is thought to be important for policy advancement generally and for health policy making in particular. *Majority party leadership* accounts for whether a member is among the leadership (e.g., majority party leader, deputy leader, whip), and a similar variable is included 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, or (for the health policy analysis) whether the member is a chair of a health-oriented subcommittee or of the committee within which such a subcommittee is located. *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.

Taken together, this set of independent variables allows us to explain why some members have more success than others in advancing health policy reforms, as captured in the Health ILESs. The simplest analysis of these scores is offered in table 3, which shows the results of an ordinary least squares regression (with robust standard errors clustered by members to account for potential nonindependence of their scores over time). Specifically, model 1 shows the results for the LES from all issue areas, while model 2 focuses solely on the Health ILESs. 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 and 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, who tend to introduce fewer bills. 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; therefore some variables are less statistically significant in model 2 than in model 1 although they have larger substantive effects. Rather than recount all of these results one by one, we use the findings in table 3 to evaluate the hypotheses from the above theoretical developments section.<sup>26</sup>

26. Given the notable increase in ideological polarization in Congress over the past thirty years, there are reasons to suspect that the relationships between legislator characteristics and effectiveness might vary across time. Auxiliary analysis not presented here, however, reveals that the results presented in this article are quite robust across decades and across Congresses.

**Table 3** Determinants of Legislative Effectiveness

	Model 1: Overall LES	Model 2: Health ILES
Lagged effectiveness score	0.522*** (0.033)	0.678*** (0.080)
Seniority	0.090*** (0.015)	0.167** (0.079)
Seniority <sup>2</sup>	-0.004*** (0.001)	-0.016*** (0.006)
State legislative experience	-0.052 (0.067)	-0.017 (0.312)
State legislative experience × legislative professionalism	0.296 (0.207)	0.631 (1.060)
Majority party	0.590*** (0.049)	0.406** (0.183)
Majority party leadership	0.057 (0.182)	0.069 (0.291)
Minority party leadership	-0.092 (0.079)	0.146 (0.231)
Speaker	-0.454** (0.206)	2.056 (1.935)
Committee chair	1.714*** (0.194)	11.08*** (3.04)
Power committee	-0.214*** (0.040)	-0.390*** (0.139)
Distance from median	0.004 (0.104)	0.353 (0.469)
Female	0.104** (0.047)	0.280** (0.140)
African American	-0.322*** (0.070)	-0.640** (0.325)
Latino	-0.053 (0.095)	-0.301** (0.132)
Size of congressional delegation	-0.0002 (0.0016)	-0.0001 (0.0040)
Vote share	0.022* (0.012)	-0.013 (0.049)
Vote share <sup>2</sup>	-0.00013* (0.00008)	0.0001 (0.0003)
Constant	-0.950** (0.449)	-0.068 (1.797)
<i>N</i>	5026	5026
Adjusted- <i>R</i> <sup>2</sup>	0.55	0.56

Note: Robust standard errors in parentheses; observations clustered by member  
 \* $p < 0.1$  (two-tailed); \*\* $p < 0.05$  (two-tailed); \*\*\* $p < 0.01$  (two-tailed)

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. In health politics, much as in other policy areas, majority party members are considerably more effective lawmakers than the average member. The very significant coefficient of 0.406 on the majority party variable implies that the average majority party member has a Health ILES of about 1.2, while minority party members average just under 0.8, yielding an overall mean of 1.0. To put it another way, our measure indicates that majority party members are about 50 percent more effective than minority party members, after controlling for all of the other considerations in model 2.<sup>27</sup> 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). Finally, the insignificant coefficients on majority party leaders and on the Speaker might be seen initially as lessening support for the partisan leadership hypothesis. But considering that the role of these leaders is to advance party goals rather than their own particular bills, these findings are not surprising. Furthermore, the coefficients on both of these variables tilt more positively for health policy proposals than for all policy proposals.

The moderate proposals hypothesis suggests that proposals near the House median position ideologically are more likely to succeed. Assuming that 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 is positive, although statistically insignificant.<sup>28</sup> Thus, there is no evidence in support of the

27. Given that health policy is historically at the forefront of the Democratic Party's agenda, it seems plausible that Democrats might be more naturally effective than Republicans in advancing health policy legislation. Auxiliary analysis reveals, however, that neither political party is particularly more effective in advancing health legislation (controlling for majority party status).

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

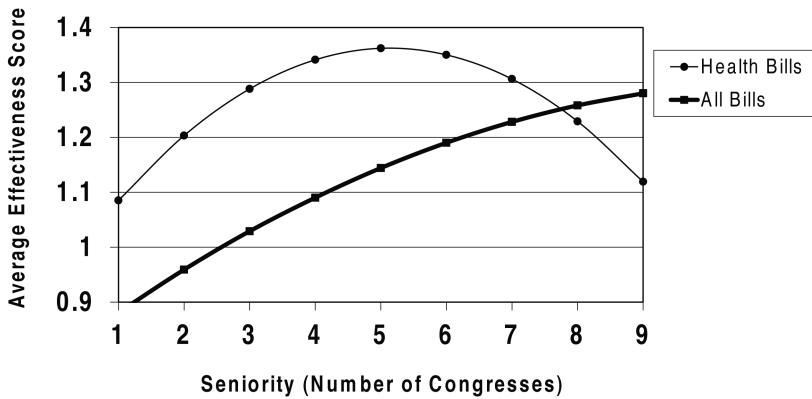
moderate proposals hypothesis. Moreover, as was seen in figure 6, slightly more proposals tend to come from the conservative and liberal ends of the ideological spectrum than from centrists. That those proposals are not immediately dismissed is further evidence against success being limited to moderate proposals.

The expertise hypothesis suggests that due to the complexity of public health issues, policy makers 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 policy making. Consistent with the expertise hypothesis, then, we see that the more senior members are more effective than junior members in advancing health policy legislation. Compared to model 1, the magnitude of the coefficients on both seniority and its squared term are larger, suggesting that seniority is even more influential at advancing health policy than the average bill. These results lend support to the idea that more senior members might be likely to light the way forward to health care reform. 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.

According to model 2, then, compared to a legislator in her first term, a member of Congress in her fifth term averages 0.28 points higher on her Health ILES. Figure 8 illustrates these findings further, comparing the relationship between legislator seniority and effectiveness in advancing health policy bills versus bills in all policy areas.<sup>29</sup> Consistent with the expertise hypothesis, the initial impact of seniority is greater for advancing health policy bills than other policy bills. As legislators become more senior, however (and particularly after their fifth term), their effectiveness in health policy declines, whereas their overall effectiveness continues to increase. Whether this stark curvilinear relationship is the result of more senior legislators diverting their attentions to other matters and leaving health policy primarily to entrepreneurs such as Waxman and Rogers deserves further attention in a future study.

Finally, the federalism hypothesis suggests that good ideas will bubble up from state experiments to the national government. While this may be true in some instances, there does not appear to be strong evidence that the conduit for such vertical policy diffusion lies with members of Con-

29. Figure 8 draws on coefficients from models 1 and 2.



**Figure 8** Seniority Influence on Effectiveness

Source: See source list in appendix

gress who draw upon their experiences in the state legislatures. The coefficient on state legislative experience is negative, and while its interaction with legislative professionalism is positive (as would be expected), neither attains statistical significance.

The findings described here are fairly robust to alternative model specifications, as reported in table 4.<sup>30</sup> 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 important enough to receive a write-up in the *Congressional Quarterly Almanac*. Also, nearly all such bills die in committee. Because members may be getting a significant boost in their

30. Additionally, because comparing coefficients across models can be problematic, the two models in table 3 were reanalyzed simultaneously via a Seemingly Unrelated Regression specification, with the two dependent variables matching those of models 1 and 2. Such an approach allows statistical tests of whether coefficients on independent variables explaining one dependent variable differ from those for the other dependent variable. Such a method yields substantive results identical to those reported here. Hypothesis tests reveal that the coefficients on lagged effectiveness score, seniority<sup>2</sup>, and committee chair are statistically different from one another in models 1 and 2 (all are greater in the Health ILES specification). All other variables' coefficients showed no significant differences between health policy making and overall policy making in Congress.

**Table 4** Robustness Checks of Regression Results

	Model 3: Logged ILES	Model 4: Modified Weights	Model 5: Substantively Significant Only
Lagged dependent variable	0.419*** (0.041)	0.653*** (0.098)	0.639*** (0.109)
Seniority	0.024** (0.010)	0.217** (0.091)	0.260** (0.105)
Seniority <sup>2</sup>	-0.0017** (0.0007)	-0.020*** (0.007)	-0.023*** (0.008)
State legislative experience	-0.031 (0.030)	-0.003 (0.356)	-0.014 (0.404)
State legislative experience × legislative professionalism	0.077 (0.092)	0.769 (1.214)	1.000 (1.410)
Majority party	0.089*** (0.019)	0.399* (0.210)	0.398 (0.245)
Majority party leadership	-0.018 (0.056)	-0.071 (0.294)	0.276 (0.358)
Minority party leadership	-0.041 (0.038)	0.189 (0.278)	0.709 (0.566)
Speaker	0.348 (0.395)	3.630 (3.032)	4.699 (4.088)
Committee chair	1.014*** (0.199)	13.02*** (3.37)	15.17*** (3.89)
Power committee	-0.030* (0.017)	-0.489*** (0.160)	-0.608*** (0.190)
Distance from median	0.116** (0.051)	0.257 (0.556)	0.064 (0.676)
Female	0.157*** (0.035)	0.183 (0.150)	0.098 (0.184)
African American	-0.106*** (0.038)	-0.696* (0.376)	-0.699 (0.437)
Latino	-0.077** (0.035)	-0.262 (0.162)	-0.223 (0.210)
Size of congressional delegation	0.0002 (0.0006)	0.0003 (0.0047)	-0.0003 (0.0057)
Vote share	0.0099** (0.0049)	-0.024 (0.062)	-0.042 (0.077)
Vote share <sup>2</sup>	-0.00006* (0.00003)	0.0002 (0.0004)	0.0003 (0.0005)
Constant	-0.415** (0.178)	0.280 (2.271)	0.882 (2.795)
<i>N</i>	5026	5026	5026
Adjusted- <i>R</i> <sup>2</sup>	0.32	0.51	0.47

Note: Robust standard errors in parentheses; observations clustered by member  
\**p* < 0.1 (two-tailed); \*\**p* < 0.05 (two-tailed); \*\*\**p* < 0.01 (two-tailed)

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, greatly reducing their impact 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 1.0. Model 5 reduces the impact of substantive and commemorative bills further, here generating scores solely for substantively significant bills.

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. Strong support remains for the expertise hypothesis, as seniority has a statistically significant coefficient in all models of table 4.

Table 5 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 squares 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 6. Model 7 instead conducts a simple logit analysis where the dependent variable indicates whether or not a member chooses to introduce health bills. Finally, model 8 reports the same analysis that was presented in model 2, but now our observations are limited to those members who actually demonstrated an interest in health policy making, as illustrated by their introduction of at least one health policy bill.<sup>31</sup>

These models shed further light on the hypotheses regarding the determinants of health policy change. As before, majority party members perform well. Their enhanced effectiveness is partly due to a nearly 20 percent greater likelihood of introducing bills (model 7) and a significant effectiveness boost among those who introduce at least one bill (model 8). The earlier findings with respect to majority party leadership and the Speaker also becomes more clear, as these individuals are indeed less likely to sponsor their own bills (model 7); but when they do advance

31. A further analysis, examining only the bills sponsored by each member that actually became law, shows consistent effects of the explanatory variables to the patterns uncovered in model 2.

**Table 5** Determinants of Health Interest and Effectiveness

	Model 6: Tobit	Model 7: Logit	Model 8: Positive ILES
Lagged effectiveness score	0.712*** (0.071)	—	0.679*** (0.074)
Seniority	0.464*** (0.166)	0.170*** (0.033)	0.088 (0.135)
Seniority <sup>2</sup>	-0.035*** (0.012)	-0.010*** (0.002)	-0.015 (0.009)
State legislative experience	-0.510 (0.679)	-0.125 (0.164)	0.060 (0.685)
State legislative experience × legislative professionalism	1.895 (2.027)	0.195 (0.481)	1.162 (2.146)
Majority party	1.034** (0.423)	0.165* (0.097)	0.749** (0.356)
Majority party leadership	-1.228 (0.884)	-0.472* (0.249)	0.403 (0.743)
Minority party leadership	-0.460 (0.922)	-0.265 (0.275)	0.452 (0.459)
Speaker	1.168 (5.005)	-0.959 (0.935)	11.41*** (0.881)
Committee chair	14.08*** (3.53)	1.416*** (0.323)	14.36*** (3.852)
Power committee	0.036 (0.317)	0.178* (0.099)	-0.645** (0.257)
Distance from median	2.061* (1.055)	0.453* (0.256)	-0.048 (0.874)
Female	2.565*** (0.488)	0.837*** (0.154)	0.303 (0.218)
African American	-1.946** (0.857)	-0.500** (0.238)	-1.204 (0.782)
Latino	-1.284 (0.859)	-0.374 (0.270)	-0.664** (0.268)
Size of congressional delegation	0.013 (0.011)	0.005 (0.003)	-0.002 (0.008)
Vote share	-0.002 (0.098)	0.018 (0.021)	-0.062 (0.098)
Vote share <sup>2</sup>	0.0001 (0.0007)	-0.00008 (0.00014)	0.0005 (0.0007)
Constant	-7.292** (3.679)	-1.825** (0.760)	2.048 (3.596)
<i>N</i>	5026	6368	2380
<i>F</i> (18, 5008)	10.55***		
$\chi^2$ (17)		121.0***	
Adjusted- <i>R</i> <sup>2</sup>			0.59

Note: Robust standard errors in parentheses; observations clustered by member  
 \**p* < 0.1 (two-tailed); \*\**p* < 0.05 (two-tailed); \*\*\**p* < 0.01 (two-tailed)



their own proposals, majority leaders (and especially the Speaker) have a greatly enhanced level of policy effectiveness (model 8). The moderate proposals and federalism hypotheses continue to receive scant support, yet an interesting finding appears regarding the relationship between extremists and health policy effectiveness. While more ideologically extreme legislators seem to fare better than centrists in advancing health policy (as indicated by the significant positive coefficients in models 3 and 6), the negative and statistically insignificant coefficient in model 8 suggests that this result is due largely to extremists' aggressive sponsorship activity. That is, extremists clearly introduce more bills than centrists, but once those bills are introduced, they do not progress any further than those of more ideologically moderate legislators. Similarly, an interesting nuance emerges regarding the impacts of policy expertise, at least as captured by seniority. More senior members are much more likely to introduce health policy bills (model 7), although the health policy bills they introduce do not seem to fare all that much better than those of their more junior colleagues (model 8).

## Conclusion

Prior to the 2010 health care reforms, scholars of congressional health policy making painted a fairly gloomy picture of the general prospects of health care reform. Health policies were viewed as mired in excessive legislative gridlock, arising from institutions biased against policy change and rife with contentious polarized politics. Although scholars and practitioners offered their own prescriptions for how to bring about change, there was little consensus: proposals ranged from strong majority party leadership to bipartisanship, from building on the expertise of more senior members and policy entrepreneurs to bringing in new ideas from the states. Perhaps after recent reforms a different narrative will take hold. However, in this article we argue that old and new assessments alike are too often built on a single event or a small handful of proposals and their fates. Instead, we advocate for an analysis of the advancement of a broader set of health policy proposals in Congress and for a comparison of 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 take into account that some of these bills are more significant than others and that some bills move further through the legislative process than 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 policy making 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 fail in resolving House-Senate differences than were other policy proposals before Congress. Although health policy making 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.

That said, our analysis suggests various elements for success in bringing about changes in health policy. Policy entrepreneurs have clearly been crucial and highly effective. Key subcommittee chairs, somewhat senior legislators, majority party leaders, and the Speaker of the House, along with rank-and-file majority party members, have all played significant roles in advancing health policy proposals through Congress. Thus proposals that are advanced by health policy experts in Congress, that build coalitions with a strong majority party base, and that 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. Along these lines, the ultimate success of the 2010 reforms followed from abandoning the quest for bipartisan support, from actions of key committee and party leaders (including the Speaker of the House), and from building on a strong majority party base. While the general patterns uncovered here will not explain the fates of each major and minor health policy proposal before Congress, this work may serve as a lens through which to examine the numerous bills that will undoubtedly follow on the heels of recent reforms.

**Appendix** Data Sources, Definitions, and Descriptive Statistics

Independent Variables	Description	Mean	Std. Dev.
Seniority <sup>a</sup>	Number of terms served by member in Congress	5.039	3.927
State legislative experience <sup>a</sup>	Equals "1" if member served in state legislature	0.479	0.500
State legislative professionalism <sup>b</sup>	Squire's index of state professionalism relative to Congress	0.290	0.145
Majority party <sup>a</sup>	Equals "1" if member is in majority party	0.577	0.494
Majority party leadership <sup>a</sup>	Equals "1" if member is in majority party leadership	0.015	0.120
Minority party leadership <sup>a</sup>	Equals "1" if member is in minority party leadership	0.016	0.127
Speaker <sup>a</sup>	Equals "1" if member is Speaker of the House	0.002	0.041
Committee chair <sup>c</sup>	Equals "1" if member is a committee chair	0.051	0.219
Chair <sup>a</sup> (health equations)	Equals "1" if member chairs a health-oriented subcommittee or the committee in which such a subcommittee is located	0.021	0.144
Power committee <sup>c</sup>	Equals "1" if member serves on Rules, Appropriations, or Ways and Means	0.247	0.431
Distance from median <sup>d</sup>	Member <i>i</i> 's DW-NOMINATE score – median member's DW-NOMINATE score	0.332	0.204
Female <sup>a</sup>	Equals "1" if member is female	0.074	0.262
African American <sup>a</sup>	Equals "1" if member is African American	0.059	0.236
Latino <sup>a</sup>	Equals "1" if member is Latino/Latina	0.030	0.170
Size of congressional delegation <sup>e</sup>	Number of districts in state congressional delegation	18.23	13.70
Vote share <sup>a</sup>	Percentage of vote received in previous election	68.42	14.03

Sources: <sup>a</sup>Constructed by authors based on *Almanac of American Politics*, various years.

<sup>b</sup>Constructed by authors based on updates to Squire (1992).

<sup>c</sup>Constructed by authors based on Nelson (1993) and Stewart and Woon (2005).

<sup>d</sup>Constructed by authors from DW-NOMINATE scores based on Poole and Rosenthal (1997).

<sup>e</sup>Constructed by authors.

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