PART

TWO

Political Institutions

CHAPTER 4

Congress

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We cannot understand health politics and policy without understanding Congress. In this chapter, Mark Peterson explores the logic of our legislature, shows how it is unique, and explains why it matters.

Congress has been both friend and foe of health policy. What it enacts, what it ignores, and what it defeats all reveal a good deal about the legislative process in the United States and reflect the changes that, over time, remake American lawmaking.

Congress has constructed a far-reaching national health policy with enormous financial consequences. A comprehensive analysis of all federal expenditures and tax benefits in 1999 estimated that federal dollars represent 40.8% of all health care spending and 50% of expenditure on personal health care.[1] But for all of its engagement with health policy, Capitol Hill has presented an insurmountable hurdle for particular kinds of policies. Except for legislation that cuts projected spending for public programs like Medicare and Medicaid, Congress has consistently rejected proposals designed to contain health care costs, even when overall health care expenditures have increased at more than two or three times the overall rate of inflation in the economy. Congress has also refused, time and again, all attempts to establish universal health insurance coverage. Even as every other advanced democracy achieved, each in its own way, the "international standard" of universal coverage and cost-containment mechanisms, Congress has rejected every effort in the United States.[2]

How are we to understand the American legislative process—with its emphasis on distributive policymaking, bursts of regulation, episodic focus on particular populations and constituencies, and (thus far) the blunt refusal to discipline health care spending or provide universal insurance coverage? What does one need to know about Congress to explain this mix of activism and denial, to ascertain "the logic of congressional action" and inaction in health policymaking?[3] In this chapter, I describe the core features of Congress. I consider how unusual election results as well as changes in the structure of Congress can alter the internal politics of lawmaking. With these fundamentals of the legislative branch in hand, I turn to the issue that is often

of paramount interest to students of health politics and policy, offering a relatively detailed analysis of the repeated failures of comprehensive health care reform. Finally, I assess how Congress has changed. Since the last round in the health care reform debates in the early 1990s, Congressional decision-making has become more partisan and more centralized.

THE BASELINE CONGRESS

One fact about Congress stands above all others. "Among the national legislatures of major countries, Congress is the only one that still plays a powerful independent role in public policymaking. . . . Only Congress initiates legislation, makes decisions on major provisions, and says 'no' to executive proposals."[4] Consider the stark difference between the United States and the United Kingdom. Three major empirical studies reveal that Congress in the post-war period adopted, typically only in part, just 6 in 10 presidential initiatives. Some presidents faired particularly poorly—Gerald Ford and Jimmy Carter could get Capitol Hill to accept only about a third of their legislative agendas.[5] In contrast, British Prime Minister Tony Blair was in office *for more than eight years* before the parliament defeated one of his major legislative proposals.[6] Congress not only frequently exercises its authority to block or substantially alter initiatives from the executive, it often plays a critical leadership role in the formative stages of policymaking. Policy ideas "proposed" by presidents often begin as bills drafted much earlier by members of Congress.[7] Based on his detailed historical analysis of 28 major statutes enacted from 1947 to 1990, Charles O. Jones determined that the impact of the legislature was "preponderant" for a quarter of the laws, and in more than half the cases Congress shared roughly equal influence with the president.[8]

What permits Congress to be so different from other national legislatures, and therefore of such unique consequence to health policymaking? The "separation of powers" and attendant checks and balances established by the US Constitution. This system of independent legislative, executive, and judicial branches of government, each with a formal claim over some aspect of lawmaking and implementation—more accurately captured by Richard Neustadt's phrase, "separated institutions *sharing* powers"—ensures that Congress is a central player in national policymaking.[9] It also fosters decision-making complexity by injecting multiple perspectives into legislative policymaking. Both the Constitution and institutional arrangements that developed later (through law, rules, and interpretation) make enacting statutes difficult; successful legislation requires assembling a daunting series of like-minded coalitions in numerous venues—committees and subcommittees within the House and the Senate, while also garnering the support of the president (or sufficiently larger majorities in both the House and Senate to override a presidential veto). Just about everything engineered by the Constitution makes legislating difficult, such as the separate constituencies and election timetables for the president, the House, and the Senate.

Elaborating on the comparative context illustrates the point. Arend Lijpjart identified two "ideal types" of democratic, constitutional design: "*majoritarian*" and "*consensus*."[10] Majoritarian systems simplify the burdens of decisionmaking by concentrating power in the hands of the leadership of the political party that won the most recent election. They dramatically limit the opportunities for independent action by the legislature. Such systems have a prime minister as the single executive leader; the prime minister and the cabinet (together forming "the government") are generally members of parliament, thus fusing the executive and legislative authority; and the legislature has only one body with policy-making power. In addition, only two parties compete meaningfully in elections and take stances on issues that clearly differentiate the

parties; in those elections a legislative district is represented by the candidate who won a plurality of the vote; lower level governments are under the authority of the national government; and the constitution is unwritten, interpreted by the parliament instead of an independent judicial branch of government. Majority party members in parliament are expected to follow the lead of their prime minister and cabinet. New Zealand's political system fits this image nearly perfectly.[11] The United Kingdom and Canada come close to this model.

Alternatively, nations that comport with "consensus" arrangements have governing systems in which taking action requires nurturing pervasive agreement among myriad policy makers located in multiple institutional settings. Everything about these systems fragments power where majoritarian systems concentrate it. As a result, consensus systems invite any interest groups with a large stakes in any policy question to work the institutional crevices of dispersed policymaking in order to shape laws more to its liking or to "veto" provisions with which it disagrees.[12] The United States possesses a number of majoritarian attributes (executive power concentrated in a single president, a two-party system, single-member legislative districts, and "first-past-the-post" plurality elections for Congress and the president); however, because of the separation of powers and the equal authority granted the two chambers of Congress, each with distinctive constituencies, along with federalism that protects the autonomy of the states (further reflected back in the Senate and tensions between the House and Senate), and a written constitution with the independent judiciary as the final interpreter, our system tilts heavily in the direction of the consensus model. In addition, the United States has few of the other social institutions—such as muscular political parties, a tradition of a strong administrative state, and a widely organized and influential labor movement—that bridge institutional divides in other countries.[13]

Knowing that Congress matters more than most national legislatures as a policy-making body, and that legislating is a complicated endeavor, does not yet tell us how and why Congress acts, or fails to act, in response to particular policy issues. For insights on these issues, we must first examine the role and orientation of legislators in the American context and the effects of specific features of Congress as an institution have on legislative decisionmaking.

The Legislator

Congress is ultimately an aggregation of its members. Its actions reflect the motivations, preferences, and choices of the individuals elected to serve as Representatives and Senators. One starting assumption is that members of Congress are "single-minded seekers of re-election."[14] That proposition may be too narrow and cynical, but even when members are primarily intent upon wielding power or pursuing the public interest through good public policy, re-election is the necessary predicate and thus an inescapable objective.[15] However, that goal creates different behavioral incentives in different systems. In many parliamentary systems, the political parties maintain close control over the slates of legislative candidates, not only determining who will run (or "stand") for election and re-election, but even what districts or constituencies they will represent. Electoral success in such settings, therefore, hinges first on satisfying the party's needs, including supporting the expressed policy positions of the party once in office.

Although there have been times in American history when the major political parties have played a significant role in candidate selection and promotion, congressional candidates and incumbents running for re-election are usually independent agents who promote their individual political interests. In some instances, party figures from local or national organizations try to entice particular individuals to seek election to Congress with promises of support but most candidates launch the race for office under their own volition. The party's nomination is determined by voters in primary elections, not the party's leadership. In 1938, incumbent conservative Southern Democrats who opposed FDR's New Deal easily won renomination and re-election despite the

president's bold efforts to defeat them. In 1990, GOP leaders were embarrassed when the white supremacist David Duke ran as the Republican challenger to incumbent Democratic Senator J. Bennett Johnston in Louisiana. In the general election, various party organizations inside and outside of Congress may provide some campaign funding, media assistance, or campaign visits by their partisan luminaries, such as the president or congressional leaders, but for the most part congressional candidates assemble their own electoral teams, hire their own consultants, do their own polling, and craft their own themes attuned to their particular constituencies. As a result, both congressional campaigns and legislative decisionmaking are especially responsive to local considerations. Members of Congress must judge even national policy issues like funding Medicaid, educating health care professionals, or containing hospital costs through the lens of their constituencies. The late Thomas "Tip" O'Neill of Massachusetts, Democratic Speaker of the House from 1977 to 1987, famously endorsed the well-worn line that "all politics is local."[16]

Congressional Organization—Legislative Parties

Political parties in Congress are the most single most important *organizational* feature of the legislature. In both the House and Senate, the party that wins the majority of seats in the election chooses the leaders of the chamber who, in turn, determine which committees will be assigned bills and organize floor deliberations. Committee and subcommittee chairs come from the ranks of the majority party, and they determine the schedule of the committee's work and hire most of its professional staff. Party affiliation is also the best single predictor of how members of the House and Senate will vote on pending rules and legislation.[17] That, however, is where any apparent similarities between Congress and other national legislatures ends. In many parliamentary systems the majority party has to hang together on important votes or, in the extreme case, the government "falls" and new elections are called. In purely "majoritarian" systems, a "government" (prime minister and cabinet) can almost always secure a legislative victory, even for the most sweeping and controversial legislation. Congress could not be more different. Since most members of Congress have their own independent constituent base, Democratic and Republican leaders often have had trouble motivating individual members to support the party's positions. House and Senate leaders of both parties understand the strong local ties. They rarely try to compel members to comply with party positions, if it would risk electoral damage, and few mavericks have been punished when they have broken ranks, even on major party priorities.[18] The effect is reflected in average "party unity scores"—the percentage of a party's members who voted with a majority of their compatriots when on a recorded roll-call vote a majority of one party countered the majority of the other party. Since 1954, for example, Democratic party unity on all such votes in the House ranged from a low of 70% in the early 1970s to a peak of 89% in 1993 (Republicans followed a similar pattern, although they acted with more sustained unity since 1993; the Senate also closely matches the House).[19]

Congressional Organization—Structural Characteristics

Any legislature has structural design features—established by the constitution, legislation, or the rules of each chamber—that largely determine which legislators can significantly affect lawmaking. Put bluntly, are institutional power and resources concentrated in the hands of the majority and its leadership or are they dispersed? With Congress, we start with the knowledge that authority is constitutionally divided between two houses with very different organizational characteristics, constituencies, electoral schedules, and incentives. But we can go further. One can imagine three possible "pure types" of organizational arrangements in each chamber. The first would be a "centralized" structure, with the majority party leadership in command of decisionmaking—agendas, organization of the committees,

staff resources, legislative mark-ups, floor debates, and so on. Given the previous discussion, it should not be surprising that the most centralized form is the Westminster-style parliament found in New Zealand or the United Kingdom. When the majority party leadership wishes to act, those in opposition do not have the institutional assets needed to block the way. The second form of legislative organization would be a "decentralized" institution in which power and resources are distributed beyond the majority party's leadership. For example, considerable authority is often granted to standing committees of jurisdiction, and thus their chairs (or the members), which provide detailed review of all bills introduced in their areas of policy jurisdiction. The consequences are most pronounced when the policy preferences of a committee—the chair, the committee members, or both—differ measurably from the rest of the party members. In this setting, committees might become veto points, unwilling to report out bills that would otherwise be agreeable to the whole chamber. Powerful committees might also be able to help move an initiative forward that the majority leadership may prefer to avoid. Other members of the chamber from both parties turn to the committee of jurisdiction for substantive policy cues and know that their future legislative interests in the policy area may be well served by supporting legislation favored by the committee. The final type of legislative structure—"fragmented"—disperses power even further. In its most pronounced form, individual legislators are provided with the kind of staff resources, institutional positions, and access to the bill amending process that permits them to influence the course and substance of legislation. Working coalitions are difficult to orchestrate and maintain when so many individuals have a claim on the legislative process. Such diffused power, however, also offers multiple legislative pathways to overcome the opposition of the leadership or a single committee.

What kind of structure best describes Congress? As a complex institution, one finds attributes of all three types, but historically there have also been some clear tendencies. First, power has almost always been more "fragmented" in the Senate than in the House. Individual senators possess more resources and larger staffs. The opportunity to filibuster during floor debates—long ago forbidden in the House—grants each senator the potential capacity to bring the institution to a halt (a powerful bargaining tool). Over the course of the 20th century, the House of Representatives cycled through all three forms of legislative organization.[20] Very early in the 20th century there was considerable centralization; the majority party leadership commanded the agenda and shaped legislative outcomes. After a revolt against the leadership (in 1910), the institution became what the congressional literature sometimes calls a "textbook Congress" (roughly 1920 to 1960). The work became decentralized. A limited number of autonomous or semi-autonomous committees run by powerful, "baron"-like chairmen—the "whales" of the legislative enterprise—dominated the agenda and often thwarted legislation desired by the leadership and the majority. Major political shifts that cumulated in the 1970s led to what is usually referred to as the "reform" Congress. Liberal Democrats in particular wanted to get around conservative committee chairs who stood in the way of progressive legislation. Lacking the wherewithal for a frontal assault on the chairs, they instead pursued new rules that ended up fragmenting power by shifting authority and resources to innumerable subcommittees and individual representatives. The 1980s witnessed the "post-reform" Congress. While power remained fragmented, leaders took more control and committees (and their chairs), now less out-of-step from the House as a whole, regained influence.[21] The mid-1990s saw a return to the highly centralized House reminiscent of the early 1900s (more on this last stage later in this chapter).

Organized Interests Present and Accounted For

Congressional policy deliberations do not, of course, occur in a vacuum, free of efforts at intervention by organized interests with stakes in the legislative outcomes. Although there is some controversy about

whether or not parliamentary systems are more resistant to interest groups, there is no question that Congress is an open target for attempts at influence, both directly through lobbying and indirectly using the media and other methods to pique Congressional constituents. Mobilizing large memberships, leveraging skilled lobbying operations, fertilizing congressional access with hefty campaign contributions, and sometimes financing sophisticated public relations drives, well-endowed interest groups—especially large, commercial interests—seek to gain entry to and to shape the views of congressional powers. For much of the 20th century this meant targeting the committees.[22] Indeed, health care policy in the United States has often been characterized as the natural product of interest group politics.[23] The American Medical Association (AMA) was the paradigmatic case in point for a long period.

The rise of social movements in the 1960s and 1970s altered this picture. They gave birth to new organizations representing consumers, women, environmentalists, and others dedicated to social change and competing with the older interests for the attention of policy makers. New "patrons of political action," including foundations and wealthy individuals, emerged to help these organizations acquire the resources they needed to organize and maintain themselves by overcoming the inherent difficulty of mobilizing large, dispersed groups of individuals for collective action.[24] The new mix of organized interests could at times make it more difficult for the established interests to work as successfully with Congress. They also helped to open up the policy-making process and broaden the agenda to include popular issues like environmental protection and occupational safety.

The Legislative Consequences

Put these pieces together—the near self-selection of locally-oriented legislators who can act independently, parties in Congress generally unable and rarely willing to force the adherence and discipline of their members; legislative power often concentrated in committees (or dispersed even more widely); and the open access of the institution to organized interests, especially those with strong constituency ties—and it is easy to ascertain what members of Congress consider to be "politically attractive" policies.[25] They create identifiable benefits that can be broadly allocated and traced back to the votes and actions of individual legislators who claim credit for their enactment. If the law entails costs, they are widely diffused, without imposing significant burdens on targeted payers. In short, they look a lot like Hill-Burton hospital construction and expansion, training of the health professions and development of their schools, and funding for biomedical research. Proposed legislation that would yield obscure benefits sometime in the relatively distant future, or whose returns are not obvious for attentive citizens, but would demand the bearing of substantial costs by powerful interests, or a bill that would explicitly redistribute the tax dollars of politically engaged constituents to the benefit of the politically withdrawn, are the most difficult to enact.

Changing circumstances, however, can modify this "baseline" dynamic of the legislative process. The rise of the environmental and consumer movements, for example, transformed the otherwise antagonistic politics of regulation by bringing competing organized interests to the legislative arena, making the costs of inaction more stark, and clarifying the benefits of pollution control for the middle class electorate.[26] Elections can bring dramatic shifts that disrupt the simple "distributive" status quo of Congress. The election of 1932 not only put FDR in the White House, but also huge new Democratic majorities in Congress that temporarily led to greater centralization of the House and a willingness to enact programs like Social Security. The election of 1964 gave Lyndon Johnson an unprecedented landslide and infused Congress with liberal Democrats who overwhelmed the House Ways and Means Committee which had been blocking Medicare.[27] In 1994, Republicans—under the leadership of Newt Gingrich—successfully nationalized the election, breaking the hold of the local imperatives in Congress. Capturing both chambers of Congress in that election, the GOP enjoyed bicameral

legislative majorities for the first time in two generations, unified their ranks, centralized House decisionmaking, and passed legislation that would have privatized Medicare (only to be thwarted by President Clinton's veto), block-granted Medicaid to the states, and carved out hundreds of billions of dollars in projected spending for these programs, which would have imposed substantial costs on beneficiaries and providers.[28]

Elections need not be so dramatic to reconfigure the internal politics of Congress. After great battles lead to stalemate (and the appearance of failed legislative responsiveness to the public), the coming of the next election can incite both parties to reach agreement on lesser programs that they deem to be sufficiently distant from partisan cleavages, popular with voters, and providing benefits that incumbents can bring home to their constituents. For example, the Health Insurance Portability and Accountability Act (HIPAA) of 1996 passed with bipartisan votes in the wake of health care reform's defeat.[29] Alternatively, the continued policy and electoral success of one party in a policy area may entice the other party to poach the issue, in the hope of eviscerating the original partisan advantage. Clinton and centrist Democrats tried that with welfare reform. President George W. Bush and the Republican Congress, in turn, used every institutional advantage of their majorities and centralized control of the House to push the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003.[30]

COMPREHENSIVE HEALTH CARE REFORM: A WINDOW INTO CONGRESS

The history of comprehensive health care reform reveals all of the elements of congressional policymaking presented in this chapter, from legislative barriers to the changing constellation of interest groups, from the role of partisanship to the changing institutional structure of legislative power.

We can begin by returning to the puzzle of American health care policy. All industrial nations and many poorer developing ones endow their citizens with some form of universal health insurance. The latter half of the 20th century brought the emergence of the near universal and reasonably consistent "international standard" of coverage and financing for medical services, albeit using quite different institutional arrangements across nations.[31] Even the Anglo countries with the most pronounced traditions of individual liberty and responsibility—England, Canada, and Australia—recognize the degree to which ill health has to do with genetic and experiential bad luck, and provide universal care. The United States is the one startling exception. The reason? When it comes to national proposals for comprehensive health care reform Congress has been an unrelenting graveyard. Not all the "homicides," however, were equally quick or certain.

Not Coming to Our Consensus

The lack of universal insurance coverage is not for want of popular support. At least as reflected in opinion polls, substantial public majorities consistently affirm that individuals ought to have coverage for medical services regardless of their incomes and social standing. Even in the context of the 2000 elections, which produced the first conservative, unified Republican government in nearly a half century, 64% of the public agreed that "it is the responsibility of the federal government to make sure all Americans have health care coverage." Significant majorities—in the range of 70% to 90% for the last 20 years—have found fault with the existing arrangements for financing and delivering health care and called, in some fashion, for major changes. Typically that support comes with the understanding that government would have to play an important role.[32]

Though universal health care had strong advocates by the 1910s, it was not until 1939, when New York Senator Robert Wagner introduced a relatively modest, state-based health care reform bill, that something resembling national health insurance

formally entered the congressional arena. That set the ball rolling. In 1943 Wagner was joined by Senator James Murray (Democrat from Montana) and Representative John Dingell (D. Michigan) to introduce the first bill to develop a national, comprehensive, universal health insurance program, this one tied to Social Security (Dingell's son replaced his father in 1955 and has re-introduced the national health insurance bill in every Congress since). In the fall of 1945, shortly after he assumed the presidency, Harry Truman became the first sitting president to propose a national, compulsory health insurance plan. He granted it a prominent place on his legislative agenda throughout the late 1940s. Some 30 years later, politicians like Democratic Senator Ted Kennedy and Republican President Richard Nixon returned national health insurance to the political agenda. By early 1974, President Nixon offered an expansive Comprehensive Health Insurance Program (CHIP), designed to use employer mandates and public coverage for the working poor and unemployed to yield universal coverage. Nixon's plan, along with the competing Democratic plans, was the first health care reform proposal to engender serious congressional attention. President Jimmy Carter proposed universal coverage in 1979 to be provided by competing private health care plans financed by both employers and government. Although President Ronald Reagan avoided the issue, President George H.W. Bush offered modest legislative overtures to expand insurance coverage, a defensive posture stimulated by rapidly escalating calls for comprehensive health care reform and the introduction of major proposals by both Democratic and Republican leaders in the House and Senate. Finally, Bill Clinton went even further, campaigning in 1992 with health care reform and universal coverage as a centerpiece of his platform. He made his Health Security Act a lead issue on his subsequent presidential agenda.

Despite all of this attention to the issue at multiple times in the previous century, and notwithstanding the hundreds of plans formed and bills introduced, some offered by presidents and a few given the full weight of their administrations, *not a single health care reform initiative has ever come to a vote on the floor of either chamber of the US Congress*. They have all been deflected by wanton congressional inaction. The first health care reform floor *debate*, held in the Senate, did not even ensue until the 103rd Congress and the presentation of Clinton's plan. How is it possible that Congress has proven so incapable of, or so unwilling to, join the international standard of universal coverage? Sven Steinmo and Jon Watts, students of cross-national politics and social policymaking, have a simple answer: "It's the Institutions, Stupid!"[33] First written before the failure of Clinton's health care reform effort, their article, subtitled "Why Comprehensive National Health Insurance Always Fails in America," argues that the design of our governing arrangements, especially Congress and its relationship with other institutions as described earlier, have made and will always make it impossible to enact such sweeping reform.

To end the story here, though, would be premature. However profound the differences noted earlier between the governing structures of the United States and the other industrial nations, American institutional arrangements and health care politics have actually varied considerably over time. They have dramatically altered the prospects of reform from one period to the next. There have been times when Congress could have enacted universal coverage, and perhaps almost did. The consistency of the policy outcome in the United States has obscured the substantial variability of the legislative policy process. Steinmo and Watts have simply drawn too bright a line. We have to ask ourselves what real opportunities for policy innovation in Congress have emerged in the past, what policy makers did with those opportunities, and exactly why health care reform met repeatedly with congressional inaction on each of those occasions.

Barriers to Coalition Building in Congress

My earlier discussion of shifts from the congressional baseline noted that new opportunities emerge in the legislative setting when a changed context boosts the

potential for pulling together winning coalitions. Let us return to three dimensions important for defining the congressional setting at any given time. I will call them "party" (the percentage of seats held by the political party that generally favors the policy change), "cohesion" (the level of unity or agreement among the members of that party), and "structural coherence" (the degree to which the legislature's decision-making authority is concentrated rather than dispersed, and thus can be coordinated by the majority party).

When examining an issue like health care reform, we would like to know what proportion of a legislative chamber's membership has a predisposition to support a general course of action, such as assuring universal coverage. That information is not available, especially over an extended number of years. On many issues, though, including health care reform, a reasonable surrogate is the relative stature of the political party most likely to endorse such a policy innovation. Although many Republicans in Congress have worked earnestly for health care reforms (the late Senator John Chafee of Rhode Island comes to mind), the most ardent advocates of universal coverage have consistently been Democrats. And they have been a fairly numerous bunch. Between 1933 and 1994 (during which the most important health care reform debates transpired), Democrats held majorities in the House of Representatives for all but four years (1947–48 and 1953–54) and in the Senate for all but 10 years (1947–48, 1953–54, and 1981–86). Sometimes those majorities were stunning in their size. During FDR's Second New Deal, Lyndon Johnson's Great Society, and Jimmy Carter's first two years, Democrats controlled 77%, 68%, and 67% of the House, respectively, and roughly the same proportions of the Senate. When in the majority since 1932, Democrats have held on average of approximately six in ten House and Senate seats. These are healthy margins and with majority control the Democrats have held the House Speakership, leadership positions, considerable leverage over the floor agenda, the chairs of all committees and subcommittees, as well as the bulk of the staff and other legislative resources. Universal coverage should have had a leg up in Congress.

However, the second dimension of relevance to coalition building, cohesion, draws attention to how limited the utility of party majorities can be, especially in the American context. Continue with political party as a proxy for the potential coalition base. A deeply divided party, even if nominally in the majority, will not be able to deliver reliable votes for significant policy initiatives like health care reform. Recall that for both Democrats and Republicans unity has never been universal and dipped quite low in the 1970s.

The evidence from 1955 to 1994, during which Democrats enjoyed continuous control of the House of Representatives, illustrates the potential problem of achieving what might be called a *reliable* majority (one that would be of sufficient size *and* unity to produce an expected majority vote in favor of policy approaches presented on the floor). If one multiplies the number of seats controlled by the Democrats (the starting base in the calculation) by the average percentage of Democrats who voted with their party on party unity votes (a measure of how likely it was at that time for individual Democratic members to vote with their party), in only 18 out of the 40 years does the result produce a slim reliable majority. Most of the time, therefore, having a majority of seats did not translate into mustering a majority of votes on contentious issues.

Of those 18 years, only five had a Democratic president (thus a chief executive who would have endorsed Democratic health care reform efforts): Kennedy's third year, the 89th Congress during Johnson's Great Society, and President Bill Clinton's first two years. As we will see in Chapter 5, President Lyndon Johnson led the passage of Medicare and Medicaid when the combined size and unity of the Democratic majority in the House was at its postwar zenith, but did not feel he had to votes to offer a more expansive health reform agenda. The situation in the Senate made successful action even less likely. Because of the filibuster, which allows any individual senator or small group of senators to block floor action by conducting endless debate, legislation can be

thwarted unless a supermajority of sixty votes is available to cut off debate (known as enforcing "cloture"). Even during LBJ's heyday in the 89th Congress, the combined Democratic seats and unity nudged a slim majority in the Senate, well short of the sustained effective coalition that would be needed in the face of serious opposition on the floor. In short, if enactment of universal coverage depended on the Democratic Party in Congress alone, there have been precious few windows of real opportunity (neither Truman nor Carter launched their initiatives during an opportune period).

The challenge to health care reformers becomes even more complicated—and daunting—when we introduce the third dimension of coalition building: the structural coherence of the legislature itself. Consider the features associated with centralization, decentralization, and fragmentation that I noted earlier. Using extensive empirical measures of the institutional attributes of specific relevance to legislating in the realm of health care reform, I have developed indices to represent the presence of factors associated with centralization, decentralization, and fragmentation in the House of Representatives and Senate from 1909 to 2000.[34] The House of Truman's day, for example, ranked low in centralization and fragmentation, but high on the second dimension, decentralization—that is, the committee chairs wielded significant power. In Truman's time, the committees that had jurisdiction over health care reform legislation were more conservative than the House as a whole, and their chairs opposed the president's national health insurance plan. Veto they could and veto they did.

Fast forward to Carter's administration and one discovers a fundamentally changed legislative institution. The Democratic majority in the House was much larger, but also much more divided within itself. The power of the committee chairs (decentralization) had been supplanted by widespread fragmentation. Every committee was required to have subcommittees of jurisdiction with their own staff resources and agenda control, and every subcommittee throughout the chamber was chaired by a different member of the House Democratic majority. Rank-and-file members also had more staff and increased influence (the House came to look a lot more like the Senate, which has always been a more fragmented institution).[35] The Carter years (and Nixon's just before) did not offer an opportune context for putting together a coalition on an issue as significant, complicated, and threatening to so many stakeholders as health care reform and universal coverage.

The Congresses during the time when Bill Clinton ran for president and took office, however, showed more promising signs.[36] Many features of fragmentation remained. However, the committees of jurisdiction—all with chairs supportive of reform and members more liberal than the House as a whole—had regained some of their influence (the decentralization index was higher) and there were more rules that enhanced the influence of the Speaker of the House to coordinate the legislative process. There were still plenty of institutional barriers, but the 103rd Congress at the start of the Clinton administration combined the attributes—Democratic majority, unity, and institutional coherence—that gave health care reform–minded coalition-builders a better organizational chance than they had had in any previous round of national health insurance debates.

Congress in the Web of Interests

For much of the 20th century, the politics of health care reform seemed to be a paradigmatic example of the power of organized interests with strong stakes in the status quo. The American Medical Association (AMA) in particular possessed all of the instruments of interest group influence, including an enormous membership residing in every legislative district, unity of purpose, the authority to speak for its membership, unrivaled expertise on the issues, and vast organizational and financial resources to lobby legislators and support candidates for office. Under its leadership, physicians, hospitals, insurers, and employers are thought to have channeled their way into the open congressional

arena, striving effectively to preserve their own interests, and fend off health care reform and universal coverage.[37] For a long time, that imagery was consistent with the observable patterns of policymaking on issues both small and large.[38] When FDR contemplated health care coverage next to Social Security and Truman proposed national health insurance, the American Medical Association led a powerful antireform alliance that included medicine, insurance, and business. It dominated the interest group scene and out-influenced what we might term the stake challengers, mainly labor unions who endorsed national health insurance. For the most part, in the decentralized Congress of that era, this antireform alliance found ready partners among the chairs and members of the committees of jurisdiction. As presidents for the first time were moving universal coverage to their programmatic agendas, reform did not stand a chance in Congress. Anticipating the result, Roosevelt pulled back from even launching an initiative, and Truman's proposal could garner no more than a single, brief committee hearing.[39]

By the time that Richard Nixon and Jimmy Carter were engaged in their own health care reform efforts, the interest group world had begun to change. Their administrations came in the wake of the social movements of the 1960s and 1970s. Many of new "citizen" organizations would eventually join with organized labor in challenging the health care "industry" and promoting universal coverage.[40] However, the antireform alliance remained unified in its opposition to such large-scale government intervention. Although the reform debates of the 1970s remained largely "inside-the-beltway" contests, reformers faced significant challenges due to the idiosyncratic features of presidential politics at the time (e.g., the ramifications of Nixon's Watergate scandal), the general divisions among congressional Democrats, and the chaotic setting of the increasingly fragmented House and Senate. However, Congress did more than hold brief perfunctory committee hearings—considerable committee attention was devoted to the issue. One possible path to compromise on health care reform even emerged that possibly could have been passed.[41] More on that story in a moment.

Between Jimmy Carter's return home to Plains, Georgia, in 1981 and Bill Clinton's bus trip from Jefferson's Monticello to his inauguration in 1993, a metamorphosis took place in the community of organized interests focused on health care reform. More than a decade of sharply rising health care costs, partial cost control programs (introduced by government and business), huge disparities in coverage provided by large and small employers, and increased medical specialization splintered the old antireform alliance. The divisions emerged both across and within the domains of medicine, insurance, and business. In the meantime, more citizen groups arrived on the scene; most were sympathetic to universal coverage but some, such as the Christian Coalition, reflected a conservative countermobilization against greater government taxation and economic regulation.[42] Ironically, the two leading antagonists in the health care reform wars of the past—the American Medical Association and organized labor—had both diminished considerably in strength. Instead of including nearly all practicing physicians, as in the past, the AMA's membership slipped to just four in ten doctors by the early 1990s. Labor's ranks had declined from representing better than a third of the labor force at its 1950s zenith to just under 15 percent.[43] By the late 1980s, these "peak associations" that once spoke for whole sectors of the economy had become "just another interest group" or "just one more PAC."[44] The AMA, for all intents and purposes, dropped entirely from the relevant set of organized interests on health care reform. Labor remained a player, but became weakened on this issue by its diminished base and its commitment to employer-based insurance.[45]

On both sides of the reform debate new organizational leaders would emerge. The National Federation of Independent Business (NFIB), the hard-right point organization for small business; the Health Insurance Association of America (HIAA), the trade association for commercial insurers; and the Pharmaceutical Research and Manufacturing Association (PhRMA), representing the drug companies, took up

the charge against government reform. On the other side, the AARP, Families USA, and Citizen Action—all either relatively recently founded or newly revitalized groups—provided much of the organizational wherewithal and grassroots mobilization for the proreform forces.[46] The early 1990s offered an opportunity for each side of the health care reform debate. Which interest group coalition would coalesce most effectively, succeed in the court of public opinion, and demonstrate efficacious use of the legislative levers of influence? The gates to the congressional graveyard were unlocked, but would they open?

Presidents in the Legislative Arena

The legislative dictum of the modern era is that the president proposes and Congress disposes. Like most maxims, this one is too simplistic. Even with the post-war enlargement of the presidency's aura in all matters of policy, foreign and domestic, Congress continues to be the source of much legislative energy and policy innovation.[47] Nonetheless, it would be difficult to envision the enactment of a reform as expansive as universal health care coverage without the collaboration, indeed the leadership, of the chief executive.[48] The only times that health care reform has been seriously on the agenda, regardless of the trends in the ranks of the uninsured or the costs of the health care system, has been when presidents have initiated formal proposals. That is not to say that their involvement has always been purely voluntary. Both Richard Nixon, with his comprehensive plan, tentatively carried forward by Gerald Ford and George H.W. Bush, with his more incremental approach, were responding to the Democrats' potential advantage on this issue. Many presidents, of course, have also used their influence to thwart reform impulses by simply ignoring the issue. Still, if one wants to assess those moments when something substantive about reform was in the air, one has to look to the actions of particular presidents.

Three possible strategies have been available for presidents interested in health care reform: combat, collaboration, and co-optation. And all three have been tried. Perhaps befitting his personality, and clearly linked to the context in which he served, Harry Truman chose combat. His plan for compulsory national health insurance, publicly financed and linked to Social Security, was favorably received by the public but ran entirely counter to the constellation of organized interests and the preferences of members of Congress who dominated health care legislation, especially (but not only) during the Republican Congress of 1947–48. This was no effort to engage the stakeholder interests or skeptics in Congress. He sought to "give 'em hell," to attack the "do nothing Republican Congress," and to mobilize public opinion (although far too casually to be effective). No matter what he might have tried, however, an institutional analysis reveals that no strategy was available that could break the lock against health care reform. Defeat was ensured by the partnership of the antireform alliance's policy monopoly with the relevant committee chairs and members in Congress who were antagonistic to major government intervention in health care financing.

A second strategy is collaboration. To a large extent, that was the theme of the 1970s. Both Nixon and Carter sought to build universal coverage on the existing system of employer-sponsored insurance, filling in the gaps with a publicly financed program. Private insurers would not be put out of business, and employers (along with labor) would continue to have a primary in offering coverage. By collaborating with both stakeholders and opposition members of Congress, each president envisioned a grand compromise.

A collaborative, bipartisan process might have won reform. In August 1974, Congress came very close to enacting universal coverage predicated on employer mandates and some public financing. A compromise appeared to be in motion among President Richard Nixon (later Gerald Ford), Senator Ted Kennedy (who had earlier advocated full public funding), Senator Russell Long (the fairly conservative Democratic chair of the Senate Finance Committee), and Wilbur Mills (the chair of the House Ways and Means Committee who was always seeking ways to

control the agenda on his terms). Losing some Southern Democrats but picking up a few Republicans, as well as holding onto all of the liberal Democrats on the Committee, Mills came within a vote or two of reporting out a bill that would have given universal coverage some momentum.[49] One can only speculate whether such a bill sent to the floor on a deeply split vote by the Committee on Ways and Means would have survived in the full House and then the Senate. Several Democrats, for example, were anticipating huge Democratic gains in the fall elections following Nixon's resignation. Many were further convinced that 1976 would bring the election of a Democratic president committed to more expansive health care reform. They might have thwarted Mills's efforts in exchange for a better package in the future.[50] In any case, two clear results stand out from the efforts of the mid-1970s. First, congressional committees (including Senate Finance) actually marked-up legislation for the first time, suggesting that some version of reform emerged into the realm of the possible. But, second, universal coverage died again—never making it out of committee, never coming to the floor of either chamber.

The Clinton period is the most beguiling of all. In the early 1990s, the problems in the health care system were more pronounced than ever. Health care costs escalated rapidly. For the first time the United States had become an unmistakable outlier, spending far more than any other nation on health care per capita and as a percent of the gross domestic product. In addition, commencing around the mid-1980s, the percentage of people with health insurance coverage started to shrink, reversing decades of broadening employer-based insurance and the enormous coverage gains achieved by Medicare and Medicaid. In another first, the AMA was hardly relevant as a health care power any longer, and to the extent it was involved in the debate, it had even endorsed universal coverage. The interest group politics of health care reform were up for grabs. As I noted earlier, too, Clinton could work with a Congress in which the size of the Democratic majorities and the general unity within them offered an unusual window of opportunity. The institutional character of the House, at least, afforded coalition-building advantages not found in previous periods. Taken together, by 1993 almost all the participants in health care reform politics and policymaking, even stakeholders who were vehemently opposed to the idea, had concluded that some version of reform would soon be enacted.[51]

Four obvious risks remained, however. President Clinton was pursuing a popular idea—health care reform—but with no particular electoral mandate generated by his feeble plurality win of just 43% in the 1992 presidential election. Both the House and Senate still yielded opportunities for many members to delay or thwart legislative action, if they chose to do so, and significant divisions remained—even among Democrats—about the best way to solve the nation's health care problems. The Republicans in Congress had, in opposition, become just as unified in their ranks as had the Democrats. Finally, all other advanced democracies had enacted and implemented their systems for universal coverage *before* the stakes in the status quo arrangements had grown so enormous for providers of all kinds, private insurers, and employers.[52]

Both during the presidential campaign and once in office, Clinton chose a health care reform strategy of co-optation. The more combative approaches taken by Democrats in the past had led to defeat. Their proposals for publicly-financed programs fed Republican rhetoric about Democrats as the "tax-and-spend" party. Several initially collaborative bipartisan efforts had also come up short, losing the support of both conservatives and liberals.[53] Clinton's approach, reflected in the "managed competition under a budget" rubric of the Health Security Act, was to co-opt the left and right simultaneously, and along the way capture the voters, interest groups, and centrist members of Congress. Liberals would be energized by his commitment to universal coverage, achieved through a combination of employer mandates and an expanded public program that replaced Medicaid for the poor and unemployed; the cost-control discipline ensured by imposing a budget on health care expenditures

backed up by insurance premium caps; and the standardization of basic coverage for people regardless of their socio-economic standing. Conservatives would resonate with the "private," market-oriented features of the initiative—the primary use of private insurance carriers, the role of competition among insurance plans to discipline costs, empowering consumers with choices between insurance products, and the movement of Medicaid beneficiaries into private insurance.[54] Other provisions and subsidies would mitigate concerns about the employer mandate's impact on small businesses. With the left and right joined, reasoned the program's architects, health providers, major business groups, insurance carriers, and other moderate stakeholders would all enlist in the coalition.

To avoid the pitfalls of previous bipartisan efforts, however, the *process* toward enacting legislation would follow the pattern Charles Jones describes as "co-partisanship."[55] Clinton and the Democrats would initially craft their version of health care reform, the Republicans would pursue their own. Then—each plan falling somewhere in the general domain of managed competition among private health insurance plans—a final compromise could be struck that was more expensive and regulatory than Republicans favored and launched more slowly, with greater variability in insurance arrangements than Democrats preferred.

That was the projection. In the end, however, Congress was once again the graveyard of reform. Despite full engagement by several House and Senate committees, intense on-going negotiations over alternatives and possible compromises, and even formal debate in the Senate chamber, universal coverage died once again without a single vote being taken on the floor of either the House or Senate. The full story, of course, is nuanced and complicated, the subject of numerous books, including my own.[56]

For our purposes here, let me highlight a few issues of particular relevance to Congress. To start, bicameralism became a major barrier. Because the Senate was more institutionally fragmented and more conservative than the House, the White House and Democratic leaders in Congress expected to pass legislation in the House first. That success would create the impetus needed to leverage favorable action in the Senate. But this strategy was stymied by the political damage of Clinton's budget and economic program, enacted a year earlier in the summer of 1993. That initiative had originally included a tax on energy consumption, calibrated using British thermal units (BTUs), a standard measure of energy. House Democrats—blasted by Republicans for raising taxes—stuck with the president in support of this controversial, strange sounding provision because he twisted arms, scrounged votes, and promised not to drop the BTU tax in the Senate. However, energy producers are more effectively represented in the Senate. To get the Senate's agreement on the economic program Clinton ultimately felt compelled to sacrifice the energy tax (Vice President Al Gore had to cast a tie-breaking final vote on the package). House members, who had taken an unpopular position on a provision that was dropped in the Senate declared they would not be "BTUed" again. They insisted that the Senate move first on health care reform, which had equally controversial elements. Action in the Senate, however, was much harder to achieve—again, it operates under more fragmented rules that permit minorities to block action by, among other things, threatening filibusters. After intense and lengthy efforts, the Senate Finance Committee was not able to report out an acceptable compromise.

Passage of health care reform in either the Senate or the House was stymied by an intense, highly mobilized opposition that brought together most Republicans, including much of their leadership, with the "No-Name Coalition," the new antireform alliance that emerged under the leadership of small business (operating through the NFIB), the private insurance carriers (HIAA), and the pharmaceutical companies (PhRMA). Clinton's method of drafting the Health Security Act, and the Byzantine substantive policy requirements of achieving universal coverage and cost control using disparate private institutions, also gave the opponents of health care reform the ammunition they needed to defeat the proposed legislation.

Because of the complexities involved in designing a fresh health care reform, and the emergence of divisive issues like the budget fight, ratification of the North American Free Trade Agreement (NAFTA, which split organized labor from the Clinton administration), and unexpected foreign policy set-backs, it took much longer to develop the president's initiative than expected. Clinton announced the plan in a major speech to the public from a joint session of Congress in September 1993, but the actual proposal was not available to Congress until the start of 1994. That gave the opposition time to find allies, marshal resources, develop a strategy, and hone a message. The Health Security Act itself, an intricate plan articulated in 1,342 pages of legislative language, provided keys to that message. Clinton's opponents unrelentingly declared the president's plan a "government takeover of health care," a bureaucrat's dream for government intervention into every nook and cranny of one's relationship with doctors, hospitals, and insurers. In short, opponents offered new variations on the trusty old arguments against universal health care. In the meantime, liberal groups, and liberal members of Congress—disgruntled by unrelated issues or unhappy with the compromises in the plan—often refused to sign on.[57]

The co-optation strategy failed on both the left and the right. Mike Lux, the White House liaison to health care groups, wrote in a May 3, 1993, confidential memorandum to Hilary Clinton, who was leading the president's health care reform effort, "I'm beginning to grow a little concerned that in our health care decisionmaking, we may end up with a reform package that excites no one except our opposition—in other words, we could end up with a bill that generates intense opposition from several powerful special interests, but only lukewarm support from the people we've counted on to be our base."[58] In a survey I conducted of health care interest groups (N = 120) after the end of the reform debate, the results are exactly as Lux predicted. Among groups that held positions and had resources that made them likely allies of Republican opponents to reform, almost 60 percent actively fought to defeat the Health Security Act. Among those organized interests that should have been targeted by Democrats and been fully mobilized advocates of reform, only about one quarter endorsed the president's plan. Another quarter favored it but did not formally lend their endorsement. Fully one half of these groups remained neutral. They liked some features of the plan but opposed others, thus preventing them from becoming active members of a coalition favorable to reform. These interest group results, I believe, closely parallel the reactions of both the public and members of Congress.[59]

Had Clinton chosen an alternative legislative strategy, would the outcome have been different? Congress may have been the graveyard, but did the president commit involuntary manslaughter? One answer is that Clinton, pursuing another strategy, could hardly have done worse. Given what appeared to be new reform coalition-building opportunities in Congress in 1993–94, it is striking that more was not accomplished. It is impossible to know whether another approach might have shifted the result all the way from one that never saw floor action in either house of Congress to enactment by both chambers. Two crucial lessons, however, can be gleaned from the recent and past congressional experiences with health care reform. First, even under the best of circumstances (albeit in relative, not absolute, terms), accomplishing major health policy change is hard in the American system. Not surprisingly, in a 2004 survey of the legislative staff in the personal offices of representatives and senators, fully nine out of ten said that it is "very true" or "somewhat true" that "significant policy change (is/was) extremely difficult" in the House and Senate.[60] Second, for those wishing to pursue significant health policy innovation, it is essential both to identify accurately the prevailing characteristics of the overall legislative setting and to match the policy approach and the political strategy supporting it to those contextual parameters. Although there were no floor votes in either the 1970s or 1990s, the legislative machinations had progressed sufficiently far that it is possible that had reform proponents made more astute connections between policy and the politics of the

time, significant reforms might have survived the legislative gauntlet.

HEALTH POLITICS AND POLICY IN A PARTISAN CONGRESS

Those concerned about either the distributive tendencies of what I call the baseline Congress or the legislative barriers to major health policy innovation may harbor a longing for Westminster-style parliamentary government. Reform advocates in Canada eventually overcame past failures and finally witnessed the enactment of universal coverage, unlike their US counterparts, precisely because of their parliamentary institutions.[61] Such a constitutional change in the United States—the value of which would be highly debatable on other grounds—is about the least likely political proposition that one could imagine. Is there a more plausible substitute and what would be its consequences?

For many decades political scientists have called for a system of "responsible party government."[62] Each of the political parties would present clear and distinctive policy platforms to the electorate and, following elections, the institutions of government splintered by the constitutional separation of powers would be joined under the umbrella of unified party government (the same party would control the presidency, House, and Senate). Presumably such an arrangement would create enhanced incentives for legislators to focus on national concerns and perspectives, as well as provide additional political "glue" to bind legislative coalitions led by the president. For a long time such a conception of American government also seemed farfetched. After 1954, the government was more frequently divided than unified. Both parties were internally split ideologically, hardly projecting clear and distinctive policy images to the electorate. In the 93rd Congress (1973–74), for example, based on roll-call votes there was considerable overlap between Democrats and Republicans. Perhaps a third of the House was lodged at the center and could have comfortably resided in either party (in addition, many Democrats were, in fact, conservative, while a number of Republicans voted like liberals).[63]

In the last decade, however, the profile changed. Largely as a result of Republican "conservatives replacing more moderate Republicans outside of the southern states and [Republican] conservatives replacing moderate and conservative Democrats in the South," the congressional parties in both the House and Senate have become both more ideologically coherent within their respective ranks and increasingly separated from one another. The ideological distance between the parties in the legislature is the largest in about a century and the most substantial since the current party system emerged in the midst of the Great Depression in the 1930s.[64] By the 107th Congress (in 2001–02), the "center" had all but disappeared. Fewer than 3% of the House members inhabited the middle, and under 4% were encompassed by the entire ideological range in roll-call voting in which both Republicans and Democrats could be found (in contrast to more than *three quarters* of the House in 1973–74).[65] Throw in unified party government—such as what Republicans have achieved for the most part since the 2000 elections—and the opportunities for effective legislative action would seem to be particularly pronounced.

At first blush, there is some evidence to suggest this result has occurred. The most significant may be in the realm of health care policy: the December 2003 enactment of the Medicare Modernization Act, arguably the most expensive and expansive piece of social policy making since the establishment of Medicare itself also incorporates more conservative, private sector approaches to social policy than any previous law. President Bush and his Republican allies in Congress succeeded with this program, designed almost entirely in their terms over Democratic objections, only because of unified party government, solidarity within Republican ranks, and the capacity of the House Republican leadership to exploit its command of the rules and

procedures to reverse a fifteen-vote defeat at the close of the normal fifteen minute voting period (in an unprecedented move, the Speaker held open voting period for nearly three hours to orchestrate some successful arm-twisting).

Experience reveals, however, that highly partisan legislative politics do not sit well within the separation of powers framework. Not only may it fail to surmount the dispersion of policy-making authority in the American system, its interaction with a system based on multiple competing institutions can exacerbate, rather than mitigate, problems in policymaking. On the first point, even with shared party majorities, the "bicameral hurdle" remains, because the House and Senate have "different electoral constituencies (district-based versus statewide), . . . just one-third of the Senate up for re-election every two years, . . . different forces that shape House and Senate election outcomes, . . . [and] the uneven powers afforded House and Senate party leaders."[66] When different parties control the House and Senate in an intense partisan environment, as happened briefly in 2001 and 2002 when Senator James Jeffords left the GOP to become an independent, the incentives against cross-chamber accommodations become even stronger. In addition, the president—still constitutionally separated from the legislature and with divergent perspectives and political needs—cannot command serious legislative attention, much less be successful. Consider the failure of President Bush to gain any legislative leverage on his proposal for partial Social Security privatization.

It is perhaps ironic that in the American institutional setting, ideologically focused parties in Congress can also lead to greater legislative dysfunction rather than less.[67] The distributive impulses of the House and Senate, for example, have not been mitigated. Indeed, in some respects they have grown worse, reflecting the continued self-selection, autonomy, and local orientation of individual legislators, as well as the capacity of favored interest groups to gain unchecked entrée through the majority party.[68] Members of the House now request about 35,000 "earmarked" individual spending requests for their districts, attempts to "secure federal dollars for pork-barrel projects by covertly attaching them to huge spending bills." In 2005, about 15,000 earmarks were incorporated into enacted legislation, a jump from 4,000 about 10 years ago. The growth in earmarks has complicated efforts to rein in the deficit and reinforces bargaining over legislation based on particularistic log-rolling rather than substantive debate.[69] Of perhaps greater significance, the separation of powers—with the multiple perspectives and constituencies represented by the different branches of government and house of Congress—requires accommodation and compromise for action to be taken.[70] Moderate members of Congress, who have credibility with both parties, may be a necessary ingredient. Sarah Binder has determined empirically that

> [a]s Congress moderates ideologically, stalemate becomes less likely. Although single party control of the branches may help to break deadlock, there are clearly limits to the power of political parties to smooth the way for legislative agreement. Intense polarization seems counter-productive to fostering major policy change . . . [because] parties have an electoral, as well as a policy-based, incentive to distinguish their records and positions, and a less incentive to bargain and compromise.[71]

At the current levels of partisan polarization, such legislative impasses are likely to become even more pronounced if the parties continue to split control of the presidency and Congress (as they did after the 2006 election). Paul Quirk and Sarah Binder, who co-chaired a recent Annenberg Institutions of American Democracy commission on the status of the legislative branch, offer a particularly worrisome assessment:

> With the relative strength of the two parties quite comparable, divided control—especially with a Democratic president and a Republican Congress—is highly likely. In the most recent period of divided control, from 1995 to 2000,

> President Bill Clinton and the Republican Congress fought a vicious battle over health care reform, ending in stalemate; allowed the federal government to be shut down for several days in a budget impasse; and spent a full year contesting a doomed effort to remove Clinton from office through impeachment. The next [period] of divided party control . . . could witness even more destructive conflict.[72]

Only time will tell whether heightened polarization will persist and congressional policymaking will remain so problematic under conditions of either unified or divided government. It is incumbent upon students of health politics and policy, however, to recognize the inherent tendencies of a legislature that is both embedded in a separation of powers system and is populated by individual members who play such an independent role in their own selection. Around that "baseline" of congressional behavior one must then assess, for any given period, the effects of changes in party control, size of party majorities, unity within party ranks, and organization of legislative authority and power. Legislative success will often depend on matching the contours of policy proposals to the dynamics of the prevailing congressional context.

STUDY QUESTIONS

1. How does the U.S. Congress stand out among the legislatures of the world? Why?
2. This chapter argues that our system makes legislation much more difficult to pass. Do you believe this an advantage (because it checks government power) or a disadvantage (because voters do not get what they want) in a modern democracy? Why?
3. How did the House of Representatives vary in its degree of centralization over the course of the 20th century (and beyond)?
4. How have scholars attempted to explain congressional reluctance to take on the matter of national health insurance?
5. In what ways did the interest group landscape change during the 1980s and 1990s, and what ramifications did this transformation have on the possibility of enacting health care reform?
6. What are the three main types of strategy employed by presidents in their attempts to shape health care policy in concert with Congress?
7. How did Congress help stymie the health care reform program of the mid-1990s?
8. Why has unified party control of the presidency and Congress, as well as increased intraparty unity, failed to significantly ease the way toward more significant legislative action?

NOTES

1. Cowan and Hartman, 2005, pp. 18, 24; Himmelstein and Woodhandler, 2002, p 92. On the second figure, see James Morone, Introduction.
2. White, 1995.
3. Arnold, 1992.
4. Binder and Quirk, 2005, p xix.
5. Barrett and Edwards, 2000; Peterson, 1990, p 232; Rudalevige, 2002, p 137.
6. Regan, 2005.
7. Peterson, 1990, pp 47–48.
8. Jones, 1994, Chapter 7.
9. Neustadt, 1960, p 42.
10. Lijphart, 1984.
11. The consequences for health care policymaking can be seen in Gauld, 2000, p 815.
12. Immergut, 1992; Adolino and Blake, 2001, pp 679–708.
13. Jacobs, 2005; Adolino and Blake, 2001, pp 679–708; Immergut, 1992; Longstreth et al., 1992.
14. Mayhew, 1974, p 5.
15. Arnold, 1992, pp 5–6; Fenno, 1973, Chapter 1.
16. Novak and O'Neill, 1987.
17. Cox and McCubbins, 1993.
18. Davidson, 1992; Hertzke and Peters, 1992; Jacobs and Shapiro, 2000; Mann and Ornstein,

1981; Rhode, 1991; Sinclair, 1982; Sinclair, 1983; Sinclair, 1989.
19. Malbin et al., 2002, p 173.
20. Peterson, forthcoming.
21. Shickler, 2005; Davidson, 1992; Rhode, 1991.
22. The extent to which interest groups wield influence over Congress remains a complicated and unsettled issue, the subject of an enormous body of literature. A useful overview can be found in Ainsworth, 2002.
23. Alford, 1975; Feldstein, 1977; Starr, 1983; Weissert and Weissert, 1996.
24. Olson, 1965; Walker, 1991.
25. Arnold, 1992, p 75.
26. See, for example, Bosso, 1987.
27. Marmor, 2000, especially ch. 4; Oberlander, 2000, Chapter 16.
28. Peterson, 1998, pp 197–208.
29. Peterson, 1998, pp 214–18.
30. Toner, 2006, pp A1, A17.
31. White, 1995.
32. Gallup Poll, September 2001; Jacobs and Shapiro, 1995.
33. Steinmo and Watts, 1995, pp 329–72.
34. Peterson, forthcoming. My measures include the characteristic and allocation of staff resources, legislative mark-up and hearing activities, the process of selecting committee chairs, and the availability of rules that empower leadership.
35. Davidson, 1992; Deering and Smith, 1984; Hertzke and Peters, 1992; Mann and Ornstein, 1981; Rhode, 1991; Sinclair, 1982; Sinclair, 1983; Sinclair, 1989.
36. Peterson, forthcoming.
37. Peterson, 2001, pp 1145–63.
38. Quadagno, 2005.
39. Campion, 1984; Peterson, forthcoming; Peterson, 1994, 103–47; Poen, 1979.
40. Peterson, 2004.
41. Peterson, forthcoming; Wainess, 1999, p 305–33.
42. Peterson, forthcoming; Skocpol, 1996.
43. Feder, 1993, p A22; Goldfield, 1987; Gottschalk, 2000.
44. Heinz et al., 1993; Peterson, 2001; Peterson, forthcoming; Sammon, 1992, p 1810.
45. Gottschalk, 2000.
46. Broder and Johnson, 1996; Peterson, forthcoming.
47. Jones, 1994.
48. Peterson, 1990.
49. Wainess, 1999.
50. Starr, 1983.
51. Peterson, 1992, pp 553–73; Peterson, 1998.
52. Jacobs, 1995, pp 143–57.
53. Peterson, 1998.
54. Hacker, 1997; Starr, 1994.
55. Jones, 1994.
56. See, for example: Gottschalk, 2000; Hacker, 1997; Jacobs and Shapiro, 2000; Broder and Johnson, 1996; Martin, 2000; Mayes, 2005; Peterson, forthcoming; Quadagno, 2005; Skocpol, 1996.
57. Peterson, forthcoming; Peterson, 1998.
58. Memorandum, 1993, p 1.
59. Brady and Buckley, 1995, pp 447–54; Brodie and Blendon, 1995, pp 403–10; Hacker, 1997; Jacobs and Shapiro, 2000.
60. Annenberg, 2004, question 9a.
61. Maioni, 1994, pp 5–30.
62. Schattschneider, 1942; Committee, 1950.
63. The estimate is based on using the NOMINATE scores developed by Keith T. Poole and Howard Rosenthal and the distribution of House members in the 93rd Congress, with "center" defined as in the range of –0.1 to +0.1 on the NOMINATE liberal–conservative scale (the full scale goes from –1.0 (most liberal) to 1.0 (most conservative).
64. Poole, 2005, p 8; Sundquist, 1973, Chapter 10.
65. The "entire range" is defined as the range on the Poole-Rosenthal NOMINATE liberal–conservative scale that is inclusive of the left-most voting Republican and the right-most voting Democrat.
66. Binder, 2005, p 12.
67. Fiorina, 2006.
68. Binder and Quirk, 2005, p 541. The most extreme example is the scandal surrounding lobbyist and former Republican congressional staffer Jack Abramoff, as well as the general

difficulties confronting Representative Tom DeLay, who was forced to resign from his post as Republican Majority Leader in the House. See Cochran, 2006, p 174; Cochran, 2005, pp 2636–41; Koszczuk and Ota, 2005, pp 2642–7.

69. Flake, 2006, p 27; Hulse, 2006, p 16.
70. See Peterson, forthcoming.
71. Binder, 2005, p 12–13; Binder, 2003.
72. Binder and Quirk, 2005, p 546.

REFERENCES

Adolino, J.R., and C.H. Blake. 2001. "The Enactment of National Health Insurance: A Boolean Analysis of Twenty Advanced Industrial Countries," *Journal of Health Politics, Policy and Law* 26 (August): 679–708.

Ainsworth, S.H. 2002. Analyzing Interest Groups: Group Influence on People and Policies. New York: W.W. Norton.

Alford, R.R. 1975. Health Care Politics: Ideological and Interest Group Barriers to Reform. Chicago: University of Chicago Press.

Annenberg Congress Survey (in the field August 4 to November 22, 2004; *N* = 252). Question 9a; are part of the Annenberg Institutions of American Democracy Surveys.

Arnold, R.D. 1992. *The Logic of Congressional Action*. Yale University Press.

Barrett, A., and G.C. Edwards, III. 2000. "Presidential Agenda Setting in Congress," in J.R. Bond and R. Fleischer, eds., *Polarized Politics: Congress and the President in a Partisan Era*. Washington DC: CQ Press.

Binder, S.A. 2005. "Elections and Congress's Governing Capacity," *extensions: A Journal of the Carl Albert Congressional and Studies Center* (Fall): 12–13.

—— 2003. Stalemate: Causes and Consequences of Legislative Gridlock Washington DC: Brookings Institution Press.

Binder, S.A., and P.J. Quirk. 2005. "Congress and American Democracy: Assessing Institutional Performance," in P.J. Quirk and S.A. Binder, eds., *Institutions of American Democracy: The Legislative Branch*. New York: Oxford University Press, pp 541–6.

—— 2005. "Introduction: Congress and American Democracy: Institutions and Performance," in P.J. Quirk and S.A. Binder, eds., *Institutions of American Democracy: The Legislative Branch*. New York: Oxford University Press, p xix.

Bosso C.J. 1987. *Pesticides and Politics: The Life Cycle of a Public Issue*. Pittsburgh: University of Pittsburgh Press.

Brady, D.W., and K.M. Buckley. 1995. "Health Care Reform in the 103rd Congress: A Predictable Failure," *Journal of Health Politics, Policy and Law* 20 (Summer): 447–54.

Broder, D.S., and Johnson, H. 1996. The System: The American Way of Politics at the Breaking Point. Boston: Little, Brown.

Brodie, M., and Blendon, R.J. 1995. "The Public's Contribution to Congressional Gridlock on Health Care Reform," *Journal of Health Politics, Policy and Law* 20 (Summer): 403–10.

Campion, F.D. 1984. *The A.M.A. and U.S. Health Policy Since 1940*. Chicago: Chicago Review Press.

Cochran, J. 2005. "Debacles, DeLay, and Disarray," CQ Weekly, October 3, pp 2636–41.

—— 2006. "The Influence Implosion," CQ Weekly, January 16, p 174.

Committee on Political Parties. 1950. "Towards a More Responsible Two-Party System." New York: American Political Science Association.

Cowan, C.A., and M.B. Hartman. 2005. "Financing Health Care: Business, Households, and Governments, 1987–2003," *Health Care Financing Review*/Web Exclusive 1 (July): 18, 24.

Cox, G.W., and M.D. McCubbins. 1993. *Legislative Leviathan: Party Government in the House*. Berkeley: University of California Press.

Davidson, R.H., ed. 1992. *The Postreform Congress*. New York: St. Martin's Press.

Deering, C.J., and S.S. Smith. 1984. *Committees in Congress*. Washington DC: CQ Press.

Feder, B.J. 1993. "Medical Group Battles to be Heard Over Others on Health-Care Changes," *New York Times,* June 11, p A22.

Feldstein, P.J. 1977. Health Associations and the Demand for Legislation: The Political Economy of Health. Cambridge: Ballinger Publishing.

Fenno, R.F. Jr. 1973. *Congressmen in Committees*. Boston: Little, Brown, Chapter 1.

Fiorina, M.P. 2006. "Parties as Problem Solvers," in A. Gerber and E. Patashnick, eds., *Promoting the General Welfare: American Democracy and the Political Economy of Government Performance*. Washington DC: The Brookings Institution Press.

Flake, J. 2006. "Earmarked Men," *New York Times,* February 9, p 27.
Gauld, R.D.C. 2000. "Big Bang and the Policy Prescription: Health Care Meets the Market in New Zealand," *Journal of Health Politics, Policy and Law* 25 (October): 815; White, *Competing Solutions*.
Goldfield, M. 1987. *The Decline of Organized Labor in the United States*. Chicago: University of Chicago Press.
Gottschalk, M. 2000. The Shadow Welfare State: Labor, Business, and the Politics of Health Care in the United States. Ithaca: Cornell University Press.
Hacker, J. 1997. The Road to Nowhere: The Genesis of President Clinton's Plan for Health Security. Princeton: Princeton University Press.
Heinz, J.P., E.O. Laumann, R.L. Nelson and R.H. Salisbury. 1993. *The Hollow Core: Private Interests in National Policy Making.* Cambridge: Harvard University Press.
Hertzke, A.D., and R.M. Peters, Jr., eds. 1992. *The Atomistic Congress: An Interpretation of Congressional Change.* New York: M.E. Sharpe.
Himelfarb, R. 1995. Catastrophic Politics: The Rise and Fall of the Medicare Catastrophic Coverage Act of 1988. University Park, PA: Penn State University Press.
Himmelstein, D.U., and S. Woolhandler. 2002. "Paying for National Health Insurance—And Not Getting It," *Health Affairs* 21 (July-August): 92.
Hulse, C. 2006. "Lawmakers Seeking Curbs on Special Spending Requests," *New York Times,* February 7, p 16.
Immergut, E.M. 1992. Health Politics: Interests and Institutions in Western Europe. New York: Cambridge University Press.
Jacobs, L.R. 1995. "The Politics of America's Supply State: Health Reform and Technology," *Health Affairs* 14 (Summer): 143–57.
—— 2005. "Health Disparities in the Land of Equality," in J.A. Morone and L.R. Jacobs, eds., *Health, Wealthy, and Fair: Health Care and the Good Society*. New York: Oxford University Press.
Jacobs, L.R., and R.Y. Shapiro. 1995. "Don't Blame the Public for Failed Health Care Reform," *Journal of Health Politics, Policy and Law* 20 (Summer): 416–7.
—— 2000. Politicians Don't Pander: Political Manipulation and the Loss of Democratic Responsiveness. Chicago: University of Chicago Press.
Jones, C.O. 1994. *The Presidency in a Separated System.* Washington DC: Brookings Institution Press, Chapter 7.
Koszczuk, J., and A.K. Ota. 2005. "The Slow Decline of a GOP 'Godfather,'" CQ Weekly, October 3, pp 2642–7.
Lijphart, A. 1984. Democracies: Patterns of Majoritarian and Consensus Government in Twenty-One Countries. New Haven: Yale University Press.
Longest, Jr., B.B. 2002. *Health Policymaking in the United States,* 3rd ed. Ann Arbor: Health Administration Press.
Longstreth, F., S. Steinmo, K. Thelen, eds. 1992. *Structuring Politics: Historical Institutionalism in Comparative Analysis.* New York: Cambridge University Press.
Mayhew, D.R. 1974. *Congress: The Electoral Connection.* New Haven: Yale University Press, p 5.
Maioni, A. 1994. "Nothing Succeeds Like the Right Kind of Failure: Postwar National Health Initiatives in Canada and the United States," *Journal of Health Politics, Policy and Law* 19 (Winter): 5–30.
Malbin, M.J., T.E. Mann and N.J. Ornstein. 2002. *Vital Statistics on Congress, 2001–2002.* Washington DC: AEI Press, p 173.
Mann, T.E., and N.J. Ornstein, eds. 1981. *The New Congress.* Washington DC: American Enterprise Institute.
Marmor, T.R. 2000. *The Politics of Medicare*, 2nd ed. Aldine Transaction.
Martin, C.J. 2000. Stuck in Neutral: Business and the Politics of Human Capital Investment Policy. Princeton: Princeton University Press.
Mayes, R. 2005. Universal Coverage: The Elusive Quest for National Health Insurance. Ann Arbor: University of Michigan Press.
Memorandum for Hillary Rodham Clinton, from Mike Lux, subject Positioning Ourselves on Health Care, May 3, 1993, Privileged and Confidential, p 1.
Morone, J.A., and L.R. Jacobs. 2005. *Healthy, Wealthy, and Fair: Health Care and the Good Society.* New York: Oxford University Press.
Neustadt, R.E. 1960. *Presidential Power.* New York: John Wiley & Sons, p 42.

Novak, W., and T.P. O'Neill. 1987. Man of the House: The Life and Political Memoirs of Speaker Tip O'Neill. New York: Random House.
Olson, M. 1965. *The Logic of Collective Action.* Cambridge: Harvard University Press.
Peterson, M.A. 1994. "Congress in the 1990s: From Iron Triangles to Policy Networks," in J.A. Morone and G.S. Belkin, eds., *The Politics of Health Care Reform: Lessons from the Past, Prospects for the Future.* Durham: Duke University Press, pp 103–47.
—— 1990. Legislating Together: The White House and Capitol Hill from Eisenhower to Reagan. Cambridge: Harvard University Press, p 232.
—— 1992. "Report from Congress: Momentum Toward Health Care Reform in the U.S. Senate," *Journal of Health Politics, Policy and Law* 17 (Fall): 553–73.
—— (forthcoming). "Stalemate: Opportunity, Gambles, and Miscalculations in Health Policy Innovation."
—— 1998. "The Politics of Health Care Policy: Overreaching in an Age of Polarization," in M. Weir, ed., *The Social Divide: Political Parties and the Future of Activist Government.* Washington DC and New York: Brookings Institution and Russell Sage Foundation.
—— 2001. "From Trust to Political Power: Interest Groups, Public Choice, and Health Care Markets," *Journal of Health Politics, Policy and Law* 26 (October): 1145–63.
—— 2004. "The Politics of Health: The Changing Community of Organized Interests." Paper prepared for delivery at the annual meeting of the American Political Science Association, IL, September 2–5.
—— (forthcoming). "The Three Branches of Government: Checks, Roles, and Performance," in The Annenberg Democracy Group, *Institutions of American Democracy: A Nation Divided* (tentative title). New York: Oxford University Press.
Poen, M.M. 1979. *Harry S. Truman versus the Medical Lobby.* Columbia: University of Missouri Press.
Poole, K.T. 2005. "The Decline and Rise of Party Polarization in Congress During the Twentieth Century," *extensions: A Journal of the Carl Albert Congressional and Studies Center* (Fall): 8.
Quadagno, J. 2005. One Nation Uninsured: Why the U.S. Has No National Health Insurance. New York: Oxford University Press.
Regan, T. 2005. "Blair Loses Key Terror Vote," CSMonitor.Com (*Christian Science Monitor*), posted November 10, at 11:00 a.m., http://www.csmonitor.com/2005/1110/dailyUpdate.html?s=rel.
Rhode, D.W. 1991. *Parties and Leaders in the Postreform House.* Chicago: University of Chicago Press.
Rudalevige, A. 2002. Managing the President's Program: Presidential Leadership and Legislative Policy Formulation. Princeton: Princeton University Press, p 137.
Sammon, R. 1992. "Fall of Striker Bill Spotlights Doubts about Labor Lobby," *Congressional Quarterly Weekly Report,* June 20, p 1810.
Schattschneider, E.E. 1942. *Party Government I.* New York: Farrar and Reinhart.
Shickler, E. 2005. "Institutional Development of Congress," in P.J. Quirk and S.A. Binder, *Institutions of American Democracy: The Legislative Branch.* New York: Oxford University Press.
Skocpol, T. 1996. Boomerang: Clinton's Health Security Effort and the Turn Against Government in U.S. Politics. New York: W. W. Norton.
Sinclair, B. 1982. Legislators, Leaders, and Lawmaking: The U.S. House of Representatives in the Post-Reform Era. Baltimore: Johns Hopkins University Press.
—— 1983. *Majority Leadership in the U.S. House.* Baltimore: Johns Hopkins University Press.
—— 1989. *The Transformation of the U.S. Senate.* Baltimore: Johns Hopkins University Press.
Starr, Paul. 1994. The Logic of Health Care Reform: Why and How the President's Plan Will Work. New York: Whittle.
—— 1983. The Transformation of American Medicine. New York: Basic Books.
Steinmo, S., and J. Watts. 1995. "It's the Institutions, Stupid! Why Comprehensive National Health Insurance Always Fails in America," *Journal of Health Politics, Policy and Law* 20 (Summer): 329–72.
Sundquist, J.L. 1973. Dynamics of the Party System: Alignment and Realignment of Political Parties in the United States. Washington DC: The Brookings Institution, Chapter 10.
Toner, R. 2006. "Rival Visions Led to Rocky Start for Drug Benefit," *New York Times,* February 6, pp A1, A17.

Wainess, F.J. 1999. "The Ways and Means of National Health Care Reform, 1974 and Beyond," *Journal of Health Politics, Policy and Law* 24 (April): 305–33.

Walker, J.L. Jr. 1991. Mobilizing Interest Groups in America: Patrons, Professions, and Social Movements. Ann Arbor: University of Michigan Press.

Weissert, C.S., W.G. Weissert. 1996. *Governing Health: The Politics of Health Policy*. Baltimore: John Hopkins University Press.

White, J. 1995. Competing Solutions: American Health Care Proposals and International Experience. Washington DC: Brookings Institution, pp 5–7.