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The Effectiveness of the Strategies Interest Groups Use to Influence Health Care Reform in The United States: A Case Study Analysis of President Clinton, Bush, and Obama's Health Care Reforms

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THE EFFECTIVENESS OF THE STRATEGIES INTEREST GROUPS USE TO INFLUENCE HEALTH CARE REFORM IN THE UNITED STATES: A CASE STUDY ANALYSIS OF INTEREST GROUP SUCCESS IN PRESIDENT CLINTON, BUSH, AND OBAMA'S HEALTH CARE REFORMS

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Chapter 1: Introduction

Attempts at health care reform have occurred in the United States since President Theodore Roosevelt. Since then, presidents have frequently attempted to try and reform the health care system in the United States; whether one aspect of the system was being reformed or a health care overhaul was being attempted, it has been tried by presidents throughout history. A key component of reform efforts and passing legislation through Congress is the activity of interest groups. Interest groups have their own special interests and when reforms are on the table, each group likely wants something slightly different out of a reform. This leads to lobbying efforts by interests at times of reform. Common lobbying efforts include inside and outside strategies (attempting to influence Members of Congress and the public) and spending. Through trying to make appeals to the public, interest groups may utilize grassroots campaigns or may use advertisements to sway public opinion in their favor. Also, in order to try and gain the provisions that they would like in a reform, interest groups may align themselves with the president. This includes supporting the president's plan publically and making deals with the administration. Finally, an organization that is ideologically aligned with Congress may be better positioned to gain provisions that they would prefer in a reform.

Looking at interest group behavior and the strategies of interest groups that appear to be most successful in a reform is useful. Interest groups can use effective strategies to gain as many provisions that they would like to see in a reform. It is important to be able to identify why some groups have a high level of success in a reform and some have a low level of success. If success is not due to chance, the causal mechanism is important to know so it can be used as an effective strategy. Both interest groups, and those working in Congress and in the White House can look at interest groups' roadmaps to success to help bargain, compromise, and create an effective reform

that satisfies the most players in a reform. Understanding the motivating and successful strategies of interest groups is important because in order to work with these groups, and in order for these groups to be successful as an organization, their mechanisms must be known.

The main frameworks for interest group theory involve theories of institutional change, interest group dynamics, the status quo, collective interests, and citizen groups. Each framework has a different approach to interest group behavior. Status quo theory focuses on how interest groups are able to initiate or block change, while collective interests touches on how interest groups can band together to try and accomplish a goal.

In this study, the strategies interest groups use to influence health care reform in the United States will be observed and analyzed. The research question being tested is: What strategies do interest groups choose to use in an attempt to influence health care reform and how successful are the different direct and indirect strategies? The hypotheses are: 1) With all other things being equal, interest groups who are more active with the reform movement are more likely to be successful in their goals than those who are less active, 2) With all other things being equal, interest groups who are aligned with presidential health care reform initiatives are more likely to be successful in their goals than those who are not aligned, and 3) With all other things being equal, interest groups who are aligned with the ideological majority in Congress are more likely to be successful in their goals than those who are not aligned with the ideological majority in Congress. These hypotheses will be tested through empirical case studies of President Clinton, President Bush, and President Obama's health care reform attempts. Key interest groups will be observed and their activity level, ideological alignment with Congress, presidential alignment, and their success level will be observed. Finally, judgments will be made about the model after each case.

This study will take the following approach, first a review of the literature and key theoretical frameworks will be provided, then the theory and methods for this study will be provided. Following that will be three case studies of presidential attempts of health care reform in the United States. At the end of each case study will be an analysis of the model for that individual case. Following the cases, however, will be an overall analysis of the model and a conclusion to the study.

Chapter 2. Empirical Literature Review

Health care reform attempts by presidential administrations in the United States date back as far as President Theodore Roosevelt. Since then, health care has been on the political agenda and interest groups have risen to either favor or oppose proposed legislation. Interest groups have been active since the creation of health care programs in the United States to either actively support or to oppose any further reform attempts in Congress. There are many studies and theories that aim to explain why interest groups have been so active and prevalent in health care reform in the United States. Many scholars have attempted to address interest group behavior in the United States. Such scholars include Mark Peterson, Thomas Gais, Jack Walker, Frank Baumgartner, Jeffrey M. Berry, Marie Hojnacki, David C. Kimball, Beth L. Leech, Kay Lehman Schlozman, Sidney Verba, and Henry E. Brady. There are three different elements to current interest group research: how the institutional system in the United States has changed, that it is significant whether or not interest groups are protecting the status quo, and broad collective interests have developed a newfound importance in American politics.

I. Institutional Changes

One of the main arguments from Mark Peterson about how interest groups operate in the United States is that "changes in these organized interests and in Congress have transformed the health care reform policy community from an 'iron triangle' dominated by an antireform alliance of medicine, insurance, and business to a more loosely bound policy network in which a reform coalition may now be able to prevail" (Peterson 1993a, 395). Iron triangles are autonomous and impermeable while issue networks are "made up of technical specialists, journalists, administrators and public administrators (Gais et al. 1984). Issue networks, however, lack "the structure and internal homogeneity of subgovernments" (Gais et al. 1984, 162) and therefore complicate situations, are unpredictable, and strain governmental leadership.

Both iron triangles and issue networks have distinguishable characteristics. Iron triangles are more sympathetic to the concerns of the large vested interests in society, policy outputs are more predictable, budget shares are more strongly fixed, and authority would be clear even though it is decentralized and complicated. Issue networks would have a less stable system of authority. There would be possible rapid mobilization of new coalitions and legislation that would be thought to have a low likelihood of passage would be able to pass through Congress. Stable policy areas could suddenly develop conflict. This system of subgovernments has barriers against redistribution, but new programs could be added as long as they did not disturb the existing system. Thus, in this system, redistribution shifts in the budget shares are likely, because as new programs are added, the budget must change accordingly (Gais et al. 1984).

To test this theory, Peterson looks at three hypotheses. The first hypothesis is that "despite the apparent structural changes the core power relationships will remain the same as in the past, and the antireform alliance will either continue to block policy change or will push

through a reform program that protects its constituent interests" (Peterson 1993a, 395). According to the second hypothesis, "the structural changes produce an atomization of power, making coalition building in support of reform impossible" (Peterson 1993a, 395). The third, and what is considered the most plausible hypothesis is, "the structural changes, in combination with the shift in politics and Clinton's election, have generated new opportunities for fundamental reform" (Peterson 1993a, 396). This is the most plausible hypothesis because it is more optimistic and is the most in line with current political environments (Peterson 1993a).

To explore these changes, Peterson sets forth three possible approaches. The first method he suggests is to comparatively look across nations and look how other democracies that are economically advanced have executed comprehensive health care finance reform, especially those with similar discussions to the United States (Peterson 1993a). The second, like the first, is a comparative approach. This method would search for the common ground in the policy domains of American politics. This approach "draws attention to fundamental reforms that have been both deliberated and executed in this country, such as the creation of the Federal Reserve and the establishment of Social Security" (Peterson 1993a, 398). The third method, and the method that Peterson uses in this study, is the approach of focusing on health policy in the United States and emphasizing the attributes of that policy domain that are subject to variation and are likely to be of consequence to governmental decisions about comprehensive health care reform (Peterson 1993a). This approach is preferred and is the one utilized in Peterson's study because it is the most favorable. The first approach falls short and is not able to estimate the probability of enacting reform given the design of the United States' government and political system (Peterson 1993a). The second approach is problematic because the policy outcomes that it compares are "…influenced by the characteristics of the individual policy domains to which

they belong and the substantive issues involved" (Peterson 1993a, 398). The third framework is the best because it enables Peterson to look at the way attributes of health policy "derives from the ways in which they motivate the national policy making process in the U.S., both individually and in the interaction with one another" (Peterson 1993a, 399). Thus, this method makes it possible to observe and study how likely it is that the President—President Clinton in this case—will have more success with comprehensive health care reform that those who attempted a reform before.

The focus of this theory is that the institutional structures in the United States have changed and that affects the context in which ideas are promoted, blocked, deliberated, decisions are made, and cues to other decision makers are formed (Peterson 1993a). A main concern is with the changes in the policy community. Main players in reform are representational communities and these communities are either stakeholders or stake-challengers. Representational communities are composed of "organized interests and members of the executive and legislative branches of government who turn proposals into policy or orchestrate vetoes of them" (Peterson 1993a, 400). The members of this community influence and motivate public opinion and then use the public's positions to advantage themselves in the eyes of elected officials to increase and build their credibility. A key role of a representational community is that "it determines which interests project an effective voice and which do not and affects which ideas and perspectives get emphasized in public debate and so gain the most currency among officials" (Peterson 1993a, 400). Ultimately, Peterson thinks that politics and structure were radically changed by the 1990s because the iron triangle system transformed to a policy network, which is a diverse and open system that allows coalitions the opportunity to succeed. This transformation will be further described in how Peterson believes structure is important and how

the American Medical Association (AMA) has lost power in the United States. The most significant factor for the prospect of reform success in the 1990s was the transformation of the health care community from an iron triangle to a policy network (Peterson 1993a).

Based on current research, "the fundamental outlines of American politics have been altered and we are aware that this transformation has been the result of many influences" (Gais et al. 1984, 163). It is clear that there are still iron triangles in the United States, but they are less powerful than they were in the 1940s and 1950s and are no longer a collection of loose subgovernments (Gais et al. 1984). The American government has changed in size and scope. It has become decentralized. The fragmentation of Congress has "allowed private interests to cultivate relationship with relatively small sets of governmental actors who possessed the authority necessary to resolve most policy issues" (Gais et al. 1984, 164). This is clear in the fact that there are hundreds of new government programs that have involved the government in many different areas that were once of only a local concern. This has created an opportunity for the development of subgovernments that would not change the decentralized structure of policy making in the United States (Gais et al. 1984).

When looking at how policy is moved, it is evident that "once the President and congressional leaders become directly involved in debate over an issue, the controversy naturally attracts the attention of larger number of people" (Gais et al. 1984, 165). This is because the mass media displays information to the public and then the public becomes more interested and involved with their elected officials and the debate (Gais et al. 1984). The authors believed that the American public had become more involved with politics and their representatives because a study showed that "the proportion of the population reporting that they had written a letter to a government official increased from 17 to 28 percent between 1964 and 1976" (Gais et al. 1984,

166). The American middle-class has also changed; they became more involved in politics in the 1960s and 1970s, and thus became a target audience for political entrepreneurs. This is important because "new constituencies could be reached who were more likely to respond to ideological appeals, and less likely to care about the maintenance requirements of large private organizations or their co-opted allies in the public sector" (Gais et al. 1984, 166).

There is "evidence of a transformation of the American system of policy making. Important new institutions and individuals have recently appeared that are willing to serve as patrons for political action in pursuit of broad collective goals" (Gais et al. 1984, 177). The increased presence of citizen groups in American politics (discussed below) who are more likely to engage in grassroots mobilization and appeal to the public to advance their goals and interests has changed the institutional dynamic. It is concluded that "the decentralized system of subgovernments is definitely being threatened" (Gais et al. 1984, 177) because policy entrepreneurs are being challenged. This has also increased the conflict level in American politics because commercial interests and citizen groups are competing against one another. Congress is affected because the change has created more problems for legislators in terms of re-election campaigns. Committees have lost their control in Congress and conflict has increased and weakened Congress' control over policy outcomes. This means that many decisions are then left up to the executive branch of government. Presidents must also bargain and debate what the subgovernments have established concerning a policy issue. Subgovernments should, however, protect the presidency from having to handle too many technical issues and debates that could be handled within the government. Therefore, the Presidency can "shape the agenda of the higher levels of government, choosing issues that will enhance their reputations and increase their future influence" (Gais et al. 1984, 181). The President is put in a difficult position because the

President must ultimately handle the decisions that were too difficult to handle in the lower levels of government. This turns the President into a conflict manager.

In The United States, "a penetrable, unpredictable competitive system of conflict resolution will emerge that would frustrate almost all efforts to provide it with national focus and leadership" (Gais et al. 1984, 184). When Congress' efforts become stumped, control and power falls to the president and his or her administration, but often they have difficulty resolving and focusing conflict as well. It is unlikely that a decentralized system of autonomous subgovernments could be re-established. A change in the representative institutions in American national government has been observed. The increased presence of citizen groups has also changed how policy is created and enacted in the Untied States. The previous system of iron triangles has moved to a system of issue networks that are fluid and composed of technical specialists, journalists, administrators, and political entrepreneurs (Gais et al. 1984).

Peterson has always argued that "institutional change can dramatically alter the dynamics of political relationships" (Peterson 1993b, 782) and that it has "practical consequences for how health policy reformers of every stripe approach one another, assess the intersection of substantive policy and political reality, and set the course for restructuring one of the largest economies in the world: the American health care financing and delivery system" (Peterson 1993b, 783). Peterson believes that others assume that there are "unyielding institutional characteristics of American government and politics that simultaneously make the reform enterprise itself extraordinarily precarious and constrict sharply the domain of viable policy options even if reform in some sense moves forward" (Peterson 1993b, 783). Peterson believes that this is incorrect and states that the 1990s are not the 1970s. This is because the problems of diminished access, rising cost, and threatened quality have been aggravated, the general public is

more ready to promote intervention by the government, and the middle class is suffering from setbacks in health security (Peterson 1993b).

The 1990s have had an institutional change that has altered the way interests are mobilized and represented in the policy-making process. Profit-sector interests, like trade associations, have had a strong advantage with organizing for political purposes (Peterson 1993b). Profit-sector interests have a low number of potential members and they have a rational basis for a member to subsidize the organizational effort. Groups with large potential memberships face what Peterson calls the "free rider" problem. This is because all of the members of their organization will benefit if their political objectives are achieved regardless of whether or not each organization participates.

The institutional change in America, according to Peterson, is due to five different factors in Congress. The first factor is that after the 1970s and through the 1980s the House was more productive at moving legislation out of subcommittees and onto the House floor, and once legislation was on the floor, the leadership was good at maintaining the agenda. Secondly, there were a large number of party, committee, and subcommittee leaders who were experienced and committed to health care reform. Thirdly, Members of Congress had become policy entrepreneurs and made their own plans to restructure the financing of new medical services. This means that many Members of Congress were knowledgeable about the problem, interested in it, and working on a solution. Fourthly, the 1992 elections brought 110 new representatives and twelve freshmen senators into the 103rd Congress. Many of these representatives campaigned on ending gridlock and finding an acceptable solution to the health care reform debate. Finally, Congress is able to do high-level policy analysis and has resources such as the Congressional Budget Office, the Office of Technology Assessment, the General Accounting Office, the

Congressional Research Service, the Physician Payment Review Commission, and the Prospective Payment Assessment Commission. These offices help Congress produce meaningful data that enable them to make informed decisions (Peterson 1993b).

Peterson notes that policy change "depends on fairly momentary 'policy windows' engendered by a confluence of problem awareness, events, public mood, electoral outcomes, and policy entrepreneurship" (Peterson 1993b, 795). Once these policy windows are open, "major shifts in policy probably depend on the results of…'political' decision making, when ideas and people with influence are both energetically in contention" (Peterson 1993b, 795). Peterson notes that this is not static and depends on bargaining and the participant's relative power and how resources are utilized. Based on his analysis, it is concluded that "the current institutional setting affords the best chance in this century for fulfilling the most ambitions reform objectives" (Peterson 1993b, 796). Reformers learn from past reforms and thus, "reformers are also cautioned by the 1970s episode to assess carefully the fluctuating politics of medical care reform and know when to strike a deal—when to fight *and* when to bargain…" (Peterson 1993b, 796).

A structure-based approach to interest group behavior is important because "conditions become perceived as problems, problems attract attention, and popular sentiment motivates adjustments in policy only through mediating institutions, which are, additionally, players in their own right" (Peterson 1993a, 497). If representation institutions, like interest groups, show the attitudes of those who have the most to lose from adjusting the policy status quo, and the government's structure allows these interests to have primary control, no variation in politics can create policy innovation except a mandate from the government unified by a strong political party (Peterson 1993a). The key part of this theory is that as the politics around health reform changes, the health policy domain has changes as well. It has changed in regards to how interests

are represented in the United States and how interest groups have access to policymakers. The end result is a whole new policy community (Peterson 1993a).

The shift from an iron triangle system to an issue network system in the United States "provides an opportunity, an opening, for reform where perhaps none ever existed before" (Peterson 1993a, 426). A policy network has been created that is more complex than before and that the current system now has roles for new ideas and players (Peterson 1993a). After each of the three hypothesis surrounding the institutional structure of government in the United States is tested, it is found that the first hypothesis, that structural changes do not have much consequence, has strong and weak components that leaves it subject to counterarguments and subjects it to questioning. It forgets to include the impacts of campaign financing and the business community in the hypothesis. This results in the consequence that "business representatives cannot join in active support of any particular reform initiative and instead may thwart those presented by other participants (Peterson 1993a, 424). It also results in the consequence that "major policy change will continue to be stymied by Members of Congress who are directly or indirectly bought off by campaign contributions from the insurance industry and the medical community" (Peterson 1993a, 424). The second hypothesis that structural changes reduce the likelihood of reform, "recognizes the dramatic shifts that have occurred in the representation community and the rearrangement of power in Congress" (Peterson 1993a, 426). This hypothesis, however, is flawed because it ignores or misinterprets features of American politics that Peterson deems significant, such as the rising number of interest groups that lead to fragmentation within the system. The third hypothesis which Peterson favors, states that structural change has introduced previously unavailable opportunities for reform. This has the most significant and optimistic outcome

according to Peterson. It allows for new ideas and players to enter the system and for new alignments to form.

The most important conclusion made is that "the [organized interests] are more willing to compromise with him [the President] than with each other" (Peterson 1993a, 429). This relates to his third hypothesis and he associates it with the structural change of the representational community. The President is important because if reformists of a majority party have disagreements while in Congress while the public is open to a reform, they will look to the President for suggestions.

The change and transformation of the representational community matters because they "indicate a growing tension in the health domain between nonprofit enterprises…and profit making providers and other businesses who remain (at least in the mid-1980s) far more antagonistic to government involvement" (Peterson 1993a, 415). Due to the changes, Congress has transformed and issue network policy communities have taken over policy domains. This led to policy networks, issue networks, knowledge communities and advocacy coalitions. These terms are ones that Peterson borrows from other researchers such as Helco, Walker, McCool, Sailsbury, and Sabatier. Advocacy coalitions are what Peterson calls "variable factions made up of both government officials and organized interests that may or may not have a partisan bias to them" (Peterson 1993a, 419). A finding that Peterson has is that there is "a representational community of both competitive stakeholders and plentiful stake-challengers, a Congress decentralized and more open—indicate that in the health care realm the policy community has all it needs to be a policy network" (Peterson 1993a, 423). This conclusion and theory plays along well with the hypotheses and research question that will be explored in this study.

There are three ways that the institutional threshold for health care reform in the United States could be lowered. The first way is for governing institutions to be substantially restructured. The second is to wait for a crisis to develop within the health care system. Political systems, even ones that appear to be slow and less responsive, can rise and respond to a threat or disaster. The final option is that the politics and government within the United States are not static. Peterson states that "access, influence, and decision making depend not only on the constitutional outlines of the political system but also on the evolving details of how private power and public authority are manifest in each policy domain" (Peterson 1993b, 785).

In the analysis, it is clear that the 1990s had an institutional change altered the way interests are mobilized and represented in the policy-making process. Profit-sector interests, like trade associations, have had a strong advantage with organizing for political purposes (Peterson 1993b). Profit-sector interests have a low number of potential members and have a rational basis for a member to subsidize the organizational effort. Groups with large potential memberships face the free rider problem.

It is also thought that certain presidents and eras may have more advantages than other when it comes to reforming health care policy. This is also due to the institutional structure and the advantages that a president has (Peterson 2011). There are three categories of problems that are perceived with the U.S. health care system that can influence the policy outcome of health care reform. These categories are costs, coverage, and consequences. Costs are defined as "a concern in terms of any or all of the following: U.S. spending as compared to that of other countries; health care inflation relative to the underlying consumer price index; and evidence of increasing spending on government budges, businesses' bottom lines, and individuals…" (Peterson 2011, 430). Coverage, is defined as, "problematic when a significant or growing

percentage of the population is uninsured; a large or rising percentage of the insured have insufficient coverage to provide adequate protection against health care costs…" (Peterson 2011, 431) or if coverage varies based on race, ethnicity, or socioeconomic status. The concept of consequence is what the actual health care system in place delivers. It is inadequate if the quality of care is poor and the nation's expenditures regarding health care are high.

There are four ways that politics has transformed from the 1970s to the 1990s. First, there was an increasing number of interests in Washington, D.C. Therefore, it was more difficult for groups to have the influence that they previously had unless an unusually strong coalition is present. Secondly, money from PACs did not have as large of a political influence on political issues that were highly-visible to the public. Lastly, organized interests' impacts depended on the "nature of the institution they are attempting to manipulate. How public authority itself is organized affects the pathways of influence" (Peterson 1993b, 791).

While noting how the United States' institutional structure has typically been arranged, it is observed that the structure was generally stable and unchanging before the 1970 and through the early years of President Nixon's presidency. However, by the mid-1970s Congress changed because of the implementation of structural reforms (Peterson 1993b). Power in Congress was institutionally redistributed. This created subcommittees for all of Congress (Peterson 1993b).

Institutional changes are important in how they changed the way of Congress and how policy is discussed and addressed in the United States. What made the 1990s a unique and good opportunity for health care reform in the United States was that "providers, insurance companies, and business have lost much of their organizational advantage, and by 1985, groups of all kinds, including citizens associations, were reporting equivalent levels of cooperative interactions with congressional committees and subcommittees (Peterson 1993b, 794).

Peterson also observes policy making through the presidencies of President Franklin Roosevelt through President Obama. The policy-problem, institutional, and political factors are observed for six periods of reform debates—1912, President Franklin Roosevelt, President Truman, President Nixon and President Ford, President Carter, President Clinton, and President Obama. This assessment is then used to determine whether or not the presidents' status at the time were "conducive to the political success of reform initiatives" (Peterson 2011, 433). This is done through comparing those eras to costs related to international measures, health care inflation, government spending, and business spending. These eras are also compared in regards to coverage according to individual spending, the uninsured, the underinsured, and disparities. The eras are also compared in regards to consequences according to quality and outcomes, international rank, and population health. The categories are coded in terms of no evidence of problem, evidence of problem but condition improving, problem evident and persistent, problem present and getting worse (Peterson 2011). They are also then coded as contextual factors influencing the politics of health care reform when it was on the agenda, from inhibiting to conducive. In this analysis, Peterson categorizes policy problems in relation to cost, coverage, and consequences and ranks them as very favorable, favorable for reform enactment, neutral, or challenge for reform enactment. Next, Peterson categorizes institutions in relation to interest groups, the House, and the Senate in the same way. Finally, Peterson ranks political resources in respect to the presidential election, the House (solid), the Senate (solid), critical juncture, and the public on the same scale. This is how information about the unity of collapse of antireform alliances is established and reform alliances are observed. Finally, whether or not issues were centralized—or in the majority-party leadership, decentralized—in the committees of

jurisdiction, or fragmented—shared with rank-and-file members are compared and observed (Peterson 1993a).

From the analysis and tables, it is concluded that President Franklin Roosevelt had more advantages than the other presidents working for health care reform because he has no evidence of problems with international measures, health care inflation, government spending, business spending, the under-insured, disparities, outcomes, international rank, or the population health. President Clinton had benefits when they entered the health care debate in the early 1990s, such as the severity of the perceived problems, the constructive changes in the interest-group community and Congress, and an increased amount of solid votes among Democrats in Congress than previously seen under President Truman and President Carter (Peterson 2011). President Clinton, however, also had disadvantages. A serious disadvantage was that he received a low amount of the popular vote when he was elected to office. President Obama entered his presidency and was able to have a health care reform debate and agenda "with more favorable contextual attributes than any president since FDR, and perhaps including FDR as well" (Peterson 2011, 435). He had benefits from previous changes in the House that led to increased influence from the leader and he had the highest first-term popular vote of any Democrat since FDR. His party, the Democrats, were able to break a Senate filibuster. According to Peterson, this (2009-2010) was the most favorable to health care reform.

Ultimately, it is determined that leadership still matters in American politics and especially in health care reform debate and politics. Peterson argues that context is important, but the advantages only matter if they utilize and exploit them correctly and to their full potential, otherwise, the advantages will not make much of a difference in reform efforts. Also, despite the number of advantages given, challenges will still remain, and it takes an effective leader to

navigate the debate properly and effectively. When observing Obama's health care reform uses, he states that Obama understood that pushing reform before opposition was able to inspire fear and collapse the public support was essential. He also notes, that Obama "chose to go for broke" (Peterson 2011, 436). Peterson credits actions of the president and how he interacted with Congress to the success of his health care reform movement.

Certain presidential administrations are more likely to have success with interest groups and policy reform because of the relationships between interest group liaisons and a presidential administration. This White House Liaison theory is based on whether or not presidents and their administration wish to be inclusive or exclusive to all interest groups with differing ideologies than their own. It also depends on the type of substantive focus an administration would like to have. The focus could either be programmatic or representational. A programmatic focus "works with interest groups to secure the passage or implementation of its policy agenda. Particular organizations attract the solicitations of the White House because of the influence they potentially wield in the legislative arena" (Peterson 1992, 613). A representational focus "emphasizes an administration's desire to reinforce its political standing, either among the president's electoral coalition or among group representatives at large" (Peterson 1992, 613). In this focus, presidents must decide which groups best support and improve the president's image to the public and Congress.

To analyze the activity of presidential administrations and interest groups, Peterson creates a typology of White House liaison with interest groups. This typology includes four different categories: liaison as governing party, liaison as consensus building, liaison as outreach, and liaison as legitimization. To set up this analysis, it is stated that there are three choices that presidents must make about the breadth of relationships and their focus on the institutional,

political, and economic contexts facing them (Peterson 1992). The first choice is what the presidents would like to accomplish, the second is how to organize the means for achieving their ends, and the third is selecting individuals to fill positions in the administration and progress toward the goals of the administration while rewarding allies, paying political debts, and quelling defeated factions (Peterson 1992). From here, the four different typologies of White House liaisons with interest groups emerge. When the substantive focus of interest group interactions is programmatic and the breadth of group interactions is exclusive, the typology is the liaison is acting as a governing party. If the substantive focus of interest group interactions is programmatic and the breadth of group interactions is inclusive, the liaison is consensus building. Thirdly, if the substantive focus of group interactions is representational, and the breadth of group interactions is exclusive, the liaison's typology is labeled as outreach. Finally, when the substantive focus of group interactions is representational and the breadth of group interactions is inclusive, the typology of the liaison is legitimization (Peterson 1992).

These typologies are applied to past situations. He states that this "demonstrates how these approaches derive from the context of a particular president's tenure in office and reflect the political and organizational biases of the individual chief executive" (Peterson 1992, 614). Through Peterson's research and interviews, he found that even when a president such as President Carter did not like interest groups, he found it necessary to work with them and even "lobby the lobbyists…to get a large constituency on an issue" (Peterson 1992, 616) in order to try and have successful policy movements. Even if an interest group could not be swayed to favor the president's interests, the administration would work to at least make the interest groups neutral on the issue so they would not oppose the president's efforts (Peterson 1992). The main case study for this research was President Reagan's administration. It was found that two-thirds

of conservative groups reported to have at least occasional interactions with the administration, while less than a quarter of liberal organizations reported having interactions with the administration. Being well positioned with Congress also made a difference for interests, because small interest groups were less likely to be selected for regular attention from the presidential administration (Peterson 1992).

II. Interest Group Dynamics and Challenging vs. Protecting the Status Quo

There are four different representational communities in the United States based on the composition of the attributes of stakeholders and stake-challengers (Peterson 1993). Stakeholders are "interests that benefit by the status quo, or at least are more threatened by revisions in it" (Peterson 1993a, 408) while stake-challengers are "the interests that want to change the status quo because they either do not benefit from it or are actually harmed by it" (Peterson 1993a, 408). It is possible for stakeholders to create a strong alliance, if they agree on a public policy, or they may become competitive and make a competitive environment if they are divided and disagree. Stake-challengers are able to work against the stakeholders and their interests, or they can be absent from the picture, or ineffective altogether. The attributes that stakeholders and stake-challengers can combine to possess are: allied stakeholders with no stake-challengers who present as block (homogeneous) representational communities, allied stakeholders with stake-challengers who present as dyad (polarized) representational communities, competitive stakeholders with no stake-challengers who present as amalgam (differentiated) representational communities, and competitive stakeholders with stake-challengers who present as network (heterogeneous) representational communities. In regards to these relationships, Peterson suggests that usually, representational communities "begin as blocks, with allied stakeholders

unencumbered by stake-challengers" (Peterson 1993a, 409) He also notes that "the interests of stake-challengers, however, are generally more diffuse and thus less likely to prompt mobilization. An individual stake-challenger cannot justify unitary action, and organized representation is achieved only if barriers to collective action are overcome" (Peterson 1993a, 409).

Each type of communities has significance. The block community, composes of allied stakeholders and stake-challengers who are not effectively present, create a homogenous community. The amalgam community, where stake-challengers are absent, but stakeholders are competitive with each other, is complex, less uniform, and less cohesive. When stake-challengers are organized and challenge stakeholders who are allied, a polarized community that is called a dyad community of opposed coalitions forms. The final community is the network, this is where stakeholders are competitive with each other and stake-challengers are vigorous. This community is loosely structured and heterogeneous (Peterson 1993a). Block communities are most common in the politics of the United States, but from the 1960s to the 1970s, the representational community became more dyadic. This is because "new stake-challenger groups increasingly polarized health care politics while stakeholders maintained their old alliance" (Peterson 1993a, 413). Now stakeholders are more competitive with each other, there are a larger number of stake-challengers, and there is a heterogeneous representational network (Peterson 1993a).

Not all interest group activity happens in plain sight of the public and often times, what interest groups want is to keep attention off of an issue to maintain the status quo. Researchers interviewed over 300 lobbyists and government officials and created a random sample of over 100 issues and identified specific 98 issues. This research was conducted from 1999-2002—the

final two years of the Clinton administration and the first two years of the George W. Bush administration. Data for this research was collected from lobbyists' quarterly disclosure reports of what issues they were lobbying and how much money was spent on each issue. Interviews were conducted asking lobbyists to give information regarding the most current issue on which they were working on that relates to the federal government. Researchers first looked at organized interest groups that were the most active. Then, they chose to work with the in-house lobbying representative. Finally, each representative provided them with an issue (Baumgartner et al. 2009). This means that they "only talked with so-called in-house lobbyists—those who work directly for the trade association or corporation that is registered as the lobbying organization" (Baumgartner et al. 2009, 5). This is the most representative sample that has been used in the study of lobbying. As previously stated, the aim of most lobbyists is not to inspire change, but to prevent it from happening. A good predictor of success in lobbying is "not how much money an organization has on its side, but simply whether it is attempting to protect the policy that is already in place" (Baumgartner et al. 2009, 6).

The interviews that were conducted identified the major players on both sides of the policy debate. Out of these interviews both government officials and outside actors were identified as major players. The study defines a side as "a set of actors who share a policy goal" (Baumgartner et al. 2009, 6). Policy actors on the same side may not necessarily be working together, but they all seek the same goal. This study identified 214 sides across the 98 issues that were observed. After attempting to interview a leading representative from each side on an issue, it was found that "the most common single goal across our 214 sides is, not surprisingly, to protect the status quo from a proposed change" (Baumgartner et al. 2009, 7). Major players determined the number of advocates on each side. Major players were defined as being "an

advocate mentioned by others (or, occasionally, who was revealed through our subsequent documentary searches) as playing a prominent and important role in the debate" (Baumgartner et al. 2009, 7). This number ranged from one to over 50, but usually was in the single-digits. For all the cases, there was a total of 2,221 advocates, with an average of 23 per case (Baumgartner et al. 2009). It was observed that 41 percent of the advocates involved were government officials themselves, which shows that government officials are not, as many have thought, neutral actors. Thus, 59 percent of major actors were lobbyists involved in various organized interests. Each set of actors has their own opinions and biases. To collect data regarding the interest group actors, the researchers looked at their "membership, budget, annual revenues, number of employees, hired lobbyists, lobbying and PAC expenditures, and more" (Baumgartner et al. 2009, 8). They also looked at congressional statements, speeches and hearing testimonies along with newspaper and television searches (Baumgartner et al. 2009). In total, they were able to obtain information about 2,220 major actors about the 98 selected issues.

Citizen groups are most often mentioned at the major participant in policy debates at 26 percent of mentions, followed by trade and business associations with 21 percent of mentions. While the press commonly mentions unions, they only make up 6 percent of the mentions by actors. It is noted that "citizen groups may spend less on lobbying and lobby on fewer issues than business organizations, but when they do lobby, they are more likely to be considered an important actor in the policy dispute" (Baumgartner et al. 2009, 11). The study also found that "individual corporations, trade associations, and professional groups constitute 74 percent of the issue identifiers in our sample, but they collectively represent only 48 percent of the major participants. Citizen groups, representing just 15 percent of the issue identifiers, are 26 percent of the major participants" (Baumgartner et al. 2009, 12).

Most cases of government participants, two-thirds, include rank-and-file Members of Congress along with committee and subcommittee leadership from both parties (Baumgartner et al. 2009). It is clear that policy making is a bottom-up process that is porous for advocates. This is an alternative to the thought that policy making is a top down process, because the actors do not frequently mention party leaders or party leadership as central figures in these policy debates (Baumgartner et al. 2009).

Most interests wish to preserve the status quo, because of this it is possible that few issues may be in the eyes of the public. It was found that most of the issues did not have newspaper or TV coverage and, on average, for each issue, nine congressional bills were introduced and three hearings were held and more than half of the issues had at least one executive department or agency as a key policy advocate for the issue (Baumgartner et al. 2009).

It is clear that there are four factors that influence interest groups and policy change in Washington. Lobbying revolves around changing current policies in Washington, it is complex with multiple and often contradictory constituencies, there are relatively homogeneous sides that mobilize to protect or to change the status quo and finally, attention in Washington is limited (Baumgartner et al. 2009, 19).

In the United States, policy change tends to not be incremental because of the status quo's strength. When change does occur, it is a large and substantial change rather than a small one. Contrary to popular belief, interest group resources do not always mean interest group success. A more indicative factor of interest group success is that interest groups who can reduce uncertainty are typically favored in times of reform. This is because policy makers do not want any uncertainly when implementing a policy. Groups that can create doubt or uncertainty toward their opposition's position, can weaken their opposition and strengthen their own stance. Just like

the status quo, stability is favored in policy making. It is hypothesized that money is not necessary for success because those with money typically compete against other groups with money. Also, those interests with large amounts of money have likely gotten what they have wanted in the past, thus the status quo fits their needs and more money would not necessarily mean that they would have more influence or better outcomes during a current reform. In terms of framing, it was found that broadly reframing an issue is rare for interest groups to do, but it does occur on an individual level. An overall bias was found toward professions and groups that can organize well and provide resources and information (Baumgartner et al. 2009).

The interest groups who tend to get what they desire as a policy outcome in Washington are usually those who are protecting the status quo. It is thought that this is because these groups have already gotten the positions that they have wanted in the past. Also, these groups are more likely to use negative argumentation. It is important to note that status quo protecting groups are only going to fully-mobilize if there is an obvious countermovement against them because they do not necessarily need nor want public attention or action. According to Baumgartner, "public-policy disputes are almost always related to existing public policies and that efforts to change an existing policy orientation usually fail" (Baumgartner et al. 2009, 239). The status quo is powerful in Washington. When looking at the out of the 98 issues observed, 58 did not change, while 13 had marginal adjustments and 27 had significant changes during the four years they were observed (Baumgartner et al. 2009). The changes are also more likely to be major than minor because changes require a lot of time and effort, and for Members of Congress and agencies to get involved in the process, more has to be at stake than a small change and there has to be a large constituency affected that will benefit (Baumgartner et al. 2009). This is significant, because when change does occur, 70 percent of the time it is catastrophic rather than marginal.

The American policy system is clearly not incremental, but a system of equilibrium. Attention is scarce in Washington, and obtaining the attention of those in Washington is a challenge for all lobbyists. Therefore, it is the largest obstacle that advocates face. What makes the policy system stable is shared information. In policy communities, policy experts are able to share information and discuss how to justify the policy, what direction to take it in, and develop common understandings (Baumgartner et al. 2009).

The causes of policy change in the United States, according to this study, are dependent on context and include having a policy window, social cascades, powerful coalitions, presidential support, and counter mobilizations (Baumgartner et al. 2009). A policy window, a concept created by John Kingdon, is when there are moments in the policy making process that allow for influence over the policy outcome and the policy making process as a whole. Changing pubic opinion, coalitions with great resources, public support from the Presidential administration and interests working against other interests can certainly have an influence on the policy outcome. There is not a single factor that resulted in policy change. Policy change takes a long time to occur and is a time consuming, effort involved process. Having an issue on the political agenda does not necessarily mean it will have action, if it is on the agenda, it is more likely to be acted upon, but being on the agenda is not sufficient for political action. There is little control over the policy process in the United States' relatively stable policy process and that those groups that are protecting the status quo typically win.

III. Collective Interests and Citizen Groups

There are three ways that cause-oriented citizen groups have benefited from new resources that aim to help reduce the collective action problem. One way that these groups have

benefited is that the "citizenry has become more educated, attuned to politics, and find greater personal reward for the actual participation in political and social action, thus diminishing free rider inclinations" (Peterson 1993b, 789). The second possible way that cause-oriented citizen groups have benefited is that those who donate to political action groups "have become much more significant sources of revenue for citizen groups, permitting these organizations to form without having to depend so extensively on unpredictable membership dues and contributions" (Peterson 1993b, 790). In 1985, voluntary organizations in the profit-making sector had almost 90% of their revenues from routine membership contributions, unlike citizen group budgets where less than half of their revenues came from routine membership contributions (Peterson 1993b). Certain changes have occurred in the United States' institutional structure surrounding the policy arena such as: organizations such as medical providers, insurance carriers, and business leaders went from having compatible interests in the 1970s to being in conflict with one another and prone to internal fissures in the 1990s (Peterson 1993b).

The system of interest groups has changed in that there is a rise of interest groups that claim to represent "broad collective interest in civil rights, occupational health and safety, environmental protection and consumer affairs" (Gais et al. 1984, 166). These groups tend to have liberal tendencies and grew out of the civil rights movement's success. However, fundamentalist groups that promote traditional religious values counter their efforts in Washington (Gais et al. 1984).

There has been an important emergence of new interest groups organized around ideological causes rather than narrow commercial or professional interests in the American political system. The different groups are divided into four different types: occupational profit sector, occupational mixed sector, occupational non-profit sector, and non-occupational citizen

groups. Profit sector occupational groups include trade associations and professional groups whose members who work mostly in the profit-making sector. Mixed sector occupational groups are small in number and consist of groups such as the National Association of Broadcasters, the American Hospital Association, the Society of American Forecasters and the National Society of Professional Engineers. Non-profit occupational groups consist of associations of universities, non-profit hospitals, state and local government agencies, and professional societies with members that work for the government, social welfare, education, or cultural agencies. Finally, citizen groups that are non-occupational organize around a common cause or an idea and are inclusive to anyone. Examples of such groups include Common Cause, Citizen for Clean Air, and Americans for Freedom (Gais et al. 1984). Upon researching these groups through surveys, it is found that the interest group system in the 1980s was controlled by the occupational sector, and the occupational non-profit sector in particular. Only 20.7 percent of respondents to the survey were classified as citizen groups. In terms of funding, "only about 22 per cent of the citizen groups receive as much as 70 per cent of their budgets from dues" (Gais 1984, 169). The majority of citizen groups receive funding from grants, contracts, gifts from wealthy individuals, and gifts from foundations. Citizen groups, importantly, have found a way to maintain their organizations even without having large memberships. All of these factors and behaviors have contributed to how citizen groups have grown in the United States.

Profit sector and citizen groups differ because "profit sector occupational groups are solidly opposed to expansions of either regulations or services and, in fact, show heavy majorities in favour of the contraction of each" (Gais et al. 1984, 170). On the other hand, "citizens groups solidly favour an expansion of government activity in both realms, establishing a clear line of ideological cleavage" (Gais et al. 1984, 170). Profit sector occupational groups and

citizen groups believed that they experienced the most opposition to their views. This challenges the subgovernment thesis that "decentralization reduces overt conflict by delegating policy-making authority to virtually independent, segmented communities of like-minded participants" (Gais et al. 1984, 170). Citizen groups exert specific behavior that makes it so they do not fit into the system of subgovernments because they appear to be unwilling to co-operate and bargain and consult about arguments that are made in that sphere. It is determined that citizen groups do not have good "insider strategies" and that they are twice as likely as occupational groups to "appeal to the public through the mass media and to engage in various forms of grass-roots lobbying at the lobbying level. Citizens organizations are also much less likely to engage in lobbying of administrative agencies than all types of occupational groups…" (Gais et al. 1984, 173). There is evidence that the environment of interest organizations has changed, especially because since 1961 "28 per cent of the profit sector organizations have since moved heir headquarters to Washington, while 19 per cent of the associations representing the non-profit sector and only 4 per cent of the citizen groups have made the same move" (Gais et al. 1984, 175-176). In terms of cooperation between interest groups and federal agencies, 46 percent of citizen groups reported an increase in cooperation, 68 percent of non-profit groups, 79 percent of mixed groups, and 62 percent of profit groups reported no change in cooperation (Gais et al. 1984).

Individuals' whose work is unskilled, unless they are members of a union, have no occupational associations to represent their interests in Washington. Also, even though there "are a small number of organizations that advocate for the poor, there is not a single organization that brings together recipients of means-tested government benefits such as Medicaid acting on their own behalf" (Schlozman et al. 2012, 346). This is yet another way American politics and interest groups have an "upper class accent" (Schlozman et al. 2012).

From 1981 to 2006, the number of active political organizations increased in the United States and this expansion in the pressure system of politics was uneven across the different categories of organizations that exist. At the same time, there has been a large growth of subnational governments in the United States, "especially local governments, and institutions, especially in the health and private sectors. Taken together, the share of organizations in the pressure system accounted for by subnational governments and the health and educational sectors rose nearly three times over the twenty-five-year period" (Schlozman et al. 2012, 357). This pressure system is fluid and constantly changes. Organized interest groups are continually entering, leaving, and re-entering the political system. From 1981 to 2006, the stake of local governments in this system increased from 5.8 percent to 13.1 percent. When they look further they find that, "not only are the well educated and affluent more likely to be affiliated with political organizations but, even among members, they are also more likely to be active in those organizations and to serve on the board or as officers" (Schlozman et al. 2012, 380). Thus, the educated feel that theses organizations speak on their behalf.

Generally, the affluent are overrepresented, but disadvantaged groups are mentioned and advocated for in Washington. The groups that are likely to mention disadvantaged groups are "drawn from categories with small numbers of organizations and constituencies with limited recourses, which suggests that the compensatory effect is very limited. Mainstream economic associations, especially trade associations, are very unlikely to mention disadvantaged groups" (on their website) (Schlozman et al. 2012, 392). The authors found that "…the advocacy of the relatively small number of organizations that do the most to diversify the perspectives brought into pressure politics not only ameliorates bias but simultaneously exacerbates it" (Schlozman et al. 2012, 383).

One of the main questions that lobbying organizations must face is whether or not to become involved, and if they do, how intensely to become involved. In consideration of this, they must think about: the availability of appropriate resources, the importance of an issue to an organization or its members, and the probability of achieving the desired policy objectives. They must also decide about the locations of their political actions. Thirty percent of the organizations listed in the *Washington Representatives* directories had offices in Washington that had in-house lobbyists. The majority or organizations, 70 percent, "do not have offices in Washington and rely on outside firms for their Washington representation" (Schlozman et al. 2012, 397). Finally, "just over one in eight, or 13 percent of all organizations, have both in-house and outside lobbyists" (Schlozman et al. 2012, 397). When observing the websites of different organizations and how those websites either present information or a call to action, compared to corporations, occupational associations, trade and other business associations, organizations advocating for social welfare or the poor, identity groups, and public interest groups, unions discuss public policy on their website 87 percent of the time and facilitate political action 72 percent of the time. This is much higher than the average of discussing public policy issues 37 percent of the time and facilitating political action 22 percent of the time.

When comparing monetary and congressional resources of the different organizations through looking at how much organizations spent, PAC spending, and how much the organizations testified before Congress, it was found that most of the money spent on lobbying is in amounts of more than $10,000 by organizations. Also, certain organizations, such as elderly identity groups, and trade and business associations spend a lot more than organizations that provide services. In regards to PAC spending, they saw "a complicated relationship to equality of political voice. Campaign giving is the realm of participation in which financial inequalities

among individuals matter most" (Schlozman et al. 2012, 440). In terms of equality and representation of the economically disadvantaged, "PAC spending is the only realm in which the activity of the economically less privileged registers at all significantly: 28 percent of PAC donations represent unions; occupational associations of those in non-managerial, nonprofessional jobs or the economically needy" (Schlozman et al. 2012, 440). Surprisingly, "the less economically privileged account for 15 percent of PAC spending, a far higher share than in any other domain" (Schlozman et al. 2012, 440). In terms of Congressional testimony, it was observed that "the balance of congressional testimony by organizations seems not only to favor those on the scene with Washington offices but also to tilt less obviously in the direction of the kinds of organizations that are especially numerous in Washington politics" (Schlozman et al. 2012, 415).

Schlozman, Verba, and Brady had seven main findings about political voice. The first was that most interest organizations in Washington only have one or two in-house lobbyists or employ a single outside lobbying firm. Secondly, membership organizations are more likely to use websites to speak about political issues or to inspire political involvement than initiations. Thirdly, "although the weight of advocacy by organizations representing business interests varies across domains of organized interest activity, in no case is it outweighed by the activity of either organizations representing the less privileged or public interest groups" (Schlozman et al. 2012, 442). Fourthly, organizations that provide services to or represent the poor are scarce. Fifthly, Unions are politically active, but because they are few in number, they only have a significant share of organized interest group activity when it comes to PAC contributions. Sixthly, identity groups are a small part of interest group activity. Finally, it is impossible to determine what share of activity should represent public goods (Schlozman et al. 2012). It is concluded that politics do

have an upper class accent and that money can be used to buy influence and professional advocacy in American politics.

Another way interests gain advantages in Washington is through promoting the idea that they have more specialized knowledge than the average person. Medical professionals in the health care lobby do this frequently. This is because such professionals claim to have some responsibility for the public good and reflect this responsibility onto the public. They make the public think that they are the ones who know how to achieve the public good (Peterson 2001). In order to have control and influence over the public and policies regarding their profession, medical professionals must make others believe that they are the only ones who can safely make decisions about the medical profession and health care in the United States.

There are seven attributes that would be advantageous for interests for interest groups to possess in the "political market." These attributes are: information, recurrent interactions with policy makers, large and dispersed membership, quasi-unanimity, organizational resources, electoral resources, and policy niche and coalition leadership (Peterson 2001). Information is important for organizations to possess because government officials need information to overcome uncertainty of how the policy action will translate into policy outcomes and uncertainly of how an official's constituency will interpret the government's actions and how that constituency will respond. Recurrent interactions with policy makers give credibly to the organizations and to the information that they present. Having a large and dispersed membership gives organizations a stronger political influence and greater ability to speak to a policy maker's constituents. If an organization is particularly good at, or well enabled to make, a grassroots campaign, this will help them even more in being a successful organization. However, interest groups with a large membership are subject to the free-rider problem and problems of collective

action where all members do not have to participate to receive the benefits. Quasi-unanimity is advantageous because "effective organized interests have to possess enough cohesion and focus on shared core interest to project something representing a unified front on high-priority policy concerns" (Peterson 2001, 1151). Organizational resources, both economic and status, make it possible for the organization to consist of "a large, skilled, experienced, and professional staff" (Peterson 2001, 1151) who know to frame issues and conduct research while communicating effectively. Electoral resources enable these organizations to receive funds and information so that effective election and re-election campaigns can be made. Policy niche and coalition leadership aids an organization's creditability, unity, and impact because an organization can claim an advantage in information and resources (Peterson 2001).

When looking at the attributes that previous literature has deemed essential for interest groups to possess to be successful, it is found that "most interests at the national or state level at any given time do not possess any of these attributes, at least reliably" (Peterson 2001, 1151). The only interest group that he finds that possesses all of the attributes is the American Medical Association (AMA). When these characteristics were deemed essential in 1963 by Arrow, nine out of ten practicing physicians were a member of the AMA and its state associations (Peterson 2001).

Physicians and the AMA weakened their own authority "when the AMA, starting in the 1950s and the 1960s, shifted the focus of its meetings and other activities from scientific exploration to more economic and political interests and avoided joining concerted efforts to measure and improve the quality of medical services" (Peterson 2001, 1158). Now managed care interests are rising in the United States and they are staking a claim to the policy area. Peterson finds flaws with managed care professionals' claim to the debate because he believes that their

motives are similar to that of physicians. There is not an ideal image where managed care professionals can eliminate information asymmetries and ensure that patients receive the best care. This is because managed care professionals, like physicians, are self-motivated and politically motivated. People would have to build trust in the insurers of the health care system and that seems unlikely to Peterson because they are for-profit organizations that are seen as being motivated by economic interests. These groups also had low public approval, in 2000, 29 percent of the public thought that managed care companies were doing a good job (Peterson 2001). It is found that physicians will be called in to be a mediator between managed care companies' protocols and the science of medicine when policy is being made. Because of this, trust is returned to physicians and this is the same situation as before.

Chapter 3. Theory

Current theories of interest group success in American politics have developed over the past century in political science research. Theories revolve around institutional changes in the United States, interest group dynamics and the status quo, and collective interests and citizen groups. These theories work to address my research questions of: What strategies do interest groups choose to use in an attempt to influence health care reform and how successful are the different direct and indirect strategies? They also relate to my three hypotheses: 1) With all other things being equal, interest groups who are more active with the reform movement are more likely to be successful in their goals than those who are less active, 2) With all other things being equal, interest groups who are aligned with presidential health care reform movements are more likely to be successful in their goals than those who are not aligned, and 3) With all other things being equal, interest groups who are aligned with the ideological majority in Congress are more

likely to be successful in their goals than those who are not aligned with the ideological majority in Congress.

I. Institutional Change

It is argued by scholars that there has been an institutional change in the United States from a system of iron triangles to a system of loose policy networks (Gais et al. 1984 and Peterson 1993a). Iron triangles, as defined by Gais et al., are autonomous and impermeable. Issue networks on the other hand are composed of specialists, journalists, and administrators. These issue networks tend to lack the structure and homogeneity that subgovernments in the United States posses internally. This results in unpredictably complicated situations that governmental leadership (Gais et al. 1984). These scholars are asking questions such as: What makes a good opportunity for change? How has the institutional structure created an opportunity for health care reform in the United States? and What type of institutional system does the United States currently have?

Scholars such as Gais and Peterson observed that politics along with the structure of American politics and government has been changing, especially since the 1990s. This is because the iron triangle system has transformed into an open and diverse policy network system (Gais et al. 1984 and Peterson 1993a). Peterson's theory has always been that institutional change can have a significant effect on and dramatically alter political relationships (Peterson 1993b). This is because institutional change has "practical consequences for how health policy reformers of every stripe approach one another, assess the intersection of substantive policy and political reality, and set the course for restructuring one of the largest economies in the world: the American health care financing and delivery system" (Peterson 1993b, 783). These changes

are what, according to scholars, had led to new opportunities for reform and a new structure in American politics.

Peterson and Gais saw that the institutional change has decentralized the American government and resulted in a change in both size and scope. As a result of this, Congress is now fragmented which allows for private interests to form relationships with small sets of government actors who can influence policy (Gais et al. 1984, Peterson 1993a). This decentralization has also allowed for many new government programs that involve the federal government in areas that were once none of its concern, resulting in subgovernments having an opportunity to develop in the United States (Gais et al. 1984). There are many key components to policy change according to Peterson. In the United States, Peterson theorizes that policy change "depends on fairly momentary "policy windows" engendered by a confluence of problem awareness, events, public mood, electoral outcomes, and policy entrepreneurship" (Peterson 1993b, 795). Once these policy windows are open, "major shifts in policy probably depend on the results of…'political' decision making, when ideas and people with influence are both energetically in contention" (Peterson 1993b, 795). These key components indicate that when policy windows are open, there is a confluence of the public and private factors, and political decision making produces results where people with influence are in contention, major shifts in policy are possible.

Ultimately, Peterson determines that leadership still matters in American politics and especially in health care reform debate and politics. This is because he provides a theoretical framework that suggests that a president with the most institutional advantages in a reform attempt, who uses them well, will have the most success. He argues that the context of the president is important, but the advantages only matter if they utilize and exploit them correctly

and to their full potential, otherwise, the advantages will not make much of a difference in reform efforts. Also, despite the number of advantages given, challenges will still remain, it takes an effective leader to navigate the debate properly and effectively (Peterson 2011).

II. Interest Group Dynamics and Challenging vs. Protecting the Status Quo

Other theories suggest that interest groups or representational communities who are protecting the status quo are more likely to succeed in their efforts. These authors seek to understand how the policy process in the United States works, who wins in politics, who loses, and why (Baumgartner et al. 2009). Peterson theorizes that representational communities typically "begin as blocks, with allied stakeholders unencumbered by stake-challengers" (Peterson 1993a, 409). Peterson also believes that "the interests of stake-challengers, however, are generally more diffuse and thus less likely to prompt mobilization. An individual stake-challenger cannot justify unitary action, and organized representation is achieved only if barriers to collective action are overcome" (Peterson 1993a, 409). A change has taken place in the representational communities of the United States. While block communities are the most common, the representational community became more dyadic from the 1960s to the 1970s. This change resulted when stake-challenger groups polarized health care politics while stakeholders kept old alliances (Peterson 1993a). As a result, according to Peterson, stakeholders are more likely to be competitive with one another, when there are more stakeholders, and the representational network is heterogeneous (Peterson 1993a).

Baumgartner et al. identified four factors that influence interest groups and policy change in Washington. They are: "first, lobbying is about changing existing public policies. Second, policies are complex, with multiple and contradictory effects on diverse constituencies. Third,

following from previous fact, 'sides' mobilized to protect or to change the status quo tend to be quite heterogeneous. And, fourth, attention in Washington is scarce" (Baumgartner et al. 2009, 19). These different factors lead to policy change in the United States, when it does happen, being significant rather than incremental because of the status quo.

Through the research of Baumgartner et al. 2009 it is theorized that interest groups who can assist in reducing uncertainty are usually favored in American politics because policy makers do not want there to be any unpredicted problems or uncertainty when implementing a policy. Also, if groups can cast doubt or uncertainty on other groups' positions, hey strengthen their own stance while the targeted groups' positions becomes weaker. Just like the status quo, Baumgartner et al. 2009 theorize that stability is favored which is how they account for the minimal impact of money and interest group spending on interest group success in American politics.

They theorize that because money competes against money and because interest have usually won their preferred position in the previously established status quo, having more money in the present is not necessary for influence or for better policy outcomes for interest groups. Part of this theory is that interest groups who get the policy outcomes that they desire in Washington are those who defend the status quo. This is because those who are protecting the status quo have already achieved what they have wanted in the past. They are more likely to use negative argumentation, because they are protecting what is already in place, which has less uncertainty than new policies. Those who are protecting the status quo are only going to fully-mobilize if there is a clear and cohesive countermovement against them (Baumgartner et al. 2009). The causes of policy change in the United States, according to this study, are dependent on context

and include having a policy window, social cascades, powerful coalitions, presidential support, and counter mobilizations (Baumgartner et al. 2009).

III. Collective Interests and Citizen Groups

Other scholars theorize that there are different types of interests in the United States. There are four different types of groups: occupational profit sector, occupational mixed sector, occupational non-profit sector, and non-occupational citizen groups. This will be explained further in-depth in the literature review, but briefly stated, profit sector occupational groups include trade associations and professional groups whose members who work mostly in the profit-making sector. Mixed sector occupational groups are small in number and consist of groups such as the National Association of Broadcasters, the American Hospital Association, the Society of American Forecasters and the National Society of Professional Engineers. Non-profit occupational groups consist of associations of universities, non-profit hospitals, state and local government agencies, and professional societies with members that work for the government, social welfare, education, or cultural agencies. Finally, citizen groups that are non-occupational organize around a common cause or an idea and are inclusive to anyone (Gais et al. 1984). Each group has their own dynamics. Citizen groups do not have good insider strategies and because of this, they are twice as likely as occupational groups to use outsider strategies and to appeal to the public through the media and grassroots lobbying (Gais et al. 1984). Also, because of their poor insider strategies, citizen groups are less likely to lobby administrative agencies (Gais et al. 1984).

IV. Assessment and A New Model

The current theories provide a good starting point for future research. When reading the past research, it is quite difficult to pull out theories and theoretical frameworks from the literature. This makes it hard to form a complete analysis of the theoretical frameworks previously completed because it is not clear what past research was really aiming to discover.

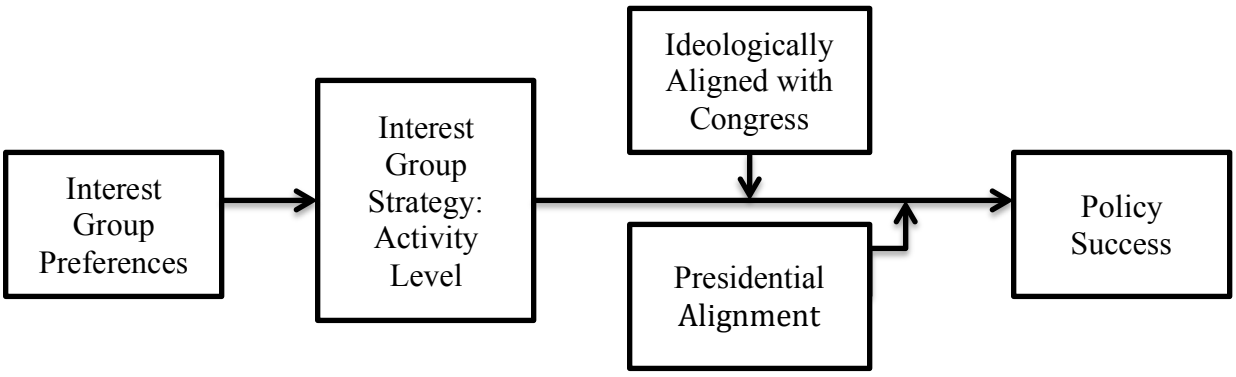
Weakness in past theories include that they do not always provide a clear question or they try to explain too many things at the same time. These theories also do not always clearly and directly look at how interest groups interact with congress and a presidential administration. Not many theories look at how interest groups' interactions with a presidential administration can be indicative of interest groups achieving the goals that they want in a policy outcome. Current interest group behavior theories tend to focus on how the institutional structure of the government has changed and the strength of the status quo, but they lack any exploration of interest group strategies to get the policy outcomes they desire in relation to interest group activity level, alignment with the ideological majority in congress, and alignment with the current presidential administration. These theories also do not always explore interest group activities from the beginning. Often, studies look at legislation that is currently in Congress and determine whether that passed or failed and label that as a failure or a success for an interest group. Most legislation, however, does not even make it to Congress and some interest groups consider creating awareness, even through legislation that fails to leave committee, a success for their organization. Current research can overlook this information and create gaps in data about interest group success and interests.

These theories raise the empirical questions of: What strategies do interest groups choose to use in an attempt to influence health care reform and how successful are the different direct

and indirect strategies? With this research I aim to explore how interest groups, through their activity level and use of direct and indirect strategies, are able to align with a presidential administration and the ideological majority in Congress to achieve their policy goals in a time of policy reform. This research will move from an institutional based approach and toward a behavior based approach. It will also utilize current behavior theory and apply it along the way, taking the best of all approaches. Status quo behavior theory is utilized when looking at interest groups' activity level and desired policy goals. Through the new theoretical framework, some of the existing gaps will be closed and new conclusions will be formed.

The framework for this study will take the following form:

Figure 1. Arrow Diagram



In this framework, Interest Group Preferences is the independent variable, Interest Group Strategy: Activity Level is an intervening variable, Ideologically Aligned with Congress is a conditional variable, Presidential Alignment is a conditional variable, and Policy Success is the dependent variable. Interest Group Preferences are the interest groups' public policy preferences for the health care reform change being observed. These preferences can be determined through the group's public statements, mission statement, past actions, and website. Interest Group

Strategy is defined as an interest group's activity level relating to the group's direct and indirect strategies. This is the activity level of how much groups use direct strategies such as meet with Members of Congress, testify in Congress, frequency of references in newspapers like the *New York* times and journals such as the *Congressional Quarterly Weekly* relating to the legislation, and how much the groups use indirect strategies such as running political ads, political spending reports and attempting to affect public opinion. Ideological Alignment with Congress is defined by comparing the interest group's values relating to the legislation with the ideological majority in Congress and determining whether or not the two are similar, or compatible. Presidential Alignment is reached is if an interest group's ideological preferences are similar to those of the president or the president's administration. All of these factors impact to policy success, which is defined as an interest group getting some of their policy preferences in a reform attempt.

Based on this model, an interest group that has a high activity level, that has a high ideological compatibility with Congress, and a high presidential alignment would be the most successful in a reform attempt. It is important to remember that success does not always mean that there is policy change. That distinction is how this model incorporates other theories' notions of protecting the status quo. High interest group activity would logically lead to higher policy success because it is reasonable to believe that the more an interest group utilizes direct and indirect strategies, the more likely it would be that they would gain more of their favored outcomes because the groups have been actively working with the policy makers—Congress—and their constituents. The ideological alignment of an interest group with Congress would affect the policy outcome because the closer the ideological goals, the more likely it is that the interest group's message will have salience with Congress and that the group will be able to negotiate and work with Congress. Also, if their ideological preferences are aligned, they already have

common ground on which to start discussion. Presidential alignment works in a similar way. If an interest group's goals are aligned with a presidential administration, there is an increased likelihood that the interest group could work with or have support from the administration. This could benefit the group and lead to increased policy success.

This model will look at how interest group preferences, strategies, and activity levels in particular lead to policy success for interest groups. Ideological alignment with the ideological majority in Congress and alignment with the president or a presidential administration can also affect an interest group's likelihood at policy success. Looking at interest group activity and success this way will allow for the observation of status quo protection activity, how interest groups work with both the president and Congress, how activity works when Congress and a presidential administration are not aligned, which activities interest groups utilize the most, and if activity level has an affect on policy success.

The current theories provide a good starting point for future research. When reading the past research, it is quite difficult to pull out theories and theoretical frameworks from the literature. This makes it hard to form a complete analysis of the theoretical frameworks previously completed because it is not clear what past research was really aiming to discover.

Weakness in past theories include that they do not always provide a clear question or they try to explain too many things at the same time. These theories also do not always clearly and directly look at how interest groups interact with congress and a presidential administration. Not many theories look at how interest groups' interactions with a presidential administration can be indicative of interest groups achieving the goals that they want in a policy outcome. Current interest group behavior theories tend to focus on how the institutional structure of the government has changed and the strength of the status quo, but they lack any exploration of

interest group strategies to get the policy outcomes they desire in relation to interest group activity level, alignment with the ideological majority in congress, and alignment with the current presidential administration. These theories also do not always explore interest group activities from the beginning. Often, studies look at legislation that is currently in Congress and determine whether that passed or failed and label that as a failure or a success for an interest group. Most legislation, however, does not even make it to Congress and some interest groups consider creating awareness, even through legislation that fails to leave committee, a success for their organization. Current research can overlook this information and create gaps in data about interest group success and interests.

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In the framework mentioned above for this study, Interest Group Preferences is the independent variable, Interest Group Strategy: Activity Level is an intervening variable, Ideologically Aligned with Congress is a conditional variable, Presidential Alignment is a conditional variable, and Policy Success is the dependent variable. Interest Group Preferences

are the interest groups' public policy preferences for the health care reform change being observed. These preferences can be determined through the group's public statements, mission statement, past actions, and website. Interest Group Strategy is defined as an interest group's activity level relating to the group's direct and indirect strategies. This is the activity level of how much groups use direct strategies such as meet with Members of Congress, testify in Congress, frequency of references in newspapers like the *New York* times and journals such as the *Congressional Quarterly Weekly* relating to the legislation, and how much the groups use indirect strategies such as running political ads, political spending reports and attempting to affect public opinion. Ideological Alignment with Congress is defined by comparing the interest group's values relating to the legislation with the ideological majority in Congress and determining whether or not the two are similar, or compatible. Presidential Alignment is reached is if an interest group's ideological preferences are similar to those of the president or the president's administration. All of these factors impact to policy success, which is defined as an interest group getting some of their policy preferences in a reform attempt.

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the policy outcome because the closer the ideological goals, the more likely it is that the interest group's message will have salience with Congress and that the group will be able to negotiate and work with Congress. Also, if their ideological preferences are aligned, they already have common ground on which to start discussion. Presidential alignment works in a similar way. If an interest group's goals are aligned with a presidential administration, there is an increased likelihood that the interest group could work with or have support from the administration. This could benefit the group and lead to increased policy success.

This model will look at how interest group preferences, strategies, and activity levels in particular lead to policy success for interest groups. Ideological alignment with the ideological majority in Congress and alignment with the president or a presidential administration can also affect an interest group's likelihood at policy success. Looking at interest group activity and success this way will allow for the observation of status quo protection activity, how interest groups work with both the president and Congress, how activity works when Congress and a presidential administration are not aligned, which activities interest groups utilize the most, and if activity level has an affect on policy success.

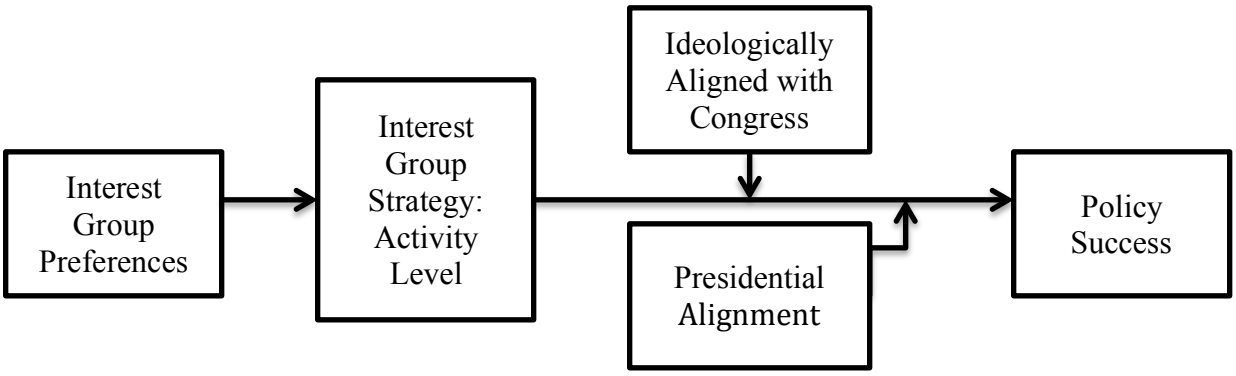
Chapter 4. Research Design and Methodology

I. Research Question, Arrow Diagram, and Variables

For this research design, a comparative case study approach will be utilized to answer the research questions of: What strategies do interest groups choose to use in an attempt to influence health care reform and how successful are the different direct and indirect strategies? The hypotheses are: 1) With all other things being equal, interest groups who are more active with the reform movement are more likely to be successful in their goals than those who are less active,

2) With all other things being equal, interest groups who are aligned with presidential health care reform initiatives are more likely to be successful in their goals than those who are not aligned, and 3) With all other things being equal, interest groups who are aligned with the ideological majority in Congress are more likely to be successful in their goals than those who are not aligned with the ideological majority in Congress. For this design the theoretical framework is:

Figure 1. Arrow Diagram



As stated in the theory section, Interest Group Preferences is the independent variable, Interest Group Strategy: Activity Level is an intervening variable, Ideological Alignment with Congress is a conditional variable, Presidential Alignment is a conditional variable, and Policy Success is the dependent variable.

II. Comparative Case Study Approach and Case Selection

A comparative case study approach will be utilized to approach these research questions and hypotheses. A comparative case study is the best approach for these research questions because the questions being asked are process questions, which are best addressed by case studies. A comparative case study has explanatory power and provides the opportunity for

replication. According to Yin, "case studies can be done by using either qualitative or quantitative evidence. The evidence may come from fieldwork, archival records, verbal reports, observations, or any combination of these" (Yin 1981, 58). It is useful for causal analysis (Johnson and Reynolds 2012). A comparative case study is useful when one is trying to explore the utility of a theory and test a hypothesis. That is why it makes the most sense to use for this research. A weakness of the case study approach is that one is limited to the cases available. The method can only answer questions such as why things happen or what is the process that leads to the outcome (Johnson and Reynolds 2012). With a comparative case study approach more control can be utilized in the research and selective and careful variation can be chosen. This method can be informative and helpful in providing understanding of causal processes and general explanations of theories (Johnson and Reynolds 2012).

This research is aiming to understand certain factors about interest groups and how the process of interest group behavior and activity works to produce interest group influence or a lack of influence in American politics. Comparative case studies are designed to understand the causal relations in a process. The cases that will be utilized in this study are: President Bill Clinton's Health Security Act, President George W. Bush's Medicare Prescription Drug, Improvement and Modernization Act, and President Barack Obama's Patient Protection and Affordable Care Act. These cases have been chosen through the method of difference. These cases will allow the study to look at health care reform through three different eras that include three different health care attempts. Comparing Obama's and Clinton's health care attempts will be beneficial because the ideological composition of Congress and the presidencies are similar, but the overall policy outcomes are different, so finding a potential explanation for this outcome is beneficial. Also, Bush's health care reform has a much different ideological composition than

the other two attempts and there was a policy change. Finding a causal explanation for how certain interests won in different cases will be beneficial for future research and health care reform attempts in the United States.

III. Operationalization and Measurement

The variables will be measured ordinally on a high, medium, low, scale. Interest group preferences are the interest groups' public policy preferences for the health care reform change being observed. These preferences can be determined through the group's public statements, mission statement, past actions, and website. Interest group strategy is defined as an interest group's activity level relating to the group's direct and indirect strategies. This is the activity level of how much groups use direct strategies such as meeting with Members of Congress, testifying in Congress, are mentioned in newspapers and journals such as the *Congressional Quarterly Weekly* relating to the legislation, and how much the groups use indirect strategies such as political spending reports. To find the mentions of interest groups in newspapers, the LexisNexis will be used. To search for interest group mentions the formula ("healthcare" OR "health care") AND ("reform" OR "proposal" OR "plan") AND ("President Name") AND ("Interest Group Name" OR "Interest Group Abbreviation"). The search will be done in specific years for the cases. Interest groups will be chosen from www.opensecrets.org in the health care spending category. For health care there are five categories of industries for the health sector. These categories are: Pharmaceuticals/Health Products, Health Professionals, Hospitals/Nursing Homes, Health Services/HMOs, and Misc Health. Well-known interest groups that may have been left out were then added to the list of interest groups. For *CQ Weekly* and *The National Journal* in the 1990s, the research will be done outside of the database. *CQ Weekly's* articles will

be searched through their website for the appropriate years and then subcategorized by health. Then the totals for each interest group will be counted. This is because their information is not available on LexisNexis. For *The National Journal* in the 1990s, the print copies will be utilized to collect data. The top spending interest groups for the year the legislation was active will be chosen. Duplicate mentions will be eliminated. The data on Opensecrets.org is not available for the years of Clinton's reform. Thus, interest groups who are frequently mentioned in *The National Journal* and well-known interests will be used. The years searched will be 1992, 1993, 1994 for the 1990's health care reform plan with President Clinton. The year searched for the early 2000's Medicare reform with President Bush will be 2003. Finally, the years for late 2000s health care reform with President Obama will be 2008, 2009, and 2010. The more newspaper mentions an interest group has, the higher an activity level an interest group would have. Ideological alignment with Congress is defined by looking at the interest group's political spending on Opensercrets.org. This is done by making a ratio of the organization's political spending for Democrats and political spending for Republicans. Then this ratio is compared to the composition of Congress. If Congress is ideologically liberal and the group has a 2:1 spending ratio in favor of Democrats, the organization would be in line with Congress ideologically and vice versa. A 2:1 spending ratio in favor of the ideology of Congress would give an interest group a high alignment with Congress. A 2:1 ratio against the ideology of Congress would be a low alignment and approximately even values would be a moderate alignment. Congress' ideology is measured through DW-Nominate scores. Presidential alignment is when an interest group's goals are similar to those of a presidential administration. If an interest group's preferences are similar to those of the president there is alignment with the president. To measure this, presidential statements and objectives will be observed. If the

president has made any proposals or recommendations to Congress, these will be considered the president's preferences. Based on how similar an interest group's preferences are to a presidential administration's that interest group will have a high, medium, or low alignment with the presidential administration. Policy success is defined as an interest group getting some of their policy outcome goals in a reform attempt. Policy outcome goals could be specific changes or no changes at all. Based on the interest groups public goals and the end policy result, it will be determined whether there is high, medium, or low policy success for an interest group.

It will be determined that there is high interest group activity if an interest group is in the top third of interest group mentions in, *The New York Times, The National Journal, CQ Roll Call, USA Today, The Washington Post,* and *CQ Weekly*. There will be low interest group activity if the group is in the bottom third. Moderate activity is when the group is in the middle third.

High alignment with the ideological majority in Congress will be when an interest group has the same ideological standing as Congress. This is determined through political spending. If an interest group and Congress have completely different ideological standings, it will be determined that there is a low ideological alignment. If either group has a mixed ideological stance, it will be determined that there is a medium ideological alignment.

Interest groups who have the same policy preferences as the president and publically endorse and support the president's plan will have high presidential alignment. Medium presidential alignment is when an interest group and a presidential administration share some policy preferences. Low presidential alignment is when a presidential administration and an interest group share few or no policy preferences.

Policy success is when an interest group gains most or all of their policy goals. Medium policy success is when an interest group gains some of their policy goals, but not many. Low policy success is when an interest group gains little to none of their policy goals. This can be observed by the following contingency table:

Table 1. Contingency Table of Variables

	Low Policy Success (non-significant)	Moderate Policy Success (Significant)	High Policy Success (Very Significant)
Interest Group Strategy: Activity Level	-	+	++
Ideological Alignment with Congress	-	+	++
Presidential Alignment	-	+	++

Interest group preferences and the actual legislation for each reform attempt/case study will be observed to collect this data.

IV. Empirical Requirements

Once the data is collected and it is determined whether or not an interest group has high, medium, or low levels on each variable, the data will be applied to the original hypotheses. First, looking at reform activity, this study will seek to see what relationship, if any there is between interest group activity and preferred policy outcomes. Second, this study will look and see if there is a relationship between interest groups who are aligned with a presidential administration and preferred policy outcomes. Finally, the ideological compatibility of interest groups with the ideological majority in Congress will be observed in relation to preferred policy outcomes for interest groups. As a result, one will be able to see if interest groups with low, medium, or high levels of activity, ideological alignment with Congress, and presidential alignment are able to be

"winners" or gain more of their preferred policy outcomes and have policy success. This would allow one to determine whether or not these interest group strategies are successful or not in cases of health care reform in the United States.

In order for an interest group to be counted in the research, it must have clear policy preferences and available data. These are criteria set in order for the model to work and for variables to have a value. Due to limitations in data requirement, five interest groups were removed from the data after initial selection. In Bush's case study these groups were the Senior's Coalition and the Association of Private Pension and Welfare Plans. Additionally, in Bush's case study, because in late 2003 America's Health Insurance Plans (AHIP) merged with the Association of Health Plans (AAHP) and the Health Insurance Association of America (HIAA) these groups were merged into one in the data. AHIP represents all three organizations in that case. In Obama's case study, these groups were Aetna Inc., Alliance for Quality Nursing Home Care, and the Association of Private Pension and Welfare Plans. Clear policy preferences are needed to determine a group's Success Level. Also, spending data for Congressional Alignment is necessary. If a group was lacking too many criteria and cannot be associated with other like-minded groups, they were not suitable for this case study.

My overall prediction is that high interest group activity, high ideological compatibility with the ideological majority in Congress, and high Presidential alignment will lead to high policy success. If an interest group does not have high values in some variables and has a mixed model or has all medium/moderate values, they will have moderate success. If all variables are low, there will be low success. The more high values an interest group has, the more policy success they will have.

Chapter 5: Case Studies

Case Study 1: President Clinton's Health Care Reform Attempt

I. Background:

Health care reform has been a topic of discussion in the United States throughout many decades. This study will focus on reform attempts throughout the 1990s, 2000s, and 2010s. To begin the case studies, President Bill Clinton's health reform plan of the 1990s will be observed. This plan began before Clinton's presidency. Comprehensive health care reform was a topic on which he campaigned on in 1992 and, Americans knew if he was elected president, it would be a topic on which he would take action. In November 1992, Clinton was elected to office. Plans for a comprehensive health care reform began as soon as he took office in January 1993.

II. Why Health Care Reform Was An Issue:

Health care reform was put on the agenda by the Clinton presidency. As soon as he took office, Clinton stated at the end of January 1992 that he would have a health care proposal for Congress within 90 days. He also stated that he hoped Congress would be able to complete the work on this bill by the end of the year (*Congressional Quarterly Almanac* 1994). It was clear to the American public and the federal government that there were evidential gaps between the reality of the health care system and what Americans wanted (Clymer et al. 1994). This health care reform overhaul aimed to "…fix a health care system that is badly broken…giving every American health security-health care" (Skocpol 1995, 1). The Clinton Administration was able to frame the issue, but they ended up lacking one "…single, easily understood objective" (Helco 1995, 4).

In order to help progress his health care plan and identify what goals he would like to see accomplished, Clinton organized a task force to draft a health care reform proposal for Congress. The task force was headed by the First Lady, Hillary Rodham Clinton, and included Cabinet members and White House staffers. A key player in the health care task force from the White House was Ira Magaziner. Ira Magaziner was a part of the Clinton administration. Before he worked on the task force, he also served as the Senior Advisor to the President for Policy Development and Chief Healthcare Policy Advisor. Magaziner and Clinton had met during their time at Oxford and were friends before the health care debate of the 1990s.

The task force consisted of 511 individuals. 412 of these individuals were full time government employees, 82 were temporary employees or specialists, and 17 were consultants. Over 130 of these members worked for members of Congress (Pear 1993). These 511 individuals composed different working groups on health care topics. Members of these groups included the congressional staffers who handled health care politics, federal health care experts, and experts from the private and public sectors. According to the Center for Public Integrity (1995), although it is stated that 511 people were part of these working groups, "court documents show that more than 1,000 people actually worked with these groups in some capacity, even though they had no official status" (The Center for Public Integrity 1995). Of those 1,000 individuals, 300 of them "worked the in private sector, including the representatives of managed care companies, the insurance industry, and small business groups" (The Center for Public Integrity 1995). Members of these groups included individuals from the "D.C. Chartered Health Plan, The National Governors' Association of Counties, the National Federation of Independent Businesses (NFIB), the U.S. Chamber of Commerce, U.S. Healthcare, Aetna, Coopers and Lybrand, and Telesis, Magaziner's former consulting firm" (The Center for Public Integrity 1995).

III. How the United States Health Care System Worked:

At the time of the Clinton health care debate, health care in the United States was delivered through several different means. One could gain health care coverage either through their employer—the private sector, the government, or an individual. Insurance coverage was paid for through payroll taxes from working adults, other taxes, and payments to health care providers and health care suppliers (Iglehart 1999).

As it stood, the private sector, or employers and employees purchased health care through insurance premiums. Employers take a percentage of an employees' paycheck, either weekly or monthly, to cover the premiums that fund health insurance coverage. Employers and not the employees' pay cover the remaining amount, about 80 percent of the premium. The income that employees pay toward health insurance premiums is exempt from federal and state taxes and the employer' costs for health insurance coverage for their employees are a tax-deductible business expense (Iglehart 1999). In 1990, 73.2 percent of Americans had health insurance coverage through the private sector (US Census Bureau, Current Population Survey, 2007).

Individuals who are not covered in employee-sponsored insurance can purchase non-group insurance on the individual market. In this system, private insurance companies administer plans and determine coverage levels. Insurance companies are able to deny people coverage based on pre-existing conditions. Individuals assume full responsibility for premiums as an out-of-pocket expense and the premium depends on the assessed health risk of the individual. Non-group insurance that is purchased by an individual tends to cost more than group plans.

The government, through Medicare, Medicaid, and other government assistance programs provides health care coverage to individuals as well. In this area, the government

collects revenue for the coverage through taxes and then pays the physicians and employees of publically operated health care facilities that accept Medicare and Medicaid. States, on an individual basis, can also collect and distribute funds for health care services. Medicaid is for low-income or disabled individuals, however, many elderly individuals are on Medicaid. This is because Medicare does not cover nursing home care, and many elderly individuals become low-income because they run through their savings paying for nursing home care, which Medicare covers. It is required by federal law that states cover poor pregnant women, children, the elderly, disabled individuals, and parents. States do have control of how they implement Medicaid and whether or not they expand coverage because states administer the program. Medicare is the largest government-controlled health care program. In 1990 there were 34,251 Americans enrolled in Medicare (2013 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds). In 1990, 13 percent of the population had health insurance through Medicare, 9.7 percent had insurance through Medicaid, and 4 percent of the population had insurance through other government programs (US Census Bureau, Current Population Survey, 2007).

Medicare is a single-payer system that is funded through 1) contributions from employers and employees that are required by law, 2) tax revenues, 3) beneficiaries' premiums, and 3) deductibles and copayments paid by patients/supplemental health insurance (Iglehart 1999). Individuals who qualify for Medicare are the disabled, those with end-stage renal disease, and individuals over the age of 65. Medicare Part A—the Hospital Insurance Trust Fund—has workers make required payments into the fund during the working years with the promise that they will receive benefits when they retire. The payroll tax that was paid was 1.45 percent of earned income both by employees and employers. The self-employed paid 2.9 percent

themselves (Tax Foundation). Part B, or the Supplementary Medical Insurance Program, of Medicare pays for physicians, outpatient services, home health services, and other services. The government only worked with approved doctors and hospitals that agreed to their prices. Funds for this program are generated through tax revenues. Participants of Part B pay monthly premiums and the enrollment is voluntary (Iglehart 1999).

Citizens of the United States themselves have out-of-pocket expenses. These expenses are "generally defined as including expenditures for coinsurance and deductibles required by insurers, as well as direct payments for services not covered for a third party. Premium amounts contributed by employees are generally not considered as out-of-pocket expenditures" (Iglehart 1999, 72).

In the health care system of the 1990s, coverage, benefits, and costs depend widely by an individual's plan. The main ways an individual could gain health care were through their employer, on an individual level, or through the government. In total, according to the U.S. Census Bureau, 13.9 percent of the population was uninsured in 1990 (US Census Bureau, Current Population Survey, 2007).

IV. Creating A Health Care Reform Proposal:

The mission of the Task Force on National Health Care Reform was to expand health care to all Americans and reduce the increasing rate of health care spending. At the time, 38 million Americans were uninsured. Every month, 100,000 more people lost their health insurance coverage. Spending on health care in the United States in 1992 had reached $832 billion. That was one-seventh of the United States' economy at the time. This spending was estimated to increase to $1.6 trillion by 2000 (*Congressional Quarterly Almanac* 1994). At the

time, many players in the health care system such as insurance companies, doctors, consumers, and unions agreed about how serious the problems of the health care system in the United States were. Americans also agreed that health care reform was necessary. According to a Wall Street Journal/NBC news poll published on March 12, 1993, 74 percent of Americans believed that reform was needed. However, the reform that the public envisioned was not always in line with the reform the government was pursuing. This is because most Americans, 85 percent, Americans were already insured, and typically, they were happy with their health insurance coverage (*Congressional Quarterly Almanac* 1994). To finance a reform, 66 percent of Americans agreed to pay higher taxes to cover the cost of a health care overhaul.

During the time of the movement around health care reform in 1993, over 500 different interest groups met with the White House staff that handles health care issues to discuss their particular concerns with the proposal (*Congressional Quarterly Almanac* 1994). For the past 60 years, health care providers had resisted changes and other sectors of the health care industry such as doctors, hospitals, and pharmaceuticals were hesitant to support change because annually, their income grew as a result of the rising costs of health care. However, some doctors were in favor of reform because of the amount of paperwork and regulations caused by the private insurance industry and the government (*Congressional Quarterly Almanac* 1994). A main cause for concern and driving factor for health care reform was that Medicaid and Medicare, part of President Lyndon B. Johnson's Great Society program, were comprising almost 30 percent of the United States' health care spending. Through these programs, the government gives health care coverage to the elderly, disabled, and the poor (*Congressional Quarterly Almanac* 1994). The system that existed in 1993 had funding from ten different sources: Medicare, Medicaid, Indian Health Service, Veterans, Department of Defense, other

federal spending state and local government health spending, private insurance and other consumer spending, workers' compensation, and auto insurance (*Congressional Quarterly Almanac* 1994).

Clinton's 245-page draft health care reform proposal was finally turned into Congress on September 22, 1993. This draft came after Congress had already negotiated a $55.8 billion deficit reduction bill, which included large cuts to Medicare. The health care reform proposal had six key goals. The first goal relies on "aspects of a health policy known as managed competition—in which doctors, insurers and hospitals competed for patients. Clinton added to that a regulatory structure to control costs and quality" *(Congressional Quarterly Almanac* 1994 338). Secondly, an economic analysis produced the concept of "gathering consumers into larger groups, known as healthcare alliances" (*Congressional Quarterly Almanac* 1994, 338) so that consumers can bargain with health insurers and get a better price and services for health insurance, essentially maximizing individuals market power with insurers. The third goal involved funding the plan. This would be done through both the private and public sectors. For the private sector, "employers would be required to pay for about 80 percent of their employees' health-care costs. Employees would pay the balance" (*Congressional Quarterly Almanac* 1994, 338). There would be subsidies available for both the employers of low-wage workers and the employees themselves. An opt-out would be available for companies with more than 5,000 employees who did not want to provide health care coverage for their employees. If employers opted out of the government purchasing system, they would have to pay an additional one percent tax on payrolls in order to cover the cost of the uninsured and underinsured. A tax on tobacco would also be added to the existing tobacco tax that would amount to about $0.75 a pack. The fourth goal of Clinton was to "reduce the rate of growth in health-care spending

nationwide by capping the rate of increase in health insurance premiums and by making cuts totaling $238 million over six years in Medicare and Medicaid" (*Congressional Quarterly Almanac* 1994, 338). The fifth goal emphasized that the health care alliances would change health care delivery because states would have control of the system and be able to buy insurance on behalf of individuals (*Congressional Quarterly Almanac* 1994). Clinton's sixth goal is that "the alliance would play the role that health insurers played under the existing system: It would negotiate with health plans (groups of doctors and hospitals) for the best insurance price for the people in the alliance and then offer the plans to everyone in the region" (*Congressional Quarterly Almanac* 1994, 338).

V. Congressional Debate and Action:

At first it seemed like Congress was open to the possibility of health care reform, although it was clear that bipartisan support would be needed because the Democrats did not have enough members to avoid filibuster and the Democrats were not as united as they could have been. At the start of the 103rd Congress in 1993, the Senate was composed of 57 Democrats, and 43 Republicans. The House of Representatives was composed of 258 Democrats, 175 Republicans and, one Independent. On October 27, 1993, Clinton formally submitted his health care reform bill to congressional leaders. Hillary Clinton led the charge to get health care reform passed and testified in Congress, often answering many questions and catering her answers to congressmen's specific districts and concerns. The hot-button issues of the debate and the reform were: health alliances, the premium caps, the employer mandate, and the subsidy cap. However, both sides tended to agree on a need for insurance reform, malpractice reform, purchasing cooperatives, and streamlining (*Congressional Quarterly Almanac* 1994).

Other Members of Congress introduced their own health care reform proposals as it became obvious that Clinton would introduce a bill and debate would occur. These bills are: Cooper-Grandy (HR 3222), McDermott (HR 1200), Michel (HR 3080), Chafee (S 1770), Wellstone (S 491), and Nickles (S 1743) (*Congressional Quarterly Almanac* 1994). The Clinton Administration had tried to set the health care reform agenda themselves, but controlling the debate around health care reform proved to be difficult.

The Cooper-Grandy proposal was a bi-partisan proposal created by Representatives Jim Cooper, D-Tennessee and Fred Grandy, R-Iowa. This proposal, HR-3222 was the main alternative to Clinton's health care reform proposal. It was centered around managed-competition. In this system, health care providers would create networks and compete for patients. People would be encouraged to join managed-care plans, but not required to do so. Another difference from Clinton's proposal was that tax deductions would be limited for health care and employer participation would be completely optional. This bill had 56 cosponsors in the House of Representatives (*Congressional Quarterly Almanac* 1993). The introduction of the bill reads that it aims to "to contain health care costs and improve access to health care through accountable health plans and managed competition, and for other purposes (HR 3222) The main difference between the Cooper-Grandy proposal and Clinton's proposal is that there were no mandates regarding health care coverage.

Representative Jim McDermott, D-Washington, offered a single-payer proposal that was similar to the system that exists in Canada. His proposal gathered over 90 cosponsors (*Congressional Quarterly Almanac* 1993). The goal of McDermott's plan was to "provide for health care for every American and to control the cost of the health care system" (HR 1200). The plan would be administered at a state-level by the terms the plan set and every citizen of the

United States, or lawful alien, would be eligible for the universal coverage.

House Republican Leader, Robert Michel, proposed a plan with large Republican support that would make expand coverage for the poor.

John Chafee, R-Rhode Island, had a proposal that was similar to Clinton's proposal on many aspects but eliminated cost controls and employer mandates. While Chafee's plan did include purchasing plans, they were voluntary (*Congressional Quarterly Almanac* 1993). The Chafee plan also included purchasing pools, a ban on coverage denial based on pre-existing conditions, vouchers for the poor to buy insurance, an individual mandate, insurance companies are prohibited from cancelling coverage, there is long term care insurance, Medicaid malpractice reform, insurers cannot set lifetime spending caps, coverage is not extended to dependents, and the self-employed are given more equal tax treatment. The goal of this plan was to have 92-94 percent of Americans covered by 2005 (Kaiser Health News 2010).

Democrat Paul Wellstone from Minnesota proposed a single-payer plan, along with other Democratic senators, that resembled Representative McDermott's plan to mimic Canada's health care system (*Congressional Quarterly Almanac* 1993).

Finally, Republican Senator Don Nickels introduced a plan that was drafted by the Heritage Foundation. This bill had 24 cosponsors and avoided government controls.

On November 20, 1993, the health care reform bill was officially introduced in the House of Representatives. It was then referred to the Ways and Means, Energy and Commerce, and Education and Labor committees. Smaller portions of the bill were referred to the Veterans' Committee, the Judiciary Committee, the Post Office and Civil Service Committee, and the Armed Service Committee. Additionally, the bill went to the Government Operations and Natural Resources Committee in the House. In the Senate, one committee needed to have

jurisdiction, and it would be difficult to give sole power to one committee regarding this bill, the bill was left on the calendar as originally written by the task force. It was taken to the floor in 1994 for both committees, the Labor and Human Resources Committee and the Finance Committee, to amend it along with any other senators who wished to make changes (*Congressional Quarterly Almanac* 1994).

Action on health care reform was halted due to the government's efforts to pass the North America Free Trade Agreement. Due to the efforts involved with NAFTA, it was clear that health care reform would not occur in 1993. Other distractions such as the economy, Whitewater, and foreign crises, deferred attention from health care reform. Thus, health care reform was put on the backburner for both Clinton and Congress, which caused the problem recognition of health care to fade from the spotlight and made it clear that no action on health care reform would occur in 1993 (Clymer et al. 1994; *Congressional Quarterly Almanac* 1994).

On September 26, 1994, Clinton's health care reform bill was declared dead by Senate Majority Leader George H. Mitchell, D-Maine. Lawmakers had originally thought that they could still act on health care reform after their summer recess, but it became clear that there was not enough time or willingness to complete the work that was needed to get a comprehensive health care reform bill passed. Issues that created the most problems and debate were the Democrats' hesitancy to accept the notion that employers would cover most of the costs and the government would have a large hands-on approach to the institution of the system. Republicans were wary of the whole reform because they felt it had too many taxes and regulations (*Congressional Quarterly Almanac* 1995).

Debates surrounding Clinton's plan focused on the ideas of health alliances, premium caps, employer mandates, and subsidy caps. Health alliances were debated because some thought

the formation and regulation of health alliances would be too much government intervention and would not be the appropriate role of the government. Acting in such a way would be "big government" according to those who opposed the alliances. Premium caps were heavily contested by the health care industry because it limits the amount insurance premium could increase annually. There was concern that the caps would allow the price to rise considerably once they expired and would not allow room for the health care industry to respond to the cost of a crisis. An employer mandate was heavily opposed by small businesses this is because the mandate would force employers to pay for employees' health insurance. Small businesses and their supporters, such as Republicans, worried that it would cause small businesses to close or to fire employees because of the burden of the cost. Large companies who already paid for insurance favored the mandate, however, because they believed that the mandate might help limit the cost-shifting that doctors and hospitals institute because of the costs of the underinsured and uninsured. Finally, the subsidy cap was contested by Liberal Democrats because it ran the risk that programs for the poor and the small business subsidies fund could run out of money in order to help the federal government avoid debt from Medicare and Medicaid (*Congressional Quarterly Almanac* 1993).

Overall, it was clear that Clinton's plan was becoming hard to sell to the public. Initially, when Clinton's proposal was introduced, 57 percent of Americans approved of the proposal and 31 percent disapproved according to a *USA Today/*CNN/Gallup poll, but six months later only 39 percent of Americans approved of the proposal and 46 percent disapproved (The Center for Public Integrity 1995). With increasing use of outside strategies by lobbyists and with Clinton's decreasing poll numbers, it was not surprising that public support was decreasing as well. It became clear that not only was health care reform a policy issue, but it was also a political issue.

Clinton would need all the Democratic support he could gather in order to pass the bill. On December 2, 1993, William Kristol sent a memorandum titled "Defeating President Clinton's Health Care Proposal." It was clear that Republicans did not want to compromise on the issue, but to offer an alternative and dismiss Clinton's. The unwillingness to compromise is clearly stated: "On grounds of national policy alone, the plan should not be amended; it should be erased" (Talking Points Memo 2013). In his memorandum he says he would like to "assess the current political climate surrounding the health care debate and to provide a winning Republican strategy that will serve the best interests of the country" (Talking Points Memo 2013). Defeating the plan became political. Kristol acknowledged that the Clinton plan lost public support and the Republicans hoped to use that to their advantage and to win support with their own plan. The health care debate became a forum to advance general Republican interests and ideals.

From when Clinton took office in 1993, health care reform had been on the agenda. He formally proposed his plan to Congress on September 22, 1993, while the bill was introduced in the House and Senate (HR 3600, S 1757) on November 20, 1993. By July 21, 1994, it was clear to the Democratic leaders that the plan would need to be scaled back if there was any chance of passing it through Congress. The bill was not scaled back because it was clear that the window of opportunity had closed and the momentum behind health care reform was dying. Finally, on September 26, 1994, health care reform was declared dead for the year, the window of opportunity for health care reform was gone for the year.

VI. Interest Group Activity:

While Congress was working on a health care reform, interest groups were also involved in their own efforts. Some interest groups stayed on the sidelines, while others were prominently

opposed or for health care reform. Interest groups also had different desires of what they wanted to come from a reform, so some supported alternative plans. Groups such as the American Association of Retired Persons (AARP) worked with the task force and submitted testimonies to Congress (Congressional Record Database). Groups such as the American Medical Association (AMA), AARP, Aetna, Prudential, Pharmaceutical Research and Manufacturers of America (PhRMA), the American Federation of Teachers, AFSCME, and others met with the White House Office of Public Liaison and the task force to express their positions of health care from. According to The Center for Public Integrity (1995), "Magaziner and other members of the task force had met with representatives of more that 1,100 groups, each voicing their opinions and concerns regarding health care reform" (The Center for Public Integrity 1995). It was clear that "the White House knew exactly what the most powerful special interest were concerned about, and elaborate efforts were made to mollify them before the President's formal plan was written or released" (The Center for Public Integrity 1995). While it is not unusual for the White House to interact with specific interests, it is notable that this many interests were meeting with the White House on a specific interest and topic in order to try and incorporate organizations' interests into the legislation proactively.

Another group that was active at the time of Clinton's proposal was the Jackson Hole group. The Jackson Hole Group consisted of members that were a part of academia, insurance companies, hospitals, H.M.O.s, doctors, businesses, government, and other organization with interests across the United States (Toner 1993). The Jackson Hole Group had been meeting and discussing health policy solutions for over 20 years and had slowly introduced managed care into the discussion and the solution in order to make health care more efficient. Through the Jackson Hole Group, business interests were presented. The Jackson Hole Group was unique in this

situation because it was part think tank and part interest group. It developed potential policy solutions while it also promoted the positions of its members. The business community in this situation was split. Big businesses were generally in favor of Clinton's proposal because they hoped that a larger pool of insured individuals could lower the cost of their insurance. This is because they generally already provide some sort of health care coverage for their employees and are disadvantaged when doctors charge more because of the high costs of providing care for the underinsured and uninsured. However, small businesses were currently not required to provide insurance for their employees, and if a mandate were instituted, they would be economically disadvantaged. They claimed that they would be at risk of closing or firing employees because they would not be able to afford to provide everyone with health insurance.

However, other organizations lobbied both members of Congress and the public such as the Health Insurance Association of America (HIAA). HIAA launched a public ad campaign with what are known as the "Harry and Louise" advertisements. These advertisements depict a couple sitting at their kitchen table discussing how Clinton's proposal would affect them, negatively. This grassroots effort was a multimillion-dollar campaign (The Center for Public Integrity 1995). Lobbying the public is a common framing technique that interest groups and organizations use in an attempt to sway public opinion in their favor. This is what interest group theory refers to as an indirect outside strategy because the interest groups are trying to influence individuals outside of the government in order to advance their objectives.

Many lobbyists also turned to grassroots efforts to try and appeal to the public. Lobbyists efforts were extensive, members of Congress said that they did not have time to schedule all the face-to-face meetings requested from "dance therapists, masseurs, chiropractors and podiatrists, armed with scripted palm cards from one trade association or another" (Krauss 1993). These

efforts are referred to as AstroTurf grassroots efforts, because it is not a pure grassroots campaign, but rather an artificially stimulated grassroots response. These campaigns involve the use of mass calls, mailings, and meetings to and with Members of Congress about their issue, but without the script from the organization, those speaking with Members likely would not know exactly what to say.

As reported by the *New York Times*, interest groups like the Pharmaceutical Manufacturers Association (PMA) and the American Academy of Family Physicians spent large amounts of money to hire lobbyists. Other groups such as AMA the National Association of Life Underwriters, and the American Dental Association (ADA) "increased their campaign contributions to lawmakers of both parties with the intention of increasing their access and influence" (Krauss 1993). The AARP made appeals to their members to contact their own Members of Congress with their stance on the issue. They utilized this tactic instead of taking an official position on health care reform. These interest groups, however, were not all trying to spread the same message. Some organizations were against the idea of reform altogether, while others wanted specific goals from a health care reform. There seemed to be a balance of forces among interest groups. They each were employing different strategies and advocating for different goals. This is an important component of interest group theory. For most issues, there is a balance of forces that attempts to help preserve the interest group balance. Details about what interest groups were trying to achieve will be outlined later on in this paper.

VII. Analysis of Interest Group Success:

VIIa. Methodological Approach:

In order to analyze interest group behavior and activity during the time of Clinton's health care reform, different interest groups were observed and compared. The following twelve interest groups were observed, American Academy of Family Physicians, American Association of Retired Persons (AARP), American Hospital Association (AHA), American Medical Association (AMA), Association of Private Pension and Welfare Plans, Blue Cross Blue Shield, Chamber of Commerce, Health Insurance Association of America (HIAA), National Association of Manufacturers, National Federation of Independent Businesses (NFIB), Pharmaceutical Manufacturers Association of America (PMA), and the Pharmaceutical Research and Manufacturers of America (PhRMA). As mentioned earlier in the methods section, interest groups for this case study were chosen based on which groups were mentioned most in *The National Journal* and the groups that were listed on www.opensecrets.org as spending the most money in the health care interest group category. For health care there are five categories of industries for the health sector. Well-known interest groups that may not have been listed by OpenSecrets were added to the list. They were compared in terms of their mentions in the *New York Times*, *CQ Roll Call*, *The Washington Post*, *USA Today, CQ Weekly*, and *The National Journal* in 1992, 1993, and 1994. Their political spending in 1992 in terms of whether or not they spent more on donations to Republicans or Democrats and how that aligns with the ideological composition of Congress was compared. Finally, the organizations' stances were compared to Clinton's objectives for the proposal to determine how much alignment there was with the President's objectives. All three aspects are rated on a low, moderate, high scale.

Interest groups were determined to have low, moderate, or high levels of newspaper mentions by being broken up into the top third, middle third, and bottom third of mentions. While Blue Cross Blue Shield, was not in the top third, it was included with the high category because it was closer to the top third than the middle third of mentions. From this data, there is evidence that, in general, those groups who have moderate and high levels of Congressional Alignment have a better success level. The only exception to this is the American Academy of Family Physicians.

Congressional alignment is determined by interest groups' donations to political parties because while partisanship is not technically equivalent to ideology, with how partisan and divided Congress has become, one can observe ideology through partisanship. Congress' DW-nominate score for 1992 was -0.046. The Democrats' DW-nominate score was -0.33 and the Republicans' score was 0.329 (Vital Statistics on Congress). Thus, Congress was more liberal and an interest group was more ideologically in line with Congress if it donated more money to liberal Members of Congress, or Democrats, rather than donating the majority of its money to conservative, or Republican Members of Congress. If there was over a 2:1 ratio in favor of Democrats, a high alignment was determined. Congressional Alignment was moderate if its spending was relatively equal, and it was low if it favored Republicans.

VIIb. Was It Alignment Or An Opposition Movement?

When looking at Table 3 below, it is clear that there are many groups that have low Presidential alignment and a high success level. This is because these groups were not in favor of the plan and advocated for protecting the status quo—a common goal in interest group theory. President Clinton's goal was to change the status quo, therefore groups who wanted to keep

things the same would not align with him. When the reform attempt failed, they achieved a high level of policy success because things remained the same. Looking at Table 2 below, it is clear that there is a strong opposition to Clinton's plan. Out of the twelve groups observed, only one group, the Chamber of Commerce, fully endorsed and supported Clinton's health care reform.

VIIc. How Interest Groups Were Categorized:

The American Academy of Family Physicians endorsed a single-payer option, which is not what the Clinton plan provided. During the time of the health care reform debate they engaged in discussions with the administration and agreed on a need for reform, but not on the type of reform that was being proposed. The American Academy of Family Physicians has a low level of success in this reform attempt because they received none of the gains that they wanted and the single-payer system was never seriously considered in Clinton's proposal. The single-payer system was not implemented and it was never a significant alternative policy alternative to proposals being offered. Their preferred option was not an option of major consideration; therefore, they had a low level of success.

The American Association of Retired Persons did not endorse the Clinton plan and called on their individual members to make an assessment and voice their individual opinions to Congress. Generally, they are in favor of comprehensive reform, but they did not publically endorse it at the time, and they were wary of the cuts in Medicare and Medicaid to fund the proposal. Therefore, the AARP was a moderate winner, because they really were advocating for change and the status quo at the same time. They wanted some change, which did not occur, but they were happy with preserving the status quo and ensuring that Medicare and Medicaid cuts

would not happen, which did occur. This balance led them to come out as having a moderate success level.

The American Hospital Association has a moderate success level because they are against any reductions in Medicare payments, but they are for health care coverage for everyone. They are determined to have a moderate success level because reductions in Medicare payments do not happen because the status quo is protected, yet health care coverage is not gained for everyone.

The American Medical Association had a high level of success because they were quite outspoken against Clinton's proposal and were intent on maintaining the status quo. They utilized the strategy of alliances and used that to try and get a beneficial outcome. They were worried about the effects of Clinton's plan and what the implications of the plan would be for doctors. In the end, the status quo was preserved, so they were successful.

The Association of Private Pension and Welfare Plans had a high level of success. This is because they were against the plan and were part of a greater group of interests against the plan because of the impact on employers. They thought the plan would increase health care costs for employers, which would cause employers to drop health care coverage. Their success level is high because employer-mandated coverage did not occur and that was their main goal.

Blue Cross Blue Shield had a high level of success because they were against the Clinton proposal. Primarily, they were against health alliances. Ultimately, health alliances did not form, and the status quo was preserved. Therefore, they had a high level of success.

The Chamber of Commerce, while they had previously not supported any initiative by President Clinton, unanimously backed universal health care coverage through employer mandates as stated by Clinton's proposal. Due to the failing of the legislation, the Chamber of Commerce had a low level of success.

Health Insurance Association of America was very against Clinton's health care proposal. They spent a lot of money ($14 million dollars on advertisements) and efforts to protect the status quo in this case. They ended up having a high level of success because the legislation failed and the status quo remained the same.

The National Association of Manufacturers had a high level of success because they were against the proposal and wanted to protect the status quo. They represent large and small manufacturers in the United States and were concerned about the employer costs and mandates. When the legislation failed and the status quo remained the same, they won.

The National Federation of Independent Business also wanted to preserve the status quo. For small businesses, the employer mandate was a serious issue. Small businesses were not previously required to provided health insurance to their employees and it was feared that a new mandate could cause small businesses to fire employees or to close. The NFIB strategically targeted swing-vote members of Congress to gain around 55 to 60 votes against the employer mandate in the Senate (Jacobs 1999). The NFIB had a high level of success when the status quo remained the same.

Pharmaceutical Manufacturers Association of America (PMA) or Pharmaceutical Research and Manufacturers of America (PhRMA)—the two organizations joined together at the end of the health care debate in the 1990s—had a moderate level of success. They supported many aspects of Clinton's plan, but they did not like that companies would have to pay rebates on Medicare patients' prescription drugs and that there would be investigations into excessive drug prices. They were also against a single price mandate for prescription drugs. The fact that they were against rebates on Medicare prescriptions and investigations, but were generally supportive of comprehensive health care is what gives PhRMA and PMA a moderate success

level. So, they were a moderate winner with the health care reform debate. When the status quo was preserved, and the monitoring of the cost of Medicare patients' prescription drugs remained the same, yet universal health care was not achieved, PhRMA and PMA had a moderate success. They did not receive what they truly wanted; yet what they did not want to occur did not happen.

VIII. Success of the Model:

In the case of the Clinton administration's attempt at health care reform in the 1990s, the model utilized in this case study does not work well. In this case study, the status quo was preserved. Therefore, groups who wanted to preserve the status quo to had high levels of success, and were likely not highly aligned with the President. Most of the active interest groups were opposed to Clinton's reform plan. This can be observed in Table 3 below. There was only one interest group observed, the Chamber of Commerce, who was fully supportive of Clinton's health care reform plan. A strong opposition to the President's plan resulted in low Presidential Alignment. As a whole, it seems that this could have affected the outcome of the plan as a whole. Interest groups were determined to be in favor of Clinton's plan if they publically supported Clinton's health care reform plan and the Chamber of Commerce is the only group that fits this description. Other groups were hesitant and against the plan as a whole.

For this case, my model does not work well; this is likely due to the strong opposition alliance that appeared to have formed during the 1990s health care debate. Out of the twelve interest groups observed, the model appears to work for five of the interest groups. These groups are the AARP, AHA, HIAA, PHA, and PhRMA. The model appears to work for these groups because they each have a high level of significance that leads to their success level.

The model works when an organization has two or more significant variables that lead to a significant outcome. The model also works when an organization as two or more low significance variables that lead to a non-significant outcome. A high variable can be thought of as being very significant, a moderate variable can be thought of as significant, and a low variable can be thought of as not significant. If an interest group has a combination of high and moderate variables and has a high or moderate Success Level the model is successful. This is because the average of the two would be significant—either high or moderate. Therefore, the expected outcome of success would be significant, or moderate. If the expected outcome is produced, then the outcome worked. The model works if it follows this pattern:

Table 2. Instances of Model Success

Variable 1	Variable 2	Variable 3	Success Level
Significant (Moderate or High)	Significant (Moderate or High)	Significant or Not Significant (Low or Moderate or High)	Significant (Moderate or High)
Not Significant (Low)	Not Significant (Low)	Significant or Not Significant (Low or Moderate or High)	Not Significant (Low)

It is important to note that Variable 1, 2, and 3 are not assigned to any particular variable. Any variable can have the assigned significance value that would meet the criteria for the model to be successful. For instance, Variable 1 is not restricted to Newspaper Mentions. Any two variables out of Newspaper Mentions, Ideological Alignment with Congress, and Presidential Alignment can fulfill the two out of three minimum requirement for matching significance or non-significance for the model to be successful in that case.

Below is a table of the interest group analysis and of the opposition movement.

Table 3: 1992, 1993, and 1994 Interest Group Analysis

Interest Group Name	Newspaper Mentions	Congressional Alignment	Presidential Alignment	Success Level
American Academy of Family Physicians	Low	High	Moderate	Low
American Association of Retired Persons (AARP)	High	High	Moderate	Moderate
American Hospital Association (AHA)	Moderate	High	Moderate	Moderate
American Medical Association (AMA)	High	Low	Low	High
Association of Private Pension and Welfare Plans	Low	Moderate	Low	High
Blue Cross Blue Shield (BCBS)	High	Moderate	Low	High
Chamber of Commerce	High	Low	High	Low
Health Insurance Association of America (HIAA)	High	High	Low	High
National Association of Manufacturers	Moderate	Low	Low	High
National Federation of Independent Businesses (NFIB)	Moderate	Low	Low	High
Pharmaceutical Manufacturers Association of America (PMA)	Low	Moderate	Moderate	Moderate
Pharmaceutical Research and Manufacturers of America (PhRMA)	Low	Moderate	Moderate	Moderate

Table 4: Whether Interest Groups Wanted President Clinton's Health Care Reform vs. Newspaper Mentions in 1992, 1993, and 1994

Interest Group Name	Want Clinton's Reform?	Newspaper Mentions
American Academy of Family Physicians	No	Low
American Association of Retired Persons (AARP)	No	High
American Hospital Association (AHA)	No	Moderate
American Medical Association (AMA)	No	High
Association of Private Pension and Welfare Plans	No	Low
Blue Cross Blue Shield (BCBS)	No	High
Chamber of Commerce	Yes	High
Health Insurance Association of America (HIAA)	No	High
National Association of Manufacturers	No	Moderate
National Federation of Independent Businesses (NFIB)	No	Moderate
Pharmaceutical Manufacturers Association of America (PMA)	No	Low
Pharmaceutical Research and Manufacturers of America (PhRMA)	No	Low

When comparing interest groups who are in favor of health care reform in the 1990s to their activity level (number of newspaper mentions) in 1992, 1993, and 1994, some observations can be made. As stated in Table 4 above, there are clearly more interest groups in opposition of reform than in favor of the health care reform being proposed at the time. Interest groups may have a mixed activity level, but those who support a reform attempt are severely outnumbered to those who wish to protect the status quo. While some of the groups labeled as "no" are typically reform-friendly, those groups were not publically friendly to the reform being proposed by

President Clinton in the 1990s, thus they were labeled as being against the Clinton plan. Without a public endorsement, interest groups were not considered to be fully in favor of the health care reform plan at the time. For example, the AARP is labeled as not being in favor of Clinton's reform plan because, at the time, the AARP did not give public support for the plan. While they were not adamantly opposed to reform, they did not give the support of their organization. Instead they encouraged their members to contact their Members of Congress and let them know their personal opinions. There was not a formal stance of the organization in favor of the reform. If there is not a clear stance of the organization in favor of this plan, they cannot be labeled as in favor of Clinton's reform.

From this observation, it is clear that unbalanced interest group activity could lead to the policy outcome. With having eleven key interest groups opposed to the Clinton plan and only one group publically supportive, it is reasonable to believe that the unbalanced activity was able to protect the status quo and lead to the bill's failure.

Groups who were not very successful in this reform were groups who supported a President Clinton's reform, such as the Chamber of Commerce. This could be because of the strong opposition. There was a strong presence of groups who were interested in preserving the status quo. The opposition clearly outnumbered those who were in favor of reform in this case. With a strong opposition, there was low presidential alignment. With a large amount of interest groups opposed to the reform movement, presidential alignment did not seem to be a significant burden for interest groups to overcome. The opposition by the interests was strong enough to allow the interest groups to succeed and the presidential reform movement to fail in this case.

Groups who supported a specific aspect of reform ended up being moderately successful. This is because they benefited from preserving the status quo, but they would have benefited if

parts of the proposed health care plan were implemented. Theses groups typically had certain aspects of the reform that they were against, but were able to reconcile the idea of comprehensive health care reform as a whole.

When applying the model specifically to these interest groups, certain conclusions may be drawn. In the case of AARP, all of the AARP's variables have a moderate-to-high level of significance, which leads to a moderate success level. In this case, the model helped predict the group's success level. The AHA has a similar presentation of variables that shows a moderate-to-high level of significance which helps lead to the AHA's moderate success level. For HIAA, having two variables with a high level of significance, helps lead to the group's high level of success. Finally, for both PMA and PhRMA, having two moderate-level variables helps lead to the groups' moderate level of success.

However, for the majority of the interest groups, the American Academy of Family Physicians, AMA, the Association of Private Pension and Welfare Plans, Blue Cross Blue Shield, Chamber of Commerce, and the National Association of Manufacturers, the model does not work.

My criteria here is that the modes is said to work when an interest group has at least two out of three of the intervening variables are moderate or high as well as the success level. This means that the intervening variables would then accurately align with the success level of the interest group.

The only groups whose success level was low, were the American Academy of Family Physicians and the Chamber of Commerce, however, the model was unable to explain why these success levels were low. The levels of success that the model was best able to explain were moderate success levels. It was only able to successfully predict one high level of success. The

reason why there were so few low success levels for the model to be able to explain is because of the strong opposition movement. The model had a difficult time explaining the effects of interest groups bandwagoning and the results of larger interest groups paving the way for smaller groups to achieve success. For instance, smaller groups are able to spend less money, be less active, and potentially have a lower alignment with the president, but have a higher level of success because larger interest groups with the same interests and desired outcomes are being active and spending money on their behalves. It is possible to see the clear-cut activity of the larger interests in this model, but the smaller interests who are benefiting from the bandwagon have a path that is harder to observe through my chart and model.

In general, with the exception of the Chamber of Commerce, the only observed group in favor of the reform, if a group has a high amount of newspaper mentions, it will have a high or moderate level of policy success. Out of the five groups with high newspaper mentions, three had a high level of policy success (AMA, Blue Cross Blue Shield, and HIAA)—which is half of the groups with high policy success, one had moderate success AARP), and one had low success (Chamber of Commerce). Those who were moderately active in newspapers generally had a high policy success level. The National Association of Manufactures and the NFIB both had high success levels and moderate newspaper mentions, while the AHA also had moderate newspaper mentions but had moderate policy success. Those groups who had low levels of newspaper mentions had mixed policy success. Both PMA and PhRMA had moderate levels of policy success, while the Association of Private Pension and Welfare Plans had a high level of policy success, and the American Academy of Family Physicians had a low level of policy success.

The clearest explanation for the difference between those with high and low success in this case is that those who were more active and who were opposed to the Clinton health care

reform had higher levels of success. A bandwagon effect occurred. Groups with less resources and power were able to benefit from being aligned with interest groups who were more active and had more influence against the reform.

Due to the large number of interest groups who do not support any reform effort—eleven out of twelve—it is very difficult for this model to be successful in this case. While the model did help explain the success outcome for some groups, the strong opposition effort is hard for the chart and theory to explain. When a few interest groups are in favor of the reform it is difficult to see how Newspaper Mentions, Ideological Alignment with Congress and Presidential Alignment will align to influence an interest group's success level. The strong opposition against the reform makes it so that Presidential Alignment and Congressional Alignment was not necessary for a group to have success.

Ideological Alignment with Congress was not a main requirement for success. Congressional Alignment did not have a large impact in this case. Looking at Congressional Alignment alone does not help to explain a significant Success Level outcome. It also does not help to explain a Success Level outcome that is non-significant. This could be because of the strong opposition movement against the reform. It is generally easier to protect the status quo than to initiate change, and based on this case, it is clearly easier to obstruct change than to win. Presidential alignment is needed to create change and win a reform, but it is not essential to obstruct a policy change. When specifically looking at the impact of Newspaper Mentions and Congressional Alignment in this case, both have four instances where an interests group's Newspaper Mention or Congressional Alignment is opposite of its Success Level. For Newspaper Mentions, there are three instances of one level deviations from the Success Level and for Congressional alignment there are four instances of this. Congressional Alignment is the

same as an interest group's Success Level four times and Newspaper Mentions is the same of Success Level five times. These numbers are so close that it is hard to distinguish the distinct impact of each. Thus, for this case, Presidential Alignment and Congressional Alignment were not essential variables for success. Simply being aligned against the movement is what allowed interest groups to have a high Success Level. This is because when Clinton lost, the strong opposition movement won.

Case Study 2: President Bush's Medicare Reform Attempt

I. Background:

In 2003, Medicare Modernization became an issue of debate as President George W. Bush pushed for the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) which was the biggest Medicare overhaul to date. Drug coverage in Medicare was debated long before Bush became the 43rd President of the United States in January 2001. When Clinton's Health Security Act failed in the 1990s, the issue of Medicare drug coverage was left unaddressed. The Balanced Budget Act of 1997 created the Medicare+Choice program, Medicare Part C, and allowed Medicare beneficiaries to enroll in the traditional Medicare program, HMOs, or preferred provider organizations. After Clinton left office, the next opportunity for reform was during Bush's Presidency. With the midterm elections in 2002, the Republicans had a majority in Congress. With this newfound majority and because the Bush Administration was pushing for a modernization of Medicare, the Republican majority wanted to take this opportunity to expand the prescription drug benefit for Medicare in a way that they could control and claim credit. Previously all attempts to reform Medicare were part of a larger health bill, but with the new Republican majority, there was a window of opportunity to pass a

Medicare reform that would include prescription coverage but would not address any other aspect of health care. This would be a single-issue reform. Bush campaigned on the issue, and quickly made it a priority within his administration. In the development of the MMA, the Senate and the House developed different plans from that proposed initially by the Bush administration. While the administration tried to delegate legislative responsibility for the plan to Congress, Bush clearly had his own preferences for the plan.

II. Why Medicare Reform Was An Issue:

Medicare reform was discussed in the campaign platforms of all the candidates in the 2000 presidential election. Both major candidates, George W. Bush and Al Gore had plans for reforming Medicare to include prescription drug coverage. Gore's plan would have a voluntary benefit in Medicare to assist low-income beneficiaries and the chronically ill against catastrophic prescription drug expenses. As a candidate Bush's plan proposed a federal subsidy for low-income beneficiaries so that they could purchase private prescription drug coverage through private insurers (Oliver et al. 2004, 307). After Medicare Part C was implemented, "the growing availability in managed care plans, coupled with the projected budget surpluses, made it more necessary to answer why the government could not help cover prescription coverage for all beneficiaries" (Oliver et al. 2004, 305). By 1999, private insurers wanted to withdraw from Medicare Part C because of the growth of HMOs. This growth made the market less favorable for their interests and resulted in millions of beneficiaries being left to shop elsewhere for prescription drug coverage (Oliver et al. 2004, 305). This lack of coverage for millions of beneficiaries added to the pressure on the federal government to add prescription drug coverage and benefits to the Medicare program. Another reason why reform was as issue was because of

the rising cost of prescription drug coverage to beneficiaries. Experts were realizing that "between 1998 and 2000 alone, overall prescription spending rose 40 percent" (Campbell et al. 205, 9) for Medicare beneficiaries. However, as the economy changed so did Bush's plan. Eventually Bush supported a plan that would incorporate prescription drug coverage into Medicare while also increasing Medicare's dependence on private insurance plans (Oliver et al. 2004, 309). Instead of giving a draft proposal to Congress, Bush made his preferences known on July 10, 2001 when he announced his two requirements for a plan. His requirements were that 1) All seniors would have the option of a subsided prescription drug benefit as part of Medicare, and 2) Medicare should provide improved health insurance options similar to those available to Federal employees (Blumenthal and Morone 2009, 395). The message from the administration was that they would support a plan that modernized Medicare along conservative lines. The reformed plan should "resemble the Federal employees Health Benefit Program, in which the federal government solicited bids from insurance companies, made the resulting options available to employees (in this case the elderly) and let the employees (Medicare eligibles) pick a plan, for which the government covered part of the premium" (Blumenthal and Morone 2009, 396). The Bush plan would not guarantee prescription drug coverage, but Medicare enrollees could purchase drug coverage though choosing a plan that covered it. Plans that covered prescription drugs would cost more money and would cost even more for the elderly. The poor would get subsidies and assistance to help pay for prescription drug coverage with this type of plan (Blumenthal and Morone 2009, 396). By during the fall and winter of 2002 and 2003, the administration's position had changed slightly. They increased funding for prescription drug coverage from $190 billion to $400 billion over 10 years (Blumenthal and Morone 2009, 399). Bush's administration also "took a less direct route and tried to get Medicare beneficiaries to

choose private health plans by dangling the prescription drug carrot before them. Medicare would offer drug benefits only under private plans; beneficiaries would choose whether to stay in the traditional program or switch for the new benefit" (Blumenthal and Morone 2009, 400).

After Bush announced his prescriptions for a plan, the House and the Senate created their own separate drafts and work out the legislative details. At the time, most legislators agreed that "the benefit should be designed to serve all Medicare beneficiaries, while providing assistance to those most in need, specifically low-income beneficiaries and those who incur very high prescription drug expenses" (Blum 2006, 1).

III. How the United States Health Care System Worked in 2003:

Prior to the attempt to reform Medicare in the early 2000s, the health care worked similarly to how it did during Clinton's attempt at health care reform. Major changes included the implementation of the Medicare+Choice program. This program, as stated above, had Medicare beneficiaries choose between the traditional Medicare program, HMOs, and preferred-provider organizations. Medicare Part C also created medical savings accounts for Medicare, strengthened fraud prevention and prosecution, and changed payment polices and formulas for providers and health plans (Oliver et al. 2004, 303). As a part of this change, the National Bipartisan Commission on the Future of Medicare was created. In the Balanced Budget Act of 1997 the State Children's Health Insurance Program was created (Key Milestones in CMS Programs).

In 2003, 85.4 percent of the population was covered by private or government health insurance according to the U.S. Census Bureau (U.S. Census Bureau). Most Americans, 70.1 percent, were covered by private health insurance. 61.5 percent of Americans had employment-

based health insurance and 10 percent had private health insurance that they purchased themselves (U.S. Census Bureau). The government provided insurance for 26.4 percent of Americans—11.9 percent of which were enrolled in Medicaid and 13.6 percent were enrolled in Medicare (U.S. Census Bureau). Finally, 3.5 percent of Americans were enrolled in Military sponsored health care and 14.6 percent of Americans were uninsured (U.S. Census Bureau).

IV. Creating A Health Care Reform Proposal:

Instead of generating a proposal, the Bush administration delegated the issue to Congress. Both the House and the Senate offered their own proposals for a Medicare reform to include a prescription drug benefit. The mostly Republican controlled Congress was committed to giving the Bush Administration a win and making reform a success (*Congressional Quarterly Almanac* 2004). The Senate bill, S 1 was introduced by Senators Charles E. Grassley, R-Iowa and Max Baucus, D-Montana. The initial House bill HR 2473 was introduced by Representative William M. Thomas, R-California and the overall House bill, HR 1, was introduced by the Speaker of the House Dennis J. Hastert, R-Illinois. The Bush administration's plan, as mentioned above, was not a formal plan, but was one he discussed in public and he did make his preferences known. In Bush's remarks on Medicare reform, he stated that he saw five goals for reform. First, senior should have choice and should have the option of keeping their current Medicare plan. Second, there will be a new range of choices of plans for all seniors. This would include a new government-run plan and other non-governmental plans. All plans would have to, at a minimum, offer as much coverage as the Government plan and offer prescription drug coverage. The Federal Government would regulate the plans. Third, the plans would compete with one another for beneficiaries' choice. This would create better plans, better benefits, service and lower

premiums. Fourth, Medicare would respond better to seniors by putting a stop-loss limit on the amount any senior would pay in a year. Finally, Medicare would be put on a path to ensure it would be maintained for the future (Bush 2001). A comparison of the plans can be observed in the charts below from pages 286-288 of Oliver et al. 2004.

Table 5. Comparison of Prescription Drug Benefits in Major Medicare Reform Proposals*

Proposal	Participation	Monthly Premium	Deductible	Coinsurance	Drug Discount Card	Low-Income Assistance	Administration	Estimated Cost of Drug Benefits
Medicare Catastrophic Coverage Act (enacted as P.L. 100–360 in 1988, repealed in 1989)	Drug benefit added to Medicare Part B	$4 per month added to Part B premium Supplemental premium for high-income beneficiaries	$600	Beneficiary pays 20% over $600, maximum tied to general catastrophic coverage limit			Federal Medicare program and Part B carriers	
Health Security Act (proposed 1993, defeated 1994)	Drug benefit added to Medicare Part B	$11	$250	Beneficiary pays 20% over $250, maximum of $1,000			Federal Medicare program and Part B carriers	
Clinton proposal (1999)	Voluntary enrollment in new Medicare Part D	$24 in 2002, increasing to $44 in 2008	None	Beneficiary pays 50%, maximum of $2,500		Full premiums, deductibles, and coinsurance below 135% of poverty Subsidies for 135% to 150% of poverty	Private regional pharmacy benefit manager selected through competitive bidding	$118 billion over ten years for drug benefits
House Republican Bill (passed in 2002)	Voluntary enrollment in new Medicare Part D	$35 to $40	$250	Beneficiary pays 25% between $250 and $1,000, 50% between $1,000 and $2,000, $100% between $2,000 and $5,000, nothing over $5,000				$350 billion over ten years, including drug benefits
House Democratic proposal (2002)	Voluntary enrollment in new Medicare Part D	$25	$100	Beneficiary pays 20% over $100, maximum of $2,000		Full premiums, deductibles, and coinsurance below 150% of poverty Subsidies for 150% to 175% of poverty	Private pharmacy benefit managers (with federal assistance in price negotiation)	
Bush administration proposal (2003)	Drug benefits included for enrollees in restructured Part C managed care plans	Unspecified	Unspecified	Stop-loss protection for all beneficiaries (estimated at $5,500 or higher)	Yes	Credit of $600 for low-income beneficiaries in discount card program		$400 billion over ten years, including drug benefits
H.R. 1 (passed House in June 2003)	Voluntary enrollment in new Medicare Part D	Estimated $35.50 in 2006 (indexed, estimated at $56 in 2013)	$250 in 2006 (indexed)	Beneficiary pays 20% between $250 and $2,000, maximum of $3,500 Stop-loss higher for income above $60,000 for individuals and $120,000 for couples	Yes	Interim credit for low-income beneficiaries in discount card program Full premiums, deductibles, and coinsurance below 135% of poverty and meeting asset test Sliding scale premiums between 135% and 150% of poverty	Part C managed care plans or private drug plans Private fallback plan with federal financial risk if no qualified coverage available in region	$415 billion over ten years for drug benefits
S. 1 (passed Senate in June 2003)	Voluntary enrollment in new Medicare Part D	Estimated $34 in 2006 (indexed, estimated at $62 in 2013)	$275 in 2006 (indexed)	Beneficiary pays 50% between $275 and $4,500, 10% over $4,500, maximum of $3,700	Yes	Interim credit for low-income beneficiaries in discount card program	Part C managed care plans or private drug plans with government-administered fallback plan if no qualified coverage available in region	$422 billion over ten years for drug benefits

Proposal	Participation	Monthly Premium	Deductible	Coinsurance	Drug Discount Card	Low-Income Assistance	Administration	Estimated Cost of Drug Benefits
						Full premiums, deductibles, and coinsurance below 135% of poverty Sliding scale premiums between 135% and 160% of poverty		
Medicare Prescription Drug, Improvement, and Modernization Act (enacted in November 2003, signed into law as P.L. 108–173)	Voluntary enrollment in new Medicare Part D Part D enrollees prohibited from buying private supplemental drug coverage Financial penalty for late enrollment	Estimated $35 in 2006 (indexed, estimated at $58 in 2013) Could vary based on enrollee's choice of plan	$250 in 2006 (indexed, estimated at $445 in 2013)	Beneficiary pays 25% between $251 and $2,250, 100% between $2,250 and $5,100, 5% over $5,100, no maximum	Yes	Full premiums, deductibles, and coinsurance below 135% of poverty and meeting asset test Sliding scale premiums and reduced deductible and coinsurance between 135% and 150% of poverty and meeting asset test Beneficiaries must make small copayments for each prescription	Part C managed care plans or private drug plans Private fallback plan with federal financial risk if no qualified coverage available in region	$409 billion over ten years for drug benefits (OMB estimates $534 billion over ten years)

*From Oliver et al. 2004 pages 286-288

V. Congressional Debate and Action:

As demonstrated above, both the House and the Senate passed their own bills. Both were passed on June 27, 2003. The House bill passed 216-215 and the Senate bill passed 76-21. The Senate also passed HR 1 after substituting in the text of S 1, the House adopted the conference report on HR 1, H Rept 108-391, with a margin on 220-215 on November 22, 2003. The Senate cleared the final bill on November 25, 2003 54-44 (*Congressional Quarterly Almanac* 2004). Democratic support for the bill dwindled after conference because they felt that the bill would help insurance and drug companies more than Medicare beneficiaries. Democrats wanted there to be more provisions to help seniors. They also were not in favor of the law's lack of provisions to cap the growing costs of pharmaceuticals or to address public support for importing drugs from Canada. Democrats were wary of the plan's cost as well, the cost estimates kept rising (*Congressional Quarterly Almanac* 2004, 11-8).

Committee actions did take place on the legislation. In the Senate, the Senate Finance Committee approved S 1, 16-5 on June 12. This was the first time that the Finance Committee

had approved a Medicare bill in five years and bipartisan support at this level was encouraging. However, Democrats were critical on the gap in prescription drug coverage for beneficiaries enrolled in private plans. This gap is commonly known as the "doughnut hole." The doughnut hole is where the enrollee pays for prescription drugs themselves, but pays the price negotiated between the insurance company and the pharmaceutical company. An individual reaches the doughnut hole because their prescription drug costs have exceeded a certain amount. The price is less than the prescription drug without insurance, but it is not as inexpensive as before they reached their coverage limit. An individual is in the doughnut hole until the minimum spending requirement for catastrophic coverage to start is reached. Once the minimum-spending requirement is reached, Medicare would once again cover the pre-set amount of prescription drug costs. Conservatives wanted to encourage competition between plans offered to seniors in order to help stimulate more choices and contain costs for seniors (*Congressional Quarterly Almanac* 2004, 11-5). They believed that through having more plans for seniors and allowing seniors to choose their own plan, insurance coverage would improve, premiums would decrease, and seniors would get better service because all of the plans would be competing for the same customer base. The Senate floor passed the bill on June 27 only after adopting an amendment that used $12 billion in unallocated funding between the priorities of Democrats and Republicans (*Congressional Quarterly Almanac* 2004, 11-5). Part of the $12 billion would go to giving subsidies to assist private insurance companies in attracting seniors and the other half would be used to provide better preventative and chronic care treatments and benefits for seniors who remained enrolled in traditional Medicare (*Congressional Quarterly Almanac* 2004, 11-5).

The House took up Medicare Reform in the Ways and Means Committee and the Energy and Commerce Committee. In both committees Republicans were able to dominate the debate

and defeat the Democrat's efforts to shape the plan (*Congressional Quarterly Almanac* 2004). The Ways and Means committee passed HR 2473—H Rept. 108-178, Part 2 on June 17 by a vote of 25-15. During the committee's debate, Democrats were concerned that the bill would change traditional Medicare too much and force beneficiaries to enroll in private health plans. The Energy and Commerce Committee passed HR 2473 on June 19 by a vote of 29-20 after a three-day markup. The debate of the bill in this committee tended to get personal, rather than purely political (*Congressional Quarterly Almanac* 2004, 11-6).

The House floor passed HR 1 216-215 at 2:33 a.m. on June 27. HR 1 is a combination of the both the Ways and Means and the Energy and Commerce Committee bills. Each committee amended the legislation according to their jurisdiction and produced reports—H. Rept. 108-178 Part I and II. During this time GOP leaders desperately tried to assemble a majority and tried to target individuals to change their votes from a "no" to a "yes" (*Congressional Quarterly Almanac* 2004). Both Jo Ann Emerson, R-Montana and C.L. "Butch" Otter, R-Idaho were convinced to change their votes at the last minute. In return for switching her vote, Emerson was promised a vote on HR 2427.[1] In order to convince Representatives to switch their votes, Vice President Dick Cheney himself lobbied the Capitol. The GOP leadership in the House also tried to change the language in the bill to try and make it more favorable for Democrats and for those who represented rural areas of the country. Such changed included provisions that would allow limited drug importation from Canada, speeding up the process for approving generic drugs, and approving $28 billion in spending for hospitals, physicians and providers in rural areas (*Congressional Quarterly Almanac* 2004, 11-7). How the House passed their bill was

[1] HR 2427 is the Pharmaceutical Market Access Act of 2003. It was introduced by Representative Gil Gutknecht, R-Minnesota, and passed the House 243-186 on July 25, 2003. This bill would amend the Federal Food, Drug, and Cosmetic Act to direct the Secretary of Health and Human Services to allow qualified individuals to import certain products (HR 2427).

controversial, but nevertheless, the bill passed and a conference was to follow to negotiate what a final bill would look like.

The conference occurred between Republican leaders—the only Democrats brought to the table were Senators John B. Breaux, D-Louisiana and Max Baucus, D-Montana. Senator Breaux was a centrist in the Democratic Party and he was seen as a key figure in swinging compromise votes from each party. He was a major player in the Democratic Party, in 1993 he was elected the Deputy Majority Whip and held that position until his retirement in 2005. Senator Baucus was the Chairman of the Senate Finance Committee. The conference report was filed on November 21, 2003 in the House of Representatives. After the conference report was filed, the House adopted it by a vote of 220-214 early on November 22 and the Senate passed it by 55-44 on November 25. Democrats were fairly unified against the bill, which forced the Republicans to pass the bill without bipartisan support. Democrat's support for the bill dwindled because they felt that it gave less assistance to seniors and more help to the insurance and pharmaceutical companies. Also, as debate about the reform continued, it became obvious that the plan would cost more and more money (*Congressional Quarterly Almanac* 2004, 11-8). In the House, Republicans did not start balloting until 3 a.m., and after an hour the Republicans were losing 216-218. In order to try and win, Speaker of the House, Dennis J. Hastert, R-Illinois, and Majority Leader Tom DeLay, R-Texas, started lobbying on the floor, targeting the individuals who had voted "no." Republicans took drastic action and held the vote open for two hours and 53 minutes which was the longest recorded tally since electronic voting started in 1973 (*Congressional Quarterly Almanac* 2004, 11-8). While lobbying was happening on the floor, party leaders such as Bush were calling Representatives and lobbying that way. The vote concluded at 5:51 a.m. with Otter and Trent Franks, R-AZ, switching their votes from "no" to

"yes" and giving the victory to the Republicans. After voting was complete, 16 Democrats in the House supported the final bill while 25 Republicans opposed the legislation.

Senator Kennedy attempted to filibuster the Senate bill on November 24, but the Senate voted 70-29 to invoke cloture and end debate. Senator Daschle also attempted to delay the voting by trying to get a point of order against the bill regarding the health savings accounts and the fiscal 2004 budget, but the Senate voted 61-39 to waive points of order regarding the budget against the bill. The Senate passed the final bill 54-44 (*Congressional Quarterly Almanac* 2004, 11-8).

The amount of coverage that Congress agreed to was not determined by research, but it was the level that Congress estimated that approximately 5 percent of beneficiaries would have prescription drug costs above the catastrophic drug coverage threshold and members of Congress believed that this was a reasonable amount (Blum 2006, 2). This means that approximately 5 percent of Medicare beneficiaries would exceed the catastrophic drug coverage limit once they have exited the doughnut hole. Some Members of Congress believed that beneficiaries should pay an amount above the catastrophic coverage threshold to control federal costs. This is over fears of unnecessary or overconsumption of prescription drugs (Blum 2006, 2). To try and remedy this, beneficiaries would have to pay 5 percent of the drug cost even after they reach the catastrophic drug cost maximum (Blum 2006, 2). Congress wanted a cost-sharing mechanism during catastrophic coverage.

VI. Interest Group Activity:

During this time of Medicare reform, interest groups were active in different ways. Below is a description of the main groups at the time and what the public was mostly seeing and hearing. The main actors were the pharmaceutical industry, the insurance industry, and the

American Association of Retired Persons. At this time the pharmaceutical industry supported shifting individual who were dual eligible for Medicare and Medicaid into the new Medicare program (Blum 2006, 2). This is because on the state-level many states were implementing efforts to contain costs that restricted access to drugs through quantity limits, higher co-pays, and preferred drug lists (Blum 2006, 2). As a whole, the pharmaceutical industry believed that the new Medicare program would allow them better access to beneficiaries than the state-run Medicaid programs that were implementing further restrictions. They held this belief despite the fact that the new Medicare Part D would also be allowed to implement restrictions (Blum 2006, 3). In this attempt at a health care reform, PhRMA was notably not unyieldingly opposed to prescription drug benefits. Instead PhRMA endorsed a new prescription drug benefit that would be a "part of a Medicare program that is modernized to allow beneficiaries to choose among qualified private-sector health plans" (Oliver et al. 2004, 306; Homer 1999, 24).

Organizations such as the Health Insurance Association of America (HIAA) or American's Health Insurance Plans (AHIP), which merged in 2003, opposed Medicare reform because they believed that a stand-alone drug insurance plan would not work and did not think that an insurance company would be willing to offer insurance for only prescription drug coverage. The president of the former HIAA said that it was "analogous to offering insurance for a haircut" (Blum 2006, 4).

The American Association of Retired Persons (AARP) endorsed the plan to reform and Modernize Medicare on November 17, 2003 (*Congressional Quarterly Almanac* 2004, 11-7). The AARP felt that the public supported expanding Medicare to include prescription drug coverage (Oliver et al. 2004, 305). The AARP's support weakened the Democrat's opposition to

reform and attracted some Democratic support for the reform (*Congressional Quarterly Almanac* 2004, 11-7).

VII. Analysis of Interest Group Success:

VIIa. Methodological Approach:

In order to analyze interest group success, a similar approach was used as previously. The same interest groups in Clinton's health care reform were observed as well as additional interest groups identified through OpenSecrets.org. The groups from OpenSecrets.org were groups who were top spenders during 2003—the year of Bush's reform. A total of 21 groups were initially observed for this case, but due to selection methods and data collection a total of 18 groups were analyzed fully. It is important to note that the American Association of Health Plans (AAHP) merged with the Health Insurance Association of America (HIAA) and formed America's Health Insurance Plans (AHIP). Thus, they do have different Newspaper Mentions and Congressional Alignment, but their goals and Presidential Alignment will be the same. So, AAHP will reference HIAA, AHIP, and AAHP as a whole.

As before, groups' mentions in the *New York Times*, *CQ Roll Call, The Washington Post, USA Today, CQ Weekly, and The National Journal* were observed and counted. For this case, mentions were only observed for the year 2003. The groups' presidential alignment and ideological alignment with Congress were also observed. Ideological Alignment with Congress was observed through looking at political spending data on OpenSercrets.org and seeing how much money an organization gave to Republicans and how much was given to Democrats. The data was observed and if the organization's spending was in line with the composition and ideological position of Congress, the organization would have a higher alignment. Finally,

Presidential Alignment was calculated by comparing the organization's stances about the reform to Bush's objectives for reform. All three variables are measured on a low, moderate, high scale.

An interest group was determined to have a high level of Newspaper Mentions if it was in the top third of groups with Newspaper Mentions. The middle third had a moderate level of newspaper mentions and the bottom third had a low level of newspaper mentions.

Ideological Alignment with Congress, as stated above, was determined by looking at political contributions by the organizations. The DW-nominate score of the 108th Congress was 0.03, with Democrats' score at -0.342 and the Republicans' total score at 0.382 (Vital Statistics on Congress). Congress, at this time, was more conservative and thus a group was more ideologically aligned with Congress if it donated more money to the conservatives, or Republican Members of Congress, rather than the Democrats, or the liberal Members of Congress. If there was over a 2:1 ratio in favor of Republicans, an organization was highly aligned with Congress. If spending was relatively equal, a moderate alignment was determined, and if the spending favored Democrats, alignment was low.

Finally, Presidential alignment was assessed by determining whether or not an interest group endorsed Bush's plan and components of the plan. A low level of alignment was given if an organization did not endorse the plan or was against the plan. A moderate level of alignment was given if an organization supported some significant aspects of the plan, but not all of the plan. Lastly, a high level of alignment was given to groups who supported most of the plan or endorsed Bush's major program components.

VIb. How the Interest Groups Were Categorized:

Aetna is a managed health care organization that sells consumer-directed health insurance as well as traditional health insurance. Aetna is determined to have a high-level of Presidential

alignment because they made public statements saying that they would be willing to participate in a reform attempt and that they would be eager to do so (Abelson 2003; Pear 2003b). They were concerned about making sure the program was adequately funded, so that the program was workable and sufficient coverage could be provided to beneficiaries (Abelson 2003). Their general attitude was supportive. Aetna wanted to work with Congress and the administration to provide a drug benefit to Medicare. They wanted this because they could gain more customers when this became law. They saw potential in this legislation and wanted to work with it. They also got some provisions they wanted in the legislation, the bill included provision for insurers such as the government would cover 74 percent of the insurance plans' cost for basic drug coverage. Beneficiaries who had drug costs that exceeded $3,600 would get an 80 percent "reinsurance" of allowable costs by the government (*Congressional Quarterly Almanac* 2004, 11-4). Reinsurance is when a third party, in this case, the government, assumes responsibility for paying part of an insurance company's claims once they hit a certain amount. This stabilizes the insurance market and makes coverage more affordable and available (Healthcare.gov.a). In the insurers' case, a government-run reinsurance program would protect them in the instance of too many high-cost beneficiaries enrolled in the plans. This helps the companies avoid huge losses and bankruptcy and offer lower premiums.

Aetna was also concerned about the providers, and the revised bill included provisions to gain support from doctors and hospitals like Aetna was fighting for in order to make sure doctors were getting adequate payments for Medicare (*Congressional Quarterly Almanac* 2004, 11-4). Therefore, when the MMA became law, they had a high level of success because they got what they wanted, the plan became law and their company had more potential for growth and they were able to get important provisions in the law.

America's Health Insurance Plans (AHIP), which includes the American Association of Health Plans (AAHP) and the Health Insurance Association of America (HIAA), has a high level of success. Ultimately, AAHP supported the legislation (Pear and Toner 2003; Oliver et al. 2004). They were willing to work with the government to create a workable plan for reforming Medicare. They were supportive of competition, incentives for generic drugs, and they wanted to ensure that small insurance providers would be protected (Allen 2003; Pear et al. 2003) Mainly, they wanted to implement a safety valve (Allen 2003). These organizations as a whole were initially hesitant to support change, but ultimately supported the reform plan. When MMA passed, theses organizations gained what they wanted and AHIP, HIAA, and AAHP had a high level of success. They were supportive of reform and reform occurred.

The American Academy of Family Physicians, the American College of Emergency Physicians and the American College of Physicians all had a high level of success because, while doctors were expressing concern that Medicare payments were not keeping up with their costs, they won provisions in the bill that blocked a scheduled 4.5 percent cut in Medicare payments to doctors that would begin in 2004 and an additional cut in 2005 was also blocked. Doctors were given a 1.5 increase in 2004 and 2005 in Medicare payments. Doctors, hospitals, and ambulance services in rural areas could get additional payments (*Congressional Quarterly Almanac* 2004, 11-4). They had a high level of success because of gaining these provisions and avoiding cuts in Medicare. Instead of losing more payments, they avoided cuts and gained increases in Medicare payments.

The AARP had a high level of success because it publically endorsed the bill and wanted to change the status quo. The AARP's Chief Executive Director at the time, William D. Novelli, said, "We strongly support the legislation and will work hard for its passage. This is not a perfect

bill, but America cannot wait for perfect. The bill provides a lot of help for low-income people and people with high drug costs, and it has strong incentives to prevent employers from dropping coverage for retirees" (Pear et al. 2003). The AARP publically and strongly endorsed the plan, therefore when the MMA was signed into law, the AARP had a high level of success.

The American Hospital Association (AHA) had a high level of success with the reform of Medicare. This is because the AHA did lobby hard for the reform and they were part of a list of supporters sent to the Ways and Means Committee in the House (Pear 2003a; List of Supporters). When the reform passed, they had a high level of success because they wanted the reform to pass.

The American Medical Association (AMA) also had a high level of success. The AMA formed a strong lobbing alliance and lobbied hard for the legislation. It was strongly in favor of the legislation and publically endorsed it (Pear 2003a; List of Supporters). The AMA did not want to protect the status quo and wanted the reform to pass, thus when the MMA became law they had a high level of success because they got what they wanted.

Blue Cross Blue Shield had a low level of success because they were overwhelmingly opposed to the reform. The Senior Vice President for Blue Cross Blue Shield said that "Small employers will be giving millions of dollars to insurance companies that are virtually unregulated" which means "It's a recipe for fraud" (Pear 2003a). However, they could have been opposed to the plan because they did not want competition from association health plans (Pear 2003a). When the plan became law and the status quo was changed, Blue Cross Blue Shield had a low level of success.

The California Healthcare Institute, Federation of American Hospitals, and Healthcare Leadership Council all publically supported the reform attempt (List of Supporters). They

endorsed a reform, thus when the MMA became law, they had a high level of success. The Federation of American Hospitals, especially, had a high level of success because hospitals won incentives in the final bill (*Congressional Quarterly Almanac* 2004, 11-4).

The Chamber of Commerce had a high level of success with the MMA. The Chamber of Commerce spent a lot of money in support of the reform and lobbied hard for it's success (Pear 2003a). The Chamber of Commerce was in support of the legislation and clearly wanted it to pass, therefore when the legislation did pass through Congress and was signed into law, they had a high level of success.

Merck & Co. was in moderately in support of the reform, the Vice President for Public Policy at Merck & Co, Ian D. Spatz, stated that, "There is great risk for the pharmaceutical industry, but there is great opportunity" (Abelson 2003). They felt like pharmaceutical companies that serve the elderly had a great opportunity to grow and benefit from this change. The organization was in support of reform, but there was risk to the change. They have a moderate level of success because as a pharmaceutical company, they won great gains by not having all drugs imported from Canada and their market increased, but there is also risk by more regulations. Merck & Co. clearly liked the provisions in the legislation. Pharmaceutical manufacturers would have a higher demand for prescription drugs and there would be 1) no direct administration of benefits by the government, 2) no explicit cost-control measures, and 3) no drug importation legislation (Oliver et al. 2004, 318). Therefore, they have a moderate level of success because they are able to be regulated more through the expansion of Medicare and they do have to negotiate drug prices with consumers who enter the doughnut hole, but they are not strictly regulated and there are not hard cost control measures or drug importation. They

wanted to have an increased customer base, but in order for that to occur, pharmaceutical companies had to accept some regulations.

The National Association of Manufacturers has a high of success because, they support the $70 billion subsidy that business who currently provide prescription drug benefits to their retirees will receive. The Vice President of Health Policy for the organization said that "We are finally ready to move forward with the Medicare reforms that we and so many others have sought for so long" (Brostoff 2003). The National Association of Manufacturers clearly wanted the reform to pass and to have their members benefit from the subsidy. When the reform passed, they had a high level of success.

The National Federation of Independent Businesses strongly supported the Medicare reform. The NFIB lobbied for the reform (Pear 2003b). They supported the change and the provisions that would benefit the business community. Therefore, when reform passed they had a high level of success.

Pharmaceutical Research and Manufacturers of America certainly had a high level of success with the MMA reform. PhRMA spent $150 million to help pass the MMA this is because they felt that "Unless we achieve enactment this year of market-based Medicare drug coverage for seniors, the industry's vulnerability will increase in the remainder of 2003 and in the 2004 election year" (Pear 2003c). Passing Medicare reform was one of their top priorities (Pear 2003d). The pharmaceutical industry also "won a critical provision from Republicans that prohibits the government from negotiating prices or discounts. That will be left to private insurance companies and drug middlemen, known as pharmacy benefit management companies" (Welch and Appleby 2003). When the MMA became law, PhRMA had a high level of success because they wanted the bill to pass and they won key provisions.

VIII. Success of the Model:

Table 6. 2003 Interest Group Analysis

Interest Group Name	Newspaper Level	Congressional Alignment	Presidential Alignment	Success Level
Aetna	Moderate	High	High	High
America's Health Insurance Plans (AHIP)	High	High	Moderate	High
American Academy of Family Physicians	Low	High	High	High
American Association of Retired Persons (AARP)	High	Low	High	High
American College of Emergency Physicians	Low	Moderate	High	High
American College of Physicians	Low	Not Available	High	High
American Hospital Association (AHA)	Moderate	Moderate	High	High
American Medical Association (AMA)	High	High	High	High
Blue Cross Blue Shield	High	High	Low	Low
California Healthcare Institute	Not Available	High	High	High
Chamber of Commerce	High	High	High	High
Federation of American Hospitals	Moderate	High	High	High
Healthcare Leadership Council	Low	High	High	High
Merck & Co	Low	High	Moderate	Moderate
National Association of Manufacturers	Moderate	High	High	High
National Federation of Independent Businesses (NFIB)	Moderate	High	High	High
Pharmaceutical Research and Manufacturers of America (PhRMA)	High	High	High	High

Looking at Table 6 above it is clear that groups that had a high level of success, were also aligned with President Bush. However, there is one exception—Blue Cross Blue Shield. These groups also tended to have a high level of alignment with Congress. In order for groups to succeed in this reform, they were also aligned with the President's preferences. When looking at the exception Blue Cross Blue Shield, who had a high alignment with Congress and a high level of Newspaper Mentions, yet had a low level of success, one can deduce that this is because of presidential influence. Blue Cross Blue Shield had low level of Presidential Alignment and was against the reform. They clearly worked hard in opposition to the movement, which is reflected in the first two variables, but they would not be aligned with the President. This results in a low level of success when the status quo is changed.

It appears that in this case that Newspaper Mentions are not determinative of an interest group's level of success. Groups who have a high level of success all appear to have varying

levels of mentions, but generally all the groups have high levels of Congressional and Presidential Alignment. However, this varying level of Newspaper Mentions could be attributed to smaller groups utilizing coalitions, networking, and bandwagoning. When looking at the chart, it is clear that smaller groups with high success level, such as: the American Academy of Family Physicians, the American College of Emergency Physicians, the American College of Physicians, the Healthcare Leadership Council, and the Seniors Coalition who all have high Success Levels, but have low Newspaper Mentions. This means that they do not need to be as active or spend as much money as larger groups who want they same things that they do. Because they are in support of the reform, they are able to get the benefits of other groups who are also endorsing and active in favor of the reform. It is a group activity. The actions of larger groups benefit smaller groups who want similar provisions in the bill, or the bill as a whole.

In this case there are 17 total interest groups observed. Of these 17, the model works to explain the Success Level outcome for the majority of the interest groups—13. These groups are: Aetna, American Academy of Family Physicians, AARP, American College of Emergency Physicians, American College of Physicians, AHA, AMA, California Healthcare Institute, Chamber of Commerce, Healthcare Leadership Council, National Association of Manufacturers, NFIB, and PhRMA. The model does not work for AHIP, Blue Cross Blue Shield, Federation of American Hospitals, and Merck & Co.

As before, the model works when an interest group has two variables that have a moderate-to-high level of significance (moderate or high), which leads to a moderate or high Level of Success.

The case of Presidential Alignment interfering with the Success Level is not as much of a problem in this case as it was in Obama's case study. This is because of the nature of Bush's

plan. The Bush administration proposed a plan that was separate from the plan of Congress. This makes it possible for a group to be in favor of a reform plan and aligned with the President, or against the President. Also, a group could be against the reform and have a different Presidential Alignment as well. Presidential Alignment was not automatically tied to a group's success level in this case. However, many groups did have the same level of Presidential Alignment as it did Success Level. 16 out of the 17 groups had the same Presidential Alignment as they did Success Level, however, it was possible for the levels to be different.

Many of interest groups who had similar Presidential Alignment Levels as they did Success Levels also had similar Congressional Alignment Levels. 10 out of the 17 interest groups had identical Congressional Alignment, Presidential Alignment and Success Levels. This would suggest that Congressional Alignment had some importance in this case. Newspaper Mention levels, however, are more variable across groups and the model does not explain them very well. Newspaper Mentions do not align as well as the other variables. This could be because of bandwagoning where the activity of larger groups benefits smaller groups with less resources.

In sum, the model shows that Presidential Alignment and Success Level are not wholly independent, but for this reform, most interest groups had a high level of success because most groups were in favor of reform and not because of their Presidential Alignment. There was a small opposition movement and groups who would normally be opposed, such as the pharmaceutical industry, won key provisions early on in order to avoid opposition.

When looking at this case, Congressional Alignment appears to have a slight impact on an interest group's Success Level. Out of the 17 groups observed, 11 had a matching Congressional Alignment and Success Level. Newspaper Mentions, however, proved to be less impactful. Only five groups had matching Success Levels and Newspaper Mentions.

In this case the model worked. It provided an explanation for why an interest group would have a high level of success for the majority of interest groups in an attempt of health care reform. In Bush's case, Presidential Alignment and Success Level were less of a tautology. Interest groups who had a significant (moderate or high) level in two or more variables were likely to have a significant Success Level (moderate or high).

Case Study 3: President Obama's Health Care Reform Attempt

I. Background:

President Obama's notions of a health care reform began on his campaign trail in 2008. During the campaign, both then Senator Obama and Senator John McCain offered competing health care plans for the United States. It was clear to the nation that whoever was elected in November of 2008 would attempt to bring health care changes to the United States. Just as other presidents before him, Obama began making plans for health care reform as soon as he took office in January 2009. However, after watching Clinton's failed Health Security Act in the 1990s fail to provide comprehensive health care coverage to Americans, Obama was determined to not make the same mistakes. Obama also had the advantage of seeing the success of Bush's Medicare Prescription Drug, Improvement, and Modernization Act. He had knowledge of how past presidents had won, and lost, with health care reform. With the Patient Protection and Affordable Care Act, Obama and his administration took a different approach and gave Congress more freedom to decide what they wanted to see in a reform while also making "sweetheart" deals with key interest groups and industries before the reform was initiated in Congress.

Why Health Care Reform Was An Issue:

In 2009 health care reform was an issue and on the agenda because the costs of services were increasing and there was still a significant population of uninsured and underinsured individuals in the United States. According to scholar Jacob Hacker, the economy was different in 2009 than previously and "America's job-based insurance tightly couples work and coverage for all but the poorest and oldest of insured citizens, heightening public anxiety about losing coverage or paying for care when the economy sours" (Hacker 2010, 864). In 2008, 14.9 percent of the population was not covered by health insurance (U.S. Census Bureau). Also, in 2008, according to the Kaiser Family Foundation, health care spending was about $2.4 trillion, which was an average of $7,868 per person (Kaiser Family Foundation 2008). The amount of the Gross Domestic Product being spent on health care in the United States increased from 7.2 percent in 1970 to 16.6 percent in 2008 (Kaiser Family Foundation 2008). In addition to more money being spent on health care, it was becoming less affordable for some individuals, according to Kaiser, "eighteen percent of the nonelderly were in families that spent over 10% of their disposable [income] on out-of-pocket health care premiums and cost sharing in 2004" (Kaiser Family Foundation 2008, Key Facts on Health Care Costs). This is a 97 percent increase in premiums for employer-sponsored health coverage. Individuals and families also reported having problems paying for heath care and health insurance. September 2008, 30 percent of respondents in a Kaiser Health Tracking Poll stated that paying for health care and health insurance was a serious problem (Kaiser Family Foundation 2008, Key Facts on Health Care Costs). According to Gallup Polls, in 2008, 64 percent of respondents felt that it was the federal government's responsibility to make sure all Americans have health care coverage. 47 percent of people were dissatisfied with the availability of affordable health care in America. When asked about the cost

of health care in America, 79 percent of respondents were dissatisfied with the cost of health care in the United States (Gallup Healthcare System Poll).

It was clear to Congress that in 2008, the growth in health expenditures was regularly outpacing the growth in income. This was making health insurance less affordable for Americans and making the problem of extending coverage to the 45 million Americans without health insurance in the United States even more difficult as time passed (Kaiser Family Foundation 2008). Another increase in health care costs was the increase in the cost of annual premiums for family coverage. In 2000, the average annual premium for family coverage was $6,438, but by 2008 this number nearly doubled to $12,680 (Kaiser Family Foundation 2008).

Due to the high costs of health care in the United States, Medicare and Medicaid expending had been increasing as well. Since 2000, Medicare expending had increased 96 percent. This increase is partly attributed to the Medicare drug benefit (Medicare Part D) that was enacted in 2005 under President George W. Bush (Kaiser Family Foundation 2008). Medicaid, on the other hand, has a relatively low cost increase due to prescription drugs because enrollees are typically eligible for both Medicare and Medicaid and when Medicare Part D became law, those individuals were transferred to Medicare (Kaiser Family Foundation 2008).

Since 2000, there has been a 107 percent increase in families' out-of-pocket expenses for their contribution to a health insurance policy. The average worker's contribution for a family policy was $1,619 in 2000 and rose to $3,354 in 2008 (Kaiser Family Foundation 2008). The out-of-pocket costs for services also rose, the amount of individuals with deductibles of at least $1,000 rose from 10 percent in 2006 to 18 percent in 2008, for workers in small businesses, that percent rose even more, from 16 percent in 2006 to 35 percent in 2008 (Kaiser Family

Foundation 2008). Note, dollar amounts have not been adjusted for changes in the Gross Domestic Product.

In sum, health care reform was on the agenda because it was a campaign issue and because the costs of health care and health insurance to both the government and the American individual were rising in the United States.

II. How the United States Health Care System Worked:

As stated earlier in the Clinton case study, health insurance in the United States could be obtained through the private sector, the government, or an individual. In 2008, 67.2 percent of Americans had health insurance through the private-sector. Of these individuals, 58.9 had the health insurance through their employer, while 9.5 purchased the plans individually (U.S. Census Bureau). The government provided insurance for 29.1 percent of Americans. Those who were enrolled in Medicaid were 14.2 percent of those individuals, while 14.3 percent were enrolled in Medicare. The remaining individuals were enrolled in other government-sponsored programs such as Military Health Care or the Children's Health Insurance Program (CHIP) (U.S. Census Bureau).

Since President Bush's Medicare Prescription Drug, Improvement, and Modernization Act became law in 2003, enrollees of Medicare now had coverage of prescription drugs through federal subsidies and tax breaks. Medicare Part D made it so that Medicare enrollees paid a monthly premium that was a minimum of $24.80. They also paid a deductible that ranged from $180 to $265 and 25 percent of all prescription drug costs up to $2,400. Once an enrollee met the coverage limit of $2,400, they hit what is commonly referred to as the "doughnut hole." This means that the enrollee has to pay for the prescription drug cost themselves, but pays the price negotiated between the insurance company and the pharmaceutical company. The price is less

than the prescription drug without insurance, but it is not as inexpensive as before they reached their coverage limit. This price is paid until the individual reaches minimum spending requirement for catastrophic coverage to start. In 2009, this amount was when an individual paid $4,350.25 of true out-of-pocket expenses and total drug spending was over $6,154. Then Medicare would once again cover 95 percent of prescription drug costs and 5 percent of costs were paid out-of-pocket.

III. Creating A Health Care Reform Proposal:

As stated earlier, when Obama went to create a health care reform proposal, he did not want to repeat the same mistakes as Clinton did with his health care reform plan in the 1990s. Therefore, Obama set out to make clear that he would let Congress negotiate the details in a health care reform proposal and he would act as an overarching voice of approval of disapproval. He made it clear what he wanted out of a reform and he helped to manage interest groups, but he did not get involved in the particulars of the plan. Due to this management style centered around overseeing a Congress-centered process, both the House and the Senate developed and passed differing reform plans. There was more debate on the subject, and compromises were made. For the Obama administration the main goal was "winning over key interest groups and pivotal Democrats" (Hacker 2011, 440) this is because "the interest group environment was more favorable for a reform push by a unified Democratic government" (Hacker 2011, 440) and "the Democrats had converged around a reform strategy that had backing from powerful organized forces within the party" (Hacker 2011, 440). This will be discussed in detail below.

IV. Congressional Debate and Action:

Plans for a comprehensive health care reform were taken up in both the House and the Senate. In January of 2009 at the start of the health care debate the Senate was composed of 55 Democrats, 41 Republicans, and two Independents who caucused with the Democrats. Towards the end of 2009, due to transitions of members, the Democrats had a supermajority in the Senate controlling 60 or more votes. The House of Representatives was composed of 256 Democrats, and 178 Republicans, with one vacant seat. A key change in this congress is that there was a "loss of more seats in conservative Southern regions and the strengthening of the Democratic position in the more liberal regions, a more homogeneous, though far from unified, caucus greeted [President Obama]" (Hacker 2010, 863).

The main debate in the House and the Senate was between Democrats and Republicans (and more liberal Democrats) on how to provide a public option to Americans, or if to provide a public option at all. A public option is "a public insurance plan modeled after Medicare that would compete with private plans to enroll those without coverage" (Hacker 2010, 862). In Congress, "middle-of-the road Democrats were touting the virtues of a 'play-or-pay' approach in which employers would be required to provide insurance or pay into a public program for with without employment based coverage (Hacker 2010, 866). Conservative Democrats, on the other hand, were calling for "more limited measures to bring down the cost of insurance and modestly expand coverage" (Hacker 2010, 866). It was clear, however, that a single-payer option was no longer just a strong demand from left of center forces. Other organizations endorsed the Democratic favored single-payer option such as major unions, liber think tanks, health care and advocacy organizations (Hacker 2010, 866).

As a whole, Congress attempted to follow the Presidents two goals, 1) to lead the way for universal health care coverage in the United States, and 2) to lower the costs of health care (*Congressional Quarterly Almanac* 2010). The Senate had bills come out of two committees, the Senate Finance committee, S 1796, and the Health, Education, Labor, and Pensions (HELP) committee, S 1679. The Senate Finance bill was approved on October 13, 2009, while the Senate HELP bill was approved on July 15, 2009. The table below adapted from *Congressional Quarterly Almanac* (2010) shows the differences in the Committee bills in the House and the Senate.

Table 7. Provisions of Committee Overhaul Bills Compared*

	SENATE VERSIONS	
	Finance S 1796. approved Oct 13	**Health, Education, Labor and Pensions** S 1679. approved July 15
Insurance Exchange		
Marketplace where uninsured individuals and some employers could choose among insurance plans, with subsidies for eligible enrollees	**Yes.** Create separate state-based exchanges for individuals and small business	**Yes.** Create state-based exchanges, or "Affordable Health Benefit Gateways," for individuals and small businesses.
'Public option'		
Government-sponsored health insurance financed by premiums and offered as an alternative in the exchanges	**No.** Consumer-owned, nonprofit cooperatives would offer plans that would compete with private insurance plans in the exchanges.	**Yes.** Health and Human Services (HHS) would create a public option and negotiate payment rates with health care providers.
Subsidies		
Tax credits to help pay for premiums and out-of-pocket costs as policies purchased through an exchange	**Yes.** Tax credits for individuals and families within comes up to 400% of the poverty level.	**Yes.** Tax credits for individuals and families with incomes up to 400 percent of the poverty level.
Individual Mandate		
Most Americans required to obtain at least a basic insurance policy	**Yes.** Enforced with tax penalty rising two $750 per individual, up to $1500 per household, in 2017. Exemptions if income is below 133 percent of the poverty level or if the cost of basic insurance exceeds 8 percent of income.	**Yes.** Enforced with minimum tax penalty of $750 per individual, up to $3000 per household. Exemptions if income is below 150 percent of the poverty line or if cost of basic insurance exceeds 8 percent of income.
Employer Mandate		
Penalty for employers who do not offer insurance benefits	**No.** No legal requirement, but employers with more than 50 workers that do not offer insurance must pay a fee for each employee who receives text credit for coverage in an exchange.	**Yes.** Employers with more than 25 workers must offer coverage and pay 60% of premium costs or pay a fine of $750 per uninsured employee ($375 for part-time workers).
Small-business Tax Credit		
	Yes. Tax credit for employers to provide healthcare benefits and have 50 or fewer workers.	**Yes.** Tax credit for employers to provide health care benefits and have 50 or fewer workers.

Abortion		
Ban on federal funding	Federal subsidies could not be used to cover elective abortion (i.e. abortions in cases other than rape, incest or danger to the woman's life). Exchange is required to have one plan but does not cover elective abortion and one that does. Enrollees getting tax credits required to pay separate premiums to get elective abortion coverage. Plans must keep those premiums and separate accounts. No discrimination against providers based on whether or not they provide abortion services.	No discrimination against providers based on whether or not they provide abortion services.
Medicaid		
Expansion of eligibility	**Yes.** Eligibility expanded to all individuals with incomes up to 133% of the poverty level. Those that want to do percent to 300% could choose between Medicaid and subsidize coverage in the exchange. Extra federal payment to states for new enrollees, rising to 32.3 percent of costs by 2019.	Outside committee's jurisdiction. Those eligible for Medicaid excluded from subsidize coverage in the exchange.
Revenue		
	▪ 40 percent excise tax paid by insurers for portion of employer–sponsored plans that exceed $1,000 for individuals, $21,000 for families, indexed for inflation. ▪ $2,500 limit on flexible health care spending accounts. ▪ Annual fees of $2.3 billion for drug industry, $4 billion for medical device industry, $6.7 billion for health insurance industry, all allocated according to market share.	Outside committee's jurisdiction.

HOUSE VERSIONS

Ways and Means HR 3200, approved July 17	**Education and Labor** HR 3200, approved July 17	**Energy and Commerce** HR 3200, approved July 31
Insurance Exchange		
Yes. Create a national health insurance exchange under a new federal agency for uninsured individuals and employers, with eligibility expanding each year. States could operate state-based exchanges if they meet requirements.	**Yes.** Same as Ways and Means.	**Yes.** Same, but those covered by Tricare or VA health benefits would also be eligible for exchange.
'Public option'		
Yes. Provide $2 billion in startup funds but require the public plan to be funded solely through premiums. Pay providers Medicare rates plus 5 percent for the first three years; government to set rates after that.	**Yes.** Same.	**Yes.** Same, except rates would be negotiated with providers at levels no lower than Medicare rates and no higher than the average rates paid by private plans in the exchange.
Subsidies		
Yes. Tax credits for individuals and families with incomes up to 400 percent of the poverty level.	**Yes.** Same.	**Yes.** Same, but credits would be larger than in the other House versions.
Individual Mandate		
Yes. Enforced through tax penalty of 2.5 percent, capped at the average cost of a basic plan in the exchange, with hardship exemptions.	**Yes.** Same.	**Yes.** Same.
Employer Mandate		
Yes. Employers with annual payroll above $400,000 must offer coverage and pay 60 percent of premium costs or pay a fine of 8 percent of payroll. Small businesses pay reduced or no fines.	**Yes.** Same.	**Yes.** Same.
Small-business Tax Credit		
Yes. Tax credit for employers that provide health care benefits and have 25 or fewer workers	**Yes.** Same.	

Abortion		
No provision.	No provision.	Private plans in the exchange would not be required to cover abortion. The public plan would have to cover abortions in cases of rape, incest, or danger to the woman's life and would not be prohibited from covering elective abortions. The act would not affect state or federal abortion laws. No discrimination against providers based on whether or not they provide abortion services.
Medicaid		
Yes. Eligibility expanded to all individuals with incomes up to 133 percent of the poverty level. Those eligible for Medicaid could choose between Medicaid and obtaining a plan in the exchange.	Outside committee's jurisdiction.	**Yes.** Federal payments would cover 100 percent of new enrollees, dropping to 90 percent in 2015.
Revenue		
▪ Graduated surtax on income above $280,000 per individual, $350,000 per family. Top rate of 5.4 percent on income above $800,000 per individual, $1 million per family. ▪ Prohibition on use of tax-advantaged flexible spending accounts for over-the-counter drugs.	Outside committee's jurisdiction.	Outside committee's jurisdiction.

* Adapted from *Congressional Quarterly Almanac* 2010. Page 13-7 and 13-7.

Once the bills were out of committee, the House and the Senate each passed their own overall bills for Medicare reform. Below is a chart representing the major provisions of both the House (HR 3962) and Senate (HR90) bills. The Senate was working on a House bill because it was legislation that the House had initially passed on October 8, 2009. They were working to pass the previously passed House bill so it could become law. All of the bills regarding Medicare Modernization originated in the House, so the Senate was working on amending House legislation.

Table 8. Health Care Overhaul: House vs. Senate*

Provision	**Passed by the House** (HR 3962) Passed November 7, 2009	**Passed by the Senate** (HR 3590) Passed December 24, 2009
Insurance Exchange		
Marketplace where uninsured individuals and some small businesses could choose among insurance plans, with subsidies for eligible enrollees	National exchange, created and run by a new federal agency. Uninsured individual and small businesses could purchase insurance from participating providers. Sates could create state-based exchanges if approved by Health and Human Services (HHS).	Created a system of state-run health insurance exchanges. If a state has not created an exchange by 2014, HHS will establish and run one in that state. Separate exchanges for small business. Groups of states could create regional exchanges if approved by HHS.
'Public option'		
Government-sponsored health insurance financed by premiums and offered as an alternative in the exchanges	Public option administered by HHS, financed through premiums. HHS would negotiate rates with providers that were no lower than Medicare rates and no higher than the average cost of private plans offered in the exchange. A new program would facilitate the creation of nonprofit, member-run co-ops to offer policies in the exchange.	No public option. Instead, the Office of Personnel Management would administer a system of national health insurance plans. OPM would have to contract with at least two plans for each exchange, including one run by a nonprofit. A new program would foster the development of nonprofit insurers to offer policies in the exchanges.
Individual Subsidies		
Tax credits to help pay premiums and out-of-pocket costs for policies purchases through an exchange	Premium and cost-sharing credits, on a sliding scale, for uninsured individuals and families with income up to 400 percent of the federal poverty level, or whose employer-sponsored plan costs more than 12 percent of their income. Out-of-pocket spending capped at $500 per individual and $10,000 per family for those with incomes between 133 percent and 150 percent of the poverty level.	Refundable premium credits for individuals and families with income of 100 percent to 400 percent of the poverty level, or whose employer-sponsored plan costs more than 9.8 percent of their income. Cost-sharing credits for those with incomes of 100 percent to 200 percent of the poverty level. Caps on out-of-pocket costs tied to income.
Individual Mandate		
Most Americans required to obtain insurance coverage through employer plans, Medicare or Medicaid, or the new exchanges	Enforced through 2.5 percent tax penalty on income above the level needed to file tax returns, up to the average cost of a policy on the exchange. Exemptions for those with too little income to file tax returns.	Enforced with tax penalty rising up to $750 per person in 2016, up to a maximum of $2,250 per family or 2 percent of household income. Penalty indexed for inflation beginning in 2017. Exemptions for those with incomes below 100 percent of poverty level.
Benefits Package		
	All plans in the exchange must offer an "essential benefits" package as defined by the government. They could offer four types: Basic, Enhanced, Premium and	All plans in the exchange must offer an "essential benefits" package as defined by the government. They could offer four types: Bronze, Silver, Gold and Platinum.

	Premium Plus. Coverage would range from 70 percent (Basic) to 95 percent (Premium) of benefit costs. No cost sharing for preventive services under the Basic plan.	Coverage would range from 60 percent (Bronze) to 90 percent (Platinum) of benefit costs. No cost sharing for preventative services. Separate catastrophic plan allowed.
Small-business subsidies		
Help for small businesses that provide health benefits	Tax credits for employers with fewer than 25 employees and average wages of less than $40,000.	Tax credits for employers with fewer than 25 employees and average wages of less than $50,000.
Employer Mandate		
Penalty for employers who do not offer insurance benefits	Employers with annual payrolls above $500,000 required to offer coverage and pay 72.5 percent of individual premium or pay penalty of up to 8 percent of payroll.	No general penalty, but employers with more than 50 full-time workers that do not offer insurance and have at least one worker getting subsidized coverage on an exchange required to pay $750 penalty for each full-time employee.
Medicaid		
Expanded eligibility	All individuals with income up to 150 percent of the federal poverty level eligible. HHS to pay 100 percent of costs for the added enrollees in 2014, and 91 percent of states' costs after that.	All individuals with income up to 133 percent of the federal poverty level eligible. HHS to pay 100 percent of costs for the added enrollees in 2014-2016, then share costs with states.
Insurance Requirements		
Regulations	▪ No denial of coverage based on pre-existing conditions. Temporary high-risk pool created for citizens and legal immigrants who have been subject to such denials. ▪ No lifetime dollar limits on benefits. ▪ Insurers prohibited from rescinding policies, except in cases of fraud. Effective July 1, 2010.	Same.
Antitrust exemption	Elimination of most of the health insurance industry's exemption from federal antitrust law.	No provision.
Dependent coverage	Plans that cover dependents must allow parents to continue coverage for children up to age 27.	Plans that cover dependents must allow parents to continue coverage for children up to age 26.
Medical loss ratio	Insurers required to spend 85 percent of premium revenue on medical claims or rebates.	Insurers required to spend 85 percent of premium revenue on medical claims or rebates in large-group market and 80 percent in small group and individual markets.

Prescription Drug Coverage		
Closing the gap, or "doughnut hole," in Medicare Part D prescription drug coverage	Gap reduced by $500 in 2010 and phased out by 2019, paid for by drug manufacturer rebates. Until 2019, drug manufacturers required to give a 50 percent discount on prescription drugs to enrollees while they are in the grasp.	One-time $500 reduction in gap in 2010. Drug manufacturers required to give a 50 percent discount on prescription drugs while enrollee is in the coverage gap.
Abortion		
Ban on federal funding	No use of funds under the act to purchase a plan on the exchange that covers elective abortion (i.e. abortion in cases other than rape, incest or danger to the woman's life). Individuals who receive federal subsides would be required to buy separate policies with their own money to get coverage for elective abortions. No discrimination against providers based on whether they provide abortion services. No effect on federal or state abortion laws.	No use of federal funds to pay for elective abortion coverage. Each exchange required to offer one plan that does not cover elective abortion. Plans that offer such coverage must collect a separate payment from each enrollee, regardless of age or sex, for the portion of the plan cost attributable to the abortion coverage. No discrimination against providers based on whether they provide abortion services. No effect on federal state abortion laws.
Medical Malpractice		
	Incentive payments to states that enact laws to provide alternatives to traditional medical malpractice litigation, if the laws do not limit attorneys' fees or impose caps on damages.	Demonstration grants to develop alternatives to existing litigation laws. The alternatives must enhance patient safety and improve access to liability insurance.
Coverage of Children		
Children's Health Insurance Program (CHIP)	No further funding for CHIP after fiscal 2013: shift children to the expanded Medicaid program of the exchange.	Increase in federal share of funding for CHIP. States required to maintain existing eligibility rules for 2019.
Revenue		
Income tax surcharge	5.4 percent tax on income over $500,000 for individuals, $1 million for families.	None.
Excise tax on high-cost health insurance	None.	40 percent excise tax on insurers for costs of employer-sponsored plans in excess of $8,500 for individuals, $23,000 for families, indexed for inflation.
Medicare hospital insurance payroll tax	No change	0.9 percent in crease in Medicare part A payroll tax rate for individuals earning more than $200,000, $250,000 for families.
Health industry fees, taxes	2.5 percent excise tax on sales of medical devices.	Annual fees on pharmaceutical, medical device and insurance industries.

* Adapted from *Congressional Quarterly Almanac* 2010. Page 13-10 and 13-11.

Speaker of the House, Nancy Pelosi, D-California, was able to secure the passage of House the bill 220-215 on November 7, 2009. Senate Majority Leader Harry Reid, D-Nevada, after a 25 day Senate session secured all 60 votes he needed to overcome a filibuster and invoke cloture. The vote to invoke cloture was 60-39 and the bill passed 60-39 on December 24, 2009.

The Senate bill above is the final bill that both houses passed. In the Senate the bill passed without a single Republican vote. On March 21, in a 219-212 vote House passed the Senate health care overhaul without any changes. The House then passed the reconciliation bill 220-211, HR 4872. The Senate, much to the relief of nervous Democrats, passed the reconciliation bill that had important House amendments to the Senate bill on March 25 by a vote of 56-43. All Republican Senators opposed the bill, along with three Democrats (*Congressional Quarterly Almanac 2011)*. This law required most Americans to have health insurance coverage by 2014 and states created American Health Benefit Exchanges, or marketplaces (*Congressional Quarterly Almanac* 2011, 9-3). On March 23, 2010, before the reconciliation bill had passed, President Obama signed the Affordable Care and Patient Protection Act into law.

The way that the Democratic leaders were able to get the House and the Senate to pass the same bill in this instance was to have the House pass the Senate bill and the pass a bill of corrections that was sent to the Senate. This corrections bill made the following changes: 1) OPM contracts with insurers to offer a minimum of two multistate plans in each exchange with one being offered by a non-profit, 2) subsidies were more generous, 3) the fee for non-compliance with the individual mandate was $695 per person up to a maximum of 2.5 percent of a household's income, 3) the employer mandate fee was larger, 4) the doughnut hole was to be closed like in the House bill over 10 years, 5) revenues were changed by increasing the Medicare

payroll tax for hospital insurance by 0.9 percent for higher income individuals and adding a 3.8 percent excise hospital insurance tax on investments that exceeded that level. The Joint Tax Committee estimated that the 10-year revenue would be $210.2 billion, which was an increase from $86.8 billion in the original Senate bill (*Congressional Quarter Almanac* 2011).

In this case, it is clear that there was a strong Democratic coalition behind the reform effort. Alternative plans were not seriously considered in the House or the Senate. The only major options were the bills that came out of committees. Strong leadership was able to help craft the debate and get to the core of arguments so that compromises could be made between interests and politicians themselves so reform had a fighting chance.

V. Interest Group Activity:

The American Medical Association (AMA) was "worried about scheduled steep reductions in Medicare payments for physicians under the terms of a 1997 law" (Hacker 2011, 438). The Democratic leaders in 2009 knew this, and so they offered a solution to the AMA's worries. Due to the Democratic leaders' offer, "the AMA endorsed not just the Senate health bill, but also the more sweeping House bill" (Hacker 2011, 439). The insurance, pharmaceutical, and hospital industries were mainly concerned with ensuring that they would have a steady revenue and patient source from the private sector. They wanted the government to create an insurance mandate that required individuals to get health care insurance (Hacker 2011). America's Health Insurance Plans, formerly Health Insurance Association of America, lobbied for this cause and "played a double game through the debate, at some points holding its fire or endorsing the reform, at others directing or funding attacks. But it was far more favorable toward action than in the past" (Hacker 2011, 439). The pharmaceutical and hospital industries, in particular, were

quite favorable to reform. They "cut sweetheart deals with President Barack Obama's team early on—deals that the White House fiercely protected from congressional attempts to undo them" (Hacker 2011, 439). The deals included "a White House commitment that neither drug companies nor hospitals would be required to give up more than a modes amount of expected revenues" (Hacker 2011, 439). These concessions to the hospital and interest group industries did have a real impact on policy. This is because they "limited the law's ability to deliver tangible benefits to the middle class and largely took off that table tools of cost control used in other nations" (Hacker 2011, 439).

The American Association of Retired Persons (AARP) publically supported Obama's reform initiative and the President said so in an op-ed piece he wrote for the New York Times. (Obama 2009). As a whole, it seemed like interest groups were more favorable to reform during this time. Organizations such as Pfizer and PhRMA were making deals with the White House in anticipation of the bills in Congress becoming law (Haberkorn 2012). Major industries knew that reform was on the horizon and was willing to make compromises rather than to push back relentlessly.

VI. Analysis of Interest Group Success:

VIa. Methodological Approach:

In order to analyze the success of interest groups, a similar methodological approach was taken as previously. The same interest groups as in Clinton's health care reform were observed as well as additional interest groups identified through the list on OpenSecrets.org of top lobbying spending during the years of the health care reform. The top two organizations for each of the five health care industries were added to the list of interest groups and duplicates were removed. A total of 21 interest groups were observed for this case. Important differences to note

are that the American Association of Health Plans merged with the Health Insurance Association of America, and together became America's Health Insurance Plans. Also, in 1994 the Pharmaceutical Manufacturers Association of America (PMA) merged with the Pharmaceutical Research and Manufacturers of America (PhRMA). Again groups' mentions in the *New York Times*, *CQ Roll Call*, *The Washington Post*, *USA Today, CQ Weekly*, and *The National Journal* in 2008, 2009, and 2010 were compared. Their presidential alignment and their ideological alignment with Congress were also compared. Ideological alignment with Congress was determined through an organization's political contributions in 2009 and whether or not that aligned with the leanings of Congress. Finally, the organizations' stances were compared to President Obama's objectives for the proposal to determine how much alignment there was with the President's objectives. All three aspects are rated on a low, moderate, high scale.

An interest group was determined to have a high level of newspaper mentions if it was in the top third of groups with the highest interest group mentions, a group had a moderate level of mentions if it was in the middle third, and finally, a group had a low level of newspaper mentions if it fell in the bottom third

Interest groups alignment with Congress was determined by looking at their political contributions. While partisanship is not ideology, with how politics has become more partisan today, it can help measure how a group is aligned. The DW-nominate score of the 111th Congress was -0.028 indicating that it, as a whole, was more liberal leaning. The Democrats' DW-nominate score was -0.361 and the Republicans' was 0.463 (Vital Statistics on Congress). As in the previous case, an interest group was more ideologically in line with Congress if it donated more money to liberal Members of Congress, or Democrats, rather than donating the majority of its money to conservative, or Republican Members of Congress. If there was over a

2:1 ratio in favor of Democrats, a high alignment was determined. Congressional Alignment was moderate if its spending was relatively equal, and it was low if it favored Republicans.

Presidential Alignment was determined on a low, moderate, high scale, by assessing whether or not an interest group or organization endorsed the president's plan and components of the plan. A low level of alignment was given if the group did not endorse or support the plan and/or they were publically against the plan. A moderate level of alignment was determined if a group supported some significant aspects of the plan, but not all. A high level of alignment was determined if a group supported most of the plan and/or endorsed the president's objectives.

VIb. How the Interest Groups Were Categorized:

America's Health Insurance Plans (AHIP) was deemed to have a moderate level of success in this instance of health care reform. AHIP attempted to both work with the White House and seemingly endorse Obama's efforts to reform health care and a health care reform in general. However, they also were funneling large amounts of money to the Chamber of Commerce in order to purchase ads to try and block the reform. A main concern of AHIP was the Medical Loss Ratio (Ungar 2012). The ratio would require health insurance companies to spend 80 percent of dollars that come from premiums on health care expenditures. Any money that was not spent would have to be refunded to the consumer. For 2011, it was estimated that the amount refunded to customers would be $1.1 billion (Ungar 2012). As the insurance lobby, AHIP was also concerned about provisions that would increase the cost of coverage such as the health insurance tax, guaranteed coverage for pre-existing conditions, no varying premiums because of age or sex, and minimum essential benefits (AHIP.org). They thought that these provisions could risk individuals not getting insured until they were ill. However, there are

provisions in the legislation that mandate that people get coverage to remedy the worry of a lack of healthy population to share the costs of the sicker population. A mandate of coverage is deal that the insurance industry would benefit from greatly and would likely not have gotten without this legislation. Because AHIP was working both sides, but they were able to make initial deals with the White House to get an insurance mandate, they were determined to have a moderate success level. While they may not have wanted a reform to pass, by having talks with the White House, they were able to get gains, although they were not fully supportive of reform.

The American Academy of Family Physicians has a low level of success because they did not get the type of health care reform that they favored. They favored an approach with a patient-centered medical home that has a universal mandate (AAFP.org). This option was not even a major option in the bills proposed in the committees; therefore they have a low level of success.

The American Association of Retired Persons (AARP) has a high level of success because they publically endorsed the health plans that were going through Congress and President Obama even stated that he had their endorsement himself (Obama 2009). The AARP endorsed both the House and the Senate bills and believed that they aligned with their goals to increase Medicare benefits and eligibility. The AARP endorsed many provisions of the new health care legislation such as provisions that would specifically benefit its members. Such provisions were ones that met their goals of making coverage affordable to younger members of AARP and protecting Medicare (AARP.org). They also supported provisions in the law that provided annual wellness exams, improved preventative services, the closing of the Medicare Part D doughnut hole, and better care coordination efforts (The Medicare Newsgroup). Due to the AARP publically supporting the bill and the bill having the provisions that the AARP approved of, they had a high level of success.

The American College of Radiology had a high level of success in this reform effort because their main concern was to reform medical malpractice (Brice 2009). Both the bills passed by the House and the Senate included provisions to include incentives to states who reform medical malpractice and find alternatives to the traditional process. Due to their limited goal and the presence of it in the final legislation, the American College of Radiology had a high level of success.

The American Hospital Association (AHA) had a moderate level of success because while they supported expanding health insurance coverage to more individuals, they were not in favor of the House bills' levels of Medicaid eligibility (Eaton 2010). They felt it was too high and could hurt the revenues of hospitals. The AHA had split goals on this bill, and because of that they had a moderate level of success. Medicaid was not expanded as much as proposed in the House bills, but it was still expanded, but so was health insurance coverage.

The American Medical Association (AMA) had a high level of success because the AMA publically endorsed the health care reform that was occurring and while they felt it was not a perfect match for their views, they felt it was good enough to endorse and support. They worked with the House leadership to pass their bills through Congress and to help the reform to progress. The reform ultimately passed, as the AMA wanted; therefore, they had a high level of success.

Blue Cross Blue Shield has a moderate level of success because they were supportive of legislation to reform health care, but they wanted a strong mandate to have people enroll in the new system so that young and healthy people can help balance the costs of older and sicker people (Zimmerman and Young 2009). Also, they were worried that without a mandate, people would wait until they were very ill to get health care coverage. Blue Cross Blue Shield sponsored a study stating that premiums would rise up to 50 percent for individual plans and 19 percent for

small group plans if the new reform were to pass Congress (Zimmerman and Young 2009). They attribute the rise to a lack of a strong enough mandate and they fear that too many unhealthy people will join in the insurance policies, but enough healthy people will not. They were quite against the requirement that insurers would have to provide insurance coverage to individuals whether or not they had a preexisting condition and felt that this, combined with a lack of a strong mandate would cause premiums to rise (Zimmerman and Young 2009). When the legislation was enacted, there was a mandate in the form of a tax penalty of $750 per individual. While this might not be seen as the strongest mandate possible, it is a mandate. In 2014 if an individual did not have health insurance, they were required to pay 1 percent of their yearly household income above the tax filing threshold, or $95 per adult, per year and $47.50 per child under 18, per year—whichever amount is higher. In 2015 this amount increased to 2 percent of an individual's yearly household income above the tax filing threshold or $325 per adult and $162.50 per child under 18—whichever amount is higher. In 2016 this amount will be 2.5 percent of yearly household income or $695 per person and $347.50 per child under 18 (Healthcare.gov.b). Since there was a fairly strong mandate instituted in the legislation—the mandate is generally the cost of a Bronze plan—but the insurance companies do have to provide coverage to individuals regardless of preexisting conditions, Blue Cross Blue Shield has a moderate level of success (Healthcare.gov.b).

The United States Chamber of Commerce has a low level of success because the Chamber was opposed to any legislation reforming the health care system. They served as a platform for organizations to donate money to in order to purchase advertisements opposing the reform. When the status quo was not preserved and reform occurred, the Chamber of Commerce had a low level of success.

DaVita Inc., along with Fresenius Medical Care also have a low level of success. Together they are the leaders of dialysis care and control a majority of the market. They were worried that with a health care reform they would risk having to close dialysis centers because of having to provide treatment to more patients at rates equal to or close to Medicare rates. They promoted an integrated care model for health care reform (Williams 2009). The private insurance market and private insurance patients are how they get most of their income, so if that income decreases, so does their profits and their productivity. When health care reform passed, Medicaid was expanded and health care prices were controlled more, DaVita Inc. and Fresenius Medical Care had a low level of success—the status quo was not preserved for them.

Eli Lilly & Co. had a low level of success because they do not support government intervention in the health care system. They believe that the free market has solutions that could help cover more Americans and single-payer along with other government run systems have proven to not be ideal (Lilly.com). When health care reform was pass and the federal government's role was more than just of a safety net, Eli Lilly & Co. had a low level of success. A free market solution was not seriously considered in any of the committee's plans and the government will now intervene in the delivery of health care in the United States.

The Federation of American Hospitals had a moderate level of success because they wanted a mixed system of health care delivery as well as an expansion of health care coverage to more Americans (Ways and Means 2009). The model that they favored would be a non-government run plan that would heavily rely on non-profits or co-ops to deliver health insurance to the uninsured. Their fear with the government intervening was that the government would set prices for services, and that would be harmful for the hospitals (Ways and Means 2009). The Federation of American Hospitals wanted a system based on private negotiation where the

government does not intervene (Ways and Means 2009). They wanted to ensure that a health care reform would not hinder the revenues of hospitals and would improve health care efficiency. The Federation of American Hospitals had a moderate level of success because while the ultimate plan was not purely mixed, it did include provisions that non-profit plans must be available in each exchange, however, the bill does allow the Secretary of Health and Human Services the ability to negotiate some premium rates with insurers. This is not the government setting up payment rates, but it is the government setting some standards, and the Federation of American Hospitals would rather have the public option regulated by the private insurance market (Ways and Means 2009). Because there are aspects of a mixed plan such as the availability of non-profit plans in each exchange, but there is government intervention.

The Healthcare Leadership Council had a high level of success because while they opposed the purely public plan that Democrats had advocated for in the past, they favored a compromise that would expand health care coverage, incentivize positive outcomes and quality, reform medical liability, eliminate exclusions for individuals with preexisting conditions, change payment methods, and create better preventative care (HLC.org). The actual legislation out of Congress expanded health care coverage, eliminated exclusions for preexisting conditions, and created better standards for preventative care. This may not have been the system the Healthcare Leadership Council had in mind, but it included many of their goals, which means they had a high level of success.

The National Association of Manufacturers had a low level of success because they wanted to protect the status quo (Eaton 2010). They feared that reform would cause small and medium sized businesses to drop their health care coverage, which would result in larger

companies paying more money for health insurance. When the status quo changed the National Association of Manufactures had a low level of success.

The National Federation of Independent Businesses (NFIB) also had a low level of success. The NFIB worried that the reform would increase costs for small businesses (NFIB.com). They were opposed to an employer mandate. When the legislation became law, the NFIB had a low level of success because there was an employer mandate. Small businesses would receive tax credits and would not be penalized unless they had more than 50 employees and an employee received subsidized coverage.

Pfizer and PhRMA both had high levels of success. The pharmaceutical industry was quick to cut deals with the White House to make it so that prescription drugs could not be imported from Canada (Hacker 2011). They paid for advertisements in support of the reform and had a public campaign in support of the reform (Armstrong 2012). The pharmaceutical industry like Pfizer and PhRMA were primarily concerned about price controls on prescription drugs from Medicare. Both groups endorsed the plan and the plan passed, making them both have a high level of success.

UnitedHealth Group had a low level of success. The group was against the reform and public insurance in general (Eggen 2009). They encouraged their employees to e-mail their representatives expressing disapproval of the legislation. UnitedHealth Group wanted higher penalties for those who did not buy health insurance and was against any cuts to Medicare (Eggen 2009). Their ultimate preference was the status quo and they did not want reform to occur. Eventually the status quo changed and the UnitedHealth Group did not have much success. Therefore, UnitedHealth Group had a low level of success.

VII. Success of the Model:

Table 9 shows the results of the interest group analysis. The results can be seen in Table 4 below.

Table 9. 2008, 2009, and 2010 Interest Group Analysis

Interest Group Name	Newspaper Mentions	Congressional Alignment	Presidential Alignment	Success Level
America's Health Insurance Plans (AHIP)	High	Low	Low	Moderate
American Academy of Family Physicians	Low	High	Moderate	Low
American Association of Retired Persons (AARP)	High	High	High	High
American College of Radiology	Low	Moderate	Moderate	High
American Hospital Association (AHA)	Moderate	High	Moderate	Moderate
American Medical Association (AMA)	High	Moderate	High	High
Blue Cross Blue Shield	Moderate	Low	Moderate	Moderate
Chamber of Commerce	High	High	Low	Low
DaVita Inc.	Low	Moderate	Low	Low
Eli Lilly & Co	Low	Moderate	Low	Low
Federation of American Hospitals	Moderate	Moderate	Moderate	Moderate
Fresenius Medical Care	Low	High	Low	Low
Healthcare Leadership Council	Low	High	Moderate	High
National Association of Manufacturers	Moderate	Low	Low	Low
National Federation of Independent Businesses (NFIB)	Moderate	Low	Low	Low
Pfizer Inc.	Moderate	Moderate	High	High
Pharmaceutical Research and Manufacturers of America (PhRMA)	Moderate	Low	High	High
United Health Group	Moderate	Moderate	Low	Low

Looking at Table 9 above, some patterns do emerge in the data. The clearest relationships emerge when looking at Presidential Alignment and Success Level. More often than not, a group's Presidential Alignment level is the same as their Success Level. This only occurs when the President's reform plan wins. This would indicate that there is a relationship between Presidential Alignment and an interest group's Success Level. When a President's plan wins, a group's Presidential Alignment and Success Level are not exclusive variables and they overlap in content. This could be problematic, but corresponds with the literature about interest group behavior. The literature suggests that an administration is part of the institution of the government that handles interest group activity. [2] The President, ultimately, must decide how to shape the agenda, who to bargain with, and he or she must be a decision maker. Interest groups

[2] See Section I of the Literature Review—Institutional Changes. This section explains further how a presidential administration interacts with interest groups in order to accomplish goals. This theory is developed thoroughly by Mark Peterson and Thomas Gais et al. (1984).

are more willing to compromise with the President than with one another, making the President crucial in times of debate, but also making it so interest group opinions and positions will likely align with the President before Congress in a time of successful reform (Peterson 1993a, 429). The Presidency can shape the agenda at times of reform and choose issues that will enhance his or her reputation and increasing their influence (Gais et al. 1984, 181). This is because if reformists of a majority party have disagreements in Congress while the public is open to a reform, they will look to the President for suggestions. This is what makes is so that an interest group's Success Level is not independent of its Presidential Alignment in situations when the President's reform movement is successful. In this case, Obama's policy is successful. While he did delegate to Congress, Obama gained most of the provisions he wanted (detailed in the narrative above). The only major provision that Obama did not get was a public option. However, the absence of the public option is not significant enough to say that Obama failed to succeed. Presidential Alignment, in this case, was connected to the interest group's Success Level.

For the reasons mentioned above it is important to note that over half of the groups observed have matching Presidential Alignment and Success Level variables. The variables match in 14 out of the 18 groups observed. The exceptions are AHIP and AARP.

Using the criteria noted in the Clinton analysis above, out of the 18 interest groups observed, the model worked for 14 of the groups and did not work for four of the groups. The groups that it did work for were: the AARP, American College of Radiology, AHA, AMA, Blue Cross Blue Shield, DaVita Inc., Eli Lilly & Co., Federation of American Hospitals, Fresenius Medical Care Healthcare Leadership Council, National Association of Manufacturers, NFIB, Pfizer, and PhRMA. The groups that the model does not help explain successes or failures for

are: AHIP, American Academy of Family Physicians, Chamber of Commerce, and UnitedHealth Group.

Out of the groups where the model worked, of particular interest are the American College of Radiology, the Healthcare Leadership Council, Pfizer, and PhRMA. As in the previous case study, the model works when an interest group has two variables that have a moderate-to-high level of significance (moderate or high), which leads to a moderate or high Level of Success.

On first glance, the American College of Radiology may look like it does not have success. This is because its Newspaper Mentions are low, its Congressional Alignment is Moderate, and its Presidential Alignment is Moderate. However, for the model to work, the interest group's variables must show some level of significance to explain a significant Success Level outcome. In the case of the American College of Radiology, there is a significant Success Level outcome, and this is explained by the model and the group's variables. Even though the group had moderate and low level variables, the moderate level variables outnumber the low level. Also, the moderate level variables are still significant. It makes sense that significance leads to significance. Therefore, it is not unreasonable that two moderate level variables can lead to a high level of success.

Another group worth explaining is the Healthcare Leadership Council. The Healthcare Leadership Council may look like its level of success is not explained by the model. However, although the group has a low, high, and moderate level for different variables, the high and moderate variables are both significant. A high variable can be thought of as very significant and a moderate variable can be thought of as significant. The average of the two would be significant—either high or moderate. Therefore, the expected outcome of success would be

significant, or moderate. The Healthcare Leadership Council did have a moderate Success Level, so in this case, the model did work.

Pfizer's high Success Level is explained by the model because all its variables do have significance. Two moderate variables and a high variable can reasonably lead to a high Success Level. All of the variables have significant levels, so a working model would have Pfizer's Success Level also be significant, which it is in this case.

PhRMA's high success level can also be explained by the model. Although it has one low variable, because the other two variables are significant (moderate and high) a significant level of success would be expected. Thus, PhRMA's high level of success is expected and explained by the model.

Out of the four groups that the model does not work for, the Chamber of Commerce's reasoning for not being a working model should be explained. It is interesting that the Chamber of Commerce has two high variables but one low variable which results in a low Success Level. The model does not work here, because two high level variables that carry a high level of significance should result in a Success Level that is also significant. It is interesting that the model did not work in this case, but perhaps this could be because of the lack of Presidential Alignment, which appears to be important in a case like this where the President wins.

United Health Group's low level of success cannot be explained by this model. The group has two moderate level variables and a low level of Presidential Alignment. With two variables that are significant, it would be expected that there would be a significant outcome for the group. However, there was not, so the behavior was not explained by this model.

For the groups that the model does not work there could be other factors that the chart does not explain influencing interest group behavior and outcomes. The main problem with the

model in this case is that Presidential Alignment and Success Level overlap. However, despite this, the model still works to explain the Success Level of most of the groups in this case.

The most successful interest groups in this reform were the AARP, the American College of Radiology, Pfizer Inc., and PhRMA. Of these four groups, three have high levels of Presidential Alignment. The American College of Radiology is the only exception and this may be because their goal was so small and specific. All groups had mixed levels of Ideological Alignment with Congress and generally, their newspaper mentions were moderate-to-high.

The least successful interest groups in this reform were groups that were mixed across all of the variables or had consistently low levels of alignment or activity. Mixed organizations are groups who have no clear patterns across all variables. This suggests that groups who have multiple mixed variables, or consistently low alignment or activity, will have a low level of success, while those who have consistently high alignment or moderate-high variables will have high levels of success. Also, in general, groups who had a low Presidential Alignment had low levels of success. It is important to note that determining the impact of activity/Newspaper Mentions versus the impact of Congressional Alignment is difficult. Five groups have complete opposite relationships between Congressional Alignment and their Success Level. There are also eight cases where the relationship deviates by one level. The five one-level deviations for Presidential to Congressional Alignment seems to be less alignment between Congress and an interest group's success than Presidential Alignment and an interest group's success. In terms of Newspaper mentions, five groups have opposite relationships between Newspaper Mentions and Success Level and five groups have a one-level deviation. That leaves eight groups who have the same Newspaper Mentions Level as Success Level. Distinguishing the impact of the two is problematic, especially in this case where the President wins. However, because it looks like

there are slightly more equivalent Newspaper Mention Levels and Success Levels than there are Congressional Alignment Levels and Success Levels, in the case where the President wins, it looks like Newspaper Mentions may have more of an impact. Although, it is important to note that both Newspaper Mentions and Congressional Alignment have the same number of opposite relationships, making a relationship hard to observe.

In sum, the model partially worked for this case. Groups who were highly aligned with President Obama had a high level of success while groups who were inconsistent and/or against the reform did not have high levels of success. This could be because groups who had low levels of success tended to have low levels of Presidential Alignment and to be in favor of preserving the status quo. In this case the status quo was not preserved and change occurred. The model was able to determine the Success Level for the majority of interest groups, but the overlapping of the Presidential Alignment variable and an interest group's Success Level makes it more difficult to interpret the model.

Chapter 6: Conclusion

The model was applied to three separate cases, Clinton's, Obama's, and Bush's health care reform attempts. In observing the effectiveness of the model, it is clear that the model was not very successful in Clinton's reform, was moderately successful in Obama's reform, and was successful in Bush's reform. The model was successful if it was able to explain an interest group's significant Success Level (moderate or high) through the group having a significant (moderate or high) level in two or more variables. It was also successful if it was able to explain an interest group's non-significant Success Level (low) through the group having a non-significant level in two ore more variables. In the Clinton case, there was a strong opposition

movement that hindered the model, in the Bush case, the model worked because the variables were relatively independent and the model explained what it set out to explain, finally in the Obama case Presidential Alignment and Success were not wholly independent, yet the model worked partially for some cases because there was alignment between variables and Success Level. When looking at the success of the model in each case, it is clear that there could have been more factors at play than this model alone could measure. Despite this, this model does have relative success in explaining the Success Level of some interest groups depending on their Newspaper Mentions, Ideological Alignment with Congress, and Presidential Alignment.

Below are some of the differences and similarities of the cases that could have affected the model. Also discussed will be an overall success analysis of the model and how it could be improved for future use.

In the Bush and Obama case, the both presidents made their goal known to Congress and the public and then the House and Senate delegated between themselves and produced a plan that eventually became law. However there were some key differences. In Obama's reform, there was no give and take between Republicans and Democrats. The plan was a predominately Democratic plan and was passed with minimal Republican support. For the most part, provisions were not put into the legislation in order to appease the Republicans or to gain their support. Compared to the other two plans, it was clear that Republicans and Democrats were not willing to bargain. However, in Bush's attempt at Medicare reform, there was, at least initially, some compromise and give-and-take between the two sides. Republicans mostly controlled the plan, but there were concessions provisions in the plan that Democrats supported. This is evident in the Senate in which some Democrats supported and voted on the bill. However, after the bill went to conference, these provisions were weakened and fewer Democrats supported the bill

because of fears that the bill was too focused on helping industries rather than seniors. After conference every vote mattered and Republican loyalty was necessary. There was little Democrat support for the legislation because of the rising estimated costs and the lack of strong provisions to protect seniors and to control the costs of prescription drugs.

Bush and Obama had key differences in their reform plans. Bush's Medicare reform was a smaller, specialized plan compared to an overhaul of the United State's health care delivery system. By having a targeted plan on a specific issue within health care, different actors and players come to the table. Also, industries have different goals than they would if the reform was comprehensive. By having a targeted approach on a specific issue, interest groups had specific preferences and the debate could also be targeted. Because of this structure, it could have been easier for both the president and interest groups in favor of reform to change the status quo. In Obama's health care reform attempt, the reform was comprehensive and a larger reform has the potential to invite more players and a longer debate. This is seen in how, compared to Bush's reform, there were many alternative bills and proposals offered in the House and Senate during Obama's health care reform attempt, but during Bush's attempt, there was always just leading Committee or House and Senate plans. This is another difference, during Obama's reform there were many more competing plans and less of a structured approach from within Congress, while during Bush's reform, Committees and Congress as a whole attempted to manage and streamline plans. There were not plans that competed with the Committee and main House and Senate plans.

Other differences between the presidents' attempts are that while they both tried to delegate the responsibility of forming a plan to Congress, Bush did outline what he would like to see in a plan more clearly and he did publically say what he would like to see in a plan. His

statements were not recommendations for Congress as he was outlining his own ideal plan for Medicare reform. Obama, however, told Congress what key provisions he wanted in a plan and said it was up to Congress to figure out a way to develop and pass legislation that would try to meet those provisions. While Bush was outlining a plan for Congress, Obama gave recommendations.

Each case had to handle different coalitions in Congress. In the case of Obama's reform, the Blue Dog Democrats heavily resisted voting to pass the reform. At the time, one-fifth of all Democrats were in the coalition and they wanted to make sure that provisions in the bill would not hurt small businesses and they wanted to keep government costs down (Bendavid 2009). The Blue Dog Coalition had 52 votes in the House, which means that if they coordinated with Republican votes, they could defeat the legislation. In order to appease this coalition, provisions were written into the bill to distribute more funds to rural doctors (which are in the Blue Dogs' districts) (Bendavid 2009). Bush did not face rebellion from internal coalitions within his own party, he just had to fight for every last Republican vote to ensure that the bill would pass the House and the Senate. In Bush's case, leaders of the party had to lobby hard the day of voting to try and sway votes against Medicare reform to votes for the reform. Deals were made with Members of Congress and the process by which lobbying was done and the vote was held resulted in a review by the Ethics Committee. Both presidents had to fight for alignment within their own party, but during Obama's reform concessions were made to appeal to the Blue Dog Democrats while during Bush's reform intense lobbying practices the day of the vote were employed.

Between Bush and Obama's reform attempt there were also similarities. Although they delegated differently, as mentioned above, both presidents at least tried to delegate legislative

responsibility to Congress. Bush did have more of an involved approach when stating his plan and ideals for Medicare reform than Obama in stating his goals for comprehensive health care reform, but importantly, both let Congress develop their own plans instead of giving Congress a bill to try and pass.

Another similarity between Bush and Obama was that they both made initial, or "sweetheart" deals with interest groups to gain their support from the beginning. Both presidents targeted the pharmaceutical industry as well as other major players. Also, both groups were able to garner support from some key groups such as the AMA, AHA, and AARP. Having the major industries—hospital, medical, seniors, and pharmaceutical—on your side is certainly a way to secure increased support for the plan and to help increase the strength of the plan in Congress. Having key players in favor of the plan is better than having them opposed to the plan. Both presidents set out to try and make deals with the interest groups to try and get them on board with reform early on. This plays into the idea of Presidential Alignment for an interest group. If the president himself is seeking out alignment, that will greatly increase the likelihood that an interest group will have a higher level of Presidential Alignment than if an interest group was left without a relationship. Having the president seek out a relationship with a group will increase the chance that the group will be in favor of the reform because the group has had the chance to tell the administration what they want and what concessions they would specifically like in order to be in favor of the reform. Without the administration working with the interest groups, the chance that the president's preferences and plans will align with that of interests are not as high. Both Bush and Obama saw the utility of seeking out relationships with interest groups and making deals early on before interest groups had a chance to lobby hard against the reform. Also, both made initial and substantial deals with the pharmaceutical industry to gain their support.

In addition to having similar deal-making methods, both Bush and Obama had a majority in Congress at the time they were pushing for a health care reform. Having control over both the House and the Senate and the ability to pass legislation through without votes from the opposition is an advantage in a situation of reform. At the time of Bush's reform, there were 48 Democratic Senators, 49 Republican Senators and one Independent Senator. In the House there were 222 Republican Senators, with one Independent who caucused with the Republicans. There were 210 Democrats and one Independent who caucused with the Democrats. For Obama's reform, the Senate was composed of 55 Democrats, 41 Republicans, and two Independents who caucused with the Democrats. Towards the end of 2009, the Democrats had a supermajority in the Senate and controlled over 60 votes. The House of Representatives was composed of 256 Democrats, and 178 Republicans, with one vacant seat.

Both presidents also were not met with a strong opposition movement. Unlike Clinton, Bush and Obama were not met with a large coalition of interest groups who did not support their plans for reform. While interest groups were not always fully on board and were not supportive of all the provisions in reform, Bush and Obama did have support from interest groups and their bills were publically endorsed by multiple groups. In these instances, interest groups were not wholly opposed to reform. They saw that the potential for reform was on the horizon and were willing to compromise and make concessions rather than try to block the plan altogether. This difference affects Presidential Alignment. When an interest group choses to participate in supporting a reform, its Presidential Alignment will be affected.

The model works well for Bush because it provided an explanation for why an interest group would have a high level of success for the majority of interest groups in an attempt of health care reform. In Bush's case, Presidential Alignment and Success Level were not

necessarily related and interest groups who had a significant (moderate or high) level in two or more variables were likely to have a significant Success Level (moderate or high). For the majority of interest groups, 13 out of 17, the model was able to accurately explain an interest group's Success Level based on the significance of the groups Newspaper Mentions, Congressional Alignment, and Presidential Alignment.

For Obama's reform, the model is able to explain the Success Level for 14 out of the 18 groups observed, but Presidential Alignment was not completely independent of an interest group's Success Level. This is because Obama's plan was the plan that passed through Congress. Although he delegated his preferences, he was able to get most of them in the legislation, therefore his ideal plan as outlined through his preferences resembled the policy outcome. This makes it difficult to separate Presidential Alignment from Success Level because, in a way, a group succeeds if the president succeeds with a reform. If, the president has a high level of success, so will the interest group because, essentially the policy outcome is the president's policy plan. This is avoided in Bush's case because the final plan was not the plan that he would have ultimately implemented. Congress acted more independently in Bush's case.

In Clinton's case, the model does not work very well. It failed to explain the Success Level for a majority of the interest groups observed. Out of 12 interest groups, it was able to explain the Success Level for five groups. This is likely because of the strong opposition movement present in Clinton's reform. It is easier for interests to block change than for change to occur. The status quo is easily protected. Also, Presidential alignment is needed when a group wants reform to occur, but when an interest group is trying to obstruct policy change and protect the status quo, Presidential Alignment it is not essential. When a group wants to stop change from occurring there is no reason for that group to align themselves with the president, that is

why the model does not work well in the instance of Clinton's health care reform attempt. Interest groups bandwagoned and attempted to block policy change. In order to do that they did not need the support of Clinton and there was no reason for them to try and align with him. Thus, the variable of Presidential Alignment was not at play as much as it was in other cases. Also, by default, when the president lost, interest groups likely had a significant level of success because they wanted the status quo to remain the same.

This model works best when there are interest groups both in favor of and opposed to the reform who have the potential to align with the president. The president's success must also not be the overall success level of the policy in order for the model to work well. If all groups are against the reform, as in Clinton's case, the data will present itself in a way that the table has a hard time interpreting because without Presidential Alignment working well, the table by itself cannot explain factors such as a strong opposition movement or bandwagoning effects.

As stated previously in the analysis after Clinton's case study, the model works when an organization has two or more significant variables that lead to a significant outcome. The model also works when an organization as two or more low significance variables that lead to a non-significant outcome. A high variable can be thought of as being very significant, a moderate variable can be thought of as significant, and a low variable can be thought of as not significant. If an interest group has a combination of high and moderate variables and has a high or moderate Success Level the model is successful. This is because the average of the two would be significant—either high or moderate. Therefore, the expected outcome of success would be significant, or moderate. If the expected outcome is produced, then the outcome worked. The model works if it follows this pattern:

Table 2. Instances of Model Success

Variable 1	Variable 2	Variable 3	Success Level
Significant (Moderate or High)	Significant (Moderate or High)	Significant or Not Significant (Low or Moderate or High)	Significant (Moderate or High)
Not Significant (Low)	Not Significant (Low)	Significant or Not Significant (Low or Moderate or High)	Not Significant (Low)

Variable 1, 2, and 3 are not assigned to any particular variable. Any variable can have the assigned significance value that would meet the criteria for the model to be successful. For instance, Variable 1 is not restricted to Newspaper Mentions. Any two variables out of Newspaper Mentions, Ideological Alignment with Congress, and Presidential Alignment can fulfill the two out of three minimum requirement for matching significance or non-significance for the model to be successful in that case.[3]

Out of the 47 total interest groups observed, the model was able to explain the Success Level for 32 of the groups. This means that the model explained approximately 68.1 percent of Success Levels. If Clinton's case is removed, it is able to explain the Success Level for 27 out of 35 groups observed. Without the Clinton case, the model explained approximately 74.1 percent of Success Levels.

The model worked as expected in Theory Section, it just did not work as well as expected. However, when the model worked, it worked as predicted. This is expressed in the following contingency table. This can be observed by the following contingency table:

Table 1. Contingency Table of Variables

	Low Policy Success (Non-Significant)	Moderate Policy Success (Significant)	High Policy Success (Very Significant)
Interest Group Strategy: Activity Level	-	+	++
Ideological Alignment with Congress	-	+	++
Presidential Alignment	-	+	++

[3] From page 77

Interest groups who had higher policy success had more significant variables than those with lower policy success. The more significant variables an interest group had, the more significant the Success Level. The reasons the model did not work as expected were discussed above. These reasons include a tautology between Success Level and Presidential Alignment, bandwagoning, and a strong opposition movement.

Initially, it was expected that interest groups' Activity Levels and Congressional Alignment would have more of an impact on a group's success level. I would have expected to see more groups who had uniform patterns of variables across the case. However, the prevalence of this was minimal and more often interest groups had a non-uniform level of activity and alignment. This is what made hard to initially observe clear patterns in the data and significance of variables.

Important factors for interest group's Success Level appeared to be their Presidential Alignment, but only when the president was able to successfully pass their favored reform. Also, it is difficult to distinguish the importance of Newspaper Mentions versus the importance of Congressional Alignment. Each variable does aligns with the Success Level in cases, but most often they are aligning with Presidential Alignment, which suggests that Presidential Alignment is the most important variable.

In hindsight there are certain things that could have been done differently. One main thing that could have been done differently would be to try and limit the tautology, or the potential of a tautology, between Presidential Alignment and Success Level. A way to combat the problem of this tautology would have been to potentially look at the deals that interest groups made before the reform with a Presidential Administration and see how that benefited their policy outcome after the reform attempt had concluded. Another aspect of this research that

could have been done different would have been to look at Congressional Alignment in a different way. Measuring Ideological Alignment with Congress is difficult and the way it was done here was through interest group spending. Another, maybe more reliable, measure of alignment could make the data more accurate and could help determine the significance of Congressional Alignment.

A methodological approach that could have been done differently is a different wording of search terms. For this project, the search terms for a specific interest group were ((“healthcare” OR “health care”) AND (“reform” OR “plan” OR “proposal”) AND (“president’s name”) AND (“interest group name” OR “interest group abbreviation”)) for a specific year. However, if the search criteria were amended to not include the president’s name, different results could have occurred. By including the name of the president involved in the reform movement, the data could have been limited. However, that is the search criteria and parameters that were set. Proportionally, the data is likely the same, but there is a chance that it could have an effect.

It is important to mention that DW-Nominate scores, which are used to determine a Congress’ ideological alignment really only states how legislators are rank-ordered compared to each other. Because of this, in some ways, it is not a true measure of ideology. Also, it weighs all votes the same. This means that roll call votes on the naming of a Post Office is weighed the same as a vote on comprehensive health care reform. By including all votes and weighing them the same, there is the potential to make less polar Members of Congress look more polarized (Trende 2012). A better measure for this study would look at Members’ votes on key issues that have a similar weight as comprehensive health care reform. This would be a slightly better measure of ideology.

The model had difficulty explaining bandwagoning by interest groups. This could slightly be observed when groups had a high level of success and had other significant variables, but a low level of activity. Likely, a group that was not very active, but was able to have a significant level of success was successful because it was able to benefit from the efforts of larger interest groups who shared the same preferences. Also, coalition formation by interest groups could have occurred, but the table does not account for that behavior. It only looks at the individual behavior of a single interest group. Thus, a way to measure or observe bandwagoning effects would strengthen the model and help explain the Success Level of groups who had lower activity and Congressional Alignment levels, but still had a significant level of success. As Peterson said, there is a free-rider problem (Peterson 1993b). Groups can benefit from the efforts of other, larger groups whether or not they are actively participating in a reform. This can make it so groups are less likely to have a high activity level or to align with the President themselves. Other groups with more strength can lobby on their behalf and they will still win.

When trying to observe interest group spending, the data was not as complete as one would have wanted or expected. This made it so looking at interest group spending as a measure of activity could only be done as an industry-wide approach, but not on the individual level like this study required. Repeating this study with a better measure of interest group spending and better spending data would greatly assist in measures of interest group activity and Congressional Alignment.

In the future, another change that could be made would be to look at different legislation. One of the problems that this model encountered was that there was not flexibility in the process. There was little room in the process for amendments to be made that would appease interest groups. A bill and legislative process where there is the potential for interest groups to oppose

the president, but get an amendment that they wanted, would have an interesting impact on the model. Observing a case where there is an outcome that is not exactly what the president wants or what the president does not want. There needs to be more than a binary outcome. This is possible through amendments and more of a general debate around a less-controversial bill.

Overall, the model worked well in one case, worked moderately-well in a second, and did not work well in a third. It is reasonable to say that the model has the potential to work, but in comprehensive health care reform there are many factors that play into the Success Level of an interest group's policy outcome. Due to this, it is hard to narrow down what exactly in the model leads to an interest group's success. Such factors include bandwagoning, opposition movements, and coalitions. The model showed in Clinton's case, in line with interest group theory, that it is easier to protect the status quo than for change to occur. However when an overhaul of Medicaid and the U.S. health care system was imminent, interest groups decided to make deals with the president and utilize Presidential Alignment. While other factors out of the scope of this study were certainly at play here, the model was able to successfully explain the Success Level for the majority of interest groups when interest groups were at the table.

When looking at the three initial hypotheses of: 1) With all other things being equal, interest groups who are more active with the reform movement are more likely to be successful in their goals than those who are less active, 2) With all other things being equal, interest groups who are aligned with presidential health care reform initiatives are more likely to be successful in their goals than those who are not aligned, and 3) With all other things being equal, interest groups who are aligned with the ideological majority in Congress are more likely to be successful in their goals than those who are not aligned with the ideological majority in Congress, it is seems that there was less support for the first and third hypothesis, but when the

president was a winner in the health care reform movement and there was not a strong opposition movement, the third hypothesis was supported by the data.

In sum, interest group behavior has always been known to be difficult to predict. This model shows that it is hard to narrow down a specific reason why interest groups succeed, but when they have a significant Activity Level (newspaper mentions), Congressional Alignment, and Presidential Alignment, they are more likely than not to have a significant policy outcome. Changes can be implemented to the model and case study approach to refine it and collect better data, but with the current data, it is reasonable to state that the more significance an interest group has at each variable, the more significant the interest group's policy outcome. This research resembled the dominant interest group theories, when interest groups are seeking to protect the status quo, the status quo typically prevails because it is easier to block change than to initiate change. Also White House liaison theory and presidential leadership was at play. It was clear that presidential leadership did matter in order for an interest group to succeed if the president's reform efforts were successful. Also, in accordance with Peterson's White House liaison theory, the White House sought out relationships with key interest groups in order to support the legislation in the eyes of the public and Congress (Peterson 1992). This model was able to explain the Success Level for the majority of interest groups at play. Congressional Alignment and Presidential Alignment appeared to be the most important variables for an interest group to have a significant Success Level. This topic can certainly be explored further and expanded to see the depth of the relationships between interest groups' behavior and policy success.

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