Distribution Agreement

In presenting this thesis as a partial fulfillment of the requirements for a degree from Emory University, I hereby grant to Emory University and its agents the non-exclusive license to archive, make accessible, and display my thesis in whole or in part in all forms of media, now or hereafter known, including display on the world wide web. I understand that I may select some access restrictions as part of the online submission of this thesis. I retain all ownership rights to the copyright of the thesis. I also retain the right to use in future works (such as articles or books) all or part of this thesis.

Signature:

_______________________________ _______________
Elizabeth J. Giltinan April 12, 2010

Voting Decisions in the U.S. House of Representatives:
The Case of Health Care Reform

By

Elizabeth J. Giltinan

Adviser Dr. Randall W. Strahan

Department of Political Science

____

Dr. Randall W. Strahan
Adviser

____

Dr. Beth Reingold
Committee Member

____

Dr. C. Monica Capra
Committee Member

____

April 12, 2010

Voting Decisions in the U.S. House of Representatives:
The Case of Health Care Reform

By

Elizabeth J. Giltinan

Adviser Dr. Randall W. Strahan

An abstract of
A thesis submitted to the Faculty of Emory College of Arts and Sciences
of Emory University in partial fulfillment
of the requirements of the degree of
Bachelor of Arts with Honors

Department of Political Science

2010

Abstract

Voting Decisions in the U.S. House of Representatives:
The Case of Health Care Reform
By Elizabeth J. Giltinan

Health care reform has proven to be a controversial topic in America for the better part of the last century. This study seeks to understand how members of the U.S. House of Representatives make voting decisions when faced with a vote on health care reform legislation by examining: (1) constituency, (2) party leadership, (3) lobby/interest groups, and (4) legislator's personal policy preferences. The study builds on the work done by John Kingdon on legislators' decision making processes, and proposes that constituency and party leadership's preferences will have the greatest influence on a member's voting decision on health care reform. This study answers this question with a mixed method approach composed of logistic regression analysis and in-person interviewing of Representatives and their staff. The findings of the study support the hypothesis that constituency preference has the greatest influence on a member's voting decision, though the influence of party leadership on a member's vote is found to be questionable and in need of further research. While also requiring further research, members' personal preferences were found to be very important to members interviewed in making their voting decisions. Surprisingly, interest groups were found not to have a significant impact on members' voting decisions; instead their influence was found to occur earlier in the legislative process, during the legislation drafting process. This study suggests that in order to attain successful passage of high-salience health care reform legislation, large constituency majorities in members' districts provide the clearest signal to members as to how to cast their votes.

Voting Decisions in the U.S. House of Representatives: The Case of Health Care Reform

By

Elizabeth J. Giltinan

Adviser Dr. Randall W. Strahan

A thesis submitted to the Faculty of Emory College of Arts and Sciences
of Emory University in partial fulfillment
of the requirements of the degree of
Bachelor of Arts with Honors

Department of Political Science

2010

Acknowledgements

I would like to express my deepest gratitude to Dr. Strahan for his help, support, and guidance throughout this process. Without his weekly direction and supervision this manuscript would be half its length, supported with one source, lacking interview data, and be riddled with split infinitives!

I would like to thank my committee members, Dr. Reingold and Dr. Capra for participating in this journey with me. I have greatly enjoyed the academic and personal experiences that I have shared with Dr. Capra over my years at Emory University, and Dr. Reingold's help with interpreting the results of the logistic regression models has been invaluable.

I would also like to thank Dr. Rob O'Reilly and Emily Ritter in the Emory University Data Center for their extraordinary help and patience. It is their help to which I owe the quantitative portion of this study, as they expended countless hours helping me sort through and merge datasets in STATA.

Lastly, I would like to thank the U.S. House members and their staff representatives who agreed to interviews and provided my study with primary source data during one of the busiest legislative weeks of the 2010 spring session.

Table of Contents

Introduction....1
Literature Review....4
Research Design....24
Data Discussion....29
Linear Probability Models: Logistic Regression Analysis....34
Interviews....43
Results and Conclusions....52
Figures....58
    Figure 1: Kingdon's Framework for Explaining Voting Decisions....58
Tables....59
    1. Summary Statistics....59
    2. HR 3962 with Only Democrats Included....59
    3. Stupak Amendment with Only Democrats Included....60
    4. HR 4872 with Only Democrats Included....60
    5. HR 3962 Only Democrats Included with a Measure of District Competitiveness....61
    6. The Stupak Amendment Only Democrats Included with a Measure of District Competitiveness....62
    7. HR 4872 Only Democrats Included with a Measure of District Competitiveness....63
    8. Interview Summary Data....63
Appendix....64
    Interview Questions 1: House Member....64
    Interview Questions 2: Staff of Representatives....65
    Interest Group Coding Methodology....66
Works Cited....79
Data Sources....83

The question of health care reform looms large in the minds of Americans today, as the issue is hotly debated from small restaurants in California to Capitol Hill. Health care reform is a hot button issue for American voters and politicians alike as the effects of reform are of a personal nature for everyone. The effects of health care reform are not the same as, for example, the effects of import quotas on Brazilian sugar. American import quotas on Brazilian sugar keep the domestic price for sugar two cents above the world price for sugar. These two cents are passed onto consumers, but in the midst of a full grocery cart, few consumers notice the additional two cents. However, the effects of health care reform are much more visible and personal than slightly elevated sugar prices. Health care reform concerns consumers' personal health and the control they have over their health care decisions and payments. Add to this the fact that American health care spending has reached 16% of GDP (the average for OECD countries is 8.9%), and health care legislation has ended up squarely in the glare of national media spotlight and scrutiny (OECD 2009).

The current focus on health care finds Congress grappling with legislation that it has fought over numerous times throughout the past century. President Theodore Roosevelt initiated the reform debate in 1912, when he made national health insurance a pillar of his re-election campaign stating, "What Germany has done in the way of old age-pensions or insurance should be studied by us, and the system adapted to our uses, with whatever modifications are rendered necessary by our different ways of life and habits of thought" (Roosevelt 1912, 135). Since 1912, the debate regarding health care reform has been ongoing in the United States of America and has been used by politicians to mobilize voters. For example, Jacob Hacker credits the 1991 Senatorial victory of Harris Wofford (D-PA) to his campaign commitment to health care reform (1999, 20). Hacker also commends health care reform for playing an integral role in the

Democrats' strategy for recapturing the White House in 1992 (1999, 39). Bill Clinton campaigned on a health care reform platform which emphasized managed competition in order to tap into voter frustration with the state of the health care system. Prior to the primaries, Bill Clinton had to compete against other strong candidates, such as Senator Bob Kerrey and Senator Paul Tsongas, who also made health care reform central pillars of their campaign platforms.

Health care is currently being used in the 21st century to mobilize voters, as was observed during the 2008 election cycle when both political parties made health care reform a central part of their campaign platforms. National telephone surveys conducted by the Gallup Organization found in March 2008 that 58% of Americans were worried "a great deal" about the American health care system (Saad, 2008). A similar survey conducted by Rasmussen Reports in March 2008, ahead of the 2008 elections, found that 49% of Americans trusted Barack Obama and the Democratic Party on the topic of healthcare, whereas only 39% reported that they trusted John McCain and the Republican Party (2008). These polling results indicate that both candidates were tapping into Americans' concerns regarding health care reform, with the eventual winner, Barack Obama and the Democratic Party doing so in a more convincing manner than John McCain and the Republican Party. While health care was not the sole factor behind the Democrats' victory, a survey by the Common Wealth Fund found that 62% of respondents surveyed stated that the presidential candidate's viewpoint on health care reform would be very important in determining their vote, while another 24% responded that it would be somewhat important (Collins and Kriss 2009, 2). This evidence from the surveys highlights the importance health care played in the 2008 elections in both candidates' campaign strategy, as well as in voters' voting decisions.

Reporters, newspaper columnists, and magazine writers (to mention a few) have documented repeated attempts by American politicians to bring about comprehensive health care reform. They have mostly been *attempts,* as almost every president who has undertaken the task (with the exception of President Johnson), has been unable to bring about the large scale, legislative reform desired. With health care costs spiraling upwards for decades, and with the U.S. lagging behind other Western democracies on several leading health indicators, political scientists are left with a single question: why?[1] Why has the American democratic system, which was designed to be responsive to voters' demands, failed to express voters' preferences for comprehensive change in the health care system with legislative action? Sven Steinmo and Jon Watts document consistent public support for systemic change in health care and found in polling results dating from 1979, that 79% of Americans supported a national health care insurance plan (Gallup Organization 1979, as cited in Steinmo 1995, 361). Twenty-eight years later the desire for health care reform among the American electorate is still strong, as highlighted in a September 2007 Rasmussen Reports national telephone survey which found that 50% of Americans favored government guaranteed universal coverage health care, while 62% of voters stated that the U.S. health care and health insurance system needs major changes (2007). After examining the demise of President Carter's health care reform program in 1979, Steinmo and Watts noted, "The American political system had once again defeated itself" (1995, 361). Building upon John W. Kingdon's influential analysis of legislators' decision making processes, this study seeks to answer the question of why voter demands have largely failed to be translated into legislation by representatives in Congress (1989).

[1] For example, in 2007, life expectancy at birth in the US was 78 years of age, compared to Japan's life expectancy at birth of 82 years of age (OECD 2009).

Literature Review

John Kingdon sets out to determine how members of the House of Representatives make voting decisions. In his book Kingdon analyzes the actors generally believed to influence legislators' voting decisions in order to determine which has the greatest influence. The actors he examines are: the constituency, fellow members of Congress, party leadership and committees, interest groups, the administration, congressional staffers, the media, and members' personal political attitudes. Kingdon examines House members' voting decisions during a session of the 91st Congress (1969) while Richard Nixon was president. Kingdon interviewed legislators weekly and discussed the factors that influenced the votes they had cast that week.

Kingdon finds that the two greatest influences on legislators' votes are the legislator's own constituency and fellow members (1989, 22). He finds that unless interest groups or lobby groups are from the member's own district, these groups have limited impact on legislators' voting decisions (Kingdon 1989, 174). Surprisingly, he finds that the other actors he examines—party leadership and committees, administration, congressional staffers, and the media—have a limited impact on congressional votes (Kingdon 1989, 23). These actors have a larger impact on legislators in the majority party, especially when the executive is of the same party as the majority party in the House (Kingdon 1989, 189). Kingdon's study has been used to guide the structure of this research project, as well as to provide a general framework for explaining Congressional decision making. The findings of his study, as well as their implications for future legislator voting decisions, will be discussed in greater detail below. This study draws on Kingdon's findings, along with work done by David W. Rohde (also discussed in greater detail below) on party leadership in the House to formulate a hypothesis regarding the relative

influence of different factors in legislators' decision making processes: (1) constituency, (2) party leadership, (3) lobby/interest groups, and (4) legislator's personal policy preferences.

Following Kingdon's method, the focus of this study has been narrowed to the level of the individual legislator and, even more specifically, to the individual voting decision. The motivation behind the vote cast by each legislator is of great importance when examining this topic. In the end, it is the vote of a majority of legislators that determines the fate of a piece of legislation. For both party leadership, as well as the voting public, it is of great value to understand what lies behind a legislator's vote. In addition to Kingdon's work, macro and micro theories exist to explain why legislation ultimately succeeds or fails. Due to the complexity of the topic, both types of theory are helpful in framing the analysis of the politics of health care reform. Macro theories address the broader context while micro models focus on individual legislators' votes.

Macro theories help explain the influence of interest groups and lobbyist organizations in the health care debate. With regard to these groups the most important macro model to keep in mind is path dependency. Path dependency as a concept is explored by social scientists and economists alike to explain social and economic phenomena, as discussed by Paul Pierson (2000). Margaret Levi provides the following illustrative explanation of path dependency (1997, 28):

> Path dependence has to mean, if it is to mean anything, that once a country or region has started down a track, the costs of reversal are very high. There will be other choice points, but the entrenchments of certain institutional arrangements obstruct an easy reversal of the initial choice. Perhaps the better metaphor is a tree, rather than a path. From the same trunk, there are many different branches and smaller branches. Although it is possible to turn around or to clamber from one to the other—and essential if the chosen branch dies—the branch on which a climber begins is the one she tends to follow.

Margaret Levi's description highlights a central implication of path dependency: that as the benefits accrued to the current system increase over time, the costs of exiting the current system also rise (Pierson 2000, 252).[2] The longer the current system is left in place, the greater the investment in the status quo, and interests invested in maintaining the status quo grow in number, increasing resistance to change.

The often-cited example of path dependency and its effect on Americans' daily lives is the QWERTY keyboard (Pierson 2000, 254). The QWERTY keyboard was designed to minimize typebar clashes, which would jam typewriters. As typists adapted to the QWERTY keyboard, the amount of time invested in learning to use the keyboard outweighed the potential speed advantages offered by alternative keyboards which came about with the rise of computers. This forced the transfer of the QWERTY keyboard system from typewriters to computers, further increasing the returns to QWERTY keyboard technology. As Brian W. Arthur discusses, the QWERTY keyboard typing system possessed four qualities which have been found to increase returns and foster resistance to change: (1) large set-up, or fixed costs, (2) learning effects, (3) coordination effects, (4) adaptive expectations (1994, 112). [3] These four aspects of systems, such as the QWERTY keyboard, which require vast technological and infrastructure investments, bring about path dependency. As Margaret Levi astutely points out, while it is not impossible to switch to an alternative system, such change grows increasingly difficult the longer

[2] The costs of switching to a plausible alternative system rise the longer benefits are awarded to the current system. The current system's costs have already been invested into the system's infrastructure, making them sunk costs. With regards to health care, providers can now reap financial gains, and are unwilling to make new investments in a new health care system based on insufficient projected returns on invested capital.

[3] Large set-up or fixed costs create a high pay-off for further investments in a given technology. When set-up or fixed costs are high, individuals and organizations have a strong incentive to identify and stick with a single option. Learning effects means that knowledge gained in the operation of complex systems leads to higher returns from their continued use. Coordination effects occur when the benefits an individual receives from a particular activity increase as others adopt the same option. Adaptive expectations deal with future expectations. If options that fail to win broad acceptance will have drawbacks later on, then individuals may feel a need to "pick the right horse" from the beginning (Arthur 1994, 112).

the system remains in place and the larger the number of interests resistant to change becomes (1997, 28). In path dependency then, there are increasing returns to scale as the system evolves, which creates institutions that are self-reinforcing.[4] Fundamentally, every choice made in favor of the existing system, strengthens the existing system. Therefore, as the system grows, so do the returns to it.

The concept of path dependency as a macro explanation for macro social policies has been applied to the American health care system to explain the difficulty of reform by scholars such as Harold L. Wilensky (2009), Sven Steinmo and Jon Watts (1995). As Wilensky explains, path dependency means that the set of decisions one can make for any given circumstance may be limited by the decisions one has made in the past (2009). In the context of health care reform and this paper, “one” refers to a legislator who is seeking to vote in favor of health care reform but who faces limitations on his current choices due to previous choices made by legislators on health care reform. The constraints of past decisions remain in place, even while past circumstances are no longer relevant.

With regard to health care legislation, path dependency is an important concept to keep in mind. The important question is to *whom* are the increasing returns accruing? The groups receiving the increasing returns are likely to become accustomed to the benefits they are receiving. Due to their vested interest in the status quo, these groups have the most to lose in a new system. In the health care debate, the entrenched interests are those enabled by existing policies to reap the most benefit from it. These groups include business interests, such as health insurance and pharmaceutical companies, as well as consumers who are well served by the existing system. During legislative initiatives to enact health care reform, these groups have been

[4] Increasing returns to scale refer to an economic property where the per-unit production cost of a product decreases as the scale of production is increased (O’Sullivan and Sheffrin 2003, 157).

observed to push back against attempts to alter the status quo. They have done so in keeping with the theory of path dependency, using all means available to them to exert pressure on legislators. Steinmo and Watts provide an example drawn from the Carter Administration's attempt at health care reform through hospital cost control legislation. They note that John Iglehart found at the time that instead of launching a public education campaign against "socialized medicine" the medical lobby used a strategy of focusing on the individual legislators as "…virtually every Member of Congress has a hospital in his or her district and these institutions effectively apply pressure on the legislators" (Iglehart as cited by Steinmo and Watts 1995, 359). This resistance by vested interests, to protect returns from the system accruing to them, is illustrative of the way in which the macro path dependency model fits with the micro, individual model. Depending on the strength of the interest group lobby vis-a-vis the individual legislator, a vote may be influenced.

Steinmo and Watts note the success of interest groups in swaying legislative votes on the Carter Administration's health care reform proposal. As interest groups' opposition to the reform package grew, support for the legislation in Congress declined. In fact congressional support declined to the point that Carter was never able to secure the necessary votes to move his legislation out of committee (Steinmo and Watts 1995, 360). Ultimately Carter's reform initiative failed in 1977, with industry leaders pledging to House members that they would cut hospital spending by two percentage points over the following two years (Aaron 2009). Members of the House believed the industry and killed the issue by calling for a national commission to study "the problem of rising costs" (Aaron 2009).

Jacob Hacker notes a similar progression of mounting opposition to health care reform during President Clinton's legislative initiative, the Health Security Act of 1993 (1997). Hacker

traces the growing opposition to the Health Security Act of 1993 through an examination of public statements, media coverage, and polling data (1997, 146). He finds that immediately after President Clinton's September 22, 1993 speech to Congress about the proposed reform plan, that roughly 60% of the American public supported health care reform. Following this enthusiastic response, however, Clinton made the critical error of neglecting to explain fully his reform proposal to the American public and medical organizations. This lack of communication from the White House provided an opening for opposition groups to protest the proposed reform plan. As the months went by, attacks on health care reform were launched by an increasingly large number of groups, all of which sought to capitalize on growing public unease with a largely unexplained, comprehensive overhaul of the American health care system. "The opponents of the proposal smelled blood in the continuing public ambivalence, and they stepped up their attacks on the proposal" (Hacker 1997, 148). The Health Insurance Association of America (HIAA) launched the infamous Harry and Louise ad campaign while the American Medical Association (AMA) came out in opposition to the proposed reform.[5] As the White House remained out of touch, opposition groups gained traction with the American public and Congress. Dana Priest, from The Washington Post, found a 20% drop in public support for President Clinton's health care reform proposal between September of 1993 and January 1994 (Priest as cited by Hacker 1999, 145). In Congress, Republican and conservative Democratic members began attacking the legislation for its lack of substantive details, which were exposed by prominent interest groups (Hacker 1999, 147). Growing discontent with Clinton's health care reform plan from organizations and the American public emboldened Congressional members to denounce the

---

[5] Harry and Louise was a $14 to $20 million year-long television advertising campaign made up of fourteen television ads and radio and print advertisements. They depict a fictional suburban, middle-class, white, married couple, despairing over aspects of health care reform and urging viewers to contact their representatives in Congress to protest reform measures (Hacker 1997, 145).

legislation and ultimately prevented it from reaching the floor of the House of Representatives to be voted on (Hacker 1997).

This acquiescence to lobby groups runs counter to John Kingdon's findings, which show that interest groups usually have very little impact upon a member's decision making process. However Kingdon also notes that a special case exists where interest groups can influence a legislator's voting decision. This special case occurs when an interest group has a direct connection with a legislator's constituency, such as a coalition of tobacco farmers from North Carolina, and when the issue at hand is of high-salience (1989, 174).[6] Such high-salience for legislative issues is often marked by increased activity and lobbying by interest groups. Kingdon's finding is very important for this study, as these two issue characteristics are present in the consideration of health care reform. These conditions have been witnessed during President Obama's health care initiative as national interest groups with state chapters, such as the American Medical Association (AMA), have been intensely active in Washington, D.C. The Center for Responsive Politics reports that in 2009 the AMA alone spent $20,830,000 for lobby related activities in Washington D.C., while the health industry as a whole spent $543,992,861 (Levinthal 2010). Such large amounts of lobbying dollars are generally surmised to have been

[6] The salience of a piece of legislation refers to its relative level of importance, in comparison with other types of legislation voted on by legislators, and as measured by the amount of attention that is aroused inside and outside of Congress. For Kingdon's House members, a salience level is determined by the involvement of elites in an issue. Low salience legislation is characterized by mass public involvement only, which provides a vague perception to legislators about constituency preferences. Kingdon finds that if an issue is of low salience, and if the intensity level is low for the mass public within a members' constituency, then legislators can choose to ignore mass public preferences without harmful electoral repercussions. Medium-salience issues are marked by district elite involvement to the exclusion of the mass public. District elite are often experts in their fields, and are highly visible in the constituency, causing legislators to take their position into account. High-salience issues find both the mass public and elites involved, more than other issues do. The involvement of elites serves to move an issue into the categories of higher salience in the minds of participants. Kingdon finds the most salient issues to also be those which have the greatest constituent intensity. He also finds that interest groups often do not bother becoming involved in an issue unless it is a salient issue with high constituent intensity (Kingdon 1989, 43).

spent in order to influence health care reform legislation (Center for Responsive Politics, 2010).[7] In such cases marked by intense activity, Kingdon finds an interest group's influence on a voting decision increases significantly. It increases from 6% of House members interviewed by Kingdon reporting that interest groups were a major factor on issues of low-salience to constituents, to 47% reporting that interest groups were a major factor on issues of high-salience to constituents (1989, 147 Table 8-1). These findings show that the influence of interest groups into decision making by legislators is variable depending on the salience of the vote under decision, as well as a group's constituency connection. This finding is in agreement with the findings of Steinmo and Watts, who in their analyses of the Carter Administration's health care proposal found interest groups effectively able to mobilize and establish constituency connections with legislators voting on health care reform (1995). In the Carter example, and in others, the impact of lobby groups has been seen to be effective, suggesting that health care legislation represents a high-salience issue, one that is marked by involvement by both the mass public and elites. This observed impact of interest groups in influencing health care legislation justifies their inclusion as a factor of decision making on health care reform votes in this study.

As Kingdon's study indicates, interest groups are not the sole factor in legislators' decision making processes. Party leadership is also included in this study as an influence on decision making on health care reform. Kingdon initially finds party leadership to have limited influence on legislators in their voting decisions. This is curious in light of the active role party leadership has taken in President Obama's health care reform initiative, likely reflecting changes in the power of party leadership in the House, as discussed by David W. Rohde (1991), which will be discussed below. Such active input from party leadership is the reason for the inclusion of

[7] It is unclear whether the lobby dollars were spent with the intention of supporting the health care reform legislation, or of obstructing the health care reform legislation. This amount represents a 12% increase in total lobbying dollars spent by the health care industry in 2009, from 2008.

party leadership in this study as a factor in legislators' health care voting decisions. As with interest groups, Kingdon finds there to be conditions under which party leadership has greater influence on legislators' decision making, where party leadership chooses to exert its influence and its resources (1989, 124). Kingdon finds that these conditions arise when legislation is on the floor which is crucial for a party's identity, such as legislation addressing a central tenet of a party's platform (1989, 124). Further, Kingdon and David W. Rohde find that legislators of the same party as the Executive are more likely to take the Executive and party leadership's desires into account when making voting decisions (Kingdon 1989, 190; Rhode 1991, 139). Kingdon states, "Congressmen, particularly Republicans, often told me that the administration's wishes did have a substantial impact on their thinking…" (Kingdon 1989, 190). Party leadership has played a significant role in President Obama's health care reform initiative; Speaker of the House, Nancy Pelosi, has been a prominent architect of the health care proposal. Her prominence is observed by the numerous news reports and articles, in such publications as the *Wall Street Journal* and *The New York Times*, which discuss the central role occupied by Pelosi in crafting health care reform legislation. This active role taken by party leadership justifies its inclusion as a factor of legislators' decision making processes on health care reform votes in this study.

The influence party leadership is able to exert has grown over past decades. Institutionalists, such as Steinmo and Watts, discuss this growth in the ability of party leaders to exert pressure on legislators, and suggest that it resulted primarily from the Congressional restructuring initiatives of the 1970's (Steinmo and Watts 1995, 358). David W. Rohde discusses the 1970's restructuring initiatives and also examines their impact on congressional voting and partisanship. He notes that the percent of party votes declined from the late 1950's until the 1980's, where a sharp resurgence of party votes can be observed (Rohde 1991, 15 Table 1.1)

Rohde credits this slump in party voting from the 1950's until the 1980's to the presence of a strong committee system that was based on seniority, instead of on party loyalty. Adding to the weakness of party loyalty was a predisposition on the part of conservative Southern Democrats to often vote with their Republican counterparts. The combination of these two conservative groups provided them with majority power in the House, while the liberal wing of the Democratic Party effectively made up the minority power, despite that the Democrats held the majority in the House during this period and the Republicans held the minority. Conservative members from both parties acquired power in the House through the seniority system, with chairman positions on powerful committees such as the Ways and Means Committee being automatically awarded to powerful, senior House members. As Rohde discusses, this practice meant that congressional power was centered in the chairman of these powerful committees, and due to the structure of House rules, there was little that could be done by party leaders to confront the chairmen should a vote not be in a party's best interest (1991, 19).

The committee seniority system worked for several years but eventually broke down as the electoral map changed, and large classes of liberal freshmen Democrats were voted into office during the 1950's and 1960's (Rohde 1991, 162). While many historical trends affected the electoral map to favor liberal Democrats over conservative Democrats, one of the largest factors driving this shift was the civil rights movement. The civil rights movement increased the voting power of enfranchised African-Americans, whose presence was especially felt in the South, where they helped enable electoral victories for liberal Southern Democrats over their conservative Democrat counterparts. Conservative Democrats shifted away from the Democratic party and were absorbed by the Republican party. The influx of liberal freshmen Democrats brought conflict to the House's power system which was based on seniority and the committee

system. Liberal freshmen became frustrated as conservative chairmen worked together to block legislative initiatives of new members. As the number of liberal Democrats in the House grew, they eventually had the power to bring about restructuring initiatives, which as Rohde discusses, were based on three objectives: (1) limitations on the powers of committee chairmen, (2) strengthening the Democratic Party and its leadership, and (3) enhancing the collective control of power in the House (1991).[8] These initiatives provided the leverage for party leaders to slowly exert their control over House members of their party—primarily through rewards for party loyalty such as the awarding of prestigious committee positions—as well as over House legislation. As Rohde discusses, aggressive leadership on the part of Speakers of the House, such as Speaker Jim Wright, further strengthened the party leadership and weakened the House committees. As party leadership strengthened, so did party loyalty and party line voting, which was accompanied by increased partisanship in the House (Rohde 1991, 169).

The structural changes made in the House of Representatives during the 1970's have had implications for passage of large, contentious legislative packages such as health care reform. The successful passage of Medicare and Medicaid by President Lyndon Johnson took place in 1965, a time-period identified by Rohde as being marked by low party loyalty (1991). Instead, the locus of control in the House was the committees and specifically the three committees with the greatest sway over House legislative matters: the Committee on Ways and Means, the Rules Committee, and the Appropriations Committee. During Johnson's Administration, the

[8] Through the restructuring reforms, the powers of the committee chairmen were largely reduced by increasing their accountability to House members. This was achieved through increasing transparency in committee voting, as well as by forcing a vote on the chairman at the opening of each Congress. Prior to the restructuring, a vote on the chairman was possible solely in the event that 10 members so requested it. The Democratic Party and its party leadership was strengthened by such innovations as the creation of the House Democratic and Steering Committee whose responsibility it is to oversee and steer Democratic legislation through the House, and whose membership includes elected party leaders. To prevent a minority from frustrating the wishes of the majority, the final restructuring initiatives sought collective control of power for House members by allowing for votes on positions of power, such as requiring Caucus ratification of Rules Committee nominations made by the Speaker of the House (Rohde 1991, Ch.2).

Committee on Ways and Means was extremely powerful, and by extension so was its chairman, Wilbur Mills. Due to this system, to pass Medicare and Medicaid President Johnson had to work with Chairman Wilbur Mills as health care legislation fell under the jurisdiction of the Ways and Means Committee; he could not work though the party leadership as it was too weak. The task of convincing Wilbur Mills to cooperate on health care legislation was a challenge, highlighted by the difficulties with which Johnson's predecessor, John F. Kennedy, was faced (Hacker 1999, 79). Jacob Hacker notes President Kennedy's inability to persuade Wilbur Mills and the House Ways and Means Committee to report his health care reform bill (1999, 79). In the face of committee resistance, there was little President Kennedy could do to further health care reform during his term. Health care reform was forced to wait for President Johnson's electoral mandate to fix the health care system. Only then did House congressional committees and Wilbur Mills feel enough public pressure to work with the president and party leadership on Medicare/Medicaid.

Due to the power structure of the House during Johnson's passage of Medicare and Medicaid in 1965, President Johnson was forced to work through the committee system. The restructuring of the House in the 1970's, and the subsequent shift of House power away from committees to party leadership, has changed the strategies that must be employed to move legislation through the House. The shift of power to party leadership, and the ensuing party line voting and increased House partisanship, means that an Executive, or a House member, seeking to launch a large scale legislative initiative must find a way to get party leadership on board. They must also be able to convince a majority of House members to vote in favor of their legislation, favoring the passage of legislation from the House's majority party. Henry Waxman (D-CA) stated, "If we have a united Democratic position, Republicans are irrelevant" (Waxman

as cited by Rohde 1991, 128). As Rohde notes, command of the majority of votes has become imperative for the passage of different types of contentious legislation, for which salience is high, such as welfare reform and Catastrophic Health Insurance, which was passed by the 100th Congress in 1988 (1991, 175).

The power center in the House has shifted from the time of President Johnson to the time of later presidents who have tried to bring health care reform to reality. This progression is best observed by noting the position of the legislator whose responsibility it is to move health care legislation through Congress. In Johnson's era, this person was Wilbur Mills, the chairperson of the House Ways and Means Committee (Hacker 1999, 79). For President Obama this person is Nancy Pelosi, the Speaker of the House of Representatives. As demonstrated, over the last century, the locus of control has shifted from the congressional committees to the political parties. Through their position of institutional power within Congress, party leaders (such as Nancy Pelosi) can now effectively exert pressure on legislators to vote in favor of legislation pertaining to the party agenda. The demands of party loyalty can be seen in the total adherence to the party line which has developed in Congress. For example, in the November 2009 vote to pass H.R. 3962-Affordable Health care for America Act in the House of Representatives, only one Republican voted in favor of the legislation, while the remaining 176 House Republicans voted against it, exhibiting strong party loyalty (New York Times, 2009).

While today party leadership clearly is an important factor to study in order to understand legislators' decision making processes, Kingdon finds that the legislators' constituency wields the greatest power over the voting decision (1989, 30). He finds that if a legislator perceives a constituency position on any issue, then the probability that the legislator will vote with the constituency is 0.76 (1989, 30). This probability increases to 0.86 for high-salience legislation,

such as health care reform, where mass public and elites in a district become vocal in announcing their preferences (1989, 44 Table 2-3). Kingdon's findings point to the importance of including constituency position as a factor in decision making when studying high-salience health care reform legislation. These findings also support the assignment of a greater influence to constituency as a decision making factor, when compared to the other factors under consideration in this study.

The importance of constituency in legislators' decision making is largely due to the electoral connection. While it has been found that incumbents usually win re-election, their fate still resides in their constituency's approval of what they do in office, as discussed by Kingdon and David R. Mayhew (1989; 2004). Kingdon hypothesizes that incumbents often win re-election because they actively seek to conform to constituency desires (1989, 31). David R. Mayhew discusses the structure of American government which forces House members to be more responsive to constituents than they are to party leadership demands (2004, 26). He explains that unlike British Members of Parliament who rely on their party for nomination for office, American House members must initially rely on their own resources and base mobilization in order to win nomination for office (Mayhew 2004, 26). Effectively, for American House members, the loyalty to constituency is re-enforced by the process through which office is achieved and maintained, through the constituency and not the party. A House member confirms these findings of Mayhew in discussions with Charles L. Clapp, "If we depended on the party organization to get elected, none of us would be here" (Clapp 1964, 351). Responsiveness to constituency bears on the minds of members constantly, "Whether they are safe or marginal, cautious or audacious, congressmen must constantly engage in activities related to election" (Mayhew 2004, 49). As Mayhew further explains members engage in election maximizing

activities such as personal advertising, credit claiming, and position taking (2004).[9] These activities shape the public image and reputation of members among their constituents. To have a reputation among constituents is an enormous advantage for incumbents in re-election races as they have a pre-established "brand" among constituents. Mayhew further states that the benefit name recognition with voters can bring to incumbents in November elections is a vital advantage (2004, 50). To maintain name recognition he notes the use of constituency newsletters, in-district meetings with constituents, local new opinion columns, and radio talk shows (2004, 51).

As members must rely on their own resources to attain political office, they are at the mercy of their constituents should they not adequately represent their home districts in the federal government. Due to this personal career risk, legislators must be responsive to the demands of their constituents if they wish to remain in office and continue carrying out constituent work in Congress. Because of their electoral power, constituent demands can significantly impact votes cast by legislators. Mayhew acknowledges that the value of incumbency in elections has risen; yet some House incumbents do lose their seats, illustrating the power possessed by constituency to punish members who do not adequately represent their district (2004, 36).

The influence of constituency desires over legislators' voting decision is noted by Kingdon upon review of his interview data. In his interviews, Kingdon finds that legislators are very aware of constituency positions on legislation in the House (1989, 30). The stronger a legislator's constituency feels about a legislative issue, the greater an impact the constituency has upon the decision making process. Kingdon notes the strength of the constituency position by

[9] Advertising has to do with any effort to disseminate one's name among constituents in such a fashion as to create a favorable image in a message having little or no issue content. It is about creating a "brand" for oneself. Credit claiming involves taking credit for small projects whose results a member can legitimately claim credit for bringing back to constituents. Position taking on issues by members can be used to tailor oneself to one's constituency, and can take numerous forms, from a written statement, to a news conference, to a recorded roll-call (Mayhew 2004).

tracking when the topic of constituency was brought up in interviews, especially spontaneous (unprompted) mentions of constituency, when legislators were discussing voting decisions. He found that slightly more than one third of the time, legislators voluntarily bring up the topic of justifying voting decisions to constituents (Kingdon 1989, 49). These findings illustrate how acutely aware legislators are of their constituents' policy preferences.

For example, a liberal Congressman explains his reasoning for never voting to abolish the Internal Security Committee to Kingdon:

> The right-wingers in the district are active as it is. I don't want to give them anything more. I vote against HUAC, and they'll raise a helluva hooraw about it. They'd write letters to the editor, and every time I'd go back there, I'll be explaining my position. It just isn't worth the fuss. I guess about 50 percent of the House really believes in the Committee. The rest of us know we won't win a fight, and if you won't win it, why create this problem? It just isn't worth the trouble (Kingdon 1989, 48).

Statements such as this are found repeatedly throughout Kingdon's interviews. These findings point towards the potential for conflict among constituency desires and the factors affecting decision making under examination in this study.

Legislators do not vote with the constituency position all of the time, leaving room for other actors to influence legislators' voting decisions. Kingdon finds that varying levels of constituency intensity and legislation saliency can bring factors of decision making into conflict with one another. He creates a tree of decision making steps that he finds legislators move through when making voting decisions (1989, 244). This tree is replicated in Figure 1.

[Figure 1 About Here]

Kingdon's decision tree shows that on non-controversial votes, votes where conflict in a legislator's environment is absent, legislators will vote with their environment (Kingdon 1989, 224). Controversial votes marked by conflict in a legislator's environment find legislators

checking the preferences of the different actors who have a stake in the legislation under review. Supporting the greater influence for constituency, the constituency is the first factor legislators turn to (Step C) when making a decision on controversial legislation. Legislators move from this point through different questions and choice scenarios, as Kingdon outlines in Figure 1 (1989, 244). They check each of the possible decision combinations of a branch before they either make a decision and cast a vote, or move onto the next decision branch. This tree shows that for highly controversial, highly-salient legislation, such as health care reform, legislators take all active factors into account before making a voting decision.

Guiding legislators through the voting decision tree are legislators' own personal preferences regarding the issues at hand, as well as their personal goals. Kingdon finds three main goals which help guide legislators through their voting decision: (1) satisfying constituents, (2) intra-Washington influence, and (3) good public policy (1989, 246). The goal of satisfying constituency is always considered first for legislators due to the importance of re-election and the control constituents possess with regards to re-election (1989, 248). In order for a goal to be invoked and relevant to the decision being made, as is illustrated in Figure 1, it must pass a critical threshold of importance. Kingdon finds legislators are seekers of consensus, which means that they seek spaces of low to no conflict when making voting decisions (1989, 247). If a single goal is most important, or all three goals are important simultaneously, a legislator will have a relatively easy time making a decision when all the goals promote the same position on an issue. As Kingdon shows in his decision tree, if conflict is absent among other actors or goals on a voting issue, meaning there is not a perceived position on the topic, then legislators will vote according to their personal opinion.

The presence of conflict among goals and actors brings legislators themselves into the fray, and forces them to grapple with the issue. Legislators are forced to examine other actors' positions in order to determine if they should vote against their personal beliefs. Luckily for legislators, such a problem is often mitigated by the recruitment process. The recruitment process usually ensures that legislators are similar to their constituencies and thus most often view voting decisions the same way as their constituencies. Kingdon finds that, "Approximately three quarters of the time… there was no conflict between the constituency position and the legislator's own attitude, at least in the Congressman's mind" (Kingdon 1989, 46). This confluence of constituency and legislator voting preferences helps minimize the number of votes on which legislators feel pressured to vote against their personal values. It does leave room however for a quarter of the time in which the legislator and the constituency are in disagreement. An interesting question would be how legislators choose to vote in such a circumstance.

To answer this question, Kingdon notes that many cases of disagreement were on issues of low constituent intensity (Kingdon 1989, 46). This means that the cases where there was a disparity between the legislator's own opinion and the demands of constituents were cases of low importance to the constituency. This low importance to constituents allows legislators to vote based on their own preferences without much fear of electoral punishment (except in string vote situations).[10] This finding provides support for the hypothesis that constituents are more attentive to high profile legislative undertakings, such as health care reform, than they are to legislation of

[10]A string vote refers to the flexibility members have to vote out of sync with the desires of their constituency. Due to generally lax oversight of House members by constituents, a member has the flexibility to periodically vote out of sync with his constituency without facing electoral repercussions. However, a member who consistently votes out of synch with the desires of his constituency, on a "string" of votes, can face a string vote situation. The cumulative effect of a string of unfavorable votes to constituents holds the potential for punishment at the polls during the next election.

low importance. Furthermore, it justifies the inclusion of variables for constituent demands and the legislators' opinion as important elements of a legislator's vote on health care. Kingdon's findings show that legislators do pay attention to constituents when making their voting decisions. They also suggest that voters do a good job of selecting representatives who will represent the district in Congress. The ability of a legislator to differ from his or her constituency should not be overlooked, as there are times when legislators' personal preferences are in disharmony with the constituency. This is an important implication of Kingdon's findings, as it affirms the existence of other potentially influential factors when legislators are deciding how to cast their votes.

The question of how to bring all these factors together to convince a legislator to vote a certain way on an issue is an essential one for the American public and for party leadership in Congress. Previous research has shown that the four factors under study in this project (constituency, party leadership, interest groups, and members' personal voting preferences) are scrutinized by legislators when making voting decisions, and thus all may play a role in the decision making process. It is highly probable however that all four of these factors do not have to be in agreement for a legislator to vote one way or another. Due to the nature of a vote, there are only two alternatives for a specific issue. This means that there are likely to be actors on either side of the fence, if they are not unified in their positions on a vote. The likelihood that legislators will vote in accordance with other actors' positions increases as the number of actors in agreement rises. As Kingdon finds, legislators favor consensus and seek it whenever possible. This leaves them likely to vote in the way which builds the most consensus and good will between themselves and other actors (1989, 259).

Kingdon's work suggests that legislators are not merely puppets of their constituents, nor are they puppets of their party's leadership. They are independent actors, in keeping with the findings of Mayhew (2004). As Kingdon's findings illustrate, legislators examine the environment for conflict, and depending of the results of their assessment proceed to make voting decisions. The high-salience nature of health care reform legislation, instead of low-salience legislation, allows actors to influence legislators' decision making who might otherwise not have much impact. This influence is largely owed to these actors having a greater stake in health care reform than they do in less salient legislation, such as measures to recognize college basketball teams for superior sportsmanship. Each component aspect, party leadership, lobby groups/interest groups, constituents, and the politician's personal preference all have a role in the outcome of the debate. The outcome of health care reform will have a lasting effect for years to come. The quality of life for millions of people, and the trillions of dollars at stake, make the examination of legislators' decision making processes on health care votes an important one, even though these types of votes may be rare. The findings of this study will illuminate the decision process legislators go through when working with highly-salient legislation and legislative reform packages. The enormous potential for change represented by this legislation makes understanding the way legislators decide their votes to be extremely important for understanding America's legislative processes.

Research Design

For this research project, I will focus on the level of the individual legislator. The broad question I am seeking to answer is what lies behind a legislator's vote; in particular, what causes an affirmative vote in favor of large scale legislative reform of the health care system? To make this study manageable I have narrowed it to the level of the individual legislator. I seek to understand if and how the factors I have identified above can explain a vote cast by a legislator. In order to address this question I plan to focus my study on the four variables I have identified above: (1) party leadership demands, (2) constituent demands, (3) the legislator's personal opinion, and (4) lobby/interest group demands.

Hypothesis: Due to the high visibility, highly salient nature of healthcare reform legislation, legislators move through a decision process which takes into account the influence of four critical actors: (1) constituency, (2) party leadership, (3) lobby/interest groups, and (4) legislator's personal policy preferences. The demands of constituency have the greatest impact upon legislators' decision processes due to constituents' control over the recruitment process which elects legislators to political office. The demands of party leadership follow constituency in importance in legislators' decision making processes; legislators of the majority party in Congress are most greatly impacted by party leadership. The remaining actors—lobby/interest groups and legislator's personal policy preferences—affect legislators' decision making processes approximately equally.

In keeping with John Kingdon's findings, I expect legislators' constituencies to have the strongest influence on their health care votes when compared to the influence exerted by the other actors mentioned above. Work done by Donald Stokes, and quoted by David Mayhew, supports the connection between legislator and constituency through Stokes' variance-component model (2004, 34). This model examines the origin of variance in election return results by national, state, and local components. Stokes' model, re-examined by Laura Vertz, John Frendreis, and James Gibson in 1987, finds that approximately 50% of variance in election returns for House members is made-up of a local component (1987, 961). This finding indicates

that House members can reasonably expect to affect approximately 50% of their election returns through their ability, or inability, to please their constituents. The expectation that constituency will have the greatest influence on legislators' voting decisions is supported by the results found by Kingdon, Mayhew, and Stokes.

To keep episodes comparable this study focuses on a single period of health care reform, the most recent one of 2009–2010 under President Barack Obama during the 111th Congress. In this period of reform, there were three House votes which will be studied: (1) The Stupak Amendment, (2) HR 3962, and (3) HR 4872. The Stupak Amendment is also known as the Abortion Funding Amendment, as it was introduced to limit federal funding in the broader health care reform bill for abortions. HR 3962 is the bill number for the Affordable Health Care for America Act, which was voted on and passed by the House on November 7, 2009. HR 4872 is the bill number for The Patient Protection and Affordable Care Act, which is the reconciliation bill, voted on in the House and passed March 21, 2010 to complete health care reform. These three votes will be treated as separate observations in the quantitative model of this study. This approach will keep the votes comparable and increase the validity of this study. The House of Representatives is being selected for examination in the study due to greater variance exhibited in health care reform votes in the House. In the Senate, health care reform votes were observed to be straight party-line votes, which leaves little variance to explain. Also, limiting this study to the House increases the manageability of the study. The amount of data required for qualitative and quantitative analysis is reduced because the number of members and votes is reduced by examining only the House rather than both the House and the Senate.

Focusing on these three votes, taken during the same Congress, will allow comparability across legislators as the voting members remained mostly unchanged between each voting

episode. These data will also allow for the isolation of the popularity of President Obama and his administration, which could affect the reform's success in the House. The study will be composed of quantitative and qualitative components. The quantitative component will consist of a logistical regression using data gathered on the factors stated in the hypothesis and discussed in the literature review. The logistical model will enable an analysis of the impact the different factors have on the probability of a legislator voting yea or nay on a health care reform bill.

In this study, the members under quantitative examination are limited to the Democratic Party. This limitation, while not optimal, nonetheless makes the most sense due to the uniformity in voting across the Republican Party. Unfortunately variation does not exist in the votes cast by House members of the Republican Party. This lack of variation makes it impossible to obtain defensible estimates about the influence of different factors on Republican members' voting decisions. While results can be obtained, they are misleading because with a quantitative approach, it is not possible to understand what influenced Republican members to all vote the same way, nay on HR 3962 and HR 4872 and yea on the Stupak Amendment. They may have all had different factors leading them to their voting decisions, but without variability it is not possible to understand which factors caused this pattern. Unfortunately this problem cannot be solved with a dichotomous party variable due to the essentially perfect uniformity in Republican members' voting, which causes a party variable to be perfectly correlated with votes under study in this paper.[11]

The qualitative component of the study consists of interview data acquired through in-person interviews with House members and their staff in Washington D.C., in March 2010. Interview questions were modeled after questions used by John Kingdon in his study and are

[11] Perfect correlation causes the party variable to be omitted from the logistical regression, even when it is attempted to be included. There was one Republican member who voted yea on HR 3962, Anh Cao (R-LA). There was perfect voting uniformity observed on HR 4872 and the Stupak Amendment.

included in the Appendix. Slightly different questions were asked of staff and members themselves, as staff often knew more regarding the substance of health care legislation, while members knew more regarding their personal decision making processes. Seven interviews were conducted: five with staff and two with members. Participants were promised anonymity and throughout this paper interviewees are not identified by name, but rather by number (seen in Table 8 below). Members were initially selected in keeping with those which made interesting cases in relation to my hypothesis, though once in Washington D.C., adjustments had to be made due to limited availability of members and staff for interviews. Interesting cases are those in which members appeared to vote out of sync with their constituencies' preferences, or represent a highly competitive district.[12] A larger, systematic sample of respondents would be desirable, but this was not possible due to time constraints.

For a measure of constituent demands, district level data on the 2008 presidential vote by party is used. Using these data I will be able to obtain a rough measure of constituent preferences with regard to health care reform. A district with a high percentage Democratic presidential vote is likely in favor of health care reform legislation, while a strong Republican district is unlikely to favor health care reform legislation. The strength of interest groups and lobby groups will be determined by examining campaign contributions, specifically political action committee contributions. The measure of interest group influence will be discussed in greater detail below in the Data and Quantitative Analysis sections.

Obtaining primary data on the politician's policy personal preference is not possible. The best available measure is a NOMINATE score, created by Keith Poole and Howard Rosenthal. These scores place legislators on an ideological spectrum, in comparison to the other legislators

[12] Highly competitive districts in the 2008 presidential elections had margins of 3-5% separating John McCain and Barack Obama.

also serving in Congress. From these scores I will be able to gain a rough measurement for the personal preference of a legislator with regard to health care reform. Accordingly, I should be able to accurately predict a legislator's health care vote, if he is voting in accordance with his personal preference. A more detailed discussion of NOMINATE scores can be found below.

Party leadership influence on members will be explored through the qualitative component of the study. It is difficult to find a measure that quantitatively captures the effect of party leadership's attempt to influence individual legislator's voting decisions on separate votes. The observable evidence would likely be constant across all legislators, as they would all be hearing the same public statements and appeals for support. The unobservable, back room type influence of party leadership cannot be reliably measured and is dependent on revelation by members or their staffs. Due to these difficulties in quantitatively measuring party leadership, a variable for party leadership is not included in the quantitative part of this study, and the influence of party leadership is assumed to be constant across the Democratic House members.

Data Discussion

The quantitative model in this study examines the effects of the constituency, members' preferences, and interest group influence in predicting a member's vote on health care reform. The model is a logistical regression limited to members in the Democrat Party. Logistical regression was selected in keeping with the dependent variable being members' yea or nay votes on the Stupak Amendment, the Affordable Health care Act of America (HR 3962), and the Patient Protection and Affordable Care Act (HR 4872). The data on members' votes on these two bills were obtained through the CQ Press Congress Collection of Key Votes. The votes have been re-coded from yea/nay in original data format, to 0=Nay and 1=Yea, in order to allow for the calculation of coefficients in logistical regression. Summary statistics can be found in Table 1.

[Table 1 About Here]

The preferences of members' constituencies on health care are measured using voting data from the 2008 presidential election by House district. As the victor of the 2008 presidential election, the vote share won in the district by Obama (*obama*) is used for this variable. This variable is continuous in structure and has values ranging from 23% to 95%. These data were acquired through a compilation of state-compiled elections returns. The presidential vote per Congressional district has been chosen instead of the House vote per Congressional district in order to increase data manageability, as district voting results for House members would have to be compiled state by state, while presidential district voting information has already been compiled by other researchers. The district results for presidential candidates are also a more accurate measure of the underlying partisanship, or ideology, of the district because it is not affected by effects of incumbency or personal support for the House candidate. The presidential

vote signals the preference of the member's constituency on health care through party line assumptions, instead of correlating with the vote cast. The presidential district voting data is used as a proxy to determine a constituency's preference on health care by assuming that a majority Democratic district (majority vote share held by Barack Obama) supports health care reform. These assumptions are drawn from the current partisan state of the House and the electorate, as discussed by David W. Rohde and Alan Abramowitz (1991; 2009).

Interest group influence on a member's vote is measured using campaign finance data from the Center for Responsive Politics (www.opensecrets.com). Campaign finance data are used instead of lobbying expenditures due to difficulties in measuring lobbying dollars, as well as in tracking the intention of lobby dollars. A company with hired lobbyists may simultaneously be lobbying for multiple causes, making it difficult to determine the intended influence of a lobbying dollar. Complicating the use of lobbying dollars is the inability to obtain data that break the health care industry lobby down into sub-categories, such as hospitals or ambulatory services. I have confirmed through interview data that the health care industry did not have a united position regarding health care reform during the period under study. Instead, support or opposition was specific to different sectors in the health care industry.

Campaign finance data for the 2008 election cycle are used as this was the election year for the 111th Congress, which is composed of the Representatives who voted on HR 3962, the Stupak Amendment, and HR 4872. The data for Political Action Committees (PACs) are the data examined, which allows for specific donors in the health care industry to be extracted from the data and used for analysis. I decided that PAC donations to member election campaigns in 2008 from industries outside of health care would not be included in the analysis due to a problem of validity. It is difficult to determine conclusively whether donors outside of health care industries

were seeking influence on health care reform or whether they were seeking influence on issues more pertinent to their specific industry. This determination of the type of legislation which donors seek to influence is important in this study, as interest groups are included due to their influence on a member's decision making process on health care reform votes.

The PAC campaign donation data for the 2008 election cycle for health care industries was extracted from the data set and used for the analysis. The different sectors of the health care industry included in the data were then coded as either pro-reform or anti-reform. This coding signals the type of influence groups were seeking on a member's vote. This coding was done by examining public statements of each donor group, either statements on their websites or statements in letters addressed to Speaker of the House, Nancy Pelosi, shortly before the health care votes on November 7, 2009. The statements used for this coding are included in the Appendix. The five largest donors in each health care sector were examined, and the majority position determined based on how the sector was coded. The donations from pro-reform groups and anti-reform groups were totaled separately, and then a percentage measure was created by placing the pro- and anti-reform donations over the total PAC campaign donations given to each candidate's campaign during the 2008 election cycle. From this an informative fractional measure was calculated that captures the influence, or lack of influence, health related interest groups sought over members' votes. The fraction of anti-reform donations from interest groups (*fracA*) is used in this study as the measure of the effect of anti-reform donations on influencing a member to vote against health care reform.

The members' own views also play a role in the voting decisions they reach. Members are ultimately individuals whose personal experiences and environment shapes the way they perceive the world around them. Interviews with both members and their staff confirm the role

the individual member's personal preferences, or personal philosophy, plays in the decision making process. A House member of the 111th Congress illuminated this reality when discussing the decision process by stating, ". . . of course there is also one's personal philosophy that comes into play when making a decision." A staff member for a different House member echoed these sentiments when describing his boss as being personally concerned about the contents of HR 3962 and whether it accomplished what it was intended to accomplish as far as lowering costs, increasing access, and "fixing the system." While Kingdon found members' personal preferences to be an important component of the decision making process, quantitatively determining a member's personal preference on a bill, as well as the strength of that preference is difficult. To solve this problem, DW-NOMINATE Scores created by Keith Poole and Howard Rosenthal are used to approximate members' preferences on HR 3962, the Stupak Amendment, and HR 4872. Specifically the 1st dimension measurement (*dwnom1*) is used, as it measures members' liberal or conservative preferences (Poole and Rosenthal 2007). The 2nd dimension is not included in this study as it has been interpreted mostly as a measure of a member's civil rights position and has been found to be of little relevance in the current political environment (McCarty, Poole and Rosenthal 1997).

These personal preference measures are calculated using member voting records as recorded in roll call votes. A yea vote on legislation which increases government involvement in the economy is coded as a liberal vote, while a nay vote on the same legislation would be coded as a conservative vote. The NOMINATE scores are scaled -1 to +1, with -1 representing the most liberal position, and +1 representing the most conservative position.[13] With House

[13] Due to the way the NOMINATE scores are created by Poole and Rosenthal, there is one outlier to the scale of -1 to +1 for the 111th Congress; Ron Paul has a NOMINATE score of 1.348 due to his libertarian ideology which stresses limited role of government in the economy. This increases his 1st dimension NOMINATE score because it measures the degree of government intervention in the economy, as voted for by legislators.

partisanship in mind as noted above by David W. Rohde, many scholars use NOMINATE scores as approximations for the personal preferences of members on legislation. For this study members with more liberal scores are assumed to be in favor of health care reform, while members with more conservative scores are summarized to oppose health care reform. The roll call vote results for HR 3962, the Stupak Amendment, and HR 4872 generally support this treatment of the NOMINATE scores as members scored as most liberal were more likely to vote in favor of HR 3962 and HR 4872 and against the Stupak Amendment, and members scored as most conservative were more likely to vote against HR 3962 and HR 4872 and in favor of the Stupak Amendment. A visual examination of the data reveals a surface level relationship between the actual votes cast by members, and the vote predicted according to NOMINATE scores. While a more robust test is needed to understand this relationship fully, this examination of the raw data reveals that members who proved to be the exception to this potential relationship tended to be Democratic freshmen members who were elected in historically Republican districts.

A final control measure is included in the data, a variable which measures gender (*Gender*) and which is a binary variable where 0=Male and 1=Female. This measure is included in the regression due to the role gender plays in the health care reform debate. There is known discrimination against women in health insurance policies due to their more extensive use of the medical system when compared to men (Pear 2008). Further, with regards to the Stupak Amendment and the abortion debate, there is an effect played by gender in shaping social elites' opinions on the debate (Jelen, Damore, and Lamatsch 2002). For these reasons gender is included as a control variable in this study.

Linear Probability Model: Logistic Regression Analysis

From these data, a logistical regression with robust standard errors was calculated to estimate the impact of each of the hypothesized decision factors on members' health care voting decisions. In the model most of the Democrat House members who voted on HR 3962, the Stupak Amendment, and HR 4872 have been included, except for five members who were installed during special elections in 2009 (John Garamendi, Judy Chu, Michael Quigley, Bill Owens, and Scott Murphy). While these members did vote on each health care reform bill, the data available for the measure of interest group influence is imprecise due to their elections in 2009, an off-cycle year. Members who did not receive PAC campaign contributions were given a value of 0 for their measure of interest group influence, *fracA*. As this measure seeks to capture the amount of influence being exerted on members, members who did not receive PAC campaign donations from an organization in the health care industry can be coded as receiving zero influence. This is not fully realistic, but as PAC campaign contributions are the best measure of the influence interest groups are seeking to exert, and as it is preferable to include these members in the analysis, it is the decision that has been made for this study. The results of the quantitative analysis are presented in Tables 2-7.

Analysis for HR 3962, limited to the Democratic members of the House, is found in Table 2. This analysis models the impact of anti-reform PAC campaign donations, constituency preferences on health care reform as observed through Barack Obama's share of the district's vote, members' preferences as observed through NOMINATE scores, and gender on the likelihood of a member voting in favor of HR 3962 on November 7, 2009. The pseudo R-squared for the analysis of HR 3962 is 0.5210, which signals that while some of the variation in members' votes on HR 3962 is being explained, there is still some variation that is not well

explained by the included variables. The analysis of HR 3962 however does prove itself better at explaining the variation which occurs in members' votes on HR 3962 than can be owed to chance, as proven by a Wald chi2 value of 33.11 and a p-value of 0.00.

[Table 2 About Here]

The only variable which appears statistically significant is *obama*, the measure for constituency preferences. This variable is strongly significant at the 1% level with a z-score of 3.66. The positive sign for the coefficient of *obama* is in the correct direction, as an increase in a district's vote share held by Barack Obama subsequently increases the likelihood a member would vote in favor of HR 3962. At its mean value of 53.76, the predicted probability of a member's vote being cast in favor of HR 3962 is 0.9316, while conversely the predicted probability of the vote being cast against HR 3962 is 0.0684. While its z-score of 3.66 makes *obama* strongly significant in the analysis, the strong effect of constituency is further seen in the large change in predicted probability engendered by an increase or decrease of one standard deviation from the mean. An increase of one standard deviation (14.82) above the mean, while holding all other independent variables at their means, increases the predicted probability of a vote being cast in favor of HR 3962 to 0.9949, while a decrease of one standard deviation below the mean decreases the predicted probability of a vote being cast in favor of HR 3962 to 0.4890. This is a very large observed absolute difference, of 0.5059 in predicted probability, of an affirmative vote on HR 3962. A one standard deviation decrease from the mean brings the predicted probability of an affirmative vote occurring below 50%. This supports the hypothesis of this paper that constituency preference will have a significant influence on members' voting decisions.

In the analysis presented in Table 2, it is interesting to note that the rest of the independent variables (*Gender*, *fracA*, and *dwnom1*) are not statistically significant. This makes sense as there is only a small change in the predicted probabilities of an affirmative vote being cast when *Gender* changes from male to female, or when *fracA* is increased or decreased one standard deviation from its mean. The sign of the coefficient of *fracA* is in the correct, negative direction, indicating a decreasing effect on the likelihood that members vote in favor of HR 3962 the more anti-reform donations they receive. However, an increase or decrease of one standard deviation from the mean for *dwnom1* does create a large change in predicted probabilities, from 0.0856 one standard deviation above the mean, to 0.9914 one standard deviation below the mean. This makes sense as a difference in members' positions on the ideological spectrum would logically be accompanied by differences in their voting decisions on health care reform.

Analysis for the Stupak Amendment (also known as the Abortion Funding Amendment), limited to the Democratic members of the House, is found in Table 3. This analysis models the impact of the same four factors of decision making as are found in Table 2, but on the likelihood of a member voting in favor of the Stupak Amendment on November 7, 2009. The pseudo R-squared for the analysis of the Stupak Amendment is 0.3326, which is lower than pseudo R-squared for the analysis of HR 3962 found in Table 2. This suggests that there is variation in members' voting decisions that is not being explained by this analysis; however a Wald chi2 value of 41.85 and a p-value of 0.00 supports the alternative hypothesis that more variation in members' votes is being explained than can be owed to chance.

[Table 3 About Here]

In the analysis of the Stupak Amendment every variable is statistically significant except for the measure of interest group influence, *fracA*. The sign of the coefficient of *fracA* is again in

the expected, negative direction. Members' preferences, as well as gender, both prove themselves to be significant for the first time when analyzing the Stupak Amendment. Members' preferences, measured with *dwnom1* have a statistically significant influence on members' voting decisions on the Stupak Amendment, with a z-score of 1.73 and significance at the 10% level. In keeping with the conservative nature of the legislation, changes in members' NOMINATE scores reveals a large impact on their likelihood of voting in favor of the Stupak Amendment. An increase of one standard deviation (0.51) above the mean, while holding all other variables constant at their means, results in a predicted probability of an affirmative vote on the Stupak Amendment of 0.7258, while a decrease of one standard deviation below the mean results a predicted probability of an affirmative vote on the Stupak Amendment of 0.0930. This significant difference in predicted probabilities between an increase of one standard deviation above the mean, and a decrease of one standard deviation below the mean, makes sense. This is because an increase above the mean, means increasing a members' score in the positive, more conservative direction, while a decrease means increasing a members' score in the negative, more liberal direction. As the Stupak Amendment is a conservative bill, a member has an increased likelihood of voting in favor of the bill if their score increases in the positive direction, and a decreased likelihood of voting in favor of the bill if their score increases in the negative direction.

The effect of gender is also found to have a significant influence on members' voting decisions on the Stupak Amendment. It is found to have a negative effect on members' voting decisions. Since the variable for gender is a dichotomous variable with female coded as 1, a negative effect of gender means that being a woman decreases a member's likelihood of voting in favor of the Stupak Amendment. When a member is a male, the predicted probability of an

affirmative vote on the Stupak Amendment is 0.1887. This predicted probability of an affirmative vote decreases when a member is female to 0.0259, a change in predicted probability of 0.1628. This effect of gender is significant at the 1% level with a z-score of -2.61. The strong significance of the influence of gender on a member's voting decision on the Stupak Amendment supports its inclusion in the analysis.

Constituency preferences have a significant influence on members' voting decisions on the Stupak Amendment, as was also found in the analysis of HR 3962. The preferences of constituents have a significant influence on members' voting decisions at the 1% level of significance, with a z-score of -3.56. This time though, in analyzing the Stupak Amendment, the effect of constituency is a negative effect, which makes sense due to the legislation's conservative nature. The greater Barack Obama's vote share in a district, the less likely a member is to vote in favor of the Stupak Amendment. In fact, an increase of one standard deviation above the mean shows a predicted probability of voting affirmatively on the Stupak Amendment of only 0.0671, while a decrease of one standard deviation below the mean shows a predicted probability of voting affirmatively on the Stupak Amendment to be 0.5689. This makes sense as districts that were carried strongly by Barack Obama would likely lean liberal in the constituencies' political preferences, causing constituents to influence members to vote against the Stupak Amendment. On the other hand, districts that were weakly carried by Barack Obama would likely lean conservative in the constituencies' political preferences, causing constituents to influence members to vote in favor of the Stupak Amendment.

Analysis for HR 4872 (also known as the Health Care Reconciliation Bill of 2010), limited to the Democratic members of the House, is found in Table 4. There are four fewer members included in the analysis of HR 4872, than were included in the analysis of the previous

two bills due to deaths and resignations that occurred among Democratic House members between November 7, 2009 and March 12, 2010. The analysis of HR 4872 models the impact of the constituency preferences, interest group influence, members' personal preference, and gender on the likelihood of a member voting in favor of HR 4872 on March 21, 2010. HR 4872 is the reconciliation bill which put an amended version of the health care reform bill approved by the Senate on December 24, 2009, to a vote in the House on March 21, 2010. The analysis of HR 4872 finds the pseudo R-squared value to be 0.5643, which is the highest pseudo R-squared value of the three bills under consideration. This suggests that the analysis of HR 4872 accounts for the most variation in members' voting decisions on a health care reform bill in this study. While there is some variation not explained in this analysis, a Wald chi2 value of 35.62 and a p-value of 0.00 supports the alternative hypothesis that more variation is explained using the factors included in this analysis than can be owed to chance.

[Table 4 About Here]

The analysis of HR 4872 provides similar results to the analysis of HR 3962; members' preferences do have a significant influence on members' voting decisions on HR 4872, while gender does not have a significant influence on members' voting decisions. In the analysis of HR 4872 however, constituency preference is found to have a significant effect on members' voting decisions. For this final analysis, the measure of interest group influence on members' voting decision *(fracA)* is again insignificant, yet with a coefficient sign still in the negative direction. This constant insignificance of the influence of anti-reform donations on members' voting decisions is puzzling, as vilifying interest groups for their manipulation of the political system is a popular past time for many Americans. The quantitative analysis section of this study as a whole does not find interest groups to have a significant influence on members' voting decisions,

though a possible explanation for this will be provided later in this paper's qualitative analysis section.

The continued significance of constituency's preference on health care reform, throughout all three analyses, provides quantitative support for the hypothesis of this paper that the preferences of members' constituencies will have the greatest influence on members' voting decisions on health care reform. In the analysis of HR 4872, constituency preference is found to be significant at the 1% level, with a z-score of 3.07. This z-score is the lowest z-score of all three analyses, suggesting that there may be a slight weakening in the influence of constituency preference on members' voting decisions on HR 4872. This is an interesting observation as the significance of members' preferences in influencing members' voting decisions on HR 4872 is found to be its strongest of all three analyses, with a z-score of -3.12 and a statistical significance at the 1% level. In fact, members' preference is the strongest influence on members' voting decisions in the analysis of HR 4872. This is compared to the earlier analysis of HR 3962, where members' preference was not significant, suggesting a strengthening of the influence of members' personal preferences about health care reform on their voting decisions.

The effect of constituency preference on members' voting decisions is found in the change in the predicted probabilities created from an increase of one standard deviation above the mean, to a decrease of one standard deviation below the mean. An increase of one standard deviation above the mean results in a predicted probability of voting in favor of HR 4872 of 0.9974, while a decrease of one standard deviation below the mean results in a predicted probability of voting in favor of HR 4872 of 0.6999. This absolute change in predicted probabilities from one standard deviation above the mean to one standard deviation below the mean is equal to 0.2975. This change is not as large as was observed in the analyses of HR 3962

and the Stupak Amendment; the absolute changes observed were equal to 0.5059 and 0.5018 respectively. This decrease in sensitivity of predicted probabilities for constituency preferences' influence on members' voting decisions, to changes of one deviation from the mean supports a weaker z-score in the analysis of HR 4872, than was observed in the analysis of HR 3962.

While the influence of constituency preferences on members' voting decisions are found in the analysis of HR 4972 to have weakened slightly, the influence of members' personal preference are found to have strengthened. An increase of one standard deviation above the mean results in a predicted probability of voting in favor of HR 4872 of 0.0203, while a decrease of one standard deviation below the mean results in a predicted probability of voting in favor of HR 4872 of 0.9797. This large increase when the NOMINATE score is increased in the negative direction makes sense, as the more liberal members are, the more likely they are to vote in favor of health care reform legislation. This is an absolute change between the two predicted probability values of 0.9594, which is much larger than the absolute change of 0.6328, observed in the analysis of the Stupak Amendment.[14] This increase in sensitivity of predicted probabilities for members' preferences' influence on members' voting decisions, to changes of one deviation from the mean supports a stronger z-score in the analysis of HR 4872, than was observed in the Stupak Amendment.

As a final note of interest in the quantitative analysis portion of this study, a variable that measures a district's competitiveness (*competition*) was added to the model for each bill, as is presented in Tables 5-7. This variable was tested in the model to determine whether the competitiveness of a member's district has an influence on a member's voting decision on HR 3962, the Stupak Amendment, or HR 4872. This question arose in light of the observed tendency of members who voted out of sync with constituency preferences to be from competitive

---

[14] The measure of members' preferences (*dwnom1*) in the analysis of HR 3962 was found to be insignificant.

districts. The question of district competitiveness and House members' voting behavior is also discussed and found to be important by David Mayhew (2004). The competition variable used is the absolute difference between a district's vote share won by Barack Obama and won by John McCain. This vote margin indicates a very competitive district when it is small and in the range of three to five percent.

When this competition variable is included in the analysis, its effect is insignificant for each bill analyzed. The coefficients' signs remain the same, z-scores remain similar, significance levels mostly do not change, and pseudo R-squared values are similar. In fact, the analysis of the Stupak Amendment yields the same pseudo R-squared value regardless of whether the competition variable is included. Also in the Stupak Amendment is the sole change in a coefficient's significance observed. The measure of constituency preference, *obama*, is reduced in significance from the 1% level when a competition variable is not included, to the 5% level when a competition variable is included. However, the variable's influence on members' voting decisions does remain significant in the analysis of the Stupak Amendment regardless of the inclusion of the competition variable. Overall, the lack of influence observed by the inclusion of a competition variable suggests that when making their voting decisions on health care reform, members are not influenced by their district competitiveness. Competitive districts would instead be sending more conflicting messages to members regarding how they should vote than would districts that were won by large margins.

Interviews

Qualitative data were collected for this research project in order to contribute to its findings, as well as to increase the project's validity. Interviews served both to provide primary source information for this study, as well as to check the results of the quantitative model. Interview material can determine whether the predictions of the quantitative model regarding what members are considering when making a voting decision are in line with what they actually think about. Interviews were conducted during the week of March 15, 2010, with five staff members and two members of the House of Representatives. Members were selected to be contacted either upon their deviation from the trend of party line voting or their location in marginal districts. Marginal districts (also known as swing districts) present an interesting question as there is a mixed message being sent to members about constituency preferences. How does a member reconcile the conflicting constituency messages in a district that voted 47% John McCain and 52% Barack Obama? For example, this situation occurred for Congressman Harry E. Mitchell (D-AZ), who ultimately voted in favor of HR 3962. Learning through interview data how a member in this difficult circumstance comes to a voting decision can provide information regarding the factor that is most critical for members when deciding a vote on high-salience legislation.

Members who deviate from their constituency's preferences can also provide interesting information. Deviation from the constituency's position occurs when a member votes yes on health care reform while being from a district strongly carried by John McCain, or when a member votes no on health care reform while being from a district strongly carried by Barack Obama. An example of such a member is Dennis Kucinich (D-OH), who was not available to be interviewed for this study, but whose district voted 59% in favor of Barack Obama. In spite of

John McCain only receiving 39% of the vote in the district, Kucinich still voted against HR 3962. Congressman Kucinich has publicly stated that his reason for voting against passage of HR 3962 is due to its lack of a single-payer system, meaning the bill was not as liberal as he desired it to be (White 2009). This case likely explains his divergence from the overwhelming trend for members from strongly Obama districts to vote in favor of passage and points to his decision making process being more strongly influenced by personal preference than constituency preferences.

Following these methods for case selection, approximately 25 members were contacted with interview requests in hopes of attaining interviews with ten of them. Individuals were not selected in a random, systematic way due to time constraints. While this would be the preferable method in order to increase the validity of the study, this method was not feasible. Once in Washington D.C., some last minute changes were made with staff members due to the upcoming reconciliation vote in the House on health care reform bill HR 4872. Because of the methods used to select interview cases for this study, the members selected for interview requests were the same ones who were receiving the highest intensity pressure from all sides regarding their vote on the upcoming reconciliation health care reform bill. This situation left them and their staffs without the time to meet with anyone other than constituents or large, national organizations, such as the American Federation of Labor and Congress of Industrial Organizations (AFL-CIO). A staff member for a House member in this situation stated, “I don’t care that my boss is on an email chain and people from Alabama [this member is not from Alabama] call in. A lot of people call in: I’m not rude, but I just don’t care. You know, get them off of the phone.”

In light of this scheduling problem, three of the interviews were with staff of members who fell into the marginal district category. No interviews were obtained with members whose votes deviated from the way they would be expected to vote based on their district's presidential vote. The last four interviews were held with members and members' staff whose votes were party line votes and who were not from marginal districts. These interviews were still useful for providing insight into the process of decision making on health care reform and into factors which influenced voting decisions. Overall, as all the interviews were relatively short, lasting an average of 30 minutes, only interview data relating to HR 3962 was collected. This focus allowed for detailed information concerning HR 3962 to be collected, although it meant that there is not interview data available on the Stupak Amendment. As HR 4872 had not yet been voted on, many members were still making their minds up about their vote and were reluctant to discuss their voting decision in much detail.

Confidentiality was promised to all members and staff who participated in this study. Subsequently the interviews were assigned numbers in order to identify and differentiate them. The interview information is found in Table 8 along with some other informative, non-identifying details. As shown in Table 8 respondents 1, 3, 4, and 6 supported the hypothesis of this paper that constituency is the most important factor that influences a member's vote.

[Table 8 About Here]

In fact, a common theme throughout the interviews, even if constituency was not mentioned as the ultimate factor in a health care reform voting decision, was the repeated quoting of former Speaker of the House Tip O'Neill's famous aphorism, "All politics is local." This emphasis on the need for members to tend their bases supports the findings of the logistic regression models, as well as the findings of Kingdon and Rohde. The decisiveness of a factor

was determined with question 7, which asked what factor was the “tipping factor” which tipped a member’s vote decisively in the yea or nay direction. Effectively the majority of the interviews conducted suggest confirmation of this paper’s hypothesis, that constituency preference has the greatest influence on a member’s vote. There is, however, only one respondent in Interview 1 where constituency was identified as the primary influence on a voting decision and where the member was from a marginal district. The two other interviews with members from marginal districts named personal philosophies as the primary influence on their voting decisions. This information suggests that in districts where there is a clear majority, there is also a clear message communicated to members about constituency preference. In marginal districts, a member receives a mixed message from constituents regarding their preferences, leaving the member to work his way through Kingdon’s decision making tree, shown in Figure 1.

Respondents 2, 5, and 7 stated personal preferences, or personal philosophies, were the primary influence on the members’ voting decisions. This finding supports the results of the logistic regression analysis where the 1st dimension NOMINATE scores, which are used as a proxy for the influence of member preferences on their voting decisions, are found to be significant in the analysis of the Stupak Amendment and HR 4872. It is enlightening to note that, as discussed above, two out of the three members interviewed who voted in line with their personal preferences on health care legislation are from marginal districts. This pattern suggests support of the process depicted in Kingdon’s decision making tree, as members must move past looking to constituency for voting cues and must then examine environmental cues and decide how to vote from there. In discussions with members and staff from marginal districts it became apparent that there was conflict among the signals from the factors they normally look to for help in making their voting decisions. To each question touching on signals from constituency,

interest groups, and party leadership, conflicting signals were reported in Interviews 2 and 5. Some of this confusion was confirmed in general throughout all of the interviews conducted, but it was at its highest in Interviews 2 and 5.

Interview 7 is an interesting case as the primary factor in the decision was personal philosophy, yet the member is not from a marginal district. This member's district is relatively safe, though as Mayhew argues, no member is "safe" should they deviate from the activities they are undertaking which allow them to be "safe" (2004, 37). This member, as stated both by staff and the member, works to make voting decisions that are grounded in moral reflection, and which move the country forward in the long run. A staff member noted, "There is a moral compass, or sieve, which all voting decisions are put through. If the legislation meets these moral requirements, then an affirmative voting decision will be decided." The same staff member also admitted that the member could be an outlier in the realm of member decision making, as the member's seniority and experiences provide greater leeway in decision making than is enjoyed by other, younger members of the House.

While possibly an outlier in overall members' decision making processes, Interview 7 yielded some of the most helpful information regarding health care reform and factors of consideration in decision making. This member's personal familiarity with the health care bill afforded the member's staff intimate knowledge of the forces that were at work in crafting the legislation. Interview 7 provided helpful information regarding the role interest groups played in the crafting of HR 3962, which had been addressed though much less concisely in other interviews. First, large national groups used connections on Capitol Hill to members and staff crafting HR 3962 to influence the structure of the bill itself. In this way large groups could guarantee they would be able to support health care reform publicly, as they had molded the bill

itself in ways beneficial to them. Secondly, a comment echoed throughout the interviews when the question regarding groups arose, was that the groups best positioned to influence the legislation were large, national groups that were well-organized and able to mobilize members efficiently.

Well-organized, national groups are able to leverage their local presence in House members' districts by gaining support, for an issue like health care reform, among the members' constituency. In this way a single organization can affect large numbers of House members in their districts, effectively guaranteeing that the organization's requests will be listened to and likely incorporated into the health care reform bill. The rise of the digital age (robo-calls, emails, electronic faxes, etc.) has enhanced the ability of large national organizations to undertake these activities, in comparison to their ability to do so when Kingdon was doing his research in the late 1960's. This evolution in interest group tactics and strategies suggests that groups have undergone a learning process with regard to the most effective ways to influence legislation. They appear to have learned that utilizing numerous local constituencies and connections in Washington D.C., in order to mold legislation in profound ways, is a more successful strategy than engaging in outright opposition to a controversial issue. This ability of national organizations to make an issue like health care reform an issue for large numbers of House members through district offices suggests further research into current interest group tactics, and their influence on legislation and members' voting decisions, is necessary.

It is interesting to note a deviation from this project's hypothesis which was found through interviews. This paper hypothesized that following constituency preferences, party leadership would have the second largest impact on members' voting decisions. While this hypothesis contradicted John Kingdon's findings, it was believed to be accurate in light of

Rohde’s work highlighting the growth in power enjoyed by party leadership since the 1970’s, as well as increases in party line votes. Interview data revealed however that party leadership had a low impact on the voting decisions of the members and their staff interviewed. Interview 2 revealed that for the member under discussion, “What party leadership is doing doesn’t really affect us. There are very few people in our district who want XXXX to follow either the Republicans or the Democrats. Congress is very unpopular right now; the most popular thing he can do is appear as though he’s bucking party leadership.” Sentiments such as this were echoed in Interviews 1, 4, 5, and 6, where party leadership did not play a significant role in the member’s voting decision. Members and staff reported contacts from party leadership lobbying them to vote in favor of HR 3962. Interview 1 stated, “The answer is yes. It’s not a rifle shot though.” Reports such as this suggest a stability and robustness in Kingdon’s findings over time. In light of Rohde’s work, these findings suggest that while party leadership may select the legislative issues it seeks to promote, it is more often the constituency and the recruitment process which bring members to vote in agreement with the party’s position, than it is the influence of party leadership on the member’s actual decision.

This low influence of party leadership on members’ voting decisions is an intriguing finding to discover through the interview data. However, this finding is reliant upon a small number of interviews, which do not make up a standardized, random sample. This makes the finding of low party leadership influence to be one which would require further investigation in a larger study. It is nonetheless interesting that the presence of party leadership as a strong factor of member decision making is lacking in all of the interviews that were conducted. While not conclusive, it is an interesting finding for this study since there is not a robust quantitative method to test for the influence of this variable. Instead, this influence was revealed through

interviews with the decision makers and their staff. Even for Interviews 3 and 7, party leadership did not play a large role in influencing their voting decisions.[15] For this study, interviews have been able to support the academic literature, as well as the quantitative models, in finding the preferences of constituency often to be the largest influence on a members' voting decision, even when it comes to such high salience legislation as health care reform. The interviews have provided data which suggest doubt of the veracity of the second part of this paper's hypothesis that, after constituency preferences, party leadership will have the greatest influence on members' voting decisions. This finding does support Kingdon's work from the late 1960's, which suggests that the power party leadership wields over members' voting decisions may be weaker than is generally surmised.

The true power of party leadership may lie in its ability to shape House legislation and control committee nominations, but not in influencing the final vote of members. As discussed by David W. Rohde, party leaders possess control over a bill's course through the House, especially when employing the closed rule option, which does not allow members the option to amend a bill before voting on it. Through this control, party leadership can significantly impact how health care reform legislation is structured and moves through the House. This can influence members' voting decisions as they are forced to vote on a whole legislative package, instead of being able to vote on the portions of reform legislation they find palatable. This may increase members' difficulties in reaching voting decisions as they cannot modify the legislation to fully suit their home constituencies or their personal preferences.

[15] However it is not valid to group these two interviews (three and seven) with the other interviews, with regards to this factor, due to these members possessing positions of leadership within the Democratic Party. As such, they are the members selecting the legislation that will be pursued, and then trying to whip other members to vote in favor of passage.

The final implication of interview data regarding the influence of interest groups supports the findings of the quantitative models. As was addressed earlier in this section, interest groups did seek influence during the 2009–2010 health care reform initiative. Unlike past reform attempts, such as President Carter's hospital cost control program where outright assaults were launched against the plan, interest groups sought to exert influence by working with members and the White House, to craft the text of HR 3962 in order to benefit their organizations and their members. They chose to focus their influence on the bill itself, instead of on members' actual voting decisions. This is not to say that there was not any work done to try to affect members' voting decisions, but the vote is not where the attention was focused. The quantitative model revealed a lack of statistically significant influence on members' votes by interest groups, which would make sense if interest groups were more focused on trying to influence the text of HR 3962 itself, rather than a member's vote on the bill.

Results and Conclusions

This project has arrived at some interesting findings, which are enhanced through the use of both quantitative and qualitative research methods. The quantitative part of this study allows for mathematical modeling of the factors hypothesized to influence House members' voting decisions on high-salience legislation, such as health care reform. The ability to analyze three votes taken on health care reform that exist within the same time period and period of reform, during the same Congress, increases the internal validity of the study. The findings of the quantitative study support the hypothesis of this paper and the work done by John Kingdon in the 1960's. The measure for constituency preferences, the vote share per congressional district that was won by Barack Obama, is statistically significant in every model. Even if constituency was not stated as the *most* important influence on a member's voting decision during an interview, it was mentioned as an important factor of consideration in every interview. The interview data obtained in the qualitative portion of this study suggests the quantitative findings are accurate, though due to the small number of interviews completed this conclusion must be tentative. The individuality in personalities due to differences in districts, parties, experiences, and regions may help explain the variance in the most important factor members cite as influencing their voting decision.

Contrary to commonly held beliefs about the "evils of interest groups," the quantitative model and qualitative data do not reveal a significant impact of interest groups on members' voting decisions. The measure for anti-reform donations' influence on members' voting decisions does not appear as a significant influence in any of the models. The sign is in the correct negative direction, illustrating that members are less likely to vote in favor of health care reform if anti-reform campaign donations received are high. However, this effect is not

statistically significant. This finding should be reassuring to people that members in Washington D.C. are trying to vote based on their conscience and to cast votes in ways which would please their constituencies. The necessity of doing so is highlighted by David Mayhew's work, which examines the path to political office as being an individual one which is reliant upon one's ability to mobilize district voters (2004, 26). The qualitative data for this study highlight a different reality for the impact interest groups have on health care reform. Interest groups are reported to have progressed up the learning curve and are now actively working to shape the text of the health care reform bill itself. In participating closely in the drafting process, groups can help craft bills that are amenable to their special interests. The effect of this activity is unknown as this was not a question under examination in this study. However, it is reasonable to expect that interest groups who participate in the drafting process will be able craft the text of a bill in such ways as to protect their interests and, subsequently, publicly state support for health care reform. The question would be whether this activity is beneficial or not for health care reform, as established national interest groups are no longer launching assaults against reform, though they are adjusting bill text to benefit themselves. This is a question worthy of further investigation.

The final factor of decision making that is explored though both quantitative and qualitative means in this study is the effect of members' own personal preferences on their voting decisions regarding health care reform legislation. The analysis of HR 3962 does not find members' personal preferences to be a significant influence on members' voting decisions, while the analyses of the Stupak Amendment and HR 4872 do find members' personal preferences to be a significant influence on their voting decisions. This is interesting, as there appears to be a reversal of the influences on members' voting decisions. From the quantitative models, it is suggested that when members voted on November 7, 2009, there was a clearer message

communicated to members from constituencies regarding constituency preferences on HR 3962 and the Stupak Amendment, than was communicated when members voted on March 21, 2010 on HR 4872. In the analysis of HR 3962, constituency preference is the only statistically significant variable. This supports the hypothesis of this paper and suggests that the preferences of constituents on health care reform were communicated clearly enough to most members that members did not need to examine other factors of voting decision making before making a voting decision.

From the quantitative analysis it appears as though the clarity of constituency preferences on health care reform became less clear when members began making their voting decisions on HR 4872. The analysis of HR 4872 finds constituency preference to have a lower z-score than was found in the analysis of HR 3962, while members' preferences become significant in the analysis of HR 4872 where they were not significant in the analysis of HR 3962. This suggests a confirmation of Kingdon's work and his decision making tree. Due to the more confused signals being sent from constituencies regarding their preferences on HR 4872, members were forced to proceed to another step in the decision making process, and to examine other cues in their environments. From the significance of members' personal preferences, it appears that a cue which members turned to for help in sorting through their voting decisions was their own preferences regarding HR 4872. This change in the factor exerting the most influence on members' voting decisions suggests an impact of time on their voting decisions. The five month time difference between November 7, 2009, and March 21, 2010, created a change in the environment of factors facing members when they began thinking about their voting decision for health care reform the second time on HR 4872.

The confusion of signals being sent to members is confirmed in the interview results, and the subsequent reliance of members on their personal preferences are found to be important for many of those who were interviewed. Members report resorting to an internal analysis and weighing of information prior to making voting decisions on contentious, high-salience health care reform legislation. For members from swing districts where clear signals are not being sent by the constituency or from interest groups, resorting to personal preferences and philosophies makes sense. As has been highlighted with the inclusion of Kingdon's decision making tree (Figure 1), members search for consensus when making their voting decisions. If they cannot find consensus, they will continue studying their environment until they discern enough clues about how they should vote to make a voting decision. In this way members eventually reach a form of consensus about their voting decision.

The important role played by personal preference in making voting decisions was underemphasized in this paper's hypothesis. The interview responses which emphasized the role personal preference played in decision making came as a surprise, since Kingdon did not find it to play a large role in decision making in his study. This lack of importance could be explained by the presence of mixed and confused signals coming from the rest of the factors of consideration normally taken into account by members when they make voting decisions. Also surprising was the insignificance of party leadership in the decision making process of members who were interviewed. As party leadership's influence on members' voting decisions is the sole measure which could not be well measured quantitatively, information gathered through interviews is vital to this study, however limited the applicability of the data is due to the small number of interviews. The five interviews where lack of party leadership influence is observed provide some evidence that members may not be influenced by party leadership to vote in favor

of health care reform, unless they are already wavering in their voting decision. As Interview 1 revealed, a member who has taken a strong position against a piece of legislation will pose extreme difficulties to party leadership in trying to influence the member to vote with the party's position.

This finding suggests disproval of the hypothesis of this paper, that party leadership has the second strongest influence on members' voting decisions, after a member's constituency. This finding does support Kingdon's work from the 1960's, which suggests that his findings are still valid and applicable to today's 111th Congress. In order to grasp more fully the influence of party leadership, a more extensive interview study would be desired, of the size Kingdon undertook in 1969 (1989). A larger interview study would also provide greater precision in the interview data obtained for this study. It would be an interesting question whether under further investigation the reported evolution of interest groups, and their approach to political influence, remains the same. If so, it would be of great use for political scientists and policy makers to study the potential impact this shift in interest group strategy has had on House legislation.

This study highlights the importance of understanding what lies behind a member's voting decision on high salience legislation such as health care reform. As was noted by Kingdon, and was supported through this study's interviews, the decision making process of members on this type of legislation is different from the process engaged in for low-salience legislation. As was stated in Interview 5, "Health care is different. It is different because it affects everyone and because it brings out everyone's passions and everyone's beliefs about the role of government in America." The distinctiveness of high salience legislation makes it important to understand how members approach making their voting decisions, especially because as this paper has discussed, the process is much different for high salience legislation

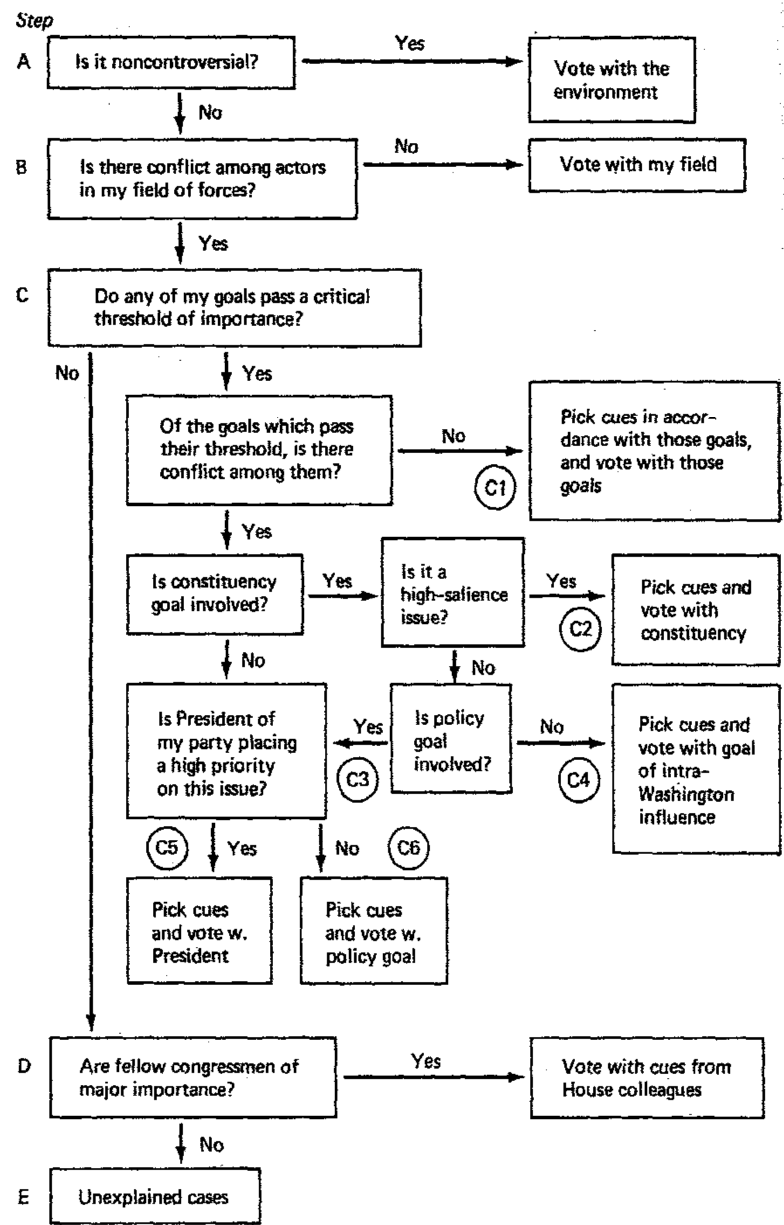
than it is for low salience legislation. This is important to understand for the proponents of large legislative programs in order to provide them with an understanding of what they need to do differently to ensure passage of high salience legislation. The results of this study indicate that constituency preference and member preference need to coincide. If they do not coincide, then the strength of the constituency's preference needs to be strong enough in a majority of districts to compel a majority of House members to vote in favor of passage. It does not appear as though members' own preference can override constituency preference; after all if it did, Mayhew's work suggests the member would be replaced during the next election with a candidate who would respect the wishes of the constituency (2004).

The requirement of large constituency majorities and coincidence of member personal preference point to the need for someone looking to bring about successful passage of high salience legislation to plan far in advance. Advance planning is necessary to provide the constituency majorities required for members to be compelled to vote in favor of the legislation. The presence of large constituency majorities was observed for Democratic members seeking to pass health care reform in 2010, when they successfully passed HR 4872. It was also observed, though, in the large number of swing districts, that passage was not guaranteed and conflict arose between constituency preferences in marginal constituencies and members' personal preferences for these districts. The final roll call vote of 220–211 saw the difficulties party leaders who were shepherding the health care reform bill through the House had in combating this conflict and in acquiring the 216 votes necessary to win passage for the reform legislation.

Figures

Figure 1

Kingdon's Framework for Explaining Voting Decisions



Source: Kingdon 1989, Table 10-1, 244.

Tables

Table 1: Summary Statistics

Variable	Observations	Mean	Standard Deviation	Minimum	Maximum
Dwnom1	435	0.05	0.51	-.758	1.35
Obama	435	53.76	14.82	23	95
Hr3962v	435	0.51	0.5	0	1
Hr4872	431	0.51	0.5	0	1
fracA	422	0.05	0.05	-0.02	0.31
Stupakrc	434	0.55	0.5	0	1
Gender	435	0.17	0.37	0	1
competition	435	23.78	19.61	0	90

Table 2: HR 3962 with Only Democrats Included

Variable	*HR 3962: Only Democrats*
Gender	Cof= 0.37 SE= 0.81 Z= 0.45
fracA	Cof= -5.64 SE= 7.67 Z= -0.74
Obama	Cof= 0.18** SE= 0.05 Z= 3.66
Dwnom1	Cof= -6.98 SE= 4.40 Z= -1.59
Pseudo R-Squared	0.5210
Wald Chi2	33.11
Number of Observations	251

Cof=Coefficient
SE=Standard Error
Z=Z-Score
**=significance at the 1% level

Table 3: Stupak Amendment with Only Democrats Included

Variable	*Stupak: Only Democrats*
Gender	Cof= -2.17** SE= 0.83 Z= -2.61
fracA	Cof= -5.57 SE= 4.99 Z= -1.12
Obama	Cof= -.1** SE=.03 Z= -3.56
Dwnom1	Cof= 3.19* SE= 1.85 Z= 1.73
Pseudo R-Squared	0.3326
Wald Chi2	41.85
Number of Observations	251

Cof=Coefficient
SE=Standard Error
Z=Z-Score
*=significance at the 10% level
**=significance at the 1% level

Table 4: HR 4872 with Only Democrats Included

Variable	*HR 4872: Only Democrats*
Gender	Cof= 1.88 SE= 1.29 Z= 1.46
fracA	Cof= -3.66 SE= 9.26 Z= -0.40
Obama	Cof= 0.17** SE= 0.06 Z= 3.07
Dwnom1	Cof= -9.43** SE= 3.02 Z= -3.12
Pseudo R-Squared	0.5643
Wald Chi2	35.62
Number of Observations	247

Cof=Coefficient
SE=Standard Error
Z=Z-Score
**=significance at the 1% level

Table 5: HR 3962 Only Democrats Included with a Measure of District Competitiveness

Variable	*HR 3962: Only Democrats with District Competitiveness Variable*
Gender	Cof= 0.34 SE= 0.82 Z= 0.42
fracA	Cof= -4.7 SE= 6.83 Z= -0.98
Obama	Cof= 0.18** SE= 0.05 Z= 3.85
Dwnom1	Cof= -7.39 SE= 4.73 Z= -1.56
Competition	Cof= -0.02 SE= 0.04 Z= -0.47
Pseudo R-Squared	0.5223
Wald Chi2	48.52
Number of Observations	251

Cof=Coefficient
SE=Standard Error
Z=Z-Score
**=significance at the 1% level

Table 6: Stupak Amendment Only Democrats Included with a Measure of District Competitiveness

Variable	*Stupak: Only Democrats with District Competitiveness Variable*
Gender	Cof= -2.17** SE= 0.83 Z= -2.61
fracA	Cof= -5.54 SE= 5.25 Z= -1.05
Obama	Cof= -.10** SE= 0.03 Z= -2.80
Dwnom1	Cof= 3.19* SE= 1.88 Z= 1.69
competition	Cof= -0.00 SE= 0.02 Z= -0.02
Pseudo R-Squared	0.3326
Wald Chi2	45.89
Number of Observations	251

Cof=Coefficient
SE=Standard Error
Z=Z-Score
**=significance at the 1% level

Table 7: HR 4872 Only Democrats Included with a Measure of District Competitiveness

Variable	*HR 4872: Only Democrats with District Competitiveness Variable*
Gender	Cof= 1.81 SE= 1.34 Z= 1.36
fracA	Cof= -2.10 SE= 7.95 Z= -0.26
Obama	Cof= 0.17** SE= 0.05 Z= 3.59
Dwnom1	Cof= -10.60** SE= 3.58 Z= -2.96
Competition	Cof= -0.04 SE= 0.05 Z= -0.96
Pseudo R-Squared	0.5714
Wald Chi2	41.74
Number of Observations	247

Cof=Coefficient
SE=Standard Error
Z=Z-Score
**=significance at the 1% level

Table 8: Interview Summary Data

Interview #	Party	Marginal District Y/N	Deciding Factor Identified	Vote on HR 3962
1	Democrat	Y	Constituency	Nay
2	Democrat	Y	Personal	Nay
3	Democrat	N	Constituency	Yea
4	Republican	N	Constituency	Nay
5	Democrat	Y	Personal	Yea
6	Republican	N	Constituency	Nay
7	Democrat	N	Personal	Yea

Appendix

Interview Questions

Interview Questions 1: House Member

1. How did you go about making up your mind last November on HR 3962 The Affordable Healthcare for America Act? What steps did you go though?
2. Were there any fellow members that you paid attention to?
    a. If no: I don't mean just following them; I mean looking to them for information and guidance?
    b. If yes: Who? Why them? What information were they able to provide that helped you focus your thought process?
3. How did the party leadership communicate with you about its preferences? How about informal groups within the party?
    a. On a scale of 1 to 10, with 10 being the greatest, how heavily did the preferences of party leadership weigh on your mind while making your voting decision?
4. What do you think your constituents wanted you to do on this issue? How was this communicated to you?
    a. Is the intensity of communication from your constituency higher on the topic of health care than on other legislative matters?
5. What did you hear from groups and organizations? How did they communicate their preferences to you?
    a. Were they national or local organizations?
        i. If they are national: Do they have local offices in your district?
    b. Did most groups which contacted you favored or opposed the House's health care bill?
    c. If you got conflicting messages from groups communicating with you how did you reconcile the competing views?
6. Did anyone in the administration or executive branch contact you? How?
7. At any point along the way, were you ever uncertain about how to vote?
    a. If no: What factor was most important in your decision?
    b. If yes: How did you overcome this uncertainty? What factor proved to be the tipping factor?
8. Was there anything that you read that affected how you viewed the House's healthcare bill?
9. What did you discuss and look to your staff people to help you with on health care legislation?

Interview Questions 2: Staff of Representatives

1. How did your boss go about making up his/her mind in November on HR 3962 The Affordable Healthcare for America Act, and when did he/she begin becoming involved in the process? What steps did he/she go though?
2. Were there any fellow members that your boss paid attention to?
    a. If no: I don't mean just following them; I mean looking to them for information and guidance?
    b. If yes: Who? Why them? What information were they able to provide that helped the member focus his/her thought process?
3. How did the party leadership communicate with your office about its preferences? How about informal groups within the party?
    a. On a scale of 1 to 10, with 10 being the greatest, how heavily did the preferences of party leadership weigh on your boss's mind while making his/her voting decision?
4. What do you think your boss's constituents wanted him/her to do on this issue? How was this communicated to your office?
    a. Is the intensity of communication from your constituency higher on the topic of health care than it is with regards to other legislative matters?
5. What did you hear from groups and organizations? How did they communicate their preferences to your office?
    a. Were they national or local organizations?
        i. If they are national: Do they have local offices in your district?
    b. Do you believe most groups which contacted your office favored or opposed the House's health care bill?
    c. How did you and your boss reconcile the conflicting messages groups were communicating to you?
6. Did anyone in the administration or executive branch contact you or your boss? How?
7. At any point along the way, was your boss ever uncertain about how to vote?
    a. If no: Which factor was most important in making the decision?
    b. If yes: How did he/she overcome this uncertainty? What factor proved to be the tipping factor?
8. Was there anything that you or your boss read that affected how the member viewed the House's healthcare bill?
9. To what extent did your boss look to you or others on the staff to help him/her with this decision? What types of questions did you discuss with your boss?

Interest Group Coding Methodology

Explanation of Coding: The following section contains information regarding the way PAC campaign donations were coded to create *fracA*, or the measure of interest group influence on a member's voting decision. All the 2008 PAC campaign donations received by each winning House member were downloaded from the Center for Responsive Politics (www.opensecrets.com). In this dataset industries are given a general letter code which is then followed by a numeric code identifying which sub-section of an industry an organization belongs to. For example, in the code H1100, the "H" signifies that the included organizations are in the health care industry, while the "1100" identifies the included organizations as being related to physicians in the health care industry. In the creation of *fracA*, only PAC campaign donations which began with an "H" for health care were kept, all the donations from other industries were dropped. This is due to, as discussed previously, a difficulty in determining the intention of PAC campaign donations from other industries, for example the lumber industry.

The donations from health care industry organizations were coded as being supportive of health care reform, or being against health care reform. The coding decision was made by first finding the five largest donors in each sub-category of the health care industry (if there were less than five, than all of the donors were included). For each of these five donors, a search was conducted for public statements, letters, papers, and presentations which stated the donor's position on health care reform. From this search, a donor was coded as being for or against the legislation. Once a majority in a sub-category was reached, the sub-category as a whole was coded as seeking a supportive or anti-reform influence on members' health care votes. The total contributions that were pro-reform, and that were anti-reform, were then summed separately and were then divided by the total PAC campaign contributions received in 2008 by each winning House member. This fraction provides a measure of the amount of a member's total PAC campaign contributions that were made up of either pro or anti-reform donations.

Below are the sub-categories that were coded for the measure of interest group influence. Each category's alpha numeric code, as well as its title, is listed. Immediately follow this, in capital letters, is the score given to the overall category, either PRO REFORM or ANTI REFORM. Below this are listed the top donors that were examined to make this determination, along with the donation amount from the organization. A World Wide Web link to the statement is included, as well as the statement which was used to make the coding decision. Each coding statement has a (PRO) or (ANTI) notation listed at the end of it, which indicated how the specific organization was coded.

NOTE: For the sub-category H1120, "Optometrists & Ophthalmologists," a coding of MIXED has been assigned due to only four organizations being recorded as having made PAC campaign donations in 2008, and there being in tie in the number or organizations that are pro-reform and that are anti-reform. This measure is not optimal; however, a member faced with this mixed message from organizations in this category would likely move on to examine another factor of decision making in his environment.

1. H1100 –Physicians
    a. PRO REFORM
    b. AMA: $786,533
        i. http://www.ama-Association.org/ama/pub/news/news/ama-affirms-support.shtml
        ii. AMA will stay engaged to get a final bill this year that improves the System for patients and physicians signed into law. Physicians are at the heart of the health care System, and the AMA considers its position at the center of the health reform debate an honor and serious responsibility. **(PRO)**
    c. American College of Cardiology: $683,000
        i. http://qualityfirst.acc.org/Pages/default_new.aspx
        ii. The American College of Cardiology is working to transform health care from the inside out. Health System reform is essential and imminent and the ACC strongly believes that the medical community needs to be at the table for this very important discussion. The ACC's Quality First Campaign aims to set a new standard for health system reform that is patient-focused, value-based and fosters continuous quality and outcomes improvement. **(PRO)**
        iii. http://www.acc.org/media/releases/highlights/2009/sept09/capitolhill.cfm
        iv. The ACC believes reform of our current health care System is essential. Forty-three percent of Medicare dollars are spent on heart disease, our country's number one killer. The ACC offers itself and its 37,000 members as a resource to Congress as they undertake important System transformation and work to improve cardiac care. **(PRO)**
    d. American College of Emergency Physicians: $529,750
        i. http://www.acep.org/pressroom.aspx?LinkIdentifier=id&id=45294&fid=3496&Mo=No&taxid=112443
        ii. Q. Does ACEP support President Obama's plans for health care reform? A.The nation's emergency physicians support the President's health care reform principles and will work to achieve the long-term benefits that reforms should bring. We are asking Congress and Obama Administration to recognize and fund the central role that emergency medicine plays in the health care system. **(PRO)**
    e. American Academy of Family Physicians: $453,500
        i. http://www.aafp.org/online/etc/medialib/aafp_org/documents/policy/fed/endorse-letters/reformbills110309.Par.0001.File.tmp/AAFPLetterRegardingHR3962and3961.pdf
        ii. Affordable Health Care for America Act (HR 3962) and the Medicare Physician Payment Reform Act (HR 3961), introduced by Representative John Dingell and other health care leaders in the House. I am pleased to inform you that, after a review of the legislation, the AAFP Board of Directors has decided to support both bills. **(PRO)**
    f. Cooperative of American Physicians: $103,600
        i. http://cap-action.com/email_1

    ii. While the Cooperative of American Physicians, Inc. (CAP) will not have an official position on these issues, we believe our members should participate in an arena that is so important to the practice of medicine. **(ANTI)**
    iii. We urge you to take it a step further by contacting your member of Congress to provide him or her with your views so that any health care legislation will preserve patient choice, allow for innovative and experimental medicine, reduce administrative and regulatory costs, and preserve physician autonomy. The physician perspective is a valuable and vital component of this process. **(ANTI)**

2. H1110-Psychiatrists and Psychologists
    a. PRO REFORM
    b. American Psychiatric Association: $219,000
        i. http://www.psych.org/MainMenu/Newsroom/NewsReleases/2009NewsReleases/APA-Encourages-Passage-of-House-Healthcare-Reform-Proposals.aspx
        ii. ARLINGTON, Va. (Nov. 6, 2009) – The American Psychiatric Association is calling for concurrent passage of H.R. 3962 (the Affordable Health Care for America Act) and H.R. 3961 (the Medicare Physician Payment Reform Act of 2009), which together provide the best opportunity for comprehensive healthcare reform. **(PRO)**
    c. Association for the Advancement of Psychology: $21,000
        i. The undersigned members of the Mental Health Liaison Group are writing to express our vigorous support for your efforts to pass health care reform legislation. Our coalition hailed the bills approved by both houses last year, including the improvements to access, quality and services provided in the Patient Protection and Affordable Care Act (H.R. 3590). We ask you to advance the mental and behavioral health needs of our nation as reform legislation moves through Congress. **(PRO)**
3. H1120-Optometrists & Ophthalmologists
    a. MIXED
    b. American Optometric Association: $1,029,936
        i. http://www.aoa.org/impactwashingtondc/
        ii. It's clear to us that H.R. 3962 will be debated and voted on by the House of Representatives over the next few days. No matter how any of us may feel about national health care reform and the scope, nature and cost of the proposals that the President and congressional leaders have been developing in order to expand health insurance coverage to uninsured Americans, each one of us can review H.R. 3962 and be proud of the impact the AOA is having in Washington, D.C., at this critical moment. Here are key AOA-backed provisions included in H.R. 3962. **(ANTI)**
    c. American Academy of Ophthalmology: $746,500
        i. http://www.aao.org/advocacy/health_reform/hr3962.cfm
        ii. Today the Academy gives its support to two House measures, the Medicare Physician Payment Reform Act (H.R. 3961) and the America's

Affordable Health Choices Act (H.R.3962). House leadership has listened and been responsive to the Academy's key concerns in these bills. **(PRO)**

d. American Soc Cataract/Refractive Surgery: $10,000
    i. http://energycommerce.house.gov/Press_111/health_care/letters/hr3962_ascrs.pdf
    ii. We, therefore, offer our support for H.R. 3962, the Affordable Health Care for America Act and H.R. 3961, the Medicare Physician Payment Reform Act. We believe that meaningful health care reform cannot be achieved without a stable Medicare reimbursement system to assure Medicare beneficiary access to high quality care. We appreciate your commitment to the concurrent advancement of H.R. 3961 and H.R. 3962. **(PRO)**
e. Outpatient Ophthalmic Surgery Association: $5,000
    i. http://newsmanager.commpartners.com/oosso/issues/2009-09-11/
    ii. However, like many providers, we have been placed on the legislative defensive by Congress' need to garner budget savings to pay for reform. The House health care reform bills would reduce 2010 rates of all providers by a "productivity adjustment" of 1.3 percent. Because CMS has proposed a CPI-U update in 2010 of 0.6 percent, ASCs could emerge with a negative 0.7 percent update. As such, our efforts now are directed at ameliorating a negative update, arguing that it is inequitable because ASCs have not enjoyed any cost-of-living adjustment since 2004. We are also opposing House health care reform bill provisions that would require ASCs to submit cost reports, arguing that it is unnecessary and burdensome since our rates are and should be tied to those paid to hospitals. **(ANTI)**

4. H1130-Other Physician Specialists
    a. PRO REFORM
    b. American Association of Orthopedic Surgeons: $1,133,000
        i. http://www.aaos.org/news/aaosnow/dec09/reimbursement4.asp
        ii. Although the AAOS has not taken a position on the House bill (HR 3962), it does oppose the Senate bill (HR 3590). According to AAOS President Joseph D. Zuckerman, MD, "This bill will significantly interfere with the ability of orthopedic surgeons to serve the best interests of our patients. It would further bureaucratize the Medicare System with a new 15-person advisory board that would not be accountable to anyone. In addition, it would prematurely institute a mandatory and punitive physician quality reporting program, decrease funding for patient access to specialty care, and impose onerous restrictions on physician-owned hospitals.
        iii. http://blog.fos-society.com/
        iv. AAOS will continue to provide updates as it analyzes HR.3962. AAOS President Joseph D. Zuckerman, MD**,** reports in his latest healthcare reform update, "we are disappointed that the SGR reforms are not included in the overall healthcare reform legislation. We will continue to work to ensure that this important issue is addressed by Congress. **(ANTI)**
    c. American College of Radiology: $1,013,500
        i. No Public Statement Found

ii. No public statements can be found, but since three out of the five favor health care reform, the stance of the American College of Radiology can remain unknown.

d. American Society of Anesthesiologists: $1,006,100

i. http://www.asahq.org/news/asanews110609a.htm

ii. This weekend the U.S. House of Representatives is scheduled to vote on H.R. 3962, the "Affordable Health Care for America Act." ASA is urging a "yes" on this vote. H.R. 3962 – which is not the same as the controversial H.R. 3200 -- includes a number of important health insurance reforms, and would ensure that physicians can negotiate payments under a scaled-down new public plan option. **(PRO)**

e. College of American Pathologists: $675,000

i. http://www.cap.org/apps/docs/advocacy/letters/pelosi_letter.pdf

ii. As the House prepares to consider health care reform legislation, the College of American Pathologists (CAP) would like to offer comments on H.R. 3962, the Affordable Health Care for America Act. The CAP represents 17,000 physicians who are specialists in diagnostic medicine and provide direct patient care through diagnostic test selection, performance, interpretation, and direction on optimal therapy options to patients and clinicians. We appreciate your leadership in addressing a range of reforms intended to improve our health care system, including innovative ways to deliver care that emphasize collaboration, coordination, and reward the cost-effective provision of health care. **(PRO)**

f. American College of Surgeons Prof Association: $626,888

i. http://www.facs.org/hcr/dingell110409.pdf

ii. On behalf of the more than 74,000 members of the American College of Surgeons (College), I write to express the College's support for the Medicare Physician Payment Reform Act (H.R. 3961) and the American Affordable health Choices Act (H.R. 3962). The College shares your desire and commitment to make quality healthcare more accessible to all Americans. We strongly believe that H.R. 3961 and H.R. 3962 are intrinsically interdependent and that true health care reform cannot be fully achieved unless the current system is rebuilt on a solid foundation. **(PRO)**

5. H1400-Dentists

a. ANTI REFORM

b. American Dental Association: $1,300,998

i. http://www.ada.org/prof/resources/pubs/adanews/adanewsarticle.asp?articleid=3825

ii. While the ADA continues to lobby health care reform legislation, the Association does not support any of the bills currently under consideration. **(ANTI)**

iii. http://www.ada.org/prof/advocacy/issues/health_care_reform.asp

iv. Although the ADA does not support the overall health care reform measures passed by the House and the Senate, there are some provisions

that would benefit dentistry and dental patients, if final legislation includes them. **(ANTI)**

c. American Association of Orthodontists: $46,000
    i. http://www.aaomembers.org/Press/NewsReleases/Changes-to-FSA-Call-to-Action.cfm
    ii. We urge Congress not to further erode the economic status of America's middle-class families by limiting the FSA benefit and capping FSA contributions at $2,000 per year. FSAs encourage individual responsibility and allow consumers to take an active role in managing health-related expenses. They should be viewed not as part of the problem, but as part of the solution. **(ANTI)**

d. American Association/Oral & Maxillofacial Surgeon: $41,500
    i. http://www.aaoms.org/docs/govt_affairs/issue_letters/house_letter.pdf
    ii. While we recognize that the process of reforming the health care system is ongoing, it would be difficult for AAOMS to support The Affordable Health Care for America Act (H.R. 3962) as passed by the U.S. House of Representatives. It is our hope that as work continues on health reform in conjunction with action by the U.S. Senate, you take the following comments under consideration. **(ANTI)**

e. North Carolina Dental Society: $13,980
    i. No Public Statement Found
    ii. As a smaller, statewide organization, no public statements can be found for the North Carolina Dental Society. The three groups who do have public statements are large, national groups who are all against health care reform. Due to the majority rule, as well as the small sums donated by this group, its stance can remain unknown without altering this coding system.

f. Indiana Dental Association: $13,776
    i. No Public Statement Found
    ii. As a smaller, statewide organization, no public statements can be found for the Indiana Dental Association. The three groups who do have public statements are large, national groups who are all against health care reform. Due to the majority rule, as well as the small sums donated by this group, its stance can remain unknown without altering this coding system.

6. H1700- Other Non-Physician Health Practitioners
    a. PRO REFORM
    b. American Physical Therapy Association: $604,000
        i. http://www.apta.org/AM/Template.cfm?Section=Advocacy&Template=/CM/ContentDisplay.cfm&ContentID=59531
        ii. The American Physical Therapy Association (APTA) strongly supports efforts to reform the United States health care delivery system to improve coverage, access, and quality of care and reduce unnecessary costs. APTA stands ready to work with the U.S. Congress and President Obama's Administration to meet this policy challenge in 2009. **(PRO)**
        iii. http://www.dredf.org/healthcare/HR-3962-Letter.pdf
        iv. Dear Speaker Pelosi: The following members of the Consortium for Citizens with Disabilities (CCD) are writing to express our deep gratitude

and strong support for critical elements of H.R. 3962, the Affordable Health Care for America Act of 2009. CCD, a coalition of national consumer, service provider, and professional organizations advocates on behalf of persons with disabilities and chronic conditions and their families. **(PRO)**

c. American Occupational Therapy Association: $246,000
    i. http://www.dredf.org/healthcare/HR-3962-Letter.pdf
    ii. Dear Speaker Pelosi: The following members of the Consortium for Citizens with Disabilities (CCD) are writing to express our deep gratitude and strong support for critical elements of H.R. 3962, the Affordable Health Care for America Act of 2009. CCD, a coalition of national consumer, service provider, and professional organizations advocates on behalf of persons with disabilities and chronic conditions and their families. **(PRO)**

d. American Speech-Language-Hearing Association: $172,500
    i. http://www.dredf.org/healthcare/HR-3962-Letter.pdf
    ii. Dear Speaker Pelosi: The following members of the Consortium for Citizens with Disabilities (CCD) are writing to express our deep gratitude and strong support for critical elements of H.R. 3962, the Affordable Health Care for America Act of 2009. CCD, a coalition of national consumer, service provider, and professional organizations advocates on behalf of persons with disabilities and chronic conditions and their families. **(PRO)**

e. American Dietetic Association: $105,500
    i. http://www.eatright.org/Media/content.aspx?id=7440
    ii. As the 2009-2010 president of the American Dietetic Association, I am pleased to tell you ADA is committed to doing our part to support a dialogue leading to meaningful health reform that benefits all Americans. ADA is the largest organization of food and nutrition professionals in the world. We believe a simple, yet bold concept should guide American health reform: The changes we make in policies and programs should actually improve the health of Americans. The first step to achieve that goal is to recognize the role nutrition plays in promoting health and in preventing and managing disease. **(PRO)**

f. American Academy of Audiology: $32,000
    i. No Public Statement Found
    ii. As a small organization, no public statements can be found for the American Academy of Audiology. The four groups who do have public statements are large, national groups who are all in favor of health care reform. Due to the majority rule, as well as the small sums donated by this group, its stance can remain unknown without altering this coding system.

7. H1710-Nurses
    a. PRO REFORM
    b. American Association of Nurse Anesthetists: $797,000
        i. http://www.aana.com/Advocacy.aspx?id=130&linkidentifier=id&itemid=130

   ii. On behalf of the 40,000 members of the American Association of Nurse Anesthetists (AANA), I am pleased to extend our support for the America's Affordable Health Choices Act (HR 3200) . As an important milestone in a long legislative process, House passage of this measure will help move our country closer to a day when health coverage is more broadly available, healthcare costs are brought under control, and healthcare delivery more effectively and safely meets the needs of the American people. **(PRO)**

c. American Nurses Association: $374,040
   i. http://www.nursingworld.org/MainMenuCategories/HealthcareandPolicyIssues/HealthSystemtemReform/What-ANA-is-Doing.aspx
   ii. ANA has long been a supporter of meaningful health care reform that assures universal access to high-quality, affordable health care for all people in the United States. In recent months, a national consensus has emerged that the health care system is broken and now is the time to fix it. **(PRO)**

d. American Academy of Nurse Practitioners: $2,300
   i. No Public Statement Found
      1. NOTE FOR THIS CATEGORY-Due to nursing association cooperation and collaboration in Congressional briefings and discussions, each independent association appears to accept the position decisions of the American Nurses Association (ANA). The ANA's public position of pro-reform is being applied to the nursing associations selected here. **(PRO)**

e. Penn Association of Staff Nurses and Allied Professionals: $500
   i. http://www.aanp.org/AANPCMS2/LegislationPractice/Legislation/AANP+Collaborates+in+Congressional+Briefings+for+Advanced+Practice+Nurses.htm
   ii. The AANP, in collaboration with the ACNP, NAPNAP, NONPF and ANA sponsored and participated in the briefing related to the role of the nurse practitioner. Other briefings focused on the role of the nurse-midwife, the anesthetist and the clinical nurse specialist. **(PRO)**
      1. NOTE FOR THIS CATEGORY-Due to nursing association cooperation and collaboration in Congressional briefings and discussions, each independent association appears to accept the position decisions of the American Nurses Association (ANA). The ANA's public position of pro-reform is being applied to the nursing associations selected here.

8. H1750- Pharmacists
   a. PRO REFORM
   b. National Community Pharmacists Association: $299,700
      i. http://www.ncpanet.org/pdf/leg/NCPA-Views-on-HR-3692.pdf
      ii. The National Community Pharmacists Association (NCPA) is providing our views on the provisions that were included in H.R. 3692, the Affordable Health Care for America Act. We appreciate all the hard work that has gone into health care reform legislation in the House, and the

many opportunities that a reformed health care system presents for pharmacists to help improve the use of prescription medications, reduce health care costs, and enhance patient care. We also appreciate your support for community retail pharmacy. NCPA represents the approximately 23,000 owners and operators of independent community pharmacies in the United States. This bill includes many provisions that we can support because they allow us to better serve our patients by strengthening the pharmacy infrastructure. However, we also have some suggestions and concerns which we outline in this letter. We look forward to working with you to address these concerns as the bill moves forward. **(PRO)**

c. Association of Community Pharmacists: $10,000
    i. No Public Statement Found

9. H2100-Hospitals
    a. ANTI REFORM
    b. American Hospital Association: $1,274,500
        i. http://www.aha.org/aha/press-release/2009/091108-st-housebill.html
        ii. Last night, the House took an historic step in making health reform a reality. While the House bill makes important progress in expanding coverage, an important goal for hospitals, there are areas for improvement. In the days ahead, America's hospitals will work to improve upon the bill for patients and families. **(ANTI)**
        iii. http://www.washingtonpost.com/wp-dyn/content/article/2009/07/24/AR2009072403255.html?hpid=topnews
        iv. Hospital opposition to key reform proposals has been an important factor in slowing the pace of negotiations in the House, contributing to this week's announcement that the Senate would not meet Obama's August deadline for a final bill. Unlike other top industry groups, including the American Medical Association, the hospital group has yet to endorse any current reform bills, and it has signaled that such approval is unlikely unless the public insurance and Medicare payment options are scrapped. **(ANTI)**
    c. California Association of Hospitals/Health System: $611,528
        i. No Public Statement Found
        ii. As a small statewide organization, no public statements can be found for the California Association of Hospitals/Health System. The three groups who do have public statements are large, national groups who are not in favor of health care reform. Due to the majority rule, as well as the small sums donated by this group, its stance can remain unknown without altering this coding system.
    d. Healthcare Association of New York State: $478,500
        i. http://www.hanys.org/news/index.cfm?storyid=1271
        ii. HANYS issued a summary of major Medicare and Medicaid hospital and continuing care provider provisions. HANYS estimates the reduction in Medicare and Medicaid payments to New York hospitals and continuing care providers at more than $12 billion over ten years. HANYS believes in

a principle of shared sacrifice in achieving health care reform; however, shared sacrifice does not mean that providers will accept exorbitant funding cuts or unconstructive policy proposals that diminish providers' ability to provide care to communities. HANYS continues to advocate to reduce the level of cuts facing New York hospitals and health systems. **(ANTI)**

iii. http://www.hanys.org/news/index.cfm?storyid=1277

iv. While HANYS supports the House leadership in putting forward a bill that would cover 96% of all Americans, we remain concerned with a number of key provider provisions; chiefly, the level of Medicare and Medicaid reductions the bill would impose on New York hospitals and health systems. HANYS continues to press members of the New York State Congressional Delegation to secure last-minute changes in the bill that would mitigate the level of these cuts. **(ANTI)**

e. Federation of American Hospitals: $467,257

  i. http://energycommerce.house.gov/Press_111/health_care/hr3962_supporters.pdf

  ii. Federation of American Hospitals

  iii. The Federation of American Hospitals, while without a public statement, are present on an internal list used by Democrat party leadership to determine interest group and donor positions on health care reform. They are present on the final list, compiled on November 6th, 2009. **(PRO)**

f. Texas Hospital Association: $352,220

  i. http://www.tha.org/HealthCareProviders/Advocacy/CommentLetters/Letter%20to%20Hutchison%20on%20Reid%20bill%20Nov%2020%202009.pdf

  ii. Notwithstanding those concerns, you have continually worked with us to articulate our concerns with the proposed legislation and we look forward to the continued cooperation. Texas hospitals believe the status quo is not acceptable, and that comprehensive reform is needed. However, we cannot support a plan that does not expand coverage in a meaningful way, is overly reliant on Medicaid expansion, has too much government intrusion in the private market and does not recognize the clinical realities of delivering health care. **(ANTI)**

10. H2200-Nursing Homes

a. ANTI REFORM

b. American Health Care Association: $877,500

  i. http://www.opensecrets.org/news/2009/07/health-cheat-sheet-moneyinpoli.html

  ii. Opposes reducing senior citizen's Medicare funding. **(ANTI)**

c. American Seniors Housing Association-$601,000

  i. http://www.seniorshousing.org/uploadedFiles/SH_PAC/CConnect%20Spring%202009.pdf

  ii. Due to stated targeting of Republicans and Moderate Democrats with PAC money, it is determined that the ASHA is anti-reform. **(ANTI)**

d. Beverly Enterprises: $387,435

i. No Public Statement Found
ii. As a small franchise organization, no public statements can be found for Beverly Enterprises. They are being coded as anti-reform due to the bulk of their funding coming from Medicaid, as the US Census Bureau determined as recently as 2007. In 2007 Medicaid paid out $59 billion to nursing homes and residential care facilities (McKnights 2009). **(ANTI)**

e. HCR Manor Care: $201,500
   i. No Public Statement Found
   ii. As a small franchise organization, no public statements can be found for HCR Manor Care. They are being coded as anti-reform due to the bulk of their funding coming from Medicaid, as the US Census Bureau determined as recently as 2007. In 2007 Medicaid paid out $59 billion to nursing homes and residential care facilities (McKnights 2009). **(ANTI)**
f. Genesis HealthCare: $159,000
   i. No Public Statement Found
   ii. As a small franchise organization, no public statements can be found for Genesis Health Care. They are being coded as anti-reform due to the bulk of their funding coming from Medicaid, as the US Census Bureau determined as recently as 2007. In 2007 Medicaid paid out $59 billion to nursing homes and residential care facilities (McKnights 2009). **(ANTI)**

11. H4000-Health Care Products
    a. ANTI REFORM
    b. Johnson & Johnson: $640,400
       i. http://www.jnj.com/wps/wcm/connect/93ee64004f55687aa020a41bb31559c7/financing-health-care.pdf?MOD=AJPERES
       ii. Studies show that innovation tends to suffer under government-financed systems. The combination of price controls, budget ceilings and other restrictions reduces incentives to invest in medical research. For example, European countries used to discover and develop more new medicines than the United States, but that's not the case any longer. While there are certainly several contributing factors, including changing tax policies in these markets, the advent of price controls in Europe is one important reason for the change. **(ANTI)**
    c. Alcon Laboratories: $,3000
       i. http://seekingalpha.com/article/188389-alcon-inc-q4-2009-earnings-call-transcript?page=5
       ii. This range does not reflect any potential impact from U.S. health care reform because it's not at all clear what, if anything may come out of Washington this year. **(ANTI)**
12. H4300-Pharmaceutical Manufacturing
    a. ANTI REFORM
    b. GlaxoSmithKline: $1,417,680
       i. http://us.gsk.com/html/healthcare/healthcare-reform.html
       ii. GSK supports the ongoing efforts by Congress and the White House to achieve comprehensive healthcare reform**. (PRO)**
    c. Pfizer Inc: $1,268,944

    i. http://www.opensecrets.org/news/2009/07/health-cheat-sheet-moneyinpoli.html
    ii. Opposes public health insurance plan. **(ANTI)**
d. AstraZeneca Pharmaceuticals: $1,074,600
    i. http://www.astrazeneca-us.com/about-astrazeneca-us/az-on-the-issues/?itemId=6122341
    ii. AstraZeneca believes that meaningful healthcare reform will require the development of a market-based system that maximizes patient choice and outcomes while minimizing system costs. Achieving positive change will require a public-private partnership driven by ideas – not ideologies. **(ANTI)**
e. Amgen Inc: $1,034,925
    i. http://money.cnn.com/video/fortune/2009/07/08/f_cs_amgen_health_care_reform.fortune/
    ii. CEO states dislike of public option plans. **(ANTI)**
f. Abbott Laboratories: $881,000
    i. No Public Statement Found
    ii. No public statements can be found for Abbott Laboratories. The three groups who do have public statements are large, national groups who are all in favor of health care reform. Due to the majority rule, as well Abbott Laboratories' stance can remain unknown without altering this coding system.

13. H4400-Pharmaceutical Wholesale
    a. PRO REFORM
    b. AmerisourceBergen Corp: $233,000
        i. http://www.amerisourcebergen.com/investor/External.File?item=UGFyZW50SUQ9MjcwNTd8Q2hpbGRJRD0tMXxUeXBlPTM=&t=1
        ii. Though healthcare reform may not be resolved for months, I am convinced that increased pharmaceutical utilization will, very appropriately, be an integral part of the new healthcare environment, positively impacting our customers, and in turn, AmerisourceBergen. The Company has the physical capacity and the management depth to meet this increased demand. **(PRO)**
    c. National Wholesale Druggists Association: $24,000
        i. http://www.healthcaredistribution.org/gov_affairs/positions/healthreform.asp
        ii. HDMA believes it is critically important that all Americans have access to high-quality, safe and affordable healthcare. HDMA is dedicated to working with the Administration, Congress and other stakeholders to help transform healthcare for the benefit of patients. **(PRO)**
    d. Cardinal Health: $17,500
        i. http://phx.corporate-ir.net/External.File?item=UGFyZW50SUQ9MTYxMzN8Q2hpbGRJRD0tMXxUeXBlPTM=&t=1
        ii. In summary, we are well positioned to compete and create value in the largest segment of the U.S. economy. We believe the demand for our

products and services is likely to increase, given the aging demographics and the focus on providing all Americans access to healthcare. **(PRO)**

e. McKesson Corp: $10,232
    i. http://drugtopics.modernmedicine.com/drugtopics/Associations/Healthcare-reform-pharmacy-services-top-agenda-at-/ArticleStandard/Article/detail/613227:
    ii. McKesson: We definitely agree that all Americans should have access to healthcare. What we are challenged with is, how are we going to pay for it and who is going to pay for it?" said Paul Julian, executive vice president and group president, McKesson Corp. Some experts estimate that the reform proposal would funnel an additional 20 million to 60 million prescriptions into the healthcare system. "If there is an increase in script count that will be great for business." **(PRO)**
f. PharMerica Corp: $6,000
    i. No Public Statement Found
    ii. No public statements can be found for PharMerica Corporation. The four groups who do have public statements are large, national groups who are all in favor of health care reform. Due to the majority rule, as well PharMerica Corporation's stance can remain unknown without altering this coding system.

Works Cited

Aaron, Henry J. May 12, 2009. "Health Care Reform: Beware of Interest Groups Bearing Gifts." *The Brookings Institution*. 24 Nov. 2009. <http://www.brookings.edu/opinions/2009/0512_health_care_reform_aaron.aspx>.

Abramowitz, Alan I. November 23, 2009. "Ideological Realignment and the Transformation of the American Party System." American Political Science Association Annual Meeting. Chicago. Paper.

Arthur, W. Brian. 1994. *Increasing Returns and Path Dependence in the Economy*. Ann Arbor: University of Michigan Press.

Brinker, Paul A., and Burley Walker. 1962. "The Hill-Burton Act: 1948-1954." *The Review of Economics and Statistics* 44.2: 208-12.

Blumenthal, David, and James Morone. 2008. "The Lessons of Success? Revisiting the Medicare Story." *The New England Journal of Medicine* 359.22: 2384-2389.

Capitol.Net. 2008. “Congress by the Numbers, 111th Congress, 1st Session.” *TheCapitol.Net*. < http://www.thecapitol.net/FAQ/cong_numbers.html> (December 15, 2009).

Clapp, Charles L. 1964. *The Congressman: His Work as He Sees It*. Washington D.C.: Brookings Institute.

Collins, Sara R., Jennifer L. Kriss. 2008. “The Public’s Views on Health Care Reform in the 2008 Presidential Election.” *The Common Wealth Fund.* <http://www.commonwealthfund.org/usr_doc/Collins_pubviewshltcarereform2008election_1095_ib.pdf.>

Hacker, Jacob S. 1999. *The Road to Nowhere*. Princeton, New Jersey: Princeton University Press.

Iglehart, John K. 1999. "Medicare." *The New England Journal of Medicine* 340.4:327-32.

Jacobs, Lawrence R. 2007. "The Medicare Approach: Political Choice and American Institutions." *Journal of Health Politics, Policy, and Law* 32.2:159-86.

Jelen, Damore, and Thomas Lamatsch. 2002. “Gender, Employment Status, and Abortion: A Longitudinal Analysis.” *Sex Roles* 47 (October):321-330.

Kingdon, John W. 1989. *Congressmen's Voting Decisions*. 2nd Edition. New York: Harper & Row.

Levi, Margaret. 1997. "A Model, a Method, and a Map: Rational Choice in Comparative and Historical Analysis." *In Comparative Politics: Rationality, Culture, and Structure, ed*. Mark I. Lichbach and Alan S. Zuckerman. Cambridge: Cambridge University Press. Pp. 19-41.

Levinthal, Dave. February 10, 2010. “Federal Lobbying Climbs in 2009 as Lawmakers Execute Aggressive Congressional Agenda.” *Capitol Eye Blog*. *The Center for Responsive Politics*. <http://www.opensecrets.org/news/2010/02/federal-lobbying-soars-in-2009.html.>

Mayhew, David R. 2004. *The Electoral Connection*. 2nd Edition. New Haven, Connecticut: Yale University Press.

McCarty, Poole, and Howard Rosenthal. 1997. *Income Redistribution and the Realignment of American Politics*. Washington D.C.: American Enterprise Institute.

New York Times. November 2009. “House Vote 887-House Health Care Bill.” *The New York Times.* <http://politics.nytimes.com/congress/votes/111/house/1/887.>

Organization for Economic Cooperation and Development. 2009. “OECD Health Data 2009 - Frequently Requested Data.” *OECD*. <http://www.oecd.org/document/16/0,3343,en_2649_34631_2085200_1_1_1_1,00.html>

Poole, Keith T., and Howard Rosenthal. 2007. *Ideology and Congress*. New Jersey: Transaction Publishers.

Rasmussen Reports. March 2, 2008. “Obama Trusted on Health Care and Education, McCain on Trade Agreements.” <http://www.rasmussenreports.com/public_content/politics/elections2/election_20082/2008_presidential_election/obama_trusted_on_health_care_and_education_mccain_on_trade_agreements.>

Rasmussen Reports. September 20, 2007. “50% Favor Government Guaranteed Health Care Coverage”. <http://www.rasmussenreports.com/public_content/politics/current_events/healthcare/september_2007/50_favor_government_guaranteed_health_care_coverage.>

Pear, Robert. October 2008. “Women Buying Health Policies Pay a Penalty.” *The New York Times.* < http://www.nytimes.com/2008/10/30/us/30insure.html.>

Pierson, Paul. 2000. “Increasing Returns, Path Dependence, and the Study of Politics.” *American Political Science Review* (June) Vol. 94, No. 2: 251-267.

Rohde, David W. 1991. *Parties and Leaders in the Postreform House*. Chicago: University of Chicago Press.

Saad, Lydia. March 28, 2008. “Economic Anxiety Surges in Past Year.” *The Gallup Organization*. <http://www.gallup.com/poll/105802/economic-anxiety-surges-past-year.aspx.>

Steinmo, Sven, and Jon Watts. 1995. "It's the Institutions, Stupid! Why Comprehensive National Health Insurance Always Fails in America." *Journal of Health Politics, Policy, and Law*. 20.2: 329-372.

White, Nathan. 2009. “Kucinich: Why I Voted No.” <http://kucinich.house.gov/News/DocumentSingle.aspx?DocumentID=153995>

Wilensky, Harold L. 2009. "U.S. Health Care and Real Health in Comparative Perspective: Lessons from Abroad." *The Forum* 7.2: 1-18.

Data Sources

Carroll, Royce, Jeff Lewis and James Lo and Nolan McCarty and Keith Poole and Howard Rosenthal. 2010. “DW-NOMINATE Scores with Bootstrapped Standard Errors: Legislator Estimates 1st to 111th House.” Version updated January 16, 2010. [Computer Text File]. < http://www.voteview.com/default.htm.>

Center for Responsive Politics. 2010. “2008 Cycle Tables: Campaign Finance Data Bulk Data.” January 28, 2010. [Excel Computer File]. <http://www.opensecrets.org/index.php.>

CQ Press Collection. 2009. “Roll Call Results for the U.S. House Vote "Health Care Overhaul -- Abortion Funding Ban"; 111th Congress.” [Excel Computer File] CQ Press Electronic Library, CQ Congress Collection [Producer and Distributor]: Washington, D.C, 2009. <http://library.cqpress.com.proxy.library.emory.edu/congress/rollcall.php?id=floorvote111-221047000.>

CQ Press Collection. 2009. “Roll Call Results for the U.S. House Vote "Health Care Overhaul -- Passage"; 111th Congress.” [Excel Computer File] CQ Press Electronic Library, CQ Congress Collection [Producer and Distributor]: Washington, D.C, 2009. <http://library.cqpress.com.proxy.library.emory.edu/congress/rollcall.php?id=floorvote111-221046000.>

Willis, Derek, and Stephan Weitberg and Shan Carter and Matthew Bloch, and The New York Times. 2010. “House Vote 887 - House Health Care Bill.” [Online]. <http://politics.nytimes.com/congress/votes/111/house/1/887.>