Party Politics & Enactment of “ObamaCare”: Another Look at Minority Party Influence

Elizabeth Rigby, George Washington University
Jennifer Hayes Clark, University of Houston - Main
Stacey Pelika

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Elizabeth Rigby
George Washington University
erigby@gwu.edu

Jennifer Hayes Clark
University of Houston
jclark10@uh.edu

Stacey Pelika
Children’s Defense Fund
stacey.pelika@gmail.com

Draft: August 9, 2011

Cartoon Source: http://www.narf.tv/2010/02/reconciliation/

Acknowledgement. Partial funding for this project was provided to the first author by the Columbian College Facilitating Fund at the George Washington University. In addition, the paper benefited from expert research assistance from Vanessa Forsberg and insightful feedback from Sarah Binder, Craig Volden, and participants at the Trachtenberg School’s Public Policy Workshop. Yet, all errors and conclusions remain those of the authors alone.
Despite President Obama’s early calls for a bipartisan approach to health reform, the Patient Protection and Affordable Care Act of 2010 passed with no Republican votes in either the House or the Senate. Its passage was accompanied by intense criticism that the reform was “rammed through” the legislative process by the majority party, whereas the administration emphasized the extensive, year-long debate over health reform and argued that the final bill represented a compromise of good ideas from both parties. We examine these conflicting claims, drawing on real-time accounts of the policy debate published in the Capitol Hill newspaper *Roll Call*. Our analyses suggest a more-nuanced balance between majority and minority party influence, which shifted as debate moves from committee, to floor, to final passage. Illuminating this balancing act provides insight into the pathways by which members of the minority party, and their policy preferences, get incorporated in our policymaking process.
In March 2010, Congress enacted and the President signed the Patient Protection and Affordable Care Act—bringing to a close a year of active political debate over health reform, not to mention nearly a century of health reform efforts (Jacobs and Skocpol 2010). Despite this success, the bill’s legitimacy remains under a cloud of criticism, with challenges to the bill in the form of court proceedings and legislation to repeal or defund what Republicans call “ObamaCare” (Kersh 2011). Underlying these challenges is a broader political discourse that characterizes the passage of health care reform as one-sided and undemocratic—with inadequate debate, consideration, and compromise. In particular, critics claim that the bill was “rammed through” the legislative process by the Democratic majority party despite the minority party’s opposition. This frustration was voiced by House Republican Leader John Boehner: “We've offered to work with the president all year. We've been shut out, shut out, and shut out.”

Indeed, by conventional metrics this was one partisan piece of legislation. Jacobs and Skocpol (2010) describe how “only Democrats were to be found among the 200 or so lawmakers in attendance [at the signing of the bill]” (p. 6), while at nearly the same time, Republican officials were filing lawsuits to declare parts of the law unconstitutional. This bifurcated partisan reaction to the bill was not surprising considering that the final bills received no Republican votes in either the House or the Senate, a “standard of unanimity in opposition only twice previously achieved in the post-World War II era on landmark legislation” (Kersh 2011, p. 620). Further, in order to overcome the of opposition of Senate Republicans, Democrats in the House and Senate forged an informal arrangement—relying on a procedural maneuver described by Rom (forthcoming) as “brilliant, tricky, and risky” (p. 16). Specifically, Democrats avoided the need for another sixty-vote coalition by the House passing the Senate bill, along with a so-called

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sidecar bill that made substantial changes to the Senate bill, but allowed for an easier path to enactment via reconciliation and a simple majority vote (Jacobs and Skocpol 2010).

Democrats challenge this picture of extreme partisanship. They note how early in the debate, President Obama called for a bipartisan approach to health reform and “spent crucial weeks and months in the middle of 2009 deferring to the efforts of Senate Finance Committee Chair Max Baucus to produce a bill supported by at least two or three Republicans” (Jacobs and Skocpol 2010). Yet, the actual debate soon polarized along partisan lines after Baucus’ Gang of Six talks broke down. In early 2010, the president tried to discredit criticism of extreme partisanship by convening a televised “Bipartisan Summit” in which he sat down and negotiated with Republican lawmakers. Yet, this move was met with further skepticism by most Republican Members of Congress, who questioned the real motives behind this attempt at bipartisanship.

Mike Pence, chairman of the House Republican Conference, voiced this wariness saying:

> The President yesterday called for us to “look for common ground.” He's challenging Republicans to present a bill at this so-called summit that's going to take place on Thursday—all the while Democrats are in some backroom, as we speak, cooking up another health care bill they will reveal next week… But what we can't help but feel like here is that the Democrats spell summit "s-e-t-u-p," and all this is going to be is some media event used as a preamble to shove through Obamacare 2.0.²

Telling a different story, the Obama administration argued that the bill represented a compromise of good ideas from Democratic and Republican policymakers. On its website, the White House posted a statement titled “Republican Ideas Included in the President’s Proposal,” which argued: “[t]hroughout the debate on health insurance reform, Republican concepts and proposals have been included in legislation. In fact, hundreds of Republican amendments were adopted during

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the committee mark-up process. As a result, both the Senate and the House passed key Republican proposals that are incorporated into the President’s Proposal.”

   Even now, more than a year after enactment, it is a challenge to reconcile these claims. On one hand, Democrats did indeed “ram through” this legislation. Yet, on the other hand, the final bill excludes a public option—the top policy priority for many Democrats, which suggests evidence of bipartisan compromise. In this paper, we examine these conflicting claims motivated by a normative concern for procedural fairness in our policymaking process—including the twin goals that that the majority prevails, yet minority rights are preserved (Durr, Gilmour, and Wolbrecht 1997; Gangl 2003; Hibbing and Theiss-Morse 2001; 2002). We aim to illuminate this balancing act in one case—health reform—in order to inform retrospective evaluations of the politics surrounding this major piece of legislation, as well as broaden our discipline’s efforts to discuss and identify procedural (un)fairness within our policymaking process.

   Health care reform represents a “hard case” for any study of bipartisanship. As discussed above, final vote tallies suggest no Republican support—with Republicans in the House voting as a block to repeal the bill nearly a year later. Further, retrospective accounts of the political debate contradict each other along predictable ideological and partisan lines. Therefore, we must move beyond common metrics for assessing partisanship to examine this question in new ways. To do so, we draw on “real-time” accounts of the health reform debate published in the Capitol Hill newspaper Roll Call between June 1, 2009 and March 24, 2010 (N=328 articles). As a source of news for insiders working in Congress or at the White House, Roll Call records the day-to-day developments on Capitol Hill in an accurate and even-handed way. Consequently, the newspaper provides rich data for us to examine the following: the policy positions adopted by Democratic and Republican policymakers; the frequency in which Democratic and Republican

3 White House webpage: www.whitehouse.gov/health-care-meeting/republican-ideas
policymakers, as well as their policy proposals, were included on the agenda versus the final bill; and the linkages among Democratic and Republican policymakers and policy proposals throughout the debate. This approach provides a new vantage point for illuminating the pathways by which members of the minority party and their ideas get incorporated in our policy process.

PARTIES AND THE POLICYMAKING PROCESS

There are good reasons to believe that the Democratic Party dominated the health reform debate. Most notably, at the start of the debate, Democrats held a substantial electoral and governing coalition in the form of a solid majority of the popular vote for the president, a large partisan majority in the House, and a filibuster-proof majority in the Senate (Rom, forthcoming). Hence, they held the institutional powers necessary to control the agenda and shape legislative outcomes (Cox and McCubbins 1993; 2005) via their power to appoint committee chairs, schedule debate, and establish the rules governing floor debate (Campbell, Cox, and McCubbins 2002; Gailmard and Jenkins 2007; Krehbiel 1998).

With these structural advantages, health care reform was politically possible, if not guaranteed (Jacobs 2010; Peterson 2011). In fact, this majority power—to steward your proposal through the legislative process—has been key in previous congressional health care debates (Marmor and Oberlander 2004; Oliver, Lee, and Lipton 2004). This was illustrated in a recent comprehensive analysis of all bills introduced in Congress from 1973 to 2002, a span that includes periods of Democratic and Republican control of each chamber. In that study, Volden and Wiseman (forthcoming) compared the fate of health care bills to other types of bills in addition to examining legislators’ effectiveness in moving the legislation they sponsored through the policymaking process. Even after accounting for other factors likely to shape legislators’ effectiveness, they found that members of the majority party are about twice as effective as
minority party members, with much of their advantage contained in their greater odds of moving legislation out of committee and to the floor.

Despite these advantages, Democrats faced many hurdles in their attempt to reform health care in this country. In particular, the minority party retained many tools to shape the agenda, especially in the Senate where minority party members have greater institutional powers to raise issues and propose amendments (Binder 1997; Gailmard and Jenkins 2008). Senators can employ the filibuster (in the absence of 60 Senators invoking cloture) to block controversial legislation, making it much harder for the majority party leaders to limit debate and control the output of the legislative process. In fact, these institutional barriers have been identified as key factors in the blockage of earlier reform efforts (Brady and Buckley 1995; Ferguson, Fowler, and Nichols 2008; Steinmo and Watts 1995) and the demise of the public option during the current debate (Halpin and Harbage 2010). Acknowledging the potential for minority obstruction, Hacker (2008) suggested a focus on procedural changes in the Senate as one of the strategies health reform proponents could pursue to improve the prospects for reform.

Beyond institutional rules, congressional Democrats faced a challenging political climate. Volden and Wiseman (forthcoming), in their broad study of congressional politics, identified more gridlock on health bills compared to other types of bills, attributing this to the large numbers of health bills dying in committee. Further, the majority held by the Democrats at the start of health reform was large, but still smaller than those enjoyed by earlier Congresses that were able to enact large-scale social legislation such as Social Security and Medicare (Peterson 2011). Further, in the final months of the debate, Senate Democrats lost their filibuster-proof majority when Republican Scott Brown was elected to fill the seat of deceased Democratic Senator Kennedy. The game-changing nature of this special election was ironically reflected in a
newspaper headline, “Scott Brown Wins Mass. Race, Giving GOP 41-59 Majority in the Senate” (Jacobs and Skocpol 2010, pg. 109). Finally, the current debate took place in a new political reality (Hacker 2008), characterized by partisan polarization and the scarcity of moderate Republicans, further exacerbating policy gridlock and leading to less expansive social reform (McCarty, Poole, and Rosenthal 2006). Not surprisingly, as a result of these limits on majority party power, the conventional wisdom going into this round of the health reform debate was that the only politically feasible strategy was a bipartisan one (Ferguson, Fowler, and Nichols 2008; Oberlander 2010). This assumption makes the critique of one-party policymaking even more surprising and in need of exploration.

ASSESSING PARTISANSHIP IN THE POLICYMAKING PROCESS

With both parties holding tools for influencing the debate, it is not clear whether Democrats unfairly dominated the process or consistently compromised in the face of constraints placed on them by the minority party. Yet, public opinion polls indicate that the public was unhappy with how reform unfolded—with the vast majority of Americans (73 percent) having reported that the debate over health care reform left them feeling that the policymaking process is broken rather than working as intended (Kaiser Family Foundation, 2010). Despite this conclusion, in many ways, the process operated as we would expect in a fragmented governance system such as ours. Jacobs and Skocpol (2010) make this point, “Despite the twists and turns of health reform’s journey, it actually followed the path and practices used for years by Republicans pressing for tax cuts, and by Democrats seeking to expand eligibility for government health care programs, such as Medicaid and the State Children’s Health Insurance Program. Only the scope of the legislation was different this time, along with the 24/7 press coverage” (p. 52).
More importantly, it is unclear what metric should be used to identify excessive partisanship when it does occur. Majority parties are expected to govern, consistent with a “responsible party model” in which a political party is expected to run for election on a clear programmatic platform and then push forward this agenda once enacted—allowing voters to choose among clearly delineated options and hold policymakers accountable for the laws they enact (APSA 1950; Jacobs 2010). At the same time, winning a majority of seats should not grant any party carte blanche to disregard the preferences of the minority party or the citizens they represent. At issue is the open question of how much power, and in what forms it, should be granted to the minority party? Empirical models of policymaking cannot answer this question. Yet, we can provide citizens with richer descriptions of partisan dynamics than our commonly-employed measures drawing on the proportion of each party voting “yea” or “nay” on individual roll call votes (i.e. Mellow and Trubowitz 2005) or even more-nuanced measures of bill cosponsorship (Harbridge 2011). Additional insight can be gained by looking more closely at the process of policy formation, and the policy content of legislation itself, in order to illuminate and assess partisan dynamics.

To develop additional metrics for examining partisan dynamics in the policymaking process, we draw from real-time accounts of the health reform debate published in Roll Call newspaper. Roll Call is a unique news source whose audience is primarily “insiders” working in congressional or executive branch offices. The news outlet provides these readers with news of the legislative branch and political happenings in Washington, D.C. To this end, 11,500 free copies of each issue are delivered to Congress and another 400 copies to the White House. To

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4 Mellow and Trubowitz (2005) examined bipartisan support, defined as a simple majority of both parties voting together or parties opposed but with a difference between them of less than 20 percentage points. Harbridge (2011) adopts another metric of bipartisanship by examining the degree to which Members of Congress from different parties co-sponsor legislation.
meet the demands of this specific audience, *Roll Call*’s coverage closely follows the Congressional calendar, publishing an issue Monday through Thursday when Congress is in session and only once weekly when out of session. As a result, this news source is well positioned to capture day-to-day developments in congressional politics, although it would be much less useful if we were trying to assess the broader media context. Due to its insider audience, this source also faces fewer incentives than the mainstream media to provide “balanced” coverage (i.e., stories that provide equal space to each side of a debate); however, like any news source, *Roll Call* aims to cover both sides of any controversial issue and so we may see an over-estimation of Republicans’ role in the health care debate.

The data used in this study come from the full-text of all 328 *Roll Call* articles published June 1, 2009 to March 24, 2010 that were tagged with the major term “health care reform” or “Obama health reform” by Lexis-Nexis. We coded and combined these data in different ways to examine additional metrics of bipartisanship versus partisan conflict, as well as how these dynamics shifted throughout the debate. First, we hand-coded these articles to identify the policy content under consideration throughout the debate. We identified 27 specific policy elements (i.e., public option, malpractice reform) and estimate the degree to which each received support or opposition from Democratic versus Republican Members of Congress. From these coded data, we identify four policy elements that most polarized the parties and four bipartisan policy elements. We compared the legislative success or failure of these eight policy elements, as well as patterns of attention to Democratic, Republican, and bipartisan policy elements. In a second set of analyses, we employed Social Network Analysis (SNA) to describe the policymaking network (policymakers and other policy proposals) surrounding these eight policy elements in
order to illuminate the ways in which Republican Members of Congress and their policy proposals were linked in the core policy debate.

PARTISANSHIP & POLICY DESIGN

To assess partisan agreement and disagreement on the content of health care reform, we needed to identify the core policy elements under consideration throughout the debate and then classify each in terms of partisan support. This was complicated by the fact that many proposals previously championed by particular Members of Congress (i.e., individual mandate, Medicare expansion) were actually opposed by those same Members during the health reform debate. For this reason, we adopted a more stringent definition of support, basing partisan classification on explicit stances adopted by Democratic and Republican policymakers during the period under study (June 2009–March 2010). To identify these stances, we hand-coded the Roll Call articles for each instance in which either the president or a Member of Congress was described as in support of or opposed to a particular policy proposal (e.g., public option). We did not code support or opposition to broad packages that included many proposals and/or compromise proposals. Further, we excluded all stances that referred to broader policy goals (e.g., cover the uninsured, reduce health care costs).

This process identified 439 coded positions. Of these, 90 percent related to one of 25 policy proposals.\(^5\) We also included two additional policy proposals: Health Savings Accounts (HSAs) and the single payer plan, which each had only two instances of coded positions but we judged to be central to some Members’ health platforms. Appendix A provides definitions for these 27 policy proposals as well as the alternative names.descriptions that we combined in our coding scheme. This process left us with 392 coded position statements—each relating to one of

\(^5\)These 25 policy proposals each had at least five coded positions throughout the time period. We dropped 47 coded instances in which a Member supported or opposed a policy that had fewer than four other coded statements.
the 27 central policy proposals—of which 57 percent captured a Democratic Member of Congress supporting a particular policy proposal, 21 percent captured a Democratic Member opposing a particular policy proposal, 13 percent captured a Republican Member supporting a particular policy proposal, and 9 percent captured a Republican opposing a policy proposal.

[Table 1 about here]

After collapsing these 392 instances of support/opposition into the dataset of 27 policy elements, we constructed three variables capturing Republican members’ positions: (1) number of instances in support, (2) number of instances in opposition, and (3) net support, calculated by subtracting number of instances in opposition from the number in support. Parallel measures were calculated for Democratic members, including stances adopted by either of the two Independent Members (Lieberman and Sanders) because they both caucused with the Democrats throughout this debate. Table 1 presents descriptive statistics for these six variables, as well as descriptive statistics excluding the public option, which was the most commonly-referenced policy element (29 percent of all coded positions).

[Figures 1 and 2 about here]

**Partisan Support for Policy Elements.** We used these measures of net Democratic support and net Republican support to compare partisan positions on these policy options. Figure 1 presents our measure of net Republican support for each policy element. Republican were reported to be in strong opposition to a few proposals, most notably the public option followed by individual mandate and millionaire tax. Similarly, they were described as strongly supportive of other policy elements: the trigger option and malpractice reform, followed by pre-existing conditions and reform to long-term care programs. Figure 2 presents the same comparison for Democrats. In contrast to the more balanced distribution among Republicans (who opposed some
policies and supported others), net Democratic support was positive for almost all the policy elements. The key exceptions were the trigger, restrictions on immigrant eligibility, malpractice reform, a tax on medical devices, and the millionaire tax. Democrats were reported to be most strongly in support of the public option and restrictions on abortions, followed by the long-term care and pre-existing conditions proposals also favored by the Republicans. The different distribution of net support among the Republican (Figure 1) versus the Democratic (Figure 2) Party suggests that the scope of policy options on the agenda were more acceptable to the Democrats than to the Republicans. This is likely because the Democratic majority was able to use its powers of agenda control to shape the policy elements under consideration. Yet, as is clear from the inclusion of policy elements that the Democrats strongly opposed, their agenda control was not complete, with the minority party also able to push some of their preferred policies onto the policymaking agenda.

Identifying Partisan and Bipartisan Policy Proposals. Comparing Figures 1 and 2, we see polarized parties, with contrasting partisan positions on the public option, trigger, and malpractice reform. At the same time, we see bipartisan support for other policies (i.e., restrictions on pre-existing conditions provisions) from both parties. To contrast these two patterns of partisan positions, we focused on the policy elements with clear signals (net support greater than 2, or less than -2). We identified eight policies (presented in Table 2, aligned by partisan support), which included two Democratic policies, the individual mandate and public option; two Republican policies, the trigger and malpractice reform; and four bipartisan policies, long-term care, pre-existing conditions, portability, and health exchanges.

Since these policies were categorized by net party support (support minus opposition), we also considered the level of intraparty agreement on each policy element. Among our coded
positions, Republicans were completely unified (either all in support or all opposed) for each of the eight policy elements. In contrast, Democratic positions were divided on three of them: 71 percent supported the individual mandate, 74 percent supported the public option, and 70 percent opposed the trigger. With the Democratic Party holding such large majorities and controlling the policy agenda, it is not surprising that much of the policy debate focused on intra-majority party debate. In comparison, the cohesiveness of the Republican Party likely assisted them in maximizing the institutional powers enjoyed by any minority party. In many ways, minority party cohesiveness may serve to counter-balance the majority party’s advantage in terms of agenda control.

Table 2 about here

Policy Enactment, by Partisan Support. One way to assess minority party influence is to compare the rate at which key policy proposals were enacted in the final legislation. As indicated by asterisks (*) in Table 2, only four of these eight policy elements were enacted. Three of these enjoyed unified support from both parties (pre-existing conditions, long-term care, and health exchanges). The other enacted element—the individual mandate—was favored by Democrats, but not Republicans. Republicans were not able to secure enactment of either of their two key policy elements, although their preference for the trigger option—a means of watering down the public option—became moot once the public option was off the table. Further, Republicans were able to block enactment of the policy they most strongly opposed, the public option, which was strongly supported by Democrats. This outcome is consistent with a notion of minority party influence in which minority parties are more effective at blocking or stopping

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6 Although the final bill did include a small, pilot grant program for state experiments with malpractice reform, this was not a substantial element of the reform as Republicans would have preferred.
legislation than advancing or enacting preferred policy proposals, such as the Republican call for reform of the malpractice system.

**Attention to Policy Elements, by Partisan Support.** To examine attention to these polarized versus bipartisan proposals throughout the debate, we turned away from our dataset of coded position statements to examine the full text of the 328 *Roll Call* articles covering this debate. We divided these articles into three policymaking phases. The first phase (*n*=161 articles) runs from June 1 through October 13 and captures the period of time in which all five House and Senate committees of jurisdiction passed a health care bill out of their committee. The second stage (*n*=87 articles) runs from October 14 through December 24, capturing both the House and Senate floor votes. The third stage (*n*=80 articles) runs from December 25 through March 24 and captures the debate leading up to final passage in both the House and Senate.

([Figure 3 about here])

To evaluate the prominence of these eight policy elements, we compared the frequency with which each element was discussed in *Roll Call* coverage, reflecting the centrality of each element to the political debate. Figure 3 presents the relative frequency (normalized to the number and length of articles) of Democratic, Republican, and bipartisan policy elements, at each stage of the debate. At the committee stage, *Roll Call* coverage was nearly even in terms of policies with Democratic versus Republican support, with a little less coverage of the four bipartisan policy elements. However, during the floor stage, coverage was much greater for the Democratic-supported public option. In contrast, during the final passage stage, it was a Republican policy element—malpractice reform—that was more prominent in coverage. In addition, this final stage was the one in which the bipartisan policy proposals received the most coverage. Therefore, the policies Republicans preferred—both partisan and bipartisan
proposals—were more prominent on the agenda during efforts to secure final passage of the bill. These analyses cannot tell us why this was the case, but it is important to note that this period followed the special election of Republican Scott Brown, which eliminated the Democratic Party’s super-majority within the Senate, a development that was seen at the time as a potentially fatal blow to the majority party influence in this debate (Jacobs and Skocpol 2010).

PARTISANSHIP & THE POLICYMAKING NETWORK

Our first set of analyses suggests somewhat greater agenda control and success in shaping the final legislation among the Democratic majority. Yet, Republican-backed policy elements were also included on the agenda, with the less controversial ones included in the final bill. Further, Republicans were able to block key policy elements that they opposed: most notably the public option. To gain greater insight into the pathways by which minority parties can impact legislation, we modeled the policymaking network surrounding this policy debate in a second set of analyses. We drew on Social Network Analysis (SNA) to map connections between these policy elements, individual Members of Congress, and the president. Conceptually, this approach follows the lead of research on policy networks and policy ideas interconnected in ways important for structuring the policymaking process (Cohen, March, and Olsen 1972; Heclo 1978; Kingdon 1995; Sabatier and Jenkins-Smith 1993). Methodologically, it builds on previous work examining ties among legislators via co-sponsorship of legislation (Fowler 2006; Cho and Fowler 2010) or joint membership on committees (Porter, Mucha, Newman, and Friend 2007). Additionally, we drew on recent work that conceptualizes political discourse as a policymaking network (Leifeld 2009).

Treating the Roll Call articles as a narrative account of the debate, though admittedly the most controversial parts of the debate, we generated an affiliation matrix capturing the number of
times each policymaker (president or Member of Congress) was mentioned within 25 words of
the mention of one of the 27 policy proposals or another policymaker. In generating this
affiliation matrix, we did not limit ourselves to explicit statements of support and opposition in
this analysis, but instead captured all co-occurrences across the Roll Call articles covering each
phase of debate. However, we did exclude policymakers and policy elements that had no
linkages to any of the four partisan and four bipartisan policy proposals identified in the earlier
analysis. This exclusion allowed us to focus on the policymaking network surrounding policy
design, rather than over-emphasizing the process and procedural aspects of the larger debate.7

For each of the three set of articles, we created a single affiliation matrix that was used to
generate a social network diagram capturing connections among policymakers, among policy
proposals, and between policymakers and policy proposals. We then zoomed in on the most
central part of each network (defined as the strongest ties among policies and policymakers) in
order to simplify the presentation and isolate the most critical actors and ideas at each point in
the health reform network. We use these diagrams to inform the development of a more narrative
account of the policymakers and policy ideas that were most central to the policymaking process,
as well as to trace the linkages tying Republican policymakers and policy proposals to this
central network. Below we describe these core social networks at each phase of the debate.

[Figure 4 about here]

Network during Committee Phase. Figure 4 presents a social network diagram
capturing the committee phase. The nodes (circles) represent individual policymakers or policy
elements, with the size of each node reflecting its degree centrality score. Degree centrality is

7This exclusion was conducted after a full affiliation matrix was generated. Rather than generating a traditional
network model, we generated an ego network model that captured connections among all nodes linked to one of the
eight policy elements. This serves to increase the centrality of the policy elements (relative to the policymakers), but
produces very similar network diagrams (and conclusions) to those produced with the full set of ties.
calculated as the normalized sum of rows and columns such that larger circles indicate policymakers or policy elements that have more connections within the policymaking network.

The most central policymaker at the committee stage was Senator Max Baucus, who chaired the Senate Finance Committee, which has jurisdiction over tax and spending issues critical to health care reform. The other policymakers with a high degree centrality were President Obama, Speaker of the House Nancy Pelosi, Majority Leader of the Senate Harry Reid, and the other members of Baucus’ “Gang of Six” that unsuccessfully sought a bipartisan compromise during the summer of 2009. This group included Baucus, along with Democratic Senators Conrad and Bingaman—as well as three Republican members of the Senate Finance Committee: Senators Grassley, Enzi, and Snowe. These were the only three Republicans included in the core network during this phase of debate. The most central policy element at this committee phase was the public option, followed by the proposal for a trigger for the public option, a compromise position pushed most notably by Republican Senator Olympia Snowe during this period of debate.

To assess the partisan composition of the network, we color-coded the nodes with Republican policymakers and the two Republican proposals in black, Democratic policymakers and their two proposals in white, and all other policy elements in gray. This illustrates a core policymaking network, composed of 14 policymakers and five policy elements, that is primarily Democratic, with the exception of the three Republican policymakers and the Republican trigger proposal. As mentioned earlier, all three Republicans were members of the Gang of Six convened by Senate Finance Committee chair Max Baucus. Two of these Republican Senators (Grassley and Enzi) were primarily linked to the network through Chairman Max Baucus and President Obama. Senator Snowe had a more central position in the network, with an additional
linkage to Senate Majority Leader Harry Reid, as well as to the central debate over the trigger option that she advocated.

Examination of the network diagram for the committee phase also illustrates a few other characteristics of this period of debate. Interestingly, the diagram is roughly divided in half, with the left-side composed of members of the House and the right-side of Senators. This suggests that at the committee phase, the two chambers operated on parallel tracks, as would be expected since committees in both chambers had jurisdiction over health care reform. The clearest linkage between the two sides of the network is the tie between Pelosi (Speaker of the House) and Reid (Majority leader of the Senate), with President Obama linked closely to these two leaders. Considering the policy elements included at this point of the debate, we see a primary focus on the public option, as well as the alternative proposals to include a trigger or co-ops as alternate vehicles for providing insurance. The inclusion of health care exchanges, which served as this vehicle in the final bill, was not central to the network at this point in the debate (although included in both house and senate versions of the bill from the beginning). The only other policy elements included here are the single-payer option and the proposal to dismantle the current employer-based health care system by eliminating the tax exclusion. Yet, both of these—quite extreme—policies were only evident on the margins of this core policymaking network.

[Figure 5 about here]

**Network during Floor Stage.** Figure 5 maps the strongest network ties during the floor debate phase. At this stage, the most central policymaker was Majority Leader Reid, whose increased prominence reflects the shift in power from committee chairs to the party leadership at this stage of the debate. The centrality of Chairman Baucus to the debate is sharply reduced, and we see the increased presence of pivotal Senators (i.e., Lincoln, Landrieu, Nelson) who
represented the key votes needed to assemble a sixty-vote Democratic majority that could avoid a Republican filibuster. Notably, the one Republican at the center of this network is Senator Snowe, whose centrality was sustained into the floor stage since she represented the most likely Republican floor vote if all sixty Democrats could not be held together. Linked closely as well was the proposal for a trigger—seen at the time as a compromise that may have won Senator Snowe’s vote. She is also tied to mentions of a state-option, another potential compromise to increase the appeal of the public option to more conservative Democrats and liberal Republicans.

At this floor stage, the public option remained the most central policy element (linked with its two potential compromise options). The other policy element included is the proposal for co-ops, which could have also been used to structure new insurance options. Yet, rather than being linked to Baucus as it was in the committee stage, discussion of co-ops was more often linked to Majority Leader Reid, who was central to assembling a winning coalition in the Senate (Rom, forthcoming). The dominance of the Senate is again obvious at this stage, which is not surprising because the Senate’s institutional rules provide a particularly challenging legislative environment, making the ongoing efforts to assemble a winning coalition particularly precarious. This imbalance may also be due to disproportionate coverage resulting from the time lag between the House floor vote (November 7th) and the Senate floor vote on Christmas Eve.

Despite the absence of many Members of the House of Representatives in the floor phase network, we can see the political salience of the enacted House bill through the inclusion of another Republican Senator: Lindsay Graham. Graham emerged in the central network during the floor debate, not because he ever considered voting with the Democrats, but due to his high-profile critiques of the House bill once it was passed. For example, on CBS’s Face the Nation on November 8th, Graham said, "The House bill is dead on arrival in the Senate.” He continued:
"Just look at how it passed. It passed 220 to 215. It passed by two votes. You had 39 Democrats vote against the bill. They come from red states, moderate Democrats from swing districts. They bailed out on this bill. It was a bill written by liberals for liberals, and people like [Sen.] Joe Lieberman are not going to get anywhere near the House bill... it is a non-starter in the Senate." Graham’s centrality illustrates another role for the minority party: to serve as outside critics who mobilize opposition and serve to reframe legislation on their own terms.

[Figure 6 about here]

**Network during Final Passage Stage.** Finally, Figure 6 maps the network ties during the final passage phase when the leaders of the two chambers negotiated the content of the final legislation, as well as the procedural path to get it enacted. The core network at this phase is dominated by Democrats, with the most central policymakers being President Obama, Speaker Pelosi, Democratic Congressman Bart Stupak, and Majority Leader Reid. Only one Republican Member of Congress was included: Congressman Darrell Issa. Congressman Issa was part of a cluster of nodes including malpractice reform (a key policy priority) and two other Republican-supported policy elements: portability and revocation of anti-trust provisions. Although included in the core network, this cluster of policies was only linked to the larger policy network through President Obama. This finding suggests that although malpractice reform was on the agenda at this stage (as suggested by the earlier frequency analysis), its consideration was separated from consideration of the core Democratic-backed policy elements that were more likely to be enacted. Also of note at this phase was the emergence of two other policy elements into the core network: health exchanges and pre-existing conditions. Both policy elements enjoyed bipartisan support and were included in the final legislation. Rather than being central to the debate throughout, these elements emerged during this final stage, linked strongly to the public option—
suggesting that these elements may have served as a substitute for the public option when it proved too difficult to assemble a winning coalition around.

**Examining Path to Enactment.** We also used the data contained in the affiliation matrix to compare the strongest ties with each policy element at each stage of the debate. Table 3 presents these results, listing the three strongest ties for the four partisan and four bipartisan policy elements, separated into those enacted versus those excluded from the final bill. We see a similar pattern for the first two enacted policies: the individual mandate and long-term care. Both had strong ties in the earlier phases and then moved off the agenda. It seems that the decision to include these elements was made early and not revisited in the final negotiations. A different pathway to enactment was found for the other two enacted policies: pre-existing conditions and health exchanges. As also illustrated in the network models above, these elements had weak or limited ties in the early two phases, but during the final passage phase, they both exhibited strong ties to core policymakers and policy elements, most notably the public option.

*Table 3 about here*

The four policy elements that were not enacted had unique sets of ties. The Democratic-backed public option was linked to President Obama, Committee Chair Baucus, and the trigger during the committee phase. The primary linkages changed to Leader Reid, pivotal Senator Snowe, and the state option during the floor phase. Yet, in the final phase, the public option was linked again to Obama; to Congressman Stupak, who was leading a coalition to limit abortion access within the policy option (serving to add controversy to this already controversial policy); and to the health exchanges, which served as the central delivery vehicle in the final legislation. The trigger policy element showed a similar set of key ties during the first two phases but fell off the agenda in the final phase once the public option moved off the table. The final two non-
enacted policies (malpractice reform and portability) were primarily linked to Republican policymakers, with two exceptions. First was the strong linkage between malpractice and Senator Whitehouse: a Democratic Senator who strongly opposed malpractice reform. The second was President Obama’s linkage to malpractice reform in the floor and final passage phases. In addition, these two policies were more likely to be strongly linked to other policy elements, suggesting a package of policy proposals centered around malpractice reform, but including waste/fraud protection, revoking anti-trust provisions, portability, pre-existing conditions, and tax credits. This package captures the core Republican proposals pushed during this debate.

CONCLUSION

This paper has brought empirical data to bear on the disputed claims of extreme partisanship in the recent reform of our health care system. Drawing on real-time accounts published in *Roll Call* newspaper between June 1, 2009 and March 24, 2010, we identify the relative prominence of Republican Members of Congress and Republican policy proposals. Our findings suggest that the Democratic majority was more successful at controlling the scope of the policy agenda, particularly during the floor vote stage. Even when Republicans were able to secure increased attention to their policy priorities (during the final stage), consideration of these policies occurred separate from the ongoing discussion of Democratic and bipartisan policy proposals that were more likely to be enacted into the law. In addition, Democratic policymakers were more central to the debate, with fewer central Republicans at each phase of the debate.

Despite this advantage to the Democratic Party, we identified a few key pathways by which a handful of Republican Members were incorporated in the debate. The first depended on the chamber in which the Republican Members served. We found that Republican Members of the House were more excluded than were Senators. In fact, no House Republican appeared
among the Members most central during the debate. Our findings also support our expectation that the pathways by which Republicans were included varied across the stages of the legislative debate. In the committee stage, the Republican Senators who were included in the central network were linked via their Committee Chair, Democratic Senator Baucus and their joint membership in the Gang of Six. Yet, during the floor stage, the only Republican included was Senator Snowe, a potential swing vote courted by the Democrats. At the final stage, the central network was Democratic, although it was at this point that the top Democratic policy proposal—the public option—was replaced with bipartisan policy elements that enjoyed broader support. We are unable to tease apart whether the distinct political network at this final phase was due to the loss of the sixty-seat margin in the Senate, the emergence of the abortion restriction proposal as a cleavage among the Democrats, the joint involvement of both chambers, or the parameters of the final negotiations themselves. Yet, it does seem that Republicans were more marginalized in this final stage, which coincides nicely with their vocal cries of extreme partisanship discussed earlier in the paper and with the Democrats’ ultimate decision to use a procedural work-around to secure enough votes to pass the bill.

We also identified many mentions (second only to the public option) of the Republican-supported proposal for malpractice reform. In fact, the prominence of malpractice reform increased throughout the debate. Yet, malpractice reform was not a policy proposal included in the central network in either the committee or floor stage. And even when malpractice did emerge in the final phase, it was included with a cluster of other policies—none of which were enacted—rather than linked with the primary set of nodes. This suggests that malpractice reform was discussed as a potential element of the reform, likely to entice more Republican support.
Yet, likely due to Democratic opposition, it was discussed only on the periphery, disconnected from the core of the political debate—with its key Democratic linkage being one of criticism.

So, after all these analyses… Should we be worried about procedural fairness in American policymaking or more narrowly within the health reform debate? Based on these empirical findings, we believe that Democrats did dominate the debate. Yet, they were not able to completely marginalize those Republicans who enjoyed greater institutional powers (as Senators), particularly if they also held key roles on powerful committees or as potential swing votes (at the stage in which those powers mattered). The power held by this handful of Republicans cannot really be known. We do, however, find it suggestive of their power that Olympia Snowe, the one Republican who was a Senator, a key committee member, and a potential swing vote, was also the advocate for the one Republican policy proposal that remained linked to the central debate, at least until the final stage. Additionally, the Democrats were not able to secure their most prominent policy proposal, the public option, which was replaced in the final stage by a Republican-backed alternative: health exchanges.

These anecdotes suggest that although Democrats controlled the agenda and dominated the process, they were quite constrained in securing their desired policy design. Yet, this constraint does not seem to stem from a bipartisan policymaking process characterized by compromise and collaboration. Instead, the ability of the Democratic majority to steamroll over its opposition was limited by a handful of powerful Republicans (a minority of the minority). Further, Democrats’ ability was likely further constrained by the emergence of policy proposals—most notably greater restrictions on abortion—that divided the Democratic majority whereas the Republican minority remained unified in their policy positions.
Thus, it seems just as disingenuous to claim that Republicans were completely shut-out, as it is to claim that Democrats were striving to include Republicans throughout the process. Instead, health reform stands as an example of how we typically expect (and actually designed) Congressional politics to proceed—with the majority party enjoying an advantage but not a monopoly in terms of policymaking authority. As a result, the majority party got a lot of what it wanted (most critically in this case, a reform bill), while the minority party was able to block that which it found most egregious (the public option) and replace that element with a policy design they could more easily accept (the exchanges, paired with insurance reforms). As such, health care reform provokes little concern that our policymaking process is broken or is procedurally unfair to the minority party. Instead, from our perspective, the more troubling issue for the long-term legitimacy of our policymaking institutions (and the laws they produce) is the disconnect between the congenial, bipartisan, and collaborative policymaking process that Americans say they want (Hibbing and Theiss-Morse 2001; 2002) and the and natural consequences of the policymaking institutions at hand.
References


# TABLE 1

Instances of Expressed Support and Opposition, by Party

<table>
<thead>
<tr>
<th></th>
<th>All Policy Elements (N=27)</th>
<th>Excluding Public Option (N=26)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>sd</td>
</tr>
<tr>
<td><strong>Republican MOCs</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Support</td>
<td>1.85</td>
<td>3.55</td>
</tr>
<tr>
<td>Oppose</td>
<td>1.26</td>
<td>4.04</td>
</tr>
<tr>
<td>Net Support</td>
<td>0.59</td>
<td>5.78</td>
</tr>
<tr>
<td><strong>Democratic MOCs</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Support</td>
<td>8.26</td>
<td>14.70</td>
</tr>
<tr>
<td>Oppose</td>
<td>3.11</td>
<td>5.12</td>
</tr>
<tr>
<td>Net Support</td>
<td>5.15</td>
<td>10.58</td>
</tr>
</tbody>
</table>

**Note:** Descriptive statistics for variables capturing the number of instances of specific support or opposition from Republican Members versus Democratic Members. Net support is calculated by subtracting instances of opposition from the number of instances of support.
# TABLE 2

Most Partisan and Most Bipartisan Policy Elements

<table>
<thead>
<tr>
<th></th>
<th>Democratic Opposition</th>
<th>Democratic Support</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Republican</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Opposition</strong></td>
<td></td>
<td>Individual Mandate(71-29)*</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Public Option (74-26)</td>
</tr>
<tr>
<td><strong>Republican</strong></td>
<td>Malpractice Reform</td>
<td></td>
</tr>
<tr>
<td><strong>Support</strong></td>
<td>Trigger (30-70)</td>
<td>Pre-existing Conditions*</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Long-term Care*</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Portability</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Health Exchanges*</td>
</tr>
</tbody>
</table>

**Note:** Table classifies policies with the strongest support and/or opposition from both parties (defined as those with net support values greater than 2 or lesser than -2). Asterisks (*) indicate policy elements that were included in the final legislation. The numbers in parentheses indicate policy elements in which Democratic support or opposition was divided (% instances of support - % instances of opposition). There were no instances of Republican positions in conflict with one another.
### TABLE 3

**Policy Elements’ Strongest Ties, by Phase of Debate**

<table>
<thead>
<tr>
<th></th>
<th>Committee-Phase</th>
<th>Floor-Phase</th>
<th>Final Passage-Phase</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Enacted</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual Mandate (D)</td>
<td>Medicaid Expansion (4)</td>
<td>Snowe (2)</td>
<td>[None]</td>
</tr>
<tr>
<td></td>
<td>Millionsaires tax (4)</td>
<td>Schumer (2)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Subsidies (4)</td>
<td>Subsidies (2)</td>
<td></td>
</tr>
<tr>
<td>Long-Term Care (B)</td>
<td>Feingold (16)</td>
<td>[None]</td>
<td>[None]</td>
</tr>
<tr>
<td></td>
<td>Kennedy (10)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Frank (8)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-Existing Conditions (B)</td>
<td>Obama (4)</td>
<td>Boustany (4)</td>
<td>Obama (4)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>[more weak ties]</td>
<td>Health Exchange (2)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Public Option (2)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Tax Credits (2)</td>
</tr>
<tr>
<td>Health Exchanges (B)</td>
<td>[Many weak ties]</td>
<td>[Many weak ties]</td>
<td>Prevention (2)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Stupak (2)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Public Option (2)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Massa (2)</td>
</tr>
<tr>
<td><strong>Not Enacted</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public Option (D)</td>
<td>Trigger (68)</td>
<td>Reid (34)</td>
<td>Stupak (8)</td>
</tr>
<tr>
<td></td>
<td>Obama (44)</td>
<td>Snowe (20)</td>
<td>Obama (4)</td>
</tr>
<tr>
<td></td>
<td>Baucus (32)</td>
<td>State Option (20)</td>
<td>Exchanges (2)</td>
</tr>
<tr>
<td>Trigger (R)</td>
<td>Public Option (68)</td>
<td>Public Option (32)</td>
<td>Lieberman (2)</td>
</tr>
<tr>
<td></td>
<td>Snowe (14)</td>
<td>Snowe (28)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Baucus (10)</td>
<td>Reid (24)</td>
<td></td>
</tr>
<tr>
<td>Malpractice Reform (R)</td>
<td>Sen. Whitehouse (18)</td>
<td>Obama (8)</td>
<td>Obama (14)</td>
</tr>
<tr>
<td></td>
<td>Baucus (10)</td>
<td>Gregg (4)</td>
<td>Issa (4)</td>
</tr>
<tr>
<td></td>
<td>Cantor (8)</td>
<td>Waste/Fraud (4)</td>
<td>Revoke Anti-trust (4)</td>
</tr>
<tr>
<td>Portability (B)</td>
<td>Cantor (8)</td>
<td>Pre-Existing Cond. (2)</td>
<td>Revoke Anti-trust (2)</td>
</tr>
<tr>
<td></td>
<td>Malpractice Reform (4)</td>
<td></td>
<td>Malpractice Reform (2)</td>
</tr>
<tr>
<td></td>
<td>Tax Credits (4)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Note:** Table presents the strongest ties for each of the four partisan and four bipartisan policy elements. Number of bi-directional ties presented in parentheses—indicating the number of co-occurrences within 25 words of each other in *Roll Call* coverage during the designated time period. Cells with fewer than three terms had ties to only the terms listed, unless otherwise noted.
FIGURE 1

Net Republican Support, by Policy Element

Note: Assessed via coded instances of support/opposition from Republican Members of Congress reported in Roll Call coverage from 6/01/09-3/25/10.
FIGURE 2

Net Democratic Support, by Policy Element

Note: Assessed via coded instances of support/opposition from Democratic Members of Congress reported in Roll Call coverage from 6/01/09-3/25/10. Includes two Independent Members as well (Lieberman and Sanders).
FIGURE 3

Prominence of Partisan and Bipartisan Elements, by Phase of Debate

A. Democratic Policies

B. Republican Policies

C. Bipartisan Policies

Note: Bars present the relative frequency of each policy element within Roll Call coverage.
FIGURE 4
Core Policymaking Network during Committee Stage (6/1–10/13)

Note: Estimated from the ego network surrounding the four partisan and four bipartisan policy elements presented in Table 2. The network diagram presents the strongest ties (>3.0 for the committee phase) among President Obama, each Member of Congress, and the 27 policy elements under debate. A bi-directional tie was recorded for each instance in which two policymakers/policy elements were included within 25 words of each other in Roll Call coverage during the designated time period. Node sizes reflect degree centrality, with larger nodes indicating policymakers/policy elements with a greater number of total ties. Node color indicates the party affiliation: black nodes represent Republican policymakers and the two Republican proposals opposed by Democrats; conversely, white nodes represent Democratic policymakers and the two Democratic proposals opposed by Republicans. All other policy elements are represented by grey nodes.
FIGURE 5
Core Policymaking Network during Floor Stage (10/14–12/25)

Note: Estimated from the ego network surrounding the four partisan and four bipartisan policy elements presented in Table 2. The network diagram presents the strongest ties (>4.0 for the floor phase) among President Obama, each Member of Congress, and the 27 policy elements under debate. A bi-directional tie was recorded for each instance in which two policymakers/policy elements were included within 25 words of each other in Roll Call coverage during the designated time period. Node sizes reflect degree centrality, with larger nodes indicating policymakers/policy elements with a greater number of total ties. Node color indicates the party affiliation: black nodes represent Republican policymakers and the two Republican proposals opposed by Democrats; conversely, white nodes represent Democratic policymakers and the two Democratic proposals opposed by Republicans. All other policy elements are represented by grey nodes.
FIGURE 6

Core Policymaking Network during Final Passage Stage (12/26–3/25)

Note: Estimated from the ego network surrounding the four partisan and four bipartisan policy elements presented in Table 2. The network diagram presents the strongest ties (>1.0 for this phase) among President Obama, each Member of Congress, and the 27 policy elements under debate. A bi-directional tie was recorded for each instance in which two policymakers/policy elements were included within 25 words of each other in Roll Call coverage during the designated time period. Node sizes reflect degree centrality, with larger nodes indicating policymakers/policy elements with a greater number of total ties. Node color indicates the party affiliation: black nodes represent Republican policymakers and the two Republican proposals opposed by Democrats; conversely, white nodes represent Democratic policymakers and the two Democratic proposals opposed by Republicans. All other policy elements are represented by grey nodes.
**APPENDIX A: Definitions of Policy Elements**

<table>
<thead>
<tr>
<th>Policy element</th>
<th>Definition</th>
<th>Coded terms</th>
<th>Source of definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>abortion restriction</td>
<td>&quot;Prohibit abortion coverage from being required as part of the minimum benefits package; require segregation of public subsidy funds from private premium payments for plans that choose to cover abortion services beyond Hyde -- which allows coverage for abortion services to save the life of the woman and in cases of rape or incest; and require there be no effect on state or federal laws on abortion.&quot;</td>
<td>abortion restriction(s), cover abortion, federal funding for abortion, Hyde amendment, pay for abortion, Stupak amendment</td>
<td><a href="http://www.kff.org/healthreform/sidebyside.cfm">http://www.kff.org/healthreform/sidebyside.cfm</a>: healthreform_sbs_full.pdf</td>
</tr>
<tr>
<td>cadillac tax</td>
<td>&quot;a high-cost policy is usually defined by the total cost of premiums, rather than what the insurance plan covers or how much the patient has to pay for a doctor or hospital visit&quot;</td>
<td>cadillac tax, cadillac plans, gold plated, goldplated, taxing benefits, taxing health benefits</td>
<td><a href="http://www.kaiserhealthnews.org/Stories/2009/September/22/cadillac-health-explainer-npr.aspx">http://www.kaiserhealthnews.org/Stories/2009/September/22/cadillac-health-explainer-npr.aspx</a></td>
</tr>
<tr>
<td>co ops</td>
<td>&quot;A non-profit, member-run health insurance organization, governed by a board of directors elected by its members. Co-ops provide insurance coverage to individuals and small businesses and can operate at state, regional, and national levels.&quot;</td>
<td>co op(s), cooperatives, coops</td>
<td><a href="http://www.kff.org/healthreform/7909.cfm">http://www.kff.org/healthreform/7909.cfm</a></td>
</tr>
<tr>
<td>employer mandate</td>
<td>&quot;An approach that would require all employers, or at least all employers meeting size or revenue thresholds, to offer health benefits that meet a defined standard, and pay a set portion of the cost of those benefits on behalf of their employees.&quot;</td>
<td>employer mandate, require businesses to purchase, require employers to purchase, require small businesses to purchase</td>
<td><a href="http://www.kff.org/healthreform/7909.cfm">http://www.kff.org/healthreform/7909.cfm</a></td>
</tr>
<tr>
<td>HSAs</td>
<td>&quot;Tax-exempt savings accounts that can be used to pay for current or future qualified medical expenses.&quot;</td>
<td>HSAs, health reimbursement account, health savings account, health savings accounts, medical savings account</td>
<td><a href="http://www.kff.org/healthreform/7909.cfm">http://www.kff.org/healthreform/7909.cfm</a></td>
</tr>
<tr>
<td>health exchange</td>
<td>&quot;A purchasing arrangement through which insurers offer smaller employers and individuals purchase health insurance. State, regional, or national exchanges could be established to set standards for what benefits would be covered, how much insurers could charge, and the rules insurers must follow in order to participate in the insurance market. Individuals and small employers would select their coverage within this organized arrangement.&quot;</td>
<td>exchanges, health exchange, individual membership associations, insurance exchange</td>
<td><a href="http://www.kff.org/healthreform/7909.cfm">http://www.kff.org/healthreform/7909.cfm</a></td>
</tr>
<tr>
<td>Topic</td>
<td>Text</td>
<td>Eligibility</td>
<td>Reference</td>
</tr>
<tr>
<td>-------</td>
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<td>-------------</td>
<td>-----------</td>
</tr>
<tr>
<td>Immigrant restrictions</td>
<td>&quot;Limit availability of premium credits and cost-sharing subsidies through the exchanges to U.S. citizens and legal immigrants who meet income limits.&quot; &quot;Require verification of both income and citizenship status in determining eligibility for the federal premium credits.&quot;</td>
<td>eligibility for immigrants, health care for immigrants, illegal immigrants, immigrant restrictions</td>
<td><a href="http://www.kff.org/healthreform/sidebyside.cfm">http://www.kff.org/healthreform/sidebyside.cfm</a>: healthreform_sbs_full.pdf</td>
</tr>
<tr>
<td>Individual mandate</td>
<td>&quot;A requirement that all individuals obtain health insurance. A mandate could apply to the entire population, just to children, and/or could exempt specified individuals.&quot;</td>
<td>individual mandate, require everyone to buy, tax on the uninsured, taxing the uninsured</td>
<td><a href="http://www.kff.org/healthreform/7909.cfm">http://www.kff.org/healthreform/7909.cfm</a></td>
</tr>
<tr>
<td>Long-term care</td>
<td>&quot;Services that include those needed by people to live independently in the community, such as home health and personal care, as well as services provided in institutional settings such as nursing homes.&quot;</td>
<td>CLASS Act, community living assistance, long term care, long term care</td>
<td><a href="http://www.kff.org/healthreform/7909.cfm">http://www.kff.org/healthreform/7909.cfm</a></td>
</tr>
<tr>
<td>Malpractice reform</td>
<td>&quot;Adopt medical malpractice reforms that limit lawsuit rewards and create state health care tribunals to review cases and render decisions. Parties will still have access to state courts if not satisfied with decisions.&quot;</td>
<td>malpractice, medical liability, tort reform</td>
<td><a href="http://www.kff.org/healthreform/sidebyside.cfm">http://www.kff.org/healthreform/sidebyside.cfm</a>: healthreform_sbs_full.pdf</td>
</tr>
<tr>
<td>Medicaid expansion</td>
<td>&quot;Expand Medicaid to all individuals (children, pregnant women, parents, and adults without dependent children) with incomes up to [133% or 150% FPL, depending on the proposal].&quot; Eligible individuals may be able to obtain coverage through Medicaid or through the exchange.</td>
<td>expand Medicaid, expanding Medicaid, Medicaid expansion</td>
<td><a href="http://www.kff.org/healthreform/sidebyside.cfm">http://www.kff.org/healthreform/sidebyside.cfm</a>: healthreform_sbs_full.pdf</td>
</tr>
<tr>
<td>Medical devices</td>
<td>“An excise tax levied on the sale of any taxable medical device.”</td>
<td>pharmaceutical manufacturing; medical device, medical devices</td>
<td><a href="http://healthreform.kff.org/Timeline.aspx">http://healthreform.kff.org/Timeline.aspx</a> [2013]</td>
</tr>
<tr>
<td>Millionaire tax</td>
<td>A surcharge (of varying levels, depending on income) will be imposed on families and individuals with incomes above certain levels, to help finance health care reform proposals.</td>
<td>millionaire tax, surcharge, tax on wealthy, tax on rich</td>
<td><a href="http://www.kff.org/healthreform/sidebyside.cfm">http://www.kff.org/healthreform/sidebyside.cfm</a>: healthreform_sbs_full.pdf</td>
</tr>
<tr>
<td>Portability</td>
<td>&quot;Rules allowing people to obtain coverage as they move from job to job or in and out of employment. Individuals changing jobs are guaranteed coverage with the new employer without a waiting period. In addition, insurers must waive any pre-existing condition exclusions for individuals who were previously covered within a specified time period. Portable coverage can also be health coverage that is not connected to an employer, allowing individuals to keep their coverage when they have a change in employment.&quot;</td>
<td>portable, portability, take insurance with you, transfer insurance policy, transferring insurance policy</td>
<td><a href="http://www.kff.org/healthreform/7909.cfm">http://www.kff.org/healthreform/7909.cfm</a></td>
</tr>
<tr>
<td><strong>preexisting conditions</strong></td>
<td>&quot;Prohibit pre-existing condition exclusions; prohibit insurers from rescinding coverage except in cases of fraud&quot;</td>
<td>pre existing condition, preexisting condition</td>
<td><a href="http://www.kff.org/healthreform/7909.cfm">http://www.kff.org/healthreform/7909.cfm</a></td>
</tr>
<tr>
<td>----------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------</td>
<td>------------------------------------------------</td>
<td>-----------------------------------------</td>
</tr>
<tr>
<td><strong>prevention</strong></td>
<td>&quot;Health care that emphasizes the early detection and treatment of diseases. The focus on prevention is intended to keep people healthier for longer, thus reducing health care costs over the long term.&quot;</td>
<td>prevention, preventive care, wellness</td>
<td><a href="http://www.kff.org/healthreform/7909.cfm">http://www.kff.org/healthreform/7909.cfm</a></td>
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<td><strong>public option</strong></td>
<td>&quot;A proposal to create a new insurance plan administered and funded by federal or state government that would be offered along with private plans in a newly-created health insurance exchange.&quot;</td>
<td>government health care option, government health care plan, public option, public plan</td>
<td><a href="http://www.kff.org/healthreform/7909.cfm">http://www.kff.org/healthreform/7909.cfm</a></td>
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<tr>
<td><strong>revoke antitrust</strong></td>
<td>&quot;Permit insurers to sell insurance policies across state lines. Insurers must designate one state as its primary state and the laws and regulations in the primary state apply to coverage offered in that state and in other states.&quot;</td>
<td>across state lines, exempt anti trust, exempt antitrust, exempt from anti, out of state insurance, revoke anti</td>
<td><a href="http://www.kff.org/healthreform/sidebyside.cfm">http://www.kff.org/healthreform/sidebyside.cfm</a>: healthreform_sbs_full.pdf</td>
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<td><strong>single payer</strong></td>
<td>&quot;A health care system in which a single entity pays for health care services. This entity collects health care fees and pays for all health care costs, but is not involved in the delivery of health care.&quot;</td>
<td>single payer, singlepayer</td>
<td><a href="http://www.kff.org/healthreform/7909.cfm">http://www.kff.org/healthreform/7909.cfm</a></td>
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<td><strong>state option</strong></td>
<td>&quot;Allow states to opt out of a national plan or public option.&quot;</td>
<td>opt in, opt out, optin, optout, state exemption, state option, states can opt</td>
<td><a href="http://www.kff.org/healthreform/sidebyside.cfm">http://www.kff.org/healthreform/sidebyside.cfm</a>: healthreform_sbs_full.pdf</td>
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<td><strong>subsidies</strong></td>
<td>&quot;Provide premium credits to individuals and families with incomes up to 400% FPL (with some variation between proposals) to help them purchase insurance through exchanges.&quot;</td>
<td>subsidized, subsidy</td>
<td><a href="http://www.kff.org/healthreform/sidebyside.cfm">http://www.kff.org/healthreform/sidebyside.cfm</a>: healthreform_sbs_full.pdf</td>
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<td><strong>tax credits</strong></td>
<td>&quot;An amount that a person/family can subtract from the amount of income tax that they owe.”</td>
<td>tax credit, tax credits, tax deduction</td>
<td><a href="http://www.kff.org/healthreform/7909.cfm">http://www.kff.org/healthreform/7909.cfm</a></td>
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<td><strong>tax medical devices</strong></td>
<td>Tax changes related to health insurance: &quot;Impose new fees on segments of the health care sector&quot; including annual fees on the pharmaceutical manufacturing sector and the medical device manufacturing sector</td>
<td>medical device, medical devices, pharmaceutical manufacturing, tax on devices</td>
<td><a href="http://www.kff.org/healthreform/sidebyside.cfm">http://www.kff.org/healthreform/sidebyside.cfm</a>: healthreform_sbs_full.pdf</td>
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<td><strong>trigger</strong></td>
<td>An alternative to the public option, in which a public or non-profit-run plan would only be implemented if certain coverage and cost-saving goals are not met by reforms of the private market, Medicaid, and Medicare.</td>
<td>trigger</td>
<td><a href="http://www.tnr.com/blog/the-treatment/what-would-snowes-trigger-look">http://www.tnr.com/blog/the-treatment/what-would-snowes-trigger-look</a></td>
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<td><strong>waste fraud</strong></td>
<td>Cost containment: &quot;Create state fraud and abuse prevention and control units to investigate and prosecute violations of state law.&quot;</td>
<td>abuse system, cutting waste, defraud, fraud, fraudulent, reduce waste, reducing waste, waste abuse, waste and abuse, waste fraud, wasteful, wastes</td>
<td><a href="http://www.kff.org/healthreform/sidebyside.cfm">http://www.kff.org/healthreform/sidebyside.cfm</a>: healthreform_sbs_full.pdf</td>
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