Public Opinion and Congressional Responsiveness in Policy Making

by

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Dissertation submitted in partial fulfillment of
the requirements for the degree of Doctor of Philosophy
in the Sanford School of Public Policy
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2017

<u>ABSTRACT</u>

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Abstract

Many factors affect responsiveness of elected policy makers to public opinion. While a full understanding of this topic is not possible without decades of careful research, this dissertation examines a few important areas. In particular, I look at the effects of party competition on legislator responsiveness, the dynamics of interest group politics and the ability of some voters to obtain disproportionate representation, and the nuances of how to interpret public opinion itself for a specific policy.

The first two chapters, on party competition and interest groups, make use of secondary data generated by the government, other scholars, and various relevant organizations. The chapters employ data on the behaviors and characteristics of members of Congress, election results, campaign finance data, and population and demographic information. Using appropriate econometric models, I find in chapter 1 that significant competition between the two major parties does serve to increase responsiveness to the public at the level of the individual legislator, with effects at the aggregate level being somewhat weaker. In recent years, it is difficult to estimate these effects because of the generally high levels of party competition and low variance across district.

Using similar data and methods, the exploratory analysis in chapter 2 suggests a relationship between unorganized groups of voters and the positions their elected

officials take, independent of party, district average public opinion, and organized interest group contributions. The results also suggest that context matters a great deal in determining which groups will be influential.

Chapter 3 examines the nature of public opinion itself, using the Affordable Care Act as a case study. I conducted a survey experiment to assess how the distribution of opinions on the Affordable Care Act might change in response to priming different design features of the law. My findings indicate that opinion on the ACA is malleable and depends on what pieces of the law people think about at the time of response. In the real world, this implies that which parts of the ACA are highlighted and how it is discussed publicly will affect its future. Policy pork, as defined in the chapter, can build up support, but wedge provisions in the law can serve to entrench the opposition further. These implications can also be applied to other complex, highly visible reform bills.

A final concluding chapter attempts to apply these findings, as well as other political science research, to the case of the Medicare Access and CHIP Reauthorization Act (MACRA). Based on my assessment of the political context of this act, which was hailed as a permanent resolution to a longstanding debate over Medicare provider payments, I argue that the debate is not actually over, and that group interests, the design of the law, and broader contextual factors will ensure the debate continues.

Dedication

To my wife, Theresa.

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Acknowledgements

I would like to thank the members of my committee: Don Taylor, Sunshine Hillygus, Frank Sloan, and Seth Sanders for their helpful feedback and advice throughout the process of planning and writing this dissertation. I'd also like to thank John Aldrich for his mentorship and extensive feedback on chapter 1. Additionally, I extend my thanks to Chris Conover, Karlyn Bowman, Angel Mira, Jian Xu, and Laura Lazarus Frankel for their feedback on earlier versions of chapter 3. Finally, many thanks to my wife Theresa for her unfailing support throughout my graduate studies.

1. Party Competition and Legislative Responsiveness

In modern democratic nations, political parties are a common, even universal institutional feature of government. Political scientists have argued for decades that democracy is "unthinkable" (Schattschneider 1942) or "unworkable" (Aldrich 2011; Aldrich and Griffin 2010) without parties. Parties, these scholars claim, are an important mechanism through which voters can hold their elected representatives accountable, a key feature of democratic government. In other words, in order for democratic representation to occur, strong political parties that compete meaningfully with each other for the right to enact clear, distinct platforms are essential.

However, this ideal of responsible party government, as it is called in political science, has not been consistently realized in American history. During a period of almost uninterrupted Democratic control of Congress from the 1950s through 1995, the strength of America's two major political parties was thought by many observers to be in decline (Aldrich 2011; Wattenberg 1990), and electoral accountability seemed to have disappeared as a result (Fiorina 1980). At least part of this decline in accountability is attributable to the inability of the Republican Party to compete meaningfully in the "Solid South," which effectively functioned as a one-party system under Democratic control during this era. Since 1980, however, as the Republican Party has made significant inroads in the South, the responsiveness of members of Congress to public opinion has increased significantly in that region (Aldrich and Griffin Forthcoming), in

turn making Congress more responsive overall. Scholars argue that without strong parties, citizens may not have any way to hold elected officials accountable for their actions, and those elected officials will have less incentive and ability to listen to their constituents.

How have changes in party competition affected electoral accountability and responsiveness to public opinion in the US? Aldrich and Griffin (Forthcoming) provide initial evidence that responsiveness has increased along with party competition since the 1980s. In this chapter, I propose to conduct further tests of this hypothesis. In addition, I will take this analysis a step further by examining whether the policies (specifically, adopted bills) that emerge during periods of greater party competition are more responsive to preferences overall. I find indications that increased party competition does indeed lead to increased responsiveness to public opinion, both at the level of the individual legislator and at the aggregate level, as well as increased mass participation in politics. By empirically supporting this link between political institutions and electoral accountability, this research will increase our understanding of the role political parties play in democratic government. Despite over a century of scholarship on parties (Epstein 1986; Ranney 1975), we are just now beginning to make this link (Aldrich and Griffin 2010), and further empirical testing is in order. The analyses I perform will also yield insights into how government can be made more responsive to public preferences, insofar as such responsiveness is desirable.

Another contribution this paper will make to research on party competition is a new index measure of party competition, based entirely on election results. There are already many indices of party competition, some of which I describe and use in my analyses below. However, all indices are based on important assumptions and may be limited by data availability at the time they are developed. My proposed index offers two potential improvements over previous indices. First, most indices are not developed with national politics or policymaking in mind, but rather as an attempt to examine the partisan profile of states. My index is designed to be used at a national level as an independent variable that might affect other things, like Congressional policy making. Second, past indices have not always made use of data on down-ballot elections, such as those for attorney general or state legislature. I have collected as much data as possible on these elections in order to consider as many aspects of electoral competition between parties as possible.

1.1 Background

How well does the US government respond to the views of its constituents? Political scientists generally agree that policy and public opinion do indeed respond to each other (Erikson, MacKuen, and Stimson 2002; Manza and Cook 2002; Soroka and Wlezien 2010). Despite its wide acceptance, there are important conditions on this prediction which still merit further exploration (Manza and Cook 2002). Thus, this study seeks at least a partial answer to a modified version of the question that begins this

paragraph: what institutional factors affect the US government's responsiveness to public opinion?

One potential institutional factor is elections. Competitive elections may provide for political accountability of elected officials to the voters, an important element of any functioning democracy. However, accountability-inducing elections cannot be taken for granted. The act of voting has multiple purposes, and therefore may be a somewhat ambiguous signal for politicians to respond to. On one hand is the prospective or mandate model of voting, in which voters give their votes to the candidate who espouses their most preferred policy platform, and the winning candidate is elected with the understanding that he/ she will proceed to enact the platform on which he/ she ran. Many influential theories of representation, such as the median voter model of Downs (1957), are based on this concept of voting. This model preserves the meaningfulness of substantive policy proposals in campaigns, but does not provide for any enforcement of the electoral mandate once the candidate is installed in office (Manin, Przeworski, and Stokes 1999).

On the other hand is the retrospective or accountability model of voting, which posits that voters will vote for the incumbents if they have performed well in office or if good conditions around election time are attributed to the incumbents. If conditions are bad and voters think the incumbent government is to blame, they will vote for the challengers and "throw the rascals out" (Manin, Przeworski, and Stokes 1999; Stokes

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1996). While this model induces representation of the public by elected officials when the public has complete information, it fails to do so when information is less complete. Manin, Przeworski, and Stokes (1999) suggest that voters may actually use their votes in both ways (prospective and retrospective), and that it is rational to do so, but with the result that governments may be somewhat less accountable when such dual-purpose voting is employed. Thus, we might expect government and government officials to be somewhat responsive to the public, but not completely so.

Because elections do not automatically induce responsiveness, we must turn to an examination of the kinds of elections that will induce responsiveness. One much-debated model in political science, the marginality hypothesis, may provide some analytical traction in this regard. This hypothesis predicts that elected officials are more responsive to public opinion when elections are competitive. The debate over this hypothesis has produced a large body of work both supporting (Ansolabehere, Snyder, and Stewart 2001; Griffin 2006) and refuting (Fiorina 1973; Gerber and Lupia 1995; Groseclose 2001) the prediction. However, as Aldrich and Griffin (2010) point out, studies along these lines do not generally measure *party* competition. Incumbent candidates in one-party systems may occasionally face strong challengers, and intra-party factional struggles may break out temporarily, but the incumbent party will not face any strong competition nationally without an opposition party that can compete meaningfully.

This is important because retrospective voting (discussed above), on which electoral accountability is based (Aldrich and Griffin 2010; Downs 1957; Manin, Przeworski, and Stokes 1999), requires a strong alternative party that can serve as a real choice for dissatisfied voters. Individual politicians and non-partisan factions do not face the same incentives parties face, because they do not recruit candidates and have no need to cultivate an inclusive group brand that is favorable to a majority of voters across both time and place. These non-partisan actors, therefore, will not be as sensitive to electoral pressures as parties. What the marginality studies have been missing is the fact that accountability might come not from electoral competition in general, but rather from competition between parties in particular. In an election in which this latter condition obtains, we might expect representatives ultimately elected and reelected under these conditions to be more responsive to public opinion. We might therefore modify the marginality hypothesis to predict that government responsiveness to public opinion will increase as party competition increases.

Political parties are institutions that organize both electoral and legislative politics. Political parties are most often viewed as a creation of elite politicians as aids in the realization of their personal political goals (Aldrich 2011). One fundamental goal of politicians in a democracy is to win election to government office (Fenno 1973; Mayhew 1974). This is not necessarily their only goal, however, as those who seek office generally seek it as a means to some end, rather than as an end in itself (Aldrich and Rohde 2001).

Thus, parties serve not merely as vehicles for winning election and ensuring reelection through enactment of party platforms, but also as ongoing purveyors of specific policy goals. In these roles, parties attract benefit-seeking activists in addition to candidates (Aldrich 1983), and it is these activists who provide much of the resources and support for the party's candidates (Aldrich 2011; Aldrich and Griffin 2010). The set of all parties in a given nation comprise the party system.

In legislative bodies like the US Congress, parties provide structure to the legislative process beyond that prescribed by formal constitutional institutions. Parties also provide great flexibility for groups of legislators to change the way legislative business is conducted from time to time, depending on the needs and circumstances of the party. However, this flexibility also means that the majority party will not always govern as a cohesive unit enacting an ideologically coherent platform and overruling the minority party's goals and opinions. According to the conditional party government model (CPG; see Aldrich and Rohde (2001)), legislative parties will act cohesively when there is more ideological consistency within the party (especially the majority) and less overlap across parties. During the decades of Democratic control of Congress starting in the 1950s, it was not until around 1980 that Democrats began to "rule" in any meaningful sense. This development followed significant reforms within the majority party that took power from the committee chairs (mostly Southern conservatives) and gave it to chamber leaders who would be more in tune with the views of more orthodox liberal

Democrats (Aldrich and Rohde 2001; Rohde 1991). According to CPG, this occurred because Democrats became more consistently liberal, Republicans more consistently conservative, and the level of overlap and cooperation between the two decreased.

In this study, I test the macro-level prediction that increased party competition in the United States leads to increased responsiveness of policy to public opinion. I will focus only on Congress and policies passed by Congress, with the understanding that other actors have important roles in the policy process as well. This macro-level hypothesis, in order to represent a plausible causal story, needs at least two things. First, it needs support from a micro-level analysis to be sure that individual actors are responding in the manner hypothesized to affect the aggregate. If that is not the case, then the macro-level trends may not be what we interpret them to be. Second, there must be a plausible mechanism linking the micro-level to the macro. Just because there is an analogous micro-level trend does not mean it aggregates up to the macro level in the way we expect.

In order to increase confidence in my test of this hypothesis, I will also examine a micro-level effect of party competition at what I will call the elected official level. However, I do not limit change in responsiveness at this level to changes within individuals. Some responsiveness at the elected official level may come as a result of changes in the people who hold elected office, rather than changes in the public views and behavior of individuals in office. Past research has shown that legislators tend to

"die with their ideological boots on", and that overall ideological change in policy happens more through replacement of old legislators with new, more representative ones than through conversion or evolution of legislator views and behaviors (Poole 2007; Poole and Rosenthal 1997). This explains the recently observed pattern of "leap-frog representation," whereby the ideal points of a district's representatives change wildly about a district median that does not change as much, but enough to defeat an incumbent in favor of the other party's candidate (Bafumi and Herron 2010).

Despite the prediction about individual legislator behavior, it is still not clear that greater party competition will aggregate to greater policy responsiveness on the whole, i.e. at the level of the legislature rather than the legislator. For a party to compete meaningfully in a given election, it must field strong candidates who have a real chance of winning. This means candidates so fielded must be sensitive to what the voters want. However, the party also needs to present a clear choice to voters in order for the party label to have any meaning. Parties need to be sufficiently distinct from one another in order to convey meaningful information to the voters.

This tension might also be thought of as a tension between a party's "establishment" leaders, who want to win elections and seek to recruit candidates who can win, and the activist wing of a party, which is more concerned with keeping the party's brand "pure" and making sure candidates and elected officials do not betray the party platform. Without the activists, parties would nominate candidates they thought

would win, and parties would essentially converge on the median voter position in each

district (as predicted by Downs (1957)), become ideologically spread out across the

country according to ideological differences across districts, and cease to provide

meaningful information about any particular candidate's ideological views. In the long

run, party competition in any meaningful sense would break down. Parties might

compete nominally in every district, but they would not compete as cohesive units with

clear agendas or platforms.

On the other hand, without the establishment, activists would only nominate

their ideological favorites, leading to national convergence of elected officials to the two

party medians (as set by the activists, see Aldrich (1983) for a description of these

dynamics), but no district-level convergence on the district medians. This would result

in very distinct parties, but ones that are not competitive or representative in any but a

few districts in the ideological center of the country. Once again, party competition

breaks down, as parties do not compete meaningfully in most districts.

The ongoing struggle between what I am calling the establishment and the

activists, however, leaves some middle ground for parties to be electorally competitive

in more districts than if the activists had their way, but also to preserve their distinct

ideological positions. This dynamic allows for more individual responsiveness through

the dynamics of party competition described above. Based on the CPG model, it also

provides better conditions for maintenance of cohesive parties and therefore greater

responsiveness of governments in general. We can therefore reasonably predict that party competition will not only increase the responsiveness of individual legislators, but also that legislatures as a whole will become more responsive to public opinion in terms of the bills they pass. Thus, assuming that my elected-official level hypothesis is supported, we will have support for both a micro-level story and an aggregative link up to the macro-level, increasing confidence in my direct test of the macro-level hypothesis and interpretation of the results.

To summarize so far, my hypotheses are as follows:

1. Elected Officials: As party competition in an elected official's state increases, the elected official will be more responsive to public opinion.

2. Macro-level: As average national party competition increases, legislative actions will be more responsive to public opinion.

I will discuss measurement of the key concepts in these hypotheses, including how I will operationalize them for testing, in the next sections. Before moving on, two other findings in the literature are important to motivate some of my specific tests. First, the effects of party competition may change over time, as the party system itself changes. Aldrich and Griffin (Forthcoming) show that parties in the American South have only become competitive in the past two or three decades, which they also show is related to a rise in responsiveness of Southern legislators. Second, it may be the case that different parties respond differently to party competition. This suggests that in addition

to an analysis that provides a single average measure over a time span, it will be worth

looking at time-varying measures as well.

1.2 Methods

My first hypothesis is that increased party competition will affect an elected

official's responsiveness to his/ her constituents' opinions. To be more operationally

specific, higher measures of party competition in a state will be associated with a

stronger positive correlation between the ideology/ legislative behaviors of members of

the US Congress and the ideology/ opinions of their constituents. Using data on

legislators who hold office o (each House race is given a unique value of o) in state s at

time t, I will construct the following OLS regression model to test my hypothesis:

$$
\begin{aligned}
Legislator\ Ideology_{ost} \\
= \beta_0 + \beta_1 Constituent\ Ideology_{ost} + \beta_2 Party\ Competition_{ost} \\
+ \beta_3 (Constituent\ Ideology_{ost} * Party\ Competition_{ost}) + \beta_4 (other\ controls) + \alpha_t \\
+ \epsilon_{ost}
\end{aligned}
$$

Generally, representation is measured in the manner represented by β_1, which is

the correlation between legislator ideology and constituent ideology. The coefficient of

interest for this chapter is the interaction term, β_3, which can be interpreted as the effect

of party competition on representation (holding constituent opinion and other variables

constant). If we define representation itself as the change in legislator ideology with

respect to changes in constituent ideology, we can take the partial derivative of the

equation above with respect to constituent ideology to obtain a stylized representation

function showing that representation varies with the level of party competition:

$$\frac{\partial (Legislator\ Ideology_{ost})}{\partial (Constituent\ Ideology_{ost})} = \beta_1 + \beta_3 Party\ Competition_{ost}$$

As noted in the first equation, I will include various controls to produce less

biased results. Electoral competition could be related to the variables of interest, so I will

include the margin of victory for each winning candidate in the model, as well as an

indicator for uncontested races. I also include indicators for Southern representatives

and Republicans (representatives from third parties are excluded, leaving only

Republicans and Democrats). Preliminary models testing controls for personal

characteristics of the legislator such as gender, race, age, time in office, etc. found these

variables were not necessary. Finally, I will include year-fixed effects (α_t) to account for

changes over time.

Given the coding of my measures (to be discussed below), a significant, positive

β_3 will provide support for my hypothesis that party competition increases

representation. I will obtain estimates of β_3 by estimating the first equation above. I will

also estimate similar models that look at different aspects of the relationship between

representation and party competition. To examine the time-varying effects of party

competition, I will estimate the first equation separately for each election cycle t

(omitting, of course, the year fixed effects α_t). I will also explore models by incumbent

party to assess any qualitative differences across parties in representational behaviors.

Testing the second hypothesis about responsiveness of the legislature as a whole will require a similar model, though with only one observation in each year. Rather than individual legislative behavior, I will model actions taken by the legislature as a whole. Thus the model will be a time series model, with one observation per biennium. I will use aggregate measures of the three main constructs of interest: party competition, public opinion, and policy. I will also include the lagged dependent variable as a predictor to control for potential path dependency, as well as three Congress-level variables: majority party, the majority party's percentage of seats in the chamber, and whether the previous election was a mid-term election. Again, the variable of interest will be the interaction between aggregate party competition and aggregate public opinion.

1.3 Data and Measurement of Key Variables

In order to estimate the models described above, I use measures of legislator ideology, constituent ideology, and party competition. My general strategy is to run multiple specifications of my models, using different measures of the variables of interest, in order to increase confidence that my results are not driven by the assumptions of any single measure. I will use data from 1870 to 2015 where possible to avoid the complex issues caused by the rise of the Republican Party and the Civil War while giving as long a time series as possible.

1.3.1 Party Competition

One contribution of this project is deeper examination of state-level party competition and its effect on national policymaking in Congress, following the lead of Aldrich and Griffin (Forthcoming). Thus, it is important to think seriously about whether indices designed to examine state-level policy making are appropriate for use here (see Dawson and Robinson 1963, esp. p. 270-275). I have developed a new party competition index meant to capture exactly the kind of party competition that matters for congressional policy makers. State-level measures are the right level for party competition, because the major political parties are organized in states. Indeed, the only nationally-elected officials in the US are the President and Vice-President. Members of the House and Senate are elected by voters in their states, and they face challenges from other politicians in their states. Candidates for federal office often come up through the ranks of state government, and are therefore direct products of the state parties rather than of a national party organization. Assessing the state parties' ability to attract votes at the state level is key to understanding party competition in America.

With this in mind, my proposed index is calculated as follows. I will use two-party general election results for each legislative and executive branch office up for election in a given year, excluding presidential elections. This includes both statewide offices like governor, lieutenant governor, attorney general, and secretary of state (where these executive offices are elected and where data on these races are available),

as well as members of the state's lower and upper legislative chambers and

representatives in both Congressional chambers.[1] I sum, for all races included in the

index, the raw Democratic vote total, and divide by the sum of the two-party vote totals

(Republicans plus Democrats) to obtain a percentage of major party votes captured by

the Democrats. This calculation is done by office o in state s at time t, excluding the

office for which the index is being calculated from both the numerator and denominator.

For example, when calculating an index for party competition for Alabama's first

congressional district (AL-1) in 2014, I will use data from all elections held in Alabama

that election cycle *except* the results from district AL-1. Mathematically, the index

calculations so far can be written as:

$$Democratic\ Competition_{o_n st} = \frac{\sum_{o|o \neq o_n} Democratic\ Votes_{ost}}{\sum_{o|o \neq o_n} Total\ Two\ Party\ Vote_{ost}}$$

When this measure equals 1, Democrats are running uncontested in the state.

Republicans are uncontested when the measure is 0. At an index value of 0.5, the two

major parties are locked in perfect competition. To obtain a unidimensional measure of

party competition, I will fold the results obtained above using the expression

$1 - |Democratic\ Competition_{o_n st} - 0.5|$. This will yield an index that ranges from 0.5

(one-party dominance) to 1 (perfect party competition).

---

[1] For states that hold odd-year elections for state offices, I combine these elections with the next even-year federal election. Unfortunately, election data before the 1950's (other than federal and gubernatorial) are not generally available. For elections in that time frame, I am still able to calculate a party competition measure using what limited data are available. Using data on only the federal and gubernatorial races does not change results or the measures themselves substantially, so I use all data available in any given year for precision.

This single-period index value will be sensitive to idiosyncratic variation in state-level party competition across election years, including variation due to the offices on the ballot that year. For some purposes, this sensitivity to statewide variation is useful. To yield a more stable, long-term view of a state's party competition, I average current and lagged values of the index in each state, as is frequently done with the Ranney index (Ranney 1976), to obtain a four-year running average. This ensures the inclusion of a gubernatorial election and at least one US Senate election in every year's index value. This measure will also not be as sensitive to candidate effects in any particular race, since many different races are accounted for in the index. In particular, this is useful in that it mitigates the effects of popular/ well-known candidates for high-profile offices like governor or US Senator. The measure also avoids some, if not all, of the effects of legislative and congressional redistricting, since the index does not depend in any way on district definitions.[2]

There are many existing measures of party competition in the literature (Ceaser and Saldin 2005; Holbrook and Van Dunk 1993; e.g. Ranney 1976). The problem I see with existing measures for my purposes is that all were developed for analysis of the effects of party competition in a state on state-level policy. Many use control of state

---

[2] Of course, there may still be some effects of redistricting. Competitive districts may have higher turnout, leading to different voting patterns than would otherwise be observed. On the other hand, a district that is not supportive enough for one party may not be contested by that party, leaving all major party votes to the dominant party, when that may not have been the case if there were a challenger. However, these forces will generally be indicative of the level of party competitiveness of the state as a whole, exactly what the index is trying to capture.

government, which although correlated with election outcomes, is not quite the same as electoral competition. Many indices do not include national election data. Those that do often include presidential vote, which I do not feel is appropriate for two reasons. First, presidential elections are unique in that they are nationally-oriented. Presidential votes are often cast with national considerations in mind, rather than particular state interests. The phenomenon of Southern Democratic supremacy at the state and congressional levels, even as Southern states voted overwhelmingly for Republican presidential candidates, illustrates this point nicely. The second reason, particular to this study, is that I plan to use presidential vote share as a measure of district ideology, as is often done in other studies at the national level, and it is therefore inappropriate to include presidential vote in the party competition measure as well. To assess robustness of my results to different measures of party competition, I do plan to estimate alternate specifications of my models using two indices: the Ranney Index (Ranney 1976) and the Holbrook and Van Dunk index (HVD; Holbrook and Van Dunk 1993).

To aggregate these measures for the test of hypothesis 2, I take the average district-level party competition measures (4-year running averages) in each election cycle.

1.3.2 Legislator Ideology

For the dependent variable, I plan to use existing measures of representative ideology. I rely mostly on the roll call-based DW-NOMINATE scores (Carroll et al. 2015,

2009). These scores are available for all Congresses back to 1789, and are commonly used

in scholarly research on Congress. However, many objections to the use of roll call votes

as measures of legislator ideology have been raised, so I will supplement my analysis

with an alternative model specification that uses Adam Bonica's campaign finance

scores (2014). In all cases, I will translate the measures so that lower values represent

conservative legislators, and higher values represent liberal legislators. The aggregate

level models will use two alternative measures of legislative liberalism: median DW-

NOMINATE scores for the chamber and the majority party.

1.3.3 Constituent Ideology

The most commonly used measure of constituent ideology in studies of

American politics is two-party presidential vote share in the state or congressional

district (e.g. Aldrich and Griffin Forthcoming; Griffin 2006). I will use the Democratic

share of the vote in the most recent presidential election for the year in question. For

presidential elections back to 1992, data on the vote by congressional district is available.

Before that time, I use county-level data mapped onto congressional districts. To

accomplish this, I use a method similar to that used in past studies such as

Ansolabehere, Snyder, and Stewart (2001). I assign multi-district counties to districts

proportional to the geographic area of the county contained in each district. For

example, if 50 percent of the land in Kings County is contained in New York's 9th

district, I assign half the population of Kings County to the 9th district. This obviously

does not take into account differences in population density within different parts of a county, but the data required to do so is not readily available. This method will suffice for my purposes.

Presidential vote share, like DW-NOMINATE scores, has the advantages of being readily available for long periods of time and being widely used in political science research. However, there are also known issues with this measure (Kernell 2009). Steps can be taken to mitigate some of the issues, such as demeaning by year to obtain a measure that is comparable across years, but this still does not solve all the measurement problems. Still, using demeaned district-level presidential election data is a "good enough" solution that precludes the need to collect harder-to-get data over the time span I examine.

For aggregate public opinion, I rely on the public mood measures described by Erikson, MacKuen, and Stimson (2002) and found on the Policy Agendas Project website. Alternative specifications will use the margin of victory of the Democratic presidential candidate in the national popular vote.

1.4 Results

1.4.1 Individual Legislators

To set up the empirical case that party competition increases responsiveness, I first present models of responsiveness by levels of district marginality (Table 1-1). These models follow the model equation above, but exclude the parameters involving party

competition (β_2 and β_3). The positive coefficients on Democratic presidential vote share (demeaned; the measure of constituent opinion) show that House members respond to their constituents, particularly after competitive elections. In districts that have either a margin of victory greater than 75 percent (column 5) or no major-party challenger (column 6), responsiveness is noticeably weaker.

Table 1-1: Models of Legislator Responsiveness

	(1)	(2)	(3)	(4)	(5)	(6)
		Margin:	Margin:	Margin:	Margin:	
		Under	25%-	50%-	Over	Uncon-
	All	25%	49.9%	74.9%	75%	tested
Democratic Share of	0.45**	0.57**	0.65**	0.52**	0.24**	0.10**
Presidential Vote	(0.01)	(0.02)	(0.02)	(0.03)	(0.02)	(0.03)
Winning Margin in	0.01	0.03	0.10**	0.02	-0.28**	
Election	(0.00)	(0.02)	(0.03)	(0.05)	(0.04)	
Uncontested Election	-0.11**					
	(0.00)					
Southern State	-0.10**	-0.05**	-0.08**	-0.15**	-0.10**	-0.12**
	(0.00)	(0.00)	(0.00)	(0.01)	(0.01)	(0.01)
Republican Incumbent	-0.65**	-0.65**	-0.62**	-0.64**	-0.77**	-0.65**
	(0.00)	(0.00)	(0.00)	(0.01)	(0.01)	(0.02)
Constant	0.41**	0.42**	0.28**	0.41**	0.68**	0.49**
	(0.02)	(0.02)	(0.05)	(0.09)	(0.07)	(0.10)
Year Fixed Effects	Y	Y	Y	Y	Y	Y
Observations	23,532	11,142	6,653	1,918	2,380	1,581
R-squared	0.85	0.87	0.87	0.87	0.83	0.73

Standard errors in parentheses. $^*\,p < 0.05$, $^{**}\,p < 0.01$

There is already responsiveness in more marginal districts, as predicted by the marginality hypothesis, but how can we detect the effects of party competition in this

data? By definition, if a district is competitive with two major-party candidates, then the party in power stands a real chance of losing the seat. If electoral competition and party competition are both present in this situation, it is econometrically very difficult to determine which factor is driving responsiveness. Indeed, the data shows very little variation in party competition for more marginal districts in a given election cycle (see Figure A-1 and its explanatory note in Appendix A). However, if party competition increases the responsiveness of districts in which electoral competition is absent, we would have stronger evidence of the validity of the party competition hypothesis.

By adding the party competition parameters (β_2, the main effect, and β_3, the interaction with constituent opinion) to the models in Table 1-1, we can test the party competition hypothesis. Table 1-2 displays these results. Looking first at the overall model in column 1, the significant interaction term indicates a significant increase in responsiveness when districts are high in party competition. To show that this is not being driven solely by electoral marginality, we can look across the table at the interaction terms for various levels of marginality. As expected, the interaction terms are not always significant in situations where marginality is high and variance in party competition therefore very low (columns 1 and 2). However, in situations with less marginality, the interaction terms indicate that party competition is actually driving any positive first-order legislator responsiveness to constituent opinion.

Table 1-2: Models of Legislator Responsiveness, Party Competition

	(1)	(2)	(3)	(4)	(5)	(6)
		Margin: Under 25%	Margin: 25%-49.9%	Margin: 50%-74.9%	Margin: Over 75%	Uncon-tested
	All	25%	49.9%	74.9%	75%	tested
Democratic Share of	-0.15**	0.17	0.65**	0.18	-0.60**	-0.35**
Presidential Vote	(0.04)	(0.18)	(0.14)	(0.16)	(0.09)	(0.10)
Party Competition	0.09**	-0.02	0.06*	0.17**	-0.20**	-0.00
Index	(0.01)	(0.02)	(0.03)	(0.04)	(0.04)	(0.05)
Party Competition	0.79**	0.44*	0.00	0.43*	1.16**	0.71**
Measure X Dem Pres.	(0.05)	(0.19)	(0.15)	(0.18)	(0.12)	(0.16)
Share						
Winning Margin in	0.02**	0.03	0.10**	0.04	-0.18**	
Election	(0.00)	(0.02)	(0.03)	(0.05)	(0.04)	
Uncontested Election	-0.08**					
	(0.01)					
Southern State	-0.07**	-0.05**	-0.08**	-0.12**	-0.09**	-0.08**
	(0.00)	(0.00)	(0.01)	(0.01)	(0.01)	(0.01)
Republican Incumbent	-0.64**	-0.65**	-0.62**	-0.63**	-0.71**	-0.69**
	(0.00)	(0.00)	(0.00)	(0.01)	(0.01)	(0.03)
Constant	0.32**	0.43**	0.23**	0.26**	0.72**	0.43**
	(0.02)	(0.03)	(0.06)	(0.09)	(0.08)	(0.10)
Year Fixed Effects	Y	Y	Y	Y	Y	Y
Observations	23,525	11,137	6,652	1,917	2,380	1,481
R-squared	0.85	0.87	0.87	0.87	0.84	0.70

Standard errors in parentheses. * $p < 0.05$, ** $p < 0.01$

When estimating models with interaction terms, collinearity between a second-order parameter and its first-order components is generally a concern. Variance inflation factors (VIFs) calculated for the models in Table 1-2 (reported in Appendix A, Table A-1) indicate that collinearity is indeed present between the party competition main effect and the interaction term in these models. Although collinearity of interaction terms is

not a concern for purposes of overall model fit/ predictive accuracy, it is a concern when

we are interested specifically in one of the parameters involved, as we are in this paper.

My concerns, however, are mitigated by the fact that although collinearity exists

between the party competition and the interaction, the main order responsiveness

parameter (constituent opinion) does not seem to be involved, as indicated by the low

VIFs on that parameter in all models. This suggests the parameter estimates for the

interaction are sensitive to party competition (and vice versa), but not to constituent

opinion. I am confident that in spite of collinearity, party competition is contributing

something meaningful to the estimation of responsiveness.

Three different versions of the models in Table 1-2 appear in Appendix A, using

different measures for some of the variables. Table A-2 shows models where Adam

Bonica's CF Scores are used as the dependent variable. These alternative models do not

show as clear a trend as those in Table 1-2, but this may partly be due to the limited time

span of the CF Scores, which are only available after 1980. Party competition has

increased since that year, and does not vary as much across districts as it did in the prior

110 years (see again Figure A-1). Models using presidential vote covering only 1980-2012

yield similar results.

Tables A-3 and A-4 show versions of my models using the Ranney and HVD

indices (respectively) as the party competition measure. The Ranney index models in

Table A-3 show a similar trend to those in Table 1-2, with party competition positively

affecting responsiveness. One difference is that the interaction term is significant no matter the margin of victory, but the magnitude of these coefficients still increases as marginality decreases. The models using HVD in Table A-4 show no clear trends, and overall do not support the hypothesis. However, the HVD index is only available since 1972, which presents the same issue as that raised for the CF Score models. The Ranney index, which is only available from 1938, may have a similar issue with respect to time, but again those results are similar to the ones for 1872-2012 in Table 1-2.

We can conclude two things from the analysis so far. First, there is a positive correlation between responsiveness and party competition, at least on average, for legislators in the post-Civil War era. Second, it appears that this relationship may vary across time. I now turn to an analysis of the changes in legislator responsiveness across time. To accomplish this, I estimated separate models of legislator DW-NOMINATE scores for each year from 1890 to 2012, using data from the ten elections prior to each year. The variables in the model are otherwise the same as those in Table 1-2, model 1. The β_3 interaction terms from these models are plotted with their 95% confidence intervals in Figure 1-1 as a time series. The x-axis indicates the final year of data used in each model, so a rough time trend can be discerned from the figure.

Figure 1-1: Change in Party Competition's Correlation with Responsiveness

As shown in the figure, changes in legislator responsiveness as a result of party competition generally decreased in the early 1900s, reaching a minimum by about 1925, and then steadily increasing over the next six decades. The imprecision of the estimates increases toward the end of the series, with the last two decades indicating a lack of correlation between responsiveness and competition. The sudden shift from very high correlations between competition and responsiveness to no correlation at all comes at a time when party competition itself was increasing in previously uncompetitive districts (see Figure A-1), particularly in the South, causing a narrower range of party

competition (i.e. the minimum level of party competition increased significantly, from 0.5 to about 0.7, while the maximum remained at 1). It may still be that as party competition increases overall, responsiveness also increases, but the legislator-level data and my models of that data cannot address that hypothesis one way or the other.

1.4.2 Legislature as a Whole

The results of my main national-level models are presented in Table 1-3. Column 1 shows that overall responsiveness to the national mood in a given year is affected by the mean level of party competition in congressional districts. The relative magnitudes and signs of the coefficients indicate an inverse response to public mood when party competition is nonexistent (when the index = 0.5, its minimum), but no net responsiveness when party competition is strong. A similar trend occurs when predicting the mean majority-party DW-NOMINATE score, but not when using the median roll-call score as the dependent variable.

Columns 1 and 3 provide tentative support for hypothesis 2, but the other models' null findings are somewhat concerning. The public mood and presidential two-party Democratic vote share are not significantly correlated (rho = 0.198, p = 0.286), indicating they are not capturing the same underlying variation. This could be a function of the different time frames captured by the two measures. The presidential vote share allows me to go from 1870 to 2014, while public mood data only ranges from 1952 to 2012. In terms of face validity, however, the public mood is the better measure

for purposes of this study. I am inclined to accept the findings using mood as more

valid, understanding the caveats raised by the alternative specifications.

Table 1-3: Models of Overall House Responsiveness

	(1) Chamber Median	(2) Chamber Median	(3) Majority Median	(4) Majority Median
Lagged Dependent Variable	-0.08	0.07	0.01	0.13**
	(0.08)	(0.07)	(0.05)	(0.04)
Mean Party Competition	-21.65**	0.41	-28.61**	-3.65
	(5.52)	(2.10)	(7.61)	(2.16)
Public Mood	-0.36**		-0.47**	
	(0.09)		(0.12)	
Party Competition X Mood	0.38**		0.49**	
	(0.09)		(0.13)	
Democratic Presidential Vote Share		0.21		-6.57
		(3.79)		(3.91)
Party Competition X Dem Votes		-0.13		6.79
		(4.24)		(4.37)
Majority Percentage in Chamber	1.19**	0.28	-0.24	-0.09
	(0.25)	(0.17)	(0.34)	(0.18)
Democratic Majority	0.28**	0.35**	0.88**	0.73**
	(0.03)	(0.03)	(0.04)	(0.03)
Election Was Midterm	-0.02	0.01	-0.02	0.00
	(0.02)	(0.02)	(0.02)	(0.02)
Constant	19.48**	-0.82	26.62**	3.11
	(5.11)	(1.88)	(7.04)	(1.92)
Observations	31	70	31	70
R-squared	0.94	0.85	0.98	0.95

Standard errors in parentheses. * $p < 0.05$, ** $p < 0.01$

Another puzzling finding of these models is the equal magnitude and opposite

direction of signs for the mood coefficients and the interaction term. The interaction is in

the expected direction, but its magnitude is only enough to cancel out the inverse

responsiveness of the House in the absence of party competition. This suggests that

party competition is necessary to prevent the House from going against the national

mood, but is not sufficient to cause the House to actually respond positively to changes

in mood. Further exploration along these lines is warranted.

Analysis of collinearity for the models in Table 1-3 (see VIFs in appendix Table

A-5) reveals high collinearity among the interaction terms and the two first-order

variables. This further attenuates the strength of conclusions that can be drawn from

these coefficients, but it may be the best that can be done quantitatively in an aggregate

context. Qualitative research and/ or analysis using data from other legislatures (states

or other countries) would be helpful in further bolstering these conclusions.

Alternative specifications shown in the appendix using the party/ chamber

means as dependent variables (Table A-6) and the mean 4-year average Ranney index as

the party competition measure (Table A-7) yield similar results to those in Table 1-2.

However, as with the legislator-level models, the HVD index yields different results. No

relationship between party competition and responsiveness is uncovered in the HVD

models (Table A-8).

1.5 Discussion

The analysis in this chapter yields tentative support for my initial hypotheses. At

the legislator level, party competition in a district is correlated with greater

responsiveness to public opinion (as measured by presidential vote shares in the district). That is, legislators in districts with meaningful levels of party competition are more responsive to their constituents' opinions as a whole than similar legislators in one-party districts.

At the aggregate level, the House of Representatives appears in these models to be inversely responsive to the public mood (as the public gets more liberal, the House becomes more conservative), *unless* average party competition is high. In that case, the House becomes non-responsive. This finding does not hold for all specifications of the model, but it does suggest that party competition is correlated to some extent with the House's reactions to public opinion.

Several caveats must be given on these results. First, changes in the effects of party competition on responsiveness seem to have occurred over time, as shown in Figure 1-3. Part of the reason the HVD index is giving different results could be the shorter and more recent time frame covered by that index relative to the Ranney index or my election-based measure. Assessing this change over time in the aggregate analysis is difficult to do quantitatively, given the low N for that analysis. Further examination of the changes in party competition's effects on responsiveness over time are needed.

A second and somewhat related caveat is that as party competition has risen in all districts to the point that there is not much variation in party competition, its effect on responsiveness becomes indiscernible. This is probably due to the inability to measure

any such effect with so little variation in the variable of interest. What my analysis

cannot say is whether the overall increase in party competition (to high levels with low

variance) has led to an increase in overall responsiveness. Again, further analysis along

these lines using different analytical strategies is warranted. Still, we can conclude

tentatively that party competition does correlate positively with the level of

responsiveness to public opinion.

Third, my analysis does not actually prove a causal relationship. Theory suggests

that legislators respond to constituents, but it could be the other way around. Using

different leads/ lags of the independent variables to change the temporal ordering do not

change the results much, probably because of high autocorrelation in all the measures

used. As much as possible, causal inference needs to be supported by appropriate

empirical strategies in future research.

An important implication of these findings with regards to policy making is that

as long as party competition remains high, members of Congress will likely respond to

their constituents, meaning public opinion will also be correlated with the positions of

individual legislators. This correlation is evident from the sorting of both House

members and voters in general into warring camps on both sides of the debate over

health reform. It is impossible to say for sure from my data whether voters are

influencing elites, or vice versa, but it is probably at least some of both. In either case,

party competition makes the views of the public relevant for understanding the actions of their representatives.

This implication allows for predictions to be drawn regarding the political future of major policies. For example, we can say that if public opinion on the ACA continues as it has been (divided evenly but strongly), then debate over the ACA will continue and only marginal wins for either side will be possible. To the extent the public has strong feelings about a policy in a political context characterized by party competition, those opinions will be useful in predicting that policy's political future.

2. Issue Publics in Health Policy

Reports of skyrocketing prices for the EpiPen, a product manufactured by pharmaceutical company Mylan to quickly treat anaphylactic shock in people with various allergies, had been circulating for some time before July 2016, according to *The New York Times* (Parker-Pope 2016). Since 2007, the price for a two-pack of EpiPens increased over 500 percent, from $100 to over $600. That month, a few parents and parent activists with large social media followings decided to start a petition against what they called price gouging. The petition was shared widely across social media, along with personal stories and photographs of receipts showing high prices for the product. Congress took notice, partly due to the 80,000-signature petition and the 121,000 letters sent to them over the course of a few weeks. High-profile politicians such as Bernie Sanders and Hillary Clinton called on Mylan to lower their prices, and the Republican-controlled Congress held high-profile hearings in which committee members from both parties grilled Mylan's top executives about their pricing practices. By the end of August, Mylan expanded its coupon and patient assistance programs and promised to release a cheaper generic version of the EpiPen. Congress has not introduced any legislation directly related to the EpiPen controversy, but its investigation did lead to the discovery of millions of dollars taken by the company due to misclassifying the EpiPen for Medicaid billing. Mylan agreed to settle the case against it for $465 million (Thomas 2016), more than $60 million higher than the company's 2nd

quarter 2016 revenues for EpiPen's entire product segment (Mylan 2016). Lawmakers'
swift response to the public outcry, with its costly end for a large player in a powerful
industry, is striking.

Another salient feature of this story is that a relatively small number of people
were successful in getting Congress to take a strong public position on the issue. The
House of Representatives is comprised of 435 voting members, each representing a
district of an average of 710,000 voters. The smallest district is Rhode Island's 1st district,
with approximately 526,000. Even if we say that the 80,000 signatures and 121,000 letters
were sent by different people (not likely to actually be the case), the resulting 201,000
people yield an average of only 462 voters per district. The uniform distribution of these
voters across districts is unlikely, but that only makes it more surprising that so many
members of Congress responded the way they did. If the 201,000 were all concentrated
in RI-1, where they would likely form a majority of the voting-eligible population, then
why would the other 434 members of Congress care? At any rate, a relatively small
handful of loosely organized voters seem to have gotten the House's attention, spurring
them to take a strong position against the interests of a well-connected pharmaceutical
company, all without formal organization.

Another story: during the debate over passage of the Affordable Care Act (ACA),
senior citizens came out strongly opposed to the proposal. The ACA was to cut
Medicare Advantage funding significantly, and seniors were afraid of anything they

perceived as weakening Medicare (see also Kaiser Family Foundation nd; Roy 2012). The

American Association of Retired Persons (AARP), which purports to represent seniors'

interests, remained publicly neutral on the ACA, and even privately supported the

Medicare Advantage cuts. A likely reason for this is the royalties the AARP receives

from the sale of licensed Medigap plans, which would come into higher demand as

people moved out of Medicare Advantage (Roy 2012). On the ACA, seniors were

without the representation of a formal, organized interest group.[1]

These two anecdotes illustrate that unorganized groups of voters can come

together to influence public policy, independent of organized interest groups. The study

of group influence in politics has traditionally focused on organized, formal groups,

such as the AARP, Pharmaceutical Research and Manufacturers of America (PhRMA),

and the American Medical Association (AMA) in the case of health care policy. The

EpiPen story is an example of unorganized groups of voters persuading their elected

officials to take a position directly counter to the interests of PhRMA and the

pharmaceutical industry, which is generally very powerful in American politics. The

second story shows an example of attempted influence by unorganized voters without

the help of their alleged organized representatives (the AARP). For which groups and in

what situations can this kind of influence occur? How might it play out in a complex

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[1] Seniors and the AARP similarly disagreed on the Medicare Catastrophic Coverage Act of 1988, which was
repealed the next year in the face of fierce opposition from Medicare beneficiaries (Rice, Desmond, and
Gabel 1990; Oliver, Lee, and Lipton 2004).

issue such as health policy? This chapter seeks to explore initial answers to these two yet

unstudied questions.

Part of the reason these issues have not been fully explored is lack of available

data. In the age of big data and increased computing power, these issues are being

removed. Government data transparency initiatives are particularly useful. This paper

makes use of government data and geocoding techniques to estimate the number of

physicians, seniors, and uninsured residents in a congressional district. This innovative

use of data can serve as a model for future studies of group influence.

2.1 Background

2.1.1 Pluralism

The original pluralist view, espoused by James Madison in *Federalist 10* and

many others since, is essentially that every voter belongs to a group or faction, and that

if all factions are brought together for purposes of making policy, their conflicts and

compromises will lead to policy that is not dominated by any one faction. The system

works when interest groups, which in theory collectively represent virtually all citizens'

interests, are encouraged to compete.

The last century has seen many intellectual challenges to that idea, such as

Schattschneider's famous quip that "the problem with the pluralist heaven is that the

heavenly chorus sings with a strong upper class accent" (Schattschneider 1960). The

basic critique of the elite pluralists is that some groups inherently have more resources

to leverage than others, leading to an asymmetry of group power. Encouraging interest group competition will only amplify these inequalities.

Indeed, ideas such as Mancur Olson's logic of collective action, by which mass-based groups must operate differently than smaller groups in order to overcome collective action problems and have any chance of success, indicate that mass-based groups might fail to adequately represent larger, generally less privileged groups of voters (for example, seniors, represented by the AARP, or parents of allergic children, who may not have any high-profile organized interest groups representing them) than the pluralists would hope. It is therefore theoretically possible that not every citizen is adequately represented by a competitive group.

Despite the cogent critiques of the elite pluralists, the EpiPen story is an example of how unorganized groups might influence policymakers and policy, particularly in the age of free mass communication via social media and other platforms. Can unorganized groups overcome the power asymmetries pointed out by the elite pluralists? Theoretically, parents are a large group with a lot of voting power. If the collective action problem can be overcome and parents coordinate enough to vote based on their interests as parents, election-seeking members of Congress would have to listen in order to obtain/ maintain office. They apparently felt compelled to do something in the face of just a hundred thousand or so parents taking a stand on the EpiPen issue. Can we expect this to happen in other instances, and for other groups?

One way to get at this question is to think about what determines legislative voting and other behaviors. Some ideas that have been studied extensively in the political science literature are parties, the median voter, and organized interest groups. Do these influences leave any room for unorganized groups of voters to make their influence felt?

2.1.2 Legislative Behavior

Given prior research on legislator behavior, there is little doubt that party matters. Partisan polarization has been a defining feature of American politics in recent decades. Research shows the two major political parties have come to take predictable and opposing ideological positions on many major issues (Adams and Merrill 2008; Brady, Han, and Pope 2007; Burden 2001, 2004; Cox and McCubbins 2005; Levendusky 2009; Petrocik 1987; Roberts and Smith 2003; Rohde 1991; Shafer and Johnston 2006). Across a range of studies, from those examining roll call-based ideal points (Poole and Rosenthal 1997, 2001) to analyses of electoral patterns (Jacobson 2003), it is clear that political elites are polarized (see also Hetherington (2009)). One potential implication of this literature is that legislative voting behavior should simply follow party lines, as with some recent prominent legislation such as the Affordable Care Act and numerous attempts to repeal it, or the Paycheck Fairness Act of 2014. Many issues, including major health care reform, are often cast in partisan terms. The ACA is one clear and prominent example of this schism in Congress. The bill was passed without a single Republican

vote in favor. Since its passage, House Republicans have tried repeatedly to repeal it, and Republican congressional and presidential candidates have made repealing and replacing the ACA a major message of their campaigns. Democrats still largely favor the reform bill, providing a stark partisan contrast. This polarization certainly provides a clear choice for voters on Election Day, an important feature of party competition that strengthens accountability (see chapter 1).

However, not all votes in Congress are partisan. The ACA is more of an exception than the rule in this regard. This may not always be easy to see, partly because the calling of roll call votes, the most convenient form of data in studying legislative decisions, is endogenous to party politics in the chamber. Still, there are numerous instances of Democrats and Republicans "crossing the aisle" to vote for the other party's bills, and of members of Congress "working across the aisle" on legislation both parties find desirable. Perhaps this bipartisanship has decreased in recent years as polarization has increased, but it has by no means disappeared completely from Congress, especially on less high-profile bills. Partisanship still matters in predicting votes, but it is not the whole story.

Within the congressional literature, the prominent counter to the party power hypothesis is that district preferences, not party control, determine voting behavior (Krehbiel 1993). The classic median voter theorem predicts that members of Congress will take positions (in this case, vote) according to the preferences of the median voters

in their districts (e.g. Downs 1957; Mayhew 1974). If legislators represent their constituents in this manner, then legislator votes will correspond to their median voter's preferences. Assuming that ideology is unidimensional, the representative simply picks the median voter's position to ensure reelection. This is the classic notion of democratic representation.

However, previous empirical studies do not always fit well with the assumptions of the median voter model (Bafumi and Herron 2010; Erikson 1978; Kingdon 1995). One potential explanation for this is group dynamics. Rather than viewing constituents as a spectrum, members of Congress might see groups of voters, each with different but not necessarily contradictory demands of their elected officials (Kingdon 1995). Fenno's (1978) classic study of House members in their constituencies uncovered a great deal of heterogeneity in representatives' perceptions of their constituents. There is also evidence that members of Congress perceive and respond to the interests of different groups on specific issues important to those groups (Bishin 2009; Hansen and Treul 2015). Constituents matter, but not always in the manner the median voter theorem predicts, and there are few explanations for these nuances offered in the congressional literature (Theriault, Hickey, and Blass 2011).

The observed deviations from the median voter theorem seem to suggest that groups matter. Often, this is modeled as organized interest groups affecting congressional behavior. It is straightforward to come up with a theoretical mechanism

for such influence. Research shows that members of congress are held accountable for their votes on particular issues, such as crime policy (Bonney, Canes-Wrone, and Minozzi 2007; Canes-Wrone, Minozzi, and Reveley 2011), depending on their level of salience at the time of the roll call and regardless of the legislator's voting record overall. Interest groups may play a key role in this dynamic, through their lobbying and campaign finance activities. As interest groups monitor elected officials, they may then try to use their influence to reward (punish) members of Congress who support (oppose) the group's position. Regarding gun policy, Shaiko and Wallace (1998) document the ability of the National Rifle Association (NRA) to mobilize both its official membership and the larger gun rights community and cite that grassroots mobilization as the reason for the NRA's success in influencing elections and policy. On the other side of the issue, gun control groups have made some strides in organizing themselves effectively, though that process has been a long one Lambert (1998). Theoretically, interest groups may therefore affect roll call votes in Congress.

Whether interest group influence is always manifested is harder to discern from the literature, which contains mixed results on the effects of interest group contributions and lobbying efforts (Smith 1995; Theriault, Hickey, and Blass 2011). Still, there is some evidence that interest groups affect roll call voting at least sometimes on some issues. In an analysis of roll call voting and dairy industry contributions in the mid-1970's, Welch (1982) finds that interest group contributions affected legislator voting behavior, though

not as much as other factors like partisanship or the size of the dairy industry in the legislator's district. On gun bills specifically, Langbein (1993) report that NRA contributions are more effective at intensifying support from legislators already committed to pro-gun policies, rather than convincing legislators to change their minds. However, the same study finds that gun control groups were not as successful in any regard in their use of campaign contributions. In a forthcoming paper (Richards Forthcoming), I find similar results when analyzing the effects of gun-related interest group contributions on roll call votes and cosponsorships.

2.1.3 Unorganized Groups

Group influence on members of Congress may not occur solely through parties, voters as a whole, or organized interests. Identifiable but unorganized groups of voters that tend to vote a certain way based on certain issues may also have an effect, independent of any financial or other organized activity, and not in quite the same way as the median voter theorem predicts. Within the public opinion literature, there is recognition that not all individuals care equally about all issues. According to the issue public perspective, voters might not have a coherent set of ideologies on which they base their vote preferences, but they are often knowledgeable or engaged on an issue or two based on self-interest, group identification, and/ or strong personal values (Krosnick 1990).

The notion of issue publics has long played an important role in explaining public opinion and political behavior, but has largely been ignored in the Congressional voting literature. Instead, that literature has largely equated passion surrounding an issue with interest groups, with campaign contributions from these groups as the measurable manifestation of a group's attempts to influence legislative behavior. However, organized groups may be elite-driven, only nominally representing the views of those they claim to represent (Skocpol 2001, 2003). They may also fail to include significant portions of the relevant population. For example, in 2012 only 24 percent of gun owners are members of the NRA, and support for gun control proposals is higher among gun owners who did not belong to the NRA (Sides 2012). Throughout its history, the American Medical Association has at times been reined in by constituent doctors for being unrepresentative of their opinions (Starr 1982). This incongruence between interest groups and issue publics suggests that whether or not interest groups have any effect on roll call voting, the issue publics may have distinct effects of their own. Most importantly, issue publics might not be organized at all – the assumption is simply that they are individuals who are more likely to vote on the basis of this policy area, given a collective shared interest in the issue.

Subconstituency theory suggests that groups matter. As Bishin (2009) articulates, group organization is not a necessary condition for group influence—elected officials are better able to achieve their electoral goals by responding to subconstituencies with

intensely held views. If these subconstituencies are perceived important to the member's

electoral prospects, they have influence whether those groups are organized or not, and

donating campaign contributions or not (Bishin 2009; Bishin and Smith 2013; Hayes and

Bishin 2012).

While subconstituency studies show that groups do not need to be organized to

effectively gain substantive representation, the literature does not explicitly distinguish

between organized interest groups and latent group interests. In the most thorough

work on subconstituency theory, Bishin uses a general definition of subconstituencies

which, although often operationalized using latent group sizes or opinions, includes

members of organized groups as well, with no analytical distinction between the two

(see Bishin 2009, 20–21). Although he recognizes the potential for these interests to be in

conflict, Bishin does not explicitly control for campaign contributions in his empirical

models. Few analyses have recognized this distinction.

Two recent exceptions provide initial support for the hypothesis that the

perceived interests of unorganized groups affect legislator voting behavior independent

of the actions of relevant organized groups. In my forthcoming paper on gun politics

(Richards Forthcoming), I find that the number of hunters in a district was correlated

with greater support for pro-gun bills and less support for gun control bills in the

House. Hansen and Treul (2015) make similar conclusions regarding the number of

lesbian/ gay/ bisexual (LGB) constituents in a congressional district and House-members' votes on LGB issues.

While these two studies are consistent with the proposed perspective, they both examine issue areas with very simple unidimensional group structures. In this chapter, I explore whether the group interest hypothesis holds for another issue area with more complex group dynamics: health policy. I also begin to make some qualitative suggestions, based on my analysis, of what kinds of groups are influential under what conditions. Specifically, I compare the relationship of unorganized groups of doctors, uninsured adults, and Medicare beneficiaries with legislator support for health-related bills.

In my analysis, I expect to find that unorganized groups have independent correlations with legislator voting behavior in at least some cases, and that different groups have different levels of influence under different circumstances. The latter prediction is vague at this point because these dynamics have not been tested in the literature yet. Therefore, a significant portion of my analysis will be exploratory in this regard. However, I do have some tentative hypotheses about how exactly groups will differ in influence. I expect that groups with more resources (doctors and Medicare beneficiaries) will have more influence than less advantaged groups (the uninsured).

2.2 Methods

I will test the hypotheses above using logit models of legislator behavior, with the dependent variable operationalized as agreeing with the Democrats' position on a bill. The Democrats' position is inferred to be the side of the vote that got a majority of Democratic votes. For example, the Democratic position on the Affordable Care Act (ACA) is "yes," and anyone voting "no" is counted as voting against the Democratic position in the model.

I present models using three levels of aggregation. An overall model will include all health bill roll call votes, as identified by Policy Agendas Project topic code 3 (Adler and Wilkerson 2003–2013), from the 108th to the 112th Congress (2003-2012). A second set of subtopic models will model voting on bills grouped by Policy Agendas Project minor topic codes. These codes identify, within health policy bills, those that deal with such topics as insurance reform, pharmaceutical and device regulations, provider payment, and legal liability. Finally, I will present separate models limited to the following sets of bills (specific bill and roll call numbers are listed in the appendix):

- The Affordable Care Act, including both bills comprising the ACA, as well as the numerous repeal attempts in the 112th Congress.

- The Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act, a medical malpractice liability reform bill that has been introduced numerous times in various forms in the last fifteen years.

- The Children's Health Insurance Program Reauthorization Act of 2007 (CHIPRA).

- The Medicare Modernization Act of 2003 (MMA), which established the Medicare Part D prescription drug benefit and made numerous important changes to Medicare.

- Bills dealing with the Sustainable Growth Rate formula (SGR), a controversial Medicare provider reimbursement model.

- The Contact Lens Consumer Fairness Act of 2003, which requires licensed providers of eye examinations to furnish the patient with a copy of their contact lens prescription.

    The following controls will be included in each model, as appropriate:

- Organized groups, operationalized as contributions from four related industry categories

- Unorganized groups, operationalized as the percentage of the district population that belongs to the group

- District characteristics: voter ideology overall, voter ideology on health policy, percent of the district that is white, percent Hispanic, percent of adults in the district with only a high school diploma, and median income

- Legislator characteristics: age and partisanship

- Bill/ roll fixed effects (when more than one bill/ roll call vote is included) and whether the vote was a party-line vote

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Each of these measures will be discussed below in more detail, including data sources and specifications. Because of the fairly large number of bill groups to be examined, I keep the model specification constant across these bill groups.

2.3 Data

2.3.1 Campaign Finance

To account for the activities of organized interest groups, which I hypothesize to be distinct from unorganized issue publics, I obtained campaign finance data on interest groups that might be thought to represent the issue publics mentioned, as well as those who might have a vested interest in the policy. For example, the American Medical Association and other provider groups contribute heavily to political campaigns, and may be thought of as an organized analog to doctors in general. Campaign finance data by industry/ issue is available from the Center for Responsive Politics' website, opensecrets.org. Specifically, I collected data on donations from healthcare provider groups such as the AMA, hospital groups like the American Hospital Association, other health industry groups such as those that represent HMO, medical device, and pharmaceutical companies, Blue Cross Blue Shield companies/ affiliates, and the AARP.

In factor analyzing the contribution data, it was apparent that contributions from three distinct industry categories were moving together: HMOs, hospitals, and pharmaceutical and medical device manufacturers (Opensecrets industry codes Q02, Q03, and Q04). If variables for these three categories were included simultaneously in

the logit models, there would be high collinearity. To prevent this, I use the total dollar amount of contributions received from all three of these industry categories.

The other campaign finance measures included in my final models are provider group contributions (Opensecrets industry code Q01), contributions from any Blue Cross/ Blue Shield company, and contributions from the AARP. For ease of interpretation, all four campaign finance measures are scaled to represent thousands of dollars.

2.3.2 Issue Publics

As mentioned previously, I will analyze the effectiveness of three potential health-related issue publics: doctors, the uninsured, and the elderly. These represent a wide array of groups, and will allow for some comparison of the responsiveness of members of Congress to each of these groups. Some may be more effective at getting their way than others, and although the tests I will present in this paper will not be able to directly explore these differences in effectiveness, prior research on these groups can be brought to bear in explaining the results. I also expect certain groups to be more represented on specific subtopics. For example, doctors will probably illicit more responsiveness on provider-specific bills. At any rate, having data on multiple potential issue publics will be advantageous in testing the issue public representation hypothesis.

The general strategy for measuring issue public strength is to obtain some estimate of the number of people belonging to a specific group (i.e. Medicaid recipients)

in a member of Congress' constituency (states for Senators, districts for House

members). Data on the uninsured and Medicare beneficiaries was collected from the

Census Bureau's Small Area Health Insurance Estimates data (United States Census

Bureau 2008–2012).

For doctors, I obtained practice data on all providers who billed Medicare in 2012

from the CMS website. Using practice address, I geocoded this data and merged it with

a congressional district map, thus linking all matched providers to a state and a

congressional district.[2] The assumption that providers affect the votes of the member of

Congress in whose district they *practice* (as opposed to district of residence), in addition

to being the best the data will allow, is defensible for two reasons. First, it is plausible to

assume that doctors live close to their practices. In some urban/ geographically small

districts, this may be somewhat more problematic, but not in any other systematic way.

Second, even if a doctor does not live in a congressional district, it is likely that both

members of Congress and their actual constituents will be somewhat familiar with

businesses in their districts, including doctors offices. Members of Congress may want to

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[2] The data is the Medicare Fee-for-service Provider Utilization and Payment Data public use file for calendar year 2012, which contains over 881,000 records. I geocoded the practice address and mapped that onto the district boundaries for each of the five congresses used in my analysis. This of course makes the assumption that there were no significant changes in the relative numbers of providers across districts over time. Geocoding was performed in ESRI's ArcMap using Duke University's US address locater. A confidence threshold of 72 out of 100 yielded a unique location match rate of approximately 86 percent of records in the CMS file. Another pass of the geocoding algorithm using a threshold of 45 provided matches for an additional three percent of records. About three percent of records had multiple matches, and the remaining nine percent could not be matched (usually because of poorly formatted addresses). I exclude the twelve percent of records which were not matched successfully to a single location.

keep economic actors in their districts happy, and doctors have at times been known to transmit messages on policy to their patients/ customers (Starr 1982). Thus, although the use of practice address is imprecise, it is likely to still provide a good measure of issue public strength, one that will do well at representing the signals actually received by members of Congress.

2.3.3 Constituent Ideology

Using data from two publicly available large-N surveys, the Cooperative Congressional Election Study (CCES) and the National Annenberg Election Study (NAES), I create an index of district opinion on health policy. The scale is generated using predicted factor scores (regression method based on orthogonal varimax rotation) following factor analysis of the survey response variables. This method allows for the survey questions to have both different scales (3-point, 5-point, etc.) and to have more or less correlation with the underlying construct I am trying to capture (attitudes on health policy). I also control for general constituent ideology estimates using the Catalist-based ideal points calculated by Xing, Hillygus, and Carin (2014). Both variables are coded so that higher values indicate relatively more conservative positions. Similar to DW-NOMINATE scores for legislator votes, these scores of constituent opinion may only be interpreted relative to one another.

2.3.4 Other Data

Information on the partisan affiliations of members of Congress is obviously necessary, and will be used in this analysis. I also control for the legislator's age, obtained from the govtrack.us website (other personal characteristics, like gender and religion, were not useful in preliminary model specification checks).

I control for the percentage of the district identified in the American Community Survey as white, those identified as Hispanic, and the percent of adults over 25 in the district the ACS identifies as having only a high school diploma. In preliminary model checks, these turned out to be the most effective, parsimonious way to control for education and race.[3] I also control for district median income, again taken from ACS. Other ACS measures were also examined in the preliminary checks, but were not helpful.

To control for bill and roll call characteristics, I include fixed effects for the bill/ roll call in each model that analyzes more than one vote. I also include an indicator for whether the vote was a party-line vote, which is defined as majorities of the two parties voting opposite ways on the bill in question.

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[3] Hispanic is included explicitly along with white because Hispanic ethnicity is correlated with the dependent variable and with being uninsured, one of the unorganized group variables in the models.

2.4 Analysis

2.4.1 Overall Model

The overall model gives the effects of the various groups and other controls on all health bills identified by the Policy Agendas Project for the 108th- 112th congresses. Table 2-1 shows the results of this model. The only organized group contributions that are significantly correlated with voting on health bills are those given by the hospital, HMO, and pharmaceutical industries. The coefficient for this effect is fairly small, indicating that a very large amount of money must be contributed to effect much change in voting. The range on this variable is quite large, ranging from essentially 0 up to $531,650. Results do not change substantially when outliers above $200,000 are omitted. Other than contributions from Blue Cross Blue Shield affiliates reaching $p = 0.096$, no other organized group contributions come close to having a significant correlation with health bill votes.

Unorganized groups, on the other hand, are quite significantly correlated with health policy votes in Congress. The percentage of the district that can be classified as physicians is quite highly correlated with voting ($p < 0.001$). The range on this variable is small (from 0.05% to 1.2%), but it is clear from the model that as this measure increases, MCs are more likely to vote with Democrats. Having more seniors in the district is also associated with voting more heavily Democratic, though this effect is not quite significant at conventional levels ($p = 0.054$).

Table 2-1: Overall Models of Voting with Democrats on Health Bills, 2003-2012

	B	SE
Hospital, HMO, Pharma/ Device Contributions ($1,000s)	0.001*	(0.000)
Provider Contributions ($1,000s)	0.000	(0.000)
BCBS Contributions ($1,000s)	-0.010	(0.005)
AARP Contributions ($1,000s)	0.296	(0.280)
Voter Health Opinion	-0.272**	(0.030)
Voter Ideology	-0.039*	(0.020)
Percent Seniors	0.009	(0.007)
Percent Uninsured	-0.026**	(0.004)
Percent Physicians	0.654**	(0.175)
Percent White	0.001	(0.002)
Percent Hispanic	0.005**	(0.002)
Percent HS Only	0.001	(0.004)
Median Income ($1,000s)	0.010*	(0.004)
Republican Legislator	-2.602**	(0.048)
Party Line Vote	-3.235**	(0.160)
Legislator Birth Year	-0.004*	(0.002)
Constant	12.168**	(3.115)
Observations	49507	
Pseudo R^2	0.456	

Standard errors in parentheses. * $p < 0.05$, ** $p < 0.01$

The uninsured rate in the district, on the other hand, has the opposite relationship. The more uninsured reside in a district, the more likely the representative is to vote with Republicans ($p < 0.001$ for the uninsured coefficient). This finding is somewhat surprising, given the general perception that Democrats tend to (at least purportedly) champion the rights of disadvantaged groups like the uninsured. This counterintuitive finding comes up in most of the other models run for this chapter, and

is robust to various alternative specifications. Including party, percent Hispanic, education, median income do not affect the negative observed relationship. A naive model in which only percent uninsured is used to predict agreement with the Democrats yields a similar negative finding (b = -0.028, p < 0.001), as do limited versions (not shown) of the model in Table 2-1. Perhaps the best way to explain this finding is that members of Congress are perceiving uninsured interests differently than we expect. It is also possible that members of Congress are responding to some group of voters whose interests are opposite those of the uninsured but whose presence is positively correlated with uninsured rates, but it is not obvious what measures could be included in the model to correct this omitted variable bias that are not already included.

One other finding that stands out is that both overall ideology and opinions on health policy among voters overall matter very strongly for votes on health bills (for both, p < 0.01). The directions of these effects are predictable: more conservative average opinions among voters are correlated with voting for the Republicans on a bill. Regarding district demographics, median income and percent Hispanic are both positively correlated with voting with the Democrats. It is worth noting the presence of these controls given the odd finding for uninsured individuals mentioned above. Both median income and percent Hispanic are highly correlated with the uninsured rate, and yet the coefficient on uninsured is robust to the inclusion of these two variables.

The overall model, despite controlling for roll call fixed effects and Policy

Agendas Project minor topic code, probably masks a lot of heterogeneity. The context of

debate and passage of any particular bill or topic is probably very different, in ways the

overall model may not capture. It is also possible that different groups (both organized

and unorganized) will have different associations with voting behavior on different bills.

If we think that organized groups will care more about specific bills relevant to them,

whereas unorganized groups of voters will care more about general principles, then it

makes sense that unorganized groups will be more important in predicting MC voting

trends overall. Next, I turn to models of voting on bills within the PAP minor topic

codes.

2.4.2 Minor Topic Code

Analysis of voting patterns by minor topic code reveal interesting patterns. Table

2-2 gives the group coefficients for each model. Other controls are included as described

in the methods section, and are shown in appendix Tables B-1 and B-2.

Table 2-2: Models of Voting with Democrats on Health Bills by Subtopic

	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
Industry $	0.00	0.00	-0.00	0.00	0.00	-0.00	-0.00	-0.00	0.00
	(0.01)	(0.00)	(0.00)	(0.00)	(0.00)	(0.00)	(0.00)	(0.00)	(0.00)
Provider $	0.01	-0.00	0.00	-0.00	0.00	0.00	-0.00	0.00	0.00
	(0.00)	(0.00)	(0.00)	(0.00)	(0.00)	(0.00)	(0.00)	(0.00)	(0.00)
BCBS $	0.05	-0.07**	0.00	-0.01	-0.06**	-0.01	-0.04	0.01	-0.04*
	(0.07)	(0.02)	(0.02)	(0.02)	(0.02)	(0.03)	(0.04)	(0.03)	(0.02)
AARP $		0.30	0.85	-0.27	0.84	1.74	5.45	5.51	0.04
		(1.00)	(1.38)	(0.37)	(1.71)	(2.81)	(6.58)	(5.73)	(1.03)
% Seniors	-0.01	-0.01	0.03	-0.02	0.01	-0.03	-0.10	-0.04	-0.02
	(0.06)	(0.03)	(0.02)	(0.02)	(0.03)	(0.04)	(0.06)	(0.04)	(0.03)
% Unins.	-0.00	-0.04	-0.03**	-0.01	-0.00	-0.02	0.01	-0.03	-0.01
	(0.04)	(0.02)	(0.01)	(0.01)	(0.02)	(0.03)	(0.04)	(0.03)	(0.02)
% Phys.	-1.22	2.09*	0.58	0.83	0.64	0.78	0.71	1.78	1.12
	(1.36)	(0.83)	(0.45)	(0.50)	(0.79)	(1.05)	(1.43)	(1.17)	(0.75)
Obs.	809	4,145	8,166	5,414	3,291	2,045	811	1,654	3,725
Pseudo R²	0.08	0.74	0.48	0.34	0.35	0.44	0.61	0.56	0.51

	(10)	(11)	(12)	(13)	(14)	(15)	(16)	(17)
Industry $	0.00	0.00	0.00	-0.00	-0.00	0.00	0.00	-0.00
	(0.00)	(0.00)	(0.00)	(0.00)	(0.00)	(0.00)	(0.00)	(0.00)
Provider $	-0.00	0.00	-0.00	-0.00	0.00	0.00	-0.00	0.00
	(0.00)	(0.00)	(0.00)	(0.00)	(0.00)	(0.00)	(0.00)	(0.00)
BCBS $	0.01	-0.012	-0.017	-0.045	0.055	0.061	0.044*	-0.016
	(0.02)	(0.03)	(0.04)	(0.03)	(0.03)	(0.05)	(0.02)	(0.04)
AARP $	5.90	-0.72*	6.80	1.597			2.89	3.83
	(3.56)	(0.34)	(7.81)	(3.46)			(1.94)	(3.31)
% Seniors	-0.00	0.03	0.07	0.05	0.02	-0.05	0.08**	0.02
	(0.02)	(0.03)	(0.06)	(0.03)	(0.04)	(0.05)	(0.02)	(0.04)
% Unins.	-0.02*	-0.03	-0.05	-0.05*	-0.019	-0.072*	-0.021	-0.038
	(0.01)	(0.02)	(0.04)	(0.02)	(0.03)	(0.04)	(0.01)	(0.02)
% Phys.	0.25	-0.10	1.87	1.70*	1.35	0.32	-0.65	1.05
	(0.47)	(0.89)	(1.49)	(0.71)	(1.06)	(1.32)	(0.55)	(0.89)
Obs.	5,340	1,631	1,229	2,111	1,189	803	5,787	1,265
Pseudo R²	0.31	0.12	0.66	0.42	0.32	0.12	0.49	0.46

Note: Topic codes for the table columns are as follows: 1- General (PAP code 300); 2-Comprehensive reform (301); 3- Insurance reform, availability, cost (302); 4- Regulation of drug industry, medical devices, clinical labs (321); 5- Facilities construction, regulation, payments (322); 6- Provider/ insurer payment, regulation (323); 7- Medical liability, fraud, abuse (324); 8- Health manpower, training; 9- Prevention, communicable diseases, health promotion (331), 10- Infants, children (PAP code 332); 11- Mental illness and retardation (333); 12- Long-term care, home health, terminally ill, rehabilitation services (334); 13- Prescription drug coverage, costs (335); 14- Tobacco abuse, treatment, education (341); 15- Alcohol/ controlled and illegal drug abuse; 16- Research and development (398); 17- Other (399). Control variables included but not shown here; see appendix Tables B-1 and B-2 Standard errors in parentheses. * $p < 0.05$, ** $p < 0.01$.

Contrary to the finding in the overall model, hospital/ HMO/ pharma contributions show a significant correlation on one topic (insurance reform), and in that case the correlation with voting for the Democratic position is negative. Again, the coefficient is small in magnitude. Blue Cross Blue Shield contributions rise significantly with votes for the Republican position on comprehensive reform, facilities, and prevention, but moves toward the Democratic position on health research. AARP contributions are negatively correlated with the Democrats' position on mental illness bills. Some of these individual findings are counterintuitive. For example, the AARP, given seniors' probable interest in mental health services, does not seem like it would be going against the Democrats on that issue.

Unorganized groups seem to matter somewhat more frequently. When the coefficients are significant, their signs are the same as those given in the overall model (seniors and physicians toward the Democrats, uninsured toward the GOP). In fact, the

signs on most of the unorganized group coefficients in Table 2-2 (significant or not) are very consistent. The signs for the organized groups, by contrast, change much more frequently. This could indicate that the unorganized groups are more predictable in their positions, at least from a statistical point of view, while organized groups take more nuanced positions that are seemingly independent of their positions on other topics.

Average voter opinions on health policy and average voter ideology (not shown in Table 2-2) are often significant, though not always. Again, the coefficients take the predictable negative direction indicating conservative voters are associated with representatives being more likely to agree with Republican positions.

Even these subtopic models mask a lot of underlying heterogeneity, so I drill down even further in the next section by discussing models of specific bills and bill groups.

2.4.3 Specific Bill Groups

The models for each of the six bill groups I analyze are given in appendix Table B-3. To help illustrate the discussion below, I will show graphs of predicted probabilities of voting with Democrats on the bill group. The figure notes give details on how to interpret the graphs.

On the Affordable Care Act and the various repeal efforts in the 112th Congress, two group variables were significantly correlated with votes: percent physicians, which tended to be higher for those voting in favor of the ACA, and the uninsured rate, which

runs the opposite direction. Figure 2-1 below shows these two relationships. No

organized group contributions were significant, and average voter opinion on health

policy was significant. On this complex bill, it seems voters, both as a whole and certain

groups in particular, mattered more than contributions from organized interest groups.
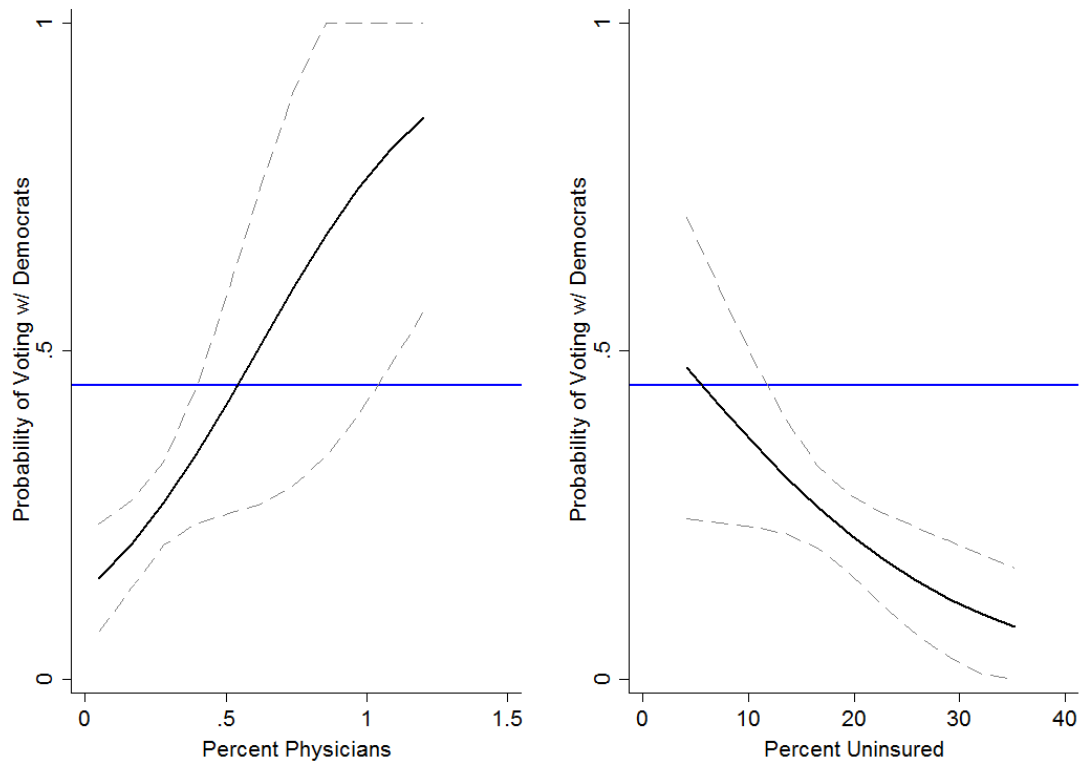
Figure 2-1: Voting with Democrats on ACA Bills by Percent Physicians and Percent Uninsured

Note: The figure shows predicted probabilities of voting with the Democrats on ACA-related bills across the ranges of the specified independent variables. The predictions are derived from the ACA model shown in appendix Table B-3, with other variables held constant at their means. The blue horizontal lines indicate the percentage of votes going to the Democratic position, essentially the mean of the dependent variable. The gray dashed lines are confidence intervals on the predictions, trimmed at 0 and 1. These

confidence intervals do not indicate significance of the slope coefficients. In this figure, both coefficients are statistically significant ($p < 0.05$).

One issue on which voters and voter groups do not seem to matter is the HEALTH Act, a medical malpractice/ tort reform bill that has been introduced in various forms by Republicans many times throughout the decade being examined. This bill is strongly supported by organized provider groups like the American Medical Association. The model shows that contributions from the AMA do indeed seem to be correlated with voting for the HEALTH Act (the Republican position). Contributions from Blue Cross Blue Shield have a similar relationship with voting. None of the unorganized group variables are significant for this bill group, and neither are the voter opinion measures.

Another interesting thing to note about the HEALTH Act is that although organized medicine is in favor of the bill and their coefficient is negative in the model, the coefficient for percent physicians is positive, indicating a countervailing trend. Figure 2-2 shows these trends, and also indicates that even though the slope coefficient on percent physicians is not quite significant, there is enough confidence in the predicted probabilities at the low end of the range to indicate a departure from the mean probability. Organized medicine wants the HEALTH Act, but it would seem MCs are perceiving more opposition to the proposal from physician voters in their districts.
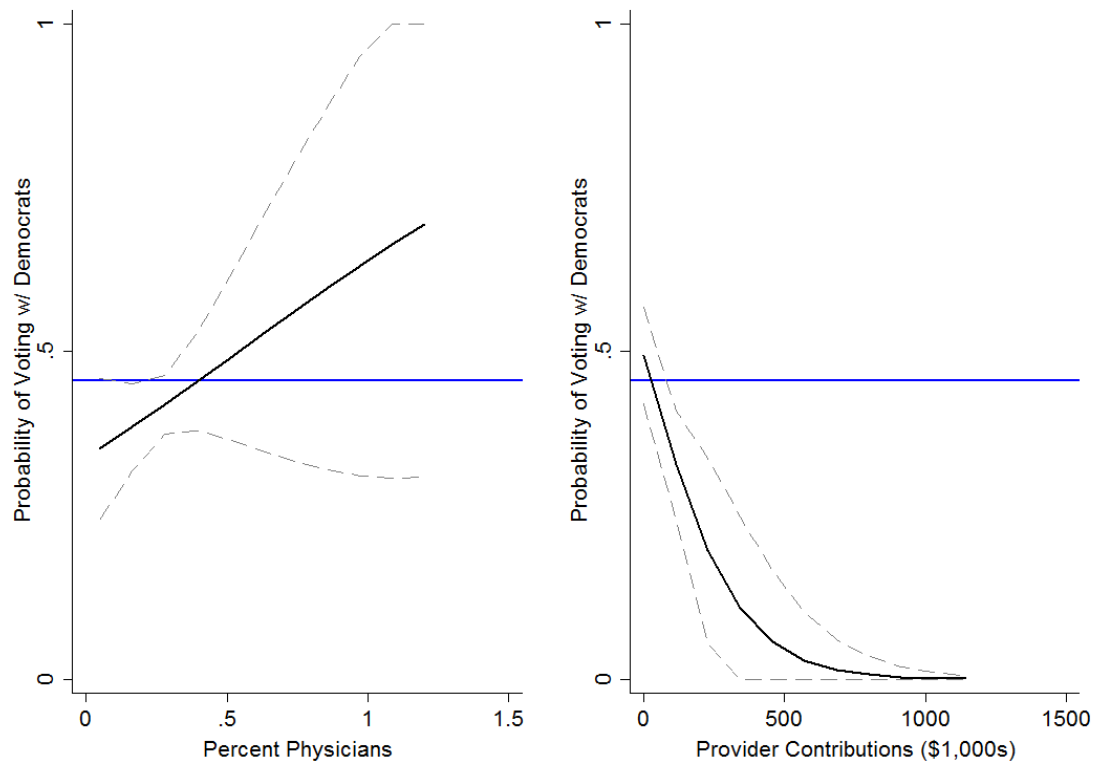
Figure 2-2: Voting with Democrats on HEALTH Act by Percent Physicians and Provider Contributions

Note: The figure shows predicted probabilities of voting with the Democrats on HEALTH Act bills across the ranges of the specified independent variables. The predictions are derived from the HEALTH Act models shown in appendix Table B-3, with other variables held constant at their means. The blue horizontal lines indicate the percentage of votes going to the Democratic position, essentially the mean of the dependent variable. The gray dashed lines are confidence intervals on the predictions, trimmed at 0 and 1. These confidence intervals do not indicate significance of the slope coefficients. In this figure, only the provider contribution coefficient is statistically significant ($p < 0.05$).

Industry experts often cite a fundamental tension between providers and payers in health care, due to the frequently competing interests of the two groups. While this

division is not always manifest, as my models on the HEALTH Act show, it does show

up in other contexts, such as the Medicare Modernization Act of 2003 (MMA). Blue

Cross Blue Shield, my proxy for the private payer industry, tended to contribute higher

amounts to those who favored MMA (the Republican position), while those who

opposed the bill tended to have more physicians in their district. Figure 2-3 shows this

finding. It is interesting to note that it is not organized medicine that is the most

significant coefficient opposing BCBS, but rather the measure of unorganized

physicians. The provider contribution coefficient is neither large nor significant.
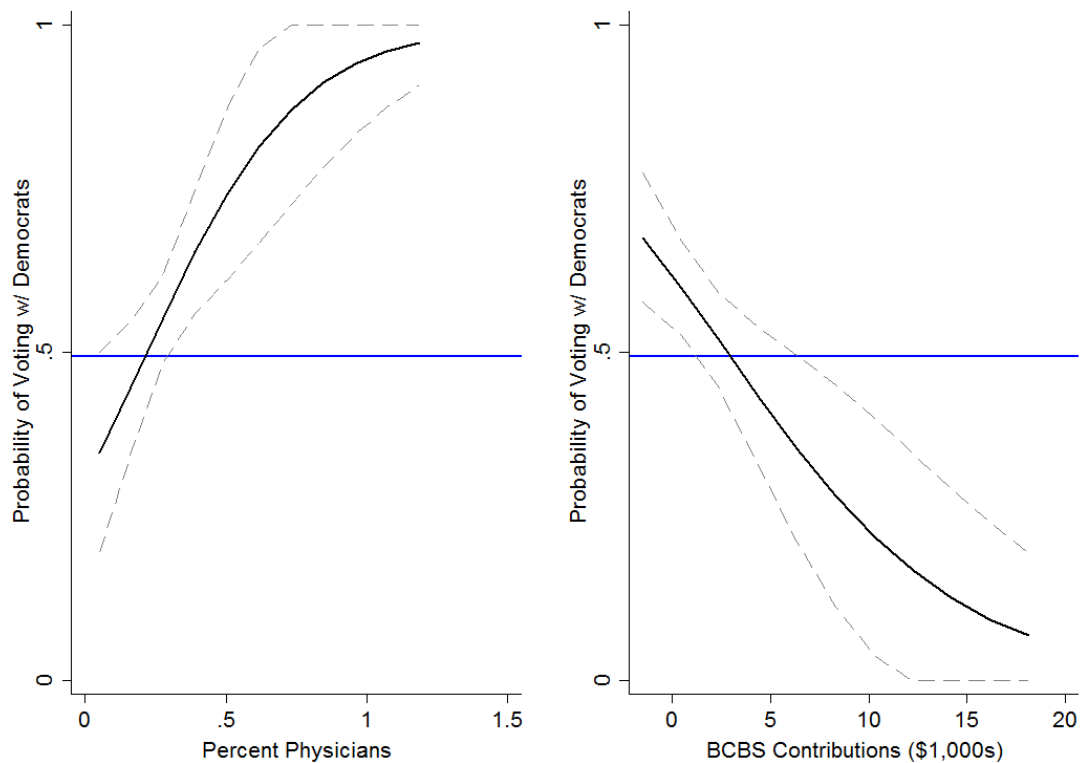
Figure 2-3: Voting with Democrats on MMA by Percent Physicians and BCBS Contributions

Note: The figure shows predicted probabilities of voting with the Democrats on the MMA across the ranges of the specified independent variables. The predictions are derived from the MMA model shown in appendix Table B-3, with other variables held constant at their means. The blue horizontal lines indicate the percentage of votes going to the Democratic position, essentially the mean of the dependent variable. The gray dashed lines are confidence intervals on the predictions, trimmed at 0 and 1. These confidence intervals do not indicate significance of the slope coefficients. In this figure, both coefficients are statistically significant ($p < 0.01$).

Most of the bill groups I have chosen involve somewhat controversial issues. Almost all votes on these bills fell along party lines. What if the issue is not one characterized by partisan conflict? A group of insurance reform bills in the 108th Congress presents the most cohesive group of bills I could find on which there was little partisan conflict, judging by voting record. On these bills, the uninsured tend to be more prevalent in districts whose representatives voted with the Republicans. Average health opinions are also significant. No other group variables were significantly related to voting, but there are no real surprises in the model, compared to the overall models and the subtopic models.

2.5 Discussion

The analysis presented in this chapter shows that although the content and/ or context of a particular bill might change the relationship, there is often an independent link between the size of a group of voters in a legislative district and the voting behavior of the district's representative on health policy. This is the case even controlling for average opinions of all voters in the district and campaign contributions of organized

groups. In some cases, such as that of physicians and the Medicare Modernization Act, organized group correlations are actually opposite those of their unorganized group counterparts. These findings fit with the initial hypothesis.

There are a couple of important limitations to the analysis which bound the implications that can be drawn. First, there is no indication from this analysis whether the perceptions of unorganized groups' interests are being driven by organized groups. This could happen, for example, through the efforts of the AARP to have their members (at least those in favor of the AARP's position) call or write to their elected officials. This would have the effect of making it look like seniors think a certain way about an issue when in fact the sample on which that perception is based is not representative. The cases in which contributions and group sizes have opposite effects are unlikely to suffer from this limitation, but this situation is not universal.

A second limitation is that campaign contributions may not be the best proxy for organized group activities aimed at influencing policy. My research design requires data tied to specific members of Congress, but such data does not exist for activities like lobbying or grassroots mobilization efforts. Campaign contributions are linked explicitly to a single representative, but may not be a group's favored or most effective method of persuasion. Furthermore, different groups may have different strategies. Some may rely quite heavily on campaign contributions, while others might make only a few token contributions while relying more on other strategies.

With those limitations in mind, it is still reasonable to conclude from this analysis that unorganized voters might matter in some cases, independent of the other activities of organized groups. One key implication of this is that efforts to affect the perceptions members of Congress have about certain key groups might in turn influence their votes on related bills. Sometimes, the perceptions could be hard to change. For example, it would be difficult to convince members of Congress that physicians want lower Medicare reimbursement rates. However, it might be possible to make the case that doctors want more or less spending on cancer research, more or less restrictions on pharmaceuticals, etc.

Subconstituency theory suggests that the groups must also be perceived to vote based on the issue at hand. It could be the case that the uninsured, for example, are not often viewed as a politically cohesive group of voters. Cross-cutting identities may obscure the interests of the uninsured in terms of voting power. Campaigns to make certain identities more salient for voters and their elected officials may be effective at getting certain policies passed. However, such actions probably require coordination and resources, and will therefore not usually arise organically from within large groups of voters.

Future studies on the influence of unorganized groups should use different levels of analysis to further establish the validity of these findings. For example, it would

be helpful to find some way to look at legislators themselves (not just their votes, as I do in this chapter) and how they view various groups of constituents.

3. Interpretive Feedback Effects and Public Opinion on the Affordable Care Act: A Survey Experiment

While the Patient Protection and Affordable Care Act (ACA) was passed almost seven years ago, the political debate over the health reform law has not yet ended. There have been numerous court cases regarding the law and specific parts thereof, with the court declaring a key piece of the law, the Medicaid expansion requirement, unconstitutional and leaving the decision up to the states. Many states have refused to expand Medicaid, and have also opted to use the Federal insurance exchange rather than setting up their own state exchanges as the law's architects initially envisioned. The House of Representatives has voted dozens of times to repeal the ACA. One recent attempt actually made it through the Senate (on reconciliation, which waives the Senate's supermajority requirements for cloture) and to the President's desk, where it was promptly vetoed. With Republicans having held both chambers in Congress and winning the presidency in the 2016 elections, talk of repeal has become even more serious. In their analysis of the ACA's shaky political foundation, Oberlander and Weaver conclude "the fight over Obamacare is not over" (2015).

Public opinion on the ACA is still mixed, with small but persistent pluralities in opposition (DiJulio, Firth, and Brodie 2015; see also Jacobs and Mettler 2016). This matters for the law's future. Public opinion affects health policy through elections and other influences on elected officials (Jacobs 1993; Jacobs and Shapiro 2000; Skocpol 1994,

1996), who will ultimately decide the law's fate. For example, the actions of some states to block Medicaid expansion and even to close down otherwise successful state health insurance exchanges, as Kentucky is in the process of doing, are a result of continued public opposition and elected officials who represent that opposition. Thus, if the law itself is designed in a way that elicits a certain public response, then policy design (or the conversation surrounding the policy as designed) becomes a relevant factor to consider in assessing a policy's political future (Campbell 2012; Oberlander and Weaver 2015; Pierson 1993, 2000).

One of the most important factors to examine is the effect of the law itself, as it is both implemented and interpreted, on public attitudes. It is possible the law was not written in such a way that will build support on its own, and that it will instead collapse, be repealed, or be watered down to the point of insignificance. Whether this will occur depends in part on how the public views the ACA in light of what the law actually does. In this study, I present findings from a survey experiment designed to examine how specific ACA provisions might affect support for the ACA overall and thereby affect public opinion.

3.1 Background

Previous research on public opinion on health reform yields some key insights regarding the politics of the ACA. Support for the ACA or health reform in general is correlated with favorability toward specific provisions in the law (Brodie et al. 2010;

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Grande, Gollust, and Asch 2011), increased knowledge of the law (Gross et al. 2012),

partisanship and self-interest (DiJulio, Firth, and Brodie 2015; Gross et al. 2012;

Henderson and Hillygus 2011), racial attitudes (Henderson and Hillygus 2011; Tesler

2012), demographic and socioeconomic characteristics (Berinsky and Margolis 2011),

and beliefs about who deserves government assistance (Gollust and Lynch 2011). Using

a panel survey design, Jacobs and Mettler (2016) analyzed within-person trends in ACA

opinion over time, as well as the effects of partisanship, perception of direct benefits

from health reform, and other factors on those overall opinions. They find that opinion

on the law has remained divided, with personal opinions remaining largely entrenched

over time, but with significant decreases in support for repealing the ACA. While they

conclude that outright repeal of the ACA grows less likely with the passage of time,

there is also no evidence that political support for the law will increase any time soon in

the manner that reformers initially hoped.

Most of the studies mentioned above examine the ways individuals with

different characteristics might view the ACA. What I test in this study is different. I am

seeking to show how the design of the ACA itself, as well as the conversation

surrounding it, affects opinions toward the ACA. This is not to say that individual-level

characteristics do not matter. However, it will be useful in future policy making

endeavors to know more about how the design of the ACA affected its reception.

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One way to test whether policy design affects public opinion is to manipulate a group's understanding of a policy and see how that group's opinion of the policy differs from a similar group with a different interpretation. This study uses a survey experiment to do just that, by examining whether priming different aspects of a reform package changes overall opinions. This procedure mirrors survey experiments reported in the survey methodology literature, such as a classic experiment reported by Schuman and Presser (1981) in which respondents were much more likely to favor allowing communist reporters into the US when they were first asked whether the Soviet Union should admit American reporters. This and other similarly designed experiments have been shown to change the "weights respondents give to the factors relevant to answering a question" (Krosnick and Presser 2010, 293). Furthermore, asking specific questions about a topic before asking more general questions can affect the context in which answers to the more general questions are generated (Krosnick and Presser 2010).

Using this survey experiment design, I test two hypotheses. First, we might expect that if ACA provisions are primed before overall opinion of the ACA is reported, those overall opinions will be different than if the specific provisions were not salient. Put another way, if respondents are primed to think about a specific provision, their average reported favorability of the ACA should differ from the favorability reported by otherwise similar respondents not primed to think about the provision.

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Second, we might expect the way in which responses to the ACA favorability question are formed to vary according to what information is salient at the time of response. If a specific provision is salient (because of priming) in a respondent's mind at the time ACA favorability is reported, then the respondent's opinion of the ACA will be more strongly affected by his/ her opinion of the salient provision. Conversely, if no specific provisions are primed, then other factors will be more important in forming the opinion.

Not all design aspects of a law will necessarily affect opinions in the same way, or at all, so we need to flesh out these predictions further by considering what effects particular kinds of policies/ design features might have on opinion. To that end, I will distinguish between "policy pork" provisions and potential wedge provisions.

I define policy pork as a provision that is expected to be almost universally favored and can feature prominently into political messaging targeted at voters or a particular group of voters. This is similar to the pork provisions analyzed by congressional scholars in the context of policy making and legislative parties (Binder and Lee 2015; Evans 2004; Smith 2007). Based on that research, pork provisions confer benefits on specific voters or groups of voters in order to entice their representative to support the overall bill. The pork ensures that, even if the member of Congress might otherwise vote against a bill on policy grounds, he or she will see a political benefit of voting in favor. Funding for a specific school, a new Federal building, or a new highway

project in the representative's district are examples of pork that have been added to unrelated bills to entice specific legislators to vote in favor.

Policy pork, in my usage, is similar to the standard definition of pork in that it may be unrelated to or severable from the broader policy, included more as a way to garner political support rather than to achieve the policy goals of the overall proposal. I view policy pork as a unique, unexplored kind of pork. Evans (2004) notes that studying pork distributed in non-geographic ways is difficult, and we could also add that pork that does not involve appropriations could be even more difficult to track. Policy pork is included in a legislative package not because it is itself an end goal of the legislation, but rather because it serves the same purpose as pork: generating political support for the bill.

One piece of policy pork in the ACA is the requirement that young adults be allowed to remain on their parents' insurance plans until age 26, which I will refer to as the dependent coverage provision for short. This provision is almost universally favored (Brodie et al. 2010). After passage, ACA proponents could point to this quick, easy benefit of the ACA and promise more good things to come if voters will just stick with this newfangled program, while downplaying the costs that must also come eventually. It is important to keep in mind that this provision is not tied to the rest of the ACA in any logical or substantive way; it could have passed on its own, and was not necessary to the policy success of the ACA. It is not obvious that allowing dependents to remain

on their parents' insurance until age 26 necessarily goes along with a mandate for most

individuals to buy health insurance.[1] The absence of a logical link between these

elements means a rhetorical link must be made and maintained, for example by calling it

part of "health reform." This is harder to do as the program progresses through

implementation and more controversial elements enter the public conversation on the

law. As a tool for managing how policy design affects opinion, policy pork only works

to the extent that opposition is broken down preemptively through early, effective

messaging on these provisions.

I will call the other type of design feature to be examined in this paper a potential

wedge provision. I say "potential" because some outside effort is required to make these

provisions politically potent. If those in favor of the policy control the discussion,

perhaps through effective use of policy pork, the wedges will not be hammered down

politically (though they might be felt in other ways). The individual mandate, the ACA's

requirement that most individuals purchase health insurance or pay a fine, is an

example of a potential wedge provision. This controversial provision has varying levels

of support, depending on the way it was described in survey questions (Grande, Gollust,

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[1] In fact, the dependent coverage provision probably works against a major purpose of the individual mandate: to bring healthy (often young!) people into the newly redesigned individual insurance market. Keeping young people in the group insurance market (on their parents' plans) by fiat will keep most of them from even considering entering the individual market, especially since the dependent coverage provision was implemented years before the newer individual marketplaces, raising the likelihood of adverse selection in those markets at least marginally. Still, the political benefits of including the dependent coverage provision as policy pork were expected to outweigh the policy costs. It would have done no good to have designed an individual market that had the best chance of long-term actuarial success if political opposition had led to the ACA's repeal before implementation.

and Asch 2011), giving it the potential to enhance public divisions on the whole reform package.

Politicians try to include as few wedge provisions as possible in a new law in order to increase its chances of political success. They want to consolidate support, not divide it, and they want to keep political opponents from creating such divisions. However, depending on the constraints imposed on would be reformers (Patashnik and Zelizer 2013), some wedges may be unavoidable. The designers of the ACA decided early on that they would try to leave intact as much of the status quo as possible (Oberlander and Weaver 2015). This meant the ACA almost certainly had to include an individual mandate, despite the political difficulty of selling such a proposal to the public. Reformers' political strategy was to include enough policy pork in the bill to head off opposition before the potential wedge provisions were implemented. Opponents, given that they were unable to stop the policy from passing, hoped to use these wedge issues to prevent such a support coalition from fully forming. However, if their base of support crumbled early by general acceptance of the pork-filled law, the opposition's wedge tactic would lose its potency.

To tie these concepts back to the hypotheses for this study, we would expect the two kinds of design features to have different effects on opinion. If policy pork like the dependent coverage provision is primed, then opinions of the ACA should become more favorable. If a wedge provision like the individual mandate is primed, overall

favorability will depend more on which side of the wedge people are on (i.e. whether they favor or oppose the mandate in particular). This adds some conditions to hypothesis 1. It also bolsters the conceptual argument in favor of hypothesis 2 in the case of wedge issues, because the wedge itself should become a more important predictor of overall opinions if people are first reminded of the wedge.

The hypotheses for this study can be summarized as follows:

1. If specific provisions of the ACA are primed before overall ACA opinion is reported, then overall favorability toward the ACA will be different than that reported by similar respondents who are not primed.

    a. If a policy pork provision is primed, we would expect to see movement in favor of the ACA.

    b. If a wedge issue is primed, aggregate opinion may not move, but opinions of certain subgroups will move in opposite directions depending on opinions of the wedge itself.

2. The correlates of overall ACA opinion will be different if specific provisions are primed, relative to the correlates for similar unprimed respondents.

    a. When a wedge issue is primed, opinions about the wedge will become more significantly correlated with overall opinions of the law.

    b. Priming a policy pork provision may also change correlates of opinion, but the prediction is admittedly weaker for this condition.

By testing these hypotheses, we can assess whether certain design aspects of the law affect the public's interpretation of and favorability toward the ACA as a whole. Note this is not a test of favorability toward the provisions themselves, nor is it an estimate of the population parameter for ACA favorability. The hypotheses deal with changes in average opinion, not estimates of average opinion itself. Data in support of these hypotheses would, however, increase confidence that priming policy provisions (thereby making respondents interpret the law differently) causes aggregate opinion change.

3.3 The Study

To test the hypotheses raised above, I conducted a survey experiment (Mutz 2011) in November 2014 on Amazon's Mechanical Turk (MTurk) service. MTurk respondents have the opportunity to complete a wide range of simple tasks, such as tagging images, coding expense reports, and taking surveys, in return for small financial rewards. Respondents opt in to each task, using MTurk's user interface that presents a list of available tasks. The list can be filtered or sorted by task metadata such as keywords, date, and payment amount. The exact topic of my survey was concealed until after respondents had opted in. Respondents knew they would take a survey, but not that it would deal specifically with the ACA. Implications of the choice of this subject pool are discussed later.
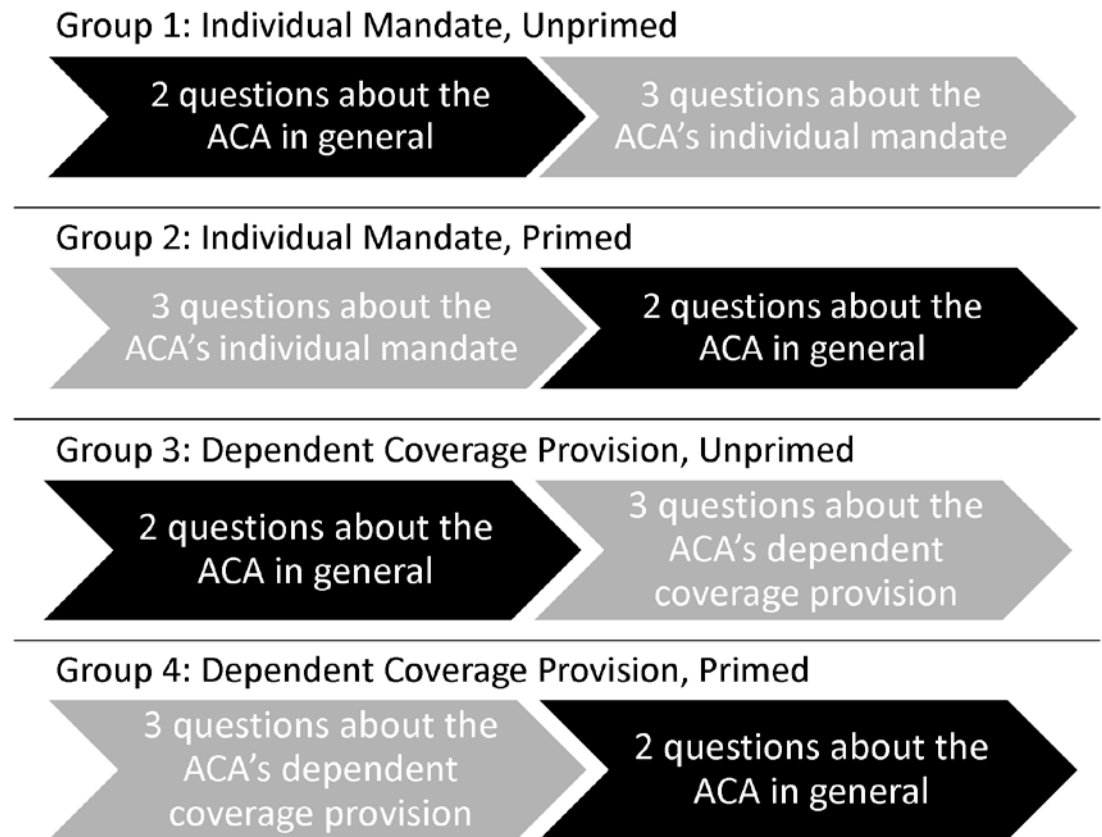
Figure 3-1: Survey Experiment Design

In the experimental portion of the survey, random assignment was used to sort

respondents into one of four experimental conditions, outlined in Figure 3-1. In two of

the experimental groups, respondents were first asked to respond to two questions

about their opinion of the ACA in general. These two groups then responded to

questions about specific pieces of the law. One group answered questions about the

individual mandate (the requirement that most individuals purchase health insurance or

pay a fine), while the other was asked about the provision requiring that adults under

age 26 be allowed to remain on their parents' insurance plans. I refer to both of these

groups as the unprimed or control groups. For the other two groups, which I refer to as the primed or treatment groups, the order of the two question blocks was reversed, so the provision-specific questions came first and the general ACA questions appeared afterward. The question wordings and their order within the blocks remained constant. Only the order of the blocks and the specific provision referred to in the questions was changed.

By manipulating the order of the questions, respondents in different groups had different considerations "at the tops of their heads" when responding to the general ACA questions. The primed groups had been primed to think about the specific provisions they were asked about immediately prior to giving their opinions of the law as a whole.

In the initial wave of the experiment (Nov. 22 and 24, 2014), 506 responses were collected. Each respondent was paid $0.40 for completing the survey (repeat responses were not allowed). This wave included my survey experiment and two separate vignette experiments conducted by two other researchers about racial group identity and terrorist recruiting messages. More information about the other two studies is available from the author upon request. My study appeared first, followed by the other two, with demographic questions at the end. After completing the experimental portion of the survey, respondents reported their level of approval of President Obama, their partisanship and political ideology, their racial identities and religious affiliation, their level of attentiveness to news and current events, their insurance status, and their

income level. Specific question wording for my experimental questions and for

demographic questions is given in Appendix C.

Upon preliminary examination of the data from the initial wave, it was

discovered that the code for my portion of the survey had failed to randomize the order

of the general ACA and specific policy questions. This meant I only had data for the two

unprimed groups, my "control" groups. In order to collect data for the other two groups,

I was able to put my survey experiment (along with the same demographic questions,

but excluding the other two experiments) back into the field on MTurk on Nov. 25, 2014,

with a compensation rate of $0.12 per respondent.[2] Those who had taken the survey

previously were barred from participating again. This second wave yielded 396

additional responses. I randomized the treatment group assignments for this second

wave in such a way that all four groups were represented, but with twice as many

respondents assigned to the two groups that had been omitted in the first wave (the

primed groups).

Collecting data on all four groups in the second wave allowed me to assess

whether respondents to the two waves were different based on observed characteristics.

I checked to ensure that there were no significant differences in the types of respondents

to the two waves. Each wave had a different estimated completion time and a different

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[2] The lower compensation is a result of not having the other two experiments in this wave, resulting in a much shorter questionnaire.

level of compensation, in addition to being fielded on different days. However, there is no indication that responses were affected by these differences. Balance checks revealed that on all 16 items relevant to my survey (including both demographic and ACA-related items), only ideology differs significantly across waves, and that difference only appears for one specification of the variable. I control for ideology in my final models reported below. Specific results of the balance checks are reported in tables C-2 and C-3 (Appendix C), along with final sample sizes within each treatment group. The analyses in the main body of this paper combine data from both waves of the survey, with treatment presumed to be given at random. Results do not change significantly when respondents from the first wave are omitted.

3.3.1 Sample Demographics and Descriptive Statistics

The use of MTurk as a survey platform has some limitations. As an opt-in survey conducted over the Internet, there is no way to randomly select respondents, nor is there any way to calculate response rates, refusal rates, margins of sampling error, or any of the usual survey metrics. The respondents to my survey do not resemble the demographic or political profiles of the US population, as can be expected from a subject pool such as MTurk. However, experimental results using MTurk have proven comparable to those obtained from other convenient subject pools often used in experiments (see Mullinix et al. 2015). Thus, for an experimental design, MTurk is an acceptable platform. For the hypotheses I am trying to test, internal validity is more

important than external validity. I will report below how the respondents to my survey are different from the population, but I see no reason to expect that my results will differ qualitatively if applied to the general population. As it is not my intent to estimate population parameters, but rather to gauge the effectiveness of an experimental manipulation, data collected on MTurk is suitable for this study.

I asked respondents for their level of approval/ disapproval of President Obama, party identification (using the standard ANES question), ideology (liberal to conservative, 7-point scale with ANES wording but no branching), racial and religious identification, level of attentiveness to news, health insurance status, and income. As mentioned above, MTurk does not provide a good platform for representative survey results, and my sample is skewed on all observable characteristics in the ways we would expect of MTurk respondents. They are more liberal and Democratic, more likely to be uninsured, and have lower incomes than we would expect from a general US adult sample. Over half of the sample reported having no religious affiliation, and only about 34 percent identified as Christian. Appendix Table C-1 gives the distributions of these political and demographic characteristics for the entire sample, as well as distributions of the opinion variables used in my study and population estimates (where available).

Item nonresponse for the survey was very low. Only five respondents skipped any questions, and these five account for all missingness in the data. The five incomplete

responses are excluded only from models that include variables for which there is missing data.

Over half of all respondents favored the ACA. The US adult population reports considerably less favorable attitudes toward the ACA, as the population estimates in Table C-1 show. Most respondents knew that the specific provision they were asked about was in the final version of the law, and over half for each provision thought the provision would affect them or someone close to them. Attitudes toward the individual mandate were somewhat mixed, though as predicted more people opposed it than supported it. The dependent coverage provision had very high favorability in this sample, perhaps a result of the generally younger profile of MTurk users, though I do not have the data to support that hypothesis for this sample. The skewed distribution of opinion on the dependent coverage provisions may affect the results of some of my hypothesis tests, which is worth noting here as a potential limitation.

While having two other survey experiments in the study (between my experiment and the demographic questions) could have affected measures like party identification, ideology, and presidential approval, I do not find any evidence that this was the case. The randomization of the treatments was done separately for each experiment. Any effects of one experiment are statistically erased from the other groups by random assignment. There are no significant differences in the distributions of demographic variables across my experimental groups.

3.3.2 Planned Analyses

In the results presented below, I set up comparisons based on the specific

provisions about which each group was asked. For example, the unprimed group asked

about the individual mandate (group 1 in Figure 3-1) is used as a control group, to be

compared to the group first primed with questions about the individual mandate (group

2). Similar comparisons are made for the other two groups, with the primed group

serving as a treatment group and the unprimed group serving as control.

To test hypothesis 1, I use t-tests of the difference in ACA favorability (a

dichotomous variable, 1 = favor, 0 = oppose or neutral) across comparable treatment and

control groups. This shows whether, as predicted, any differences in average opinion

appear between primed and unprimed groups. I also break the four groups down by

favorability toward the provisions asked about, which will prove useful in

understanding what the data tells us about hypothesis 1.

Testing of hypothesis 2 employs OLS regression models of ACA favorability

estimated separately for the two groups of policy conditions.[3] Interactions between all

variables and whether the respondent was primed are included to test for differences in

specific coefficients across groups. Wherever an interaction term is significantly different

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[3] While it is generally good practice to use ordered logit model specifications for ordered categorical variables, I deliberately use OLS in this study because the nonlinearities of ordered logit models make the interpretations of the interaction terms less clear. For testing hypothesis 2, it is important to have cleanly interpretable tests of differences in predictors across the primed and unprimed groups. I use ordered logit specifications as a robustness check, reported briefly later in the text and in Appendix C, tables C-7 and C-8, but I rely on the OLS models in my main analysis.

from zero, we can conclude that the (conditional) correlation between that variable and

ACA opinion is different across conditions. Additionally, F-tests of the joint significance

of the interaction terms tell us whether being in the primed group significantly changes

the overall correlations. These tests will indicate whether the considerations used to

form reported ACA opinion are different across primed and unprimed groups (within

policy conditions).

3.4 Results

If priming different considerations had any effect on opinions, as expected in the

first hypothesis, we would expect to see differences in ACA approval levels between the

treatment and control groups. Accordingly, I use basic t-tests to determine whether there

were significant differences in the mean levels of ACA approval by experimental group.

As displayed in Figure 3-2, the two unprimed groups hold similar distributions of

opinions on the ACA, and changes occur in the expected directions for the primed

groups. That is, support for the ACA is 16 percentage points higher for those primed to

think about the popular dependent coverage provision compared to their unprimed

counterparts (t = -3.22, p < 0.001), while priming the controversial individual mandate

yields somewhat lower favorability, though this latter change is not statistically

significant (t = 1.13, p = 0.261).
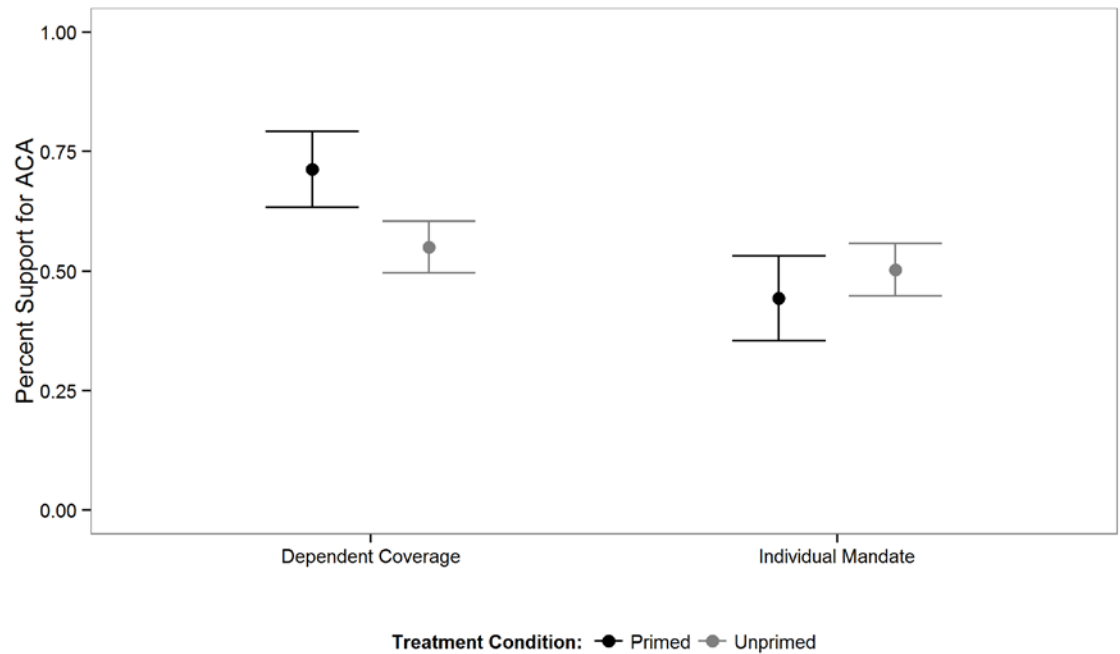
Figure 3-2: ACA Favorability by Experimental Group

Note: Error bars represent 95% confidence intervals based on unpooled standard errors. The numbers underlying this figure appear in Appendix C, Table C-4.

The slight decrease in favorability for the group primed with the individual mandate questions shown in Figure 3-2 is commensurate with the more mixed feelings toward the individual mandate expressed in the survey. The dependent coverage provision, by contrast, had much clearer positive effects on the other primed group's perceptions of the ACA. One possible reason for the less significant effect of the individual mandate is the nature of the prime. As Grande, Gollust, and Asch (2011) found in their study, feelings on the individual mandate were relatively more positive when using a description of the policy similar to the one I employed.
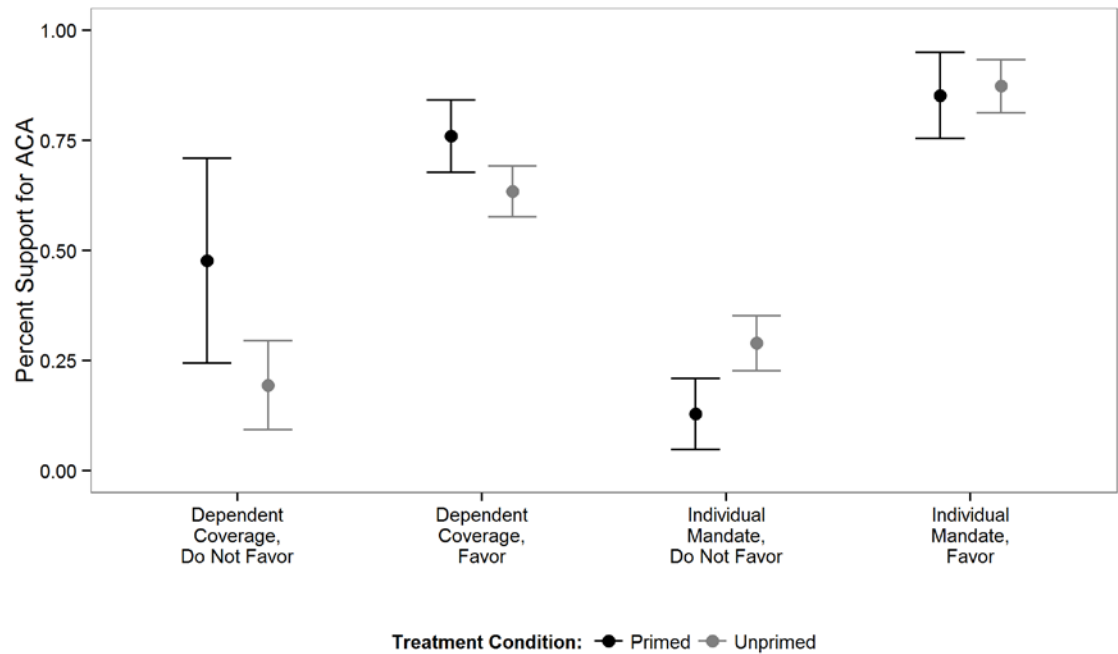
Figure 3-3: ACA Favorability by Experimental Group and Provision Support

Note: Error bars represent 95% confidence intervals based on unpooled standard errors. The numbers underlying this figure appear in Appendix C, Table C-4.

We might expect that priming the individual mandate will only negatively affect overall ACA opinions of those who oppose the individual mandate. Thus, another way to analyze this data is to break the groups down further into those who favored and did not favor each provision. Figure 3-3 shows this subgroup analysis (I group the middle response category with those opposed, hence the more inclusive label "do not favor"). Among those who do not favor the individual mandate, opinions of the ACA are 16 percentage points less favorable when primed (t = -2.71, p < 0.01). For the group that

favored the individual mandate, the prime did not change opinions appreciably ($t = -0.374$, $p = 0.709$).

The same is not true of those in the dependent coverage conditions. No matter how individuals in this group felt about the specific provision, priming the provision increased favorability toward the ACA in general. In fact, those who did not favor the ACA saw increases in favorability of 28 percentage points as a result of the prime ($t = 2.61$, $p < 0.05$). This group is somewhat small (only 21 people in the primed portion had less than favorable opinions of this provision), limiting the precision of the estimates for this group. Still, we see evidence here that priming different pieces of the law had different effects on people's opinions. For the individual mandate, the effect depends on how the person feels about the individual mandate. For the dependent coverage provisions, the effect of the prime is not dependent on provision-specific opinions. The discussion section will elaborate further on why this qualitative distinction is important in the context of policy feedbacks.

The main findings in Figures 3-2 and 3-3 hold for various subsets of the sample and various specifications of the test. Using the continuous seven-point scale as the dependent variable rather than the dichotomous variable yields qualitatively similar results. Effects are similar when the samples are split into those who knew the provisions made it into the final version of the law and those who did not, though it is interesting to note that the effects are stronger for those who did not know the

dependent provision was in the law. The individual mandate prime was also stronger

for those who did not know the individual mandate was in the ACA, but the prime was

not significant for either group.

The results presented above might be biased if the question order affected

respondents' opinions of the specific ACA provisions. Imagine an experiment designed

to test the hypothesis that priming *general* ACA opinions affects opinions of a *specific*

ACA provision, a causal ordering opposite my hypotheses. If we can use my experiment

to support both causal stories, then we cannot logically conclude that either is valid

because it means the provision-specific questions have been contaminated by order

effects. However, in t-tests similar to the ones reported above, but with provision-

specific opinions as the dependent variables, asking the overall ACA questions first

creates no significant differences in opinions on either provision. For the individual

mandate groups, $t = -1.34$ ($p = 0.18$), and for the dependent coverage groups, $t = -0.67$ ($p = 0.51$). For the dependent coverage groups in particular, this is remarkable given the

potential for cognitive dissonance to decrease peoples' willingness to favor any part of a

law they just said they opposed on the whole. That is what happened if we only look at

the point estimates, but again that effect is not significant. Apparently, people are not as

willing to judge the ACA's parts based on the whole as they are to judge the whole

based on which parts are salient at the time of response.

We might also expect the null findings just described because of the way the experiment was administered. In the initial instructions, respondents are reminded that a "health reform bill known as the Affordable Care Act (ACA) or Obamacare was signed into law in 2010." The provision questions also referred back to the ACA, regardless of when they appeared in the survey. This means every respondent was "primed" to think about the ACA, with the only difference being that some of the respondents had answered two questions about the ACA before giving their opinions on specific provisions. Empirically, this difference in the level of the ACA prime does not seem to have had any effect, as the t-tests above show. Thus, it is reasonable to assume that the question order manipulation is not affecting opinions of the specific provisions. "Reverse priming" does not seem to be an issue for this study.

As predicted by our first hypothesis, ACA opinions appear to be subject to priming effects. Based on hypothesis 2, we also expect to see differences between treatment and control groups in terms of the predictors of ACA approval. To test this prediction, I estimated OLS regression models for the two policy groups separately, with the final models using level of ACA approval (a seven-point scale ranging from very unfavorable to very favorable) as the dependent variable and opinions of specific provisions, presidential approval, partisanship, and ideology as predictors. I have switched to the continuous variable for this analysis, as opposed to using the dichotomous variable, to take advantage of the greater variance in the continuous

variable. As described above, an indicator variable for whether the person was primed or not and interactions between this indicator and all other predictor variables were also included. Other covariates like income, race, religion, and insurance status did not significantly affect the coefficients of interest when included, so I exclude those from the final models reported below.[4] Because of the way the interaction terms are specified, the two models can actually be presented as four separate models, one for each experimental group, as in Figure 3-4, which plots the coefficients and 95% confidence intervals. Tables containing full model information, including the interaction terms, are found in Appendix C (tables C-5 and C-6). The models show that opinions of specific provisions significantly affect overall opinions of the ACA in all treatment groups. As support for either of the two provisions increases, support for the ACA overall also increases. However, in the individual mandate models, the effect of provision-specific opinions is stronger for the primed group than the unprimed group, with a difference in effect size of about 0.14 (t = 1.80, p = 0.072) on the seven-point scale. What this means is that the prime made the effect of individual mandate opinions on ACA opinions stronger relative to the unprimed group.

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[4] The coefficients in the final models all change by negligible amounts when the other controls are included, with no changes in significance. Measures of model fit barely change at all. I am confident that the more parsimonious model reported in the text and Figure 3-4 explains as much of the relevant variation as I can with the measures I collected. This, of course, does not preclude unobserved factors from having effects on ACA opinion. However, I am most interested in the changes in coefficients, which are extremely robust across specifications of the model and appear to be driven by random assignment to treatment group, strengthening our ability to draw causal inferences. There are also no significant changes in the models when presidential approval or ideology are omitted. I include these variables because opinions of the ACA are strongly correlated with opinions of President Obama and ideology (as the final models show).
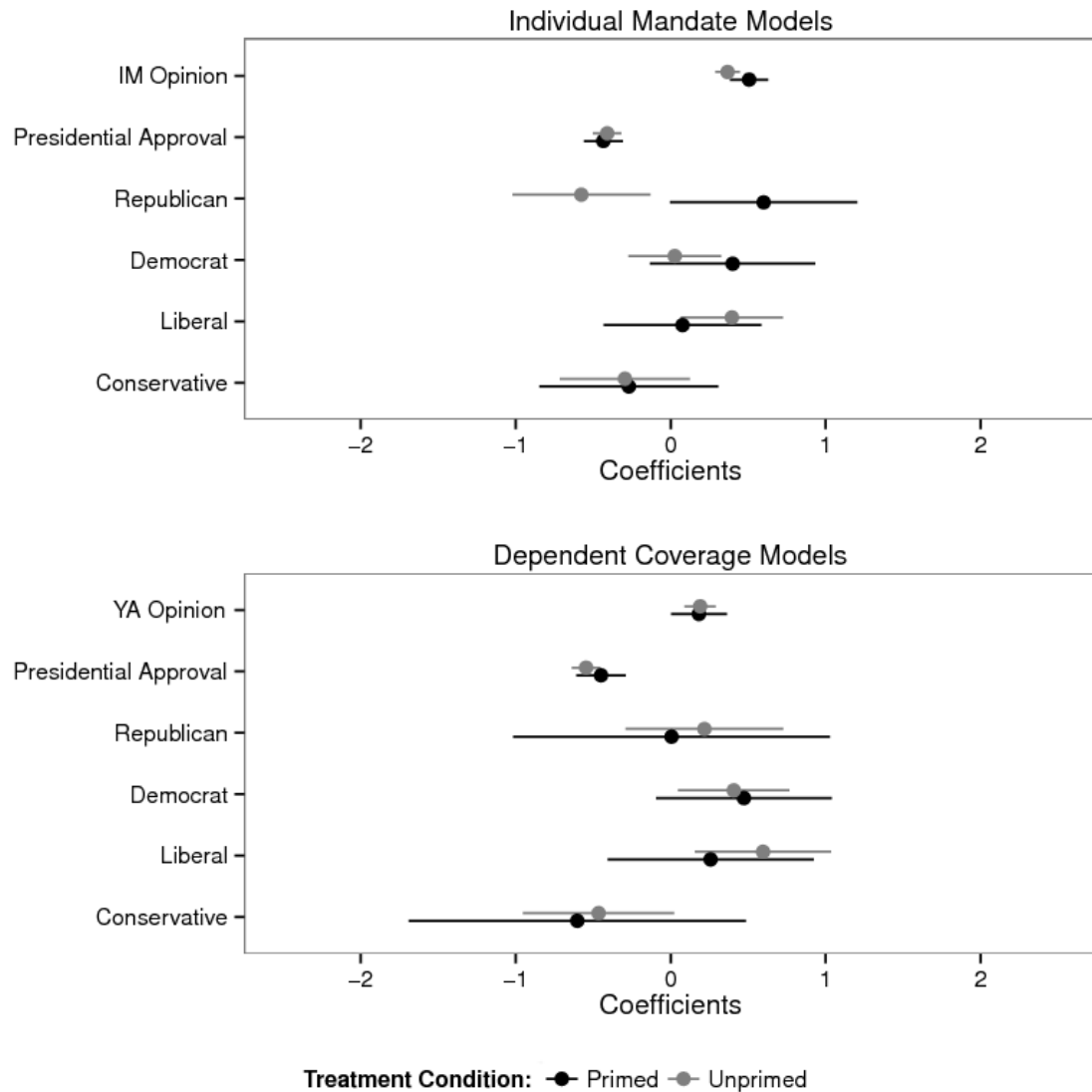
Figure 3-4: Models of ACA Approval by Treatment Group

Note: Coefficient values measured on the x-axes represent the marginal changes ACA favorability (on a seven-point scale) given a 1-unit increase of the specified predictor. The opinion and presidential approval control variables are also continuous seven-point scales. The partisanship and ideology variables are all dummies, with independents and moderates excluded as the baseline categories. No other variables are included in the

model. "Other" categories for partisanship and ideology are included in the models, but not shown for brevity. The constants for the models are also not shown. Sample sizes for the models were 124 for primed individual mandate model, 321 for the unprimed individual mandate model, 129 for the primed dependent coverage model, and 325 for the corresponding unprimed model. See Appendix C for an explanation of the disparities in group sample sizes. The adjusted R^2's for the models range from 0.46 to 0.76. Full models are shown in tabular form in Appendix C, tables C-5 and C-6.

The individual mandate results also reveal that priming this provision makes Republican partisanship an insignificant predictor of overall ACA opinion. This change is statistically meaningful, based on the significant interaction terms ($t = 3.00$, $p < 0.01$). Given the general strength of partisanship as a predictor of individual political attitudes, including those related to the ACA (Henderson and Hillygus 2011; Jacobs and Mettler 2016), the fact that partisanship can be rendered an insignificant predictor of ACA opinion is striking. This suggests that opponents of the law may be able to overcome partisan divisions by appealing to design aspects such as the individual mandate. F-tests of joint significance of the interactions also confirm that the predictors of primed and unprimed individual mandate groups are indeed different overall ($F = 2.64$, $p < 0.01$).

There is no consistent or significant difference in the primed and unprimed coefficients for the dependent coverage group models ($F = 0.93$, $p = 0.494$; no single interaction term is significantly different from zero). This may be a result of the low variance in opinions of the dependent coverage provision. Most respondents (almost 82 percent) liked this provision at least somewhat, and only eight percent had even a slightly unfavorable view of it.

An alternative specification of these models using ordered logit instead of OLS does not qualitatively change these results (see Appendix C, tables C-7 and C-8). As mentioned, the coefficients of interest are also not affected appreciably by the inclusion of other demographic variables. However, logit models with the dichotomous ACA approval variable used in the t-tests above as the dependent variable, the priming effects described in the individual mandate models disappear. This is because most of the changes being picked up by the ordered logit models are occurring in the lower range of the ACA approval scale. Priming the individual mandate affects those who already oppose the ACA, which means the dichotomous variable (favor or oppose) does not change. This presents an important caveat to the analysis of hypothesis 2: prime-driven changes in the predictors of opinion might only occur among those already opposed to the law.

As with hypothesis 1, reverse causality/ opposite causal ordering may threaten our ability to draw causal inferences. It may be the case that ACA opinions are also causing changes in provision-specific opinions, depending on which was asked about first. Models in which the provision opinions are the dependent variables and overall ACA opinions are controlled indicate that ACA opinions do indeed affect provision-specific opinions. However, there are no significant differences in the effects of ACA opinions based on priming. The model coefficients, tested jointly as above, are also not significantly different. The threat of endogeneity is still present, and future work may be

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needed to get unbiased estimates of the conclusions I make here. Still, there is tentative

support for my hypotheses, and reverse causality does not appear to directly explain

those results.

3.5 Discussion

This study has explored the nature of public opinion on the ACA, specifically

investigating how two provisions in the law affect overall opinions. One policy, the

dependent coverage provision, was found to be effective pork for supporters,

significantly increasing general ACA support relative to the unprimed group. When

respondents answered questions about this provision first, their opinions of the ACA

were more favorable than those of the unprimed group. While priming the individual

mandate, a potential wedge issue, did not affect opinions overall, it did for the subset

who opposed the individual mandate. Furthermore, priming this more controversial

provision changed the way people formed their opinions of the ACA. The individual

mandate prime made respondents' opinions of the provision even more salient and their

partisanship less salient in expressing their favorability toward the law as a whole. Both

the policy pork provision and the wedge provision worked as predicted.

What does this mean for the ACA's political future? I will not be able to predict

precise changes in public opinion, but I can comment on general trends to watch. First,

many of the ACA's more popular policy pork provisions are safe. Despite the promises

of Republican presidential candidates and others to "repeal every word of Obamacare,"

to take the wording of Republican Senator and presidential candidate Ted Cruz, portions like the dependent coverage provision are politically untouchable. There are probably also many parts of the law that have remained out of the public eye that will remain similarly safe (see chapter 2 for a discussion of the group-based politics that will predominate in these cases).

However, this policy pork does not appear to have neutralized the potency of potential wedge issues in the ACA, something which supporters hoped to have already accomplished at this point in the law's implementation. Polls on the ACA have shown largely stable levels of support and opposition throughout the past six years. Now that the individual mandate and other significant provisions are being implemented, the pork provisions are much less relevant, having been buried in a deluge of rhetoric about choice and government overreach vs. responsibility and the public good.

As controversial features of the ACA like the individual mandate, Medicaid expansion, the employer mandate, and the Cadillac tax (in 2018) are implemented, their divisiveness will become more apparent, and there is little that can be done to prevent it at this point. My survey experiment shows that interpretive feedback effects are strong for the individual mandate, enough to significantly increase the level of opposition to the ACA overall. Keep in mind that I did not even try to present the mandate to respondents in an unfavorable light. My questions did not mention the mandate's more detestable features, like the fine for noncompliance. Health reform opponents will

certainly be less kind in talking about this provision. While I did not directly test how people would behave if primed with both the individual mandate and the dependent coverage provision, the fact that the wedge still works as opponents would intend at this point is not good news for ACA supporters. Parts of the ACA are still very much ground zero for political conflict, and will be for the foreseeable future.

What we will see in the coming years is the political equivalent of trench warfare over the ACA, with both sides fighting fiercely over inches they will probably not hold for long, barring some major external shock such as a wave election. While the broader status quo prevails, the wedges will continue to be driven in, casting the ACA in terms that are certain to divide the public and reinforce the conflict. With no pork left at their disposal to advance positive interpretations of the law, ACA supporters must now hope the law can hold together long enough for more people to benefit and for opponents to give up the fight as they try to hold together what support they do have on their side of the wedge issues. While reformers did make a swift and powerful initial advance in passing the ACA and implementing its easier provisions, the opposition has now had time to firmly entrench itself and hold its position, forcing ACA supporters to do the same. Opponents, however, have no way to effect universal opposition to the ACA (just divisive wedges), so a quick, decisive victory was never a realistic option for them, and will not be for either side in the foreseeable future.

4. Conclusions and Implications for MACRA's Political Future

My dissertation so far has examined three factors that affect congressional policy making. Chapter 1 has examined the effects of party competition on responsiveness to public opinion. I find that significant competition between the two major parties does serve to increase responsiveness to the public at the level of the individual legislator, with effects at the aggregate level being somewhat weaker. In recent years, it is difficult to estimate these effects because of the generally high levels of party competition and low variance across districts.

Chapter 2 explored the effects of both organized and unorganized interest groups on health policy positions in Congress. While much of the work in that chapter was exploratory, the data presented do suggest a relationship between unorganized groups of voters and the positions their elected officials take, independent of party, district average public opinion, and organized interest group contributions. The results also suggest that context matters a great deal in determining which groups will be influential.

Chapter 3 examined the nature of public opinion itself, using the Affordable Care Act as a case study. The survey experiment reported on in that chapter indicates that opinion on the ACA is malleable and depends on what pieces of the law people think about at the time of response. In the real world, this implies that which parts of the ACA

are highlighted and how it is discussed publicly will affect its future. Policy pork, as

defined in the chapter, can build up support, but wedge provisions in the law can serve

to entrench the opposition further. These implications can also be applied to other

complex, highly visible reform bills.

In this concluding chapter, I examine another recent piece of health legislation,

the Medicare Access and CHIP Reauthorization Act (MACRA). I will draw on the

conclusions of the prior three chapters to inform my discussion of the law's past and my

predictions about its future.

After seventeen temporary suspensions of the Sustainable Growth Rate formula

(SGR) since 2003 and just hours before a large SGR-induced rate cut would have gone

into effect, Congress passed a permanent "doc fix," the Medicare Access and CHIP

Reauthorization Act (MACRA) on April 14, 2015. The next day, a Kaiser Health News

reporter optimistically declared "Medicare's troubled physician payment formula will

soon be history" (Carey 2015). Referring to the fact he and his colleagues would no

longer have to pass temporary SGR-suspension measures after failed negotiations every

few months, Rep. Fred Upton (R-Michigan) said, "Stick a fork in it, it's finally done."

Looking no further than the overwhelming bipartisan margins by which

MACRA passed both chambers, this ebullience seems well-founded. But is the fight over

Medicare provider payments really over? The bill's move toward value-based payments

is significant, part of a larger trend in policy and industry away from volume-based

payments. However, the fundamental tension between providers and policy makers in terms of payment, exacerbated by SGR, is not fully resolved in MACRA. Whereas MACRA has been hailed as a significant improvement in the status quo, a new baseline from which only minor adjustments will be made for the foreseeable future, can we expect this to actually be the case? Based on the findings of my dissertation, I argue that although the battle over SGR is over, the war over payment models in general is far from concluded. MACRA has effected a paradigm shift in Medicare payment policy, but in doing so has set the field of the next battles over Medicare payments.

This is so for three reasons. First, the payment model MACRA institutes in place of SGR is not a stable compromise. Second, the tools used to gather approval for this permanent doc fix were mostly political, leading to a solution that is severable from the rest of the bill and therefore politically vulnerable. Finally, the context in which MACRA passed is neither unique nor temporary, indicating that the bill is not even a departure from business as usual in the health policymaking arena, but rather bears important resemblances to previous doc fix bills. For these reasons, it is likely that the payment models in MACRA will be challenged politically and probably altered during or very soon after implementation.

4.1 MACRA's payment models do not resolve the underlying conflict.

MACRA came about as an attempt to resolve disputes between various stakeholders over Medicare provider payment models. Despite being hailed as a

compromise that will last permanently, MACRA does not actually resolve the

underlying dispute it is meant to solve, and therefore is an unstable compromise.

4.1.1 The SGR Debate

In the debate over Medicare payment models generally, three of the principal

groups of participants were doctors and other healthcare providers, fiscal conservatives

("budget hawks"), and patient advocates, especially those representing the elderly. As

discussed in chapter 2, these groups can include both organized elements that directly

lobbied Congress and unorganized groups of voters who might be activated if their

interests are threatened. SGR placed these three groups in direct conflict.

Congressional budget hawks were the ones responsible for SGR in the first place.

Taking advantage of rising federal revenues, congressional Republicans shifted gears

after the 1996 election from grand crusades on health care policy to piecemeal cost-

cutting measures (Starr 2011, 140–43). The Balanced Budget Act of 1997 included many

such measures, including the SGR. Were it not for the many temporary suspensions of

SGR, the budget hawks' zeal for fiscal responsibility would have led to cuts which

doctors (and many others) felt were unbearably draconian (Laugesen 2009).

The three groups mentioned above are apparent in this debate. Patient advocates

worry about what would happen to patients' access to medical care if SGR were to

actually go into effect. Doctors themselves worry about access, too, at least in the sense

that low Medicare payment rates would prevent them from serving and gaining revenue

from a significant customer segment. However, the patient advocates are not entirely in the doctors' camp. Particularly when it comes to quality, they are more in line with conservatives in wanting greater value in return for whatever providers are paid. Still, these advocates, along with the political liberals who often join them, are more willing to engage in deficit spending to achieve quality goals, making them a distinct third party in the debate.

Once the doctors and patient advocates realized what SGR would mean for reimbursement and access, there was overwhelming bipartisan support for replacing the SGR with a payment model that would be deemed more responsible (Oberlander and Laugesen 2015). Even some of the budget hawks felt SGR might have gone too far. For political reasons, SGR was doomed to fail almost from the start. Once it became clear SGR was going to lead to significant rate cuts, physician groups pressured Congress to temporarily suspend the SGR's implementation seventeen times. These suspensions occurred under both Presidents Bush and Obama, and under both Republican and Democratic congressional majorities. Organized physician groups were able to exert disproportionate influence (see chapter 2) to prevent SGR cuts from taking effect by framing the policy as unpredictable and unreliable (chapter 3; see also Laugesen 2009).

The reason all the suspensions were only temporary was that the stakeholder groups could not agree on how to replace SGR, and particularly how to fund a

replacement (Oberlander and Laugesen 2015).[1] In general, budget hawks are not

inherently opposed to spending if it can be paid for. It was deficit spending in particular

they took issue with, and Medicare is one of the largest drivers of federal budget deficits.

If SGR were repealed and doctors given higher reimbursement rates, then the money

would have to come from somewhere else. Within the Medicare budget, that would

mean having at least some beneficiaries pay higher premiums and, through cost-sharing

mechanisms, take on more financial responsibility for keeping costs down. Liberals and

patient advocates would not go along willingly with these proposals. Liberals also

would not tolerate cuts to other programs to pay for an increase in Medicare expenses,

and tax increases are generally out of the question in American politics. Despite

agreement that SGR had to go, arguments over funding for a permanent doc fix left

Congress at an impasse for over a decade.

4.1.2 The MACRA Payment Model

MACRA seemed to many observers to portend a significant change in the status

quo. Among other things, the bill repealed SGR (rather than temporarily delaying

implementation) and laid the framework for a new payment model, the Quality

Payment Program (QPP). This model contains two tracks: the Merit-based Incentive

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[1] Given SGR's significant budget cuts, almost any conceivable fix would end up increasing Medicare
expenses dramatically on paper, even though the fact SGR was never implemented means it likely did not
have much actual effect.

Payments System (MIPS) and the Alternative Payment Model (APM) track.[2] While the AMA itself billed this new model as giving doctors choice in Medicare reimbursement issues (American Medical Association nd), I argue that neither of these choices will be acceptable to doctors when implemented, at least not as long as the other stakeholders maintain their positions.

4.1.2.1 MIPS Track

The MIPS option in MACRA, which the AMA says will likely be the primary payment method for at least the beginning stages of implementation (Madara 2015), replaces three prior quality measures with a single composite performance score, on which bonuses and penalties will be based. The rates are set to start at between -4% and +4% of base rates in 2019, with the range increasing to modifiers between -9% and +9% by 2022 and continuing at these levels in perpetuity. The bonuses/ penalties will be added or subtracted from the usual Medicare Part B base rate.

As long as it was all theoretical, doctors were probably strongly enticed by the possibility of 9% bonuses over current rates. However, two other factors in the law ensure that a significant number of providers will face negative bonuses and feel it.

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[2] For a description of the MACRA bill, see the official bill summary (United States Congress 2015). For more details on MACRA's payment models, see Center for Medicare and Medicaid Services (nd) and Cragun (2015). For more information on the APM track specifically, see Wynne and Horowitz (2016). The discussion about MACRA's specifics draws on these sources, as well as conversations with experts and others familiar with MACRA's drafting and passage.

First, the program is mandated to be budget neutral, meaning the sum of all adjustments across all providers will be zero. This introduces competitive incentives into the industry. In order to not be assessed a penalty, doctors will have to make whatever investments are necessary to get a MIPS score above the median. This will increase doctors' total costs, even if they are not assessed a penalty by CMS. With these competitive pressures and the budget neutrality requirement, the bonus in expectation is actually zero, despite the increased effort required to achieve it. Doctors as a group thus have an economic reason to be dissatisfied with a new arrangement that forces them into a prisoners' dilemma situation. Once the dust of the SGR battle settles and the nice theories about 9% bonuses turn into less rosy realities, doctors may find their victory is not quite what they had in mind.

Second, the base rates themselves are not set to increase as much after the MIPS provisions kick in. In fact, between 2020 and 2025, rate increases are fixed at zero. Thereafter, physicians still participating in MIPS will only receive base rate increases of 0.25% per year. This likely is not nearly enough to offset the rising costs mentioned above, meaning those costs will have noticeable impacts on doctors' bottom lines. Perhaps some will be able to achieve bonuses that can actually offset the costs, but this will only exacerbate the plight of the doctors who then must be assessed penalties to keep the bonuses budget-neutral. If there are any winners, there have to be losers. Because base rates will not keep up with the cost increases required to avoid large

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penalties, MIPS will quickly become another reviled Medicare payment model, like the

SGR before it.

4.1.2.2 APM Track

If MIPS is not acceptable, doctors can choose to enter the APM track instead.

However, many of the same issues exist in this track as in MIPS, though in different

form. This track essentially incentivizes physicians to enter alternative payment models

(APMs), such as accountable care organizations (ACOs) by providing 5% annual lump

sum bonuses on their Medicare payments from 2019 to 2024. Thereafter, base rates for

APM participants will increase by 0.75% (instead of 0.25%, as in MIPS).

Some physicians have seen significant financial benefits from participation in

APMs, but not all. Furthermore, in order to satisfy both the budget hawks and patient

advocates, APMs will need to force providers to accept more financial risk by facing

penalties for not hitting quality benchmarks and by pushing more patients into APMs

(which might decrease the average health of the relevant risk pools). Otherwise, the

interests that supported SGR and value-based payment models in the first place will

begin to seek more drastic measures to achieve their goals.

The key statutory language here is the requirement that physicians in APMs

assume "more than nominal risk." While it was all just talk, this probably sounded fine

for doctors, especially compared to SGR. However, the AMA has already expressed

concerns to CMS that if the measures and programs in the APM track (and MIPS) are

not set up "correctly," physicians will not be able to succeed in the programs (Madara 2015). Physicians and physician groups are lobbying CMS to approve new APM models, which will probably be set up in ways favorable to physicians (AdvantEdge 2015). These actions have in turn led progressives, patient advocates, and even fiscal conservatives to lament that because the statutory requirements for quality measures are rather sparse, doctors will have a disproportionate influence on the rulemaking process, allowing them to essentially write their own rules (Kliff 2015), as has been the case with Medicare providers in the past (Balla 1998). These disgruntled groups' recourse is to go back to Congress and start crying foul play.

Furthermore, use of the APM model as it is likely to be implemented could lead to consolidation in the provider industry, with more physicians joining hospital groups and other large provider groups (Kutscher and Rubenfire 2016). Small physician practices will not be able to succeed in the APM track, and will be stuck with the less desirable MIPS track if they do not consolidate. If they do consolidate, then a more concentrated provider industry will be even more ideally situated to extract concessions from government agencies, to the chagrin of their opposing stakeholders. Either way, no one is going to be happy with the APM track. It was not designed in a way that allows it to satisfy all sides, and that will become even more apparent as details and final rules come forth.

Significant grumbling ensued following a proposed final rule issued by CMS on April 27, 2016 (CMS Press Office 2016; Kuhrt 2016). AMA president Steven Stack seemed satisfied that "CMS has been listening to physicians' concerns" (Byers and Mulero 2016), but the provider community's response still indicates they are not fully satisfied with the proposed implementation and will likely try to get more concessions. On the other hand, American Hospital Association president Tom Nickels expressed deep disappointment with "CMS's narrow definition of alternative payment models, which could have a chilling effect on providers' ability to experiment with new patient-centered, value-driven payment models" (Byers and Mulero 2016). If the hospital industry, which is often much more closely aligned with provider interests and actually could stand to gain from more physicians joining hospital physician groups as described above, can express disappointment over the proposed rule, then budget hawks and patient advocates will certainly not be entirely pleased. If physicians do not end up assuming what budget hawks feel is "more than nominal risk," or if quality of care and truly value-based payments do not increase as much as patient advocates would like, then legislative battles will resume, perhaps with legal challenges as well.

Federal officials took thousands of comments on the proposed rule, mostly from providers and related groups. Among the biggest complaints they received were the inflexibility in the rule and the ambitious timeline for implementation. The final rule, released by CMS on October 14, 2016 (Center for Medicare and Medicaid Services 2016),

was predictably more flexible. It allows for varying degrees of compliance with MIPS in 2017, as well as joint reporting by small rural practices. The initial reactions to the final rule from the provider community were mostly positive, but interestingly still included many of the same concerns about flexibility (Rappleye 2016). The Medical Group Management Association, for example, said, "It's disappointing that flexibility provided for quality reporting in 2017 largely disappears in 2018 and beyond." Unfortunately for those holding this position, there isn't much more flexibility in the statute for CMS to take. Provider groups do not seem to be satisfied without the flexibility to completely opt out of the QPP, a concern they will eventually have to take up with Congress.

4.1.3 Pushing MACRA off the Cliff

Even an unstable compromise can last if nothing happens to disrupt the delicate balance. In a political climate prone to violent storms that arise over more trivial policy matters, it is unlikely MACRA will exist in a calm environment. Take, for example, the case of a proposal in an early version of the ACA which would allow doctors to be compensated for consulting with patients about their preferences for end-of-life care. Sarah Palin and others successfully labeled this provision "death panels," which led to the provision being omitted from the bill (Farber 2009). This major freak-out happened over a policy that would have been inconsequential for the vast majority of Americans, yet it resulted in the policy being changed.

The only difference with MACRA is that it is a much more substantial policy

than the alleged death panels. If MACRA is implemented as written, it will not just

affect a few Medicare patients at the very end of their lives. It will generate significant

upheaval in one of the largest industries in the American economy, one that touches

virtually everyone in the country. No hyperbole about a government panel

recommending euthanization of sick elderly people is necessary to generate controversy

around MACRA. It will generate its own controversy. The argument could even be

made that because it is so consequential for "who gets what, when, and how", MACRA

deserves vigorous dialogue and considerable vetting in the public sphere (see Lasswell

1936 for a classic exposition of the definition and purpose of politics). However,

MACRA is too unstable as a compromise to avoid being altered significantly in the

process of such vetting.

4.1.4 An Unstable Compromise

As long as the stakeholders in the argument do not relinquish their positions or

realize different interests, there is no scenario under which all sides will be completely

happy with the MACRA payment model as it is implemented. Oberlander and

Laugesen (2015) point out that "physician payments are both a source of income and an

instrument of cost containment. The result is an inevitable tension in health policy:

medical professionals typically want higher payments, whereas governments prefer to

pay less." This argument, along with my findings on group interests and conflict,

suggests that the MACRA payment model described above is an unstable compromise because as these groups continue to lobby Congress for changes, legislators will listen and respond. The fight will probably begin anew in the administrative rulemaking arena as MACRA is implemented, but inevitably it will spill back into Congress. SGR has been replaced not by a fix, but by a temporary truce as a new lightning rod for debate is erected.

4.2 MACRA's payment model is severable, and therefore politically vulnerable.

If MACRA does not solve the underlying conflict over payment models, how did it pass in the first place? Both chapters 2 and 3 of my dissertation, on the effects of group interests and public opinion, as well research on policy feedbacks (Campbell 2012; Oberlander and Weaver 2015; Pierson 1993, 2000), suggest that broad reform packages can gain political support by including proposals different groups will like. Indeed, there is something for everyone in MACRA, or at least enough that the bill has passed without creating any significant backlash from the public or from key stakeholder groups. However, this left the payment model piece vulnerable to future political attack.

MACRA engages in a fair amount of obvious logrolling across issues, stretching its scope far beyond a simple reform of Medicare payment models (see United States Congress 2015 for a list of the bill's provisions). Liberals got an extension on CHIP, but not full funding for the reauthorization. Fiscal conservatives got more means-testing of Part B and D premiums and a budget neutrality clause in the new MIPS payment track,

but they also had to swallow an additional $141 billion in deficit spending. Doctors got a repeal of the SGR and an opportunity to rework or replace certain onerous and opaque quality measures, but not without putting themselves on the hook for more significant investments in care quality and commitment to value-based payment models with "more than nominal risk." The elderly and patient advocates got rid of the SGR's threats to provider access and higher physician commitment to patient quality, but had to trade away first-dollar Medigap coverage and accept higher premiums for Medicare beneficiaries.[3]

Many of these provisions are entirely superfluous to the new payment models, but they helped make the bill politically palatable for a wide range of groups. Similar to the young adult coverage provisions in the ACA (described in chapter 3), MACRA's reauthorization of CHIP, for example, is probably widely popular. If a member of Congress is ever challenged on his/ her MACRA vote in a campaign setting, it will be very easy to respond with a statement like "I voted to give health insurance to poor kids and improve care access for our seniors." Such a statement would likely placate all but the most conscientious fiscal conservatives. Conservatives themselves can also honestly say they were supporting responsible Medicare payment reform and voted for the rich to pay their fair share instead of benefiting at the taxpayers' expense. It is no accident

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[3] In addition to the means-testing provisions of MACRA, which would only affect a very small portion of Medicare beneficiaries (Cubanski and Neuman 2015), the SGR would have indirectly held down Medicare premiums by keeping program costs down. Part B and D premiums are tied to these program costs, with all beneficiaries paying at least 25% of their share of the average cost.

that CHIP reauthorization, a ban on first-dollar Medigap coverage, and means-testing for Medicare premiums all ended up in a bill meant ostensibly to deal with the SGR.

Politically, MACRA was a huge success because it successfully brought enough benefits to the groups involved and did not provoke other groups or the general public in any significant way. However, this short-term political success may have come at the expense of enacting a more effective solution to Medicare's fiscal woes. The payment model itself is entirely severable from the rest of MACRA. In legal and logistical terms, it could be removed very easily without affecting CHIP, Medigap, means-testing, or any of the more attractive features of the bill. An outright repeal of MACRA or the QPP is unlikely because it would likely revert the relevant portions of the US Code to the SGR, but that does not mean the QPP itself would not be significantly altered by another "permanent doc fix." The QPP's severability leaves it politically vulnerable despite the widespread support for the bill in which it was passed.

On its own, this vulnerability does not mean MACRA payment models will soon be repealed. However, when considered alongside the instability of the MACRA compromise, we can conclude that the inevitable debates over the new models will probably lead to significant alterations because MACRA does not occupy a defensible position. As long as no significant changes occur in the overall political context that would lock it in place, it seems that MACRA will be subject to many significant

alterations as it goes into effect. As we will see next, there is no reason to believe that such contextual changes have occurred or will occur to cover MACRA's vulnerability.

4.3 MACRA is business as usual.

The only thing that can save MACRA from itself is a meaningful change in the political context, such as a policy window created by economic and political forces (Kingdon 1995). This dissertation has examined some of these conditions that might change (party competition, groups, framing and public opinion), but there is nothing to suggest that these factors are changing in a way that would help MACRA's case. Conditions in the economy and the federal budget also do not seem to be helping. Still, if the balance of group interests' power in Congress shifts away from provider interests, or if certain institutions change dramatically (particularly if stricter budgetary procedures are adopted), MACRA may be shielded from future meaningful debate and allow it to become entrenched as a baseline for future marginal adjustment.

Again, there is no evidence that the overall political context has changed in a way that would make MACRA a special or unexpected occurrence, nor is there reason to suspect any future changes that would politically lock MACRA in place. Three facts support this point. First, MACRA as a piece of legislation actually looks quite similar to other recent health legislation, including some of the former SGR suspension bills. Second, the dynamics of party competition and congressional responsiveness have not changed significantly in decades and do not appear to be changing, giving stakeholder

groups incentives to continue lobbying for their preferred positions. Finally, MACRA does not get the feedbacks right, meaning it will do nothing to prevent future debate over its existence.

4.3.1 SGR II

Though MACRA was different than previous temporary doc fix bills in that it permanently repealed SGR rather than merely delaying implementation, the qualitative differences essentially end there. MACRA looks like any other doc fix bill. For example, the 2014 temporary fix was not just a bill to delay SGR implementation. Among other things, it also extended maternal, infant, and early childhood visiting programs enacted previously, delayed the transition of medical coding systems to ICD-10 until October 2015, and amended the ACA to remove limits on deductibles in employer-sponsored plans (United States Congress 2014). There was something for everyone in the 2014 bill, a pattern which should sound familiar after the discussion above about logrolling in MACRA. Prior SGR bills show similar patterns. Because no one could agree on exactly what to do with SGR, doing anything required a lot of compromises on irrelevant policies and programs.

Both MACRA and the SGR bills epitomized eleventh-hour brinksmanship. MACRA's passage literally hours before severe SGR rate cuts were scheduled to take effect was by then a very predictable plot twist. Congress had practiced this dangerous maneuver 17 times before. Some SGR suspension bills were even passed after cuts took

effect, with the bills undoing the cuts retroactively. This is not simply an amusing sidebar in the history of Medicare payment reform. Rather, it shows quite clearly that Congress could not figure out what to do about this policy no one liked, and that did not change with MACRA. The same maneuvers that led to the temporary suspensions were used to craft the permanent doc fix. Certainly the fact that SGR itself is now gone forever has brought temporary relief, but MACRA is in many respects no different than any other doc fix bill. The only difference is that it replaced SGR with another policy with which no one in Congress will know what to do after implementation begins in earnest.

MACRA is also similar to SGR in its initially being heralded as a magic "silver bullet" that would solve all our healthcare woes, specifically through better management of health resource utilization (Marmor and Oberlander 2012). This thinking has only led to disappointment, and there is not yet enough evidence to suggest that value-based payments will work either (Vladeck 2012). It might be the case that dumping SGR at this point in time was made possible partly by the emergence of the value-based payment movement as a "logically powerful" alternative, as Bruce Vladeck calls it, despite also being "inconsistent with the facts" (Vladeck 2012). To all sides in this debate who had tired long ago of the recurring SGR controversy, this new idea probably sounded like a great way to finally end the drama. Throughout the whole SGR ordeal, the bipartisan consensus was that SGR had to go. All MACRA did was embody that consensus in a bill

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that to which almost no one had other objections. The MACRA vote was probably more of a vote to repeal SGR than to enact QPP.

4.3.2 Victory or Truce?

As shown in chapter 1, party competition has been alive and well over the past few decades. Combined with the consensus among political scientists that elite polarization is both real and significant (for a review, see Hetherington 2009), what we have is a recipe for policy instability, especially when the policies are unstable themselves. MACRA does not represent a departure from this trend. Despite the large bipartisan majorities in favor of it, different sides like different things about the bill. In fact, the diversity of support-building handouts in the bill show that legislators are responding very keenly to certain groups. Groups that successfully catch the ears of Congress once will only be emboldened to try again for their cause. MACRA's payment models were not really a victory for anyone, but rather a temporary truce in a larger debate. The findings in the rest of my dissertation give no indication that broader contextual or institutional factors will be changing any time soon, all but ensuring the truce will end.

Even the surprise election of Donald Trump and a unified Republican government does not change the essential underlying context of the debate. With the dust beginning to settle from the tumultuous 2016 presidential election, it is important to consider whether the election of Donald Trump on a populist, reactionary platform

changes any of the conclusions drawn so far about context. Certainly Trump's election

spells uncertainty for the health care industry overall, with repeal of the ACA rising to

the top of Congress's 2017 agenda. However, the context in which MACRA and

Medicare payments reside is not likely to see much change. If anything, Trump's

election will only serve to strengthen the position of the budget hawks, who seem to

have been put on the disadvantage during the Obama years.

MACRA's passage was a tactical win for doctors in the sense that it relieved

them of SGR and all its apocalyptic uncertainty. The medical community came out

ahead, even though their victory was far from secure. What Donald Trump's election

does is legitimize the budget hawks' position, at least rhetorically. When the President-

elect of the United States threatens to cancel Boeing's contract for Air Force One, citing

cost, budget hawks on congressional health committees will be emboldened to take

similarly austere stances toward Medicare payments. Even if some of the policies put

forth by Trump himself are likely to add to deficit spending,[4] his election has changed

the nature of the conversation in Washington, DC surrounding the federal budget.

Budget hawks certainly will continue to have significant opposition from providers and

progressives, so it is unlikely that something like SGR will return in the near-future, but

when doctors come back to Congress asking for more budget authorizations for QPP,

[4] See, for example, the Committee for a Responsible Federal Budget's analysis of the budgetary impact of
Donald Trump and Hillary Clinton's campaign promises (Committee for a Responsible Federal Budget
2016). Trump's proposals, if enacted, would increase the national debt by roughly $5.3 trillion. Still, the
broader point about rhetoric remains.

congressional Republicans will likely say "no." Physicians are unlikely to take "no" for an answer when their livelihoods are on the line, and thus the conflict will continue.

One important feature of the politics surrounding MACRA which has been solidified rather than altered by the 2016 election is the partisan polarization in Congress. Since Election Day, the Democrats have largely doubled down on their prior positions, with many vowing to fight the efforts of a unified Republican government to significantly alter Medicare and other programs. Given all the powerful groups that have such high stakes in Medicare, they are likely to put up a good fight as far as payment models go.

It is also worth noting that Trump's pick to lead the Department of Health and Human Services, Rep. Tom Price (R-GA), has at times come out against various alternative payment models, such as bundled payments. As a medical doctor himself, he is a staunch advocate of providers' views on payment. The Trump election legitimizes the position of the budget hawks in general, but his pick of Tom Price paradoxically also strengthens the hands of providers. On the issue of provider payments, expect to see these camps come into direct conflict.

4.3.3 Feedback Effects

Had MACRA been crafted differently, it may have been able to engineer its own long-term support. This kind of feedback effect helped make the Medicare program one of the most firmly entrenched social policies in America just a few years after its passage

in 1965. After years of intense opposition, Medicare passed on a huge wave of support for liberal Democrats in the 1964 election, a wave without which Medicare might not have been able to make it ashore (Oberlander 2003; Starr 1982). Doctors themselves, previously vehement opponents of a massive government intrusion into their livelihood, quickly changed their opinions of the program in part because it became one of their most important revenue sources (Colombotos 1969). In the half-century since its passage, Medicare has generally been viewed by all sides as a baseline policy from which marginal adjustments will be made (witness the rise of Medicare Advantage, the Part D prescription Drug benefit, etc.), rather than being itself an object of existential debate.

Part of this successful consolidation around Medicare was the way it was designed and implemented. Policy feedback research attests that Medicare got the feedbacks right in many important ways (Campbell 2011; Oberlander and Weaver 2015). Medicare catalyzed its own political support by quickly building a supportive constituency for the program itself that consisted of players on both sides of the pre-passage debates. Implementation also went smoothly, denying would-be opponents any opportunities to call for writing the program off as an administrative failure.

MACRA has none of these advantages. As discussed above, the MACRA compromise is both unstable and politically vulnerable. It simply was not designed to avoid significant debate over its major provisions. As the various groups resume their

battle positions, the coalition of support around the payment models in MACRA will be severely challenged. Doctors will want quality measures with no bite and higher reimbursements. Patient advocates and budget hawks will attempt to move the dial the other way. Neither side will be happy with the way the program is implemented. MACRA, like SGR before it, will be caught in the middle of the debate.

4.4 MACRA will not endure as passed.

MACRA is not a permanent resolution of the debates over Medicare payment models. The new model is itself an unstable compromise that is severable from the more favorable elements of the bill and not likely to be saved by changes in political context, whether exogenous or self-induced. MACRA has effected a temporary truce by delaying implementation of the new model for a few more years, but providers, policy makers, and other stakeholders in the debate can expect to be back in the trenches of this war before too long.

What would a permanent solution look like? As Oberlander and Laugesen (2015) put it, "The SGR is gone, but there is no permanent fix for physician payment." While my research cannot prescribe such a policy in detail, I can comment on three political factors required for a successful, permanent resolution. First, there almost certainly needs to be a realignment of stakeholder interests. This realignment could be induced by a new policy, as occurred when Medicare implementation led doctors to rethink their opposition to the new cash cow, or it could occur exogenously as factors realign and

savvy policy entrepreneurs (see Kingdon 1995) exploit an opportunity to solidify any temporary consensus on what should be done. For example, if budget hawks are able to generate budget surpluses without changing Medicare, that would be a good time to address Medicare payment models with the budgetary constraints and time pressures at least temporarily removed. Even if the surpluses disappear, a policy could be designed and implemented during the window of opportunity that consolidates political support and becomes the new baseline for marginal changes.

Second, a lasting compromise policy will need to be able to stand on its own without making extraneous compromises. Such compromises only serve to pass a bill, and do nothing politically for the new program during implementation. To the extent that compromise occurs, it should occur within the payment model itself, or the compromise will be a sham. All the relevant stakeholders need to have a reason to support the compromise, not just the bill, and that support needs to last not just until the President signs it but also after CMS issues final rules.

Third, there may need to be a significant reframing of the issue for the broader public. The public, to the extent they know about this issue at all, currently understands it in terms of access to physicians. This is evidenced by the way MACRA was titled: it is an Act dealing with Medicare *Access* and CHIP Reauthorization. That puts the public firmly, if often unknowingly, on the side of "their doctors," as the AMA so often phrases it. With the public sidelined in this manner, stakeholder groups are free to continue their

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squabbling largely out of the public eye. Contrast this with the debate over the original

SGR enactment, which came as part of the Balanced Budget Act of 1997 and was framed

only as an attempt to make the federal government more fiscally responsible. With party

competition now as fierce as ever in Medicare's history, overall public opinion is a

significant factor in congressional policymaking (see chapter 1). If the public sent clear

enough signals to elected officials that they wanted something specific done, elected

officials would have almost no choice but to listen, whatever the organized stakeholders

thought.[5] In fact, an arousal of public opinion could effect (or at least be effected by) a

realignment of group interests along the lines of my first point above.

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[5] We are seeing just such a scenario with the GOP's recent actions on repealing the ACA. While public opinion on this policy is not well understood beyond a superficial level (see chapter 3), it can be said with certainty that there is significant opposition to some of its most important provisions, and the 2016 election outcome has lent significant validation to the Republican position on the issue.

Appendix A. Supplement to Chapter 1
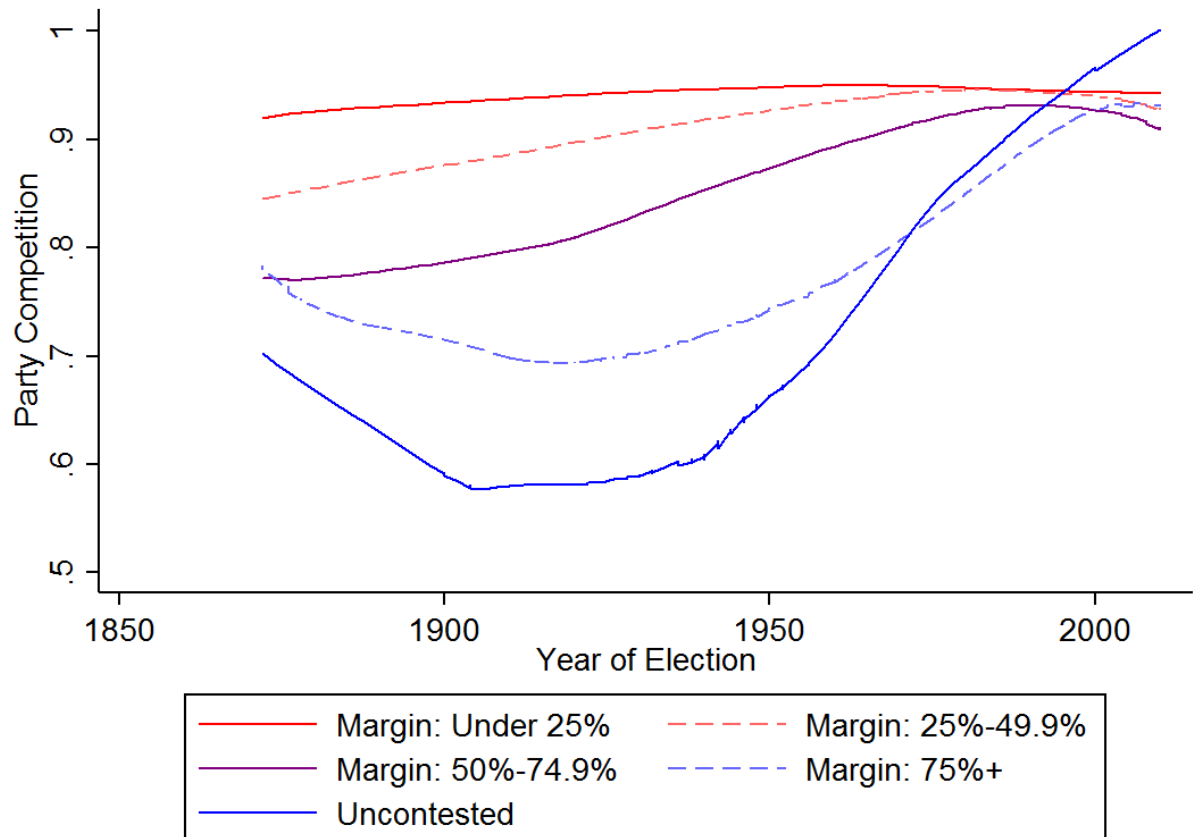
Figure A-1: Party Competition over Time by District Marginality

The lines are lowess-smoothed representations of the moving-average party competition for the five groups indicated. Higher values on the vertical axis indicate greater party competition.

Table A-1: Variance Inflation Factors for Models in Table 1-2

	(1)	(2)	(3)	(4)	(5)	(6)
		Margin: Under	Margin: 25%-	Margin: 50%-	Margin: Over	Uncon-
	All	25%	49.9%	74.9%	75%	tested
Democratic Share of Presidential Vote	3.10	1.35	1.46	2.44	3.85	5.29
Election-based Index	34.03	153.62	89.57	70.15	31.28	28.33
Party Competition Measure X Dem Pres. Share	31.42	155.40	91.22	69.79	30.34	24.58
Winning Margin in Election	2.03	1.06	1.05	1.20	1.27	
Uncontested Election	1.57					
Southern State	1.93	1.31	1.36	2.06	1.90	1.72
Republican Incumbent	1.65	1.34	2.00	2.95	2.72	3.21
Mean VIF	7.99	9.31	15.89	11.27	8.17	23.83

Cells are variance inflation factors (VIFs) calculated for each corresponding model in Table 1-2. The VIFs for the fixed effects are calculated and accounted for in the mean VIFs, but not shown separately here. The general rule of thumb is that VIFs below 3 are ideal, and VIFs below 10 are acceptable. Collinearity is substantially affecting parameter sensibility when the VIF > 10.

Table A-2: Models of Legislator Responsiveness, Bonica CF Scores

	(1)	(2)	(3)	(4)	(5)	(6)
		Margin: Under	Margin: 25%-	Margin: 50%-	Margin: Over	Uncon-
	All	25%	49.9%	74.9%	75%	tested
Democratic Share of	2.71**	2.42	4.24**	2.97*	2.82**	-2.75
Presidential Vote	(0.54)	(1.52)	(0.96)	(1.26)	(1.00)	(3.37)
Party Competition	0.37**	0.24	0.15	0.25	0.17	0.45
Index	(0.08)	(0.16)	(0.13)	(0.26)	(0.20)	(0.45)
Party Competition	-2.07**	-1.48	-3.12**	-1.77	-2.30*	3.64
Measure X Dem Pres.	(0.58)	(1.64)	(1.02)	(1.36)	(1.08)	(3.58)
Share						
Winning Margin in	-0.05**	0.19*	-0.10	-0.37*	-0.10	
Election	(0.02)	(0.09)	(0.09)	(0.19)	(0.19)	
Uncontested Election	-0.03					
	(0.03)					
Southern State	-0.21**	-0.19**	-0.20**	-0.24**	-0.20**	-0.28**
	(0.01)	(0.02)	(0.01)	(0.03)	(0.03)	(0.05)
Republican Incumbent	-1.28**	-1.41**	-1.18**	-0.99**	-1.16**	-1.02**
	(0.01)	(0.01)	(0.02)	(0.04)	(0.04)	(0.08)
Constant	0.21**	0.49**	0.40**	0.35	0.21	0.09
	(0.08)	(0.15)	(0.13)	(0.27)	(0.27)	(0.51)
Year Fixed Effects	Y	Y	Y	Y	Y	Y
Observations	5,508	1,931	2,266	587	576	153
R-squared	0.85	0.87	0.86	0.85	0.87	0.83

Standard errors in parentheses. * $p < 0.05$, ** $p < 0.01$

Table A-3: Models of Legislator Responsiveness, Ranney Index

	(1) All	(2) Margin: Under 25%	(3) Margin: 25%- 49.9%	(4) Margin: 50%- 74.9%	(5) Margin: Over 75%	(6) Uncon- tested
Democratic Share of Presidential Vote	-1.02** (0.05)	0.12 (0.20)	-0.22 (0.16)	-0.70** (0.21)	-0.36** (0.13)	-1.39** (0.16)
Ranney Index	0.25** (0.01)	0.15** (0.02)	0.18** (0.02)	0.20** (0.05)	0.16** (0.05)	0.36** (0.07)
Party Competition Measure X Dem Pres. Share	1.92** (0.07)	0.67** (0.23)	1.06** (0.19)	1.45** (0.25)	1.02** (0.18)	2.59** (0.27)
Winning Margin in Election	-0.01* (0.01)	0.03 (0.03)	0.06* (0.03)	0.07 (0.07)	-0.27** (0.06)	
Uncontested Election	-0.04** (0.01)					
Southern State	-0.10** (0.00)	-0.08** (0.01)	-0.09** (0.01)	-0.14** (0.01)	-0.12** (0.01)	-0.05** (0.02)
Republican Incumbent	-0.60** (0.00)	-0.61** (0.00)	-0.60** (0.01)	-0.59** (0.01)	-0.63** (0.02)	-0.52** (0.02)
Constant	0.14** (0.01)	0.21** (0.02)	0.24** (0.03)	0.11 (0.06)	0.38** (0.08)	0.01 (0.06)
Year Fixed Effects	Y	Y	Y	Y	Y	Y
Observations	12,927	5,397	4,474	1,131	1,133	889
R-squared	0.84	0.84	0.86	0.84	0.83	0.70

Standard errors in parentheses. * $p < 0.05$, ** $p < 0.01$

Table A-4: Models of Legislator Responsiveness, HVD Index

	(1)	(2)	(3)	(4)	(5)	(6)
		Margin: Under	Margin: 25%-	Margin: 50%-	Margin: Over	Uncon-
	All	25%	49.9%	74.9%	75%	tested
Democratic Share of	0.80**	1.15**	1.08**	0.70**	0.35**	0.87**
Presidential Vote	(0.05)	(0.13)	(0.10)	(0.13)	(0.13)	(0.31)
HVD Index	0.00**	0.00**	0.00**	0.00**	0.00*	0.00**
	(0.00)	(0.00)	(0.00)	(0.00)	(0.00)	(0.00)
Party Competition	-0.00	-0.01**	-0.01**	-0.00	0.01*	0.01
Measure X Dem Pres.	(0.00)	(0.00)	(0.00)	(0.00)	(0.00)	(0.01)
Share						
Winning Margin in	0.02**	0.10*	0.06	0.13	-0.25**	
Election	(0.01)	(0.04)	(0.04)	(0.08)	(0.09)	
Uncontested Election	-0.04**					
	(0.01)					
Southern State	-0.04**	-0.04**	-0.04**	-0.07**	-0.08**	-0.04
	(0.01)	(0.01)	(0.01)	(0.02)	(0.01)	(0.03)
Republican Incumbent	-0.63**	-0.64**	-0.62**	-0.60**	-0.63**	-0.51**
	(0.00)	(0.01)	(0.01)	(0.02)	(0.02)	(0.03)
Constant	0.22**	0.24**	0.23**	0.18**	0.49**	0.17**
	(0.01)	(0.02)	(0.02)	(0.06)	(0.09)	(0.06)
Year Fixed Effects	Y	Y	Y	Y	Y	Y
Observations	6,904	2,443	2,795	788	687	241
R-squared	0.87	0.86	0.87	0.88	0.89	0.88

Standard errors in parentheses. * p < 0.05, ** p < 0.01

Table A-5: Variance Inflation Factors for Models in Table 1-3

	(1) Chamber Median	(2) Chamber Median	(3) Majority Median	(4) Majority Median
Lagged Dependent Variable	1.99	1.96	2.17	1.62
Mean Party Competition	184.17	61.46	185.14	60.43
Public Mood	1993.25		1992.00	
Party Competition X Mood	2342.79		2340.10	
Democratic Presidential Vote Share		685.54		676.11
Party Competition X Dem Votes		766.82		760.11
Majority Percentage in Chamber	2.02	1.16	2.02	1.16
Democratic Majority	2.18	1.65	2.34	1.65
Election Was Midterm	1.03	1.03	1.04	1.02
Mean VIF	646.78	217.09	646.40	214.59

Cells are variance inflation factors (VIFs) calculated for each corresponding model in Table 1-3. The general rule of thumb is that VIFs below 3 are ideal, and VIFs below 10 are acceptable. Collinearity is substantially affecting parameter sensibility when the VIF > 10.

Table A-6: Overall House Responsiveness, Mean Ideologies

	(1) Chamber Mean	(2) Chamber Mean	(3) Majority Mean	(4) Majority Mean
Lagged Dependent Variable	0.53**	0.43**	0.01	0.12**
	(0.11)	(0.09)	(0.04)	(0.04)
Mean Party Competition	-5.21	-0.17	-30.10**	-3.18
	(3.57)	(1.18)	(7.21)	(2.14)
Public Mood	-0.09		-0.49**	
	(0.06)		(0.11)	
Party Competition X Mood	0.09		0.52**	
	(0.06)		(0.12)	
Democratic Presidential Vote Share		-0.39		-5.27
		(2.13)		(3.87)
Party Competition X Dem Votes		0.26		5.39
		(2.39)		(4.33)
Majority Percentage in Chamber	0.41*	0.20	-0.21	-0.09
	(0.17)	(0.10)	(0.32)	(0.18)
Democratic Majority	0.09**	0.10**	0.87**	0.73**
	(0.02)	(0.02)	(0.04)	(0.03)
Election Was Midterm	-0.01	0.00	-0.02	0.00
	(0.01)	(0.01)	(0.02)	(0.02)
Constant	4.76	0.04	27.95**	2.66
	(3.32)	(1.05)	(6.67)	(1.90)
Observations	31	70	31	70
R-squared	0.93	0.73	0.98	0.95

Standard errors in parentheses. * $p < 0.05$, ** $p < 0.01$

Table A-7: Overall House Responsiveness, Ranney Index

	(1) Chamber Median	(2) Chamber Median	(3) Majority Median	(4) Majority Median
Lagged Dependent Variable	-0.00 (0.03)	0.02 (0.04)	0.02 (0.05)	0.08 (0.07)
Mean Ranney Index	-10.34** (2.22)	2.23 (2.36)	-9.45* (3.82)	-1.95 (4.24)
Public Mood	-0.16** (0.03)		-0.14* (0.05)	
Ranney X Mood	0.18** (0.04)		0.16* (0.06)	
Democratic Presidential Vote Share		3.15 (3.85)		-3.36 (6.92)
Ranney X Dem Votes		-4.00 (4.63)		3.53 (8.31)
Majority Percentage in Chamber	1.23** (0.21)	1.13** (0.26)	-0.10 (0.37)	0.34 (0.47)
Democratic Majority	0.28** (0.02)	0.22** (0.03)	0.84** (0.04)	0.70** (0.05)
Election Was Midterm	-0.02 (0.01)	-0.02 (0.02)	-0.02 (0.02)	-0.01 (0.03)
Constant	8.08** (1.84)	-2.55 (1.93)	7.87* (3.16)	1.19 (3.47)
Observations	30	36	30	36
R-squared	0.96	0.89	0.98	0.94

Standard errors in parentheses. * $p < 0.05$, ** $p < 0.01$

Table A-8: Overall House Responsiveness, HVD Index

	(1) Chamber Median	(2) Chamber Median	(3) Majority Median	(4) Majority Median
Lagged Dependent	-0.03	-0.04	-0.02	-0.04
Variable	(0.03)	(0.03)	(0.05)	(0.05)
Mean HVD Index	0.02	-0.00	0.10	-0.04
	(0.06)	(0.02)	(0.12)	(0.04)
Public Mood	0.01		0.06	
	(0.04)		(0.08)	
HVD X Mood	-0.00		-0.00	
	(0.00)		(0.00)	
Democratic Presidential		-0.10		-4.33
Vote Share		(2.04)		(3.52)
HVD X Dem Votes		0.01		0.11
		(0.05)		(0.08)
Majority Percentage in	0.82*	0.77**	-0.98	-0.88
Chamber	(0.30)	(0.25)	(0.55)	(0.43)
Democratic Majority	0.34**	0.36**	0.94**	0.96**
	(0.02)	(0.03)	(0.05)	(0.05)
Election Was Midterm	0.01	0.01	0.02	0.02
	(0.01)	(0.01)	(0.03)	(0.02)
Constant	-1.49	-0.66	-4.01	1.32
	(2.45)	(0.97)	(4.61)	(1.68)
Observations	21	21	21	21
R-squared	0.98	0.98	0.99	0.99

Standard errors in parentheses. * $p < 0.05$, ** $p < 0.01$

Appendix B. Supplement to Chapter 2

Bill Groups

The six bill groups mentioned in the text contain the following bills (with specific

roll call votes where specified, otherwise all votes on the bill are used; most bills only

have one roll call vote):

- ACA and related, includes both bills comprising the ACA and repeal bills from

    112th Congress: 111th Congress- HR 3590, HR 3962 (roll call vote #887); 112th

    Congress- HR 2, HR 1213, HR 2576, HR 6079.

- HEALTH Act, dealing with medical malpractice liability/ tort reform: 108th

    Congress- HR 5, HR 4280; 109th Congress- HR 5; 112th Congress- HR 5.

- CHIP Reauthorization Act of 2007: 110th Congress- HR 3963 (3 votes), HR 976 (3

    votes).

- Medicare Modernization Act of 2003, established Medicare Part D and Medicare

    Advantage programs and other important changes: 108th Congress- HR 1 (2

    votes).

- "Doc Fix" bills temporarily suspending the sustainable growth rate formula

    (SGR), a controversial Medicare provider payment formula: 110th Congress- HR

    6331 (2 Votes); 111th Congress- HR 3961.

- Insurance reform (PAP minor topic code 302) bills from the 108th Congress: HR

    660, HR 2596, HR 4279, HR 4281.

Table B-1: Models of Voting with Democrats on Health Bills by Subtopic, Part 1

	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
Hospital, HMO, Pharma/	0.000	0.000	-0.002*	0.002	0.002	-0.000	-0.000	-0.001	0.002
Device Contributions ($1,000s)	(0.005)	(0.002)	(0.001)	(0.001)	(0.002)	(0.002)	(0.003)	(0.002)	(0.002)
Provider Contributions	0.005	-0.001	0.000	-0.000	0.001	0.001	-0.003	0.000	0.001
($1,000s)	(0.004)	(0.001)	(0.001)	(0.001)	(0.001)	(0.002)	(0.002)	(0.001)	(0.001)
	0.046	-0.066**	0.003	-0.008	-0.058**	-0.005	-0.041	0.010	-0.039*
BCBS Contributions ($1,000s)	(0.066)	(0.022)	(0.015)	(0.016)	(0.022)	(0.032)	(0.043)	(0.027)	(0.019)
		0.298	0.849	-0.265	0.838	1.737	5.453	5.507	0.037
AARP Contributions ($1,000s)		(1.004)	(1.382)	(0.369)	(1.711)	(2.805)	(6.575)	(5.730)	(1.026)
Voter Health Opinion	-0.581*	-0.671**	-0.268**	-0.191*	-0.137	0.111	-0.091	-0.421*	-0.115
	(0.282)	(0.140)	(0.079)	(0.088)	(0.134)	(0.182)	(0.253)	(0.191)	(0.124)
Voter Ideology	0.126	-0.019	-0.106*	0.018	0.020	-0.047	0.334	-0.084	-0.078
	(0.199)	(0.083)	(0.052)	(0.058)	(0.090)	(0.125)	(0.181)	(0.122)	(0.083)
Percent Seniors	-0.008	-0.006	0.033	-0.023	0.009	-0.032	-0.095	-0.039	-0.017
	(0.063)	(0.034)	(0.017)	(0.020)	(0.030)	(0.039)	(0.059)	(0.039)	(0.027)
Percent Uninsured	-0.000	-0.041	-0.034**	-0.008	-0.002	-0.024	0.009	-0.033	-0.014
	(0.038)	(0.021)	(0.011)	(0.013)	(0.020)	(0.027)	(0.039)	(0.028)	(0.018)
Percent Physicians	-1.217	2.091*	0.584	0.825	0.643	0.779	0.707	1.782	1.121
	(1.360)	(0.830)	(0.450)	(0.503)	(0.790)	(1.054)	(1.433)	(1.173)	(0.751)
Percent White	0.022	-0.018*	0.005	0.004	0.001	0.008	-0.003	0.012	0.009
	(0.014)	(0.007)	(0.004)	(0.005)	(0.007)	(0.010)	(0.014)	(0.011)	(0.007)
Percent Hispanic	-0.011	0.022**	0.008*	0.006	-0.014*	0.004	0.003	0.008	-0.007
	(0.013)	(0.007)	(0.004)	(0.004)	(0.007)	(0.009)	(0.013)	(0.010)	(0.006)
Percent HS Only	0.000	-0.006	-0.007	0.006	-0.018	-0.002	0.044	0.018	-0.011
	(0.044)	(0.020)	(0.012)	(0.013)	(0.020)	(0.028)	(0.038)	(0.027)	(0.018)

	1	2	3	4	5	6	7	8	9
Median Income ($1,000s)	-0.035	0.032	0.002	0.027*	-0.005	-0.010	0.026	-0.003	-0.001
	(0.041)	(0.021)	(0.012)	(0.013)	(0.020)	(0.027)	(0.037)	(0.027)	(0.018)
Republican	-0.745	-5.082**	-2.465**	-1.181**	-1.700**	-2.984**	-4.560**	-3.686**	-3.378**
	(0.452)	(0.198)	(0.123)	(0.136)	(0.226)	(0.309)	(0.502)	(0.370)	(0.231)
Party Line Vote		-6.164**	-4.793**	-0.786**	-2.650**	-2.916**	-4.509**	-2.566**	-2.419**
		(0.392)	(0.287)	(0.162)	(0.216)	(0.254)	(0.365)	(0.292)	(0.240)
Legislator Birth Year	-0.006	-0.024**	0.000	0.003	-0.007	-0.010	-0.003	-0.020*	0.003
	(0.016)	(0.007)	(0.004)	(0.005)	(0.007)	(0.010)	(0.014)	(0.009)	(0.006)
Constant	13.512	56.337**	4.330	-4.719	16.941	24.972	12.670	43.422*	0.205
	(31.130)	(14.093)	(8.213)	(9.254)	(13.812)	(19.001)	(26.527)	(18.060)	(12.354)
Observations	809	4,145	8,166	5,414	3,291	2,045	811	1,654	3,725
Pseudo R^2	0.075	0.739	0.476	0.343	0.348	0.443	0.608	0.564	0.510

Note: Topic codes for the table columns are: 1- General (PAP code 300); 2- Comprehensive reform (301); 3- Insurance reform, availability, cost (302); 4- Regulation of drug industry, medical devices, clinical labs (321); 5- Facilities construction, regulation, payments (322); 6- Provider/ insurer payment, regulation (323); 7- Medical liability, fraud, abuse (324); 8- Health manpower, training; 9- Prevention, communicable diseases, health promotion (331). Standard errors in parentheses. * $p < 0.05$, ** $p < 0.01$.

Table B-2: Models of Voting with Democrats on Health Bills by Subtopic, Part 2

	(10)	(11)	(12)	(13)	(14)	(15)	(16)	(17)
Hospital, HMO, Pharma/	0.002	0.003	0.002	-0.002	-0.001	0.003	0.003	-0.004
Device Contributions ($1,000s)	(0.001)	(0.002)	(0.003)	(0.002)	(0.002)	(0.004)	(0.001)	(0.003)
Provider Contributions	-0.000	0.001	-0.002	-0.000	0.000	0.001	-0.001	0.001
($1,000s)	(0.001)	(0.002)	(0.002)	(0.001)	(0.001)	(0.002)	(0.001)	(0.002)
BCBS Contributions ($1,000s)	0.006	-0.012	-0.017	-0.045	0.055	0.061	0.044*	-0.016
	(0.015)	(0.029)	(0.039)	(0.027)	(0.029)	(0.051)	(0.017)	(0.035)
AARP Contributions ($1,000s)	5.899	-0.720*	6.799	1.587			2.888	3.834
	(3.564)	(0.338)	(7.814)	(3.461)			(1.943)	(3.308)
Voter Health Opinion	-0.294**	-0.567**	0.089	-0.024	-0.645**	-0.674**	-0.334**	-0.079
	(0.082)	(0.164)	(0.245)	(0.124)	(0.178)	(0.245)	(0.099)	(0.161)
Voter Ideology	-0.027	0.153	-0.184	-0.060	-0.021	0.018	-0.094	-0.224*
	(0.056)	(0.102)	(0.159)	(0.085)	(0.110)	(0.149)	(0.061)	(0.108)
Percent Seniors	-0.004	0.025	0.073	0.046	0.022	-0.046	0.082**	0.015
	(0.017)	(0.033)	(0.059)	(0.027)	(0.035)	(0.045)	(0.021)	(0.038)
Percent Uninsured	-0.024*	-0.031	-0.047	-0.047*	-0.019	-0.072*	-0.021	-0.038
	(0.012)	(0.023)	(0.038)	(0.019)	(0.025)	(0.035)	(0.014)	(0.024)
Percent Physicians	0.254	-0.103	1.866	1.697*	1.351	0.324	-0.647	1.047
	(0.471)	(0.891)	(1.485)	(0.712)	(1.063)	(1.324)	(0.553)	(0.885)
Percent White	0.016**	-0.014	-0.021	0.001	-0.003	-0.000	-0.012*	0.001
	(0.004)	(0.009)	(0.013)	(0.007)	(0.010)	(0.013)	(0.005)	(0.008)
Percent Hispanic	0.003	0.004	0.019	0.018**	-0.017*	0.025	0.008	0.002
	(0.004)	(0.008)	(0.012)	(0.006)	(0.008)	(0.013)	(0.005)	(0.008)
Percent HS Only	0.029*	0.026	-0.011	0.024	-0.004	0.016	-0.022	-0.005
	(0.012)	(0.024)	(0.035)	(0.018)	(0.026)	(0.035)	(0.014)	(0.023)

Median Income ($1,000s)	0.017	0.000	0.032	0.008	0.031	-0.012	0.048**	-0.025
	(0.012)	(0.023)	(0.036)	(0.019)	(0.024)	(0.034)	(0.015)	(0.025)
Republican	-2.214**	-1.174**	-3.248**	-3.448**	-2.516**	-0.601	-2.286**	-2.397**
	(0.129)	(0.233)	(0.434)	(0.189)	(0.253)	(0.331)	(0.142)	(0.234)
Party Line Vote	-3.116**		-5.693**	-1.405**			-3.346**	-3.663**
	(0.279)		(0.426)	(0.201)			(0.277)	(0.280)
Legislator Birth Year	0.004	-0.002	-0.025	-0.007	-0.014	0.006	-0.007	0.000
	(0.004)	(0.008)	(0.013)	(0.007)	(0.009)	(0.012)	(0.005)	(0.009)
Constant	-5.457	7.488	56.014*	16.034	29.176	-8.009	17.227	5.525
	(8.579)	(16.253)	(25.801)	(13.083)	(16.885)	(23.392)	(10.027)	(17.732)
Observations	5,340	1,631	1,229	2,111	1,189	803	5,787	1,265
Pseudo R-squared	0.306	0.115	0.664	0.419	0.316	0.119	0.485	0.459

Note: Topic codes for the table columns are as follows: 10- Infants, children (PAP code 332); 11- Mental illness and retardation (333); 12- Long-term care, home health, terminally ill, rehabilitation services (334); 13- Prescription drug coverage, costs (335); 14- Tobacco abuse, treatment, education (341); 15- Alcohol/ controlled and illegal drug abuse; 16- Research and development (398); 17- Other (399). Standard errors in parentheses. * $p < 0.05$, ** $p < 0.01$.

Table B-3: Models of Voting with Democrats on Health Bills, Selected Bill Groups

	(1)	(2)	(3)	(4)	(5)	(6)
Industry $	-0.003	0.005*	-0.002	-0.001	-0.006	-0.004
($1,000)	(0.002)	(0.002)	(0.003)	(0.004)	(0.005)	(0.002)
Provider $	0.002	-0.002	-0.006*	0.001	0.001	0.003
($1,000)	(0.002)	(0.002)	(0.002)	(0.002)	(0.002)	(0.002)
BCBS $	-0.044	0.016	-0.088*	-0.082	-0.170**	-0.011
($1,000)	(0.031)	(0.024)	(0.035)	(0.044)	(0.060)	(0.030)
AARP $	0.528		0.531		-3.090	
($1,000)	(1.304)		(2.562)		(3.550)	
Voter Health	-1.021**	-0.675**	-0.304	-0.674**	0.028	-0.544**
Opinion	(0.224)	(0.166)	(0.174)	(0.165)	(0.255)	(0.205)
Voter	-0.043	-0.021	0.152	0.058	-0.286	-0.103
Ideology	(0.124)	(0.104)	(0.118)	(0.108)	(0.173)	(0.127)
Percent	-0.062	0.084*	0.014	0.081	-0.014	0.001
Seniors	(0.054)	(0.033)	(0.042)	(0.044)	(0.059)	(0.041)
Percent	-0.075*	-0.073**	-0.012	-0.055*	-0.005	-0.001
Uninsured	(0.033)	(0.024)	(0.026)	(0.023)	(0.038)	(0.029)
Percent	3.025*	0.643	1.250	0.677	3.723**	0.574
Physicians	(1.295)	(0.996)	(0.992)	(0.911)	(1.401)	(1.193)
Percent	-0.016	-0.000	-0.014	0.003	0.000	0.011
White	(0.011)	(0.009)	(0.010)	(0.008)	(0.015)	(0.011)
Percent	0.031**	0.008	0.011	0.010	0.006	0.009
Hispanic	(0.010)	(0.008)	(0.009)	(0.007)	(0.013)	(0.010)
Percent HS	0.004	0.042	0.001	-0.012	0.005	0.031
Only	(0.031)	(0.023)	(0.025)	(0.024)	(0.038)	(0.030)
Med. Income	0.045	0.059*	0.031	-0.026	0.008	0.040
($1,000s)	(0.033)	(0.023)	(0.026)	(0.026)	(0.039)	(0.028)
Party Line		-1.931**				-2.829**
Vote		(0.223)				(0.290)
Republican	-6.532**	-3.321**	-4.708**	-4.776**	-4.583**	-3.802**
	(0.402)	(0.242)	(0.256)	(0.275)	(0.343)	(0.348)
Legislator	-0.041**	0.000	-0.008	-0.008	0.008	-0.006
Birth Year	(0.011)	(0.008)	(0.009)	(0.010)	(0.014)	(0.010)
Constant	83.391**	0.869	17.350	16.828	-15.002	12.302
	(21.534)	(16.287)	(18.450)	(18.668)	(27.414)	(19.523)
Observations	2,475	1,607	1,685	1,682	850	1,184
Pseudo R²	0.815	0.444	0.621	0.605	0.624	0.450

Note: The column numbers refer to the following bill groups: 1- ACA and related; 2- CHIP Reauthorization Act, 2007; 3- HEALTH Act (medical liability/ tort reform); 4- PAP minor code 302, insurance reform bills, in 108th Congress; 5- Medicare Modernization Act of 2003; 6- "Doc Fix" bills, dealing with the sustainable growth rate formula. The bills contained in these groups are given in the beginning of Appendix B. For the ideology and health opinion variables, higher values are conservative. Standard errors in parentheses. * $p < 0.05$, ** $p < 0.01$.

Appendix C. Supplement to Chapter 3

Descriptive Statistics and Balance Checks

The first three tables in this appendix section contain the distributions for each relevant item in the survey (Table C-1), along with population comparisons where available, and balance checks for the two waves of the sample (Tables C-2 and C-3).

The disparities in sample sizes across treatment groups are a function of the randomization error and resulting setup of the second wave. In order to perform the balance checks necessary to ensure the group assignments could be treated as random, I collected a small number of respondents in the control groups in wave 2 to act as a bridge to the control group respondents in wave 1. Specifically, I collected twice as many treatment group responses as control group responses in wave 2.

Table C-1: Descriptive Statistics

Variable	Freq	%	Pop%	Variable	Freq	%	Pop %
Presidential Approval[a]				**ACA Opinion[e]**			
Approve	434	48.2	46.6	Favorable	489	54.2	46
Neutral	88	9.8	---	Neither	99	11.0	---
Disapprove	378	42.0	43.0	Unfavorable	314	34.8	37
Total	900			Total	902		
Party Identification[b]				**Repeal ACA?[e]**			
Republican	129	14.3	21.2	Repeal all of it	193	21.4	29
Democrat	363	40.3	32.5	Change some	529	58.7	39
Independent/ Other	408	45.3	46.3	Leave as it is	179	19.9	20
Total	900			Total	901		
Political Ideology[b]				**IM: In the Law?**			
Liberal	499	55.5	26.0	Yes	348	78.0	---
Moderate/ Other	214	23.8	42.5	No	26	5.8	---
Conservative	186	20.7	31.5	Not sure	72	16.1	---
Total	899			Total	446		
Race[c]				**IM: Favor or Oppose?**			
White	701	77.9	61.9	Favor	172	38.6	---
All others	199	22.1	38.1	Neither	46	10.3	---
Total	900			Oppose	228	51.1	---
Religion[d]				Total	446		
None	490	54.6	13.2	**IM: Affects You?**			
Christian	310	34.5	82.6	Yes	256	57.4	---
Other	98	10.9	4.2	No	143	32.1	---
Total	898			Not sure	47	10.5	---
News Attentiveness				Total	446		
Very closely	159	17.7	---	**Dep Cov: In the Law?**			
Somewhat closely	434	48.3	---	Yes	327	71.7	---
Not too closely	264	29.4	---	No	12	2.6	---
Not at all	42	4.7	---	Not sure	117	25.7	---
Total	899			Total	456		
Insurance Status[e]				**Dep Cov: Favor or Oppose?**			
Uninsured	173	19.2	15	Favor	373	81.8	---

Private	503	55.9	---		Neither	47	10.3	---
Public	176	19.6	---		Oppose	36	7.9	---
Other/ DK	48	5.3	---		Total	456		
Total	900				**Dep Cov: Affects You?**			
Income[c]					Yes	247	54.3	---
Less than $25,000	239	26.6	*23.1*		No	184	40.4	---
$25,000 - $49,999	300	33.4	*23.5*		Not sure	24	5.3	---
$50,000 or more	360	40.0	*53.4*		Total	455		
Total	899							

Table source notes:

[a] Population estimates obtained from Gallup's Presidential Job Approval Center online tool (Gallup nd). The results for November 24-30, 2014, are reported.

[b] Population estimates obtained from the 2014 GSS (variables partyid and polviews). For the party identification data, I combine independent leaners with independents for both surveys.

[c] Population estimates obtained from the 2014 American Community Survey (single year data), accessed on American Factfinder.

[d] Population estimates obtained from the 2010 wave of the Baylor Religion Survey (Baylor University 2010). The Baylor Survey included many more response options than the MTurk survey.

[e] Population estimates obtained from Kaiser Family Foundation Health Tracking Poll, November 2014 (Kaiser Family Foundation 2014). For the insurance status question, 85% of KFF respondents said they had some form of insurance, but the survey did not ask for specific types of coverage. For the ACA opinion question, no middle response option was given on the KFF poll. For the ACA repeal question, I combined two of KFF's response options ("scale back what the law does," 17%, and "expand what the law does," 22%) to obtain the middle category, "change some of it."

Table C-2: Similarity across Waves: Political and Demographic Variables

	Overall		Wave 1 (Long)		Wave 2 (Short)	
	Freq	**%**	**Freq**	**%**	**Freq**	**%**
President Approval						
Approve	434	48.22	234	46.4	200	50.5
Neither	88	9.8	48	9.5	40	10.1
Disapprove	378	42.0	222	44.1	156	39.4
Total	*900*	*100.0*	*504*	*100.0*	*396*	*100.0*
Chi² statistic (p-value)			*1.983*		*(0.371)*	
Party Identification						
Republican	129	14.3	78	15.5	51	12.9
Democrat	363	40.3	198	39.3	165	41.7
Independent	345	38.3	187	37.1	158	39.9
Something else	63	7.0	41	8.1	22	5.6
Total	*900*	*100.0*	*504*	*100.0*	*396*	*100.0*
Chi² statistic (p-value)			*3.915*		*(0.271)*	
Political Ideology						
Liberal	499	55.5	271	53.9	228	57.6
Moderate	190	21.1	96	19.1	94	23.7
Conservative	186	20.7	119	23.7	67	16.9
Other	24	2.7	17	3.4	7	1.8
Total	*899*	*100.0*	*503*	*100.0*	*396*	*100.0*
Chi² statistic (p-value)			*9.835*		*(0.020)*	
Race						
White	701	77.9	394	78.2	307	77.5
African American	51	5.7	31	6.2	20	5.1
Latino/ Hispanic	51	5.7	30	6.0	21	5.3
Asian/ SE Asian/ Indian	81	9.0	41	8.1	40	10.1
Other	16	1.8	8	1.6	8	2.0
Total	*900*	*100.0*	*504*	*100.0*	*396*	*100.0*
Chi² statistic (p-value)			*1.837*		*(0.766)*	

Religion						
None	490	54.6	262	52.2	228	57.6
Christian	310	34.5	186	37.1	124	31.3
Other	98	10.9	54	10.8	44	11.1
Total	*898*	*100.0*	*502*	*100.0*	*396*	*100.0*
Chi^2 statistic (p-value)			*3.314*		*(0.191)*	

News Attentiveness						
Very closely	159	17.7	102	20.3	57	14.4
Somewhat closely	434	48.3	239	47.5	195	49.2
Not too closely	264	29.4	141	28.0	123	31.1
Not at all	42	4.7	21	4.2	21	5.3
Total	*899*	*100.0*	*503*	*100.0*	*396*	*100.0*
Chi^2 statistic (p-value)			*5.770*		*(0.123)*	

Insurance Status						
Uninsured	173	19.2	98	19.4	75	18.9
Employer	399	44.3	230	45.6	169	42.7
Private	104	11.6	61	12.1	43	10.9
Public	176	19.6	90	17.9	86	21.7
Other/ DK	48	5.3	25	5.0	23	5.8
Total	*900*	*100.0*	*504*	*100.0*	*396*	*100.0*
Chi^2 statistic (p-value)			*2.753*		*(0.600)*	

Income						
Less than $15,000	110	12.2	51	10.1	59	14.9
$15,000 - $24,999	129	14.3	74	14.7	55	13.9
$25,000 - $34,999	134	14.9	69	13.7	65	16.4
$35,000 - $49,999	166	18.5	94	18.7	72	18.2
$50,000 - $74,999	208	23.1	128	25.4	80	20.2
$75,000 - $99,999	81	9.0	47	9.3	34	8.6
$100,000 or more	71	7.9	40	8.0	31	7.8
Total	*899*	*100.0*	*503*	*100.0*	*396*	*100.0*
Chi^2 statistic (p-value)			*8.099*		*(0.231)*	

Note: Many of the response categories have been collapsed for presentation purposes. Percentages may not sum to 100 due to rounding. The Chi^2 statistics are results of a test for dependence between the survey form/ wave and the specified variables. These statistics indicate there is no dependence on survey wave for most of these variables,

with the exception of ideology. That dependence disappears when testing alternate specifications of the variable (not shown).

Table C-3: Similarity across Waves: ACA and Provision Opinion Data

	Overall		Wave 1 (Long)		Wave 2 (Short)	
	Freq	**%**	**Freq**	**%**	**Freq**	**%**
ACA Opinion						
Very favorable	113	12.5	56	11.1	57	14.4
Moderately favorable	197	21.8	109	21.5	88	22.2
Slightly favorable	179	19.8	103	20.4	76	19.2
Neither	99	11.0	59	11.7	40	10.1
Slightly unfavorable	95	10.5	51	10.1	44	11.1
Moderately unfavorable	113	12.5	71	14.0	42	10.6
Very unfavorable	106	11.8	57	11.3	49	12.4
Total	*902*	*100.0*	*506*	*100.0*	*396*	*100.0*
Chi² statistic (p-value)			*5.191*		*(0.520)*	
Repeal ACA?						
Repeal all of it	193	21.4	118	23.4	75	18.9
Change some, leave rest	529	58.7	292	57.8	237	59.8
Leave the whole law as it is	179	19.9	95	18.8	84	21.2
Total	*901*	*100.0*	*505*	*100.0*	*396*	*100.0*
Chi² statistic (p-value)			*2.830*		*(0.243)*	
IM: In the law?						
Yes	348	78.0	195	78.0	153	78.1
No	26	5.8	15	6.0	11	5.6
Not sure	72	16.1	40	16.0	32	16.3
Total	*446*	*100.0*	*250*	*100.0*	*196*	*100.0*
Chi² statistic (p-value)			*0.036*		*(0.982)*	
IM: Favor/ oppose?						
Strongly favor	26	5.8	18	7.2	8	4.1
Favor	69	15.5	36	14.4	33	16.8
Slightly favor	77	17.3	38	15.2	39	19.9
Neither	46	10.3	22	8.8	24	12.2
Slightly oppose	76	17.0	48	19.2	28	14.3

Oppose	59	13.2	35	14.0	24	12.2
Strongly oppose	93	20.9	53	21.2	40	20.4
Total	*446*	*100.0*	*250*	*100.0*	*196*	*100.0*
Chi² statistic (p-value)			*6.769*		*(0.343)*	

IM: Affects you?

Yes	256	57.4	142	56.8	114	58.2
No	143	32.1	82	32.8	61	31.1
Not sure	47	10.5	26	10.4	21	10.7
Total	*446*	*100.0*	*250*	*100.0*	*196*	*100.0*
Chi² statistic (p-value)			*0.142*		*(0.931)*	

Dep: In the law?

Yes	327	71.7	176	68.8	151	75.5
No	12	2.6	6	2.3	6	3.0
Not sure	117	25.7	74	28.9	43	21.5
Total	*456*	*100.0*	*256*	*100.0*	*200*	*100.0*
Chi² statistic (p-value)			*3.298*		*(0.192)*	

Dep: Favor/ oppose?

Strongly favor	183	40.1	93	36.3	90	45.0
Favor	128	28.1	70	27.3	58	29.0
Slightly favor	62	13.6	39	15.2	23	11.5
Neither	47	10.3	30	11.7	17	8.5
Slightly oppose	14	3.1	9	3.5	5	2.5
Oppose	13	2.9	9	3.5	4	2.0
Strongly oppose	9	2.0	6	2.3	3	1.5
Total	*456*	*100.0*	*256*	*100.0*	*200*	*100.0*
Chi² statistic (p-value)			*6.181*		*(0.403)*	

Dep: Affects you?

Yes	247	54.3	131	51.4	116	58.0
No	184	40.4	110	43.1	74	37.0
Not sure	24	5.3	14	5.5	10	5.0
Total	*455*	*100.0*	*255*	*100.0*	*200*	*100.0*
Chi² statistic (p-value)			*2.002*		*(0.368)*	

Note: "IM" indicates the individual mandate questions. "Dep" indicates questions about the dependent coverage provision. All categories in this table are as they appeared on the survey. Percentages may not sum to 100 due to rounding. The Chi² statistics are

results of a test for dependence between the survey form/ wave and the specified variables. These statistics indicate there is no dependence on survey wave for any of these variables.

Analysis Tables

The next set of tables (C-4 through C-8) give full results of the analyses summarized in chapter 3, as well as some robustness checks mentioned in the text.

Table C-4: Means and T-tests

Policy	Opinion of Policy	Total N (primed)	Change in ACA Opinion	T-Stat	P-Value
Individual Mandate	**Overall**	**446 (124)**	**-0.060**	**-1.127**	**0.261**
	Favor	172 (54)	-0.021	-0.374	0.709
	Do Not Favor	274 (70)	-0.161	-2.711	0.007
Dependent Coverage Provisions	**Overall**	**456 (129)**	**0.163**	**3.219**	**<0.001**
	Favor	373 (108)	0.125	2.346	0.020
	Do Not Favor	83 (21)	0.283	2.609	0.011

Note: Dependent variable is binary, with 1 = favorable toward ACA and 0 = neutral or unfavorable toward ACA.

Table C-5: OLS Models of ACA Opinion, Individual Mandate Groups

Variables	(1) Primed	(2) Unprimed	(3) Difference
Individual Mandate Opinion (1-7)	0.506**	0.367**	0.139
	(0.0627)	(0.0400)	(0.077)
Presidential Approval (1-7)	-0.435**	-0.410**	-0.025
	(0.0636)	(0.0467)	(0.082)
Party ID (Baseline = Independent)			
Republican	0.599	-0.577*	1.176**
	(0.305)	(0.226)	(0.392)
Democrat	0.400	0.0260	0.374
	(0.269)	(0.152)	(0.322)
Other	0.784	-0.0911	0.876
	(0.516)	(0.245)	(0.598)
Ideology (Baseline = Moderate)			
Liberal	0.0761	0.395*	-0.318
	(0.257)	(0.168)	(0.318)
Conservative	-0.270	-0.296	0.025
	(0.291)	(0.213)	(0.373)
Other Ideology	-1.007	0.119	-1.125
	(0.738)	(0.421)	(0.885)
Constant	3.635**	4.513**	-0.878
	(0.464)	(0.330)	(0.589)
Observations	124	321	445
Adjusted R-squared	0.763	0.697	0.717
F-test for difference of models			2.64**

Note: Dependent variable is seven-point scale, ranging from very unfavorable to very favorable opinion of ACA. Standard errors in parentheses. ** $p<0.01$, * $p<0.05$.

Table C-6: OLS Models of ACA Opinion, Dependent Coverage Provisions

Variables	(1) Primed	(2) Unprimed	(3) Difference
Dependent Coverage Opinion (1-7)	0.182*	0.190**	-0.008
	(0.0912)	(0.0511)	(0.103)
Presidential Approval (1-7)	-0.450**	-0.546**	0.096
	(0.0806)	(0.0477)	(0.092)
Party ID (Baseline = Independent)			
Republican	0.00522	0.217	-0.212
	(0.516)	(0.259)	(0.567)
Democrat	0.472	0.407*	0.065
	(0.286)	(0.183)	(0.335)
Other	0.682	-0.109	0.791
	(0.496)	(0.269)	(0.554)
Ideology (Baseline = Moderate)			
Liberal	0.257	0.595**	-0.338
	(0.336)	(0.224)	(0.398)
Conservative	-0.603	-0.465	-0.138
	(0.549)	(0.248)	(0.591)
Other Ideology	0.113	-0.0884	0.201
	(0.750)	(0.406)	(0.838)
Constant	5.260**	4.957**	0.303
	(0.716)	(0.430)	(0.822)
Observations	129	325	454
R-squared	0.458	0.620	0.594
F-test for difference of models			0.93

Note: Dependent variable is seven-point scale, ranging from very unfavorable to very favorable opinion of ACA. Standard errors in parentheses. ** p<0.01, * p<0.05.

Table C-7: Ordered Logit Models of ACA Opinion, Individual Mandate Groups

Variables	(1) Primed	(2) Unprimed	(3) Difference
Individual Mandate Opinion (1-7)	1.000**	0.696**	0.305
	(0.143)	(0.084)	(0.157)
Presidential Approval (1-7)	-0.704**	-0.709**	-0.005
	(0.136)	(0.093)	(0.160)
Party ID (Baseline = Independent)			
Republican	1.082	-1.061*	2.143**
	(0.621)	(0.422)	(0.755)
Democrat	0.464	0.003	0.466
	(0.515)	(0.160)	(0.583)
Other	0.892	-0.091	0.983
	(1.135)	(0.441)	(1.217)
Ideology (Baseline = Moderate)			
Liberal	0.363	0.685*	-0.321
	(0.501)	(0.298)	(0.582)
Conservative	-0.535	-0.381	-0.153
	(0.578)	(0.379)	(0.690)
Other Ideology	-1.738	0.191	-1.929
	(1.201)	(0.730)	(1.406)
Observations	124	321	445
Pseudo R-squared			0.320
Chi^2 test for difference of models			19.12**

Note: Dependent variable is seven-point scale, ranging from very unfavorable to very favorable opinion of ACA. Partisan independents excluded as baseline. Ordered logit cut-points not shown. Coefficients are changes in logged odds (logit coefficients). Standard errors in parentheses. ** $p<0.01$, * $p<0.05$.

Table C-8: Ordered Logit Models of ACA Opinion, Dependent Coverage Groups

Variables	(1) Primed	(2) Unprimed	(3) Difference
Dependent Coverage Opinion (1-7)	0.371**	0.314**	0.056
	(0.135)	(0.079)	(0.155)
Presidential Approval (1-7)	-0.727**	-0.833**	0.106
	(0.131)	(0.082)	(0.082)
Party ID (Baseline = Independent)			
Republican	-0.025	0.192	-0.216
	(0.729)	(0.386)	(0.824)
Democrat	0.889*	0.594*	0.295
	(0.413)	(0.272)	(0.492)
Other	1.041	-0.222	1.264
	(0.720)	(0.411)	(0.829)
Ideology (Baseline = Moderate)			
Liberal	0.113	0.757*	-0.644
	(0.490)	(0.320)	(0.585)
Conservative	-0.775	-0.609	-0.166
	(0.771)	(0.363)	(0.851)
Other Ideology	0.109	-0.472	0.581
	(1.572)	(0.644)	(1.698)
Observations	129	325	454
R-squared			0.239
Chi² test for difference of models			2.76

Note: Dependent variable is seven-point scale, ranging from very unfavorable to very favorable opinion of ACA. Partisan independents excluded as baseline. Ordered logit cut-points not shown. Coefficients are changes in logged odds (logit coefficients). Standard errors in parentheses. ** $p<0.01$, * $p<0.05$

Survey Instrument

Below are the survey questions and instructions seen by the respondents, as well as material used to recruit respondents on Amazon MTurk. The survey itself was fielded using Qualtrics; prospective respondents were given a link on MTurk to the Qualtrics survey site. At the end of the survey, they were given a unique code to enter on MTurk in order to receive compensation. The logistics of compensation was handled by DISM. I have no links to compensation data, nor did I have any role in authorizing the disbursement of compensation money. Text in *[brackets and italics]* was not seen by the respondent, and indicates special coding instructions and other information.

Recruiting Information on MTurk:

Description: Share your opinions by taking a survey

Instructions: This task requires completing a brief survey in which you will share your opinions about various topics. You will also read and respond to several brief news articles. The survey will take about 8 minutes *[2-3 for the short form]* to complete. Your answers are entirely anonymous and will be kept confidential. To proceed, please:

1. Click the link provided below. This will direct you to a secure, confidential, and entirely anonymous external site.

2. Upon completing the survey, you will see a randomly generated number. Return here and enter the number in the text box provided. Your work will be rejected if

you take less than 4 minutes to complete the survey *[this restriction was not placed on the short form]*, so please take your time and answer each question to the best of your ability.

Reward: $0.40

Time Allotted: 20 minutes *[this is a maximum time allowed for completion of the task; the average completion times was under 7 minutes for the long form.]*

Qualifications Required: Location is in the US, 95% approval rate, must be at least 18 years of age to participate.

<u>Survey Instrument:</u>

[consent] Thank you for your interest in this research study. Please read the following information and click the button below to signify your consent to participate and begin the study.

<u>Title of Study:</u> Politics and Public Opinion

<u>What you will be asked to do:</u> If you consent to participate in this study, you will be asked a series of questions on various topics that you may read about in a newspaper or hear in the news. You may be asked to read an article and answer questions about it *[this sentence was removed from the short form of the survey, since it only applied to the other two survey experiments]*. In addition, you will be asked to answer some basic demographic

questions about yourself. Participation in the study will take about 8 minutes of your time.

Rights: Participation in this study is completely **voluntary**. You may choose to withdraw from the study at any time for any reason.

Benefits and Risks: There are no direct benefits or any anticipated risks associated with your involvement in this study.

Compensation: If you choose to participate in this study, you will receive $0.40. To receive compensation, you must complete the study, although you are free to skip any questions you do not want to answer.

Confidentiality: Your responses to all survey questions will be kept completely **anonymous**. The researcher has no way of knowing your identity and cannot connect your responses to you.

IRB: If you have any concerns about your rights as a participant in this study, you may contact the Chair of the Human Subjects Committee (Institutional Review Board) at ors-info@duke.edu. Please reference IRB Study #C0686 in your communication with the IRB.

Questions and Additional Information: If you have any questions about this study, please contact the researchers. Robert Richards can be reached by e-mail at robert.richards@duke.edu, Angel Mira can be contacted at angel.mira@duke.edu, and Jian Xu can be contacted at djian.xu@duke.edu.

By clicking on the NEXT button and completing this survey, you give your consent to participate in this study.

[page break]

[instruct] Thank you for participating in the study. You will be asked a series of questions about various topics in the news. Please answer the questions to the best of your ability, but if you are not able to answer a question for any reason, you may skip it and move on. At some points in the survey, you will also be asked to read some brief news articles *[this sentence was removed from the short version]*. You will not be able to use the "back" button on your browser.

As you may know, a health reform bill known as the Affordable Care Act (ACA) or Obamacare was signed into law in 2010. The first few questions you will see are about this law.

[page break]

[Ideally, randomization of the following groups of questions took place as follows: <aca> and <repeal were shown first for half the sample, followed by questions about a specific policy in the ACA, either individual mandate (<im_know>, <im_op>, and <im_affect>) or coverage of young adults (<ya_know>, <ya_op>, and <ya_affect>). For the other half, <aca> and <repeal> came after the three specific questions about one specific ACA policy (again, the policy is randomly assigned within this group). Half the sample will see each policy. This gives rise to four experimental treatments: General approval followed by individual mandate Qs, general approval followed by

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coverage of young adults Qs, individual mandate Qs followed by general approval, and coverage

of young adults Qs followed by general approval. The randomization failure is explained in the

main body of this paper.]

[aca] Given what you know about the health reform law, do you have a generally

favorable or generally unfavorable opinion of it?

   ○ Very favorable (1)

   ○ Moderately favorable (2)

   ○ Slightly favorable (3)

   ○ Neither favorable nor unfavorable (4)

   ○ Slightly unfavorable (5)

   ○ Moderately unfavorable (6)

   ○ Very unfavorable (7)

[page break]

[repeal] Going forward, what do you think Congress should do about the health reform

law?

   ○ Repeal all of it (1)

   ○ Change some parts, but leave the rest in place (2)

   ○ Leave the whole law as it is (3)

[page break]

[im_know] While Congress was debating the health reform law, it was proposed that the law include an individual mandate, which would require almost all Americans to have health insurance or face paying a fine. To the best of your knowledge, did this proposal make it into the final version of the law?

◯ Yes (1)

◯ No (2)

◯ Not sure (3)

[page break]

[im_op] Do you favor or oppose a law requiring almost all Americans to purchase health insurance?

◯ Strongly favor (1)

◯ Favor (2)

◯ Slightly favor (3)

◯ Neither favor nor oppose (4)

◯ Slightly oppose (5)

◯ Oppose (6)

◯ Strongly oppose (7)

[page break]

[im_affect] Would an individual insurance requirement, as described in the previous questions, directly affect you or someone close to you?

○ Yes (1)

○ No (2)

○ Not sure (3)

[page break]

[ya_know] While Congress was debating the health reform law, it was proposed that the law allow young adults to remain on their parents' insurance plans until age 26. To the best of your knowledge, did this proposal make it into the final version of the law?

○ Yes (1)

○ No (2)

○ Not sure (3)

[page break]

[ya_op] Do you favor or oppose allowing young adults to remain on their parents' plans until age 26?

○ Strongly favor (1)

○ Favor (2)

○ Slightly favor (3)

○ Neither favor nor oppose (4)

○ Slightly oppose (5)

○ Oppose (6)

○ Strongly oppose (7)

[page break]

[ya_affect] Would a policy extending the length of time young adults can keep their parents' insurance, as described in the previous questions, directly affect you or someone close to you?

○ Yes (1)

○ No (2)

○ Not sure (3)

[page break]

[The other two survey experiments occurred at this point in the long version of the survey. Details on those are available from the author. After completing both of those experiments, respondents moved into the demographics portion of the survey. Respondents to the short version moved immediately into the demographics.]

[demog] Thank you for your responses so far.

Finally, we have just a few brief questions about you. These will be used for statistical purposes only.

[page break]

[pres_app] Generally speaking, would you say you approve or disapprove of the way Barack Obama is handling his job as president?

○ Strongly approve (1)

○ Approve (2)

○ Somewhat approve (3)

○ Neither approve nor disapprove (4)

○ Somewhat disapprove (5)

○ Disapprove (6)

○ Strongly disapprove (7)

[page break]

[pid] Generally speaking, do you usually think of yourself as a Republican, a Democrat, an Independent, or what?

○ Republican (1)

○ Democrat (2)

○ Independent (3)

○ Something else (4)

[page break]

[Respondents only saw the party ID followup corresponding to their answer to the first party ID question, <pid> above.]

[pid_ind] Do you think of yourself as closer to the Republican Party or to the Democratic Party?

○ Closer to the Republican Party (1)

○ Closer to the Democratic Party (2)

○ Neither (3)

[pid_txt] What is that? _____

[pid_r] Would you call yourself a strong Republican or a not very strong Republican?

    ○ Strong Republican (1)

    ○ Not very strong Republican (2)

[pid_d] Would you call yourself a strong Democrat or a not very strong Democrat?

    ○ Strong Democrat (1)

    ○ Not very strong Democrat (2)

[page break]

[ideology] We hear a lot of talk these days about liberals and conservatives. Where would you place YOURSELF on this scale, or haven't you thought much about this?

    ○ Extremely liberal (1)

    ○ Liberal (2)

    ○ Slightly liberal (3)

    ○ Moderate, middle of the road (4)

    ○ Slightly conservative (5)

    ○ Conservative (6)

    ○ Extremely conservative (7)

    ○ Don't know, haven't thought about it (8)

[page break]

[race_ident] Please indicate which of the following racial categories you most identify

with:

- ○ White (1)

- ○ African American (2)

- ○ Latino/Hispanic Origin (3)

- ○ Asian/ Southeast Asian/ Indian (4)

- ○ Other (5) _____

[page break]

[religion] Of the following, which best describes your religious affiliation?

- ○ None (1)

- ○ Protestant Christian (2)

- ○ Catholic (3)

- ○ Jewish (4)

- ○ Muslim (5)

- ○ Hindu (6)

- ○ Other (please specify) (7) _____

[page break]

[attentive] Thinking about your day to day life, how closely would you say you follow

news about world affairs and foreign policy issues--would you say you follow it very

closely, somewhat closely, not too closely, or not at all?

○ Very closely (1)

○ Somewhat closely (2)

○ Not too closely (3)

○ Not at all (4)

[page break]

[ins_stat] What is your current health insurance status today?

○ Do not have insurance (1)

○ Have insurance through employer/ work/ school (2)

○ Privately purchased insurance (3)

○ Medicare (4)

○ Medicaid (5)

○ Insured by military/ TRICARE (6)

○ Other public/ government/ state sponsored insurance (7)

○ Something else (8)

○ Don't know (9)

[page break]

[income] Considering all sources of income and all salaries, please indicate what your

household's total annual income in 2013 was before taxes:

○ Less than $15,000 (1)

○ $15,000 - $24,999 (2)

❍ $25,000 - $34,999 (3)

❍ $35,000 - $49,999 (4)

❍ $50,000 - $74,999 (5)

❍ $75,000 - $99,999 (6)

❍ $100,000 or more (7)

[page break]

[comment] If you have any comments about the survey, please enter them below.

Otherwise, click next to finish the survey.

[text entry box for comments]

[end of survey; Respondents were next routed to a screen thanking them for their responses and giving them their unique compensation code. In the long form, this page also included a debrief on the deception used in the other two survey experiments.]

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Biography

Robert Richards was born on December 9, 1988, in Pembroke Pines, FL. He attended Brigham Young University as a Gordon B. Hinckley Presidential Scholar (awarded by BYU) and a National Merit Scholar from 2007-2013 (including two years of missionary service in upstate New York from 2008-2010). He graduated *magna cum laude* from BYU with a Bachelor of Arts in Political Science and a minor in Psychology. Upon graduating from BYU, Robert entered the PhD program in Public Policy at Duke University's Sanford School of Public Policy. In 2015, Robert published a co-authored peer-reviewed article with Chris Conover in *Nursing Outlook* entitled "Economic Benefits of Less Restrictive Regulation of Advanced Practice Registered Nurses in North Carolina." He was awarded a competitive Graduate School Summer Fellowship for the summer of 2015, and was awarded first place in the Prothro Graduate Student Paper Competition for best student paper submitted to the Southern Association of Public Opinion Researchers in October 2015. Robert is a graduate student fellow at the Duke Initiative on Survey Methodology.