

Cross Pressures

THE CONTEMPORARY POLITICS OF HEALTH REFORM



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*T*he past decade has witnessed some amazing twists and turns in U.S. health care politics. Starting in 1993, President Bill Clinton attempted to push through a comprehensive reform that would have guaranteed health insurance to all Americans, extending coverage to low-wage workers who predominated in the ranks of the uninsured. Yet within a year, public opinion turned as interest groups and partisan forces mobilized against the reform proposals, leading Clinton to abandon them (Broder and Johnson 1996; Skocpol 1997). After the 1994 midterm elections, Republicans took control of Congress and redefined health care reform to mean containing costs and restructuring Medicaid and Medicare. But Republican proposals, too, proved unpopular and largely failed (Peterson 1998).

Health reform proposals then concentrated on incremental adjustments until 2003, when Republicans in control of the presidency and both houses of Congress just barely pushed through a major enhancement and restructuring of the Medicare program, which covers 40 million elderly and disabled Americans (on the politics of this episode, see Skocpol 2004). In one of the most extraordinary episodes in U.S. health care politics, Republicans sponsored the addition of a prescription drug benefit to Medicare, a public-sector program they had long questioned, while most Democrats criticized and opposed the legislation even though it mandated expanded benefits.

How are we to understand the contemporary politics of health reform? How do issues rise on the agenda, and what forces determine the shape and fate of legislative proposals? We use insights from political science research on agenda setting and policymaking to examine key episodes and trends, especially the Clinton health reform episode of 1993–1994, the attempted Republican cutbacks of the mid-1990s, and the enactment of Medicare restructuring in 2003. Proposed reforms that make headway, we argue, build on existing public-private arrangements and are more likely to be successfully enacted if they are inherently ambiguous and stress benefits and subsidies rather than cost-constricting regulations or funding cuts. We then draw upon knowledge of past episodes to speculate about the future course of health reform politics.

A Perspective on Reform Episodes

Health reform is inherently multidimensional. Reform can be defined to the public in terms of new benefits, effects on existing benefits, coverage expansions, cost reductions, access to new medical treatments, balance between government role and market-based approaches, effects on small businesses, and so forth. Because of the many dimensions to health reform issues, shifts in definition can create unexpected swings in the direction of policymaking.

The multidimensionality of health care issues—along with the public-private nature of U.S. health care financing and delivery systems—means that major bills are often highly complex. It is not uncommon for major reform proposals to include provisions that simultaneously attempt to expand coverage, contain costs, and address the quality of care—not to mention provisions designed to appeal to policymakers holding diametrically opposed preferences about markets and government. Complexity and ambiguity are necessary to forge compromises in the U.S. political system, which allows many players to exert vetoes as legislation proceeds. Yet when legislation addresses multiple aspects of an issue, it can also become increasingly tricky to reach closure. Choices regarding which element to address first create more avenues for strategic maneuvering, affecting possibilities for success and leading to continuing struggles in the aftermath of both enacted and failed legislation.

Moreover, reform attempts “feed back” into future politics (Hacker 2002; Pierson 2000). However they turn out, reform episodes affect balances of political power, which in turn influence the types of reforms next debated. New interest groups may be activated and new stakes defined. Large-scale health reforms can also alter balances of partisan power. For example, the defeat of the 1993–1994 Clinton plan helped propel Republicans back into control of the House of Representatives for the first time in four decades.

We posit three key phases during episodes of health reform: getting issues onto the agenda, debating policy, and producing outcomes. This analysis enables us to identify when and how key political factors come into play (for further elaborations, see Baumgartner and Jones 1993; Downs 1972; and Kingdon 1995). Early in a reform episode, for example, public opinion typically favors changes, especially those that improve benefits. But once policy debates begin, interest groups and partisan forces can sway public opinion in new directions.

The Public’s Influence

Because of persistent trends in the health care system—including increases in the numbers of the uninsured and rising premium and prescription drug costs—the public has favored extending insurance coverage for some time. At any given juncture, specific concerns may vary by subgroup and focus on lack of insurance, costs to those who are covered, or scope of coverage. As they become salient, these public concerns influence the reform possibilities discussed by politicians and help set the legislative agenda.

Coverage and costs were the key public concerns in the early 1990s, when an economic downturn threatened the insurance coverage of many middle-class Americans, even as the rising cost of private insurance greatly concerned employers. The Clinton proposals aimed to address such concerns by linking cost controls and new guarantees for the middle class to coverage extensions for the uninsured. By the mid-1990s, concerns about reducing the federal budget deficit had become salient among much of the U.S. voting public. After capturing control of Congress in 1994, Republicans attempted to link Medicare and Medicaid “reforms” to cutbacks in public spending, which would, they said, help reduce the deficit.

More recently, politicians have focused on another public concern: the adequacy of Medicare in an era when prescription drugs have become central to health care. The needs of low-wage workers without any health insurance coverage are arguably much greater than the needs of elderly Americans for cheaper prescription drugs, as only about a quarter of the elderly lack drug coverage of any kind. Nevertheless, elderly concerns tend to weigh heavily with office-seeking politicians. The elderly are especially attentive to politics, and older voters of all income levels participate in elections at higher levels than their younger counterparts (Campbell 2003). Older voters are a swing constituency vital to both parties, constituting about 25 percent of voters in presidential elections and about 30 percent of voters in off-year congressional contests.

When elderly concerns about paying for prescription drugs grew acute in the 1990s and early 2000s, therefore, office-seeking politicians of both parties paid attention. Indeed, President George W. Bush convinced conservative Republicans, normally opposed to public entitlements, to vote for the Medicare prescription drug benefit in 2003. Republicans believe that denying Democrats an advantage with elderly voters may be the key to retaining governing power in the years ahead.

In short, public concerns spur politicians to keep talking about extending health insurance coverage or other apparently popular goals, especially in election or pre-election years. Nevertheless, as major debates unfold opponents of change can also gain leverage with public opinion. Once proposals begin to move through Congress, considerations apart from simple public hopes play an equal or greater role—especially partisanship, interest group activity, pre-existing institutional arrangements, and budget considerations. As such factors come to the fore, public support for legislative innovations may wane, especially if there are competing proposals for reform or debates switch to a focus on possible cuts in existing benefits.

Such influences certainly sparked shifts in public opinion during the 1993–1994 debates over the Clinton health plan, when the middle class worried that comprehensive reform might threaten existing health insurance (Blendon 1995; Jacobs and Shapiro 2000). During the mid-1990s, Republican proposals for cutbacks in Medicare spending via provider payment reductions also backfired when President Clinton gained popularity after suggesting other means of reducing deficits. Public preferences for benefits thus trumped any general desire for restrained federal spending.

Changes in the focus of debates and accompanying shifts in public opinion were also discernible in the 2003 Medicare reform episode. Even though this legislation passed, public doubts grew as opponents pointed out the gaps in prescription drug coverage and highlighted the ways the new law might undermine broader guaranteed coverage in Medicare. The elderly had high hopes for adding a prescription drug benefit to Medicare (*Washington Post/Kaiser/Harvard* 2002). But by the time the legislation was on the verge of passing, a clear majority of Americans over age fifty opposed it (National Annenberg Election Survey 2003; Skocpol 2003) and doubts remained after the law was enacted (Milbank and Deane 2003). While shifts in public opinion helped to block enactment of major reforms in 1993–1994 and 1995, this time Congress acted before public worries became obvious. Yet public disillusionment may still matter in future skirmishes over issues that the legislation leaves unresolved.

The Role of Parties and Ideology

U.S. parties and legislators approach health reform issues with ideological preferences as well as concerns about elections and public constituencies. In health care, a major source of disagreement concerns the role of government in America's complex and mixed public-private system of health care financing. Liberals want to expand government guarantees and regulations because they believe that competing private insurers, left to their own devices, will tend to exclude sick or costly people. Conservatives, in contrast, believe that market competition maximizes choice and should ultimately lower costs, or at least shift them toward individuals who can make choices and trade-offs.

In recent times, ideological polarization between activists and members of Congress affiliated with the two major parties has grown considerably (Fiorina 2002, 526, figure 4; Poole and Rosenthal 2001). Although the parties are relatively evenly balanced in Congress as well as among the electorate, this polarization means that slight shifts in power can make a big difference in the shape of compromises as well as the chances for legislative success.

Enacted health care reforms tend to reflect complex compromises between public guarantees and private provision. Nevertheless, the party in power sets the framework that governs such compromises. In 1993, President Clinton and congressional Democrats tried to work out a middle-of-the-road system for universal coverage that relied on private insurers and the employer-based insurance system. Still, they aimed for an overarching framework of public guarantees, regulations, and cost containment. In contrast, during the 2003 Medicare reform episode, Republicans tried—and to some degree succeeded—in making the prescription drug benefit conditional on new subsidies for private market forces in Medicare.

Despite these considerations, there are forces that cut against ideological and partisan polarization. Ideology still varies to some degree within each major party, for example, perhaps especially in the Democratic Party, where politicians favoring market competition in public programs coexist with others who would like a unified “single-payer” health insurance system financed entirely through taxation.

Constituency pressures on elected officials also cut across the partisan divide and force them to veer from ideological preferences, especially among Republicans. Regardless of party, for example, legislators from rural areas have distinct goals from those from more populated areas. There may be only one or a few insurance providers in any given rural area; private managed care may remain undeveloped; and rural hospitals struggle to provide comprehensive, convenient services to sparse and often aging populations. Even conservative Republicans may see more limited possibilities for unfettered market competition in such circumstances. Legislators from rural areas thus demand increasing payment rates for rural providers, and the 2003 Medicare legislation could not have passed if it had not included such subsidies.

The Power of Interest Groups

A crowded universe of interest groups also shapes attempts at health care reform, with some groups likely to help set agendas and others more likely to quietly influence the details of legislation.

Since the 1960s, interest groups of many kinds have proliferated in the United States (Berry 1997). Such proliferation has been especially marked in the health care arena—in large part because of increases in federal regulation and spending (Peterson 1993; Skocpol 2003, 146–147, table 4.2; Walker 1991). A rise in the number of public interest groups representing health care consumers creates new capacity for pushing health-related issues onto the public agenda. Nevertheless, professionals run many such public interest groups out of national offices. They may be good at putting problems on the agenda, but they do not usually have the organizational infrastructure or reach to pull millions of citizens into active lobbying on behalf of health care reform (Skocpol 2003). Thus popular issues may appear on the agenda, but lack staying power when ideological divisions occur or opposing interest groups mobilize (cf. Skocpol 1997 for the story of how this happened in the 1993–1994 Clinton health reform episode).

Interest groups representing providers, medical manufacturers, and health insurers have also multiplied. Business groups are highly organized in very specialized ways and they may see huge stakes in even slight adjustments of federal subsidies or regulations. Depending on the issue, the strategies of these groups can range from behind-the-scenes negotiations to increasingly sophisticated public campaigns.

The Clinton health reform episode opened a new chapter in the strategic use of technologies by provider, manufacturer, and insurance groups to reach the general public, key legislators, and grassroots supporters (Broder and Johnson 1996). These groups are often able to affect the details of proposed new legislation as it works its way through congressional committees. Interest-group brokered compromises often increase the complexity and opacity of health care legislation, making it hard for the general public to follow the debate and outcome (Pear and Toner 2003). Pressure from provider and insurance groups may also increase the likelihood that reform proposals will contain expensive subsidies and weak federal regu-

latory authority, because business interests are looking for profits and room to maneuver in the marketplace.

The Ironies of Budget Politics

Budget constraints have been an almost constant factor in health reform politics since the 1970s. Medical care spending consumes a growing share of federal and state budgets and employer payroll expenses. Congressional rules requiring the “costing out” of reform proposals ensure that their costs play a role in the policy debate. Further complicating matters is the fact that, while budgetary pressures concern policymakers, cost containment is not popular with the public and is often opposed by provider interests as well.

For ideological reasons, politicians disagree about preferred responses to rising costs. Liberals believe in using public clout to control costs, while conservatives favor market competition. Policy experts—including those who share policy goals—may also disagree regarding preferred approaches because of the difficulty of assessing how markets work under imperfect competitive conditions. Ironically, all these cross pressures produce a situation in which politicians pay loud lip service to “cost control,” but successful legislation actually provides generous payoffs to beneficiaries and providers—leading to recurrent problems with rising costs.

Efforts to address costs in ways the public can easily perceive have proven politically risky. The Medicare catastrophic legislation of 1988 relied on financing paid by seniors themselves, but seniors soon opposed that step. Their public outcry was most dramatically illustrated by images of a group of angry seniors surrounding Representative Dan Rostenkowski’s car, and Congress soon repealed the controversial legislation (Oberlander 2003). The effort to contain costs while expanding coverage was a major factor in the unwieldy design of—and public skepticism about—the Clinton health reform plan (Skocpol 1997).

The public reacted no more favorably in 1995 to Republican legislation that attempted to reduce Medicare payments to health care providers. The widespread shift to managed care in the mid-1990s also provoked public wrath (Blendon et al. 1998). The peculiar gaps in coverage in the Medicare prescription drug legislation were clearly due to the \$400 billion ceiling for projected spending, and much of the wariness that seniors are now expressing reflects worries that their drug costs—and perhaps also Medicare premiums—may actually rise.

Public worries about the possible effects of cost controls are magnified by the concerns of business interest groups about limits to federal subsidies or regulatory adjustments that promise to shift rising costs toward private-sector employers, insurers, or providers. Of the three recent efforts at major health care reform—the 1993–1994 Clinton plan; the mid-1990s Republican-sponsored public-sector cuts; and the 2003 Medicare restructuring—the only proposal to actually pass (the 2003 restructuring) was the one that most thoroughly combined weak cost controls on the private sector, benefit increases, and generous subsidies for businesses.

Even though Republicans sponsored and promoted this legislation, it features

higher Medicare subsidies for hospitals, physicians, and health maintenance organizations. The final legislation also prohibits federal Medicare authorities from using their regulatory and bargaining powers to lower drug prices. The bill was stripped of provisions that would have the import of cheaper, publicly regulated prescription drugs from Canada. And the final legislation also included subsidies to induce private employers to retain retiree prescription drug benefits. Finally, in adding a modest new drug benefit for all Medicare beneficiaries, the legislation was far from effective “cost control” and guarantees continuing struggles over how to fund Medicare.

Messy Compromises and Future Prospects

Budget constraints promise to loom ever larger in struggles over all aspects of government’s role in health care, given recent major tax cuts, a growing federal deficit, the coming retirement of baby boomers, and likely continued increases in health care costs above the overall inflation rate due to ongoing technological change (Newhouse 1992). With strong bipartisan support, lawmakers doubled the National Institutes for Health budget between 1999 and 2003 and enhanced resources for expedited FDA (Food and Drug Administration) review of new drugs, thus fostering the new technology that drives spending growth. These expansions, combined with popular demands for extended health care coverage, are sure to strain the federal budget, giving politicians, including some Democrats, incentives to find “reforms” that reduce costs appearing on public budgets—or at least appear to do so. The recent record, however, is not promising for actually enacting effective budget cuts or cost controls. Though the 1993–1994 Clinton legislation and the mid-1990s Republican reform proposal featured cost controls, both of these efforts fell short of enactment.

Our understanding of past reform debates suggests that if differences do not produce stalemate, compromises necessarily take the form of complex and ambiguous measures that opposing players can interpret as partial victories. From the perspective of expert policy designers, this means that carefully constructed proposals will emerge from the political process—if at all—in substantially altered form. Many provisions of complex compromise bills are designed to satisfy interest groups; while others allow both conservatives and liberals to imagine that they have received “half a loaf” and can return to fight for more or less governmental provision on another day.

Even when efforts are made to forge complex compromises, however, there is no guarantee that proposals will be enacted, or prove stable after initial enactment. Public opinion may turn against complex compromises, as it did in 1993–1994. Or the public may be disillusioned by budget-driven compromises that seek financing from beneficiaries or that limit the scope of benefits, as occurred in extreme form with the repeal of Medicare catastrophic legislation in 1989, and may occur again with the current Medicare prescription drug legislation. Research suggests that cost containment approaches are more politically feasible when they are

less visible to the public and not easily attributable to the actions of readily identifiable politicians (Arnold 1990; Pierson 1994).

Going forward, policymakers face contradictory pressures to expand health insurance coverage and benefits while, at the same time, limiting increases in federal outlays. Growing ideological polarization also ensures that partisans will want to head in opposite directions—toward or away from greater government regulation—in each wave of reform. Changes can be stymied by an inability to reach political compromise over competing approaches and goals, or by lack of commitment to allocate public funds toward expanded benefits desired by the public.

The Medicare prescription drug legislation opens rather than forecloses new rounds of debate about this vital part of the U.S. health care financing system. Left unsettled is government's role in regulating pharmaceutical prices and subsidizing health care markets. Reliance on private drug plans to negotiate pharmaceutical prices was key to convincing a Republican-led Congress to pass the legislation. But if prescription prices continue to rise rapidly, the role of government could easily expand, much as it did in the face of medical price inflation after Medicare was created in 1965.

The 2003 law reconfigures arrangements and subsidies to private health plans that serve Medicare beneficiaries and may lead to increased enrollment in HMOs (health maintenance organizations). Yet it is unclear whether the subsidies will be enough to attract health plans and Medicare beneficiaries who remain wary following their prior bad experiences with changes in the late 1990s. In earlier rounds of policymaking for Medicare, many private providers entered the Medicare HMO market, only to withdraw after government subsidies were trimmed. The new subsidies to private providers are unlikely to produce cost savings to the federal budget. If budget struggles intensify, politicians could once again find it easier to trim provider subsidies than to trim benefits or raise Medicare premiums. Republicans may approach such issues with a different mindset than most Democrats, but they, too, are subject to voter expectations and popular pressures.

Beyond Medicare, expanded coverage for the uninsured remains the great unsettled question in the mixed U.S. health insurance system. Circumstances in 2004 are in some ways startlingly similar to conditions a decade ago. Private premium increases reached double digits each year from 2001 to 2003, increasing by 13.9 percent in 2003 (Gabel, Claxton, and Holve 2003). Following recent economic slowdowns, the number of uninsured increased, reaching 43.6 million in 2002 (Mills and Bhandari 2003). A presidential election season induces politicians, especially Democrats, to address issues of coverage and costs with an eye to the concerns of average voters.

But prospects for making headway on coverage for the uninsured are at least as mixed as in 1993–1994. Public concern regarding health care costs has risen, but concerns about the economy, war, and terrorism rival health care in public priorities for government action. As with the 1993–1994 reform episode, despite signs of growing consensus on the need for expanded coverage, proposed policy approaches range widely from those that build on existing programs to those that

make more dramatic departures (Butler 2003; Collins, Davis, and Lambrew 2003; Davis and Schoen 2003; Kahn and Pollack 2001; Meyer and Wicks 2001, 2002).

Thus, even though policy elites have moved closer to consensus, it is unclear whether politicians will seek a financing mechanism for broad-based coverage expansions for the uninsured—especially given the ballooning of projected federal budget deficits (Congressional Budget Office 2003). Democratic primary voters tend to reward candidates whose proposals are more expansive and costly than the general public may be willing to support. The outcome of the 2004 election will affect the prospects for reform, though partisan divisions are sure to persist even if Democrats gain ground. If Democrats and Republicans do not find common ground on measures to aid the uninsured in low-income working families, their plight will remain unresolved. And the political cost of inaction to office seekers may be slight, because lower-income, working-aged Americans do not vote at especially high levels.

In the past, reforms that have moved from conception to enactment have somehow addressed cross pressures—usually by building on existing arrangements and incorporating compromises that give a little to all key players. Looking ahead, coverage expansions—whether in Medicare or to the uninsured—are sure to return to the political agenda because the underlying problems remain salient to the American public. Yet once on the agenda, proposals for expanded benefits tend to become entangled in sweeping visions of how to retool the health care system or reduce federal spending. This makes forging stable compromises difficult. Some reforms may survive the political process in a version that departs substantially from original proposals. But the necessary compromises lead to health policies that will never be perfect from anyone's perspective—whether politician, payer, provider, patient, or policy analyst—inevitably setting the stage for continuing political battles.

Health care reform is certain to remain central to U.S. electoral politics and governance in the years ahead. But it is just as certain to remain unsettled, subject to messy compromises, partisan clashes, and ambiguous decisions.

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