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Reflections

The Road to Somewhere: Why Health Reform Happened

Or Why Political Scientists Who Write about Public Policy Shouldn't Assume They Know How to Shape It

Jacob S. Hacker

Why did comprehensive health care reform pass in 2010? Why did it take the form it did—a form that, while undeniably ambitious, was also more limited than many advocates wanted, than health policy precedents set abroad, and than the scale of the problems it tackled? And why was this legislation, despite its limits, the subject of such vigorous and sometimes vicious attacks? These are the questions I tackle in this essay, drawing not just on recent scholarship on American politics (including my own) but also on the somewhat-improbable experience that I had as an active participant in this fierce and polarized debate. My conclusions have implications not only for how political scientists should understand what happened in 2009–10, but also for how they should understand American politics. In particular, the central puzzles raised by the health reform debate suggest why students of American politics should give public policy—what government does to shape people's lives—a more central place within their investigations. Political scientists often characterize politics as a game among undifferentiated competitors, played out largely through campaigns and elections, with policy treated mostly as an afterthought—at best, as a means of testing theories of electoral influence and legislative politics. The health care debate makes transparent the weaknesses of this approach. On a range of key matters at the core of the discipline—the role and influence of interest groups; the nature of partisan policy competition; the sources of elite polarization; the relationship between votes, activists, and elected officials; and more—the substance of public policy matters. Focusing on what government actually does has normative benefits, serving as a useful corrective to the tendencies of political science to veer into discussions of matters deemed trivial by most of the world outside the academy. But more important, it has major *analytical* payoffs—and not merely for our understanding of the great health care debate of 2009–10.

As the health care debate reached fever pitch last August, an email arrived in my inbox. The subject line was innocuous enough: “comment.” The text, less so: “You are working for the enemies of this nation. I was making 6 figures before you were even born you little punk. You have no right to take the liberties that this country has fought and died for and try to destroy it! You should be ashamed of yourself! [. . .] You should be shipped to Gitmo!” A few days later, a similar message—

with some choice words thrown in—was left on my office voicemail, surprisingly to me, in a female voice. I saved the message, just in case.

Over the coming months, my hate mail—and yes, fan mail—became a running marker of the polarized debate. I tried to stop reading the full text of the messages, immediately deleting them or saving them to a folder I had created for the particularly threatening ones. When, in early 2010, Republican Scott Brown captured the Massa-

Jacob S. Hacker (jacob.hacker@yale.edu) is Stanley B. Resor Professor of Political Science at Yale University. For astute comments on this essay, I thank Diane Archer, Paul Pierson, Steve Teles, and Jeffrey C. Isaac. Paul deserves special thanks—for his patience as I disappeared to work on health care while we were finishing a co-authored book (Winner-Take-All Politics, Simon & Schuster, 2010), for the scores of joint ideas that are reflected in this essay (at this point figuring out their original authorship is impossi-

ble), and, above all, for his longstanding and deep friendship. Elizabeth Kelley provided able research assistance. Finally, I wish to thank the many experts, activists, and elected officials who made it possible for me to play the role in the debate that I did, including first and foremost Diane Archer, but also Roger Hickey, Avram Goldstein, Richard Kirsch, Jonathan Cohn, Tim Jost, and Harold Pollack. The many others who helped me know who they are and probably prefer no one else did.

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chusetts Senate seat opened by Ted Kennedy's death, I received the following reasoned response to an op-ed that another political scientist and I had written arguing that Democrats could and should still push ahead:

communist fucking rat. you rat vermin motherfuckers will be exposed. well will tea party freedom and liberty and the constitutional republic and you fuckers will pay for your treason.
i will not go down easy and live in 1984 you fucking animals!

Compared with that missive, the note I received the next day was a model of wit: "No wonder Americans are overwhelmingly against this monstrosity, when PhDs from Yale can't even muster a cogent defense of it."

Of course, the hate mail I received was a trickle compared with the flood that poured into Congress and the White House. Yet Congress and the White House were writing the law. I was merely, as one critical article more or less accurately put it, "an academic who has no medical background and doesn't serve in the Obama administration, and whose original proposal was published in a largely unread book." My "largely unread book" was *The Road to Nowhere*, an account of the rise and fall of the Clinton health plan published in 1997.¹ And while it did not contain my "proposal" (I published the proposal that would provoke so much ire a few years later in 2001), it did, unbeknownst to me at the time, launch me on the path that would end with me in the crosshairs of conservative agitation and the nation with a new health care law.²

All of which raises two obvious questions: How did I end up in the crosshairs? And how did the nation end up with a new health care law? The former question is beyond

trivial compared with the latter. The only reason for interest in it, at least outside my immediate family, is that it has implications for the latter. Fortunately, it can be answered quickly: I became directly involved in promoting what I saw as good policy and, in particular, what came to be called the "public option"—a public insurance plan modeled after Medicare that would compete with private plans to enroll those without coverage. To my great and mostly pleasant surprise, the public option became a central aspect of the original House and Senate bills. It also became a central topic of controversy dividing Democrats from Republicans—and Democrats from Democrats, as became clear when my home-state senator, Joe Lieberman, insisted on its removal from the Senate bill in return for his vote to end a Republican filibuster. Lieberman did constituency service of a sort by citing my support for a proposed compromise public option to which he had agreed as one reason he had backed out of the deal ("Lieberman vs. the 'Public Option' Patriarch" headlined a piece on Lieberman's about-face in the *New York Times*).³

The second question—Why did health care reform happen?—is the core subject of this essay. It is really three questions: (1) Why, after nearly a century of defeat, did health care reform pass in 2010? (2) Why, nonetheless, was the legislation so limited compared with the scale of the problems it addressed and with the aspirations of reformers? (3) And why, to turn to the most vivid element of the past two years (certainly judging from my email inbox), did that legislation still provoke such intense, angry, and polarized political conflict? The answers to these three questions turn out to say a good deal about contemporary American politics. It also has

something to say about why American politics researchers should give public policy a more central place in their investigations, though not necessarily as much of a place as I ended up giving it.

Why Did It Happen?

The passage of the Patient Protection and Affordable Care Act in March 2010 (hereafter, the “Affordable Care Act”) was a remarkable policy breakthrough. Its price tag, roughly \$1 trillion in federal spending over ten years (funded through tax increases and spending reductions), only gives a partial sense of its scope. The bill involves extensive new regulation of private health insurance, the public creation of new insurance-purchasing organizations called “exchanges,” the reorganization and expansion of Medicaid for the poor, and both major reduction in spending growth within and substantial changes to the Medicare program for the aged and disabled, including the creation of a new independent commission to control Medicare spending. Given all this, the more revealing numbers concern not federal spending, but the predicted effects: more than 30 million Americans newly covered by 2019 and a substantial reduction in the cost of insurance for those who buy it through the exchanges, thanks to large new federal subsidies for coverage, greater economies of scale in administration, and new insurance rules that prohibit price discrimination against higher-risk patients.⁴

To be sure, as I will emphasize shortly, the Act fell well short of the international health policy standard of universal coverage and robust efforts to restrain medical costs. The affluent democracy closest to us in terms of the structure and history of health insurance—Switzerland—has featured subsidized universal insurance since the mid-1990s, and its per-capita spending is roughly 60 percent of ours.⁵ But in light of the long history of reform’s defeat, the Affordable Care Act represents a decisive departure from the past politics and policy of American health care.

What accounts for that departure? The obvious answer is the election of a Democratic president, the Democratic capture of Congress in 2006, and the strengthening of that majority in 2008. It was not, of course, so much President *Obama’s* election as the election of a Democratic president that mattered. During the campaign, all of the leading congressional Democratic candidates essentially endorsed the same basic health reform framework (about which I shall say more shortly), and many of the key health policy players within the administration would have likely been the same had another of these candidates been elected instead. But given how far apart Democrats and Republicans have become on health care (the Republican candidate John McCain denounced Obama’s proposal as a “government takeover”), the election of a Democratic president was a prerequisite for action of the sort that occurred in 2010.⁶

No less consequential was the *composition* of the Democratic majority with which that Democratic president was able to work. As recently as the fight over the Clinton health plan, the Democratic caucus featured a substantial southern conservative bloc that posed serious hurdles to intraparty agreement on health care. One need only recall the high-profile carping of Representative Jim Cooper—who made his name and raked in tens of millions in health industry contributions by publicly questioning the Clinton approach—to appreciate how difficult bridging the Democratic divide was.⁷ This time around, after the loss of more seats in conservative Southern regions and the strengthening of the Democratic position in more liberal regions, a more homogenous, though far from unified, caucus greeted the incoming president. There were simply fewer Jim Coopers to worry about. (Indeed, even Jim Cooper was cooperating.)

Those familiar with contemporary American politics research will recognize that the foregoing is basically the standard interpretation of lawmaking in this subfield.⁸ Take the preferences of elected officials, figure out where the status quo is relative to those preferences, add the basic voting rules, compare where elected officials are to the status quo, and, voila, you have either gridlock or change. There is undeniable truth to this view—the shifts of 2006 and 2008 were indeed preconditions for reform—and the research that this increasingly sophisticated “spatial” perspective on lawmaking has sparked has clarified many core aspects of legislative politics.

And yet there is something deeply unsatisfactory about this standard perspective as well. For starters, it says nothing about fundamental issues of agenda setting and policy design: Why were members of Congress voting on the particular approach that they ended up endorsing? Why in this session of Congress? Why did President Obama push forward on this goal given how much else was on his plate? In addition, by packing all the influences on lawmaking into the black box of congressional preferences, this perspective has little or nothing to say about the competing pulls of constituents, groups, leaders, and legislators’ own ideologies. How, for example, did Democrats overcome the interest group opposition that had stymied past efforts? Why did they hold sufficiently together in the face of substantial moderate defections, especially in the House, where the so-called Blue Dogs barked loudly but eventually did not bite? Did the leadership of Speaker of the House Nancy Pelosi—whom many (including me) believe turned the tide after Brown’s victory—matter, and if so, why? Finally, the standard view errs, in my view, by treating the preferences of legislators as precisely defined ideal points that remain roughly constant over time, when in fact legislators positions are determined relationally and strategically and therefore deeply shaped by the shifting context of political contests. Without this relational perspective, it is difficult to answer a central question raised

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by 2009–10 reform drive: Why did Republicans universally oppose it when more than a handful had previously expressed policy views not so different from where the legislation ended up?

In tackling these larger questions, the place to begin is with a comparison of the spectacular *failure* of health care reform in 1993–94. Why were things so different fifteen years after Bill Clinton lost his cause and then his Congress? Besides the obvious change in the composition of Congress, three factors stand out. The first was economic context; the second, group conflict; the third, Democratic coalescence.

Economic Context

By economic context, I do not mean simply that the problems in American health care were worse in the late 2000s than in the early 1990s (though they certainly were).⁹ The failure of policymakers to either halt the rise in the share of Americans lacking adequate coverage or stem the inexorable growth of costs could serve as Exhibit A in the case for seeing government inaction in the face of worsening problems as a consequential “non-decision.”¹⁰

Yet American politics is never simply about solving recognized problems, even when they affect a growing share of the middle class. The collapse of America’s patchwork public-private system has been predicted many times, and each time it has continued to limp along, hemorrhaging dollars, enrollees, and good will, yet still maintaining crucial reservoirs of support. Indeed, on a variety of measures, public opinion on health care in the late 2000s looked remarkably similar to the contours of opinion in the early 1990s, when reform went down in flames. In both periods, Americans expressed substantial dissatisfaction with core features of American health financing, but also substantial satisfaction with their own insurance and care. In both, there was strong majority support for government action to broaden coverage tempered by deep ambivalence about the prospect of government involvement and persistent confusion that could be exploited by critics of action. Looking across the large range of surveys on health care, one would be hard pressed to identify a major swing in favor (or against) reform in the run-up to the 2008 election.¹¹

A crucial difference between 1993–94 and 2009–10, however, was the larger economic climate. America’s job-based insurance tightly couples work and coverage for all but the poorest and oldest of insured citizens, heightening public anxiety about losing coverage or paying for care when the economy sours. The steep downturn that worsened through the 2008 election was far deeper and longer than the 1991 recession that helped Bill Clinton ascend to the presidency. Widespread and continuing economic angst first bolstered the Democrats’ electoral standing in 2008 and then fueled continuing public concern about health and economic security in 2009–10. Revealingly, surveys

done in early 2010 showed that while the majority of Americans had serious concerns about the Democratic reform bills, the majority also said they would be “angry” or “disappointed” if nothing were done. And by a stable two-to-one margin, those polled said that the serious economic problems facing the country made it more, not less, important to “take on health care reform right now.”¹² These findings stand in stark contrast to polls done during the tail end of the debate over the Clinton health plan, when—amid the same sort of fierce attacks—a majority said they would rather Congress did nothing than pass a bill.

Still, it would be hard to argue that the problems in health care or generalized public support for action were themselves decisive. They may have been necessary conditions for reform, but they were also longstanding, if intensified, conditions, and they were certainly not sufficient conditions. Instead, I would emphasize developments at the level of interest groups and political elites as distinctly pivotal in improving the prospects for change.

Group Conflict

Start with interest groups. The worsening state of American health insurance may not have pointed inexorably toward reform. But it did have very particular costs for key stakeholders. Consider the big media sensation of the last round: “Harry and Louise.” Named for the two actors who starred in them, the Harry and Louise ads were run by the Health Insurance Association of America against the Clinton health plan. In the original ads, Harry Johnson and Louise Clark (whose names were never given) fretted about the horrors of government involvement at the kitchen table and concluded “There has to be a better way.” Never seen by many Americans—they were run on CNN and in select markets—the ads were nonetheless an inside-the-beltway sensation that perfectly captured the shifting tide against the Clinton plan and the coalescing rejectionist strategy of the interest-group juggernaut that had formed against it.¹³

It is notable, then, that TV viewers in 2009 were greeted with Harry and Louise singing a very different tune. Fifteen years older but still sitting at the kitchen table, Harry says, “Looks like we may finally get health care reform.” Louise replies, “It’s about time. We need good coverage people can afford.”¹⁴ Harry and Louise 2.0 were not the creation of the insurance industry, which now lobbied under the banner of America’s Health Insurance Plans (AHIP). Rather, they had been resurrected by the pharmaceutical and hospital lobbies, which ended up pouring tens of millions into the debate, a good deal of it spent promoting (in a gauzy, general way) the cause of reform. And notwithstanding their new sponsors, the Harry and Louise ads once again perfectly encapsulated the interest-group battlefield that advocates of reform faced—only this time the battlefield was considerably more favorable.

At the heart of the shift was a stark financial reality confronting the medical industry: Americans were increasingly being priced out of its goods and services. The economic downturn magnified the panic in industry quarters by producing a large drop in the reach and generosity of insurance. Fewer Americans with insurance meant not just fewer insurance subscribers but also fewer paying patients for hospitals, doctors, and drug companies. Over the prior two decades, moreover, all of the key industry actors had become much more reliant on government for their revenues. For example, Medicare Part D—the Republican-backed 2003 prescription drug law—had created a generous new stream of payments for drug companies and insurers.

The industry-backed solution was a simple quid pro quo: accept greater public regulation and involvement in return for greater guaranteed financing. In particular, government had a power the industry did not—the power to require that people had health insurance—and it was this requirement that the insurance industry in particular wanted to harness. For some once-fearsome groups, the general concern about declining revenues centered on the improvement of payments under existing public programs. Such was the case with the American Medical Association (AMA), the interest-group scourge of reform-minded Democratic Presidents from Franklin Roosevelt through Harry Truman.¹⁵ (Lyndon Johnson overcome AMA opposition in 1965, but only after reformers had limited their ambitions to covering the aged.) During the current debate, the AMA—much less influential than during its heyday—was concerned about steep scheduled reductions in Medicare payments for physicians under the terms of a 1997 law. In 2009, with so-far-undelivered promises from Democratic leaders that a permanent “fix” to the 1997 formula would be made, the AMA endorsed not just the Senate health bill, but also the more sweeping House bill, a striking development in light of its past resistance.

AHIP, however, was unquestionably the most important group changing its tune. In Massachusetts, insurers had supported a law that regulated their practices in return for a requirement of coverage, which would ensure a stable customer base. During the debate over federal reform, AHIP was never wholly on board; it fiercely opposed the public option I was advocating, and it quietly funneled millions to the Chamber of Commerce to support a massive lobbying and attack-ad campaign designed to limit the law’s reach. But it also never adopted the take-no-prisoners approach that insurers had taken in 1993.¹⁶ This was a crucial difference.

The two sectors that revived Harry and Louise—the hospital and pharmaceutical industries—were even more clearly on board the health-reform train. In fact, they had bought tickets. Both industries cut sweetheart deals with President Obama’s team early in the debate—deals that the White House fiercely protected from congressio-

nal attempts to undo them in the coming months. These bargains traded avowed industry support for reform (expressed in ads like the Harry and Louise ones) in return for a commitment from the White House that neither drug companies nor hospitals would be required to give up more than a modest amount of expected revenues. Implicitly, the terms of the deal were even blunter: The White House promised to protect hospitals and drug manufacturers from those (like me) who believed that government should play a stronger countervailing role. In return, the industries wouldn’t kill reform.¹⁷

As the deeper element of these deals came to light, critics questioned whether they represented real sacrifice by the industries or were consistent with Obama’s promise of a new kind of politics. Amid the controversy, it was easy to miss the deeper implications of the administration’s preemptive co-optation—implications too often downplayed or ignored by contemporary students of American politics, who have virtually abandoned the study of interest groups. The reality is that even on issues about which Americans care deeply, organized interests have powerful sway.¹⁸ Spending on lobbying—which has long dwarfed campaign spending—has risen dramatically in the last fifteen years. Between 1998 and 2010, the health industry devoted nearly \$4 billion to lobbying, more than a half a billion of which was spent in 2009 alone.¹⁹ As we shall see, the Obama administration consistently acted as if the crucial swing votes in Congress depended not on wavering citizens, but on organized interests with the greatest ability to shape the positions of congressional moderates within the Democratic Party.²⁰

The administration may have been correct. The up-front concessions were substantial: They limited the law’s ability to deliver tangible benefits to the middle class and largely took off the table tools of cost control used in other nations, such as provider rate-setting and government negotiations for lower drug prices. But without a single Republican on board by the final votes, Democratic leaders needed all the party backing they could get. The splitting of the interest-group juggernaut that had unleashed its barrage on the Clinton plan made that task less daunting. So too did another development at the level of elites: the convergence of Democrats around a broad reform approach even before the debate began.

Democratic Coalescence

President Obama came into office vowing not to repeat President Clinton’s big mistake and dictate to Congress exactly what it should produce. Instead, he would facilitate a congressionally centered process, weighing in when necessary to ensure key goals were met. The wisdom of this strategy is now well recognized—even if, as will become clear, it had some obvious costs.

What is less recognized is that the approach was feasible only because so much intraparty agreement already existed

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about the proper direction forward. The three leading Democratic candidates in the presidential race—Obama, John Edwards, and Hillary Clinton—endorsed not similar reform plans, but essentially the same reform plan. Their common approach owed a heavy debt to the Massachusetts example, a beacon highlighting a path toward meaningful reform that could placate key interests. Yet the shared Democratic reform vision moved beyond the basic structure of the Massachusetts reform law (an individual requirement to have coverage coupled with an expansion of Medicaid and the creation of new insurance purchasing exchanges) to include stronger cost-containment measures, stricter employer requirements, and the creation of a public option to compete with private insurers. Even before President Obama's election, congressional Democratic leaders indicated they would take this same tack, and while the process took twists and turns that will be discussed shortly, the final law's broad outlines closely followed the script written during the 2008 campaign.

Now that the law has passed, it is easy to take this convergence for granted. Yet a quick glance back at 1993–94 reminds us it was hardly foreordained. Then, at least three broad approaches battled for supremacy. The most liberal elements of the party backed a Medicare-like single-payer system in which all Americans would be insured within a single public program. Middle-of-the-road Democrats were touting the virtues of a “play-or-pay” approach in which employers would be required to provide insurance or pay into a public program for those without employment-based coverage. And a substantial bloc of conservative Democrats were calling for more limited measures to bring down the cost of insurance and modestly expand coverage. The dissensus was one reason why the Clinton policy team felt moved to develop its own plan, building on its campaign proposal for “managed competition”—an ambiguous combination of such liberal elements as mandated employer contributions and such conservative elements as near-exclusive reliance on the private health insurance industry for the expansion of coverage.²¹

This time around, congressional Democrats had their own preferred policy approaches, but all seemed to understand that the song they were singing had to come from the same hymnbook. This coalescence reflected strategic judgments at least as much as sincere commitments. It embodied a serious attempt to forestall the intraparty squabbles that had contributed to the defeat of reform in 1994. It also reflected hard advance thinking about what was possible through a legislative process in which both organized interests and pivotal senators far more conservative than their party as a whole would have disproportionate influence. And, as such, it embodied huge preemptive concessions to key industry stakeholders. All of this was incorporated into Democrats' basic policy aims well prior to the visible legislative battles.

Why did leading Democrats come to this strategy? It is difficult to overstate the role of the failure of the Clinton plan. A deeply scarring experience, the imbroglio had led not only to fifteen years of inaction and incrementalism but also the Republican control of Congress that continued through 2006. Any notion that a near-miss on health care in 2009–10 would allow for a quick recovery and return to the field by reform advocates was implausible at best. Democrats would have one shot when the window opened again, and they had better be ready to use it.

Related to this broad recognition of the imperatives of intraparty agreement was a concerted effort by policy advocates and Democratic-affiliated interest groups to bring the party back to the health care issue on stronger political ground. Since I played a role in this effort, I cannot claim to have a wholly objective view of its wisdom or effects.²² But from my vantage point as an informal adviser to the health policy teams of the leading Democratic presidential candidates, it was clear that the candidates were searching for a formula that would bridge the differences within the party, while bringing Democrats back to an issue they had left fallow.²³

That formula, already described, included a major element of the single-payer vision in the form of the public option. Yet this was but one part of a reform package that largely built on, rather than supplanted, private employment-based coverage. More ambitious than what Democrats had been seeking for years, it was an approach less ambitious than many Democrats, especially single-payer supporters, wanted. Crucially, this formula had the strong backing of a growing network of interest groups and advocacy organizations on the left side of the political spectrum that were openly pressing for a intraparty compromise. These included the major unions, liberal think tanks, health care advocacy organizations, and left-leaning pressure groups.

During the 2008 campaign, many of these forces would join together to back Health Care for America Now! (HCAN), a nonprofit issue advocacy organization with substantial funding that brought together scores of pro-reform organizations at the national and state levels. HCAN was something of a departure for reform advocates. A legacy of the concerted organizing that took place against President Bush's 2005 proposal to partially privatize Social Security, the progressive advocacy network it built upon sought to go beyond general lobbying in favor of campaigning for a specific compromise package that was both politically realistic and programmatically ambitious. Using a strategy pioneered by conservative organizations like Americans for Tax Reform (the anti-tax group with the famous no-new-taxes pledge that most Republican officeholders now sign), HCAN put out a list of specific elements that any reform package had to contain and obtained endorsements of the package from candidates Obama and Biden and 190 members of Congress. These principles included “a choice of a private insurance plan, including

keeping the insurance you have if you like it, or a public insurance plan without a private insurer middleman that guarantees affordable coverage.”²⁴

By the time of Obama’s victory in 2008, then, not only was the interest-group environment more favorable for a reform push by a unified Democratic government, but Democrats had converged around a reform strategy that had backing from powerful organized forces within the party. These forces, moreover, had been especially active during the 2008 campaign in ensuring that Democrats signed on to a politically realistic approach before the party next had an opportunity to pursue its longstanding cause. In 2009, the opportunity arose.

Why Was It So Limited?

“When you actually look at the bill itself, it incorporates all sorts of Republican ideas,” declared one knowledgeable analyst of the Democrats’ approach. “I mean, a lot of commentators have said, ‘You know, this is sort of similar to the bill that Mitt Romney passed in Massachusetts.’”²⁵ The analyst knew what he was talking about. He was Barack Obama, speaking on the *Today* show in March 2010. Critics of the Affordable Care Act painted it as a socialist plot. Yet the legislation was, indeed, not so different from the reform law that Governor Romney—who would become a fierce critic of the bill—had signed into law in 2006. Nor was it all that far from the reform package backed by moderate Republicans as an alternative to the Clinton health plan back in 1993. And since the plan owed a big debt to the Massachusetts example, it also owed a debt to the Heritage Foundation, which worked publicly to shape and support the law.²⁶ Indeed, the Affordable Care Act included elements that Obama himself had fiercely criticized as a candidate when they were proposed by his GOP opponent John McCain. One blog post on the website of the health policy journal *Health Affairs* described the emerging package as the “Obama-Romney-McCain Health Plan.”²⁷

The point should not be taken too far. Simply adding Republican ideas to a mostly Democratic reform vision does not a centrist policy proposal make. Yet, substantively, the proposal was undoubtedly heavily constrained and limited—whether compared with the health policy precedents of other nations, the scale of the problems it tackled, the center of gravity of the Democratic Party, or even the Democratic reform blueprints of the campaign.

Some of these limits were rooted in the fragmented political institutions and distinctive health policy path that caused the United States to end up as the only advanced industrial nation without universal insurance and serious cost control. For decades, America’s longstanding reliance on private employment-based health insurance had posed formidable hurdles to efforts to broaden coverage under public auspices.²⁸ America’s distinctively

privatized system gave rise to resourceful and entrenched organized interests that fought vigorously to preserve their turf. It also created fault lines and vulnerabilities in public support for expanded government coverage, causing many Americans otherwise sympathetic to reform to worry that increased government involvement would negatively affect *their* coverage. Indeed, the last big end run around this system, the passage of Medicare in 1965, had arguably fragmented the potential reform coalition even further, by covering the most vulnerable and sympathetic segment of the population. (An irony of the debate was that many of those who rushed to congressional town hall meetings to denounce the public option as incipient socialism were enrolled in the program on which it was modeled.) It was this basic political reality—that most Americans *had* coverage, however costly and insecure, and could be easily frightened into believing that reform would impose losses on them—to which the Democratic policy approach (“keeping the insurance you have, if you like it”) responded.²⁹

But the limits of the Affordable Care Act also had contemporary roots, and none more so than the Senate filibuster. It is now taken for granted that any legislation of more than trivial importance that does not have special procedural protections (such as the budget reconciliation process) will need at least sixty Senate votes to overcome a filibuster. Those waging filibusters are wont to describe it in almost constitutional terms—as a bedrock feature of American politics that enshrines the Founders’ commitment to deliberation and government restraint. But the filibuster is of course a Senate rule with no standing in the Constitution, and the filibuster on display in 2009–10 had little in common with the filibuster of a half-century ago, immortalized (with plenty of dramatic license) in *Mr. Smith Goes to Washington*. As the health reform debate revealed, today’s filibuster is far more frequent, far more routine, far more partisan, and far more significant for both policy substance and legislative procedure than anything seen before.

Here is a critical aspect of American legislative politics to which political scientists *have* paid increasing attention, to their credit. And many of the key conclusions of this burgeoning scholarship were on vivid display in 2009–10.³⁰ The first and most important conclusion is that the filibuster has become a normalized tool of minority obstruction. Cloture motions to end filibusters tell part, but only part, of the story. Since the 66th Congress of 1919–20, more than 1,200 motions have been filed to invoke cloture.³¹ *More than 80 percent of them were filed since the 97th Congress of 1981–82, and more than 60 percent just since the 103rd Congress of 1993–94.* Although the filibuster surely displaced other, less formal forms of Senate obstruction, these activities were simply nothing like the hard-and-fast “rule of sixty” that now reigns. Controversial laws were routinely passed with majorities well short of the cloture threshold (which

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was *higher* before the 1970s). As the dean of congressional scholars David Mayhew has put it, “Never before has the Senate possessed any anti-majoritarian barrier as concrete, as decisive, or as consequential.”³²

What cloture motions cannot show is who is using this anti-majoritarian barrier and how exactly it is “consequential.” The first element is easy to understand: Filibusters are now used by the minority party. The dramatic polarization of the parties is the main reason for this. But it also reflects changes in cloture rules in the 1970s that made it less costly for minority party leaders to wage filibusters by allowing parallel consideration of other legislation, even as filibusters hold up bills. To the intense Senate minority factions that waged high-profile filibusters in earlier eras (think of the fierce battles against civil rights waged by Southern Democrats), the prominence of the obstruction was precisely the point—they were signaling to their constituents their intense commitment to a (disreputable) cause. But to the contemporary minority party, the lower procedural and legislative costs of filibusters were a big plus, allowing them to stop or scale back bills they did not like without blocking other action their constituents wanted or being cast as obstructionist in voters’ eyes. With the costs down and the incentives up, any lingering norms against filibustering faded into history.

An important milestone in this transformation, revealingly, was the 1993–94 health care reform debate. It was then that Senate Minority Leader Bob Dole declared that “You need 60 votes to do anything around here”—which was not accurate as a matter of history but was a clear statement of GOP strategy and a prescient forecast of what was to come.³³ On health care and other fronts, Republicans found in 1993–94 that obstructionism not only failed to hurt them politically, but actually paid off: When gridlock reigned and public opinion soured, it was the majority, not the minority, that suffered.

The filibuster matters in part because of how skewed the Senate already is in favor of less populated and generally more conservative states, thanks to the “great compromise” of two senators per state. This skew is actually greater now than it was in earlier eras when the filibuster was less commonly used. Compared with a population-based apportionment, the Senate is more rural, more Republican, and whiter, with effects on the apportionment of funds, the representation of minority groups, and the outcome of big legislative fights like the health care debate.³⁴ Even when a filibuster is unsuccessful, it shifts the center of political gravity substantially away from the center.

During the health care battle, this shift was on display on matters both big and small. Most plainly, it elevated Senator Finance Committee Chair Max Baucus of Montana to the position of power broker on health care, an issue to which he had paid little attention prior to 2008. The fact that President Obama and Democratic leaders

waited for months for Baucus as he made futile efforts to gain the support of key Republicans on his committee (in the end, only Olympia Snowe of Maine signed on, and then only temporarily) was a reflection less of Democratic faith that bipartisanship could be achieved than of a recognition that Baucus had the votes of the moderate Democrats who would decide whether a filibuster could succeed. Just a picture of the negotiating table where Baucus’s bipartisan “Gang of Six” sat told the story of the modern mal-apportioned Senate. The three Republicans and three Democrats in the “gang,” including Kent Conrad of North Dakota and Mike Enzi of Wyoming (the third-least and least populated states, respectively), collectively represented about 2.7 percent of Americans.³⁵

Less plainly, the elevation of the most conservative Democrats to the role of brokers also heightened interest-group power, for it was these Democrats who—thanks to their pivotal position as well as their greater sympathy toward industry demands—had the ears (and dollars) of the interest groups pouring money into Washington. Baucus, for example, collected nearly \$1.5 million in contributions from health-related companies and their employees in 2007 and 2008, as it became clear that he would be the center of the coming health care storm.³⁶ Because of the sway of the moderates, everyone understood that the Finance Committee would largely set the ceiling for Democrats’ ambitions, and organized interests worked hard to make sure that, on critical issues, this ceiling was set as low as possible. Before the design work unfolded, much of Baucus’s former staff was snapped up by prominent lobbying firms; those who were not went into the Obama White House, where they would compete with those firms for Baucus’s attention.³⁷

We can see how much the filibuster mattered simply by comparing the House and Senate bills.³⁸ My own efforts to promote a public option with strong requirements on employers and insurers initially focused on the House, which moved ahead in stunningly quick fashion with coordinated action across the three committees with jurisdiction. And there the Democratic caucus was overwhelmingly receptive: The basic blueprint included not just a public plan modeled after Medicare. It also had a national exchange in which the public plan would be offered alongside regulated private plans, rather than a decentralized framework of state-based exchanges whose creation and operation was partially dependent on the cooperation of state governments. Last, but not least, the bill had a tough requirement for employers that ensured that all but the smallest employers either had to provide coverage or pay to cover their workers through the exchange.

None of these three important elements—not the public option, not the national exchange, and not the robust requirements on employers—was in the bill passed by the Senate, and needless to say, none made it into the final

bill. In a unicameral system, or even our bicameral system without the filibuster, each of them would likely have been included. What stood in the way of the public option, in the end, was less Joe Lieberman than a once-obscure procedural rule that has metastasized into a serious barrier to the legislative goals of both parties, but especially to those who wish to harness a gridlocked government to address social problems.

Was a procedural end run possible? The budget reconciliation process was always a theoretical possibility. It was, after all, the means by which the final small pieces of the Affordable Care Act were put in place when Brown's victory robbed Senate Democrats of the sixty sewn-up votes they had lined up to pass the already-gelling compromises between the House and Senate. But reconciliation to tweak the final bill was a very different animal, in sequence and in purpose, from reconciliation to pass the bill in the first place. A series of increasingly strict rules govern use of the reconciliation process precisely because it is so tempting, in a sixty-vote Senate, to pass legislation through it.³⁹ While the limits imposed by these rules are not entirely clear, and committed majorities could likely bend even those that are, it would have been virtually impossible to pass the whole of health care reform through reconciliation. The regulations and new administrative institutions at the heart of reform simply would not have been closely enough linked to budgetary totals to be germane. Ironically, some of the elements of reform that faced the hardest road in getting the last few votes in the Senate—such as the public option and progressive taxes to fund subsidies for coverage—could have been easily accomplished through reconciliation. The Congressional Budget Office (CBO), which estimates the budgetary effect (or “scores”) of all significant bills, reported that a public option with payment rates tied to Medicare's rates would save around \$150 billion over ten years.⁴⁰

The germaneness rules left at least one possible reconciliation route that could have been employed: taking the highly popular regulatory parts out of the bill and passing them separately through the normal process. Though possible, this route was viewed by Democratic leaders and the White House as precluded by the resistance of Senate moderates—who feared not only a more ambitious bill less to their liking, but also a move away from the filibuster that so heightened their sway. To be sure, these Democrats eventually signed on to the final reconciliation fixes, but that was only after they had largely obtained what they wanted and no other path existed. And there is an argument to be made that the very threat of reconciliation—which the Obama White House, unlike President Clinton in 1993, never ruled out entirely—pressed moderates to support a bill closer to the middle of the party than their own views. But at least until the post-Brown desperation set in, reconciliation never seemed a live enough option to create great pressure on the moderate Democrats who held most of the cards.

Putting aside the procedural question, did Democrats leave money on the table? Could they have gotten more? My own verdict is that more could have been achieved—the public option came remarkably close—but not a great deal more. At the same time, Democrats could also have achieved much, much less. Moving a bill of this scope through our rickety, polarized political process is a challenge of monumental proportions. Success was hardly guaranteed, and reform almost failed at three key junctures: in January, when some in the White House cautioned against tackling health care at all; in August, when town hall meetings erupted into angry conservative “Tea Party” protests; and then again in February, when Scott Brown captured Ted Kennedy's former Senate seat. In each case, advocates—including President Obama and Speaker Pelosi, who should get the lion's share of the credit for restarting the moribund reform campaign after Brown's election—pressed forward despite the risks.

Given how close the odds were, it would be foolish to be too critical of the strategic choices made. But it is still worth examining those choices critically. The White House organized for combat in an environment dominated by interest groups and congressional moderates. Unlike the Clinton team, it focused on cutting deals and shepherding the congressional process rather than either dictating policy or “selling” that policy to the public. Only when the reform train was in danger of derailing entirely—in August, when President Obama gave a high-profile speech to a joint session of Congress; and after Brown's victory, when the White House called a bipartisan summit aimed at winning the PR war and outlined its own final compromise—did this general strategic inclination give way to energetic efforts at pushing reform in a direction of the administration's choosing or casting the poorly understood legislative packages in a more inspiring rhetorical light.

By strategically forgoing a more robust attempt to steer the bill or make the case for it, the White House largely accommodated, rather than pushed back, against the elite focus of the debate that left many Americans alienated about the product and the process. This choice was, in part, just another manifestation of how the President and his advisers—Chief of Staff Rahm Emmanuel foremost among them—saw the central goal: winning over key interest groups and pivotal Democrats, not voters. And however much one might lament this perception, it surely reflected the political challenges they faced. It does not fully explain, however, why the White House chose to use its muscle to shape the bill in ways that made it demonstrably *less* popular with Americans—a second choice, or rather set of choices, worth examining.

For all the talk of the President's hands-off stance, he and his team used those hands quite firmly not just to broker deals with key interests, but also to press for a preferred outcome on three important policy matters:

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insisting that there be a reasonably tough individual requirement for people to have coverage; calling for a tax on high-cost health plans; and creating an independent Medicare commission to bring down the rate of increase in the program's spending. On two of them, the "individual mandate" and the insurance tax, the President was both flouting majority public opinion and abandoning stances he had adopted during the campaign—and, indeed, stances he had used to criticize his main primary challenger (Hillary Clinton, over the individual mandate) and his general election opponent (John McCain, over the insurance tax).

In all three cases, but particularly the first two, the briefest answer to why the President chose to spend his political capital on these less-than-popular measures was that getting good CBO "scores" depended on it. Without the mandate, CBO's analysts were skeptical that the exchanges could expand coverage without becoming a dumping ground for high-cost patients, because healthier people who were not strongly required to have insurance might wait until they needed it to enroll. And CBO analysts, like most economists, were willing to credit large cost savings to cutting back the health insurance tax break—even as they evinced great skepticism toward other cost-control ideas. The focus on the degree to which the package reduced future deficits, in turn, flowed from prior commitments. Not only had Democrats reinstated the "pay-as-you-go rules" requiring new initiatives be fully funded, but in addition, the long-term budgetary risks of rising health spending were central to the case for reform made by the President and his closest advisers (such as Peter Orszag, head of the Office of Management and Budget).⁴¹

Still, it is useful to ask whether the salutary emphasis on budgetary control could have pushed the administration toward other choices that might have resonated more with Americans. By contrast with the health insurance tax, for example, the public option could have produced substantial savings, and it polled extremely well throughout the debate despite the fierce attacks on it. However, the public option faced even fiercer interest-group resistance than did the health insurance tax (whose main opponents, congressional liberals and unions, dearly wanted reform to succeed). A more concerted push by the White House might well have preserved a public option in the bill, but one that would likely have had to start out weak and gain cost-control leverage over time.

And herein lay the deeper problem with CBO scoring: While it appropriately emphasized what was written in law and exclusively focused on economic effects, it gave no credit for institutions that could evolve with future enactments to do more, and few demerits for institutions that, experience suggested, were likely to be hard to create or marshal toward intended outcomes. These biases were an outgrowth of a budget-vetting process that helped reform along by creating a credible common standard for debate

over what bills would do. But they were biases, and one of their most salient outcomes was to encourage political players to embrace policy choices that, it soon became clear, fostered highly polarized attacks.

Why Was It So Polarized?

Harper's Magazine often provides astute commentaries on public affairs, but after the health care debate, I found the following observation particularly apt: "American politics has often been an arena for angry minds. In recent years we have seen angry minds at work mainly among extreme right-wingers, who have now demonstrated . . . how much political leverage can be got out of the animosities and passions of a small minority."⁴² This gem appeared on *Harper's* pages in 1964. Its author was Richard Hofstadter.

Hofstadter's classic "The Paranoid Style in American Politics"—newly vivid against the backdrop of "Tea Party" protests—provides an entry into my final question: Why was the debate over health care so polarized and angry? The attacks on me (prompted in part by a YouTube video made by conservative critics that cast me as an evil Rasputin eager to wipe out private insurance) were just a small tip of much larger iceberg. One of the President's health policy advisers, the respected bioethicist Ezekiel Emanuel (yes, Rahm's brother) was labeled "Obama's Deadly Doctor" and accused—with no more credible basis than those behind the much milder attacks on me—of advocating forced euthanasia of the disabled.⁴³ And then there were those famous but wholly mythical "death panels" in the bill, an imagined threat voiced by conservative critics that was given credence by mainstream Republicans.⁴⁴ Political fights today are noisy and nasty, but the fringe attacks in the health care battle seemed unusually fierce and unusually unhinged, especially given that the bill they were directed at was, after all, not so different from policies previously supported by GOP officeholders.

It is tempting to search for a cause in the opinions of the general public—which were divided over the bill to the end. But the general public's reaction to the legislation was characterized not by mobilized opposition or support, but by anxiety about the effects of reform on their own care and coverage, generalized mistrust of government, and deep confusion about what the law would actually do. Perhaps the most revealing indicator of the last was a series of polls done on the features of the House and Senate bills. Consistently, the core elements of the bills—with the notable exception of the individual mandate, the insurance tax, and the very slow proposed implementation—were quite popular, with positive assessments outweighing negative assessments by large margins. Yet just as consistently, the general assessment of the "health care bill" or "Obama's health plan" hovered around 50 percent or less.⁴⁵ Some portion of that opposition was made up of supporters of reform who felt the

bills did not go far enough, but still, the gut response of Americans to what they thought was being done was not disproportionately favorable.⁴⁶ What they thought was being done, however, had only a tenuous relationship to what was in fact being done. Only around half, and sometimes less, of respondents were aware of most of the popular provisions; the rest said these central items were not in the bill at all.⁴⁷

Yet this is mostly beside the point of grasping the fiercely polarized nature of the debate, for the sharpest attacks on the bill simply did not grow out of broad public reactions. Instead, they were concentrated within a sizable but nonetheless distinctly minority portion of the electorate, many of whom gathered under the “Tea Party” banner. The initial reaction to the movement was to see it as a spontaneous populist eruption of working-class, politically independent anger. The polls done since then suggest that, as a group, Tea Party supporters are in fact slightly upscale, very conservative Republicans.⁴⁸ Many are the “angry minds” of Hofstadter’s famous essay, but what is so striking is how much influence they have come to exert within the Republican Party. Without slighting the influence of the liberal “netroots” or organized labor, there is simply nothing comparable on the Democratic side of the aisle.

A puzzling feature of American political polarization, made vivid by the health care debates, is that it has been driven more by the shift of Republicans to the right than by the shift of Democrats to the left. Ideological scores of members of Congress based on roll-call votes bear this out, as do more detailed studies that look at the ways in which the GOP’s caucus has changed due to the replacement of new members or ideological movement of existing ones.⁴⁹ The shrinking of the Republican caucus in Congress brought about in part by disillusionment with some of the party’s conservative stands has, ironically pulled the party even further right. Moderate Republicans were the ones most likely to lose, and the remaining moderates faced growing pressures to align themselves with the more conservative caucus that remained.⁵⁰

The causes of asymmetric polarization and the growing sway of the base call for greater scholarly investigation. Part of the reason for their neglect may be the continuing sway of the median-voter model, which predicts party and candidate convergence at the mode of the opinion distribution. No one seriously believes that convergence is the current norm. But the model suggests that polarization should at least be symmetric, giving middle-of-the-road voters nowhere else to go. Perhaps more important, its focus on the voter-politician nexus pushes analysts strongly toward constituency-based explanations of polarization. More broadly, the explosive body of scholarship on the ideological positions of legislators as judged by roll-call votes, so helpful in fueling recent theorizing about Congress, tends to slight the deeply rela-

tional nature of partisan political conflict. It is difficult to understand the unified rejection by Republican officeholders and candidates of a health care framework that once had nontrivial GOP support as just an inevitable expression of their ideal points. Whether the alternative is the consideration of “strategic disagreement” or “repositioning” or the process of “party position change” or search for “durable competitive advantage,” more attention should be paid to the sometimes-rapid shifts in party stance that flow from the interplay of partisan policy competition and the demands of the most intense, active, and organized elements of party coalitions.⁵¹

In the health care debate, what that interaction produced was hardening of Republican opposition. It bears repeating: Not a single Republican voted for the final health care bill in either house of Congress.⁵² When Scott Brown won in Massachusetts, the strategy seemed to have paid off. And while the health care bill ultimately passed, the Republican strategy did succeed in powerfully shaping perceptions of the bill, and it has had major consequences for the future of the debate over health care policy. A strong argument can be made that had moderate Republicans joined with Democrats, the bill would have been much closer to the ideal points of GOP legislators.⁵³ But that only makes it all the more notable that Republicans held together, taking the risk of a bill with a stronger Democratic stance in return for gambling for the outcome they almost realized: complete and total victory.

Where did that unity come from? The frequent claim that the Republican side of the party aisle is more homogeneous ideologically, with more self-professed conservatives in the GOP fold than self-professed liberals in the Democratic fold, is questionable on its own terms (evangelical social conservatives and upscale economic conservatives are hardly identical) and as an explanation of the pattern. As a wave of important scholarship in American politics has shown, partisan polarization is simply very hard to explain by charting the preferences of ordinary voters—which is not to say that it does not have big implications for those voters.⁵⁴

Instead (drawing on my joint work with Paul Pierson, which informs this entire essay), I would stress the degree to which activists and allied groups within the parties, and especially the Republican Party, have come to police the range of acceptable opinion held by officeholders.⁵⁵ Processes of recruitment and certification—how people are brought into the elite party fold and how they are vetted by groups and activists on the road to elected office—require much greater emphasis in American politics research. More research should center on the policing function played by conservative anti-tax groups like the aforementioned Americans for Tax Reform and the prominent Club for Growth (which targeted both Senator Arlen Specter before his shift into the Democratic fold and Robert Bennett of Utah, a reliably conservative Republican who

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nonetheless was seen as too willing to deal with Democrats and lost his GOP primary in May 2010).⁵⁶ More attention should also be paid to the efforts of groups to shape elite opinions and re-center American politics—witness the Chamber of Commerce’s unprecedented spending in 2010 to push back against the Obama agenda.

Above all, there is a need to complicate the simple dyadic models of representation so popular within American politics research. Ordinary voters matter enormously. But their knowledge and attention are limited, and their choices are heavily constrained by elite dynamics that shape who runs for office and with what policy goals. So it will be in November of 2010, when a Republican Party pulled toward greater conservative homogeneity by an enraged faction of voters and by mobilized, intensely passionate groups will be the only option that Americans have to express their manifest dissatisfaction with American governance.

Was It Worth It?

Among the most remarkable features of the great health care debate of 2009–10 is the degree to which it seemed to have produced not a ripple in public views of American government or to have measurably improved the Democrats (grim) fall electoral prospects. Given how widely shared and popular the goals of the legislation are—broader, more affordable coverage for tens of millions of Americans and greater health security for all Americans—there is surprisingly little prospect it will revive general public faith in government any time soon. Advocates comfort themselves with the analogy of Social Security, which over time grew from a “cruel hoax” (as Republican presidential candidate Alf Landon decried it in 1936) into the “third rail” of American politics.⁵⁷ But Social Security expanded in a much more favorable political and fiscal context for liberal policy aims, and it was far more simple and direct than the law now before us. It will take hard work to implement a complex statute while protecting and defending a law that does not deliver big tangible benefits for years. And all of this is to put aside the vital task of building upon what Senator Tom Harkin rightly described as a “starter home.”⁵⁸

For me, the question of whether it was worth it has a clear answer. When my 10-year-old daughter woke up with a nightmare about a red-eyed purple monster she called the “health care debate,” I realized anew the toll my years of shuttling to and from Washington had taken. But I also thought about the millions of Americans woken up by a crying daughter who wonder whether they have insurance or can afford treatment if she is ill. The health care bill was incomplete and imperfect in many ways. But was also a vital first step.

Nor do I have any regrets about stepping into the realm of policy advocacy. I could not have wished for stronger

support from the institutions where I was based, nor from the people who worked so tirelessly to support me. I recognize that this sort of work is not highly valued within political science. Why that is may seem self-evident—policy recommendations seem to be a breach of objectivity and a distraction from real scholarship—but that does not explain why academic economists routinely engage with public issues while political scientists appear more reticent. Political scientists have the potential to say at least as much about how institutions and policies are structured and might be better structured as economists do. And our profession once had far less reluctance about speaking the truth that it discovered to the power that it studied.

The health reform debate reminds us of something that students of American politics too often forget or trivialize: policy substance matters.⁵⁹ It matters, most obviously, because what government does has an enormous effect on Americans. But it also matters because of the political ramifications of this obvious but oft-neglected fact. Fights over policy are fights over who gets to exercise government authority toward what ends. For this reason, party leaders and mobilized groups expend enormous resources to influence the outcome of those fights. Political scientists often treat policy as a black box or an ideological label. But this is to miss the extent to which it is policy substance itself—“who gets what, when, and how,” in Harold Lasswell’s famous phrasing—that is the key concern of political contestants.⁶⁰ More than simply the sweet spot on a left-right spectrum, the approach taken by Democrats in 2009–10 embodied a set of strategic political judgments that in turn had major implications for what reform could and could not do to change the lives of Americans.

Political scientists should not simply leave their desks and enter the political fray, at least unless the calling is so loud it cannot be ignored. And they should be under no illusion that professional rewards will follow if they do. But we as political scientists should, I am ever more convinced, be more attuned to the contours of public policy and the process by which it is made—not because it will make our work more “relevant” (though it will), but because it will make us better political scientists, with a stronger grasp of the forces that drive politics and of the larger stakes of our research ventures. If we were to let ourselves be guided a little more by the fascination with what government does that first sparked the profession, we might just see a broader, though not always prettier, picture of how and for whom our democracy works.

Notes

- 1 Hacker 1997.
- 2 The original proposal was entitled “Medicare Plus” and published in *Covering America*, see Hacker 2001. I updated it in 2007 as “Health Care for America” in Hacker 2007. Over the course of 2008

- and 2009, I wrote many reports, articles, and op-eds pressing for the public option, including Hacker 2008a, Hacker 2009a, and Hacker 2009b.
- 3 Herzenhorn 2009.
 - 4 Congressional Budget Office 2010.
 - 5 Organisation for Economic Co-Operation and Development 2009.
 - 6 Cooper and Bosman 2008.
 - 7 Lieberman 1994.
 - 8 See in particular Krehbiel 1998, and McCarty, Poole, and Rosenthal 2006.
 - 9 Just to name three areas where the indicators headed South, health care costs were much higher, topping \$2.5 trillion in 2009, or more than \$8,000 per capita, up from \$4,560 per capita (adjusted for inflation) in 1990. See Truffer et al. 2010 and Center for Medicare and Medicaid Services 2010. At the same time, many more Americans lacked coverage: 15.3 percent of the population in 2008, up from 13.1 percent in 1992, see University of Minnesota 2009. . And of even greater political significance, more Americans lacked *adequate* coverage, with perhaps as many as three in ten nonelderly Americans—most of them squarely middle class—counted as “underinsured” in 2007, see Consumer Reports 2007.
 - 10 Bachrach and Baratz 1963; Hacker 2004.
 - 11 Hacker 2009c.
 - 12 These survey findings were obtained from Kaiser Health Tracking Polls. See Kaiser Family Foundation 2010b and Kaiser Family Foundation 2010a.
 - 13 Hacker 1997.
 - 14 Serafini 2009.
 - 15 Hacker 2002.
 - 16 Stone 2010.
 - 17 See Blumenthal 2010, CNN 2009, and Cohn 2009b.
 - 18 Bawn et al. 2006; Winters and Page 2009; Hacker and Pierson 2010.
 - 19 Center for Responsive Politics 2010b; Center for Responsive Politics 2010a. These are the official numbers, which almost certainly understate actual spending to influence policymaking, and they do not include spending by business groups like the Chamber of Commerce, which spent more than \$144 million in 2009, much of it to influence health reform, see Center for Responsive Politics 2010c.
 - 20 This argument draws on Hacker and Pierson forthcoming.
 - 21 Hacker 1997.
 - 22 For good summaries of my work, see Campaign for America’s Future 2007, Campaign for America’s Future 2008, Campaign for America’s Future 2009, and Hickey 2008.
 - 23 It is easy to forget how central the public option was to the campaign proposals of the leading Democrats.
- John Edwards said that “over time, the system may evolve toward a single-payer approach if individuals and businesses prefer the public plan”, see, Noah 2007. Meanwhile, Obama’s top campaign adviser on health care, Cutler 2007, wrote about Obama’s campaign proposal: “If you don’t have health insurance through your employer, you will be enrolled into a new, comprehensive public health insurance plan that emphasizes prevention, chronic care management and quality care. The benefits will be similar to those available today to every federal employee. This plan will enjoy the great efficiencies we see in public plans like Medicare but, if you still cannot afford it, you will receive a subsidy to pay for it. Of course, you can choose private insurance if you prefer but the private plans will have to compete on a level playing field with the public plan—without the extra payments that tip the scales in favor of private Medicare Advantage plans today” .
- 24 Healthcare for America Now! 2008.
 - 25 Zimmerman 2010.
 - 26 Haislmaier 2006.
 - 27 Goodman 2008.
 - 28 See Suzanne Mettler’s contribution to this issue.
 - 29 Hacker 2002; Hacker 2008c.
 - 30 See in particular Wawro and Schickler 2006, Binder and Smith 1996, and Koger 2005.
 - 31 See United States Senate 2010.
 - 32 Mayhew 2008, 274.
 - 33 Klein 2009.
 - 34 Lee and Oppenheimer 1999; Griffin 2006.
 - 35 Yglesias 2009.
 - 36 At one event organized by the Democratic Senatorial Campaign Committee in May, twenty or so industry players were asked to contribute \$10,000 or more to meet personally with him. See Eggen 2009.
 - 37 See chapter 10 of Hacker and Pierson 2010.
 - 38 And even this comparison understates the impact, since House leaders knew well that controversial stands they took would likely be overruled in the second chamber.
 - 39 Keith 2008.
 - 40 These scores were never officially released but widely known, see Cohn 2009a.
 - 41 On pay-as-you-go, see Congressional Budget Office 2009.
 - 42 Hofstadter 1964.
 - 43 Scherer 2009.
 - 44 Nyhan 2010.
 - 45 Kaiser Family Foundation, January 2010.
 - 46 In CNN 2010, for example, 43 percent of respondents opposed the legislation because it was too liberal; 39 percent supported it; and 13 percent opposed the legislation because it was not liberal enough (5 percent had no opinion).

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- 47 Kaiser Family Foundation 2010a.
 48 Zernike and Thee-Brenan 2010.
 49 See the discussion in chapter 1 of Hacker and Pierson 2005.
 50 This is confirmed by Poole-Rosenthal scores measures of the ideological position of members of Congress based on roll-call votes. See Carroll et al. 2010.
 51 Gilmour 1995; Weaver 2000; Karol 2009; Teles 2008, 265–67.
 52 The lone Republican floor support received throughout the reform stage *****or SAGA?***** was an aye vote cast in favor of the original House bill by William Cao of Louisiana, who held a seat in an overwhelmingly Democratic district that he won after the sitting Democrat had been found with \$90,000 in cash from influence-peddling in his freezer. Olympia Snowe, Republican of Maine, did vote for the Senate Finance Committee bill, but later joined the unified opposition of the party.
 53 Frum 2010.
 54 For a good recent synthesis, see Levundusky 2009 or Abramowitz 2010.
 55 Hacker and Pierson 2005.
 56 Catanese 2010. It is worth nothing, however, that Utah's caucus-based primary process is distinctive—and distinctly favorable to intense activists.
 57 Altman 2005.
 58 Waddington 2009.
 59 Hacker and Pierson 2009.
 60 Lasswell 1936.

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