

Brokering Health Policy: Coalitions, Parties, and Interest Group Influence

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Abstract Assuming a position as broker between disconnected interests is one way for an interest group to influence the making of federal health policy. This study demonstrates how groups use their connections with political parties and lobbying coalitions to augment their brokerage positions and enhance their influence over policy making. Evidence is drawn from statistical analysis of 263 interviews with health policy elites and a qualitative case study of the debate over the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. The results explain, in part, how interest groups play their brokerage roles as dispersed actors in a decentralized system, rather than as central mediators that intervene in a wide range of policy disputes.

On December 8, 2003, President George W. Bush signed into law the Medicare Prescription Drug, Improvement, and Modernization Act (P.L. 108–173). The act included the most significant changes in Medicare since the program’s inception, notably the addition of a “Part D” prescription drug benefit. Numerous interest groups played important roles in brokering the compromise that would become the final legislation. The most visible move was made by AARP (formerly the American Association

The data collection and interviewing for this project began in 2002–2003 when I was a special guest in governance studies at the Brookings Institution and was completed in 2003–2004 when I was a visiting scholar in the Centennial Center of the American Political Science Association. I am grateful for the warm hospitality of both institutions and for helpful suggestions from Frank Baumgartner, Jeffrey Berry, Michael Bloom, Diana Cohen, Kevin Esterling, Colleen Grogan, Jacob Hacker, John Mark Hansen, Robert Hauck, Marie Hojnacki, Thomas Holyoke, Edward Laumann, Jeffrey Milyo, Colm O’Muircheartaigh, Clayton Nall, Marilyn Olin, John Padgett, Catherine Potter, Mark Schlesinger, Ed Tudor, and Leora Vegosen.

of Retired Persons), when it endorsed the legislation in exchange for the modification of a few key provisions of the bill. AARP's endorsement provided political cover for wavering Democrats who wanted to support the legislation, diverted attention away from Senator Ted Kennedy's campaign against the bill, and further divided the community of aging organizations by nudging the well-respected Alzheimer's Association toward endorsement (Broder and Goldstein 2003; Iglehart 2004; Oliver, Lee, and Lipton 2004).

Although it received less media attention than AARP, the Archer MSA (medical savings account) Coalition played a similarly important role in the Medicare debate. The coalition of forty-nine interest groups—including prominent organizations such as the National Federation of Independent Business (NFIB), the American Medical Association (AMA), and the Christian Coalition of America—pressed for the creation of tax-preferred health savings accounts (HSAs) through the legislation. Many conservative members of Congress supported the accounts in principle, but had to be persuaded that achieving this goal was worth expanding entitlement spending without mandating more radical reforms in Medicare, which was a perspective that some Republicans held of the bill. Just as AARP had afforded political cover for Democrats, the Archer MSA Coalition offered a rationale for unsure Republicans to vote for the bill by securing vocal support from key conservative groups and activists. Given the narrow margin by which the bill passed, a strong case can be made that the efforts of both the Archer MSA Coalition and AARP were pivotal in enacting the legislation.¹

The influential role of myriad interest groups over Medicare policy is not exceptional, but is exemplary of groups' efforts to shape policies pertaining to issues like breast cancer (Casamayou 2001; Lance, Weisman, and Itani 2003), diabetes (Burgin 2003: 804), and national health insurance (Skocpol 1996; Johnson and Broder 1996). Beyond anecdotes about specific policy events, however, relatively little systematic evidence exists on how and when interest groups are able to broker changes in health policy. Comprehensive studies that examine a large number of health interest

1. The final votes in favor of the bill were 220–215 in the House and 70–29 in the Senate. However, the razor-thin nature of the margin of victory is clear only considering that the bill passed the House only after the vote was held open for three hours (the normal voting period is fifteen minutes) in the middle of the night (from 3 a.m. to 6 a.m.) to allow Republican Party leaders enough time to reverse the original vote of 218–216 against passage. In the Senate, a point of order on budget rules was defeated by the necessary sixty votes only after Senator Trent Lott voted with his party on the point of order, even though he opposed the final bill. The article by Iglehart (2004) contains a detailed account of these events.

groups rely on data that were collected in the late 1970s and early 1980s (Carpenter, Esterling, and Lazer 2004; Fernandez and Gould 1994; Heinz et al. 1993; Laumann and Knoke 1987). These studies carefully examine brokerage in informal communication networks, but shed little light on why groups like AARP and the Archer MSA Coalition sometimes make a critical difference and other times are impotent to achieve their goals in contemporary health policy debates.

This article argues that multiple sources of brokerage in policy networks contribute to interest group influence over health policy. Brokerage depends on informal communication networks, formal coalitions of interest groups, and political parties. This perspective accounts for the roles of brokers as dispersed actors in a decentralized system, rather than as central mediators that intervene in a wide range of policy disputes. Research to date has focused on influence through informal communication networks but has ignored the possibility that coalitions and parties also shape the ability of groups to build bridges across disparate interests. Coalitions are a standard part of interest groups' strategic repertoires that frequently put them in touch with other organizations with which they would not ordinarily connect (Browne 1988; Heaney 2004a; Hojnacki 1997, 1998; Hula 1999; Loomis 1986). Likewise, parties are a dominant feature of congressional health politics, especially since the Washington political environment became more partisan in the mid-1980s (Polsby 2004; Zelizer 2004) and health policy became a locus of partisan battles in the early 1990s (Hacker and Skocpol 1997). In this context, interest groups that serve as brokers across traditional partisan boundaries have enhanced opportunities to influence health policy.

The article begins by developing a theory that integrates coalitions and parties into traditional understandings of interest group brokerage through informal communication networks. Second, it presents the results of an empirical study that explores influence and brokerage through interviews with 263 health policy elites. It assesses the structure of the contemporary health policy domain, reports a series of regression models of interest group influence, and considers the implications of the findings for the policy process in health care. The article concludes by illustrating the strategic relevance of brokerage through private networks, formal coalitions, and political parties with a case study of how interest groups helped to transform Medicare in 2003.

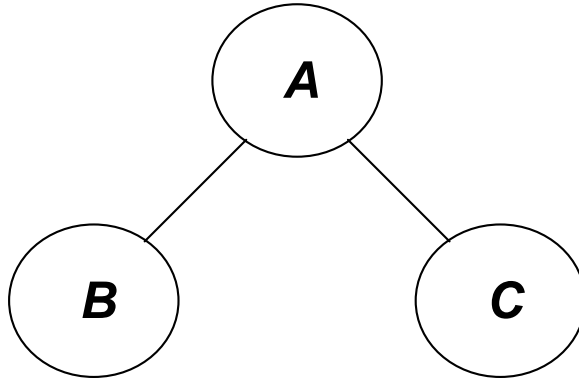


Figure 1 Brokerage in a Simple Network

Brokers in Policy Networks

Interest groups develop opportunities to act as brokers as they form connections with other interest groups working on health policy. A *broker* is an intermediary that facilitates transactions by standing between other interest groups that are not connected directly to one another (Marsden 1982). As is illustrated by the simple network in figure 1, *A* is a broker between *B* and *C* because *A* is connected to *B* and to *C*, but *B* and *C* are not connected to each other (Gould and Fernandez 1989). For example, Paralyzed Veterans of America (PVA) serves as a broker between other veterans' organizations (like Disabled American Veterans [DAV]) and medical research interest groups (like the Association of American Medical Colleges [AAMC]) by conveying veterans' priorities to the medical research community and filtering news about research developments to veterans' organizations. By being known and respected by groups that interact infrequently with one another, PVA is able to promote its own agenda on spinal chord injuries, for example, in the way it mediates the relationship between DAV and AAMC.

In addition to its role with respect to any pair of other interest groups, a group may occupy a position of brokerage vis-à-vis a larger network of groups. When a group is linked to a network in such a way that it creates many connections between groups that are otherwise disconnected, it has a high degree of "betweenness" and thus possesses the general potential for brokerage in the network (Freeman 1979). AAMC is an organization that occupies such a position. The unique position of medical colleges within health care systems connects AAMC to hospital trade associations,

medical specialty societies, clinical researchers, and disease advocates because it has a stake in each of these areas. This organization is situated between and respected by many different organizations, giving it the general potential to advance its agenda during these interactions, especially on issues pertaining to medical research.

This article highlights three ways in which interest groups obtain positions of brokerage in policy networks and use them to influence public policy. A first way is through navigating informal communication networks. Groups form communication networks when they work with other groups that care about the same policy issues (Hecló 1978). Communicating through networks is a way to settle intramural conflicts privately, devise strategies to approach legislative debates, and implicitly or explicitly coordinate lobbying activities. Participation in communication networks requires groups to nurture relationships with their partners by sharing timely, relevant, and accurate information in order to maintain mutual trust. The potential costs of communicating through interorganizational networks include the risk that sensitive information may leak or that decisions may be made based on inaccurate information acquired through the network. Groups strategize in forming network ties, though they neither dictate their ties with other organizations, which require reciprocation, nor necessarily make optimal investments from an efficiency perspective (Carpenter, Esterling, and Lazer 2003).

Evidence on the reputations of interest groups active in health policy indicates that they are often able to translate their positions in communication networks into influence over policy decisions. In their study of health policy networks in the late 1970s, Laumann and Knoke (1987; see also Carpenter, Esterling, and Lazer 2004; Fernandez and Gould 1994) demonstrate that interest groups leverage their structural positions in communication networks to build reputations for influence over health policy. A related study by Heinz et al. (1993: 285–290) investigated the possibility that there is a consistent, central broker on health policy issues. Evidence from their sample of eighteen notables in health policy failed to identify such a person, contrary to the elite theory of Mills (1956). However, this research leaves open the possibility that brokerage in communication networks is performed by episodic actors—rather than consistent brokers—and that brokers are drawn from outside the set of the most notable elites.

A second way for interest groups to develop opportunities for brokerage is by working together through formal coalitions. Whereas informal communications may be kept private and confidential, formal coalitions involve

public declarations of the alliances involved, thus evoking a qualitatively different relationship. Interest groups use coalitions to gain attention from Congress, show strength in numbers, and speak with one voice. Because of the public-audience aspect coalition work, interest groups sometimes join coalitions with other groups with whom they do not often communicate privately. Especially when they consist of strange bedfellows, coalitions form novel connections among groups, as when the AFL-CIO and the Chamber of Commerce work together in a coalition to reduce the number of Americans without health insurance.

Although some interest groups do not participate in formal coalitions, most groups manage a portfolio of multiple coalitions that puts them in touch with a diversity of other groups about an array of issues. For example, the American Public Health Association (APHA) works in coalition with state health departments on bioterrorism, liberal advocacy groups on women's health, and psychiatrists on mental health. If a group's pattern of contacts in formal coalitions differs considerably from its private communications, then coalition memberships have the potential to afford it an alternative mechanism to situate itself as a broker between other interest groups.

A third way for interest groups to become influential brokers is to build bridges across specific boundaries that are particularly difficult to cross. Gould and Fernandez (1989) emphasize that the nature of the work performed by a broker depends on the larger communities of which the groups are a part. As is illustrated by the simple network in figure 2, suppose that *A* and *B* are members of community 1, while *C* is a member of community 2. The task of brokerage in this case is not just to bridge disconnected groups, but also to build a bridge between two communities. *A* functions as a "gatekeeper" for community 1 when she decides whether or not to allow *C* to have access to *B*. Alternatively, *A* functions as a "representative" to community 2 if she decides to grant a request by *B* to be introduced to *C*.² This perspective on brokerage requires the investigator to specify the boundaries of the communities that are to be crossed.

Political parties are important examples of communities with boundaries that are difficult to cross in making health policy. Over the past

2. Serving as a broker does not require groups to cross community boundaries. For example, if *A*, *B*, and *C* were all members of community 1, then *A* could still play a broker's role by serving as a *coordinator* within the community. If *A* is a member of community 1, and *B* and *C* are both members of community 2, then *A* is considered an *itinerant* broker. If all three are members of different communities, then *A* is a *liaison*.

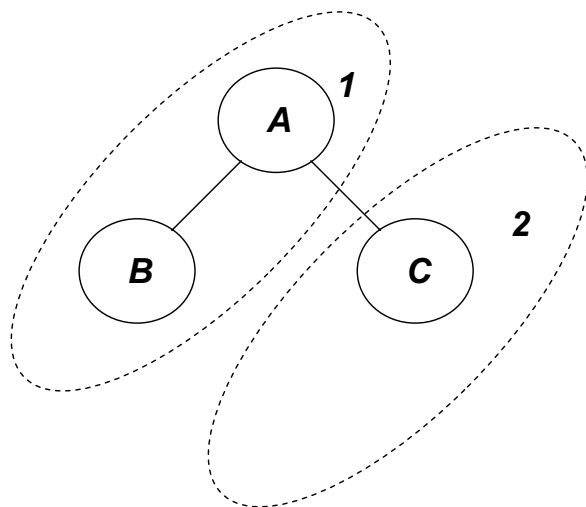


Figure 2 Brokerage between Two Communities

fifteen years, both political parties have turned to health issues to gain advantage over the other party. National health insurance, Medicare, prescription drug coverage, and stem cell research served as wedge issues during presidential and major congressional campaigns from 1991 through 2004. At the same time that parties have developed new techniques to elicit loyalty from their own elected officials (Pearson 2005), they sought increased loyalty from interest groups (Heaney 2005). One interest group, Americans for Tax Reform, even spearheaded an effort (openly referred to as the K Street Project) to demand loyalty to the Republican Party from other interest groups (Chaddock 2003; Confessore 2003). Under these conditions, interest groups are under considerable pressure to stay close to the party line. Thus interest groups that are able to cross this structural hole and reach out to groups aligned with the other party have the enhanced potential to influence public policy by promoting compromises that might otherwise be difficult to identify in a polarized political environment (cf. Burt 1992).

Three hypotheses are implied by these arguments:

H1 Interest groups augment their influence over health policy by increasing their potential for brokerage in informal communication networks, other things equal

H2 Interest groups augment their influence over health policy by increasing their potential for brokerage in formal coalitions, other things equal

H3 Interest groups augment their influence over health policy by brokering between interests affiliated with the major political parties either through (a) informal communication networks or (b) formal coalitions, other things equal

These hypotheses collectively imply that interest groups gain influence over health policy by nurturing brokerage positions in policy networks, beyond their use of other techniques, such as inside lobbying, outside lobbying, and campaign involvement. Groups need not occupy a position at the center of the entire network in order to serve as brokers, as Heinz et al. (1993) argue, if they can connect to other groups through communications, coalitions, or bipartisanship.

Model and Measurement

This research partially replicates Laumann and Knoke's (1987) study for 2003.³ I interviewed 95 health policy staff on Capitol Hill and 168 interest group representatives working on health issues between April and October 2003. The interviews consisted of structured and semistructured questions that gathered information about influence reputations, informal communications, coalitions, partisanship, and other strategic behavior. Appendix A describes the data collection methods and interview procedures. Appendix B lists the 171 interest groups included in the research. Appendix C lists the 117 coalitions included in the research. Using the data collected in the interviews, I estimate a series of statistical models of interest group influence as a function of brokerage, partisanship, inside lobbying, outside lobbying, campaign involvement, organizational characteristics, and type of organizational membership.

3. The advantages of replication are that it draws upon a well-developed approach to studying networks that has withstood scrutiny over the years, while at the same time addressing new questions about coalitions and parties. A difficulty of replication is that the world of interest group politics in health policy has changed enormously since the days of the Carter administration. In particular, the number of active organizations in the domain has exploded (Baumgartner and Leech 1999: 103; Laugesen and Rice 2003; Leech et al. 2005). The criteria for selecting organizations for inclusion in the study are adjusted to the current reality by using new data sources, such as the lobbying reports mandated under the Lobbying Disclosure Act of 1995 and Web pages that contain information about organizational structures, policy positions, and lobbying activities.

Dependent Variable

Interest group influence, the dependent variable in this study, is measured with two different indicators.⁴ The first indicator uses data from the congressional staff interviews. It is a simple count of the number of times an interest group is cited as a “key mover” by congressional staff. The second indicator, using data from interviews with interest group representatives, is a simple count of the number of times an interest group is cited as “especially influential and consequential” by other groups, which is identical to the question asked by Laumann and Knoke (1987).⁵

Brokerage

The responses of interest group representatives to questions about communication with each of the 171 groups in the study are the data for brokerage in the communication network. Two groups are connected in this network if and only if representatives of both groups recognize the existence of the connection, regardless of whether that communication was described as occasional or regular.⁶ The coalition membership lists obtained through

4. I rely on a reputational measure of interest group influence, similar to the ones used by Gamson (1966), Fernandez and Gould (1994), and Laumann and Knoke (1987). Reputational measures have a number of advantages when compared with direct-observation approaches to measuring influence, such as analyzing roll-call votes or narrative case studies. First, reputational measures (assuming they rely on knowledgeable informants) incorporate behind-the-scenes activities that direct observation cannot detect. Second, reputation measures allow for the analysis of influence across a wide range of issues, rather than a limited number of issues, as is usually the case with direct observation. Third, reputation measures enable the comparison of groups according to a similar metric, whereas direct observation makes it difficult to compare groups across issues. Fourth, even if reputation does not capture true influence perfectly, reputation is itself a resource (Gamson 1966), so actual influence and reputation for influence tend to reinforce each other.

5. Although I interviewed different populations of informants and asked them slightly different questions, I expect that these measures tap the same underlying concept of influence. The “revolving door” effect in Washington enables these populations to coevolve, so it is likely that they understand the concept of influence in similar ways. Of the 168 interest group representatives I interviewed, 156 had at one time worked as staff in Congress. Many of the congressional staff I interviewed will one day become professional lobbyists. In an important sense, these two populations reflect essentially the same pool of individuals, which is stratified according to stages of the career path.

6. Three groups (the American Society for Clinical Pathology, the National Rehabilitation Association, and the National Alliance of Breast Cancer Organizations) declined to be interviewed for this study. I dealt with these connections differently than connections in the other groups. If another group indicated a connection with one of these groups, I counted these groups as connected, despite the absence of corroboration. Also, I assumed that these three groups are not connected with one another. This assumption is reasonable given that they work on substantively different areas of health and they are each small, relatively nonprominent participants in the health policy domain.

interviews with interest group representatives are the data for brokerage among coalitions. I included a coalition in the data if it consisted of two or more of the interest groups in the study and if it made a public statement of its existence and membership.⁷ A public statement might consist of a letter to public officials signed by the members of the coalition or posting the membership list to an organizational Web site. Two organizations are connected in this network if they are members of the same coalition; the more coalitions they have in common, the more connected they are. For both the informal communication network and coalitions, brokerage is indicated by Freeman's (1979) measure of betweenness.⁸ Consistent with H1 and H2, the betweenness measures for communications and coalitions are expected to enter the equation with statistically significant, positive signs.

A group's partisan brokerage score is a simple count of the number of times the interest group is situated between disconnected interest groups of opposite parties, either as a gatekeeper or as a representative (Gould and Fernandez 1989: 100). I determined the partisan affiliation of each interest group by subtracting the number of regular, reliable lobbying ties it had with Republicans from the number of regular, reliable ties it had with Democrats.⁹ Interest groups were taken as affiliated with a party

7. This research examines 117 of the 232 coalitions that were mentioned by the respondents. There are several reasons why a mentioned coalition might not have been included in the research. The first and most common reason is that the members did not make a public declaration of the coalition's existence. I considered these "informal coalitions" to be a part of the informal communication network. The second most common reason is that the coalition was only tangentially connected to the health policy domain, so most of the major partners were primarily participants in another policy domain. For example, a coalition that addresses issues of food-borne illness might draw one elite health policy participant, but would be more likely to draw elite participants from other domains, like agriculture. Third, a coalition may have focused on a relatively narrow subset of the health policy community or mobilized largely state-level actors. For example, a coalition might have one elite national participant, but then many state-level elites. The statistical effect of failing to include nonelite coalitions in the analysis is likely to dampen the significance of brokerage effects, because the research design selects on the dependent variable. However, because the research includes a wide range of elites, the bias created by this effect is minimal.

8. Freeman (1979) explains that betweenness is calculated in three steps. First, identify all of the geodesics in a given network. A *geodesic* is the shortest path between any two points in the graph. Second, for every pair of groups in the network, count the number of times each group is on the geodesic for that pair. The *betweenness proportion* is the percent of geodesics between any pair of groups that include the group in question. Third, betweenness is calculated as the sum of all the betweenness proportions for which the pairs of groups are unique. A more formal statement of this computation is given by Borgatti, Everett, and Freeman (2002: help command): "Let b_{ijk} be the proportion of all geodesics linking vertex j and vertex k which pass through vertex i . The betweenness of vertex i is the sum of all b_{ijk} where i, j and k are distinct. Betweenness is therefore a measure of the number of times a vertex occurs on a geodesic."

9. These are the ratings of lobbying ties based on the interviews with Capitol Hill staff. Respondents could rate an interest group's regularity of contact as "regular," "occasional," or

if they had a net difference of three ties or greater with that particular party. Interest groups with a net difference of 0, 1, or 2 were categorized as independent.¹⁰ Consistent with H3a and H3b, the partisan brokerage measures are expected to enter the equation with statistically significant, positive signs.

The partisan brokerage hypotheses are essentially more specific versions of the general brokerage hypotheses. H1 and H2 imply that some kind of network brokerage leads to influence. H3a and H3b specify that party boundaries are at least part of what is being brokered. Since partisan brokerage is an alternative to betweenness as a way of conceptualizing brokerage, it is not possible to test H1 and H2 simultaneously with H3a and H3b. Instead, I estimate separate sets of models: the first set includes the betweenness measures and the second set includes the partisan brokerage measures.

Control Variables

Partisanship. While interest groups gain influence by brokering across partisan boundaries, they may also be rewarded for being loyal parts of the party machine (Greenstone 1969). Particularly during eras of intense partisanship, groups and parties have strong incentives to collaborate with one another (Hershey 1993). For example, the National Federation of Independent Business is trusted closely by Republicans, and the Children's Defense Fund is highly respected in Democratic circles, which enables both groups to enjoy special access to party leaders and to direct attention to their agendas. I measure partisanship as the absolute value of the difference between the number of regular, reliable contacts with Republicans and the number of regular, reliable contacts with Democrats. Thus I hypothesize that as interest groups become more partisan (either more Democratic or more Republican), they gain increased influence over the policy process.

The question naturally arises as to what the relationship is between par-

"never" and its reliability as "usually," "sometimes," or "never." When a respondent marked an interest group as both regular and reliable, this was taken as an indication that the group was a trusted partner within that particular congressional office.

10. I experimented with three alternative systems of categorization. One alternative is to use a cutpoint of two ties rather than three ties. A second alternative is to use two categories, where groups either lean Republican or do not lean Republican. A third alternative categorizes groups as leaning Democratic or not leaning Democratic. I found, in the regression results reported in tables 3 and 4, that the alternative systems of categorization did not affect the substance of the regression results.

tisan brokerage and partisanship. Can an interest group develop a highly partisan reputation among congressional staff and still reach out to interest groups aligned with the other side (the multivocal hypothesis)? Or must groups choose between the role of broker and that of intense partisan (the strategic choice hypothesis)? I conduct a competitive test of these hypotheses by including the interaction between combined partisan brokerage (informal communications plus formal coalitions) and partisanship as variable in the model. A positive coefficient supports the multivocal hypothesis, whereas a negative coefficient supports the strategic choice hypothesis.

Inside lobbying is the practice of making private appeals to members of Congress by providing technical and political information that is useful in the legislative process (Austen-Smith 1993; Milbrath 1963). For example, the Planned Parenthood Federation of America lobbies Congress by providing information about the health benefits and risks of contraceptive technologies. Inside lobbying is examined in this project by using two variables: the amount of money that groups spend on their lobbying efforts in millions of dollars and the number of times they testified before Congress on health-related issues in 2003.¹¹ I hypothesize that as lobbying activities increase, a group's influence increases, other things being equal.

Outside lobbying is the practice of bringing pressure to bear on Congress by making appeals publicly and encouraging grassroots supporters to contact Congress directly (Kollman 1998; Hojnacki and Kimball 1999). The Health Insurance Association of America's (HIAA) campaign against President Clinton's health care proposal in 1993–1994 is a classic example of this strategy applied to health care (Goldstein 1999). Outside lobbying is included in this project by using two variables: grassroots mobilization, as indicated by the number of times congressional staff reported that an interest group is well organized at the state or district level; and whether the organization advertises in Washington media. I hypothesize that interest group influence increases with outside lobbying activities, other things being equal.

Campaign involvement is a way for groups to demonstrate their relevance by participating in efforts to reelect or defeat members of Con-

11. Testimony before congressional committees is not lobbying, per se, because it is a response to an information request by Congress (Lobbying Disclosure Act of 1995, Public Law 104–65, Section 3[8][A][vii]). Testimony is categorized as lobbying activity for the purpose of this research because it is tactically similar to other inside-lobbying activities.

gress. If an interest group becomes involved in elections, then reelection-interested politicians may cater to this group during the legislative process in an effort to forestall its opposition at election time and earn the support of the group or an affiliated group. For example, the AMA's political action committee contributes to elections in order "to help elect (or reelect) legislators who would be more generally sympathetic to the economic and practice concerns of AMA physicians" (Wilkerson and Carrell 1999: 335). The measure of campaign involvement included here is political action committee (PAC) expenditures in millions of dollars. I hypothesize that higher PAC contributions translate into higher levels of influence.

Organizational characteristics included in the research are the organization's age and whether the organization is health focused. I hypothesize that older organizations are more influential because they have demonstrated adaptability through survival and have had time to build respect among other actors in the policy domain (Carpenter, Esterling, and Lazer 2004; Stinchcombe 1965). For example, APHA, which was founded in 1872 by physicians serving as state and local public health officials, possesses moral authority—and thus influence—because of its longevity as the peak association for public health in the United States (Starr 1982: 185). I hypothesize that organizations that have a health focus are more influential than those focused on another policy, because of expertise in their issue niche (Browne 1990). For example, DAV is more influential on veterans' health issues than is the American Legion. Both organizations speak for veterans, but because DAV specializes in health concerns, Congress is likely to give it greater credence in this area.

Organizational types in the study include academic organizations, citizen advocacy groups, nonmember advocacy organizations (with volunteers), professional societies, trade associations, veterans' service organizations, and labor unions. A dummy variable for each type is included in the model for statistical control.

A Contemporary View of Influence in Health Policy Networks

Data gathered from interviews with 263 health policy elites are used to generate rankings of the "most influential" interest groups (reported in table 1). Separate lists are provided for scores by interest group representatives and congressional staff, though the two groups agree on eight of the top ten most influential groups, with congressional staff giving

Table 1 Most Influential Interest Groups in Health Policy, 2003

Rank	Influence Citations	Interest Group
K Street Rankings (April–October, 2003)		
1	134	AARP (formerly the American Association of Retired Persons) (aarp)
2	129	American Medical Association (ama)
3	108	Pharmaceutical Research and Manufacturers of America (phrma)
4	102	American Hospital Association (hospit)
5	98	National Governors Association (nga)
6	95	AFL-CIO (aflcio)
7	89	American Association of Health Plans (aahp)
8	85	Health Insurance Association of America (hiala)
8	85	Families USA (fam)
10	84	U.S. Chamber of Commerce (chamber)
Congressional Staff Rankings (April–June, 2003)		
1	82	Pharmaceutical Research and Manufacturers of America (phrma)
2	74	American Medical Association (ama)
3	68	AARP (formerly the American Association of Retired Persons) (aarp)
4	63	American Hospital Association (hospit)
5	52	U.S. Chamber of Commerce (chamber)
6	47	AFL-CIO (aflcio)
7	39	National Governors Association (nga)
8	38	National Right to Life Committee (nrlc)
9	36	Association of Trial Lawyers of America (atla)
10	35	American Association of Health Plans (aahp)

Source: Author interviews with 95 congressional staff and 168 interest group representatives (2003)

Note: Group abbreviations are in parentheses.

slightly more attention to non–health-focused organizations.¹² On each list, AARP, medical doctors, the pharmaceutical industry, and hospitals are considered the most influential interests. One revealing aspect of the findings is the changing status of the AMA in the health policy domain. In Laumann and Knoke's (1987: 174) rankings of influential organizations,

12. Interviews with interest group representatives and congressional staff members yielded remarkable concurrence on the question of influence, with influence scores from the two populations having a Pearson's correlation coefficient of 0.919. The close match between these variables is strong evidence that influence has been measured reliably.

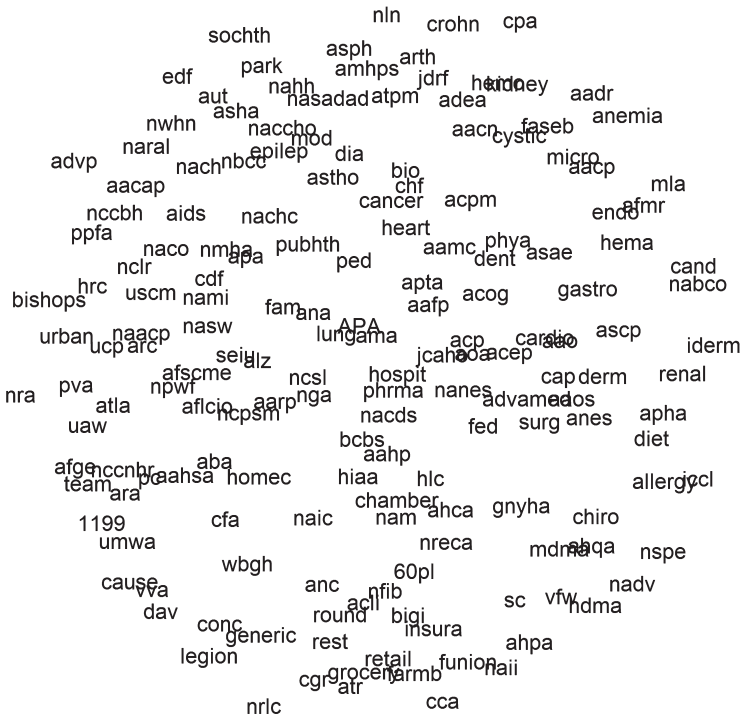


Figure 3 U.S. National Health Policy Communication Network, 2003

the AMA is positioned on top and is significantly above all other interest groups, with the American Hospital Association ranked a distant second. However, my results show that in 2003 the AMA is roughly coequal in the top position with several other major organizations. Consistent with the arguments of Laugesen and Rice (2003) and Peterson (1993, 2001), the rankings establish that the AMA is still a key player, but it no longer occupies the hegemonic position in the health policy domain that it once did.

A snapshot of the contemporary health policy communication network is represented by figure 3. This graph depicts the results of multi-dimensional scaling performed in Ucinet 6, which places groups in a two-dimensional space based on their similarity to each other in the network.¹³ In the informal communication network (figure 3), the AMA, the American Hospital Association, the American Psychiatric Association, and

13. The corresponding interest groups and label definitions are reported in appendix B.

the Pharmaceutical Research and Manufacturers of America (PhRMA) occupy central places, while groups like the American Chiropractic Association and the National Council of La Raza assume the periphery. Other groups tend to cluster by sector. For example, the south central region of the network consists of general business interests, the east central region is a cluster of medical specialty societies, and unions and patient groups assume the west central region, while public health organizations occupy the northeast.

A replication of figure 3 using Laumann and Knoke's (1987) data is provided in figure 4. Perhaps the most politically significant difference between the two figures is that during 1977–1980, PhRMA occupies a peripheral position in the southwest corner, which contrasts notably with its central position in 2003. Also noticeable is the absence of a discernible “hollow core” structure in figure 3, as predicted by Heinz et al. (1993), despite its presence in figure 4. In 1977–1980, there was a clear gulf through the center of the graph between the nursing and mental health interests in the northwest and the provider groups and disease researchers in the southwest. In 2003, however, several groups crowd the center of the graph.

The coalitional relationships reported in figure 5 are similar to those in figure 3, but there are notable variations that reflect differences between private communication and formal coalitions. Public health–oriented groups, such as the APHA and the American Heart Association, play a more central role publicly than they appear to play behind the scenes. In comparison, PhRMA assumes a relatively peripheral role in formal coalitions compared with its central place in private networks. The AMA plays a central role in both networks.

Descriptive statistics for the entire sample of interest groups are reported in table 2. The standard deviation is larger than the mean for both measures of influence, reflecting the skew in these distributions. A few groups received a large number of citations, but most received only a handful. A total of 147 of 171 groups received at least one citation from another interest group representative, and 134 groups received at least one citation from a congressional staff member.

Opportunities for brokerage are similarly distributed in a skewed fashion. In the informal communication network, Families USA (a citizen advocacy group working on health care issues, especially Medicaid), AAMC, and AARP, respectively, have the most potential for brokerage, whereas 61 groups have informal communication brokerage measuring less than 0.100. When brokering across partisan lines is taken into

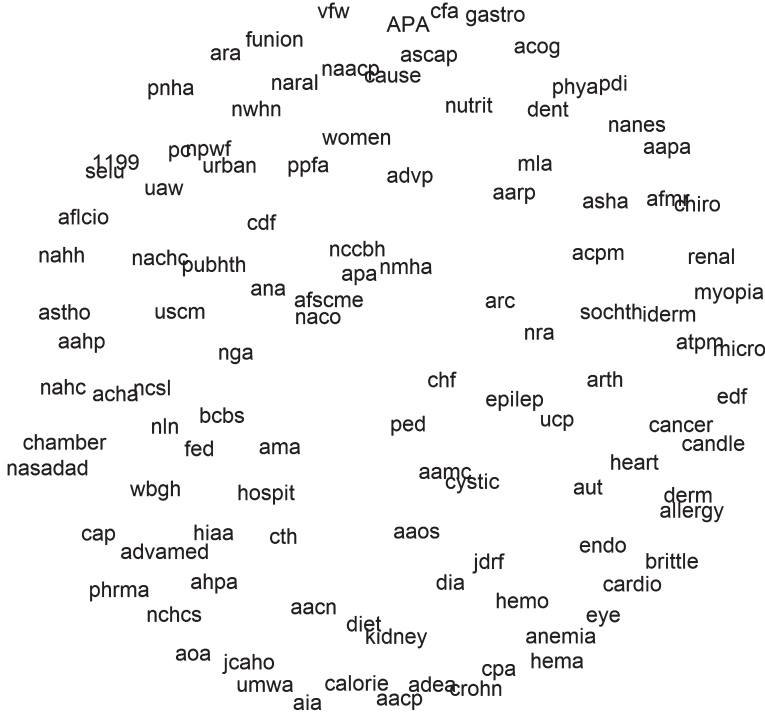


Figure 4 U.S. National Health Policy Communication Network, 1977–1980

Source: Laumann and Knoke (1987). Note: This figure is a representation of the communication proximities matrix using the metric multidimensional scaling routine in Ucinet 6 (Borgatti, Everett, and Freeman 2002). See appendix B for the names of many of the organizations in this figure. For organizations with name changes during the 1980–2003 interval, abbreviations for 2003 are used here. For organizations no longer in existence, names and abbreviations are as follows: American Brittle Bone Society (brittle), Calorie Control Council (calorie), Community Nutrition Institute (nutrit), Council of Teaching Hospitals (cth), Friends of Eye Research, Rehabilitation, and Treatment (eye), Myopia International Research Foundation (myopia), Pennsylvania Diabetes Institute (pdi), Physicians National Housestaff Association (pnha), Women’s Lobby (women), and National Council of Health Care Services (nchcs).

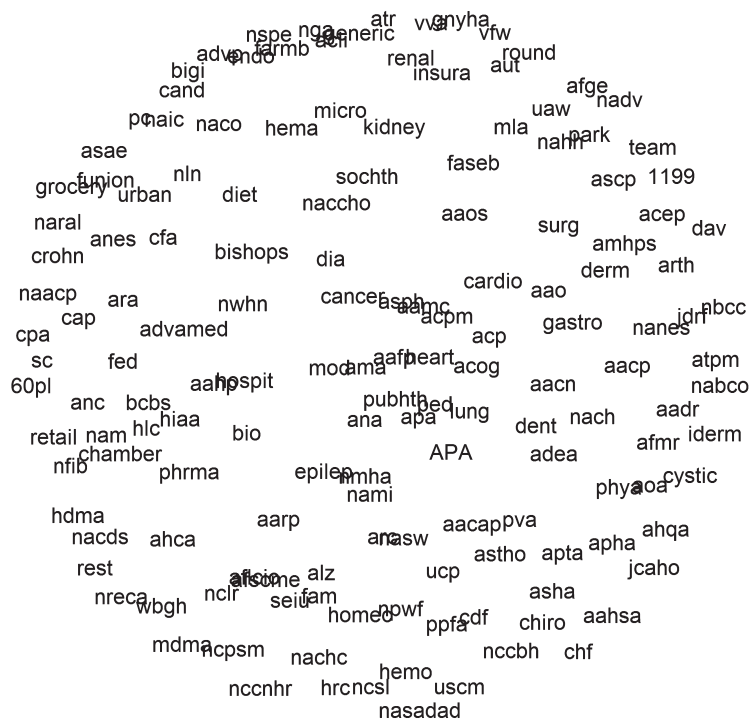


Figure 5 U.S. National Health Policy Coalition Network, 2003

account, Families USA remains first, while the National Conference of State Legislatures and PhRMA enter the top three, followed by AARP.

Among formal coalitions, the highest potential for brokerage is captured by the Chamber of Commerce, the HIAA, and the Service Employees International Union, respectively, whereas 81 organizations have coalition brokerage of less than 0.100. The leading bipartisan brokers in coalitions are an entirely different set, dominated by the American College of Obstetricians and Gynecologists, the AMA, and the American Psychological Association.

Regression Results

Four negative binomial regression models (reported in table 3) test the statistical relationship between influence and potential for brokerage.¹⁴

14. Estimation was performed in Stata 8.0. The α is significantly different from zero in all four models, which implies that overdispersion is present, making negative binomial a more appropriate statistical model than Poisson regression (Cameron and Trivedi 1998: 70–72).

Table 2 Descriptive Statistics

Variables	Standard			
	Mean	Deviation	Minimum	Maximum
Influence				
Number of citations by interest group representatives ^a	20.281	26.26	0	134
Number of citations by congressional staff ^b	9.415	14.06	0	82
Brokerage				
Betweenness in communication network ^b	0.744	1.420	0	8.163
Betweenness among coalitions ^c	0.453	0.935	0	3.930
Partisan brokerage in communication network (in thousands) ^{a,b}	0.714	0.441	0	4.442
Partisan brokerage among coalitions (in thousands) ^{b,c}	0.738	0.891	0	3.478
Partisanship				
Partisan bias of lobbying contacts ^a	3.754	3.374	0	17
Interaction of partisan brokerage and partisanship (in millions) ^{a,b,c}	0.048	0.118	0	0.636
Inside lobbying				
Federal lobbying expenditures in millions, 2003 ^d	1.573	4.692	0	48.400
Number of testimonies before Congress, 2003 ^e	0.649	1.713	0	12
Outside lobbying				
Number of staff citations for grassroots lobbying ^a	12.333	12.103	0	64
Media advertising inside the Beltway, 2001–2002 ^f	0.275	0.448	0	1
Campaign involvement				
PAC expenditures in millions, 2001–2002 ^g	0.462	1.418	0	9.624
Organizational characteristics				
Organizational age ^h	58.964	35.127	0	156
Health-focused organization ^h	0.696	0.461	0	1
Organizational type				
Academic ^h	0.053	0.224	0	1
Citizen advocacy ^h	0.252	0.434	0	1
Nonmember advocacy ^h	0.059	0.236	0	1
Government officials ^h	0.053	0.224	0	1
Professional society ^h	0.386	0.487	0	1

(continued)

Table 2 Descriptive Statistics (continued)

Variables	Standard			
	Mean	Deviation	Minimum	Maximum
Trade association ^h	0.278	0.448	0	1
Labor union ^h	0.059	0.236	0	1
Veterans' service ^h	0.023	0.150	0	1

Sources:^a Author interviews with 168 interest group representatives (2003)^b Author interviews with 95 congressional staff (2003)^c Membership rosters for 117 health policy coalitions (2003)^d U.S. Senate, Office of Public Records, *Lobby Filing Disclosure Program* (2004)^e U.S. House of Representatives (2004) and LexisNexis (2003)^f Annenberg Public Policy Center of the University of Pennsylvania (Falk 2003)^g Center for Responsive Politics (2003)^h *Encyclopedia of Associations* (Hunt 2002), organizational Web pages, and interest group interviews

PAC = political action committee

Models 1 and 2 use the influence citations by interest group representatives as the dependent variable, whereas models 3 and 4 rely on citations by congressional staff. Models 1 and 3 measure brokerage using betweenness, whereas models 2 and 4 include partisan brokerage in the model, along with a variable for interaction between partisan brokerage and partisanship.

The estimates of models 1 and 3 show that brokerage through informal communication networks and brokerage through coalitions are both significant, positive contributors to interest group influence.¹⁵ The regression coefficients imply that a one-unit increase in potential for brokerage in the communications network would earn a group about 1.709 more citations from other interest groups and about 0.587 more citations from congressional staff, when all other variables are at their means or modes (in the case of dummy variables). For a group with a mean level of influence, this would constitute an increase of about 6 percent in the eyes of congressional staff and about 8 percent in the eyes of other groups. Further,

15. To check the robustness of the results to the measurement of brokerage in the informal communication network, I reestimated brokerage by using the criteria that only one group had to recognize the connection in order for it to be present. The one-group and two-group measures of betweenness are highly correlated, registering a Pearson's correlation coefficient of 0.903. Further, when I reestimated the negative binomial regressions by using the one-group measure of betweenness, I found that although the exact regression parameters change, all coefficients retain their original significance and direction. A similar check is not necessary for formal coalitions because the existence of a formal list of members substantially reduces subjectivity about the existence of a connection between groups.

Table 3 Negative Binomial Regressions on the Number of Influence Citations per Interest Group

Independent Variables	Citations by Interest Group Representatives		Citations by Congressional Staff	
	1	2	3	4
Brokerage				
Betweenness in communication network	0.148* (0.048)		0.119* (0.052)	
Betweenness among coalitions	0.547* (0.144)		0.396* (0.158)	
Partisan brokerage in communication network		0.489* (0.101)		0.467* (0.109)
Partisan brokerage among coalitions		0.275* (0.096)		0.146 (0.107)
Partisanship				
Partisan bias of lobbying contacts	0.106* (0.022)	0.155* (0.029)	0.098* (0.023)	0.136* (0.032)
Interaction of partisan brokerage and partisanship		-2.200* (1.010)		-2.016 (1.073)
Inside lobbying				
Federal lobbying expenditures in millions, 2003	-0.007 (0.015)	0.005 (0.015)	0.012 (0.018)	0.176 (0.169)
Number of testimonies before Congress, 2003	0.057 (0.097)	0.0124 (0.095)	0.025 (0.104)	-0.267 (0.102)
Outside lobbying				
Number of staff citations for grassroots lobbying	0.032* (0.007)	0.023* (0.006)	0.041* (0.007)	0.035* (0.007)
Media advertising inside the Beltway, 2001–2002	0.370* (0.152)	0.408* (0.145)	0.441* (0.167)	0.459* (0.160)
Campaign involvement				
PAC expenditures in millions, 2001–2002	0.082 (0.053)	0.076 (0.051)	0.091 (0.056)	0.081 (0.052)
Organizational characteristics				
Organizational age	0.004 (0.002)	0.002 (0.002)	0.001 (0.002)	-0.001 (0.002)

(continued)

Table 3 Negative Binomial Regressions on the Number of Influence Citations per Interest Group (continued)

Independent Variables	Citations by Interest Group Representatives		Citations by Congressional Staff	
	1	2	3	4
Health-focused organization	-0.480*	-0.482*	-0.511*	-0.506*
	(0.165)	(0.158)	(0.185)	(0.178)
Organizational type				
Academic	-0.896*	-0.782*	-0.465	-0.354
	(0.358)	(0.343)	(0.429)	(0.412)
Citizen advocacy	0.184	0.229	0.239	0.288
	(0.185)	(0.179)	(0.214)	(0.205)
Nonmember advocacy	0.080	0.297	-0.073	0.124
	(0.324)	(0.318)	(0.373)	(0.364)
Professional society	-0.849*	-0.698*	-0.774*	-0.620*
	(0.202)	(0.190)	(0.227)	(0.211)
Trade association	0.205	0.246	0.396	0.450*
	(0.192)	(0.181)	(0.209)	(0.198)
Government officials	0.641	0.278	0.652	0.273
	(0.329)	(0.319)	(0.362)	(0.355)
Veterans' service organization	-0.658	0.109	0.376	1.177
	(0.982)	(0.985)	(1.054)	(1.063)
Labor union	-0.777*	-0.346	0.074	0.404
	(0.352)	(0.356)	(0.373)	(0.374)
Constant	1.579*	1.334*	0.684*	0.476
	(0.262)	(0.264)	(0.301)	(0.301)
Log likelihood	-588.555	-582.367	-459.396	-453.674
χ^2	176.050*	188.430*	169.730*	181.180*
α	0.516*	0.457*	0.551*	0.479*
<i>N</i>	171	171	171	171

Source: Same as table 2.

Note: Standard errors are in parentheses.

PAC = political action committee

* $p < 0.05$

the coefficients imply that a one-unit increase in potential for brokerage in the coalition network would earn a group about 6.317 more citations from other interest groups and about 1.957 more citations from congressional staff, when all other variables are at their means or modes. These increases would be about 21 percent in the eyes of other staff and 31 percent in the eyes of other groups.

The estimates of models 2 and 4 show that when interest groups use informal networks to broker across party lines, they can enhance their influence over health policy, as indicated by the significant, positive coefficients on these variables. However, the effects of partisan brokerage among coalitions are not robust. The coefficient is positive and significant in model 2, but is insignificant in model 4. This inconsistency suggests that while interest group representatives see the influence value of brokering coalitions across party lines, congressional staff members do not observe this effect as distinct from other factors contributing to interest group influence.

Partisanship exhibits a robust positive, significant effect on influence in all four models. When interest groups are regarded as devoted partisans, they are able to translate this status into influence. However, consistent with the strategic choice hypothesis (but inconsistent with the multivocal hypothesis), the interaction between partisan brokerage and partisanship is negative and significant in informal communication networks.¹⁶ This result implies that interest groups must choose between playing the role of partisan broker or loyal partisan, since they lose influence when they try to do both simultaneously. An example of a group that plays this losing strategy is Families USA, which is regarded as a highly partisan, Democratic-leaning group, but also builds informal networks on both sides of the aisle. A group in this position is more likely to be viewed as insincere and opportunistic than as influential.

The effects of the control variables on influence are consistent across all four models. Neither inside lobbying nor campaign involvement proves to be a statistically significant determinant of interest group influence in any specification of the model. Likewise, organizational age is insignificant in all models. However, outside lobbying is a robust determinant of influence, as verified by the positive and significant coefficients on grassroots mobilization and media advertising in each model. Counter to Browne's (1990) issue niche hypothesis, health-focused groups are less influential on health policy than are non-health-focused groups, other things being equal. The negative coefficient may exist because, as Heaney (2004b) argues, the benefits of specialization by interest groups often derive from membership niches rather than issue niches. Groups like the Chamber of Commerce and the American Legion are listened to on health issues

16. I estimated models 2 and 4 with and without the interaction variable. Inclusion or omission of the interaction does not alter the statistical significance of other variables in the equation.

because they represent broad constituencies rather than because of issue expertise. The only consistently significant effect of organizational type was that professional societies are less influential than other types of groups. In these data, the professional societies largely represent medical specialty groups, such as dermatology, cardiology, and internal medicine. The influence of these groups may be reduced by the prominence of the AMA, which is more likely to garner the attention of political elites when the physician's perspective is sought.

A skeptical reader may suspect that visibility rather than influence is captured by these equations. Indeed, it is likely that the two concepts are closely related to each other: influential groups are highly visible and visible groups may seem to be influential, even if they really are not. It is wise to note that visibility may be readily translated into influence in a status-obsessed town such as Washington. Still, it is important to examine the data for signs that influence rather than visibility is revealed by the analysis. The number of times congressional staffs indicate that they are contacted by a group—regardless of whether those contacts are rated as reliable or unreliable, occasional or regular—may be a good barometer of visibility. The number of raw contacts reflects whether the group is visible on Capitol Hill, regardless of whether it is liked, trusted, or influential. Raw contacts have a correlation of 0.569 with congressional staff influence citations and 0.640 with interest group influence citations, which is significantly less than the correlation that the two indicators of influence have with each other (0.919). Both congressional staffs and interest group representatives agree that influence and visibility are related to each other, but they also agree that they are not the same thing.

Negative binomial models 5 and 6 are estimated with visibility (i.e., raw contacts) as the dependent variable (reported in table 4). A similar pattern of significant independent variables is uncovered here as in models 1–4. The first major difference between the models of visibility and the models of influence is that brokerage in the informal communication networks is not a significant determinant of visibility, though it does predict influence. This difference is to be expected since informal, private communications are, by their nature, not necessarily visible. The second major difference is that health-focused groups do not suffer a liability of visibility, whereas they do suffer a liability of influence. This difference also makes sense: health-focused groups are likely to try as hard to influence policy as non-health-focused groups on health policy issues, even if they are less successful, other things being equal. These results strongly suggest that there are detectable differences between influence and visibility that are consis-

Table 4 Models of Visibility

Independent Variables	Raw Contacts with Congressional Staff	
	5	6
Brokerage		
Betweenness in communication network	0.022 (0.022)	
Betweenness among coalitions	0.184* (0.064)	
Partisan brokerage in communication network		0.111* (0.041)
Partisan brokerage among coalitions		0.176* (0.040)
Partisanship		
Partisan bias of lobbying contacts	0.038* (0.009)	0.064* (0.013)
Interaction of partisan brokerage and partisanship		-0.986* (0.440)
Inside lobbying		
Federal lobbying expenditures in millions, 2003	0.013 (0.007)	-0.009 (0.007)
Number of testimonies before Congress, 2003	0.005 (0.041)	-0.022 (0.038)
Outside lobbying		
Number of staff citations for grassroots lobbying	0.029* (0.003)	0.025* (0.007)
Media advertising inside the Beltway, 2001–2002	0.441* (0.167)	0.123 (0.064)
Campaign involvement		
PAC expenditures in millions, 2001–2002	-0.020 (0.025)	-0.013 (0.023)
Organizational characteristics		
Organizational age	-0.001 (0.001)	-0.001 (0.001)
Health-focused organization	-0.081 (0.073)	-0.047 (0.067)
Organizational type		
Academic	-0.064 (0.131)	-0.075 (0.123)
Citizen advocacy	0.239 (0.078)	0.047 (0.073)
Nonmember advocacy	0.073 (0.141)	0.093 (0.136)

(continued)

Table 4 Models of Visibility (continued)

Independent Variables	Raw Contacts with Congressional Staff	
	5	6
Professional society	-0.083 (0.083)	-0.072 (0.077)
Trade association	-0.047 (0.079)	0.010 (0.075)
Government officials	0.382 (0.145)	0.322 (0.136)
Veterans' service organization	-0.026 (0.406)	0.324 (0.388)
Labor union	-0.209 (0.157)	-0.079 (0.152)
Constant	2.837* (0.113)	2.732* (0.111)
Log likelihood	-651.952	-640.814
χ^2	176.58*	198.86*
α	0.088*	0.072*
<i>N</i>	171	171

Source: Same as table 2.

Note: Standard errors are in parentheses.

PAC = political action committee

* $p < 0.05$

tent with the brokerage hypotheses examined in this research. However, it is still important to acknowledge that influence and visibility are related and are sometimes difficult to distinguish from each other.

The same skeptical reader may suspect that network brokerage is simultaneously related to policy influence. However, there are three reasons not to be concerned about this possibility. First, previous research on interest group networks does not point to group influence levels as a determinant of network structure. Second, I interviewed separately the leaders of seventy-four of the coalitions examined in this research, asking them about the factors they considered when attracting groups to their coalitions (Heaney 2005). Only one coalition leader cited the need to find influential groups to be a part of the coalition. Most of the other leaders emphasized identifying groups that share their values and objectives, that represent the diversity of interests affected by an issue, and that do the work necessary to make the coalition effective. Third, I statistically examined the pos-

Table 5 Endogeneity Analysis Using the Hausman Test

Endogenous Variables	Citations by Interest Group Representatives	Citations by Congressional Staff
Betweenness in communication network	-0.350 (0.924)	-0.812 (0.599)
Betweenness among coalitions	1.477 (1.644)	0.289 (1.935)
Partisan brokerage in communication network	-0.024 (0.059)	0.044 (0.063)
Partisan brokerage among coalitions	0.000 (0.020)	0.010 (0.022)

Note: Instrumental variables are downtown office and Hill office. Standard errors are in parentheses.

* $p < 0.05$

sibility of endogeneity by using the Hausman (1978) test. I constructed eight models with brokerage as an endogenous variable, one model for each of the potentially endogenous variables in models 1–4. The results in table 5 report the endogenous components of each equation, none of which proved to be statistically significant. These three considerations lend substantial confidence to the conclusion that simultaneity bias does not undermine the estimation of the parameters reported in this study.¹⁷

Whither the Hollow Core?

The findings of this research are in marked contrast to claims of a hollow core in the health policy domain. Has a new generation of health policy brokers emerged since Heinz et al. (1993) conducted their fieldwork in the early 1980s? Has the hollow core been filled? My answer is that the hollow core has shrunk somewhat, but also that it was never that hollow in the first place. Health politics have undergone changes that altered the

17. The instrumental variables used to estimate the endogenous models are whether the organization has offices (1) in downtown Washington or (2) on Capitol Hill as instrumental variables. Office location may play an important role in the ability of an interest group to network with other organizations. For example, the American Academy of Pediatrics has an office near Metro Center in downtown Washington, making it an ideal location for coalition meetings. Office location should affect a group's ability to network, but should not affect influence directly. Lawmakers do not care whether lobbyists are coming from K Street or from nearby northern Virginia, but they care about the positions they take and the methods they use to advance their agendas.

structure of interest group relationships and influence, but some of the variance between the two studies must be attributed to differences in conceptualization and research design.

If the hollow core is conceived narrowly, then Heinz et al. (1993) surely are correct that it exists. My research affirms that there is not a single, central broker in health policy. There is no analog to Robert Moses—the master builder of New York City’s metropolitan infrastructure—or Cosimo de’ Medici—the father of Renaissance Florence (Caro 1974; Padgett and Ansell 1993). The AMA may have once played that role, but it does not play it today. Mills’s (1956) vision of a power elite in American policy making gives way to neopluralism, which depicts the dynamic clash of multiple, coequal elites as the driving force in the policy process (McFarland 2004).

If Heinz et al. (1993) are right to see the core of policy domains as hollow, they are wrong to equate this property with the absence of brokers. Neither Heinz et al. (1993) nor Laumann and Knoke (1987) measure the potential for brokerage directly, simply equating the lack of activity at the core with absence of brokerage on the periphery of policy making. However, both Fernandez and Gould (1994) and Carpenter, Esterling, and Lazer (2004) document the existence of brokerage dynamics among health interest groups when they reanalyze Laumann and Knoke’s (1987) data, with which my results for brokerage in communication networks are consistent. An equivalent test of brokerage among interest groups is impossible to conduct in the Heinz et al. (1993) data because individual people, rather than interest groups, are the units of analysis.

The hollow-core argument is most persuasive with respect to the lack of central actors *among* the four policy domains Heinz et al. (1993) examine, but the hollow-core pattern is less clear *within* the health policy domain in particular. Labor, energy, and agriculture may well operate around a hollow core, but the patterns in health policy are less clearly characterized in this fashion (Heinz et al. 1993: 273, figure 10.2; 286, figure 10.11; 288, figure 10.14; 332, figure 11.7). The relative complexity of health policy in comparison with the other domains creates overlapping relationships among interest groups that are in tension with a hollow core. This tension draws groups toward the center of the system. My research affirms that health policy exhibits a more integrated pattern of relationships than do other domains.

Previous studies did not explore the possibility of brokerage through coalitions and between parties, so it is impossible to establish conclusively whether these are “new” avenues to brokerage or whether they long went

undetected.¹⁸ Although it is not beyond imagination that social scientists systematically ignored vital processes in interest group politics for many years, it is perhaps fair to say that scholars began to devote increased attention to parties and coalitions as they increased in political importance during the mid-1980s. Thus the shrinking of the hollow core coincides with the rise of coalitions and parties in interest group politics, as well as the rising salience of health policy on the national agenda and continually increased crowding of groups in the domain (Baumgartner and Talbert 1995). These trends provide incentives for interest groups to work together in ways that Heinz et al. (1993) say that they do not. Although partisanship may push some interest groups apart, the incentives for partisan brokerage are sufficient to bring other groups into the structural holes created by partisanship. The strategic value of working through coalitions similarly creates incentives for interest groups to forge ties with groups with which they are not accustomed to working.

The Transformation of Medicare in 2003

The preceding analysis establishes the statistical relationship between brokerage and interest group influence with a high degree of confidence. However, the question remains: how does this general theoretical relationship lead concretely to alterations in public policy? I answer this question by focusing on the case of the joint House-Senate conference report on Medicare reform in 2003. The advantages of analyzing the politics of this conference are that they (1) dealt with a well-defined set of issues on which groups either won or lost with relative clarity, (2) were the last stage at which groups had a say before the legislation was finalized, and (3) involved many of the same leading actors that were interviewed in the statistical portion of this research. My analysis draws on a new set of open-ended, anonymous interviews, conducted between December 2003 and February 2004, with thirty individuals who were direct participants in the debate over the conference report.¹⁹

18. Heinz et al. (1993) ask respondents their opinions of coalitions, but do not collect the kind of detailed coalition membership data that are necessary to analyze brokerage among coalitions.

19. I interviewed several Republican and Democratic staff members in the House and Senate who were close to the conference negotiations. The sample was weighted toward interviews with Republicans, because Democrats were excluded from many of the most sensitive negotiations. I also interviewed one professor, one scholar from a leading think tank, and interest group representatives from associations of citizens, veterans, hospitals, doctors, pharmaceutical manufacturers, insurance companies, trades, and unions. The interviews were set up on the

This section proceeds, first, by outlining the big picture issues on the interest group politics of Medicare reform. Second, I provide examples of the three bases of brokerage examined in this article (communication networks, coalitions, and parties) and one example of failed brokerage. Third, I speculate on the likely implications of this analysis for implementation of the legislation. This discussion is intended to illustrate how brokerage matters and to deepen the understanding of its operation, but should not be construed as proving or disproving any hypotheses tested in this research.

The Big Picture

The creation of an outpatient prescription drug benefit was an issue in every major effort to reform Medicare since it was dropped from the markup of the original legislation in 1965 (Marmor 2000; Oberlander 2003; Oliver, Lee, and Lipton 2004). A window of opportunity opened to enact the benefit in 2003 for several reasons, including President Bush's desire to use the achievement in his 2004 reelection campaign, control of the agenda by a unified Republican government, and the political will of key congressional leaders, especially Senate Majority Leader Bill Frist and House Speaker Dennis Hastert (Iglehart 2004). If national political leaders were responsible for opening the window, over five hundred interest groups were willing to climb through it by taking a public stance on the legislation (Sandlin 2003; U.S. House of Representatives, Committee on Ways and Means 2003a, 2003b). The thirty-two coalitions that organized for or against specific aspects of the conference report are listed in table 6. In addition to these coalitions, Democratic and Republican party leaders set up two "grand coalitions" that either supported or opposed the entire bill during the last two weeks of debate.

While the attention of the news media was drawn to features of the prescription drug benefit for Medicare recipients—from discount cards to doughnut holes—the interest group politics of the legislation were less about prescription drugs under Medicare than about many other features of the legislation. Established hospitals wanted to stop the construction of

basis of personal connections, so they were not systematic or random, though they were chosen with the intention of achieving politically balanced representation of most of the key interests. The interviews were unstructured, so my questions varied from case to case, though they were all targeted at the ultimate question of who influenced the content of the conference report and how they did so.

Table 6 Lobbying Coalitions and Medicare Reform, 2003

Coalition Name	Members	Key Medicare Issues
Alliance of Specialty Medicine	Medical specialty societies (e.g., cardiology, radiology)	Physician reimbursement
Alliance to Improve Medicare	Healthcare Leadership Council, insurance interests, business interests	Prescription drug benefit, cost containment, private plan participation
Anti-reimportation Coalition	Pharmacy groups, biotechnology industry, business interests	Safety of imported prescription drugs
Archer MSA Coalition	Conservative advocacy groups, insurance interests, small business interests	MSAs/HSAs
Campaign to Preserve—Not Privatize—Medicare	Public Citizen, consumer advocates, religious groups	Privatization
Cancer Leadership Council	ACS, ASCO, cancer patient and provider groups	Average wholesale price reform, oral cancer drugs
Clinical Laboratory Coalition	American Clinical Laboratory Association, other lab industry interests	Clinical lab copayment, competitive bidding for laboratory services
Coalition for a Competitive Pharmaceutical Market	Generic Pharmaceutical Association, pharmacy interests, insurance interests, business interests	Hatch-Waxman reform, generic drugs
Coalition for Access to Medical Services, Equipment, and Technology	Home care industry, medical device industry, patient advocates, disability service providers	Competitive bidding for durable medical equipment
Coalition for Fair Payments to Health Care Providers Treating Emergency Undocumented Immigrants	American Hospital Association, state and regional hospital	Funding for hospitals with the highest volume of undocumented immigrants associations
Coalition to Protect America's Health Care	American Hospital Association, AAMC, hospitals, health systems	Payments to hospitals
Consortium for Citizens with Disabilities	Disability patient advocates, mental health groups, disability service providers	Medicare-Medicaid dual eligibles, disability, privatization
Employers' Coalition on Medicare	U.S. Chamber of Commerce, business interests (e.g., Caterpillar, IBM, Motorola)	Employer mandates, retiree health coverage, employer participation

(continued)

Table 6 Lobbying Coalitions and Medicare Reform, 2003 (continued)

Coalition Name	Members	Key Medicare Issues
Geographic Equity in Medicare Coalition	Iowa Medical Society, Iowa Hospital Association, rural providers	Payments to rural providers
Independence through Enhancement of Medicare and Medicaid	Patient advocates, providers of disability services, medical device industry	Durable medical equipment, access to assistive technologies
Indirect Medical Education Coalition	American Hospital Association, AAMC, medical specialty societies	Payments for indirect medical education
Leadership Council of Aging Organizations	AARP, unions, patient advocates, providers of aging services	Prescription drug benefit, low-income, disability, premium support, Medicare+Choice
Low-Income Provisions Coalition	AARP, Families USA, aging advocates, consumer advocates	Prescription drug benefit, dual eligibles, nursing home copayments
Mental Health Liaison Group	Associations of providers of mental health services, patient advocates	Mental health copayment equity
Multiple Sclerosis Prescription Drug Coalition	National Multiple Sclerosis Society, patient advocates, MS drug manufacturers	Part B coverage of immunomodulating drugs for multiple sclerosis
Niche Hospital Coalition	American Hospital Association, Federation of American Hospitals	Physician self-referral to specialty hospitals
Opponents of a Home Health Copayment	Home care industry, visiting nurses associations, patient advocates, unions	Copayments for home health care
Partnership for Safe Medicines	PhRMA, biotechnology industry, pharmacists, business interests	Importation of prescription drugs
Pharmacist Provider Coalition	Pharmacy organizations	Medication therapy management
Pharmacy Benefits All Coalition	Pharmacy organizations	Medication therapy management, mail order, use of PBMs
Public Hospital Pharmacy Coalition	Public hospitals	Inpatient drug prices at public hospitals
Rural Hospital Coalition	Rural hospitals	Payments to rural hospitals

Table 6 (continued)

Coalition Name	Members	Key Medicare Issues
Rx Benefits Coalition	Pharmacy benefit managers, insurance associations, business associations	Prescription drug benefit, formularies, delivery mechanisms
Rx Health Value	AARP, insurance interests, consumer advocates, unions, business interests	Hatch-Waxman reforms, generic drugs
Safety Net Hospitals Coalition	American Hospital Association, AAMC, children's hospitals	Payments to Medicaid Disproportionate Share Hospitals
Therapy Cap Coalition	Providers of rehabilitation services	Rehabilitation therapy caps
Update Coalition	AMA, medical specialties, nonphysician providers	Payments to professional providers under Part B

Source: Interviews with representatives of 168 interest groups, interviews with 30 informants on Medicare issues, coalition letters, press releases, and coalition Web pages

AAMC = Association of American Medical Colleges; AARP = formerly American Association of Retired Persons; ACS = American Cancer Society; AMA = American Medical Association; ASCO = American Society of Clinical Oncology; HSAs = health savings accounts; MS = multiple sclerosis; MSAs = medical savings accounts; PBMs = pharmacy benefit managers; PhRMA = Pharmaceutical Research and Manufacturers of America

new specialty hospitals designed to siphon off the most profitable patients (cf. table 6, Niche Hospital Coalition). Doctors sought improved reimbursement rates for Medicare services (cf. table 6, Update Coalition). Large employers pressed for improved terms in providing retiree health benefits (cf. table 6, Employers' Coalition on Medicare). Small businesses concentrated on expanding the availability of tax-preferred health savings accounts for all citizens (cf. table 6, Archer MSA Coalition). Even AARP—the supposed power broker that made the prescription drug benefit a reality—devoted much of its negotiating energy to win the removal of an obscure provision (Section 631 of the Senate version of the bill) that would have modified the Age Discrimination in Employment Act to the advantage of business interests.²⁰ The balkanized nature of the group

20. A coalition did not form on this issue, but AARP addressed the issue independently. Numerous sources claimed that Section 631 was the linchpin for the legislation: removing this provision was the necessary condition for winning AARP's endorsement. A prominent Democratic Senate staff member complained that "AARP was obsessed with Section 631" and advised, "If you want to win a lot of money, then play cards with AARP" (author interview, February 19, 2004). The staff member argued that winning on 631 was not as valuable as AARP believed; instead it should have held out for further concessions.

politics of the bill clarifies why brokerage is often decentralized in health policy making: negotiation cannot be facilitated by a single, central power broker, but instead only by dispersed brokers dealing with myriad issues, from copayments for clinical laboratory services to timing the availability of generic drugs on the market.

The primary purpose of the conference negotiations was to reconcile the differences between the House and Senate versions of the bill. While rumors throughout the summer of 2003 suggested that the differences were irreconcilable (Adams 2003), negotiators reached an agreement that settled several major policy issues. For example, Senate negotiators won the debate over *premium support*—an effort by House conservatives to allow private health plans to compete against fee-for-service Medicare—by reducing it to a demonstration project (repackaged as “comparative cost adjustment”) beginning in 2010 (P.L. 108–173, Section 241). In contrast, House negotiators won the inclusion of health savings accounts in the conference report, despite their absence from the Senate version of the bill (P.L. 108–173, Section 1201). The Senate blocked a House effort to allow the reimportation of prescription drugs from twenty-five nations with advanced drug regulatory systems (Rovner 2003: 2619). The two chambers struck a compromise on reimbursing physician-administered outpatient drugs by using the “average wholesale price” method, which allegedly over-reimburses physicians for their services (U.S. House of Representatives 2003: 578–581).

Although I argue in the following three sections that interest groups brokered many issues addressed by the conference, it is also essential to recognize that not all changes in the conference report were the result of interest group influence and that not all interest group influence was a result of brokerage. For example, the defeat of the radical premium-support proposal appears to have had little to do with interest groups, which were not highly visible in advocating for or against premium support.²¹ This change was essentially a concession by Republican leaders to Democratic senators. The Republican leadership had little invested in this proposal, though Democrats opposed it bitterly. As one Republican congressional staffer recounted, “Premium support had a constituency of one: Bill Thomas [the Republican Chairman of the House Ways and Means Committee]” (author interview, February 29, 2004). Once the legislation

21. One formal coalition did exist on this issue: the Campaign to Preserve—Not Privatize—Medicare. However, I did not encounter any evidence that this coalition or its members were a factor in congressional deliberation on the issue of premium support.

was signed into law, U.S. Secretary of Health and Human Services Tommy Thompson commented on the likelihood of implementing the scaled-back premium-support provision simply by saying, “I’ll believe it when I see it” (Schuler 2003: 3058).

Numerous examples of how groups exerted influence as their own direct agents, rather than as brokers, emerged in the politics of the conference report. For example, the insurance industry, as represented principally by the then recently merged American Association of Health Plans and Health Insurance Association of America (AAHP-HIAA, presently known as America’s Health Insurance Plans [AHIP]), exerted considerable influence in writing Title II of the act. Title II dealt with the implementation of Medicare Advantage, a renamed version of Medicare+Choice that is intended to increase the participation of private health plans in Medicare. The final conference report provisions in Title II did not closely resemble either the House or Senate versions of the bill (U.S. House of Representatives 2003: 523–570). AAHP-HIAA worked privately with Republican congressional staff to rewrite this title, effectively subsidizing congressional attention to the provision (Hall and Deardorff 2006; see also Bauer, Pool, and Dexter 1963). As a senior lobbyist for the insurance industry explained, “The conferees needed [insurance industry lobbyists] to explain how Medicare+Choice worked and how to fix it. The House and the Senate versions [of the bill] wouldn’t have done it. We were needed to rewrite the legislation in a functional way” (author interview, February 25, 2004).

A final part of the big picture is that party leaders were not at all indifferent to the involvement of interest groups in the conference negotiations. Contrary to conventional notions of groups working to pressure elected officials, the parties sought to use interest groups to help make their case to the public—a kind of reverse outside lobbying. Republican leaders were particularly savvy on this point, seeing AARP’s endorsement as a way to signal to the public that they were not opposing the well-being of the elderly. Likewise, Republican leaders actively sought the AMA’s endorsement, which they received in exchange for positive update in the Medicare fee schedule for physician services.

Republicans actively mobilized a grand coalition of groups to support the legislation by using lobbyist Susan Hirschmann (former chief of staff to House Majority Leader Tom DeLay) as captain of the whipping operation. Small medical specialty societies and associations of allied health professionals were vulnerable targets for party discipline, as Republican leaders expected them to voice public support for the entire bill in

exchange for narrow pork-barrel provisions, such as funding for provider-specific studies and demonstration projects. These exchanges underscore how close relationships between parties and interest groups lead not only to increased group influence, but also to augmented party control (Greenstone 1969).

Brokerage through Informal Communication Networks

The name-brand pharmaceutical industry, as represented by its leading trade association, PhRMA, proved to be the master of brokerage through informal channels. While PhRMA was widely feared as a powerful giant throughout the spring and summer of 2003, it made a number of missteps in lobbying on the reimportation of prescription drugs that began to tarnish its reputation on Capitol Hill. Thus it quickly became difficult or impossible for PhRMA to be a visible part of formal coalitions and still retain its influence. The solution was to coordinate privately with interest groups (like the American Pharmacists Association) and coalitions (like the Pharmacist Provider Coalition) that were more palatable to critical observers and to communicate its message directly to Congress through inside lobbying. During the height of the conference negotiations, two oft-repeated maxims on Capitol Hill were “PhRMA has more lobbyists than Congress has members” and “PhRMA has more money than God.” Although both statements are significant exaggerations, they reflect a general mood among Democrats and Republicans alike that PhRMA simultaneously is extremely powerful and has overstepped its legitimate bounds.

A key issue in the conference report on which PhRMA played a critical brokerage role was the use of pharmacy benefit managers (PBMs) to deliver the prescription drug benefit. PBMs assume a middle-market function in the sale of pharmaceuticals by contracting with networks of pharmacies, negotiating rebates, and managing available lists of medications known as *formularies*. After successfully blocking a government-administered drug benefit during the Clinton administration (partially through the stealth creation of the Citizens for Better Medicare coalition), PhRMA was willing to promote the use of PBMs because, as one industry lobbyist explained, “If we are going to do this benefit, we should do it through a private delivery system” (author interview, March 26, 2004). PhRMA helped to broker a position for the PBMs in part by attacking alternative proposals and in part by coordinating privately with the Rx

Benefits Coalition, which was set up to display broad support for the PBM industry.

The adoption of PBMs as the mode of implementation put PhRMA in an optimal negotiating position with respect to access to accurate information about formulary design, a highly technical but financially consequential aspect of the legislation. PhRMA drew upon this advantage successfully to mold provisions on formularies with respect to the definitions of therapeutic classes, tiering of benefits, and consumer rights to appeal denial of coverage. These modifications collectively made the drug benefit more generous in ways calculated to enhance the profits of the name-brand drug manufacturers.

Brokerage through Coalitions

As mentioned earlier, conservative interest groups marshaled the Archer MSA Coalition to gain considerable influence through brokerage. Since small business owners and employees stood to gain the most from HSAs, the National Federation of Independent Business (NFIB) played a leading role within the coalition. The nature of its brokerage was to serve as a bridge between pro-business interest groups and socially conservative interest groups. It easily solicited the involvement of organizations like the 60 Plus Association (the so-called conservative alternative to the AARP), the American Dental Association, and the Small Business Survival Committee, which had clear financial and ideological reasons to support HSAs. However, it was much less obvious as to why socially conservative organizations such as the Christian Coalition of America, the Traditional Values Coalition, and Phyllis Schlafly's Eagle Forum should care about this issue. The great success of the NFIB as a coalition broker was precisely in bringing these socially conservative groups on board, which helped to signal to conservative members of Congress that HSAs were an important, even critical, aspect of conservative-styled health reform. As a staff member to a Republican House member recalled, "When we saw whose names were affixed to that letter [circulated by the Archer MSA Coalition] people began to sit up and take notice. We realized that HSAs mattered more to the conservative cause than we had first thought" (author interview, March 12, 2004).

The American Clinical Laboratory Association (ACLA) is another example of an interest group that exercised influence by brokering coalitions. ACLA led the Clinical Laboratory Coalition in a fight against Section

431 of the Senate version of the bill, which would have required Medicare beneficiaries to make a 20 percent copayment on all clinical laboratory tests. A typical \$5 urine analysis would have required a \$1 copayment. Since clinical laboratory tests were one of the few Medicare services that did not require a copayment under current law, this proposal appeared to be reasonable on its face. However, the industry claimed that the administrative costs of billing for copayments would be a catastrophic expense that could threaten the economic health of many laboratories. In fighting this provision, ACLA served as a bridge between large business interests, such as the Advanced Medical Technology Association (AdvaMed), and laboratory professionals, represented by organizations like the American Society for Microbiology. Linking these interests helped members of Congress to appreciate the potentially broad effects of the provision, which resulted in the elimination of the proposed copayment from the legislation. However, contrary to the interest of the industry, the final bill placed a five-year freeze on updates in the Medicare fee schedule for clinical laboratory services (P.L. 108–173, Section 627).²²

Bipartisan Brokerage

AARP's involvement in the politics of the conference is the most notable example of bipartisan brokerage. AARP worked closely on the legislation with left-leaning organizations, such as Families USA, the AFL-CIO, and the Center on Budget and Policy Priorities, which are its usual partners on many issues, from maintaining traditional Social Security to stopping the block granting of Medicaid. However, in addition to working with its usual partners, AARP engaged privately with numerous right-leaning organizations, such as the Business Roundtable, PhRMA, and the American Enterprise Institute.

For a few short months in the summer and fall of 2003, AARP occupied the balance of power between leading Democratic interests and dominant Republican interests. This position augmented its standing in negotiating directly with former Republican House Speaker Newt Gingrich and aids to Bill Frist. AARP gained influence not only through private networking between the left and the right, but also because its public endorsement of

22. Another significant aspect of this story is that ACLA was able to enlist representatives of small laboratories to educate members of Congress about the economic effects of the legislation within their districts. This outside-lobbying strategy created grassroots pressure on Congress to eliminate the copayment.

the bill left the Leadership Council of Aging Organizations (LCAO) in disarray. The council is the leading formal coalition of interests of the aging, with AARP being its most prominent member. When AARP and the Alzheimer's Association split with LCAO on this issue, LCAO could no longer function in its role as a broker. Thus AARP gained influence, in part, by blocking other organizations from exercising brokerage.

While AARP established influence through bipartisan brokerage in private communication networks, Rx Health Value exerted bipartisan brokerage as a formal coalition. This coalition was concerned primarily with modifying the Hatch-Waxman Act of 1984 (P.L. 98–417), which enabled name-brand drug manufacturers to apply for an automatic thirty-month stay in the marketing of a generic drug. However, a loophole in the act enabled patent holders to receive multiple successive thirty-month stays, effectively extending the life of the patent for several years. Rx Health Value advocated closing this loophole to enable patent holders to apply for only one thirty-month stay (P.L. 108–173, Section 1101). This change was intended to bring generic drugs to market more quickly and thus enable consumers and insurance companies to save money on the purchase of prescription drugs.

The common ground of the Rx Health Value coalition was opposition to name-brand drug manufacturers. The coalition was forged across traditional partisan boundaries by linking Democratic-leaning unions (including the United Auto Workers and the American Federation of State, County and Municipal Employees) and consumer advocates (including AARP, the National Consumers League, and Families USA) with Republican-leaning business interests (such as the Blue Cross and Blue Shield Association and the Washington Business Group on Health) and physician organizations (like the American Academy of Family Physicians). Genuinely nonaligned groups, like the National Organization of Rare Disorders, also joined the coalition. It would be an exaggeration to suggest that Rx Health Value was pivotal in securing a place for Hatch-Waxman reforms in the conference report, since nontrivial support existed among members of Congress for this change. However, the coalition and its bipartisan nature contributed to countering the weight of PhRMA in opposing the provision.

Failed Brokerage

If acting as a broker is a clear path to influence, then it may seem that all interest groups should be able to use this strategy to their advantage.

However, serving as a bridge between otherwise disconnected interests is easier said than done. Brokerage is valuable in part because it is risky and is not always possible. The issue of competitive bidding for durable medical equipment is one on which the leading interests attempted to broker a diverse coalition, but found that their efforts yielded little fruit. The Balanced Budget Act of 1997 (P.L. 105–33, Section 4319) established demonstration projects that allowed for the competitive acquisition of durable medical equipment, prosthetics, eyeglass frames, and custom-fabricated orthotics. The conference agreement nationalized this demonstration program to the chagrin of many users and producers of these products.

Opponents of competitive bidding formed the Coalition for Access to Medical Services, Equipment and Technology (CAMSET), which bridged patient groups (like the well-respected Paralyzed Veterans of America) and industry interests (such as the Medical Device Manufacturers of America). However, opponents of the provision never convinced congressional negotiators that the broad interests supposedly supporting the coalition were politically committed to that position; they did not believe that the coalition *on paper* was a coalition *in fact*. Hence, it was relatively easy, from a political point of view, for the conference to keep competitive bidding requirements in its report, despite nominal opposition. CAMSET was a noble attempt at brokerage, but it failed to actualize its full potential.

Brokering Implementation

With the creation of a new menu of federal benefits comes the realignment of incentives for interest groups to mobilize in Washington (Stein and Bickers 1996). An important question about Medicare reform is how it will affect the viability and influence of particular organized interests. Pear (2005: A1) reports that “the new Medicare law has touched off explosive growth in lobbying by the health care industry, whose spending on advocacy here far exceeds that of consumer groups and other industries like defense and banking.” The emergence of this “lobbying-industrial complex” led the *New York Times* (2005) to editorialize that “it is time to enact credible controls [on this industry].” Is this conclusion consistent with the relationship between brokerage and influence uncovered in this research?

The growth in the size of an interest community does not translate directly into more influence for its participants. Indeed the reverse is likely true, with “more groups” meaning “less clout” for each individual group (Salisbury 1990). My findings suggest that new statutory targets

and a growing community of interests around Medicare are likely to produce a shift in the locus of brokerage rather than the growth of influence. Although a rigorous analysis of brokerage during implementation would require a new study, some predictions can be deduced based on a modest amount of speculation.

One likely effect is that although PhRMA was essential in securing a role for PBMs in Medicare, the informational advantage in lobbying in this area has shifted from PhRMA (and its member companies) to the PBMs themselves (like Caremark), the trade associations that represent them (especially the Pharmaceutical Care Management Association [PCMA]), and the professionals that staff them (represented by the Academy of Managed Care Pharmacy [AMCP]). When the Centers for Medicare and Medicaid Services finds itself inundated with requests for modifications of formularies, PCMA and AMCP will be the most well-positioned organizations to sort through those petitions and broker decisions with political and technical considerations dually in mind. Similarly, AdvaMed, the peak association for the medical device industry, will be well positioned to broker any necessary changes in the implementation of device coverage.

A second likely effect is that as the politics of Medicare moves from creating a new benefit to paying for it in real time, questions of domestic price controls and reimportation of prescription drugs are likely to return to the top of the agenda. With AARP and PhRMA already having well-defined positions on these points, the balance of power may shift elsewhere. This debate is an opportunity for the AMA to reassert itself as a preeminent broker in health policy. The AMA has already announced support to expand the power of the U.S. Secretary of Health and Human Services to negotiate lower prices for drugs (Pear 2004). It may be positioned to maneuver on these issues in policy networks to a greater degree than the other leading organizations.

Conclusion

Serving as brokers between otherwise disconnected organizations is a key way that interest groups exert influence over health policy. Groups achieve positions of brokerage by navigating informal communication networks, formal coalitions, and political parties. Their strivings to influence policy occasionally situate them at the center of a policy network, but more routinely enable them to extract gains across a variety of different issue areas. The core of this policy space is hollow in the formal sense that no

one dominant player is fixed in the center. However, hollowness does not adequately capture the essence of the brokerage process. Groups actively fill roles as brokers on a regular basis, which enables them to induce tangible changes in health policies.

The enactment and implementation of the Medicare Prescription Drug, Improvement, and Modernization Act illustrate the substantive nature of interest group brokerage. The federal government's intervention in health policy through the management of Medicare touches nearly every corner of the health policy domain, and Medicare reform is often explicitly about more than just Medicare. As in the health policy domain writ large, interest groups are more likely to get what they want in these debates when they connect interests across business, labor, consumers, and political parties through private networks and formal coalitions. Some of the consequences of this maneuvering have been an expansion of drug formularies in Medicare and the creation of the option of health savings accounts for all Americans. Given the numerous problems that have arisen in the implementation of the drug benefit, it seems probable that new opportunities for interest groups to press for changes by acting as brokers will continue to arise (Pear 2006).

The party-group nexus is perhaps the least understood and the most dynamic aspect of brokerage. Stem cell research is an example of an issue on which interest group advocates have played an enormously effective part in building bridges across party boundaries. The Coalition for the Advancement of Medical Research (CAMR) was founded in 2001 by opponents of President Bush's policy on stem cell research. The coalition had ninety-three member organizations by 2005, spanning advocates for patients, disease research, universities, and medical professionals. Although stem cell research is largely a Democratic issue, CAMR was able to build support among Republican-leaning interest groups and politicians because of the leadership of groups like the Juvenile Diabetes Research Foundation International (JDRF). As a result, it won support early from prominent Republican senators, especially Arlen Specter and Orrin Hatch, and later from Majority Leader Bill Frist (Stolberg 2005). Although CAMR and JDRF have been successful to date in bringing moderate Republicans into the stem cell fold, the larger challenge is to broker between interests *within* the Republican Party. Winning support from Senator Frist is a promising start down this path, but more progress might be made by mimicking the strategy of the Archer MSA Coalition: if CAMR drew genuinely conservative interest groups into the coalition, this might help to spur fence-sitting Republican House members to lend

their support to stem cell research. Organizations like Americans for Tax Reform and the 60 Plus Association—which are fiscally conservative but not wedded to the right-wing Christian interests that most vehemently oppose stem cell research—are strong possibilities for extending the coalition in a politically advantageous fashion.

The decentralized and increasingly multiplex nature of brokerage in health policy has important implications for the nature of elite responsiveness to citizen demands. When the weight of public sentiment called for a prescription drug benefit under Medicare, the benefit was purchased at the expense of a wide array of pork-barrel benefits for doctors, rural health providers, insurance companies, pharmaceutical manufactures, and others. If Mills (1956) were right that a unified elite governs the policy process, the cost of democratic responsiveness might have been exchanges with a few leading central actors. However, many interest groups are positioned to extract their pound of flesh in the policy negotiation process. Similarly, when Congress and the President finally relent to the public's demand for lifesaving stem cell research, the cost to the public will likely involve tax cuts, regulatory changes, and reimbursement increases for the supportive interest groups that make the winning coalition possible. The neopluralist context of contemporary health politics prevents a single interest group from holding public policy hostage, but well-positioned brokers collectively can influence the outcomes of debates on specific issues. As a result, prominent health policy debates are demonstrably affected by the emergence or absence of skilled interest group brokers in a policy domain once thought to lack this kind of leadership.

Appendix A: Data Collection and Interview Procedures

The research design involved two phases. The first phase, referred to as boundary specification, determined which organizations were included in the research (Laumann, Marsden, and Prensky 1989). Since networks do not have natural boundaries and it is impossible to include all active interest groups in the study, the goal of boundary specification was to produce a sample of groups that are (or are among) the most prominent in the domain.

I applied three criteria in selecting organizations. First, I included all interest groups from Laumann and Knoke's (1987) study that were still in existence in 2003.²³ Second, I classified the level of activity of all interest groups in national health policy according to the frequency with which they testified before Congress on health policy matters between 1997 and 2002 and the lobbying expenditures they reported to Congress between 1997 and 2002, under the Lobbying Disclosure Act of 1995 (LexisNexis 2003; U.S. Senate, Office of Public Records 2003).²⁴ I selected all interest groups that ranked in the top fifty organizations on either frequency of testimony or lobbying expenditures, as well as any organization in the top one hundred on both categories. Third, I circulated a preliminary list to an ideologically balanced panel of health policy experts and asked them to nominate other important organizations for inclusion in the research. Application of these criteria yielded a final list of 171 prominent interest groups.²⁵

The second phase of the research involved interviews with elite informants on the activities of these groups. I drew informants from the ranks

23. To define interest groups, I rely on Salisbury's (1984) distinction between interest groups and institutions. Interest groups are non-political party, nongovernmental organizations with members. They are distinct from individual corporations, state and local governments, universities, and think tanks that do not have members. My study considers an organization an interest group if it has members or has memberlike interactions with ordinary citizens (e.g., by relying heavily on volunteers).

24. I determined which organizations lobbied on health policy by relying on the following categories in the lobbying disclosure reports: health, Medicare and Medicaid, medical research, and pharmacy.

25. I included an organization in the research if it met any one of the three criteria. This list is shorter than it would be if the original approach followed by Laumann and Knoke (1987) had been replicated exactly. However, the fundamental practical consideration limiting the number of organizations listed is that respondents must actually look at and respond to the list. If the list had been much longer, it probably would have been difficult to retain the participation of many elite respondents.

of congressional staffs and governmental affairs staffs (and contract lobbyists) of interest groups. For congressional staff, I contacted the principal majority and minority staff member from each committee working on health issues, the legislative assistant working on health in the office of every U.S. senator, and all House members assigned to health-relevant committees, as well as a random sample of House offices.²⁶ In all, I contacted 230 congressional staff working on health policy, 95 of whom agreed to be interviewed for this project, for a response rate of 41.30 percent.²⁷

Interviews with congressional staff members were conducted in person between April and July 2003. I asked the respondents to look at the list of 171 interest groups and respond to the following four questions/requests (the fourth question was asked of personal staff members only):

1. Rate the influence of each interest group as a key mover, important player, active group, unimportant on health issues, or unknown.
2. Which organizations on this list do you meet with regularly or occasionally?
3. Of those that you meet with, which ones provide information that is usually reliable, sometimes reliable, or unreliable?
4. Which organizations are especially well organized in your district or state?

To establish contact with representatives of the 171 interest groups, I relied heavily on referrals to secure interviews.²⁸ I began by soliciting referrals from congressional staff members and then sought referrals from interest group representatives. For the few groups for which I could not secure a referral, I contacted the organization “cold” through postal mail, e-mail, or telephone. In all, I interviewed representatives of 168 of the 171 interest groups in the study between April and October 2003.²⁹ I asked

26. Contacts were made by postal mail, e-mail, and telephone. The vast majority of contacts were “cold contacts,” which did not rely on referrals or personal acquaintances. However, thirteen individuals were contacted through referral.

27. Staff respondents included thirty-three from the Senate, sixty-two from the House, forty-six Democrats, forty-nine Republicans, eighteen from committees, and seventy-seven from personal staff.

28. While interviews were secured by referral, the groups in the study were determined by the four criteria outlined above in the numbered list. Hence the sample selection procedures do not qualify as “snowball” methodology (Wasserman and Faust 1994: 33).

29. Interviews were conducted with sixteen executive directors, thirty-nine vice presidents, seventy-four directors of government relations, twenty-seven assistant directors of government relations, and twelve contract lobbyists (or individuals with equivalent ranks). Most of the interviews (163) were conducted in person, though five of them were conducted over the telephone at the request of the respondents.

the respondents to look at the list of 171 interest groups and answer the following two requests:

1. Please place a check mark after the name of all organizations on this list with which your organization discusses health policy matters. Indicate whether these discussions occur occasionally or regularly by checking the appropriate column.
2. As I have indicated, all of the organizations on this list are very active in the national health policy area. But I would now like you to circle the codes of those organizations that stand out as especially influential and consequential in formulating national health policy.

Then I asked the respondents,

3. From time to time, organizations form coalitions for the purpose of collectively advancing their objectives in the policy process. Can you tell me which health policy–related coalitions your organization has been a part of during the 107th or 108th Congresses?

If the respondent indicated membership in a coalition, I followed up with inquiries for contact information, public statements, and Web pages, if I had not already obtained that information from other sources.

Appendix B: Interest Groups Included in the Research

60 Plus Association (60pl)

AARP (aarp)

Advanced Medical Technology Association (advamed)

AFL-CIO (aflcio)

AIDS Action Council (aids)

Alliance for Retired Americans (ara)

Alzheimer's Association (alz)

American Academy of Child and Adolescent Psychiatry (aacap)

American Academy of Dermatology (derm)

American Academy of Family Physicians (aafp)

American Academy of Orthopaedic Surgeons (aaos)

American Academy of Otolaryngology (aao)

American Academy of Pediatrics (ped)

American Academy of Physician Assistants (phya)

American Association for Dental Research (aadr)

American Association of Colleges of Nursing (aacn)
American Association of Colleges of Pharmacy (aacp)
American Association of Health Plans (aahp)
American Association of Homes and Services for the Aging (aahsa)
American Association of Nurse Anesthetists (nanes)
American Bar Association (aba)
American Benefits Council (abc)
American Cancer Society (cancer)
American Chiropractic Association (chiro)
American College of Cardiology (cardio)
American College of Emergency Physicians (acep)
American College of Obstetricians and Gynecologists (acog)
American College of Physicians (acp)
American College of Preventive Medicine (acpm)
American College of Surgeons (surg)
American Council of Life Insurers (acli)
American Dental Association (dent)
American Dental Education Association (adea)
American Diabetes Association (dia)
American Dietetic Association (diet)
American Farm Bureau Federation (farmb)
American Federation for Medical Research (afmr)
American Federation of Government Employees (afge)
American Federation of State, County, and Municipal Employees
(afscme)
American Gastroenterological Association (gastro)
American Health Care Association (ahca)
American Health Planning Association (ahpa)
American Health Quality Association (ahqa)
American Heart Association (heart)
American Hospital Association (hospit)
American Insurance Association (insura)
American Legion (legion)
American Lung Association (lung)
American Medical Association (ama)
American Nurses Association (ana)
American Osteopathic Association (aoa)
American Pharmacists Association (apha)
American Physical Therapy Association (apta)
American Psychiatric Association (APA)

American Psychological Association (apa)
American Public Health Association (pubhth)
American Social Health Association (sochth)
American Society for Clinical Pathology (ascp)
American Society for Microbiology (micro)
American Society of Anesthesiologists (anes)
American Society of Association Executives (asae)
American Society of Hematology (hema)
American Speech-Language-Hearing Association (asha)
Americans for Tax Reform (atr)
Arthritis Foundation (arth)
Association for the Advancement of Psychology (advp)
Association of American Medical Colleges (aamc)
Association of Minority Health Professions Schools (amhps)
Association of National Advertisers (nadv)
Association of Schools of Public Health (asph)
Association of State and Territorial Health Officials (astho)
Association of Teachers of Preventive Medicine (atpm)
Association of Trial Lawyers of America (atla)
Autism Society of America (aut)
Biotechnology Industry Organization (bio)
Blue Cross and Blue Shield Association (bcbs)
Business Roundtable (round)
Candlelighters Childhood Cancer Foundation (cand)
Children's Defense Fund (cdf)
Christian Coalition of America (cca)
Citizens for Public Action on High Blood Pressure and Cholesterol (cpa)
Coalition for Health Funding (chf)
College of American Pathologists (cap)
Common Cause (cause)
Concord Coalition (conc)
Consumer Federation of America (cfa)
Cooley's Anemia Foundation (anemia)
Council for Government Reform (cgr)
Crohn's and Colitis Foundation of America (crohn)
Cystic Fibrosis Foundation (cystic)
Disabled American Veterans (dav)
Endocrine Society (endo)
Environmental Defense (edf)
Epilepsy Foundation (epilep)

Families USA (fam)
Federation of American Hospitals (fed)
Federation of American Societies for Experimental Biology (faseb)
Generic Pharmaceutical Association (generic)
Greater New York Hospital Association (gnyha)
Grocery Manufacturers of America (grocery)
Health Insurance Association of America (hiala)
Healthcare Distribution Management Association (hdma)
Healthcare Leadership Council (hlc)
Human Rights Campaign (hrc)
Independent Insurance Agents and Brokers of America (bigi)
International Brotherhood of Teamsters (team)
International Council of Cruise Lines (iccl)
Joint Commission on Accreditation of Healthcare Organizations (jcaho)
Joint Council of Allergy, Asthma, and Immunology (allergy)
Juvenile Diabetes Research Foundation International (jdrf)
March of Dimes Birth Defects Foundation (mod)
Medical Device Manufacturers Association (mdma)
Medical Library Association (mla)
NARAL Pro-Choice America (naral)
National Alliance for Hispanic Health (nahh)
National Alliance for the Mentally Ill (nami)
National Alliance of Breast Cancer Organizations (nabco)
National Association for Home Care (homec)
National Association for the Advancement of Colored People (naacp)
National Association of Chain Drug Stores (nacds)
National Association of Children's Hospitals (nach)
National Association of Community Health Centers (nachc)
National Association of Counties (naco)
National Association of County and City Health Officials (naccho)
National Association of Independent Insurers (nair)
National Association of Insurance Commissioners (naic)
National Association of Manufacturers (nam)
National Association of Social Workers (nasw)
National Association of State Alcohol and Drug Abuse Directors
(nasadad)
National Breast Cancer Coalition (nbcc)
National Citizens' Coalition for Nursing Home Reform (nccnhr)
National Committee to Preserve Social Security and Medicare (ncpssm)
National Conference of State Legislatures (ncsl)

National Council for Community Behavioral Healthcare (nccbh)
National Council of La Raza (nclr)
National Farmer's Union (funion)
National Federation of Independent Business (nfib)
National Governors Association (nga)
National Hemophilia Foundation (hemo)
National Kidney Foundation (kidney)
National League for Nursing (nlm)
National Mental Health Association (nmha)
National Partnership for Women and Families (npwf)
National Rehabilitation Association (nra)
National Restaurant Association (resta)
National Retail Federation (retail)
National Right to Life Committee (nrlc)
National Rural Electric Cooperative Association (nreca)
National Society of Professional Engineers (nspe)
National Union of Hospital and Health Care Employees (1199)
National Urban League (urban)
National Women's Health Network (nwhn)
Paralyzed Veterans of America (pva)
Parkinson's Action Network (park)
Pharmaceutical Research and Manufacturers of America (phrma)
Planned Parenthood Federation of America (ppfa)
Public Citizen (pc)
Renal Physicians Association (renal)
Seniors Coalition (sc)
Service Employees International Union (seiu)
Society for Investigative Dermatology (iderm)
The Arc of the United States (arc)
United Auto Workers (uaw)
United Cerebral Palsy Association (ucp)
United Mine Workers of America (umwa)
U.S. Chamber of Commerce (chamber)
U.S. Conference of Catholic Bishops (bishops)
U.S. Conference of Mayors (uscm)
Veterans of Foreign Wars (vfw)
Vietnam Veterans of America (vva)
Washington Business Group on Health (wbgh)

Appendix C: Coalitions Included in the Research

21 CFR Part 11 Coalition
 340B Coalition
 Ad Hoc Group for Medical Research Funding
 Advocates for Highway and Auto Safety
 Alliance for Childhood Cancer
 Alliance for Pharmaceutical Care
 Alliance of Specialty Medicine
 Alliance to Improve Medicare
 American Council on Fitness and Nutrition
 American Tort Reform Association
 Americans for Long Term Care Security
 Americans for Nursing Shortage Relief
 Antitrust Coalition for Consumer Choice in Health Care
 Archer MSA Coalition
 Association Health Plan Coalition
 Brain Advocacy Coalition
 Californians Allied for Patient Protection
 Campaign for Quality Care
 Campaign for Tobacco Free Kids
 Campaign to Preserve — Not Privatize — Medicare
 Cancer Leadership Council
 CDC Coalition (Centers for Disease Control and Prevention)
 Children's Environmental Health Network
 Citizens for Better Medicare
 Citizens for Long-Term Care Coalition
 Clinical Laboratory Coalition
 Coalition for a Competitive Pharmaceutical Market
 Coalition for Access to Medical Services, Equipment, and Technology
 Coalition for Affordable and Reliable Health Care
 Coalition for Affordable Health Coverage
 Coalition for American Trauma Care
 Coalition for Children's Health
 Coalition for Compassionate Access
 Coalition for Fair Medicare Payment
 Coalition for Fairness in Mental Illness Coverage (Mental Health Parity Coalition)
 Coalition for Genetic Fairness

Coalition for Health Funding
Coalition for National Science Funding
Coalition for the Advancement of Medical Research (CAMR)
Coalition on Human Needs
Coalition to Protect America's Health Care
Confidentiality Coalition
Consortium for Citizens with Disabilities
Council of American Kidney Societies
Cover the Uninsured Week Coalition
Digestive Disease National Coalition
Doctors Against Handgun Injury
Employers' Coalition on Medicare
Endocrine Sister Society Forum
Family Health Plus
FamilyCare Act Coalition
Federal AIDS Policy Partnership
Federation of American Societies for Experimental Biology
Federation of Associations of the Schools of the Health Professions
Federal Medical Assistance Percentage (FMAP) Coalition
Friends of AHRQ (Agency for Health Research and Quality)
Friends of Cancer Research
Friends of HRSA (Health Resources and Services Administration)
Friends of Indian Health
Friends of NICHD Coalition (National Institute of Child Health and
Human Development)
Friends of NIDCR (National Institute of Dental and Craniofacial
Research)
Friends of VA Medical Care and Health Research
Generations United
Genetic Alliance
Genome Action Coalition
Global Campaign for Microbicides
Health Benefits Coalition for Affordable Choice and Quality
Health Coalition on Liability and Access
Health Professions and Nursing Education Coalition
Health Professions Network
Independence through Enhancement of Medicare and Medicaid
Coalition
Independent Budget
Interfaith Coalition for Long Term Care

Leadership Council on Aging Organizations
 Long Term Care Campaign
 Medicaid Action Coalition
 Mental Health Liaison Group
 National Alliance for Caregiving
 National Alliance for Eye and Vision Research
 National Alliance for Nutrition and Activity
 National Coalition for Cancer Research
 National Coalition for LGBT Health (Lesbian, Bisexual, Gay, and Transgendered)
 National Coalition on Health Care
 National Coalition to Support Sexuality Education
 National Colorectal Cancer Roundtable
 National Council on Folic Acid
 National Council on Patient Information and Education
 National Gulf War Resource Center
 National Health Council
 National Medical Liability Reform Coalition
 National Organization for Rare Disorders
 National Organizations Responding to AIDS Coalition
 National Partnership's Patients' Bill of Rights Coalition
 NIAMS Coalition (National Institute of Arthritis and Musculoskeletal and Skin Diseases)
 One Voice Against Cancer
 Opponents of Association Health Plans
 Partnership for Clear Health Communication
 Partnership for Prevention
 Partnership for Safe Medicines
 Patient Access Coalition
 Patient Access to Responsible Care Alliance
 Patient and Consumer Coalition
 Pharmacy Benefits All Coalition
 Renal Coalition
 Research to Prevention
 Research!America
 Rx Benefits Coalition
 Rx Health Value
 Smallpox Compensation Coalition
 Staffing NOW Campaign
 STOP Stroke Coalition

Task Force on the NGA Medicaid Task Force (National Governors Association)
Therapy Cap Coalition (\$1500 Cap Coalition)
Transplant Roundtable
Tri-Alliance (of Rehabilitation Professionals)
Tri-Council of Nursing Organizations
USAction

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