Participation without Representation?
Senior Opinion, Legislative Behavior,
and Federal Health Reform

Katharine W. V. Bradley
Jowei Chen
University of Michigan

Abstract   Why do legislators sometimes engage in behavior that deviates from the expressed policy preferences of constituents who participate in politics at high rates? We examine this puzzle in the context of Democratic legislators' representation of their senior citizen constituents on the Patient Protection and Affordable Care Act of 2010 (ACA). We find that legislators' roll-call votes on the ACA did not reflect the stated preferences of their respective senior constituents; by contrast, these roll-call votes did reflect the preferences of nonsenior adults. We draw upon a theoretical framework developed by Mansbridge to explain this apparent nonresponsiveness to seniors on the ACA. This framework distinguishes between promissory representation, whereby legislators merely respond to constituents' preferences, and anticipatory representation, whereby legislators respond to constituents' underlying policy interests, even when such interests conflict with expressed preferences. By considering the Medicare provisions in the ACA and analyzing Democratic legislators' floor speeches on health reform, we provide preliminary evidence that members of Congress engaged in anticipatory representation of their senior constituents by attempting to educate seniors about how the ACA serves their policy interests.

How well do legislators represent the various age groups within their constituencies? Scholars have long noted that older individuals vote at higher rates, after controlling for income, education, and other demographics (Verba and Nie 1972; Wolfinger and Rosenstone 1980). Andrea

Louise Campbell's seminal work extends these findings, arguing that seniors' participation has been growing since the 1950s and that "seniors are now the super-participators of American democracy" (Campbell 2003a: 14). Campbell asserts that lower income and education are smaller impediments to participation for seniors than for nonseniors due to the existence of social welfare policies that motivate them: Social Security and Medicare provide seniors with both material support for participation and self-interested reasons to engage in politics (Campbell 2002, 2003a). Given that seniors participate in politics at relatively high rates, especially around the policies most salient to them, should we expect legislators to respond to their policy preferences?

Campbell's tests yield a partial answer to this question. While congressional Republicans' votes on a set of Social Security and Medicare bills vary according to the proportion of seniors in their districts, congressional Democrats' votes do not, and Campbell finds no evidence that seniors' letter writing affects votes by members of either party (Campbell 2003a). Democrats' apparent lack of "responsiveness" is largely due to the fact that they generally vote in favor of seniors' interests. However, important research puzzles remain, particularly given the significant ideological variation among congressional Democrats and their respective districts. How responsive are Democratic legislators to the policy preferences of different age groups when votes are on bills that pit the interests of age groups against each other? If legislators are relatively less responsive to their oldest constituents, are they simply ignoring seniors, or might they be representing seniors in unexpected ways?

In this article, we examine senior representation in the context of the Patient Protection and Affordable Care Act of 2010 (ACA). We build upon and extend Campbell's work by describing alternative ways to view senior representation in this context. Specifically, we draw on Mansbridge's (2003) careful explication of different types of representation to argue that legislators engaged in "anticipatory" representation by acting on seniors' underlying interests in health insurance policy, rather than merely responding to seniors' expressed preferences.

In the next section, we provide background on ACA policy and public opinion, and we discuss alternative theoretical lenses through which we might view legislative behavior in this context. We then compare the March 2010 vote on the ACA to district-by-district survey data on citizens' preferences regarding federal health insurance policy. We also exploit variation in the content of floor speeches made during the major House debate on federal health reform.

We focus on health reform because this policy area is particularly appropriate for analyzing legislators' sensitivity to the concerns of different age groups. Senior citizens already have Medicare coverage and thus have a vested interest in fighting off potential policy threats to these benefits (Campbell 2003b, 2011). Meanwhile, adults under the age of 35 suffer from the highest rates of noninsurance. Consequently, political preferences on health reform are polarized across age groups, creating an ideal situation for identifying whether legislators responded to the preferences of older, middle-aged, or younger constituents as they made vote choices and floor speeches.

The ACA is a reasonable but imperfect test case for a study of representation on health insurance policy. No Republican voted for the ACA, at least partly because Democratic leadership censored the legislative process by disallowing amendments. More generally, there are many alternative explanations for variation in ACA votes, such as interest group pressure. Nonetheless, the ACA is the most salient piece of health insurance legislation in recent years, and the fact that it affects adults across the age spectrum—adults who have starkly different policy preferences—allows us to build on Campbell's work by comparing legislative behavior with the opinions of different age groups. We find that legislators are more responsive to the expressed preferences of nonsenior adults, but we argue that legislators engage in anticipatory representation of seniors' underlying interests even while they appear to be unresponsive to seniors' expressed preferences.

Theoretical Framework: Public Opinion, Age, and Representation in the ACA Context

In this section, we further explain why the ACA offers a unique opportunity to examine the legislative representation of seniors on health policy. We then discuss contrasting models of representation, noting in particular whether these models privilege seniors' expressed preferences or their underlying interests.

How do opinions about health insurance and health reform vary by age? Overall, the ACA targets material benefits to nonelderly Americans because seniors in the United States already enjoy robust health coverage relative to citizens of other ages. As figure 1 shows, uninsurance rates peak in young adulthood, steadily decline before the age of Medicare eligibility, and bottom out when people reach age sixty-five. Thus senior citizens
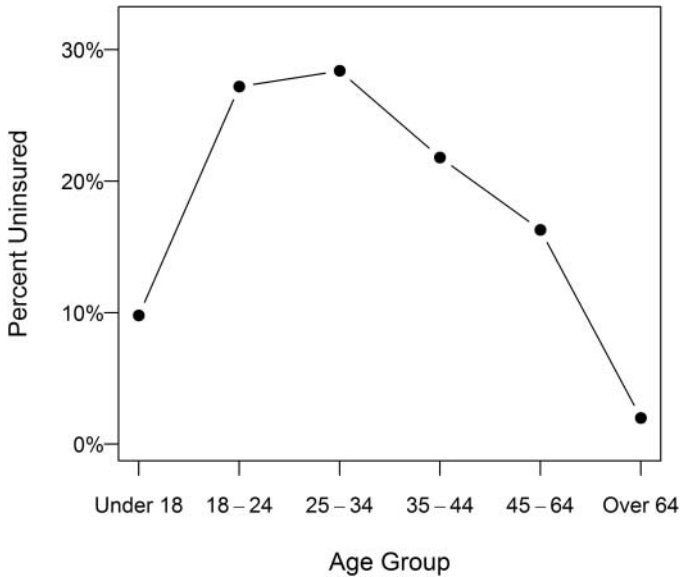
Figure 1   Lack of Health Insurance by Age, 2010

Source: US Census Bureau, Current Population Reports, P60–236 (DeNavas-Walt, Proctor, and Smith 2011)

have less reason than younger adults to support the idea of expending federal resources to cover the uninsured. Indeed, survey results from the Cooperative Congressional Election Study (Ansolabehere 2012, 2013a, 2013b) show a general downward trend by age in respondents' support for increased federal spending on health coverage for the uninsured (fig. 2).

Older adults may also perceive the extension of health benefits to other age groups as a threat to their own coverage. Seniors may fear that the cost of new coverage programs will reduce the resources available for Medicare. A compounding factor may be that seniors believe they have already paid for Medicare through individual tax payments, whereas those eligible for new benefits under various coverage proposals have not made similar contributions toward their own coverage. This sense of having already paid for expected benefits heightens the threat posed by new spending authorizations like the ACA (Campbell 2011). Generational conflict over this issue was particularly acute during the 2009–10 reform effort due to Tea Party claims that the ACA would extend "unearned" benefits to undeserving people (Skocpol and Williamson 2012).
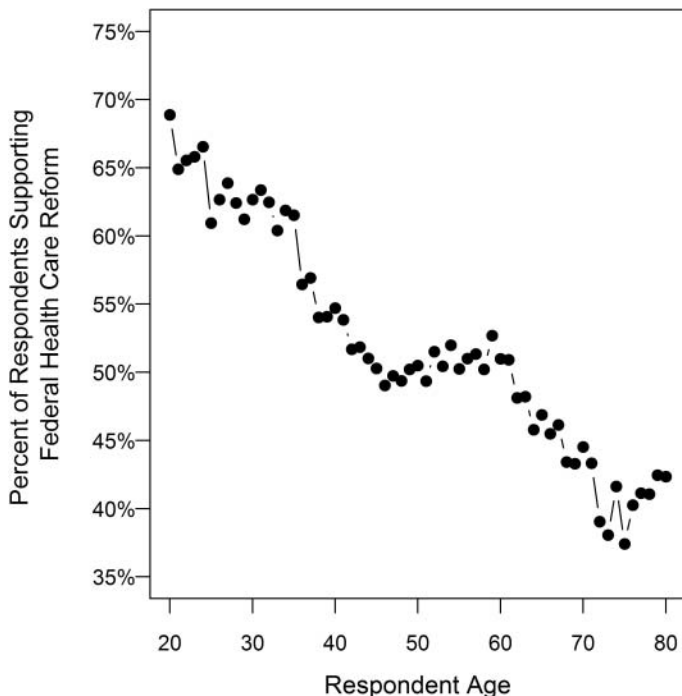
Figure 2 Support for Federal Expansion of Health Coverage by Age
  Source: CCES 2008, 2010, and 2011 (Ansolabehere 2012, 2013a, 2013b)

Most importantly, the ACA made changes to Medicare plan and provider payments that many politicians described as "cuts," evoking past attempts to reduce benefits and framing the ACA as bad for Medicare. Campbell (2003b) has shown that seniors have been quick to perceive and act on past threats to Medicare and Social Security. The ACA may have constituted a less direct threat to Medicare than the 1980s-era bills Campbell examines, many of which proposed cuts to benefits. However, the distinction between reduced plan and provider payments and benefit cuts may not have been obvious to many seniors. Indeed, confusion about the Medicare provisions of the bill was widespread. Table 1 illustrates this confusion: only a minority of seniors gave correct answers to questions about health reform in a poll sponsored by the National Council on Aging (NCOA 2010).

Echoing the other survey results we present in this article, a Kaiser Health Tracking Poll fielded within weeks of the ACA's passage reveals a large disparity by age among respondents who agreed that the country is

Table 1   Senior Citizen Misinformation on the Affordable Care Act's Effects on Medicare

Survey Statement	Percent Responding "True"	Percent Responding "False"	Percent Responding "Don't Know"
"The new law will result in future cuts to your basic Medicare benefits."	42%	22% (correct response)	37%
"As a result of the new law, the solvency of the Medicare Trust Fund will be extended by about 9 years to 2026."	24% (correct response)	22%	54%
"As a result of the new law, the Medicare prescription drug coverage gap, sometimes known as the 'donut hole,' will be gradually closed, and those hitting the gap will receive $250 this year."	42% (correct response)	12%	45%
"The law provides a new, free yearly wellness visit and prevention plan for people with Medicare."	33% (correct response)	13%	54%
"The health care reform law will cut Medicare payments to doctors."	45%	14% (correct response)	41%

Source: NCOA 2010.

Notes: Respondents include 636 US residents aged 65 and older. Percentages may not add up to 100 percent due to rounding.

better off under the new law (KFF 2010a) (fig. 3). This finding is consistent with those of other survey organizations. Gallup polls conducted in the wake of the ACA's passage reveal that opposition to the bill was sharpest among senior citizens: approximately 60 percent of elderly respondents described the ACA as "bad," whereas only 40 percent of respondents under age thirty voiced similar opposition to the reform bill. Middle-aged respondents opposed the bill at a 44 percent rate (Saad 2010).

Given these divergent opinions about health reform and the ACA, how should we interpret legislative representation of different age groups, and
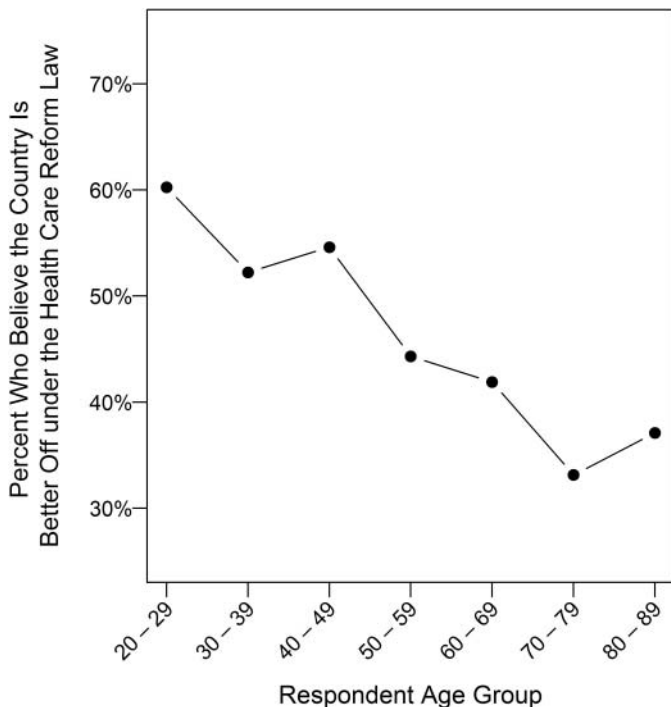
Figure 3   Approval of the ACA by Age

Source: Kaiser Health Tracking Poll, April 9–14, 2010

of seniors in particular? We draw upon the theoretical framework provided by Jane Mansbridge (2003) to address this question. Mansbridge describes four different forms of representation, which she calls "promissory," "anticipatory," "gyroscopic," and "surrogate." We focus on promissory and anticipatory representation because these forms are both pertinent to this context but have opposing implications for what we should expect legislators to be doing.

First, in the promissory representation model, the "relatively unmediated" will of constituents directs future legislative behavior (Mansbridge 2003: 516). In this model the will of constituents is static — Mansbridge explains that voters typically issue their instructions to legislators via an election, although we see no reason that static opinion data could not work in a similar way. If legislators do not "respond" to voters' expressed preferences by creating policy based on those preferences, they are doing a poor job of representing their constituents. The promissory model is very

similar to Campbell's implicit theory of representation, as Campbell asks whether legislators respond to seniors' preferences. She defines "responsiveness" as "how seniors' message was heard and transformed into policy by Congress," where "transformed into policy" refers to the ways members of Congress voted on relevant legislation (Campbell 2003a: 115). Working within this model, we measure the connection between voter opinion and legislators' vote choice. Our analysis suggests that nonsenior adults enjoyed better promissory representation on the ACA than seniors did.

The concept of anticipatory representation, by contrast, permits legislators to pay attention to the underlying interests of their constituents rather than only react to static, "unmediated" constituent opinion. In this model, representation has a dynamic, deliberative element, in that legislators explain how policy decisions connect with constituents' underlying needs, thereby possibly changing voters' opinions and resulting in more positive evaluations at the next election. Thus, what appears to be a lack of legislator response to point-in-time opinion data, or an election mandate, may be something other than a lack of promissory representation: legislators may be considering voters' underlying needs in addition to or instead of their opinions. One implication of the anticipatory model is that if legislators think there is a gap between underlying interests and expressed preferences, we should see policy making directed toward the former, accompanied by explanations designed to educate voters. As we discuss later, our data on floor speeches, though only a partial measure of public education, reveal legislators' attempts to explain how the ACA benefits seniors' underlying policy interests.

In the anticipatory model, therefore, legislators' attempts to change voters' minds constitute valuable education, although Mansbridge concedes that judging the quality of the education process is not easy. Distinguishing education from manipulation is particularly difficult because defining voters' underlying interests is subjective. Indeed, other legislative scholars propose dynamic models of the legislator-constituent relationship that have much less benign implications. In particular, Jacobs and Shapiro (2000) argue that politicians rely first on their own partisan concerns to arrive at a policy objective, and then on public opinion data to use "crafted talk" to sell the policy and get it enacted. Hence, what looks like representation is, instead, roughly its opposite. It is straightforward to apply this model to the ACA case because Democratic leadership designed the law and censored all amendments, no Republicans voted for the bill, and, as we discuss below, both sides attempted to counter the other by appealing to seniors' expressed preferences in their characterizations of how the ACA

would affect Medicare. Historically, seniors' self-interest and desire to protect the Medicare status quo have led to dramatic spikes in their political participation (see Kollman 1998 for a vivid account of senior reaction to the Medicare Catastrophic Coverage Act). Thus, one might interpret legislators' rhetoric around the ACA as crafted talk targeting seniors, designed to protect legislators' electoral futures.

Jacobs and Shapiro provide a plausible theory concerning policy making on the ACA especially because this case combined a partisan policy design process with legislators' apparent attempts to change public opinion. Nevertheless, there are several reasons that anticipatory representation is an appropriate model here. First, it is reasonable to interpret the Medicare provisions in the ACA as sincere attempts to improve Medicare quality and sustainability, thereby addressing seniors' underlying interests. While seniors' expressed preference has been to maintain the Medicare status quo, Democrats' actions to change Medicare as part of federal health reform could conceivably have been taken with seniors' interests in mind, *despite* the electoral threat represented by high levels of senior participation. Second, while seniors generally oppose the extension of public coverage programs to other groups, the actual extension of such benefits does not necessarily harm seniors if legislators endeavor to strengthen Medicare at the same time. Third, there is some recent evidence to suggest that legislators might expect to be able to change seniors' minds after a major health insurance policy change has been enacted, and not merely because of crafted talk: although there are many contrasts between the ACA and the Medicare Modernization Act of 2003, which established a prescription drug benefit, the latter experienced wide public disapproval around the time of passage but became an unexpected policy success, with higher enrollment, higher beneficiary satisfaction, and lower premiums than expected (Oberlander 2007). While this outcome may not have been due to legislative education of constituents, it does provide a reason for legislators to be optimistic that seniors will realize other new policies serve their interests.

What were the Medicare-related provisions in the ACA, and what was the partisan debate surrounding them? These provisions include several benefit improvements: notably, the ACA closes the "donut hole" in prescription drug benefits and makes a number of preventive services available at no cost to seniors. The ACA also strives to increase the sustainability of Medicare by reducing increases in direct spending by $390 billion over federal fiscal years 2010–19 (Davis et al. 2010). Changes to Medicare financing and payments include reductions to annual payment updates for

some providers, such as acute care hospitals, and increases in payment to other providers, such as primary care physicians in underserved areas. The ACA also reduces subsidies to commercial Medicare Advantage plans and increases the Medicare tax for wealthy individuals (Davis et al. 2010; KFF 2010b).

These financing and payment changes engendered claims that the ACA makes harmful cuts to Medicare and motivated Republicans' strenuous warnings to seniors about the dangers of health reform. Some current Medicare beneficiaries may indeed experience these changes as harmful. For example, some Medicare Advantage enrollees—comprising about 25 percent of the 49 million Medicare beneficiaries in 2011—may lose benefits as a result of reduced subsidies to Medicare Advantage plans (Newhouse 2010). From a policy perspective, however, higher payments to these commercial carriers relative to standard, fee-for-service Medicare expenditures have wasted taxpayers' money on nonessential benefits (notoriously, gym memberships) and contributed to fiscal instability (Cooper and Trivedi 2012; KFF 2011; Rucker 2009).

We acknowledge that improvements to long-term sustainability might not be in the interests of the very oldest seniors. Nevertheless, some of the Medicare financing changes in the ACA have a relatively short-acting impact on the Medicare Trust Fund, changing the projected date of its exhaustion from 2017 to 2029 (CMS n.d.). Hence, these financing changes have a significant impact on a large proportion of current Medicare beneficiaries. In addition, these financing changes reduce near-term political pressure to overhaul the program in a way that seniors might strongly oppose. Democrats, therefore, argued that changes to Medicare in the ACA would benefit Medicare overall: increased prescription drug and other preventive benefits are clearly helpful, and more efficient financing improves the program's stability. Given that seniors generally prefer to maintain the Medicare status quo and that these changes accompany a large new coverage program for nonseniors, it was a more challenging rhetorical task for Democrats to explain how these changes benefit seniors than for Republicans to claim that the ACA harms Medicare.

Health Reform and Responsiveness to Age Groups: ACA Votes

In this section, we build on recent work on subconstituency representation to determine whether legislators are more responsive to the policy preferences of younger or older constituents. Does relative opposition to health

reform among seniors explain legislators' vote choices on the ACA? If so, we might conclude that the promissory model is the right fit for legislative representation of seniors on health policy issues.

Representation research has moved increasingly away from measuring the impact of constituent mean opinion on voting behavior (e.g., Miller and Stokes 1963) and toward analyses of district heterogeneity and subconstituency opinion (Arnold 1990; Bishin 2009; Clinton 2006; Fiorina 1974; Griffin and Newman 2008; Hall 1996; Jackson and King 1989; Krehbiel 1993; Wright 1989). These studies all build on the idea that legislators tend to view their districts as comprising groups of people who play different electoral roles (Fenno 1978) and are attentive to different issues (Arnold 1990). Benjamin Bishin (2009) provides a recent, comprehensive study of subconstituency representation. Bishin argues that legislative responsiveness should vary across subconstituencies, which are defined by social identities that affect issue perception and preference. While age may not constitute a "social identity" for all age groups, it does, as illustrated earlier, color issue perception and preference on health insurance policy. Because seniors have distinct preferences, legislators can activate senior constituents via rhetoric about health policy in hopes that seniors will then support legislators' reelection bids.

A second theoretical reason to analyze legislative responsiveness across voter age groups is that political participation varies substantially by age (see fig. 4). As Valentino Larcinese (2007) points out, differences in turnout among different segments of the population make simple applications of the median voter theory problematic, as the theory assumes that everyone votes at the same rate. Larcinese focuses on preferences and turnout among different income segments, but his point holds for different age segments because preferences and turnout also differ by age.

Regardless of whether we focus on seniors' high voting rates at baseline or the potential for legislators to activate them further, we might expect legislators to pay more attention to seniors' expressed preferences and less to those of younger voters. In this analysis, we identify the constituents to whom the 111th House legislators responded as Congress voted on federal health reform. We focus on the House because, as Clinton (2006) notes, the House was designed to more closely represent the views of citizens than the Senate (*Federalist* 52; see Hamilton, Madison, and Jay 2002). In addition, there is almost no variation in the Senate vote among the members of each party, which prevents within-party analysis. Following Campbell, we leverage the fact that age is an important issue-relevant dynamic underlying representation on health care policies.
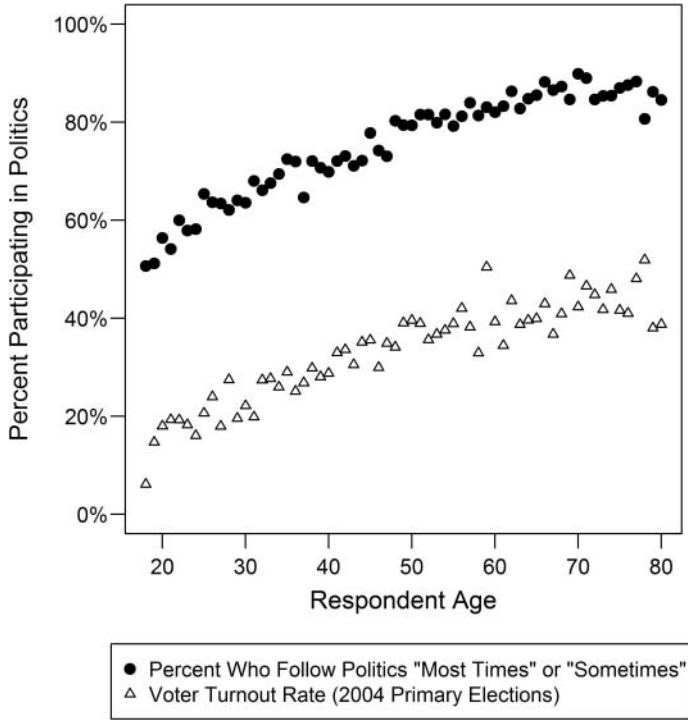
Figure 4 Political Participation by Age

Source: 2004 National Annenberg Election Survey (NAES variables *cRB11* and *cKA01*)

Congressional Vote

Our dependent variable is House members' votes on the ACA. Although floor votes constitute only a small fraction of legislative activity and do not necessarily reflect prefloor preferences and activities (Hall 1996), they do present an opportunity to analyze how one component of legislative behavior reflects public opinion.

Specifically, we examine the House roll-call vote on H.R. 3590 that occurred on March 21, 2010. The House held several votes on the ACA; the March 21 vote was a roll call on a motion to concur in the Senate amendments to the Patient Protection and Affordable Care Act. All 178 Republicans voted against this bill (GovTrack 2010). Of the Democrats, 219 voted in favor and 34 against. We analyze only the votes of Democratic House members. We also exclude the vote of Hawaii's first congressional district, as this seat was vacant at the time.

Constituency Preferences by Age Group

To measure constituent opinion in each district, we aggregate individual-level Common Content data from the 2008, 2010, and 2011 Cooperative Congressional Election Studies (CCES; Ansolabehere 2012, 2013a, 2013b).[1] The 2008 CCES surveyed 32,800 US adults; of these, 26,935 respondents answered a four-point question about their preferences on federal coverage policy.[2] This survey question shows a lack of senior support for expanded government-sponsored health insurance that is comparable to the lack of senior support for the ACA itself. The 2010 and 2011 CCES surveyed 55,400 and 20,150 US adults, respectively, asking respondents a two-point question about their opinion on health reform.[3]

We dropped "skipped" / "not asked" responses and collapsed remaining responses to create a dummy variable taking the value of 1 if respondents answered "support" (52,621 respondents) and 0 otherwise (49,235 respondents). This sample produces a total of 101,856 responses, yielding an average of 221 responses per district.

Within each congressional district, we then split all respondents into quartiles, ranked on respondents' self-reported ages. Hence, the first quartile consists of the youngest one-fourth of each district's respondents, who are typically thirty-nine or younger. Each district's fourth quartile includes the oldest one-fourth of respondents, typically sixty-one and older. The average median age, which separates the second and third quartiles, is fifty-one years. We use this approach in order to ensure that age quartiles are of equal size within each district. We then calculate the percentage of respondents in each age quartile who affirmed their support for expanded health coverage or for the ACA itself. We use these four per-district percentages as the primary independent variables in our analysis of the predictive power of each age quartile's preferences. Thus, dividing each district into quartiles allows us to make inferences about the relative importance of the opinions of different age groups to members of Congress.

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1. The CCES is an ongoing Internet-based survey conducted by YouGov/Polimetrix of Palo Alto, California. See projects.iq.harvard.edu/cces.

2. "Do you favor or oppose the US government guaranteeing health insurance for all citizens, even if it means raising taxes?" (CCES 2008 variable *CC417*).

3. "Congress considered many important bills over the past two years. For each of the following tell us whether you support or oppose the legislation in principle. Roll Call—Comprehensive Health Reform Act: Requires all Americans to obtain health insurance. Allows people to keep current provider. Sets up health insurance option for those without coverage. Increase taxes on those making more than $280,000 a year" (CCES 2010 variable *CC332D* / CCES 2011 variable *CC341D*).

Table 2   Descriptive Statistics for Variables in ACA Analysis

Variable	N	Range	Mean	SD
Individual-level survey responses	101,856	0,1	0.52	0.50
House vote on H.R. 3590, Democrats only	257	0,1	0.85	0.36
First age quartile (youngest)	257	0.35–0.96	0.66	0.12
Second age quartile	257	0.29–1.0	0.58	0.14
Third age quartile	257	0.22–1.0	0.57	0.13
Fourth age quartile (oldest)	257	0.17–0.91	0.51	0.14
Percent uninsured per district	257	0.04–0.43	0.17	0.07
Percent with private coverage per district	257	0.3–0.88	0.68	0.12
Vote margin of legislator in 2008 election	257	0.0–1.0	0.42	0.27
Percent unionized per state	257	0.03–0.25	0.14	0.06

Control Variables

We control for several political and demographic variables. First, we control for the percentage of each district's population that is uninsured and the percentage that possesses private health insurance, as estimated by the 2008 American Community Survey (ACS) (US Census Bureau n.d.). Overall, we expect that policy-minded members of Congress should support health care reform if health coverage is a greater problem in the district.

Second, we control for each district's vote margin in the 2008 House general elections (US House of Representatives Office of the Clerk 2009). We do so because House members from marginal districts might be more likely to vote against their party and in favor of the opinions of subconstituencies of particular importance (Griffin 2006). Marginality could magnify the importance to legislators of major subconstituencies, or those with strong interests, whether these are older adults or other groups.

Third, we control for the percentage of the district's state that consists of union members (US Bureau of Labor Statistics 2010). Unions provide a forum for political organization and participation and can therefore help to magnify the impact of public opinion on elected officials where they are a robust presence. We provide descriptive statistics for all variables in table 2.

Models

Table 3 estimates the following logit model by analyzing Democratic House members' votes on the ACA:

Table 3 District-Level Logistic Regression of Democratic
House Members' ACA Votes

Dependent Variable: District's representative voted for H.R. 3590

	Model (1)	Model (2)
First age quartile (youngest)	5.0*	7.2+
	(2.3)	(3.9)
Second age quartile	5.5*	7.8*
	(2.2)	(3.7)
Third age quartile	4.4*	7.2*
	(2.2)	(3.5)
Fourth age quartile (oldest)	3.3	0.1
	(2.1)	(3.4)
Percent uninsured	—	29.9*
		(12.0)
Percent privately insured	—	14.3*
		(6.2)
Vote margin	—	−0.9
		(1.0)
Percent unionized	—	30.0*
		(12.1)
Constant	−7.8***	−27.3**
	(2.0)	(8.8)
N	257	257

Notes: Only districts with Democratic representatives are included (all House Republicans voted against H.R. 3590). Standard errors in parentheses.
*$p < .05$; **$p < .01$; ***$p < .001$; +$p < .10$ (two-tailed).

$$\text{logit}\,(Vote = Aye) = \begin{cases} \beta_0 + \beta_1 \cdot (\text{1st Quartile}) + \beta_2 \cdot (\text{2nd Quartile}) \\ \quad + \beta_3 \cdot (\text{3rd Quartile}) + \beta_4 \cdot (\text{4th Quartile}) \\ + \beta_5 \cdot (\%\ \text{Uninsured}) + \beta_6 \cdot (\%\ \text{Privately Insured}) \\ \quad + \beta_7 \cdot (\text{Vote Margin}) + \beta_8 \cdot (\%\ \text{Union}) + \varepsilon, \end{cases}$$

where *1st Quartile* represents the support for health care spending on the uninsured by the youngest quartile of CCES respondents in the district, and *4th Quartile* represents the stated support by the oldest quartile in the district. In these models and all other quartile-based analyses, we weight observations by the number of respondents in each district in order to account for uncertainty due to sample size. In table 3, we present estimates for the logit models with and without control variables.

Results

Overall, the logit results show that Democratic House members were more likely to vote on behalf of nonsenior adults who supported health reform. The basic model shows that opinions of voters in the first, second, and third age quartiles (on average, age eighteen to age sixty-one) in each district have greater influence on roll-call votes than the opinions of the oldest quartile. In the full model with control variables, nonsenior age groups have even more influence on legislators' votes, while senior opinion remains an insignificant predictor.

At what age do expressed preferences begin to have less explanatory power for ACA votes? To measure more precisely the year-to-year dynamics in representation as constituents age, we also estimate a series of models using all possible fifteen-year age groups from the CCES data. We regress the ACA vote of the respondent's legislator onto whether the individual respondent supports health reform (fig. 5). The estimated coefficients for these logit regressions thus indicate the strength of the statistical relationship between Democratic House members' votes and the preferences of their constituents within each fifteen-year age group. Figure 5 reveals that out of all age groups, younger-middle-aged voters enjoyed the strongest legislative representation. Seniors' preferences had less relatively less influence on legislators' votes.

Predicted Constituency Preferences across Ages

Because of the relatively small number of CCES survey respondents in some congressional districts, we conduct the following robustness check to further examine the responsiveness of legislators to constituents of different ages. We adapt Gilens's (2005) approach and estimate predicted probabilities, within each congressional district, that constituents of various ages support health reform. We model the relationship between support for health reform and age as a fourth-order polynomial logit regression. We estimate such a regression for each congressional district separately. We then use these district-specific regression results to calculate the predicted level of support for more federal spending on the uninsured among constituents at four different ages: eighteen, thirty-five, fifty-five, and seventy-five.

Having estimated public opinion among each of these four ages within each congressional district, we then use these estimated constituent preferences as the primary independent variables in table 4 to predict legislators' votes on the ACA. As before, we estimate this ACA roll-call vote
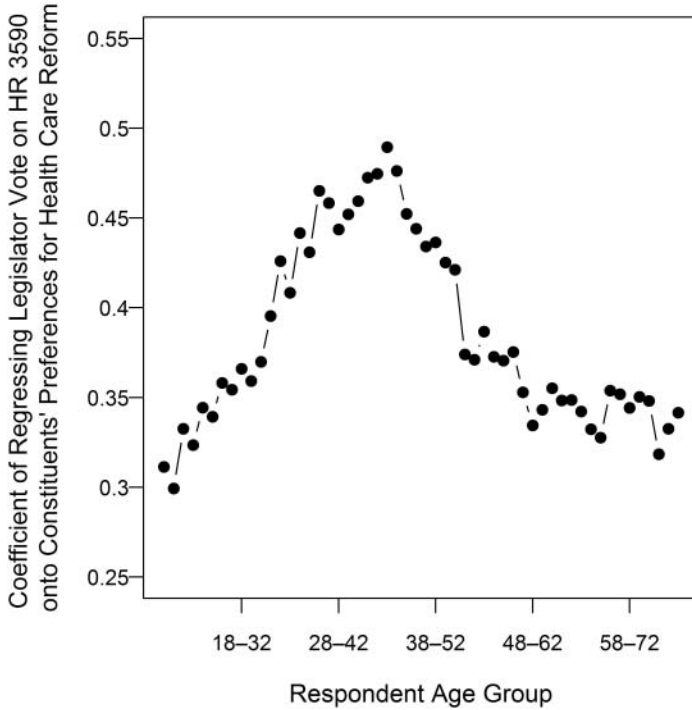
Figure 5 Coefficient of Regressing Legislator Vote on HR 3590 onto Voter Preference by Fifteen-Year Age Groups

Source: CCES 2008, 2010, and 2011 (Ansolabehere 2012, 2013a, 2013b)

model both with and without the control variables described earlier. Hence, the full logit model is:

$$\text{logit } (Vote = Aye) = \begin{cases} \beta_0 + \beta_1 \cdot (Age18) + \beta_2 \cdot (Age35) \\ + \beta_3 \cdot (Age55) + \beta_4 \cdot (Age75) + \\ \beta_5 \cdot (\% \text{ Uninsured}) + \beta_6 \cdot (\% \text{ Privately Insured}) \\ + \beta_7 \cdot (\text{Vote Margin}) + \beta_8 \cdot (\% \text{ Union}) + \varepsilon, \end{cases}$$

where $Age18$ and $Age75$ represent the predicted percentage of constituents in district i of ages eighteen and seventy-five, respectively, who support health reform. The remaining control variables are identical to those used in table 3.

Table 4 Logistic Regression of Democratic Legislators' ACA Votes onto Constituents' Predicted Opinions on Health Reform

Dependent Variable: District's representative voted for H.R. 3590

	Model (1)	Model (2)
Predicted support for health reform for respondents aged 18	1.7 (1.1)	1.7 (1.2)
Predicted support for health reform for respondents aged 35	4.1* (1.9)	3.2 (2.1)
Predicted support for health reform for respondents aged 55	6.1* (2.5)	6.0* (2.6)
Predicted support for health reform for respondents aged 75	2.3+ (1.3)	2.4+ (1.4)
Percent uninsured	—	20.0* (8.1)
Percent privately insured	—	9.9 (4.9)*
Vote margin	—	−0.2 (0.9)
Percent unionized	—	9.5* (4.2)
Constant	−5.9*** (1.5)	−16.6** (5.2)
N	257	257

Notes: Only districts with Democratic representatives are included (all House Republicans voted against H.R. 3590). Standard errors in parentheses.
  *$p < .05$; **$p < .01$; ***$p < .001$; +$p < .10$ (two-tailed).

Results

The table 4 results confirm and elaborate upon the results shown in table 3. The opinions of fifty-five-year-old constituents have the greatest explanatory power. The estimate of legislators' responsiveness to the opinions of seventy-five-year-olds is also statistically significant but is smaller in magnitude. These results corroborate the finding in table 3 that the opinions of senior citizens were not an important predictor of legislators' ACA votes.

Further Tests with Other Legislation

We conduct two additional robustness checks that compare public opinion by age and congressional votes on health insurance legislation. First, we

analyze the House vote on H.R. 2, the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA). We acknowledge that this bill is not perfectly comparable to bills that threaten seniors' interests more directly; CHIPRA made no changes to Medicare at all. We might therefore expect legislators to disregard senior opinion about children's coverage. Nevertheless, the CHIPRA case presents a compelling opportunity for analysis because there were clear differences by age in support for federal spending on children's health insurance, and seniors vote at much higher rates than the younger voters who were most supportive of this policy.

For this bill, we measure public opinion using a different set of CCES questions regarding voters' preferences for children's health insurance. The 2008, 2010, and 2011 waves of the CCES each asked one question about whether respondents supported Congress's decision to fund or reauthorize CHIP.[4] The 2008 and 2010 waves asked this question of all respondents (32,800 and 55,400, respectively); for the 2011 wave there were 6,728 responses. Analyzing respondent opinion across ages, figure 6 illustrates a continuous decline in support for children's health insurance spending as respondents become older.

To explain roll-call votes on CHIPRA, we measure the percentage of respondents in each of four age quartiles within each district that supports the Children's Health Insurance Program. Again, we dropped "skipped" / "not asked" responses and collapsed remaining responses to create a dummy variable taking the value of 1 if respondents answered "support" (62,172 respondents) and 0 otherwise (32,201 respondents). Within each congressional district, we calculated the percentage of respondents in each age quartile who affirmed their support for federal spending on children's health insurance.

The House vote on CHIPRA occurred on January 14, 2009. A total of 250 Democrats voted on the bill, 248 in favor and 2 opposed, with 5 not voting (GovTrack 2010). Forty-one Republicans voted for the bill, 137 opposed, and 1 did not vote. We analyze all votes on this bill because there is insufficient variation in the Democratic vote alone.

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4. The initial prompt was the same for all three surveys: "Congress considered many important bills over the last two years. For each of the following tell us whether you support or oppose the legislation in principle." CCES 2008: "Fund a $20 billion program to provide health insurance for children in families earning less than $43,000" (CCES 2008 variable *CC316e*; included a "not sure" answer choice). CCES 2010 and CCES 2011: "The State Children's Health Insurance Program insures children in low income households. Act would renew the program through 2014 and include 4 million additional children" (CCES 2010 variable *CC332B* / CCES 2011 variable *CC341B*; no "not sure" choice).
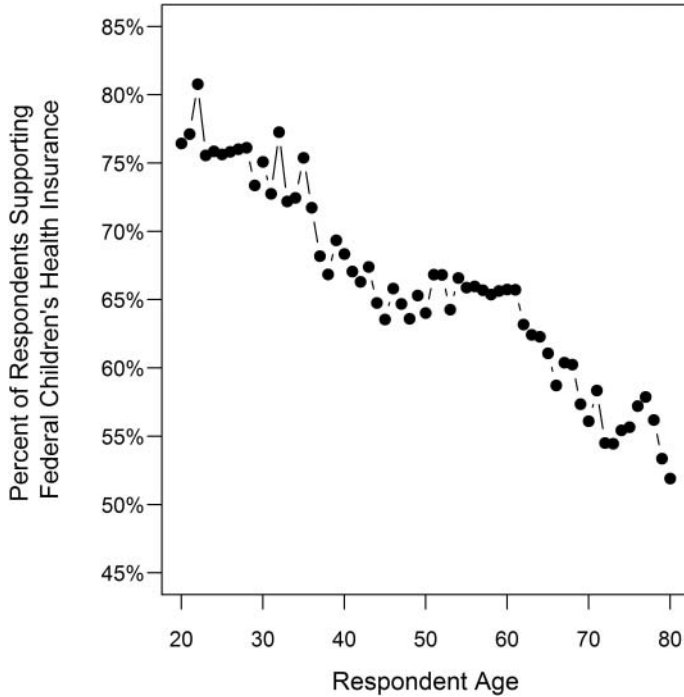
Figure 6 Support for Federal Children's Health Insurance by Age

Source: CCES 2008, 2010, and 2011 (Ansolabehere 2012, 2013a, 2013b)

Table 5 presents estimates of whether legislators' votes on CHIPRA were responsive to public opinion among each of the four age quartiles within each district. Once again, the table 5 results confirm that seniors enjoy less legislative responsiveness in roll-call voting on health insurance policy than nonsenior adults. The basic model estimates reveal that House members were more likely to vote in favor of reauthorizing CHIP on behalf of districts with higher proportions of older-middle-aged adults who supported federally funded health insurance for children. In contrast with the ACA analysis shown in table 3, the opinions of the oldest quartile are a statistically significant explanation for votes. However, the opinions of voters in the third age quartile (on average, ages fifty-two to sixty-two) in each district have significantly greater explanatory power than the opinions of the oldest constituents. The opinions of younger adults in each district are never a significant predictor of votes. In the full model, older-middle-aged adults have even more influence on legislators' votes relative to seniors.

Table 5 District-Level Logistic Regression of All House Members' Votes on CHIPRA

Dependent Variable: District's representative voted for H.R. 2

	Model (1)	Model (2)
First age quartile (youngest)	−1.3	−2.4
	(1.8)	(2.1)
Second age quartile	−1.7	0.4
	(1.9)	(2.0)
Third age quartile	13.6***	19.4***
	(2.3)	(4.2)
Fourth age quartile (oldest)	7.9***	5.1**
	(1.7)	(1.8)
Democratic member	4.8***	7.1***
	(0.6)	(1.1)
Percent uninsured	—	31.0**
		(9.5)
Percent private	—	18.0**
		(6.2)
Vote margin	—	1.0
		(0.7)
Percent unionized	—	25.2***
		(5.5)
Constant	−12.1***	−36.3***
	(1.9)	(3.2)
N	434	434

Note: Standard errors in parentheses.
*$p < .05$; **$p < .01$; ***$p < .001$; +$p < .10$ (two-tailed).

As a final robustness test, we consider the 2003 chamber passage vote on the Medicare Modernization Act (MMA), which authorized the first Medicare prescription drug benefit (Medicare Part D). We consider only Democrats for this vote because we are primarily interested in Democrats' responsiveness to seniors, and there is (barely) sufficient variation among Democrats' votes for analysis: 195 Democrats voted against H.R. 1, and 9 in favor (GovTrack 2010). Interpretation of these votes, and of senior opinion itself, is not as straightforward as in the ACA and CHIPRA analyses. The ACA and CHIPRA arguably constituted policy threats to Medicare in seniors' eyes, even if, in the case of CHIPRA, the threat was exclusively indirect. By contrast, H.R. 1 authorized a Medicare-specific, senior-only health benefit. However, the design of this benefit was widely

criticized as stingy and overly complicated. Hence, many seniors and senior lobbies, including AARP, held out hope for a more generous prescription drug benefit and actively opposed H.R. 1.

To measure public opinion on H.R. 1, we use data from the 2004 National Annenberg Election Survey (NAES) National Rolling Cross-Section.[5] The NAES surveyed 81,422 adult residents of the United States, asking 22,030 of these respondents two questions about whether they favor the Medicare prescription drug bill that recently passed.[6] The 2004 NAES survey was fielded one year after the bill's passage but two years before implementation of Part D. We count the percentage of each age quartile within each district that either "strongly" or "somewhat" favors the MMA rather than opposing it. Overall, 79 percent of respondents expressed support for the bill. We do not include any of the previous control variables for this analysis because the controls are not as relevant to this policy decision, with the possible exception of vote margin. Rather than a decision to provide health insurance to un- or underinsured populations, the vote on H.R. 1 represented a choice to provide additional benefits to already-insured seniors. Thus we estimate only the basic model in table 6.

We might expect that senior opinion about the proposed Medicare prescription drug benefit should matter for Democrats' votes because seniors were the only age group targeted by the policy. However, we again find that senior opinion is not a substantively or statistically significant explanation for votes. In this instance, the opinions of younger-middle-aged voters have more predictive power.

Health Reform and Responsiveness to Age Groups: ACA Floor Speeches

Our roll-call vote analyses have suggested that seniors' expressed preferences are not a reliable explanation for ACA votes, notwithstanding seniors' opposition to the policy and high political participation rates. At this point in the analysis, however, it is premature to conclude that seniors

5. The NAES is a telephone survey, commissioned by the Annenberg School for Communication and the Annenberg Public Policy Center of the University of Pennsylvania (Romer et al. 2006). The CCES Common Content does not include questions about Medicare Part D.

6. "{12/4/03–12/7/03: In November, Congress passed | 12/8/03–6/24/04: President Bush has signed} a Medicare bill, which among other things provides prescription drug coverage for senior citizens and allows private companies to provide some Medicare services. From what you have heard or read, do you favor or oppose this bill?" (NAES variable *cCC17*, which is a four-point question with a "strongly" follow-up.) "The Medicare prescription drug law that was recently enacted—do you favor or oppose this?" (NAES variable *cCC18*, which is a two-point question with no "strongly" follow-up.)

Table 6 District-Level Logistic Regression of Democratic House Members' Votes on Medicare Modernization Act

Dependent Variable: District's representative voted for H.R. 1

First age quartile (youngest)	1.2
	(1.6)
Second age quartile	2.7+
	(1.5)
Third age quartile	− 0.2
	(1.2)
Fourth age quartile (oldest)	1.0
	(1.3)
Constant	− 5.1***
	(1.4)
N	203

Notes: Only districts with Democratic representatives are included. Standard errors in parentheses.
*p < .05; **p < .01; ***p < .001; +p < .10 (two-tailed).

are not represented on health insurance policy because the relatively weak link between senior opinion and legislators' votes casts doubt only on the promissory model of representation.

In order to move beyond roll-call votes and to consider representation more broadly, we examine the content of speeches about health reform made on the floor of the House. These speeches provide a snapshot of legislative communication; they are only a small part of the education process the anticipatory model requires. However, floor speeches do yield information on what legislators are trying to explain and indicate which constituents might be the target of these explanations.

On November 7, 2009, the House conducted approximately four hours of debate on its federal health reform bill, the Affordable Health Care for America Act (H.R. 3962), which was eventually discarded in favor of the Senate version. Although the final passage vote on the bill that became law (H.R. 3590) did not occur until March 2010, the major floor debate in the House occurred in November. The legislation did change substantively between the version that the House initially debated and the version that was enacted, but the provisions affecting Medicare and seniors largely remained intact.

In these floor-debate speeches, which we obtained from VoteSmart .org, many legislators made reference to seniors' concerns (or potential

concerns), generally arguing that the bill would strengthen Medicare or weaken or endanger Medicare. Republicans clearly attempted to leverage senior opposition to the bill by highlighting reductions in Medicare Advantage payments or a planned rise in Part D (prescription drug) premiums, among other provisions. Conversely, Democrats attempted to allay seniors' concerns by emphasizing that the bill was "no threat to Medicare," frequently pointing out that it would close the "donut hole" in prescription drug benefits and that changes in Medicare financing would increase the program's sustainability. The floor speech by Steny Hoyer (D-MD), who at that time was House Majority Leader, provides an example of this language: "I want to say to our seniors: you can count on Medicare, on a Federal program, for dignity and peace of mind in your golden years. And that will not change. Today we will vote to protect your access to your doctor, to encourage Medicare physicians to cooperate on higher quality care, to keep your Medicare solvent for longer, and to bring an end to the donut hole that leaves prescription drugs unaffordable for so many."

Dependent Variable

The following analysis is similar to our vote analysis but takes the content of floor speeches as the dependent variable. Specifically, we examine whether senior opinion explains Democrats' decisions to talk about seniors' concerns during floor speeches, as measured by mentions of the term *Medicare*. We considered several different key words for this analysis, including *seniors*, *Part D*, *Medicare premiums*, *Medicare Advantage*, *raise premiums*, *cuts*, *prescription drugs*, *rural*, *hospitals*, and *donut/doughnut hole*. Most speeches that use any of these terms designed to address seniors' concerns use the word *Medicare*. Although there is some variation in the way members refer to Medicare, these references are very similar among members of each party, and even more so among Democrats who voted for H.R. 3962; Republicans were unified in their opposition to the bill. We therefore measure Democrats' choice to attempt to explain the Medicare provisions in the bill by using mentions of "Medicare" as a dichotomous indicator variable. As speech length is determined exogenously by factors such as legislator seniority, this dichotomous coding serves to remove the impact of variation in speech length, which creates opportunities to say "Medicare" and related words more times. Our measure considers the choice to *not* make a speech to be equivalent to making a speech and not talking about seniors' concerns. Of the 257 House Democrats, 108 made a speech on the floor, and of those, 69 mentioned

Medicare. Most used this word once; the highest count was sixteen times by a single member.

Explanatory Variables

We use the same per-district age quartiles indicating the proportion of each age group supporting federal health reform. Following Campbell, we also use the proportion of seniors per district, which comes from the five-year (2006–10) district estimates of the American Community Survey. In addition, we consider legislator ideology, as measured by first-dimension DW-NOMINATE scores, which range from −1 to +1, where −1 is very liberal and +1 is very conservative (Carroll et al. 2011).

Theoretical Predictions

What kind of relationship between senior opinion and use of the term *Medicare* in a floor speech should we expect to see? This analysis tests for two different possibilities. First, Democratic legislators might have discussed Medicare if their senior constituents were relatively supportive of health reform; in this case, legislators with relatively opposed senior constituents would have remained silent on the topic of Medicare. Such a relationship would suggest that legislators avoided mentioning Medicare in order to reduce its salience and avoid being punished at the polls by seniors opposed to health reform. Under this hypothesis, the coefficient on the fourth age quartile would be positive and statistically significant.

The second possibility is that legislators engaged in a strategy of educating constituents, providing support for the anticipatory representation theory. If legislators were willing to address Medicare even when their senior constituents were not strongly supportive of federal spending on the uninsured, the coefficient on senior opinion would either be insignificant or negative. An insignificant coefficient would mean that legislators mentioned Medicare as frequently to opposed senior constituents as they did to supportive senior constituents. A negative coefficient would indicate that legislators focused their educational efforts on relatively opposed senior constituencies.

Results

Table 7 illustrates that the effect of the opinions of the oldest voters on Democrats' decisions to explain the Medicare provisions in the ACA on

Table 7 Logistic Regression of Democrats' Speeches on Affordable Health Care for America Act

Dependent Variable: Legislator mentioned "Medicare" during floor debate on H.R. 3962

	Model (1)	Model (2)	Model (3)
First age quartile (youngest)	−2.1	−1.9	−2.8+
	(1.5)	(−1.5)	(1.6)
Second age quartile	−0.1	0.7	−0.5
	(1.4)	(1.5)	(1.4)
Third age quartile	2.8+	3.1+	2.5*
	(1.7)	(1.7	(1.7)
Fourth age quartile (oldest)	1.2	0.8	−0.2
	(1.4)	(1.4)	(1.5)
Percent of district's population aged 65 and over	—	0.1	—
		(0.1)	
Legislator's DW-Nominate score	—	—	−2.8*
			(1.3)
Constant	−1.8*	−3.5**	−1.4
	(0.8)	(1.3)	(0.8)
N	257	257	257

Notes: Data include Democratic House members who voted on H.R. 3692 (November 7, 2009). Standard errors in parentheses.
    *$p < .05$; **$p < .01$; ***$p < .001$; +$p < .10$ (two-tailed).

the House floor is not significant in any model. The proportion of district residents aged sixty-five and older is also not significant. The opinions of older-middle-aged constituents are statistically significant, as is legislator ideology. More liberal Democrats were more likely to talk about the Medicare provisions in the ACA.

The lack of relationship between senior opinion and the word *Medicare* in floor speeches points to the possibility of anticipatory representation. Democratic legislators chose to educate senior constituents on the Medicare provisions of the bill without regard to senior constituents' opinions. Why wouldn't legislators engaging in anticipatory representation simply focus their efforts on the seniors most opposed to federal spending on the uninsured? Under the anticipatory model, we should see legislators educating their uninformed constituents, regardless of constituents' political opinions. As we note above (see table 1), there was widespread misunderstanding about the contents of the ACA and the changes it makes to

Medicare; hence, legislators may have been interested in educating even those seniors who were predisposed to support the idea of health reform. Given seniors' general lack of knowledge about the bill and their underlying interests in Medicare, congressional Democrats' pro-ACA votes and efforts to explain Medicare improvements suggest that the anticipatory model provides the best way to understand senior representation on health reform.

Discussion

Do senior citizens' uniquely high levels of political participation and engagement on health insurance policy result in better legislative representation of seniors than of other age groups? The answer depends on how one conceptualizes representation. We argue that searching for evidence of representation by comparing point-in-time opinion data with congressional votes, consistent with the promissory model, would lead us to conclude that legislators do a poor job of representing seniors in this policy area. However, after accounting for the Medicare provisions in the ACA, and the congressional floor speeches that endeavored to explain the impact of these provisions, anticipatory representation becomes a plausible alternative interpretation of legislative behavior in the ACA context.

The results of this analysis suggest that Democratic legislators weighed the opinions of nonseniors more heavily than the opinions of older constituents when voting on federal health reform. This apparent unresponsiveness to seniors occurred despite seniors' sharp political views on health reform, despite their active political mobilization around Medicare (Campbell 2002, 2003a), and despite their past formidable political opposition to perceived threats to Medicare (Campbell 2003b, 2011). When we consider the lack of relationship between speech content and senior opinion, legislators who voted for the ACA and chose to talk about Medicare appear to be even less concerned about seniors. Indeed, one might interpret these speeches as mere justifications for pro-ACA votes when viewed through the lens of promissory representation.

Consistent with that interpretation, if we focus on the relationship between legislators' votes (and speeches) and the opinions of middle-aged constituents, we might conclude that legislators are engaging in a long-term party-building strategy. Could it be that legislators are less willing to prioritize expressed senior opinion, since seniors will simply become too old to vote in future elections? We reject this explanation because all but the very oldest seniors vote at high rates, and our "senior" group begins, on

average, at age sixty-one. Legislators should expect most of the voters in this group to be active for many election cycles.

Indeed, the complexity of the policy context compels us to reconsider legislators' behavior because the Democrats who voted for the ACA may have been doing so with seniors' underlying interests in mind. While it may be the case that legislators responded to the expressed support for coverage reform among nonsenior adults, we suggest that legislators concurrently represented seniors: at a minimum, legislators' decision to enhance insurance coverage for nonseniors was made with attention to protecting and improving Medicare. And as former House Majority Leader Moyer's floor speech illustrates, many Democrats' speeches about the ACA endeavored to educate seniors about improvements to Medicare benefits and sustainability. These changes, combined with Democrats' efforts to explain them, suggest that legislative behavior in this case was consistent with the anticipatory representation model.

We acknowledge that we do not provide conclusive proof that pro-ACA legislators were engaging in anticipatory representation—as Mansbridge (2003) explains, anticipatory representation requires a dynamic, high-quality, multipronged education process. Floor speeches are only a very small part of the constituent education required for anticipatory representation. Nevertheless, our analysis cautions against attempts to evaluate the quality of legislative representation simply by comparing constituent opinion to roll-call votes. Instead, a more thorough evaluation of senior representation in the health policy context requires broad consideration of both the content of legislation and the substance of legislative communication.

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Katharine W. V. Bradley is a PhD candidate at the University of Michigan in the Health Services Organization and Policy Program with a joint concentration in political science. Her research focuses on bureaucratic politics, legislative behavior, state Medicaid programs, and federal health reform. She is coauthor (with David K. Jones and Jonathan Oberlander) of "Pascal's Wager: Health Insurance Exchanges, Obamacare, and the Republican Dilemma" in the *Journal of Health Politics, Policy and Law.*

Jowei Chen is assistant professor in the Department of Political Science and faculty associate at the Center for Political Studies, University of Michigan. His research focuses on bureaucratic politics, distributive spending, redistricting, and legislatures. He has published papers in the *American Journal of Political Science*, the *American Political Science Review*, and the *Quarterly Journal of Political Science*.

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