

Diagnosing American Health Policy's Many Maladies

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Unhealthy Politics: The Battle over Evidence-Based Medicine. By Eric M. Patashnik, Alan S. Gerber, and Conor M. Dowling. Princeton, NJ: Princeton University Press, 2017.

Fragmented Democracy: Medicaid, Federalism, and Unequal Politics. By Jamila Michener. Cambridge: Cambridge University Press, 2018.

When Bad Policy Makes Good Politics: Running the Numbers on Health Reform. By Robert P. Saldin. Oxford: Oxford University Press, 2017.

All is not well in American health policy. To be sure, as we approach the tenth anniversary of its enactment, the Affordable Care Act (ACA) has made meaningful headway in addressing the problem at which it was most targeted: the United States' uniquely high rates of uninsurance. Following the enactment of the law's major coverage provisions in 2014, the uninsured rate has dropped from 15% to 9% in 2017 (Kaiser Family Foundation 2019). Nonetheless, the law has been limited by courts, by federalism, by implementation difficulties, by the repeal of the individual mandate by a Republican Congress, and now by a hostile federal administration seeking to undo what parts of the law it can through administrative means (Jost 2018). Trends in private insurance are also troubling—perhaps most notably, the prevalence of high deductibles is skyrocketing even in employer-provided plans, historically considered the “good” kind of insurance (Bureau of Labor Statistics 2018). To put it plainly, the ACA has not solved all of America's health coverage problems. And this accounting does not even consider major health policy problems the ACA left more or less untouched: the quality of medical care, the inadequacy of the patchwork system of traditional Medicaid, and the ab-

sence of a robust national program to fund long-term care for the elderly and people with disabilities.

It is to the latter three problems that these three books direct our attention. In this sense, they represent a welcome shift in the health policy literature away from the passage and implementation of the ACA's coverage provisions and to issues that are in some ways more fundamental to Americans' lives.

UNHEALTHY POLITICS

In *Unhealthy Politics*, Eric Patashnik, Alan Gerber, and Conor Dowling examine the American medical system's remarkable lack of commitment to evidence-based medicine. Opening with attention-grabbing anecdotes and data on the failure of American doctors to heed strong research evidence, they paint a concerning picture. Not only do many or most medical treatments delivered in the United States lack a strong research base in the form of randomized control trials (RCTs) with placebos, doctors frequently persist in the use of costly or risky treatments even in the face of evidence that they offer little to no benefit. Moreover, even in areas where the RCT evidence base is solid (e.g., pharmaceuticals), effectiveness research comparing treatments to other potentially less costly or risky treatments is rare; for Food and Drug Administration (FDA) approval, a drug need only prove to be more effective than a placebo, not another drug or treatment. Patashnik, Gerber, and Dowling go on to offer a compelling account of how the United States ended up here.

The book is a remarkable example of the contribution that political science has to make to discussions of policy problems that have chiefly concerned other fields (medical and health services researchers and health economists in this case). Patashnik, Gerber, and Dowling bring to bear not only a wealth of original survey evidence collected over the course of years (see also Gerber et al. 2014) but also a wealth of theoretical insights from the policy process and legislative

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politics literatures. The survey evidence, theoretical grounding, and historical background all coalesce into a theory of “zero-credit politics” (chap. 5) that helps to bring some welcome sophistication to accounts of policy entrepreneurship. The authors take a step back for a systematic look at the incentives that might drive or discourage entrepreneurship on public-spirited reforms like evidence-based medicine. They find that the risks (reputational damage, loss of credit if another “entrepreneur” co-opts the idea) often outweigh the benefits of entrepreneurship. Leadership aimed at solving public problems, then, becomes a classic undersupplied public good.

The reasons zero-credit politics is such an apt model for the evidence-based medicine question are many. The authors’ survey evidence suggests that voters are more likely to reward legislative leadership on issues of particular importance to their district rather than those of national importance like evidence-based medicine (119). Anecdotal evidence suggest that public awareness of this issue is virtually nonexistent in any case (137). But most daunting of all are the forces assembled on the other side.

While the pharmaceutical and medical device industries are formidable enough opponents, their prestige and influence pales beside that of the medical profession. Doctors double as villains and heroes in Patashnik, Gerber, and Dowling’s account—they are both the chief obstacle to reform and the only realistic hope for salvation. If there is one theme the findings of *Unhealthy Politics* drives home most convincingly and clearly, it is this: no reform effort aimed at increasing the role of evidence-based medicine and comparative effectiveness research in the United States can possibly succeed if medical doctors are largely hostile to it. Doctors are not only respected as scientific experts, they occupy a trusted role in the individual lives of hundreds of millions of Americans, and the public is resolutely against measures that would limit the discretion of their doctors to do what is right for them, regardless of what arguments are brought to bear (chap. 3). “Rationing,” “one-size-fits-all,” and “cookie-cutter” all prove to be very effective epithets employed by defenders of the medical status quo (138).

While none of this should come as a great surprise to an observer of American health policy, or even necessarily to average Americans who trusts their doctors, Patashnik, Gerber, and Dowling also contribute an important nonobvious insight: doctors have successfully imbued their professional associations with some of the trust and prestige they enjoy, to the point where the public views medical societies as less self-serving than other interest groups (65–66). In chapter 4, the authors present evidence from a survey of doctors that suggest their own expectations of their professional associations are quite different from those of the public—they expect as-

sociations to play an “attack dog” role in questioning the validity of studies that challenge standard practice, and they place little importance on the role of medical societies in sanctioning doctors who fail to provide the best care (103). Notably, doctors place much more trust in their specialty associations than in the American Medical Association—a troubling pattern given that the more specialized groups seem more fiercely protective of the status quo (101).

In the face of such odds, a frontal political assault is out of the question. Instead, the authors build to a series of achievable and promising recommendations in the final chapter aimed at broadening the coalition for evidence-based medicine, improving the prestige (à la Carpenter 2010) of the embattled Patient Centered Outcomes Research Institute created by the ACA, and working strategically with partners in industry and the medical profession (170–80).

There is some tension in this final chapter that the authors fail to address, however. The chapter is heavily indebted to Patashnik’s (2008) own account of why some public interest reforms endure while others are either reversed outright or undermined over time. Perhaps the most provocative and memorable insight from that work is that reforms that are the most destructive and disruptive have the greatest chance of survival: reforms endure when they remake the bad old institutions of governance that produced parochial policy in the first place and when they force private sector actors to change their patterns of investment such that there is “no going back.” In the case of evidence-based medicine, this would likely entail significant changes to the United States’ federalized system of state medical boards (which constitute “self-regulation” by the medical profession; 83–91), to Medicare’s toothless “reasonable and necessary” coverage standard, to the FDA’s placebo-only RCT requirements and its lack of jurisdiction over surgical procedures, or perhaps to all of these. Moreover, these changes would have to be substantial enough to force doctors and the pharmaceutical and medical device industries to change the way they do business. Is such a model of enduring reform really compatible with Patashnik, Gerber, and Dowling’s call for partnerships, cooperation, and consensus building?

FRAGMENTED DEMOCRACY

With her new book *Fragmented Democracy*, Jamila Michener makes a bold contribution to our understanding of Medicaid, America’s largest and arguably most crucial program for both the poor and people with disabilities. (Full disclosure: I have collaborated with Michener on other projects related to Medicaid but was not involved in this research.) Continuing in the tradition of Soss’s (1999, 2000) pathbreaking study of cash welfare beneficiaries, Michener investigates the “political lives”

of Medicaid beneficiaries with a mixture of qualitative and quantitative approaches. What lessons about politics do people learn from their experiences with Medicaid, and how do those lessons affect their political engagement? In the process of her investigation, Michener gains a new appreciation for the importance of place—states, counties, cities, and neighborhoods—in conditioning the “policy feedbacks” of Medicaid. This leads to a new theory of “contextualized policy feedback” (27), wherein economically and racially disadvantaged people are politically disempowered through their experiences with Medicaid in some contexts more than others and empowered in some instances.

Among other things, *Fragmented Democracy* is a testament to the power of in-depth interviews with the people most intimately familiar with a social program: its beneficiaries. The “policy feedbacks” of Medicaid on political behavior have been the focus of some quantitative scholarship in recent years by myself and others, including Michener (Baicker and Finkelstein 2018; Clinton and Sances 2018; Haselswerdt 2017; Haselswerdt and Michener, forthcoming; Michener 2017). While these large-*n* studies have their place, Michener’s conversations with dozens of Medicaid beneficiaries reinforce that the relationship between experiences in the program and “political life” are linked in ways a detached observer would never have considered. In the chapters presenting interview evidence, remarkable insights seem to come almost at the rate of one per page. We learn that even the most disengaged beneficiaries attribute their difficulties with the program to politics (69), that beneficiaries are surprisingly knowledgeable about Medicaid’s federalized structure and the differences between state programs either via their own experiences or those of friends and family (70–71), that they clearly perceive retrenchment and expansion of state Medicaid policy through changes in their own experiences (72), and that they see negative experiences with caseworkers as failings of the system rather than the workers themselves (74–75). We learn how the physical spaces and neighborhood locations of Medicaid offices and clinics profoundly shape beneficiaries’ understanding of the program and their place in it (114, 122–26), that it is much easier to organize actual Medicaid beneficiaries rather than potential beneficiaries of the ACA’s Medicaid expansion (151), and much more. While *Fragmented Democracy* is a true mixed-methods work, incorporating quantitative evidence from surveys (e.g., 75–83) and administrative data (e.g., 108–13), it is in these interviews that it makes its most enduring contribution.

What can beneficiaries do politically? While the quantitative feedback literature has focused on voting, Michener adopts a broader definition of participation, including activism (chap. 7) and seeking redress for grievances with the

program via “particularized resistance”—a new term Michener coins to convey what she contends is the inherently political nature of administrative “fair hearing” requests by Medicaid beneficiaries (chap. 5). But respondents’ likelihood of engaging in any of these sorts of participation is heavily influenced by where they live and by individual characteristics (especially socioeconomic status and race). A poor, black person who must travel a long way to a Medicaid office in a dangerous and dilapidated location to face a hostile and overworked caseworker in order to secure the benefits to which he or she is entitled is unlikely to have experiences that will foster participation. But confident, educated, white beneficiaries, like “Riley” and “Kay” in Michener’s account, who find early success in getting what they want from the Medicaid bureaucracy may be spurred to greater rather than lesser levels of political engagement. This account is consistent with quantitative findings that suggest a bump in voter participation in the context of Medicaid benefit expansions, which tend to target the less desperately poor, although I hasten to add that more work is needed to solidify these causal mechanisms.

One criticism of Michener’s study emerges when one considers it in light of Soss’s (1999, 2000) work on welfare. Soss paired his interviews and observations about people on welfare (Aid for Families with Dependent Children [AFDC]) with those reliant on the Social Security Disability Insurance (SSDI) program, and it is in this comparison that Soss was able to establish his key insight about the “political lessons” of welfare: relative to SSDI, where beneficiaries felt protected by rules, AFDC beneficiaries were more or less at the mercy of caseworkers who had a great deal of discretion, teaching them that they were helpless to influence government. While Michener offers a great deal of comparison across places, her study lacks this comparative dimension across policies or modes of coverage. While the book already packs in a great deal of analysis, this does feel like something of a missed opportunity. After all, Medicaid is not the only form of insurance that is profoundly shaped by federalism and by place, and struggles with bureaucracy are not limited to government programs—there may be insights to be gained by contrasting the experiences of Medicaid beneficiaries with the privately insured.

WHEN BAD POLICY MAKES GOOD POLITICS

Relative to Michener and Patashnik, Gerber, and Dowling, in *When Bad Policy Makes Good Politics* Robert Saldin focuses on a more specific problem with the politics of health policy in the United States: the perverse incentives created by the congressional budgeting reforms of the early 1970s. Specifically, Saldin details the troubled history and failure of the Community Living Assistance Services and Supports

(CLASS) Act, a component of the ACA that, while included in final passage, was quickly abandoned as unworkable by the Obama Administration.

The CLASS Act was intended as a first step in addressing one of the greatest risks facing Americans: financial ruin brought about by the need for long-term care, either in the home or a nursing facility. Under the status quo, which persists in the wake of the CLASS Act's failure, the only way the majority of Americans can afford long-term care (which can easily run \$90,000 a year in residential facilities) is through Medicaid, which often requires families to impoverish themselves by "spending down" to qualify. The private market for long-term care insurance is small and dysfunctional, since only the highest-risk individuals are interested in coverage (indeed, most Americans seem unaware of the risk in the first place). These issues are familiar to anyone who has read Campbell's (2014) account of a family member's experiences with America's inadequate safety net for people who find themselves in need of such care. The CLASS Act would have attempted to address the long-term care coverage gap by establishing a new national insurance program, but the devil, as Saldin demonstrates, truly was in the details. The program, as enacted, was clearly unworkable—it promised low premiums, no underwriting (differential pricing based on risk), voluntary participation, and fiscal sustainability. No realistic analysis could have concluded that achieving all of this was remotely possible, and indeed, none did at the time (76–79). The CLASS Act was a perfect recipe for an insurance "death spiral," in which only high-risk individuals sign up, leading to price increases that drive out lower-risk participants, leading to still more price increases.

How did this come to pass? Saldin convincingly refutes two conventional wisdoms about the CLASS Act (10–12). One is that it was all a cynical ploy by Obama and his legislative allies to bolster the overall chances of health reform—the Congressional Budget Office (CBO) actually deemed the CLASS Act as a large revenue raiser in its "score" of the legislation, meaning the ACA's backers could tout deficit reduction as one of the law's virtues. In fact, however, the backers of health reform were at best suspicious of and at worst hostile to the inclusion of long-term care in the ACA, as health activists believed that the inclusion of a long-term care benefit helped to tank the Clinton White House's health reform efforts of the early 1990s. While ACA backers eventually jumped at the chance to include more budgetary "savings," Saldin's account clearly establishes that health reformers and the long-term care coalition were distinct, and their alliance was an uneasy one.

The other conventional wisdom about the CLASS Act is that it was poorly designed through a mixture of naivety

and incompetence by do-gooder advocates. In fact, it was anything but. Saldin demonstrates that the CLASS Act's design flaws were not the result of bumbling idealism—long-term care activists in the United States were actually weathered combatants in a long and losing battle to establish something, anything, at the national level to address this massive policy problem, and they had learned many hard lessons along the way. The CLASS Act was designed not to be good policy but to meet the political prerequisites for enactment in the modern Congress. In a "fiscalized" era (Patashnik 1999), following the 1974 budget reforms of the Congressional Budget Impoundment and Control Act (CBICA), that meant a program that could claim to be "deficit neutral" or, better yet, a "revenue raiser" that could be attached to a broader piece of legislation, since long-term care had historically failed to move on its own. On the basis of experience, advocates also sought to avoid the political headaches that come with mandatory participation, even though the prospects for a workable voluntary program were poor. In Saldin's words, the overarching lesson of failure for the long-term care coalition was that "Only Bad Policy Stands a Chance" (59). With this historically contingent account, Saldin's book makes a good companion to Hacker (2010) and Starr (2011), who analyze the overall health reform effort through a lens of political learning. Like so much else in the ACA, the CLASS Act can only be understood in light of what came before.

Saldin goes on to detail the CLASS Act's unlikely movement through the legislative process, which was made possible because the program could be claimed to raise revenue under the CBO's rules: it would not start paying out benefits until five years after it would begin to collect premiums (an astronomically long waiting period), and the CBO's 10-year budget window expired before the real bills would come due, at least according to projections. CBO, to its credit, noted the long-term unsustainability of the program, but the "bottom-line" figure was all that mattered (78–79). It was in this trickery that CLASS supporters were able to shop their bill to health reformers as a "pay-for," even though (as critics noted) any revenue generated would be intended to pay for CLASS beyond the 10-year window, not for other portions of the ACA (90).

The absurdity reaches a climax in Saldin's narrative when CLASS Act supporters attempt to mitigate its flaws in the Senate bill with a series of legislative "fixes." While backers started with a list of changes that could have addressed some of the plan's problems, they were deemed too ambitious because they would have cut too much from the bill's illusory budget "savings." Thus, a more modest list of fixes was devised, but this led to a new set of problems. Following CLASS champion Senator Edward Kennedy's (D-MA) death and

the subsequent loss of his crucial sixtieth Democratic Senate seat to a Republican, it was imperative that the ACA pass through the Senate via the budget reconciliation process, passing muster under the Byrd Rule, which holds that all provisions must make a significant budgetary impact. The Senate parliamentarian ruled that the modest CLASS fixes did not meet this standard, and they were thus abandoned (104–5). The story is a striking testament to the complete failure of the 1970s budget reforms to “rationalize” American public policy: advocates were incentivized to craft a deliberately terrible bill to game the budget system, discouraged from adding robust policy improvements, and then told, when a more modest set of improvements was offered, that they were not sizable enough to be incorporated under the rules. If Joseph Heller had written *Catch-22* about the US Congress, one wonders whether he could have devised such a pointless sequence of frustrations.

There is a big question here that Saldin raises but does not venture to fully answer—are the advancements in health policy that many advocates, leaders, and citizens seem to want compatible with any sort of “budgeting” regime at all? These questions are of particular relevance at the present moment, as the emerging left wing of the new Democratic House majority struggles with leadership over whether to keep or jettison rules on budgeting and taxation (Stein 2018). Saldin’s account of Lyndon Johnson’s open (and characteristically colorful) contempt for budget projections in the establishment of Medicare and Medicaid is instructive (26–29). The ACA, too, as is well established by Saldin, passed only through deliberate manipulation of the budget rules, and if anything, the establishment of Medicare’s prescription drug benefit under the Bush Administration was even less scrupulous (113–15). Saldin argues for rule changes that would make the budget system more difficult to game, although he is clear-eyed about how all rules can potentially be abused (124–25). But it is not even clear whether preserving the budgeting system and making it “better” is something that Americans should want at all. As Greer (2018) notes in his review of Saldin’s book, Blumenthal and Morone’s (2009) advice to “hush the economists” on health reform is well supported by Saldin’s account.

If budgeting rules have been a failure, what can take their place? Should we pine for the good old days before CBICA, when Congress muddled through with a mixture of custom, norms, and a booming postwar economy (20–25)? It is unlikely that these conditions could be re-created. But it is possible to envision a new path, a future when Congress keeps the best part of CBICA’s legacy, the expert information provided by the CBO, without chaining itself to “fiscalized” politics. The CBO, and bodies like it, can do more than count dollars

and cents. The failed ACA “repeal-and-replace” episode of 2017 illustrates this vividly—the CBO made headlines not with its budgetary projections but with its estimates of the health coverage losses that would result from various Republican replacement plans (e.g., Abutaleb 2017). This was an instance of the CBO’s technocratic expertise being brought to bear on normative questions beyond taxation and spending. Perhaps the future health advocates (including long-term care advocates) should hope for is one in which the congressional policy-making process considers budgetary information, not for its own sake but in light of the real-world problems to be solved. Perhaps economists need not be “hushed” entirely but asked a different set of questions.

CONCLUSION

These are not optimistic books, and this is not an optimistic essay. This should come as no surprise. In troubled times for health policy, scholars owe it to their audiences to assess the problems as they see them. Perhaps the reason each of these books presents such a daunting path to true reform is that each of the three is presenting a pathology not just of health policy but of the American polity more broadly. The failure of evidence-based medicine is not the only time professional or sectoral self-governance has produced bad results for the American public or the only case in which legislators have failed to show strong leadership in favor of reform. The federalized and place-based elements of Medicaid that serve to disempower many poor and nonwhite beneficiaries coexist with a similar geographic patchwork of electoral rules that more or less directly disenfranchise the same populations (Gross 2018). The CLASS Act is just one example of how the shift to a more fiscalized congressional process has produced policy that was not just poorly designed but deliberately so (see Saldin’s own account of the Bush tax cuts; 109–13). We would miss the mark, however, if we saw health policy problems as epiphenomenal—merely products of a dysfunctional system. Health policy presents unique problems but unique opportunities as well. The central importance of health to the lives of all Americans, and the continued salience of health at the center of our politics, suggests that health policy could provide the impetus for broader systemic reform.

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