

Impact of WSLC Lobbying on Health Care Legislation in Washington State

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Abstract

This research looks at the influence that interest group lobbying has on state-level health care policy by examining the impact of Washington State Labor Council (WSLC) lobbying intensity on the likelihood that health care legislation received a floor vote during the period of 2000 to 2010. The paper quantifies lobbying intensity by examining the WSLC's legislative reports, newsletters, position papers, resolutions, and President's Columns for the eleven-year period. It reaches the tentative conclusion that the intensity of WSLC lobbying does, indeed, influence the likelihood that health care legislation will receive a vote in the Washington State legislature.

Introduction

The United States is the only industrialized western nation that does not have universal health coverage. And despite decades of discussions about implementing a universal health care system, the federal government is still struggling to make headway and only recently managed to pass a law increasing the regulation of the insurance industry. Even without a national health care plan, the United States spends approximately 15 percent of its GDP on health care, compared to an average of 9 percent in industrialized countries that do have universal coverage (Gottschalk 2008, 78). And despite spending a relatively large percentage of GDP on health care, the US has fewer hospital beds, doctors, and nurses per capita than many other industrialized states (78). The US health care system is in crisis. It has been for decades, and, until recently, the national government had been unable to develop and implement a plan for universal coverage. Consequently, for more than a decade individual states have taken it upon themselves to provide localized health care fixes.

As a result, much of recent healthcare policy reform in the U.S. has occurred at the state rather than the federal level. Although Maine, Massachusetts, and Vermont are the only states to have enacted plans for universal coverage of state residents, fourteen other states were also moving towards comprehensive health care reform. This list included Washington, which in 2007 passed a bill requiring health care for all children by 2010.¹ In addition to pushing for statewide universal healthcare, between 2006 and 2008, 26 states approved or adopted income eligibility expansions for Medicaid and State Comprehensive Health Insurance Plans (SCHIP), seven states reduced asset testing and other financial barriers to the two programs, and six states expanded health insurance coverage for adults.² Consequently, an analysis of health care policy in the US is not complete without an analysis of state level political dynamics.

Shortly following the demise of the Clinton Health Care plan, a flurry of books was written about how the states would step in to meet the health care needs of their citizens. Because these books were written so soon after the failure of the federal health care plan, however, they are often quite speculative, and the analyses do not cover the full panoply of developments in state sponsored health care initiatives, particularly those that have occurred in the last decade. Rich and White, for example, published a book in 1996 speculating about what states would do to meet the health care needs of their citizens and whether or not states were equipped for the challenge facing them. Since 1996, however, states have enacted various types of health care reform, and this process has yet to be analyzed.

¹ Kaiser Commission on Medicaid and the Uninsured, <http://www.kff.org/uninsured/upload/State-Health-Reform1.pdf>

² National Conference of State Legislatures, <http://www.ncsl.org/Default.aspx?TabId=14516>

Sparer's (1996) analysis goes beyond that of Rich and White to create a larger theoretical model explaining the variation in the form that state health care plans have taken. In particular, after the Clinton plan failed, some states were given greater discretion when applying Medicaid in order to encourage them to implement their own health care initiatives. The hope was that some of these states would serve as models for others. Sparer uses the variation created by this initiative to conduct a thorough comparison of the Medicaid programs in New York and California. Based on his analysis, he argues that bureaucratic variables account for variation between states and that federal leadership is needed in order to reform the health care system. By not looking beyond Medicaid and by limiting his analysis to only two states, however, Sparer misses many of the reforms that states have enacted. In addition, he relies exclusively on bureaucratic politics to explain policy variations between states, when other factors, such as interest groups, may also play a role in shaping policy.

Hackey (1998) takes on the ambitious challenge of providing an "analytical model to compare differences in the policy choices, implementation, and outcomes of state initiatives to control hospital costs" (2). In his analysis, Hackey compares Massachusetts, New Hampshire, New York, and Rhode Island's approaches to controlling health care costs, and he concludes that "different regulatory regimes reflect fundamental differences in (1) the nature of the decision making and implementation process and (2) the ability of state agencies to change the behavior of health care providers" (14). Hackey, though, does not include health care coverage in his analysis and theoretical model. As a result, although a number of books have been written about state level health care policy, a variety of important factors still need to be explored. For example, the role of interest groups in shaping state health care legislation is

absent in current studies. In addition, most studies focus on one type of health care policy, failing to account for or analyze the large variation in the forms that health care policies have taken.

In this paper, therefore, I shall focus on the role that labor has played in shaping and supporting state health care plans because labor has historically been one of the major interest groups involved in health care lobbying at the state level. Specifically, I shall examine the role that the Washington State Labor Council (WSLC) has had in shaping Washington State's health care initiatives by analyzing whether WSLC lobbying increased the likelihood that health care legislation would receive a vote in the Washington state legislature. I chose to look at the WSLC because it is the largest labor organization in Washington State, representing hundreds of local unions, and two of its core programs are legislative advocacy and political action.³

In this study the primary dependent variable is whether or not individual bills made it to a vote in the Washington state legislature. The primary independent variable is the intensity of the Washington State Labor Council's lobbying around specific issue areas, as measured through an analysis of the WSLC's legislative reports, newsletters, position papers, resolutions, and President's Columns (available on the WSLC website). The findings of this paper will contribute to our understanding of labor's influence on the health care system at the state level and, more broadly, to our understanding of the state level political dynamics of health care policy.

Background

³ See <http://www.wslc.org/whoweare.htm>

The majority of research on the shaping of healthcare policy in the US has focused on the national level. Schauffler and Wilkerson (1997), for example, examined the influence of public health interest groups and coalitions on the national health care reform debates in the 103rd congress (Jan 3, 1993 - Jan 3, 1995) and found that “The most effective influence on health care reform legislation was early, sustained personal contact with Congress members and their staffs, accompanied by succinct written materials summarizing key points” (Schauffler and Wilkerson 1107).

Similarly, Carrell and Wilkerson (1999) looked at the role that interest groups have played in shaping federal health care policy in the US by analyzing the American Medical Political Action Committee’s (AMPAC) giving strategies in elections for the House of Representatives. They found that AMPAC contributions did not appear directly to affect roll call votes, but rather that “AMPAC contributes to promote access to decision makers and to help elect (or reelect) legislators who would be expected to be more generally sympathetic to the economic and practice concerns of AMA physicians” (Carrell and Wilkerson 335). They argued, then, that “the best opportunities to shape the substance of health legislation typically occur in venues other than on the floor” (349), a conclusion that I built on when constructing this study.

More recently, Baumgartner et al. (2009) conducted a comprehensive study of the impact of lobbying on federal policy, following ninety-eight randomly selected issues over the course of four years (1999-2002). This study is one of the most in-depth looks at the impact of interest groups on legislation, and nearly one-fourth of the ninety-eight issues were related to health care. The authors concluded that most lobbying is geared towards protecting the status

quo, in part explaining why the federal government has faced so much difficulty on the health care reform issue.

All of the aforementioned studies about interest group influence on health care policy have analyzed the national rather than state level. Given that much of health care policy in the last decade has been at the state level, this project will fill an important gap in the current body of research: by looking at health care initiatives at the state level this study will further our understanding of the role that interest groups play in shaping a large portion of health care policy. Washington State, in particular, provides a fruitful case for this analysis because it has had success in passing some health care proposals, such as universal coverage for children, at the same time that it has experienced set backs in other areas, such as health coverage for the poor. By using Washington State as a case study, therefore, we will be able to look at both successes and failures.

Methodology

In this paper, I analyze the intensity of WSLC lobbying around health care issues and how that intensity impacted the likelihood of health care legislation receiving a vote in the Washington state legislature. I selected whether or not legislation *received* a floor vote as my independent variable rather than whether or not it *passed* a floor vote because numerous studies have shown that interest group lobbying does not influence legislators' positions on roll call votes (see Grenzke, 1989; Chappell, 1982; Wayman, 1985; Welch 1982; and Gutermuth 1999). Rather, "the best opportunities to shape the substance of health legislation typically occur in venues other than on the floor" (Carrell and Wilkerson 349; see also Hall, 1997; and Wright

1990). For example, many interest groups, including AMPAC, focus on electing or reelecting legislators sympathetic to their positions rather than trying to influence specific votes (Carrell and Wilkerson 335).

In addition, contributions have been found to affect politicians' legislative involvement without impacting their votes, buying time rather than votes (Hall and Wayman, 1990). Hall and Wayman point out that, "participation is crucial to determining legislative outcomes; and voting is perhaps the least important of the various ways in which committee members participate" and that, "while members' voting choices are highly constrained, how they allocate their time, staff, and political capital is much more discretionary" (802). Because much political maneuvering around legislation occurs at the committee rather than the floor level, buying politicians' time is a worthy investment for interest groups. Given the combination of these factors, the question of whether or not a bill reaches the floor at all is more indicative of lobbying success or failure than whether or not the bill passes a floor vote.

The intensity of lobbying is the primary independent variable in this analysis. Lobbying intensity was calculated by analyzing the content of the WSLC's legislative reports, newsletters, and position papers from the years 2000 to 2010 using keywords to represent major legislative topics (See Appendix 1 for an explanation of how intensity was calculated).⁴ The dependent variable is the number of bills in each major health care related issue area⁵ that made it to a

⁴ Table 3 (Appendix 6) shows the intensity of lobbying around each major issue, the individual bills that are grouped within each major issue, the number of times a specific bill was mentioned, and whether or not each bill made it to a vote. By summing up the total number of bills in each major area that received a vote, we calculate the dependent variable for Model 1.

⁵ By grouping bills by major issue area rather than concentrating on individual bills, I am able to focus on how well or poorly the overall issue fared rather than on how specific bills fared. For example, although many individual

floor vote in the last eleven years, either in the House or the Senate.⁶ For the reasons explained earlier, whether or not the bills passed the vote is not taken into account in this analysis (See Appendix 2 for an explanation of the models used and the regression results).

Conclusions

The models demonstrated that as lobbying intensity increased, the number of bills that received a vote within each major issue area also increased. These findings are promising because even with a small sample size, lobbying intensity did appear to have an impact on the likelihood that health care legislation would receive a vote (See Appendix 2, Tables 1 and 2).

The results, therefore, show that the more attention the WSLC paid to specific health care issues, the more likely it was that legislation within those areas went to a vote.

These results are promising but still inconclusive. One structural problem with the research design is that it is hard to know whether increased WSLC lobbying led to an increased number of bills receiving a vote, or whether the increased likelihood of a bill receiving a vote and/or higher numbers of potential bills relating to a specific legislative issue led to increased lobbying. A future study could potentially compare across states, include a wider range of issues, or examine WSLC health care lobbying over a longer time period. Another option would be to look at whether or not legislation that the WSLC opposed made it to a vote. For example, in Carrell and Wilkerson's (1999) examination of the impact of AMA lobbying on the federal

bills on one major topic may fail to get a vote, other bills on the same major topic may succeed, indicating that progress has been made on that topic. See Appendix 4 for a list of issue areas as well as the dictionary terms and bills related to each issue area.

⁶ For instance, under the major topic of Prescription Drug Costs, five bills made it to a floor vote, therefore Prescription Drug Costs gets a value of five, whereas under the major topic of the Health Care Responsibility Act, zero bills made it to a floor vote, given this issue area a value of zero. These numbers indicate that progress was made on the former issue but not on the latter and, by counting the total number of bills in the issue area that make it to a vote, give a degree to that progress.

level, the researchers found that in their study period, none of the bills that the AMA formally opposed made it to a vote (349-350). It is possible, therefore, that the WSLC has an impact not only on which bills make it to a vote but also on which bills do not.

Nevertheless, this study is the first to comprehensively examine WSLC lobbying around health care issues in Washington State. Given that most health care legislation in the last two decades has been created at the state level and that labor has been one of the most prominent pro-health coverage interest groups, this issue deserves attention. And this paper does make strides towards understanding which pieces of legislation labor has chosen to support and the success and failure of that legislation at the state level. Therefore, it deepens our understanding not only about what impact the WSLC has on legislative success, but also about what the WSLC priorities are in terms of health care legislation. At the same time, this paper offers a new approach to quantifying interest group lobbying, which could be refined for use in future studies.

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Appendix 1: Calculation of Lobbying Intensity

The process of designing this study was both inductive and deductive. I began by putting all of the legislative reports, newsletters, and position papers from the years 2000 to 2010 into an Excel spreadsheet in which each row was one article. In the end, I had almost 150 articles to analyze. In addition, I created a separate file that contained all of the President's Columns and resolutions from that eleven-year period. I then used a custom program written in C# to reformat the articles in Excel in order to use Excel to put each sentence into a separate cell.

After creating a list of terms related to health care and health care legislation specific to Washington State (see Appendix 3), I used another custom program, also written in C#, to search the Excel files for those terms. The program returned a file with the frequency of each term as well as the exact cell locations of the terms. Next, I read the specific sections of every newsletter and legislative report that referred to any of the search terms. Using the information gleaned from the documents, I created a comprehensive dictionary of health care legislation in Washington State in the last eleven years that I could use to measure the intensity of WSLC lobbying around each issue and each piece of legislation (see Appendix 4).

The dictionary includes sixteen major health care related legislative issues that labor supported. For each issue, I included terms that are used primarily, and almost exclusively, when referring to that issue as well as the numbers of legislative bills pertaining to that issue (see Appendix 4). In constructing the dictionary, I paid attention to the fact that in many cases, entire paragraphs would be written about a legislative issue that only referenced the full name of the issue once. Consequently, in order to differentiate between one mention of an issue

versus an entire paragraph (or more) about an issue, I included variations on the spelling of the issue, shortened phrases that represent the title of the issue, and acronyms. In addition, the dictionary includes the numbers of the bills associated with the major legislative issues. As a result, not all legislative issues have the same number of entries in the dictionary. However, the number of entries in the dictionary does not predict the intensity with which the WSLC lobbied for the issue; indeed, some issues with longer dictionary entries had a lower intensity of lobbying than issues with shorter dictionary entries.

Once the dictionary was constructed, I used another program to calculate the frequency per article of each dictionary term. Because the WSLC documents that I analyze relate specifically to the legislative issues on which the WSLC is focusing its lobbying efforts, frequency counts provide a snapshot of how intensely the WSLC lobbied around each issue. The basic logic is that increased attention to issues in the WSLC's lobbying-related documents correlates with increased lobbying efforts around those issues. In order to calculate the overall intensity with which the WSLC lobbied for each issue, however, I not only counted the frequency at which terms for each legislative issue appeared in the newsletters, legislative reports, and position papers, but I also created rules to account for the fact that the appearance of issues in the legislative reports, President's Columns, and resolutions is indicative of increased intensity of lobbying around issues. Therefore, while each occurrence of dictionary terms in newsletters, legislative reports, and position papers counts as 1 point, the inclusion of the topic in legislative reports, which are issued once per year and indicate the WSLC's major lobbying initiatives for the year, added 5 points per report. In addition, if the topic appeared in the President's Column, I added 5 points. Finally, I added 2 points for each resolution pertaining specifically to

one of the legislative issues (see Appendix 5 for the coding rules). In the end, the higher the total point count, the higher the intensity of lobbying around an issue.

Some issues, such as Prescription Drug Costs, continued to be major lobbying issues over a number of years and for multiple bills. Because the major topic was the same, I counted prescription drug costs as one legislative issue and included all of the prescription drug cost related bills under that major issue in the dictionary. Based on reading through newsletters and position papers, I determined that the topic was consistent enough across years that although the legislation changed slightly with each iteration, the WSLC was essentially lobbying for the same thing. As a result, the intensity of lobbying around prescription drug costs has a rather high score in Model 1. Based on my reading of the newsletters, legislative reports, position papers, and resolutions, that result is an accurate reflection of the intensity of lobbying of the WSLC and not simply a result of how the dictionary was constructed.

Appendix 2: Regression Analysis and Results

In order to calculate whether increased intensity of lobbying was successful, I began by running a basic ordinary least squares (OLS) regression that used the intensity totals for each of the sixteen major topics as the independent variable and the number of bills related to each major topic that went to a vote as the dependent variable:

$$\textit{Model 1: Vote Count} = f(\textit{Intensity})$$

This model is problematic, however, because it lacks control variables. For example, year could be relevant because political factors such as who controls the governor's office or the legislature could impact which bills go to a vote. Likewise, how close the session is to the next election could impact lobbying successes or failures. In addition, length of legislative sessions in Washington State varies, which could impact the likelihood of making progress on issue areas (although many of the issue areas continued across years, making this point less relevant). Finally, non-political factors, such as the state of the economy, could also have an impact on both legislative and WSLC priorities. Lobbying around the sixteen issue areas, however, often spans multiple years, and for each, the number of years it spans varies. Consequently, I decided one model should be included that considered the issue areas as wholes rather than dividing them by year.

Nevertheless, given the potential problems listed above, I also ran two mixed effects models that divide the issue areas by year. By using mixed effects models, I am able to divide the primary independent variable, lobbying intensity, by year while still having it vary by major issue area. This is important because although lobbying within each issue area varies from year

to year, lobbying in subsequent years likely builds on previous years' work. Therefore, lobbying intensity cannot entirely be disaggregated by year. At the same time, I am also able to control for multiple variables in these models that I was not able to control for in the first model:

Model 2: Vote Count (by issue and year) = f(Intensity + Legislative Session Length + Year)

Model 3: Vote Count (by issue and year) = f(Intensity + Legislative Session Length + Year + GDP)⁷

For example, in Washington State, legislative sessions last 105 calendar days in odd numbered years versus 60 calendar days in even numbered years. Because the legislative session length could impact lobbying success, I included a dummy variable for session length, with even numbered years coded as 0 and odd numbered years coded as 1. I also included year in the model to account for factors that vary by year, such as who controls the legislature and how close the session is to the next election. Additionally, in Model 3 I included Washington State's GDP⁸; however, because the GDP is only available through 2008, this model excludes 2009 and 2010 and thus only spans nine years. For both of these models, the dependent variable is the number of bills that received a floor vote per issue area per year. For example, although the "Prescription Drug Costs" issue area received five floor votes in total, it only received one floor vote in 2002.

The OLS regression demonstrated that as lobbying intensity increased, the number of bills that received a vote within each major issue area also increased. Though the model is limited, these findings are promising because even with a small sample size (the N was 16

⁷ Models 2 and 3 were run in R using the `lmer` command in the `lme4` package.

⁸ GDP data taken from the U.S. Department of Commerce Bureau of Economic Analysis' website: <http://www.bea.gov>

because there were 16 major issue areas), lobbying intensity did appear to have an impact on the likelihood that health care legislation would be voted on.

	Model 1
Intercept	0.43 (0.34)
Lobbying Intensity	0.02 (0.004)
R-Squared	0.50
F-statistic	13.88
N =	16

Table 1: Shows the estimates and standard errors (in parentheses) for each independent variable. Lobbying Intensity was statistically significant, indicating that lobbying intensity may, in fact, impact the likelihood of health care legislation receiving a vote in the Washington state legislature.

According to the model, when lobbying intensity around an issue area increased by a factor of one, the number of bills on average that went to a vote in that issue area increase by 0.02. In other words, when lobbying intensity increased by a factor of five, on average one additional bill in that issue area went to a vote. This finding is highly statistically significant. Given that intensity scores ranged from two to 240, an increase of five in lobbying intensity is well within the range of possibility. Additionally, the R-squared for this model is 0.50, which, although not as high as one might like it to be, is reasonable for a model with only one independent variable and no control variables.

	Model 2	Model 3
Intercept	-1.37 (14.35)	23.93 (101.5)
Lobbying Intensity	0.03 (0.008)	0.03 (0.009)

Session	0.01 (0.04)	0.02 (0.05)
Year	0.001 (0.007)	-0.01 (0.05)
GDP	N/A	0.000002 (0.000004)
<hr/>		
Number of Groups	16	16

Table 2: Shows the estimates and standard errors (in parentheses) for each independent variable. Lobbying Intensity was statistically significant in both Models 2 and 3, indicating that lobbying intensity may, in fact, impact the likelihood of health care legislation receiving a vote in the Washington state legislature. Because there is some controversy about how to calculate p-values for these effects models, I have not included p-values.

In both Models 2 and 3, lobbying intensity is a statistically significant predictor of how many bills within an issue area received a floor vote. In these models, when lobbying intensity around an issue area increased by a factor of one, the number of bills on average that went to a vote in that issue area increased by 0.03, which is slightly higher than what was predicted by Model 1, albeit not by a substantively significant amount. Interestingly, the inclusion of GDP (and exclusion of data from the years 2009 and 2010) did not change the influence of lobbying intensity on the number of bills to go to a vote, and none of the control variables were statistically significant. The results from these three models indicate that increased attention to health care legislation on the part of the WSLC did have an impact on how likely it was that legislation within issue areas went to a vote.

Appendix 3: Initial Search Terms

1. "health insurance"
2. "health care"
3. "prescription drug"
4. "medicaid"
5. "Patients' Bill of Rights"
6. "Basic Health Plan"
7. "Fair Share Health Care"
8. "Coverage for all Children"
9. "Health Partnership"

Appendix 4: WSLC Health Care Lobbying Intensity Dictionary

Legislative Issue #1: Prescription Drug Costs

Subtopics/Terms:

- prescription drug (when NOT in same row as 2664 or 6241 or "prescription privacy")
- drug companies
- SB 5030
- SB 5026
- SB 5027
- SJM 8001
- HB 1652
- HB 1319
- HB 1703
- SB 6201
- SB 5026
- SB 6268
- SB 6368
- HB 2431
- HB 1214
- SB 5904
- HB 1091
- HB 1219
- 1168
- 1194
- 1316

Legislative Issue #2: Prescription Privacy

Subtopics/Terms:

- prescription drug (when in same row as 2664 or 6241 or "prescription privacy")
- prescription privacy
- HB 2664
- SB 6241

Legislative Issue #3: Health Care Costs (general)

Subtopics/Terms:

- HB 1825
- SB 5729

Legislative Issue #4: Patient Bill of Rights

Subtopics/Terms:

- Patient Bill of Rights
- patients bill of rights
- patients' bill of rights
- SB 6199
- HB 2331

Legislative Issue #5: Medicaid Waiver

Subtopics/Terms:

- medicaid waiver
- HB 2461

Legislative Issue #6: Stabilize the Health Insurance Market

Subtopics/Terms:

- stabilize the health insurance
- HB 2798

Legislative Issue #7: Insurance company coverage of mental health issues

Subtopics/Terms:

- mental health
- HB 1154

Legislative Issue #8: Small Employer Health Insurance Partnership Program

Subtopics/Terms:

- Health Insurance Partnership
- HB 2572
- Healthy Washington Coalition
- Healthy WA Coalition
- HB 2537

Legislative Issue #9: Health Care Coverage for all Children

Subtopics/Terms:

- all children
- children's health care access
- HB 1071
- SB 5093

Legislative Issue #10: Stabilizing Insurance Premiums

Subtopics/Terms:

- Insurance premiums
- HB 1910
- SB 5861
- HB 2499
- insurance rate accountability
- SB 5261
- HB 1234
- SB 6252
- HB 2513

Legislative Issue #11: Washington Health Partnership (goal: cover all WA residents by 2012)

Subtopics/Terms:

- Health Partnership
- SB 6333
- SB 5945
- Health care for all
- Healthy Washington Coalition
- HB 2536
- coverage for all

Legislative Issue #12: Health Care Disclosure Act (would require state agencies to report the employment status of Medicaid and BHP recipients)

Subtopics/Terms:

- health care disclosure
- HB 3047

- HB 1486
- SB 3079
- Wal-Mart

Legislative Issue #13: Health Care for Washington Workers

Subtopics/Terms:

- health care for Washington workers
- health care for WA workers
- HB 1830
- HB 2785
- ESHB 2460
- HB 2460
- Health Care Lite

Legislative Issue #14: Health Care Responsibility Act

Subtopics/Terms:

- Health Care Responsibility Act
- HCRA
- SB 5704
- SB 5637
- HB 1702

Legislative Issue #15: Fair Share Health Care

Subtopics/Terms:

- Fair share
- SB 6356
- HB 2517

Legislative Issue #15: Taxpayer Health Care Fairness

Subtopics/Terms:

- Taxpayer Health Care Fairness
- SB 6147
- HB 2094
- SB 5977

Appendix 5: Coding Rules

1. Each occurrence of dictionary term in a newsletter = + 1
2. Each occurrence of dictionary term in a legislative report = + 1
3. Each occurrence of dictionary term in a position paper = + 1
4. Legislative issue discussed in a legislative report = + 5 per report
5. Legislative issue discussed in President's Column = + 5
6. Resolution about legislative issue = + 2 for each Resolution

Appendix 6: Tables

Legislative Issue/Bill Number	Lobbying Intensity	Year	Vote: 1=yes 0=no
Prescription Drug Costs	260		
SB 5030	1	2001	0
SB 5026	4	2001	0
SB 5027	1	2001	0
SJM 8001	1	2001	0
HB 1652	1	2001	0
HB 1319	1	2001	0
HB 1703	2	2001	0
SB 6201	2	2002	0
SB 5026	4	2002	0
SB 6268	2	2002	0
SB 6368	5	2002	1
HB 2431	5	2002	0
(E2S)HB 1214	30	2003	1
SB 5904 (WSLC opposed bill; bill did not get a vote)	5	2003	
HB 1091	2	2003	0
HB 1219	1	2005	0
SSHB 1168 (Senate)	3	2005	1
SSHB 1168 (House)	3	2005	1
HB 1194	1	2005	1
1316	1	2005	0
Prescription Privacy	43		
HB 2664	7	2008	0

SB 6241	8	2008	1
Health Care Costs (general)	5		
HB 1825	3	2007	0
SB 5729	2	2007	0
Patient Bill of Rights	10		
SB 6199	2	2000	1
HB 2331	5	2000	1
Medicaid Waiver	3		
HB 2461	1	2002	0
Stabilize the Health Insurance Market	2		
HB 2798	1	2004	0
Mental Health Parity	17		
HB 1154	4	2005	1
Small Employer Health Insurance Partnership Program	47		
E2SHB 2572	7	2006	1
HB 2537 (House)	5	2008	1
HB 2537 (Senate)	5	2008	1
Coverage for all Children	7		
HB 1071	1	2007	0
2SSB 5093	3	2007	1
Insurance premiums	42		
HB 1910	1	2005	0
SB 5861	1	2005	0
HB 2499	2	2006	0
SB 5261	11	2008	1

HB 1234	3	2008	0
SB 6252	1	2010	0
HB 2513	1	2010	0
Washington Health Partnership	71		
SSB 6333	16	2008	1
SB 5945	4	2009	1
HB 2536	6	2008	0
Health Care Disclosure	83		
HB 3047	1	2004	0
HB 1486	5	2005	1
ESHB 3079 (House)	2	2006	1
ESHB 3079 (Senate)	2	2006	1
health care for Washington workers	31		
HB 1830	4	2003	0
HB 2785	8	2004	0
ESHB 2460 (opposed)	2	2004	1
HB 2460	3	2004	0
Health Care Responsibility Act	58		
SB 5704	1	2003	0
SB 5637	7	2005	0
HB 1702	7	2005	0
Fair Share	106		
SB 6356	10	2006	0
HB 2517	10	2006	0
Taxpayer Health Care Fairness	35		

SB 6147	1	2007	0
HB 2094	22	2007	0
SB 5977	1	2007	0

Table 3: Lobbying intensity of major legislative issues and individual bills as well as whether or not the bill got a vote.