SEEKING THE CENTER
Politics and
Policymaking at
the New Century

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In September 1993, Bill Clinton captured the imagination of the television audience when he promised to create a new right for all Americans, the right to health coverage, embodied in a red, white, and blue plastic card he described as the “health security card.” A poll taken by Robert Blendon on the night of the viewing found 80 percent of voters willing to pay more in taxes to make health care universal and to contain escalating costs. Clinton appointed his own wife to lead the health care reform crusade, and for a few flushed weeks Hillary Rodham Clinton was universally hailed as the lady of the hour. Health care reform seemed imminent and irresistible. Yet by late winter of 1994, the president’s reform bills were languishing in critical congressional committees. Even before its legislative demise in the summer of 1994, the reform episode was admitted by friend and foe alike to be the perfect example of how not to conduct public policy.

It is striking that a policy initiative enjoying such popular will and moral force could have met with an egregious demise, and volumes have been dedicated to explaining national health reform’s downfall. It is not my purpose to contribute to this vast literature; rather, I propose to use the sad plight of national health reform to reflect on differences in policymaking campaigns—the caustic conflicts of a high-salience, interest-driven legislative battle versus the more quiet negotiations of ideas-driven policymaking described in the New Politics of Public Policy.
pert debate over ideas. Later during the health care reform legislative cycle, the fragile consensus over managed competition fell apart as the contradictions in the proposal emerged. At the same time, technical-rational ideas about policy were subsumed in a larger debate over the role of government in society, as vested interests opposing health care reform managed to refocus the public’s attention.

The health care reform case also suggests quite a bit of interplay between ideas and interests. Ideas were quite critical to societal actors’ perceptions of their own interests in health policy. Even the allegedly most material of actors—business managers—found their interests transformed by ideas. Technical experts within the firm brought companies in line with the thinking of technical experts elsewhere.

In reciprocal fashion, interests influenced both the generation of and public reception to the ideas underlying reform. Health care reform came to be based on managed competition not only because the idea was compelling but because it protected companies’ vested interests in the employer-based system. At the same time, the ultimate demise of health care reform reflected the ability of its opponents to reframe the managed competition idea as antithetical to the interests of both employers and the broader public. The leaders of the opposition engaged in “spin control,” selective polling, and other tactics to cast a rightist tint on the policy initiative.

Second, the health care reform case illustrates how high political salience can diminish the role of technical expertise, distort the public’s perception of policy tools, and reduce a bill’s likelihood of passage. Although political salience may be manipulated by political entrepreneurs as a strategy for building political will, salience may also increase the likelihood of interest group conflict and decrease the power of political experts. Before the reform legislative cycle, quiet, major changes were taking place in the organization of the health care system, which James Morone has categorized as “slouching toward national health reform.” Similar major changes in the post-reform period might be characterized as hurrying toward managed care. During the congressional debate, however, political salience dramatically distorted the very managed competition initiatives that were subsequently adopted by the market.

Of course, as Schattschneider notes, interest groups recognize the political power of salience and often manipulate scope to increase or to suppress salience. These groups may work to increase the political salience of an issue to move it out of the technical-rational realm and to recast it in more ideological terms. When issues gain visibility, it becomes more difficult for policy entrepreneurs to retain control and to pursue an ideas-driven legislative strategy.

In the case of national health reform, one sees political entrepreneurs both deliberately manipulating salience and responding to interest group efforts to increase the visibility of the issue. Clinton’s decision to increase the salience of health care reform by identifying it as the major initiative of his first term reflected the realpolitik conflict of party politics and a conflation of a new president’s political ambitions with policy needs. The politics was transformed as the two parties made the issue a test for party identification and control, and the outcome may have been different if they had chosen a different vehicle for this partisan conflict.

The Clinton administration also chose the high-salience route because it believed that true reform would require a tremendous amount of political will. Health policy is an area with deeply entrenched interests. The patchwork pattern of public/private provision in health made for a very intricate mix of interests growing out of current benefits and privileges on both the supply and demand side. These interests invested enormous resources to change the terms of the health care reform debate. The policymakers within the administration were well aware of the drawbacks of increasing the salience of the issue, but they felt that increased salience through a class-based mobilization was necessary for action, even though this mobilization would distort the policy process and detract from expert power.

Thus, the case of health care reform reveals the paradoxical nature of political salience. A key reason for increasing political salience is to generate political will, but ironically salience pushes action and at the same time delimits it. Political will can, in fact, inhibit policy legislation, and policy entrepreneurs may achieve more where there is a policy vacuum without much public demand. But in issue areas such as health care in which entrenched interests block action in the absence of political will, comprehensive change may be impossible without full-scale interest mobilization and high political salience.

**Ideas in Policy Change: The Rise and Fall of Managed Competition**

The health care reform case strongly confirms the volume’s emphasis on ideas as a powerful determinant of policy: ideas brought health care reform to the national agenda, and the supplanting of
technical-rational ideas with broader ideological conflict ultimately killed reform. Ideas were an initial powerful support for comprehensive overhaul of the health system. Although national health reform had been traditionally viewed as a socialist’s dream, in the late 1980s the concept became associated with cost control and system rationalization. A pivotal constituency for reform in this early period was experts from both the public and private realm who believed the health system to be highly irrational and profoundly disturbed. As Mark Peterson has argued, it was this consensus of expert opinion, even drawing supporters from the medical and business communities, that radically changed the prospects for national health reform.  

Agreement about the problem did not translate into consensus about the solution; indeed, over the years a chasm had existed between advocates of market solutions and those desiring regulatory change. Health care reform advocates were divided among those wanting a single-payer plan, a regulatory approach called play-or-pay, and incremental market reforms, the most comprehensive being the Heritage Foundation plan.  

The single-payer approach would create a single pool financed by taxes that would negotiate with hospitals and doctors; many plans would abolish private insurance and depend on public administration.  

11 Woolhandler and Himmelstein argued that a Canadian-style system would save $69 to $83.2 billion in administrative costs.  

12 Critics retorted that the Canadian national debt is twice as high as that of the United States per capita and that the Canadian federal government is shifting costs to the provinces.  

13 Others worried that the national government would not be competent to administer the plan and that quality would decrease without competitive market pressures.  

The play-or-pay system was a mixed public-private system that offered global budgets to limit costs, regulated rates to reduce inequities, and employer mandates to expand coverage. Supported by many congressional Democrats, the play-or-pay feature meant that employers would either play and offer health insurance or pay a new payroll tax of 5 to 8 percent, used to expand the public program.  

14 Critics worried that play-or-pay would create a new burden on business, increase the hourly cost for workers receiving the minimum wage by up to $0.80, and precipitate a loss of jobs. Some saw play-or-pay as a first step toward a single-payer system, especially after the proposal to set the “pay” rate at 7 percent of payroll when many company health costs are as much as 14 percent of payroll.  

The Heritage Foundation tax credit or voucher system sought to reintroduce competition into the health care market. The plan would change all employment-related benefits into direct wages, and workers would pay for premiums directly. All heads of households would be required to buy at least catastrophic insurance, but state mandating of specific benefits would be illegal. In its pure form, the Heritage plan entailed almost as much government monitoring as play-or-pay, although it left the reform process to the private market.  

18 President George H. Bush’s plan adopted pieces of the Heritage approach without a realistic funding strategy, and critics worried that this plan would fail to meet the needs of the very ill.  

Considerable disagreement divided supporters of these three plans; no technical consensus pointed the way to easy legislation. But a new idea, managed competition, briefly offered a means for reconciling market and regulatory approaches.  

20 Managed competition, based on work by Alain Enthoven, sought to change the market incentives for both providers and consumers by aggregating consumers into large purchasing cooperatives. A national board would determine a standardized benefit package; only plans that provide the package would be certified as “accountable health plans.”  

21 Advocates argued that managed competition could accomplish dramatic changes in the health-financing landscape without excessive government intervention.  

The Clinton administration proposal borrowed from both play-or-pay and managed competition plans. In keeping with the spirit of play-or-pay, Clinton proposed that all employers be mandated to provide health benefits to their employees. To contain costs, Clinton proposed a national board to set spending targets for the amount to be spent on health care. Combined with these regulatory efforts to contain costs was the market-oriented managed competition proposal. Employer-paid premiums would be aggregated into non-government purchasing cooperatives that would coordinate coverage and restrain costs.  

22 The concept of managed competition appealed to the New Democrats and to President Clinton, as fitting with the president’s efforts to rewrite the boundaries between the market and the welfare state. Although social initiatives are usually viewed as a drag on economic growth, the Clinton administration sought to reconcile the ancient antagonism between social welfare and accumulation by
organizing social policy to support economic growth and by using markets to achieve social ends. Clinton argued that markets alone are insufficient to spur growth and international competitiveness; instead, government must assist industry through incentives strategically calculated to maximize America’s competitive advantage. Thus, health joined labor market initiatives to guarantee a productive workforce for the postindustrial future. At the same time, the mandate offered a means of achieving social ends without threatening the private health-financing market. Employer mandates were the epiphany of a new social philosophy that sought not to create expanded public programs but to correct the functioning of the private markets.

Political feasibility also made the managed competition idea seem attractive. The administration recognized that big business and large insurance companies were attracted to the idea (discussed later). Managed competition also claimed to be more fiscally viable than plans requiring greater government intervention. As Patashnik and Pierson point out in this volume (see chapters 2 and 3, respectively), our national obsession with budget deficits combined with the politician’s fear of bearing the tax responsibility burden greatly constrain the development of new government programs. Managed competition avoided this conundrum with a hidden tax in the form of an employer mandate and thus could claim to offer wonderful benefits with very little fiscal costs. Something happened to the ideas informing health care reform; namely, the technical-rational ideas of bureaucrats became lost in a broader ideological conflict over the role of government. At this point experts could no longer control the debate, and the fortunes of health care reform declined. In a few pages we will consider how this substantial shift in the ideas underlying health care reform occurred, but first let us look at another important way that ideas shaped the health care reform process—in their impact on business managers’ perceptions of their own interests.

**Linking Ideas and Interests: Employer Support for Reform**

In emphasizing the power of ideas, one runs the danger of neglecting interests or of drawing overly stark comparisons between ideas and interests. In fact, the two are deeply connected: ideas shape interests and interests shape ideas.

The enormous impact of ideas on interests in the case of national health reform can be documented with the transformation in the thinking of corporate purchasers of health. By the late 1980s and early 1990s, most business managers seemed accepting of both systemic reform and employer mandates. In my study of randomly sampled Fortune 200 companies, over half of the business respondents (54 percent) supported mandates, and another 19 percent felt mixed on the subject. In 1991 a Harris poll found two-thirds of a corporate sample at least somewhat accepting of a mandated standard benefits plan. Membership polling within the major umbrella associations supported the findings of academic business surveys. In a 1992 study, 55 percent of National Association of Manufacturers (NAM) members favored a play-or-pay approach (complete with employer mandates) as part of overall system reform. A NAM survey in 1993 found a majority supporting mandates and health alliances for firms with more than five hundred employess. A June 1994 Washington Business Group on Health survey of large firms showed 72 percent supporting a requirement for all companies to offer insurance, 59 percent wanting firms to pay a portion, and 71 percent objecting to an arrangement that allowed small business to escape the mandate. As one lobbyist put it, “Business from the far right has moved to the center in saying that the federal government needs to be involved.”

Business supporters of health care reform were motivated by complicated reasons. Economic circumstance was certainly important. For many years employers have been major providers of health benefits, covering almost two-thirds of the nonelderly population in the United States. But in recent times health costs have grown enormously, claiming 8.3 percent of salaries and wages by 1989. In the age of multinational trade, export-oriented firms wanted to keep labor costs low. Corporate supporters of health care reform wanted government to force their competitors to offer benefits and to end cost shifting. Some big corporate spenders (often with fast commitments to their unions, such as auto and steel firms) wanted, like the government, to bail them out by assuming some of the costs of social provision. Finally, many firms believed that a coherent health policy could rationalize the current system.

But material conditions are insufficient to explain managers’ preferences for reform; rather, one must investigate the new ideas about the role of human resource investments in competitive strategies. Some managers following a laissez-faire approach continued
to believe that spending cuts in both the private and public realms were necessary to be competitive because these cuts would reduce labor costs and to free up investment capital. Yet others bought into the high-performance workplace logic that recommended rationalizing, targeting, and often expanding social investment spending by governments and/or firms in order to develop a competent, productive workforce. Many business managers agreed with Jim O’Connell (Ceridan) that the interest in social issues reflected concerns about productivity: “Companies not only have a conscience, but in addition there’s a profitability motive.”

The importance of ideas in managers’ perceptions of their interests is illustrated in my study of firm preferences for health care reform. Companies that supported employer mandates in health care reform had an institutional capacity to grasp the technical-rational ideas underpinning national health reform, a quality I have labeled corporate policy capacity. Three institutional factors enhanced companies’ corporate policy capacity: private-sector policy expertise, the political organization of managers, and social policy legacies within business. First, the expansion of private policy expertise within the firm affected how business managers thought about their interests and increased their receptivity to the ideas underpinning health care reform. Thus, the companies in my study with institutionalized policy expertise in the form of Washington government affairs offices were significantly more likely to support mandates. Oddly, these firms began forming Washington, D.C., government affairs offices in the 1970s to fight the expansion of government regulations. Yet meeting with public sector regulators and congressional staffers over time exposed them to technical policy arguments and brought them to view social problems from a more technical and less ideological perspective than others in the business community. Government affairs positions came to be staffed by experts with considerable professional training in their substantive fields, who were then able to influence top management’s perceptions of their firms’ interests.

Second, business support for health care reform was shaped by prior corporate experiences with private benefits. When private welfare plans failed, firms often moved toward government solutions. Many managers described their path to systemic reform as one of increasing frustration with firm-level efforts to change provider behavior.

Finally, the firms that developed their preferences collectively in group settings were significantly more likely to accept employer mandates. The collective exploration of health problems exposed respondents to a range of new information that expanded their perspectives and transformed their thinking. Managers developed their preferences in various types of groups, even those with no national policy focus. For example, area coalitions were formed before health care reform became an important issue, were created to try to control local markets, and were originally oriented to market solutions. Yet this community activism at the local level led to activism at the national level. A participant of a trade association task force explained that the deliberative process radically altered her perspective: “On most issues I am a hard-core Republican, but I’m radical on this issue. I generally don’t believe in regulation, but regulation should be when the market breaks down, and it has in health care. I know that I sound like a bleeding liberal, but we need to know that each person will be accounted for. Maybe employers will have to pay more, but at least it will be explicit.”

The Impact of Interests on Ideas

Just as ideas inform interests, interests also influence both the generation of and public reception to ideas. For example, the emergence of managed competition as a central organizing principle of health care reform reflected the policy legacies of the employer-based system and managers’ vested interests in the status quo. Market approaches tend to enjoy greater ideological acceptability in general, but even more important, the managed competition plan was built on market changes already afoot in the business community. Since the 1980s, many companies had been securing provider services through managed care networks, such as point-of-service (POS) plans, and had used their large patient pools to secure advantageous rates for their customers. In 1992, Foster Higgins found nearly three-fourths of the firms sampled offering a managed care option (either POS or HMO). The cognitive step from managed care to managed competition promised to be a small one, and policymakers believed that business managers would be instinctively drawn to a national solution that was close to what they were already doing at the microlevel.
The policy choice of managed care was consistent as well with the business coalition movement that had developed to increase purchaser power at the local level; this institutional innovation provided a model for the consumer purchasing groups in the managed competition plan. Managers had been quite impressed by the Enthoven concept of community-based purchaser coalitions to restate market rationality into the health system, and important corporate forums such as the Jackson Hole group and the Managed Health Care Association were devoted to the managed competition idea. Finally, the big insurers' move into managed care offered a compelling political draw: these giants hoped to administer the purchaser cooperatives. Thus, interests were important to the original choice of managed competition as a vehicle for reform.

In reciprocal fashion, interests played an important role in the reframing of the Clinton initiative and the recasting of the rights embodied in the proposal. Recognizing that liberals had an advantage in idea generation, conservative think tanks had for some time been creating forums for developing counter-ideas. Think tanks and foundations such as the Citizens for a Sound Economy sought with spin control to change the ideas associated with comprehensive health care reform. Through the use of devices such as the famous Harry and Louise ads, the opponents of reform amazingly transformed a market approach—managed competition—into a symbol of big government intrusion into private lives. The media campaign was actually less interested in affecting public opinion than in affecting how Congress viewed public opinion. As a result, the ads were mainly shown in Washington, D.C., or in districts with uncommitted legislators. But the nightly news greatly increased the circulation: major interest groups received 798 seconds of (free) news coverage about their ads. The Harry and Louise ads alone got 324 seconds of free air time. The Health Insurance Association of America (HIAA) spent $15 million on advertising attacking Clinton in 1994.

The opponents of reform were also able to reframe the rights debate connected to the health initiative. The central ambition of the reform measure was to establish a new right to universal health coverage, packaged by the administration as "security of decent health care for every American family." According to the Schuck typology, this right should have been of the strongest kind, as it was morally based as opposed to legally based and grounded in natural law. Yet this new right was too vulnerable to withstand the opposition, when naysayers countered with an opposing right—the right to choose—thus adding an odd inverse of the language of abortion to the debate. Rather than questioning the right to health, health care reform's detractors argued that the solution proposed would threaten other rights. In this vein, Tod Lindberg wrote, "Universal coverage—something Americans supported in the abstract—suddenly paled in importance compared with the loss of certain features of the current system that people had taken for granted (the right to choose their own doctors, for example)." This vulnerability was accentuated by the fact that health access is highly divisible, and most citizens already enjoy this de facto right, making a new initiative problematic especially when it potentially threatened their right to choose. Some feared that the new right would take health access out of the private domain in which it had rested comfortably for many years, and many Americans resisted further government intrusion into the health domain. Thus, President Clinton was told, "Mind your own business," in the American Spectator.

The following section on political salience delves more deeply into the strategies used by health care reform's opponents to change the fundamental terms of the reform debate from ideas about fixing the technical problems of the system to arguments about the role of the state.

The Politics of Salience: Party Ambitions and Reform's Demise

Health care reform readily appears to support another theme of this volume: that policy is more easily passed when it is handled by policy experts under conditions of low political salience. Comparing the dialogue during the reform debate to discussion of health policy before and after illustrates how salience removed health policy from the domain and language of experts. Political salience increased enormously during the health care reform battle, and the type of bureaucratic adjustments that were easily made before and after the legislative cycle were suddenly cast as major shifts in the boundary between public and private. The efforts of both parties to increase the political salience of reform harmed the legislation's chances for enactment.
Although physicians and their interest groups traditionally dominated the health policy arena, in the fifteen years before Clinton’s health security bill, bureaucrats steadily challenged the medical profession’s dominion. These changes were highly incremental, producing a revolution so quiet that even the major players seemed unaware of its implications. Under the guise of cost containment, regulators introduced limits on new medical facilities, rigid reimbursement schemes for Medicare patients, and procedures to monitor physician decisions. Private sector consumers also pursued a range of cost controls that curtailed physician power.

The period following the reform legislative cycle also saw huge changes in health financing. Corporate providers of health have flocked to managed care in droves since the 1980s, despite health care reform opponents’ arguments that managed competition attacked consumer choice. HMO enrollment went from two million in 1970 to fifty-one million in 1995. A Foster Higgins survey found that by 1995 managed care networks had come to cover 71 percent of workers who received health benefits through their jobs. The 1996 Kassebaum-Kennedy health insurance legislation made many incremental regulatory changes in the health universe and kiddie care established universal access for a new beneficiary group: the nation’s children.

It is true that the recent managed care developments differ from Clinton’s managed competition proposal in important ways. National health reform sought both to group providers into managed care networks and to enhance the market power of disadvantaged consumers by aggregating them into purchasing pools. But the changes that are reorganizing the health care market today are largely hurting consumers with the least amount of market power. Rate regulation is being phased out in many states, and while competitive contracting with managed care networks helps large corporate customers, it makes it more difficult than ever for providers to extend charity to the uninsured and to train young doctors. Yet, while these market innovations lack the scope of the Clinton health plan, they add up to fairly profound modifications of the health policy universe.

Political salience is also important to the health story in its impact on the legislative fortunes of reform. Although the initial stages of the health care reform legislative process seemed driven by ideas and bureaucratic experts, both parties struggled to increase the political salience of the issue and, subsequently, dam-

aged reform’s chances for enactment. Ira Magaziner and Hillary Rodham Clinton began the health care reform process in the same bureaucratic technical-adjustment mode that influenced many past important health changes. Rather than offer a simple working document for Congress to elaborate, they decided to articulate good policy answers to the host of problems embedded in the goal of reforming our nation’s health system.

The administration appointed a task force of more than five hundred members broken down into thirty-four subgroups to develop aspects of the bill. Congressional staffers, agency officials, doctors, economists, administrators, and ethicists met for sixteen-hour days to discuss 1,100 separate policy questions that needed answers. The subgroups were asked to generate possible solutions to each question that could then be presented to the president to decide. President Clinton’s subsequent 1,400-page proposal for health care reform reflected this extensive deliberation.

It is rather ironic for our purposes that the administration was subsequently vilified for its bureaucratic approach. Staffers on the Hill felt that the large complicated bill offended almost everyone: “It was not in the interests of anyone to push—everyone’s second-best choice was to do nothing.” Legislators felt rebuffed by the administration in efforts to shape proposal development. One Democratic House staffer echoed the sentiment of many when he remarked, “The task force was a sham; they knew what they wanted going in. In July 1992, a high-level guy [from the administration] came and told me what they were going to do. There was really no consultation with Congress.” Congressional aides also felt that there was an incentive in the administration’s game to hold back commitment to the bill until the end of the process that increased. Fewer concessions may have been made to special interests had the administration sent a brief proposal to Congress and allowed legislators to make the deals and work out the thorny issues.

The bureaucratic approach miscarried in part due to contradictions within the plan and within the concept of managed competition. The Clintons failed to provide an adequate financing scheme for its very large benefits package and lost credibility in the process. Some doubted that health care reform could be achieved without a tax hike and some worried that the cost control mechanisms were excessively weak in the president’s plan. Many initial business supporters considered the minimum benefits package excessive and
worried about losing control over their company plans and being transformed into “check writers.” The details of the administration’s health alliances prompted widespread concern because only firms with five thousand employees were permitted to opt out of the public plan, managers worried that few could elude the public pool. Because the public alliances were to span entire regions, companies feared losing their current considerable purchasing leverage over providers. A Foster Higgins model predicted that few companies would find it economical to continue to operate their own plans or would find appealing the option of forming a corporate alliance. Many felt that Clinton’s proposal was excessively complicated and despite claims to the contrary, created a new federal bureaucracy. As Rick Smith of the Association of Private Pension and Welfare Plans (APPWP) put it, “Bill Clinton gave mandates a bad name.”

The bureaucratic approach also floundered because the Clinton administration was torn between wanting to leave reform under the domain of experts and making reform into a major source of political credit. The credit seekers won out, and the politics was transformed as the two parties made the issue a test for party identification and control. Indeed, the outcome may have been different if they had chosen a different vehicle for this partisan conflict (substantiating Landy and Levin’s and Shapiro’s arguments about elections in chapters 1 and 18, respectively).

To some extent, Clinton’s decision to increase the salience of health care reform reflected the realpolitik conflict of party politics and a conflation of a new president’s political ambitions with policy needs. Clinton made health care reform a major point in his campaign and announced that renovating the nation’s medical system would be a major initiative of his first term.

Yet the administration’s decision to pursue a politics of salience also reflected a realistic appraisal of the interest group world. The administration was caught in a vice grip between rallying the mass public with a populist attack on insurers and providers and working behind the scenes with experts in both the public and private sectors. It opted for populism and decided that drug companies and insurers were perfect for the role of villain. The need to rally mass support also prompted a shift in focus from cost containment to access, but corporate supporters responded best to the administration’s plan when the problem was framed as curbing costs. Stan Greenberg argued for framing the issue as one of access because people would doubt that the government could really curb costs:

The dominant goal should be health care security: that people will have health insurance and that they will never lose it, never. . . . Health care security has much more power than the cost argument, and it is much more believable: people think we can deliver on security; they are not sure we can deliver on cost control. There is also an emotion in security (lacking in cost) that empowers our rationale for bold changes.

Perhaps deserved, the language of heroes and villains elicited emotional, ideological responses that undercut the business policy experts’ ability to portray the issue in technocratic terms and to sell the plan to their firms. Clinton’s dealings with business purchasers was also complicated by Democratic legislators’ demands in the fall of 1993 that the Clintons “shut down the process” of making deals with interests. Suddenly, after promises to the contrary, the Clintons seemed uninterested in adapting to corporate concerns. The administration quietly reassured groups that their demands were consistent with the administration’s own “end-game scenarios.” But this behind-the-scenes strategy did nothing to assuage the fears of the groups’ mass memberships who could judge the Clinton plan only by its public manifestation. Thus, NAM president Jerry Jasinowski told Magaziner, “I have a problem with some of my members. They’re afraid that you’re rope-a-doping me.” Others told the administration, “[Corporate opponents] say that you’re going to roll us and that you won’t be flexible. If you made some of the changes that you yourselves admit, even if you don’t change employer mandates or benefits, it gives us something to work with.”

The Republicans also worked to increase the political salience of health care reform, especially after Republican pollster Bill McInturff told Gingrich that health care reform’s defeat could lead to a Republican House. Most Washington observers ultimately concluded that conservative Republicans were determined to block any bill with a Democratic label, even centrist efforts. Supporting this theory was William Kristol’s advice to the Republican right:

The fate of health care reform is now out of the hands of Bill and Hillary Clinton... Acting Presidents Mitchell and Gephardt will unveil a new Democratic health care bill... the actual
details of this not-quite-universal-coverage bill don’t matter. *Sight unseen, Republicans should oppose it.* Those stray Republicans who delude themselves by believing that there is still a “mainstream” middle solution are merely pawns in a Democratic game. . . . Our enemy is no longer Clinton, it is Congress.”

The Republicans’ interaction with the big business community is informative. GOP legislators pressured big business to reject reform, directing employers toward incremental alternatives, framing the health debate in larger terms, and capitalizing on the Republican party’s historical relations with individual companies. The message to business was that health care reform was “a new entitlement” and “a whole package” and that firms shouldn’t sell out for individual benefits. One aide remembered her congressman’s admonishment: “If you want our help in killing the Clinton plan, don’t do separate deals on other things.” Again and again we were trying to lay out the big picture for them. “Maybe you can accept the deal right now, but think about what can be done to you in 10 years.”

The Republicans also threatened to retaliate in other policy areas if companies joined the Democrats on health care reform, forcing them to choose between health and issues more directly tied to core production activities. Shortly before the Business Roundtable vote, Newt Gingrich told two dozen CEOs that “their interests were best promoted by being principled rather than going for short-term deals.” Ameritech, a longtime supporter of health care reform, planned to sponsor a presentation by President Clinton. Republican congressmen on the House Energy and Commerce Committee told the company that if it supported the president, it would be punished in other regulatory areas under the committee’s jurisdiction. Caterpillar and several telecommunications companies received similar threats. CEOs were told, “If you are going to come back and ask for help in future areas, you should know that it’s not in your interests” to support mandates.

Congressional Republicans take much of the credit for the dramatic policy reversal of the Chamber of Commerce. The Chamber vice president, Bill Archey, worked with the chamber’s Health and Employee Benefits Committee to endorse an employer mandate, managed competition, and a standardized benefits package. This position greatly angered the House Republican Conservative Opportunity Society, who demanded a meeting with the Chamber’s president Richard Lesher and Archey and “read them the riot act.” Jim Bunning (R-KY) gave a speech against big government, big labor, and big business (causing one participant to wonder whether Bunning knew that the organization included big Fortune companies). John Boehner (R-OH and chairman of the group) sent letters on congressional letterhead to Chamber of Commerce constituents saying that they should cancel their Chamber membership. Dick Armey asked for an opportunity to offer the Republican view to the board before the Chamber took any action. Meanwhile, the National Federation of Independent Business initiated a membership drive against the Chamber. Few members resigned, but the chamber reversed its position on reform.

The Republicans worked closely with business groups opposing health care reform, an effort discussed in greater detail later. On the House side, Billy Pitts (an aide for Bob Michel) ran a Monday morning meeting of congressional aides on the key committees and business representatives from the Health Care Equity Action League and the major small business associations. Pitts would identify the issue of the week, and the group would “brainstorm on strategies, line up key amendments to focus on, and make sure that everyone was pulling in one direction.” Participants would identify “who was gettable and who wasn’t” and discuss “what kinds of pressures to bring to bear in the districts.” A big topic of conversation was “when to put the plug on reform so that it didn’t look like the Republicans had pulled the plug.”

**Political Salience and Interest Groups**

The health care reform case certainly shows that political salience killed the measure’s chances of sneaking through as bureaucratic reform and that politicians’ decisions to make it into a party-defining issue contributed to this fate. But the case also raises the question of whether salience is a cause or an effect of interest group power. Just as salience can work to increase or decrease interest representation, interests work to augment or to suppress salience.

Opposing interests often increase the political salience of issues to remove these issues from the purview of experts and to recast them in stark ideological terms. In these cases, it may be hard for
policy entrepreneurs to pursue ideas-driven policymaking. Health care is a classic policy area marked by a high degree of vested interests. The patchwork pattern of public/private provision makes for a very intricate mix of interests growing out of current benefits and privileges on both the supply and demand sides. In such a situation, the freedom of movement available to policy experts is greatly constrained.

Thus, the story of the health care reform struggle is incomplete without reference to the way that reform’s opponents struggled both to increase the salience of the issue and to change the terms of the debate. In this section, we explore two critical junctures in the reform saga in which opponents were able to set back greatly the policy’s prospects: the campaign to prevent NAM from supporting reform and the struggle to stop the Energy and Commerce Committee from producing a bill.

Although many managers in large companies supported health care reform in the early stages, the major business organizations were unable to deliver an official position to this effect. As has been discussed earlier, the Chamber of Commerce came the closest, but active interference by the House Republicans made the group change course. An active campaign by reform’s opponents within the major business associations also played a major role in suppressing support for health care reform. The umbrella organizations were unable to overcome the divisions within their ranks, reflecting the perennial tendency of such groups to sink to lowest common denominator politics.75

The experience within NAM exemplified how difficult it was for umbrella organizations with a minority representation of health care providers to exert leadership in health care reform. Nearly all NAM members (99 percent) offered benefits in 1988, and a NAM-commissioned Foster Higgins study found health care costs representing 37.2 percent of employers’ profits.76

NAM investigated health care reform in a white paper entitled “Meeting the Health Care Crisis,” cosponsored with the Washington Business Group on Health a symposium to consider legislative issues, and formed a health care task force to develop a NAM policy.77 Some of the task force companies (GE, Allied Signal, and Motorola) were drawn to a managed care approach; others (Southern California Edison and Chrysler) favored regulation. Ultimately, the task force supported a play-or-pay plan much like that of the National Leadership Coalition’s. The NAM newsletter was to brag that “NAM policy initiatives will help maintain the association’s continuing key role in the health debate, broadly representing the business community.”78

The NAM board debated the task force recommendations from February until October of 1991. The association’s tax task force, which viewed play-or-pay as a corporate tax, opposed the recommendations; providers and insurers also lobbied hard against health care reform.79 Finally, in October the board voted down the task force proposal and instead endorsed a set of principles that were essentially a reiteration of long-standing policy. One task force member complained, “Last September NAM received the Lewin report claiming that $11.5 billion has been cost-shifted onto its members. NAM should have been outraged but has done nothing with that. Isn’t there some responsibility of the leadership to rattle chains, rather than giving in to Aetna and the pharmaceuticals?”80

After its 1991 failure, the health care reformers within NAM commissioned another Foster Higgins survey of NAM members on health care issues. Insiders hoped that solid member support would move the board toward comprehensive health care reform.81 The study showed 55 percent of the members favoring a play-or-pay approach (complete with employer mandates) as part of overall system reform.82 An NAM survey in the late summer of 1993 found a clear majority of its members backing mandates and health alliances for firms with more than five hundred employees.83

The Clinton administration hoped to gain NAM support and met with the association a number of times throughout 1993. NAM tried to remain open to the variety of health proposals on the legislative table and gave the president kudos for putting the issue on the congressional agenda. According to Magaziner, NAM president Jerry Jasinowski was one of the first individuals to see the draft in the summer of 1993. An informal deal was struck: Jasinowski agreed to a resolution that he would take before the board; the administration would fix five issues troubling to large employers. In reference to a September 1993 press release praising the Clinton plan, Jasinowski wrote, “I avoided any mention of mandates in order to imply that they may be a cost that business has to pay to get comprehensive reform; and to signal that mandates are not likely to be a top priority concern to manufacturers.”84 The administration felt that with NAM and the Chamber of Commerce on
board and the Business Roundtable divided between its insurer constituents and large employer purchasers of health care, it might be able to push through a reform package.

But renewed efforts to push NAM toward supporting a comprehensive health care reform were stymied by providers and fast-food magnates on the board. Opponents circulated a letter to members in advance of the February 1994 board meeting, framing the Clinton health plan in very different terms from the technical fix that its supporters advocated and emphasizing the political salience of the measure. Opponents also highlighted the Clinton administration’s promise to assume some of the costs of early retiree coverage (a boon to the automobile and steel industries), a move that divided the supporters of comprehensive reform within the organization. NAM staff reported going into the board meeting having “good things to say about the Clinton bill” and watching the board do an 180-degree turn.85

Another critical juncture in the health care reform episode was the failure of the House Energy and Commerce Committee to report out a bill, and interest group opponents were largely responsible for this omission. The committee’s chair, John Dingell, was highly motivated to enact reform; his father had been a sponsor of national health reform in 1943. But the committee was rich with representatives from rural and southern areas, helpful to the chair in his conservative positions on environmental regulation but obstructive when it came to his more liberal views about health care. The conservative Democrats were worried about getting “BTUed,” as when Clinton moved away from the energy tax in the stimulus package that he had earlier urged conservative Democrats in the House to back. Jim Slattery (D-KS) was running for governor and wanted to maintain good relations with the small businessmen in his state.

Dingell made many concessions to the conservative Democrats: making alliances voluntary in order to allow insurers to stay in business, introducing community rating slowly, and exempting small businesses from mandates. He promised legislators that he would not publicly identify plan supporters before he had lined up all of the votes. The Democratic leadership worried about pressures on conservative members during Easter recess but ultimately felt that all but Slattery had made a firm commitment. Shortly before the break, Dingell’s staff leaked a compromise plan to the press “in order to show the members that there was movement on some is-
sues that were giving them heartburn. The expressed purpose of the leak was to let the legislators on the fence know that headway was being made.”86

The leak backfired when the opposition mobilized against Clinton and the compromise plan. The Republicans and their small business allies targeted Slattery and other conservative Democrats to keep the committee from passing a bill. NFIB sent action alerts to all of its members in the ten districts with swing legislators and faxes to about 10 percent of its members. The organization contacted all eight thousand members in the state of Kansas and as part of the Coalition on Jobs and Health Care held a press conference the day before Slattery was to appear with President Clinton in Topeka.87 NFIB also did action alerts in a series of moderate Republicans’ districts as a kind of preventative measure. The association compiled the list from the Republicans who had voted for the family leave act. Meanwhile, Pizza Hut, headquartered in Topeka, wrote to all of the local Chambers of Commerce in Kansas. Denny Hastert worked closely with a group to resist the mandate that included the National Restaurant Association, JCPenney, and Pepsico, among others. The National Restaurant Association developed a formula for members to evaluate the economic impact of mandates on their enterprises. Hastert also arranged for the restaurateurs to fax their legislators en masse from a national meeting in Chicago.88 The object of these activities was to convey that the Dingell compromise was unacceptable: “We wanted to create an atmosphere for the Slatterys of the world where they thought that they were doing a back-room deal on the Dingell plan that was quite new, and then they had small businessmen in their districts come up and say, ‘Vote no on Dingell.’”89

Ultimately Slattery reversed his position on the mandate, even though he had been strongly inclined to support his former mentor, John Dingell. NFIB was thrilled with Slattery’s about-face. In early March, he had told a group of NFIB representatives that he was going to endorse a mandate and that there was no way out of it. One participant said that the legislator was very defiant about backing mandates: “he was very bold; it was a brave performance.”90

The impressive show of force of the bill’s opponents, many of whom came from the small business community, is illustrated by the large concessions developed by legislators to try to buy off the small business opposition. The bill increasingly benefited small
business interests; for example, legislators gradually expanded the size of firms to be excluded from a mandate. A Wyatt study showed that under a partial mandate (exempting firms with fewer than one hundred employees), large employers would cover 14.7 million more individuals than they would under a full mandate. By the end of the legislative cycle, the bill that initially attracted big business because it could reduce cost shifting was shifting more costs than ever.

The intensive effort to change the public perception of the Clinton health plan largely succeeded. By May 1994 Clinton’s public approval rating had dropped to 48 percent, with a 44 percent disapproval rating; this undoubtedly reflected dissatisfaction with his health plan.

**Conclusion**

The case of national health reform bolsters two themes of this volume related to ideas and political salience in policymaking. Ideas were critical to placing health care reform on the public agenda and to bringing even employers to support comprehensive system overhaul. The power of ideas is heartening to those who desire governmental activism; even under conditions of divided government and the widely touted stalemate between branches and parties, innovation is possible.

Health care reform also reveals that political salience, especially as it enhances interest mobilization, can be an obstacle to policy legislation. Although conventional wisdom suggests that political will is necessary to create space and resources for policy initiatives, political entrepreneurs are often most successful when they offer policy based on strong ideas in areas with little public demand for action. A comparison of health care reform to other cases in this volume demonstrates an irony in the strategy of augmenting salience to increase political will: salience pushes action and at the same time delimits it.

At the same time, health care reform raises important questions about the power of ideas and the use of political salience as a policy strategy. The health legislative episode suggests that some categories of public policy are more amenable to idea-driven policymaking than others. New ideas are most likely to change the policy landscape when they are consistent with the distributioonal status quo and not threatening to entrenched interests.

New ideas and new rights find ready acceptance when they are consistent with the distributioonal status quo. Thus, Baumgartner and Jones note that the "buttressing" ideas of policy monoplies are usually connected to core political values, which limit the possible range of policy change. Rights that purport to redistribute resources are more difficult to create. The right to universal access to health care, for example, had many redistributive consequences, not only between the haves and have-nots but between cost bearers and cost shifters.

Policy initiatives driven by ideas are also more likely to succeed in the absence of entrenched, opposing interests; otherwise, putting the issue on the public agenda may require an enormous amount of countermobilization. Thus, most of the agenda-setting and social movement literature is not relevant to ideas-driven policymaking, because it describes a politics of change that depends on the mobilization of political will. Ultimately it may be very difficult for new policy ideas to succeed in issue areas where entrenched interests block action in the absence of political will. Comprehensive change in interest-intensive areas such as health care may be impossible without full-scale interest mobilization and high political salience.

**Notes**

6. For discussions related to these themes, see chapters 1, 2, 3, 5, and 10 in this volume.
9. For relevant discussion, see chapters 1 and 18 in this volume.
11. Representatives Marty Russo, Senators Bob Kerrey (D-NE), Tom Daschle (D-SD), Howard Metzenbaum (D-OH), and Paul Simon (D-IL) all sponsored single-payer bills.
12. Steffie Woolhandler and David Himmelstein, "To Save a Penny Two Are Spent," Division of Social and Community Medicine, unpublished paper, Cambridge, Massachusetts, no date.
14. The bill was proposed by Majority Leader George Mitchell (D-ME), Edward Kennedy (D-MA), John D. Rockefeller VI (D-WV), and Donald Riegle (D-MI). It imposes a payroll tax of 7 percent. Funds from this tax would be used to create a new public insurance plan called "AmeriCare," which would also absorb Medicaid. Edward Kennedy, "An Affordable Health-Care Plan for All," Boston Globe, June 6, 1991, p. 21.
27. Unpublished survey provided by the administration.
28. NAM survey described in interview by Ira Magaziner; "Washington Business Group on Health," paper provided by the administration, no date.
33. Phone interview with Jim O’Connell, May 1996.
34. Martin, Stuck in Neutral, chapter 3.
36. For a similar finding, see Edward Handler and John Mulkern, Business in Politics (Lexington, Mass.: Lexington, 1982), 8, 27.
40. Interview with industry representative, March 1993.
44. Interview with industry representatives, September 1992.
57. Interviews with congressional staffers.
60. Interview with Rick Smith.
63. Interviews with Ira Magaziner, July and September 1993.
64. The least optimistic end-game scenario showed phased-in universal coverage, possibly voluntary alliances of one hundred or fewer, less stringent triggered premium caps, a smaller benefits package, lower Medicare and Medicaid cuts, and a cut in the 1 percent corporate assessment. “Passing Health Care Reform: Policy and Congressional Summary” (December 17, 1993, but first draft had been developed in August 1993), 10–14; obtained from the White House.
65. Interview with Magaziner, September 1993.
69. Interview with congressional staffer in leadership role.

70. Interview with congressional staffer in leadership position.
71. Interview with Chamber of Commerce staff.
72. The group included the National Federation of Independent Business, the National Restaurant Association, the National Retail Association, and the Health Insurance Association of America, among others.
73. Interview with participating lobbyist.
74. Schattschneider, The Semi-Sovereign People.
75. Martin, Stuck in Neutral.
79. Interview with industry representative, June 1992.
80. Ibid.
81. Ibid.
83. Unpublished survey provided by the administration.
85. Interview with NAM staffers.
86. Interview with staffer, November 15, 1994.
87. The coalition included NFIB, National Retail Federation, National Restaurant Association, Pepsico, General Mills, and JCPenney.
88. Interview with staffer, November 12, 1994.
89. Interview with industry representative.
90. Interview with industry representative.
93. Policy monopolies with stable institutional structures originate in powerful ideas; these structures are destroyed by interest group access to the policy agenda. See Frank Baumgartner and Bryan Jones, Agendas and Instability in American Politics (Chicago: University of Chicago Press, 1993), 7.