The Rise and Demise of Clinton’s Health Security Act of 1993
Preface

My decision to write about the rise and demise of Bill Clinton’s attempt to reform the nation’s health care system arose from a desire to understand why Americans had failed to seize a historic opportunity to provide all citizens with equal access to basic health care services. I have lived and worked in New York for a number of years and have thus had the opportunity to experience the American health care system. It is a system marked by chance and full of contradictions; those with health insurance stand to receive the best medical services money can buy, while the uninsured go wanting.

Today, ten years after the fact, it is particularly relevant to understand what happened to the Clinton plan. Once again the nation’s health care experts warn of an imminent health care crisis with a dangerous combination of escalating health care costs and rising numbers of uninsured. As expected in an election year, health care reform has become a favorite topic among the nation’s political leaders, including President Bush and his Democratic challenger John Kerry. Whether all the talk will be followed by action remains to be seen. By analyzing the events that led to the rise and demise of the Clinton Health Security Act of 1993, we will gain an understanding of the difficulties associated with enacting comprehensive health care reform and thus be able to gauge the prospects for success of future reform measures.

I would like to thank my husband and my mother for all their invaluable help and support during this writing process. Henrik Bødker also deserves a big thank you for his expert guidance and general enthusiasm.
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Introduction

On September 22, 1993 President Clinton presented Congress and the nation with his long-awaited plan to reform the national health care system. The time was ripe, he said, for “America to fix a health care system that is badly broken … giving every American health security; health care that can never be taken away, health care that is always there.”

National polls showed that the president was acting in response to the concerns of the public. Support for national health care was at a forty-year high, and voters ranked health care as the third most important issue in their choice for president in the 1992 election. A Gallup poll showed that 91 percent of Americans agreed that there was “a crisis in the health care system,” and a majority was in favor of substantial reform. With these figures in mind, reforming the health care system would seem the politically responsive thing to do. A Democratic president with a Democratic majority in Congress sponsoring an initiative with popular backing, Bill Clinton seemed destined for success, and for reelection in 1996.

One year later, almost exactly to the date, the Health Security Act lay in shambles on the congressional floor. The president’s signature initiative had lost popular support, failed to pass Congress and may have inadvertently contributed to a Republican “revolution” in the 1994 midterm elections sweeping in the first Republican-dominated House in 40 years. What had seemed like a sure thing only a year ago was now a dead duck and America’s millions of uninsured would have to wait for another chance at comprehensive health care reform.

This paper will follow the rise and subsequent demise of President Clinton’s plan to reform the American health care system. The main objective will be to understand why health care reform that seemed destined to succeed nonetheless suffered stunning defeat.

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I will begin with a brief introduction to the American health care system and a look at some of the previous attempts to reform it. This will be followed by a discussion of the social and political situation in the early 1990s, which contributed to the demand for reform, and made Bill Clinton an active player in its provision. I will proceed with a look at the features of Clinton’s Health Security Act, and the first part of this paper will conclude with Clinton’s introduction of his plan to Congress and the nation on September 22, 1993.

The second part, which will concern the reasons for the plan’s demise, will begin with an analysis of some of the structural and design-related problems with the plan itself. This will bring us to a central part of this paper, which will discuss the opposition mobilized by political players and special interest groups and analyze their key role in the defeat of health care legislation.\(^5\) Included in this section will be a critical look at the business community whose support was so essential for passage of the plan but ultimately eluded the Clinton Administration. Next, I will analyze the role played by the American public whose views on health care seemed to turn on a dime within the span of 10 short months. People were, perhaps, not as keen on reform as they claimed to be. Finally, I will discuss briefly the actions of the five congressional committees that preceded the plan’s final demise. Understanding how the various players worked to influence and ultimately block the passage of any type of serious health care legislation will reveal important aspects about the political decision-making process, and show us why future attempts to enact comprehensive health care policy indeed face difficult odds.

To understand the circumstances and events that led to the rise and demise of Clinton’s health care reform plan, I have relied on a wealth of material written about the subject, including newspaper articles, magazines, books and Web sites. Perceivably an analysis of actual proceedings, e.g. from political dealings, could have uncovered even more details, but because of the extent of the readily available material, I have not deemed it necessary to do so. Many of the articles I have used date back to the months of the actual debate in 1992-1994 while others are retrospective in nature. I have sought political balance in my reference material and a fairly equal distribution of

\(^{5}\) Although the Christian Coalition is a special interest group by all intents and purposes, I have grouped it with the section about political obstacles to reform because of the association’s close ties with the right wing of the Republican Party.
arguments for and against Clinton’s reform plan. Nevertheless, the majority of after-the-fact analyses is, perhaps understandably, biased against those groups who blocked Clinton’s reform efforts.

My analysis will not include an in-depth account of the existing US health care system or of its perceived ills, nor will I draw in comparisons with other countries’ systems. While these are interesting subjects, the length of this paper does not lend itself to such multifaceted discussions.

1. The US Health Care System

The health care system in the United States is a study in contradictions – a strange mixture of excess and deprivation. Medical and technological advances have enabled U.S. hospitals and doctors to provide their patients with the most sophisticated and expensive medical care in the world. Indeed, the U.S. spends more than any other country on medical services: per capita, the amount is more than twice that of any of the Western European countries. With an overabundance of expensive medical equipment and doctors, many Americans are being over-treated, yet at the same time, the country has the largest pool of uninsured of any developed nation. In fact, the US is the only democratic nation that does not provide its citizens with access to universal health care.

The American people receive health care coverage through a mixture of private and public insurance. Most people who work full-time are insured through their employers (61.3 percent of the population, see Appendix 1). The link between employment and health insurance stems from the Second World War, a time when companies faced an extremely tight labor market and simultaneous wage controls. In order to entice and keep workers, companies began to offer their employees health benefits. When the war ended, the practice stuck, partly as a result of union pressure, but also because companies continued to see the value in the system, especially as benefit costs usually do not come from company profits but from employees’ foregone wages. Even with employer-sponsored health insurance, many employees still have to

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pay for a share of the premiums themselves (see Appendix 2). Many also face co-payments when they visit the doctor or are hospitalized.

Those Americans who are not covered by their employer may qualify for Medicare or Medicaid. Medicare provides insurance to people with disabilities and all Americans 65 and older (13.4 percent), while the part state, part federal program Medicaid covers low-income Americans (13.3 percent). This still leaves a large section of the population without coverage: in 2002, 43.6 million Americans (15 percent) were uninsured. Those who lack health insurance predominantly belong to low-income working families – a full 70 percent of the uninsured are from families where at least one person holds a full-time job. The so-called working poor do not get insurance through their place of employment and cannot afford to buy it on their own, yet at the same time, they are too “well off” to qualify for Medicaid. Although those without insurance by law must receive basic care in the nation’s emergency rooms, they are generally undertreated and receive little or no preventive care. According to a recent study by the Institute of Medicine (IOM), 18,000 Americans die prematurely every year because they do not have health insurance, in part because they discover too late that they suffer from a treatable disease.

Even among those with health insurance, a large number have inadequate policies that do not cover all of the costs of medical treatment. To this group of underinsured, one serious illness can lead to financial ruin. In fact, nearly half of all personal bankruptcy cases are related to problems with paying for medical bills and the general loss of income in connection with catastrophic illness.

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10 Mills, op. cit., p. 2. See also Appendix 1.
11 Ibid., p.3.
12 Rowland, op. cit.
Continuously rising costs of health care have aggravated the situation. For three years in a row, premiums for health insurance have risen by double-digit figures, at rates far beyond the rise in employee wages or overall inflation (see Appendix 3). America currently spends 15 percent of its economy on health care related services, which amounts to a total of $1.55 trillion, or an average of $5,440 per person (see Appendix 4). Increasing health care costs put average Americans, their employers and state governments under added strain to pay for health related services. The causes for premium increases are many and include: the high cost of developing and providing technologically advanced treatment methods, rising administration costs, expensive prescription drugs, insurance companies’ pursuit of profits, and, of course, the prevailing demand for expensive care. Employers have responded to rising costs by eliminating health insurance programs or shifting a larger share of the costs onto employees, while state governments have been forced to cut funding for public health programs, including Medicaid. Many of those who self-insure have had no choice but to forego health insurance altogether.

Clearly, there is a moral objective to provide all Americans with access to adequate health care and an economic objective to curtail rising health care costs but as we shall see in the following sections, the question of how – and even, if – fundamentally to reform the American health care system has eluded legislators for many years.

1.2 Previous Attempts at Health Care Reform

The pursuit of health care coverage for all Americans has surfaced on the political agenda regularly in the last century. Predictably, public demand for political action has coincided with periods of economic uncertainty and an increase in the number of uninsured. Changing governments have typically been driven by an ideological desire to provide coverage to their fellow citizens coupled with a fiscal need to control the ever-increasing cost of health care. Yet as the history of national health care reform

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efforts demonstrates, providing the nation with universal access to health care has been anything but easy:

When Roosevelt and his New Deal architects were designing the Social Security program in 1935, they considered including a national health insurance program in the bill. Yet the medical community, and especially the American Medical Association (AMA), was fiercely opposed to any type of intervention in the “doctors business” by the government or any other “financial intermediaries.”

Fearing defeat of the entire bill if the provision was included, the FDR Administration backed away leaving legislation for universal health care for a later date.

In 1945 and again in 1949 President Truman proposed to include universal health insurance with Social Security but without success. This was partially due to obstinate Southern Democrats, “Dixiecrats,” on key Committees who were determined to punish Truman for his advancement of social issues and civil rights to minorities in the south and did so by blocking most of his legislative initiatives. Truman also had to contend with fierce opposition by the AMA whose members claimed that Truman’s health insurance plan would make doctors “slaves.”

Against repeated accusations by the AMA and Republican Party members of trying to enact “socialized medicine,” neither of Truman’s attempts at health care reform stood much of a chance in the highly charged atmosphere of the Cold War era.

Nineteen sixty-five saw success in terms of health care financing when President Johnson oversaw the enactment of Medicaid and Medicare, both cornerstones of his Great Society program to end poverty. Johnson’s success was partially the result of the large majority liberal Democrats enjoyed in both Houses, but also of the general wind of change brought on by the social movements of the sixties making it politically viable – and desirable – to go against interest groups. Johnson’s was the last successful attempt to enact national health care policy.

President Nixon tried to resuscitate the ideal of universal health care in 1974 proposing to expand Medicare and Medicaid to the many uninsured Americans, and to require employers to provide their workers with basic health care coverage. Nixon’s proposal – unusual for a Republican – became highly unpopular with the business community who resented the financial burden of having to provide employee coverage. Extensive lobbying by business groups and, once again, the AMA helped to block for the passage of the bill. Nixon’s entanglement in the Watergate affair brought his noble proposal to a final fall. Carter too pursued health care reform but his proposal was also killed by Congress in 1979.21 In 1991, public demand for health care reform once again propelled the issue to the forefront of the political agenda.

2. Rise of Clinton’s Health Care Reform Plan
2.1 Social and Political Climate
By the early 1990s, America’s number of uninsured had reached 38.9 million.22 Another 40 million were considered underinsured because their insurance was limited in case of serious illness.23 The lingering effects of Reagan’s supply-side economics of the 1980s were greatly to blame for the dismal figures. Contrary to what the Reagan administration had envisioned, hefty tax cuts – primarily benefiting the wealthy and large corporations – had not resulted in economic growth and an influx of money to the public coffers. Instead, the nation faced a fiscal crisis of gigantic proportions as the federal deficit and national debt both skyrocketed: between 1980 and 1992, the federal deficit went from $59 billion to $300 billion while the national debt increased from $914 billion to over $3 trillion.24 The budget deficit kept inflation and interest rates high making it difficult for American products to compete on the international markets. By November 1982, the nation found itself in its worst recession since the Depression.25 Thousands of businesses went under, blue-collar unemployment soared, and an increasing number of people joined the ranks of the uninsured. Although the

21 For more on Carter’s efforts, cf. Starr, op cit, pp. 411-417.
23 Ibid.
economy had recovered by Reagan’s second term, his successor George Bush still had to contend with the exorbitant federal budget deficit, which had reached $220 billion by 1990.26

Towards the end of 1990 and the beginning of 1991, the nation once again faced a recession, and although it was much milder than the one experienced under Reagan, it still had significant ramifications for the job market. In the name of corporate downsizing, millions lost their jobs and with it their health insurance policies. This time, the middle-class too was hard hit with more managerial and white-collar employees than usual falling victim. Those who did have employer-sponsored health care coverage worried about losing it or about having to pay an increasingly larger share themselves. Many were in situations of so-called “job-lock” wanting to change jobs but hesitant to do so because they might lose their health insurance in the process.

Employers too were feeling the effects of the economic downturn and rising costs of health insurance. Between 1970 and 1989, the cost of employer-sponsored health insurance grew by 163 percent and businesses were increasingly beginning to see the costs as an unmanageable burden.27 Businesses who paid for their employees’ health insurance complained about the unfair disadvantage this additional cost gave them in the competition with non-paying businesses. Many, particularly small businesses, felt compelled to eliminate benefits entirely or shift a greater share of the financial burden of coverage onto the employees.

Also at the national level, health care costs were soaring; between 1983 and 1993, health care cost tripled from $300 billion to a staggering $900 billion a year, roughly one seventh of the U.S. Economy.28 Particularly alarming was the fact that government outlays for health care continued to rise at 11 percent per year, about three to four times the rate of inflation in the rest of the economy – a development that

26 Bush’s desire to bring the deficit under control was one of the driving forces behind the budget deal he struck with Democrats – a deal which may ultimately have cost him his presidency as it forced him to go back on his promise to enact no new taxes, cf. “Bush, George Herbert Walker,” Microsoft® Encarta® Online Encyclopedia 2004. http://encarta.msn.com/encnet/refpages/RefArticle.aspx?refid=761571000&MSID=6A50CF28217445D58CDF9908B6A28797, accessed March 5, 2004.
28 Ibid., p. 2.
threatened to drive up the deficit even further. More and more, health care reform appeared to be the kind of political issue that would guarantee voter support while addressing an issue of national importance.

A special election in 1991 for a Pennsylvania Senate seat erased any doubt about the political appeal of the issue. Underdog Harry Wofford, a liberal Democrat, unexpectedly won the race by focusing on the economic worries of the middle class, and especially their fears about affordable health care. An effective TV ad hit the nail on the head, showing Wofford in a hospital: “If criminals have the right to a lawyer, I think working Americans should have the right to a doctor …. I’m Harris Wofford, and I believe that there is nothing more fundamental than the right to see a doctor when you’re sick.” This message resonated with the middle class and health care reform was deemed the decisive issue for voters in the election. Post election polls showed that Pennsylvanians were even willing to pay slightly higher taxes in order to gain the security of a national health care plan.

In Washington, politicians took note of the event. They had long known that the middle class in particular was increasingly concerned about the availability and affordability of health care, but the Pennsylvania election thrust the issue to the center of the political stage. It was clear that the time was ripe for reform, and health care became one of the main political issues for the 1992 presidential election. Numerous proposals for reform sprouted from political players and business groups alike. Even the American Medical Association, historically opposed to any kind of reform, came up with a plan that would provide universal health insurance via employer funding. The plans that were considered viable options for health care reform were generally one of three types: market-oriented, single payer and play or pay.

The market-oriented approach was favored by Republicans, including President Bush, although some conservative Democrats, notably Tennessee Congressman Jim Cooper, also advocated this type of approach as a way to reshape the health care system. Under the market-oriented approach, there would be no public-sector

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29 Blendon, op. cit., p. 12
31 Ibid.
32 Indeed Jim Cooper introduced the Cooper bill in October 1993 as one of many alternatives to the Clinton bill. The Cooper bill ended up being very popular among groups who wanted to give the
controls of any kind to curtail rising health care costs or expand the number of insured. Instead of burdening employers with an “employer mandate” – the requirement that they help pay for their workers’ medical insurance – individuals would be in charge of providing their own health care. Tax credits to low-income Americans and tax deductions to higher earners would help make this happen. Small businesses that did provide their employees with health insurance would be encouraged to band together in purchasing pools allowing them to benefit from the economies of scale enjoyed by large corporations in their negotiations with health insurance companies. To bring down costs further, market-oriented supporters advocated the spread of “managed care” plans, or Health Maintenance Organizations (HMOs), via tax incentives.33

Supporters of the single-payer system belonged to the opposite end of the political spectrum. Proponents of this plan were liberal Democrats who advocated universal coverage financed via payroll or general taxes. The plan did not advocate changes in the existing structure of health care providers; services would still be provided by hospitals and doctors, some profit and some nonprofit in nature. The main difference, aside from the idea of payroll taxation, was the establishment of a federal or state entity to manage all payments for health services. This had been the approach adopted by the Canadians in 1971 when they started offering national insurance to its citizens, and they had been successful in curbing rising health care costs by Instituting global spending limits and negotiating annual payments to hospitals and physicians. Although the single payer scheme had its supporters in Congress, it was not considered a serious contender primarily because of Americans’ known reluctance to accept an increased role of government and the idea of a payroll tax.

Primarily backed by Democrats, the play-or-pay approach was a hybrid type of plan that would ensure universal coverage by requiring all employers to either “play,” that is provide health insurance to their employees, or “pay” some kind of tax to help...
fund governmental coverage for those without insurance. A new public program would cover all of those not employed or insured by their employers. This approach would also seek cost containment through the use of global budgeting and the increased use of health care networks. Yet the appeal of the play or pay approach quickly began to wane as studies showed that faced with a choice, most employers would “pay” instead of “play” and presumably dump previously insured employees into the public program, creating a huge fiscal albatross around the government’s neck. Nonetheless, it was a middle-of-the-road plan that had some backers, including Bill Clinton until he learned of an appealing alternative, i.e. managed competition within a budget.

Governor Bill Clinton of Arkansas too had made health care reform a central part of his presidential platform. It went hand in hand with his promise to improve the plight of the forgotten, hard-working middle class who had been hard hit during the economic slowdown and recession of the 1980s and early 1990s. Clinton had been vague about exactly what type of plan he favored for health care reform, but he finally settled on “managed competition within a budget.”34 As we shall see in the section “Framework of the Plan,” managed competition was a compromise between market-oriented and government-centered reform: it promised universal health insurance through private competition among existing health care providers but it included a government set budget cap on annual health care spending as well as caps on health insurance premiums to keep them in check.35

In November 1992, Bill Clinton was elected President of the United States. Along with his promise to improve the economy, his commitment to universal health care had been one of the decisive issues for voters. To be sure, expectations were high when the first baby-boomer president entered the White House; Americans were genuinely optimistic about their new president and his abilities to bring about much needed reform of the health care system. Now all Clinton had to do was carry through on his promise.

34 Clinton’s main ideas about managed competition were largely based on the findings of Stanford University economist Alan Enthoven, cf. Alan Enthoven, “The History and Principles or Managed Competition,” Health Affairs, vol. 12, Supplement, January 1993, pp. 24-48.
35 Although I describe the main features of the plan in the section “Framework of the Plan,” space constraints, and the intricate nature of the plan, make it impossible to render an in-depth discussion of all its details. The key features of Clinton’s managed competition within a budget plan are skillfully described in Paul Starr & Walter Zelman, “A Bridge to Compromise: Competition Under A Budget,” Health Affairs, vol. 12, Supplement, January 1993, pp. 7-23.
2.2 The Health Security Act

On January 25, 1993, five days after he entered the White House, Bill Clinton announced the formation of the President’s Task Force on National Health Care Reform. The task force would be co-chaired by his wife, Hillary Rodham Clinton, and his long-time friend and senior policy advisor, Ira Magaziner. In the words of the president, “Although the issue is complex, the task force’s mission is simple: to…prepare health care reform legislation that I will submit to Congress this spring.”

The issue was indeed complex and in spite of the simple mission, spring would turn to fall before the task force’s plan would be ready for the American people, and it would be October before the bill, dubbed the Health Security Act of 1993, was submitted to Congress and its committees.

For the special task force it was full speed ahead. They enlisted help from some 500 people, most of whom were budget or policy officials borrowed from other parts of the government, but the group also included outside scholars, experts, nurses and physicians. Representatives from groups with stakes in the existing system were not brought in, but the task force held many hearings and consulted with members of such groups. The idea was to get feedback and to learn about their special concerns and aspects they were particularly keen on having incorporated into the bill. Naturally, the aim was also to determine what the specific points of contention were and, to the extent possible, to attempt to mollify special interest groups before the president’s plan was revealed.

In addition, the task force met frequently with congressional leaders and their staffs to get their input and to build the foundation for future cooperation on the bill. Indeed members of Congress gave Clinton high marks for “laying the political

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37 Ibid.
groundwork necessary for his proposal to get the careful consideration of both parties.”

2.2.1 Framework of the Plan

The key points of the task force’s hard labor were presented to Congress and the public by the president in his nationally televised address on September 22, 1993. Sprinkling his speech with personal anecdotes, Clinton illustrated the urgency for adopting universal health care: “Millions of Americans are just a pink slip away from losing their health insurance, and one serious illness away from losing all their savings. Millions more are locked into jobs they have now just because they or someone in their family has once been sick and they have what is called a preexisting condition. And on any given day, over 37 million Americans – most of them working people and their little children – have no health insurance at all.” The road to health care reform as envisioned by the president and his task force would be guided by six basic principles: security, simplicity, savings, quality, choice and responsibility.

2.2.1.1 Security

This was the most important aspect of the plan, promising every American the right to a comprehensive health care package on par with those being offered by Fortune 500 companies. Access to health care would be a right of citizenship and not a fringe benefit of employment, and a health security card issued to every citizen would be proof of entitlement. Americans would no longer have to worry about losing coverage if, for instance, they changed jobs, lost their business, got sick, divorced or were widowed. It would mark the end of insurance companies’ practice of “cherry picking” the healthy while denying coverage to the sick, to people with so-called pre-existing conditions or to people who were otherwise deemed high-risk. There would be

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41 Fortune 500 companies are the 500 largest public companies in the U.S. in terms of revenue as listed by Fortune Magazine. These companies are able to offer their employees some of the best and most comprehensive health care policies in the country.
government set caps on how much insurance premiums could rise from year to year, and limits on the deductibles people would have to pay within a given year for doctors’ visits or hospitalization.

### 2.2.1.2 Simplicity

This principle promised to overhaul the existing administrative chaos with a myriad of health care plans and insurance forms that for years had driven up administration costs for hospitals, doctors, employers and consumers alike. With the adaptation of the Health Security Act, the hundreds of claim forms would be replaced by one standard form, something that was bound to cut administrative costs substantially and give health care professionals more time to spend with their patients instead of on paperwork. All insurance companies would be required to offer a uniform comprehensive benefits package, allowing consumers to compare plans and providers effortlessly.

### 2.2.1.3 Savings

For many it made sense that if a previously uninsured section of the population suddenly had to be covered, something had to give. Yet Clinton believed that the present system contained plenty of opportunity for savings if only Americans were willing to accept reorganization in the provision of their health care services.

The central innovation in the managed competition system was the development of regional health purchasing alliances. The alliances would be set up by the states and run as regional purchasing groups, to collect and distribute premiums, license health care providers, certify health plans and offer them to consumers. In effect, the alliances would take over the job as intermediary traditionally done by employers. As the existing system had demonstrated, large corporations enjoyed lower insurance rates and more comprehensive health plans from the insurance industry simply because of the bargaining strength connected to their size. The Health Security Act proposed to transfer this concept onto the national scene via the alliances, which, because of their size, would be able to negotiate with insurance companies for optimum premium prices.
Employers, employees and governments would all pay funds to the alliances and they in turn would pay the health plans. The alliances would offer three types of health care plans for consumers to choose from and the share paid by individuals would be influenced by the type of plan chosen. Insurance plans would compete for members by improving quality and holding down costs, not by excluding high-risk patients. Large corporations with more than 5000 employees would be able to join the alliances, opt out and self-insure, or join other large corporations to form their own corporate health alliances under a comparable benefit system.\(^{42}\)

Financing would be based on a shared responsibility between employers and individuals. An employer mandate would require employers to pay the largest share of the health care insurance premiums, 80 percent on average, while employees would be required to pay the rest.\(^{43}\) Of course, employers would be free to pay the full amount if they so desired. Premiums would vary according to family status only, e.g. the premiums for a family of four would, of course, be higher than those for a single person. There would, however, be a cap on employer contributions so that no firm with less than 5000 employees would pay more than 7.9 percent of payroll.\(^{44}\) In addition, small businesses (75 employees or less) would receive discounts and the self-employed would be able to deduct 100 percent of health insurance costs from taxable income.\(^{45}\) Annual contributions would be capped at $1,500 for individuals and $3,000 for families.\(^{46}\) The federal government would step in and subsidize payments for the unemployed and poorest segments of society.

A federal National Health Board would interpret rules about coverage and benefits, assure that average premiums stayed within set limits, and monitor the performance of the plans, providers and the overall system.


\(^{43}\) Ibid.

\(^{44}\) William Jefferson Clinton, Health Security The President’s Report to the American People, (The White House Domestic Policy Council, October 1993), p. 40. This was a fact that was often overlooked by the media who tended to focus solely on the 80 percent figure thus greatly exaggerating actual costs.

\(^{45}\) Ibid.

\(^{46}\) Ibid.
2.2.1.4 Choice
Free choice of doctor was an issue particularly on the minds of Americans as they learned of the president’s plan. The Health Security Act promised to expand the number of choices by offering three types of health care plans. No longer would health insurance purchasing decisions rest with the employer; instead, doctors and consumers alike would be able to make informed decisions about the type of plan they wanted to belong to. Patients would be able to follow their doctors to the health plan in which the doctors participated, and once a year they would be able to switch plans if they so desired.

2.2.1.5 Quality
A number of quality assurance measures were built into the plan, including the establishment of a National Quality Management Council. The council would set up quality indicators to measure various performance aspects leading to an annual public report about the health plans. Not only would this report help consumers in their choice of plans but providers too, would be able to use it as a guide to tell them where to concentrate their future efforts. A focus on preventive care and a shift from specialist to primary care were other features of Clinton’s plan that would help improve quality and cut costs at the same time, a provision that was predictably unpopular with the large section of specialist doctors.

2.2.1.6 Responsibility
This last principle was an appeal to all groups to help root out fraud, frivolous malpractice suits and join in the collective goal to ensure health care coverage for all and curtail the rising costs of health care. These were the main tenets of the president’s health care reform plan as he spoke to his fellow Americans that evening. Pleading for bipartisan cooperation in enacting his, or a comparable plan, to “guarantee every American comprehensive health benefits that can never be taken away,” Clinton was

47 The three plans offered were HMOs, free-for-service and Preferred Provider Organizations (PPOs). The type of plan chosen would have an effect on co-payment amounts. There would be no co-payments for members of HMOs, small co-payments for the PPOs and a high co-payment for the fee-for-service plans. For a more detailed description, see William Jefferson Clinton, *Health Security The President’s Report to the American People*, (The White House Domestic Policy Council, October 1993), p. 31.
well aware of the difficulties ahead.\textsuperscript{48} It was one thing to have produced what could only be described as a gargantuan legislative proposal in a very short time. Actually selling the plan to the American people, to members of Congress, and, not least, to players in the existing system would prove an even greater challenge.

The immediate response was very positive: \textit{The New York Times} declared “The Clinton Health Plan Is Alive On Arrival”\textsuperscript{49} and polls registered strong popular support with 59 percent in favor of the plan and 31 percent opposed.\textsuperscript{50} For a brief moment, even moderate Republicans and groups with vested interests in the existing system were hesitant to criticize the plan, which, if nothing else, they considered a good starting point for negotiating a final health care bill. To most it seemed that this time, comprehensive health care reform would become a reality, and the five committees with jurisdiction over health care legislation – Senate Finance, Senate Labor and Human Resources, House Education and Labor, House Ways and Means, and House Energy and Commerce – got down to business.

Six months later, however, the picture was less rosy. The public had turned against the plan by March 1994, when more Americans opposed President Clinton’s plan than favored it.\textsuperscript{51} A Gallup/CNN poll showed that 63 percent believed the plan would entail too much government, and 37 percent thought they would be worse off with the enactment of the plan while only 19 percent thought they would be better off.\textsuperscript{52} In Congress, the bill was beyond resuscitation, and on September 26, Senate Majority Leader George Mitchell pronounced it dead.\textsuperscript{53} The most promising attempt at health care reform in recent times had failed miserably and in the process inflicted the equivalent of an electoral beating on the Democratic Party during the midterm elections.

As the dust settled, there were no shortages of “I-told-you-so’s” from political pundits, commentators and health care specialist alike. This is what happens when big

\textsuperscript{48} “Address of the President to the Joint Session of Congress,” September 22, 1993, as reprinted in Ibid., p. 106.
\textsuperscript{50} The Roper Center, "Health Care Update," vol. 5, no. 5, p. 94, July/August 1994.
\textsuperscript{51} Ibid.
government headed by a president without the majority of the popular vote appoints his wife to be in charge of efforts to fix what is not broken, socialize health care and impose restrictions on private enterprise. The fact is that the Clinton plan was no liberal scheme; it was a moderate attempt at health care reform based on market interests and government involvement. The Clinton Administration had worked very hard and they had listened to the concerns of all imaginable groups involved in the health care system in their efforts to strike a balance. All indicators pointed towards enactment of reform: the American public wanted it, or at least some type of reform of the health care system, and so did the leader in the White House. With all the pieces of the puzzle in place for major reform of the health care system, the Health Security Act, or a variety thereof, should have been passed. On the face of it, it is truly a mystery why this did not happen, and in the remainder of this paper, I will look at the main reasons for the demise of President Clinton’s ambitious health care reform plan.

3. Demise of Clinton’s Health Care Reform Plan

3.1 Conceptual and Strategic Problems with the Plan

3.1.1 It Is All in the Name

As we have seen, Bill Clinton had made health care reform one of the main issues in his campaign for the presidency. To demonstrate his commitment to the issue, he not only lent his name to the plan but he was also personally involved in its design, and by appointing his wife to co-chair the task force, he further strengthened this tie. Clearly, the implementation of universal health care was a cause that was ideologically very close to his heart, and politically, it could be the ticket to reclaiming the presidency in the 1996 elections, and a prominent place in the history books. However, the close association of the president with health care reform may have backfired in a number of ways:

For the Republican Party, it gave them an incentive to defeat the proposal. Many members of Congress could think of nothing better than to see this Washington newcomer with grandiose ideas about reform fall flat on his face. Especially the right wing of the Republican Party was eager to defeat Clinton, whom they saw as the embodiment of all that was wrong with society. A 1960s incarnate, Clinton had dodged
the draft, demonstrated against the war in Vietnam, smoked pot, married a feminist and now he thought he was going to reform the ways of Washington politics. Defeating Clinton and his health care reform plans united the Republican Party in a common cause and provided them with the perfect chance to ensure a power grab for their party, as we shall see later.

Among the public, the close connection between the Clinton name and health care reform may have muddied personal sentiment. While many people supported the president in his quest for health care reform, an equal number had doubts about Clinton’s character. Clinton’s attempts to lift the ban on homosexuals in the military at the beginning of his term certainly rubbed some people the wrong way, and later on, Whitewater and Clinton’s alleged extramarital encounters further complicated public opinion. To some extent, people were unable – or unwilling – to separate the personal feelings they had about the president from the issue of health care provision. A Wall Street Journal article from March 1994 illustrated this issue very well: when identified by name, only 37 percent of respondents favored the Clinton plan. However, when the same plan was described, but without identifying it, 76 percent said it had either “a great deal of appeal” or “some appeal.”

Clearly, the negative campaign run by the opposition had a lot to do with the mixed emotions experience by the public, as we shall see later in section 3.4. Perhaps to an equal extent, this confusion among the public in its support for his plan illustrates how miserably the Clinton Administration failed in its attempts to explain the plan to the public, an issue we will also revisit later.

Bill Clinton’s choice to appoint his wife to co-head the task force proved to be particularly contentious. While it did signal his commitment to the issue, it might, however, have curtailed an honest dialogue with policymakers and advisors, who might have thought twice before pressing their views. As expressed by an anonymous insider “The person who’s in charge shouldn’t sleep with the President, because if you sleep with the President, nobody is going to tell you the truth.”

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however, there is no indication that task force members or any of the working group members suffered under this notion. Instead, the strong anti-Hillary sentiment seemed to be tied to the right-wing agenda and their hatred for the president and the first lady, greatly aided by the insurance industry, and the media, of course. As we will see later, Hillary Clinton took a step outside the box of first lady protocol when she publicly attacked the insurance industry for their role in obstructing health care reform. Predictably, the insurance industry responded in kind.

Much of the controversy surrounding Hillary Clinton’s role in health care legislation had been brewing for some time. Throughout Clinton’s presidential campaign, he had played up his wife’s strength, telling voters that they were getting a “two-for-one” deal if he was elected. A Yale-trained lawyer and former partner of a prestigious Arkansas law firm, Hillary Clinton was not the embodiment of a typical first lady, and certainly stood in stark contrast to the grandmother-like, non-threatening image projected by her predecessor, Barbara Bush. On several occasions, her remarks landed her in a firestorm of controversy, most notably during the Clintons’ appearance on the nationally televised program 60 Minutes to answer charges of his infidelity. When asked to explain her position to the allegations of his infidelity, she remarked that she was “not sitting here because I’m some little woman standing by my man like Tammy Wynette. I’m sitting here because I love him and respect him.”

Many women all over the country, including Tammy Wynette, were put off by her remarks. Later on in the campaign, a collective gasp could be heard from traditionalists all over the country when Hillary Clinton remarked “I have done the best I can to lead my life. I suppose I could have stayed home and baked cookies and had teas.” Republicans, homemakers and the press accused her of belittling the millions of housewives across the country, and no amount of Hillary-sponsored cookie recipes could help soothe their hostility.

One way or another, most people had a very strong opinion about Hillary Clinton by the time she entered the White House. Some accused her of having co-presidency aspirations, others complained about her many hairstyles, while still others saw her as a do-good first lady like Eleanor Roosevelt. From the serious to the banal,

56 Miller Center of Public Affairs Web site, University of Virginia, http://www.americanpresident.org/history/billclinton/firstlady/, updated June 8, 2004
57 Ibid.
Hillary Clinton was nothing if not a controversial figure. In hindsight, the decision to put her at the helm of the task force – and in charge of reforming the national health care system – was arguably not the best road towards consensus building. Irrespective of her personal and professional skills, her role in health care reform ultimately worked against the passage of the bill, but she received considerably help from other sources.

3.1.2 Development and Complexity of the Plan

Critics of the health reform plan were quick to lay the blame of its failure on the Administration’s decision to work out complex legislation behind closed doors. In the words of an article in *The New Republic* “[The paper trail] shows how a few within the Administration – and a secretive few – were uninterested in practical change in health care … They were interested in conceiving of a total overhaul of the system according to the dictates of what a small group of experts deemed rational.”

White House media officials had made the questionable decision to keep the names of the regular task force members secret. The reasoning behind this choice was that task force members had very little time to work out a massive legislative proposal and that it would therefore be prudent to “protect” them from having to field requests for interviews from the media. If the media did not know who was working on the proposal, they obviously could not contact them for information. Of course, it also helped ward off any negative media stories while the task force was in session. Opponents of reform immediately took offense to the secrecy issue and three groups, led by the Association of American Physicians and Surgeons, filed a suit in federal court. In March, the Federal District Court ruled that the task force’s official meetings had to be open to the public, while the working groups could continue to meet in private.

Further accusations of secrecy arose later on in the process as the task force got down to the business of putting things on paper, a time when they did in fact work “in

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secret” away from the public, the media and the opposition. However, this is not an uncommon procedure; every Administration works out proposals behind closed doors before presenting them to Congress and the public. It gives the parties involved the opportunity to concentrate on the task ahead without constantly having to explain issues being considered. It is likely that objections to this method of policy making originated with some of the people who had been consulted by the task force and thought that their views would be included only to be disappointed to learn that they would not, or at least not to the extent that they had hoped. Along the same lines, congressional members who were not invited to work directly with the task force, felt shut out and were less likely to support the final bill.

The one group that was clearly excluded from the start was the Washington press. The Administration had decided to take the health care message directly to the people via talk shows, above the heads of the Washington press. Emerging details being considered for the bill were not communicated, and when leaks about the plan did happen, they were often incorrectly reported by the press. Clearly it was a huge mistake not to keep the press informed during the task force’s deliberations, not only because it helped the Administration earn the negative label of being secret, but also because it severed the link to the public who relied on the printed media for information about the plan.

The Health Security Act quickly came under fire because of its length – 1,342 pages in all – and perceived complexity. There were several reasons why the Administration worked out a comprehensive plan. For one it would give them something to bargain with during congressional negotiations. Another reason for the voluminous report had to do with the fact that the health care reform plan had to be marketed to the middle class. Without the support of this group and their continued demand for health care reform, Clinton knew it was unlikely that he would be able to get the support he needed in Congress. As a carrot to the middle class, the Administration went for a comprehensive plan with benefits that were on par with or better than the coverage, they were used to. This, the Administration hoped, would ensure popular demand for reform. However, the plan backfired: not only did this

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decision add many pages and complexity to the report, but ordinary people, on whose support the Administration had relied, remained silent and inactive in their support.

Similarly, to win the support of the elderly, the president had included certain benefits for this group, including coverage of prescription drugs and a new program for home-based long-term health care. In spite of the fact that the American Association of Retired Persons (AARP) had worked closely with the Clinton Administration on those particular benefits, they were at best ambivalent in their backing of the president’s plan, as we shall see later. In the end, concessions did not have the desired effect. Support among the group of people aged 65 and up, showed the biggest decline with a 25 percent drop in support between September 1993 and April 1994.62

The practice of the Congressional Budget Office (CBO) had a lot to do with both length, complexity and specificity of the plan. Since the Reagan years, all proposals submitted to Congress were required to be “costed out” by the CBO to ensure that all projected expenditures were offset by projected savings or revenues. The Health Security Act too would face such “costing out” as a guarantee that reform would not drive up the deficit further. As Clinton himself envisioned health care reform as a means to reduce the budget deficit, he was naturally very concerned that their proposal would stand up under the scrutiny of the CBO, even though it meant a much more detailed plan with tighter regulation than they had originally envisioned.

As we have seen, there were a variety of reasons why the Health Security Act was very comprehensive and complex. Because of the many parts and details, it became very difficult for the Clinton Administration to explain the plan in simple familiar terms to the public and the media. The scale of the program also provided fertile ground for misunderstandings and misinterpretations, and it made it easy for groups of opposition to pick out issues they found particularly troubling and target their message against reform. Even groups that outwardly supported the Clinton plan ended up qualifying their support hoping to influence one issue or another to their advantage.

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3.1.3 The Big Delay

Momentum for health care reform was severely compromised by a series of delays, most of which were beyond the control of the Administration. Keenly aware of the fact that it needed to use the presidential honeymoon to its advantage, the Administration originally tried to make health care legislation part of the budget bill. Not only would it allow them to ride the wave of public support but perhaps even more important, budget bills only need a simple majority vote in order to pass. The Administration felt sure that they would be able to get fifty-one votes from among the fifty-seven Democrats in the Senate, and it certainly was a much more appealing option than going the normal route, which would require sixty votes to end the inevitable filibuster by Republicans.63 However, the plan was shot down by Senator Robert Byrd, Chairman of the Senate Appropriations Committee and custodian of Senate rules and traditions who did not believe that a health care reform bill affecting one seventh of the national economy should be slipped in with the budget.

Precisely because of the potential for including the health care plan in the budget negotiations, the task force had worked very hard to complete most of their work by the end of May 1993. They were also trying to fulfill the president’s promise to the American people to present health care legislation to Congress within the first 100 days of taking office.64 However, before the plan could be completed, the president had to give his final opinion on some key issues, but by then Clinton had become deeply immersed in the budget negotiations. Not only did this take away from the time he could dedicate to finalizing the plan, but budget negotiations proved to be so tough, that the White House became concerned that any leaks about the financing of health care reform would influence sorely needed budget votes.65 As a result, all work on health care reform abruptly stopped and so did any public communication about it.

Budget negotiations dragged on much longer than anticipated, and when the budget

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63 As we will see, the Health Security plan went “the normal route” and it did become the target of a filibuster – the Senate tactic of using unlimited debate to delay or block legislation, which can only be ended by a two-thirds majority vote. For more information about filibuster tactics, cf. http://www.senate.gov/artandhistory/history/common/briefing/Filibuster_cloture
65 As Theda Skocpol explains, California’s representatives in Congress threatened to vote against the budget when they learned that a tax on wine was being considered as a way to help pay for the health care reform. Theda Skocpol, Boomerang Health Care Reform and The Turn Against Government, (New York: W.W. Norton & Company 1997), p. 59.
The reconciliation bill finally passed, it did so with exclusive Democratic backing and with Vice President Al Gore casting the tie-breaking vote, an ominous warning of the trouble that lay in wait for Clinton’s health care bill. It would be August 1993 before the president was able again to dedicate his full attention to health care reform and help finalize the last pieces of the puzzle.

To follow up on the successful televised presentation of his plan in September of 1993, Clinton had been scheduled to appear at several media events in October and early November in order to bring the plan to the public. The idea was that he would head the nationwide campaign and thus ensure continued support for his plan. Everything finally seemed to be on the right track, but not for long.

On the international scene, American soldiers were killed in Somalia and images of a dead American soldier being dragged through the streets forced the issue on the presidential agenda through most of October. Later the presidency of Boris Yeltsin was in danger through a series of internal conflicts; other problems arose in Haiti and Bosnia, all of which also demanded the attention of the president and his foreign advisors.

In Congress, the North American Free Trade Agreement (NAFTA) negotiations were heating up. A so-called “New Democrat,” Clinton believed in free trade and the adaptability of the American work force to a global economy. He also felt that the enactment of NAFTA would bring a much-needed shot in the arm to the American economy. The treaty had to be passed by Congress by the end of 1993, and Clinton decided to get into a no-holds barred lobbying campaign in order to ensure that the deadline was met. However, not only did the negotiations take up time he should have spent explaining his health care reform plan, but in his fervent support of NAFTA, Clinton may have ended up alienating groups whose support he would need for the enactment of his health security bill. Such groups included liberal Democrats and trade unions that were dead set against NAFTA and the inevitable loss of jobs they believed the agreement would entail.

The task force could only watch with increasing alarm as windows of opportunity were slowly being closed, and momentum for reform came close to a halt. Not only did the delays provide opponents of reform with the time they needed to organize their forces, but groups who had previously pledged their support were
starting to backpedal. Following an internal revolt, the Chamber of Commerce reversed its stance in support of the employer mandate, as we shall see in the section “Defection by the Chamber of Commerce.” The powerful Business Roundtable too defected, something that had a profound effect on the shift in the overall business sentiment.  

By January 1994, Whitewater burst onto the national scene further damaging the public’s perception of the president and, by association, his health care plan. By spring, the economy was improving and Americans worried less about health care coverage while businesses were less concerned about inflation and thus rising health care costs.  

Clearly, this series of delays in introducing and explaining the Health Security Act severely hurt the odds for reform – probably in more ways than the Administration could have imagined at the time. It is of little comfort to know that the delays were unintentional and a consequence of the business of politics where presidents rarely set their own agendas. The negative effects of the delays were further aggravated by a series of obstacles laying at the wait for the Health Security Act – obstacles that would ultimately lead to its demise.

3.2 Political Obstacles to Reform

3.2.1 Disunited Democrats – Opposition from Within

Although Clinton enjoyed a Democratic majority in both houses, it was fairly narrow: 257 to 176 in the House and 56 to 44 in the Senate. Nonetheless, he hoped to be able to squeeze his health care reform through by rallying his fellow Democrats and some of the more moderate Republicans. This, however, would prove to be no easy task.

Despite appeals from the White House not to introduce any alternative bills until the president had reveal his plan, some party members did not heed that request, and the Democratic Party appeared split over what course the road towards health care reform should take. Conservative Democrats favored the Cooper plan for market-oriented health reform with no guarantee of universal coverage, no spending limits or price controls and, more important, no employer mandate. Many of the congressional Democrats had been in office for a long time and over the years, they had built up relationships with business groups and organizations on whose contributions they

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relied to run reelection campaigns. Backing Clinton’s plan, and thereby requiring businesses to pay for employees’ health insurance, might jeopardize that support.

The fact that Cooper’s bill did not include the provision for guaranteed universal coverage, made it next to impossible for Bill Clinton to compromise with this section of the Democratic Party. In his January 1994 State of the Union address, President Clinton had declared himself open to all sorts of compromises and suggestions save one; the promise of universality. Any legislation returned to him that did not provide for universal access to health care would promptly be vetoed.67 It was a threat that did not exactly make it easier for legislators in charge of working out a compromise bill.

Liberal Democrats supported the single-payer approach to universal health care. Led by Senator Paul Wellstone (D-MN) and Representative Jim McDermott (D-WA), the Wellstone-McDermott bill enjoyed significant support gaining up to ninety congressional sponsors at the same time as the Clinton bill was being debated.68 The Clinton plan did include measures to appease single-payer advocates with its provisions to allow each state to implement a single payer system if it wanted to do so later. Although this group was ideologically closer to the Clinton proposal than the Cooperites, its mere existence showed how divided the Democratic Party was and the difficulties the Administration faced.

With managed competition, Bill Clinton had sought middle ground hoping to unite the two wings of the Democratic Party. Yet internal disarray and quibbling remained and ultimately let to inaction within the party and to confusion among the public, as the media delighted in reporting the latest showdown. At a time when conditions finally seemed ripe for the enactment of major social reform, the party historically favored by the public to enact such legislation was unable to agree on one viable option. As we shall see, the Republican Party had no trouble deciding on the best course of action.

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68 Theda Skocpol, Boomerang Health Care Reform and the Turn Against Government, (New York: W.W. Norton & Company), p.103.
3.2.2 Ideological Opposition from the Political Right

“The Republicans enjoyed a double triumph, killing reform and then watching jurors find the President guilty. It was the political equivalent of the perfect crime.”

Until Clinton’s election, the division of power between Republicans and Democrats had been relatively stable: Democrats enjoyed continuous control of the House between 1969 and 1992 and of the Senate for all but six years, while Republicans were in control of the White House during the same period for all but four years. As Brookings Institution scholar Allen Schick explains, periods of divided government have been much more conducive to “bipartisan support for significant legislation than when a single party [has] controlled the White House and Capitol Hill.” This is because there is a greater incentive for the parties to cooperate during periods of divided control, as the parties know that they have to compromise in order to avoid complete gridlock. When one party controls both houses of Congress and the presidency, it is more inclined to go it alone. The election of Bill Clinton thus upset the balance of power between the parties, putting the Democrats in control of both houses in Congress and the White House. The new power structure had a galvanizing effect on the Republican Party members who united in opposition determined to deny Clinton any victories and to regaining some of the power it had lost.

The obstructionist position of the Republican Party was not as pronounced at first. Indeed, when popular support for health care reform was high, and all indicators pointed towards the enactment of some form of health care bill, Republicans were careful not to be cast on the opposing side. After President Clinton’s September speech – indeed throughout most of 1993 – many members of the Republican Party declared

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71 Ibid. As Allen Schick explains: In the twenty years between 1949 and 1994 of same party rule in the House and the White House, 56 percent of significant laws passed with bipartisan majority. But during the twenty-six years of divided rule during the same period, the House passed 72 percent of major laws with bipartisan majority. The same pattern applies to the Senate.
themselves ready to work out a compromise. A significant 85 percent of Republicans professed support for fundamental changes or completely rebuilding the system.72

Yet the conciliatory gestures among some Republicans were short-lived and all but faded as the air of inevitability about health care reform began to wane. House Minority Leader, Newt Gingrich, and fellow right wing Republicans were redefining the political direction for the Republican Party in preparation for the upcoming midterm elections in November 1994. Central to this new and improved Republican Party image was intellectual strategist William Kristol. Kristol had served as Dan Quale's vice presidential chief of staff and was the main architect of the conservative think tank, the Project for the Republican Future. Militantly anti-government, Gingrich and Kristol believed it was their party’s duty to put a stop to all the government handouts that weakened the entrepreneurial spirit of Americans. Kristol believed that “passage of the Clinton health care plan in any form would be disastrous. It would guarantee an unprecedented federal intrusion into the American economy. Its success would signal the rebirth of centralized welfare-state policy … [and] it would destroy the present breath and quality of the American health care system, the world’s finest.”73 The real fear of the Republican Party was, of course, that the middle-class would keep up the pressure for enactment of Clinton’s plan and subsequently reward the Democratic Party in the midterm elections. Unless Republicans could redefine the debate, their minority status in Congress was bound to perpetuate.

In effect killing two birds with one stone, right wing Republicans set out to convince the middle-class that its support for the Clinton plan, in any version, would lead to government-controlled, inferior health care. In a series of memorandums to Republican leaders, Kristol provided the blueprint for how to redefine the debate. Party leaders were instructed to use any given opportunity publicly to question the need for reform, and highlight the adverse affects of the Clinton bill. Messages, Kristol argued, should concentrate on the issues of quality and freedom of choice. Polls showed that people were generally satisfied with the overall quality of their own care, and Kristol knew that if Republicans could make people think that the quality of their own care

was being threatened, they would be more inclined to oppose the plan. The same effect could be achieved by convincing the public that the Clinton plan would tamper with the sacred doctor-patient relationship, taking away peoples’ choice to see their current doctors. Of course, it was not true: one of the plans offered, the “fee-for-service” option, would enable people to keep seeing their own doctor. However, it did not matter; the seed had been planted.

One of New Gingrich’s friends in arms, Representative Dick Armey, helped stoke the fire. In an article in *Wall Street Journal*, he appealed to the fears of many Americans calling the Health Security Act a “bureaucratic nightmare that will ultimately result in higher taxes, reduced efficiency, restricted choice, longer lines and a much bigger federal government.” He included a chart of the many new federal programs and bureaucracies that the Clinton Plan would supposedly create – a chart that would quickly become one of the opposition’s favorite tools in their agitation against reform (see Appendix 5). Humorists and media alike found this doctored chart very useful in their often overly simplified discussion of the plan. Bob Dole used it in his State of the Union response to convince an increasingly uneasy public that the Clinton plan was bureaucracy run amok. It was all right there for people to see with their own eyes.

Elizabeth McCaughey put a further negative spin on the debate, when she published an article titled “No Exit” in *The New Republic* in February 1994. McCaughey happened to be running as the Republican nominee for lieutenant governor of New York and her purportedly unbiased look at the plan was anything but that. With blatant disregard for the facts, she proclaimed, among other things, that “the law will prevent you from going outside the system to buy basic health coverage you think is better,” and that “the doctor can be paid only by the plan, not by you.” Even though the White House issued a point for point rebuttal of her many falsehoods, which the magazine declined to publish, her article became very influential, not only in conservative circles, but also among the public frightened by news media renditions of McCaughey’s worst-case scenarios, neatly packaged in sound-bite format.

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The Republicans received unexpected but welcomed help in the late 1993, early 1994 in the form of a barrage of reports concerning the Clintons’ involvement in the so-called Whitewater affair. And in February 1994, rumors of presidential extra marital activities gained in strength when a former state employee, Paula Jones, filed a lawsuit against the President charging him with sexual harassment and civil rights violations. To Republicans and their supporters, both incidents provided further ammunition in their battle, and they wasted no time tying the supposedly flawed character of Bill Clinton to health care reform. Again and again, the message to the public, disseminated via the conservative radio network, was that the Clintons clearly could not be trusted to overhaul an industry affecting one seventh of the American economy.

Inside the Republican Party, the weakened president and the upcoming Midterm elections encouraged Kristol to advocate outright opposition to any compromise on health care reform. In a July memorandum, Kristol warned wayward Republicans of supporting any new health care bill that the Democrats might put forward in an attempt to compromise. “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.”76 To Republicans, health care reform per se had ceased to have any political value at all. It was only interesting in as far as it could serve as a political means to humiliate the president and finally gain control of Congress.

And their efforts paid off. Moderate Republicans, who had been inclined to compromise, did indeed back down against threats of being unseated or of losing seniority within the Republican Party unless they toe the new party line.77 For the Democrats, the effect of this ideological showdown over health care reform was, of course, that they could not find the votes they needed to pass reform, as we shall see later in “Committee Breakdown.” The Democratic margin in the Senate was just too narrow, particularly as Clinton could not rely on the support of some of his own, such

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as Bob Kerry and Joseph Lieberman, both running for reelection, and both dead set against the employer mandate.\textsuperscript{78}

The persistent portrayal of the Clinton plan as a big bureaucratic monster clearly stuck with the public who, despite admitting that they did not know a lot about the plan, became convinced that it would entail too much government and have a negative impact on the quality of their own health care. The very group Clinton had set out to help, had turned against him at the end of the debate, and the Republican Party had played a significant role in this conversion. As we shall see, the Republican Party was also instrumental in orchestrating the change in position among certain businesses and organizations that normally sided with Republicans but had declared themselves in favor of the Clinton plan.

To be sure, the right wing of the Republican Party spared no means to bring defeat to the Clinton plan, especially when they realized that this gave them the opportunity to sharpen their own political standing in the upcoming midterm elections. Along the way, they received a great deal of help from the Christian Coalition, the National Federation of Independent Business (NFIB), the Health Insurance Association of America (HIAA), and ultimately from various business coalitions such as the Chamber of Commerce and the Business Roundtable, as we shall see in the following sections.

\textbf{3.2.2.1 The Christian Coalition}

An integral part of the Republican right wing, the Christian Coalition would prove an indispensable alley in right-wing efforts to bury Clinton’s health care reform plan. Founded in 1989 by failed presidential candidate Pat Robertson, the Christian Coalition remained focused on “core family values” such as abortion, and gay rights (they vehemently oppose both) as well as instituting prayer in schools. In the early nineties, executive director Ralph Reed helped reshape that core value set to include other family issues like taxes, crime, education and health care. At one of the Coalition’s conferences in September 1994, Pat Robertson, not one prone to modesty, described his Coalition as being on a divine mission: “We are seeing the Christian

\textsuperscript{78} As explained in Paul Starr, “What Happened to Health Care Reform?” \textit{The American Prospect}, vol. 6, no. 20, December 1, 1995, p. 27.
Coalition rise to where God intends it to be in this nation, as one of the most powerful political forces that have ever been in the history of America.” While the divine link is questionable, he may have had a point: the Christian Coalition is part of the Evangelical Christians in America, which comprises between one-fourth and one-third of the population, thereby making them the largest single voting block in the country, and certainly a religious and political force to be reckoned with.80

Calling the inauguration of Bill Clinton a “repudiation of our forefathers’ covenant with God,” the Christian Coalition was no friend of the Clintons or their health care plan. Clinton had already angered members of the organization with his attempts to lift the ban on homosexuals in the military, and his position on abortion only made matters worse.82 Clinton, they believed, was an incorrigible womanizer whose political powers the Coalition vowed to curtail in the 1994 midterm elections. The first line of attack was the defeat of Clinton’s health care reform, which the Coalition described as a “bureaucratic, Byzantine, European-style syndicalist nightmare.” According to Ralph Reed, the defeat of Clinton’s health care legislation was the “group’s highest priority.” Health care reform, they believed, would pressure families into joining health alliances against their will and in the process curtail their choice of doctors. What was worse, the Clinton plan would fund elective abortions, something they could not in good conscience support.85

Already notorious for its use of grassroots tactics to further its causes, the organization rallied its 1.4 million supporters to grassroots opposition against the Clinton plan.86 In its biggest lobbying campaign ever, the Coalition set aside $1.4 million of its annual $20 million budget to influence the debate.87 Congressional

80 Jost, op. cit., p. 896. This is in the words of Reed himself but the figure is indirectly supported in Sydney Blumenthal, “Christian Soldiers,” The New Yorker, July 18, 1994, p. 37 listing Evangelical Protestants as the single largest constituent within the Republican party for the 1992 presidential election.
81 Jost, op cit, p. 904.
82 On his first day in office, Clinton signed an executive order to overturn anti-abortion regulations from the Regan and Bush years, as described in Jost, op. cit., p. 904.
84 Ibid.
85 The Clinton plan did include coverage for abortion but, in an attempt to skirt the issue, it did not actually mention the word calling instead for coverage of “pregnancy-related services.”
members were flooded by 30 million postcards that had been distributed through churches and preprinted with the poignant words “Don’t let bureaucrats decide my family’s choice of a doctor.”\textsuperscript{88} Although used to hearing from constituents during debates, members were besieged by mail in an example of what Congressmen have come to term “Astroturf” mobilization, i.e. non-spontaneous, manufactured grassroots mobilization.\textsuperscript{89} Irrespective of the term, it was an effective way to make representatives aware of Coalition members’ position on health care reform.

Other efforts by the Coalition to influence health care reform included advertisements in the printed media, on the radio and television. Rush Limbaugh and fellow right-wing radio talk show hosts helped spread the word to tens of millions of Americans appealing to their fear of big government and a rationed health care system. In a Henry J. Kaiser Family Foundation survey, members of Congress listed talk radio as the media source with the most influence on the outcome of the health care debate with \textit{The New York Times} as a distant second.\textsuperscript{90} There were, however, many other forces at work, and as we shall see in the following sections, the Christian Coalition received a great deal of help from many other interest groups.

\section*{3.3 Interest Groups}

People inside the Clinton Administration were well aware that their plans to reform the health care system would be met by a storm of interest group activity. Interest groups, for all their faults and merits, have always been an integral part of the political process in America – a reflection of what is ideally a democratic and participatory system. Indeed their role in American politics dates back to the Constitution; the right to associate is one of the first mentioned in the Bill of Rights. Interest groups are formed specifically to influence government decisions and shape the overall political agenda to reflect the wishes of their members. Legislators in turn rely on the information lobbyists provide to stay abreast of complicated issues, and, more than ever, on financial contributions to run expensive reelection campaigns.

\textsuperscript{88} Balz, op. cit., p. A6.
Although one of the Founding Fathers, James Madison, warned against the “mischief of factions,” or organized interests, to band together and override the rights of other citizens, he did not want to prohibit their creation.\(^91\) Instead, he argued, the solution would be to ensure a system where factions would flourish. This pluralist system, he believed, would allow many factions to jockey for power and influence over public policy and eventually lead to an equilibrium in keeping with the preferences of the population at large.

By the time Bill Clinton entered the White House, the number and power of interest groups had reached heights unimaginable to the Founding Fathers. Clinton realized, of course, that his plans to reorganize the role of existing medical providers and possibly reduce their share of the $800 billion annual health care pie would be met by heavy resistance.\(^92\) In an effort to placate the well-entrenched groups Clinton had decided to base his reform plans on the system already in place instead of proposing completely to revamp it.\(^93\) This, he figured, would bring less resistance, and perhaps even cooperation, from the existing players. As we shall see, that did not happen.

Once the Health Security Act appeared in print, stakeholder groups sprung into action employing a combination of direct lobbying in Washington, advertising, grassroots agitation and financial contributions in order to influence the final bill to reflect the specific concerns of their particular group. Literally hundreds of groups – the task force said they heard from more than 1,100 groups\(^94\) – were involved at various levels, and when the cost of battle was totaled, special interests had spent upwards of $300 million to influence the outcome, making it the most heavily lobbied piece of legislation in U.S. history.\(^95\) Advertising costs alone accounted for more than $50 million and most of it was spent by opponents of reform.\(^96\)

\(^93\) In other words, he purposefully maintained the mixture of private and public insurance instead of instituting the federal government as the sole provider of health insurance.
\(^94\) Center for Public Integrity, op. cit., p. 83
\(^95\) The Center for Public Integrity lists the total number of dollars spent at $100 million, cf. op. cit., pp.1 and 83. An article in *The New York Times* estimates that the number was closer to $300 million – all spent against reform, with a measly $15 million spent by proponents, primarily the Democratic National Convention (DNC), cf. Adam Clymer, “Hillary Clinton Says Administration Was Misunderstood on Health Care,” *The New York Times*, October 3, 1994, p. A12.
\(^96\) Center for Public Integrity, op. cit., p. 2.
The discussion of the role of special interests in the defeat of Clinton’s health care reform plan will be divided into two parts. The first part will discuss the position and methods of influence used by five of the most important interest groups representing insurance companies, small businesses, physicians, the elderly and big business. The second part, “Interest Groups, Money and Congress,” will take a specific look at the monetary link between legislators and interest groups in the health care debate of 1993-1994.

3.3.1 The Health Insurance Association of America (HIAA)

The Health Insurance Association of America (HIAA) was one of the fiercest, most organized and ultimately most effective opponents of health care reform. HIAA’s member base consisted exclusively of small and midsized insurance companies handling approximately 60 million of the nation’s 180 million health insurance policyholders.\(^97\) HIAA members objected to many of the changes introduced by the Clinton Administration, and particularly to the creation of the large health alliances, which by their very nature catered to the large insurance companies. HIAA and its members doubted that the new structure would leave any business for them, and thus set out in a fight for its very existence.

The HIAA had already demonstrated its effectiveness by playing an important role in the defeat of “Proposition 166” – a health care reform proposition rejected by Californians in early 1992, which to some extent resembled Clinton’s Health Security Act.\(^98\) The experience the HIAA gained from this battle proved invaluable on the national health care reform front: not only did the organization have its resources and infrastructure in place, but it had learned an important lesson about the importance of television commercials. To help ensure another victory, they hired the same


advertising firm that had helped them win in California to help them defeat the Clinton proposition.

The HIAA had another ace up its sleeve in the form of Bill Gradison. Gradison had recently given up his congressional seat to become the HIAA’s head lobbyist and knew the Washington game from the inside. A ranking Republican, he had worked on the House Ways and Means subcommittee on Health, and knew a lot about complicated health care issues. When Clinton’s task force invited him to give his input, he explained that there were three things about the plan that were especially bothersome to his association: the introduction of mandatory health alliances, community rating and budget caps. While his association was in favor of some of the aspects of the Clinton plan, including the quest for universal coverage funded by an employer mandate, as stated in the organization’s own 1991 “Campaign to Ensure All Americans,” there was quite a gap between the two.

From the onset the White House, and Hillary Clinton in particular, had made several public attacks on the integrity of the insurance industry, accusing them of “price-gouging, cost-shifting and unconscionable profiteering.” As a result, the HIAA’s lobbying efforts and further requests for meetings were largely unanswered by the Administration, and in an effort to be heard, the HIAA decided to change tactics. In the words of Bill Gradison: “We didn’t feel we had any other option, when you get right down to it, but to try to go directly to the public and try to influence the legislative process that way.” That is precisely what they set out to do.

The HIAA’s infamous $12 million “Harry and Louise” television campaign is widely credited as one of the main reasons for the 18 percentage point drop in public

99 “Community rating” refers to the insurance practice of insuring all customers for similar premiums, i.e. the opposite of what most insurance companies do today when they “cherry pick” the best customers (the young and the healthy) to insure and refuse coverage to others. Under the community rating system, insurance companies cannot deny coverage to anyone, and all members, sick and healthy, pay basically the same premiums.


support over a six-month period between September 1993 and February 1994.\textsuperscript{103} The first in a series of ads ran in September of 1993, even before the president’s health care reform plan had been formally presented to the public, and they continued to run throughout the health care debate of 1993-94. The commercials depicted Harry and Louise, an “ordinary” couple, discussing their doubts about the Clinton plan in exchanges like this:

“Louise: This plan forces us to buy our insurance through these new mandatory Government health alliances.

Harry: Run by tens of thousands of new bureaucrats.

Louise: Another billion-dollar bureaucracy.”\textsuperscript{104}

In another commercial, the couple worried that their choice of health plans would be limited and medical services cut: “They choose, we loose,” were the closing words.\textsuperscript{105} The advertisements and catchy slogans raised issues that hit home with the public who grew increasingly skeptical as 1994 wore on.

Although the commercials initially only aired in certain districts, like Washington D.C. and New York, they quickly gained nation-wide notoriety as journalists across the country used them to illustrate opposition to the Clinton plan. In fact members of the media were so intrigued by the ads that they actually broadcast them more times to exemplify opposition than HIAA itself.\textsuperscript{106} The attention intensified when in November of 1993 Hillary Clinton criticized the ads for distorting the truth. The exchange of fire between a Washington association and the first lady was very unusual for two reasons. The HIAA’s ads marked the first time that a lobbying group so directly opposed a president and his policies, and also the first time that any group had used television advertisements to this extent in order to influence public opinion.


Hillary Clinton’s move was unusual in that no first lady had ever publicly attacked an American industry. Of course, it all made for very entertaining news and the media reveled in the stories, providing the HIAA with additional millions in free advertising.

Using the ads as political leverage, the HIAA periodically offered the Clinton Administration to take them off the air in return for specific concessions. Interestingly, one such deal was struck between the HIAA and the then Chairman of the House Ways and Means Committee, Dan Rostenkowski (D-Ill.). Rostenkowski knew that health care reform needed the support of business in order to pass, and in January of 1994, he brokered a deal, where HIAA agreed to stop their ads in certain districts where committee members were up for election in return for concessions to the insurance industry. However, the deal fell through when Rostenkowski had to resign from the Committee in the face of an indictment on corruption charges, and the ads soon went back on the air.

Because of the notoriety of the adds, the HIAA was able to fundraise a total of almost $50 million to spend on lobbying, an astonishing $30 million more than its normal annual operating budget. The HIAA spent some of its fund-raising loot on a grassroots campaign among its members and their families urging them to contact their local congressman to express their views on health care reform. The campaign resulted in a veritable siege on congressional members each of whom received about one thousand contacts – phone calls, visits or letters – from HIAA members. Indeed the Henry J. Kaiser Family Foundation survey of members of Congress involved with health care legislation identified the insurance industry and the HIAA as the interest group with the greatest influence in the congressional debate and decisions on health care reform.

As we have seen, the Health Insurance Association of America was significant player in the defeat of the Health Security Act. By entering the debate early and using a combination of aggressive television commercials and highly organized grassroots agitation, they were able to exert formidable pressure on the legislative process. As we

108 PBS NewsHour Online, op. cit.
109 Ibid.
shall see later, by the time most of the congressional committees had reported out their bills, the health alliances had all been made voluntary and the community rating system rejected. Of course, the HIAA had received help from other interest groups, many of whom employed similar strategies in their efforts to influence legislation, as we will see in the following sections.

3.3.2 The National Federation of Independent Business (NFIB)

The HIAA found an ally in the National Federation of Independent Business (NFIB) whose 607,000 small-business members were equally opposed to the Health Security Act.111 To the NFIB, the employer mandate was the most contentious aspect of the plan. Most of their members did not provide health insurance to their employees and were adamantly opposed to being forced to do so despite the heavy subsidies they were being promised by the government. The NFIB was convinced that the added cost of health insurance would cause thousands of small businesses to go bankrupt threatening a national recession. Earmarking $40 million – two-thirds of their annual budget – for the fight against the employer mandate, the organization set out to defeat the Health Security Act.112

In one of its first moves, which also helped to garner attention from the media, the NFIB declined invitations to meet with the task force; they were not interested in compromise, only in the total defeat of any proposal with mandatory employer contributions. That objective was best achieved in the real corridors of power and the NFIB immediately began to lobby Congress, dispatching six lobbyists’ teams in the House and four in the Senate.113

At the same time, the NFIB launched a carefully orchestrated grassroots campaign mobilizing thousands of members in the fight to defeat the Clinton plan. In the words of John Motley, chief lobbyist for the federation, it was the “largest single focused grass-roots lobbying campaign we have ever done ….”114 Responding to their organization’s steady stream of “Fax Alerts” and “Action Alerts,” tens of thousands of

113 The Center for Public Integrity, op. cit., p. 6.
114 Ibid.
NFIB members contacted their local Congressmen to convey their position on the employer mandate in particular and health care reform in general. NFIB tactics were primarily focused on districts with swing Committee legislators who might be tempted to vote for a compromise version of the health care bill. One such member was Jim Slattery (D-KS.) of the Energy and Commerce Committee. When the time for a vote for a compromise bill came, it was one vote short, and the Energy and Commerce Committee was unable to report out a bill, as we shall see later in “Committee Breakdown.” Slattery had been subject to intense pressure from small business owners in his district who had convinced him to vote against reform. One of the reasons why Slattery had been so open to suggestions was the fact that he was running for governor and concerned about offending a group whose support he would need later.115

Slattery was only one of many congressional members who felt the presence of the NFIB. Indeed, when surveyed by the Henry J. Kaiser Family Foundation, congressional members listed small business and the NFIB as the interest group with the second most influence in the congressional debate and decisions on health care reform.116 John Motley himself boasted of his association’s political influence: “I see us … the business community, the opposing forces, in a position of controlling between 55 and 60 votes in the Senate, not controlling but, you know, having.”117 As we shall see in the following section and in “Defection by the Chamber of Commerce,” the NFIB also exerted its influence in more subtle, but no less influential ways.

3.3.3 The American Medical Association (AMA)
As we have seen, the AMA had played a prominent role in the defeat of nearly all health care reform efforts since 1935: from Roosevelt to Clinton, the association of physicians had vigorously fought measures that threatened to “come between” doctors and their patients. It was thus a surprise when the AMA’s executive vice president, James A. Todd, in October 1993 declared before a congressional committee that the association was ready to “… go forward with the president, with his committee and

117 The Center for Public Integrity, op. cit., p. 5.
with the Congress to get it done”, i.e. to enact reform. The AMA had already put its vision for health care reform down on paper in its “Health Access America” plan published in the wake of Wofford’s surprise victory in 1991. The plan shared certain ideas with Clinton’s plan, including the quest for universal health care to be partially financed by mandatory employer contributions.

Although the AMA no longer spoke as a unified voice of physicians in America, the association was nonetheless a force to be reckoned with representing 41 percent of the nation’s doctors with 300,000 members. With a well-endowed campaign war chest, an active grass-roots network and the special ability of doctors to influence their patients’ opinion, it is not surprising that the Clinton Administration was very eager to count the AMA among its supporters. Getting an endorsement from the influential group would not only bring great credibility to his plan as well as valuable publicity but it would also deprive opponents of another forceful advocate.

The AMA’s professed support for the Clinton plan was, however, anything but consistent, partially because the association’s members were internally divided making it difficult to decide on the official position of the association. The solution to the AMA was to play both horses. Publicly the AMA continued to profess support for health care reform, and the association worked actively with the task force gaining several concessions, including caps on insurance premiums instead of price controls. At the same time, it mounted newspaper and grassroots campaigns that raised questions about certain aspects of the plan, e.g. the health alliances, which organization members feared might limit patients’ choice of physicians. One campaign provided 630,000 doctors with pamphlets for display in their offices. Patients waiting to see their doctor could read about the risks that health care reform might curtail their rights to see their own doctors and compromise the quality of their care.

The AMA’s “1993 Campaign Action Kit” provided doctors with pre-approved scripts to use when speaking in various public venues against health care reform: “I am a doctor, and the more I hear politicians and pundits talk about health system reform,

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118 The Center for Public Integrity, op. cit., p. 53.
121 Ibid.
the more I realize the one voice they don’t hear anymore is the voice of my patients,” one script read.\textsuperscript{122} The real issues to AMA members – which neither the pamphlets nor the scripts mentioned anything about – were the perceived threats health care reform posed to physicians’ autonomy and future earning potentials.

In May 1994, the AMA suddenly came out in support of the Wellstone single payer proposition to be financed via individual taxes.\textsuperscript{123} The move was the result of member dissatisfaction with the increasing influence insurance companies were exerting on medical decisions in order to save money. Doctors who belonged to Health Maintenance Organizations (HMOs) run by insurance companies were tired of having their decisions about medical procedures second-guessed. They also objected to the fact that doctors had no say over the reimbursement fees set by managed care companies and that doctors could be removed from the provider list as the insurance companies saw fit. To many in the AMA, it would be preferable to have the government as the intermediary and in charge of reimbursing their medical fees.

Yet only a few months later in August 1994, the AMA joined forces with the American Federation of Labor/the Congress of Industrial Organization (AFL-CIO) and the American Association of Retired Persons (AARP) to sponsor advertisements urging Congress to pass legislation that would achieve universal coverage through employer contributions, in effect once again throwing their support behind the Clinton plan.\textsuperscript{124} Within weeks, however, the AMA backed down from this position joining other skeptics. The flip-flop in position by the AMA was partially a result of its divided senior leadership. One of the association’s vice-presidents was John B. Crosby, a former aide to Mr. Gephardt (D), who was in charge of coordinating the association’s health policy. The conservative Lee J. Stillwell was also vice-president but he was the head of the Washington office, and had a background with the National Federation of Independent Business (NFIB). Predictably, the two vice-presidents did not see eye to eye in deciding the best direction for their organization, and their differences reflected those of the members at large.

\textsuperscript{122} Ibid.
\textsuperscript{123} Dana Priest, “AMA Welcomes Liberal Senator’s Help In Swing Against Big Health Care Firms,” \textit{Washington Post}, May 31, 1994, p. A4
Not only was the AMA internally split on its position on health care reform, but the association also had to contend with outside pressure from conservative Republicans who were very unhappy about some of the moves their old ally was making. Angered about the AMA’s decision to cosponsor advertisements with the AFL-CIO and the AARP at a time when the Clinton legislation was being debated in Committees, Newt Gingrich and fellow Republicans sent a letter to the AMA stating that they were “… dismayed by the actions of the leadership of the AMA.” which was “out of touch with the rank-and-file physicians.” Clearly the “reverse lobbying” efforts by Republican party members had influenced the AMA to change its position. After all, the AMA was only too aware that it would have to appeal to those same party members in future lobbying efforts.

At the same time, and perhaps not by coincidence, NFIB affiliates engaged in “cross-lobbying” telling their AMA counterparts that if they continued to push for the employer mandate, the NFIB would start lobbying for limiting medical fees. This was certainly a threat that caught the attention of the AMA and its members, who, if anything, were sensitive to measures that threatened to curtail their income. This double dose of pressure was enough to make the AMA back away from demands for employer-sponsored health care and universal health care for the rest of the debate. This was of course another blow for the Clinton Administration who had hoped to count the AMA among its active supporters in the fight to reform the health care system. In some respects, the story of the AMA is similar to that of the American Association of Retired Persons (AARP).

### 3.3.4 The American Association of Retired Persons (AARP)

With 33 million members (accounting for roughly one-fourth of the registered voters in the country) and an annual budget of $300 million, the AARP was the largest and one of the most active trade organizations in the country. AARP members were understandably concerned about proposed cuts in Medicare and its gradual integration.

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125 Ibid.
126 Normally interest groups lobbying members of Congress. In the health care debate, party members actively lobbied interest groups, thus the term “reverse lobbying.”
into the health alliances, but overall, there seemed to be few points of contention between the Clinton plan and the AARP. This was, of course, no accident. The Clinton Administration had listened carefully to the concerns of the important AARP members when legislation was formulated. Provisions such as prescription drug coverage and home-based long-term care had been included with the elderly in mind, and in return, the Administration counted on the AARP to get actively involved in the push for health care legislation. Unfortunately, like the AMA, the AARP was hesitant and ambivalent in its support for the Clinton plan.

In November 1993, the association had decided not to formally endorse the Clinton plan even though the AARP’s Board of Directors thought it was the best plan available. In February 1994, following a direct appeal from the president for an endorsement, the AARP again refused to give an outright endorsement choosing instead to repeat their November statement that cited the Clinton plan as “the strongest and most realistic blueprint to date for achieving our goals.” Although the statement itself was positive, it was obviously not the show of support the White House had hoped for, just as the Clinton plan was beginning its journey through Congress. The question is, of course, why the AARP decided to straddle the fence at a time when their support was so critical.

Part of the answer goes back to 1988 when the AARP had endorsed and lobbied extensively for the passage of the Medicare Catastrophic Coverage Act, which expanded Medicare to cover the cost of catastrophic illness. When the act passed, many of the AARP’s well-off members were infuriated to learn that they would in effect pay the bill through higher taxes and premiums, and they effectively forced Congress to repeal it one year later. The incident left the AARP in a weakened position as some left the organization accusing it for being out of touch with the views of its members. The AARP did not want to repeat the mistake by endorsing the Clinton plan, and when their members’ support for the Clinton plan began to decline over confusions about proposed Medicare cuts, the AARP decided to play it safe. Instead of giving an outright endorsement, the organization decided to leave it up to the

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129 Ibid.
130 Ibid.
individual members to choose to endorse the Clinton or any other plan, e.g. by getting involved in grassroots activities.

The trouble was that, like the rest of the public, AARP members were increasingly confused about the plans available, and they could arguably have benefited from some guidance from their organization. The Clinton plan was the option that took into account the main concerns of the elderly as a group – the AARP had worked with the administration to ensure that this was the case – and the AARP would clearly have acted in the interest of its members by publicly endorsing it. Doing so might have required the organization to devote some resources to educating its members about the plan, but in the end, it would have been worth their while. Instead, the organization kept an air of impartiality, and ran ads that called for certain provisions, such as prescription drug coverage, to be included in any legislation that passed Congress. It was not until August 1994 that the AARP publicly announced their support for the Mitchell bill, the Senate version of the Clinton bill, but by then it was too late to make an impact.

The position of the AARP was emblematic of the many interest groups ostensibly supportive of the president’s plan. While publicly proclaiming that they shared the Clinton plan’s goals for health care reform, most would stop short of an outright endorsement – or give it too late in the game – in an effort to leave all doors open for bargaining as the bill wound its way through congressional committees. Many groups were so focused on trying to shape legislation to their specific, often narrow, goals that they ended up with nothing, contributing instead to the plan’s demise. As we shall see in the next section, they received a great deal of help from another initial and very important supporter of health care reform, i.e. the business community.

### 3.3.5 The Business Community

Opposition from the HIAA and the NFIB was expected – after all their members believed they had much to lose from the reform. Yet overall, most businesses, big and small, stood to gain from Clinton’s reform plans. Throughout the 1970s and 1980s, health care costs had risen sharply and the financial burden of insuring employees was
Companies that did provide coverage for their employees were unhappy about the uneven playing field this gave them in the competition with non-paying companies, at home or abroad. Many companies believed that the employer mandate would help put an end to the free ride some of the non-paying companies were getting as their workers often enjoyed dependant coverage through their spouses’ place of work. In the competition with foreign companies, increasing health care costs made American products less competitive; Ford Motor company complained that cars manufactured in the U.S. cost $500 more per car than cars manufactured in Japan simply because of health care costs, and Chrysler Corp. spent more on health care than on steel. As a result, business became more open to the idea of government regulation in the health care field. Ford CEO Harold Polling spoke favorably of national health care reform at Clinton’s economic summit in December 1992, and the three large business lobbies, the Business Roundtable, the U.S. Chamber of Commerce and the National Association of Manufacturers (NAM), pledged their support for universal coverage and cost containment, the central goals of the president’s plan.

However, by 1994 they had a change of heart and their defection, and that of the business community in general, played a big role in the demise of Clinton’s health care reform plan. The question that begs to be answered is, of course, what happened to make business reverse its position.

### 3.3.5.1 Defection by the Business Roundtable

A powerful organization made up of the CEOs of Fortune 500 companies, the Business Roundtable was in favor of universal health care and cost containment. But the organization was internally divided about the shape of reform. Some members of the large organizations, like Xerox, Chrysler, Ford, and General Motors, IBM, and Kodak already insured their workers. This group of companies advocated the Clinton plan’s

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131 As mentioned earlier, the cost of employee health benefits grew by 163 percent between 1970 and 1989.
132 It is fairly common that married couples receive health care coverage for the entire family through e.g. the husband’s place of work. The wife’s employer thus gets a “free ride” by not having any expenses for health care coverage.
use of the employer mandate to finance universal health care, which, they hoped, would put a stop to the unfair competition they experienced with the non-paying companies.

Another group consisted of many large insurance and drug companies like Prudential, CIGNA, Abbott and Eli Lilly. While this group favored a managed care type of health care reform, they were opposed to the employer mandate and, naturally, to premium caps designed to curtail their income. Consequently, they preferred the Cooper plan.

A third group included companies like General Mills, PepsiCo, Sears and the Marriott Corporation. Some of the companies provided insurance to their full-time staff but not to their increasing pool of part-time workers, and as a result, they were against any plan that would bring major changes to the health care system and force them to pay for all their employees.

The last group within the Business Roundtable consisted of companies that did cover their employees but nonetheless objected to government-sponsored reform for ideological reasons. If the government was allowed to impose restrictions and rules upon business in relation to health care, there was no telling where they would stop: give them an inch and they might take a mile. It did not matter that the Clinton plan would save them money. Companies in this group included General Electric and Union Pacific.136

Clinton’s task force consulted extensively with members of the Business Roundtable throughout the development phase to ensure their continued support once the plan was released in October 1993. By then negotiations had become very bumpy and the internally divided Roundtable expressed increasing concerns about a number of features of the Clinton plan. Proposed measures such as price controls, the employer mandate, states’ rights to experiment with single-payer plans and the formation of large purchasing alliances that threatened smaller companies’ ability to compete were particularly troublesome to the organization. The head of the Roundtable’s health care task force, Robert C. Winters, was also the CEO of Prudential, and, like the other insurance and pharmaceutical companies, his company was predictably against price

136 As John B. Judis explains, Union Pacific had “costed it out” and stood to gain millions annually. Nevertheless, they were against reform, cf. Ibid., p. 68.
controls and the Clinton plan in general. Despite the Administration’s assurances that a compromise could be reached, Winters pressed Business Roundtable members to back the Cooper plan, which he saw as a good alternative for future health care reform negotiations. Better go with Cooper’s plan than be saddled with all the regulations of the Clinton plan, his argument went. Winters and other companies that sold health insurance or did not provide their employees with health insurance were able to outmaneuver the companies in favor of reform, and when the Business Roundtable members voted in February of 1994, the majority favored the Cooper plan.137

The defection of the powerful Business Roundtable was the first in a series of defections by the business community. NAM followed suit very soon as did the Chamber of Commerce as we shall see in the following section.

3.3.5.2 Defection by the Chamber of Commerce

The Chamber’s 200,000-member base consisted of small and medium-sized businesses, 67 percent of which provided health insurance to their employees.138 To this group, rising health care costs was the cause of great concern and demands to resolve the problem and level the playing field were growing.

Even before Clinton convened his task force, Robert Patricelli, the head of the Chamber’s Health Committee, had written a report concluding that the only way to control rising health care costs would be through a government run system financed by an employer mandate. By March 1993, the findings had become the official policy of the Chamber, and although it disagreed with the Clinton Administration about certain issues, such as the size of the employer contribution (the Chamber wanted it set at 50 percent of premiums, not 80), the Administration and the Chamber were definitely on the same page. Chamber members met frequently with the task force while the plan was being shaped in order to give their input, much to the chagrin of conservative Republicans who were unhappy to see their old ally cooperating with Democrats and believed that it was “the Chamber’s duty to categorically oppose everything that Clinton was in favor of.”139

137 Ibid., p. 65.
138 Ibid., p. 67.
139 Ibid.
Patricelli was scheduled to testify before the House Ways and Means Committee on February 3, 1994, and his testimony would include the Chamber’s professed support of the employer mandate.140 As the procedure dictates, Patricelli’s testimony was submitted in advance but before he had the chance to appear before the Committee, conservative Republicans had learned of his plans, which they swiftly and efficiently set out to derail. House Republicans contacted local Chambers and their members urging them to put pressure on the national chapter to reject the employer mandate. Until they changed their position, Republicans refused to attend Chamber functions and warned the Chamber that if they continued to support the employer mandate, Republicans would be indifferent to future lobbying efforts from the Chamber. The Chamber of Commerce too, had joined the ranks of interest groups who had fallen victim to reverse lobbying by right-wing politicians. In the face of such intense pressure, the Chamber caved in and reversed its position: it could no longer support the employer mandate, and specifically not the president’s Health Security Act. In the words of Patricelli, the president’s plan would now impose such a burden “of high employer premium contributions, rich benefits and counterproductive regulation and new federal and health alliance bureaucracy that we believe it cannot even be used as a starting point for committee markup.” 141 It was nothing less than a total repudiation of Clinton’s plan, orchestrated in part by the Republican right.

There was another reason for the Chamber’s complete turnaround. The Chamber members who did not pay for health insurance for their employees were predictably against the Chamber’s initial acceptance of the employer mandate, and they were very vocal in their dissent. Many members threatened to leave the organization and join the National Federation of Independent Business (NFIB) instead. The NFIB wasted no time trying to recruit new members from this very interesting group. This act of cross lobbying by the NFIB and the ensuing prospect of a member exodus certainly helps explain why the Chamber changed its mind, and for the next five months helped finance opposition to universal health coverage. Yet there were other

140 Theda Skocpol, Boomerang Health Care Reform and the Turn Against Government, (New York: W.W. Norton & Company), p. 158.
reasons for the change in position among the business community, as we shall see in the following section.

### 3.3.5.3 Other Developments behind Sagging Business Support

More generally, the changed position of the business community witnessed between 1992 and 1994 may be seen in the light of other, yet related developments. Because of the fierce opposition mobilized by small businesses, the Clinton administration had tried to appease this group, perhaps at the expense of big business. The cost advantages big business stood to gain with compulsory health care coverage were being watered down, they felt, and they began to question the role of government as a provider of national health coverage. As their own efforts to reduce employee health insurance costs were beginning to show some effect, this sentiment only grew stronger.

Some of the measures large corporations had initiated to reduce their health care costs included company exercise programs, anti-smoking education, and, most importantly, a shift of their work force into managed care programs (such as Health Maintenance Organizations (HMOs)), interestingly one of the three types of health care plans the Clinton legislation offered. Clearly the cost control aspects of HMOs were working as demonstrated by a significant 6.7% drop in employer-based insurance premiums between 1991 and 1994.142 Worrying less about controlling their own health care costs, business became more concerned about government controls that threatened their entrepreneurial room to maneuver, especially when they did not come with some form of payoff. By early 1994, business had become convinced that they, not the government, were better equipped to contain costs and negotiate with health care insurance providers.

Meanwhile the general economic situation was improving: the dollar declined against Western European currencies and the Japanese Yen, alleviating many companies’ competitiveness problems. Finally, the passage of NAFTA gave business cause for optimism. In short, things were looking up for big business by 1994, and their economic reasons for reform disappeared causing them to lose interest in government sponsored reform.

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Some companies went one step further taking active steps to defeat the Clinton plan. Large corporations like Marriott, IBM, General Mills, Safeway supermarket chains, Abbott Laboratories, Mobil, and Prudential Assurance enlisted the help of their employees and although their approach differed somewhat, the end-goal was the same: to get millions of employees involved in a grassroots lobbying campaign against reform. To help convince those among the employees who were confused about the reasons to go against the Clinton plan, the corporations stressed the layoffs and wage reductions that the Clinton plan would force them to make. Many corporations helped their employees express their views effectively by providing them with sample letters to mail to their local congressional representative. The pharmaceutical giant Abbott Laboratories furnished its employees with a toll-free number that automatically generated and mailed a personalized letter to their congressman. General Mills provided its 120,000 employees with preprinted postcards addressed to their local representative expressing their concerns about the Clinton bill and its perceived extra costs to the companies.\footnote{Martin Walker, “US Business Asks Workers to Attack Clinton Health Bill,” \textit{The Guardian}, August 24, 1994, p. 12.}

The changed position of the Chamber of Commerce, NAM, the Business Roundtable and big business in general was a significant blow to the Clinton Administration who had counted on the help of the business community to market their reform plans. Indeed, early demands from big business that the government do something about the rising health care costs had been instrumental in making reform a political issue in the first place. Yet the business community was anything but consistent in its support, which in the end, all but evaporated for a variety of reasons, most of which were closely related to the pursuit of their own narrow agenda. This decline in business support clearly played a significant role in the overall defeat of the Clinton plan as it removed outside pressure for bipartisan support. In the words of John Dingell, the chairman of the House Energy and Commerce Committee, the loss of support from the business community was “a defining event” that severely influenced the position of his committee and its inability to report out a bill, as we shall see later.\footnote{Scott Greer, Peter Swenson, “Foul Weather Friends: Big Business and Health Care Reform In the 1990s in Historical Perspective,” Northwestern University, July 11, 2000, p. 9.}
As we have seen, Clinton’s efforts to reform the American health care system were met by heavy resistance from interest groups who worried that their present role in the health care system would somehow be diminished or regulated by Clinton’s reform plans. Interest groups lobbied, advertised, mobilized their grassroots, and generally spared no means in their efforts to influence the debate and its outcome to fit in with their own narrow goals and interests. Clearly the plan’s overall ideological goal of providing coverage to all Americans was not an issue that weighed heavily on their minds. The Health Insurance Association of America (HIAA) waged all-out warfare on the Clinton administration, using a lethal combination of television advertisements and grassroots activity. The National Federation of Independent Business (NFIB) also spared no means to defeat the employer mandate, excelling at grassroots activities that brought great pressure on members of Congress. The American Medical Association (AMA) played a game of cat and mouse with the administration, promising then withdrawing their support. The American Association of Retired Persons (AARP) was also elusive in its support, failing to provide the crucial endorsement in time. The business community too went through a reversal in position first demanding reform, and when they got it, refusing to back it, and event set out to defeat it. The Chamber of Commerce and the Business Roundtable both went through this magical transformation process.

We have looked at the actions of only five of the groups involved. Knowing that an additional 1,094 groups actively worked to influence the final legislative outcome helps us understand why health care legislation would prove so elusive, and we have yet to add the money factor to the equation.

3.3.6 Interests Groups, Money and Congress
The picture of special interests and their influence on the 1993-1994 health care debate would not be complete without a specific look at the monetary link between them and the nation’s lawmakers. It is a link that has become increasingly important with the advent of television, as the costs of re-election campaigns have reached dizzying proportions and politicians have come to rely on individual and political action committee (PAC) contributions for financing.
According to an article in *The New York Times*, “political action committees formed by insurance companies, doctors, hospitals, drug companies and others in the health care industry contributed more [than] $26 million to members of Congress from January 1993 to last May [1994].”\(^{145}\) Members on the five committees with jurisdiction over health care received a good chunk of this amount: $8,240,694 between 1993 and early 1994.\(^{146}\) Looking at two of the key committees, the House Ways and Means Committee and the Senate Finance Committee, the top five recipients received an average of $302,710 and $257,535, respectively in PAC contributions during 1991-1994.\(^{147}\) Some members saw significant increases in PAC contributions as the debate heated up in Congress, particularly those on the Finance Committee.\(^{148}\) Senator Moynihan, head of the Finance Committee, thus saw his PAC contributions shoot up by $278,230 from $28,490 in 1991-1992 to $306,720 during 1993-1994.\(^{149}\) Clearly, contributors were eager to make sure that committee members would pay attention to their particular concerns during the legislative process.

Labor unions figured at the top of the list of congressional donors for the 1991-1994 period, giving $29,949,902 million in PAC and soft money contributions, although a large share of this money was given to influence the outcome of NAFTA negotiations.\(^{150}\) Health care providers and their associations gave $14,514,703 and were second in donor size during 1991-1994, while insurance companies came in third donating $12,749,581 million.\(^{151}\) Looking specifically at some of the individual groups discussed earlier, the AMA gave an impressive $6,263,920 in PAC and soft money contributions in the 1991-92 election cycle and $747,250 in the first eight months of


\(^{147}\) Ibid., pp. A71-75.

\(^{148}\) This was probably because Finance and House Ways and Means historically have served as gateways for health insurance legislation. If health bills fail to leave either of those committees, they are generally considered doomed, cf. Jonathan Oberlander, “The Politics Of Health Reform: Why Do Bad Things Happen To Good Plans?” *Health Affairs – Web Exclusive*, August 27, 2003, p. 404.

\(^{149}\) The Center for Public Integrity, op. cit., p. A-74.

\(^{150}\) Ibid., p. A-30. Most groups and organizations had several issues up for debate that they were trying to influence, but according to the campaign finance records legislation, groups do not have to disclose the specific legislative rationale behind a donation or sponsored trip. It is thus impossible to say exactly which portion of the figures was given with a view to influencing a specific issue, including health care reform.

\(^{151}\) Ibid.
1993.\textsuperscript{152} The HIAA and the NFIB spent relatively little giving $317,672 and $379,712, respectively choosing instead to use their money for advertising and grass-root efforts.\textsuperscript{153} Ford Motor Co. gave $514,264 during 1991-1994, while Prudential donated $756,626.\textsuperscript{154} Although health care reform was not the only issue donators sought to influence, it was a policy area that proved particularly enriching to the campaign coffers of congressional members, particularly those sitting on the important committees.

Health care industry groups also sought to “educate” members of Congress by taking them on all-expense paid trips around the country and abroad. More than 85 members of Congress were part of 181 trips, half of which went to popular vacation spots in California and Florida.\textsuperscript{155} The AMA distinguished itself as the organization that took members of Congress on the most educational trips: 55 over a two-year period.\textsuperscript{156} Other groups with health care-related interests, e.g. the Tobacco Institute, Phillip Morris, and the AFL-CIO, sponsored 355 trips for 155 members of Congress and their spouses.\textsuperscript{157} The tobacco industry was, of course, lobbying against the promised tax on tobacco products, and it was already among the top five campaign contributors having donated $6,662,076 in soft money and PAC money during 1991-1994.\textsuperscript{158} Legislators from southern, tobacco-producing states, such as the Carolinas, were under tremendous pressure from their constituents to fight any legislation that would levy additional taxes on tobacco. In a letter to Hillary Clinton, Rep. H. Martin Lancaster (D-NC) voiced the concerns of representatives from all tobacco-producing states: “… I continue to be disturbed by Ira Magaziner’s focus on tobacco as the only source of taxation to support health care. … It will break my heart to do so, but please know that I will do everything in my power to defeat a health reform package which

\textsuperscript{153} The Center for Public Integrity, op. cit., p 51.
\textsuperscript{154} Ibid., pp. A-12, A-24.
\textsuperscript{155} Ibid., p. 77.
\textsuperscript{156} Ibid., p. 77.
\textsuperscript{157} Ibid., p. 79.
\textsuperscript{158} Ibid., p. A-30.
singles out tobacco.”159 Clearly, ideology could be compromised when faced with the risk of being unseated by tobacco-employed constituents.

Another link between money and legislators existed in the form of stock holdings. In the health care debate, legislators found themselves in a position where they had to decide on issues that would have a direct impact on the earnings of companies in which they held stock. The Center for Public Integrity examined the financial disclosure statements of members of Congress for 1993 and discovered that “134 members, their spouses or dependent children held health care-related assets,” with most concentrated in the pharmaceutical industry.160 Of those 134, 40 members were on committees with jurisdiction over health care legislation.161 While such a link may give rise to concerns of conflicts on interest, it is, of course, unrealistic to expect that legislators immediately dispose of stock in a given industry that happens to be affected by a congressional debate. More problematic, however, were the sudden stock purchases legislators made in companies whose earnings might be affected by legislative decisions. Legislators like Senator Danforth (R-MO), a member of the Senate Finance Committee, purchased considerable stock in health care related companies during 1993-1994.162

As we have seen, generous campaign contributions and educational trips were some of the additional means special interest groups employed in order to gain the all-important political access and influence over final health care legislation. Although campaign finance legislation was tightened following the Watergate scandal, which revealed millions of dollars in illegal donations to Nixon’s reelection campaign, the practice of donating money to legislators through PACs remains a stable of the American political system.163 Even though the link between financial contributions and

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160 The Center for Public Integrity, op. cit., p 80.
161 Ibid.
162 Ibid., p. 81.
163 The number of PACs has increased greatly in the past 30 years, and PAC spending by interest groups has shot up by more than $500 million between 1997 and 2000, cf. Theodore J. Lowi & Benjamin Ginsberg, American Government Freedom and Power, (W.W. Norton & Company, New York, 2002), p. 325. It is doubtful that the recent Campaign Reform Act of 2002, which curtailed the use of soft money and placed restrictions on campaign advertisements, will have any significant effect cf. www.citizen.org/congress/campaign/legislation/bcra.html
the voting pattern of elected officials remains shrouded in controversy,\footnote{164} evidence – and common sense – suggest that donors who give generous contributions often get something in return for their “wager” when it becomes time to legislate.\footnote{165} To what extent the financial contributions and educational trips from special interest groups actually affected the actions of legislators involved with the 1993-1994 health care reform debate, we can only speculate. When asked, legislators maintained that they were not significantly influenced by financial contributions from special interests, noting that such contributions were given by groups from all sides of the issue and as a means to gain access instead of influence.\footnote{166} Yet as all agree, access is the first step towards political influence and certainly the well-endowed contributors had the upper hand in this respect. Moreover, the exchange of so much money between government officials and industries they sought to regulate certainly raises legitimate concerns about the integrity of the nation’s lawmakers during the health care reform debate.

To be sure, the cumulative effect of all the means of influence used by interest groups was to damage Clinton’s chances for health care reform greatly. With their singularity of purpose, excellent organizational skills and, above all, superior financial powers, interest groups were able to exert their influence on many levels simultaneously, all of which impacted on the political process in one way or another. Crucial to their agenda was the change that occurred in public opinion, as we shall see in the next section.

### 3.4 Public Opinion

As we have seen, Bill Clinton and his task force clearly thought they were acting in response to public demand when they set out to reform the health care system. Literally


\footnote{165} George W. Bush rewarded the banking sector for its generous contributions by signing bankruptcy laws that made it easier for banks to collect credit card debt from consumers. The law brought tens of millions of dollars to the banks every year. Similarly, contributions from Molten Metal Technology to the Clinton-Gore campaign may have ensured the million dollar contracts the company later won with the Department of Energy, cf. Lowi and Ginsberg, op. cit., p. 327.

hundreds of polls had been taken before and after the president’s introduction of his plan, and although some were “customized” to the specific goals of interest groups, most were carried out by independent media groups and organizations. With some variation, the polls all showed that a majority of Americans were in favor of a major overhaul of the health care system – a system that most also believed to be in a crisis.\textsuperscript{167} When Bill Clinton was elected president, a great majority of Americans wanted the Administration to do something to address the very real concerns they had about their future health coverage, both in terms of portability, affordability and general access. As expected, the public responded favorably to the president’s plan when it was revealed in September 1993, with 57 percent in favor of the plan and 31 percent opposed.\textsuperscript{168} Yet by March 1994, public support had begun to erode when support for the plan had dropped to 44 percent, and by July the number had fallen even further to 37 percent.\textsuperscript{169}

In order to understand the initial favorable response and subsequent drop in public support over a relatively short time, it is necessary to look at some of the preconceived notions Americans brought to the health care debate. These preconceptions and key beliefs help explain how opponents of reform so successfully could turn the public against the reform it clearly had said it wanted, and neutralize the demand for political action.

\textbf{3.4.1 Unwilling to Make Sacrifices}

Various surveys and opinion polls taken between 1990 and 1994 help identify some of those defining characteristics of the American public – characteristics that pointed to a very ambivalent public with unrealistic expectations of their government.

According to a May 1993 poll, eight in ten Americans were highly satisfied with the quality of their own health care, but only 51 percent were satisfied with the


\textsuperscript{169} Ibid., and The Roper Center, “Health Care Update,” vol. 5, no. 5, July/August 1994, p. 94.
quality of health care in the country as a whole. ¹⁷⁰ People also believed that access to care should be a fundamental right for all, a right the government should ensure if needed. ¹⁷¹ However, altruistic sentiments and general demands for reform could easily be tempered by messages suggesting that personal sacrifices would be required for the benefit of the broader good. Messages like “your ability to choose doctors and hospitals could be restricted” and “there will be rationing, and some expensive treatments may no longer be available” significantly increased the percentage of respondents less likely to support reform. ¹⁷² This unwillingness of Americans to make personal sacrifices was partially connected to their belief that they were not responsible for the problems associated with escalating health care costs that so negatively affected their ability to pay for health insurance. ¹⁷³ Instead, Americans blamed rising costs on the prevalence of greed among health care professionals and hospitals, malpractice suits, and general waste and inefficiency in the health care system. ¹⁷⁴ To experts, the rising costs could be explained by an aging population, the abundance of and resulting demand for high-tech medical equipment and treatment methods, and by the public’s reluctance to embrace any type of restrictions in their access to medical care. The problems with rising costs, as Americans saw it, were easily fixed by cracking down on the wasteful system, and curbing the power of insurance companies. This is what Clinton promised to do, and the public rewarded his initiative by backing his plan when it was revealed. Yet with time, and the relentless attacks from the many opponents of reform, the public began to wonder if the Clinton plan really could curb costs and cover many millions more at the same time. Where, they wondered, would the money really come from? Suggestions from groups such as the right-wing Republican Party that Clinton’s plan would be partly financed by enacting drastic reductions in the quality of and access to health care began to ring true, particularly among the many who were generally happy with their health care.

¹⁷¹ Yankelovich, op. cit., p. 12.
¹⁷² Blendon et al., op. cit., p. 280.
¹⁷⁴ Blendon, op. cit., p. 281.
Other signs of early, albeit passive, reservations among the public toward the Clinton plan had to do with the fact that the majority of people did not believe that they would personally benefit from the plan. In an October 1993 poll, a meager 28 percent thought that they would be better off under the Clinton plan, and only 12 percent thought that they would see any net gains, e.g. in the form of lower costs and increased quality of care. These figures are startling when considering that the Clinton plan was tailored to improve the health care arrangements of most Americans – not just those without insurance. This reluctance of so many Americans to believe that their situation would improve was partly a result of their ever-present cynicism towards their government.

3.4.2 Lack of Faith in Federal Government

By the time Clinton had moved into the White House, health care had moved up as second on the list of issues Americans wanted their government to address. March 1993 surveys showed that Americans were almost evenly divided in their views about who should run the health insurance system with 41 favoring the government and 39 percent preferring private insurers. At the same time, Americans’ trust in their government was at an all-time low, partially because of the economic downturn and rising deficit but also because of the lingering effects of the Vietnam War, Watergate and the Iranian hostage crises. In 1992, only 22 percent of Americans said they trusted their government to do what was right always or most of the time. By comparison, more than 70 percent had expressed that kind of faith in their government when Lyndon Johnson enacted Medicare in 1963. Americans’ general cynicism toward their federal government’s abilities was reflected in the polls where 77 percent of respondents thought that they could “never” or “only some of the time” trust their

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175 Ibid., p. 277.
177 Blendon et al., op. cit., p. 277.
178 These factors certainly aggravated Americans’ faith in their government. However, mistrust in (the federal) government is a well-known political value in a country where private enterprise is always favored over public.
180 Ibid.
government in Washington to do the right thing. 181 And 69 percent agreed that anything run by the government was usually inefficient and wasteful. 182 Sixty-five percent also thought that the federal government already controlled too much of their daily lives. 183

The relationship between Americans and their government in the health care issue was, in other words, one of ambivalence. People wanted their government to help resolve the health care problems, but they had a hard time believing it could do the job efficiently, and certainly refused to accept any government-imposed restrictions or trade-offs in the care they received, or how it was provided. Although the features of the Clinton plan appealed to a great many people when adequately described, 184 the fact that it was explicitly designed by the federal government made it impossible for many fully to believe in its contents. The mistrust of government, the myth of the self-reliant individual and the innate sense among Americans always to favor private enterprise over public were political values that the opposition managed to use with great success. Their messages of big government bureaucracy at work found a very receptive base. To overcome the wavering faith among Americans in their government’s ability to do right and the preconceived notions they held about the health care system, the Clinton Administration had to embark on a publicity tour of its life. As we shall see in the next section, efforts by the Clinton Administration to influence public opinion were, at best, insufficient.

3.4.3 Failure to Maintain Public Support

Clinton and his people had to convince the public that their plan was workable, and that it would bring benefits to the entire population, not just the poor. But explanations from the Administration were sorely lacking. There was no prolonged campaign that sought to educate the public about the new structures of the Health Security Act, particularly the contentious health alliances, employer mandates and the general financing of the plan. We have already seen how the president’s changing agenda

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182 Ibid.
183 Ibid.
partially had foiled his public relations campaign, but the situation was further aggravated by a lack of funds and a shrinking of the traditional Democratic base for grassroots mobilization.

The Democratic National Convention (DNC) did get involved in the health care reform battle but it got off to a very rocky start. During the spring and summer of 1993, the DNC had set up the educational and nonpartisan National Health Care Campaign (NHCC) to help fund grassroots activities in key states where passage of the bill would be difficult. The status as educational and nonpartisan was important because it would allow the NHCC to avoid paying taxes on funds raised and to circumvent the finance disclosure laws, which meant that donors could remain anonymous. But the NHCC immediately came under attack from the right and the media who challenged the nonpartisan nature of the project, which was quickly moved it back under the authority of the DNC.185 This meant, of course, that the DNC would see significantly less money than it had hoped for, and this affected their advertising efforts a great deal. To make matters worse, one of the usually very reliable donors, the AFL-CIO, was still incensed by Bill Clinton’s support of NAFTA and kept its purse strings tightly closed for parts of 1993.186 The Democratic Party had already seen a significant drop in both financial support and grassroots mobilization efforts from private sector labor unions because of their dwindling membership base. Membership in labor unions among private sector employees fell from 37 percent in the 1960 to just 11.5 percent in 1992 and thus partially robbed the Democrats of a reliable donor and information venue.187

Yet there were other methods available to the Clinton administration that could have helped the public see the benefits of reform. Tying the Clinton plan to “real-world” success stories of government-sponsored reform could have helped bridge the gap between Americans’ desire for health care reform and the government’s role in providing it. As Robert J. Blendon of the Harvard University School of Public Health

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185 A large share of the money from the non-disclosed contributors was bound to come from the health care industry that was being reformed, hence the criticism, cf. Center for Public Integrity, *Well-Healed: Inside Lobbying for Health Care Reform* (Washington D.C.: Center for Public Integrity, 1994), p 65.
186 The AFL-CIO (correctly) believed that NAFTA would lead to a great loss of American jobs.
argues, Hawaii’s model for obtaining universal coverage through an employer mandate would have been an obvious choice as it contained many of the same features as the Clinton plan. Instead, partially for fear of being labeled “big government,” the Administration down-played the inner workings of their plan claiming that Americans did not need to know all the details, just as they did not need to know how to operate a plane in order to fly. In one respect, the Administration was right on target: Americans did not know much about the plan. In the week following Clinton’s speech, only 21 percent claimed to know a lot about the plan. One month later that number had declined to 17 percent and in November, it was even lower with only 13 percent claiming to know a lot about Clinton’s health care plan. A whopping 77 percent did not know the meaning of “managed competition.” The problem was, of course, that people were not flying, because they wanted more details about the plane and its flight path before hopping on board.

The media bore some of the blame for the gap in public knowledge of the Clinton plan – or any of the other plans being discussed in Congress. Incredibly, President Clinton’s attempt to get national airtime to explain his health care plan in more detail was rebuffed by networks who were not interested in losing additional advertising revenue. It was thus left up to reporters to explain the plan to the public, and they did so according to what has become the norm in a country where news stories fill the airwaves 24 hours a day. Competing for viewers, reporters focused on new and enticing angles to describe the stories of the day: the political games and interest group struggles, the daily arguments in the committees, new plans being proposed, etc. The American people did not need a play-by-play from reporters; they

188 In the Hawaiian model, universal coverage was achieved gradually, with full-time workers as the first to achieve guaranteed coverage in 1974. The part-time and nonworking sections of the populations were included 15 years later; cf. Robert J. Blendon et al. “What Happened to Americans’ Support For The Clinton Health Plan?” Health Affairs, vol. 14, no. 2, summer 1995, p. 16.
needed in-depth, clear and unbiased explanations of the contents of the plans being discussed and how they would be affected by them.

As we have seen, the failure of the Clinton administration to explain clearly, how the plan would achieve its key goals left Americans open to focused messages from the well-endowed opposition, and to their own dormant feelings about government bureaucracy and inefficiency. This lack of information – and to an equal extent the unwillingness or inability of the public to seek it out – prevented Americans from coming to terms with the competing and conflicting views they held on health care reform and the government’s overall role in providing it.

Predictably, public pressure for government action began to wane, and by the summer of 1994, 61 percent preferred that Congress leave health care reform legislation to the following year.\(^{193}\) By August, 68 percent told a Gallup poll that they preferred Congress to adopt a gradual approach to health care reform stretching over several years rather than pass comprehensive legislation this year.\(^{194}\) With public pressure fading, Congress was free finally to let go of the perilous health care reform issue. However, as we shall see in the next section, House and Senate Committees struggled with health care legislation for quite some time before they finally abandoned the difficult and politically divisive issue.

### 3.5 Committee Breakdown

As mentioned, the political climate at the time of health care legislation was marred by a polarization of the political parties. Democrats, finally in control of both Houses and the Presidency, were determined to legislate with or without the Republicans. Republicans, on their part, were determined to do what they could to deny Democrats any political victories, and formed an impenetrable united front against health care reform. The divisiveness between the two parties was reflected in the committees and impeded their ability to produce passable legislation.

The five committees that would handle health care reform legislation certainly were facing an uphill battle. In the House, the bill was referred to three committees:


Ways and Means, Energy and Commerce, and Education and Labor. In the Senate, the bill was handled by the Finance Committee and the Labor and Human Resources Committee.

The House Ways and Means Committee had a long record of producing passable legislation. Its chair Dan Rostenkowski (D-IL) was a highly respected and very skilled lawmaker with the ability to cajole committee members towards bipartisan resolutions. However, in an atmosphere that clearly was not conducive to intraparty cooperation, Rostenkowski was forced to look for votes exclusively from among the Democrats, some of whom were very conservative. An already difficult situation grew worse when Rostenkowski was indicted on corruption charges in May 1994 and had to resign as chairman – an event later described as the beginning of the end for health care reform.\textsuperscript{195} His replacement, Sam Gibbons (D-FL), struggled to work out a compromise and on June 23, his committee was able to report out a bill by a narrow 20-18 vote, with no Republican backing.\textsuperscript{196} The bill included the goal of universal coverage by adding a new part to the Medicare program that would absorb the uninsured. Concessions in the form of larger subsidies for small businesses, a reduced tobacco tax and increased rights for big businesses to self-insure were included in the bill.

The House Energy and Commerce Committee was chaired by John Dingell (D-MI) a long-time proponent of universal health care. Committee membership was most representative of the House, and any bill that the Committee would report was given good odds for becoming law. John Dingell worked hard to get his committee to report a bill but he faced strong opposition from fellow Democrats, including Jim Cooper who continued to advocate his own plan. In addition, heavy lobbying of committee members by the HIAA made it impossible for Dingell to get the support of members such as Jim Slattery of Kansas who, as we have seen, was worried about alienating the small businesses in his home state. Neither Cooper nor Slattery were willing to consider an employer mandate so necessary for the financing of universal coverage, and Dingell did not want to budge on his desire to report a bill with universal coverage.

On June 28, 1994, Dingell admitted defeat in a letter to the Speaker of the House stating that his committee was hopelessly deadlocked and unable to work out a compromise bill.\textsuperscript{197}

The House Education and Labor committee had an easier time reporting out a bill but this was primarily because of its ideological makeup, which was to the left of the president’s. Chaired by William D. Ford (D-MI), the committee marked up a very liberal bill resembling the Clinton plan but with even more coverage. Approved by a vote of 26-17 (with no Republican support), the bill was given little attention by House Majority Leader Richard Gephardt (D-MO) when he put together a compromise of the House Committees’ bills.\textsuperscript{198} It was nonetheless a signal to other Democrats to keep the liberal wing of the party in mind.

In the Senate, Ted Kennedy (D-MA) chaired the Labor and Human Resources Committee, which, like the Finance Committee, had a long history of bipartisan cooperation. Kennedy, a revered and skilled lawmaker, had fought for national health insurance for most of his life and was very devoted to the issue. Kennedy’s committee was loaded with liberals but in an effort to produce passable health care legislation Kennedy fashioned a compromise that was supposed to appeal to Republicans: health purchasing alliances were made voluntary and small businesses were given the right to opt out of the employer mandate and pay a 2 percent payroll tax instead. Yet nothing could satisfy Republican legislators determined to foil any signs of Democratic success so close to the upcoming elections. When the committee voted to approve their bill on June 9, 1994, only one Republican, Senator Jeffords (R-VT), joined the Democrats in approving it.\textsuperscript{199}

The final committee to look at health care reform was the important Finance Committee chaired by Patrick Moynihan (D-NY). Moynihan himself had been very ambivalent in his support of the Clinton plan. On one occasion, he had publicly called the financial figures in the Clinton plan “fantasy numbers” and stated that the country did not have a health care crisis but it did have a welfare crisis.\textsuperscript{200} Nonetheless, he was

\textsuperscript{197} Ibid., p. 213.
\textsuperscript{198} Ibid.
\textsuperscript{200} PBS NewsHour Online, “A Detailed Timeline of the Healthcare Debate portrayed in \textit{The System},” reprinted from Haynes Johnson and David S. Broder, \textit{The System: The American Way of Politics at the
determined to report out a bill – with or without universal coverage.201 After long and
difficult negotiations, and largely as a result of the work of the “mainstream” group, a
coalition of six Democrats and six Republicans, the committee reported out a bill. It
was the only bill that had been fashioned with the cooperation and support of
Republican committee members, although not Bob Dole who was as elusive as ever.202
In the final bill, universal coverage had been watered down; the employer mandate
would only be enacted if 95 percent coverage had not been achieved by the year
2002.203

By the time they were done, all of the committees had rejected key provisions
in the Clinton plan, including the mandatory health alliances, which had been made
voluntary, and the community rating system. The House Ways and Means, the House
Education and Labor as well as the Senate Finance Committees managed to report out
bills that included the employer mandate as the primary means to finance health care
insurance.

It was now up to the Senate and House Majority Leaders to consolidate the
committee bills into what they deemed passable in their respective chambers. House
Majority Leader Gephardt based his bill on the work of the Ways and Means bill, as it
was most likely to obtain the needed majority votes. Revealed on July 29, Gephardt’s
bill included Clinton’s employer mandate but with some concessions for small
businesses as well as a Medicare Part C program to cover the unemployed.204 The
House was scheduled to start deliberation of the bill in the middle of August but
Democratic leaders, doubtful that they would be able to muster the majority votes,
wanted to defer a floor vote until after they had seen what the Senate would pass. In

Breaking Point, (Back Bay Books, April 1997) http://www.pbs.org/newshour/forum/may96/
background/health_debate_page1.html.
201 The desire to report out a bill may partly have been driven by pride and a sense of duty. After all, the
Finance Committee was, along with House Ways and Means, the leading committee on health care
issues.
202 Dole was busy carving out his platform for the 1996 presidential election. Clearly separating his
views from those of Clinton was one important tactic.
262.
204 Julie Rovner, “Congress and Health Care Reform,” in Intensive Care: How Congress Shapes Health
Policy, eds. Thomas E. Mann and Norman Orenstein (Washington DC: Brookings Institute, 1995), p
218.
the official reason for the delay, they were waiting for the CBO to score the Gephardt bill.\textsuperscript{205}

In the Senate, Majority Leader Mitchell (D-ME) took the Finance bill as his starting point and ended up with a version that settled for 95 percent coverage by 2002 and an employer mandate of 50 percent that only kicked in if the 95 percent mark had not been reached by other measures.\textsuperscript{206} It was obviously not “universal coverage” as the president had said he wanted but it was as close to the real thing as they could go without losing the support of the Democrats on either flank. Bill Clinton declared his support for the Mitchell plan noting that it met his objectives set out in his State of the Union address.\textsuperscript{207} It did so only by some stretch of the imagination but it was a reflection of the president’s sense of reality: he knew that the Mitchell plan was the next best thing at a time when the political atmosphere inside the Beltway was marked by partisanship and Republican obstructionism. With hardly any outside pressure demanding that elected officials continue to pursue the goal of universal coverage, there really was little else he could do.

The Senate began consideration of the Mitchell bill on August 9, 1994 but deliberations and amendments continued for far longer than anticipated as a result of Republican tactics to drag out the process – they were not going to be rushed on an issue of such importance, Dole stated.\textsuperscript{208} It was really a warning to Democrats that Republicans were going to use the Senate filibuster procedure to block a vote. Even after a much needed summer recess, legislators were no closer to reaching an agreement when they reconvened in September, and Democratic leaders became increasingly aware that they did not have the 60 votes needed to break a filibuster. Congressional rules allowing a minority of Senators to block legislation thus played an important role in the bill’s final demise.

On September 20, the situation took a turn for the worse when House Minority Whip Newt Gingrich (R-GA) and fellow Republican leaders paid a visit to the

\textsuperscript{205} As mentioned, CBO rules required all bills to be costed out to ensure that projected expenses were matched up against revenue. The process – although fiscally responsible – dragged out the process and in some ways hampered legislators’ room to maneuver.
\textsuperscript{206} Rovner, op. cit., p. 218.
\textsuperscript{208} Rovner, op. cit., p 219
president to tell him that if Democrats continued to press for any of the health care reform bills, he would not get the Republican support needed to pass the GATT trade treaty.\textsuperscript{209} Clinton considered the treaty vital for the American economy and this undisguised threat from Republicans was one of the final nails to be hammered into the health care reform coffin. On Monday September 26, 1994, Mitchell officially pulled the plug before the bill could come to a floor vote in either House.\textsuperscript{210} Mitchell, who had passed on a Supreme Court nomination to pursue health care legislation, left little doubt about who he believed was responsible for the indefinite postponement of health care reform, stating that the “insurance industry on the outside and a majority of Republicans on the inside proved to be too much to overcome.”\textsuperscript{211} Bob Dole, on the other hand, expressed his satisfaction to see “democracy in action. That’s what happened. That’s the way it is supposed to work.”\textsuperscript{212}

The indisputable result was that Clinton’s ambitious attempt to revamp the nation’s health care system had suffered stunning defeat. The opportunity for America to enact comprehensive health care legislation had come and gone, perhaps for good.

4. Conclusion

Driven in part by ideological conviction, public pressure and a fiscal need to curtail rising health care costs, Bill Clinton set out to provide all Americans with access to decent health care coverage during a brief period of optimism at the beginning of his presidential term. The country could afford to provide health care coverage to all its citizens, he believed, if it were willing to restructure its supply of health services. The Health Security Act, the result of the painstaking work of Clinton’s special health care task force, provided the blueprint for the path towards universal health care.

Reform of the health care system was from the get go a hugely controversial topic, as it concerned the issue of how involved government should be in the lives of its citizens, and because its outcome was certain to affect all members of society, including the existing providers of health care services. Although well received, the

\textsuperscript{209} Ibid., p. 223.
\textsuperscript{211} Ibid.
\textsuperscript{212} Ibid.
Health Security Act soon came under fierce attack from interest groups and the Republican right, and in the end, crucial support from the business community and the public slowly abated as legislators abandoned the difficult issue in September 1994. The election gains by the Republican Party in the November elections were partly the result of the public’s dissatisfaction with the Clinton administration and its inability to carry through on its promise.

As we have seen in this paper, there were indeed many factors that contributed to the final fall of President Clinton’s health care reform plan. The Clinton Administration carried some of the blame by committing a number of conceptual and strategic errors and by failing adequately to explain the plan to the public. Clinton himself may have misinterpreted his mandate for reform – after all, he had been elected with only 43 percent of the popular vote – and certainly, he misjudged the amount of support he would receive from members of his own party. At the same time, the prospect of bipartisan cooperation was quickly quashed as members of the Republican right realized just how much they had to gain by defeating the president and his plan before the midterm election. Sparing no means in their quest for power, they put great pressure on old allies who had declared themselves open to reform efforts. Publicly they used every opportunity to discredit the Clinton plan, painting it the quintessential example of big government run amok that was bound to lead to inferior health care for all. Their messages found a receptive audience among a public that was incapable of reconciling its desire to see national health care enacted with its long-held distrust of government and unwillingness to make any sacrifices.

At the very center of the demise of the Clinton plan were the many interest groups who to one extent or another worried that their future role in the health care system might be compromised. Although almost all of the groups publicly declared their support for reform, their actions unequivocally spoke of organizations dedicated to the pursuit of self-interests and self-preservation. Sparing no means to reach their various goals, the groups spent an astonishing amount of money on advertising, grassroots mobilization, and lobbying to ensure that final legislation reflected their specific concerns.

To a great extent, the demise of the Clinton plan was the inevitable result of politics as usual in Washington – a reflection of the many opposing forces that come
into play and make comprehensive legislative initiatives difficult to enact. Certainly, interest groups are, and have always been, an integral part of the political game and their participation in the health care reform debate was obviously expected. What made Clinton’s health care reform plan “unusual” was the fact that it had implications for almost every interest group in the land and called them to battle simultaneously. The result was, as we have seen, a massive fight and jostling for influence, which led to tremendous confusion and completely overshadowed the plan’s greater purpose. The Health Security Act had, in some ways, ended up the victim of “hyperpluralism” – too many groups seeking to influence the political process.\(^{213}\) In the absence of any political will – and the pressure from the public to ensure it – the inevitable outcome was complete and utter political gridlock, not the equilibrium envisioned by Madison. *Health Affairs*’ editor John Iglehart clearly thought his government was to blame stating “… representative government is supposed to be the arbiter between competing rival groups, not the patsy of the most powerful.”\(^{214}\)

The demise of Clinton’s reform plan illustrates with startling clarity the shortcomings of a political system that is so influenced by factions. Chief among those is the fact that the groups without an organized voice and without money do not have any leverage in the political process. Without money, there can be no financial contributions to lawmakers who constantly worry about raising enough money for their reelection campaigns. Without money, there can be no advertising, direct lobbying in Washington or organized grassroots mobilization to influence public opinion and congressional representatives. In the health care debate, those without money included the millions of uninsured, who did not have any powerful lobbying groups advocating on their behalf and as a result were largely ignored.\(^{215}\) To be sure, the forces of counterbalance that could have kept reform efforts on track moving towards consensus building were outnumbered, outmaneuvered, outsmarted and, above all, outspent by opponents of reform.

More and more, the very system that Madison warned against has become a fact of the American political landscape, and the risk remains that legislation will

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\(^{215}\) The fact that this segment traditionally does not vote clearly aggravates the situation.
increasingly reflect the will of a select, financially powerful few and not of the greater majority. As Carter put it in his farewell address, echoing Madison’s warning, “the national interest is not always the sum of all our single or special interests.”

Bill Clinton, America’s first baby-boomer president, set out to reinvent the health care system and improve the plight of many of his fellow citizens. What he got was a sobering lesson in the complicated ways of health care politics in Washington. That the Clinton plan, in any verity, failed to pass Congress is regrettably not such a mystery after all.

Afterword

Despite promises from politicians to keep health care reform on the top of the political agenda for 1994-1995, the issue took a backseat when Congress reconvened to a new and revised look following the midterm elections. Clinton’s failure to reform the system left American political leaders gun-shy about comprehensive health care legislation. For a while, they were able to duck the issue as the problems associated with the high costs of health care coverage temporarily abated in the mid to late nineties when more and more Americans were herded into Health Maintenance Organizations by their employers looking to save money.

Subsequent measures by Congress to address the persistent problems with a flawed health care system have been few and incremental in nature. One such measure was the 1996 Health Insurance Portability and Accountability Act (HIPAA) sponsored by Ted Kennedy (D-MA) and Nancy Kassebaum (R-KS). Although the act was widely cited as a proof of bipartisan cooperation and commitment to resolve the nation’s health care problem, it did not break any major ground. The act merely guarantees that people who lose their jobs are assured the right to extend their health care coverage for six months provided, of course, that they paid for it themselves. The question of how...

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217 These managed care plans were just one of the types of insurance plans Clinton’s plan offered – one that was unpopular because of its perceived limited choice of physicians. Ironically, by rejecting Clinton’s plan, Americans ended up with fewer choices and the managed care type of plans that they did not want.

people without jobs would be able to pay for health insurance obviously did not weigh heavily on legislators’ minds.

A more admirable program, the State Children’s Health Insurance Program (SCHIP) was created in 1997 through the Balanced Budget Act. SCHIP provides health care coverage for children of parents who are too well off to qualify for Medicare but too poor to afford private health insurance. However, despite its good intentions, this program too has experienced its share of problems as cash-strapped state governments simply run out of money to fund it.219

In December 2003, President Bush signed the Medicare Prescription Drug, Improvement and Modernization Act, which is intended to offer some relief to the nation’s senior citizens. Starting in 2006 the Act will provide Medicare recipients with government reimbursements of prescription drug costs, covering up to 75 percent of all drug costs.220

As it has become custom in an election year, health care reform has yet again returned to the center of the political stage. President Bush and Democratic challenger John Kerry have each offered their suggestion on how to deal with the continued health care crisis. Perhaps as expected, neither candidate advocates a comprehensive overhaul of the health system, although Kerry’s proposal aims at providing coverage to significant share of the nation’s uninsured. Bush, true to Republican wisdom, proposes to shift more responsibility on to consumers and touts his “consumer-driven” health care system with individual Health Savings Accounts (HSAs) as the way forward. Through the HSAs, Americans and their employers can contribute tax-free dollars to pay for health care related expenses.221 In addition, Bush wants to extend tax credits to low and moderate income families to help them pay for private insurance. Projections

221 The idea is that when consumers have to spend their own, albeit tax-free, money on health care services, they will be more conscious of the cost of medical care. This awareness will encourage them to shop around for the best prices and avoid “unnecessary” care, cf. www.georgebush.com/HealthCare/Read.aspx?ID=2185. It is, of course, ludicrous to think that people in need of care, i.e. the sick, are in a position to bargain for the best price.
by the Office of Management and Budget (OMB) estimate that Bush’s tax incentives will provide coverage for 4 million uninsured people.222

Senator John Kerry proposes a solution that first and foremost seeks to cover all the uninsured children by expanding the scope of the SCHIP program, and instituting the federal government as the primary payer of the program’s costs. In addition, Kerry wants to make the Federal Employees Health Care Benefits Program available to all Americans so that they can enjoy the same health insurance benefits as members of Congress. Like Bush, Kerry also proposes tax credits as a way to make it easier for small business, the unemployed and moderate-income families to afford health insurance.223 Kerry’s plan hopes to provide coverage to an additional 27 million Americans.224

Incremental patchwork attempts and campaign rhetoric notwithstanding, the country continues to wrestle with the fundamental problems of how to provide health care coverage to all its citizens and curtail escalating health care costs. As saw in section 1, more than 43 million Americans currently go without health insurance, and health care costs now account for 15 percent of the nation’s economy, which amounts to a total of $1.55 trillion, or an average of $5,440 per person.225 Last year, the cost of health care coverage rose by 13.9 percent, and the annual cost of a typical family plan is now more than $9,000 per year.226 The National Coalition of Health Care projects that the annual price of a family plan will be $14,525 by 2006.227 It is – yet again – becoming increasingly impossible for average Americans, and their employers, to

223 For more information about Bush and Kerry’s plans, please visit their official web sites www.georgebush.com/HealthCare/Read.aspx?ID=2185 and www.johnkerry.com/issues/healthcare/
224 Collins, op. cit., p. 9.
226 Robin Toner, “Biggest Divide? Maybe It’s Health Care,” The New York Times, May 14, 2004, p. A1, and Daniel Akst, “Why Do Employers Pay for Health Insurance, Anyhow?” The New York Times, November 2, 2003, Section 3, p. 4. As Uwe Reinhardt explains, the development is unsustainable. At $9,000 per year and an annual wage of $40,000, health care costs now account for 22.5 percent of wages. If over the next ten years wages will rise by an inflation rate of 4.5 percent while health care premiums go up by the projected 15 percent, health insurance premiums will consume more than half of all wages (54 percent), cf. Uwe E. Reinhardt, “Is There Hope For The Uninsured,” Health Affairs – Web Exclusive, August 27, 2003.
227 The National Coalition on Health Care is the nation’s largest alliance of businesses aiming to improve the country’s health care system, cf., “Crisis and Cost of Inaction,” Briefing, National Press Club, May 19, 2003.
afford decent health insurance, and for the state and federal governments to fund public health programs.\textsuperscript{228}

Piecemeal political action is clearly not the answer – political consensus must be reached on how fundamentally to reorganize the provision of the nation’s health care services. The $64,000 question is, of course, whether the U.S. will ever be able to pass comprehensive legislation that ensures national health insurance to all. Keeping both Johnson’s success and Clinton’s failure in mind, the short answer is a very weak maybe. To be sure, the odds against reform are greater for a number of reasons, chief among those is the fact that the political will to go against special interests is next to non-existent. As expressed by Princeton economist Uwe Reinhart, members of Congress have not viewed ambitious proposals, like Clinton’s, as “a sufficiently worthwhile social goal to warrant the expenditure of the political capital the goal implies, which includes overriding the objections of a health care industry known for its generosity in financing political campaigns.”\textsuperscript{229} Moral obligations from elected officials to help the uninsured – obviously not terribly significant to begin with – are thus easily tempered. As the budget surplus gained under Clinton yet again has turned into a deficit, it has become easier for elected officials to evade their moral responsibility under the guise that the nation is unable to afford national health coverage.\textsuperscript{230}

Opportunities for special interests to influence, modify and outright defeat health care legislation are almost endless. Health care bills must make a long, winding way through Congress and its many committees before they even reach the point of a floor vote in either House.\textsuperscript{231} There is in other words “an institutional bias in U.S. politics favoring the status quo.”\textsuperscript{232}

\textsuperscript{229} Reinhardt, op. cit.
\textsuperscript{230} The $3.1 trillion budget surplus Bush had when he entered the White House could well have been used towards ensuring health care for all. Instead, he squandered it by twice offering tax cuts that overwhelmingly benefited the wealthy part of the population.
\textsuperscript{231} Even after that, bills must pass a conference committee before the president can decide to sign or veto the bill.
Significant political pressure from the uninsured is unlikely as the uninsured typically belong to the income segment of the population that does not vote or join advocacy groups. Politicians thus generally do not pay much attention to the opinions of those at the bottom of the income distribution ladder. In a society like the American that values individualism and self-reliance, the uninsured are equally unlikely to find any solidarity from their voting peers, who are generally happy with their own level and quality of care.

Finally, Americans do not trust their federal government to play a significant role in the provision of health care services. Thus, prospects for America’s uninsured are grim, although not completely hopeless, as witnessed by the passage of Johnson’s Medicare and Medicaid acts. Occasionally, the stars do align and the conditions for enacting comprehensive health care legislation present themselves. Dr. Henry Simmons of the National Coalition on Health care talks of a convergence of factors, a “Perfect Storm,” that have to coincide before the groundswell for comprehensive reform becomes so strong that the nation’s lawmakers no longer can evade the issue.233 In many way similar to those that preceded Clinton’s introduction of his plan, these factors include: a sustained economic downturn pushing an even greater share of middle-income, voting Americans into unemployment and uninsurance; a persistent public pressure for political action; continuously rising health care costs leaving state governments and the business community unable to foot the bill; and finally, a large single-party majority in Congress to ensure passage of the bill.234 Although many of the ingredients for the perfect storm seem to be in place this election year, Americans should hold no hopes for comprehensive reform unless they replace the current Republican Congress and president. Even then, as the history of national health care reform teaches us, the road to decent health care coverage for all is certain to be uphill all the way.

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233 The National Coalition on Health Care, op. cit., p. 2.
234 Clinton’s own measures to improve the economy thus worked against his health care plan. And as mentioned, he did have the needed majority in Congress.
Danish Summary

Bill Clintons valgløfte om at reformere det fallerede amerikanske sundhedssystem havde i høj grad været med til bringe ham til magten i 1992. Amerikanske vælgere havde i opinionsundersøgelser klart givet udtryk for deres ønske om et mere ligevægtigt sundhedssystem hvor alle, uanset deres arbejdsmæssige eller sociale status, havde adgang til basal lægehjælp. Ønsket om reform af sundhedssystemet var ligeledes drevet af den nyvalgte regerings behov for at få lagt låg på de eksploserende sundhedsudgifter, der lå som en tikkende bombe under det amerikanske system. Kort efter sin indsættelse udpegede Bill Clinton sin hustru, Hillary Clinton, til at lede en særlig arbejdsgruppe, der skulle udarbejde lovforslaget til gennemførelse af den længe ventede reform.


begejstrede for den nye ungdommelige præsident, og chancen for at ydmyge ham og vinde stort i ved det kommende valg var uimodstæ elig. Den største rolle i planens endelige fald havde de mange interessegrupper, der frygtede at Clintons reformplaner ville lægge bånd på deres eksisterende virkemåde og fratage dem en berigende indtægtsskilde. Clintons reformplaner bragte over 1100 interessegrupper på banen, og til sammen brugte de omkring $300 millioner på græsrodsmobilisering, reklamer, lobbyisme og økonomiske tilskud til regeringsmedlemmer i deres kamp om at opnå indflydelse over den endelige lovs ordlyd.

Resultatet var, at debatten om sundhedsreform blev så fordrejet og forvirrende, at det blev umuligt at opnå politisk enighed. Clintons plan blev i vid udstrækning offer for de pengestærke interessers magt og stigende indflydelse over den politiske proces. Denne gang gik det ud over de mange amerikanere uden sygeforsikring, der ikke kunne møn stre nogen nævneværdig modvægt og derfor blot kunne vinke farvel til en historisk chance for en bedre tilværelse.
Bibliography

Books


Articles, Polls and Reports


Web Sites


Presidential Statements


Appendices

Appendix 1

![Figure 1. Type of Health Insurance and Coverage Status: 2001 and 2002](image)

(In percent)

<table>
<thead>
<tr>
<th>Category</th>
<th>2002</th>
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<tr>
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*Change is statistically different from zero at the 90 percent confidence level.

†Military health care includes: CHAMPUS (Comprehensive Health and Medical Plan for Uniformed Services)/Tricare and CHAMPVA (Civilian Health and Medical Program of the Department of Veterans Affairs), as well as care provided by the Veterans Administration and the military.

Note: The estimates by type of coverage are not mutually exclusive; people can be covered by more than one type of health insurance during the year.

## Exhibit A

Average Annual Premium Costs for Covered Workers, Single and Family Coverage, 2003

### Conventional

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* Estimate of total premium is statistically different from All Plans by coverage type.

**Note:** Family coverage is defined as health coverage for a family of four.

Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits: 2003
Appendix 3

Increases in Employer Health Insurance Premiums Compared to Increases in Overall Inflation and Workers’ Earnings, 1988-2003

Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits: 2003
Appendix 4


Appendix 5