"Weaving the Safety Net, Strand by Strand: State Healthcare Regimes"

Chapter 2: Polarized Parties, New Labor

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Introduction

Although scholars disagree about the normative values of the private welfare state, a rough consensus has emerged about its empirical effects. The presence of the private welfare state fragments politics, rendering comprehensive reform of various social programs such as retirement programs, health insurance, and tax reform extremely difficult. American political institutions such as the separation of powers and federalism exacerbate this fragmentation. Although most of the literature on the private welfare state focuses on national politics,[1] its distinctive politics cast a new light on the politics of the American states as well, particularly on the debate about the capacity and ability of states to generate social policy.[2]

Regardless of where one stands in this argument, it is crucial to define exactly what we mean by state capacity. Is it institutional strength, such as the

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[1] Christopher Howard, *The Hidden Welfare State: Tax Expenditures and Social Policies in the United States* (Princeton: Princeton University Press, 1997); Jacob S. Hacker, *The Divided Welfare State: The Battle Over Public and Private Social Benefits in the United States* (New York: Cambridge University Press, 2002); Margaret Weir, "Wages and Jobs: What is the Public Role?" in Margaret Weir, ed., *The Social Divide: Political Parties and the Future of Activist Government* (Washington, D.C.: Brookings, 1998): 268-311. For exceptions *see* David Brian Robertson, *Capital, Labor, and State: The Battle for American Labor Markets From the Civil War to the New Deal*; Theda Skocpol, *Protecting Soldiers and Mothers: The Political Origins of Social Policy in the United States* (Cambridge, MA: Belknap Press of Harvard University, 1996).

[2] For a good summary of the debate, *see* Michael S. Sparer, "Myths and Misunderstandings: Health Policy, the Devolution Revolution, and the Push for Privatization," *American Behavioral Scientist* 43 (September 1999): 138-154; Deborah A. Stone, "Why States Can't Solve the Health Care Crisis," *The American*

professionalization of legislatures?[3] Is it the strength of parties at the state level measured by financing or organization?[4] Is it the ability of state policy makers to resist rule by state interests because of independent financial and ideational resources, as measured by policy outputs?[5]

In this chapter I argue for a definition of state capacity that takes account of the political development of our hybrid public/private welfare state. The politics of the private welfare state pose a unique challenge to state policymakers. State success in policy making depends not only on traditional measures of capacity, such as agency budgets or professionalized legislatures, but also on the ability of policy makers to understand both private and public systems of social provision, in this case, both public and employer-based and other private insurance programs.[6] Negotiating this fragmented policy environment marked by powerful interests (insurance companies, unions, employers, health care providers, and state and federal agencies and government) and violently competing ideas about the proper role of government, is an enormous task regardless of the number of staff a legislator has, or the length of his term.

Prospect (Spring 1992): 51-60; John E. McDonough, "States First: The Other Path to National Health Care Reform," *The American Prospect* (Spring 1992): 61-66.

[3] Keith E. Hamm and Gary F. Moncrief, "Legislative Politics in the States," in Virginia Gray and Russell L. Hanson, eds., *Politics in the American States: A Comparative Analysis* (Washington, D.C.: Congressional Quarterly Press, 2004): 157-193.

[4] Malcolm E Jewell and Sarah M. Morehouse, *Political Parties and Elections in American States*, 4th ed (Washington, D.C.: Congressional Quarterly Press, 2000).

[5] For the debate, *see* George J. Stigler, "The Economic Theory of Regulation," *Bell Journal of Economics and Management Science* 2 (1971): 3-21; William T. Gormley, "Regulatory Issue Networks in a Federal system," *Polity* 18 (1986): 595-620; William D. Berry, Richard C. Fording, and Russell L. Hanson, "Reassessing the 'Race to the Bottom' in State Welfare Policy: Resolving the Conflict Between Individual-Level and Aggregate Research," *Journal of Politics* 65 (2003): 327-349; Robert S. Erikson, Gerald C. Wright, and John P. McIver, *Statehouse Democracy: Public Opinion and Policy in the American States* (Cambridge: Cambridge University Press, 1993);

[6] The fact is that "private" health insurance is something of a misnomer, as states are heavily involved in regulation of employer-based benefit plans. Nevertheless, while governments set the parameters of private action, decisions about eligibility, and extent of benefits are in private sector hands (employers, unions and some other associations, or individuals).

I argue that political parties and labor have been particularly suited to the task of helping policymakers make sense of health insurance policy and craft reforms. Only parties have traditionally been "big tents" incorporating various interests and ideas, acting as ideational petri dishes for the cultivation of creative combinations of public and private reforms. Labor has been heavily invested at different times with advocating greater public health insurance programs and more generous employer health plans.

The reforms that were enacted during this period in the 1980s and beginning of the 1990s exemplified this negotiated health care regime. Leaders "were more concerned with piecing together a set of tangible and politically viable reforms than with engineering an intellectually coherent product."[7] Indeed, these reforms were far from perfect solutions, often taking a "patched on" quality. The percentage of those without health insurance actually rose slightly during the economic boom in the mid and late-1990s, from 13.4 percent in 1990 to 14.3 percent in 1999. The drop is almost entirely due to the drop in employer-provided health insurance; while the percentage of people insured by public programs remained steady, the percentage of people getting insurance from their employer dropped during that time period from 73.2 percent to 71 percent.[8]

Any efforts to understand the prospects for systemic and effective reform must take into account the significant changes to parties and labor in the last twenty years. Both have changed due to the same larger contextual changes in American political and economic development: the rise of candidate centered campaigns, the nationalization of politics, the formation and power of single-issue and public interest groups, and rise of

[7] Thomas R. Oliver and Pamela Paul-Shaheen, "Translating Ideas Into Actions: Entrepreneurial Leadership in State Health Care Reforms," *Journal of Health Politics, Policy and Law* 22 (1997): 721-788 , 746.
[8] U.S. Census Bureau, "Historical Health Insurance Tables," at http://www.census.gov/hhes/hlthins/historic/hihistt1.html. Accessed April 15, 2004.

the service economy. At the state level these changes have contributed to increased political competition between the parties, larger influence of the national parties on state parties, and the decline of bipartisanship at the state level. Too, we have seen the decline of traditional manufacturing and trade unions and the rise of service and governmental employees unions.

These changes, which came to fruition in the 1990s, have had a mixed effect on state-level capacities to enact policies that expand health insurance. States have vastly more information resources and expertise in health care issues. Competition between the parties has facilitated the expansion of some programs like the State Children's Health Insurance Program (SCHIP). Unions are becoming more closely aligned with a broader progressive movement to sunder the ties between employment and health insurance. However, parties are mirroring their national counterparts and have also become more polarized at the state level. Pressure from national parties and newly powerful single-issue interest groups has made bipartisan compromise about health insurance reforms less likely. Newly powerful service unions such as the Service Employees International Union (SEIU) and the Association of Federal, State, County and Municipal Workers (AFSCME) resist compromise reforms that older unions endorsed. The following sections outline the ways that the private welfare state complicates politics, the ways that state parties and labor respond, and the character of changes in these "linkage" mechanisms between public and private welfare and its effect for policy making.

Fragmentation

The U.S. is a distinctive welfare state because of our system of using the private sector extensively in social transfer programs such as health insurance and pensions. In this view, the combination of public and private social provision has been anything but harmonious. Fragmentation, inefficiency, and a bias toward private sector solutions that reinforce inequality are the result.[9] These characteristics also interact with the policy process to create the American health care regime at the state level. How does the private welfare state affect policy and politics at the state level?

The state health care policy process, characterized by the interaction of interests, institutions, and ideas, embody this fragmentation. The institutions that make and implement policy in the public and private sectors are different. On the public side are state health departments, Medicaid implementing agencies, and legislative health care committees; on the private side are state departments of insurance, and legislative insurance and commerce committees. Although the policies they shape and implement affect each other tremendously, communication between the staffs of these departments is rare, and the prevalent values and ethos of each sector is often radically different.[10] The configuration of interests reflects (and contributes to) the fragmentation as well. Concerned with private insurance are the insurance companies, investor-owned hospitals, and economists, among others. On the public side reside child and welfare activists, providers who accept Medicaid, and teaching hospitals. The results of this pervasive

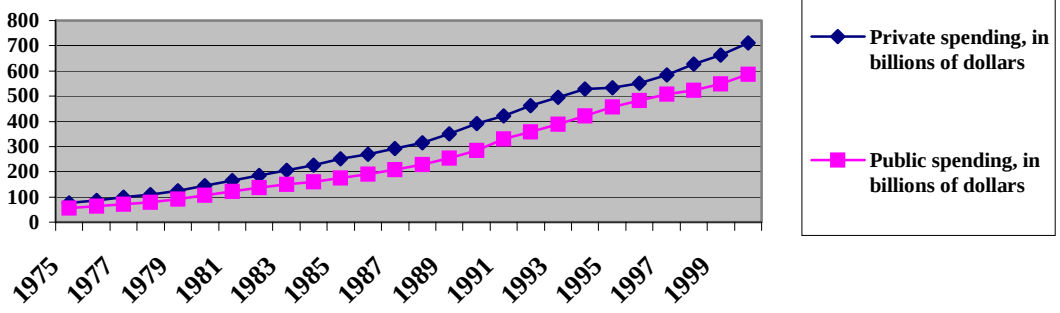
[9] Hacker, *The Divided Welfare State,* 279; Howard, *The Hidden Welfare State,* 181, 191; Marie Gottschalk, *The Shadow Welfare State: Labor, Business and the Politics of Health Care in the United States* (Ithaca, NY: Cornell University Press, 2000): 160-162.

[10] Thomas P. Weil and Norman E. Jorgensen, "The Triparate Regulation of America's Health Services," *Spectrum* (Winter 1996): 39-43; Deborah A. Stone, "The Struggle for the Soul of Health Insurance," in James A. Morone and Gary S. Belkin, eds., *The Politics of Health Care Reform: Lessons From the Past, Prospects for the Future* (Durham, NC: Duke University Press, 1994): 26-56.

fragmentation provide a cautionary side to the resurgence of state health care policy making.

In the 1980s and 1990s states became significantly more active in regulating private sector health insurance and expanding the reach of Medicaid. At the same time, states have slowly seen the ways in which public and private programs are inseparable. As the Figure 1 below shows, health care spending in the public and private sectors closely track each other, and most health care changes, such as the aging population and the development of ever more expensive medical technology, affect both sectors. The decline in private sector coverage and the expansion of Medicaid eligibility has created a group of people who waver uncertainly between coverage by their employers, coverage by Medicaid, and no coverage at all.

Figure 1. Public and private health care spending, 1975-2000



Source: Centers for Medicare and Medicaid Services, *Health Care Financing Review*, various years.

In particular, the federal government, state agencies, and interested groups all contribute to the inability of policymakers to pass reforms that affected both public and private insurance.

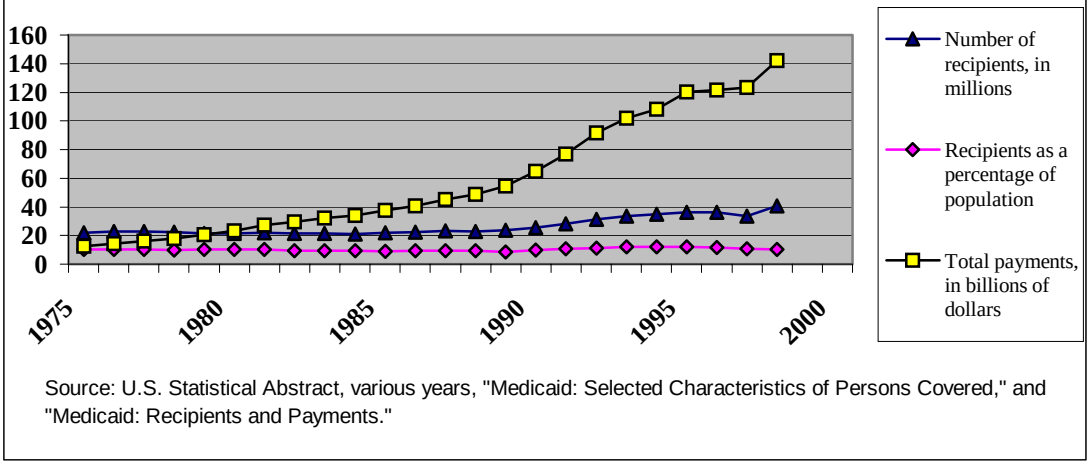
Federal Medicaid policies and insurance regulation have been both a boon and a bane to state legislatures and agencies.[11] States benefit from federal matching policies in the Medicaid program, particularly throughout the 1980s, as Congress expanded the program to new categories of people.[12] Partly as a result of these new mandates, Medicaid costs rose rapidly from $23 billion to $142 billion in the 1980s and 1990s (Figure 2). Reacting to the rise in congressional mandates and costs, states began to collectively protest. In 1989 forty-eight governors formally asked Congress to declare a moratorium on new Medicaid mandates, and in 1996 the National Governors Association adopted a bipartisan resolution encouraging Medicaid devolution. The resolution stated that Medicaid's goal should be to use limited dollars most effectively to maximize care availability for low-income people, rather than expand benefits or cover the middle class.[13] Although Congress cut Medicaid costs in the 1997 Balanced Budget Act, it also created a new block grant, the State Children's Health Insurance Program. SCHIP provided 20.3 billion dollars for states to expand their Medicaid programs or set up

[11] Medicaid created three categories of eligible persons. The first is those receiving categorical aid, such as the then-Aid to Families With Dependent Children. The second is those who quality for categorical aid programs in every aspect (assets and family composition, for example) but income. The third, and most expansive category, is all "medically needy" children under 21, regardless of categorical aid eligibility. Medically needy people are those defined as able to pay normal living expenses but not extraordinary medical expenses. Medicaid guaranteed that health care providers would be paid a "reasonable cost" for their services. States have discretion over the amount and duration of most benefits. John J. DiIulio and Richard P. Nathan, "Introduction," in Frank J. Thompson and John J. DiIulio, Jr., eds., *Medicaid and Devolution: A View From the States* (Washington, D.C.: Brookings, 1998): 4-5, 1-13.

[12] The benefit expansion began with the 1981 Omnibus Budget and Reconciliation Act, which allowed states to apply for 2176 or 1915c waivers to provide services such as homemakers, personal care assistance and case management for recipients. Most states took advantage of these waivers; some states such as New York, which had already provided these services, jumped at the chance to shift their costs to the federal government. In 1986 Congress made it easier for states to cover pregnant women and children with incomes less than one hundred percent of the federal poverty line regardless of AFDC eligibility, and in 1988 made such coverage mandatory. Congress expanded this mandate in 1989 to include pregnant women and children under six with incomes up to 133 percent of poverty, and in 1990 raised the children's age from six to nineteen. For the low-income elderly, Congress mandated in 1988 that states partially subsidize all qualified elderly (who also received Medicare), and in 1990 Congress mandated that states pay Part B Medicare premiums for elderly with incomes up to 120 percent of poverty. DiIulio and Nathan, "Introduction."

separate state programs to cover low-income uninsured children.[14] Congress, congruent with the delinking of Medicaid from welfare, envisioned SCHIP as a health insurance program distinct from welfare but covering many children in poverty.[15]

Figure 2. Medicaid growth, 1975-1998



Source: U.S. Statistical Abstract, various years, "Medicaid: Selected Characteristics of Persons Covered," and "Medicaid: Recipients and Payments."

States were also stymied by their experiments with Medicaid managed care. Encouraged by the Department of Health and Human Services (DHHS) under Clinton, states began to contract with a variety of health maintenance organizations to provide services on a capitated, rather than fee-for-service, basis.[16] State and national legislators

[13] Ibid., 5.
[14] Andy Schneider, "Overview of Medicaid Provisions in the Balanced Budget Act of 1997, P.L. 105-33." Center on Budget and Policy Priorities, September 2001. Available at: http://www.cbpp.org/908mcaid.htm. Accessed December 10, 2002.
[15] Diane Rowland and Rachel Garfield, "Health Care for the Poor: Medicaid at 35," *Health Care Financing Review* 22 (Fall 2000): 23.
[16] Capitation gives a provider a flat fee per patient, regardless of the volume of services provided. Frank J. Thompson, "The Faces of Devolution," in Frank J. Thompson and John J. DiIulio, Jr., eds., *Medicaid and Devolution: A View From the States* (Washington, D.C.: Brookings, 1998): 14-55.

hoped that introducing managed care into the Medicaid program would cut program costs. They also hoped that private market characteristics of managed care—cost-sharing, incentives for more preventive care, and competition over price for services—would be introduced into a public program. But DHHS routinely rejected state waiver requests to introduce private insurance mechanisms such as cost-sharing into the program.[17] Congress contributed to states' frustration by restricting Medicaid managed care organizations as well. Congress strictly regulated the level of services the managed care organizations must provide. States that wanted to deviate from these regulations had to apply for waivers from DHHS.[18] In spite of federal restrictions, states expanded their Medicaid managed care programs throughout the 1990s. While only 9.5 percent of the Medicaid population was enrolled in a managed care program in 1992, by 1995 29.4 percent of recipients were enrolled, and by 1998 that figure had increased to 53.5 percent.[19]

After the period of rapidly increasing enrollment throughout the 1980s and early 1990s, however, some states have actually reduced the number of enrollees, in part because managed care companies are wary of doing business in the Medicaid market because of federal regulations.[20] The transition to Medicaid managed care has not lived up to the expectation that, "as major health service purchasers, Medicaid agencies will approach the task of converting from payers to aggressive, value-based purchasers by

[17] Robert Hurley and Stephen Zuckerman, "Medicaid Managed Care: State Flexibility in Action." The Urban Institute, March 2002. Available at: http://www.urban.org/UploadedPDF/310449.pdf. Accessed July 8, 2003.
[18] Ibid.
[19] U.S. Health Care Financing Administration, "National Summary of Medicaid Managed Care Programs and enrollment, June 30, 1998." Available at: http://32.97.224.53:80/medicaid/trends98.htm. Accessed July 28, 2003.

emulating many of the activities of private employers who have embraced capitated managed care."[21]

The Employee Retirement Income Security Act (ERISA) is another aspect of federal policy that hampers state health reform. The 1974 federal law, which vests power to regulate certain employee health benefit plans with the federal government rather than the states, stymies states' crafting of comprehensive reforms that build on and expand employer-provided health insurance.[22] In the early and mid 1990s several states, most notably Oregon, Washington, and Massachusetts, tried to pass laws that would achieve close to universal coverage of all citizens. The most popular form of financing was some kind of employer mandate, usually a variation on what was known as "pay or play." Businesses must either cover their own employees (play) or contribute a share of their employees' wages to a general fund run by the states to cover the uninsured (pay).

Often the plans they developed ran afoul of the federal law ERISA. In Washington's case, the Supreme Court ruled that pay or play could not apply to businesses that self-insured, because Washington had attempted to regulate a company benefits plan, which ERISA forbids. In this case, the decision did not ban the implementation of an employer mandate, but its ruling that the law did not apply to self-insured plans—about forty percent of all businesses nationally—distorted the pay or play concept so much as to render it unworkable for Washington and presumably other

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[20] John Holahan and Shinobu Suzuki, "Medicaid Managed Care Payment Methods and Capitation Rates in 2001: Results of a New National Survey," Urban Institute, at http://www.urban.org/UploadedPDF/410660_MMCPaymentMethods.pdf. Accessed March 21, 2004: 27.
[21] Robert E. Hurley and Susan Wallin, *Adopting and Adapting Managed Care for Medicaid Beneficiaries: An Imperfect Translation* (Washington, D.C.: Urban Institute, 1998): 4.
[22] General Accounting Office, "Access to Health Care: States Respond to Growing Crisis," June 1992 (GAO/HRD-92-70).

states.[23] The inapplicability of many laws regulating private insurance to self-insured plans means that many efforts to expand health insurance through a combination of the private and public sectors, such as in Massachusetts and Washington, are doomed from the start. Only Hawaii, with its ERISA exemption, has been able to combine an employer mandate and Medicaid program in a relatively seamless web of health insurance coverage. Federal courts have recently shown signs of a willingness to reexamine the application of ERISA to state insurance and health plan laws.[24] If ERISA is weakened, states may revive these efforts.

At the state level, agencies and legislatures reinforce the separation of public and private insurance. State Medicaid and SCHIP plans are shaped and implemented through agencies usually housed in state health and welfare departments. Laws and regulations governing state private health plans are crafted in state departments of insurance. The staffs of these departments often share different backgrounds, expertise and orientations toward health insurance. Despite the introduction of managed care into Medicaid, there remains little communication between Medicaid and insurance department staff. Medicaid Health Maintenance Organizations (HMOs) are regulated through health and welfare departments; employer-based HMOs are regulated through insurance departments.

Medicaid officials are institutionally and programmatically inclined toward concerns about equity—that all those eligible for a program are enrolled and can receive

[23] Mary Ann Chirba-Martin and Troyen A. Brennan, "The Critical Role of ERISA in State Health Reform," *Health Affairs* 13 (Spring 1994): 142-156; Wendy Parmet, "Regulation and Federalism: Legal Impediments to State Health Care Reform," *American Journal of Law and Medicine* 19 (1993): 132-140.
[24] Alice A. Noble and Troyen A. Brennan, "The Stages of Managed Care Regulation: Developing Better Rules," *Journal of Health Politics, Policy, and Law* 24 (December 1999): 1275-1305, 1290-1300; Patricia A. Butler, "Kentucky's 'Any Willing Provider' Law and ERISA: Implications of the Supreme Court's

benefits, and those not eligible are purged from the program. There are no negotiations in Medicaid managed care about covered services, because unlike in private sector HMOs, benefits are set down in law. Instead, the problems many states encounter with Medicaid HMOs were concerns about inequitable treatment,[25] due in part to the inexperience of Medicaid officials in writing and overseeing managed care contracts.

State Medicaid agencies found themselves entering an area in which they had no experience: establishing new ways of overseeing managed care, crafting capitation contracts, and overseeing plans. Employers who offer an array of managed care plans can assume (whether rightly or wrongly) that employees will voluntarily select the best plans, thus eliminating lower-quality plans with minimal effort by the employer. However, Medicaid enrollees often lack the ability to choose the best plans, and often the state chooses only one plan per geographic area, making the state take on the role of program evaluation as well.[26] Many states have hired independent enrollment brokers or benefits counselors to educate and assist program officials and beneficiaries in choosing plans and to try to avoid future scandals about mistreatment.[27]

State Medicaid officials might have had an easier transition had they received advice and expertise about issues such as contract negotiations from state insurance officials. Staffers of insurance departments have much more experience regulating

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Decision for State Health Insurance Regulation." Portland, ME: National Academy for State Health Policy, 2003. Available at: http://www.nashp.org/Files/GNL51_ERISA.pdf. Accessed July 28, 2003.

[25] In late 1994, a series of newspaper articles uncovered evidence of poor medical care, exorbitant salaries paid to HMO owners, and illegal obstacles to medical care among many Medicaid MCOs. Some plans gave out toasters and baby diapers to welfare clients to entice them to join, only to set considerable roadblocks to accessing treatment. Medicaid officials doubted they could adequately police the plans absent additional legislative oversight. Bill Mass, "Thriving Medicaid HMOs Are Under Fire," *St. Petersburg Times* (January 15, 1995): 18.

[26] Although employers are increasingly evaluating programs, they do so on the basis of quality and cost measures that they, not the federal government, craft. Employers thus retain the final say in what constitutes a quality managed care program, whereas states lack that ability. Hurley and Wallin, 7.

[27] Ibid., 17-18.

managed care companies, and could advise Medicaid departments about potential problems, such as inadequate oversight, with managed care. However, there is little evidence from case studies and interviews that officials from the two agencies consult about managed care, or any other matter. State Medicaid agencies are therefore often forced to rely on the expertise of their peers in other states. In the earliest days of Medicaid managed care, it was common for state Medicaid officials to cut and paste whole passages of other states' managed care contracts into their own contracts, regardless of the political and economic differences between the states.[28] Legislative committees dealing with Medicaid and SCHIP are often those of health and welfare as well, reinforcing the separation of private and public insurance.

Insurance department staff, reflecting the focus of their work, speak the language of the market. Their expertise—judging the effect of premium rate changes, crafting community rating proposals, making it easier for small businesses to purchase health insurance—often does involve questions of equity. Primarily, however, employer-provided health insurance is a business, and health insurance companies are selling a product to business and individuals. Insurance officials must focus their attention on the effect of a rate change, or employer mandate, or any other policy, on the entrance and exit of insurance companies into and out of any given market.[29] State legislative committees and staff reflect this orientation. Private insurance legislation is usually crafted in insurance or commerce committees, where the question of market supply and demand, entrance and exit from the market, are paramount.

[28] Hurley and Zuckerman.
[29] Carol Gentry, ""Chiles Views Reform Plan as His Legacy," *St. Petersburg Times* (January 24, 1993): 1D.

One example of the complications caused by this specialization occurred when states considered measures to make insurance more affordable for small businesses. One popular strategy was to create health plan purchasing cooperatives for small businesses in order to make it easer and more affordable for them to buy insurance. By 1995, twenty-seven states had created these pools.[30] Legislators often debated whether the state should run the cooperatives or whether businesses should be free to run them with only the permission and blessing of government. Even conservatives, though, found it hard to argue with the promise of cost savings that could be achieved by strong government agencies with bargaining power. Legislative insurance committee members, unfamiliar with agency creation, asked insurance department officials for assistance in writing proposals to create state-run employer pools. But these staffers too were inexperienced at developing proposals that covered both the public sector and private market. In the end, most efforts to create these pools failed.[31]

The worldviews of agency staff, and to a smaller extent, of legislators, are reinforced through their interest group contacts. Insurance departments communicate primarily with insurance companies, businesses, and insurance officials in other states. Medicaid officials communicate with their counterparts in other states, with federal Medicaid officials, with advocates for Medicaid clients, and with Medicaid managed care companies. The extent of this segregation cannot be overstated. It ensures that the concerns that Medicaid officials and legislators hear will rarely, if ever, touch upon the

[30] Gail A. Jensen and Michael A. Morrisey, "Employer-Sponsored Health Insurance and Mandated Benefit Laws," *Milbank Quarterly* 77 (1999): 425-459, 431.
[31] Thomas R. Oliver and Robert M. Fiedler, "State Government and Health Insurance Market Reform," in *Health Policy Reform: A View From the States* 2nd ed, Howard M. Leichter, ed. (Armonk, NY: M.E. Sharpe, 1997): 47-100, 52-58.

issues that insurance officials and legislative experts discuss with insurance companies and business representatives.

The health care regime is thus significantly segregated on an institutional level, which reflects and reinforces segregation at the ideational and interest-based levels as well. This fragmentation presents a formidable obstacle to state policy makers who want to undertake comprehensive reform of the health care regime. Despite these various impediments to comprehensive reform, state policy makers often persist in their efforts to try to achieve sweeping health care reform that includes and integrates both public and private spheres. They have often been assisted in doing so by the role of political parties and labor. As the sections below caution, however, reliance on either parties or unions as acting as brokers between private and public welfare is increasingly misplaced.

State political parties

State political parties in the mid-1970s through the 1980s were a breed apart from their counterparts today. Parties were often loosely organized, fairly amateur organizations with ill-defined functions. In part this was because there was so little competition between the parties in each state. For example, the southern Republican parties were still relatively nascent while the southern Democratic parties were juggernauts. Given the lack of electoral competition, parties had little incentive to modernize, and had little if any contact with their national party counterparts. Often, state parties' closest ties were to state interest groups such as business.[32] As a result, in many parts of the country it was fairly hard to determine the ideological differences between the two parties.

Throughout the late 1970s through the 1980s, states parties underwent a massive transformation into independent entities. These changes were driven largely by an influx of resources and expertise from the national parties. The Republican party was the first to envision creating a vertical network of strong national, state and local parties, but the Democrats soon followed. The national parties infused the state parties with large resources during this time, and by the 1999-2000 election cycle, the national Republican and Democratic parties transferred $184 and $226 million to their state parties respectively.[33] The influx of resources had results in strengthening party organizations. Between 1983 and 1999 the average state party's budget increased eight-fold.[34] Organizationally, parties became significantly stronger. Both Republicans and Democrats have state chairmen, organizations, and central headquarters in all fifty states. State parties are significantly more likely to contribute to governors, state legislators, Congress members, hold fundraisers, and conduct public opinion surveys.

The Republican party in particular sought to become competitive in states, particularly in the south, where public opinion was increasingly in line with the national Republican party. Their efforts bore fruit. While in 1975, there were 37 states with Democratic legislative control (both chambers), in 1985 that number had decreased to 27, and by 1995 Republicans had control of 19 legislatures, while the Democrats controlled 18.[35] Partisan change was striking in the South. During the 1950s, no southern gubernatorial election resulted in a change in party; in the 1990s, 38.1 percent of

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[32] V.O. Key, *Southern Politics in State and Nation* (New York: Knopf, 1949); Hamm and Montcrief.
[33] Bibby and Holbrook, 79.
[34] John H. Aldrich, "Presidential Address: Southern Parties in State and Nation," *The Journal of Politics* 62 (August 2000): 643-670, 659.
[35] Peter L. Francia, Paul S. Herrnson, John P. Frendreis, and Alan R. Gitelson, "The Battle for the Legislature: Party Campaigning in State House and State Senate Elections," in *The State of the Parties: The*

elections resulted in a party change.[36] From 1985 to 1995, expenditures for state legislative campaigns increased 70 percent.[37]

Concurrent with these changes, the 1980s and 1990s marked a period of innovation when states tried to forge solutions to health care insurance problems. States finally had the resources to understand and acquire knowledge about the health care system, and expansions of Medicaid at the national level required states to increase their administrative and policy making abilities.[38] Legislatures had become much more professionalized and had acquired resources on their own, such as full-time personal and committee staffs.[39] And the federal social programs passed in the 1960s and 1970s required that states play important roles in policy implementation and even formation.[40]

The information policy makers received when they examined the health care issue was complex and in many ways troubling. The 1980s saw a shift toward a corporate-driven model of health insurance and business' rapid adoption of managed care as a way to lower health care costs. Despite an initial savings from managed care, however, health care inflation soon rose to double the rate of general inflation. The expansion of Medicaid at the federal level imposed new requirements on states to cover ever-

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*Changing Role of Contemporary American Politic*s, John C. Green and Rick Farmer, eds., (Lanham, MD: Rowman and Littlefield, 2003): 171-189: 173.

[36] John F. Bibby, *Politics, Parties, and Elections in America* (Belmont, CA: Wadsworth, 2003): 66-70.

[37] Francia, Herrnson, Frendreis, and Gitelson, 173.

[38] DiIulio and Nathan, 1-13.

[39]James King, "Changes in Professionalism in U.S. State Legislatures," *Legislative Studies Quarterly* 25 (2000): 327-343.

[40] Richard C. Elling, "Administering State Programs: Performance and Politics," in *Politics in the American States: A Comparative Perspective* 8th ed., Virginia Gray and Russell L. Hanson, eds. (Washington, D.C.: Congressional Quarterly Press, 2004): 261-289, 262. That process was well on its way by the late 1960s. See Martha Derthick, *The Influence of Federal Grants; Public Assistance In Massachusetts* (Cambridge, MA: Harvard University, 1970).

increasing groups of people, but the overall impact of private sector changes resulted in an aggregate increase of uninsured of one million per year from 1988 to 1998.[41]

In response, policy makers tried frame health care reforms as ways to leverage both the public insurance system and employer-based plans to achieve the highest coverage possible. They eschewed wholly public programs such as single payer and wholly private efforts such as health saving accounts or other mechanisms for individuals to purchase insurance. Instead, reforms often consisted of some combination of employer incentives or even mandates to offer insurance coverage, expansion of public programs such as Medicaid, and regulations to lower the costs of insurance.

Employer mandates, adopted by several states, were attractive options for several reasons. First, the financial burden of a mandate on state government would be considerably smaller than a wholly public program. Second, there was a prevalent view that many businesses were shirking their responsibilities to insure their workers and passing the cost of their care onto government and other employers. Third, the system appealed to state policymakers as an innovative public-private partnership containing the best features (equity and cost effectiveness) of each. Mandates were often in the form of a "pay or play" option for businesses: they could insure their workers (sometimes with financial assistance from the state) or pay a tax to the state to use for a public insurance program to cover the working uninsured who were ineligible for Medicaid. Medicaid expansion, while largely driven by incentives from the federal government, was utilized by states in innovative ways to cover older children and the working uninsured. Finally, insurance regulation was endorsed by members of both parties. Liberal Democrats

[41] Henry J. Kaiser Family Foundation, "The Uninsured and Their Access to Health Care," (January 2003), at http://www.kff.org/uninsured/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=14185.

argued that the abuses of insurance company premium pricing needed to be curbed, and conservative Republicans, while philosophically opposed to new regulation, argued that regulation's benefits would accrue to small businesses that found insurance too expensive. In the 1980s and 1990s, all fifty states adopted one or more insurance regulations aimed at making private insurance more accessible and affordable.[42]

The changes to parties at the state level, however, began to exert cross-cutting pressures against these compromise reforms. Parties now have the most potential for becoming independent, idea-generating institutions. The role of state parties has also expanded as a result of the Federal Election Campaign Act, as national parties funnel money to the states to implement national campaigns and provide assistance to candidates for federal office.[43] In the 1999-2000 election cycle, for example, the Democratic National Committee (DNC) sent $115 million to state parties and the Republican National Committee (RNC) send $126.9 million to the states (see Figure 3.).[44]

Yet state parties also have grown increasingly dependent on their national counterparts for both financial resources and ideas. National parties widely view the states as "breeding grounds" for future national candidates and transfer their resources accordingly.[45] Some of the most visible conflict between state and national parties is

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Accessed April 29, 2004.

[42] Blue Cross and Blue Shield Association, "State Small Group Insurance Reform Laws," 2001.

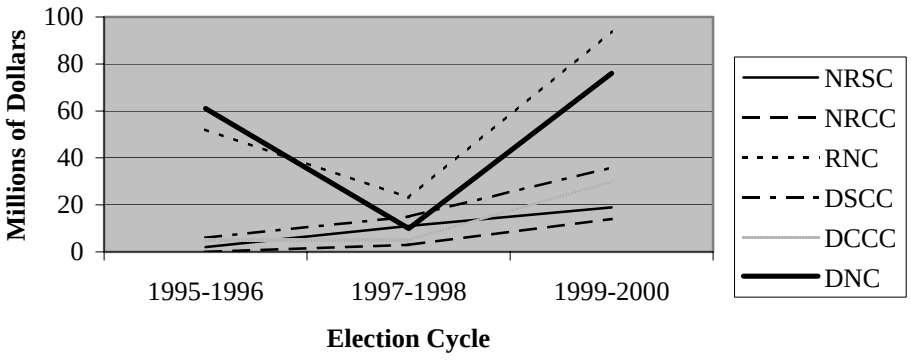
[43] This role was formed from the 1996 Supreme Court decision *Colorado Republican Financial Campaign Committee v. Federal Election commission* (Colorado I, 518 U.S. 604 [1996]), in which state parties were freed from the national restrictions of the FECA. For an overview, see Raymond J. La Raja, "State Parties and Soft Money: How Much Party Building?" in John C. Green and Rick Farmer, eds., *The State of the Parties: The Changing Role of Contemporary American Politics* (Lanham, MD: Rowman and Littlefield, 2003): 132-150.

[44] Bibby, 82.

[45] John F. Bibby, "State Party Organizations: Coping and Adapting to Candidate-Centered Politics and Nationalization," in *The Parties Respond*, 1st ed., ed L. Sandy Maisel (Boulder, CO: Westview Press): 23-49.

when the national parties support primary candidates opposed by the state parties.[46] Often this assistance stems from the national party's national considerations, such as the balance of power in Congress, rather than from a strategy to force state parties in a particular ideological direction, but sometimes it is intended to scare a candidate back to a party line.

Figure 3. National Party Committee Soft Money Transfers to State Party Committees, 1995-2000 (millions of dollars)



Contributing to the ideological pressure is the growth of issue based groups that are informally aligned with the parties but often much more ideologically extreme. One party official argued that without the assistance of allied groups such as the Christian Coalition, the National Federation of Independent Business, and the National Rifle

[46] Bibby, *Politics, Parties, and Elections in America*, 75.

Association, the Republicans might not have retained control of the House in 1996.[47] On the left, the new groups consist of an array of groups—feminist, minority, labor and environmental groups such as Emily's List, the National Education Association, and NAACP and the Sierra Club. These groups play an especially large role in Democratic campaigns. In 2000, for example, the AFL-CIO spent $46 million on issue advocacy meant to topple vulnerable House Republicans.[48]

Independent groups can informally align and strategize with the parties, but they can also exert independent, and often contradictory pressure on elected officials. For example, the Club for Growth, a conservative group headed by Republican/libertarian Steven Moore, has provided substantial financial assistance to Republican candidates at the state and national levels who endorse its fiscal conservatism. It is providing considerable assistance, for example, to Pat Toomey, a Pennsylvania Republican who is challenging Senator Arlen Specter for the nomination. Republican Rich Bond testified to the importance of these outside groups using an example of TV ad "rating points," which measure ad reach into markets: "It takes the planning and strategy of campaigns almost totally out of your control. You plan on 1,000 rating points for your close, and all of a sudden, there are 3,000 points from outside groups. Its like a space ship landing."[49]

But at the state level, much of the party pressure against compromise comes from Republicans. One scholar notes, "The galvanization of Republican opposition to government-sponsored health care appears to have diffused to the states."[50] As a

[47] Elizabeth Drew, *Whatever it Takes: The Real Struggle of Political Power in America* (New York: Viking, 1997): 15, 85, 207.
[48] Bibby, *Politics, Parties, and Elections in America*, 121.
[49] David S. Broder and Ruth Marcus, "Wielding Third Force in Politics," *Washington Post* (September 27, 1997): A1.
[50] Christopher Stream, "State Efforts to Expand Health Coverage: One Bite at a Time," *Journal of Health Politics, Policy, and Law* 29 (April 2004): 305-312, 310.

Washington state legislator, Congresswoman Linda Smith actively solicited the assistance of single-issue groups to initiate a backlash against state spending and health reforms. The backlash was in part prompted by the state's 1993 adoption of a set of health reforms designed to achieve universal coverage, including an employer mandate (which was repealed in 1995) and a commitment to achieve universal coverage.[51] Smith created the Taxpayer Protection Coalition, a loose collection of a few anti-tax state coalitions. The group wrote and heavily funded a successful campaign for Initiative 601, which imposes a spending cap based on the rate of inflation and population growth and requires voter approval for certain tax increases. After voters approved the initiative, several social advocate groups challenged the measure in court. Smith solicited the assistance of the Pacific Legal Foundation, known for its legal defense of property rights against environmental laws and whose slogan is "rescuing liberty from the grasp of government."[52] The foundation's lawyers successfully defended the law in the state supreme court in 1994. Smith touted the Initiative 601 experience in her 1994 Congressional campaign,[53] and was part of that year's Republican takeover of the House.

In the summer of 1997, the Democrat-controlled California legislature supported expanding the state Medicaid program, Medi-Cal. However, governor Pete Wilson adamantly opposed an expansion of the public program, preferring instead to subsidize private health insurance for families. Wilson's opposition to public programs stemmed in part because of his political philosophy, but a large factor was his presidential aspirations.

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[51] Len Nichols, Leighton Ku, Stephen Norton, and Susan Wallin, "Health Policy for Low-Income People in Washington," *New Federalism: Highlights From State Reports* (July 1998). Washington, D.C.: Urban Institute.

[52] Pacific Legal Foundation web site, at http://pacificlegal.org. Accessed April 15, 2004.

[53] Linda Smith for Senate, "Against All Odds: Congresswoman Linda Smith's Incredible Grassroots Advocacy Continues to Deft the Odds." Available at http://wayne.hazard.org/IMHO/Mailer.html. Accessed April 19, 2004.

Wilson "wanted to secure his bona fides among conservative Republicans both in California and elsewhere in the nation" by rejecting the proposal. Furthermore, his Republican counterparts in the legislature were pushing Wilson to take a strong stance against expanding public spending for Medicaid.[54]

In part because of this set of incentives for ambitious legislators and governors, parties are more unified ideologically and more polarized within legislatures. Aldrich and Battista argue that the increases in partisan competition are resulting in more ideological polarized legislatures, especially in the South.[55] The implications of these changes in state parties are relatively ominous. First, it is becoming much harder to forge bipartisan support for public-private reforms.[56] By the mid-1990s legislators increasingly began to eschew bipartisan cooperation on health care matters. The passage of the State Children's Health Insurance Programs in 1997 only briefly alleviated these trends. The SCHIP program gave states federal matching money as an incentive to expand their public insurance programs to cover more children beyond state Medicaid eligibility. Both the financial incentives and the political popularity of programs for children contributed to a spate of legislation in the late 1990s expanding insurance coverage.[57]

But SCHIP has not alleviated the fundamental philosophical divide within states over the question of whether expanding public insurance programs is in the public

[54] Howard Leichter, "Ethnic Politics, Policy Fragmentation, and Dependent Health Care Access in California," *Journal of Health Policy, Politics, and Law* 29 (April 2004): 177-201, 189.
[55] John H. Aldrich and James S. Coleman Battista, "Conditional Party Government in the States," *American Journal of Political Science* 46 (January 2002): 164-172.
[56] Stream, 305-312.
[57] William P. Brandon, Rosemary V. Chaudry, and Alice Sardell, "Launching SCHIP: The States and Children's Health Insurance," in *The New Politics of State Health Policy*, Robery B. Hackey and David A. Rochefort, eds. (Lawrence, KS: University of Kansas Press, 2001): 142-185.

interest.[58] Indeed, Arizona Republican Governor Jane Hull's alliance with state Democrats to support participation in the SCHIP program angered conservative leaders enough to launch a campaign to challenger her in the Republican primary. Although Hull defused the opposition, she was able to do so only by significantly watering down the proposal by narrowing the eligibility criteria, to the dismay and anger of legislative Democrats. [59]

In some states with candidate section processes hospitable to single-issue groups, party candidates are selected and elected who are considerably more ideologically extreme than the public, exacerbating the stalemate.[60] In Minnesota, a bipartisan program called HealthRight to increase access to health insurance was vetoed by governor Arne Carlson in 1992.[61] Carlson, a conservative Republican, won the state Republican gubernatorial primary largely because of the support of the Christian Coalition, which had won control of the locally-based nominating process.[62] Created by a bipartisan committee dubbed the "Gang of 7," the HealthRight plan would create funded health insurance for all state residents with incomes up to 275 percent of the federal poverty level, and would implement several new insurance regulations in the private market. The package of reforms had been carefully crafted to cover both the public and

[58] Indeed, the many states have taken advantage of a provision in the SCHIP law that allows states to administer SCHIP in an agency separate from the Medicaid program. Despite the administrative costs involved in creating an entirely new agency, states have done so as part of an effort to make the SCHIP program as small as possible. Glenn Beamer, "State Health Care Reform Politics and the Unfortunate End of the 1990s," *Journal of Health Politics, Policy and Law* 29 (April 2004): 293-304.
[59] Howard Fischer, "GOP Effort Seeks to Oust Hull in Primary: Kids' Health Proposal Upsets Conservatives," *The Arizona Daily Star* (April 21, 1998); Chris Moser, "Capitol Games Just Get Weirder: Dems, Not GOP, Support Hull on 'KidsCare' Plan," *The Arizona Republic* (April 21, 1998).
[60] Dan Coffey, "State Party Agendas: Representation in an Era of Polarized Parties," Dissertation Prospectus, April 2004.
[61] Howard M. Leichter, "Minnesota: The Trip From Acrimony to Accommodation," in *Five States That Could Not Wait*, Daniel M. Fox and John K. Iglehart (Cambridge, MA: Blackwell Publishers, 1994): 112-113.

private policies, but Carlson considered its provisions too onerous to health care providers and an unwise expansion of government.

Reinforced by political ambition, single-issue groups, and legal resources, policy makers are newly polarized at the state level. The effect of the new state party polarization remains to be seen; in some states with one party control of all branches of government we may start to see more comprehensive sweeping reforms. In the short term, however, the evidence supports the conclusion that the polarization threatens more than facilitates health care reform

Labor

Labor's effect on health insurance and health policy is a hotly debated subject. Labor was an important institution of compromise in the past and a primary impetus for the growth of the private welfare state, and its political strategies have hurt comprehensive health reform at the national level. What is less clear is the effect that labor has at the state level. State federations and locals are not simply pawns of their national unions. Labor is more closely connected to the Democratic party, but it also communicates intensely with employers through collective bargaining. Hence labor at the state level has served a kind of broker function, bringing both political parties and employers to the table to hammer out largely incremental, moderate reforms.

The changes that have affected state political parties, however, have also affected labor in the states as well. In the last twenty years, as union membership plunged, labor has embarked on an effort to build organizationally and attract new members such as

[62] Daniel Elazar, Virginia Gray, and Wyman Spano, *Minnesota Politics and Government* (Lincoln, NE: University of Nebraska Press, 1999).

service workers and public employees. Labor has also capitalized on the expanded role for interests in campaign financing through creating PACs and engaging in issue advocacy. These new efforts and groups have led to an infusion of new, more progressive ideas at both the national and state levels. However, the newly powerful service and government employee unions often reject the broker role embraced by older trade and craft unions. In programmatical philosophy and political strategy these unions often resemble other single-issue groups rather than their counterparts like the umbrella federation AFL-CIO. While labor is emerging in the states as a vociferous advocate of public programs, in many states it no longer seeks to engage bipartisan groups or create political alliances with employers. The ascent of the service and government employees' unions and, more importantly, the ideas they espouse, signals further atrophy in the informal links between parties and among interests that facilitated previous reform.

Obstructionist and Broker

The role of labor as both a broker between employers and employees, liberals and conservatives, is well documented. Labor's preference for preserving the employer-based system of health care benefits impeded the enactment of health care reform at the national level. The preference of labor for private benefits stemmed from a shift in labor's stance in the 1940s from advocating state insurance plans to collective bargaining over benefits. Apparently labor leaders, especially Walter Reuther of the United Auto Workers, incorrectly strategized that the high cost of providing employee health insurance would prompt business to advocate for a larger federal role in health insurance provision. In the wake of the devastating Taft-Hartley Act, labor also believed that

business-provided benefits were a way to "shore up member loyalty and protect union security."[63]

Labor in 1978 endorsed an employer mandate as part of an effort by the Democrats to attain support on the right for health care reform.[64] Labor bargained on developing ties to employers that had been used in the past, based on a belief that once business and labor met behind closed doors, mutually attractive compromises could be worked out. Both AFL-CIO president Lane Kirkland and SEIU president John J. Sweeney adhered to this view,[65] which originated with Arthur J. Goldberg of the Steelworkers in the post-war era.[66] Throughout the 1980s and 1990s labor, led by the United Auto Workers and Sweeney of the SEIU, became increasingly tied to business in changing the framework of the health care debate from focusing on social justice to stressing economic competitiveness. In the 1993 health care debate, the AFL-CIO assiduously avoided endorsing any particular plan, and the Steelworkers also declined to endorse a single payer system.

At the state level there is certainly evidence to support the argument that labor has been obstructionist. Indeed, the AFL-CIO has always been way of state-level initiatives, arguing that labor policy, when left to the states, would create a "race to the bottom" effect. Labor often plays the role of broker and is not hesitant to oppose reforms if it believes its own interests are threatened. The Massachusetts AFL-CIO opposed a proposed employer mandate in 1995 because it included a provision to lower the state

[63] Gottschalk, 43.
[64] Tom Wicker, "The Health Insurance Minefield," *The New York Times* (December 20, 1977): A35.
[65] Gottschalk, 88.
[66] David L. Stebenne, *Arthur J. Goldberg: New Deal Liberal* (New York : Oxford University Press, 1996).

minimum wage by ten cents,[67] and in 1994, the AFL-CIO didn't endorse Proposition 1986, a statewide single payer system initiative. Instead, the measure was supported by an alliance of labor and community groups.[68]

The 1980s saw a push by labor to work with business to lower health care costs. Corporations formed informal and formal collaborations with labor individually and through institutions such as statewide health care cost containment councils. "Unions," said the *New York Times*, "seem to be discovering a self-interest in joint approaches to the broader questions of bringing the [health care] system under control." These efforts were realized in the shift to prepaid health care plans such as HMOs that used methods like utilization review to cut costs.[69] Together, business and labor created institutions that "molded the incentives and political behavior of labor and other groups and posed formidable obstacles to achieving universal health care."[70]

The benefits of such alliances have been real but often short-lived. General Motors and the United Auto Workers achieved a reduction in its health care costs by 10 percent in 1985, but by 1987 they were facing a 30 percent rise.[71] And there was tremendous resistance among some of the locals for labor's endorsement of employer-based reform, and a sense that the leadership was out of touch with the grassroots. At the state level in particular, the role of state and local unions in breaking from their national counterparts has been well documented.[72] Locals began forming alliances "New Left"

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[67] McDonough, 267.
[68] Gottschalk, 96-152.
[69] Milt Freudenheim, "Labor's Efforts to Cut Costs," *The New York Times* (July 9, 1985): D2.
[70] Gottschalk, 39.
[71] Joan O'C. Hamilton, "Health Care Costs Take a Turn for the Worse," *Business Week* 3077 (October 31, 1988): 120.
[72] Nelson Lichtenstein, "Labor in the Truman Era: Origins of the 'Private Welfare State'," *in The Truman Presidency*, Michael J. Lacey, ed. (Cambridge: Cambridge University Press, 1989): 151; Beth Stevens, "Labor Unions, Employee Benefits, and the Privatization of the American Welfare State," *Journal of*

and progressive groups.[73] These alliances were formed in part because of the frustration of many unions with the paucity of employer health care benefits. From 1986 to 1989, the percentage of strikes caused primarily by a decrease in health care benefits increased from 18 to 78 percent.[74]

Reinvigoration and Advocacy

Labor has been affected by economic and political changes that have forced them to rethink their political orientations and strategies. There has been a precipitous decline in trade-based unions in the last 20 years.[75] The service and public employee unions that have enjoyed rapid growth are less likely to embrace bipartisan brokerage. Party reforms that contributed to increasing party polarization and the rise of the right have also prompted union officials to rethink their traditional broker role and move toward more progressive politics and adversarial strategies. At the same time, the enactment of FECA and other campaign reforms created new opportunities for unions to contribute to campaigns through the creation of PACs and issue advocacy.

Policy History 2 (1990): 233-260; Ann Shola Orloff and Theda Skocpol, "Why Not Equal Protection? Explaining the Politics of Public Social Spending in Britain, 1900-1911, and the United States, 1880s-1920," *American Sociological Review* 49 (1984): 726-751; Jill Quadagno, "Welfare Capitalism and the Social Security Act of 1935," *American Sociological Review* 49 (1984): 632-647; David Brian Robertson, "The Bias of American Federalism: The Limits of Welfare State Development in the Progressive Era," *Journal of Policy History* 1 (1989): 261-291; Theda Skocpol and John Ikenberry, "The Political Formation of the American Welfare State in Historical and Comparative Perspective," *Comparative Social Research* 6 (1983): 87-148.

[73] Jeremy Brecher and Tim Costello, "A New Labor Movement in the Shell of Old?" in *The Transformation of U.S. Unions: Voices, Visions, and Strategies From the Grassroots*, in Ray M. Tillman and Michael S. Cummings, eds., (Boulder, CO: Lynne Rienner Publishers, 1999): 9-25, 15.

[74] Tim Bonfield, "Health Care No. 1 Cause of Strikes," *Cincinnati Business Courier* 7 (May 21, 1990): 1; "Unions and Health Care," *Business and Health* 9 (August 1991): 8-10; Steve Early, "Labor's Health Problem: While Fighting Givebacks, Union's Can't Lose Sight of the Big Healthcare Picture," *The Nation* 277 (July 7, 2003): 20.

[75] Bureau of Labor Statistics, "Union Members Summary," (January 31, 2004), at http://www.bls.gov/news.release/union2.nr0.htm. Accessed April 29, 2004.

The decline of trade labor has been partially compensated for by the development of public sector and service-based unions. Government employees are covered under different labor laws than are private-sector employees, and in the 1960s and 1970s many states enacted public employee union collective bargaining. By the early 1980s, 34 percent of public sector employees were unionized, compared to less than 15 percent in the 1950s.[76] The AFSCME is now the second-largest union in the AFL-CIO, after the Teamsters. Service-based unions also experienced rapid growth.

In the aftermath of congressional reforms in the 1970s, the AFSCME and service unions like the National Education Association expanded their Washington offices and grew less willing to defer to the leadership of the AFL-CIO on policy issues. Party reforms, such as the overhaul of the Democratic primary process with the McGovern-Fraser Commission, shifted power from the older craft and manufacturing unions (who were closely tied to party elites) and toward the public employee and service unions, which had cultivated ties with public interest groups that were increasingly influential in the primary process. A sign of the winds of change came in 1980, when not only the AFL-CIO endorsed Ted Kennedy against incumbent Jimmy Carter, but several state unions also defied the national organization, arguing that Kennedy was not significantly progressive. Instead, they endorsed Mo Udall.[77] An analysis of policy resolutions passed by the ALF-CIO over the 1980s shows that the service and manufacturing unions proposed the vast majority of the resolutions for social insurance programs such as

[76] Daniel B. Cornfield, "Union Decline and the Political Demands of Organized Labor," *Work and Occupations* 16 (August 1989): 292-322, 295.
[77] Taylor E. Dark, *The Unions and the Democrats: An Enduring Alliance* (Ithaca, NY: Cornell University Press, 1999): 17, 84-85, 97, 101.

national health insurance; the older craft unions made almost none, stressing instead organizational resolutions.[78]

The increasing power of the AFSCME and SEIU helped to elect John J. Sweeney in an upset victory over Tom Donahue, the establishment candidate, for leadership of the AFL-CIO. His slate's victory, which also included Richard Trumka of the United Mine Workers and Linda Chavez-Thompson of AFSCME, was engineered by Gerald McEntee of AFSCME and Sweeney, then of the SEIU.[79] Sweeney's SEIU was known for aggressive organizing campaigns such as the Justice for Janitors movement, that resulted in membership growth from 625,000 to 1.1 million during Sweeney's tenure.[80] The old guard had seen the changes coming and tried to head off an upset. In 1994, Lane Kirkland called for a reassessment of single-payer and called for the states to initiate experiments in policy. But Sweeney gained support by campaigning on a pledge to reestablish previously sundered ties between the union and other liberal public interest groups, and a pledge to forge a "new social contract" to counter deregulation and global competition.[81]

Sweeney immediately set to making sure these philosophical and strategic changes filtered down to the state level. Sweeney transformed the AFL-CIO's Organizing Institute, which was formed in 1989 to assist unions in forming strategies, crafting policy positions, and train organizers. Long a bastion of moderate policy making, Sweeney wanted to transform it into a program to craft progressive reforms. Under Sweeney, the Institute started to train college students and community activists in

[78] Cornfield, 312.
[79] Peter Kilborn, "Bringing Down Labor's Giant Leader: Union Presidents Recount 2-Year Plan to Unseat Lane Kirkland," *New York Times* (September 4, 1995).
[80] James Worsham, "Labor Comes Alive," *Nation's Business* (February 1996): 16.

union political organizing. As an official described, "I felt that we had to get into the structure…get them [locals] to change their culture." These new trainees held strong views about the role of unions. Not only should the locals agitate for greater benefits for their members, the activists argued, but they should also try to create broad political change to benefit the working class generally.[82]

Resistance to this creeping centralization was common among the locals which, understandably, felt that they were being pushed to change their political and organizing tactics and ethos. But opposition also came from more radical activists and grassroots organizers, who worried that the Institute would stifle democracy at the grassroots level. What if, they argued, the next leader of the AFL-CIO was considerably more conservative than Sweeney? Retaining power in the locals and the state federations would provide stability despite possible shakeups at the top levels of leadership.[83] Sweeney thus found that to many grassroots activists, the national AFL-CIO was significantly behind the curve in the political and strategic transformation of labor.

These grassroots activists lived up to their label, employing a new kind of political activity called "social movement unionism."[84] In their capacity in state labor federations and locals, activists have reached out to civil rights, feminist, and academic activists and have often taken more radical stands for an entirely public system of social

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[81] Dark, 4; Stanley Aronowitz, *From the Ashes of the Old: American Labor and America's Future* (New York: Houghton Mifflin, 1998): 18; Worsham, 16.
[82] Amy Foerster, "Confronting the Dilemmas of Organizing: Obstacles and Innovations in the AFL-CIO Organizing Institute," in Lowell Turner, Harry C. Katz, and Richard W. Hurd, eds., *Rekindling the Movement: Labor's Quest for Relevance in the 21st Century* (Ithaca, NY: Cornell/ILR Press, 2001): 155-181.
[83] Ibid., 179.
[84] Paul Johnston, *Success While Others Fail: Social Movement Unionism and the Public Workplace* (Ithaca, NY: Cornell/ILR Press, 1994).

insurance.[85] These locals are dedicated to expanding the boundaries of the welfare state, and extremely critical of public-private partnerships. This resistance is both self-interested and genuinely felt, as public sector employees unions have formed coalitions to battle the "downsizing" of public goods.[86]

Fortunately for the activists, the ties between labor and the national Democratic party were already relatively strong in the 1980s and 1990s. Labor provided significant financial help to Walter Mondale's 1984 and the Democratic 1988 and 1992 congressional campaigns, and reestablished working relationships with Congressional leaders.[87] The AFL-CIO Executive Council formed a Political Works Committee, charged with crafting a long-term strategy for increasing labor's power within the Democratic party. It won 35 seats out of 325 on the Democratic National Committee, and provided $2.5 million of the DNC's 1983 budget of $7 million.[88] The degree of collaboration between the AFL-CIO and Jim Wright's House of Representatives was significant. Every Monday the most important labor lobbyists met to decide the legislative priorities for the week. They then met with lobbyists from the other, smaller unions, disseminated information about issues and strategies, and gave out lobbying assignments. Wright's staff was in daily contact with Robert McGlotten, the AFL-CIO's director of legislation, and labor became in effect an "arm of the Democratic leadership,"

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[85] John B. Sweeney, "America Needs a Raise," in Steven Fraser and Joshua B. Freeman, eds., *Audacious Democracy: Labor, Intellectuals, and the Social Reconstruction of America* (New York: Houghton Mifflin, 1997): 13-21; Philip Dine, "Newt Gingrich Gets Credit for Labor's Aggressive Political Strategy," *St. Louis Post-Dispatch* (September 6, 1996): C1.

[86] Aronowitz, 76.

[87] Evidence abounds showing the correlation between AFL-CIO campaign contributions and legislative outcomes. See Marick F. Masters, Robert S. Atkin, and John Thomas Delaney, "Unions, Political Action, and Public Policies: A Review of the Past Decade," *Policy Studies Journal* 18 (1989-1990): 479; James T. Bennett, "Private Sector Unions: The Myth of Decline," *Journal of Labor Research* 12 (1991): 1-12; and Arthur Shostak, *Robust Unionism: Innovations in the Labor Movement* (Ithaca, NY: ILR Press, 1991): 190-202.

[88] Thomas Byrne Edsall, *The New Politics of Inequality* (New York: W. W. Norton, 1984): 164.

cajoling House members on particular votes.[89] The effort at the national level has been a success. Democrats are increasingly more dependent on labor for campaign contributions. Unions increased their PAC contributions from $10,321,000 to $35,547,000 between the 1977-78 and 1987-88 election cycles.[90] After the 1994 elections, business contributions shifted heavily toward the Republicans, leaving Democrats even more dependent on labor for campaign funds.[91]

Attention also shifted to the state level. Union campaign and allied contributions to the Democrats increased. In 2000-2001, labor contributed $41 million to state parties, 93 percent of which went to Democrats. Labor is the largest source of state Democratic funds, challenged only by trial lawyers. Labor had strong "527" groups which have become the new conduits for soft money after the passage of the Bipartisan Campaign Reform Act in 2002. These groups can spend money on issue ads, "direct mail, phone banking and staff who train campaign workers."[92] From 2000 (the first year 527s were required to report their spending) to 2002, labor-related 527s spent $124.2 million.[93] The AFL-CIO also began to increase the information and communication capabilities of state and local federations. Through mass mailings, polling, and databases, state federations

[89] Dark, 144-145.
[90] John T. Delaney and Marick F. Masters, "Unions and Political Action," in George Strauss, Daniel Gallagher, and Jack Fiorito, *The State of the Unions* (Madison, WI: Industrial Relations Research Organization): 320.
[91] James Shoch, "Organized Labor Versus Globalization: NAFTA, Fast Track, and PNTR With China," in Lowell Turner, Harry C. Katz, and Richard W. Hurd, eds., *Rekindling the Movement: Labor's Quest for Relevance in the 21st Century* (Ithaca, NY: Cornell/ILR Press, 2001): 275-313, 276.
[92] Public Citizen, "Déjà vu Soft Money: Outlawed Contributions Likely to Flow to Shadowy 527 Groups That Skirt Flawed Disclosure System," April 2002. Section 527, for which these groups are named, is a tax code provision designed to protect political party income from taxation. Recently, however, the IRS and courts have broadened the scope of the law to apply to nonprofit groups as well, and after 1996, when the Sierra Club set up a 527 group, it is increasingly used to avoid federal election campaign contribution limits. John M. Broder and Raymond Bonner, "The Money Factor: A Political Voice, Without Strings," *The New York Times* (March 29, 2000): A1.
[93] Center For Public Integrity, "Expenditures by 527 Committee Type," at http://www.publicintegrity.org/527/. Accessed April 19, 2004.

had access to the national federation's data banks, including poll results, economic data, and addresses of local union members.[94] Labor also began a concerted effort to effect state elections and referendums. AFSCME head Sweeney recounts his decision to invest in the states:

> It first came to our attention, what we had, when we ran ads in New York about (Governor George) Pataki and Medicare cuts. It built his negatives up 17 percent in two-and-a-half weeks. We figured at that point we had something that could work, could resonate. The issues were hot with the American people.[95]

The formal and informal alliances between state unions and locals and state Democratic parties were also strengthened to counter the surge of Republican power in the states. Labor was increasingly willing to use this renewed clout to urge state Democrats to move to the left on health care and other issues. The betrayal that labor felt over the Democratic-enabled passage of the North American Free Trade Agreement still stung,[96] and labor became increasingly aggressive in pushing the party to the left. In Ohio, the state AFL-CIO formed the Single Payer Action Network to pressure Ohio Democrats to abandon private sector reform and concentrate on eliminating private insurance. Its leader, William Burga, a second-generation steelworker, said that the federation had "slipped" by inadequately pushing Democrats to outline their positions.[97]

Labor also became increasingly willing to buck both the Democrats and Republicans, and began to make a concerted push at the state level for single payer plans

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[94] William J. Lanouette, "Labor Beginning Earlier to Press For Democratic Victories in November," *National Journal* (May 8, 1982): 817-819; Maxwell Glen, "Labor Trying to Bring Its Rebellious Members Back to the Democratic Fold," *National Journal* (October 30, 1982): 1837-1840.
[95] Dine, "Newt Gingrich Gets Credit for Labor's Aggressive Political Strategy."
[96] Celia Viggo Wexler, "Re-Organized Labor: Unions Regroup as Shrinking Membership Weakens Their PACs," *Pittsburgh Post-Gazette* (November 12, 1995): E1.

and rejecting incremental or moderate proposals. The AFL-CIO holds regional health care conferences to discuss policy stances with state federations. However, activists criticize these meetings as being "open only to union reps and too narrowly focused on 'recent best practice given the current climate.'"[98] The meetings violate not only the policy preferences but also reject a more open, grassroots-driven process.

The state AFL-CIO's endorsement of an employer mandate in California in 1994 angered some of its affiliates who wanted sweeping reform. The state teachers' union and AFSCME joined a group called Health Care for All that lobbied for a single payer alternative, Proposition 186, and provided 25 percent of its funding.[99] The chair of the group criticized play or pay because it creates a "two-tier system" of benefits. The expansion of the progressive agenda and concerns is seen in the justification for the unions' rejection: "Since those with the public package will more likely be people of color, the two-tiered system will have a racial character."[100] Similar alliances for single payer plans are in Maine,[101] Texas,[102] Arkansas,[103] and Missouri.[104]

These groups have posed problems for state Democratic parties. In the past, unions and businesses were allies of a sort, and agreed with the more moderate, employer-based system of health insurance. These new groups challenge that

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[97] Sandra Livingston, "A Pledge of Action: New AFL-CIO Leader Plans to be Aggressive," *Cleveland Plain Dealer* (June 9, 1994): C1.
[98] Early, 20.
[99] Sally Lehrman, "Unions Finance Campaign for Single-Payer Measure: Teachers and Government Workers Fund Quarter of Cost," *The San Francisco Examiner* (October 18, 1994): A4.
[100] Steve Early, 20.
[101] Andrew Kekacs, "Health Care Report Draws Fire at Meeting: People's Alliance Challenges Reform Panel's Cost Figures," *Bangor Daily News* (July 18, 1995).
[102] Cindt Rugeley, "Single-Payer Health system Urged For State," *The Houston Chronicle* (September 9, 1992): A1.
[103] Ariel R. Frank, "Spending Plan Targets Medicaid: Health First Latest Proposal to Earmark State's Tobacco Settlement," *Arkansas Democrat-Gazette* (February 22, 2000): B1.
[104] Phil Linsalata, "Health Care Reform Advocate Sees Tide Turning," *St. Louis Post-Dispatch* (May 10, 1992): B6.

equilibrium and force the Democrats to either move significantly to the left or lose an important ally and campaign contributor. In Massachusetts, 1995 saw efforts by state Democrats to ensure that a 1988 employer mandate would be implemented in the face of opposition by new governor William Weld. Democrats' efforts to gather enough legislative votes to override the veto were both aided and complicated by the Jobs with Justice campaign, endorsed by more than fifty state unions, that eschewed a mandate and demanded a referendum for a single-payer system.[105]

The Washington Education Association and the state AFSCME also opposed an employer mandate proposed in 1993 by the Democratic governor Mike Lowry, and supported by his predecessor, Democratic governor Booth Gardner, as well as the Democratic chairs of the House and Senate committees with jurisdiction over health policy. Instead they supported a single payer plan. Senate Health Care Committee chair Phil Talmedge protested that the plan was politically unfeasible. "Show me the votes for a $15 billion tax increase and I'll support this. They aren't there. Businesses aren't going to stand for a huge payroll tax to pay for a system over which they'll lose direct control."[106] As a result of labor pressure, the Democrats were persuaded to attach a provision capping insurance premiums, which drove some Republicans from support. Meanwhile, business was opposed to the mandate. Boeing sent letters to its employees saying that the legislation would result in "termination" of their health care benefits and replaced by a plan "under the control of the state government."[107] In the House, no

[105] Early, 20.
[106] Jim Simon, "Some Unions Oppose Health Bill: Issue is Job-related Vs. Universal Care," *The Seattle Times* (February 16, 1993): B1.
[107] Tom Paulson, "Conference Work Next Up For Health Bill: Key Question on Reforms Vs. Existing Pacts," *Seattle Post-Intelligencer* (April 10, 1993): A1.

Republicans voted for the bill. Nine Democrats, meanwhile, voted against the bill because of their support for single payer.[108]

Some state AFL-CIO's have resisted the new unionism.[109] As the case study of Pennsylvania shows, many unions are trying to work for change with employers and the parties while using that access to push for a national, single-payer plan. But the long-term trends augur well for the more activist, progressive branch of the labor movement. The trend of union alignment with the public sector, rather as acting as a broker between the public and private spheres, is likely to accelerate. Although 55 percent of union membership is now in the private sector, in the next decade unions will have majority public sector membership. "The center of gravity in the union movement," one economist notes, "will shift from public to private."[110] As that shift accelerates the pressure on state Democrats will likely mount to shift farther to the left on health reform.

Conclusion

States face various unpleasant tradeoffs in crafting and enacting health care reform. Larger political and economic changes in the past two decades have made these choices particularly unpalatable and difficult. The economic downturn, combined with the drying up of funds from the tobacco settlement,[111] makes the growth of public programs harder to finance and private sector regulations harder to justify. This chapter has shown the ways in which the coexistence of public and private health insurance both contributes to and reflects differences in ideas about the proper role of government and

[108] Simon, "House OK's Health Reform: Bill Would Provide Coverage For All in State."
[109] Paul J. Kenkel, "Minnesota Unions Challenge State's Tax For Health reform," *Modern Healthcare* (June 28, 1993): 32.
[110] Worsham, 16.

differences in institutional and interest groups orientations. Larger political developments in the last twenty years have reduced the ability of state parties and labor to address this fragmentation through acting as links between public and private health insurance.

It is important to note that in the long terms the effects of decline of old labor and the rise of issue-driven, polarized parties are not unambiguously negative or positive. Many state voters now face political parties and programs that are clearly distinct from one another. In a sense, at both the state and national levels we are significantly closer to a system of "responsible party government " than we were twenty years ago.[112] Unions and their Democratic allies can and do argue convincingly that their rejection of compromise measures helps them ultimately achieve universal coverage and the end of employer-based health insurance. Indeed, the larger economic trends support an argument for the decoupling of employment status and health insurance.[113]

In the immediate term, however, eschewing incremental reform increases the chance of stalemate resulting in no reforms at all. The polarization of parties is increasingly being enshrined through state redistricting that preserves safe districts for strong partisans.[114] Furthermore, it is difficult to envision the possibility of enactment of either a thoroughly government- or private-sector-based health care regime anytime soon. The constitutional barriers to a parliamentary-type system of responsible parties—notably federalism and separation of powers—make it necessary for one party to achieve

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[111] Martha A. Derthick, *Up In Smoke: From Legislation to Litigation in Tobacco Politics* (Washington, D.C. :Congressional Quarterly Press, 2002).
[112] American Political Science Association, "Toward a More Responsible Two-Party System," *American Political Science Review* 44 (1950): Supplement.
[113] Beamer, 293-304.
[114] Coffey, "State Party Agendas: Representation in an Era of Polarized Parties."

overwhelming electoral success to enact its ideal agenda. Such a scenario is unlikely in the near future. For the time being, at least, we must make do with what we have.

State policy makers, furthermore, don't have the luxury of waiting for an open policy window to exact their ideal reforms, whatever the character. They must therefore, if only out of short term necessity, find a way to replace the "bridging" functions of state parties and labor. The next chapter shows one important way in which state actors—governors in particular—try to create propitious environments for reform. The creation of task forces, commissions, and other extra-constitutional structures to resolve ideological differences and strategies have grown increasingly popular in the last 20 years, and their limitations show the intractability of the new politics.