
THE RISE AND RESOUNDING DEMISE OF THE CLINTON PLAN

by Theda Skocpol

Prologue: *The great health reform debate of 1994 ended with a whimper, on the heels of an election that turned out the powerful Democratic majority in the House and Senate and sent some of its most influential members packing. What role did health care reform play in this turning of political fortunes? Was it the unwitting victim? Or was it, in fact, the catalyst? In this paper Theda Skocpol argues that the political reversal of the November 1994 elections might turn out to be one of the biggest turning points in twentieth-century American history and that, far from being a mere casualty, the Clinton plan and Congress's failure to adopt it (or anything else) contributed materially to the revolt of the electorate. This is ironic, Skocpol notes, because the Clinton plan was itself designed as a middle-of-the-road compromise between the market-based and the regulation-based reforms that had been discussed up to that point. The demise of the Clinton plan is notable, she writes, not just as an attempted policy change that "fizzled out, leaving the same terrain clear for a revised attempt to solve the same problems from a similar starting point." Indeed, the words and actions of the 104th Congress early in its first session suggest that this starting point has been eradicated from the American political landscape. Skocpol teaches in the departments of government and sociology at Harvard University and has published widely on the politics of U.S. social policy making, past and present. She received a doctorate in sociology from Harvard. Her most recent book, *Social Policy in the United States: Future Possibilities in Historical Perspective*, was published by Princeton University Press earlier this year. She currently is studying episodes of attempted health care reform across the twentieth century.*

The night of 22 September 1993 President Bill Clinton gave a stirring speech to Congress and the nation, calling for “America to fix a health care system that is badly broken . . . , giving every American health security—health care that’s always there, health care that can never be taken away.”¹ Millions listened to the president, and polls taken right after the speech and over the next few weeks registered strong support. “The Clinton Plan Is Alive On Arrival,” trumpeted the *The New York Times*, as moderate Republicans and leaders of groups with a stake in the health care system promised to cooperate in working out reforms.²

Historic themes resonated as the Clinton plan was unveiled. Its very title, “Health Security,” hearkened back to the Social Security Act of 1935, and the “Health Security Card” that every American would receive was obviously meant to encourage a sense of safe and honorable entitlement. How ironic, then, that just barely a year later both the Clinton plan and the Democratic party—the legatee of the New Deal whose achievements President Clinton had hoped to imitate and extend—lay in a shambles.

The collapse of the 1993-1994 campaign for health care reform lurked in the electoral upheavals of November 1994. Many voters were punishing Democrats for having been in charge during a time when Washington was “a mess” and not delivering desired results. A crucial minority of voters—particularly “swing” Independents and former Ross Perot supporters—were disappointed in President Clinton in part because they believed he had proposed a “big government solution” to health care reform.³ An election-night survey of voters sponsored by The Henry J. Kaiser Family Foundation found that a substantial majority (especially those who voted Republican) believed that the Democrats’ reform plan entailed too much “government bureaucracy” and could have reduced the quality of their own health care.⁴

These dramatic events remind us that the demise of President Clinton’s Health Security plan was not just an attempted policy change that fizzled out, leaving the same terrain clear for a revised attempt to solve the same problems from a similar starting point. The presentation and decisive defeat of the Clinton plan was a pivotal moment in U.S. politics. To understand this failure, we must ask why the Clinton administration devised a plan that not only was defeated in Congress but also helped to fuel a massive political upheaval. Only against the backdrop of the upheaval, moreover, can we make sense of possibilities for the future.

A Way Through The Middle?

President Clinton and his advisers had every reason to believe that they were acting with the tide of U.S. politics. By 1990 public support for national health care reform was at a forty-year high, and Americans over-

whelmingly felt that insurance should be available to everyone.⁵ Harris Wofford's improbable triumph in a special fall 1991 senatorial election in Pennsylvania thrust health care reform to the front burner in Washington, D.C.⁶ The financing of health care had become a middle-class issue as well as a problem for the working near-poor, whose jobs often do not carry health benefits. Middle-class concerns focused on "dramatic increases in health care costs," as more and more employers shifted expenses onto covered workers, and on "fear of losing all or part of their health care benefits in our employment-based system of health insurance," particularly during a period of extensive corporate downsizing. As opinion analysts Robert Blendon and Karen Donelan summed up, "60 [percent] of Americans worry they may not be adequately insured in the future."⁷

Bold health reform proposals proliferated both inside and outside of government. During the 102d Congress some two dozen reform bills were introduced.⁸ Reform proposals, many of them sweeping, also came from business groups, trade unions, insurance companies, and assorted health policy experts.⁹ Even the American Medical Association (AMA), historically the bitterest enemy of government-sponsored health reforms, came up with a plan for guaranteed universal health insurance.¹⁰

Committed presidential leadership was lacking while George Bush remained in office, yet the American people sought such leadership. In early 1992 the public told pollsters that health care reform (ranked right after the economy and foreign affairs as a policy topic it wanted addressed by presidential candidates.) Not surprisingly, the leading Democratic presidential candidates, including Bill Clinton of Arkansas, committed themselves to pursuing national health care reform if elected.¹² The party needed to overcome racial divisions over intractable issues such as welfare reform and affirmative action; it had to highlight issues that could unite more and less privileged Americans. Successful sponsorship of national health care reform could revive the electoral fortunes of the Democratic party.

Contrary to accusations that the Clinton administration prefers a "liberal, government-takeover" approach to health care reform, during the 1992 presidential campaign Bill Clinton gravitated toward "competition within a budget" as an approach explicitly distinct from previously defined liberal as well as conservative alternatives. Once he found this middle way, Clinton never wavered from it.

Back in 1991 and 1992 three major visible alternatives simmered in the national debate over health care reform. Market-oriented reforms not aiming for universal coverage or cost control were identified with the Republicans, and they had very little appeal for Democrats (and little backing from health policy experts, for that matter).¹³ At the other end of the partisan spectrum, various sorts of Canadian-style single-payer schemes, calling for

taxes to displace private health insurance, were favored by a few health policy experts, by various advocacy groups, by a sizable group of congressional Democrats, and by Democratic presidential hopeful Sen. J. Robert Kerrey (D-NE).¹⁴ Despite its potential to save money while retaining patients' and providers' autonomy, most U.S. politicians feared endorsing single payer, because it would necessitate switching from employer-provided insurance and private insurance premiums toward explicit general or payroll taxation. Not surprisingly, Bill Clinton rejected the single-payer approach.¹⁵ Determined to win middle-class votes for the Democratic ticket, Clinton was running a moderate campaign based on promises to reduce taxes on everyone except the very rich. In the midst of an economic slowdown, moreover, he did not want to threaten immediate, wrenching changes for employees of big insurance companies or for workers currently happy with the health insurance packages arranged through their employers. The third major alternative in 1991-1992 was "play-or-pay," so labeled because it would require all employers either to offer and partially pay for health insurance for all employees, or else pay a kind of "quit tax" to help subsidize expanded governmental coverage for all Americans either not employed or not insured by their employers. This approach had come to seem the most pragmatic road to national health insurance by the start of the 1992 presidential campaign.¹⁶

As Clinton sparred during the presidential primaries with Senator Kerrey and former Senator Paul Tsongas (D-MA), he found that he had to go beyond a general promise and outline what he would actually do about national health care reform. Clinton's first move in January 1992 dallied with play-or-pay.¹⁷ But this proved transitory. As President Bush attacked the payroll taxes and alleged antibusiness thrust of play-or-pay proposals identified with congressional Democrats, Clinton pulled back from that approach.¹⁸ An intellectual conversion also occurred during the spring and summer, as Clinton talked with such advisers as John Garamendi, the insurance commissioner of California; Walter Zelman; and Paul Starr.¹⁹ Building upon and modifying ideas from economist Alain Enthoven (who advocated managed care and regulated competition among health insurance plans), these advisers convinced Clinton that it would be possible to use regional insurance purchasing agencies along with modest new tax subsidies to push the employer-based U.S. health care system toward cost efficiency and universal coverage.²⁰

This approach, dubbed "competition within a budget," was just what Clinton was looking for. It promised, at once, to satisfy the public's desire for affordable universal coverage and to further the cost reductions so favored by powerful elites.²¹ Managed competition would please big employers and large insurance companies, allowing the would-be president to

court and work with these powerful interests. This approach could presumably also be sold both to mainstream Democrats who care primarily about universal coverage and to “New Democrats” in the Democratic Leadership Council who want market-oriented reforms that minimize taxes and public spending.

Indeed, Clinton was especially attracted to the public finance features of managed competition. If he were to be elected president after a campaign promising deficit reduction and avoidance of taxes, his health care reform plan must not include huge new taxes and must have sufficient regulatory teeth to persuade Congressional Budget Office (CBO) officials that Medicare and Medicaid costs would be reduced. Competition within a budget might enable a new Clinton administration to do all of this, while still promising universal health security. The budgetary logic of the approach was irresistible to a moderate Democrat who wanted to both cut the deficit and free resources for new public investments.

In November 1992 Bill Clinton was elected president with 43 percent of the popular vote (and a much more commanding margin in the electoral college). The new president soon turned to working on economic reforms and budget cutting. Meanwhile, he convened a Health Reform Task Force under the leadership of his longtime friend and business consultant, Ira Magaziner, and the First Lady, Hillary Rodham Clinton. Most of the work of the task force took place in a few frantic months from January to May 1993, but its report could not be finalized until after President Clinton got his first budget through the contentious Congress at the end of the summer. The task force mobilized at least part-time participation from hundreds of government officials, health policy experts, congressional staffers, and some state-level officials. Groups with a stake in the existing U.S. health care system were not officially represented, but the task force held many hearings and consulted with hundreds of representatives of stakeholder groups. The purpose of such consultations was not political bargaining; rather, task force members tried to identify ideas and concerns that they should take into account in fleshing out the president’s approach to health care reform. Because the task force tried to maintain a modicum of confidentiality during its deliberations, it did not help to lay a basis of public understanding for the emerging Clinton reform plan.²² Later on, once the plan came under attack for its alleged overreliance on governmental bureaucracy, the fact that it had been fleshed out in the first place by a huge, governmentally centered task force became an added liability—one more thing that furthered demonization by the plan’s opponents. Still, it is difficult to believe that the process followed by the task force was decisive in itself, apart from the actual contents of the Clinton Health Security plan and the political conflicts that unfolded after it was unveiled.

A Failure Of D/democratic Communication

Analysts have placed the fatal wounding of comprehensive health care reform in 1993-1994 at various points in time, ranging from the earliest months of the Clinton administration when the task force did its work, to the end of the summer of 1994 when Congress at last gave up trying to fashion a “mainstream” compromise. In my view, the critical period was the last three months of 1993, from the time of the president’s late September speech to the beginning of 1994, by which point concerted partisan campaigns against universal health care reform had locked into place and the support of elite and middle-class Americans for ambitious health reforms had begun to slide inexorably downhill. From then on, momentum toward inclusive reform was irretrievably lost.

This presumes that it was never realistic to expect major stakeholders in the present system to keep bargaining over changes in the rules of the game, unless they saw that the voting public continued to want such changes. Nor could one expect the fractious Congress to fashion a difficult compromise, unless a majority of the public remained committed to some sort of presidentially sponsored comprehensive health care reform. President Clinton and his allies had to hold the public’s interest and support as the details of their approach were spelled out, not because the president’s bill had to be enacted unchanged, but simply to ensure that the parties involved would remain willing to bargain. Favorable public opinion was essential to render some Republicans willing to join the insufficient Democratic majority for passage of legislation in the filibuster-prone Senate, and also to give Democratic House and Senate leaders the leverage they needed to ride herd on competing committees and self-promoting colleagues.

By 1994 the faith of Americans in the federal government to “do what is right” (either “always” or “most of the time”) was at an extremely low point; fewer than one-fifth of Americans had that level of trust in Washington.²³ Against this backdrop, it is remarkable that President Clinton’s Health Security speech was received as well as it was; for a time Americans were open to the idea that the federal government might be able to ensure health security for everyone. Given this general skepticism, surely the president and his advisers should have realized that they had to follow the introductory September speech with a convincing vision of how new governmental regulations would actually work to deliver on the overall goals the president had articulated. But during the fall of 1993 the Clinton administration failed to produce such a vision, for some good reasons.

The first reason flows from something political scientists know well: Presidents do not control their own agendas.²⁴ Soon after President Clinton introduced his health reform plan, he got diverted into dealing with numer-

ous other domestic and foreign policy crises that clamored for his attention. Another reason was that the Health Security bill's proponents took it for granted from the start that key elements (such as mandatory alliances and premium caps) might have to be bargained away. During the summer 1993 budget battle, the president had been criticized by the media as a "waffler" when he backed away from specific provisions he had originally presented; obviously, he and his advisers did not want to face such criticism again, should it be necessary for Clinton to support an altered health reform bill. The Clinton administration drew up its detailed 1,342-page bill so that the CBO could estimate its costs, as required by law. Yet the president proclaimed himself flexible about the mechanisms of his plan, allowing room for congressional modifications. Inadvertently, therefore, the president ended up outlining mechanisms that critics could attack, while his administration failed to mobilize wholeheartedly on behalf of those mechanisms.

Looking at the situation more broadly, there was also the problem of the weakness of the institutionally given "means of political communication" open to a U.S. president and allied policy promoters in the 1990s, especially if they are Democrats. The Democratic party no longer has a national, locally rooted infrastructure of loyal local organizations and allied groups (such as labor unions) through which concerted grass-roots political campaigns can be run.²⁵ The conservatives right now have such an infrastructure, in the form of grass-roots Christian fundamentalist groups and Rush Limbaugh-style talk radio. But Democrats depend on pollsters, media consultants, and television to get messages out to the citizenry. Yet pollsters and political consultants tend to think in terms of appealing labels ("Health Security") and advertising slogans ("security that can never be taken away") rather than in terms of explanatory discussions.

Given the way the national media operate, the president cannot be sure of getting television coverage to speak directly and at length to the American people. Had the president asked for more airtime, perhaps the networks would have refused to cover additional explanatory speeches so soon after the September address. There is also the matter of how television and newspapers cover complicated and controversial issues such as national health care reform. As various observers have argued, the media tend to focus not on the substance and adequacy of proposals, but on the "horse races" among conflicting politicians and interest groups.²⁶ To the degree that President Clinton had to rely only on media coverage to get his plan across to the American people, he was certain to face an erosion of sympathy and a steady increase of public disillusionment.

No doubt realizing that they could not rely on routine media coverage alone, the president's allies tried to construct a grass-roots campaign on behalf of health care reform.²⁷ During the summer of 1993, just as the

Clinton plan was being formulated in the task force, an attempt was made to set up a nominally nonpartisan "National Health Care Campaign" designed to raise its own funds to target messages to twenty-one states identified as keys to the ultimate passage of legislation. Almost immediately this project came under legal attack as not really "nonpartisan," and the White House moved it under the auspices of the Democratic National Committee. This resulted in reduced funding and less capacity to mobilize coalitions that included groups that had to maintain nonpartisan identities. Much later, after the Clinton plan had been unveiled, Sen. Jay Rockefeller (D-WV) initiated the Health Care Reform Project, a promotional coalition headed by John Rother of the American Association of Retired Persons (AARP). This well-organized effort devoted itself to mobilizing support for universal health care in swing congressional districts. But it could not specifically promote or explain the president's bill as such, because member groups, including the AARP, had not endorsed the Clinton plan, only certain broad goals for reform.

Throughout 1993-1994, in fact, reform-minded politicians and groups in and around the Democratic party were unable to unite on even the most basic "how-to" features of health reform. Clinton's plan was not based on the major alternatives to which Democrats were loyal in 1991 and 1992, and the new president did not attract most Democrats to his specific approach. Democrats treated the president's bill as grist for protracted bargaining over this or that provision, and as fodder for infinitely complicated legislative maneuvering in five different House and Senate committees.²⁸ Continuing policy disagreements greatly undercut not only the explicability and credibility of Clinton's plan once it was officially announced, but also the possibilities for any compromise in Congress.

Finally, there were problems inherent in the Clinton plan itself. The plan was intricate and called for daring leaps of innovative organization building. At the same time, its supporters were ambivalent about explicitly discussing the governmental mechanisms that would be involved in implementing the new arrangements.

Many commentators have condemned the Clinton plan for its complexity, much of which was actually inherent in the existing private/public arrangements that the president wanted to modify, not revolutionize. In any event, sheer complexity was not the major difficulty. When Medicare was debated and enacted in the mid-1960s the legislation was complicated, but its sponsors had the advantage of being able to build on widespread public understanding of and affection for the well-established Social Security program of contributory retirement insurance.²⁹ The elderly, and many others in American society, appreciated the universal and non-means-tested nature of Social Security, and they had an operational image of how

earmarked payroll taxes worked to fund federally administered benefits for individual elderly persons. When he introduced his 1993 Health Security bill, President Clinton tried to invoke the Social Security precedent once again. This time, however, the analogy was purely rhetorical; it held only for the goal of universal, secure coverage. There was no relevant analogy to Social Security with regard to how governmental mechanisms in the proposed system would actually work.

The key mechanism was the mandatory purchasing cooperative, something the Clintonites labeled the “health care alliance.” One or more of these new governmental institutions would be established in each state, and they would have all sorts of revenue-channeling, data-collecting, information-dispersing, and legal powers in relation to employers, insurers, and citizens. Clinton plan supporters never found any consistent examples of existing organizations that health alliances could be said to resemble. Sometimes alliances were likened to health purchasing cooperatives (such as CalPERS in California), and sometimes they were said to resemble food co-ops or grain co-ops for farmers. Yet there was no clear, convincing, well-understood, and popular federal program precedent. Not surprisingly, in a poll taken in February 1994 only one in four Americans claimed to know what a “health alliance” was.³⁰

Promoters of the Clinton plan tried to avoid discussing the alliances as a new sort of governmental organization. Instead of telling Americans simply and clearly why this kind of governmental endeavor would be effective and desirable, their accommodation to the public’s distrust of government was to pretend that President Clinton was proposing a virtually government-free national health security plan. Alliances were portrayed as if they were giant voluntary groups.³¹ Promoters operated like advertisers, using images of voluntarism and words about choice to prevent, or calm, Americans’ fears about a government takeover of or bungling in the health care system. Arguably, however, vague and evasive explanations of the new system merely left Americans open to alternative descriptions purveyed by the plan’s fiercest opponents.

An Ideal Foil For Antigovernment Countermobilization

Opponents determined to defeat or change President Clinton’s proposal for national health care reform swung into action even as the plan was unveiled. Many groups with an occupational or financial stake in the present U.S. health care system had already presented their concerns to the task force. The minute the Clinton plan officially appeared, all of those groups could quickly decide how disappointed or angry they were with each relevant detail of the vast plan. Their leaders and staffs could gear up to

notify members across the country about threatening features of the plan, to run press conferences, and to lobby Congress for changes. Well-endowed and vitally threatened groups (such as the Health Insurance Association of America [HIAA], the association of smaller insurers that the Clinton plan might have put out of business) also could fund public relations campaigns designed to influence public opinion against the Clinton overhaul. In the end, according to a study by the Center for Public Integrity, health care reform would become “the most heavily lobbied legislative initiative in recent US. history.” During 1993 and 1994 “hundreds of special interests cumulatively . . . [spent] in excess of \$100 million to influence the outcome of this public policy issue.”³²

At first, neither public opinion nor political observers were much influenced by complaints of the many groups that had a stake in the existing health care system. These were understood to be opening gambits in bargaining over the details of legislation to be hammered out in Congress. President Clinton himself kept saying that he was not wedded to all of the details of his proposal. Most early critiques of the Clinton plan were accompanied by disclaimers that their sponsors joined the president in wanting comprehensive reform of some sort.

From very early on, however, there were hints of a much more hard-edged, total, and sincerely ideological opposition from the right wing of the Republican party. Soon after the president’s September speech, then House Republican Whip Newt Gingrich (R-GA) “promised an attack over costs and big-government inefficiency.”³³ The 13 October Wall Street Journal carried a mocking letter from Rep. Richard K. Armev (R-TX) on “Your Future Health Plan.” According to Armev, “the Clinton health plan would create 59 new federal programs or bureaucracies, expand 20 others, impose 79 new federal mandates and make major changes in the tax code. . . . [T]he Clinton plan is a bureaucratic nightmare that will ultimately result in higher taxes, reduced efficiency, restricted choice, longer lines, and a much, much bigger federal government.” Cleverly, Armev accompanied his letter with a “flow chart” and “Clinton plan glossary” allegedly illustrating the hierarchical and ramified administrative carapace that would tower over hapless “patients” should the Clinton plan be enacted. The Armev chart (or cousins to it) soon became a staple of attacks on the Clinton plan.

Toward the end of 1993 right-wing Republicans realized that their ideological fortunes within their own party, as well as the Republican partisan interest in weakening the Democrats as a prelude to winning control of Congress and the presidency, could be splendidly served by first demonizing and then totally defeating the Clinton plan. William Kristol of the Project for the Republican Future started to issue a steady stream of strategy memos urging all-out partisan warfare. Public support for the Clinton plan had

begun to erode since September, Kristol pointed out, and “an aggressive and uncompromising counterstrategy” by the Republicans could ultimately kill the plan, if it convinced middle-class Americans that there really was not a national health care crisis, after all. Noting that polls showed most Americans to be satisfied with their personal health care, Kristol argued that Republicans should “insistently convey the message that mandatory health alliances and government price controls will destroy the character, quality, and inventiveness of American medical care.”³⁴

During 1994 the hard-line conservative attack on the Clinton plan brought together more and more allies and channeled resources and support toward antigovernment conservatives within the Republican Party. Ideologues and think tanks launched lurid attacks on the plan. Small-business members of the National Federation of Independent Business (NFIB) and other associations mobilized against the proposed employer mandate.³⁵ Portrayals of the plan as a bureaucratic takeover by welfare-state liberals were regular grist for Rush Limbaugh and other right-wing hosts of hundreds of news/talk radio programs that reach tens of millions of listeners (indeed, more than half of voters surveyed at polling places in the November 1994 election said they tuned to such shows, and the most frequent listeners voted Republican by a three to one ratio).³⁶ Similarly, Christian Coalition groups, already attacking Bill and Hillary Clinton on cultural issues, began to devote substantial resources to the anti-health care reform crusade.³⁷ Moderate Republicans who had initially been inclined to work out some sort of compromise began to backpedal in the face of such antireform pressures from within their own party. And interest groups whose leaders had been prepared to bargain over reforms soon were pressured by constituents and Republican leaders to back off from cooperation with the Clinton administration and congressional Democrats.³⁸

Despite all of the resources—money, moral commitment, and grass-roots communications networks—that the conservative right could mobilize, the question remains of why such attacks proved to be as influential as they were. Middle-class Americans were (and remain) concerned about both the security of their access to affordable health care and the overall state of the nation’s health care financing system. Centrist Democrat Bill Clinton had done his best to define a market-oriented, minimally disruptive approach to national health care reform, and his plan was initially well received. Nevertheless, by midsummer 1994 and on through the November election, many middle-class citizens—Independents, moderate Democrats and Republicans, and former Perot supporters—had come to perceive the Clinton plan as a misconceived “big-government” effort that might threaten the quality of U.S. health care for people like themselves.

Of course, 1994 is hardly the first time when political conservatives and

business groups have used strong anti-statist rhetoric to attack Democrat-sponsored social programs. For example, back in 1934-1935 conservatives argued that the American way of life would come to an end if Social Security were enacted. Congress passed it anyway. But the overall governmental situation that Franklin D. Roosevelt and the Democrats faced in debating Social Security in the mid-1930s was instructively very different from the context in which President Clinton fashioned and fought for his Health Security program. It is not just that Democrats enjoyed much greater electoral and congressional majorities in 1935 (after all, many Democrats back then were southern conservatives who often opposed federal government initiatives). The more important differences between Social Security and Health Security have to do with the kinds of governmental activities they called for, and how their respective program designs related to preexisting stakeholders in the given policy area.

Some officials involved in planning the 1934 Social Security legislation wanted to include a provision for health insurance, but President Roosevelt and his advisers wisely decided to set that aside. Because physicians and the AMA were ideologically opposed to governmental social provision, and were organizationally present in every congressional district, Roosevelt feared that they might sink the entire Social Security bill if health insurance were included.³⁹ Instead, Social Security focused on unemployment and old-age insurance and public assistance.

Parts of Social Security called for new payroll taxes, yet these taxes were tiny and came at a time when most U.S. workers paid few taxes and were mainly worried not about taxes but about getting or holding onto jobs. Of course, business leaders hated the new taxes, but in the midst of the Great Depression business opposition carried little weight with public opinion or elected officials and could be overridden. Beyond promising new insurance protections to employed citizens, Social Security also offered federal subsidies to public assistance and health programs that already existed, or were being enacted, by most of the states. Roosevelt administration policymakers wanted to accompany the new subsidies with a modicum of national administrative supervision, but Congress stripped most such prerogatives out of the bill before it became law. In the end, the Social Security Act mostly promised to distribute money. Citizens (and state and local governments) were wooed with promised benefits and not threatened with the reorganization of services to which they already felt accustomed.⁴⁰

Think of the contrast between Social Security and President Clinton's Health Security proposal. Clinton's plan was formulated during the post-Reagan political and governmental era, when taxes are electorally anathema and public budgeting is extraordinarily tight. Thus, the proposed Health Security legislation was deliberately designed to offer little new

federal revenue to most people or groups.⁴¹ What is more, it was put forward in the midst of a U.S. health care system already crowded with many institutional stakeholders and in which most middle-class workers already had health insurance coverage of some sort. Although the Clinton plan offered new coverage to millions of uninsured persons and promised new levels of security to the already insured, it also entailed a lot of new regulations that would affect insurance companies, health care providers, employers, and states. These new regulations were designed intricately and fairly tightly to ensure that rising private and public health care costs would come down—the rationale for including both insurance premium caps and mandatory regional purchasing alliances.

Historically, Americans have been perfectly happy to benefit from federal government spending, and even to pay taxes to finance spending that is generous and benefits privileged groups and citizens, not **just** the poor.⁴² Such benefits are especially appealing if they flow in administratively streamlined ways. But Americans dislike federal government regulations not accompanied by generous monetary payoffs. Ironically, precisely because Bill Clinton, the New Democrat, was working so hard to save money, he inadvertently ended up designing a health care reform plan that appeared to promise lots of new regulations without widespread payoffs. Established participants in the current health care system became increasingly worried that the Clinton plan might squeeze or reorganize the way in which they were accustomed to delivering, financing, and/or receiving health care. The right-wing critique of meddlesome governmental bureaucracy resonated so widely because it focused such worries.

Finally, not only did the Clinton plan end up provoking worries about federal regulations without payoffs, it also took on the baggage of whatever fears people had about the spread of managed health care. The Clinton plan aimed to save public and private money in large part by using federal and state regulations of the insurance market to encourage the spread of high-quality managed care plans. Such plans were already well established in certain parts of the United States, especially in the West and parts of the Midwest, but were hardly present in the South and many parts of the East. At the time when Clinton's Health Security plan was being formulated and launched in 1992 and 1993, many Americans remained "unenthusiastic" about the notion of controlling costs through managed care and managed competition.⁴³ Managed care was especially new and likely to be seen as worrisome by well-insured upper-middle-class persons in the East, particularly in New York City, the heart of the nation's media empires and the hub of the constituency of Senate Finance Committee Chairman Daniel Patrick Moynihan (D). Journalists and other writers stoked the public's worries about managed care, falsely implying that low-cost and low-quality

versions of such care were what President Clinton had in mind for every one.”

From a broad historical perspective, Clinton’s Health Security plan had many strikes against it from the start. The very societal and governmental contexts that originally made it quite rational for a centrist Democratic president to choose a reform approach emphasizing firmly regulated competition within a budget simultaneously made that approach ideal for political countermobilization by antigovernment conservatives. The president and his allies could have done a better job than they did of explaining the regulatory mechanisms in their plan. But even if the Clinton administration had communicated more effectively, the plan might still have gone down to a defeat that backfired badly against the Democrats. The bedrock fact is that the Clinton plan promised too much cost-cutting regulation and not enough payoffs to organized groups and middle-class citizens pleasantly ensconced in the existing U.S. health care system.

What Happens Next?

Americans who voted in the 1994 elections continue to care deeply about governmentally sponsored health care reform. Health care is even more of a priority for voters now than it was in 1992, although voters now want step-by-step changes fashioned by Congress and state governments.⁴⁵ Hefty majorities continue to favor definite steps toward covering the uninsured, especially children and low-income persons. Most also oppose any cuts in government spending on Medicare, Medicaid, and Social Security.

There is scant reason to believe that these public expectations are going to determine what happens in 1995 or 1996 in Washington. Following their November 1994 triumph, Republicans are treating their “Contract with America” as a blueprint for governing. The contract says nothing about health care reform; it overwhelmingly emphasizes welfare cuts, destruction of federal regulations, and huge tax cuts disproportionately targeted on business and the top income quintiles. To achieve the order of tax and spending cuts they are promising, the Republicans will have to slash funding for (and perhaps abolish) Medicaid and Medicare. Conservative Republicans have in mind abolishing Medicare in favor of tax-subsidized vouchers or individual medical savings accounts, combined with efforts to encourage the elderly to enroll in for-profit managed care plans.⁴⁶ Fierce battles over Medicare may soon emerge, with Democrats defending the program as one that maximizes choice of doctors for the elderly, while certain Republicans trumpet the supposed appeals of “choice” among insurance companies and managed care plans.⁴⁷

If Republicans in the 104th Congress address health care beyond cutting

existing public programs, they are likely to do so only by enacting regulatory reforms: rules encouraging modest “portability” of coverage for workers changing jobs; rules discouraging insurance companies from permanently refusing coverage to persons with preexisting health problems; and rules discouraging medical malpractice litigation. President Clinton and some congressional Democrats may go along with such minimal national regulatory changes, to appear to be “doing something about health care reform” without committing any public resources. But such changes could make insurance coverage more expensive for businesses and insured middle-class Americans, and they certainly would not address the overall problems of rising health care costs, shrinking insurance coverage of the population, and cost shifting from employers to workers.

Health care reform remains potentially a good issue for Democrats, but they are not likely to achieve credibility on this problem or other problems until they come to terms with the overall political challenge they face. Defending Medicare may help the Democrats politically in the near term, but this alone will not address the broader issues of cost and coverage that inspired President Clinton’s 1993 effort in the first place. People in the Clinton administration and beyond who care about maximizing chances for eventual inclusive health care reform might do best to support state-level innovations for the immediate future. Many states are already experimenting with health care reforms that include possibilities for extending coverage to the currently uninsured. States could experiment more boldly if the current federal Employee Retirement Income Security Act (ERISA) regulations were changed to allow state governments to regulate all employers in their jurisdiction (making it possible to ask big employers who now self-insure to contribute to the costs of covering uninsured workers). After a few years of varying state-level reforms, big business would once again come to the federal government asking for some sort of uniform national health insurance system to even out procedures and coverage across the states. Health care reform would, once again, come to the top of the federal government’s agenda, and it might do so in a way more favorable to universal coverage and cost control than would be possible in 1995 and 1996.

Very possibly, however, Americans who favor governmentally mediated universal health insurance have just had-and lost-their last opportunity for achieving it. Six times over the course of the twentieth century (in the late 1910s during the 1930s) in the late 1940s) during the mid-1960s, during the 1970s, and in the early 1990s) reform-minded professionals pushed for government financing of health care for all, or large categories of, Americans. Again and again comprehensive plans for “rational” and “cost-efficient” reforms were drawn up, amidst great optimism that at last

“the time was ripe” for the United States to join the rest of the civilized democratic-industrial world in providing broad health care coverage for its citizens.⁴⁸ Only once did such efforts succeed, during the mid-1960s when Medicare and Medicaid were enacted at the height of the Great Society.

Not only did that single success come at a juncture when liberal Democrats, very briefly, enjoyed the kind of ideological elan and congressional leverage that conservative Republicans enjoy in 1995, but it was also a time when Americans overwhelmingly trusted the federal government to do good and effective things, when Americans even briefly thought that the federal government might wage a winning “war on poverty.” Perhaps even more important, this was a time when Social Security could serve as a positive model for how the federal government could extend nondemeaning health security to all of the elderly.

Health reformers searching for optimistic historical analogies often take heart in the example of President Harry S. Truman. After his campaign for universal health insurance was defeated in 1948-1950, Truman and his allies devised an “incremental” strategy that eventually led to the enactment of Medicare in 1965.⁴⁹ Reformers dream of doing this again, perhaps pushing toward universal health insurance by next focusing on extending coverage to all American children.⁵⁰ But today the policy legacies and governmental conditions are not as favorable as they were in the wake of Truman’s presidency. Now a fully mature program, Social Security has become since the 1980s an object of persistent criticism by fiscal conservatives who consider its universalism to be “too expensive” for the federal government to preserve in the future.⁵¹ Current struggles in Washington focus on how to cut taxes and federal spending, not on their gradual expansion, as was the case under moderate Republicans and Democrats during the 1950s and early 1960s. Democrats may look back wistfully to Harry Truman, cherishing his improbable electoral triumphs and the progressive legacies that grew even out of his policy failures. But Truman and the postwar era of U.S. governance are truly dead and gone.

Even an issue like health security—central as it is for many Americans—will not, in itself, bring about a political revival for Democrats or a resurgence of faith in government. As the failure of President Clinton’s courageous effort shows, the future of inclusive health reform depends on Americans’ coming to believe that government can offer minimally intrusive solutions to the heartfelt needs of individuals and families. If progressives are actually to achieve universal health care coverage in America, it will be because new rationales for the role of government, and new majority political alliances, have been achieved first. I believe that such new rationales and alliances can be forged, because most Americans still want government to function efficiently, compassionately, and fairly on behalf of every-

one. Yet the new rationales for government, as well as new majority political alliances, will necessarily have to be achieved on bases very different from the ones that prevailed in the aftermath of the New Deal.

NOTES

1. Quotes in this paragraph from the president's speech come from the prepared text, as reprinted in E. Eckholm, ed., *Solving America's Health-Care Crisis* (New York: Times Books, 1993) 301-314.
2. P. Starr, "What Happened to Health Care Reform?" *The American Prospect* (Winter 1995): 20; and A. Clymer, "The Clinton Plan Is Alive On Arrival," *The New York Times*, 3 October 1993, E3.
3. Polling and focus group data supporting this appear in S.B. Greenberg et al., *Third Force: Why Independents Turned Against Democrats—And How to Win Them Back* (Washington: Democratic Leadership Council, November 1994).
4. "National Election Night Survey," press release (Menlo Park, Calif.: The Henry J. Kaiser Family Foundation, 15 November 1994); and W. Schneider, "Why Health-Care Reform May Be Beyond Saving," *Los Angeles Times*, 14 August 1994, M1, M6.
5. R.J. Blendon and K. Donelan, "Public Opinion and Efforts to Reform the U.S. Health Care System: Confronting Issues of Cost-Containment and Access to Care," *Stanford Law and Policy Review* (Fall 1991): 146.
6. D. Russakoff, "How Wofford Rode Health Care to Washington," *The Washington Post National Weekly Edition*, 25 November-1 December 1991, 14-15; and R.J. Blendon et al., "The 1991 Pennsylvania Senate Race and National Health Insurance," *Journal of American Health Policy* (January-February 1992): 21-24.
7. Blendon and Donelan, "Public Opinion and Efforts to Reform the U.S. Health Care System," 147.
8. A list of "Proposals for Universal Health Coverage Introduced in the 102d Congress through August 2, 1991, and Selected Recent Bills" appears in R.J. Blendon, J. Edwards, and A.L. Hyams, "Making the Critical Choices," *Journal of the American Medical Association* (13 May 1992): 2514-25 16, Table 6. See also M.A. Peterson, "Report from Congress: Momentum toward Health Care Reform in the U.S. Senate," *Journal of Health Politics, Policy and Law* (Fall 1992): 553-573.
9. See, for example, Blendon et al., "Making the Critical Choices," 2512-2513, Table 5.
10. American Medical Association, *Health Access America: The AMA Proposal to Improve Access to Affordable, Quality Health Care* (Chicago: AMA, 1990); and J.S. Todd et al., "Health Access America-Strengthening the U.S. Health Care System," *Journal of the American Medical Association* 265, no. 19 (1991): 2503-2506.
11. Blendon et al., "Making the Critical Choices," 2509.
12. *Ibid.*, 2511, Table 4.
13. R.A. Knox, "Health Care Leaps to Top of Political Agenda," *The Boston Globe*, 29 December 1991, 1,16.
14. K. Grumbach et al., "Liberal Benefits, Conservative Spending: The Physicians for a National Health Program Proposal," *Journal of the American Medical Association* 265, no. 19 (1991): 2549-2554; and R. Kerrey, *Health USA Act of 1991* (Washington: U.S. Senate, 1991), explained in R. Kerrey, "Why America Will Adopt Comprehensive Health Care Reform," *The American Prospect* (Summer 1991): 81-90.
15. An engaging story about Bill Clinton's brief consideration and quick rejection of single payer in November 1991 appears in T. Hamburger, T. Marmor, and J. Meacham, "What the Death of Health Reform Teaches Us about the Press," *The Washington Monthly*

- (November 1994): 35.
16. R. Pollack and P. Torda, "The Pragmatic Road toward National Health Insurance," *The American Prospect* (Summer 1991): 92-100.
 17. Bill Clinton for President Committee, "Bill Clinton's American Health Care Plan: National Insurance Reform to Cut Costs and Cover Everybody" (Typescript, Little Rock, Arkansas, January 1992), 7. My copy of this, which I received from Clinton headquarters in April 1992, does not have a date. The January date is based on J.S. Hacker, "Setting the Health Reform Agenda: The Ascendance of Managed Competition" (Unpublished senior honors thesis, Harvard College, Committee on Degrees in Social Studies, November 1993), 111. My account of Clinton's embrace of managed competition during the presidential campaign draws insights from chapter 4 of this thesis, which is being revised for publication by Princeton University Press.
 18. Hacker, "Setting the Health Reform Agenda," 111-112.
 19. See A. Enthoven and R. Kronick, "A Consumer Choice Health Plan for the 1990s: Universal Health Insurance in a System Designed to Promote Quality and Economy," *The New England Journal of Medicine* (5 and 12 January 1989): 29-37; J. Garamendi, "California Health Care in the 21st Century: A Vision for Reform" (Department of Insurance, State of California, February 1992); and P. Starr and W. Zelman, "A Bridge to Compromise: Competition under a Budget," *Health Affairs* (Supplement 1993): 7-23.
 20. Cogent discussions of the practical and intellectual steps through which a "liberal synthesis" version of managed competition was worked out appear in Hacker, "Setting the Agenda," chapters 2 and 3; and in the Preface to P. Starr, *The Logic of Health Care Reform: Why and How the President's Plan Will Work*, revised and enlarged edition (New York: Whittle Books, in association with Penguin Books, 1994).
 21. Ordinary Americans care most about attaining secure protection and keeping their own insurance payments low, while experts and institutional leaders such as employers and politicians are obsessed with spending less overall and having each major organizational sector spend less on health care. On this, see R.J. Blendon, T.S. Hyams, and J.M. Benson, "Bridging the Gap between Expert and Public Views on Health Care Reform," *Journal of the American Medical Association* (19 May 1993): 2573-2578.
 22. This point is made by former Rep. Dan Rostenkowski (D-IL), "Rostenkowski Analyzes Health Reform Failure" (Speech prepared for delivery at the Harvard School of Public Health, 5 December 1994), 1. The reasons why task force leaders said little to the media, and the problems this caused, are cogently discussed in J. Fallows, "A Triumph of Misinformation," *Atlantic Monthly* (January 1995): 26-37.
 23. A timeline of the percentage of Americans, from 1958 to 1994, answering "always" or "most of the time" to the question, "How much of the time can you trust the government in Washington to do what is right?" has been put together by my colleague Robert Putnam from National Election Studies (1958-1990) and Gallup Polls (1992-1994).
 24. C.O. Jones, *The Presidency in a Separated System* (Washington: The Brookings Institution, 1994), Chapter 5.
 25. D.R. Mayhew, *Placing Parties in American Politics: Organization, Electoral Settings, and Government Activity in the Twentieth Century* (Princeton, N.J.: Princeton University Press, 1986), Chapter 11; and M. Ganz, "Voters in the Crosshairs: How Technology and the Market Are Destroying Politics," *The American Prospect* (Winter 1995): 100-109.
 26. Hamburger et al., "What the Death of Health Reform Teaches Us about the Press;" K.H. Jamieson and J. Cappella, "Newspaper and Television Coverage of the Health Care Reform Debate, January 16-July 25, 1994" (Report by the Annenberg Public Policy Center, Philadelphia, Pennsylvania, 12 August 1994); J.N. Cappella and K.H. Jamieson, "Public Cynicism and News Coverage in Campaigns and Policy Debates"

- (Paper presented at the Annual Meeting of the American Political Science Association, New York City, 4 September 1994); and Rostenkowski, "Rostenkowski Analyzes Health Reform Failure," 2.
27. The account in this paragraph is based on an interview with Heather Booth of the Democratic National Committee.
 28. A. Schick, "How a Bill Didn't Become a Law," in *How Congress Shapes Health Policy*, ed. T.E. Mann and N.J. Ornstein (Washington: The Brookings Institution, 1995).
 29. L.R. Jacobs, *The Health of Nations and the Making of American and British Health Policy* (Ithaca, N.Y.: Cornell University Press, 1993), Chapter 9.
 30. Blendon et al., "Making the Critical Choices," 1543.
 31. As, for example, in the explanatory pamphlet "Health Security: The President's Health Care Plan," which was distributed by the Clinton administration starting in the fall of 1993. Pages 8 and 9 of the pamphlet discuss "The System after Reform," describing health alliances as "groups of individuals, families, and local businesses who use their combined purchasing power to negotiate for high quality, affordable health care." The word choice appears like a mantra throughout the pamphlet. We are assured that "the President specifically rejected a government-run health care system and broad based taxes" and that the "U.S. Government will create a framework for reform and then get out of the way." We do not learn how the framework will be created.
 32. The Center for Public Integrity, *Well-Healed: Inside Lobbying for Health Care Reform* (Washington: The Center for Public Integrity, July 1994).
 33. Clymer, "The Clinton Plan Is Alive On Arrival," E3.
 34. W. Kristol, "Defeating President Clinton's Health Care Proposal" (Washington: Project for the Republican Future, 2 December 1993), 1-4. See also "Kristol Ball: William Kristol Looks at the Future of the GOP," *Policy Review* (Winter 1993): 15.
 35. C.J. Martin, "Mandating Social Change: The Struggle within Corporate America over National Health Reform" (Paper presented at the Annual Meeting of the American Political Science Association, New York City, 1-4 September 1994).
 36. T. Egan, "Triumph Leaves No Targets for Conservative Talk Shows," *The New York Times*, 1 January 1995, 1 and 22. For a sense of how Rush Limbaugh discussed the Clinton plan, see his *See, I Told You So* (New York: Pocket Star Books, 1993), especially 167-174, where ridicule of Hillary Rodham Clinton is a running theme.
 37. R. Toner, "Hillary Clinton Opens Campaign to Answer Critics of Health Plan," *The New York Times*, 16 February 1994, A11.
 38. Martin, "Mandating Social Change," and G.K. Wilson, "Interest Groups in the Health Care Debate" (Paper prepared for the conference, "Health Reform: Past and Future," The Brookings Institution, Washington, D.C., 23-24 January 1995).
 39. D.S. Hirshfield, *The Lost Reform: The Campaign for Compulsory Health Insurance in the United States from 1932 to 1943* (Cambridge, Mass.: Harvard University Press, 1970), Chapter 2.
 40. The one new national program enacted in 1935, contributory retirement insurance, came in an area in which state governments had not previously legislated. What is more, the few corporate pension plans that had developed during the 1920s mostly collapsed during the Depression. What we today call "social security" was thus fashioned on uncluttered terrain.
 41. It is true that the task force incorporated certain sweeteners for key interests into the Health Security bill. The elderly (and the AARP) were to get prescription drug benefits, and large corporations with generous health plans were to get government subsidization of early retirees. But these sweeteners were fairly minor in the overall scheme, and even their intended beneficiaries doubted that they would survive congressional deliberations. Fiscal constraints operated on Congress as well as on the president, making it difficult for any group to be given-or reliably promised-federal subsidies.

42. T. Skocpol, "Targeting within Universalism: Politically Viable Policies to Combat Poverty in the United States," in *The Urban Underclass*, ed. C. Jencks and P.E. Peterson (Washington: The Brookings Institution, 1981), 411-436.
43. Blendon et al., "Bridging the Gap," 2576.
44. The New Republic, for example, stoked fears about managed care in E. McCaughey, "No Exit" (7 February 1994): 21-25, and in a steady stream of editorials; and feature articles about the risks of managed care also appeared in the Atlantic Monthly and The New York Times Sunday Magazine. Also, during the 1994 health care reform debate, best-selling author and physician Robin Cook published *Fatal Cure* (New York: G.P. Putnam's Sons, 1994), a medical horror story about the arrival of managed care in a small Vermont town. The direct villains in the novel are hospital administrators and capitalists, but every few pages we are reminded that governmental regulations are pushing these villains to cut costs and murder patients. The back of the volume carries a quote from the Detroit News calling it "a hair-raising, cautionary tale about the possible pitfalls of impending health-care reform in America."
45. "National Election Night Survey."
46. R. Toner, "Gingrich Promises Medicare Tough Look, Bottom to Top," *The New York Times*, 31 January 1995, 1 and A14. Of course, this is highly ironic, given that conservatives attacked the Clinton Health Security plan for allegedly aiming to drive Americans into managed care plans.
47. Republicans may also try to provoke generational tensions over access to health insurance. Thus, Republican pollster Frank Luntz suggests that Republicans ask, "Is it 'fair' for Medicare recipients to have even greater choice of doctors and facilities than the average taxpayers who are funding the system?" This was included in a strategy memo aimed at teaching Republicans to use "moral" arguments to sell huge federal spending and program cuts, so that Republicans can avoid seeming "mean" and "uncaring." Excerpts from Luntz's memo are reprinted in "Attention! All Sales Reps for the Contract with America!" *The New York Times*, 5 February 1995, E7.
48. See P. Starr, *The Social Transformation of American Medicine* (New York: Basic Books, 1984); and T. Skocpol, "Is the Time Finally Ripe? Health Insurance Reforms in the 1990s," *Journal of Health Politics, Policy and Law* (Fall 1993): 531-550.
49. M.M. Poen, *Harry S. Truman versus the Medical Lobby: The Genesis of Medicare* (Columbia, MO.: University of Missouri Press, 1979).
50. See the call for such an approach by the Editorial Board of *The New York Times* in "Anybody Home?" *The New York Times*, 8 January 1995, E18.
51. P.G. Peterson, *Facing Up* (New York: Simon and Schuster, 1993). I discuss the attacks on "entitlements" in "Remaking US. Social Policies for the 21st Century," the conclusion to *Social Policy in the United States: Future Possibilities in Historical Perspective* (Princeton, N.J.: Princeton University Press, 1995).